

The Year

Annual Report and Accounts 2025/26

For the year ended 31 March 2026



HC 595

NHS England

Annual Report and Accounts 2025/26

For the period 1 April 2025 to 31 March 2026

Presented to Parliament pursuant to Section 13U of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012, the Health and Care Act 2022 and regulations made under the 2022 Act.).

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Foreword: A view from Dr Penny Dash, Chair

This annual report tells a story of meaningful progress – progress made possible by the dedication of hundreds of thousands of NHS staff working every day to deliver better care for the people who depend on them.

Across almost every measure, the NHS is moving in the right direction. There is genuine cause for celebration in what has been achieved in the last year and real confidence in what lies ahead.

This year also marked a landmark moment for the health service with the publication of the 10 Year Health Plan for England. It was a whole NHS effort shaped by the voices of patients, communities and staff across the country – and it provides us with a shared framework for what must be different over the next decade.

The service is coming together with real purpose to deliver the plan's ambition. The 3 shifts it sets out – from hospital to community, from analogue to digital, and from sickness to prevention – remain our guide.

Accelerating the delivery of neighbourhood health – bringing care closer to home and making it more convenient – must now be a priority. This requires fundamental changes to the delivery of care for people with long term conditions, to people who are frail, elderly or at the end of their life, to people accessing urgent and emergency care and to people who need a specialist opinion or intervention. The changes needed have been much discussed and described over the last 10 to 20 years – we now need to deliver.

The shift from analogue to digital is underway and will accelerate over the next 1 to 2 years, reshaping how care is delivered – through tools like the NHS App – and laying the foundations for a more productive, responsive, effective and safer health service.

Alongside, I am committed to transforming the NHS's approach to quality so that patients and their families consistently receive the care they deserve. This will continue to be a priority working alongside my National Quality Board colleagues.

I want to make sure we see progress in a number of other areas: too many people are still waiting too long for treatment; urgent and emergency care continues to operate under sustained pressure despite increases in staffing levels; there is too much variation in the quality and productivity of service delivery; we continue to have low utilisation of estate and equipment; and health inequalities that hold back too many communities persist.

I know that it has been another challenging year for colleagues, particularly those in integrated care boards (ICBs) and NHS England as we navigate significant change. I continue to be impressed by the hard work and commitment I see and hope we will be in a more stable position over the next year.

The progress captured in this report is a tribute to our brilliant and professional workforce. I am grateful to every member of staff who has contributed to it, and I remain committed to an NHS that serves patients and communities with the care and compassion they deserve – and in which our staff feel genuinely valued and supported.

Dr Penny Dash
Chair, NHS England

Performance report

Performance overview

Summary

The performance overview section provides a clear and accessible summary of performance during 2025/26. It sets the context for the detailed financial and governance disclosures that follow and helps users of the report understand:

- who we are and what we do, including our mission, values and role within the wider health and care system
- how we've performed, highlighting progress against strategic objectives and setting out major achievements and areas for improvement
- why it matters, reinforcing our commitment to transparency, accountability, and continuous improvement in delivering high-quality care for patients and communities

More detailed performance information, along with additional context, is contained within the performance analysis, from page 17.

Chief Executive's overview

The past year has marked a genuinely extraordinary moment for the NHS. Against a backdrop of record demand, significant financial challenge and industrial action, NHS staff have delivered something remarkable – a transformation in performance now being felt by patients across England.

In March 2026, 65.3% of patients were seen within 18 weeks, as the waiting list fell by more than 312,000 – the largest year-on-year reduction in 16 years. The number of people waiting more than a year has dropped by almost half, and the overall waiting list is at its lowest in 3 and a half years. Staff delivered more elective care than at any point in the history of the service to make this happen, despite managing multiple rounds of Industrial Action by resident doctors.

That achievement sits alongside significant progress elsewhere. There were more than 1.5 million appointments in general practice every working day – the highest number on record. We have seen further improvement in patients' experience: more than three-quarters of patients (76.7%) rated their overall experience of their GP practice as good last year – up from 75.4% the previous year.

3 quarters of A&E patients were seen within 4 hours – our best performance since 2021/22. Ambulance response times for Category 2 callouts were more than 5 minutes faster than the year before. NHS Talking Therapies met both access standards.

And all of this was delivered while keeping in line with the NHS budget and achieving productivity growth of 2.8% – nearly 5 times the historical average and exceeding the government's 2% target.

Crucially, patients have noticed. Dissatisfaction with the NHS has fallen by its biggest margin in nearly 3 decades.¹

¹ <https://www.kingsfund.org.uk/insight-and-analysis/reports/public-satisfaction-nhs-social-care-2025-bsa>

None of this happened by accident. It reflects a reset in how we work – trusting local leaders, focusing on outcomes rather than processes, and a willingness to navigate together an extraordinary range of simultaneous pressures: a £4.5 billion deficit, a new operating model, a major reorganisation, a record winter and industrial action.

Building on this year's progress, we must now go further and faster: resetting outpatient care, expanding neighbourhood services, growing the NHS App as the digital front door, and investing in our people through the new NHS College of Leadership and Management.

Finally, I want to acknowledge the commitment of our colleagues across every part of the service, particularly while many have had to deal with change and the huge uncertainty that brings.

The progress the NHS has made is visible and palpable for patients. I hope everyone can take genuine pride in that and draw confidence from it as we continue building a health service we can all be proud of for generations to come.

Sir James Mackey

Chief Executive

About NHS England

NHS England leads the National Health Service in England, sharing with the Secretary of State for Health and Social Care the legal duty to promote a comprehensive health service, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022).

NHS England has a wide range of statutory functions, responsibilities and regulatory powers. Our purpose is to create the conditions for an ambitious and high quality NHS. We empower our people and partners to solve problems, provide outstanding care for every patient and improve the nation's health.

The 10 Year Health Plan sets the vision and objectives up to 2035. It describes 3 shifts that will take place over the next decade, with care moving from hospital to community, analogue to digital and sickness to prevention. To help the NHS plan and implement the 10 Year Health Plan, the Medium Term Planning Framework sets out priorities for the NHS for 2026/27 to 2028/29.

Our structure

NHS England is governed by a unitary Board which is accountable to the Government, Parliament and the public. Our Chief Executive Officer, Sir James Mackey, is accountable to Parliament and the Secretary of State for Health and Social Care for the effective running of NHS England and the performance of the NHS across England.

We operate through 7 regional teams which work directly with NHS providers and ICBs across the country. Most services are commissioned by ICBs, which work across 36 integrated care

systems (ICs) comprising NHS organisations, primary care professionals, local councils, social care providers and community partners.

Organisational change

NHS England and Department of Health and Social Care integration

In March 2025, the Prime Minister announced significant structural changes affecting NHS England and the Department of Health and Social Care. The government confirmed that NHS England would be abolished with its functions being integrated into the Department.

The objectives for this integration include: reducing administrative processes; eliminating operational duplication; and reallocating resources to support frontline clinical staff, including nurses, doctors, and other healthcare professionals. The changes represent a significant shift in the governance and operational structure of health services' administration in England.

During 2025/26, the government took steps to implement these changes ahead of legislation. In November 2025, a single joint executive team was established across the Department of Health and Social Care and NHS England. The team comprises the Department of Health and Social Care Permanent Secretary and NHS England's Chief Executive alongside senior leaders from both organisations. National Priority Programmes were also announced to drive delivery of the government's key health priorities.

The Health Bill, introduced following the King's Speech in May 2026, will provide the legislative basis for the abolition of NHS England and the transfer of its functions either to the Secretary of State (exercised through the restructured DHSC) or the wider system. NHS England is working closely with DHSC to prepare for this transition, with legal transfer planned for April 2027 subject to parliamentary approval.

Integrated care boards

ICBs have been introducing new organisational arrangements as they redesign their structures and footprints to implement the Model ICB Blueprint, supporting their focus on strategic commissioning and reducing running costs.

6 new ICBs were established and the boundary of an existing ICB was widened on 1 April 2026 through the abolition of 12 existing ICBs. The changes consolidate the reductions in running costs realised through clustering of these ICBs in 2025 and allow further efficiencies to be achieved.

Clusters enable ICBs to work together through shared leadership and combined teams. However, clustered ICBs remain separate legal entities with unchanged boundaries, separate financial allocations and legal duties.

How we measure performance

The NHS Constitution sets out the rights of patients, the public and staff. We measure and monitor NHS provider and system / ICB performance against a wide range of constitutional performance standards and publish statistics relating to these core constitutional standards on NHS England's website every month.²

This annual report covers the metrics and explains performance against the NHS's strategic priorities to improve patient outcomes in 2025/26:

- reduce the time people wait for elective care
- improve A&E waiting times and ambulance response times
- improve patients' access to general practice
- improve access to urgent dental care
- improve patient flow through mental health crisis and acute pathways
- improve access to children and young people's mental health services

In delivering on these priorities for patients and service users, we asked ICBs and providers to work together to:

- drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future
- live within the budget allocated, reducing waste and improving productivity
- maintain our collective focus on the overall quality and safety of our services

Support programmes

In 2025/26, the recovery support programme (RSP) for the most challenged organisations was replaced by the National Provider Improvement Programme (NPIP)³, a new mandated intensive improvement programme which was supporting 9 trusts (as supported by NPIP) as of the end of March 2026. 4 ICBs also received intensive support via the RSP during the year, all of which exited by Spring 2026. In 2024/25, 4 ICBs were receiving intensive support via the RSP and 5 trusts entered the RSP, while 3 exited it and one was dissolved as part of an organisational acquisition.

Directions and undertakings

NHS England has statutory accountability for oversight of both ICBs and providers of NHS services.⁴ NHS England issued 1 undertaking to an ICB and 15 undertakings to providers⁵ during 2025/26. 5 trusts agreed new undertakings (2024/25: 7) and 5 agreed revised undertakings (2024/25: 9), with compliance certificates issued to 10 organisations.

By March 2026, 44 trusts had active undertakings (2024/25: 43) and, of the 7 ICBs with active undertakings at 31 March 2025, 2 received compliance certificates during 2025/26 and 5 remained subject to undertakings. 1 new set of undertakings was agreed during the year, resulting in 6 ICBs with active undertakings at 31 March 2026 (2024/25: 7).

In addition, NHS England imposed 2 additional licence conditions under section 111 of the

² <https://www.england.nhs.uk/statistics/statistical-work-areas/>

³ <https://www.england.nhs.uk/system-and-organisational-oversight/national-provider-improvement-programme/>

⁴ <https://www.england.nhs.uk/long-read/nhs-enforcement-guidance/>

⁵ <https://www.england.nhs.uk/publication/nhs-provider-directory/>

Health and Social Care Act 2012.

No discretionary requirements or other enforcement actions were taken during the year.

All undertakings and compliance certificates are published on NHS England's website.⁶

See ministerial directions on page 81 and further detail within the Privacy, transparency and trust section on page 74.

ICB and NHS provider annual reports

2025/26 ICB annual reports and accounts were published on their individual websites.⁷

All NHS trusts and NHS foundation trusts (FT) in England publish an annual report and accounts on their websites. The results of all NHS trusts and FTs are published by NHS England in Consolidated Provider Accounts.⁸ These are presented separately from those of NHS England, as NHS England is not the parent body of providers.

Overview of 2025/26 operational performance

Reduce the time people wait for elective care

The NHS has remained focused on reducing waits for planned treatment. By the end of March 2026, 65.3% of patients received treatment within 18 weeks, achieving the ambition of 65%. The number of patients waiting over 52 weeks fell to 1.3% but remained above the target of "under 1%". 72.8% (target 75%) of patients met the 62 day standard for cancer pathways, and 79.4% (target 80%) received a diagnosis within 28 days. Improvements were supported by diagnostic recovery plans, local improvement activity, and capital investment in additional capacity.

Improve A&E waiting times and ambulance response times

Urgent and emergency care (UEC) remained under sustained pressure, but performance improved compared with 2024/25. By March 2026, A&E 4-hour performance reached 77.1%, moving towards the 78% ambition. Category 2 ambulance response times averaged 30 minutes and 4 seconds, progressing towards the 30-minute target. Investment in new ambulances, expanded Same Day Emergency Care (SDEC) units, strengthened discharge processes, and national efforts to reduce corridor care supported this progress, though standards were not yet fully met.

Improve patients access to general practice and urgent dental care

Access to general practice (GP) continued to shift towards digitally enabled first-contact care. Patient experience scores increased by 1.6 percentage points to 74.5%, supported by 100% of practices offering digital messaging and 81% providing online consultations. These changes reduced administrative burden and increased flexibility for patients. Community suppliers went fully live for GP record access, improving information flow between services. Delivery models for dentistry continued to evolve, with strides being made to meet the government manifesto commitment to increase access by 700,000 extra dental appointments to support urgent dental care and improve routine availability.

⁶ <https://www.england.nhs.uk/publication/nhs-integrated-care-board-directory/>

⁷ <https://www.england.nhs.uk/integratedcare/integrated-care-in-your-area/more-about-each-integrated-care-system/>

⁸ <https://www.england.nhs.uk/?s=Consolidated+Provider+Accounts>

Improve patient flow through mental health crisis and acute pathways and improve access to children and young people mental health services

Adult mental health pathways saw measurable improvement. The average length of stay in adult acute beds reduced to 55.3 days in March 2026 (March 2025: 58.2 days), and inappropriate out-of-area placements continued to fall. Crisis response performance strengthened; 77.5% of very urgent referrals received face-to-face follow-up within 4 hours (March 2025: 66.8%). In March 2026, access for children and young people expanded further, with 879,955 children and young people receiving NHS-funded support, an increase of 4.7% from the previous year. Investment in community crisis alternatives, enhanced guidance, and stronger multidisciplinary working supported improved flow across crisis and acute pathways.

Address inequalities and strengthen prevention

Reducing inequalities remained central to NHS oversight through the Core20PLUS5 framework.⁹ Clearer metrics improved performance conversations and consequently the prioritisation and targeting of actions.

Preventative care showed progress, with 69.5% of hypertension patients and 50.6% of those with high cholesterol treated to target as of December 2025. Childhood vaccination performance continued to improve following rollout of the measles, mumps, rubella and varicella (MMRV) vaccine and an earlier second measles dose, strengthening protection and reducing outbreak risks. These improvements contributed to reducing unwarranted variation and preventing avoidable illness.

Make the shift from analogue to digital

Digital transformation accelerated and increasingly underpinned recovery, productivity and access. By March 2026, 94% of trusts had implemented Electronic Patient Records (EPR), reducing paper-based risks and improving safety. The NHS App reached 25.7 million users, becoming central to booking, prescriptions and health record access.

Based on observational before/after comparisons, the NHS Federated Data Platform (FDP) enabled improved theatre utilisation, discharge coordination and real-time operational oversight. Digital messaging and online consultations in primary care reduced the number of missed appointments, improved triage and increased appointment flexibility. Strengthened cyber-security capabilities improved national resilience against increasing digital threats.

Live within our means: reducing waste and maximising productivity

For the period April 2025 to March 2026 acute provider productivity improvement reached an estimated 2.8%, and when including non-acute providers was 3.4%, against the Government target of 2%. Workforce numbers increased across services, as agency spending fell due to stronger compliance with national price caps.

⁹ <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>

Staff engagement declined slightly, and sickness absence, particularly among nursing and ambulance support staff, remained a concern. New workforce standards, retention activity and long-term planning supported the foundations for improved productivity and operational stability.

Maintain our collective focus on the overall quality and safety of our services

Quality and safety remained central to NHS delivery. The Patient Safety Strategy¹⁰ continued to reduce harm, with Martha's Rule¹¹ empowering patients and families to escalate concerns. The Medical Examiner system significantly improved the accuracy of death certification and the Maternity Outcomes Signal System (MOSS) provided near real-time detection of maternity safety concerns, enabling rapid review processes. Continued training strengthened safety capability and maturing digital tools supported ongoing improvements in safety and care quality.

¹⁰ <https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/>

¹¹ <https://www.england.nhs.uk/patient-safety/marthas-rule/>

Performance analysis

In this section, we provide detail on the work we have delivered during the year. These key areas of performance relate closely to the objectives set out in our Operational Planning Guidance (OPG) and 10 Year Health Plan, and reflect progress made against the aims in the Government's mandate to the NHS.

For more detail on how we delivered against the mandate, see page 172.

Key performance indicators

Priority	Success measure	Ambition to March 2026	2025/26 performance
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	65%	65.3%
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	72%	69.6%
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	<1%	1.3%
	Improve performance against the headline 62-day cancer standard to 75% by March 2026	75%	72.8%
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	80%	79.4 %
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from Emergency Department (ED) within 4 hours by March 2026	78%	77.1%
	Proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	<=10%	10.0%
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	30 minutes	30 minutes 4 seconds
Improve patients access to GP and urgent dental care	Improve patient experience of access to GP as measured by the Office for National Statistics (ONS) Health Insights Survey	72.9%	74.5%
	The target, in line with the national ambition, to provide 700,000 more dental appointments.	700,000	1.8 million ¹²

¹² April to October 2025 data showed 1.8 million additional appointments were offered. For more detail see page 22.

Priority	Success measure	Ambition to March 2026	2025/26 performance
	Achieve 100% coverage of digital GP messaging capability	100%	100%
	Achieve 98% coverage for online consultation capability in GPs	98%	81%
Improve patient flow through mental health crisis and acute pathways and improve access to children and young people mental health services	Reduce average length of stay in adult acute mental health beds	Monitor and/or limit percentage of inpatients with over 60-day length of stay	24.2% (0.8% points lower than 2024/25)
	Increase the number of children and young people accessing services to achieve the national ambition for 345,000 additional children and young people aged 0 to 25 compared to 2019	840,254	879,955
	Reduce reliance on mental health inpatient care for adults with a learning disability and autistic people, delivering a minimum 20% reduction on March 2024	1,396 people in inpatient care	1,880
	Deliver a balanced net system financial position for 2025/26	Deliver a balanced net system financial position	£70 million RDEL underspend (0.035%)
Live within our means; reducing waste and maximising productivity	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	Reduce agency spend by 30% from March 2025	46.8%
	Close the activity / Whole Time Equivalent (WTE) gap against pre-Covid levels (adjusted for case mix)	Reduce total activity/WTE gap to March 2020	2.8%
	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	Severe mental illness (60% minimum coverage)	65.2%
Maintain our collective focus on the overall quality and safety of our services		Monitor early cancer diagnosis rates	59.3%
	Increase the % of patients with hypertension treated according to National Institute for Health and Care Excellence (NICE) guidance, and the % of patients with GP recorded cardiovascular disease (CVD), who have their cholesterol levels managed to NICE guidance	Hypertension 80%	69.5% ¹³
		Monitor cholesterol levels rates (baseline March 2025 48.25%)	50.6% ¹³
	Improve safety in maternity and neonatal services, delivering the key actions of the 'Three year delivery plan'	2025/26 data is not available until 2028/29. See page 33 for further detail.	

¹³ Latest available data as at 22 July 2026.

Reduce the time people wait for elective care

The 2025/26 NHS OPG¹⁴ and Elective Reform Plan¹⁵ set out a clear priority to reduce elective care waiting times. This included improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement. In what has been a disruptive year with industrial action and high demand growth, the NHS is seeing patients faster. Consequently, referral to treatment time performance improved throughout 2025/26. The 65% ambition was met in March 2026, with performance reaching 65.3% and maintained into early 2026/27. 81 acute providers met their 5% improvement ambition.

There has been a continued drive to reduce long waits, with patients waiting over 52 weeks consistently decreasing throughout 2025/26 to 1.3% in March 2026 against the 1% target – achieving a reduction of around 95,000 patients over the year.

We provided additional funding to NHS hospitals to increase elective appointments and treatments, as well as offering more choice to patients on how and where to receive care. As a result, the proportion of patients waiting no longer than 18 weeks for a first appointment was 69.6% by the end of March 2026 but remained below the national target of 72%.

We supported the NHS to prioritise cancer waiting times performance. The proportion of patients receiving a first treatment within 2 months (62-day performance) of referral or consultant upgrade reached 72.8% by March 2026 but was below the 75% target. The proportion of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of an urgent referral (Faster Diagnostic Standard Performance) to at least 80% by March 2026 fell short by 0.6 percentage point and was 79.4%.

The ability to carry out diagnostic tests continued to be vital for supporting elective recovery and early cancer diagnosis. The NHS delivered a record 30 million diagnostic tests in 2025/26 and the average wait time was 2.9 weeks. This included 8.7 million tests delivered in Community Diagnostic Centres, which is 2 million more than in 2024/25. We continued to take a strong approach to performance management with targeted intervention and support being provided to the most challenged providers.

¹⁴ <https://www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/>

¹⁵ <https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/>

Improve A&E waiting times and ambulance response times

The 2025/26 NHS OPG and UEC Delivery Plan¹⁶ for 2025/26 set clear priorities to improve ambulance response times, reduce handover delays, improve A&E waiting times and tackle long waits and discharge delays. This was supported by almost £450 million of capital investment and targeted improvement support for challenged trusts focusing on front-door processes.

Driven by high demand, UEC services faced sustained pressure throughout 2025/26 with A&E attendances 2.2% higher than 2024/25, an early and prolonged respiratory illnesses season, and ongoing capacity constraints across health and care services. Despite this, ambulance response times and A&E performance improved from 2024/25, although national standards and the target to March 2026 were not met.

Ambulance performance, Category 2 response times and Hear-and-Treat

We conducted a national review and identified the need to tighten definitions and standardise measurement to reduce unwarranted variation. We also supported ambulance capacity through a mix of national and local funding and delivered over 1,000 double-crewed ambulances. We saw ambulance response times improve, particularly for patients with time critical conditions such as stroke, heart attack, sepsis and major trauma (Category 2). The average Category 2 response time was more than 5 minutes faster (30 minutes and 4 seconds) than the previous year (2024/25: 35 minutes and 22 seconds), but 4 seconds slower than the ambition of 30 minutes. Ambulance handover delays reduced with the average handover taking 29 minutes and 55 seconds (2024/25: 34 minutes and 57 seconds). This was against the expectation of working towards delivering all hospital handovers within 15 minutes, and ensuring no handover takes longer than 45 minutes. We expanded the 'Hear-and-Treat' and 'See-and-Treat' models and helped ensure only those patients who urgently needed it were taken to hospital. 17.9% of incidents were closed over the phone, a higher proportion than the previous year (2024/25: 15.8%).

A&E 4-hour performance and long waits

4-hour performance was 77.1% by March 2026 which was below the 78% ambition for March 2026, a 2.1% improvement against March 2025 (75%) and remained below the NHS constitutional standard of 95%. 12-hour waits were 10% as an average across 2025/26 (2024/25: 10.5%), against the expectation that no more than 10% of patients should wait over 12 hours.

Performance remained challenged throughout the year, particularly during the winter peak, reflecting sustained demand, high bed occupancy and discharge delays that constrained flow. We led targeted action to improve length of stay and non-admitted performance during winter to strengthen operational grip and standardise front door urgent care processes. We published the Model Emergency Department¹⁷ in February 2026, setting out expectations for safer, more

¹⁶ <https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/>

¹⁷ <https://www.england.nhs.uk/publication/the-model-emergency-department-high-performing-urgent-and-emergency-care-pathways/>

consistent front door processes, improved redirection of patients to the right care pathway (streaming), and better management of demand and flow.

Through capital investment we supported the expansion of approximately 40 SDEC and Urgent Treatment Centres, helping to improve streaming and enable more patients to be assessed, treated and discharged without admission. These improvements were underpinned by approved capital business cases progressed during 2025/26, with the full benefits of some schemes expected to be realised over subsequent years.

Reducing corridor care remained a critical priority; this refers to patients receiving care in areas not designed or equipped for clinical treatment (for example, corridors), which is not acceptable as routine practice. National action focused on developing a clear definition of corridor care for which was published in March 2026.¹⁸

Neighbourhood health, urgent care at home and discharge

Improvements in urgent care at home contributed to stronger neighbourhood health services and supported system resilience throughout 2025/26. Urgent Community Response aims to provide urgent care to individuals at home within 2 hours: the response rate was 85.4% at the end of March 2026 (March 2025: 84.6%); virtual ward capacity was 12,643 beds with 83.5% occupancy (2024/25: 12,825 and 76.2%). Alongside intermediate care, these services supported timely alternatives to admission and improved flow. The rollout of urgent care clinical action cards helped strengthen senior clinical decision making and reduce avoidable conveyance and admission to hospital.

Reducing length of stay and delayed discharge remained critical to overall UEC performance, through the Better Care Fund and joint working alongside action to strengthen intermediate care pathways and coordination. While progress was made, constraints in social care capacity and increasing complexity of need continued to limit the pace of improvement, particularly during peak winter pressure.

Improve patients' access to general practice and improve access to urgent dental care

In primary care we saw good progress in improving access to GP appointments, with 69.6% of people (2024/25: 67.3%) reporting good overall experience of contacting their practice in the 2025 GP Patient Survey. In the March 2026 Health Insight Survey 74.5% of people (March 2025: 72.9%) described contact with their practice as easy. In March 2026, 1.55 million GP appointments per working day were delivered (up 4.0% on March 2025).

In March 2026, there were 30,070 fully qualified GP WTE (March 2025 (28,693, a 4.8% increase). The Additional Roles Reimbursement Scheme supported recruitment, with 3,580 recently qualified GPs claiming through the scheme between October 2024 and March 2026.

A key change in the 2025/26 GP contract required practices to keep online consultation tools open throughout core hours, making it easier for patients to request appointments. As at March

¹⁸ <https://www.england.nhs.uk/publication/corridor-care-definition/>

2026, 98.0% of practices reported compliance. An emergency contraception service was successfully launched in October 2025.

As part of 2025/26 operational planning, all ICBs developed action plans for GPs setting out how they will support transformation and performance improvement. This is complemented by the national GP Improvement Programme, which supported over 600 practices in 2025/26.

In April 2025 NHS England launched the Utilisation and Modernisation Fund for capital investment in the GP estate during 2025/26. The purpose of the fund is to improve the quality of the current estate to increase capacity and deliver more appointments. Investment remains on track across 792 projects with a projected spend of £102 million.

During 2025/26, in line with the government manifesto commitment, NHS England worked with systems to deliver 700,000 additional urgent dental appointments. The scope was expanded in February 2026 to include a wider range of appointment types¹⁹, following advice from the Chief Dental Officer.

This wider scope ensured patients with other serious dental conditions that had been excluded from the initial definition could access the care they needed. Data shows 1.8 million extra dental appointments were delivered in the first 7 months of 2025/26, with publication of full year data expected in August 2026.

To shift care closer to home we focused on digitally enabling community pharmacy to deliver clinical services that reduce GP and UEC demand. At the end of February 2026, community pharmacies had delivered 3.05 million Pharmacy First clinical pathway consultations.

Improve patient flow through mental health crisis and acute pathways and access to children and young people mental health services

To help meet national mental health goals for 2025/26, we implemented strategies to improve pathways for people in crisis and acute care, and expanded access to mental health services for children and young people.

Inpatient care improvements

Discharge process improvements reduced the average length of stay in adult acute beds to 55 days in March 2026 (March 2025: 58 days). The proportion of discharges after more than 60 days decreased to 24.2% in March 2026 (March 2025: 25%). These improvements were supported by the implementation of the inpatient mental health improvement guidance, wider dissemination of discharge and housing best practice, and new local authority guidance. Collaboration between regional mental health leads and the intensive support team strengthened recovery out of hospitals and helped deliver smoother transitions out of inpatient care.

Inappropriate out-of-area placements decreased from a peak of 495 in June 2024 to 276 in March 2026. To support further reductions, we allocated £75 million capital across 2025/26 and 2026/27 for ICB-led schemes, most becoming operational from April 2026. ICBs also received

¹⁹ <https://www.gov.uk/government/news/patients-to-benefit-from-improved-access-to-dental-appointments>

an additional £42 million in ongoing funding for mental health inpatient commissioning, supported by national guidance for local planning.

Crisis response enhancements

In March 2026, 23.2% of mental health attendances at A&E breached the 12-hour standard. To address this, dedicated mental health emergency departments (MHEDs) are being rolled out to provide specialised assessment and treatment areas co-located within A&E. Early implementers have diverted attendances from A&E, enabling faster assessment before crisis teams intervene. Capital investment and national implementation support aims to establish up to 85 MHEDs by 2029/30, increasing capacity and reducing waits.

We required local health systems to enhance crisis response through the rollout of crisis text services by spring 2026 and further integration of 24/7 neighbourhood mental health centres, offering walk-in and rapid-response support. Crisis response pathways improved during the reporting period. In March 2026, 77.5% of “very urgent” community-based referrals received face-to-face follow-up within 4 hours, and 69.2% of “urgent” referrals were seen within 24 hours in March 2026.

The NHS maintained its commitment to annual physical health checks for people with severe mental illness, with at least 60% minimum coverage targeted. By the end of March 2026, 65.2% (316,183 of 484,784) received all 6 elements of the check (March 2025: 66.5%). Updated Lester tool guidance²⁰ now supports post check interventions.

Children and young people’s services

Expanding access for children and young people remained a priority. In the 12 months to March 2026, 879,955 children and young people aged 0 to 17 received a first contact from an NHS funded mental health service, a 4.7% increase since March 2025 and 69% higher than December 2019. Variation continues across regions and work with regional leadership is ongoing to analyse causes and provide targeted support.

By spring 2025, mental health support teams covered 52% of pupils and learners (around 5 million individuals) and 41% of schools/colleges (around 10,100 institutions). Coverage is projected to rise to 60% of pupils/learners and 48% of schools/colleges by May 2026. The Medium-Term Planning Framework targets 100% coverage by 2029, supported by ring-fenced funding for early intervention.

Productivity improvement in mental health services

In 2025/26, all mental health providers submitted improvement plans supported by NHS England’s productivity analysis packs. The packs helped identify areas for action and informed planning for 2026/27. Trust-level productivity trends will support transparent performance measurement and ongoing operational improvement.

²⁰ <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2024/07/20231002-PH-SMI-Scenario-FINAL-WITH-NEW-LESTER-TOOL-LINK-and-year-updated.pdf>

Learning disability services

At the end of March 2026, there were 1,880 adults with a learning disability and adults with autism in mental health inpatient settings, 35% higher than the end-of-year target of 1,396 and representing an increase of 8% (135 people) from the March 2024 baseline. The number of adults with a learning disability in inpatient settings decreased by 11% (110 people), while the number of adults with autism – including people diagnosed during their admission - increased by 36% (260 people). 225 children and young people were in inpatient care in March 2026, (greater than the operational plan of 183), though numbers remain small and subject to fluctuation.

In 2025/26, we made £124 million available in system baselines to strengthen community infrastructure for people with a learning disability and people with autism. Within the £473 million capital allocation linked to the return-to-constitutional-standards programme, up to £38 million supports accommodation-based alternatives to hospital, with a further £13 million in housing capital enabling discharges. Updated national mental health guidance now better reflects the needs of autistic people and those with a learning disability, including new eating disorder guidance.

Address inequalities and strengthen prevention

Addressing and reducing health inequalities remains a key priority for patient outcomes as we make the shift towards prevention.

We strengthened national accountability for reducing health inequalities by embedding clearer and more transparent metrics into the NHS Oversight Framework, aligned with the Core20PLUS5 approach. To support this, the Statement on Information on Health Inequalities²¹ was refreshed. This sets out clearer expectations for NHS trusts, FTs and ICBs on how they should collect, analyse and publish data and evidence to understand inequalities across their populations and care pathways.

We also built a more systematic NHS-wide performance and delivery approach. This included a consolidated set of health inequalities indicators, disaggregated analysis of key performance trends, enhanced regional performance conversations, and clearer expectations for ICBs and trusts. Together, these changes helped ensure that the health inequalities drivers of performance and delivery pressures are consistently visible and acted upon.

The first phase of the national evaluation of Core20PLUS5 was completed. The evaluation identified where the model has driven measurable improvements and where variation persists. This provides a robust evidence base to inform future policy and commissioning decisions, refine performance expectations, and strengthen the NHS contribution to reducing the gap in healthy life expectancy.

²¹ <https://www.england.nhs.uk/long-read/nhs-englands-statement-on-information-on-health-inequalities/>

Prevention and proactive care

We prioritised prevention and proactive care within the GP contract, with increased focus on reducing cardiovascular events by supporting GPs to treat more people to target blood pressure and lipid levels.

Hypertension treatment levels were 69.5% in December 2025 after a reported peak of 70.3% in March 2025. The number of people treated for hypertension increased by 6.76% in September 2025, 6.4 million people reflecting the increasing demand on this service. Treatment to target level for high cholesterol recorded in GP increased 50.6% in December 2025.

We worked with Heart UK to produce a new patient-facing resource on cholesterol management and published it during Heart Month.²² We made sure quality and outcomes framework indicators and payment thresholds aligned with national ambitions for blood pressure and lipid management by looking at the primary care incentives and developed quality improvement data packs for ICBs to support improvement.

Vaccination and immunisation programme

Vaccination is still one of the most powerful tools in public health around the world. As it stands, MMR vaccination coverage remains below the recommended World Health Organisation benchmark of 95%. As of December 2025, dosage uptake up to 5 years old was 83.9%. Analysis of 2023 to 2025 uptake trends show under-performance was driven by reduced confidence, access barriers, socio-demographic and cultural influences, inconsistent local advocacy and limitations in data quality and call/recall systems. These insights have shaped our programme priorities and national delivery.

Our national goals are to reach and maintain at least 95% coverage in routine childhood vaccination programmes, and to ensure at least 95% coverage for 2 doses of the MMR vaccine in older groups, using both opportunistic and targeted catch-up strategies. Between April 2023 and February 2026 using existing NHS vaccination infrastructure, we led a co-ordinated national programme to stabilise and improve MMR uptake and reduce the short and medium term risk of measles outbreaks. A major milestone was the successful introduction of the combined MMRV vaccine from January 2026, replacing MMR for eligible cohorts and adding universal protection against varicella (chickenpox). The second dose of a measles-containing vaccine has also been brought forward from 3 years 4 months to 18 months, strengthening early immunity. This is a significant enhancement of the childhood immunisation schedule and a key enabler of wider recovery objectives.

²² [https://www.heartuk.org.uk/downloads/heart-uk-brochures/j9349huk-risk-infographicaw-final-\(1\).pdf](https://www.heartuk.org.uk/downloads/heart-uk-brochures/j9349huk-risk-infographicaw-final-(1).pdf)

Making the shift from analogue to digital

The NHS relies on timely, accurate information to deliver safe and effective care. Moving from paper-based processes to digital services is essential to improving patient experience, supporting staff, and making better use of public funding.

Building the digital foundations through Electronic Patient Records

As of March 2026, our Frontline Digitisation programme enabled 94% of trusts to have an EPR system, and all remaining trusts signed contracts with their preferred suppliers so they can proceed with implementation, supporting the NHS ambition for universal EPR adoption. By the end of the year, compliance with national minimum EPR capability standards rose from 41% to 76%, strengthening clinical safety, enabling smoother handovers, and improving efficiency of care delivery. Together, these improvements are creating the foundations for a more joined up NHS where information follows the patient rather than sitting in paper files or local systems. To continue this progress, a Frontline Digitisation programme is being stood up in 2026/27 to support and improve compliance with EPR standards.

Turning data into better care through the NHS Federated Data Platform

Building on digital records, the FDP is helping the NHS use data to actively improve care and productivity. FDP is a secure system that brings together NHS data from different places into one view so staff can access what they need more easily. It helps NHS staff make quicker, better decisions (for example, planning care or services) by giving near real-time data and reducing the need to use multiple systems. During 2025/26, the platform scaled rapidly, with around 113 NHS trusts and 41 ICBs using it by March 2026.

The FDP is directly supporting the NHS to deliver patient care. By March 2026, it had enabled the treatment of over 111,589 additional patients in theatres. To support elective care, around 4.6 million waiting list records were reviewed to help ensure patients were on the correct waiting lists, ultimately enabling quicker treatment for those that required treatment. Nearly 348,000 patients had their hospital discharge managed through the platform, contributing to a 15% average reduction in clinically unnecessary hospital days. In cancer services, early results show an almost 7% improvement in patients receiving a diagnosis within 28 days of referral. These metrics are based on an observational before/after comparison showing changes following the introduction of the NHS FDP Inpatient theatre module. We cannot therefore draw conclusions about cause and effect as other variables have not been controlled for.

The NHS App as a digital front door for patients

The NHS App continued to replace letters, phone calls and paper forms and unnecessary face to face appointments with simple digital access to services. In 2025/26, 25.7 million people used the app, an increase of 21% on the previous year.

In secondary care, 96% of acute trusts connected their Patient Engagement Portals to the NHS App, allowing people to view, update and manage their hospital appointments in one place. During 2025/26, patients used these features around 70.3 million times, helping reduce missed

appointments and free up staff time. In primary care, 76% of GP practices could be contacted through the app, with around 2.4 million online requests starting there each month.

Digital messaging through the NHS App also grew rapidly, with 100% of GP practices and 58% of acute trusts using it to communicate with patients. In 2025/26, the NHS sent 305 million messages through the app, a 65% rise on the previous year. This shift to digital communication had a direct impact on patient experience and efficiency. Over the past year, the NHS App supported around 260,000 patient interactions each day, helping avoid 1.75 million missed appointments, reducing the need for 27 million letters and 24 million text messages, and saving an estimated 4.1 million hours of clinical and administrative time.

Access to health information has also improved. There were 230 million views of GP health records in 2025/26, up 54%, supported by clearer test result displays that helped patients understand their care and reduce follow-up queries.

Repeat prescription use through the NHS App continued to grow in 2025, with 69.6 million requests made, a 38% increase on the previous year. We began rolling out a new prescription tracking feature across community pharmacies, allowing people to check the status of their prescription before travelling. This has helped prevent unnecessary trips for patients and reduced the number of calls pharmacies receive for updates, freeing up staff time.

Strengthening cyber security as digital use grows

As more NHS services move online, protecting patient data and keeping systems running safely is essential. During 2025/26, national cyber services helped strengthen the resilience of the NHS while reducing disruption to frontline care.

Improvements in threat detection, automation, and national monitoring contributed to an 80% reduction in cyber incident response deployments compared with previous years. This meant fewer major incidents requiring emergency intervention and less disruption for staff and patients. National cyber services also reported a 93% service satisfaction rate in 2025, reflecting growing confidence across the system.

The NHS improved its ability to identify and respond to threats in real time. A national threat intelligence sharing platform is now live in approximately 290 organisations, allowing information about cyber risks to be shared quickly across health and care services.

Making referrals faster and more efficient

We continued to modernise how patients are referred for care and how appointments are managed by expanding digital services. The NHS e-Referral Service now manages around 80,000 referrals every working day, helping GPs and other clinicians send referrals, book appointments, and ask specialists for advice online. Use of Advice and Guidance continued to grow, with 2.5 million requests and 66% of these resolved with advice alone between March 2025 and April 2026, meaning many patients got the right support without needing a hospital visit. This helped clinicians access specialist input quicker and ensured patients were directed to the most appropriate care first time.

Digitising screening and prevention services

Digital transformation is also improving how the NHS delivers screening and preventative care. During 2025/26, digital communications for cervical screening replaced more than 4 million paper letters, sped up results and reduced administrative costs. More importantly, this shift contributed to a 46% increase in uptake of the service and helped more people receive screening earlier, ultimately saving lives.

One of the most advanced examples was the use of automated retinal image analysis within the NHS Diabetic Eye Screening Programme. In 2025/26, the largest real-world evaluation of artificial intelligence (AI) in NHS screening analysed over 200,000 screening encounters and 1.2 million retinal images. The systems demonstrated sensitivity of approximately 97% to 100% in detecting sight-threatening disease, with consistent performance across age, sex, ethnicity and deprivation groups.

Improving prevention, productivity and safety across services

Beyond these core areas, digital services are improving prevention and staff productivity. Our Record a Vaccination service went live across over 1,250 sites. In maternity units, it replaced manual data entry and saved clinicians an average of 2.5 minutes per vaccination. Similarly, Managing Vaccinations in Schools was used by over 40% of teams to replace paper processes with digital consent, contributing to an over 25% increase in consent and over 10% increase in vaccine uptake in pilot areas. These services ensured real-time data sharing with GP practices and created more accurate and safer national records for patients. The NHS Health Check online service launched across 10 local authorities and more than 25 GP practices. This enabled people to complete the NHS Health Check (which supports early identification of cardiovascular risk) remotely.

Live within our means, reducing waste and maximising productivity

Productivity improvements and workforce development remained central priorities for us in 2025/26, as the service worked to reduce the productivity gap created during the pandemic years and strengthen long-term operational resilience. Our productivity plan for the year focused primarily on technical efficiencies, including stronger operational and financial disciplines, clearer clinical standards, and reducing variation in performance across organisations.

Productivity and efficiency progress

For 2025/26 planning, each NHS organisation received benchmarking data to support setting productivity and efficiency targets. Alongside this, NHS England published best practice operational improvement guides and co-ordinated national and local improvement initiatives. Progress was made across more than 30 nationally tracked metrics, supporting delivery of the minimum target of a 2% increase in productivity required to meet government performance goals within the agreed financial envelope.

Over the past 18 months, we worked with the ONS and other economic experts to develop a more timely and accurate productivity measure for every NHS secondary trust. As a result, we published trust-level productivity growth statistics followed by monthly updates, to enable NHS

leaders to track in-year progress more accurately, understand variation, and drive targeted improvement.

March 2026 estimates suggest productivity has improved for acute providers by 2.8% in 2025/26, based on cost-weighted activity increasing by 2.7% and real terms resource use reducing by 0.2%. Estimates for non-acute trusts are limited by data quality and should be used carefully. When these are included, NHS productivity is estimated at 3.4% based on 3.4% more activity and 0% lower resource use. We continued to work with providers to improve data quality.

These results reflect the commitment of NHS frontline staff, clinical and operational managers, and system leaders in implementing local productivity plans, optimising existing resources, and delivering core elements of the national productivity strategy. Their work has contributed to improved patient services and better value for taxpayers.

Building the future workforce

The 10 Year Health Plan sets out a clear and ambitious vision for the future. The NHS has continued to make progress in developing a sustainable long-term workforce capable of delivering high-quality care. The 10 Year Workforce Plan, due to be published in 2026, was developed using detailed modelling and policy concepts to ensure the NHS is best placed to meet patient needs now and for the next decade.

Improving workforce capacity

Ensuring the NHS has the right number of staff with the right skills remained essential to improving productivity and service quality. Workforce numbers have continued to increase across primary and secondary care, meeting or exceeding planned levels.

In primary care, workforce numbers – including GPs, nurses, direct patient care roles and administrative staff – increased by 2.2% in 2025/26 (2024/25: 1.9%). In secondary care, the workforce now stood at 1.49 million WTE, 1.3% above planned levels across acute, mental health, community and ambulance services. The number of secondary care staff working in corporate or administrative functions stood at 304,516 – this is 11,208 higher than our commitment to reduce levels to those in April 2022 (293,308).

Alongside workforce growth, we took a strategic approach to managing temporary staffing costs. Agency spend was the lowest on record, on track to eliminate agency expenditure by 2029, as per the commitment in the 10 Year Health Plan. Agency costs made up 2.6% of the medical NHS pay bill in 2025/26, down from 4.2% in 2024/25, representing a cost reduction of approximately £328 million (34%). Agency costs made up 0.6% of the Agenda for Change (AfC) pay bill in 2025/26, down from 1.3% in 2024/25, representing a cost reduction of approximately £568 million (0.7%). On aggregate for agency spend, we achieved a 43.2% reduction across 2025/26, higher than the 30% reduction target, with spending approximately £896 million less in 2025/26 than 2024/25.

We did not hit the aggregate bank reduction of 10% with provisional data showing approximately 5.2% reduction year-on-year, however, spend is around £338 million lower in 2025/26 than 2024/25.

NHS England 2025/26 planning guidance set NHS organisations the requirement to close the activity/WTE gap against pre-Covid levels (adjusted for case mix²³). Latest data suggests Implied Workforce Productivity for 2025/26 compared to 2024/25 is +2.8%. This demonstrates progress against the planning ask and continued improvements in future years will be needed to close the full gap to 2019/20. Latest estimates suggest the Implied Workforce Productivity gap comparing 2025/26 to 2019/20 is -6.4%.²⁴

Strengthening staff experience and retention

Staff experience and engagement remained central priorities during 2025/26. The 2025 National NHS Staff Survey and National Quarterly Pulse Survey showed a small decrease in levels of staff engagement, with scores (out of 10) falling to 6.75 in 2025 (2024: 6.85).

Motivation, one component of the staff engagement score, was at a 5-year low, with the largest decline among staff who had worked for their organisation for 3 years or more. Organisational change and ongoing operational and financial pressures were likely contributing factors.

Sickness absence remained an area of concern, standing at 5.14% at March 2026 (March 2025: 4.9%). Nursing and ambulance support staff had some of the highest sickness levels, and mental health conditions remained the leading cause of sickness absence. We supported systems to prioritise sickness reduction as part of wider organisational resilience and productivity strategies.

Despite these challenges, progress was made across several commitments to improve staff experience, and to ensure the NHS continued to be an attractive and rewarding employer. We worked on finalising a refreshed NHS management and leadership framework²⁵ to strengthen capability across the service.

Procurement of a new national payroll system to replace ESR was underway, with the aim of offering improved functionality for all NHS staff.

Plans for training and development opportunities continued to expand. Our plans included delivering 2,000 nursing apprenticeships over the next 3 years, and prioritising areas of greatest need UK medical graduates in specialty recruitment, from 2026.

We finalised a new set of national staff standards²⁶, designed to improve staff experience and promote consistency which were published in July 2026.

²³ Activity levels are adjusted for case mix to account for changes in the complexity of patients and treatments over time, ensuring comparisons with pre-Covid performance reflect differences in workload as well as the volume of care delivered.

²⁴ Whole-time equivalent (WTE) staff in post at March 2026 compared with pre-covid FTE at March 2020 was 21% higher. Rolling year activity to February 2026 compared with rolling year to February 2020 shows the overall activity weighted change at 13.3%. The productivity gap is 6.4% <https://data.england.nhs.uk/providers/workforce-and-activity/activity/2020>

²⁵ <https://www.england.nhs.uk/leaders/nhs-leadership-and-management-framework/>

²⁶ <https://lmframework.leadershipacademy.nhs.uk/standards/>

Maintain our collective focus on the overall quality and safety of our services

During 2025/26, we continued to strengthen quality, patient safety and governance across the NHS, building on commitments within the 10 Year Health Plan and the Dash Review. We remained responsible for driving continuous improvement, working with ICBs and providers to enhance safety, clinical effectiveness and patient experience.

Quality governance

During 2025/26, we refreshed the National Quality Board with updated terms of reference and renewed membership to ensure the Board maintains the expertise required to oversee national quality priorities and adapts to evolving system needs.

We reviewed quality governance to better identify and escalate risks at national, regional and ICB levels, and improved how quality data is used and shared. These changes were informed by system feedback and aligned closely with the direction set out in the 10 Year Health Plan.

The public satisfaction survey ran from 26 August 2025 to 6 October 2025. This showed a 6 percentage point increase (against 2024) in the number of British adults who were satisfied with how the NHS is run, the first increase in satisfaction since 2019. There was also the largest fall in dissatisfaction in 25 years, falling from 59% in 2024 to 51%.²⁷

We created a new Quality strategy to guide the NHS, which was published in July 2026. The strategy re-establishes the 3 domains of quality: patient safety, clinical effectiveness and patient experience – as the framework for improvement. It sets national priorities such as supporting modern service frameworks, accelerating work on patient experience and voice, and improving maternity safety.

Patient safety

During 2025/26, the NHS Patient Safety Strategy reached its seventh year. We estimate that it is now delivering the impact originally forecast in 2019, saving around 1,000 lives and over £100 million in care costs each year. National patient safety programmes continued to deliver substantial results, including:

- over 1,900 neonatal lives saved
- more than 600 cerebral palsy cases avoided in premature babies
- over 1,900 deaths prevented through medicines safety improvements
- over 1,900 potentially lifesaving interventions linked to Martha's Rule calls

Martha's Rule

In 2025/26, we launched phase 2 of Martha's Rule, which gives patients and families the right to escalate urgent concerns about deterioration directly to a critical care outreach team. Phase 2 expanded implementation to all adult and paediatric acute inpatient services and piloted the approach in maternity and neonatal units, EDs, community hospitals and mental health settings.

²⁷ <https://www.kingsfund.org.uk/insight-and-analysis/reports/public-satisfaction-nhs-social-care-2025-bsa>

Between September 2024 and March 2026:²⁸

- 13,481 Martha's Rule escalation calls have been received
- 72% were escalated by families or carers
- 4,336 (32%) related to acute deterioration
- 574 cases required transfer to Intensive Care Unit/High Care Unit, enhanced care, specialist services or wards
- 1,930 deterioration-related calls (45%) led to changes in treatment, including antibiotics, scans or procedures

These findings show that Martha's Rule has become a significant safety intervention, supporting earlier recognition of deterioration by combining clinical assessment with patient and family insight.

Learning from patient safety events

Throughout the year, we continued implementing the patient safety incident response framework, our national approach to reducing unnecessary bureaucracy, improving patient and family involvement and promoting more effective learning.

We expanded use of the learn from patient safety events system, which captures over 3 million patient safety incidents each year and enables real-time analysis.

The latest data for 2025/26 showed:

- 64% of incidents caused no harm
- 30% caused low harm
- 5% caused moderate harm
- 0.5% caused severe harm
- 0.5% resulted in death

We reviewed all fatal and severe harm incidents weekly and issued National Patient Safety Alerts²⁹ (NatPSAs) when system-wide action was required. In 2025/26, we issued 3 alerts:

- Adult breathing circuits lacking a patent exhalation route – 11 December 2025
- Incorrect recording of penicillin allergy as penicillamine allergy – 20 November 2025³⁰
- Delayed administration of rasburicase for tumour lysis syndrome – 9 September 2025

Alongside NatPSAs, we increasingly provided targeted guidance and case studies, most recently updated on 26 January 2026. Together, these interventions are estimated to save 160 lives each year and £13.5 million in treatment costs.

Medical Examiner system

The statutory Medical Examiner system became fully operational in September 2024, enabling independent scrutiny of all deaths not investigated by a coroner. Over the first 12 months, medical examiners in England and Wales reviewed more than half a million deaths, identifying 27,000 concerns for local follow-up and supporting bereaved families, 97% of whom take up the opportunity to speak to someone independent. Medical examiners have significantly improved

²⁸ <https://www.england.nhs.uk/statistics/statistical-work-areas/marthas-rule/marthas-rule-2025-26/marthas-rule-programme-march2026/>

²⁹ <https://www.england.nhs.uk/patient-safety/patient-safety-insight/patient-safety-alerts/#list-of-nhs-england-and-nhs-improvement-national-patient-safety-alerts-alerts-issued-since-november-2019>

³⁰ <https://www.england.nhs.uk/2025/11/harm-from-incorrect-recording-of-penicillin-allergy-as-penicillamine-allergy/>

accuracy in death certification: the ONS recorded only 3 uncertified or unknown deaths in 2025, compared with an estimated 10,000 annually before implementation. In 2025 the number of deaths referred to coroners fell to the lowest ever recorded, down 24% compared to 2023 (the final complete year before medical examiners were fully operational) and helping prevent unnecessary distress and delay to the bereaved, while coroners ordered 10,000 fewer post-mortems, releasing resources for clinical work.

Building safety capability

We continued strengthening national capability for patient safety improvement. During 2025/26, more than 1.4 million staff completed Level 1 Patient Safety Syllabus training, over 800 patient safety specialists were in place across providers and ICBs, and all NHS organisations had patient safety partners contributing directly to safety governance.

Maternity outcomes signal system

We launched the MOSS nationally in November 2025. MOSS uses near real-time maternity data to detect unusual patterns (“signals”) that could indicate emerging intrapartum safety concerns. When a signal occurs, providers must complete a rapid safety review within 8 working days. During 2025/26, we began enhancing the system by integrating brain injury data, reducing over-signalling and redeveloping MOSS on the FDP.

In 2023, we set out a 3-year plan to make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families (with 2025/26 being the last year of that 3-year plan). The actions taken during this period have started to demonstrate signs of improvement in safety and quality. More babies are surviving pregnancy and birth, with the stillbirth rate in England falling to 3.8 per 1,000 births in 2024, around a quarter lower than in 2010. More babies are also surviving the first weeks of life, and fewer are being born prematurely, with the preterm birth rate falling from 8.1% in 2023 to 7.9% in 2024, the first reduction since 2020. However, maternal mortality increased in the latest reporting period (excluding COVID-19-related deaths), with the rate rising from 11.3 per 100,000 maternities in 2021 to 23 to 12.5 per 100,000. In response, we published the Maternal Care Bundle in January 2026, targeting the 5 leading direct causes of maternal death to improve outcomes and reduce preventable harm.

Women reported better experiences of care, with the 2025 CQC maternity survey showing improvements across almost all measured areas. The workforce strengthened, with record numbers of midwives employed – 27,591 WTE midwives in February 2026, up from 23,807 in March 2023 and vacancy rates fell from 13% in August 2022 to 2.6% in February 2026. 7-day bereavement services are now available in every trust, ensuring families can access compassionate support when needed.

However, unwarranted variation remains and through the Medium Term Planning Framework³¹, we asked ICBs to implement best-practice resources, including the Sands National Bereavement Care Pathway³² for stillbirth and neonatal death. Our investment in neonatal care

³¹ <https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/>

³² <https://www.sands.org.uk/professionals/national-bereavement-care-pathway>

has delivered 42 of the 54 funded neonatal cots, with the remaining 12 due by July 2028. Access to specialist support has also expanded, with Maternal Mental Health Services available in 41 of 42 ICBs and Perinatal Pelvic Health Services operating in 39 of 42 areas. NHS England did not deliver our commitment to introduce a patient-reported experience measure (PREM) by 2025; however, significant progress has been made and maternity services will be the first area to implement a national PREM, with trusts testing a validated measure in 2026.

Despite the progress that has been made, there remain serious concerns about maternity care. During 2025 the Secretary of State for Health and Social Care announced there would be a national independent investigation of NHS maternity and neonatal services led by Baroness Amos. Alongside, there are ongoing independent reviews of maternity care at Leeds and Sussex. The Ockenden review of maternity services at the Nottingham University Hospitals NHS Trust reported its findings in June 2026.

Reinforced Autoclaved Aerated Concrete (RAAC)

The NHS has identified 64 hospital sites in England with RAAC which the Government plans to remove entirely from the NHS estate by 2035. 7 heavily affected hospitals are being replaced as part of the New Hospital Programme. In addition, the Government has allocated over £2.8 billion since 2021 to identify, mitigate and eradicate RAAC in other facilities. So far, 30 hospital sites have completed their removals, with another 21 hospital sites on track to complete by the end of 2029/2030.

Innovation, research and life sciences

NHS England supports innovation, research and life sciences to improve patient outcomes and deliver the Government's 3 shifts: from hospital to community, analogue to digital, and sickness to prevention. NHS England also has a statutory duty to facilitate and promote health research and its application across the health service.

Over the last year, NHS England worked in partnership across the research sector to reduce clinical trial set-up times, making progress towards the Prime Minister's commitment and implementing a standardised national approach to commercial research contracting. Work to embed research into everyday NHS care progressed, including delivery of Medium Term Planning Framework requirements for research and e-learning modules to promote research engagement among NHS staff.

Targeted action was taken to address health inequalities in research participation through the delivery of the Research Engagement Network, widening access for under-represented groups. NHS England also strengthened access to knowledge and evidence by providing a single national digital infrastructure, supported by e-learning and local NHS library and knowledge specialists to equip the workforce to use and apply published research.

To support system transformation and service planning, NHS England's horizon scanning included work on genomics point-of-care testing, early cancer detection and antimicrobial resistance, alongside 4 market intelligence reports focused on strategic priorities such as AI-enabled triage and lipid point-of-care testing. A total of 23 innovation use-cases were

referred to NICE, with 12 considered for the National HealthTech Access Programme³³ and 2 progressing to technology appraisal.

Innovation adoption continued at scale and included expansion of AI-enabled dermatology triage, mobilisation of digital therapeutics for mental health and musculoskeletal conditions, and planning for the large-scale adoption of innovative medicines affecting over 680,000 respiratory, cardiovascular and liver patients. NHS England also supported innovation capacity through the Health Innovation Networks, the Clinical Entrepreneur programme, the NHS Innovation Accelerator, and the NHS Innovation Service, while investing over £13 million through Small Business Research Initiative Healthcare to develop new technologies.

System working

Developing the new NHS operating model

Advanced foundation trusts

In 2025/26, NHS England launched the Advanced Foundation Trust (AFT) programme to deliver the 10 Year Health Plan commitment to provide greater autonomy to high-performing NHS trusts and FTs. We consulted on the AFT guide for applicants, setting out policy aims, eligibility requirements and detailed assessment criteria. The first 6 candidate trusts were assessed in March 2026, and further trusts will be considered in 2026/27, with the ambition for all trusts to achieve AFT status by 2035.

Integrated health organisations

The 10 Year Health Plan also announced the introduction of integrated health organisation (IHO) contracts, a new opportunity for highly capable trusts to hold the health budget for a local population. This will support integration, shift resources from hospital to community, focus on population health and tackle inequalities. We consulted on a draft assessment framework for IHO designation as part of the AFT guide for applicants. The first candidates for IHO designation were announced in November 2025 and designation decisions will be made during 2026/27, in preparation for the first IHO contracts to go live in April 2027.

Strengthening commissioning

During 2025/26, NHS England implemented a major programme to strengthen strategic commissioning and ensure the financial sustainability of ICBs.

The Model ICB Blueprint was published in May 2025. This was developed with ICB leaders and clinical representatives and sets out a clear vision and future functions for ICBs, a mapping of statutory functions and duties, and arrangements for safe transition to future operating models.

The Blueprint provides a consistent national framework for streamlining ICB operating models, sharing functions, adopting technology and collaborating at scale. 32 of the 42 ICBs began implementing clustering arrangements in 2025/26 through shared executive teams, ahead of

³³ <https://www.nice.org.uk/news/articles/faster-fairer-access-to-healthtech-under-new-national-programme>

forming larger ICBs to support scale opportunities and the intention to align with strategic authority footprints.

In November 2025 a Strategic Commissioning Framework was published which sets an ambitious new approach to how ICBs will deliver this clearer role. From 2026/27, a national 2-year Strategic commissioning development programme will strengthen commissioning capability and provide practical support to help systems shift investment into neighbourhood and community-based care. This represents the first significant national investment in commissioning capability in more than a decade. These reforms reinforce partnership with local government and complement the national Neighbourhood health implementation programme to support more integrated, preventative, population-focused care.

Independent patient choice and procurement panel

NHS England hosts the independent panel for patient choice and procurement. The panel has responsibility for reviewing representations from providers about qualification of providers by ICBs for services where the legal rights to choice apply and providing advice to relevant authorities about decisions under the provider selection regime. Cases can be referred to the independent panel where other processes have not resolved issues. During 2025/26 the panel published reports on 19 provider selection cases.

Sustainability

Taskforce on Climate-Related Financial Disclosures (TCFD)

The DHSC Group Accounting Manual (GAM) has incorporated the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies over the past 3 years, in line with HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions, as these are calculated nationally by NHS England. The GAM has also adapted the requirements for scenario analysis in the strategy section of the TCFD disclosures to better fit the needs of the public sector.

While NHS England does not currently consider climate change to be a principal risk, the future impact of climate change on healthcare is significant and therefore material to the organisation.

The below section therefore includes disclosures, as interpreted and adapted by the GAM, around:

- governance – recommended disclosures (a) and (b)
- risk management – recommended disclosures (a) to (c)
- metrics and targets – recommended disclosures (a) to (c)
- strategy – recommended disclosures (a) and adapted (b) and (c) as set out in the GAM

Climate change poses a major risk to health and wellbeing, as well as a significant service delivery and financial threat to the NHS, impacting both infrastructure and services for patients.

The Greener NHS³⁴ programme leads the way for the NHS to reduce the impact of climate change on public health and the environment, save money and reach net carbon zero. In 2020 we became the world's first health system to commit to reaching net zero and take action to reduce the future impacts of climate change. The government's commitment to this target was reinforced in the 10 Year Health Plan.

Governance

NHS England's Chief Sustainability Officer is accountable for delivery of the Greener NHS Programme to the NHS England Executive. The progress report Delivering a Greener NHS: Five Years On was presented to the Board in September 2025, outlining progress over the past 5 years and future opportunities. The Regional Greener NHS Board, and the Sustainability board, chaired by NHS England's Chief Sustainability Officer, provides oversight of regional assurance activity and supports progress monitoring. Attendees include director-level regional and national Greener NHS senior responsible owners.

Reporting on most TCFD disclosures, and related emergency readiness assurance, is the responsibility of NHS organisations. They are required to have arrangements in place for adverse weather events. Climate change adaptation and adverse weather are included in the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR), the basis of the EPRR annual assurance process. NHS England's EPRR team oversees and provides assurance to the DHSC on the NHS ability to respond in emergencies including those that are climate related.

As per the Green Plan guidance requirement, NHS organisations should report an annual summary of progress on delivery of green plans to their board and publish this in their annual report. NHS England's regional teams support assurance of delivery of annual green plan priorities.

For NHS England as an individual organisation, progress was measured and regularly reported to the Executive Corporate Group throughout the year every 2 months. Where necessary, progress, opportunities and risks can be reported to the Board via the NHS Executive.

Strategy

The main risks to future healthcare delivery associated with climate are heatwaves, flooding and vector-borne diseases. These are all impacting healthcare in the short-term, and when considered against a global warming pathway of 2°C or lower are likely to increase in the medium (2035) and long term (2050). Heating and flooding incidents on NHS sites also prevent healthcare delivery, causing delays to patient care and adding further burden to the health system.

Annual heat-related mortality is expected to reach 10,000 deaths per year by the 2050s under a high warming climate scenario. The Health Effects of Climate Change report found total costs of heat-related mortalities from climate change and related socio-economic change in England have been estimated at approximately £6.8 billion per year in the 2020s, rising to £14.7 billion

³⁴ <https://www.england.nhs.uk/greenernhs/>

per year in the 2050s. Heat waves are also an increasing risk to healthcare delivery, with reported incidents of overheating triggering a risk assessment in NHS secondary care sites rising to 6,822 in 2022/23 following record temperatures that year.

Flooding is also a current risk that will worsen over time. Changes to rainfall patterns are expected to cause increased health service disruption from direct flooding of NHS sites and disruption to critical services (water, energy, transport) causing operational challenges. In 2024/25, there were 391 reported incidents of flooding triggering a risk assessment at NHS secondary care sites. The greatest population health risk from flooding is negative mental health impacts, with flood victims at greater risk of depression, anxiety, and post-traumatic stress disorder.

Vector-borne diseases (such as chikungunya, dengue and Zika viruses) could become transmissible in London and other parts of the UK in the medium to long term due to the establishment of *Aedes albopictus* and spread of *Culex* mosquitoes.

The Greener NHS team has produced the NHS Climate Change Risk Assessment Tool which is available for NHS organisations to use to assess climate change related risks.

Risk management

For NHS England estates, no risks concerning climate change and NHS England have been recorded on either the Strategic Risk Register (SRR) or Operational Risk Register (ORR) during 2025/26. Risks are assessed through our climate change risk assessment, which considers short term and long-term flood risk, air quality, and temperatures, and by monitoring our performance against environmental targets. Further detail on NHS England's Risk Management Framework can be found on page 68.

NHS England co-led publication of the 4th health and climate adaptation report outlining climate risks across the health system, and identifying mitigating actions, including recommending that NHS trusts undertake a climate change risk assessment using the NHS Climate Change Risk Assessment Tool.

NHS England contributed to the risk to health and social care delivery in the UK's climate change risk assessment and has associated actions identified in the 3rd National Adaptation Programme including raising awareness of climate impacts among NHS staff, incorporation of adaptation within green plans and incorporation of climate risks within NHS building codes and the standard contract. NHS England is working alongside government departments and health system partners to address the impacts of climate change on health and social care. This includes contributing to the development of the 4th National Adaptation Plan (NAP4), which will set out the government's approach to improve preparedness to the impacts of climate change.

Impact of heat and floods on the broader NHS estate is managed through NHS England capital considerations alongside other priority investment.

Metrics and targets

As an ALB to DHSC, NHS England as an individual organisation is in scope for the Greening Government Commitments (GGCs). Detailed reporting on the relevant GGCs metrics can be found in the appendices on page 184.

Guidance for NHS Green Plans published by NHS England in 2025/26 provided a set of suggested metrics³⁵ that can be used to monitor progress locally, including the number of overheating and flood occurrences triggering a risk assessment. NHS England monitors the number of heating and flooding incidents in hospitals triggering a risk assessment through the Estates Returns Information Collection (ERIC). In 2024/25, there were 2,333 overheating occurrences and 391 flood occurrences. These metrics will be reviewed in 2026/27, after which consideration will be made to setting appropriate targets and baseline.

The NHS has 2 net zero targets: to achieve net zero for all the emissions that the NHS directly controls by 2040 – referred to as the NHS Carbon Footprint (NHS CF); and to achieve net zero for all the emissions that the NHS influences and directly controls by 2045 – referred to as the NHS Carbon Footprint Plus (NHS CF+). More detail on these concepts and progress so far can be found in the first 5 year review of the Greener NHS programme.³⁶

As set out in the DHSC GAM, NHS bodies are not required to disclose emissions as part of the metrics and target pillar of TCFD disclosures, as NHS England provides estimates of NHS total emissions. Estimated NHS CF emissions for the NHS in 2025/26 were 4,450 ktCO₂e. This estimate, combined with evidence of action across the NHS, suggests that in 2025/26 the NHS was on track to meet net zero commitments for 2028 to 2032 and demonstrates progress towards the 2040 net zero target for the NHS CF. More detail is included in the appendices.

During 2025/26, progress was supported by targeted action, including:

- publication of updated organisational green plans and national 5-year review of progress for the NHS CF and NHS CF+
- a partnership with Great British Energy that saw investment of £130 million in solar generation projects in over 260 hospitals across the country
- a further £700,000 invested to support a reduction of nitrous oxide waste, which has been shown to be up to 80% at some sites – total investment now stands at £1.6 million, and emissions have reduced by almost 100ktCO₂e since 2019/20
- improving respiratory care and optimising the use of inhalers, which is supporting patients to better manage their respiratory conditions and reducing direct emissions from inhalers by 420ktCO₂e since 2019/20
- increasing electrification across the NHS fleet, with 11% of all vehicles now zero emission, supported by £18 million investment in electric vehicle charging infrastructure since April 2025
- investing £70 million in energy efficiency measures, through the NHS Decarbonisation Fund in partnership with the Department for Energy Security and Net Zero

Indicators of progress in key areas will be developed and used to monitor progress in future.

More detail is covered in the appendices on page 184.

³⁵ Unless otherwise stated, the baseline year is 2017/18

³⁶ <https://www.england.nhs.uk/long-read/five-years-greener-nhs-progress-forward-look/>

Chief Financial Officer's report

NHS context

This document is the annual report and accounts for the NHS England group. In discharging its responsibilities, NHS England considers the NHS as a whole, which includes NHS trusts and NHS foundation trusts. In 2025/26, the NHS was organised into 42 'systems', being each ICB and their partner NHS providers. Systems delivered a £563 million deficit in 2025/26 in aggregate, which is £400 million less than 2024/25 on a like-for-like basis. Across systems, the total efficiency in 2025/26 totalled £10.2 billion.

This represents a 17% increase on the previous year (2024/25: £8.7 billion of efficiencies delivered). The level of overspend in front-line organisations has reduced by over one third, and the number of organisations delivering plan increased from 70% to nearly 80%. Agency spend was almost halved, from £2.1 billion to £1.2 billion.

NHS England group

The financial statements for the year ending 31 March 2026 are presented later in this document on a going concern basis (as per Note 1.5 of the accounts) and show the performance of both the consolidated group – covering the whole of the commissioning system – and NHS England as the parent of the group. The group comprises NHS England, the 42 ICBs and Supply Chain Coordination Ltd (SCCL).

NHS England is required to manage total NHS spending within a fixed revenue limit. The total General RDEL limit for 2025/26 was £202,470 million.

Funding and allocations

In 2025/26, core funding for the NHS on a like-for-like basis increased in real terms, although this growth was largely absorbed by cost and demand pressures across the system. An additional £2.24 billion was allocated to NHS systems to support them specifically in achieving financial balance and breaking even. During the year, further funding was made available to meet emerging and exceptional pressures. This included additional funding provided by the DHSC to NHS England to reflect the outcome of the Review Body on Doctors' and Dentists' Remuneration and NHS Pay Review Body recommendations. A further £750 million was allocated to offset the additional costs arising from industrial action, ensuring continued service delivery and mitigating financial risk to providers.

£420 million was transferred to meet redundancy liabilities and total funding was reduced by £238 million relating to the income from the voluntary scheme for branded medicines, pricing, access, and growth (commonly referred to as VPAG) relative to the opening allocation.

In 2025/26, elective recovery continued to be a key national priority, with delivery expected within overall system allocations, reflecting a shift towards reduced ringfencing and greater financial flexibility for local systems.

Operational performance

In 2025/26, both access standards were met for NHS Talking Therapies, with more than 8 in 10 people referred accessing the services within 6 weeks and almost everyone accessing within 18 weeks. The NHS also delivered on average more than 1.5 million appointments in general practice every working day last year, which is the highest number on record.

And, despite a total of 15 days' industrial action by resident doctors, the NHS delivered more elective care than at any point in its history – including a record 30 million tests, checks and scans. This helped cut the waiting list by 312,000 – the largest reduction in the waiting list since 2010. It also ensured services delivered the 65% 2025/26 18-week target and the biggest improvement in referral to treatment performance in over a decade and a half.³⁷

A record number of patients were seen in A&E last year, yet waits were the shortest since 2021/22, with 3 quarters of patients arriving in A&E seen within 4 hours. Ambulance response times for category 2 callouts, such as suspected heart attacks and strokes, were on average more than 5 minutes faster last year than the year before, and the quickest in more than half a decade.

There remains pressure on flow across the health and social care system, with an average of 12,978 inpatient beds per day occupied by patients with a delayed discharge – representing a small increase on 2024/25. Work continues to improve discharge processes and increase capacity to support timely discharge from hospital.

Alongside, the NHS reported delivering more than £10 billion of efficiency savings in 2025/26 and continues to deliver annual productivity improvements above the national 2.0% target set in the 10 Year Health Plan.

Timeliness of local accounts

In preparing the NHS England group accounts based on consolidation schedules from ICBs, we are reliant on each ICB submitting their audited annual report and accounts to us. We and the DHSC issue directions to NHS bodies on the timing by which these should be submitted.

The timeline on which these national accounts are finalised depends on both when the deadline for local audited accounts is set, and compliance with that deadline. For many years prior to 2019/20 the local audit deadline in the NHS was around the end of May. The deadline is set in consultation with the audit firms on what they are willing to sign up to. In recent years the local audit deadline has been around the end of June but has been brought forward incrementally, and for ICBs was set as 19 June for 2025/26.

Following some years of less timely delivery in the commissioning sector, 95% of ICBs met the audited accounts deadline for 2025/26, following performance of 100% in 2024/25 and 90% in 2023/24. Local ICBs and their auditors achieving the audit deadline is currently not a significant constraint in achieving earlier reporting for the NHS England groups accounts. However the deadline itself remains a limiting factor: the local audit deadline set as it was for this year meant

³⁷ Excluding periods affected by the COVID-19 pandemic

we were unable to achieve the cut-off of the summer Parliamentary recess for finalising these accounts. They have been finalised to be laid before Parliament upon its return in early September; this is earlier than any point since 2019. The accounts for the years 2019/20 to 2022/23 were published in January following the year end, and October for 2023/24 and 2024/25.

NHS England and the DHSC continue to work closely with the Ministry of Housing, Communities and Local Government on the relevant elements of its work to reform 'local' audit. The English Devolution and Community Empowerment Act 2026 contains reforms to local audit for which commencement is expected to begin this autumn. The changes include establishing the Local Audit Office, a body to coordinate local audit with responsibilities including determining the framework for auditors to follow, rules for eligibility to be a local auditor, and inspection and enforcement. Bringing these functions together will help set the foundation to strengthen the audit market. These changes will directly apply to audits of NHS trusts and ICBs; separately the DHSC's NHS Modernisation Bill, currently in Parliament, intends to extend the same arrangements to NHS foundation trusts.

As well as reforms to the local audit system, we have continued our broader work to improve timeliness in NHS financial reporting including:

- encouraging auditors to give clear reporting to audit committees where the preparer's quality of draft accounts or working papers needs to improve
- working closely with NHS bodies to ensure they appoint external auditors in good time, which helps increase the likelihood of deadlines being achieved
- working with NHS bodies where financial reporting issues arise to ensure they are able to address findings effectively
- regular engagement with the audit firms and responding to their feedback to continue to strengthen the NHS financial reporting landscape, and working with partners to make sure training and guidance is available for preparers and
- liaising with broader stakeholders on wider matters that can cause delays in NHS accounts.

NHS England and the DHSC have an ambition to return to laying the main national consolidated accounts before Parliament in advance of the summer Parliamentary recess in July. Achieving this in the years ahead would require the audit community to accept a significantly earlier deadline for audited accounts than is currently the case. At the present time it is not clear that this is achievable in the short term. We will continue to focus on streamlining processes for preparation and audit of local and national accounts to the extent this falls within our role to seek to facilitate the earlier finalisation of accounts wherever possible, notwithstanding the operational changes affecting NHS England and ICBs over the coming year.

Financial performance

Revenue Department Expenditure Limit (RDEL) general (non-ringfenced)

The DHSC sets several technical financial targets for the NHS England Group, including the core operational limit (general RDEL) described in the table below. These limits are ringfenced, which means that underspends on the other revenue limits cannot be used to support core patient services covered by the general RDEL limit.

	2025/26		2024/25		2023/24		2022/23		2021/22		2020/21	
Financial performance	Expenditure plan	Expenditure actual	Under/(over) spend against plan		Under/(over) spend against plan		Under/(over) spend against plan		Under/(over) spend against plan		Under/(over) spend against plan	
	£m	£m	£m	%	£m	%	£m	%	£m	%	£m	%
ICBs ³⁸	171,166	170,911	255	0.1%	145	0.1%	(122)	(0.1%)	64	0.1%	195	0.2%
Direct commissioning	14,613	14,257	356	2.4%	72	0.3%	297	1.1%	552	1.8%	310	1.1%
NHS England admin / central programmes / other ³⁹	16,691	16,116	575	3.4%	580	3.7%	1,080	7.9%	537	5.7%	192	2.9%
Total	202,470	201,284	1,186	0.6%	797	0.4%	1,255	0.7%	1,153	0.7%	697	0.5%

2025/26 performance against key financial performance duties

a) Revenue limits

	2025/26				2024/25	
	Limit £m	Actual £m	Underspend £m	Target met	Underspend as % of limit	Underspend £m
RDEL – general	202,470	201,284	1,186	✓	0.6%	797
RDEL – ring-fenced for depreciation and operational impairment	393	329	64	✓	16.3%	64
Annually Managed Expenditure limit for provision movements and other impairments	700	238	462	✓	66.0%	278
Technical accounting limit (e.g., for capital grants)	250	237	13	✓	5.2%	36
Total revenue expenditure	203,813	202,088	1,725		0.8%	1,175

b) Administration costs (within overall revenue limits above)

Total administration costs	2,497	2,107	390	✓	15.6%	392
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c) Capital limit

Capital expenditure contained within our capital departmental expenditure limit	768	682	86	✓	11.2%	15
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The Funding and Allocations section summarises significant in-year funding changes, while Note 21 reports performance against statutory expenditure limits. As these disclosures serve different purposes and are prepared on different bases, the figures are not intended to reconcile directly.

³⁸ ICBs were formed on 1 July 2023. All figures on this row prior to 1 July 2023 relate to CCGs.

³⁹ Supply Chain Coordination Ltd included in 'other'

Financial priorities for 2026/27

Our financial priorities for 2026/27 support the delivery of the ambitions set out in the 10 Year Health Plan, while maintaining strong financial control and improving value for money across the NHS. The focus remains on sustaining recovery in core services, improving productivity and laying the foundations for long-term financial sustainability.

Productivity and value for money are central to delivery of the 10 Year Health Plan. In 2026/27 we will continue to support system and provider-led initiatives that make better use of workforce, estates, digital and technology, while ensuring that resources are targeted towards interventions that deliver the greatest benefit for patients and populations.

Our workforce remains critical to achieving the Plan's long-term ambitions. Throughout 2026/27 we will continue to support staff wellbeing, retention and productivity, ensuring workforce plans are affordable, sustainable and aligned to new models of care. This will support the delivery of safe, high-quality services and enable the NHS to respond to future demand within available resources.

In 2026/27, NHS planning will focus on:

- delivering credible and balanced organisational financial plans, maintaining overall financial discipline and supporting financial sustainability over the medium term
- continuing to reduce corporate and operational costs, ensuring expenditure is aligned with a streamlined operating model
- improving productivity and value for money, including further reductions in agency and bank spend and more effective workforce deployment
- targeting available resources to priority services, with continued emphasis on elective recovery alongside investment in prevention, early intervention and care closer to home
- maintaining robust financial controls and intervening proactively where there is a risk to delivery of board-approved plans, ensuring accountability and timely corrective action

These priorities will support continued recovery while strengthening the foundations for long-term financial sustainability of the NHS.



Elizabeth O'Mahony, Chief Financial Officer

Sir James Mackey, Accounting Officer

20 August 2026

Accountability report

The accountability report sets out how NHS England meets key accountability requirements to Parliament and is comprised of 3 key sections:

The corporate governance report sets out how the organisation was governed during 2025/26, including membership and organisation of our governance structures and how they support achievement of our objectives. The report includes:

- Directors' report (from page 50)
- Statement of Accounting Officer's responsibility (page 64)
- Governance statement (from page 65)

The remuneration and staff report sets out our remuneration policies for executive and non-executive directors (NEDs) and how these policies have been implemented for the reporting period, including salary information and pension liabilities. The report provides detailed information on remuneration and staff, from page 81.

The parliamentary accountability and audit report (from page 111) brings together key information to support accountability to Parliament, including a summary of fees and charges, contingent liabilities and the Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament.

Accountability to Parliament and the public

During 2025/26, NHS England has continued to work closely with the National Audit Office (NAO) in their work to test whether public bodies are delivering value for money. During this period, the Chief Executive and other senior leaders gave evidence to Public Accounts Committee (PAC) hearings on reducing NHS waiting times for elective care⁴⁰; costs of clinical negligence⁴¹; financial sustainability of adult hospice care⁴²; progress on the New Hospital Programme⁴³; and supporting people with frailty outside of hospitals.⁴⁴

This work resulted in 27 PAC recommendations for NHS England, of which 20 were accepted.

In 2025/26, the NAO published reports on costs of clinical negligence⁴⁵; the financial sustainability of England's adult hospice sector⁴⁶; primary and community healthcare support for people living with frailty⁴⁷; update on the New Hospital Programme⁴⁸; and the costs of tackling drug harms in prisons.⁴⁹

There were 16 recommendations for NHS England from the NAO.

In response to the PACs recommendations, NHS England has:

- provided a clear plan for reaching the 1% operational standard for 6 week waits for diagnostic tests by March 2029, through a combination of funded capacity increases, productivity improvements and demand optimisation
- supported NHS trusts to work towards full connection of acute hospitals to the NHS App by April 2026 to support a shift away from default in-person appointments, enabling wider use of remote monitoring, Patient Initiated Follow-Up and automated rescheduling
- continued to ensure the NHS is accountable for patient safety by collecting information through the Learn from Patient Safety Events Service, introduction of the Patient Safety Incident Response Framework and implementation of Dr Penny Dash's review of patient safety across the health and care landscape

Bi-annual updates are provided to the Government on all open PAC recommendations via HMT's Treasury Minute progress reports.

In the past year, NHS England and the Department of Health and Social Care have brought their work closer together, streamlining how we engage with both the NAO and the PAC as part of our new shared leadership arrangements.

⁴⁰ <https://committees.parliament.uk/work/9042/reducing-nhs-waiting-times-for-elective-care/publications/>

⁴¹ <https://committees.parliament.uk/work/9277/costs-of-clinical-negligence/>

⁴² <https://committees.parliament.uk/work/9279/Financial-sustainability-of-adult-hospices-in-England/publications>

⁴³ <https://committees.parliament.uk/work/9512/new-hospital-programme-update/>

⁴⁴ <https://committees.parliament.uk/work/9509/supporting-people-with-frailty-outside-hospitals/>

⁴⁵ <https://www.nao.org.uk/reports/costs-of-clinical-negligence/>

⁴⁶ <https://www.nao.org.uk/reports/the-financial-sustainability-of-englands-adult-hospice-sector/>

⁴⁷ <https://www.nao.org.uk/reports/primary-and-community-healthcare-support-for-people-living-with-frailty/>

⁴⁸ <https://www.nao.org.uk/reports/update-on-the-new-hospital-programme/>

⁴⁹ <https://www.nao.org.uk/reports/the-costs-of-tackling-drug-harms-in-prisons/>

Corporate governance report

Directors' report

The Board

The key responsibility of the Board is to provide strategic leadership to the organisation, including:

- setting the overall direction of NHS England, within the context of the NHS Mandate from government
- approving the business plan, which is designed to support achievement of our strategic objectives and monitor our performance against it
- holding the NHS Executive to account for its performance and for the proper running of the organisation, including operating in accordance with legal and government requirements
- determining which decisions it will make and which it will delegate to the executive, committee or sub-committee, via the Scheme of Delegation
- ensuring high standards of corporate governance and personal conduct
- monitoring performance against core financial and operational objectives
- providing effective financial stewardship
- promoting effective dialogue between NHS England, government departments, partners, ICSs, providers of healthcare and the communities served by the NHS

In accordance with paragraph 2 of Schedule 1(A) to the 2006 Act (also set out in section 4.1 of the Standing Orders), the Board comprises the chair, 9 NEDs and 7 executive directors including the chief executive. The 2 Co-National Medical Directors were joint members of the Board under provision 4.7 Joint Members in the Standing Orders.

Appointments

The chair and NEDs are appointed by the Secretary of State for Health and Social Care, and executive members of the NHS England Board are appointed by the chair and NEDs.

The appointment of the chief executive is subject to the Secretary of State for Health and Social Care's consent. There was 1 Associate NED on the Board during 2025/26 (appointed in April 2024) and their tenure ended on 1 October 2025. The Board appointed 5 board advisers, 3 of whom were previously non-executive committee members and were reappointed as Board Advisers on 1 June 2025, and 2 were appointed on 1 August 2025. 1 Board Adviser's tenure ended on 31 December 2025.

Board members

Directors who served on the NHS England Board during the year are listed in the table below, along with their attendance.⁵⁰

Members	Role	Term ends	Number of eligible Board meetings attended
Dr Penny Dash	Chair	31 March 2029	6/6
Sir Andrew Morris ⁵¹	Deputy Chair	31 August 2026	6/6
Jeremy Townsend	Non-Executive Director	30 September 2026	4/6
Professor Sir Robert Lechler	Non-Executive Director	18 February 2027	6/6
Mark Bailie	Non-Executive Director	18 February 2027	6/6
Dr David Bennett ⁵²	Non-Executive Director	31 July 2027, or until NHS England is disestablished	2/4
Ravi Gurumurthy ⁵³	Non-Executive Director	31 July 2027, or until NHS England is disestablished	4/4
Paul Corrigan ⁵⁴	Non-Executive Director	31 July 2027, or until NHS England is disestablished	4/4
Professor Sir Sam Everington ⁵⁵	Non-Executive Director	31 July 2027, or until NHS England is disestablished	3/4
Louise Ansari ⁵⁶	Non-Executive Director	31 July 2027, or until NHS England is disestablished	3/4
Sir James Mackey ⁵⁷	Chief Executive Officer		6/6
David Probert ⁵⁸	Deputy Chief Executive Officer/ Interim Director General, Performance and Delivery		5/6
Elizabeth O'Mahony ⁵⁹	Chief Financial Officer/ Director General, Finance		6/6
Duncan Burton	Chief Nursing Officer for England		6/6
Professor Meghana Pandit ⁶⁰	Co-National Medical Director - Secondary Care	30 September 2026	4/6
Dr Claire Fuller ⁶¹	Co-National Medical Director - Primary Care		5/6
Sarah-Jane Marsh ⁶²	National Priority Programme Director for Urgent and Emergency Care		5/6
Paul Dinkin ⁶³	Director General, Strategy and Healthcare Policy		2/2

⁵⁰ Biographical details are published on our website <https://www.england.nhs.uk/about/nhs-england-board/our-leadership-team/>

⁵¹ Sir Andrew Morris's term as Non-Executive director was extended until 31 July 2027, or until NHS England is disestablished.

⁵² Dr David Bennett was appointed on 1 August 2025.

⁵³ Ravi Gurumurthy was appointed on 1 August 2025.

⁵⁴ Paul Corrigan was appointed on 1 August 2025.

⁵⁵ Professor Sir Sam Everington was appointed on 1 August 2025.

⁵⁶ Louise Ansari was appointed on 1 September 2025.

⁵⁷ Sir James Mackey was appointed on 1 April 2025.

⁵⁸ David Probert was appointed as Deputy Chief Executive Officer on 1 May 2025, and Interim Director General, Performance and Delivery on 1 November 2025.

⁵⁹ Elizabeth O'Mahony was appointed Chief Financial Officer on 1 April 2025, and Interim Director General, Finance on 1 November 2025. She was appointed as Director General, Finance on 11 December 2025.

⁶⁰ Professor Meghana Pandit was appointed on 1 April 2025 and is a joint member with Dr Claire Fuller under Standing Order 4.7.

⁶¹ Dr Claire Fuller was appointed on 1 April 2025 and is a joint member with Professor Meghana Pandit under Standing Order 4.7.

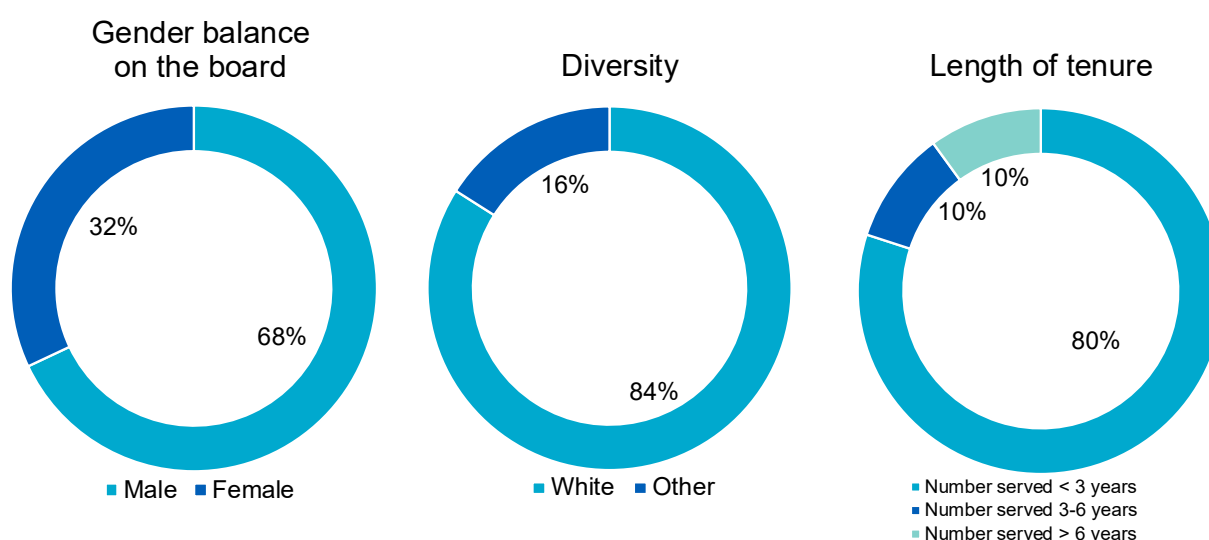
⁶² Sarah-Jane Marsh became a Board member from 29 May 2025.

⁶³ Paul Dinkin was appointed on 12 January 2026.

Former members	Role	End date
Professor Sir Mark Walport	Non-Executive Director	24 June 2025
Mike Coupe	Non-Executive Director	31 July 2025
Professor the Baroness Mary Watkins	Non-Executive Director	31 July 2025
Professor Sir Simon Wessely	Non-Executive Director	31 July 2025
Jane Ellison	Non-Executive Director	31 July 2025
Professor Sir Stephen Powis	National Medical Director	20 July 2025
Suresh Viswanathan	Associate Non-Executive Director	1 October 2025
Tom Kibasi	Executive Director of Strategy	11 January 2026

Board diversity

The charts below show the composition of the Board members by gender, diversity, and tenure as of 31 March 2026.



The governance structure

The Board Governance Framework was reviewed and updated in September 2025 to streamline and strengthen decision making, reflect organisational changes and support the planned integration with the DHSC. 3 new Board committees were established: People Committee, Strategy Committee, and Finance and Performance Committee. A fourth committee, the Research, Innovation, and Growth Board, was established in February 2026. The People and Remuneration Committee and Nomination Committee were disbanded and their duties transferred to the newly established People Committee. The Workforce, Training and Education Committee was also disbanded and its duties transferred to the People Committee and Finance and Performance Committee. The New Hospital Programme Delivery Committee was discontinued and its duties reassigned to the DHSC New Hospital Programme Board, and an NHS England NED was appointed to chair this Board. An overview of the Board governance framework is shown on the next page and individual Board committee reports can be found from page 55 to 62. A report detailing the business considered by the Board committees is provided for each Board meeting.

Board activity and administration

There were 6 NHS England Board meetings during the year, each including a public and private session. The option for members of the public to attend public sessions in person was available throughout the year, excluding 1 meeting held in the South West region. Public sessions were live video streamed and published on our website along with the agenda, papers, and minutes.⁶⁴

In addition to the 6 formal meetings, the Board also held various NED and Executive sessions, subject-specific workshops and deep dives.

During 2025/26, the Board provided strategic leadership and oversight across a wide range of programmes that supported delivery of the 10 Year Health Plan and ensured that NHS England continued to meet its statutory functions. The Board considered and approved key national frameworks, including the NHS Oversight Framework for 2025/26⁶⁵, which set out the approach to assessing performance and identifying areas for improvement across providers and ICBs.

The Board oversaw medium and long-term planning arrangements, including the Medium -Term Planning Framework for 2026/27 to 2028/29⁶⁶, and received updates on delivery of the 10 Year Health Plan. This included consideration of the evolving operating model for the NHS, updates on ICB mergers and running cost plans, and development of the Model Region Blueprint.

Quality and safety remained a significant focus throughout the year. The Board reviewed the developing National Quality Strategy, received updates on national improvement priorities such as UEC, frailty, outpatients, and digitalisation, and endorsed a strengthened model for supporting improvement across systems. The Board also examined NHS estates matters, including a review of estate challenges across the NHS and the actions required to address risks to patient safety.

The Board maintained close oversight of operational and financial performance. Routine reporting covered the integrated performance position, in-year financial forecasts, and progress in delivering 2025/26 plans. The Board also approved the NHS Supply Chain business plan for 2026/27 in its role as sole shareholder.⁶⁷

The Board continued to provide oversight of national workforce planning, including the development of the 10 Year Workforce Plan, and received updates on leadership capacity and the capability of national improvement functions. It also reviewed major clinical and service programmes, including the National Cancer Plan, the UEC medium-term strategy, Neighbourhood Health, and reforms to planned care.

⁶⁴ <https://www.england.nhs.uk/about/nhs-england-board/meetings/>

⁶⁵ <https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/>

⁶⁶ <https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/>

⁶⁷ <https://www.supplychain.nhs.uk/about-us/business-plan/>

Digital and data transformation formed a substantial part of the Board's business. The Board considered the NHS Tech, Digital and Data delivery plan, Spending Review business cases, and data transparency reforms.

The Board continued to discharge its governance responsibilities. It reviewed the organisation's principal risks, received statutory reports on use of the NHS England Seal, and continued to hold public Board meetings, ensuring transparency and accountability to Parliament and the public.

Review of Board effectiveness and performance evaluation

Board effectiveness has been reviewed on a regular basis, primarily through annual internal reviews. Due to changes in leadership in 2024/25 a formal internal review was not undertaken; however, the Board continued to reflect on its effectiveness through more informal means. Changes made to the Board's committee structure in September 2025, as set out above, were intended to support improved effectiveness and clarity of oversight. At the time of writing, the internal Board effectiveness review for 2025/26 is being implemented.

Events after the reporting period

On 1 April 2026, changes were made to the NHS England Executive team. Following a year in post as Deputy Chief Executive and Interim Performance and Delivery Director General, David Probert returned to his substantive role at University College London Hospitals. Glen Burley, Financial Reset and Accountability Director, and Professor Meghana Pandit, Co-National Medical Director for Secondary Care, were appointed as joint Deputy Chief Executives. Sarah-Jane Marsh was appointed Chief Operating Officer of NHS England. Our website is updated regularly to reflect appointments.⁶⁸

⁶⁸ <https://www.england.nhs.uk/about/nhs-england-board/our-leadership-team/>

Board committees

Audit and Risk Assurance Committee (ARAC)

Role	The Committee's primary role is to provide assurance to the Board about the integrity of NHS England's financial statements and the comprehensiveness, reliability and integrity of its internal control, risk management and governance processes.
Frequency	The Committee met 6 times in the financial year.
Membership	The Committee is made up of 3 NEDs and 1 non-voting member. Additional attendees are invited to meetings to assist with committee business. The Committee can meet with the internal and external auditors without management when required, and the auditors have direct access to the Board Chair and committee chair to support independence.
Principal activities during the year	ARAC approved the internal audit plan and reviewed regular progress reports, including the annual Head of Internal Audit Opinion. The Committee evaluated risk management governance and reviewed NHS England's principal risks. The Committee also assessed the integrity of NHS England's financial reporting and approved the 2024/25 Annual Report and Accounts. Additionally, it reviewed details of losses and special payments and considered NAO reports and management letters, including updates on the NAO Value for Money Programme. ARAC has held 2 joint sessions with the DHSC's Audit and Risk Committee. They reviewed organisational transition governance and risk relating to the DHSC-NHS England Transformation Programme, a joint approach to internal audit provision, internal audit planning principles and accounts and external audit.

Members	Number of eligible meetings attended	Comment
Jeremy Townsend (Chair)	6/6	Non-Executive Director
Mark Bailie	3/6	Non-Executive Director
Paul Corrigan ⁶⁹	4/4	Non-Executive Director
Mike Coupe ⁷⁰	2/2	Non-Executive Director
Jane Ellison ⁷¹	2/2	Non-Executive Director
Richard Douglas	6/6	Non-Executive Chair of DHSC's Audit Committee (non-voting member)

⁶⁹ Paul Corrigan joined the Committee membership on 18 September 2025.

⁷⁰ Mike Coupe left the NHS England Board on 31 July 2025.

⁷¹ Jane Ellison left the NHS England Board on 31 July 2025.

Finance and Performance Committee

Role	The Committee was established by the NHS England Board to provide oversight and objective assurance on NHS England's and the wider NHS's financial and operational performance, and on risks within the Committee's remit. The Committee considers system performance across finance, operational delivery and workforce domains, including financial sustainability, productivity and performance against key operational standards, to identify areas where improvement is required and to ensure that appropriate actions are in place to support the delivery of organisational objectives.
Frequency	The Committee met 3 times in the financial year.
Membership	The Committee is comprised of 4 NEDs, including the Chair of NHS England, alongside executive members including the Chief Executive Officer, Chief Financial Officer and other senior leaders responsible for performance, delivery and priority programmes. Additional directors attend each meeting to support the business of the Committee.
Principal activities during the year	During the year, the Committee provided oversight of financial planning, performance and delivery across NHS England, including regular review of the financial position, risks and forecasts, and scrutiny of the 2026/27 planning process, system plans and allocations. It approved key elements of the financial framework, including the Payment Scheme and capital allocations, and examined reforms to incentives and contracting to strengthen accountability and support the shift towards community based care. The Committee also reviewed operational, workforce and education performance, supported assurance on challenged systems, and considered winter and delivery risks. In addition, it scrutinised major transformation proposals, including the NHS Online Programme.

Members	Number of eligible meetings attended	Comment
Dr Penny Dash	2/3	Chair of NHS England
Sir Andrew Morris	3/3	Deputy Chair, NHS England
Jeremy Townsend	2/3	Non-Executive Director
Professor Sir Sam Everington	2/3	Non-Executive Director
Sir James Mackey	2/3	Chief Executive Officer
Elizabeth O'Mahony	3/3	Chief Financial Officer/ Director General, Finance

Data, Digital and Technology Committee

Role	The role of the Committee is to consider and make recommendations on the digital and technology strategy, including cyber strategy, to the Board and oversee its implementation. It provides strategic oversight, assurance, and expert advice on the development, implementation, and governance of digital, data, and technology functions across NHS England and the wider NHS.
Frequency	The Committee met 6 times in the financial year.
Membership	The Committee is made up of 2 NEDs, 2 Board Advisers and 3 executive members. A DHSC NED joined in September 2025 and the DHSC Permanent Secretary joined in January 2026. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The Committee provided oversight of a broad portfolio of strategic initiatives, including the NHS England Resilience Programme, Cyber Accelerator, development of the NHS App, implementation of the EPR, and the Single Patient Record. It received regular performance and delivery reports, including updates on business planning and spending review preparations, and reviewed the digital and technology operating model. The Committee also championed clear business ownership of technology investments to ensure that the operational and organisational changes required to realise the intended benefits are in place.

Members	Number of eligible meetings attended	Comment
Mark Bailie (Chair)	6/6	Non-Executive Director
Robert Lechler	6/6	Non-Executive Director
Mark Walport ⁷²	1/1	Non-Executive Director
Michael Coupe ⁷³	2/2	Non-Executive Director
Suresh Viswanathan ⁷⁴	3/3	Associate Non-Executive Director
Steve Woodford ⁷⁵	5/5	Non-Executive Member
Daniel Benton ⁷⁶	1/1	Non-Executive Member
Jamie Saunders	4/4	Board Adviser
Junaid Bajwa ⁷⁷	3/3	Board Adviser
Julian Hunt ⁷⁸	3/3	Interim Director General, Technology, Digital and Data
Ming Tang ⁷⁹	3/3	Chief Data and Analytics Officer / Interim Chief Digital Information Officer
Paul Dinkin	1/2	Director General, Strategy and Healthcare Policy
Phil Jordan	3/3	DHSC Non-Executive Director
Sam Jones	2/2	Permanent Secretary

⁷² Mark Walport left the NHS England Board on 24 June 2025

⁷³ Mike Coupe left the NHS England Board on 31 July 2025.

⁷⁴ Suresh Viswanathan left the NHS England Board on 1 October 2025.

⁷⁵ Steve Woodford's tenure as a Non-Executive Member ended on 31 December 2025.

⁷⁶ Daniel Benton's tenure as a Non-Executive Member ended on 31 May 2025.

⁷⁷ Junaid Bajwa joined the Data, Digital and Technology Committee in November 2025.

⁷⁸ Julian Hunt became a full member of the Committee in November 2025.

⁷⁹ Ming Tang became a full member of the Committee in November 2025.

Quality Committee

Role	The primary role of the Committee is to support the Board in ensuring that quality, defined as clinical effectiveness, safety, experience, being well-led and sustainability, continues to improve and develop in order to meet the needs of patients in England. In doing this, the Committee receives assurance as to whether NHS England is delivering its functions, initiatives and policies in a way that ensures continuous improvement in the quality and safety of services, patient experience and clinical effectiveness. This includes reducing inequalities in health outcomes.
Frequency	The Committee met 5 times in the financial year.
Membership	The Committee is made up of the Chair of NHS England, 4 NEDs, 4 National Directors and up to 4 Patient and Public Voice (PPV) members. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The Committee oversaw the development of an Integrated Quality Report and contributed to the development of an NHS Quality Strategy. The Committee received updates on issues and challenges for a number of clinical programmes including Maternity and Neonatal, Children and Young People, Palliative and End of Life care, Stroke, and Learning Disability and Autism. The Committee also reviewed all risks relating to quality of care and patient safety on the risk register, ensuring appropriate mitigations are in place.

Members	Number of eligible meetings attended	Comment
Professor Sir Robert Lechler (Chair) ⁸⁰	4/4	Non-Executive Director
Professor Sir Simon Wessely ⁸¹	0/1	Non-Executive Director
Dr Penny Dash	5/5	NHS England Chair
Louise Ansari ⁸²	3/4	Non-Executive Director
Professor Sir Sam Everington ⁸³	4/4	Non-Executive Director
Professor the Baroness Mary Watkins ⁸⁴	1/1	Non-Executive Director
Dr Aidan Fowler	2/5	National Director of Patient Safety
Sir Andrew Morris	1/5	Non-Executive Director
Duncan Burton	4/5	Chief Nursing Officer for England
Professor Sir Stephen Powis ⁸⁵	0/1	National Medical Director
Professor Meghana Pandit	5/5	Co-National Medical Director (Secondary Care)
Dr Claire Fuller ⁸⁶	3/5	Co-National Medical Director (Primary Care)
Sarah Jane Marsh	4/5	National Priority Programme Director for Urgent and Emergency Care
Amanda Doyle	1/5	National Director for Primary Care and Community Services

⁸⁰ Professor Sir Robert Lechler declared a conflict of interest and recused himself from one meeting, which was chaired by the NHS England Chair, Penny Dash.

⁸¹ Professor Sir Simon Wessely left NHS England on 31 July 2025.

⁸² Louise Ansari became a member of the Quality Committee in September 2025.

⁸³ Professor Sir Sam Everington became a member of the Quality Committee in September 2025.

⁸⁴ Professor the Baroness Mary Watkins left the NHS England Board on 31 July 2025.

⁸⁵ Professor Sir Stephen Powis left NHS England on 20 July 2025.

⁸⁶ Dr Claire Fuller declared a conflict of interest and recused herself from one meeting.

Members	Number of eligible meetings attended	Comment
Andrea Lewis ⁸⁷	1/1	Interim Deputy Chief Nursing Officer
Michelle Bateman ⁸⁸	4/4	Deputy Chief Nursing Officer
Patient and Public Voice members	5/5	

Research, Innovation and Growth Board

Role	The Research, Innovation and Growth Board has been established to support delivery of ambitions set out in the 10 Year Health Plan and Life Sciences Sector Plan related to innovation in health and healthcare.
Frequency	The Board met once in the financial year.
Membership	The Board is made up of the Chair of NHS England, 1 NED, 7 National Directors, the Director Office for Life Sciences, and individuals from industry. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The Board agreed to its terms of reference and proposed a future workplan. It also received updates regarding a European MedTech leaders Event and NHS Genomics. The Board discussed accountabilities and delegated business from the Life Sciences Delivery Board.

Members	Number of eligible meetings attended	Comment
Dr Penny Dash	1/1	Chair, NHS England
Robert Lechler	1/1	Non-Executive Director
Alex McLaughlin	1/1	Interim Director, Office for Life Sciences
Paul Dinkin	1/1	Director General, Strategy and Healthcare Policy
Fiona Bride	1/1	Interim Director General, Commercial and Growth
Jules Hunt	1/1	Interim Director General, Technology, Digital and Data
Professor Meghana Pandit	1/1	Co-National Medical Director
Jonathan Benger	1/1	Chief Executive, National Institute for Health and Care Excellence
Ben Bridgewater	1/1	Executive Chair, Health Innovation Network
Lucy Chappell	1/1	Chief Scientific Advisor
Elizabeth O'Mahony	0/1	Chief Financial Officer / Director General, Finance
David Probert	0/1	Interim Director General, Performance and Delivery
Louis Taylor	0/1	CEO, British Business Bank
Lawrence Tallon	0/1	Chief Executive, Medicines and Healthcare products Regulatory Agency

⁸⁷ Andrea Lewis stepped down from her interim role in June 2025.

⁸⁸ Michelle Bateman was appointed in June 2025.

People Committee (formerly People and Remuneration Committee)

Role	The Committee supports the Board in ensuring that NHS England, as an employer, has effective arrangements in place for the recruitment, development and management of its people. It provides strategic oversight and assurance to the Board in relation to people management, leadership capability, talent and organisational development. The Committee supports the Board in ensuring that high calibre leaders are in place across NHS England and, where appropriate, across the wider NHS in England. In discharging its responsibilities, the Committee exercises delegated authority on behalf of the Board in relation to senior appointments, terminations and remuneration matters within its remit, ensuring these are undertaken in line with agreed policies and governance.
Frequency	The Committee met 5 times in the financial year.
Membership	The Committee is made up of 3 NEDs and the Chair of NHS England. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The Committee oversaw leadership, culture and people management across NHS England during a period of significant organisational change. It provided assurance on leadership arrangements to support the transition to 27 ICBs, including Chair and Chief Executive appointments, succession planning and associated risks. The Committee reviewed progress in strengthening management and leadership capability, including the development of national standards and improvement of line management at scale. It maintained oversight of senior appointments and talent pipelines, with a focus on diversity, independence and candidate experience. A key area of focus was the NHS England voluntary redundancy (VR) programme, where the Committee monitored delivery, financial parameters and workforce risks, including organisational capacity and alignment with the future operating model. The Committee also provided assurance on improvements to people management and HR operations and oversaw organisational development activity to support cultural alignment and staff engagement during transformation. The Nominations Committee did not meet between 1 April 2025 and 31 August 2025, when its duties were transferred to the People Committee.

Members	Number of eligible meetings attended	Comment
Jane Ellison (Chair) ⁸⁹	3/3	Non-Executive Director
Louise Ansari (Chair) ⁹⁰	2/2	Non-Executive Director
Sir Andrew Morris ⁹¹	5/5	Non-Executive Director
Dr Penny Dash ⁹²	3/5	NHS England Chair
Paul Corrigan ⁹³	2/2	Non-Executive Director
Professor the Baroness Mary Watkins ⁹⁴	3/3	Non-Executive Director

⁸⁹ Jane Ellison left the NHS England Board on the 31 July 2025.

⁹⁰ Louise Ansari joined the People Committee in September 2025.

⁹¹ Sir Andrew Morris was a member of PRC and became a member of the People Committee.

⁹² Dr Penny Dash joined PRC on the 1 April 2026 and is a member of the People Committee.

⁹³ Paul Corrigan joined the People Committee in September 2025.

⁹⁴ Professor the Baroness Watkins left the NHS England Board on the 31 July 2025.

Strategy Committee

Role	The role of the Committee is to support the Board by shaping the strategic direction of NHS England as well as the broader health and care strategy. The Committee is responsible for ensuring that the organisation is aligned with and delivering on its strategic priorities, including those outlined in the 10 Year Health Plan. The Committee informs and supports the delivery of a set of high priority strategies and policy programmes to deliver improvements in access, quality, value and outcomes across the NHS alongside a reduction in health inequalities and wider public health efforts.
Frequency	The Committee met 3 times in the financial year.
Membership	The Committee is made up of 3 NEDs, the Chair of NHS England, the Chief Financial Officer, Chief Executive Officer, National Medical Directors, Chief Nursing Officer for England, Director General and the Deputy Chief Executive Officer for Strategy and Healthcare Policy. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The Committee reviewed all current and planned strategy and policy projects and work programmes. It reviewed and endorsed strategies including Quality, Professional Strategy for Nursing and Midwifery, UEC and considered the strategic approach to improving services for Children and Young People. They endorsed the 10 Year Workforce Plan, Centre Led Commercial Intervention Approach, Payment system objectives and proposed work priorities and the Productivity Plan.

Members	Number of eligible meetings attended	Comment
Dr David Bennett (Chair)	3/3	Non-Executive Director
Professor Sir Sam Everington	2/3	Non-Executive Director
Ravi Gurumurthy	3/3	Non-Executive Director
Penny Dash	3/3	Chair of NHS England
Sir James Mackey	1/3	Chief Executive Officer
Elizabeth O'Mahony	3/3	Chief Financial Officer/ Director General, Finance
Paul Dinkin ⁹⁵	2/2	Director General, Strategy and Healthcare Policy
Duncan Burton	2/3	Chief Nursing Officer for England
Claire Fuller	2/3	National Medical Director (Primary Care)
Professor Meghana Pandit	2/3	National Medical Director (Secondary Care)
David Probert	2/3	Deputy Chief Executive Officer

⁹⁵ Paul Dinkin became a member of the Strategy Committee in January 2026.

Workforce, Training and Education Committee

Role	The Committee's role was to have oversight of all functions that ensure the NHS in England has a workforce with the capacity, knowledge, skills, values and behaviours to deliver compassionate, high-quality health and care to the people it serves.
Frequency	The Committee met once in the financial year. It was disbanded in April 2025 as part of the updated governance framework.
Membership	The Committee was made up of 3 NEDs and 2 Non-Executive members. Additional attendees were routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The Committee was assured on delivery of the Workforce, Training & Education (WT&E) delivery plan and of performance across the system against the WT&E priorities for the NHS.

Members	Number of eligible meetings attended	Comment
Sir Andrew Morris (Chair)	1/1	Non-Executive Director
Professor the Baroness Mary Watkins	1/1	Non-Executive Director
Professor Sir Mark Walport	1/1	Non-Executive Director
John Latham	1/1	Non-Executive Member
Professor Andrew George	1/1	Non-Executive Member

Board disclosures

Functional conflicts

NHS England maintains a policy on conflicts between functions to support compliance with its duty under new section 13SB of the National Health Service Act 2006 (inserted by section 34 of the Health and Care Act 2022). The policy sets out arrangements to minimise the risk of conflicts, including those arising between the regulatory functions and NHS England's other functions, and describes how any conflicts will be managed. It includes processes for handling individual conflicts (notifiable to the Board Secretariat) and provides for escalation to a non-executive panel where required.

The need to mitigate functional conflicts was considered as part of the setup of the Independent Patient Choice and Procurement Panel. The Panel is structured in a way that reduces the risk of conflicts with NHS England functions. Panel members are employees for tax purposes only, are not managed by NHS England, and are treated as a separate group. There may be potential conflicts between individual Panel members and the organisations involved in specific cases. To manage this, conflicts are checked at the start of each Panel meeting and before panel members are assigned to cases. With 5 panel members available, and only 2 required for each case, there is capacity to allocate members who have no declared conflict. During 2025/26, no conflicts were notified to the Board Secretariat.

Disclosure of personal data breach incidents

For the disclosure of personal data breach incidents, NHS England follows the Data Security and Protection Toolkit (DSPT) Incident Reporting process guidance. This is in line with the UK General Data Protection Regulation (UK GDPR). The DSPT sets out the reporting requirements for NHS organisations where a potential or actual incident may lead to a personal data breach as defined under UK GDPR. All organisations that have access to NHS patient data and systems must use DSPT to provide assurance that they are practising good data security, and where required under UK GDPR, to report a personal data breach to the Information Commissioner's Office (ICO).

In 2025/26, NHS England reported 382 personal data breaches to the Data Protection Officer (DPO). 4 of these were reported to the ICO voluntarily or where they met the threshold for reporting under UK GDPR.

Register of Board members' interests

Personal interests held by Board and committee members are managed in accordance with the NHS England Standing Orders and the Standards of Business Conduct policy. The organisation maintains a register of members' interests to ensure that potential conflicts of interest can be managed appropriately. Board members and executives are also required at the beginning of each Board and committee meeting to declare any personal interest they might have in any business on the agenda and abstain from relevant Board or committee discussions as required. Where potential conflicts arise, they are recorded in the Board and committee minutes along with any appropriate action to address them. A copy of the register of interests is available on our website. Note that this only reflects Board members currently in post.⁹⁶

Details of related party transactions, where NHS England has transacted with other organisations during the year to which a Board or an executive is connected, are set out in Note 19 on page 167.

Directors' responsibility statement

The Annual Report and Accounts have been reviewed in detail by NHS England's ARAC and Board. At each point it has been confirmed that the Annual Report and Accounts, taken as a whole, are considered to be fair, balanced, and understandable. They provide the information necessary for NHS England's stakeholders to assess the business model, performance, and strategy.

Directors' third-party indemnity provisions

NHS England has the appropriate director's and officer's liability indemnity in place for legal action brought against, among others, its executive and NEDs, by virtue of its membership of the statutory Liabilities to Third Parties Scheme administered by NHS Resolution. During 2025/26, there were no legal claims brought against NHS England directors.

⁹⁶ <https://www.england.nhs.uk/publication/our-board-members-register-of-interests>

Human rights

NHS England supports the Government's objectives to eradicate modern slavery and human trafficking. The NHS England Slavery and Human Trafficking Statement for the financial year ending 31 March 2026 is available on our website.⁹⁷

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health and Social Care (with the consent of HM Treasury) has directed NHS England to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS England and of its income and expenditure, statement of financial position and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual (FrEM)⁹⁸ and in particular to:

- observe the Accounts Direction issued by the DHSC, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards, as set out in the Government FrEM, have been followed and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis
- confirm that the Annual Report and Accounts are fair, balanced, and understandable, and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that they are fair, balanced and understandable.

The National Health Service Act 2006 (as amended) schedule 1(A) paragraph 15(4) states that the Chief Executive shall be the Accounting Officer of NHS England.

The responsibilities of the Accounting Officer, including responsibilities for the propriety and regularity of the public finances for which the Accounting Officer is answerable and for keeping proper records and safeguarding NHS England's assets are set out in Managing Public Money (HM Treasury, July 2013, as amended April 2026).⁹⁹

As the Accounting Officer for NHS England, I have taken the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS England's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

⁹⁷ <https://www.england.nhs.uk/long-read/modern-slavery-guidance-and-annual-statement/>

⁹⁸ <https://www.gov.uk/government/publications/government-financial-reporting-manual-2025-26>

⁹⁹ <https://www.gov.uk/government/publications/managing-public-money>

Governance statement

This governance statement covers NHS England, its system leadership role of the NHS, directly commissioned health services, and oversight and assurance of the commissioning system.

Following the government's announcement in March 2025, NHS England will undergo significant structural reform as part of the 10 Year Health Plan to build an NHS fit for the future. The organisation's functions will be streamlined and integrated into the DHSC subject to parliament's approval, to increase efficiency and alignment and redirect resources towards frontline patient services. This structural transformation represents part of broader healthcare reforms that are necessary to address the critical challenges facing the NHS and ensure its long-term sustainability.

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS England's aims and objectives, while safeguarding public funds and the assets for which I am personally responsible in accordance with Managing Public Money and as set out in my Accounting Officer appointment letter.

This includes the assurance of several organisations which are part of the wider commissioning system, including those organisations hosted by NHS England.

My responsibilities in relation to the oversight of ICBs are set out from page 71.

Board arrangements

Information on our Board and its committees is set out from page 55.

Freedom to Speak Up

Our report on whistleblowing disclosures made by NHS workers is published on our website.¹⁰⁰

Government functional standards

Functional standards¹⁰¹ set out what needs to be done, and why, for different types of functional work and were mandated for use in Governmental departments and their Arm's Length Bodies (ALBs) from the end of March 2022. The extent to which these standards are adopted across NHS England varies, and certain elements of the standards are not applicable to the organisation.

¹⁰⁰ <https://www.england.nhs.uk/ourwork/freedom-to-speak-up/whistleblowing-disclosures/>

¹⁰¹ <https://www.gov.uk/government/publications/dao-0521-mandating-functional-standards-from-end-september-2021>

Governance arrangements and effectiveness

Governance framework

The Governance Manual brings together key strands of governance and assurance, including the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Assessment against the Corporate Governance in Central Governance

Departments: Code of Good Practice 2017 Compliance Checklist

As part of implementing best practice, an assessment is undertaken each year against this checklist from HM Treasury. NHS England is compliant¹⁰² against the provisions of the code, with the following exceptions:

Ref	Code provision	Exception
4.7	Through the Board Secretariat, the Department provides the necessary resources for developing the knowledge and capabilities of Board members, including access to its operations and staff	This responsibility is shared between the Chair, the Chief Executive's private office and the Board Secretary
4.11	The Board Secretary's responsibilities include arranging induction and professional development of Board Members	This responsibility is shared between the Chair, Chief Executive's private office and the Board Secretary
4.12	The lead Non-Executive board member supports the chair to ensure a board effectiveness evaluation is carried out annually, and is carried out with independent input at least once every 3 years	Board effectiveness has been reviewed on a regular basis, primarily through annual internal reviews. Due to changes in leadership in 2024/25 a formal internal review was not undertaken; however, the Board continued to reflect on its effectiveness through more informal means. Changes made to the Board's committee structure in September 2025 were intended to support improved effectiveness and clarity of oversight. At the time of writing, the internal Board effectiveness review for 2025/26 is being implemented. An independent external review has not been undertaken in the last 3 years, due to significant ongoing organisational change.
5.5	The Head of Internal Audit is periodically invited to attend Board meetings, where key issues are discussed relating to governance, risk management, or control issues across the department and its ALBs	The Head of Internal Audit routinely attends ARAC meetings

¹⁰² It should be noted that the following provisions in the code do not apply to NHS England: Sections 1, 2.3, 2.11, 3.3a, 3.3b, 3.3c, 3.6e, 3.7, 3.8, 3.9, 3.14, 3.19, 4.9, 4.12, 4.13, 4.14, 5.7, 5.8 and 6.

Corporate assurance

The NHS England corporate assurance framework, set out below, helps to provide assurance on organisational stewardship and the management of significant risks to organisational objectives.

Assurance activity	How does it add value?
Organisational change framework Guidelines for assessing and implementing major changes across the organisation.	The framework provides a consistent approach to thinking about the impact of organisational change, including on people, infrastructure, financial and legal issues.
Risk management framework Our approach to managing risk, including tools and methodologies for identifying, assessing, mitigating, documenting and reporting risk.	The framework enables a consistent approach to be taken across the organisation, allowing identification of cross-directorate risks and challenges. It provides a mechanism for managers to identify risks, supports the management of risk and provides a route of escalation to those accountable.
Programme management framework The policies, tools, methodology and resources that provide an approach to managing, controlling and assuring the delivery of projects and programmes in the organisational portfolio.	Provides staff with a framework to manage, control and deliver projects and programmes. Provides the organisation with consistency of reporting and monitoring, confidence of delivery of outcomes to enable decision-making and better resource control.
Contract management framework Guidelines for the assurance required for managing third-party contracts.	Ensures directorates responsible for major contracts assign a contract manager and put arrangements in place to monitor supplier performance. Obtains assurance over the services provided.
Corporate policy framework The methodology and approach for creating, maintaining and amending policies.	Provides an approach to help ensure policy documents are not developed in isolation, so they are balanced against the priorities of the organisation.

We work with the support of both our internal and external auditors to strengthen and embed our assurance framework. All directorates and regions have designated leads with responsibility for ensuring that risk management, implementation of internal audit actions and other key assurance activities are properly carried out, including regular reporting and escalation.

During 2025/26, the corporate governance and compliance teams worked across the organisation to improve and embed controls by:

- ensuring that officers declared relevant interests in line with the Standards of Business Conduct Policy
- introducing 'horizontal' risk oversight by subject matter experts, strengthening corporate risk awareness, risk aggregation and escalation
- further enhancing risk governance, mapping our most significant risks to Board Committees for more direct oversight and challenge
- carrying out targeted interventions with teams to ensure the timely completion of actions arising from internal audit reviews
- undertaking assurance reviews for some of our statutory functions
- conducting checks that expense claims and travel bookings are compliant with the business travel and expenses policy.

Management assurance

During 2025/26, the Board received assurance through a structured programme of regular reporting and focused discussion aligned to its agreed agenda cycle. Board meetings included standing items providing oversight of performance against statutory and constitutional requirements, delivery of strategic priorities, and key quality, workforce, and financial metrics. In addition, the Board received in-depth reports on priority programmes and areas of risk, enabling scrutiny of delivery, emerging issues, and mitigating actions.

This assurance was complemented by the work of board committees, which met regularly and reported to the Board on progress, risks and issues within their respective remits. Collectively, this approach supported the Board in discharging its responsibilities for oversight of performance, quality and delivery throughout the year.

Individual programme boards and oversight groups, each with responsibility for delivery of their programmes, meet frequently, with representatives from national and regional teams.

Assuring the quality of data and reporting

The Board has agreed the information it requires to carry out its duties. The Board is confident that performance reports have been through appropriate management review and scrutiny, and that reporting continues to evolve to meet changing organisational needs.

Risk governance

NHS England manages a wide range of risks to support the delivery of safe, effective services and meet our long-term objectives. The Board sets the organisation's overall risk appetite, outlining how much risk we are willing to take, and keeps our risk profile under regular review. The Board monitors our most significant risks and the actions being taken to reduce their likelihood and impact.

The ARAC provides independent oversight of how well risks are being managed. It reviews the effectiveness of our risk management systems and ensures that appropriate controls are in place across NHS England.

Executive and Board committees review key strategic and operational risks throughout the year. They test whether actions to manage risk are robust and whether further action or escalation is required. Periodic in-depth reviews provide additional assurance where risks are more complex or remain outside our agreed appetite.

The Executive Risk Group brings together senior leaders to monitor risks across the organisation and provide assurance on their management to ARAC. They also undertake detailed deep-dive reviews of risks when needed. The NHS Executive also regularly reviews all risks recorded on the SRR and ORR.

Leadership on risk is provided by the Chief Executive Officer and directors collectively, who set expectations for how risk should be identified and managed across the organisation. Each directorate and region maintains its own risk register and is responsible for keeping those risks under regular review. The NHS England Executive collectively own the SRR and ORR, with named directors accountable for each risk.

During the year NHS England has complied with the main principles of The Orange Book: Management of Risk.

Significant risks

Across the SRR and ORR, NHS England monitors more than 40 risks. The SRR focuses on risks that could affect delivery of our long-term strategic objectives, while the ORR covers key risks linked to systems, processes and in-year performance.

Our risk profile changes throughout the year in response to events and emerging priorities. NHS England considers its most significant risks to be those strategic risks which, over the course of the year, had a very high risk score and remained outside our agreed risk appetite. Those 3 strategic risks meeting that definition are set out in the following section and will remain under ongoing review.

Risk: There is a risk that without robust prioritisation and actions to improve productivity, the funding allocation for the NHS will be insufficient

This year the key controls and mitigations for this risk have focussed on supporting NHS organisations to identify efficiency and productivity improvement opportunities and increase financial grip. NHS England has also identified savings through a review of internal spending. These measures have stabilised the in-year position which gives increased confidence that the NHS can live within the spending review envelope. NHS England continues to support efficiency work in providers and identify opportunities for increasing productivity – including the rollout of technology solutions.

The Medium-Term Planning Framework was published, emphasising financial accountability, phasing out deficit support funding from 2026/27, and requiring 2% annual productivity improvement alongside service transformation aligned with the 10 Year Health Plan.

Financial discipline across the NHS has strengthened significantly over the course of the year. As a result, the risk's current score at the year-end has reduced from 25 to 16. This improvement reflects stronger medium term financial planning, tighter in-year financial management and efficiency delivery.

The target score has been reduced from 20 to 12. This now aligns with the organisation's risk appetite and reflects the progress made to mitigate the risk. The target is ambitious but achievable if current improvements continue.

Looking ahead, NHS England will ensure financial mitigations stay robust as workforce and system pressures develop in 2026/27, NHS England is also preparing for the next spending review and is continuing to work to support the development of efficiency work in all NHS organisations.

Risk: There is a risk that malicious cyber actors deploy widespread, catastrophic cyber-attacks against the NHS leading to patient harm and/or data misuse causing knock-on financial consequences.

The Cyber Improvement programme is focused on delivering against the Cyber Strategy for Health and Care, which seeks to improve Cyber resilience by 2030. During 2025/26 500 staff were trained to increase cyber awareness, 23 Cyber apprentices were embedded in frontline organisations, moving closer to the aim of making our people the greatest asset to reduce cyber risk. Significant direct funding and access to the technical remediation service was directed at frontline organisations to increase cyber resilience, for example through hardening identity management and privileged access to systems. A threat intelligence sharing capability was implemented with almost 1,000 users onboarded, enabling Health & Care organisations to receive current and curated Cyber threat information. An operational data platform was developed enabling the national CSOC to receive more precise information regarding potential threats. The DSPT¹⁰³ continues to be aligned to Cyber assessment framework and was uplifted to include independent Operators of Essential Services and Genomics as part of the annual assessment. Incident response and recovery processes have been improved through the development of a Cyber incident and response strategy, guidance and toolkit for the national team and adult social care. A National incident response exercise took place in February 2026, helping to test processes and develop muscle memory. Exercise scenarios have been developed and tested for regional teams, increasing preparedness.

Although there has been significant progress in the last year, there is still much more to do, before the risk score can be reduced from 20, this includes supporting Boards to understand the level of cyber risk they are carrying and putting in place robust plans and support to reduce the risk. Increasing onboarding of organisations to central services providing 24/7 monitoring and delivering a credible and scalable supply chain assurance process. This is against a backdrop of structural uncertainty and considerable variation across the sector in cyber security maturity, risk management practices, and levels of preparedness. This is included in the plan for the Cyber Improvement programme up to 2030 and we will look for opportunities to accelerate work in these areas. Alongside this, we are developing the Cyber Target Operating model for Health

¹⁰³ <https://www.dsptoolkit.nhs.uk/>

and Care, which will be a good step forward in strengthening clarity for organisations relating to their responsibilities and accountabilities for cyber.

Risk: There is a risk of significant data breach resulting in accidental or unlawful loss, alteration, unavailability, unauthorised disclosure of, or access to, personal data causing patient and employee harm, poor clinical outcomes, damage to public trust, lost productivity and financial loss.

Over the past year, the overall level of risk associated with a significant NHS England data breach has remained high, reflecting the continued complexity of the threat environment, the high levels of data processed by NHS England and the wide range of potential causes. Whilst a wide range of cyber, security and data protection risk reducing actions were delivered in 2025/26 (with cyber and security actions progressed in response to linked but separate strategic risks), the overall risk position has not materially reduced due to a variety of risk factors including (but not limited to) external cyber threats, supply chain vulnerabilities and evolving risks such as AI. These risk factors are not unique to NHS England.

The information governance (IG) risk reduction focus for 2025/26 was centred on strengthening governance, controls and staff awareness which resulted in the implementation of updated DPIA templates, data breach response procedures, internal guidance, including on the use of generative AI, raising staff awareness on data breach reduction actions and data breach reporting, and the delivery of training, including the launch of a new mandatory records management training module, all intended to mitigate the risk. For 2026/27, the risk reduction focus builds on the actions delivered in 2025/26, including targeted IG risk reduction actions to mitigate the causes, likelihood and severity of a significant data breach. The implementation of the plan began during quarter 1 of 2026/27 and includes a new IG compliance monitoring process to proactively identify areas for improvement in specific business areas, and further improvements to IG policies, procedures, standards, guidance, staff awareness and training.

Additionally, the Operational Risk Register recorded 9 risks over the course of the year with a very high risk score. 5 of those risks were closed in- year reflecting the implementation of mitigation plans. The 4 ORR risks with very high risk scores which remain open at the end of the financial year are related to:

- Historical non-compliance with IR35 regulations
- System support for the management of Performers List Regulations, Responsible Officer Regulations and NHS England policy related to professional standards
- Digital workforce retention and recruitment
- Ability to deliver proportionately cyber secure and resilient services.

NHS oversight and support

In June 2025, NHS England published the NHS Oversight Framework for 2025/26, setting out how providers and ICBs are assessed through delivery segments and provider capability ratings. The framework provides a holistic view of performance and organisational grip, supporting transparency through the publication of delivery segments and league tables, which are updated quarterly. The 2025/26 framework was transitional, with a commitment to refresh it for 2026/27 in line with the 10 Year Health Plan.

Regulating independent providers of NHS services

All independent providers (IPs) of NHS services are required to hold a provider licence, unless exempt under regulations. The provider licence gives NHS England the ability to safeguard continuity of services for patients if a provider gets into difficulty. As of 31 March 2026, 156 IPs hold a provider licence, as did 3 NHS-controlled providers.

Under the 'commissioner requested services' policy, commissioners are required to tell NHS England's independent provider team which of their services commissioned from IPs need the protections of the licence's continuity of services conditions. Under the 'hard to replace providers' policy, NHS England can apply the same protections where providers deliver regional or national services of significant scale or complexity. As of 31 March 2026, 55 licensed providers were subject to the licence's continuity of services conditions.

During 2025/26 NHS England had reasonable grounds to suspect 2 IPs were in breach of licence conditions. NHS England accepted enforcement undertakings¹⁰⁴ from both organisations. As of 31 March 2026, the undertakings remain in place.

Mergers and acquisitions

NHS England is responsible for risk rating statutory transactions. No statutory transactions were completed during the reporting period.

NHS subsidiaries

NHS England continues to work with key stakeholders across the wider system to update the policy and associated support and regulatory processes for NHS subsidiaries¹⁰⁵ to ensure that they strike the right balance between protecting staff and preserving the freedoms of trusts to innovate in ways that strengthen, rather than fragment, the NHS.

Direct commissioning by NHS England and delegation to ICBs

NHS England's direct commissioning functions cover primary care; specialised services, health and justice, armed forces and vaccinations and screening. NHS England has already delegated responsibility to ICBs for the commissioning of primary care and in April 2025 it also delegated responsibility for an agreed set of specialised services to ICBs. In March 2026 NHS England issued a letter regarding its plans (subject to legislation) to transfer further commissioning functions to ICBs.¹⁰⁶

Primary care services

In 2025/26, NHS England assured delivery of ICBs' delegated commissioning of primary care services (primary medical, dental (primary, secondary and community), general ophthalmic and pharmaceutical services). This has been done in line with the NHS Oversight Framework and ICB annual assessment, with continuous review of key indicator metrics throughout the year. Unwarranted variation and commissioning improvement has been addressed through regional teams throughout the year.

¹⁰⁴ <https://www.england.nhs.uk/publication/regulatory-action-licensed-independent-healthcare-providers/>

¹⁰⁵ <https://www.england.nhs.uk/publication/forming-or-changing-a-subsiary/>

¹⁰⁶ <https://www.england.nhs.uk/long-read/direct-commissioning-update/>

Specialised services

Specialised services support people with a range of rare and complex conditions, often involving innovative treatments for rare cancers, genetic disorders, complex medical conditions or surgical needs.

In April 2025, NHS England delegated commissioning responsibility for 70 specialised services to all ICBs in the North East and Yorkshire, London, South East and South West regions, and an additional 11 services to those ICBs in the Midlands, North West and East of England regions that took on full delegated commissioning responsibilities in April 2024.

The specialised commissioning allocation for specialised services was £28.4 billion at the end of 2025/26. Most of this allocation was issued to ICBs (delegated specialised services) and regional teams (retained specialised services), with the remainder held centrally for national budgets such as the Cancer Drugs Fund and other national programmes.

Local ICB governance arrangements and annual reporting requirements apply to the £16.8 billion spend allocated to ICBs across England, as responsible commissioners. NHS England remained the accountable commissioner for delegated and retained services, with oversight via regional accountability reporting lines.

During 2025/26, the Delegated Commissioning Group for Specialised Services brought together responsible and accountable commissioners to provide strategic direction for the 70 delegated services, set national standards and approve national transformational gateway documents.

The National Commissioning Group (NCG) for Specialised, Health and Justice Armed Forces Services oversaw the commissioning of specialised services by NHS England, set strategic direction and standards, and managed gateway approvals.

The Clinical Priorities Advisory Group made formal recommendations on treatments and interventions for adoption across delegated and retained services.

Health and justice

Health and justice services comprise health services in adult prisons and pre and post custody services, Immigration Removal Centres, children and young people's secure and detained and sexual assault referral centres. At the end of 2025/26 the commissioning allocation for Health and Justice services was £954 million. National partnership agreements support the collaborative approach to aligning strategic priorities with our partners in the Ministry of Justice, His Majesties Prison and Probation Service, Youth Justice Board and Department for Education. Commissioners are supported through the Health and Justice Delivery and Oversight Group nationally, and this feeds into the NCG. NHS England regional teams are the responsible commissioners for health and justice services, working in conjunction with the appropriate national health and justice teams.

Armed Forces

Armed Forces directly commissioned services comprise of secondary and community care for serving personnel and families registered with Defence Medical Services; veterans prosthetics, 3 bespoke physical and mental health services for veterans and the national Armed Forces

Training and Education programme which is available to all NHS staff. They are the responsibility of the national armed forces commissioning team. The national NHS and Ministry of Defence Partnership Agreement and work programme is also agreed and implemented by the national Armed Forces team. This is overseen by the Armed Forces Oversight Group which feeds into the NCG.

Vaccinations and screening – governance and the Section 7A agreement

The annual NHS Section 7A public health functions agreement between NHS England and the DHSC sets out the arrangements under which the Secretary of State delegates responsibility to the NHS England Board for commissioning certain NHS public health services. Under that agreement, NHS England commissions 11 screening programmes, 22 immunisation programmes, and Child Health Information Services (CHIS).

Internal assurance in 2025/26 was provided through the NHS England Vaccinations and Screening Delivery and Transformation Board, informed by programme-specific boards for screening, vaccinations, and CHIS programmes.

Subject to legislation, responsibility for commissioning vaccination, CHIS and almost all components of screening services will be delegated to ICBs in April 2027. Our expectation is that during 2026/27 ICBs will take a more central role in shaping these services. This will be achieved through closer collaboration and partnership with NHS England, as the accountable organisation, and will build on the strong joint working arrangements already in place.

Other assurance

Privacy Transparency and Trust (PTT)

The Privacy, Transparency & Trust (PTT) function provides an operational IG service covering data protection, confidentiality and records management advice and support. This enables NHS England to meet data protection compliance requirements, minimise privacy and confidentiality risks, manage corporate records, and respond to, investigate and report personal data breaches¹⁰⁷ in its processing of personal data and confidential patient information. Following the transfer of the IG Policy & Engagement Team from the Joint Cyber Unit into PTT in October 2025, the PTT function also now produces IG guidance that support other NHS organisations with their IG compliance.

In 2025/26, the PTT function has delivered IG advice, assurance, support and guidance that have enabled NHS England to:

- deliver national digital, technology and data products, platforms and services to other parts of the NHS e.g. Digital Screening and Vaccination Services, NHS App, NHS.net Connect (including Co-Pilot), the continued roll out of the FDP and GP Connect for Medical Examiners
- provide strategic IG support to key NHS 10 year plan programmes
- collect analyse and standardise data on securely controlled analytical platforms lawfully and transparently including the Outcomes and Registries Programme, the Model Health

¹⁰⁷ See 'Disclosure of personal data breach incidents' within the 'Board disclosures' section on page 62

Programme, Getting it Right First Time (GIRFT), Equality, Diversity & Inclusion Programme, and the Health and Growth Accelerator Programme

- support the NHS England and DHSC Transformation Programme on proposed legislative changes required to transfer NHS England's digital and data related functions to the DHSC
- working with the Department for Education to support the uptake of vaccinations in schools through safe and appropriate information sharing, and developing pilots to use the NHS number as a single unique identifier for the purposes of safeguarding
- provide advice and guidance as part of the proposed gender dysphoria data linkage study required following the Cass review¹⁰⁸ and the development of the new Statutory Instrument to support organisations to achieve this¹⁰⁹
- collect, analyse, use and share data for operational, planning, commissioning and research purposes. This includes supporting 6 new Secretary of State directions¹¹⁰ including directions to establish the Open Safely Research Service for research beyond COVID-19, the Digitrials Recruitment Service and the establishment of the General Practice Extraction Service (GPES) GP Data for Consented Research Service¹¹¹
- support other NHS organisations to respond to cyber incidents, including providing information on our website¹¹² to the public and guidance to impacted organisations to support their response to the 2024 attack on Synnovis, a laboratory service provider
- provide guidance on IG matters to other NHS organisations through publication of new guidance on the NHS England IG Portal¹¹³ including Using AI-enabled ambient scribing products¹¹⁴ and template DPIAs for Open Safely¹¹⁵ and the Child Protection Information System¹¹⁶
- effectively manage its corporate records including updates to internal policies and procedures training and transferring historic records to The National Archives
- process personal data appropriately including publication of new corporate IG Policy, new DPIA Procedure, guidance and template, establishing a new DPIA Register and publishing new internal guidance on the Acceptable Use of AI to support the roll out of Co-Pilot within NHS England
- respond to individual rights requests made under UK GDPR, including requests for access to personal data. During 2025/26 NHS England responded to 871 requests from individuals for their personal data
- provide assurance that NHS England is practising good data security, and that personal information is handled appropriately, through its annual submission against the updated standards set out in the DSPT.¹¹⁷ All mandatory standards were met in 2025/26.

Under section 13U(2)(d) of the National Health Services Act 2006, the annual report must contain an assessment of how effectively NHS England has discharged its relevant data functions.¹¹⁸ NHS England has published information on our website¹¹⁹ about the ways NHS England protects data and has regard to the Statutory Guidance on NHS England's Protection of Patient Data (Statutory Guidance)¹²⁰ in the discharge of its function and elsewhere in this Annual Report. In addition, during 2025/26:

¹⁰⁸ <https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143642/https://cass.independent-review.uk/>

¹⁰⁹ <https://statutoryinstruments.parliament.uk/instrument/1nftSDTX/timeline/oQWSkrv6>

¹¹⁰ Under section 254 of the Health and Social Care Act 2012

¹¹¹ <https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notice/secretary-of-state-directions>

¹¹² <https://www.england.nhs.uk/synnovis-cyber-incident/>

¹¹³ <https://transform.england.nhs.uk/information-governance/guidance/>

¹¹⁴ <https://transform.england.nhs.uk/information-governance/guidance/using-ai-enabled-ambient-scribing-products-in-health-and-care-settings/>

¹¹⁵ <https://transform.england.nhs.uk/information-governance/guidance/open-safely-dpia-templates/>

¹¹⁶ <https://transform.england.nhs.uk/information-governance/guidance/child-protection-information-system-cp-is-template-dpia/>

¹¹⁷ <https://www.dsptoolkit.nhs.uk/>

¹¹⁸ As defined in section 253(3) of the Health and Social Care Act 2012

¹¹⁹ <https://www.england.nhs.uk/about/protecting-and-safely-using-data-in-the-new-nhs-england/>

¹²⁰ <https://www.gov.uk/government/publications/nhs-englands-protection-of-patient-data>

- Following changes in the NHS England Executive Team in April 2025, Dr Vin Diwakar the Interim National Director of Clinical Transformation was appointed as the Senior Information Risk Officer (SIRO) for NHS England. Professor Meghana Pandit, the National Medical Director for Primary Care took over the role of Caldicott Guardian in July 2025 following the retirement of Professor Sir Stephen Powis. Duncan Burton, the Chief Nursing Officer for England, took over the role of SIRO from January 2026 following further Executive Team changes.
- The PTT sub-directorate moved from the Deputy Chief Executive Directorate to the Technology, Digital and Data (TDD) Directorate in November 2025 as part of the establishment of the Joint Executive Team structure between NHS England and the DHSC. PTT was directly accountable for the performance of its functions to the interim Director General for TDD, maintaining separation of function from the Digital, Data and Analytics sub-directorates, in line with the Statutory Guidance.
- An updated internal NHS England Functional Conflicts of Interest policy was produced in October 2025 to provide more specific guidance on how SIRO conflicts of interest would be managed in line with the Statutory Guidance.
- NHS England seeks advice from its Advisory Group for Data (AGD) on specific data access requests and to support the development and maintenance of precedents, standards, and internal guidance on data access for planning, commissioning and research as set out in the Statutory Guidance. AGD includes a representative of the DPO who along with other NHS England and independent members provided NHS England with advice on 184 data access applications and on a range of other matters including Open Safely, the DigiTrials Recruitment Service and carried out consent reviews to support the establishment of the GPES Data for Consented Research Service. Minutes of AGD minutes containing advice provided and the AGD Terms of Reference are publicly available on the NHS England website.¹²¹

Commissioning support units

4 Commissioning Support Units (CSUs) continue to provide services to ICBs, trusts, NHS England and local authorities and met their financial targets in 2025/26. In line with the 10 Year Health Plan commitment to build ICB strategic commissioning capability, a programme has been established to close CSUs by 31 March 2027 and transition functions appropriately.

Supply Chain Coordination Limited

SCCL is the company owned by NHS England which manages the NHS supply chain. It undertakes its procurement services and transacts with customers and suppliers, leveraging the collective buying power of the NHS to support them to achieve their financial, operational and strategic objectives.

NHS England is the sole shareholder of SCCL, a UK incorporated company. SCCL's Articles of Association include a range of matters reserved for shareholder decision. NHS England has established a governance framework regarding its shareholdings. In addition to controls set out in the company's Articles of Association, NHS England appoints directors who sit on the Board and Committees of SCCL and holds quarterly accountability meetings to review performance against KPIs and financial targets, both of which are agreed by the NHS England board annually.

¹²¹ <https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/advisory-group-for-data/advisory-group-for-data-minutes> and <https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/advisory-group-for-data/membership>

Counter fraud

NHS England has a dedicated counter fraud team which undertakes proactive activities to prevent and detect fraud, including fraud risk assessments and data-led detection activity, as well as the reactive investigation of allegations of fraud relating to NHS England's operations and activities.

The Director of Financial Control has day-to-day operational responsibility for the function, and the Chief Financial Officer provides executive support and direction. We continued to work collaboratively with key partners in both proactive and reactive areas, including the Public Sector Fraud Authority, the DHSC, NHS Counter Fraud Authority, NHS Business Service Authority and law enforcement agencies.

NHS England public Inquiries

NHS England has a legal requirement to comply with Public Inquiries. In 2025/26 NHS England participated in or responded to the following:

- UK COVID-19 Public Inquiry¹²²
- Thirlwall Public Inquiry¹²³
- Lampard Public Inquiry¹²⁴
- Southport Public Inquiry¹²⁵
- Nottingham Inquiry¹²⁶
- Fuller Inquiry¹²⁷
- Angiolini Inquiry¹²⁸

The NHS England Inquiry team provided end-to-end support across all inquiries in 2025/26, including preparation through commenting on scope and terms of reference, record collation, evidence disclosure and providing written and oral evidence submissions. Response work included input from policy and strategic and operational teams. Key themes included mental health and maternity and neonatal policy, emergency planning and preparedness, safeguarding and governance and accountability.

March 2026 marked the completion of live hearings for the COVID-19 Inquiry, closing over 2 and a half years of public evidence sessions during which NHS England supported the Inquiry in examining pertinent matters and reaching well informed conclusions.

The Inquiry team is also focused on the publication of Inquiry reports, with several published in 2025/26 and more due in 2026/27. NHS England has established working-level internal governance to collate and assure the implementation of recommendations. Additionally, we are working in partnership with the DHSC and the Health Services Safety Investigations Body, to develop a recommendations hub to support transition into the new DHSC.

¹²² <https://covid19.public-inquiry.uk/>

¹²³ <https://thirlwall.public-inquiry.uk/>

¹²⁴ <https://lampardinquiry.org.uk/>

¹²⁵ <https://www.southport.public-inquiry.uk/>

¹²⁶ <https://nottingham.independent-inquiry.uk/>

¹²⁷ <https://webarchive.nationalarchives.gov.uk/ukgwa/20250731110329/https://fuller.independent-inquiry.uk/>

¹²⁸ <https://www.angiolini.independent-inquiry.uk/>

To support the growing number of inquiries, the team is developing a suite of materials to share best practice with frontline NHS organisations as they prepare for inquiries and is collaborating with the Cabinet Office to share learning, to improve approach and outcomes.

Looking ahead to 2026/27, the team is preparing for newly announced inquiries into child sexual abuse committed by grooming gangs, and further inquiries focused on mental health services (Tees Esk and Wear Valleys NHS FT) and independent reviews on maternity and neonatal care (Leeds Teaching Hospitals NHS Trust and University Hospitals Sussex NHS FT).

Control issues

Key Financial Reconciliations

During the financial year, the financial system used by NHS England, CSUs and ICBs – the Integrated Single Financial Environment, or ISFE – was upgraded to a new platform and updated into a shared service. Both the original ISFE and the upgraded ISFE system and services are provided by NHS Shared Business Service. 3 key reconciliations which are the responsibility of NHS SBS were not completed satisfactorily when the system went live on 1 October 2025. Since the issues with reconciliations have been identified, they have been performed or completed as required, and no financial loss has been identified as a result. NHS England has worked with NHS SBS to identify where key reconciliations are not in place or are not completed so that the control environment can be improved, and this work continues as the system continues to be embedded across the NHS England group.

Off payroll workers

Processes for procurement, onboarding and offboarding of off payroll workers are in place but were not being consistently complied with during the year. There were instances of duplicate timesheets or errors between timesheets and invoices due to insufficient invoice review processes. In addition, processes to assess services for IR35 were not applied consistently, resulting in instances where assessments were not completed to determine if the resources were in scope of IR35. An internal audit review identified that invoices pertaining to the New Hospital Programme did not all have evidence of review by NHS England's national Off-Payroll Worker team in order for them to be assessed for IR35 implications.

In relation to organisation-wide processes, work has progressed during the year to strengthen controls and improve compliance across the following areas:

- New onboarding and offboarding processes have been implemented for OPWs, including strengthened arrangements to ensure mandatory training is completed and recorded appropriately.
- Invoice approval arrangements have been reinforced to ensure appropriate authorisation prior to payment, with exceptions subject to review.
- Processes and guidance have been strengthened to support IR35 compliance, including access to IR35 panels to enable appropriate determinations.

In relation to the New Hospital Programme specifically, enhanced controls have been implemented to strengthen IR35 compliance and improve governance over NHP Professional

Services Business Cases. As part of these changes, a default position was established requiring all PSBCs to be assessed as in-scope (inside IR35) unless clearly evidenced otherwise. NHP Procurement colleagues are now responsible for completing and reviewing the IR35 assessment at the point of business case submission.

Payments to technology, digital and data contractors

Towards the end of the year a review identified weaknesses in the operation and oversight of contract management arrangements in relation to the Digital Transformation of Screening Programme. There were instances where contractors were paid day rates which exceeded maximum contractual day rates, and timesheet records were incomplete and not always subject to appropriate approvals.

The next steps are under active discussion at the time of writing. Initial steps have already been taken to strengthen staff training, review processes, and to strengthen oversight arrangements.

Suspended medical practitioner payments

During the year, NHS England identified two overpayments totalling £36,806 through its own control and review processes, where payments were not made in full accordance with the relevant determinations. These overpayments arose where information required from external parties was not received on a timely basis.

In three separate cases, NHS England exercised judgement in applying complex determination requirements, resulting in overpayments of £1,209 and £3,804 and, in another example, an underpayment of £25,525. The amounts involved were not material, either individually or in aggregate.

NHS England does not consider these cases to represent control failings or indicate any systemic weakness in its control environment. Their identification through established assurance processes demonstrates the effectiveness of the overall assurance framework. NHS England has continued to strengthen its control environment, contributing to a reduction in both the number and severity of issues identified compared with previous years.

Review of economy, efficiency and effective use of resources

Allocations

NHS England has responsibility for allocating the NHS funding agreed with the DHSC as part of our mandate. Please see the Chief Financial Officer's Report (from page 40), for information on allocations.

ICB auditor referrals and regularity opinions

During 2025/26, 5 ICBs (2024/25: 5 ICBs) were referred to the Secretary of State by their auditor under Section 30 of the Local Audit and Accountability Act 2014, due to forecasting that expenditure would exceed income during the financial year.

ICB auditors issue an opinion on regularity, which considers whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The 5 referrals noted above lead to the local regularity opinion being qualified.

In addition, the auditor of South Yorkshire ICB has further qualified its regularity opinion on a separate matter. The auditor's report states: "In the case of 8 exit packages, the ICB has calculated the redundancy entitlement using temporary hours or roles in the calculation of reckonable pay. This means reckonable pay for the basis of redundancy has been inflated for non-contractual elements. The resulting impact of this is that £73k of non-contractual payments were incurred without appropriate approval, resulting in irregular expenditure."

Financial performance monitoring

The financial position across the commissioning system was reported monthly using the Integrated Single Financial Environment system and through provision of supporting information. These collections included key elements of provider reporting which facilitated the focus on overall system reporting. Alongside this, NHS providers continued to report their monthly financial position to NHS England. This reporting has enabled a detailed monthly review by regional and national finance leadership teams and NHS England's Chief Financial Officer.

Individual ICB, system, direct commissioning and provider financial performance is monitored against KPIs including balance sheet indicators and performance against efficiency plans, in addition to the reported year-to-date and forecast position.

The financial position of commissioners is consolidated and reported in the overall NHS England accounts. NHS England is not the parent entity of NHS trusts and NHS FTs; the financial position of providers is reported separately in the consolidated NHS provider accounts.

Cabinet Office efficiency controls

During 2025/26, NHS England operated within the Government's Cabinet Office efficiency and spend control framework. These controls currently apply across a range of spending categories, with additional approvals required for expenditure above defined thresholds, including for professional services and consultancy. Where applicable, approvals were sought from the DHSC, and, in some cases, from Ministers or HM Treasury.

In line with the Government's announced reforms to the Spending Control and Accountability Framework¹²⁹, responsibility for managing spend controls within delegated limits is being transferred to departments. From 2026/27, NHS England will therefore operate under arrangements where such controls are exercised through the DHSC, with central HMT approvals being retained above the delegated limits.

Ministerial Directions

The Secretary of State issued 6 new directions to NHS England under section 254, of the Health and Social Care Act 2012, as set out on page 74. In addition, 11 direction specifications, which connected with existing directions, were also issued. The Secretary of state issued the routine financial directions, making provision for NHS England's budgets and financial limits.

Head of Internal Audit conclusion

Internal audit's conclusion is based on a programme of work designed to address the specific assurance requirements of the NHS England Board and Accounting Officer. It is their opinion of the overall adequacy and effectiveness of the NHS England framework of governance, risk management and internal control as they operated during the year to 31 March 2026 based on the work undertaken. Results of internal audit work, including remedial actions agreed with management, have been regularly reported to management and ARAC.

The conclusion is given in the context of NHS England having faced significant financial and operational pressures in the health and care system; responsibilities for some specialised commissioning functions being delegated to ICBs; significant changes in the Executive; further organisational changes including a voluntary redundancy programme; and ongoing uncertainty arising from the announced abolition of NHS England and integration of its functions into DHSC.

The conclusion of internal audit is that the risk management framework operated during the financial year, so that the most significant risks to the delivery of NHS England's strategies and its most significant operational risks were identified, managed and escalated to allow action to be taken.

The view of internal audit is that there was a governance framework at the end of the financial year, but this did not operate consistently throughout the year. This was due to the gaps in the cadence of meetings, the changes in executive remits, and the time taken to appoint the permanent executive team and to reset and update the Governance Manual, including the

¹²⁹ <https://www.gov.uk/government/publications/reforming-the-spending-control-and-accountability-framework>

Standing Financial Instructions. In addition, the internal audit work on the transformation programme governance reported a lack of clarity on the roles and escalation points in the governance structure.

Internal audit concluded that limited assurance could be provided over the effectiveness and efficiency of the internal control framework, with the exception of 2 areas where the reports provided nil assurance as the agreed management actions had not yet been completed. Some of the weaknesses in internal controls for core processes were assessed as being fundamental to the system of controls.

The recommendations raised by internal audit have been accepted by management and actions agreed to address these. Given the timing of reviews and nature of agreed actions, not all of these had been completed by the year end. Where possible, interim solutions have been put in place while activity remains focussed on the implementation of the agreed actions.

Despite the challenge of implementing actions in a timely manner in the context of the ongoing operational pressures, the number of open actions reduced from 299 in July 2025 to 148 in July 2026, and the number of overdue actions reduced from 136 to 67 over the same period.

There remains significant reliance on third party providers of core services, such as payroll processing, and there remains a requirement to further embed the contract management framework to obtain assurance over the delivery of services.

Remuneration and staff report

Organisational change

The Government announced on 13 March 2025 that NHS England will be abolished as an ALB and integrated into a restructured DHSC, with the total headcount reduced by around 50%. We have started conversations with colleagues in Government about the design of the new DHSC and the timetable for this transition. To support the headcount reduction we have started a VR programme, which is based on the national NHS model voluntary redundancy scheme, approved by HM Treasury. The scheme opened on Monday 1 December and closed at 5pm on Tuesday 16 December 2025. We have measures in place to make sure that no colleagues receive less favourable treatment when applying for VR on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation, or on the grounds of trade union membership. Our Equality Impact Assessment will continue to look at any positive or adverse impact(s) of voluntary redundancy on protected characteristic groups. We will continue to develop this in consultation with our trade union colleagues.

In November 2025, DHSC and NHS England's new Joint Executive Team came into effect, providing unified leadership across both organisations to deliver the 10 Year Health Plan and drive forward the Government's priorities.

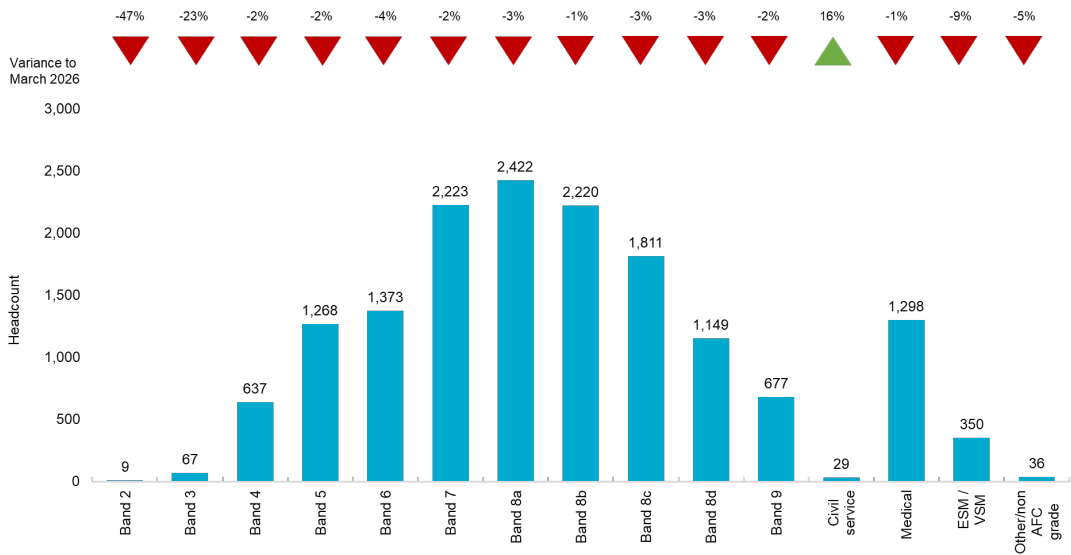
We continue to work closely with the DHSC and to design and implement the new organisation that will bring together many of the existing functions of NHS England and the DHSC.

Our workforce

Staff numbers

On 31 March 2026, NHS England directly employed 15,569 staff (14,088.8 WTE). Of these, 15,169 were permanently employed, and 400 were employed on payroll on fixed term contracts of employment. A further 1,733 people were engaged in an off-payroll capacity, including agency staff and secondees. Since March 2025, we have been working towards reducing our headcount. To support this, we have put in place recruitment restrictions and in March 2026 carried 2,995 vacancies. We have launched an organisation-wide VR programme, with around 700 colleagues leaving by 31 March 2026 and further VR exits expected through 2026 and 2027.

Staff by grade



The chart shows the headcount by pay band on 31 March 2026. Detail on staff numbers and costs for NHS England and the consolidated group, including CSUs, are presented from page 91. The headcount of permanent and fixed term staff in NHS England decreased by 3% since 31 March 2025.

Staff turnover

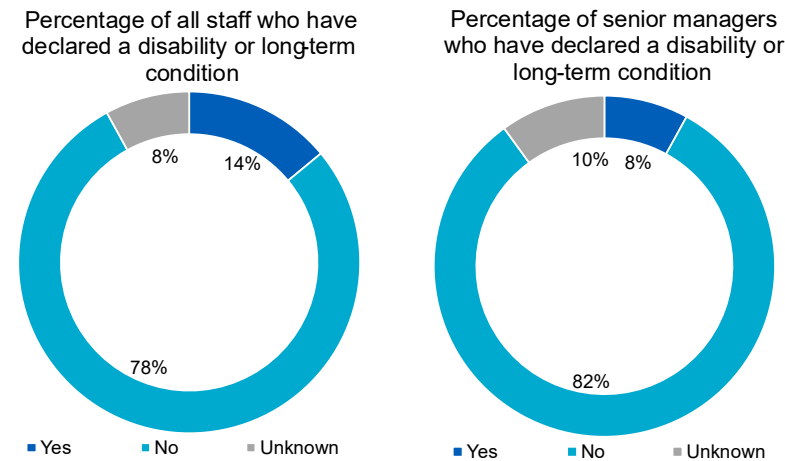
Turnover increased in 2025/26 compared to 2024/25. The headcount has decreased and the number of people leaving the organisation increased.

Staff turnover (%)

	2022/23	2023/24	2024/25	2025/26
NHS England	11.01%	16.52%	7.09%	8.93%
Total	10.90%	16.52%	7.09%	8.93%

Equality, diversity, and inclusion

The charts below reflect the proportion of all staff and senior managers¹³⁰ who have reported a disability or long-term condition, in ESR. There has been an increase of 4% of staff who report a disability and an increase of 2% in senior managers from 2024/25.

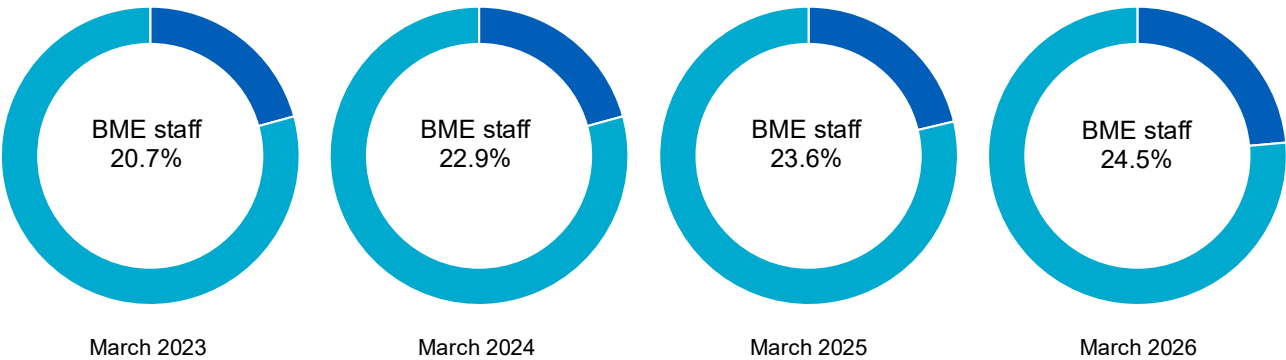


¹³⁰ Senior Managers are classed as employees receiving a full time equivalent salary of £109,179 or more.

Ethnicity of all staff and senior managers

Improving our diversity levels at senior pay bands

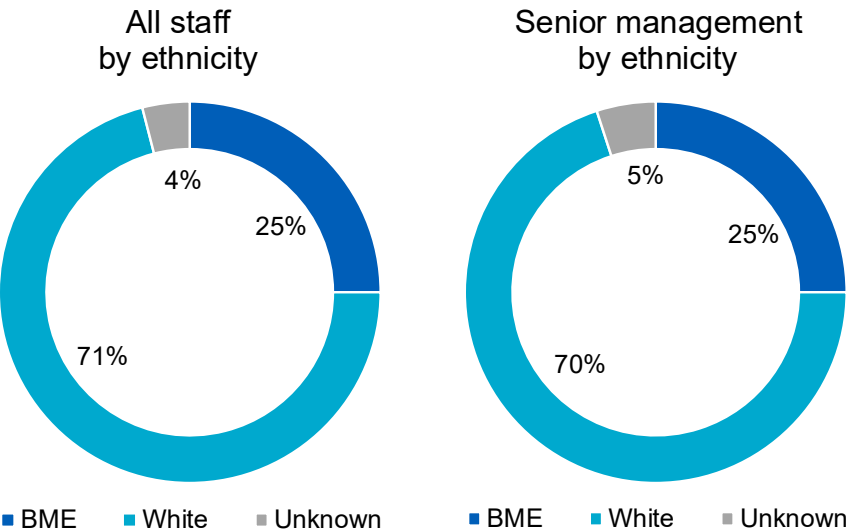
Figures below show the overall percentage of black or minority ethnic (BME) staff and the change over the last 4 years.



The proportion of people employed by NHS England who consider themselves to be from a BME heritage increased by 0.9% since 31 March 2025.

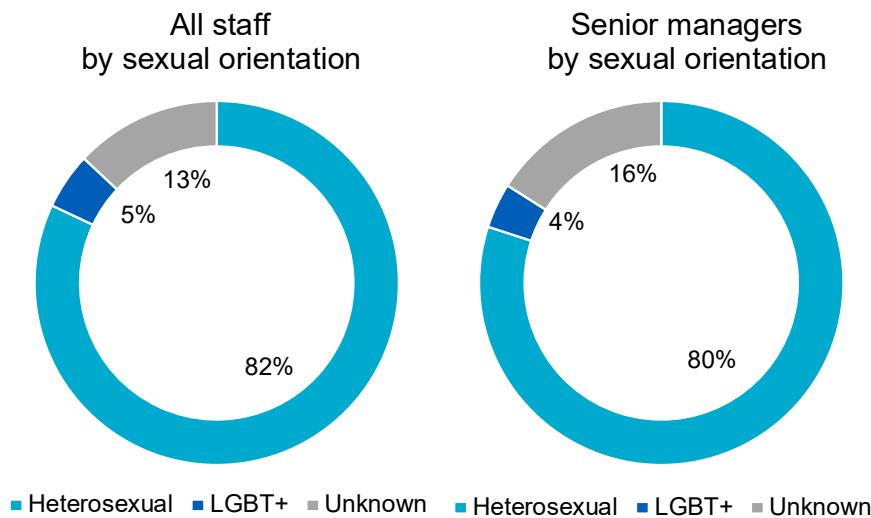
The proportion of senior managers who identify as BME has increased to 24.5% (2024/25: 23.6%).

The graphs below show ethnicity for all staff and senior managers, as reported in ESR.



Sexual orientation of staff and senior managers

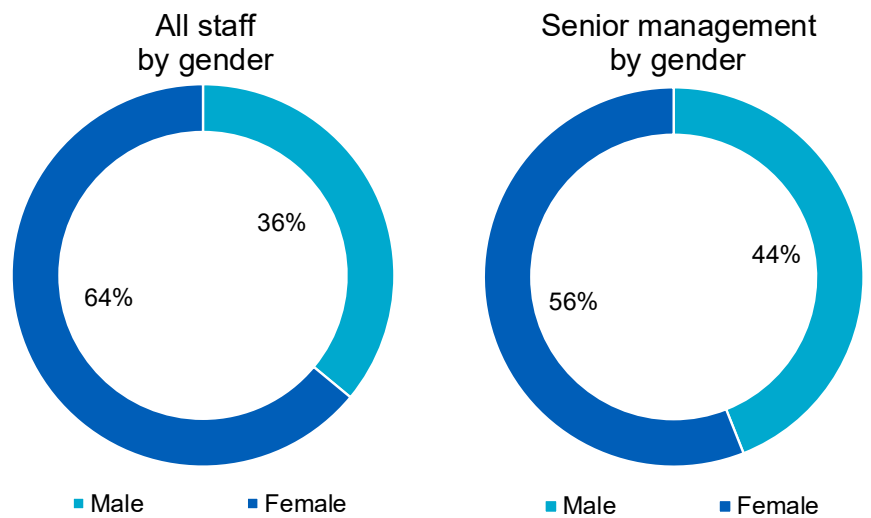
The percentage of staff who disclose their identity as lesbian, gay, bisexual and transgender (LGBT+) is 5.0% as of March 2026 (2024/25: 4.9%). The breakdown of sexual orientation declaration is detailed below, including an overview of senior managers who have declared as LGBT+ in ESR 4.4% (2024/25: 4.1%).



Gender of all staff and senior managers

Between 31 March 2025 and 31 March 2026 NHS England’s total female “on payroll” workforce increased by 0.2%. There has been an increase in the number of female senior managers to 56.2% (31 March 2025: 55.4%). Our latest diversity pay gap report published in March 2026¹³¹, shows NHS England employed 15,658 people. 9,960 (63.61%) of our workforce were women and 5,698 (36.39%) were men. The gender diversity of NHS England Board members is set out on page 52. The graphs below highlight gender reporting in ESR:

All staff and senior managers by gender



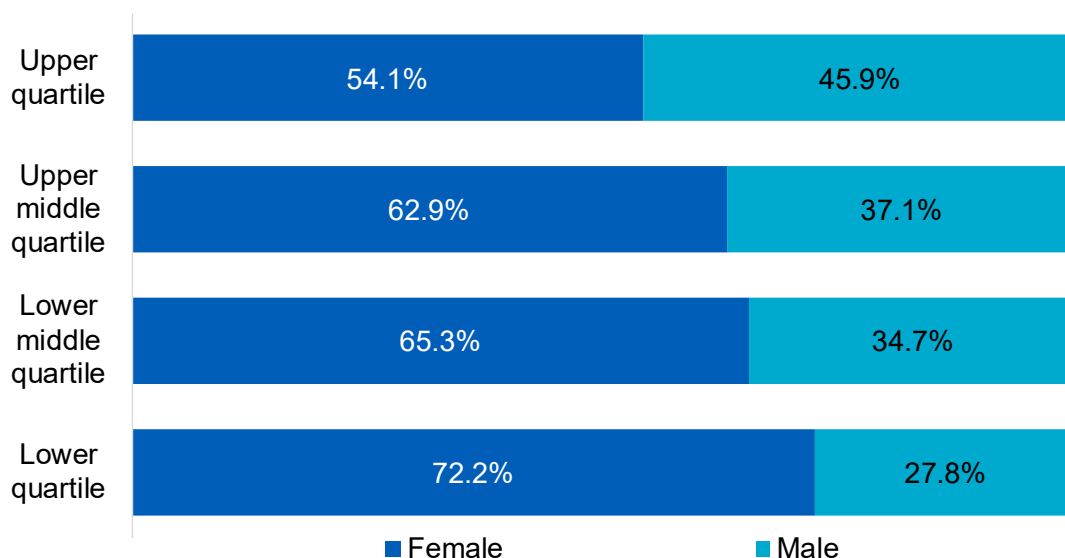
¹³¹ <https://www.england.nhs.uk/long-read/diversity-pay-gap-reporting-2024-25-for-nhs-england/>

Gender pay gap

We have produced a gender pay gap report as at 31 March 2025. The gender pay gap trend for NHS England made improvements from the previous year. On 31 March 2025, the mean gender pay gap was 10.6%, this meant women earned on average 10.6% less per hour than men. The median gender pay gap was 11.2%. When comparing to 2023/24, the mean gender pay gap decreased by 0.8 percentage points, while the median gender pay gap has increased by 2.5 percentage points.

Year	Mean gender pay gap
2025	10.6%
2024	11.4%
2023	11.8%
2022	14.7%
2021	16.2%

Pay quartiles by gender in NHS England



Women represented 63.61% of the workforce and accounted for 54.09% of the highest-paid roles (upper quartile) as of 31 March 2025. Women also held 72.16% of the lowest-paid quarter of jobs in NHS England, with men accounting for 27.84% of these roles.

Women form the majority of staff in pay bands 3 to 9, while men slightly outnumber women in Band 2. However, the proportion of men increases at the most senior levels.

Women earn more than men in pay bands 2, 5 and 6, while men have higher earnings in bands 3, 4, 7 and above. These differences are likely influenced by factors such as length of service, working hours (part-time versus full-time) and pay step progression.

Sickness absence

Sickness absence for the reporting period was as follows:

	WTE days available	WTE days lost to sickness absence	Sickness absence rate
2025/26	5,210,675	168,343	3.23%
2024/25	5,217,850	158,887	3.05%

Employment policies

We have a range of employment policies that reflect the culture of NHS England and support our ambition to be an Employer of Choice. Our employment policies are supported by a robust Equality Impact Assessment (EQIA) process and informed by engagement with staff networks and other stakeholders. This approach helps us identify and consider potential impacts on people with protected characteristics, including disabled colleagues, and supports the development and implementation of policies that promote fairness, equality of opportunity and inclusion throughout recruitment and employment.

Our achievements include:

- continued development of effective working relationships with our trade union colleagues on our Policy Subgroup, with a specific focus on policies that enable and support organisational change
- harmonised the 3 legacy policies on managing sickness absence
- approved the review of several key policies and guidance documents
- reviewed the impact on our policies in view of the implementation of the Employment Rights Act 2025
- strengthened our EQIA approach, including a review of the EQIA process to ensure more robust, evidence-based assessments
- reprioritised the policy schedule in view of organisational needs
- improved accessibility through the development of clear policy summaries for our most frequently used policies
- continued to work closely with the National Policy team to enable us to adapt and align our policies to the National People Policy Framework.

Partnership working

NHS England fully recognises the vital contribution of trade unions in representing the interests of colleagues and our organisation. We work closely in partnership with our recognised trade unions on important employment matters. Partnership work includes consulting on organisational change, as a legal requirement, and, given the scale and pace of organisational change, maintaining effective and constructive partnership working, as well as developing and refining our policies, and discussing and negotiating on a wide range of issues affecting people and the organisation.

To support integration, we have established a Joint Partnership Forum, bringing together National Trade Union Officers and management representatives from the Department of Health and Social Care and NHS England, to facilitate joint discussions on workforce, policy and organisational implications arising from integration and ongoing change.

To facilitate partnership working, NHS England has a National Partnership Forum that meets every quarter. This forum provides strategic direction for other important sub-groups that focus on specific issues. Sub-groups include policy, organisational change, and the Local Negotiating Committee. In addition, regional and corporate engagement forums provide a mechanism to address local issues, ensuring these can be escalated appropriately into national partnership structures where required.

Staff Engagement

The 2025 staff survey achieved a record response rate of 66%, giving us our most comprehensive picture of colleague experience to date. The results reflect the cumulative pressures of a third major change programme in as many years, ongoing headcount reductions, and a fundamental shift in how we work. Only 3% of colleagues felt that change is managed well, only 12% could see a clear vision for the future, and nearly 90% reported feeling frustrated because of work. Learning and development remains our lowest-scoring area, with just 23% feeling that development activities have improved their chances of career progression.

The survey also reveals significant and unacceptable inequalities in the day-to-day working experience of different colleague groups.

BME colleagues reported less positively than white colleagues on every indicator of the Workforce Race Equality Standard questions. On the Workforce Disability Equality Standard questions, all but 1 question scored more negatively by colleagues with long lasting health conditions or illnesses.

Neurodivergent colleagues, carers, colleagues who are gay or lesbian, and those with a mental health condition or long term illness scored more negatively than their peers in every people promise measure.

These disparities are not marginal; they reflect real inequalities we are committed to addressing.

There are also, however, genuine strengths to acknowledge: line management scores remain above 70% and continue to improve, flexible working satisfaction is high, and 79% of colleagues who responded feel supported with reasonable adjustments and we will continue to explore how we can strengthen this even further. We are taking action and the Improving NHS England Together programme is the primary vehicle for change, with work already under way on learning provision and appraisal redesign. Directorates and regions are developing local action plans, in collaboration with staff. They are focused on the priorities that matter most in their areas, and survey findings are feeding directly into the wider transformation programme's work on organisational culture.

We are working with trade unions, staff networks and their executive sponsors to address the disparities identified, and we are clear that supporting colleagues through the period ahead is not optional – it is the foundation on which we will build a better place to work during the transition.

Talent management, Learning and Development

Our people data continues to indicate under representation of some protected characteristics at some grades. We recognise that shifting the dial on diversity and creating an inclusive environment takes time and requires dedicated and consistent action using a wide range of levers. HR policies and practices reflect our commitment to supporting under represented staff groups through our approach to equality and diversity. Examples of our progress during 2025/26 across talent management and organisation development include:

- Continuing to embed the principles within our inclusive recruitment handbook.
- Successfully concluding our Accelerated Development Programme pilot, which was established to provide development placements of 12 months for colleagues from BME, disabled and LGBT+ communities. We are looking carefully at the evaluation data to inform next steps for 2026/27.
- Delivering our fourth cohort of the 10,000 Black Interns Programme, with 71 interns joining us for an 8-week paid placement across national directorates and regions. Feedback demonstrates strong impact, with an average satisfaction score of 4.7 out of 5 and 94% of interns likely to recommend the programme. We have plans to deliver our fifth cohort, with 87 interns joining us in Summer 2026.
- Concluding our first mandatory 4-module Line Manager Development programme designed to reset, refresh and upskill our leaders. The programme was rolled out to 6,000 line managers, achieving 85% participation and overwhelmingly positive feedback.
- Investing in making improvements to our Learning and Development (L&D) offer by introducing: an enhanced framework and partnership agreement with our supplier KMPG; a new learning App and catalogue; a 'one stop' L&D intranet hub; an extended coaching and mentoring offer; and simplifying our approach to Mandatory and Statutory Training.
- Delivering the annual people survey, achieving our highest response rate to date (66%). The insight from this will inform future engagement and our work on culture, values and behaviour for 2026/27.
- Engaging colleagues on the importance of appraisals and quality conversations which saw compliance increase from an average of 59% to 76% across the organisation - with many national directorates and regions achieving significantly above this average.
- Introducing a series of facilitated Leadership Support Circles which aim to support senior leaders to build valuable peer networks, share challenges and grow their leadership through reflection and action. Early evaluation data demonstrates that 100% of participants would recommend taking part.

Employee benefits and staff numbers (subject to audit)

Detail on staff numbers and costs for NHS England and the consolidated group, including CSUs, will be available end of May:

Average number of people employed

Parent 2025/26	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	13,757	4,911	846	41	19,555
Of the above:					
Number of WTE people engaged on capital projects	158	-	3	-	161
Parent 2024/25	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	14,120	5,946	939	48	21,053
Of the above:					
Number of WTE people engaged on capital projects	77	-	11	-	88
Consolidated group 2025/26	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	37,694	4,911	1,805	41	44,451
Of the above:					
Number of WTE people engaged on capital projects	158	-	3	-	161
Consolidated group 2024/25	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	37,771	5,946	2,138	48	45,903
Of the above:					
Number of WTE people engaged on capital projects	77	-	11	-	88

Employee benefits

Parent group 2025/26	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	1,003,851	254,154	74,160	4,072	1,336,237
Social security costs	136,349	33,724	21	-	170,094
Employer contributions to NHS Pension Scheme	214,717	54,509	-	-	269,226
Other pension costs	-	-	-	-	-
Apprenticeship Levy	4,971	1,210	-	-	6,181
Termination benefits	118,877	85,216	-	-	204,093
Gross employee benefits expenditure	1,478,765	428,813	74,181	4,072	1,985,831
Less: Employee costs capitalised	(16,782)	-	(555)	-	(17,337)
Net employee benefits excluding capitalised costs	1,461,983	428,813	73,626	4,072	1,968,494
Less recoveries in respect of employee benefits	(104)	(242)	-	-	(346)
Total net employee benefits	1,461,879	428,571	73,626	4,072	1,968,148

Parent group 2024/25 ¹³²	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	967,202	290,506	83,628	4,282	1,345,618
Social security costs	111,503	31,886	2	-	143,391
Employer contributions to NHS Pension Scheme	205,176	62,203	3	-	267,382
Other pension costs	-	-	-	-	-
Apprenticeship Levy	4,905	1,403	-	-	6,308
Termination benefits	2,057	6,056	-	-	8,113
Gross employee benefits expenditure	1,290,843	392,054	83,633	4,282	1,770,812
Less: Employee costs capitalised	(7,612)	-	(1,293)	-	(8,905)
Net employee benefits excluding capitalised costs	1,283,231	392,054	82,340	4,282	1,761,907
Less recoveries in respect of employee benefits	(2,143)	-	-	-	(2,143)
Total net employee benefits	1,281,088	392,054	82,340	4,282	1,759,764

¹³² Prior year has been restated due to a remapping of costs.

Consolidated group 2025/26	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	2,423,670	254,154	153,360	4,072	2,835,256
Social security costs	337,639	33,724	1,198	-	372,561
Employer contributions to NHS Pension Scheme	508,573	54,509	1,029	-	564,111
Other pension costs	7,492	-	28	-	7,520
Apprenticeship Levy	11,410	1,210	-	-	12,620
Termination benefits	637,784	85,216	-	-	723,000
Gross employee benefits expenditure	3,926,568	428,813	155,615	4,072	4,515,068
Less: Employee costs capitalised	(16,782)	-	(555)	-	(17,337)
Net employee benefits excluding capitalised costs	3,909,786	428,813	155,060	4,072	4,497,731
Less recoveries in respect of employee benefits	(11,305)	(242)	(329)	-	(11,876)
Total net employee benefits	3,898,481	428,571	154,731	4,072	4,485,855

Consolidated group 2024/25 ¹³³	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	2,349,626	290,506	173,427	4,282	2,817,841
Social security costs	267,128	31,886	612	-	299,626
Employer contributions to NHS Pension Scheme	487,537	62,203	750	-	550,490
Other pension costs	6,516	-	-	-	6,516
Apprenticeship Levy	11,100	1,403	-	-	12,503
Termination benefits	4,053	6,056	-	-	10,109
Gross employee benefits expenditure	3,125,960	392,054	174,789	4,282	3,697,085
Less: Employee costs capitalised	(7,612)	-	(1,293)	-	(8,905)
Net employee benefits excluding capitalised costs	3,118,348	392,054	173,496	4,282	3,688,180
Less recoveries in respect of employee benefits	(27,660)	-	-	-	(27,660)
Total net employee benefits	3,090,688	392,054	173,496	4,282	3,660,520

CSUs are part of NHS England and provide services to ICBs and other external bodies.

The employment contracts or secondment of almost all of these staff are held for NHS England on a “hosted basis” by the NHS Business Services Authority.

¹³³ Prior year has been restated due to a remapping of costs.

Exit packages, severance payments and off-payroll engagements

Expenditure on consultancy and contingent labour

Expenditure on consultancy is detailed in the Annual Accounts under Note 4: Operating expenses. NHS England and CSUs procured consultancy services worth £25.4 million during the financial year, an increase of £8.5 million since the previous year (2024/25: £16.9 million).

Across the group, there was a total spend of £52.6 million on consultancy services during the period, against £48.4 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given in the employee benefits table on page 92, under the 'other' column.

Net expenditure for NHS England and CSUs in this area was £78.2 million in 2025/26, against £88 million in 2024/25. Across the group, there was a total spend of £157.4 million on contingent labour during the year, against £177.7 million the previous year.

Further detail on efficiency controls, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our governance statement from page 65.

Contingent labour	2025/26 £000	2024/25 £000	(Increase) / Decrease £000
Parent including CSU other	78,253	87,915	9,662
Group other	159,687	179,071	19,384

Consultancy	2025/26 £000	2024/25 £000	(Increase) / Decrease £000
Parent consultancy	25,414	16,886	(8,528)
Group consultancy	52,634	48,363	(4,271)

Off-payroll engagements

NHS England is committed to employing a capable, talented, and diverse on-payroll workforce to support the delivery of its business. It is recognised that in some specific circumstances the use of off payroll workers (OPWs), working alongside our on-payroll workforce, can be helpful. For some of our time-limited programmes, short-term contracts are appropriate. The following tables identify OPWs engaged by NHS England during 2025/26. OPWs engaged by ICBs are reported in ICB annual reports and published on their websites.¹³⁴

Off-payroll engagements on 31 March 2026, covering those earning more than £245¹³⁵ per day are as follows:

Off-payroll engagements	NHS England (number)	CSUs (number)	Total (number)
Number of existing engagements as of 31 March 2026	1,021	-	1,021
Of which, the number that have existed:			
for less than 1 year at the time of reporting	464	-	464
for between 1 and 2 years at the time of reporting	262	-	262
for between 2 and 3 years at the time of reporting	149	-	149
for between 3 and 4 years at the time of reporting	145	-	145
for 4 or more years at the time of reporting	1	-	1

The reporting methodology includes individuals engaged via third party contracts in addition to agency workers.

The majority of the individuals reported above were engaged via third party contracts mainly undertaking software development and maintenance on the main digital platforms such as the NHS App.

All off-payroll engagements were subject to a risk-based assessment as to whether assurance was required that the individual was paying the right amount of tax and, where necessary, assurance has been sought.

¹³⁴ <https://www.england.nhs.uk/publication/integrated-care-boards-in-england/>

¹³⁵ The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

New off-payroll engagements

New off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245¹³⁶ per day are as follows:

New off-payroll engagements	NHS England (number)	CSUs (number)	Total (number)
Number of OPWs engaged during the year ended 31 March 2026	1,493	26	1,519
Of which:			
Number not subject to off payroll legislation ¹³⁷	1,493	26	1,519
Number subject to off-payroll legislation and determined as in-scope of IR35 ¹³⁷	-	-	-
Number subject to off-payroll legislation and determined as out of scope of IR35 ¹³⁷	-	-	-
Number of engagements reassessed for compliance or assurance purposes during the year	-	-	-
Of which:			
Number of engagements that saw a change to IR35 status following review	-	-	-

Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2025 and 31 March 2026 are shown in the table below:

Off-payroll board member/senior official engagement	NHS England (number)	CSUs (number)	Total (number)
Number of off-payroll engagements of Board members and/or senior officers with significant financial responsibility, during the financial year	-	-	-
Total number of individuals on-payroll and off-payroll who have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year	342	26	368

Details of exit packages agreed over the year are detailed in the following tables.

All contractual severance payments were subject to full external oversight by the DHSC.

¹³⁶ The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

¹³⁷ A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Exit packages agreed during the year (subject to audit)

Parent	2025/26		
	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	5	84	89
£10,001 to £25,000	18	442	460
£25,001 to £50,000	30	803	833
£50,001 to £100,000	29	1,259	1,288
£100,001 to £150,000	12	161	173
£150,001 to £200,000	13	120	133
Over £200,001	-	3	3
Total	107	2,872	2,979
Total cost (£000)	7,064	180,177	187,241

Parent	Departures where special payments have been made 2025/26	
	Number	£
Less than £10,000	1	10,000
£25,001 to £50,000	-	-
Over £200,001	1	330,000
Total	2	340,000

	2024/25		
	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	17	2	19
£10,001 to £25,000	48	-	48
£25,001 to £50,000	34	3	37
£50,001 to £100,000	37	2	39
£100,001 to £150,000	19	1	20
£150,001 to £200,000	10	-	10
Over £200,001	-	-	-
Total	165	8	173
Total cost (£000)	8,683	349	9,032

	Departures where special payments have been made 2024/25	
	Number	£
Less than £10,000	-	-
£25,001 to £50,000	1	38,988
Over £200,001	-	-
Total	1	38,988

Consolidated group	2025/26		
	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	72	329	401
£10,001 to £25,000	147	1,290	1,437
£25,001 to £50,000	125	1,828	1,953
£50,001 to £100,000	133	2,617	2,750
£100,001 to £150,000	68	942	1,010
£150,001 to £200,000	40	566	606
Over £200,001	-	6	6
Total	585	7,578	8,163
Total cost (£000)	31,624	502,476	534,100

Consolidated group	Departures where special payments have been made 2025/26	
	Number	£
Less than £10,000	2	20,000
£25,001 to £50,000	-	-
Over £200,001	1	330,000
Total	3	350,000

	2024/25		
	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	146	43	189
£10,001 to £25,000	119	79	198
£25,001 to £50,000	99	69	168
£50,001 to £100,000	108	96	204
£100,001 to £150,000	49	40	89
£150,001 to £200,000	28	15	43
Over £200,001	-	-	-
Total	549	342	891
Total cost (£000)	24,566	18,413	42,979

	Departures where special payments have been made 2024/25	
	Number	£
Less than £10,000	-	-
£25,001 to £50,000	1	38,988
Over £200,001	-	-
Total	1	38,988

Analysis of other agreed departures (subject to audit)

Parent	2025/26		2024/25	
	Other agreed departures Number	Other agreed departures £000	Other agreed departures Number	Other agreed departures £000
Voluntary redundancies including early retirement contractual costs	2,862	179,226	6	203
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	8	611	1	107
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	2	340	1	39
Total	2,872	180,177	8	349

Consolidated group	2025/26		2024/25	
	Other agreed departures Number	Other agreed departures £000	Other agreed departures Number	Other agreed departures £000
Voluntary redundancies including early retirement contractual costs	7,281	493,358	259	16,445
MARS contractual costs	229	6,567	27	726
Contractual payments in lieu of notice	71	2,212	73	1,034
Exit payments following Employment Tribunals or court orders	-	-	4	169
Non-contractual payments requiring HMT approval	2	340	1	39
Total	7,583	502,477	364	18,413

As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number of exit packages will not necessarily match the total number in the table above.

These tables report the number and value of exit packages agreed in the financial year.

The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of NHS England.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where NHS England and ICBs have agreed early retirements, the additional costs are met by NHS England or the ICB and not by the NHS Pension Scheme and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report.

Remuneration report

People and Remuneration Committee

Detail on the role and activity of the People and Remuneration Committee is given in our Directors' Report on page 50.

Percentage change in remuneration of highest paid director (subject to audit)

Percentage change in remuneration of the highest paid director	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	39.25%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	4.58%	0%

The average percentage increase in salary and allowances from 2024/25 to 2025/26 in respect of the highest paid director can be explained by the changes to NHS England's Executive Team and Board structure/membership effective 01 April 2025 that resulted in a new highest-paid director/member.

The primary reason for the average percentage increase in salary and allowances from 2024/25 to 2025/26 in respect of employees of the entity, taken as a whole, can be explained by the implementation of a 3.6% AfC pay award. Additionally, the mass organisational change that commenced across NHS England from 01 April 2024 following the merge with NHS Digital on 01 February and Health Education England on 01 April 2023 and resulted in a change to NHS England's organisational staff profile continued into the 2025/26 reporting period.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director/member in NHS England in the financial year 2025/26 was £370,000 to £375,000 (2024/25: £265,000-£270,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2025/26	25th percentile	Median	75th percentile
Total remuneration (£)	46,580	59,343	81,652
Salary component of total remuneration (£)	46,580	58,487	81,652
Pay ratio information	8.00:1	6.28:1	4.56:1
2024/25 ¹³⁸	25th percentile	Median	75th percentile
Total remuneration (£)	44,806	56,698	79,616
Salary component of total remuneration (£)	44,806	56,454	78,814
Pay ratio information	5.97:1	4.72:1	3.36:1

¹³⁸ The prior year disclosure for 2024/25 includes Non-Executive Directors.

The pay ratio information for the 2025/26 financial year is consistent with the pay, reward and progression policies for the employees taken as a whole, due to applying all nationally mandated pay awards where applicable and adhering to the relevant pay progression principles. The changes to NHS England's Executive Team and Board structure/membership effective 01 April 2025, that resulted in a new highest-paid director/member, also contributed to this.

In 2025/26, no employees received remuneration in excess of the highest-paid director/member (2024/25: none). Remuneration ranged from £24,465 to £375,000 (2024/25: £7,883 to £270,000). The change in remuneration range from 2024/25 to 2025/26 is due to updated guidance that NEDs are out of scope of fair pay disclosures.

Total remuneration includes salary, non-consolidated performance-related pay (PRP), benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value (CETV) of pensions.

Policy on remuneration of senior managers

The framework for the remuneration of executive directors is set by DHSC through the ESM pay framework for ALBs.

It is NHS England's policy to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience for the effective running of a more than £202 billion organisation, while recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for executive directors was undertaken by the People and Remuneration Committee and the Nominations Committee. Final decisions are made by the DHSC ALB Remuneration Committee and HM Treasury, where appropriate.

Performance-related pay

The PRP arrangements for national (executive) directors are set out in the ESM pay framework for ALBs. They follow guidance prescribed by DHSC and are in line with HM Treasury requirements. As a local policy decision, NHS England does not currently allocate any funding for PRP non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Executive HR Group and the People and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2025/26.

Secondees are subject to the terms and conditions of their employing organisation.

Policy on senior managers' contracts

Contracts of employment for senior managers are open-ended and recurrent, unless otherwise specified. Notice periods follow the provisions of the ESM contract of employment, as applied by NHS England, of 6 months' contractual notice.

Termination payments can only be authorised where they are contractual and, subject to the value involved, may still require further approval from the DHSC Governance and Assurance Committee.

Any proposed non-contractual special severance payment requires formal approval from DHSC and HM Treasury.

Payments for loss of office (subject to audit)

Payments were made to 4 senior managers to compensate for loss of office in 2025/26, and details of these payments are included in the remuneration table on page 102.

Payments to past directors (subject to audit)

A payment was made to 1 past director during 2025/26, and details of this payment is included in the remuneration table on page 102. However, no compensation has been paid on early retirement.

Senior managers' service contracts

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Sir James Mackey Chief Executive Officer	1 April 2025	6 months		
David Probert Deputy Chief Executive Officer	6 May 2025	6 months		Left NHS England 31 March 2026
Elizabeth O'Mahony Chief Financial Officer	1 April 2025	6 months		
Professor Sir Stephen Powis National Medical Director	1 March 2018	6 months		Left NHS England 20 July 2025
Duncan Burton Chief Nursing Officer for England	25 July 2024	6 months		
Dr Vinod Diwakar National Director of Transformation (Interim)	18 September 2023	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Left NHS England 19 November 2025
Dr Claire Fuller Co-National Medical Director	1 April 2025	6 months		
Professor Meghana Pandit Co-National Medical Director	1 April 2025	6 months		
Tom Kibasi Executive Director of Strategy	16 May 2025	6 months		Ceased Board membership 11 January 2026
Sarah-Jane Marsh National Director of Urgent and Emergency Care	29 May 2025	6 months		
Paul Dinkin Director General for Strategy and Healthcare Policy	12 January 2026	6 months		

Remuneration (salary, benefits in kind and pensions) 2025/26 (subject to audit)

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Pension-related benefits (bands of £2,500) ¹³⁹ £000	(e) Total (a to e) (bands of £5,000) £000
Sir James Mackey ¹⁴⁰ Chief Executive Officer	325-330	9,900	0	0	335-340
David Probert ¹⁴¹ Deputy Chief Executive Officer	135-140	2,800	0	45-47.5	185-190
Elizabeth O'Mahony ¹⁴² Chief Financial Officer	240-245	0	0	240-242.5	480-485
Professor Sir Stephen Powis ¹⁴³ National Medical Director	70-75	0	0	0	70-75
Duncan Burton Chief Nursing Officer for England	195-200	0	0	147.5-150	345-350
Dr Vinod Diwakar ¹⁴⁴ National Director of Transformation (Interim)	130-135	0	0	167.5-170	300-305
Dr Claire Fuller ¹⁴⁵ Co-National Medical Director	205-210	0	0	190-192.5	395-400
Professor Meghana Pandit ¹⁴⁶ Co-National Medical Director	280-285	0	25-30	0	310-315
Tom Kibasi ¹⁴⁷ Executive Director of Strategy	120-125	0	0	30-32.5	155-160

¹³⁹ The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.

¹⁴⁰ Sir James Mackey commenced in post on 01 April 2025. Sir James Mackey's salary was recharged to NHS England from The Newcastle Upon Tyne Hospitals NHS Foundation Trust where he was also formally employed and retained a post. Sir James Mackey's benefit in kind relates to a salary sacrifice Lease Car and the remuneration figures noted in the above table reflect the salary sacrifice deductions; the full salary equivalent is £360,000-£365,000.

¹⁴¹ David Probert covered this post from 06 May 2025 to 31 March 2026. 50% of the salary costs for David Probert were recharged to NHS England from the University College London Hospitals NHS Foundation Trust where he was also formally employed and retained a post, therefore the above figures disclose 50% of salary. David Probert's benefit in kind relates to a salary sacrifice Lease Car and the remuneration figures noted in the above table reflect the salary sacrifice deductions; 50% of the full salary equivalent is £155,000-£160,000.

¹⁴² Elizabeth O'Mahony had a retrospective salary increase approved for 2025/26. The full year equivalent salary is £300,000 - £305,000. Backpay was received after year end therefore the Greenbury pension figures reflect the previous salary actually paid in year.

¹⁴³ Professor Sir Stephen Powis left NHS England on 20 July 2025 and received a Lieu of Annual Leave payment of 0-£5,000, which is included within the remuneration figures noted in the table above. The full year equivalent salary is £235,000-£240,000.

¹⁴⁴ Dr Vinod Diwakar left NHS England on 19 November 2025. Dr Vinod Diwakar took the following periods of unpaid leave 06-07 November, 10-14 November and 17-19 November 2025, and the remuneration noted in the above table reflects this. The full year equivalent salary is £210,000-215,000.

¹⁴⁵ Dr Claire Fuller opted to sacrifice £0-£5,000 of salary to purchase additional Annual Leave during the reporting period and the remuneration figures noted in the above table reflect this.

¹⁴⁶ Professor Meghana Pandit's salary was recharged to NHS England from Oxford University Hospitals NHS Foundation Trust where she was also formally employed and retained a post.

¹⁴⁷ Tom Kibasi commenced in post on 16 May 2025 and ceased Board membership on 11 January 2026. The full year equivalent salary is £185,000-£190,000.

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Pension-related benefits (bands of £2,500) ¹³⁹ £000	(e) Total (a to e) (bands of £5,000) £000
Paul Dinkin ¹⁴⁸ Director General for Strategy and Healthcare Policy	0	0	0	0	0
Dame Emily Lawson ¹⁴⁹ Chief Operating Officer (Interim)	175-180	0	0	0	175-180
Stephen Russell ¹⁵⁰ Chief Delivery Officer	160-165	0	0	0	160-165
Christopher Hopson ¹⁵¹ Chief Strategy Officer	125-130	0	0	0	125-130
Navina Evans ¹⁵² Chief Workforce Officer	145-150	0	0	0	145-150
Julian Kelly ¹⁵³ Chief Financial Officer	100-105	0	0	0	100-105
Sarah-Jane Marsh ¹⁵⁴ National Director of Urgent and Emergency Care	195-200	0	0	25-30	225-230

¹⁴⁸ Paul Dinkin commenced in post on 12 January 2026. Paul Dinkin's salary costs were retained wholly by the Department of Health and Social Care where he was formally employed and retained a post.

¹⁴⁹ Dame Emily Lawson received a Pay in Lieu of Notice (PILON) payment of £130,000-£135,000 and a redundancy payment of £45,000-£50,000 in June 2025 as compensation for loss of office. The remuneration figure noted in the above table reflects the total of these two payments.

¹⁵⁰ Stephen Russell received a PILON payment of £105,000-£110,000 and a redundancy payment of £160,000-£165,000 in June 2025 as compensation for loss of office. Stephen Russell secured alternative NHS employment within the 12-month redundancy clawback period and was required to repay £105,000-£110,000 of the redundancy payment back to NHS England. The remuneration figures noted in the above table reflect the total of the PILON payment and the reduced redundancy payment.

¹⁵¹ Chris Hopson's post was removed from NHS England's Executive Team effective 01 April 2025. Chris Hopson received a Pay in Lieu of Notice (PILON) payment of £105,000-£110,000 and a redundancy payment of £20,000-£25,000 in July 2025 as compensation for loss of office. The remuneration figures noted in the above table reflect the total of these two payments.

¹⁵² Navina Evans' post was removed from NHS England's Executive Team effective 01 April 2025. Navina Evans received a Pay in Lieu of Notice (PILON) payment of £100,000-£105,000 and a redundancy payment of £45,000-£50,000 in September 2025 as compensation for loss of office. The remuneration figures noted in the above table reflect the total of these two payments.

¹⁵³ Julian Kelly received a PILON payment of £100,000-£105,000 in April 2025 following exit via resignation on 31 March 2025.

¹⁵⁴ Sarah-Jane Marsh commenced Board membership on 29 May 2025. Sarah-Jane Marsh's salary was recharged to NHS England from Birmingham Women's & Children's NHS Foundation Trust where she was also formally employed and retained a post. The full year equivalent salary is £230,000 to £235,000.

Remuneration (salary, benefits in kind and pensions) 2024/25 (subject to audit)

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Pension- related benefits (bands of £2,500) ¹⁵⁵ £000	(e) Total (a to e) (bands of £5,000) £000
Amanda Pritchard ¹⁵⁶ Chief Executive Officer	385-390	0	0	10-12.5	395-400
Dame Emily Lawson ¹⁵⁷ Chief Operating Officer (Interim)	260-265	0	0	0	260-265
Stephen Russell ¹⁵⁸ Chief Delivery Officer	205-210	1,000	0	0	205-210
Jacqueline Rock ¹⁵⁹ Chief Commercial Officer	160-165	2,100	0	97.5-100	260-265
Professor Sir Stephen Powis National Medical Director	240-245	0	0	0	240-245
Julian Kelly ¹⁶⁰ Chief Financial Officer	230-235	0	0	55-57.5	290-295
Dame Ruth May ¹⁶¹ Chief Nursing Officer	60-65	300	0	0	60-65
Duncan Burton ¹⁶² Chief Nursing Officer for England	135-140	0	0	105-107.5	240-245
Dr Vinod Diwakar National Director of Transformation (Interim)	215-220	0	0	0	215-220
Christopher Hopson Chief Strategy Officer	215-220	0	0	52.5-55	270-275
Navina Evans Chief Workforce Officer	205-210	0	0	0	205-210

¹⁵⁵ The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.

¹⁵⁶ Amanda Pritchard left NHS England on 31 March 2025 and received a Pay in Lieu of Notice (PILON) payment of £105,000-£110,000 and a Lieu of Annual Leave payment of £5,000-£10,000. The remuneration figure noted in the above table reflects the total of these two payments, plus Amanda's 2024/25 remuneration of £265,000-£270,000. However, the PILON and Lieu of Annual Leave payments were paid to Amanda during the 2025/26 reporting period.

¹⁵⁷ Dame Emily Lawson left the Chief Operating Officer post on 31 March 2025.

¹⁵⁸ Stephen Russell left the Chief Delivery Officer post on 31 March 2025. Stephen Russell's benefit in kind relates to a Lease Car.

¹⁵⁹ Jacqueline Rock left NHS England on 31 December 2024. The full year equivalent salary is £215,000-£220,000. Jacqueline Rock's benefit in kind relates to a Lease Car.

¹⁶⁰ Julian Kelly left NHS England on 31 March 2025 and received a Lieu of Annual Leave payment of £15,000-£20,000. The remuneration figure noted in the above table reflects the total of this payment, plus Julian's 2024/25 remuneration of £215,000-£220,000. However, the Lieu of Annual Leave payment was paid to Julian during the 2025/26 reporting period.

¹⁶¹ Dame Ruth May left the Chief Nursing Officer post on 24 July 2024. The full year equivalent salary is £190,000-£195,000. Dame Ruth May's benefit in kind relates to a Lease Car.

¹⁶² Duncan Burton commenced in post on 25 July 2024. The full year equivalent salary is £195,000-£200,000.

Pension benefits (subject to audit)

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age on 31 March 2026 (bands of £5,000) £000	Lump sum at pension age related to accrued pension on 31 March 2026 (bands of £5,000) £000	CETV on 31 March 2025 ¹⁶³ £000	Real Increase in CETV £000	CETV on 31 March 2026 £000	Employer's contribution to partnership pension £000
Sir James Mackey ¹⁶⁴ Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
David Probert ¹⁶⁵ Deputy Chief Executive Officer	2.5-5	2.5-5	40-45	115-120	836	51	925	0
Elizabeth O'Mahony Chief Financial Officer	10-12.5	22.5-25	85-90	230-235	1,639	246	1,940	0
Professor Sir Stephen Powis ¹⁶⁶ National Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Duncan Burton Chief Nursing Officer for England	7.5-10	10-12.5	70-75	170-175	1,300	145	1,492	0
Dr Vinod Diwakar ¹⁶⁷ National Director of Transformation (Interim)	7.5-10	12.5-15	105-110	270-275	2,270	188	2,630	0
Dr Claire Fuller Co-National Medical Director	7.5-10	17.5-20	55-60	115-120	1,009	209	1,261	0
Professor Meghana Pandit ¹⁶⁸ Co-National Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tom Kibasi ¹⁶⁹ Executive Director of Strategy	0-2.5	N/A	0-5	N/A	0	13	38	0
Paul Dinkin ¹⁷⁰ Director General for Strategy and Healthcare Policy	0	0	0	0	0	0	0	0
Sarah-Jane Marsh ¹⁷¹ National Director of Urgent and Emergency Care	2.5-5	0	75-80	170-175	1,448	31	1,536	0

¹⁶³ As per previous submissions, the column CETV on 31 March 2025 is the uninflated value whereas the real increase in CETV is the employer-funded increase.

¹⁶⁴ Sir James Mackey chose not to be covered by the NHS Pension arrangements during the reporting period.

¹⁶⁵ David Probert covered this post from 06 May 2025 to 31 March 2026, therefore the Pension Benefits disclosed are pro-rata for this period. Additionally, only 50% of the pension costs for David Probert were recharged to NHS England from the University College London Hospitals NHS Foundation Trust where he was also formally employed and retained a post, therefore the above figures are further pro-rata to reflect this.

¹⁶⁶ Professor Sir Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting period.

¹⁶⁷ Dr Vinod Diwakar left NHS England on 19 November 2025, therefore the Pension Benefits disclosed are pro-rata for this period.

¹⁶⁸ Professor Meghana Pandit chose not to be covered by the NHS Pension arrangements during the reporting period.

¹⁶⁹ Tom Kibasi covered this post from 16 May 2025 to 11 January 2026, therefore the Pension Benefits disclosed are pro-rata for this period.

¹⁷⁰ Paul Dinkin commenced in post on 12 January 2026. Paul Dinkin's salary and pension costs were retained wholly by the Department of Health and Social Care where he was formally employed and retained a post.

¹⁷¹ Sarah-Jane Marsh commenced Board membership from 29 May 2025, therefore the Pension Benefits disclosed are pro-rata for this period.

Cash equivalent transfer values (subject to audit)

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred into the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pensions liability

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be 4 years, with approximate assessments in intervening years". A breakdown of the above follows on the next page.

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Policy on remuneration of Non-Executive Directors

The remuneration of NEDs is set by DHSC on appointment and is non-pensionable. All NEDs are paid the same amount, except the Chair and Chair of ARAC, to reflect the equal time commitment expected from each NED. The Chair and Chair of ARAC are entitled to higher amounts to reflect the increased time commitment associated with their respective roles.

Some NEDs, including 1 of the Deputy Chairs, have opted to waive their contractual remuneration. NEDs do not receive PRP or pensionable remuneration.

Non-Executive Director service contracts

Name and title	Date of appointment	Unexpired term at 31 March 2026	Notice period	Provisions for compensation for early termination	Other details
Dr Penny Dash Chair	01 April 2025	36 months	3 months	None	
Jeremy Townsend Non-Executive Director Chair of ARAC	1 October 2020	6 months	3 months	None	
Michael Coupe Non-Executive Director	1 January 2021	0 months	3 months	None	Left NHS England on 31 July 2025
Sir Andrew Morris Non-Executive Director and Deputy Chair	1 July 2022	16 months	3 months	None	Appointment term extended to 31 July 2027
Professor the Baroness Mary Watkins Non-Executive Director	27 January 2023	0 months	3 months	None	Left NHS England on 31 July 2025
Professor Sir Simon Wessely Non-Executive Director	27 January 2023	0 months	3 months	None	Left NED role on 31 July 2025
Sir Mark Walport Non-Executive Director	27 January 2023	0 months	3 months	None	Left NHS England on 31 July 2025
Mark Bailie Non-Executive Director	19 February 2024	10 months	3 months	None	
Jane Ellison Non-Executive Director	19 February 2024	0 months	3 months	None	Left NHS England on 31 July 2025
Professor Sir Robert Lechler Non-Executive Director	19 February 2024	10 months	3 months	None	
Dr David Bennett Non-Executive Director	01 August 2025	16 months	3 months	None	
Paul Corrigan Non-Executive Director	01 August 2025	16 months	3 months	None	
Professor Sir Sam Everington Non-Executive Director	01 August 2025	16 months	3 months	None	
Ravi Gurumurthy Non-Executive Director	01 August 2025	16 months	3 months	None	
Louise Ansari MBE Non-Executive Director	01 September 2025	16 months	3 months	None	

Non-Executive Director remuneration (including salary entitlements)

Salaries and allowances 2025/26 (subject to audit)

Name of Non-Executive Director	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Pension- related benefits to the nearest £1,000 ¹⁷² £000	(e) Total (a to d) (bands of £5,000) £000
Dr Penny Dash	60-65	0	0	N/A	60-65
Jeremy Townsend	10-15	0	0	N/A	10-15
Michael Coupe ¹⁷³	0-5	0	0	N/A	0-5
Sir Andrew Morris	5-10	0	0	N/A	5-10
Professor the Baroness Mary Watkins ¹⁷⁴	0-5	0	0	N/A	0-5
Professor Sir Simon Wessely ¹⁷⁵	0-5	0	0	N/A	0-5
Sir Mark Walport ¹⁷⁶	0-5	0	0	N/A	0-5
Mark Bailie ¹⁷⁷	5-10	0	0	N/A	5-10
Jane Ellison ¹⁷⁸	0-5	0	0	N/A	0-5
Sir Robert Lechler	5-10	0	0	N/A	5-10
Dr David Bennett ¹⁷⁹	5-10	0	0	N/A	5-10
Paul Corrigan ¹⁸⁰	5-10	0	0	N/A	5-10
Professor Sir Sam Everington ¹⁸¹	5-10	0	0	N/A	5-10
Ravi Gurumurthy ¹⁸²	5-10	0	0	N/A	5-10
Louise Ansari ¹⁸³	0-5	0	0	N/A	0-5

¹⁷² Non-Executive directors do not receive pensionable remuneration and therefore have no pension-related benefits

¹⁷³ Michael Coupe left NHS England on 31 July 2025. The full-year equivalent salary is £5,000-£10,000.

¹⁷⁴ Professor the Baroness Mary Watkins left NHS England on 31 July 2025. The full-year equivalent salary is £5,000-£10,000.

¹⁷⁵ Professor Sir Simon Wessely left his NED role on 31 July 2025. The full-year equivalent salary is £5,000-£10,000.

¹⁷⁶ Sir Mark Walport left NHS England on 31 July 2025. The full-year equivalent salary is £5,000-£10,000.

¹⁷⁷ Mark Bailie donated 100% of his non-executive director remuneration to charity via NHS England's Give As You Earn scheme during the reporting period.

¹⁷⁸ Jane Ellison left NHS England on 31 July 2025. The full-year equivalent salary is £5,000-£10,000.

¹⁷⁹ Dr David Bennett joined NHS England on 01 August 2025. The full year equivalent salary is £5,000-£10,000.

¹⁸⁰ Paul Corrigan joined NHS England on 01 August 2025. The full year equivalent salary is £5,000-£10,000.

¹⁸¹ Professor Sir Sam Everington joined NHS England on 01 August 2025. The full year equivalent salary is £5,000-£10,000.

¹⁸² Ravi Gurumurthy joined NHS England on 01 August 2025. The full year equivalent salary is £5,000-£10,000.

¹⁸³ Louise Ansari joined NHS England 01 September 2025. The full-year equivalent salary is £5,000-£10,000.

Salaries and allowances 2024/25 (subject to audit)

Name of Non-Executive Director	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Pension-related benefits to the nearest £1,000 ¹⁸⁴ £000	(e) Total (a to d) (bands of £5,000) £000
Richard Meddings ¹⁸⁵	60-65	0	0	N/A	60-65
Wol Kolade ¹⁸⁶	0	0	0	N/A	0
Jeremy Townsend	10-15	0	0	N/A	10-15
Michael Coupe	5-10	0	0	N/A	5-10
Sir Andrew Morris	5-10	0	0	N/A	5-10
Sir David Behan ¹⁸⁷	0-5	0	0	N/A	0-5
Professor the Baroness Mary Watkins	5-10	0	0	N/A	5-10
Professor Sir Simon Wessely	5-10	0	0	N/A	5-10
Sir Mark Walport	5-10	0	0	N/A	5-10
Mark Bailie ¹⁸⁸	5-10	0	0	N/A	5-10
Jane Ellison	5-10	0	0	N/A	5-10
Sir Robert Lechler	5-10	0	0	N/A	5-10
Professor Dame Helen Stokes- Lampard ¹⁸⁹	0-5	0	0	N/A	0-5

¹⁸⁴ Non-Executive directors do not receive pensionable remuneration and therefore have no pension-related benefits

¹⁸⁵ Richard Meddings donated 50% of his Non-Executive director remuneration to charity via NHS England's Give As You Earn scheme during the reporting period.

¹⁸⁶ Wol Kolade waived his entitlement to Non-Executive director remuneration. Wol Kolade left NHS England on 24 March 2025.

¹⁸⁷ Sir David Behan left NHS England on 31 August 2024. The full-year equivalent salary is £5,000-£10,000.

¹⁸⁸ Mark Bailie donated 100% of his Non-Executive director remuneration to charity via NHS England's Give As You Earn scheme during the reporting period.

¹⁸⁹ Professor Dame Helen Stokes-Lampard left NHS England on 14 October 2024. The full-year equivalent salary is £5,000-£10,000.

Parliamentary accountability and audit report

All elements of this report are subject to audit.

Remote contingent liabilities

There were no remote contingent liabilities.

Notation of gifts over £300,000

NHS England made no political or charitable donations of gifts during 2025/26

Regularity of expenditure: Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise and are therefore subject to special control procedures compared to the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Details of any losses and special payments relating to ICBs can be found within individual ICBs annual reports which are published on ICB websites. A list of ICBs along with links to their websites, can be found on the NHS England website.

Losses

The total number of NHS England losses cases, and their total value, was as follows:

	Parent				Consolidated group			
	Total number of cases 2025/26 Number	Total value of cases 2025/26 £000	Total number of cases 2024/25 Number	Total value of cases 2024/25 £000	Total number of cases 2025/26 Number	Total value of cases 2025/26 £000	Total number of cases 2024/25 Number	Total value of cases 2024/25 £000
Administrative write-offs	129	369	150	1,886	446	2,262	423	2,597
Fruitless payments	248	2,553	260	19,578	287	17,002	269	19,834
Stores losses	25	17	149	90	510,317	2,957	108,500	2,003
Bookkeeping losses	-	-	-	-	22	46	14	24
Constructive loss	-	-	-	-	-	-	1	1
Cash losses ¹⁹⁰	108	92	1,028	897	109	92	1,033	994
Claims abandoned	-	-	-	-	3	3	23	31
Total	510	3,031	1,587	22,451	511,184	22,362	110,263	25,484

2025/26 Disclosure: Administrative write off

£0.475 million - NHS Northeast London ICB (QMF) recognised an administrative write off for irrecoverable balances arising from a non NHS provider of administrative services entering administration. Following confirmation from the Joint Administrators that there is no realistic prospect of recovery, the balance has been written off in full.

2025/26 Disclosure: Fruitless payments

£2.34 million - These losses have occurred as a result of payments made to settle historic employment tax liabilities following engagement with HMRC.

¹⁹⁰ Cash losses in 2023/24 includes 9k relating to 2024/25 disclosed at the earliest opportunity, as per Managing Public Money guidance.

£14.34 million - relates to NHS West Yorkshire ICB that has identified that certain deductions required for GP out of hours payments were not processed correctly. This has resulted in overpayments between 2016/17 to 2024/25. The ICB is exploring options to recover these.

2025/26 Disclosure: Store losses

£2.96 million - Of this, £2.94 million relates to various stock items that cannot be utilised in healthcare facilities as the stock has reached the manufacturers expiry date; damaged or unserviceable items and therefore requires writing off.

2024/25 Disclosure: Administrative write off

£1 million - This relates to irrecoverable dental debts that were owed due to underperformance on the dental contracts.

£0.5 million - This write off relates to 25 GP irrecoverable aged debts due to being beyond the 6-year recovery period or dissolution of companies following liquidation.

2024/25 Disclosure: Fruitless payments

£17 million - This payment is where continuing health care should have been awarded to individuals and when the payments were made including redress values, the tax liability was not deducted by CCG's and paid over to HMRC which is now due following various court proceedings.

£2.2 million - This relates to payroll worker tax compliance within the former Health Education England which has now transferred to NHS England upon the Health Education England and NHS England merger.

2024/25 Disclosure: Store losses

£2 million – Of this, £1.9 million relates to various stock items that cannot be utilised in healthcare facilities as the stock has reached the manufacturers expiry date and therefore requires writing off.

2024/25 Disclosure: Cash losses

£0.9 million - These debts relate to irrecoverable bursaries that have been paid to eligible medical or dental students to cover costs incurred by students that were due to be paid back from scenarios such as the student leaving the course early.

Special payments

The total number of NHS England special payments cases, and their total value, was as follows:

	Parent				Consolidated group			
	Total number of cases 2025/26 Number	Total value of cases 2025/26 £000	Total number of cases 2024/25 Number	Total value of cases 2024/25 £000	Total number of cases 2025/26 Number	Total value of cases 2025/26 £000	Total number of cases 2024/25 Number	Total value of cases 2024/25 £000
Compensation payments	2	21	8	56	12	67	13	86
Compensation payments Treasury Approved	34	43	20	34	36	253	20	34
Extra Contractual Payments	-	-	-	-	3	43	3	133
Extra Contractual Payments Treasury Approved	-	-	1	4,058	-	-	1	4,058
Ex Gratia Payments	3	85	1	-	18	973	11	142
Ex Gratia Payments Treasury Approved	1	35	-	-	1	35	1	-
Special Severance Payments Treasury Approved	1	330	-	-	1	330	-	-
Special Severance Payments (requires treasury approval)	1	10	1	39	1	10	1	39
Total	42	524	31	4,187	72	1,711	50	4,492

2025/26 Special Severance Payments

Parent entity

There was 1 special severance payment that has had HMT treasury approval: During 2025/26 £330,000 special severance payment was made to settle an employment related claim. Settlement was agreed to conclude the employment relationship mitigating the risk of ongoing litigation and associated financial impacts.

There was 1 special severance payment that did not have HMT approval: During 2025/26 there was a £10,000 employment-related settlement paid to a former employee. The payment was not originally classified as a special severance payment but was further reviewed by NHS England and determined to meet the relevant criteria. Retrospective approval has been sought. As HM Treasury approval had not been obtained at the time of payment, the expenditure is irregular.

The payments noted above is also included in the Exit Package disclosures from page 97.

2024/25 Special Severance Payments

There was 1 special severance payment that did not have HMT approval as follows:

NHS South, Central and West CSU During 2024/25, the CSU has paid one special severance payment in the parent account for £38,988. It relates to a settlement agreement payment made to the individual. The payment was not approved by NHS England or HMT and is therefore irregular. The payment noted above is also included in the Exit Package disclosures from page 100.

2024/25 Extra Contractual Payments

£4,058k - This is a claim for damages for breach of the General Ophthalmic Services contract brought by a supplier against NHS England.

Cost allocation and setting of charges

NHS England certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

2025/26	Note	Parent			Consolidated group		
		Income £000	Full cost £000	Surplus/ (deficit) £000	Income £000	Full cost £000	Surplus/ (deficit) £000
Dental	2 & 4	-	(98,451)	(98,451)	848,169	(3,896,788)	(3,048,619)
Prescription	2 & 4	-	(203,402)	(203,402)	732,752	(13,306,948)	(12,574,196)
Total fees and charges		-	(301,853)	(301,853)	1,580,921	(17,203,736)	(15,622,815)

2024/25	Note	Parent			Consolidated group		
		Income £000	Full cost £000	Surplus/ (deficit) £000	Income £000	Full cost £000	Surplus/ (deficit) £000
Dental	2 & 4	-	(92,751)	(92,751)	796,508	(3,718,746)	(2,922,238)
Prescription	2 & 4	-	(146,907)	(146,907)	730,413	(12,790,072)	(12,059,659)
Total fees and charges		-	(239,658)	(239,658)	1,526,921	(16,508,818)	(14,981,897)

The fees and charges information in this note is provided in accordance with section 6.7.1 of the Government FRM. It is provided for fees and charges purposes and not for IFRS 8 purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges¹⁹¹ are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2025/26, the NHS prescription charge for each medicine or appliance dispensed was £9.90. However, around 95% of prescription items¹⁹² are dispensed without charge each year where patients are exempt from charges or hold a pre-payment certificate. In 2025/26 pre-payment certificates were charged at £32.05 for 3 months or £114.50 for a year. A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges¹⁹³ which fall into 3 bands depending on the level and complexity of care provided. From 1st April 2025, the charge for Band 1 treatments was £27.40, for Band 2 was £75.30 and for Band 3 was £326.70. Prior to this uplift the charge for Band 1 treatments was £26.80, for Band 2 was £73.50 and for Band 3 was £319.10.

Sir James Mackey, Accounting Officer

20 August 2026

¹⁹¹ <https://www.legislation.gov.uk/uksi/2024/456/contents/made>

¹⁹² <https://www.nhsbsa.nhs.uk/statistical-collections/prescription-cost-analysis-england/prescription-cost-analysis-england-202324>, "Additional Tables", "Table 4A"

¹⁹³ <https://www.legislation.gov.uk/uksi/2024/271/regulation/4/made>

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of NHS England and its group for the year ended 31 March 2026 under the National Health Service Act 2006 and the Health and Social Care Act 2012.

The financial statements comprise the NHS England and its group's

- Statement of Financial Position as at 31 March 2026;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the group financial statements is applicable law and UK adopted International Accounting Standards.

In my opinion, the financial statements:

- give a true and fair view of the state of the NHS England and its Group's affairs as at 31 March 2026 and their total net expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects, the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom (2024)*. My responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's *Revised Ethical Standard 2024*. I am independent of NHS England and its Group in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the NHS England and its group's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the NHS England and its Group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for NHS England and its group is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which requires entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report but does not include the financial statements and my auditor's certificate thereon. The Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the National Health Service Act 2006 and the Health and Social Care Act 2012.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of NHS England and its group and its/their environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Reports.

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept by the NHS England and its Group or returns adequate for my audit have not been received from branches not visited by my staff; or
- I have not received all of the information and explanations I require for my audit; or
- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and Accounting Officer are responsible for:

- maintaining proper accounting records;
- providing the C&AG with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the C&AG with additional information and explanations needed for his audit;
- providing the C&AG with unrestricted access to persons within NHS England and its Group from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- preparing financial statements which give a true and fair view in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012;
- preparing the annual report, which includes the Remuneration and Staff Report, in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012; and
- assessing NHS England and its Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS England and its group will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006 and the Health and Social Care Act 2012.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a

material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, I:

- considered the nature of the sector, control environment and operational performance including the design of NHS England and its group's accounting policies.
- inquired of management, NHS England's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the NHS England and its Group policies and procedures on:
 - identifying, evaluating and complying with laws and regulations;
 - detecting and responding to the risks of fraud; and
- the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS England and its group's controls relating to NHS England's compliance with the National Health Service Act 2006, Health and Social Care Act 2012, Health and Care Act 2022, Managing Public Money, employment law and Secretary of State determinations relating to suspension payments to suspended medical practitioners;
- inquired of management, NHS England's head of internal audit and those charged with governance whether:
 - they were aware of any instances of non-compliance with laws and regulations;
 - they had knowledge of any actual, suspected, or alleged fraud;
- discussed with the engagement team including relevant component audit teams regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within the NHS England and its Group for fraud and identified the greatest potential for fraud in the following areas: revenue recognition, posting of unusual journals, complex transactions and bias in management estimates. In common with all audits under ISAs (UK), I am required to perform specific procedures to respond to the risk of management override.

I obtained an understanding of the NHS England and its group's framework of authority and other legal and regulatory frameworks in which the NHS England and Group operates. I focused on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of the NHS England and its Group. The key laws and regulations I considered in this context included National

Health Service Act 2006, Health and Social Care Act 2012, Health and Care Act 2022, Managing Public Money, employment law, tax legislation, relevant legislation relating to fees charged by the NHS England, and Secretary of State determinations relating to suspension payments to suspended medical practitioners.

Audit response to identified risk

To respond to the identified risks resulting from the above procedures:

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management, the Audit and Risk Assurance Committee and in-house legal counsel concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the Board and internal audit reports;
- I addressed the risk of fraud through management override of controls by testing the appropriateness of journal entries and other adjustments; assessing whether the judgements on estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; enquiring with the component auditors about findings of their audits; and using the work of component auditors with respect to management override of controls.

I communicated relevant identified laws and regulations and potential risks of fraud to all engagement team members including internal specialists and relevant component audit teams and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

Other auditor's responsibilities

I am required to obtain sufficient appropriate audit evidence to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control I identify during my audit.

Report

I have no observations to make on these financial statements.

Gareth Davies

26 August 2026

Comptroller and Auditor General

National Audit Office, 157-197 Buckingham Palace Road, Victoria, London SW1W 9SP

Annual Accounts

Statement of comprehensive net expenditure for the Year ended 31 March 2026

	Note	Parent		Consolidated group	
		2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Income from sale of goods and services	2	(584,806)	(607,736)	(6,703,407)	(6,319,642)
Other operating income	2	(4,211)	(3,382)	(87,082)	(92,184)
Total operating income		(589,017)	(611,118)	(6,790,489)	(6,411,826)
Staff costs	3	1,968,148	1,759,764	4,485,855	3,660,520
Purchase of goods and services	4	198,754,710	189,149,954	199,768,667	189,239,310
Depreciation and impairment charges	4	280,995	286,658	329,352	329,136
Provision expense	4	78,494	5,097	235,509	38,531
Other Operating Expenditure	4	229,589	232,263	4,024,675	3,827,392
Total operating expenditure		201,311,936	191,433,736	208,844,058	197,094,889
Net operating expenditure		200,722,919	190,822,618	202,053,569	190,683,063
Finance income		(15)	(12)	(812)	(33)
Finance expense	13	16,933	14,623	24,502	21,620
Net expenditure for the year		200,739,837	190,837,229	202,077,259	190,704,650
Other (gains)/losses		11,445	1,323	10,504	1,890
Net (gain)/loss on Transfer by Absorption	12	-	1,485	-	1,040
Total net expenditure for the year		200,751,282	190,840,037	202,087,763	190,707,580
Other comprehensive net expenditure					
Items which will not be reclassified to net operating costs					
Net (gain)/loss on revaluation of Financial Asset ¹⁹⁴		(43)	(64)	-	-
Total Other Comprehensive Net Expenditure		(43)	(64)	-	-
Comprehensive net expenditure for the year		200,751,239	190,839,973	202,087,763	190,707,580

The notes on pages 129 to 169 form part of this statement.

¹⁹⁴ The change in revaluation of financial assets represents the change on equity instruments measured at fair value through OCI in respect of NHS England investment in SCCL.

Statement of financial position as at 31 March 2026

		Parent		Consolidated group	
		31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Non-current assets	Note				
Property, plant and equipment	5	305,218	310,282	347,069	355,871
Right of use assets	6	91,970	112,379	248,057	284,087
Intangible assets	7	702,180	537,979	741,601	583,482
Trade and other receivables	9	4,552	11,058	4,552	11,058
Other financial assets	9	139,900	139,857	1,106	1,106
Total non-current assets		1,243,820	1,111,555	1,342,385	1,235,604
Current assets					
Inventories	8	203	850	155,545	173,360
Trade and other receivables	9	741,985	800,042	2,426,859	2,524,540
Cash and cash equivalents	10	159,201	425,586	256,342	551,215
Total current assets		901,389	1,226,478	2,838,746	3,249,115
Total assets		2,145,209	2,338,033	4,181,131	4,484,719
Current liabilities					
Trade and other payables	11	(2,549,006)	(2,334,594)	(12,087,616)	(10,839,901)
Right of use asset lease liabilities	6	(19,510)	(22,257)	(42,635)	(46,672)
Other financial liabilities	11	-	-	(28,270)	(18,269)
Provisions	14	(172,019)	(70,738)	(455,985)	(195,373)
Total current liabilities		(2,740,535)	(2,427,589)	(12,614,506)	(11,100,215)
Total assets less current liabilities		(595,326)	(89,556)	(8,433,375)	(6,615,496)
Non-current liabilities					
Trade and other payables	11	-	-	(9,245)	(7,985)
Right of use asset lease liabilities	6	(82,268)	(98,114)	(215,213)	(246,768)
Other financial liabilities	11	-	-	(130,000)	(100,000)
Provisions	14	(248,808)	(274,846)	(295,740)	(312,914)
Total non-current liabilities		(331,076)	(372,960)	(650,198)	(667,667)
Total assets less total liabilities		(926,402)	(462,516)	(9,083,573)	(7,283,163)
Financed by taxpayers' equity and other reserves					
General fund		(908,088)	(445,434)	(9,084,359)	(7,285,224)
Revaluation reserve		786	2,061	786	2,061
Other reserves		(19,100)	(19,143)	-	-
Total taxpayers' equity		(926,402)	(462,516)	(9,083,573)	(7,283,163)

The notes on pages 129 to 169 form part of this statement. The financial statements on pages 123 to 127 were approved by the Board and signed on its behalf by:

Sir James Mackey, Accounting Officer
20 August 2026

Statement of changes in taxpayers equity for the year ended 31 March 2026

Parent 2025/26	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2025		(445,434)	2,061	(19,143)	(462,516)
Changes in Total Taxpayers' Equity for 2025/26					
Total Net Expenditure for the year		(200,751,282)			(200,751,282)
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)		-	-	43	43
Transfers between reserves		1,275	(1,275)	-	-
Comprehensive net expenditure for the year		(200,750,007)	(1,275)	43	(200,751,239)
Grant in Aid		200,287,353	-	-	200,287,353
Balance at 31 March 2026		(908,088)	786	(19,100)	(926,402)

Parent 2024/25	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2024		(1,047,932)	2,222	(19,207)	(1,064,917)
Changes in Total Taxpayers' Equity for 2024/25					
Total Net Expenditure for the year		(190,840,037)			(190,840,037)
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)		-	-	64	64
Transfers between reserves		161	(161)	-	-
Comprehensive net expenditure for the year		(190,839,876)	(161)	64	(190,839,973)
Grant in Aid		191,442,374	-	-	191,442,374
Balance at 31 March 2025		(445,434)	2,061	(19,143)	(462,516)

Consolidated group 2025/26	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2025		(7,285,224)	2,061	-	(7,283,163)
Changes in Total Taxpayers' Equity for 2025/26					
Total Net Expenditure for the year		(202,087,763)	-	-	(202,087,763)
Transfers between reserves		1,275	(1,275)	-	-
Comprehensive net expenditure for the year		(202,086,488)	(1,275)	-	(202,087,763)
Grant in Aid		200,287,353	-	-	200,287,353
Balance at 31 March 2026		(9,084,359)	786	-	(9,083,573)

Consolidated group 2024/25	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2024		(8,020,187)	2,230	-	(8,017,957)
Changes in Total Taxpayers' Equity for 2024/25					
Total Net Expenditure for the year		(190,707,580)	-	-	(190,707,580)
Other Movements in reserve		-	-	-	-
Transfers between reserves	12	169	(169)	-	-
Comprehensive net expenditure for the year		(190,707,411)	(169)	-	(190,707,580)
Grant in Aid		191,442,374	-	-	191,442,374
Balance at 31 March 2025		(7,285,224)	2,061	-	(7,283,163)

The general fund is used in public sector accounting to reflect the total assets less liabilities of an entity, which are not assigned to another reserve.

Other reserves in the parent relate to fair value losses on equity investments designated as fair value through other comprehensive income under IFRS 9.

The notes on pages 129 to 169 form part of this statement.

Statement of cash flows for the year ended 31 March 2026

Cash flows from operating activities	Note	Parent		Consolidated group	
		2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Net expenditure for the financial year		(200,751,282)	(190,840,037)	(202,087,763)	(190,707,580)
Depreciation and amortisation	4	280,995	286,658	329,278	329,136
Impairments and reversals	4	-	-	74	-
Other non-cash adjustments		-	(52)	-	(607)
Movement due to transfers by absorption	12	-	-	-	(1,077)
Interest paid		3,711	3,248	11,233	10,031
(Gain)/Loss on disposal		11,445	1,323	10,504	1,890
Unwinding of discount	14	13,222	11,373	13,269	11,454
Change in discount rate		(15,478)	(1,949)	(15,542)	(2,007)
(Increase)/decrease in inventories	8	647	320	17,815	(13,434)
(Increase)/decrease in trade & other receivables	9	64,563	(40,274)	104,027	(47,091)
Increase/(decrease) in trade & other payables	11	91,439	(402,679)	1,165,363	(485,385)
Provisions utilised	14	(24,846)	(47,465)	(52,860)	(113,551)
Increase/(decrease) in provisions		102,552	13,847	293,703	41,398
Net cash outflow from operating activities		(200,223,032)	(191,015,687)	(200,210,899)	(190,976,823)
Cash flows from investing activities					
Interest received		-	-	15	20
Payments for property, plant and equipment		(22,470)	(10,832)	(75,099)	(23,525)
Payments for intangible assets		(285,238)	(252,063)	(285,727)	(253,269)
Proceeds for other financial assets		-	-	4,395	-
Proceeds from disposal of assets: property, plant and equipment		64	-	64	441
Net cash outflow from investing activities		(307,644)	(262,895)	(356,352)	(276,333)
Net cash outflow before financing activities		(200,530,676)	(191,278,582)	(200,567,251)	(191,253,156)
Cash flows from financing activities					
Grant in aid funding received	SoCTE	200,287,353	191,442,374	200,287,353	191,442,374
Other loans received		-	-	30,000	115,000
Other loans repaid		-	-	(2,195)	(126,295)
Repayment of Lease Liability	6.2	(23,062)	(24,622)	(50,459)	(54,675)
Cash Transferred under absorption	12	-	-	-	1,077
Net cash inflow from financing activities		200,264,291	191,417,752	200,264,699	191,377,481
Net increase (decrease) in cash & cash equivalents		(266,385)	139,170	(302,552)	124,325
Cash & Cash Equivalents at the Beginning of the Financial Year	10	425,586	286,416	532,946	408,621
Cash & Cash Equivalents at the end of the Financial Year	10	159,201	425,586	230,394	532,946

The notes on pages 129 to 169 form part of this statement.

There is no separate disclosure under IAS 7 for cash and non-cash movements in liabilities arising from financing activities because the values are immaterial.

Notes to the financial statements

1. Statement of accounting policies

These financial statements have been prepared in a form directed by the Secretary of State under Schedule 1(A), paragraph 15(2) of the NHS Act 2006 (as amended by the Health and Care Act 2022) and in accordance with the Financial Reporting Manual (FReM) 2025/26 issued by HM Treasury and the DHSC Group Accounting Manual (GAM) issued by the Department of Health & Social Care. The accounting policies contained in the FReM and DHSC GAM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM or DHSC GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS England for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS England are described below. They have been applied consistently in dealing with items considered material to the accounts.

The functional and presentational currency is pounds sterling and figures are expressed in pounds thousands unless expressly stated. Two sets of figures are presented – the first relating to NHS England itself (the Parent) and a second set of consolidated figures (Consolidated Group). The entities making up the Consolidated Group are declared in Note 22.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Net Expenditure in the period in which they arise.

1.1 Operating segments

Income and expenditure are analysed in the Operating Segments note (note 18) and reflect the management information used within NHS England. Information on assets less liabilities is not separately reported to the function equivalent to the Chief Operating Decision Maker and therefore in accordance with IFRS 8 does not form part of the disclosure in note 18.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

1.3 Basis of consolidation

These accounts comprise the results of the NHS England statutory entity as well as the consolidated position of NHS England, 42 ICBs and SCCL. Transactions between entities included in the consolidation are eliminated.

CSUs form part of NHS England and provide services to ICBs. The CSU results are included within the Parent accounts as they are not separate legal entities.

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2025.

1.5 Going concern

NHS England's financial statements are produced on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. NHS England is financed by grant-in-aid and draws its funding from the DHSC. Parliament has demonstrated its commitment to fund the DHSC for the foreseeable future via the latest Spending Review and the passing of the Health and Care Act 2022.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. Primary legislation will be required to integrate and effect the demise of the statutory entity NHS England and the Health Bill 2026 will provide the legislative footing to do this. The date of demise is expected to be 31 March 2027. At the reporting date, and pending the proposed legislative changes, public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services continue to be provided in the public sector the financial statements are prepared on the going concern basis. The current assessment is that in the absence of a detailed plan to the contrary, current services in line with The Act will continue to be provided. The statement of financial position has therefore been drawn up at 31 March 2026, on a going concern basis.

1.6 Transfer of functions

As public sector bodies within a Departmental Boundary are deemed to operate under common control, business reconfigurations are outside the scope of IFRS 3 Business Combinations. When functions transfer between two public sector bodies the FReM requires the application of "absorption accounting". Absorption accounting requires that entities account for their transactions in the period in which those transactions took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Net Comprehensive Expenditure and is disclosed separately from operating costs.

1.7 Revenue recognition

In the application of IFRS 15 a number of practical expedients have been employed. These are as follows:

- NHS England is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less
- NHS England is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with the value of the performance completed to date.

The main source of funding for NHS England is grant-in-aid from the Department of Health & Social Care. NHS England is required to maintain expenditure within this allocation.

The Department of Health & Social Care also approves a cash limit for the period.

NHS England is required to draw down cash in accordance with this limit. Grant-in-aid is drawn

down and credited to the general fund. Grant-in-aid is recognised in the financial period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

IFRS 15 is applicable to revenue in respect of dental and prescription charges in line with the adaptation in IFRS 15 which states that the definition of a contract includes revenue received under legislation and regulations. Revenue for these charges is recognised when the performance event occurs, such as the issue of a prescription or payment for dental treatment.

Income received in respect of penalty charge notices issued in relation to non-payment of prescribing and dental charges is recognised on a cash receipts basis.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Other operating revenue is recognised when the service is rendered and the stage completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that the economic benefit associated with the transaction will flow to the group. Income is measured at fair value of the consideration receivable.

The value of the benefit received when NHS England accesses funds from the government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 Grant in Aid

The main source of funding for NHS England is grant-in-aid from the Department of Health & Social Care. NHS England is required to maintain expenditure within this allocation.

The Department of Health & Social Care also approves a cash limit for the period.

NHS England is required to draw down cash in accordance with this limit. Grant-in-aid is drawn down and credited to the general fund. Grant-in-aid is recognised in the financial period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

IFRS 15 is applicable to revenue in respect of dental and prescription charges in line with the adaptation in IFRS 15 which states that the definition of a contract includes revenue received under legislation and regulations. Revenue for these charges is recognised when the performance event occurs, such as the issue of a prescription or payment for dental treatment.

Income received in respect of penalty charge notices issued in relation to non-payment of prescribing and dental charges is recognised on a cash receipts basis.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Other operating revenue is recognised when the service is rendered and the stage completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that the economic benefit associated with the transaction will flow to the group. Income is measured at fair value of the consideration receivable.

The value of the benefit received when NHS England accesses funds from the government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.9 Employee benefits

Recognition of short-term benefits – retirement benefit costs:

Past and present employees are covered by the provisions of the NHS Pensions schemes. The schemes are unfunded, defined benefit schemes that cover NHS employers, general practitioners and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the organisation commits itself to the retirement, regardless of the method of payment.

Salaries, wages and employment related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following year.

1.10 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

The provision of funding to group bodies by the NHS England parent matches the recipient's cash needs and is accounted for on a cash basis in the period in which it is paid. These payments finance ICBs' operating expenditure. These transactions are eliminated at the NHSE group level as indicated in Note 4 .

1.11 Value added tax

Most of the activities of the group are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.12 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the group
- it is expected to be used for more than 1 financial year
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000, or
- collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control

Where an asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Measurement of property, plant and equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historical cost as a proxy for current value in existing use. This is in accordance with FReM requirements as these assets have short useful lives or low values or both.

Balances held in the Revaluation reserve relate to balances inherited from 1 April 2013. In line with our accounting policy, no further revaluation gains have been recognised.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is charged to operating expenses.

1.13 Intangible non-current assets

Intangible non-current assets are non-monetary assets without physical substance that are capable of sale separately from the rest of the group's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the group; where the cost of the asset can be measured reliably; and where the cost is at least £5,000 or collectively the cost is at least £5,000 with each individual item costing more than £250.

Intangible non-current assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

From 1 April 2025, subsequent measurement of intangible assets is at cost less depreciation. Prior to 1 April 2025, intangible assets were carried at depreciated historic cost as a proxy for current value in existing use.

1.14 Research and development

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial, and other resources to complete the intangible asset and sell or use it
- the ability to reliably measure the expenditure attributable to the intangible asset during its development.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.15 Depreciation, amortisation and impairments

Freehold land, assets under construction, investment properties, stockpiled goods and assets held for sale are neither depreciated nor amortised.

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight-line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which economic benefits or service potential is expected to be obtained from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance

leases are depreciated over the shorter of the lease term and the estimated useful life unless NHS England expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, an entity checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit or reduction in operational capacity are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

Depreciation/amortisation is charged as follows:

	Minimum life (years)	Maximum life (years)
Buildings excluding dwellings	5	20
Plant and machinery	5	10
Transport equipment	5	10
Information technology	2	10
Furniture and fittings	5	10
Computer software: purchased	2	5
Licences and trademarks	2	5
Development expenditure (internally generated)	2	5

1.16 Government grant funded assets

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.17 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

There are further expedients or elections that have been employed by NHS England in applying IFRS 16. These include:

The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.

The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

NHS England will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.12 instead.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

NHS England is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 NHS England has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

NHS England is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. Peppercorn arrangements are capitalised at current value in existing use where they are held for their operational capacity. They are valued, depreciated and impaired as described for purchased assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.17.1 NHS England as a lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. NHS England employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure. Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16. Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset NHS England applies a revised rate to the remaining lease liability.

Where existing leases are modified NHS England must determine whether the arrangement constitutes a separate lease and apply the Standard accordingly.

Where an implicit rate cannot be determined, the incremental borrowing rate determined by HM Treasury annually is applied. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less or is elected as a lease containing low value underlying asset by NHS England.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value and are utilised using the First in First Out method of inventory controls.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and are readily convertible to known amounts of cash with insignificant risk of change in value.

In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management. Cash, bank and overdraft balances are recorded at current values.

1.20 Provisions

Provisions are recognised when there exists a present legal or constructive obligation exists as a result of a past event, it is probable that the group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 2.40 percent (2024/25: 2.40%) in real terms. All general provisions are subject to 4 separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- a nominal short-term rate of 3.64 percent (2024/25: 4.03 percent in real terms) is applied to inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date
- a nominal medium-term rate of 4.22 percent (2024/25: 4.07 percent in real terms) is applied to inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date
- a nominal long-term rate of 5.32 percent (2024/25: 4.81 percent in real terms) is applied to inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date

- a nominal very long-term rate of 5.07 percent (2024/25: 4.55 percent) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

1.21 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which NHS England and ICBs pay an annual contribution to NHS Resolution, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability rests with the group.

1.22 Non-clinical risk pooling

The NHS England group participates in the Property Expenses Scheme and the Liabilities to Third Parties scheme. Both are risk pooling schemes under which NHS England and ICBs pay an annual contribution to NHS Resolution and, in return, receive assistance with the cost of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when they become due.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation, or the amount of the obligation cannot be measured sufficiently reliably

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities that are required to be disclosed under IAS37 are stated at discounted amounts.

1.24 Financial assets

Financial assets are recognised on the statement of financial position when the group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired, or the asset has been transferred and the group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

As available for sale financial assets, the group's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the consolidated statement of net comprehensive expenditure on de- recognition.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.24.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.24.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.24.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.24.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, NHS England recognises a loss allowance representing expected credit losses on the financial instrument.

NHS England adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. NHS England therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social

Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and NHS England does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.25 Financial liabilities

Financial liabilities are recognised in the statement of financial position when the group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged; that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Accounting standards that have been issued but have not yet been adopted

The FReM does not require the following Standards and Interpretations to be applied in 2025/26. These standards are still subject to HM Treasury FReM adoption.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK-endorsed and not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK-endorsed and not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating income

	Parent		Consolidated group	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Income from sale of goods and services (contracts)				
Education, training and research	7,961	11,499	9,257	18,014
Non-patient care services to other bodies	421,196	449,663	4,753,145	4,437,923
Prescription fees and charges ¹⁹⁵	-	-	732,752	730,413
Dental fees and charges ¹⁹⁵	-	-	848,169	796,508
Other contract income	154,549	146,115	354,005	332,756
Recoveries in respect of employee benefits	1,100	459	6,079	4,028
Total income from sale of goods and services	584,806	607,736	6,703,407	6,319,642
Other operating income				
Rental revenue from finance leases	-	-	-	21
Rental revenue from operating leases	-	-	1,045	1,007
Charitable and other contributions to revenue expenditure: non-NHS	-	150	1,060	848
Non-cash apprenticeship training grants revenue	2,282	1,470	3,298	2,220
Other non-contract revenue	1,929	1,762	81,679	88,088
Total other operating income	4,211	3,382	87,082	92,184
Total operating income	589,017	611,118	6,790,489	6,411,826

Intercompany trading is eliminated between bodies within the NHS England group upon consolidation.

¹⁹⁵ In line with the adaptation in the HM Treasury Financial Reporting Manual prescription fees and charges and dental fees and charges are treated as revenue arising from a contract and accounted for under IFRS15.

2.1 Disaggregation of revenue

We disaggregate our revenue from contracts with customers by the nature of the revenue. This is shown in Note 2. Note 2.1 provides the disaggregation in line with our operating segments reported in Note 18.

Income from sale of goods and services (contracts)

Parent 2025/26	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Education Training Activity Plan ¹⁹⁶ £000	Other £000	Intercompany eliminations £000	Total £000
Income from sale of goods and services (contracts)								
Education, training and research	-	-	-	5,985	1,986	-	(10)	7,961
Non-patient care services to other bodies	-	-	3,142	181,920	107	489,482	(253,455)	421,196
Prescription fees and charges	-	-	-	-	-	-	-	-
Dental fees and charges	-	-	-	-	-	-	-	-
Income generation	-	-	-	-	-	-	-	-
Other contract income	-	-	27,289	71,276	124	13,041	42,819	154,549
Recoveries in respect of employee benefits	-	-	-	933	167	-	-	1,100
Total income from sale of goods and services	-	-	30,431	260,114	2,384	502,523	(210,646)	584,806

Parent 2024/25	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Multi-Professional Education and Training Investment Plan £000	Other £000	Intercompany eliminations £000	Total £000
Income from sale of goods and services (contracts)								
Education, training and research	-	-	-	9,880	1,654	-	(35)	11,499
Non-patient care services to other bodies	-	-	2,167	166,087	152	476,233	(194,976)	449,663
Prescription fees and charges	-	-	-	-	-	-	-	-
Dental fees and charges	-	-	-	-	-	-	-	-
Income generation	-	-	-	-	-	-	-	-
Other contract income	-	-	24,974	74,967	241	14,374	31,559	146,115
Recoveries in respect of employee benefits	-	-	1	431	27	-	-	459
Total income from sale of goods and services	-	-	27,142	251,365	2,074	490,607	(163,452)	607,736

¹⁹⁶ Education Training Activity Plan was formally known as Multi-Professional Education and Training Investment Plan.

Consolidated group 2025/26	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Education Training Activity Plan ¹⁹⁷ £000	Other £000	Intercompany eliminations £000	Total £000
Income from sale of goods and services (contracts)								
Education, training and research	3,514	-	-	5,985	1,986	-	(2,228)	9,257
Non-patient care services to other bodies	269,301	4,632,111	3,142	181,920	107	489,482	(822,918)	4,753,145
Prescription fees and charges	732,752	-	-	-	-	-	-	732,752
Dental fees and charges	848,169	-	0	-	-	-	-	848,169
Income generation	86	-	-	-	-	-	(86)	-
Other contract income	186,808	-	27,289	71,276	124	13,041	55,467	354,005
Recoveries in respect of employee benefits	6,398	-	-	933	167	-	(1,419)	6,079
Total income from sale of goods and services	2,047,028	4,632,111	30,431	260,114	2,384	502,523	(771,184)	6,703,407

Consolidated group 2024/25	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Multi-Professional Education and Training Investment Plan £000	Other £000	Intercompany eliminations £000	Total £000
Income from sale of goods and services (contracts)								
Education, training and research	9,676	-	-	9,880	1,654	-	(3,196)	18,014
Non-patient care services to other bodies	264,993	4,293,437	2,167	166,087	152	476,233	(765,146)	4,437,923
Prescription fees and charges	730,413	-	-	-	-	-	-	730,413
Dental fees and charges	796,508	-	-	-	-	-	-	796,508
Income generation	-	-	-	-	-	-	-	-
Other contract income	176,640	-	24,974	74,967	241	14,374	41,560	332,756
Recoveries in respect of employee benefits	4,687	-	1	431	27	-	(1,118)	4,028
Total income from sale of goods and services	1,982,917	4,293,437	27,142	251,365	2,074	490,607	(727,900)	6,319,642

¹⁹⁷ Education Training Activity Plan was formally known as Multi-Professional Education and Training Investment Plan.

3. Employee benefits

3.1. Employee benefits table

Employee benefits ¹⁹⁸	Parent		Consolidated group	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Salaries and wages	1,336,237	1,345,618	2,835,256	2,817,841
Social security costs	170,094	143,391	372,561	299,626
Employer contributions to NHS Pension scheme	269,226	267,382	564,111	550,490
Other pension costs	-	-	7,520	6,516
Apprenticeship levy	6,181	6,308	12,620	12,503
Termination benefits ¹⁹⁹	204,093	8,113	723,000	10,109
Gross employee benefits expenditure	1,985,831	1,770,812	4,515,068	3,697,085
Less: Employee costs capitalised	(17,337)	(8,905)	(17,337)	(8,905)
Gross employee benefits excluding capitalised costs	1,968,494	1,761,907	4,497,731	3,688,180
Less recoveries in respect of employee benefits	(346)	(2,143)	(11,876)	(27,660)
Net employee benefits	1,968,148	1,759,764	4,485,855	3,660,520

Staff numbers can be found in the Accountability Report on page 83

3.2 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be 4 years, with approximate assessments in intervening years. An outline of these follows:

3.2.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026

¹⁹⁸ Prior year has been restated due to a remapping of costs.

¹⁹⁹ Increase in termination benefits has been caused by the restructuring programs in place arising from the reorganisation of the ICBs and the proposed integration of NHS England with the DHSC.

with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

3.2.2 Principal Civil Service Pension Scheme

Past and present employees are covered by the provisions of the Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and Other Pension Scheme (CSOPS). These schemes are unfunded, defined benefit schemes covering civil servants. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to NHS England of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For defined contribution schemes, such as Civil Service partnership pensions, NHS England recognises the contributions payable for the year.

NHS England recognises the full cost of benefits paid under the Civil Service Compensation Scheme, including the early payment of pensions.

4. Operating expenses

	Parent 2025/26 £000	Parent 2024/25 £000	Consolidated group 2025/26 £000	Consolidated group 2024/25 £000
Purchase of goods and services – cash				
Services from other ICBs and NHS England	20,018	3,612	-	-
Services from foundation trusts	13,579,768	20,299,506	92,051,624	86,707,407
Services from other NHS trusts	5,239,708	7,987,170	41,554,333	40,285,209
Services from other Whole of Government Accounts (WGA) bodies ²⁰⁰	13,179	15,937	21,076	87,544
Purchase of healthcare from non-NHS bodies	1,210,470	1,185,360	21,967,373	20,363,312
Purchase of social care	1,655	-	1,407,715	1,325,063
General dental services and personal dental services	98,451	92,751	3,896,788	3,718,746
Prescribing costs	2,650	-	10,692,813	10,547,895
Pharmaceutical services	200,752	146,907	2,614,135	2,242,177
General ophthalmic services	12,415	4,868	676,597	655,046
GP primary care services	928,801	971,170	14,751,655	13,681,967
Supplies and services – clinical	(428,258)	(511,462)	(336,181)	(430,936)
Supplies and services – general	227,816	690,752	1,674,657	1,884,122
Consultancy services	25,414	16,886	52,634	48,363
Establishment	827,661	845,103	1,148,115	1,159,875
Transport	6,794	8,764	137,322	132,488
Premises	31,297	37,080	341,363	352,693
Audit fees ²⁰¹	1,110	1,110	13,457	12,546
Other non-statutory audit expenditure	-	-	3,022	3,574
Other professional fees	423,867	371,550	518,271	460,547
Legal fees	13,601	15,238	46,362	47,552
Education and training	344,326	143,044	374,292	174,637
Education Training Activity Plan Expenditure ²⁰²	6,169,753	5,797,024	6,157,946	5,777,263
Funding to group bodies ²⁰³	169,801,180	151,026,114	-	-
Total purchase of goods and services - cash	198,752,428	189,148,484	199,765,369	189,237,090
Other operating expenditure - cash				
Chair and non-executive members	174	173	6,815	7,718
Grants to other bodies	224,893	215,976	259,873	234,003
Clinical negligence	-	-	168	168
Research and development (excluding staff costs)	1,672	225	25,660	22,037
Other expenditure	8,590	17,267	16,764	21,645
Other operating expenditure - cash	235,329	233,641	309,280	285,571
Total operating expenses - cash	198,987,757	189,382,125	200,074,649	189,522,661

²⁰⁰ Services from other WGA bodies comprises expenditure with the DHSC, DHSC arm's length bodies and NHS Blood and Transplant.

²⁰¹ Of the total audit fees in the parent entity £640k relates to the NHS England audit and £470k to the Consolidated Provider Account audit. In both financial years NHS England purchased no non-audit services from NAO. Details of ICB audit fees and non-audit expenditure can be found in the underlying individual ICB accounts.

²⁰² Education Training Activity Plan Expenditure was formally known as Multi-Professional Education and Training Investment Plan Expenditure

²⁰³ Funding to group bodies is shown above and represents cash funding drawn down by the ICBs. These balances are eliminated on consolidation.

	Parent 2025/26 £000	Parent 2024/25 £000	Consolidated group 2025/26 £000	Consolidated group 2024/25 £000
Depreciation and impairment charges - non cash items				
Depreciation	139,644	153,703	181,126	191,326
Amortisation	141,351	132,955	148,152	137,810
Impairments and reversals of right-of-use-assets	-	-	74	-
Total depreciation and impairment charges	280,995	286,658	329,352	329,136
Provision expense – non-cash items				
Change in discount rate	(15,478)	(1,949)	(15,542)	(2,007)
Provisions	93,972	7,046	251,051	40,538
Total provision expense	78,494	5,097	235,509	38,531
Purchase of goods and services – non-cash				
Non-cash apprenticeship training grants	2,282	1,470	3,298	2,220
Total purchase of goods and services – non-cash	2,282	1,470	3,298	2,220
Other operating expenditure – non-cash items				
Expected credit loss on receivables	(6,437)	(2,003)	1,166	33,475
Inventories written down	-	-	2,944	1,913
Inventories consumed	697	625	3,711,285	3,506,433
Total other operating expenditure	(5,740)	(1,378)	3,715,395	3,541,821
Total other operating expenses – non-cash	356,031	291,847	4,283,554	3,911,708
Total operating expenditure excluding employee benefits	199,343,788	189,673,972	204,358,203	193,434,369

Intercompany trading is eliminated between bodies within the NHS England group upon consolidation.

5. Property, plant, and equipment

Parent 2025/26	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2025	333	1,119	2,213	-	705,289	31,825	740,779
Additions purchased	-	-	-	-	113,457	290	113,747
Additions donated	-	-	-	-	-	-	-
Reclassifications	-	(1,119)	1,119	-	-	-	-
Disposals	-	-	-	-	(242,394)	(1,817)	(244,211)
Cost or valuation at 31 March 2026	333	-	3,332	-	576,352	30,298	610,315
Depreciation 1 April 2025	248	-	908	-	419,706	9,635	430,497
Reclassifications	-	-	-	-	-	-	-
Disposals	-	-	-	-	(242,394)	(1,757)	(244,151)
Charged during the year	35	-	722	-	114,083	3,911	118,751
At 31 March 2026	283	-	1,630	-	291,395	11,789	305,097
Carrying Value at 31 March 2026	50	-	1,702	-	284,957	18,509	305,218
Asset financing:							
Owned	50	-	1,702	-	280,511	18,509	300,772
Donated	-	-	-	-	4,446	-	4,446
Total at 31 March 2026	50	-	1,702	-	284,957	18,509	305,218

Parent 2024/25	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2024	1,627	1,119	2,577	591	876,033	31,489	913,436
Additions purchased	-	-	105	-	89,807	2,084	91,996
Additions donated	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals	(1,294)	-	(469)	(591)	(260,551)	(1,748)	(264,653)
Cost or valuation at 31 March 2025	333	1,119	2,213	-	705,289	31,825	740,779
Depreciation 1 April 2024	1,461	-	908	591	552,245	8,226	563,431
Reclassifications	-	-	-	-	-	-	-
Disposals	(1,294)	-	(469)	(591)	(260,551)	(1,748)	(264,653)
Charged during the year	81	-	469	-	128,012	3,157	131,719
At 31 March 2025	248	-	908	-	419,706	9,635	430,497
Carrying value at 31 March 2025	85	1,119	1,305	-	285,583	22,190	310,282
Asset financing:							
Owned	85	1,119	1,305	-	278,818	22,190	303,517
Donated	-	-	-	-	6,765	-	6,765
Total at 31 March 2025	85	1,119	1,305	-	285,583	22,190	310,282

Consolidated group 2025/26	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2025	23,093	1,119	18,115	103	748,795	47,901	839,126
Addition of assets under construction and payments on account	-	10,432	-	-	-	-	10,432
Additions purchased	328	-	-	-	115,531	410	116,269
Reclassifications ²⁰⁴	171	(7,056)	1,119	-	1,921	3,852	7
Disposals	(685)	-	(975)	-	(251,467)	(2,739)	(255,866)
Cost or valuation at 31 March 2026	22,907	4,495	18,259	103	614,780	49,424	709,968
Depreciation 1 April 2025	6,235	-	6,917	103	453,578	16,422	483,255
Reclassifications ²⁰⁴	-	-	-	-	-	-	-
Disposals	(685)	-	(971)	-	(251,464)	(2,638)	(255,758)
Charged during the year	1,896	-	10,451	-	117,505	5,550	135,402
At 31 March 2026	7,446	-	16,397	103	319,619	19,334	362,899
Carrying Value at 31 March 2026	15,461	4,495	1,862	-	295,161	30,090	347,069
Asset financing:							
Owned	15,461	4,495	1,862	-	290,715	30,090	342,623
Donated	-	-	-	-	4,446	-	4,446
Total at 31 March 2026	15,461	4,495	1,862	-	295,161	30,090	347,069

Consolidated group 2024/25	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2024	23,830	34,309	12,391	694	923,469	43,793	1,038,486
Addition of assets under construction and payments on account	-	6,573	-	-	-	-	6,573
Additions purchased	557	-	10,426	-	91,720	2,226	104,929
Reclassifications	-	(39,763)	-	-	758	4,929	(34,076)
Disposals	(1,294)	-	(4,702)	(591)	(267,152)	(3,047)	(276,786)
Impairments charged	-	-	-	-	-	-	-
Cost or valuation at 31 March 2025	23,093	1,119	18,115	103	748,795	47,901	839,126
Depreciation 1 April 2024	5,517	-	9,453	694	588,875	15,025	619,564
Reclassifications	-	-	-	-	-	-	-
Disposals	(1,292)	-	(4,329)	(591)	(267,167)	(3,045)	(276,424)
Charged during the year	2,010	-	1,793	-	131,870	4,442	140,115
At 31 March 2025	6,235	-	6,917	103	453,578	16,422	483,255
Carrying Value at 31 March 2025	16,858	1,119	11,198	-	295,217	31,479	355,871
Asset financing:							
Owned	16,858	1,119	11,198	-	288,452	31,479	349,106
Donated	-	-	-	-	6,765	-	6,765
Total at 31 March 2025	16,858	1,119	11,198	-	295,217	31,479	355,871

²⁰⁴ Reclassifications have been made between property, plant and equipment and intangible asset categories during the year. These reclassifications have no impact on the net book value reported, as the movements across asset cost and accumulated depreciation/amortisation offset in aggregate.

6. Right-of-use assets

6.1 Right-of-use assets

Parent 2025/26

	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2025	-	155,531	-	705	20,004	-	176,240
Additions	-	724	-	-	-	-	724
ROU Dilapidation	-	(201)	-	-	-	-	(201)
Lease remeasurement	-	495	-	-	(56)	-	439
Modifications	-	(117)	-	-	-	-	(117)
Disposals on expiry of lease term	-	(2,880)	-	(251)	(230)	-	(3,361)
Derecognition for early terminations	-	(1,088)	-	-	-	-	(1,088)
Cost/Valuation at 31 March 2026	-	152,464	-	454	19,718	-	172,636
Depreciation 01 April 2025	-	54,927	-	406	8,528	-	63,861
Charged during the year	-	17,270	-	139	3,484	-	20,893
Disposals on expiry of lease term	-	(2,876)	-	(253)	(225)	-	(3,354)
Derecognition for early terminations	-	(734)	-	-	-	-	(734)
Depreciation at 31 March 2026	-	68,587	-	292	11,787	-	80,666
Net Book Value at 31 March 2026	-	83,877	-	162	7,931	-	91,970

Parent 2024/25

	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2024	-	155,645	-	472	10,965	-	167,082
Additions	-	1,582	-	215	10,162	-	11,959
ROU Dilapidation	-	402	-	-	-	-	402
Lease remeasurement	-	6,469	-	18	(618)	-	5,869
Modifications	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	(7,980)	-	-	-	-	(7,980)
Derecognition for early terminations	-	(587)	-	-	(505)	-	(1,092)
Cost/Valuation at 31 March 2025	-	155,531	-	705	20,004	-	176,240
Depreciation 01 April 2024	-	43,868	-	291	6,145	-	50,304
Charged during the year	-	19,255	-	115	2,614	-	21,984
Disposals on expiry of lease term	-	(7,980)	-	-	-	-	(7,980)
Derecognition for early terminations	-	(216)	-	-	(231)	-	(447)
Depreciation at 31 March 2025	-	54,927	-	406	8,528	-	63,861
Net Book Value at 31 March 2025	-	100,604	-	299	11,476	-	112,379

Consolidated group 2025/26	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2025	1,097	415,176	12	1,306	20,668	64	438,323
IFRS 16 Transition Adjustment	-	-	-	-	-	-	-
Additions	-	14,001	-	-	-	-	14,001
ROU Dilapidation	-	5,033	-	-	-	-	5,033
Lease remeasurement	-	1,258	-	-	(56)	-	1,202
Modifications	-	(117)	-	-	-	-	(117)
Disposals on expiry of lease term	-	(12,795)	-	(253)	(229)	-	(13,277)
Derecognition for early terminations	-	(12,217)	(8)	-	-	-	(12,225)
Cost/Valuation at 31 March 2026	1,097	410,339	4	1,053	20,383	64	432,940
Depreciation 01 April 2025	313	144,057	12	932	8,860	62	154,236
Charged during the year	125	41,777	-	205	3,615	2	45,724
Disposals on expiry of lease term	-	(9,365)	(8)	(253)	(226)	-	(9,852)
Derecognition for early terminations	-	(5,225)	-	-	-	-	(5,225)
Depreciation at 31 March 2026	438	171,244	4	884	12,249	64	184,883
Net Book Value at 31 March 2026	659	239,095	-	169	8,134	-	248,057

Consolidated group 2024/25	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2024	1,097	417,292	12	1,073	11,630	85	431,189
Additions	-	17,952	-	215	10,161	7	28,335
ROU Dilapidation	-	1,353	-	-	-	-	1,353
Lease remeasurement	-	10,435	-	18	(618)	-	9,835
Modifications	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	(21,819)	-	-	-	(28)	(21,847)
Derecognition for early terminations	-	(10,037)	-	-	(505)	-	(10,542)
Cost/Valuation at 31 March 2025	1,097	415,176	12	1,306	20,668	64	438,323
Depreciation 01 April 2024	187	123,108	9	698	6,344	66	130,412
Charged during the year	126	48,077	3	234	2,747	24	51,211
Disposals on expiry of lease term	-	(21,812)	-	-	-	(28)	(21,840)
Derecognition for early terminations	-	(5,316)	-	-	(231)	-	(5,547)
Depreciation at 31 March 2025	313	144,057	12	932	8,860	62	154,236
Net Book Value at 31 March 2025	784	271,119	-	374	11,808	2	284,087

6.2 Right of use asset lease liabilities

Parent	2025/26 £'000	2024/25 £'000
Lease liabilities at 01 April	(120,371)	(124,410)
Additions purchased	(724)	(8,150)
Interest expense relating to lease liabilities	(3,711)	(3,250)
Repayment of lease liabilities (including interest)	23,062	20,680
Lease remeasurement	(397)	(5,870)
Disposals on expiry of lease term	59	-
Derecognition for early terminations	304	628
Transfer (to)/from other public sector body	-	-
Other	-	1
Lease liabilities at 31 March	(101,778)	(120,371)

Consolidated group	2025/26 £'000	2024/25 £'000
Lease liabilities at 01 April	(293,440)	(308,611)
Additions purchased	(13,323)	(24,495)
Interest expense relating to lease liabilities	(6,666)	(6,071)
Repayment of lease liabilities (including interest)	50,447	50,686
Lease remeasurement	(2,160)	(9,771)
Modifications	-	(65)
Disposals on expiry of lease term	360	311
Derecognition for early terminations	6,934	4,571
Transfer (to)/from other public sector body	-	-
Other	-	5
Lease liabilities at 31 March	(257,848)	(293,440)

6.3 Right of use asset lease liabilities - maturity analysis of undiscounted future lease payments

Parent	2025/26 £'000	2024/25 £'000
Within 1 year	(23,740)	(21,533)
Between 1 and 5 years	(46,618)	(50,335)
After 5 years	(45,494)	(51,551)
Balance on 31 March	(115,852)	(123,419)
Effect of discounting	14,074	3,048
Included in:		
Current right of use asset lease liabilities	(19,510)	(22,257)
Non-current right of use asset lease liabilities	(82,268)	(98,114)
Balance on 31 March	(101,778)	(120,371)

Consolidated group	2025/26 £'000	2024/25 £'000
Within 1 year	(49,533)	(48,449)
Between 1 and 5 years	(122,615)	(131,123)
After 5 years	(118,563)	(131,986)
Balance on 31 March	(290,711)	(311,558)
Effect of discounting	32,863	18,118
Included in:		
Current right of use asset lease liabilities	(42,635)	(46,672)
Non-current right of use asset lease liabilities	(215,213)	(246,768)
Balance on 31 March	(257,848)	(293,440)

6.4 Amounts recognised in statement comprehensive net expenditure

Parent	2025/26 £'000	2024/25 £'000
Depreciation expense on right-of-use assets	20,893	21,984
Interest expense on lease liabilities	3,711	3,250
Expense relating to short-term leases	-	756
Expense relating to leases of low value assets	1,802	-

Consolidated group	2025/26 £'000	2024/25 £'000
Depreciation expense on right-of-use assets	45,724	51,210
Interest expense on lease liabilities	6,666	6,071
Expense relating to short-term leases	334	1,010
Expense relating to leases of low value assets	19,610	-
Expense relating to variable lease payments not included in the measurement of the lease liability	135	54
Gain/(loss) from sale and leaseback transactions	-	-

6.5 Amounts recognised in statement of cash flows

Parent	2025/26 £'000	2024/25 £'000
Total cash outflow on leases under IFRS 16	23,062	24,622
Total cash outflow for lease payments not included within the measurement of lease liabilities	-	-

Consolidated group	2025/26 £'000	2024/25 £'000
Total cash outflow on leases under IFRS 16	50,447	54,675
Total cash outflow for lease payments not included within the measurement of lease liabilities	135	164

7. Intangible non-current assets

Parent 2025/26	Computer software: purchased £000	Development expenditure £000	Payments on Accounts & Assets under construction £000	Websites £000	Total £000
Cost or valuation at 1 April 2025	46,442	894,298	60,841	7,370	1,008,951
Additions purchased	9,475	257,648	23,046	594	290,763
Additions internally generated	-	26,243	-	-	26,243
Reclassifications	-	7,160	(7,160)	-	-
Disposals	(19,525)	(32,556)	(4,285)	-	(56,366)
At 31 March 2026	36,392	1,152,793	72,442	7,964	1,269,591
Amortisation 1 April 2025	32,420	431,953	-	6,599	470,972
Reclassifications	-	-	-	-	-
Disposals	(19,525)	(25,387)	-	-	(44,912)
Charged during the year	8,314	132,938	-	99	141,351
Transfer (to) / from other public sector body	-	-	-	-	-
At 31 March 2026	21,209	539,504	-	6,698	567,411
Carrying Value at 31 March 2026	15,183	613,289	72,442	1,266	702,180
Asset financing:					
Owned	15,183	613,289	72,442	1,266	702,180
Total at 31 March 2026	15,183	613,289	72,442	1,266	702,180

Parent 2024/25	Computer software: purchased £000	Development expenditure £000	Payments on Accounts & Assets under construction £000	Websites £000	Total £000
Cost or valuation at 1 April 2024	69,772	666,640	83,970	9,153	829,535
Additions purchased	1,608	189,239	52,311	-	243,158
Additions internally generated	-	8,906	-	-	8,906
Reclassifications	(661)	77,876	(75,432)	(1,783)	-
Disposals	(24,277)	(48,363)	(8)	-	(72,648)
Transfer (to) / from other public sector body	-	-	-	-	-
At 31 March 2025	46,442	894,298	60,841	7,370	1,008,951
Amortisation 1 April 2024	44,866	357,916	-	6,565	409,347
Reclassifications	-	-	-	-	-
Disposals	(24,277)	(47,053)	-	-	(71,330)
Charged during the year	11,831	121,090	-	34	132,955
At 31 March 2025	32,420	431,953	-	6,599	470,972
Carrying Value at 31 March 2025	14,022	462,345	60,841	771	537,979
Asset financing:					
Owned	14,022	462,345	60,841	771	537,979
Total at 31 March 2025	14,022	462,345	60,841	771	537,979

Consolidated group 2025/26	Computer software: purchased £000	Development expenditure £000	Payments on Accounts & Assets under construction £000	Websites £000	Total £000
Cost or valuation at 1 April 2025	93,054	894,761	69,439	7,369	1,064,623
Additions purchased	10,074	257,648	23,246	594	291,562
Additions internally generated	-	26,243	-	-	26,243
Reclassifications ²⁰⁵	8,838	7,160	(15,957)	-	41
Disposals	(19,682)	(32,556)	(4,286)	-	(56,524)
Impairments charged	(197)	-	-	-	(197)
At 31 March 2026	92,087	1,153,256	72,442	7,963	1,325,748
Amortisation 1 April 2025	42,130	432,413	-	6,598	481,141
Reclassifications ²⁰⁵	48	-	-	-	48
Disposals	(19,682)	(25,388)	-	-	(45,070)
Impairment charged	(124)	-	-	-	(124)
Charged during the year	15,114	132,939	-	99	148,152
At 31 March 2026	37,486	539,964	-	6,697	584,147
Carrying Value at 31 March 2026	54,601	613,292	72,442	1,266	741,601
Asset financing:					
Owned	54,601	613,292	72,442	1,266	741,601
Total at 31 March 2026	54,601	613,292	72,442	1,266	741,601

Consolidated group 2024/25	Computer software: purchased £000	Development expenditure £000	Payments on Accounts & Assets under construction £000	Websites £000	Total £000
Cost or valuation at 1 April 2024	90,464	667,103	83,968	9,153	850,688
Additions purchased	2,813	189,239	52,311	-	244,363
Additions internally generated	-	8,906	-	-	8,906
Reclassifications	24,816	77,876	(66,832)	(1,784)	34,076
Disposals	(25,039)	(48,363)	(8)	-	(73,410)
At 31 March 2025	93,054	894,761	69,439	7,369	1,064,623
Amortisation 1 April 2024	50,483	358,377	-	6,564	415,424
Reclassifications	-	-	-	-	-
Disposals	(25,038)	(47,055)	-	-	(72,093)
Charged during the year	16,685	121,091	-	34	137,810
At 31 March 2025	42,130	432,413	-	6,598	481,141
Carrying Value at 31 March 2025	50,924	462,348	69,439	771	583,482
Asset financing:					
Owned	50,924	462,348	69,439	771	583,482
Total at 31 March 2025	50,924	462,348	69,439	771	583,482

²⁰⁵ Reclassifications have been made between property, plant and equipment and intangible asset categories during the year. These reclassifications have no impact on the net book value reported, as the movements across asset cost and accumulated depreciation/amortisation offset in aggregate.

8. Inventories

Parent 2025/26	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2025	-	-	850	850
Additions	-	-	50	50
Inventories recognised as an expense in the period	-	-	(697)	(697)
Write-down of inventories (including losses)	-	-	-	-
Balance at 31 March 2026	-	-	203	203

Parent 2024/25	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2024	-	-	1,170	1,170
Additions	-	-	305	305
Inventories recognised as an expense in the period	-	-	(625)	(625)
Write-down of inventories (including losses)	-	-	-	-
Balance at 31 March 2025	-	-	850	850

Consolidated group 2025/26	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2025	147,539	19,492	6,329	173,360
Additions	3,678,541	9,443	8,430	3,696,414
Inventories recognised as an expense in the year	(3,690,059)	(11,185)	(10,041)	(3,711,285)
Write-down of inventories (including losses)	(2,944)	-	-	(2,944)
Balance at 31 March 2026	133,077	17,750	4,718	155,545

Consolidated group 2024/25	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2024	138,104	13,185	8,637	159,926
Additions	3,494,490	18,389	8,901	3,521,780
Inventories recognised as an expense in the year	(3,483,142)	(12,082)	(11,209)	(3,506,433)
Write-down of inventories (including losses)	(1,913)	-	-	(1,913)
Balance at 31 March 2025	147,539	19,492	6,329	173,360

9. Trade and other receivables

Parent	2025/26 Current £000	2025/26 Non-current £000	2024/25 Current £000	2024/25 Non-current £000
NHS receivables: revenue	89,787	-	116,185	-
NHS prepayments	138,690	-	153,533	-
NHS accrued income	21,529	-	3,703	-
NHS non-contract	-	-	-	-
Non-NHS and other WGA receivables: Revenue	252,630	-	185,897	-
Non-NHS and other WGA prepayments	57,064	4,552	213,961	11,058
Non-NHS and other WGA accrued income	189,942	-	98,678	-
Non-NHS and other WGA non-contract	-	-	-	-
Expected credit loss allowance-receivables	(17,871)	-	(24,678)	-
VAT	9,468	-	51,694	-
Finance lease receivables	-	-	-	-
Other receivables and accruals	746	-	1,069	-
Total	741,985	4,552	800,042	11,058
Other financial assets ²⁰⁶	-	139,900	-	139,857
Total current and non-current	886,437		950,957	

Consolidated group	2025/26 Current £000	2025/26 Non-current £000	2024/25 Current £000	2024/25 Non-current £000
NHS receivables: revenue	708,095	-	702,885	-
NHS prepayments	144,323	-	161,240	-
NHS accrued income	87,913	-	72,021	-
NHS non-contract	127	-	830	-
Non-NHS and other WGA receivables: Revenue	726,230	-	675,573	-
Non-NHS and other WGA prepayments	356,313	4,552	536,302	11,058
Non-NHS and other WGA accrued income	406,562	-	325,299	-
Non-NHS and other WGA non-contract	4,908	-	7,835	-
Expected credit loss allowance-receivables	(85,120)	-	(86,086)	-
VAT	41,192	-	88,610	-
Finance lease receivables	409	-	556	-
Other receivables and accruals	35,907	-	39,475	-
Total	2,426,859	4,552	2,524,540	11,058
Other financial assets ²⁰⁶	-	1,106	-	1,106
Total current and non-current	2,432,517		2,536,704	

²⁰⁶ Other financial assets within Parent relate to the NHS England investment within NHS Supply Chain Co-ordination LTD, which is a component of the Consolidated Group and so removed at Group. The Consolidated Group relates to 1 ICBs investment.

10. Cash and cash equivalents

	Note	Parent		Consolidated group	
		2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Balance at 1 April		425,586	286,416	532,946	408,621
Transfer in from other org under absorption		-	-	-	1,077
Net change in year		(266,385)	139,170	(302,552)	123,248
Balance at statement of financial position date		159,201	425,586	230,394	532,946
Made up of:					
Cash with the Government Banking Service		112,383	383,688	210,201	509,958
Hosted cash/cash in hand		46,818	41,898	46,141	41,257
Cash and cash equivalents as in statement of financial position		159,201	425,586	256,342	551,215
Bank overdraft: Government Banking Service	11	-	-	(25,948)	(18,269)
Total bank overdrafts		-	-	(25,948)	(18,269)
Balance at statement of financial position date		159,201	425,586	230,394	532,946

For details of bank overdraft see Note 11.

Included within hosted cash/cash in hand above is £19.3 million (2024/25 £41.9 million) held on behalf of NHS England by the NHS Business Services Authority; and £27.5 million held by G.L.Hearn Ltd (2024/25 £58.3 million).

11. Trade and other payables

Parent	2025/26 Current £000	2025/26 Non-current £000	2024/25 Current £000	2024/25 Non-current £000
NHS payables: revenue	48,915	-	84,740	-
NHS payables: capital	58,803	-	18,503	-
NHS accruals	474,504	-	865,400	-
NHS deferred income	1,391	-	1,487	-
NHS contract liabilities	-	-	-	-
Non-NHS and other WGA payables: revenue	93,289	-	195,216	-
Non-NHS and other WGA payables: capital	124,683	-	126,581	-
Non-NHS and other WGA accruals	1,446,038	-	709,481	-
Non-NHS and other WGA deferred income	4,915	-	3,537	-
Non-NHS contract liabilities	-	-	-	-
Social security costs	18,693	-	17,012	-
VAT	615	-	1,103	-
Tax	19,422	-	19,231	-
Payments received on account	2	-	(4)	-
Other payables and accruals	257,736	-	292,307	-
Total	2,549,006	-	2,334,594	-
Other financial liabilities				
Bank overdraft - Government Banking Service	-	-	-	-
Loans from Department of Health and Social Care ²⁰⁷	-	-	-	-
Total	-	-	-	-
Total trade & other payables (current)	2,549,006		2,334,594	-
Total trade & other payables (non-current)		-		-
Total trade & other payables (current and non-current)		2,549,006		2,334,594

Consolidated group	2025/26 Current £000	2025/26 Non-current £000	2024/25 Current £000	2024/25 Non-current £000
NHS payables: revenue	290,140	-	235,656	-
NHS payables: capital	508	-	-	-
NHS accruals	1,489,440	-	1,629,211	-
NHS deferred income	29,915	-	1,026	-
NHS contract liabilities	191,769	9,245	173,406	7,985
Non-NHS and other WGA payables: revenue	1,524,513	-	1,884,538	-
Non-NHS and other WGA payables: capital	126,777	-	127,149	-
Non-NHS and other WGA accruals	6,948,148	-	5,633,948	-
Non-NHS and other WGA deferred income	31,099	-	86,197	-
Non-NHS contract liabilities	15	-	-	-
Social security costs	41,578	-	36,266	-
VAT	40,974	-	40,085	-
Tax	45,565	-	42,223	-
Payments received on account	2	-	168	-
Other payables and accruals	1,327,173	-	950,028	-
Total	12,087,616	9,245	10,839,901	7,985
Other financial liabilities				
Bank overdraft - Government Banking Service	25,948	-	18,269	-
Loans from Department of Health and Social Care ²⁰⁷	2,322	130,000	-	100,000
Total	28,270	130,000	18,269	100,000
Total trade & other payables (current)	12,115,886		10,858,170	
Total trade & other payables (non-current)		139,245		107,985
Total trade & other payables (current and non-current)		12,255,131		10,966,155

²⁰⁷ Loans from the Department of Health and Social Care represent amounts issued to SCCL to provide a working capital facility

12. Net gain/(loss) on transfer by absorption

Business combinations within the public sector are accounted for using absorption accounting principles.

2025/26

There were no transactions accounted for using absorption accounting principles in 2025/26.

2024/25

On 1 April 2024 the DHSC transferred Informatics GPIT responsibility to NHS England. The liabilities related to the transfer are shown in the table below.

On 1 October 2024 Dudley Integrated Health and Care NHS Trust transferred functions to Black Country ICB. The assets and liabilities related to the transfer are shown in the table below.

Parent 2024/25	Department of Health and Social Care £'000	
Transfer of payables	(1,485)	
Net gain (loss) on transfers by absorption	(1,485)	
Consolidated group 2024/25	Department of Health and Social Care £'000	Dudley Integrated Health and Care NHS Trust £'000
Transfer of cash and cash equivalents	-	1,077
Transfer of receivables	-	647
Transfer of payables	(1,485)	(1,276)
Transfer of provisions	-	(3)
Net gain (loss) on transfers by absorption	(1,485)	445

13. Finance costs

	Parent		Consolidated group	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Interest				
Interest on loans and overdrafts	-	-	4,518	4,090
Interest on obligations under finance leases	3,711	3,250	6,666	6,071
Interest on late payment of commercial debt	-	-	49	4
Other interest expense	-	-	-	1
Total interest	3,711	3,250	11,233	10,166
Provisions: unwinding of discount	13,222	11,373	13,269	11,454
Total finance costs	16,933	14,623	24,502	21,620

14. Provisions

Parent	2025/26 Current £000	2025/26 Non-current £000	2024/25 Current £000	2024/25 Non-current £000
Restructuring	-	-	-	-
Redundancy	117,887	-	12,689	-
Equal pay	-	135	-	-
Legal claims	244	502	174	626
Continuing care	-	-	-	-
Clinician tax charge	7,270	198,129	6,983	218,270
Other	46,618	50,042	50,892	55,950
Total	172,019	248,808	70,738	274,846
Total current and non-current	420,827		345,584	

Parent 2025/26	Restructuring £000	Redundancy £000	Equal pay £000	Legal claims £000	Continuing care £000	Clinician tax charge £000	Other £000	Total £000
Balance at 1 April 2025	-	12,689	-	800	-	225,253	106,842	345,584
Arising during the year	-	115,880	135	146	-	-	25,260	141,421
Utilised during the year	-	(7,447)	-	(39)	-	(5,008)	(12,352)	(24,846)
Reversed unused	-	(3,235)	-	(161)	-	(12,216)	(23,266)	(38,878)
Unwinding of discount	-	-	-	-	-	13,116	106	13,222
Change in discount rate	-	-	-	-	-	(15,746)	70	(15,676)
Balance at 31 March 2026	-	117,887	135	746	-	205,399	96,660	420,827
Expected timing of cash flows:								
Within one year	-	117,887	-	244	-	7,270	46,618	172,019
Between one and five years	-	-	135	502	-	25,111	29,833	55,581
After five years	-	-	-	-	-	173,018	20,209	193,227
Balance at 31 March 2026	-	117,887	135	746	-	205,399	96,660	420,827

Consolidated group	2025/26 Current £000	2025/26 Non-current £000	2024/25 Current £000	2024/25 Non-current £000
Restructuring	5,919	-	1,644	-
Redundancy	236,166	-	21,068	-
Equal pay	-	135		
Legal claims	14,265	3,845	6,909	3,411
Continuing care	64,875	20,662	55,484	10,338
Clinician tax charge	7,270	198,129	6,983	218,270
Other	127,490	72,969	103,285	80,895
Total	455,985	295,740	195,373	312,914
Total current and non-current	751,725		508,287	

Consolidated group 2025/26	Restructuring £000	Redundancy £000	Equal pay £000	Legal claims £000	Continuing care £000	Clinician tax charge £000	Other £000	Total £000
Balance at 1 April 2025	1,644	21,068	-	10,320	65,822	225,253	184,180	508,287
Arising during the year	5,626	248,074	135	11,503	71,868	-	75,382	412,588
Utilised during the year	(102)	(11,657)	-	(1,243)	(15,911)	(5,008)	(18,939)	(52,860)
Reversed unused	(1,249)	(21,319)	-	(2,470)	(36,231)	(12,216)	(40,334)	(113,819)
Unwinding of discount	-	-	-	-	25	13,116	128	13,269
Change in discount rate	-	-	-	-	(36)	(15,746)	42	(15,740)
Balance at 31 March 2026	5,919	236,166	135	18,110	85,537	205,399	200,459	751,725
Expected timing of cash flows:								
Within one year	5,919	236,166	-	14,265	64,875	7,270	127,490	455,985
Between one and five years	-	-	135	3,845	20,662	25,111	39,000	88,753
After five years	-	-	-	-	-	173,018	33,969	206,987
Balance at 31 March 2026	5,919	236,166	135	18,110	85,537	205,399	200,459	751,725

Continuing care' refers to NHS funding for complex packages of care in the community. This includes the following: NHS Continuing Healthcare, where an individual, aged 18 or over, has been assessed as having a 'primary health need' and the NHS has responsibility for arranging and funding a package of health and social care. Children and Young People's Continuing Care, where individuals, up to their 18th birthday, have complex needs arising from disability, accident or illness and require care and support that cannot be met by existing universal or specialist services alone the NHS can fund an additional package of healthcare. Joint packages of health and social care are where an individual's care or support package is funded by both the NHS and the local authority. NHS funded nursing care where funding is provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse. These are set out in the National Framework for NHS Continuing Healthcare and NHS funded nursing care. The amount included in the table above as 'Continuing Care' represents the best estimate,

at the year-end date, of the liabilities of the NHS England group relating to the obligation of the NHS to pay for cases of such care and deliver these services.

The Clinician Tax Charge provision in the parent is £205 million for the commitment to pay clinicians in the NHS Pension Scheme for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement, in line with the ministerial direction to the DHSC and NHS England.

The significant increase in the redundancy provision arises from the reorganisation of ICBs and the integration of NHS England and the DHSC.

Other provisions in both the parent and the group is primarily provisions for pension disputes and dilapidations.

The NHS Resolution financial statements disclose a provision of £45,170,923 as at 31 March 2026 in respect of clinical negligence liabilities and employment liability scheme of NHS England (31 March 2025: £46,931,324).

15. Contingencies

	Parent		Consolidated group	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Contingent liabilities				
Employment tribunal	1,211	2,288	1,273	2,335
NHS Resolution employee liability claim	-	-	-	1
Redundancy	-	-	3,159	-
Continuing healthcare	-	-	18,509	13,858
GP Non-Reimbursable property costs	-	-	3,837	3,092
Legal claims	2,577	1,864	3,751	2,503
Liverpool Community Health Trust (re Maternity and neonatal investigation)	500	500	500	500
Joint Procurement Challenges	-	-	-	550
His Majesty's Revenue and Customs	41,161	71,362	41,742	71,362
LGPS Pension Indemnity	1,500	-	1,500	-
Clinical Negligence Claim	-	-	5	10
Total contingent liabilities	46,949	76,014	74,276	94,211

	Parent		Consolidated group	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Contingent assets				
Legal cases	-	-	-	756
Greenacres, Droitwich Road, Hanbury, Redditch	-	-	762	762
Total contingent assets	-	-	762	1,518

Contingent liabilities are those for which provisions have not been recorded as there is a possible obligation depending on uncertain future events, or a present obligation where payment is not probable, or the amount cannot be measured reliably.

Contingent assets are those where a possible asset arises from a past event and whose existence will be confirmed only by the occurrence or non-occurrence of an uncertain future event not wholly within the control of the entity. These are disclosed only when the inflow of economic benefit is probable.

16. Commitments

16.1 Capital commitments

	Parent		Consolidated group	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Property, plant and equipment	15,742	11,825	16,967	11,825
Intangible assets	-	300	119	1,520
Total	15,742	12,125	17,086	13,345

16.2 Other financial commitments

NHS England has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	Parent		Consolidated group	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
In not more than 1 year	1,129,581	1,070,225	1,533,869	1,426,722
In more than 1 year but not more than 5 years	1,058,248	1,000,862	1,281,777	1,710,842
In more than 5 years	49,585	26,998	70,818	346,500
Total	2,237,414	2,098,085	2,886,464	3,484,064

In the parent account the most significant contracts relate to:

- Health and Justice healthcare contracts with PPG
- Cloud Service Delivery Partner
- NHSMail Collaboration Licensing Platform

Excluding the largest parent financial commitments already disclosed, the most significant other group commitments relate to:

- a contract between HCRG Care Services Ltd. and NHS Bath and North East Somerset, Swindon and Wiltshire ICB in relation to Community Services.

17. Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS England is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the

financial reporting standards mainly apply. NHS England has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing NHS England and the ICBs in undertaking their activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS England standing financial instructions and policies agreed by the ICB Governing Bodies. Treasury activity is subject to review by the NHS England internal auditors.

Currency risk

NHS England is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based.

NHS England has no overseas operations. NHS England therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

NHS England does not have any borrowings that are subject to interest rate risk.

17.1.3 Credit risk

Because the majority of NHS England revenue comes from parliamentary funding, NHS England has low exposure to credit risk. The maximum exposure as at the end of the financial year is in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk

NHS England is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament.

NHS England draws down cash to cover expenditure, as the need arises. NHS England is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

18. Operating segments

Consolidated group 2025/26	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Education Training Activity Plan ²⁰⁸ £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(2,139,454)	(4,634,006)	(31,122)	(263,087)	(2,384)	(503,085)	780,855	(6,792,283)
Gross expenditure	173,277,157	4,633,963	14,440,755	11,079,846	5,882,444	346,736	(780,855)	208,880,046
Total net expenditure	171,137,703	(43)	14,409,633	10,816,759	5,880,060	(156,349)	-	202,087,763
Revenue resource expenditure								
Revenue departmental expenditure limit								201,612,924
Annually managed expenditure								238,077
Technical expenditure								236,762
Net expenditure for the financial year charged to financial performance limits								202,087,763

Consolidated group 2024/25	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Education Training Activity Plan £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(2,080,437)	(4,293,837)	(27,292)	(253,344)	(2,075)	(491,870)	736,916	(6,411,939)
Gross expenditure	152,974,602	4,293,773	24,321,053	10,318,372	5,321,429	627,206	(736,916)	197,119,519
Total net expenditure	150,894,165	(64)	24,293,761	10,065,028	5,319,354	135,336	-	190,707,580
Revenue resource expenditure								
Revenue departmental expenditure limit								190,522,217
Annually managed expenditure								(28,393)
Technical expenditure								213,756
Net expenditure for the financial year charged to financial performance limits								190,707,580

The reportable segments disclosed within this note reflect the current structure of NHS England with the activities of each reportable segment reflecting the remit of the organisation.

These operating segments are regularly reported to the NHS England Board of Directors for financial management and decision-making purposes.

The activities of each segment are defined as follows:-

ICBs - bodies that are responsible for planning most NHS services in their area including commissioning healthcare services, as defined in the Health and Care Act 2022

SCCL - the management function for the NHS Supply Chain operating model

Direct Commissioning - the services commissioned by NHS England as defined in the Health and Social Care Act 2012

NHS England - the central administration of the organisation and centrally managed programmes

Education Training Activity Plan - a multi-year view of our future NHS workforce investment. It optimises domestic education and training by balancing professional, geographical, and clinical service demand with education capacity

Other - includes commissioning support units, national reserves, technical accounting items and legacy balances

²⁰⁸ Education Training Activity Plan was formally known as Multi-Professional Education and Training Investment Plan Expenditure

Multiple transactions take place between reportable segments, all of which are eliminated upon consolidation as shown in the "Intra-group eliminations" column. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure.

19. Related party transactions

Related party transactions associated with the Parent are disclosed within this note. As disclosed in note 1.3 NHS England acts as the parent to 42 ICBs whose accounts are consolidated within these Financial Statements. These bodies are regarded as related parties with which the Parent has had various material transactions during the year; those transactions are disclosed in those entities' financial statements.

The Department of Health and Social Care, as the parent of NHS England, is regarded as a related party. During the year NHS England has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

For example:

- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution;
- NHS Business Services Authority;
- NHS Property Services;
- NHS Shared Business Services (NHS Business Services Authority Equity Investment)

In addition, NHS England has had a number of significant transactions with other government departments and their agencies including His Majesty's Revenue and Customs, Ministry of Justice and His Majesty's Prison and Probation Service. No related party transactions were noted with Board members or key management personnel other than the compensation paid to them which can be found in the remuneration report on page 98.

The following individuals hold or have held director positions within NHS England for the financial year ended 31 March 2026 and during the year NHS England has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out below.

2025/26

Name and Position in NHS England	Related Party	Nature of Relationship	Expenditure with Related Party £000	Income from Related Party £000	Amounts owed to Related Party £000
Professor Sir Mark Walport - Non-Executive Director	Imperial College Health Partners	Chair	3,808	-	-
Professor Sir Simon Wessely - Non-Executive Director	Combat Stress	Vice President	1,000	-	-

Name and Position in NHS England	Related Party	Nature of Relationship	Expenditure with Related Party £000	Income from Related Party £000	Amounts owed to Related Party £000
Professor Sir Mark Walport - Non-Executive Director	Imperial College Health Partners	Chair	3,487	-	-
Professor Sir Simon Wessely - Non-Executive Director	Combat Stress	Vice President	1,000	-	83

20. Events after the end of the reporting period

There are no adjusting events after the reporting period which will have a material effect on the financial statements of NHS England.

From 1 April 2026, the number of ICBs has reduced from 42 ICBs to 36 due to ICB mergers. These were not in effect at the reporting date and do not impact the financial position of NHS England for the year ended 31 March 2026. Further mergers are due to take place from 1 April 2027 and full details are available on the NHS England website.

The Accounts were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller & Auditor General.

21. Financial performance targets

The Secretary of State for Health and Social Care issues financial directions to NHS England for each financial year. Annex A2 to the document '2025 to 2026 revised financial directions to NHS England' sets out NHS England's total revenue resource limit and total capital resource limit for 2025/26 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to the DHSC.

	2025/26 RDEL Non ringfenced £000	2025/26 RDEL Ringfenced £000	2025/26 Total RDEL £000	2025/26 Annually managed expenditure £000	2025/26 Technical £000	2025/26 Total £000	2024/25 Total £000
Expenditure limit	202,470,000	393,000	202,863,000	700,000	250,000	203,813,000	191,883,000
Actual expenditure	201,283,646	329,278	201,612,924	238,077	236,762	202,087,763	190,707,580
Surplus	1,186,354	63,722	1,250,076	461,923	13,238	1,725,237	1,175,420

	2025/26 Capital departmental expenditure limit £000	2025/26 Capital annually managed expenditure £000	2025/26 Total £000	2024/25 Capital resource limit £000
Annual Limit	768,000	13,000	781,000	639,000
Actual expenditure	681,919	4,753	686,672	610,963
Surplus/(Deficit)	86,081	8,247	94,328	28,037

NHS England is required to spend no more than £2,497,000k of its Revenue Departmental Expenditure Limit on matters relating to administration. The actual amount spent on RDEL administration matters to 31st March 2026 was £2,106,750k, as set out below:

	2025/26 £000	2024/25 £000
Administration limit:		
Net administration costs before interest	2,237,184	1,760,411
Less:		
Administration expenditure covered by AME/Technical funding	(130,434)	8,131
Administration costs relating to RDEL	2,106,750	1,768,542
RDEL Administration expenditure limit	2,497,000	2,161,000
Underspend	390,250	392,458

The various limits of expenditure set out in the table above stem from the limits imposed by HM Treasury on the DHSC. Departmental Expenditure Limits are set in the Spending Review, and government departments may not exceed the limits they have been set. This control is passed down to NHS England by DHSC and NHS England may not therefore exceed its Departmental Expenditure Limit.

Annually Managed Expenditure is subject to budgets set by HM Treasury. Departments must manage AME closely and inform HM Treasury if they expect AME to rise above forecast. Any increase requires HM Treasury approval.

22. Entities within the consolidated group

NHS England acts as the Parent of the group comprising 42 ICBs (2024/25: 42 ICBs) whose accounts are consolidated within these Financial Statements.

A full list of the ICBs can be found on the NHS England website <https://www.nhs.uk/nhs-services/find-your-local-integrated-care-board/>

NHS England acts as the Parent of SCCL whose accounts are consolidated within these financial statements. Copies of their accounts can be found on their website <https://www.supplychain.nhs.uk/sccl/>

The parent entity of NHS England is the DHSC.

The largest group of entities for which group accounts are drawn up and of which NHS England is a member is the DHSC Group.

Copies of the accounts can be obtained from the website www.gov.uk/government/publications.

Appendices

Appendix 1: How we delivered against the government's mandate

The government's 2025 mandate set out 5 core objectives for NHS England: cutting waiting times, improving primary care access, reforming UEC, strengthening the operating model, and driving efficiency and productivity. This appendix summarises NHS England's performance against each objective in the 2025 mandate, drawing on delivery data for April 2025 to March 2026.

Reform to cut waiting times

NHS England's approach to reducing waiting times has been guided by the Elective Reform Plan, which set a target for 65% of patient pathways to be within 18 weeks by March 2026, with all trusts expected to deliver at least a 5% improvement. Progress towards this commitment has been steady. As of March 2026, 65.3% of pathways were within 18 weeks an increase of 5.5% points compared to March 2025 (59.8%).

Improvements have been supported by increased elective and diagnostic activity, including delivery of 5.2 million additional appointments, tests and procedures (July 2024–June 2025) against a commitment of 2 million, and a record 30 million diagnostic tests delivered between April 2025 and March 2026. However, performance against the 6-week diagnostic standard has deteriorated, with 21.2% of patients waiting over 6 weeks as of March 2026 (2024/25: 17.4%), highlighting a key constraint on further progress and a focus for recovery to support delivery of longer-term 18-week ambitions.

Alongside elective recovery, NHS England has continued to improve cancer waiting times and outcomes. Cancer survival is at an all-time high, with one-year survival for patients diagnosed in 2020 at 74.6% and 5-year survival for patients diagnosed in 2016 at 55.7%. NHS England co-developed the National Cancer Plan, published in February 2026, which set stretching targets for cancer waiting times and patient outcomes. Performance against cancer waiting time standards in March 2026 was reported as 92.8% for the 31-day standard and 72.8% for the 62-day standard, representing year-on-year improvements of 1.3% points in each case, with performance against the Faster Diagnosis Standard at 79.4%, below the 80% threshold. Outcomes have also improved, with Rapid Registration data showing the early diagnosis rate reached 59.3% to March 2026, 3.5 percentage points higher than pre-pandemic levels, equivalent to over 10,000 more people diagnosed at stages 1 and 2 per year. NHS lung cancer screening has diagnosed more than 10,000 cancers to date, with 76% diagnosed at an early stage.

Patient choice has also been strengthened, with the NHS App supporting greater control over care, and the independent sector delivering over 440,000 NHS patient contacts.

Reform to improve Primary Care access

Improving access to primary and community care has remained central, alongside making progress to develop neighbourhood health services and teams. GP delivered over 1.6 million appointments per working day and nearly 69.6% of patients reported good overall experience of contacting their practice in the 2025 GP survey (2024: 67.3%), and 76.8% of people describing

contact with their practice as easy in the January 2026 Health Insight Survey²⁰⁹ (January 2025: 73.8%).

Online consultation tools were widely adopted under the 2025/26 GP contract. From 1 October 2025, practices were required to keep these tools open throughout core hours to support easier patient access. By December 2025, 98.7% of practices reported compliance.

In April 2025, NHS England launched the Utilisation and Modernisation Fund to support capital investment in the GP estate during 2025/26, improving estate quality and increasing capacity for additional appointments. Investment is on track across 792 projects, with a projected spend of £102 million.

Expansion of primary and community services was most evident in pharmacy and dental provision. Community pharmacy delivered 3.05 million Pharmacy First consultations, and dental activity rose with an additional 1.8 million courses of treatment. Alongside digital innovation and neighbourhood health initiatives, these changes are supporting more integrated, accessible care close to home.

Reform to improve urgent and emergency care

The mandate set out an ambition to improve UEC, including reducing A&E waiting times and Category 2 ambulance response times, improving patient flow and supporting timely discharge. Performance against these standards continued to improve during 2025/26, although services remained under sustained pressure. A&E attendances rose by 2.0% in 2025/26 compared to 2024/25. In March 2026, 77.1% of patients were seen within 4 hours, up on last year, while the proportion of patients waiting more than 12 hours reduced to 10% as an average over the reporting period (2024/25: 10.5%).

Average Category 2 ambulance response times improved in this reporting period to 30 minutes 4 seconds, more than 5 minutes faster than 2024/25, while ambulance handover times reduced to an average of 29 minutes and 55 seconds, supporting faster turnaround of ambulances and quicker access to care for patients.

Delivery was supported by implementation of the UEC Plan, which set out system-wide actions to improve patient flow, discharge and safety, and expand alternatives to hospital care. In 2025/26, patient flow through mental health crisis and acute pathways improved, supported by sustained investment, national access via NHS 111 #Mental Health, expanded community-based alternatives and the rollout of MHEDs.

Urgent Community Response services continued to expand, with referral rates rising from 163 to 186 per 100,000 population year-on-year by December 2025, an 11% increase across April–December 2025, and around 85% of patients consistently seen within the 2-hour standard, helping to ease pressure on ambulance services and reduce emergency bed usage. Despite these actions, pressures remain. Emergency admissions have reduced, but delayed discharges

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<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland>

have stayed broadly stable and higher than anticipated, reflecting increased patient complexity and the need for continued improvement.

Reform to the operating model

NHS England continued to refine its operating model during 2025/26, publishing an updated Oversight and Assessment Framework and implementing segmentation and capability assessments to better target support to local organisations. High-performing organisations were assessed to be approved for increased freedoms, while challenged providers received more intensive targeted support - including through the National Provider Improvement Programme. Financial incentives were also used to strengthen the link between performance and local investment decisions.

In parallel NHS England strengthened the operating model for systems by supporting ICBs in their role as Strategic commissioners. This included updated national frameworks for community health, neighbourhood health, and population based delivery, alongside practical support such as coaching, regional expertise and shared learning. Development of a commissioning capability self-assessment and approval of a 2-year strategic commissioning development programme further underpinned ICB capability for future delivery.

Reform to drive efficiency and productivity

During 2025/26, NHS England worked in partnership with the DHSC to monitor delivery of revenue and capital spending plans and outcomes against jointly agreed metrics, including productivity. Delivery was supported by a zero-based approach to setting central budgets, strengthened in-year controls (including a moratorium on non-essential spend), digital integration through the FDP and Connecting Care Records, and targeted financial and operational support to systems and providers.

These actions enabled NHS England and the DHSC to remain within allocated budgets without recourse to additional Treasury funding, deliver £9 billion of efficiency savings by month 11, and exceed the 2% productivity target agreed between the department and HM Treasury during Spending Review 2025, with acute hospital productivity achieving 2.8% April 2025 to March 2026 and productivity across all trusts achieved 3.4% (excluding outliers). Digital integration progressed at scale, with the FDP and Connecting Care Records adopted by 171 trusts and 41 ICBs, enabling faster clinical decision-making and delivering measurable benefits. These included 111,589 additional patients treated in theatres by March 2026, improving theatre utilisation, hundreds of thousands of patients safely removed from waiting lists, and nearly 94,000 patients supported on their cancer pathway with reduced diagnostic times for some patients. Improvements in digital integration and system flow also contributed to a 15% average reduction in clinically unnecessary hospital days. Strengthened financial controls supported improved system-wide financial balance, although challenges remain in a minority of organisations. These metrics are based on an observational before/after comparison showing changes following the introduction of the NHS FDP Inpatient theatre module. We cannot therefore draw conclusions about cause and effect as other variables have not been controlled for.

Appendix 2: Meeting our Public Sector Equality Duty

In May 2025, NHS England's Board approved and published NHS England's equality objectives and targets for 2025/26. Progress was reviewed during 2025/26 and in June 2026, the Board considered a paper²¹⁰ recommending approval and publication of the review report for 2025/26²¹¹ and updated equality objectives and targets for 2026/27.²¹²

In developing our equality objectives and targets, we are required to focus on the Equality Act (2010)'s 9 protected characteristics²¹³ where there is evidence of a need to take strategic action to address discrimination or other matters that are unlawful, advance equality of opportunity, or foster good relations.

The 2025/26 review report demonstrates how NHS England continued to comply with its statutory requirements under the Equality Act 2010's Public Sector Equality Duty²¹⁴ (PSED) and the associated Specific Equality Duties (SEDs).²¹⁵ Central to these statutory requirements is the duty to publish equality information annually. The full 2025/26 review report is available on NHS England's website.²¹⁶ This report provides a range of key equality information as of 31 March 2026, as required by the SEDs and it considers key developments. Recent and planned developments considered include.²¹⁷

- changes to employment and equality legislation that came into force during 2025/26
- provisions that will come into force during 2026/27 and future years
- planned changes on extending pay gap reporting to disability and ethnicity which are not expected to come into force before March 2027

The review report also:

- provides a summary assessment of performance against our 8 equality objectives and associated 2025/26 targets²¹⁸
- provides further information on other equalities focused work undertaken by NHS England during the reporting period (2025/26)²¹⁹
- considers progress against the 4 recommendations approved by the Board for 2025/26 and provides appropriate recommendations for 2026/27 taking account of the fact that it is proposed that this will be NHS England's final year as a separate legal entity.²²⁰

²¹⁰ NHS England » Specific Equality Duties Review Report – as at 31 March 2026

²¹¹ <https://www.england.nhs.uk/long-read/review-progress-2025-26-equality-delivering-objectives-meeting-requirements/>

²¹² <https://www.england.nhs.uk/long-read/nhs-england-equality-objectives-and-targets-for-2026-27/>

²¹³ <https://www.equalityhumanrights.com/equality/equality-act-2010/protected-characteristics>

²¹⁴ <https://www.legislation.gov.uk/ukpga/2010/15/section/149>

²¹⁵ <https://www.legislation.gov.uk/ukxi/2017/353/contents>

²¹⁶ <https://www.england.nhs.uk/long-read/review-progress-2025-26-equality-delivering-objectives-meeting-requirements/>

²¹⁷ <https://www.england.nhs.uk/long-read/review-progress-2025-26-equality-delivering-objectives-meeting-requirements/#5-major-legislative-and-nhs-reforms-and-the-impact-on-nhs-england-s-equality-objectives-and-targets>

²¹⁸ <https://www.england.nhs.uk/long-read/review-progress-2025-26-equality-delivering-objectives-meeting-requirements/#3-progress-against-the-2025-26-equality-objectives-and-targets>

²¹⁹ <https://www.england.nhs.uk/long-read/review-progress-2025-26-equality-delivering-objectives-meeting-requirements/#4-meeting-our-public-sector-equality-duty-our-wider-equality-information>

²²⁰ <https://www.england.nhs.uk/long-read/review-progress-2025-26-equality-delivering-objectives-meeting-requirements/#5-major-legislative-and-nhs-reforms-and-the-impact-on-nhs-england-s-equality-objectives-and-targets~:text=5.3%20Progress%20against%20the%20recommendations%20set%20for%202025/26>

Appendix 3: Reducing health inequalities

NHS England continued to discharge its statutory, governance and delivery support responsibilities for health inequalities.

Our strategic approach to reducing healthcare inequalities

During 2025/26 we realigned programme delivery into 5 priority workstreams, prioritising 10 Year Health Plan implementation.

Priority 1: Equitable shift to Neighbourhood Health

To embed the Framework for NHS Action on Inclusion Health²²¹, we worked with partners (including DHSC, the Office for Health Improvement and Disparities, and UK Health Security Agency) to develop a suite of national resources: a self-assessment tool for the framework; a data intelligence dashboard, and a service mapping tool.

We published a Community Languages and Translation Framework for Action²²², supported implementation through a community of practice, and worked with the Royal College of Obstetricians and Gynaecology on the production of cross-cultural communication standards.²²³

Alongside His Majesty's Prison and Probation Service, we delivered a health information campaign for adults under supervision of probation services; contributed to the Chief Medical Officer's report, The Health of People in Prison on Probation and in the Secure NHS Estate in England²²⁴; and co-funded the set-up of 4 Probation Health Hubs.

Priority 2: Equitable shift from analogue to digital

We worked with stakeholders to develop a Digital Exclusion Risk Atlas, an NHS analytical tool that identifies patterns of digital exclusion across England by combining various indicators into a single risk index. As digital pathways expand, it will enable local commissioners to map people at risk of digital exclusion to appropriate service access channels and support.

We published and launched an Ethnicity Recording Improvement Plan²²⁵ setting out actions to improve the quality of ethnicity data in health datasets and implementation is ongoing.

Priority 3: Equitable shift from sickness to prevention

The government has committed to halving the regional gap in healthy life expectancy. NHS England and the DHSC have been developing evidence and metrics to support delivery, including measures to quantify NHS contribution.

With NHS Providers, we published a health literacy briefing for senior NHS leaders²²⁶ scaled the Health Literacy Community of Practice nationally with Northeast and North Cumbria ICB and contributed to the update of key resources including the NHS Health Literacy Readability tool and Patient Information Forum TICK.²²⁷

²²¹ <https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/>

²²² <https://www.england.nhs.uk/long-read/improvement-framework-community-language-translation-and-interpreting-services/>

²²³ <https://www.rcog.org.uk/media/11ypcshk/cross-cultural-communication-and-language-support-standards-for-maternity-care-and-womens-health.pdf>

²²⁴ <https://www.gov.uk/government/publications/the-health-of-people-in-prison-on-probation-and-in-the-secure-nhs-estate-in-england>

²²⁵ <https://www.england.nhs.uk/publication/ethnicity-recording-improvement-plan/>

²²⁶ <https://nhsproviders.org/resources/improving-health-literacy-in-the-nhs>

²²⁷ <https://piftick.org.uk/> Trusted health information

Priority 4: Transforming accountability and performance

We strengthened national accountability for reducing health inequalities by embedding more transparent metrics within the NHS Oversight Framework, aligned with the Core20PLUS5 approach.

We refreshed the Statement on Information on Healthcare Inequalities²²⁸, to meet NHS England's statutory duty, setting out how relevant NHS bodies should collect, analyse and publish information on inequalities access and outcomes (13SA of the NHS Act 2006).

The Healthcare Inequalities Improvement Board holds strategic oversight of progress against agreed national indicators in the Health Inequalities measurement framework, and of any further development of the indicators.

To strengthen accountability, we worked with the NHS Confederation to develop the Health Inequality Assurance Framework, a self-assessment tool for ICBs to track progress against strategic objectives and develop commissioning plans to tackle health inequalities.

Priority 5: Sickle Cell and Thalassemia Quality Improvement

To support the shift to community-based care and improve sickle cell patients' experience (reducing re-admissions and length of stay, and increasing self-management), we have:

- provided direct access to emergency care for sickle cell patients, through the introduction of 7 ED Bypass Units in high prevalence areas offering 24/7 service
- rolled out Community Accelerator services within Manchester and across the 5 London ICBs and developed 2 new haemoglobinopathy community services in Birmingham and Sheffield.

In shifting from analogue to digital, we developed a centrally held single patient registry and digital flag alert system for all patients with sickle cell and thalassaemia, as part of the National Disease Registration Service.

We are co-developing community resources with sickle cell carriers, to prevent crises and support self-management, including:

- launching a new education programme with e-learning modules, training and communication material
- delivering targeted communications campaigns, and an event for 90 sickle cell and thalassaemia patients
- introducing a blood genotyping programme, enabling detection of previously undetectable antibodies.

The programme has also initiated a GIRFT project for sickle cell and thalassaemia, led by Clinical Lead Dr Wale Atoyebi.

²²⁸ <https://www.england.nhs.uk/long-read/nhs-englands-statement-on-information-on-health-inequalities/>

Framework for action – Core20PLUS5 approach

Core20PLUS5²²⁹ remains our national and system-level approach to help reduce healthcare inequalities and a phase one longitudinal evaluation report has been made available on NHS Futures.²³⁰ Yale School of Public Health has published a case study report analysing the NHS Core20PLUS5 approach.²³¹

We concluded the Core20PLUS Ambassadors programme with a graduation event, sustained regional networking, and gathered 175 case studies to share best practice on tackling health inequalities.

We provide strategic oversight and funding for the NHS Race and Health Observatory, ensuring alignment with national priorities, and co-developed and presented the annual report on healthcare inequalities to the NHS England Board, strengthening evidence-based action and accountability for ethnic health inequalities.

²²⁹ <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>

²³⁰ <https://future.nhs.uk/InequalitiesImprovement/view?objectID=273712357>

²³¹ <https://cases.som.yale.edu/nhs-england-core20plus5-approach/access>

Appendix 4: Working in partnership with people and communities

To discharge its legal duty to involve the public, NHS England has an assurance process in place for its commissioning decisions that affect the recipients of NHS services, including their carers and representatives. National and regional reporting on public involvement provides assurance that NHS England has met its legal duty. A paper setting out how NHS England meets its legal duty was received by the Quality Committee in September 2025.

During 2025/26 we continued to respond to the feedback gathered during the 10 Year Health Plan engagement, including the early development of the Frailty and Dementia Modern Service Framework, detailed below.

In August 2025, we published a new policy on working in partnership with people and communities for NHS England.²³² This policy, approved by NHS England Board, sets out the various approaches to involving people in our work, actively seeking the voices of individuals who do not necessarily engage with the organisation and ensuring that those who get involved are treated equitably and consistently. A policy implementation guide was published alongside the policy to ensure a consistent approach is applied across NHS England.

To support systems in delivering the 10 Year Health Plan, we developed guidelines on how working with people and communities helps implement the '3 shifts'. We worked with a steering group including ICBs, providers and patient organisations and gathered case studies of effective practice. The guidelines will be published in early 2026/27.

In 2025/26 an audit was undertaken to evaluate the effectiveness of the processes to achieve compliance with the Public Involvement Duty, set out in Section 13Q of the NHS Health Services Act 2006. As a result, we will strengthen the oversight and assurance process.

Examples of how we involve people in our work

Cancer programme engagement

The NHS Cancer Programme continued to engage People and Communities through its diverse PPV Forum, ensuring that a broad range of lived experience shapes transformation across the programme.

In 2025/26, the PPV Forum played a central role in developing the National Cancer Plan, published on World Cancer Day in February 2026, with PPV Partners appointed as equal members of Expert Reference Groups (ERGs) and the Forum itself embedded within programme governance for scrutiny and challenge. Alongside ERG involvement, 5 full Forum sessions enabled wider participation from PPV Partners, including a dedicated discussion with Minister Ashley Dalton. Their contribution was recognised at the highest levels of government, with 10 PPV Partners invited to a Downing Street reception marking the launch of the National Cancer Plan. The Plan reflects patient voices throughout, incorporating direct quotes and insights from PPV Partners.

²³² <https://www.england.nhs.uk/publication/policy-on-working-in-partnership-with-people-and-communities/>

Maternity and service user voice

The Maternity and Neonatal Programme works with 14 PPV Partners who represent service user voice across programme initiatives and are included on its board, committees, and steering groups. This helped to ensure that women, babies, and families were central to national policy and decision-making. In addition, NHS England has 7 regional PPV Partners who contribute service user voice to the regional Maternity & Neonatal boards and co-ordinate the Maternity and Neonatal Voices Partnerships (MNVPs) across England. MNVPs support ICBs and provider trusts to listen to the experiences of women and families, and bring together service users, staff and stakeholders to plan, review and improve local maternity and neonatal care. This influences improvements in the safety, quality, outcomes, and experience for those accessing maternity and neonatal care.

Maximising the impact of NHS volunteers and the Voluntary, Community and Social Enterprise (VCSE) sector

Volunteering

This year, the focus has been on embedding core services to better support volunteering across the NHS:

- At the end of September 2025, the NHS Volunteering website²³³ was formally launched. Over 250 recruiter partners have been onboarded to use the service to boost recruitment of potential volunteers. An average of around 10,000 people visited the website each month.²³⁴
- The national volunteering data collection continued to provide consistent and appropriate measures to track the number of NHS volunteers in NHS Trusts. In line with our rollout, 2025/26 was the first year that trusts were mandated to collect diversity data about volunteers. All the data is publicly available on the NHS England Data site.²³⁵
- The 15 system level partnerships across England in the Volunteering for Health programme (run in partnership with NHS Charities Together and CW+²³⁶), continued to yield useful insight in developing volunteering in local health systems. The learning from their work is shared across the system and is helping to shape policy.

Voluntary, Community and Social Enterprise

The ICB VCSE Community of Practice has continued to regularly meet and support each other through the current challenges around restructure, as well as sharing best practice and other innovative work.

The National Health and Wellbeing Alliance, which has been running in its current iteration since 2021, came to an end in March 2026. The alliance was essential in capturing the voices and views of those who are more likely to experience health inequalities, brought into policy and guidance development across the DHSC, NHS England and UKHSA. This work has enabled greater collaborative working between the centre and the VCSE sector and a greater focus on

²³³ <https://volunteering.england.nhs.uk/volunteer>

²³⁴ Usage based on unique user visits between September 2025-February 2026)

²³⁵ <https://tabanalytics.data.england.nhs.uk/t/Public/views/VolunteerWorkforceDataDashboard/Summary?%3Aembed=y&%3AisGuestRedirectFromVizportal=y>

²³⁶ <https://www.cwplus.org.uk/>

intersectionality in research and projects focussing on health inequalities. An impact report for the Health and Wellbeing Alliance has been published.²³⁷

Working in partnership with carers

In 2025/2026, working with other government departments we strengthened our partnership approach to unpaid carer identification and support. This work extends to young carers. A cross-government summit was held in January 2026, and recommendations were made to support ongoing, joint working to improve outcomes for young carers. We produced a short video to accompany Supporting Young Carers guidance for GPs and staff²³⁸, featuring young carers with lived experience.²³⁹

We held focus groups with GP, exploring best practice, barriers, and opportunities in identifying any personalised care and support planning of unpaid carers. Following stakeholder engagement, we updated the NHS England Supporting carers in GP: a framework of quality markers, which is scheduled for publication in Summer 2026.

We have collaborated with other internal teams to ensure unpaid carers are included in national workstreams such as Neighbourhood health, the mandatory training review, and the NHS Quality Strategy.

Networks and forums

NHS England supports a broad range of forums and advisory groups, bringing together people from diverse communities and health areas. These include the NHS Youth Forum; the Innovation, Research and Life Sciences Strategic Co-Production Group; the LGBT+ Sounding Board; and the Genomic Medicine Service People and Communities Forum.

Many of NHS England's forums are members of the NHS Citizen Advisory Group, which meets on a regular basis to help connect voices from across different programme areas, speaking directly to programme and policy leads on a wide range of national themes. The Advisory Group champions appropriate, effective, and meaningful engagement, including identifying good practice and opportunities for improvement. During 2025/26, discussions with relevant leads included the Professional Nursing and Midwifery Strategy; Chaperones within the NHS; Diagnostic Demand Optimisation; the NHS Experience Excellence Framework; and the National Neighbourhood Health Implementation Programme.

²³⁷ <https://www.nationalvoices.org.uk/publication/vcse-hwa-impact-report/>

²³⁸ <https://youtu.be/ZzK6OY9mvBo>

²³⁹ <https://www.england.nhs.uk/commitment-to-carers/supporting-young-carers-guidance-for-gps-and-staff/>

Further examples of involvement undertaken by 3 of the forums that are members of the NHS Citizen Advisory Group are included below:

1. NHS England's Older People's Sounding Board²⁴⁰ Working in partnership with the independent organisation National Development Team for Inclusion²⁴¹, the Sounding Board has involved a diverse group of 25 older people alongside policy and decision makers, from both NHS England and the DHSC. During 2025/26, topics considered have included:
 - early development of the Frailty and Dementia Modern Service Framework, which aims to enable high-quality, consistent delivery of services across the healthcare system
 - ensuring that older people's voice is fed into the Frailty Improvement Collaborative, which has established 7 delivery sites and which aims to learn how to shift care from hospital to community settings
 - exploring how technology might enable people to live more independently and safely at home, in ways that matter to people and their families and carers.
2. Primary and Community Services Strategic Co-Production Group: With support from the user-led charity Independent Lives, the Strategic Co-production Group has 30 members, including people with long-term health conditions and/or disabilities and family carers. Together, they have contributed to discussions with over 40+ programmes across NHS England and DHSC during the year, including:
 - contributing to the design phase of the New Hospital Programme, understanding key issues from different perspectives, such as reducing infections, mental health and personalised care
 - discussing different options within patient choice, such as waiting times and the balance between quicker appointments versus longer waits with specialist inputs
 - exploring the expanded use of personal health budgets, which was set as a target within the 10 Year Health Plan to help support the shift from hospital to community.
3. Learning Disability and Autism Advisory Group: Having increased the diversity of membership last year across multiple protected characteristics, the group has this year focused on co-production, co-design, and in particular achieving the following:
 - Mental Capacity Act guidance resources
 - Stomp Stamp standards to support people to receive the most appropriate medication
 - Identifying barriers and solutions to equitable access to health care and shared these with system partners and DHSC.

We also provided smaller groups of members with relevant experience to assist with work including:

- Reasonable Adjustment Digital Flag implementation
- Data Uses Register accessibility
- Neighbourhood and Community health provision
- Modern service standards refresh
- Stomp Stamp working group

²⁴⁰ <https://www.england.nhs.uk/get-involved/get-involved/how/forums/nhs-england-older-peoples-sounding-board/>

²⁴¹ <https://www.ndti.org.uk/>

Members also supported on 2 national procurements:

- National Autism Training for Psychiatrists (Enhanced Level)
- Neurodevelopmental Credential

Through the Forum, which has more than 10,000 members, we shared key national campaign information in more accessible language to widen reach, help raise awareness, explain complex messages and help improve services. We used social media and monthly update email bulletins, along with easy read and plain English versions of a co-produced newsletter.

LGBT+ Evidence Review

In April 2025, the Secretary of State for Health and Social Care commissioned an LGBT+ Health Evidence Review. The aims of the Review were to examine the barriers to healthcare that LGBT+ people face; to provide an evidence-based understanding of LGBT+ health inequalities in terms of access, experience and outcomes; and to better understand why they persist and to make recommendations for change.

We held over 40 engagement sessions across England to involve people and communities to inform the Review. The sessions were focused on topics such as primary care and mental health, as well as identity specific topics including:

- Global majority communities
- Disabled people
- Learning disability, autism and neurodiversity
- People seeking asylum, refugees
- People experiencing homelessness
- Faith and religious communities

3 key questions framed the engagement events:

1. What do we need to know that we do not know?
2. Why have we not made progress in the past? What have been, and currently are, the barriers to making progress on reducing LGBT+ health inequalities?
3. How do we make things better? What are the top 3 actions that would fundamentally shift the dial on LGBT+ health inequalities?

The learning from these engagement events has been used to inform the LGBT+ Evidence Review alongside other sources of data which is expected to be published in 2026/27.

Aside from this, the LGBT+ programmes also host the LGBT+ Sounding Board, which provides a structured platform for meaningful involvement, enabling members to shape national policy development, comment on emerging priorities, and inform the implementation of the LGBT+ Health Evidence Review. This work ensured that the voices of LGBT+ people, particularly those most underserved, were embedded in decision-making processes, supporting co-production, improving transparency, and strengthening the alignment between lived experience and service transformation. Through this partnership-based approach, NHS England has improved how equality considerations, patient insight, and community-led challenge inform the design and delivery of national programmes, such as the national New Hospital Programme.

Appendix 5: Sustainability

Metrics and targets – NHS England

This section covers the metrics set out in the Sustainability Reporting Guidance 2025/26.²⁴² As an ALB to the DHSC, NHS England as an individual organisation is in scope for the Greening Government Commitments. For the 2025-2030 GGCs, the 2025/26 reporting period serves as the baseline year rather than a year with target reductions to achieve. At the time of writing, we are waiting for the targets to 2030 to be published by the government. NHS organisations who are not ALBs to DHSC are not in scope for the GGCs but are required to develop Green Plans.

Scope

All reporting in this section covers NHS England and the CSUs. Each trust and ICS has its own Green Plan and will report its sustainability performance separately. We have chosen to include scope 3 business travel emissions, recognising that they account for a large portion of our overall greenhouse gas emissions.

Reporting methodologies

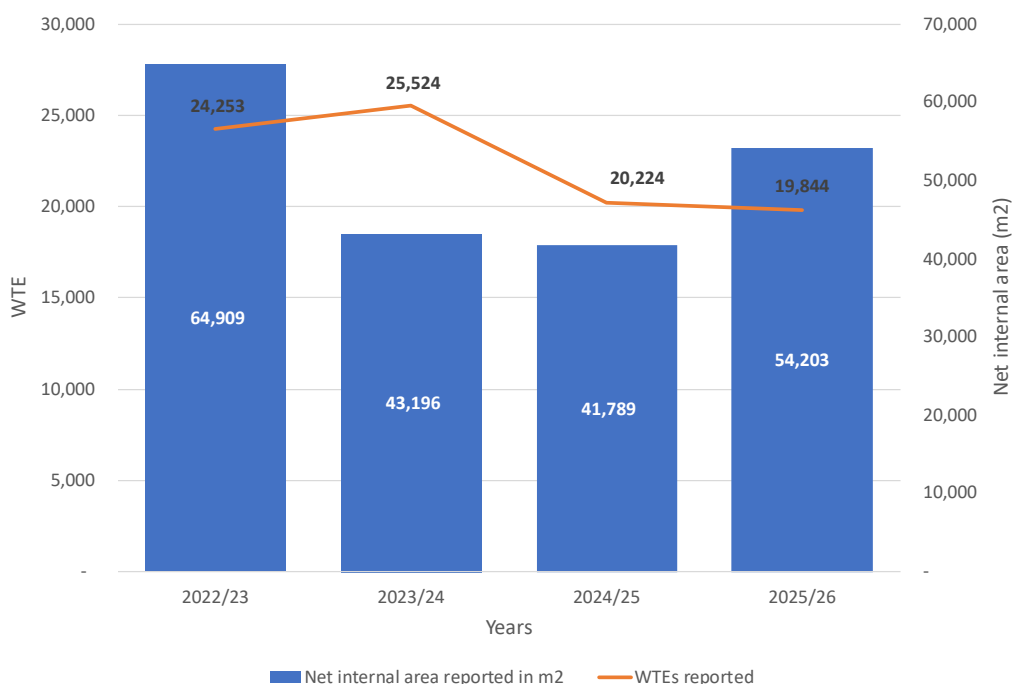
The organisational boundary reflects NHS England's UK-based estate and activities. In some buildings where we are tenants of a government department, energy, waste and water information for the whole building will be reported in their annual reports and published on their websites. For all other sites, we report on the proportion of the site that we occupy. Emissions have been calculated using activity data (including energy consumption, fuel use and business travel) and the UK Government greenhouse gas conversion factors for company reporting. Where complete data is not available, estimates have been applied using appropriate proxies and assumptions.

Provision of data

Where actual figures for energy, water and waste were unavailable owing to a lack of data from suppliers and landlords, we have made our best efforts to estimate using available data. Estimates are based on averages per m² of Net Internal Area (NIA).

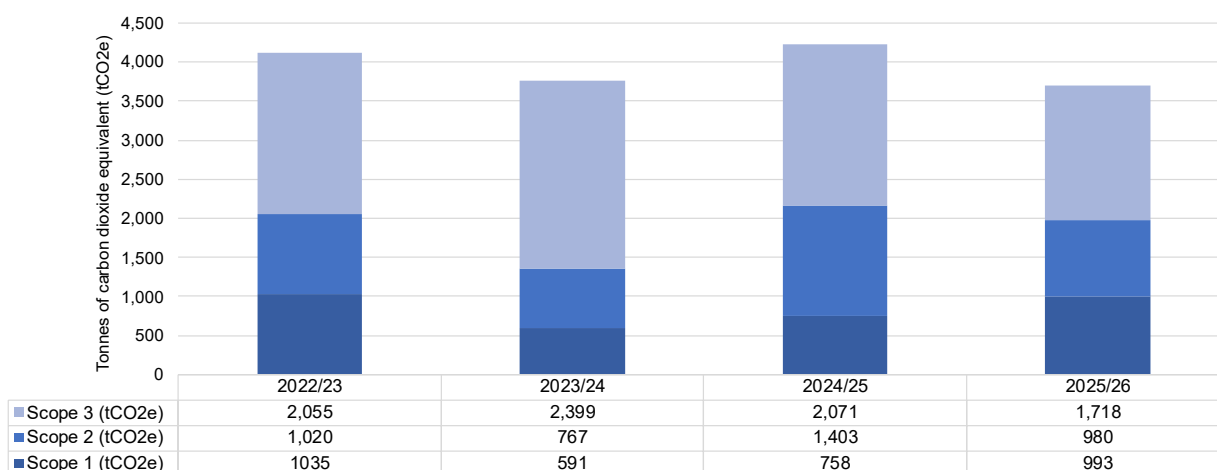
²⁴² [Sustainability Reporting Guidance 2025-26 - GOV.UK](#)

Contextual information



The NIA for 2025/26 has increased for reporting purposes to include some offices where we are tenants of Government Departments or their executive agencies, and those organisations do not report the whole building in their sustainability reporting. We have included these offices in this report; to improve the accuracy of our baseline year but they have not been included in previous years on the assumption that the buildings were being reported by the Government Department or executive agency.

Greenhouse gas emissions



Related use and cost²⁴³

Related use	2022/23	2023/24	2024/25	2025/26
Scope 1 ²⁴⁴ Business travel kms	414,563	699,852	779,279	88,603 ²⁴⁵
Scope 1 Gas kWh	5,302,724	2,926,969	3,721,038	4,949,638
Scope 2 ²⁴⁶ Electricity kWh	5,273,549	3,718,599	6,774,884	5,534,108
Scope 3 ²⁴⁷ Business travel kms	30,503,294	36,891,801	34,699,153	31,109,046

Related cost (£)	2022/23	2023/24	2024/25	2025/26
Scope 1 Business travel	£145,519	£217,832	£181,429	£30,831 ²⁴⁸
Scope 1 Gas	£240,222	£310,546	£284,342	£390,368 ²⁴⁹
Scope 2 Electricity	£824,398	£1,214,235	£1,112,591	£1,485,224 ²⁵⁰
Scope 3 Business travel	£8,116,240	£11,237,624	£9,994,513	£9,072,137 ²⁵¹
Total	£9,326,379	£12,980,237	£11,572,875	£10,978,560

Waste

Waste comes from the offices across our corporate estate and is classed as municipal waste. We do not have any major mineral, hazardous, regulated, or other waste to report.

Waste by waste stream (tonnes) ²⁵²	2022/23	2023/24	2024/25	2025/26
Incinerated with heat recovery	131	83	52	107
Recycled	210	76	99	169
Landfill	1	-	2	-
Incinerated without heat recovery	-	-	-	-
Anaerobic digestion	-	-	-	6
Composting	-	-	-	6
Total	342	159	153	288
Landfill %	0.17%	0.00%	1.31%	0.00%
Recycling rate	61%	46%	46%	61%

²⁴³ The presentation of travel-related sustainability metrics has been simplified for 2025/26. Prior year figures have been aggregated to provide a consistent basis of comparison with current year disclosures. No underlying data has been restated.

²⁴⁴ Scope 1 emissions are from sources owned or controlled by NHS England

²⁴⁵ Salary sacrifice cars have previously been categorised as "fleet" and counted as Scope 1. The definition in the Government Fleet Commitment has changed to exclude salary sacrifice vehicles.

²⁴⁶ Scope 2 emissions are the result of electricity consumed which is supplied by another party

²⁴⁷ Scope 3 emissions are all other emissions which occur because of activity in an organisation's value chain, but which are not owned or controlled by the accounting entity

²⁴⁸ Estimated. Scope 1 business travel undertaken by the CSUs has been estimated based on Agenda for Change mileage rates.

²⁴⁹ Estimated. The cost of gas usage for the CSUs has been estimated using the cost per kWh paid by NHS England.

²⁵⁰ Estimated. The cost of electricity usage for the CSUs has been estimated using the cost per kWh paid by NHS England.

²⁵¹ Estimated. The cost of business travel for the CSUs has been estimated using NHS England's average cost per km for each mode of transport.

²⁵² Figures for anaerobic digestion and composting have not previously been collected

Cost of waste disposal

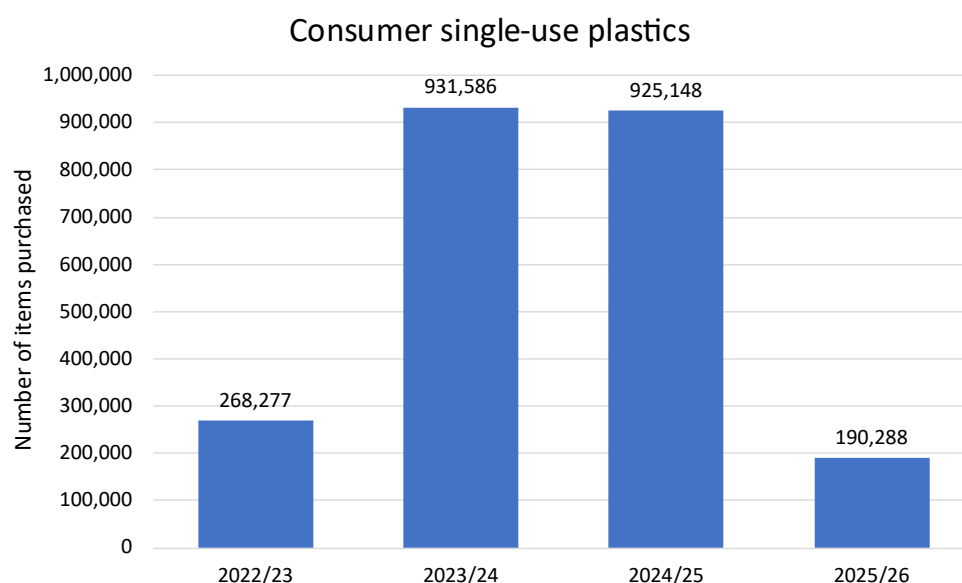
	2022/23	2023/24	2024/25	2025/26
Incinerated with heat recovery	£83,808	£14,469	£6,252	£14,188
Cost of recycling	£100,952	£14,274	£17,996	£30,924
Landfill	£0	£0	£0	£0
Incinerated without heat recovery	£0	£0	£0	£0
Anaerobic digestion	-	-	-	£454
Composting	-	-	-	£454
Total	£184,761	£28,743	£24,248	£46,020

NHS England ICT and digital waste disposal²⁵³

2024/25 ²⁵⁴				2025/26			
	Units	Weight (tonnes)	Value returned (£)		Units	Weight (tonnes)	Value returned (£) ²⁵⁵
Reuse	-	81	-		1,611	4	-
Recycling	-	145	-		5,377	12	-
Incineration with energy recovery	-	-	-		-	-	-
Incineration without energy recovery	-	-	-		-	-	-
Landfill	-	-	-		-	-	-
Total	-	226	-		6,988	16	-

Consumer single-use plastics

Changes were implemented this year to reduce the consumption of consumer single use plastics (CSUPs). These changes saw the use of CSUPs reduce by almost 80%. Wherever possible, any remaining CSUPs are plant-based plastics.



²⁵³ CSU data is unavailable.

²⁵⁴ The number of units and financial value returned were not reporting requirements in 2024/25, so we do not hold this information.

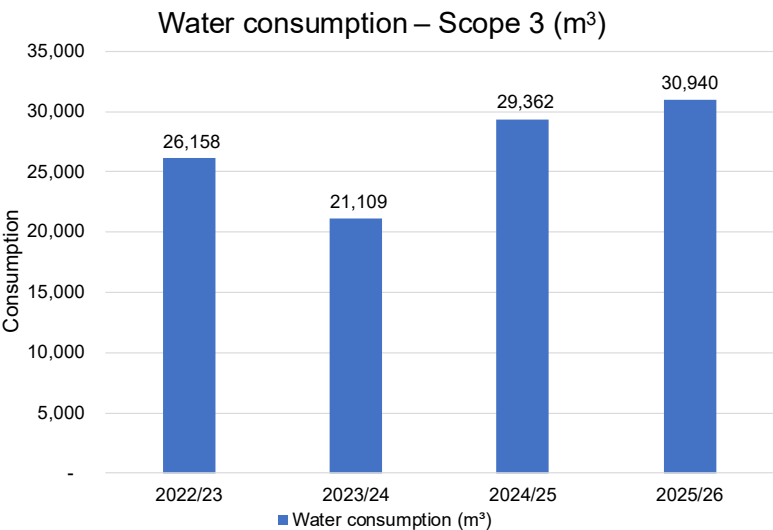
²⁵⁵ The value returned is not known.

Re-use schemes

Surplus furniture is often reused across the public sector through the Cabinet Office reuse scheme or is donated to other public and charitable organisations locally. The surplus furniture from 3 office closures this year were donated to a school charity and to other public organisations through the Cabinet Office reuse scheme.

Finite resource consumption

Water consumption (m³)



Although overall water use has increased due to the increased size of the estate being reported, it has reduced from last year per m² of NIA.

There are no other material finite resources to report that have not already been included.

Sustainable procurement

Our policy is outlined in the published net zero supplier roadmap²⁵⁶, supported by guidance aligned with Procurement Policy Note (PPN) 002²⁵⁷ on the Social Value Model and PPN 006²⁵⁸ on Carbon Reduction Plans. We are committed to eradicating modern slavery in line with PPN 009²⁵⁹ and have integrated a risk assessment tool into our e-commerce system to support this effort. Additionally, our Evergreen Sustainable Supplier Assessment²⁶⁰ tool helps suppliers align with our net zero and sustainability goals. Dashboards have been developed to monitor implementation of social value and carbon reduction plan policies regarding sustainable procurement within the procurement portal.

²⁵⁶ <https://www.england.nhs.uk/greenernhs/get-involved/suppliers>

²⁵⁷ <https://www.gov.uk/government/publications/ppn-002-taking-account-of-social-value-in-the-award-of-contracts>

²⁵⁸ <https://www.gov.uk/government/publications/ppn-006-taking-account-of-carbon-reduction-plans-in-the-procurement-of-major-government-contracts>

²⁵⁹ <https://www.gov.uk/government/publications/ppn-009-tackling-modern-slavery-in-government-supply-chains/ppn-009-guidance-on-tackling-modern-slavery-in-government-supply-chains-htm>

²⁶⁰ <https://www.england.nhs.uk/nhs-commercial/sustainability/evergreen/>

Nature recovery and biodiversity

We do not own any natural capital or landholdings.

NHS Emissions

The NHS has committed to reducing greenhouse gas emissions (GHGs) under our direct control (the NHS Carbon Footprint) to 2,900 ktCO₂e by 2028 to 2032 and to net zero by 2040 – the government’s commitment to this target was reinforced in the 10 Year Health Plan.

The provisional estimate of NHS CF emissions for 2025/26 is 4,450 ktCO₂e, down from an updated estimate of 4,600 ktCO₂e for 2024/25, and 17% lower than an updated estimate of 5,350 ktCO₂e for 2019/20. Improvements to methodology have reduced estates emissions by 100-200ktCO₂e in each year compared to previously published figures. Year-on-year progress in 2025/26 is due to further progress in reducing emissions from inhalers and nitrous oxide waste reduction plus reduced buildings energy emissions.

This estimate, combined with evidence of action across the NHS, suggests that in 2025/26 the NHS was on track to meet commitments for 2028-32 and demonstrates progress towards the 2040 net zero target for the NHS Carbon Footprint.

The first 5-year review of Greener NHS progress was published in 2025²⁶¹, including updated estimates for the baseline year for NHS net zero targets (1990) and emissions estimates for financial years 2019/20 to 2024/25. Figures included here therefore cannot be directly compared with previous NHS England Annual Report and Accounts estimates. They are based on both actual and forecasted data as at end May 2026 and may be subject to revision as final input data is published and further methodological improvements are made. A description of the methodology and data used to produce these estimates is publicly available.²⁶²

The breakdown of estimated 2025/26 NHS CF emissions into Greenhouse Gas Protocol Scopes 1, 2 and 3 is included in the table below (figures are rounded to the nearest 50ktCO₂e). Updated figures for 2024/25, based on latest available data, are also included in the table.

²⁶¹ <https://www.england.nhs.uk/long-read/five-years-greener-nhs-progress-forward-look/>

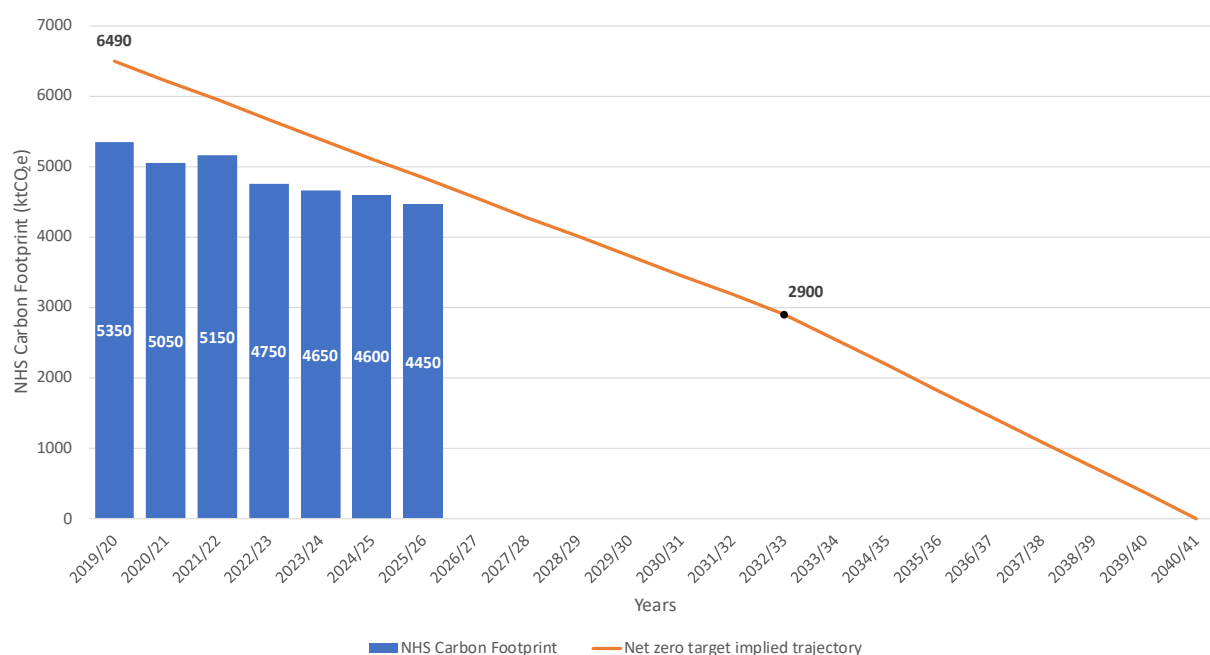
²⁶² https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5506082

NHS Carbon Footprint estimates²⁶³

	Estates	Medicines	Fleet and business travel	Total (ktCO ₂ e)
Updated 2024/25 NHSCF (ktCO ₂ e)	3,000	950	650	4,600
Provisional 2025/26 NHSCF (ktCO ₂ e)	2,950	850	650	4,450
Breakdown of 2025/26 provisional estimate by Greenhouse Gas Protocol Scopes				
Scope 1	Onsite combustion of fossil fuels	Anaesthetics	Owned and leased fleet	
Estimated NHS emissions (ktCO ₂ e)	1,750	200	150	2,100
Scope 2	Electricity / purchased heat and steam	-	-	
Estimated NHS emissions (ktCO ₂ e)	600	N/A	-	600
Scope 3	Well to tank emissions, waste and water	All inhalers and anaesthetic manufacturing	Business travel	
Estimated NHS emissions (ktCO ₂ e)	550	650	550	1,750

NHS Carbon Footprint trajectory²⁶⁴

A trajectory of NHSCF emissions estimates is shown in the chart, alongside the straight-line trajectory between 1990 baseline emissions, the 80% interim reduction target in 2032, and net zero in 2040.



²⁶³ Breakdown of provisional 2025/26 NHS Carbon Footprint emissions estimates by Greenhouse Gas Protocol scopes, and updated 2024/25 estimate. Figures are rounded to the nearest 50kt CO₂e.

²⁶⁴ NHS Carbon Footprint emissions from 2019/20 to 2025/26. The orange line indicates the straight-line trajectories between 1990 baseline emissions, the 80% interim reduction target of 2900ktCO₂e in 2032, and net zero in 2040

The provisional estimate of NHS CF+ emissions for 2025/26 is 26.8 MtCO₂e. Updated estimates of 2024/25 and 2019/20 NHS CF+ emissions are 26.9 MtCO₂ and 27.0 MtCO₂e respectively. NHSCF+ emissions per finished admitted episode were 7% lower in 2025/26 than in 2019/20.

Provisional NHS CF+ emissions in 2025/26 are approximately at 2019/20 levels despite increased spend and activity, however, the full impact of NHS action cannot be reflected in these estimates due to methodological limitations. Updated 2019/20 and 2024/25 estimates have decreased compared with previous estimates due to lower than forecast non-pay spend, plus improvements to methodology. Future updates will improve the ability to monitor progress in key areas of the NHS CF+, as well as providing further emission breakdowns.

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