Department of Health & Social Care

Department of Health and Social Care

Annual Report and Accounts 2025-26

For the year ended 31 March 2026

HC 696

Department of Health & Social Care

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Secretary of State for Health and Social Care Annual Report presented to Parliament pursuant to Section 247D of the National Health Service Act 2006

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This is part of a series of departmental publications which - along with the Main Estimates 2025-26 and the document Public Expenditure: Statistical Analyses 2026 - present the government's outturn for 2025-26 and planned expenditure for 2026-27.



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Permanent Secretary's overview



As Permanent Secretary, I am proud of the role the Department of Health and Social Care (DHSC) plays in supporting ministers to lead the nation's health and care system.

Working with our arm's length bodies, the NHS and social care partners, our purpose is to help people live more independent, healthier lives for longer, supported by safe, high-quality care. I am very grateful to staff and volunteers across health and social care, as well as the charities and other partners we work with, whose dedication underpins everything we have achieved this year.

Since my appointment in June 2025, I have been struck by both the scale of the challenges facing the system and the opportunity to make lasting improvements for patients, service users, carers, staff and volunteers. During 2025-26, my focus, and the department's, has been on delivering the transformation set out in the government's 10 Year Health Plan, through three fundamental shifts:

- hospital to community
- analogue to digital
- sickness to prevention

This Annual Report and Accounts sets out our financial and delivery performance from 1 April 2025 to 31 March 2026 and I am proud of the progress that has been made throughout the year.

Over the course of the year, there were substantial achievements - reducing the elective waiting list by 3.5% whilst also meeting the target of 65% of elective patients being seen within 18 weeks, increasing the number of booked GP appointments by 2%, and increasing the proportion of patients seen within 4 hours in A&E by 1%, despite a 2.2% increase in A&E attendances. We also achieved NHS productivity growth of 2.6% against a target of 2%.

Despite these pressures, including increasing demand, resident doctor industrial action and a challenging fiscal environment, DHSC and the NHS managed within budgets, without drawing on additional funding from the Reserve, for the first time since 2016-17.

There is of course more – much more – still to do; the experience of people still waiting for diagnosis, treatment or support reminds us why sustained improvement in timely, high-quality care remains a critical objective.

The same commitment to dignity, support and better outcomes must also shape adult social care. The new Prime Minister has made clear the need to end decades of drift and build a system that gives people security and support when they need it, recognising the

pressures on older and disabled people, families, unpaid carers and the care workforce. He has called for a person-centred, high-quality care service that starts at home and provides free personal care for older people, based on need rather than ability to pay. Baroness Casey's independent commission has now been accelerated, alongside the Big Conversation on Care, to help build consensus on a sustainable, more integrated model of care and support that delivers the Prime Minister's vision for a National Care Service.

In a landmark moment for public health, the Tobacco and Vapes Act reached Royal Assent, creating the UK's first smoke-free generation. DHSC subsequently launched a consultation to expand smoke-free places by making it illegal to smoke, vape or use heated tobacco in public children's playgrounds and outside education settings in England. This will build on action taken against the other biggest contributors to ill health – obesity, lack of physical activity and alcohol.

Maternity and neonatal services rightly remained under national scrutiny following the heartbreaking experiences of women, babies and families affected by harm or bereavement, and are a key priority for the new Secretary of State. The independent investigation led by Baroness Amos has reinforced the need to listen, learn and act with urgency, with a new Maternity and Neonatal Commissioner to be appointed, National Taskforce and action plan intended to strengthen safety, accountability, equity and compassion across services.

In 2025-26, we invested £1.7 billion in health and care research, making the UK one of Europe's largest funders in life sciences. The year saw up to £600 million being committed to set up the Health Data Research Service, and work continues for it to become operational by the end of 2026. The UK is making strong progress towards faster clinical trial set-up. In the first half of 2025-26, 73% of eligible commercial interventional trials completed set-up within 150 days, up from 45% in the same period the previous year. In most recent months, every eligible study met the target - helping patients access potentially groundbreaking treatments sooner.

In recognition of the breadth of work carried out across the broader health family, I would like to mention two examples of their valued contributions. In March 2026, the UK Health Security Agency and local partners responded to the meningococcal group B outbreak in Kent to protect students, families and the wider community. And during 2025-26, the Care Quality Commission published 90 assessment reports on how Local Authorities are delivering adult social care, highlighting outstanding care and also where improvements can be made.

Delivering lasting improvement will require a different way of working, and I welcomed the 10 Year Health Plan's focus on a new operating model for the NHS. This includes ensuring we are making the best use of new technology including AI.

Integrated Care Boards will have an increasingly important role as strategic commissioners, using evidence, population health insight and local partnerships to shape services around need, while neighbourhood health services and new delivery models help bring care closer to home. Together with changes at national level, including legislation to abolish NHS England, this new approach represents a major shift in how the NHS is organised and led.

I recognise the scale of this transformation, including the impact on colleagues affected by organisational change. I want to thank everyone for the work they are doing and I am grateful for the professionalism, commitment and care shown by all of our staff and our partners as we continue to focus on delivering better outcomes for the people we serve.

Samantha Jones OBE
Permanent Secretary of the Department of Health and Social Care

Performance report

Role, purpose, structure and funding

This section introduces the role and purpose of DHSC and sets out how funding flows from Parliament through the health and social care system. It also sets out our key achievements at a glance and key finance facts.

Our role and purpose

Our role and purpose are to:

- support and advise our ministers: we help ministers shape and deliver policy that delivers the government's objectives
- set direction: we anticipate the future and lead debate, ensuring we protect and improve global and domestic health
- ensure accountability: we make sure DHSC and our arm's-length bodies deliver on our agreed plans and commitments
- act as guardians of the health and care framework: we make sure the legislative, financial, administrative and policy frameworks are fit for purpose and work together
- troubleshoot: in the last resort, the public and Parliament expect us to take the action needed to resolve crucial and complex issues

DHSC is leading the mission to build an NHS fit for the future which starts with tackling waiting lists. We will make progress towards returning to NHS performance standards and improve access to services. We want to see fewer lives being lost to the biggest killers, including cancer, cardiovascular disease and stroke, and suicide. This means diagnosing and treating patients earlier and enabling people to better manage their health and care. People deserve to live in a fairer Britain, where everyone lives well for longer. A healthy society and functioning health system should also ensure people can live their life to the fullest without major health issues holding them back.

The Government's 10 Year Health Plan for England: fit for the future, published in July 2025, set out the fundamental and necessary 'big shift' reforms in the way our health services deliver care.

The Performance Summary and Analysis from pages 21 to 99 in this Annual Report and Accounts describes progress in delivering the Plan and the work we have performed to fulfil our Strategic Outcomes (detailed at page 22).

Our structure

The Secretary of State for Health and Social Care and other DHSC ministers are accountable to Parliament for the provision of comprehensive health and social care in England. DHSC works through its arm's-length bodies (ALBs) listed at **Note 19**, which we support and hold to account in carrying out their responsibilities.

To enable the system to work flexibly, critical day-to-day operational decisions are made by professionals working in provider organisations, supported by the strategic, operational, and regulatory functions delivered by our ALBs.

DHSC prioritises building strong and effective working relationships with each of its ALBs via departmental sponsorship teams. These teams, in line with the Cabinet Office ALB Sponsorship Code of Good Practice, work collaboratively to ensure accountable, efficient, and effective health and care services are provided to the public.

Our ALBs also play a key role in reforming the health system by delivering the changes set out in the 10 Year Health Plan, which will also be supported through DHSC's transformation programme.

On 13 March 2025, the government announced its intention to abolish NHS England and transfer the majority of its functions into DHSC. This will support the Government's broader reform agenda, including improving efficiency, empowering local decision-making, and ensuring public accountability.

By reforming the centre of the health and social care system, the objective is to establish a more streamlined, accountable and effective centre for the health and care system. The change will bring together strategy, policy, and system oversight within a single organisation, with clearer lines of accountability to ministers and Parliament, and a sharper focus on outcomes for patients and the public. By reducing duplication between national bodies and strengthening strategic leadership, the reform will enable a more coherent approach to setting priorities, allocating resources, and holding the system to account. The reformed DHSC will have a greater focus on working through local systems and partners, whilst ensuring national consistency where it adds most value.

It is expected that, alongside ICB restructuring, the transformation could deliver up to £1 billion in annual savings by the end of the Parliament, driven primarily by reductions in headcount against a March 2025 baseline.

DHSC and NHS England have established a transformation programme to deliver this change. Legislation was introduced to Parliament on 14 May 2026. The programme is being delivered in phases to prepare for the transition, subject to the will of Parliament, in April 2027. A key underpinning principle is to ensure continuity of service delivery throughout the transition, maintaining focus on frontline performance while enabling long-term transformation.

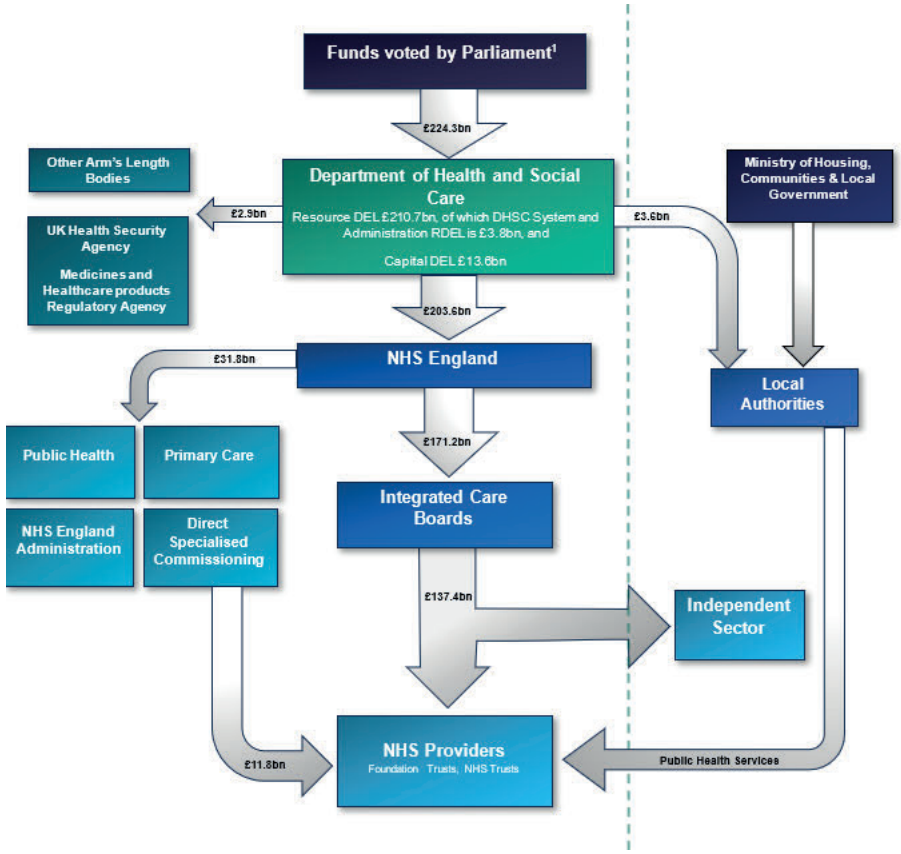
Our funding

DHSC secures funds for health and care services and remains accountable for this funding, which is allocated to the most appropriate local level. For the 2025-26 financial year, DHSC had a resource departmental expenditure limit of £210.7 billion and had funding to invest a further £13.6 billion to fund capital items such as new hospitals and equipment, as detailed in **Table 5** at page 100.

Figure 1 demonstrates how funding flows around the system, using agreed budget totals for 2025-26 per the supplementary estimate.

Separately, but not shown in **Figure 1**, DHSC is responsible for securing funds for adult social care through the spending review settlement, albeit the Ministry of Housing, Communities and Local Government remains accountable for the allocation of those funds to local authorities.

Figure 1: Funding flows in the health and care system, 2025-26 (per supplementary estimate)



[1] The reference to 'Funds voted by Parliament' includes funding from National Insurance contributions that are not included in the Parliamentary vote on DHSC's budget. This funding is received directly from HMRC via the National Insurance Fund which is provided for in legislation.

Budgeted figures are used in the diagram above with actual figures used by exception where allocations are not included in budgets.

The dashed line indicates the boundary of consolidation for DHSC and shows local authority funding to health.

Risk management

Risk management enhances strategic planning and prioritisation across DHSC, supports the delivery of departmental objectives, and strengthens organisational agility in responding to emerging challenges. It also plays a critical role in preventing harm and reducing the likelihood or impact of failure across the DHSC's activities.

DHSC's risk management policy is to:

- identify and understand its risks
- maintain clear accountabilities for the management of those risks
- apply robust and consistent risk management procedures to prevent and mitigate potential harm or failure
- ensure that staff at all levels possess the necessary competencies to manage risk effectively

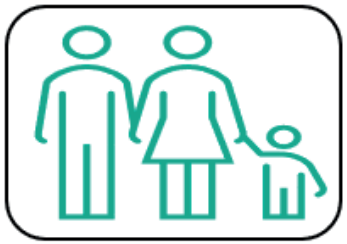
Some of the key activities in mitigating DHSC's principal risks are set out in the detailed performance analysis from page 23. DHSC's Leadership Group, the Audit and Risk Assurance Committee, and Departmental Board members have challenged and advised on the controls and actions being taken to further mitigate them, through regular discussion of risk overall and through regular 'deep dive' examination of particular risks as well as risk management. Further details of DHSC's risk management policies are set out in pages 156 to 158 in the Governance Statement.

DHSC's principal risks during 2025-26 are set out overleaf.

Principal Risk	Description
Cyber Incident	There is a risk that a large-scale cyber-attack occurs against DHSC, its ALBs and/or the wider health and care system, causing significant patient harm including loss of life; detrimental reputation impact for the NHS; loss of public trust; and significant financial cost.
Adult Social Care Major Provider Failure	There is a risk that growing pressures in the adult social care system, external shocks, or business management, or a combination of these factors, result in the sudden failure of a major or 'difficult to replace' provider.
People	There is a risk that DHSC is not the right size and shape or lacks the skills and capacity it needs to deliver on its priorities.
Continuity of Supply of Medicines and Medical Products	There is a risk that because supply chains for medical products are complex, global, and highly regulated, they can be vulnerable to a variety of acute shocks (e.g., manufacture failure, demand spikes, trade restrictions) and have inherent chronic vulnerabilities that pose a risk to security of supply.
Pandemic Preparedness	There is a risk that DHSC is unable to mobilise the health and care system to prevent, prepare, or respond and mobilise adequately to a major national infectious disease hazard, such as pandemic flu or other novel infection.
CBRN Risk to the Health and Social Care System's Preparedness and Response Capability	There is a risk that preparedness is insufficient to enable frontline responders, the public, or the health and social care system to respond effectively in the event of a chemical, biological, radiological, or nuclear incident.
Industrial Action	There is a risk that disputes over pay and/or working conditions escalate to periods of industrial action which impact on NHS recovery and on finances.
Future Funding	There is a risk that we fail to secure sufficient future funding through the Spending Review 25 and/or to prioritise and plan effectively to meet rising demand, and support the government's priorities for health and social care and ensure financial sustainability.

Principal Risk	Description
Health and Emergency Service (Ambulance) Critical National Infrastructure (CNI) 	There is a risk that the health Sector CNI cross-system resilience and security could be compromised due to lack of organisational awareness of their CNI assets and protection in place for these. Or that CNI is not seen as a priority for ALBs.
National Power Outage 	There is a risk that DHSC is unable to mobilise the health and care system to prepare and respond in a National Power Outage (NPO) and that the impact of an NPO will have significant impact on delivery of the NHS and public health impacts which result from a lack of water, food spoilage, and disruption to medical supplies.
Long-term NHS Sustainability 	There is a risk that DHSC is not able to successfully implement the 10 Year Health Plan's objective of a new model of care which delivers similar or better quality of care at lower/similar cost, with implications for longer-term NHS sustainability.
Workforce, Finance, and Activity 	There is a risk that activity, workforce and finance are misaligned in ways that contribute to failure to deliver recovery ambitions in priority service areas or to live within available resources either at trusts or system level.
Health Inequalities 	There is a risk that the government fails to address growing health disparities with consequences for health, society, and the economy.
In-year Funding 	There is a risk that we failed to secure sufficient funding and/or priorities and plan effectively to contain in-year spending within the allocated budget.

Achievements at a glance



Improved access to NHS dentistry, with a focus on urgent dental appointment capacity



Target of 65% of patients beginning treatment within 18-weeks achieved in March 2026



National Cancer Plan published to ensure 3 in 4 cancer patients survive for 5 years or more



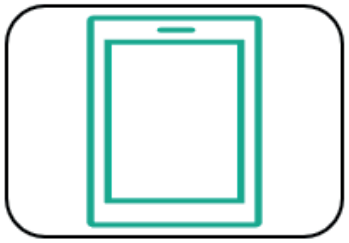
First Men's Health Strategy published to tackle mental health and physical challenges men and boys face



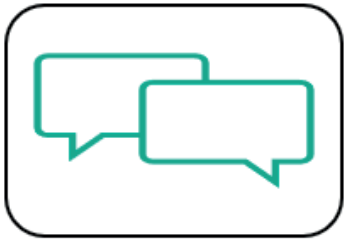
NHS mental health spending increased to £15.7 billion (from £14.9 billion in 2024-25)



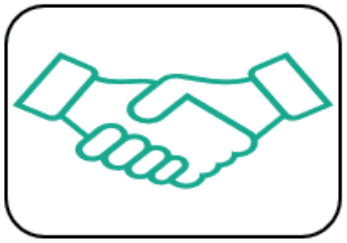
Passage of Tobacco and Vapes Bill



26.9 million people used the NHS app. An increase of 20% from last year



Introduced legislation to create the Single Patient Record

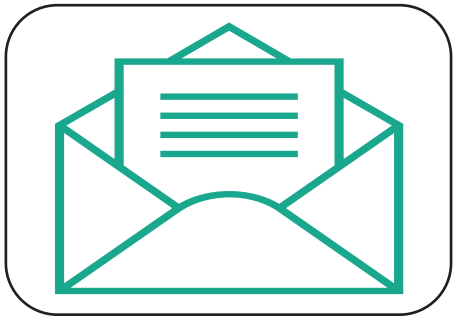


Increased GP access through GP contract reform since March 2025, including an 8.9% spending boost

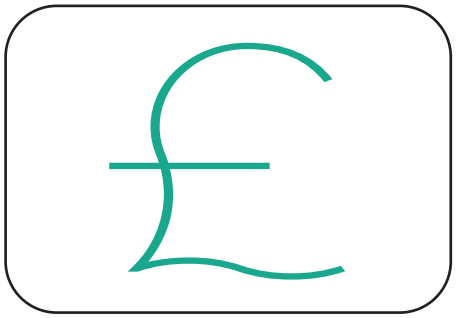


Work progressed in response to independent commission on adult social care

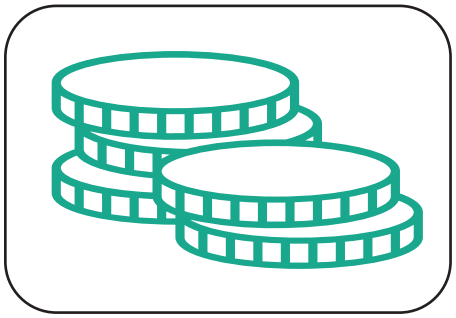
Key finance facts



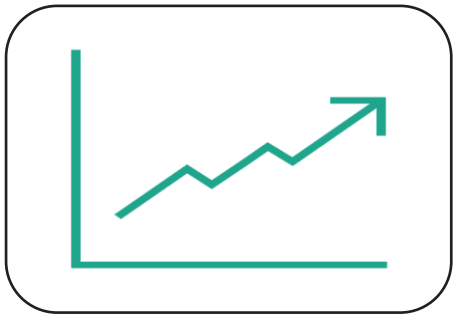
DHSC remained within all Parliamentary spending limits without requiring additional in-year reserve funding, for the first time since 2016-17



£13.3 billion (net) investment in capital



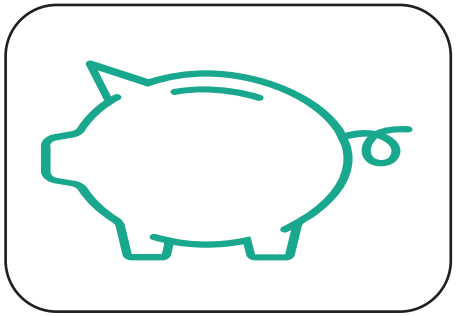
NHS England's £198 billion RDEL (excluding depreciation) budget was the biggest of any ALB in government



23% spending growth in real terms since 2019-20



Over £1.1 billion CDEL invested in addressing critical infrastructure risks and removing reinforced autoclaved aerated concrete across the NHS estate



DHSC underspent its Resource DEL[1] budget by only 0.2%, making every pound count for patients and public



£1.7 billion invested in transformative health and care research



£10.2 billion of efficiencies and savings delivered across the NHS

[1] Against its total resource departmental expenditure limit, excluding depreciation and impairments

Secretary of State for Health and Social Care Annual Report 2025-26

The Secretary of State is required by section 247D of the National Health Service Act 2006, (the 2006 Act), to publish an annual report (laid before Parliament pursuant to section 247D(3)) on the performance of the health service in England. The report must include an assessment of the effectiveness of the discharge of the duties under sections 1A and 1C of the 2006 Act.

This report includes an assessment of how effectively the Secretary of State has discharged their duties under sections 1A (duty as to improvement in quality of services) and 1C (duty as to reducing health inequalities) of the 2006 Act, as required under section 247D(2) of the 2006 Act, and is supplementary to the full Department of Health and Social Care (DHSC) Annual Reports and Accounts 2025-26.

The Secretary of State is under a duty in section 1A of the 2006 Act to exercise their functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the matters listed at 1A(1)(a) (the prevention, diagnosis or treatment of illness) and 1A(1)(b) (the protection or improvement of public health). In discharging this duty, the Secretary of State must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services and the Secretary of State must have regard to quality standards prepared by the National Institute for Health and Care Excellence (NICE) as set out in section 234 of the Health and Social Care Act 2012. Under section 1C of the 2006 Act, the Secretary of State is under a duty to have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service.

A full performance analysis for 2025-26 can be found in the ‘Detailed performance analysis’ section of the DHSC Annual Report and Accounts 2025-26. Assessments of the effectiveness of the discharge of the duties under sections 1A and 1C of the 2006 Act can be found below.

Assessment for section 1A (duty as to improvement in quality of services)

Prevention, diagnosis, or treatment of illness

During 2025-26, there was a focus on improving 18-week referral to treatment (RTT) performance, supporting the government’s commitment to return by March 2029 to the NHS constitutional standard that 92% of patients wait no longer than 18 weeks from referral to consultant-led treatment. This ambition was underpinned by a set of Operational Planning Guidance targets for the year, notably that by March 2026 performance against the standard should reach 65% nationally. That target was exceeded, with performance of

65.3% in March 2026 representing an in-year increase of 5.5 percentage points - the greatest annual improvement outside of the pandemic since October 2009. The NHS also made progress cutting waiting lists, which fell by over 312,000 across the year. In October 2025, NHS England published the Medium-Term Planning Framework, setting clear multi-year expectations for the system to reach the constitutional standard by March 2029.

Cancer

Cancer continued to be one of the leading causes of mortality in England during 2025-26 and improving cancer outcomes remained a priority for DHSC and NHS England. In February 2026, the government published the National Cancer Plan for England, reaffirming its commitment to meeting all the cancer waiting time standards by the end of this Parliament and setting out a range of reforms and a long-term strategy to modernise cancer services and improve outcomes across the cancer pathway. The plan set out a long-term ambition that, by 2035, 75% of people diagnosed with cancer will be living well or cancer-free five years after diagnosis, representing an additional 320,000 lives saved over the lifetime of the plan.

Cancer waiting time standards remain a key measure of NHS cancer performance and are intended to ensure patients receive timely diagnosis and treatment. On diagnosis, the NHS's ambition in 2025-26 was to achieve 80% performance against the faster diagnosis standard (cancer diagnosed or ruled out within 28 days) by March 2026, with an operational standard of 75%. The operational standard was exceeded – meaning around 95,000 more people had cancer diagnosed or ruled out within 28 days in 2025-26 than in the previous year - though overall performance was just below the ambition, at 79.4% in March 2026. On treatment, the NHS's 62-day standard measures the time from urgent referral to first treatment, and in 2025-26 the operational standard was 85%. There were year on year improvements again in 2025-6, although performance did not reach the operational standard. In March 2026, 72.8% of patients received treatment within 62 days, an improvement on last year (71.4%), and the 62-day cancer backlog continued to reduce during the year (to 13,995, a reduction of 59% compared to the pandemic peak in May 2020).

Urgent and emergency care

Under the delivery of the Urgent and Emergency Care (UEC) Plan for 2025-26, DHSC and NHS England implemented a range of measures designed to improve UEC performance. These included: actions aimed at eliminating the practice of corridor care from the NHS before the end of this Parliament; the publication of new national clinical standards to support more consistent, high-quality care and improved flow through hospitals; and steps to strengthen transparency (for example the publication, for the first time, of site-level Accident and Emergency (A&E) performance data) and access (for example, the expansion of the National Booking Service for flu). As part of the UEC Plan, over £450 million of capital funding was provided to expand UEC capacity, including: new and

expanded Same Day Emergency Care and Urgent Treatment Centres; additional mental health crisis capacity; and nearly 1,000 replacement ambulances by March 2026.

For the third consecutive year, there was a year-on-year improvement in performance in 2025-26 against both the key NHS wait time targets of patients being admitted, transferred or discharged within four hours (78%) and reducing average Category 2 ambulance response times to 30 minutes (the headline indicator for 'emergency call' responses). Performance also improved in the winter period (November 2025 to February 2026); despite 1.6% (143,458) more attendances and 6% (183,638) more emergency incidents than in winter 2024-25, four-hour performance was 1.2 percentage points better and Category 2 ambulance response times were seven minutes and four seconds faster. Overall performance against the four-hour measure in March 2026 was slightly below target at 77.1% and the average Category 2 ambulance response time target was missed by four seconds. This was against a backdrop of increased demand for UEC services, with over 600,000 more A&E attendances in 2025-26 than the previous year.

General practice

DHSC's aim for general practice in 2025-26 was to improve access for patients and respond to growing demand. Appointment numbers in 2025-26 were consistently higher than 2024-25, and numbers of FTE doctors and other direct patient care staff continued to increase. As of March 2026, there were 30,071 full-time equivalent fully qualified GPs FTE working in practices and primary care networks. This is the highest number of fully qualified FTE GPs since the introduction of the current methodology in September 2015.

The 2026 GP Patient Survey showed that 76.7% of respondents had a positive overall experience with their GP practice, an increase of 1.3 percentage points from 2025 (75.4%), continuing the upward trend from 2024; additionally, when asked about waiting times for appointments, over two-thirds of patients (69.3%) described the wait as "about right" continuing the upward trend from 2024.

Mental health/neurodevelopmental and learning disability

Improving NHS mental health, learning disabilities and autism services in England remained a high priority through 2025-26. Significant steps were taken to stabilise and improve service but much more remains to do to address growing demand and improve patient experience and outcomes. The latest Adult Psychiatric Morbidity Survey, published in November 2025, estimated that around one in five adults in England (9.4 million people) are affected by a common mental health condition, with demand for mental health services remaining high throughout the year

DHSC has worked closely with NHS England, alongside cross-government and sector partners, to implement the commitments set out in the 10 Year Health Plan which was published in July 2025. These include recruiting an additional 8,500 mental health workers before the end of this Parliament, rolling out Mental Health Support Teams in schools and

colleges to reach full national coverage by 2029, and expanding access to Mental Health Emergency Departments to ensure patients get fast, same-day access to specialist support in an appropriate setting. Six community-based Mental Health Centre pilots in England are now operating - in Birmingham, York, Copeland, Tower Hamlets, Lewisham and Sheffield, providing open-access to treatment and support for adults with severe mental health needs.

Women's health

Work also continued to improve women's health outcomes, including through the publication of our Renewed Women's Health Strategy for England, on 15 April 2026. The Strategy aligns with the 10 Year Health Plan to shift care into the community, harness digital innovation and strengthen prevention so women can live healthier, more fulfilled lives. In addition, we are implementing a number of measures to reduce gynaecology waiting lists and ensure that women get equal access to high-quality elective care. We have improved women and girls' awareness and driven research to benefit women's health. In 2025, we announced that menopause will be included in routine NHS health checks for over 40s, raising awareness of symptoms and giving women the confidence to seek help. We are improving workplace support for women through a number of measures in the Employment Rights Act 2025.

Maternity

Progress continued to be made in the delivery of the three-year plan to improve maternity and neonatal services, with the introduction of a maternal care bundle, a perinatal culture and leadership programme and expanded maternal mental health services. An early warning system, the Maternity Oversight Signal System (MOSS), and an inequalities dashboard were also put in place. The national independent investigation into NHS maternity and neonatal care was commissioned in June, alongside setting up the National Maternity and Neonatal Taskforce to translate the recommendations from the national investigation into a new, national action plan. Local reviews into Leeds Teaching Hospitals NHS Trust and University Hospitals Sussex NHS Foundation Trust were announced.

Dentistry

The latest data for 2025-26 shows continued improvement to NHS dental activity across a wide range of measures. There were 37.6 million courses of treatment (COT) delivered, which is 6.2% more than in 2024-25. In 2025-26, COTs for adult patients increased by 6% to 25 million, and by 7% for child patients to 13 million. There were 76.8 million units of dental activity (UDA) delivered, which is 5.1 % higher than 2024-25. 18.8 million adults were seen by an NHS dentist, which is an increase of 2% compared to 2024-25, and access to NHS dental care for children has now recovered to above pre-pandemic levels. In the 12 months to 30 June 2026, 7.2 million children were seen by an NHS dentist, 151,000 (2.1%) higher than the pre-pandemic figure (7.0 million) for the 12 months up to

30 September 2019. In addition, 4 million urgent NHS dental appointments were delivered in 2025-26, which is 8.4% more than in 2024-25.

The government is committed to ensuring people can access dental care when they need it. In 2025-26 ICBs commissioned additional urgent dental appointments and there is now an urgent care safety net available in all areas of the country. In 2025-26 we started to introduce a package of reforms to the dental contract for 2026-27 which address some of the pressing issues that dentists and dental teams have been experiencing. In March 2026 we announced that we are increasing dental school places in England from 809 to 859, supported with around £11 million per year once the expansion is fully implemented, allowing two new dental schools to open in NHS regions with no undergraduate dentistry training.

The prevention of oral health problems is vital. Since 2025, we have invested £21.5 million to implement the national supervised toothbrushing programme for 3-5 year olds, to reach up to 600,000 children in the most deprived areas of England. Our innovative, 5-year partnership with Colgate-Palmolive saw 4 million toothbrushes and toothpastes donated in 2025-26. We have also progressed with our plans to expand Community Water Fluoridation across the North-East of England. 6 million people are already covered by the scheme, and this latest intervention is expected to reach an additional 1.6 million people and reduce tooth decay and inequalities in dental health.

Primary prevention

We are tackling the leading preventable causes of ill health, including tobacco use, obesity, physical inactivity, alcohol-related harm and air pollution. The landmark Tobacco and Vapes Act progressed through parliament and received Royal Assent, and we have continued to invest in support to help adult smokers quit. To improve diet and increase physical activity, we are delivering a range of measures, including fulfilling the government's manifesto commitment to restrict junk food advertising on TV and online, and continuing to develop a national campaign to encourage millions more people to walk. We are also providing local authorities with £3.4 billion in ringfenced funding over the next three years to deliver vital drug and alcohol treatment and recovery services. Finally, to support gambling harms prevention projects, we allocated £54 million of statutory levy funding over two years (April 2026 to March 2028) to voluntary, community and social enterprise organisations and local authorities.

During 2025-26, we have laid the foundations to support our prevention agenda for future generations. In November 2025, we published England’s first Men’s Health Strategy, setting out the government’s 10-year vision for men's health and the actions we are taking to improve the health and wellbeing of all men and boys in England. Since its launch, significant work has been undertaken on implementing the commitments set out in the Strategy. In March 2026, the Men’s Health Community Fund - a £6.3 million programme - was launched in partnership with Movember and the People’s Health Trust.

We have continued to invest in the NHS Health Check, a core component of England's CVD prevention programme, and in the development of a new digital service – NHS Health Check Online – to sit alongside the existing face to face service commissioned by local authorities. The Cardiovascular Disease Modern Service Framework (CVD MSF) was published in July 2026, delivering on a commitment made in the 10 Year Health Plan and accelerating progress towards the ambition to reduce premature mortality (<75) from heart disease and stroke by 25% within a decade. The CVD MSF sets a clear, goal-focused approach, identifying 12 priority actions that the system should prioritise now to drive measurable improvement in outcomes and inequalities alongside 12 challenge areas that we will work with industry, academia, the voluntary and community sector and the health and care system to tackle together including by building evidence and developing innovative new approaches.

In June 2025, the government agreed to make major changes to improve cervical screening, shifting the programme to a risk-based approach in line with a UK National Screening Committee recommendation, and putting in place arrangements to introducing home self-sampling kits for those who have failed to attend appointments in a clinical setting. DHSC also agreed an additional antenatal test opportunity for one of the serious genetic conditions that affects babies and significantly reduces quality of life and life expectancy, enabling parents to be better informed and seek relevant support and advice.

Secondary prevention

In December 2025, we also published the new HIV Action Plan to drive progress towards our ambition to end new HIV transmissions in England by 2030. Backed by over £170 million, the plan sets out how the government will enable every level of the healthcare system to work together to engage everyone in prevention, testing and treatment, and tackle stigma.

Adult social care

The total number of people receiving long-term support in England showed an increase from 666,000 on 30 April 2025 to 685,000 on 31 March 2026.

This trend is driven by the increase in long-term support delivered in community settings, which covers home care and support in the form of direct payments from the local authority that people can then use to buy their own care and support. The number of people receiving long-term support in the community increased from 470,000 on 30 April 2025 to 490,000 on 31 March 2026. This number increased in all age groups.

Statistics drawn from Client Level Data (CLD) are published quarterly in the adult social care client level data publication and were first released in March 2024. The publications of the activity report and ASCOF towards the end of 2026 (covering April 2025 to March 2026) will also present statistics calculated using CLD.

We have commissioned NICE to adapt the evidence standards framework for digital health technologies to support evidence-based decision making for digital technologies used in adult social care. This framework will bring clarity, consistency and transparency to evidence generation and decision making across the sector, supporting those purchasing technology to make better investment decisions.

Patient safety and quality

Over the past year, the DHSC and NHS England have continued to strengthen patient safety, improve the quality of care, and embed a culture of learning across the NHS. Through the 10 Year Health Plan and Dr Penny Dash's review of the patient safety landscape, action is being taken to create a simpler and more effective patient safety system.

In 2025-26, NHS England's Patient Safety Strategy continued to support safer systems through the Patient Safety Incident Response Framework, Patient Safety Syllabus, Framework for Involving Patients in Patient Safety and Learn from Patient Safety Events service, which supports learning from more than 3 million incidents each year.

The Strategy is estimated to save around 1,000 lives and over £100 million in care costs annually. Key impacts include:

- safer neonatal care, including more than 1,900 neonatal lives saved through safer care bundle interventions
- more than 600 cases of cerebral palsy in premature babies prevented, saving an estimated £600 million in lifetime care costs
- Martha's Rule expanded to every acute hospital in England, with more than 13,000 escalation calls leading to treatment changes for over 1,900 patients
- improvements in medicines safety, including chronic pain and opioid prescribing

The first full year of the statutory medical examiner system has strengthened independent scrutiny of deaths, improved engagement with bereaved families and helped identify cases requiring further review.

Dr Dash's review found the patient safety landscape to be complex and fragmented. The Government accepted the majority of the nine recommendations and is implementing reforms to clarify roles, strengthen oversight through the National Quality Board (NQB), develop an NQB recommendations hub, move the Patient Safety Commissioner to the MHRA and strengthen staff and patient voice functions. DHSC and NHS England are working with partners to implement these changes, with legislation taken forward through the NHS Bill where required.

Patient safety will remain central to improving NHS quality, supported by the planned update to the Patient Safety Strategy following the 10 Year Health Plan and the new Quality Strategy published on 14 July.

Further detailed information can be found on pages 73 to 75 of this Annual Report and Accounts.

NICE quality standards

NICE quality standards are concise sets of prioritised statements designed to drive and measure quality improvements within a particular area of health or care. Between 1 April 2025 and 31 March 2026, NICE published 3 new quality standards on overweight and obesity management, suspected sepsis in over 16s and kidney cancer. NICE also updated a further 9 quality standards to align with updated guidance.

Overall assessment (section 1A)

The Secretary of State's assessment is that there was clear progress in several areas during 2025-26 in discharging the duty to secure continuous improvement, including improvements in elective care, access to general practice and dentistry, and action to strengthen prevention and patient safety. However, significant challenges remain, particularly given the ongoing pressures on urgent and emergency care and in responding to growing demand and improving outcomes in mental health services. The 10 Year Health Plan provides the framework for further improvement through the shifts from hospital to community, analogue to digital and sickness to prevention.

Assessment for section 1C (duty as to reducing inequalities)

An update on progress in tackling health inequalities can be found under the 'Detailed Performance Analysis' section of the DHSC Annual Report and Accounts 2025-26.

As set out there, Ministers have published a 10 Year Health Plan in England, informed throughout by the need to address inequalities in both access and outcomes, framed by an overall goal to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone. This is supported by a Men's Health Strategy, and a refreshed Women's Health Strategy, and by attention to healthy equity in implementation of the three major shifts described by the 10 Year Health Plan.

NHS England has continued to implement the flagship Core20PLUS5 approach for adults and children and young people to support integrated care systems to reduce inequalities. The approach for adults focuses on improving cardiovascular disease, cancer, respiratory, maternity and mental health outcomes in the poorest 20 percent of the population, along with ethnic minorities and inclusion health groups.

In line with current legal duties, NHS England is required to assess the performance of each ICB and publish a summary of the outcomes of its assessments. The assessment includes the extent to which ICBs have fulfilled their statutory obligations regarding health inequalities. The review of 2024-25 performance, which includes a health inequalities summary for each ICB, was published in December 2025.

Overall assessment (section 1C)

The Secretary of State's assessment is that some progress was made during 2025-26 in discharging the duty to reduce health inequalities, although sustained action is needed to achieve improvements in access and outcomes. The 10 Year Health Plan places reducing inequalities at the centre of reform, supported by continued implementation of Core20PLUS5 and targeted action on prevention, women's and men's health, and oral health.

Performance summary

Strategic outcomes

The summary table overleaf provides an at-a-glance overview of how we worked towards delivering DHSC strategic outcomes in the financial year 2025-26. These outcomes included work to advance delivery of the three big reform shifts set out in the 10 Year Health Plan as follows:

- from ‘hospital to community’, bringing care closer to where people live, including through a new neighbourhood health service to deliver more proactive and personalised care

- from ‘analogue to digital’, by rolling out new technologies and digital approaches to modernise the NHS, including bringing together a single patient record, owned by the patient, shared across their care teams, putting people in control of their own health

- from ‘sickness to prevention’, shortening the amount of time people spend in ill-health by preventing illnesses before they happen, as well as earlier identification and management of chronic conditions

Further details can be found in the Detailed Performance Analysis section of this Annual Report and Accounts.

Strategic Outcomes



1: An NHS that is there when people need it: provide timely access to high-quality health and care

The NHS improved access despite continued demand pressures. The 18-week elective waiting time ambition was achieved, with performance reaching 65.3% in March 2026, with performance improving by 5.5 percentage points over the previous year. Over 171 trusts and 41 ICBs were using the Federated Data Platform by year end, supporting elective recovery and patient flow. General Practice delivered 391 million appointments, and community pharmacies provided over 3.4 million Pharmacy First consultations.



2: Fewer lives lost to the biggest killers: reduce premature mortality

We accelerated the shift towards prevention through action on smoking, obesity, vaccination and cardiovascular disease. The Tobacco and Vapes Act received Royal Assent, while an additional £70 million supported local stop smoking services. Around 500,000 more people received a flu vaccination than the previous winter, and over 3.5 million blood pressure checks were delivered by community pharmacy.



3: Fairer Britain, where everyone lives well for longer: reduce the number of years people spend in ill-health (compressed morbidity)

We continued to tackle health inequalities and improve support for people to live independently. Adult social care funding was announced to increase by over £4.6 billion by 2028-29 compared to 2025-26, while 83% of CQC registered care providers now use digital social care records, supporting over 91% of people drawing on care. Mental health spending increased to over £15.7 billion, and more than 880,000 children and young people received NHS-funded mental health support. The government also published England's first Men's Health Strategy and refreshed the Women's Health Strategy.

Cross-Cutting Themes



Workforce



New hospital programme



Technology and innovation



Emergency preparedness



Science, research and evidence

Detailed performance analysis

Structure of the performance analysis section

This performance analysis provides a detailed narrative of our performance and includes the following sections:

- Performance on priority outcome and cross cutting areas
- Financial performance across the group
- Secretary of State's Annual Report
- Sustainability report and performance in other areas including correspondence, Parliamentary Questions and fraud and error.

Introduction

The detailed performance analysis section provides an evidence-based, analytical overview of how DHSC has performed against its strategic outcomes during 2025-26 for the health and social care system. The analysis covers the key areas that can be measured within each of the three outcomes.

We also set out the approach taken to delivering productivity and efficiency commitments across the NHS, which is vital to the achievement of both high performance for patients and financial sustainability.

Strategic outcome one

An NHS that is there when people need it: provide timely access to high-quality health and care

Key areas of work

- Elective care
- Cancer waiting times
- Diagnostics
- Urgent and emergency care
- Mental health, autism and learning disabilities
- General practice
- Dentistry
- Community pharmacy

Key achievements

- Achieved target of having 65% of patients beginning treatment within 18 weeks
- National Cancer Plan for England was published
- Reformed GP contract
- Expansion of digital services for patients, and record NHS app use
- Expansion of community pharmacy services

Performance summary of key areas against 2025-26 targets and operational standards

Figure 2: Performance summary

Key performance against 2025-26 targets and operational standards

2025-26 performance (year to 31 March 2026 unless otherwise stated)

Elective care

Performance measure	Target / standard (2025-26)	2025-26 performance	Assessment
Patients waiting no longer than 18 weeks for treatment (referral to treatment)	65% of patients by March 2026 (planning target)	**65.3%** 5.5 percentage-point improvement on 2024-25	✓ Target achieved
Patients waiting no longer than 18 weeks for a first appointment	72% of patients (planning target)	**69.6%** 4.8 percentage-point improvement on 2024-25	! Target narrowly missed
Patients waiting more than 52 weeks (as a proportion of the total waiting list)	Less than 1% of the total waiting list (planning target)	**1.3%** 1.1 percentage-point improvement (86,000 fewer waits) on 2024-25	! Target narrowly missed

Diagnostics

Performance measure	Target / standard (2025-26)	2025-26 performance	Assessment
Patients waiting six weeks or more for a diagnostic test	Less than 1% (operational standard)	**21.2%** 406,925 patients	! Standard not achieved

Cancer

Performance measure	Target / standard (2025-26)	2025-26 performance	Assessment
Faster Diagnosis Standard: cancer diagnosed or ruled out within 28 days	80% by March 2026 (planning ambition) 75% (operational standard)	**79.4%** Operational standard exceeded	! Planning ambition narrowly missed; standard exceeded
Treatment within 62 days of an urgent referral	85% (operational standard)	**72.8%** (up from 71.4% in March 2025)	! Standard not achieved
Treatment within 31 days of decision to treat	96% (operational standard)	**92.8%**	! Standard not achieved

Urgent and emergency care

Performance measure	Target / standard (2025-26)	2025-26 performance	Assessment
A&E patients admitted, transferred or discharged within four hours	78% by March 2026 (planning target) 95% (constitutional standard)	**77.1%** in March 2026 74.9% across 2025-26	! Planning target not achieved
Average Category 2 ambulance response time	30 minutes across 2025-26 (planning target) 18 minutes (constitutional standard)	**30 minutes and 4 seconds** (4 seconds outside target)	! Planning target not achieved

Key: ✓ Achieved ! Not achieved

Note: Targets are 2025-26 operational planning guidance unless stated. Performance relates to year to 31 March 2026 unless stated otherwise.

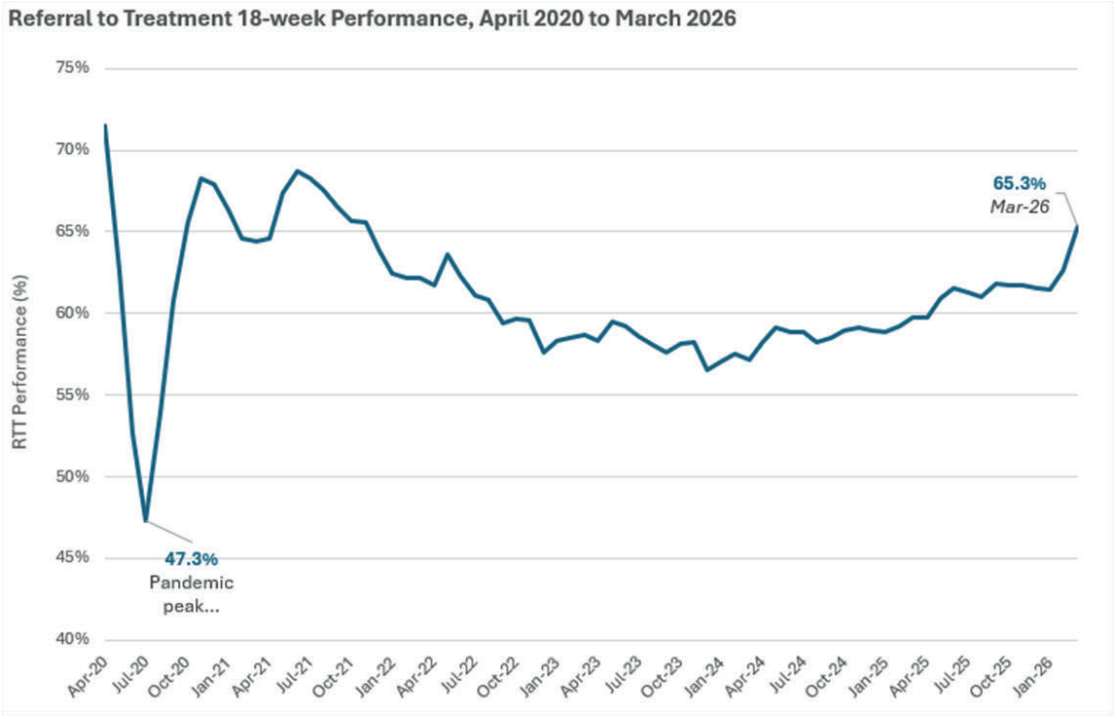
Elective care

Significant progress in elective performance continued in 2025-26 despite high levels of demand and periods of industrial action.

While the operational planning guidance targets to improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72%, and to reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list were narrowly missed, significant in-year progress was made in both areas. In 2025-26, the proportion of the total waiting list over 52 weeks dropped by 1.1 percentage points, with an overall reduction of 86,000 waiting over a year. The proportion of waits below 18 weeks for a first appointment also improved by 4.8 percentage points. Improvements across both metrics supported DHSC achieving the headline 65% 18-week referral to treatment target in March 2026.

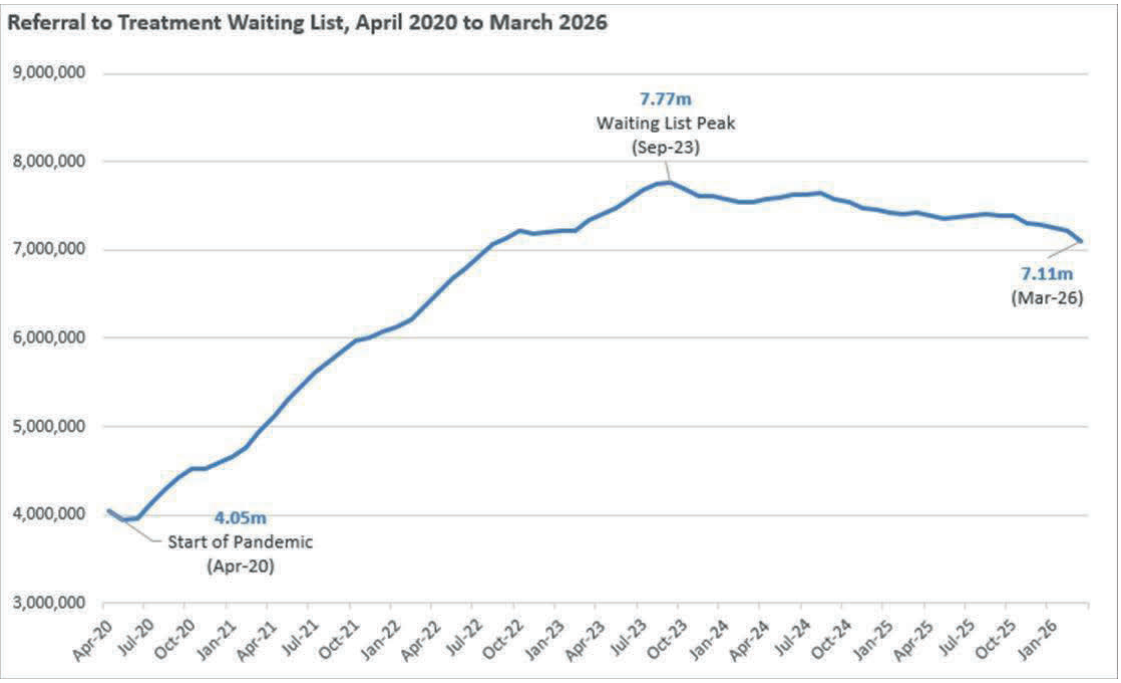
The medium-term planning framework has focused on only one elective target for 2026-27: every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%). While there are no longer specified targets to reduce time to first appointment and 52-week waits, improvements in both are inherently incentivised in driving performance towards the electives target. Nationally, DHSC and NHS England are working together to continue to monitor these two metrics to support the NHS to minimise long waits and work towards returning to the 18-week referral to treatment constitutional standard.

Figure 3: Referral to treatment 18-week performance, April 2020 to March 2026



Source: RTT Waiting Times Report

Figure 4: Referral to treatment waiting list, April 2020 to March 2026



Source: Consultant led referral to treatment waiting times data (NHS England)

The government set a national ambition that by March 2026, 65% of patients will wait no longer than 18 weeks for consultant-led treatment. Published data for March 2026 shows that DHSC have successfully met this ambition. Since meeting the target, DHSC has maintained 18-week referral to treatment performance in the early part of 2026-27, despite industrial action taking place in April 2026.

The reforms and modernisation DHSC has implemented, alongside the effort of our hardworking NHS staff, has made this possible. DHSC has improved 18-week performance by 5.5 percentage points this year, the greatest yearly improvement outside of the pandemic since October 2009 (based on 12-month rolling).

The key challenge to performance in 2025-26 was the 15 days of industrial action by resident doctors that limited the in-year elective activity the system was able to deliver. The impact on performance was exacerbated by high demand on the waiting list. 2.6% more waits were added to the waiting list compared to 2024-25.

Despite these challenges, thanks to the efforts of NHS staff, 3.5% more patient pathways left the waiting list than in 2024-25, helping the system achieve the March 2026 18-week performance target. Crucial performance gains were delivered through reforms to the delivery of elective care and the maximising of administrative and clinical resources:

- the upscaling of Advice and Guidance in 2025-26 – the process of GPs seeking advice from clinical specialists before referring a patient for elective treatment – supported 1.67 million patients to get care in the right place without unnecessarily

being added to elective waiting lists (April 2025 to March 2026), helping patients receive appropriate care in primary and community settings instead

- increased efforts to validate patient records have significantly reduced the number of erroneously recorded waits on the list, for example to remove duplicate records, or ensure accurate recording of completed pathways. This helps ensure only those who need to be on a list are on it and reduces the number and impact of unnecessary and missed appointments

- a time-limited national drive to increase elective activity in quarter 4 of 2025-26 led to a 3.8 percentage point improvement in 18-week performance across January to March 2026

Gynaecology waiting lists and referral to treatment performance

The Elective Reform Plan, published in January 2025, set out the reforms the NHS is making to improve gynaecology waiting times across England. This includes piloting gynaecology pathways in Community Diagnostic Centres (CDCs) for patients with post-menopausal bleeding and prioritising gynaecology for treatment in surgical hubs. 13 surgical hubs opened during the 2025-26 financial year, taking the total number of operational hubs in England to 125; with around half offering gynaecology services. DHSC also increased the relative funding available to incentivise providers to take on more gynaecology procedures (15% for some gynaecology services).

Between March 2025 and March 2026, the number of patient pathways on the gynaecology waiting list fell by nearly 22,000 to 560,866. In the same period, 18-week performance improved by 5.1 percentage points, from 55.8% to 60.9%.

Diagnostics

Diagnostics capacity

The Elective Reform Plan also sets out the productivity and modernisation efforts needed to return to the 18-week constitutional standard by the end of this Parliament. The plan commits to transform and expand diagnostic services and speed up waiting times for tests, a crucial part of reducing overall waiting times and returning to the referral to treatment 18-week standard.

The 2025 Spending Review confirmed over £6 billion of additional capital investment over five years across diagnostic, elective and urgent care capacity. This includes £600 million in capital funding for diagnostics in 2025-26 to support longer-term improvements in diagnostic infrastructure and capacity.

This included funding to support the continued expansion and development of CDCs, alongside investment in diagnostic equipment, including MRI and CT scanners and 20 new

DEXA scanners announced in March 2026. These investments are intended to support improved access to diagnostic services and contribute to reducing waiting times over the coming years.

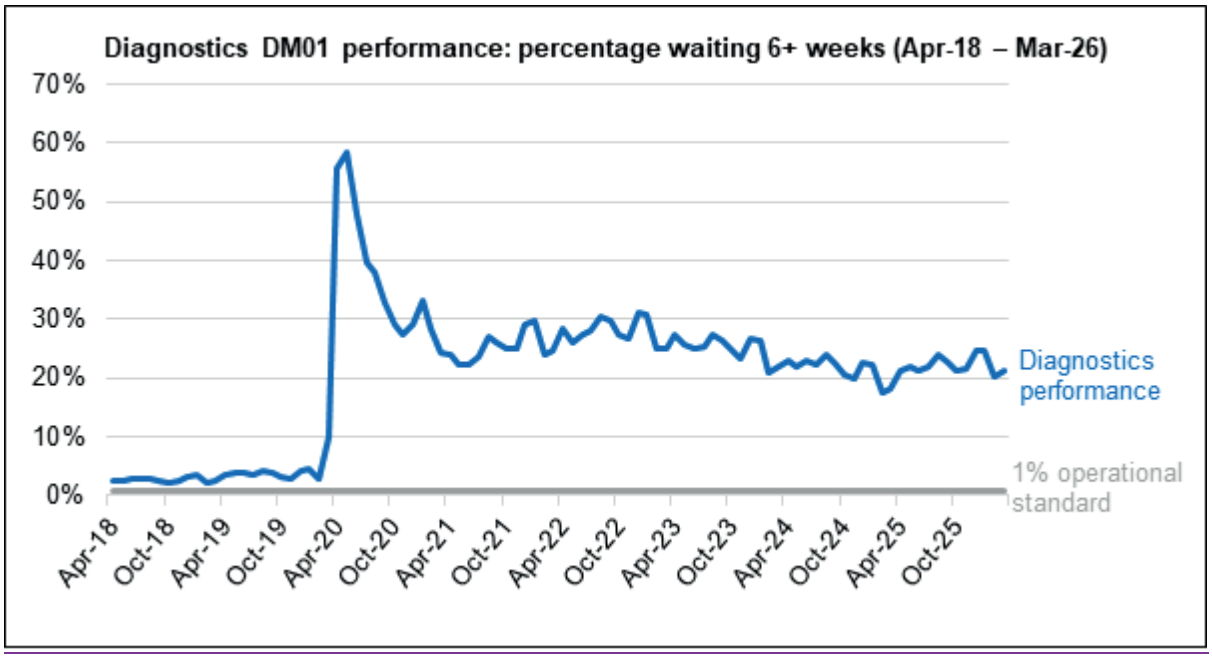
Diagnostic waiting times

The NHS operational standard for diagnostic waiting times is that less than 1% of patients should wait six weeks or more for a diagnostic test from referral. There was no separate planning guidance target for 2025-26.

In March 2026, the operational standard was not met nationally. At the end of the month, 406,925 patients were waiting six weeks or more for one of the 15 key diagnostic tests, representing 21.2% of patients waiting.

Over the previous 12 months, the proportion of patients waiting six weeks or more for a diagnostic test varied between 20.2% in February 2026 and 24.8% in December 2025.

Figure 5: Percentage of patients waiting six weeks or more for a diagnostic test



Source: Diagnostic Waiting Times and Activity Data

In February 2026, NHS England for the first time published data on the percentage of histopathology cases that are reported within 10 days of receipt, nationally as well as by NHS provider (acute and specialist NHS Trusts), ICB and region. This will bring greater accountability to performance both nationally and locally. Latest data can be found at NHS England histopathology performance data.

Cancer performance

Cancer continued to be one of the leading causes of mortality in England during 2025-26 and improving cancer outcomes remained a priority for the government and NHS England.

Improved performance on the Faster Diagnosis Standard means that around 95,000 more people have had cancer diagnosed or ruled out within 28 days between April 2025 and March 2026, compared to the previous 12 months (April 2024 – March 2025).

In February 2026, the government published the National Cancer Plan for England, setting out a long-term strategy to modernise cancer services and improve outcomes across the cancer pathway. The plan set out a long-term ambition that, by 2035, 75% of people diagnosed with cancer will be living well or cancer-free five years after diagnosis, representing an additional 320,000 lives saved over the lifetime of the plan.

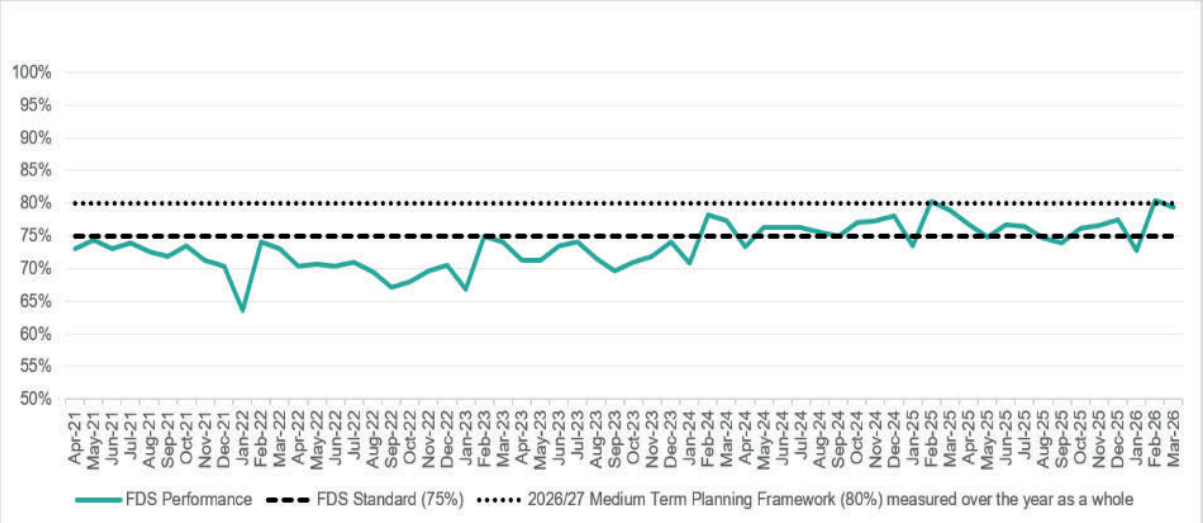
Cancer waiting times performance

The NHS continued to prioritise recovery and improvement across cancer waiting time standards during 2025-26. Cancer waiting time standards remain a key measure of NHS cancer performance and are intended to ensure patients receive timely diagnosis and treatment.

The 2025-26 NHS Planning Guidance set an ambition for the NHS to achieve 80% performance against the faster diagnosis standard by March 2026, against the operational standard of 75%.

Performance against the faster diagnosis standard remained above the operational standard throughout much of 2025-26. In March 2026, performance against the faster diagnosis standard was 79.4%.

Figure 6: Faster diagnosis standard current performance

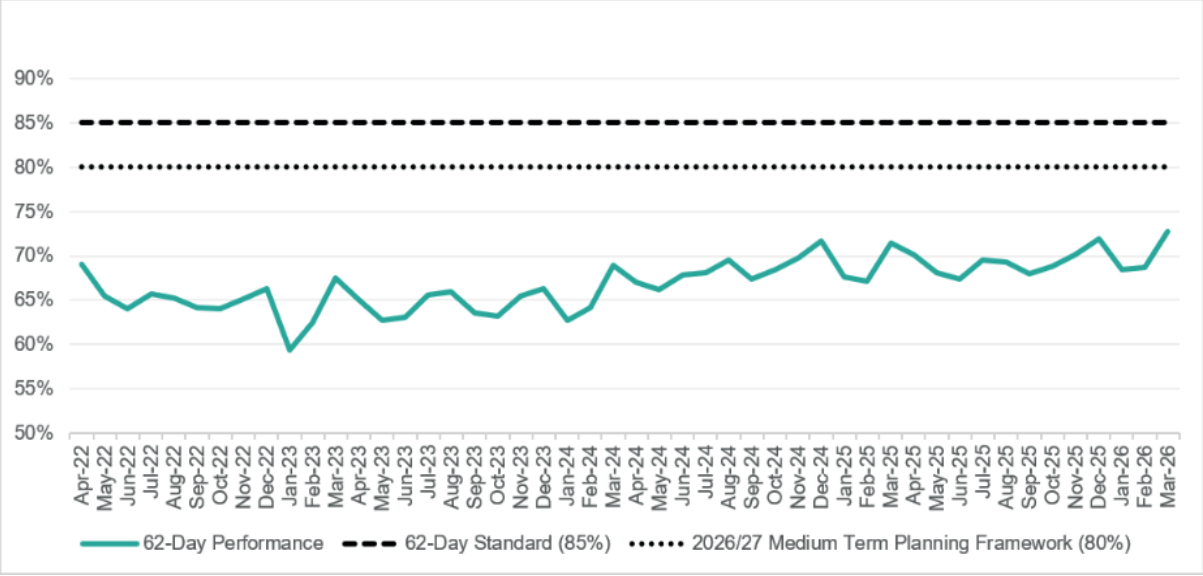


Source: Cancer Standards Waiting Times data (NHS England)

Performance against the 62-day standard, which measures the time from urgent referral to first treatment, improved compared to March 2025 when performance stood at 71.4% but remained below the operational standard during 2025-26. In March 2026, 72.8% of patients received treatment within 62 days.

The 62-day cancer backlog continued to reduce during the year. At the end of March 2026, the backlog stood at 13,995, a reduction of 59% compared to the pandemic peak recorded in May 2020.

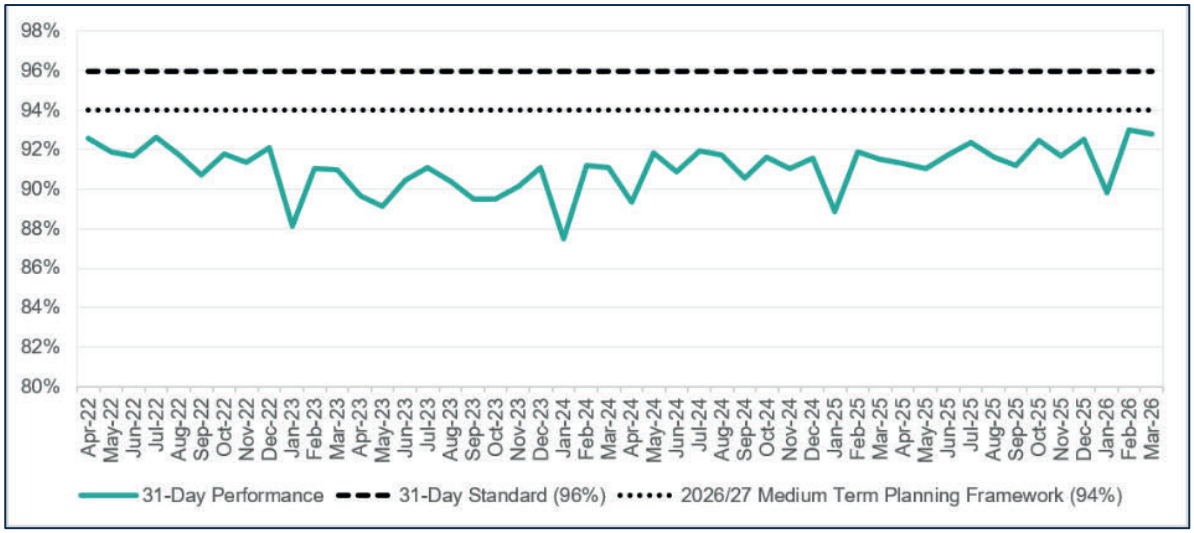
Figure 7: 62-day referral to treatment standard – current performance



Source: Cancer Standard Waiting Times Data (NHS England)

In March 2026, 92.8% of patients received treatment within 31 days of a decision to treat. This was achieved against the operational standard of 96.0%.

Figure 8: 31-day decision to treat standard – current performance



Source: Cancer Standard Waiting Times Data (NHS England)

The National Cancer Plan reaffirmed the government's commitment to meeting all cancer waiting time standards by the end of this Parliament and set out a range of reforms intended to improve pathway performance sustainably, including reducing diagnostic delays, expanding straight-to-test pathways and improving the use of real-time data and analytics.

Cancer demand and treatment activity

Demand for cancer services remained high throughout 2025-26. In March 2026, around 12,904 urgent referrals for suspected cancer were seen per working day, compared to 9,448 per working day in March 2019 before the pandemic. Over 17 million urgent referrals were made between March 2020 and March 2026.

In the 12 months to March 2026, more than 3.2 million people were seen following an urgent GP referral for suspected cancer, representing a 37% increase compared to the equivalent pre-pandemic period.

The number of people diagnosed with cancer continues to rise, placing increasing pressure on treatment capacity across the NHS. The NHS continued to deliver high levels of cancer treatment activity during the year despite wider operational pressures across the health service. In the 12 months to March 2026, around 374,000 people received their first cancer treatment.

The government continued to support investment in modern cancer treatment infrastructure during the year, including through the £70 million programme for new radiotherapy machines across England. The programme aims to improve access to more modern and precise radiotherapy treatment techniques and support increased treatment capacity.

Cancer pathway reform and innovation

During 2025-26, the government and NHS England continued work to modernise cancer pathways and support improved diagnosis and treatment.

The National Cancer Plan set out reforms intended to support more efficient and personalised cancer care pathways, including expanding straight-to-test pathways, improving turnaround times for diagnostics and pathology services, reducing unnecessary outpatient appointments and improving use of data and analytics through the Federated Data Platform.

The NHS also continued to expand non-specific symptom pathways during 2025-26. These pathways support patients presenting with symptoms that do not clearly indicate a single tumour type and are particularly important for improving diagnosis for cancers that are harder to detect at an early stage.

Early diagnosis and inequalities

Improving earlier diagnosis and reducing inequalities in cancer outcomes remained major priorities throughout 2025-26.

The National Cancer Plan identified persistent variation in cancer outcomes linked to geography, deprivation and ethnicity, and set out ambitions to improve equitable access to

diagnosis, treatment, innovation and personalised support. The plan highlighted the importance of reducing unwarranted variation in access to specialist services and ensuring patients receive high-quality care regardless of where they live.

The Targeted Lung Cancer Screening Programme continued to expand during 2025-26, supporting earlier diagnosis for people at higher risk of lung cancer. The programme forms part of wider efforts to improve outcomes for cancers with historically poorer survival rates.

The government also continued to support innovation in inherited cancer risk identification through the National Disease Registration Service's National Inherited Cancer Predisposition Register, supporting more targeted surveillance and earlier intervention for people at increased genetic risk of cancer.

The plan also reaffirmed the government's commitment to improving personalised care and support for people living with and beyond cancer. During 2025-26, NHS England continued work to improve access to personalised care plans, clinical nurse specialists and supportive oncology services.

The plan also aligned with the government's wider ambitions to shift more care from hospitals into community settings and improve integration between cancer services, primary care and neighbourhood health services.

Urgent and emergency care

As part of delivering the Urgent and Emergency Care (UEC) Plan for 2025-26, DHSC and NHS England have:

- recognised that corridor care is unacceptable and has no place in a modern NHS except in genuinely exceptional circumstances. To improve transparency and support action to eliminate its use, NHS England has published the first national definition of corridor care and set out additional measures aimed at driving the practice out of the NHS before the end of this Parliament

- provided over £450 million of capital investment to expand urgent and emergency care capacity, including:

    - new and expanded Same Day Emergency Care and Urgent Treatment Centres (UTCs)

    - additional mental health crisis capacity

    - connected care records for ambulance services and

    - nearly 1,000 replacement ambulances by March 2026

- published new national clinical standards, including Model Emergency Department and The Model Acute Pathway, supporting more consistent, high-quality care and improved flow through hospitals

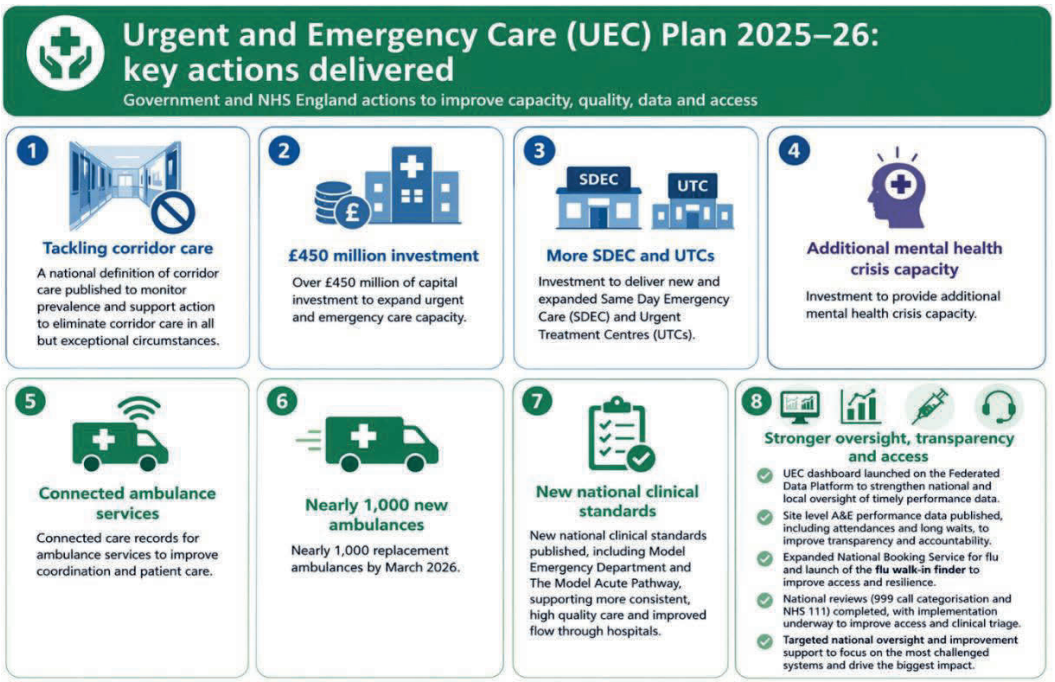
- published, for the first time, site-level Accident and Emergency (A&E) performance data, including attendances and long waits, improving transparency and accountability

- expanded the National Booking Service for flu and launched the flu walk-in finder, improving access to vaccination and supporting system resilience

- completed national reviews, including 999 call categorisation and the NHS 111 review, with implementation underway to improve access and clinical triage

- targeted national oversight and improvement support, using consistent performance measures to identify the most challenged systems and focus support where it can make the biggest difference

Figure 9: Urgent and emergency care (UEC) plan 2025-26



These actions have delivered measurable improvements despite continued growth in demand as follows:

- despite 1.6% (143,458) more attendances in winter 2025-26 than 2024-25 (November to February), we treated 3.3% (215,782) more patients in under four hours, and 1.7% (10,711) fewer patients have spent over 12 hours in an emergency department

- four-hour performance has been 1.2 percentage points better and 12-hour performance 0.4 percentage points better than winter 2024-25

- despite 6% (183,638) more incidents in winter 2025-26 compared to winter 2024-25, Category 2 (main headline indicator for 'emergency call' ambulance responses) response times have been 7 minutes and 04 seconds faster

The UEC Plan 2025-26 included commitments to:

- improve A&E wait times to a minimum of 78% of patients being admitted, transferred, or discharged within four hours by March 2026

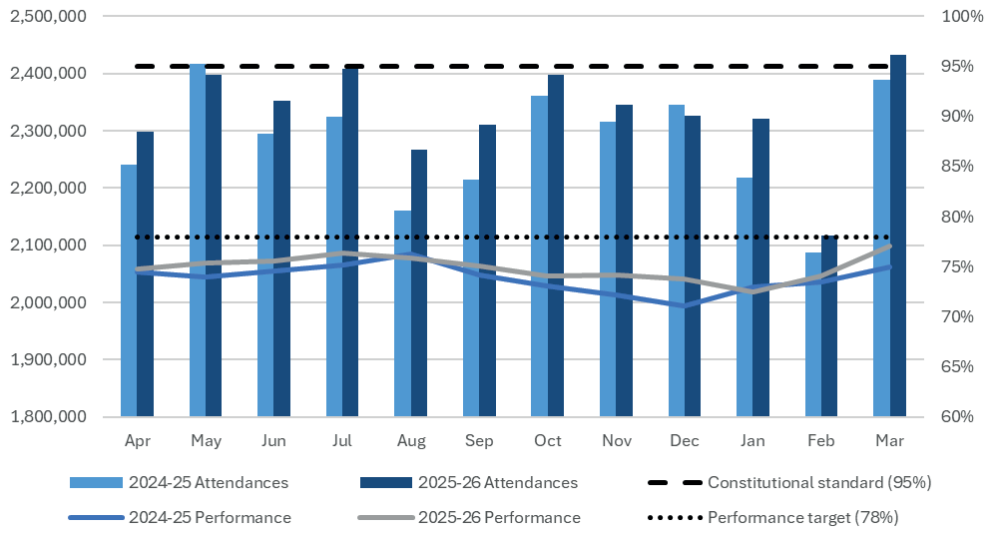
- reduce average Category 2 ambulance response times to 30 minutes over 2025-26

Neither of these overall performance targets were met in 2025-26, although both showed a year-on-year improvement. The average Category 2 target was missed by only four seconds, with several ambulance trusts achieving against the 30-minute target. Against a long-term trend of declining performance, this was the third year of year-on-year improvements.

A&E attendances increased by 2.2% from 27,367,598 in 2024-25 to 27,973,101 in 2025-26. Emergency admissions in 2025-26 were 6,451,848, a decrease of 1.1% from 6,522,815 emergency admissions in 2024-25.

As shown in **Figure 10**, four-hour performance was 77.1% in March 2026, below the performance target of 78% and the constitutional standard of 95%. In 2025-26, four-hour performance was 74.9%, an improvement from 73.9% in 2024-25.

Figure 10: A&E attendance and performance in 2024-25 and 2025-26

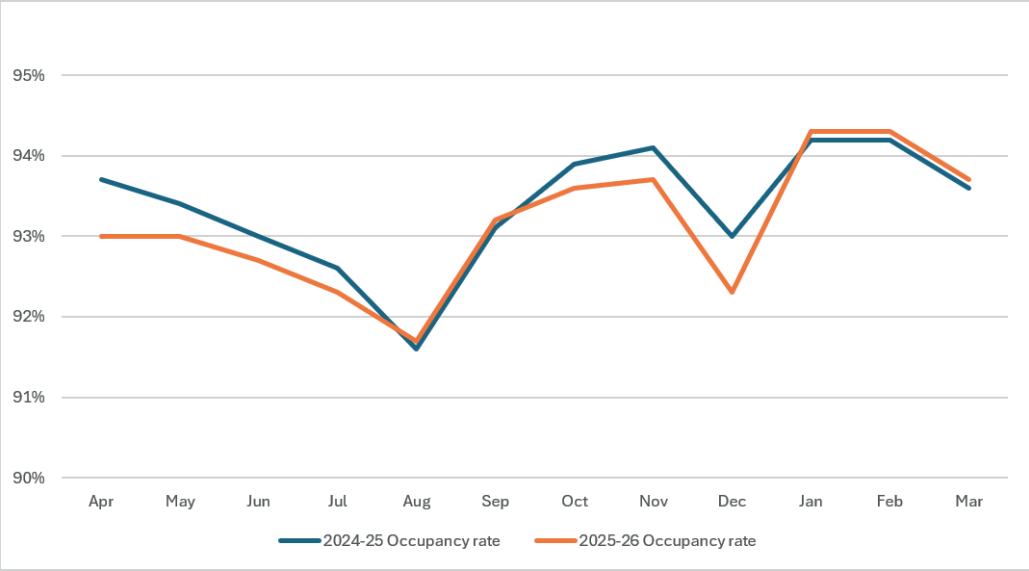


Source: A&E Attendances and Emergency Admissions (NHS England)

In addition, a further indicator of A&E service pressures is the proportion of patients who spend more than 12 hours in A&E. 12-hour performance improved from 9.9% of A&E patient attendances in March 2025 to 9.0% in March 2026, and overall year-on-year performance has seen an improvement from 10.4% in 2024-25 to 10.0% in 2025-26.

As shown in **Figure 11**, general and acute (G and A) bed occupancy levels remained consistently high throughout 2025-26, reaching a maximum occupancy of 95.6% in January 2026. This is the same as 2024-25's peak figure of 95.6% in January 2025.

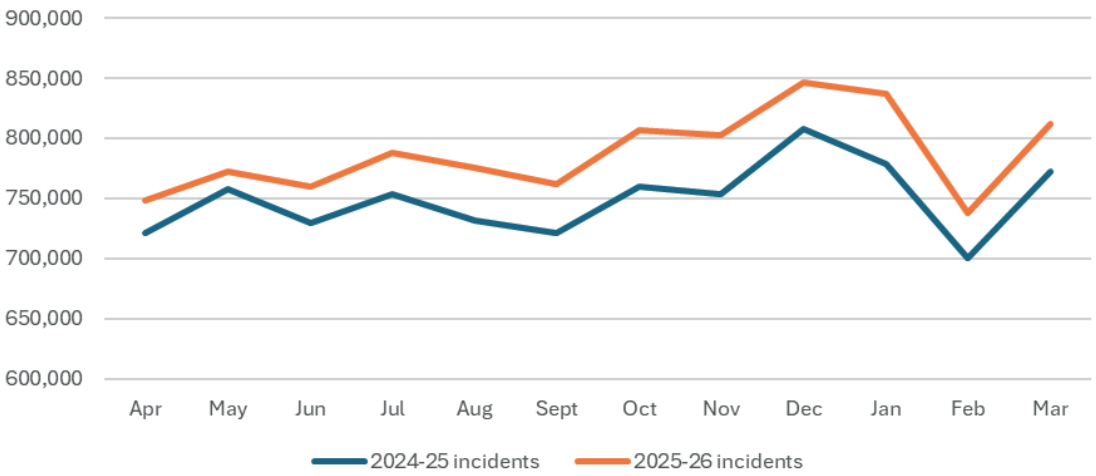
Figure 11: General and acute (G and A) occupancy, type 1 trusts only



Source: Bed Availability and Occupancy (NHS England)

Figure 12 sets out overall average ambulance incidents per day. In 2025-26, this equated to, on average, 25,886 incidents per day, 5.1% higher than in the previous year and 7.9% higher than the pre-pandemic baseline of 23,998 per day (2019-20).

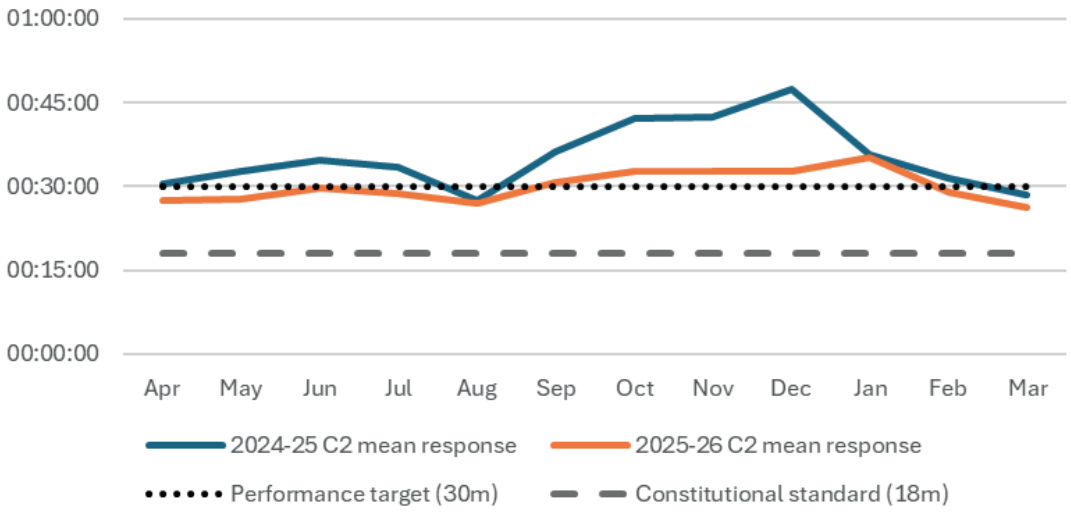
Figure 12: Overall ambulance incidents demand per day 2024-25 and 2025-26



Source: Ambulance Quality Indicators (NHS England)

The average Category 2 response time was 30 minutes and 04 seconds, improving by 4 minutes and 18 seconds but exceeding the recovery plan performance target of 30 minutes and the constitutional standard of 18 minutes. **Figure 13** compares Category 2 response times in 2024-25 and 2025-26.

Figure 13: Category 2 mean ambulance response time 2024-25 and 2025-26



Source: Ambulance Quality Indicators (NHS England)

Mental health access and waiting times

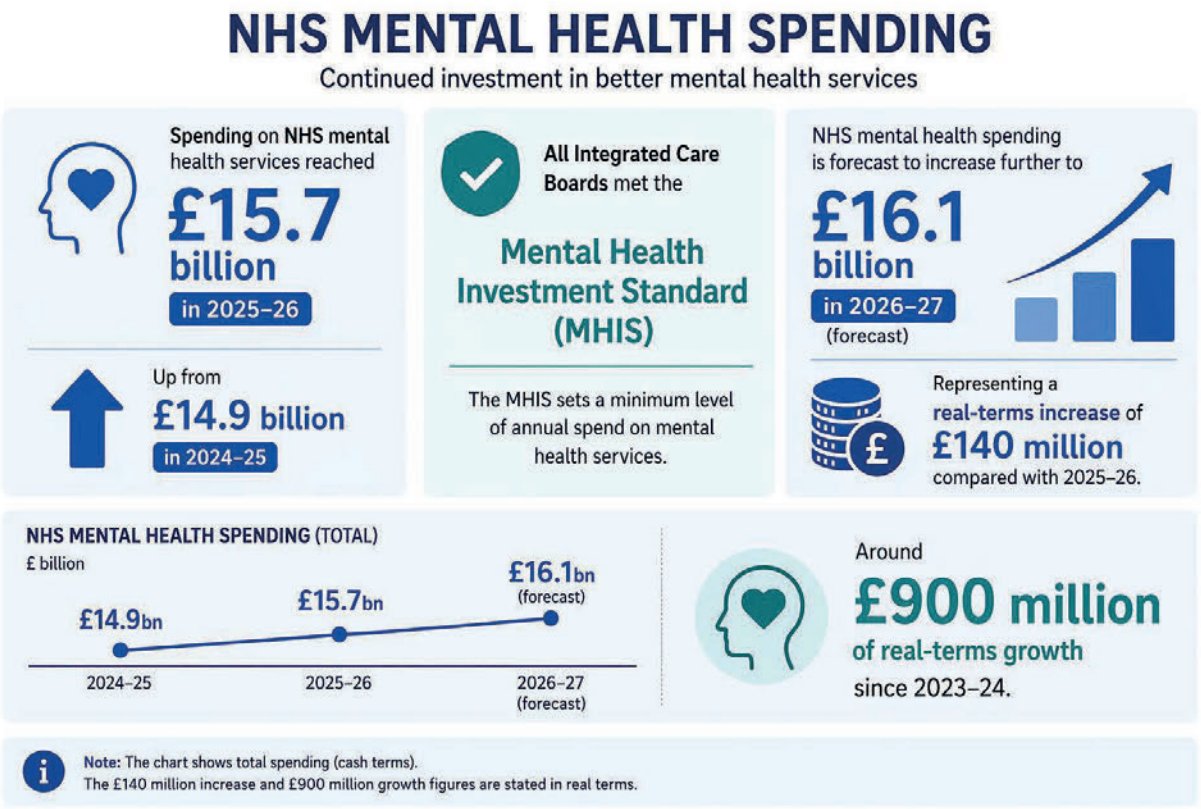
During 2025-26, significant steps were taken to stabilise and improve NHS mental health services, while recognising that there is much more to do to address growing demand and improve patient experience and outcomes. The latest Adult Psychiatric Morbidity Survey, published in November 2025, estimated that around one in five adults in England (9.4 million people) are affected by a common mental health condition, with demand for mental health services remaining high throughout the year.

As part of the government's mission to build an NHS fit for the future, DHSC has worked closely with NHS England, alongside cross-government and sector partners, to drive progress against the commitments set out in the 10 Year Health Plan. These include recruiting an additional 8,500 mental health workers before the end of this Parliament, rolling out Mental Health Support Teams in schools and colleges to reach full national coverage by 2029, and expanding access to Mental Health Emergency Departments to ensure patients receive fast, same-day access to specialist support in an appropriate setting.

Improving access to services

Spending on NHS mental health services reached around £15.7 billion in 2025-26, up from £14.9 billion in 2024-25.

Figure 14: NHS mental health spending



The government has continued to expand NHS Talking Therapies services. In February 2026, people receiving NHS Talking Therapies accessed an average of 8.7 treatment sessions per referral. This builds on the £592 million investment package announced in the Autumn Statement 2023 to expand and improve NHS Talking Therapies between 2024-25 and 2028-29, increasing access to treatment and improving recovery outcomes.

In addition to NHS Talking Therapies, Individual Placement Support, the employment support service within community mental health teams, aiming to help people gain and retain paid employment, also received funding for an additional 100,000 places between 2024-25 and 2028-29. In the 12 months to March 2026, 48,112 referrals accessed IPS during 2025-26.

Support for children and young people (CYP)

Over 880,000 children and young people under 18 were supported through NHS-funded mental health support in the 12 months to March 2026, compared with 840,000 in the 12 months to March 2025. This represents an increase of nearly 5%. The expansion of Mental Health Support Teams (MHSTs) in schools and colleges continued to support the government's commitment to achieve 100% national coverage by an accelerated target of 2029. Around 168,000 children and young people received at least one contact from an MHST in the 12 months to March 2026, with more than an additional 786,000 pupils and learners across 1,746 schools and colleges now having access to an MHST following expansion in 2025-26.

DHSC also continued to invest in early intervention and community-based support for children and young people. DHSC has provided a further £7 million of funding to support 24 Early Support Hubs across England, bringing total funding to more than £20 million since April 2024. By April 2027, this funding will have supported the delivery of over 30,000 additional community-based interventions for children and young people, helping prevent escalation and reducing pressure on specialist services.

New models of care

To support more integrated and accessible care, six community-based Mental Health Centres were opened in Birmingham, York, Copeland, Tower Hamlets, Lewisham and Sheffield. These centres bring together community, crisis and evidence-based inpatient care, alongside wider support for welfare, employment and social care needs. The government has provisionally allocated £473 million in capital investment over the next four years to support further expansion of these community-based Mental Health Centres, alongside other projects including Mental Health Emergency Departments, eliminating out-of-area placements and locked inpatient rehabilitation, and expanding learning disability and autism crisis accommodation capacity where capital is the primary constraint.

Suicide prevention

The government also strengthened support for suicide prevention and crisis care. A new Suicide Prevention Pathfinder programme for middle-aged men was announced in November 2025 as part of the Men's Health Strategy for England, with the aim of investing up to £3.6 million over three years in neighbourhood-based support in areas where middle-aged men are at greatest risk of suicide. In parallel, the 'Staying Safe from Suicide' guidance and associated e-learning package for all mental health professionals were introduced through the NHS Medium Term Planning Framework to support safer and more consistent care.

Legislative reform - Mental Health Act 2025

In December 2025, the Mental Health Act received Royal Assent, delivering the government's manifesto commitment to modernise mental health legislation. The Act will provide people with severe mental health conditions with greater choice, autonomy, enhanced rights and support, while ensuring patients are treated with dignity and respect throughout treatment, and continuing to provide the necessary powers to keep patients and the public safe. The legislation also introduces measures to improve care and support for people with a learning disability and autistic people, reducing reliance on hospital-based care where individuals could be better supported in the community. Implementation will be phased over approximately ten years to ensure the necessary workforce and system capacity are in place. Public consultation on the draft Code of Practice will be launched in 2027, as part of work to commence the first phase of reforms.

General practice

GP contract

On 28 February 2025, NHS England published a letter setting out the changes to the GP contract for 2025-26, which set out the requirements of general practices and Primary Care Networks from 1 April 2025 to 31 March 2026. There was £1.1 billion of investment in the GP contract in 2025-26, bringing total spend to £13.2 billion. This was an 8.9% boost to the GP contract, which was faster than the 5.8% growth to the NHS budget as a whole. The 2025-26 GP contract was agreed with the General Practitioners Committee England, a committee of the British Medical Association.

The changes to the 2025-26 contract were focused on meeting key manifesto commitments. This included the commitment to bring back the family doctor by incentivising practices to identify patients who would most benefit from continuity of care and building capacity in general practice by increasing flexibilities in how they recruit staff. The aim was to improve productivity, optimise workforce balance, and support the hiring of more GPs.

To improve access, from 1 October 2025, the 2025-26 GP contract required practices to have their online consultation portals switched on throughout core hours, providing parity between digital, walk-in and phoning in. This will ensure patients can reach their practice via the means that suits them best, helping to end the 8am scramble and supporting the switch from analogue to digital.

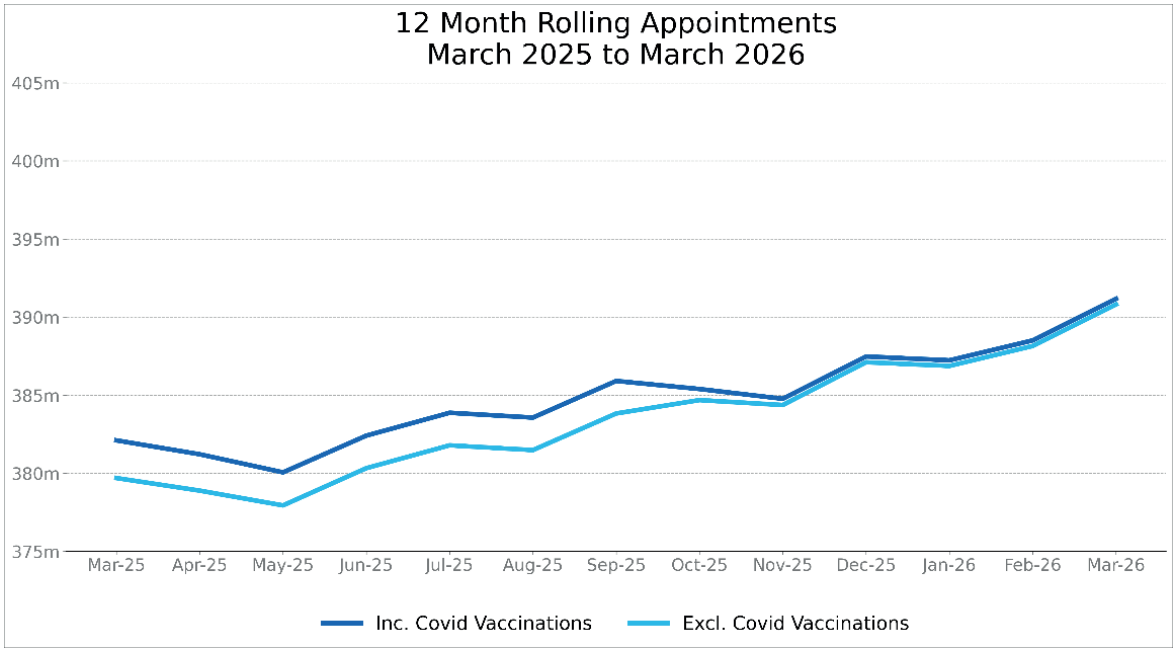
To support progress towards a neighbourhood health service through greater focus on prevention and system integration, and reduce bureaucracy, the 2025-26 GP contract removed 32 targets no longer required in the Quality Outcomes Framework (QOF). A large proportion of the funding released (circa £198 million) was used to strengthen existing targets for cardiovascular disease.

A new Advice and Guidance Enhanced Service was introduced, with up to £80 million of funding to incentivise GP practices to seek specialist advice prior to referral. This supported closer working between general practice and secondary care, improved care pathways, and the government's commitment to cutting bureaucracy.

GP appointment data

Appointment numbers in 2025-26 were consistently higher than in 2024-25. As shown in **Figure 15**, in the 12 months to March 2026, an estimated 391.2 million appointments were booked across all general practices and Primary Care Networks (PCNs) in England. This is an increase of 2% compared to the 12 months up to March 2025 (382.1 million) and an increase of 26% compared to the 12 months up to March 2020 (310.3 million).

Figure 15: 12-month rolling sum of appointments, including PCN appointments



The ONS Health Insight survey shows an increase in patients finding it easy to contact their GP, from 72.9% in March 2025 to 74.5% in March 2026. In March 2026, using the NHS App was perceived to be the easiest way to contact a GP practice, with 84.2% of people describing it as “easy”. There has also been a year-on-year increase of 3 percentage points (62.5% - 65.5%) of people able to see their preferred healthcare professional.

2025-26 has seen continued delivery of NHS England’s Primary Care Access Recovery Plan and the shift to modern general practice in practices across England. Delivery of online consultation by all practices by 1 October 2025 has been a significant milestone, complemented by Cloud Based Telephony. In the Medium-Term Planning Framework we have set a new target for 90% of clinically urgent patients to be dealt with on the same day by March 2027.

Dentistry

During 2025-26, DHSC supported delivery of the government’s manifesto commitments on dentistry, with a focus on improving access - particularly to urgent dental care - alongside dental contract reform and introducing a supervised toothbrushing scheme. The NHS dentistry underspend reduced from £392 million in 2023-24 to £36.4 million in 2024-25 and £36 million in 2025-26.

DHSC worked closely with NHS England to increase capacity for urgent dental appointments. Integrated care boards (ICBs) were asked to commission additional urgent care capacity from April 2025, with specific expectations set for each region. In September 2025, this was supported by an incentive scheme which rewarded providers who delivered a set target of additional urgent appointments. This successfully put in place an urgent

care safety net for patients who needed to be seen quickly. In February 2026, on the advice of the Chief Dental Officer, we broadened the scope of the commitment to include all appointments to ensure that the capacity that ICBs had commissioned could be used to see all patients in need – not just those who met the clinical definition of urgent.

During 2025-26, there was continued improvement in NHS dental activity across a wide range of measures, including the delivery of 37.6 million courses of treatment (COTs), 6.2% more than in 2024-25. In 2025-26, COTs for adult patients increased by 6% to 25 million, and by 7% for child patients to 13 million. There were 76.8 million units of dental activity (UDA) delivered, which is 5.1% higher than 2024-25. 18.8 million adults were seen by an NHS dentist, which is an increase of 2% compared to 2024-25, and access to NHS dental care for children has now recovered to above pre-pandemic levels. In the 12 months to 30 June 2026, 7.2 million children were seen by an NHS dentist, 151,000 (2.1%) higher than the pre-pandemic figure (7.0 million) for the 12 months up to 30 September 2019. In addition, 4 million urgent NHS dental appointments were delivered in 2025-26, which is 8.4% more than in 2024-25.

In July 2025, DHSC launched a public consultation on a package of reforms to the dental contract to address some of the pressing issues that dentists and dental teams have been experiencing. The reforms sought to prioritise those with the greatest need, shifting care away from clinically unnecessary check-ups. In December 2025, DHSC published the government response to the consultation which set out the overall positive response to the reforms and announced that the government intended to implement the proposals set out in the consultation, with some amendments made in light of the feedback received. The first phase of these reforms, focusing on improving access to and remuneration for urgent dental care and incentivising preventative oral care for children came into force on 1 April 2026. The second phase of the reforms introducing the new complex care pathways came into force from June 2026.

In April 2025, DHSC started its rollout of the national targeted supervised toothbrushing programme for children aged three to five, backed by £11 million in 2025-26 (and a further £10.5 million in 2026-27). As part of this, DHSC established an innovative partnership with Colgate-Palmolive which is donating over 23 million toothbrushes and toothpastes over the next 5 years. In 2025-26, 4 million free toothbrushes and tubes of toothpaste were delivered to children in the most deprived areas of England.

Strengthening the workforce is key to the government’s ambitions to rebuild NHS dentistry. In March 2026, the government announced an increase in dental school places in England from 809 to 859, supported with around £11 million per year once the expansion is fully implemented, allowing two new dental schools to open in NHS regions with no undergraduate dentistry training. We are also supporting increased access to registration exams for overseas-trained dentists, with a £420,000 investment to significantly expand the Royal College of Surgeons’ Licence in Dental Surgery Exam, while supporting an increase to the General Dental Council's Overseas Registration Exam. Both improvements

are expected to allow over 2,000 more dentists to practise in the UK, each year, from 2028-29 onwards.

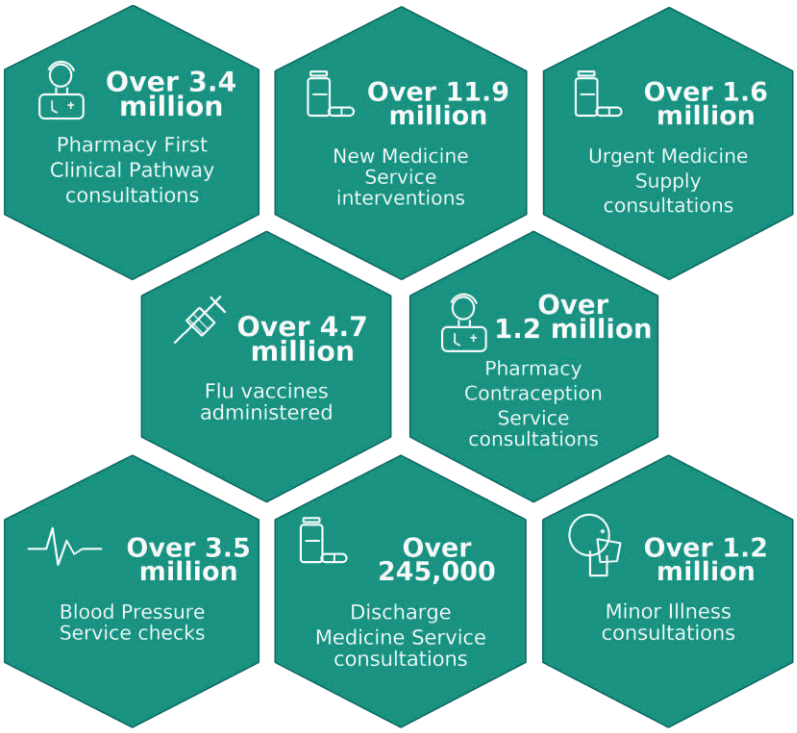
In 2025-26, DHSC continued to implement the government's ambition to expand water fluoridation, which will see investment of £136 million over five years to maintain existing schemes and expand further across the North-East of England to reduce tooth decay and its impacts.

Community pharmacy

In 2025-26, funding for the core Community Pharmacy Contractual Framework increased to £3.073 billion in 2025-26. This represented the largest funding uplift of any part of the NHS, at over 15% compared with 2024-25. The clinical services offer introduced in 2024-25 continued and was expanded from October 2025 to include free emergency contraception on the NHS through community pharmacy. Depression was also added to the New Medicine Service as an eligible therapeutic area, enhancing mental health support from community pharmacies.

Community pharmacy continued to provide information, health advice and a range of clinical services. Contractors also ensured access to pharmacy medicines and signposted people to other services to best support them in managing their health. Uptake of commissioned clinical services also continued to grow over the year.

Figure 16: Community pharmacy services in 2025-26



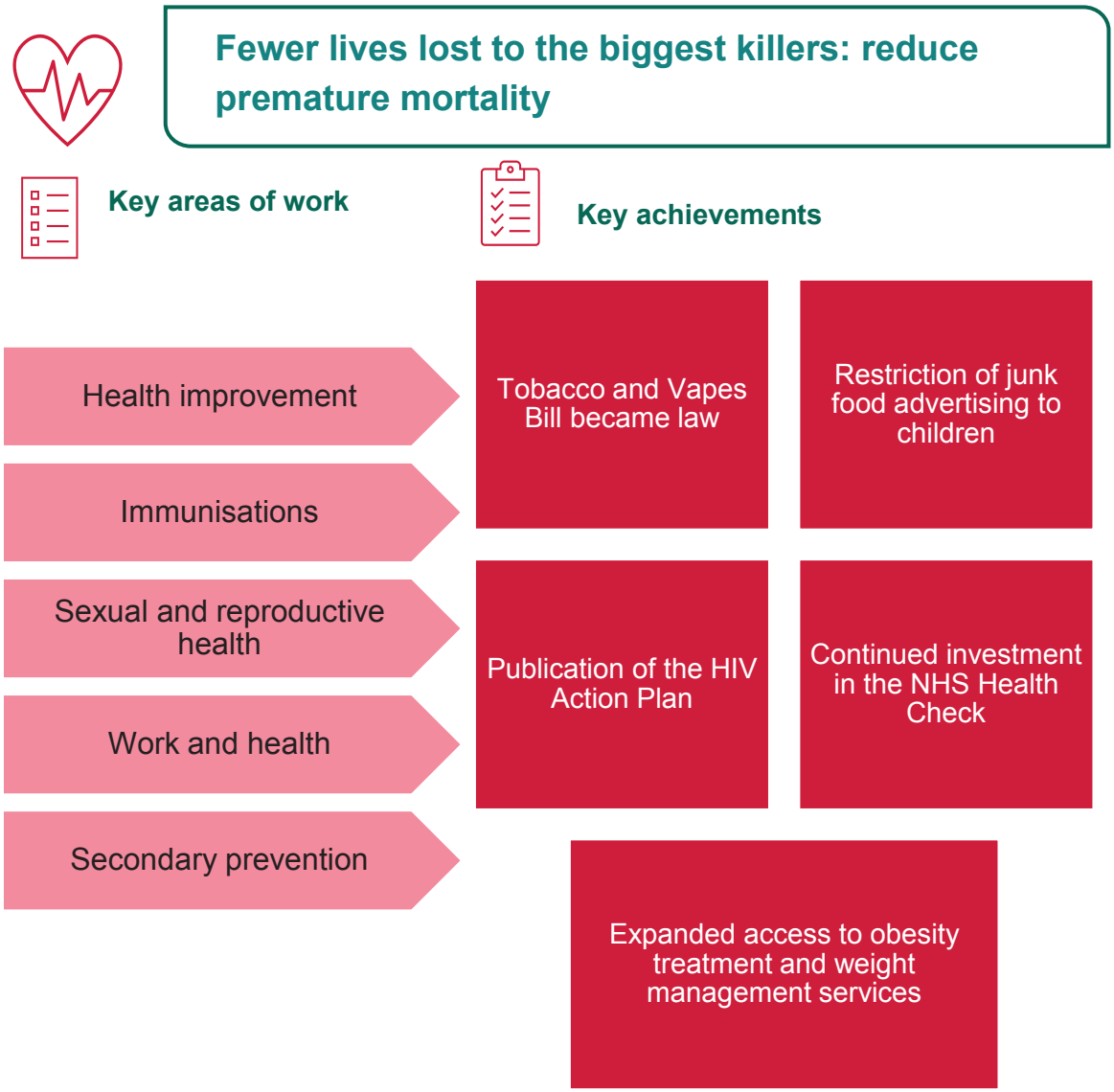
Eye care

Over 13 million NHS sight tests were delivered in 2025-26. Those eligible for free NHS sight tests include children, people aged 60 and over, people on income-related benefits, and certain groups at particular risk of eye disease. Following regulations being laid in November 2024, ICBs have also been commissioning NHS sight testing services in their areas, for children and young people with learning disabilities and/or autism attending special educational settings, where the settings have requested to host a service. NHS England has also continued to work with ICBs to improve IT connectivity between primary care optometry and secondary care. This aims to facilitate faster referrals for patients.

During 2025-26, ophthalmology waiting times have improved, with progress in reducing both 18-week performance and the number of patients waiting over a year as follows:

- as of the end of March 2026, 72.9% of ophthalmology referral to treatment (RTT) pathways in England were waiting within 18-weeks, a performance improvement of 4.7 percentage points since the end of March 2025
- as of the end of March 2026, 4,418 ophthalmology RTT pathways in England were waiting over 1 year, 4,067 fewer than at the end of March 2025

Strategic outcome two



Public health and health improvement

As set out in our 10 Year Health Plan, primary prevention is critical to improving health, boosting participation in the labour market, narrowing inequalities and reducing costs to the NHS. Around one in eight deaths in England is considered preventable. To this end, we are delivering bold action against the biggest drivers of ill health - tobacco, obesity, physical inactivity and alcohol - and helping people to make healthier choices every day. In addition, we are working with partners across health, policing and the wider public sector to drive down drug use, make our streets safer and build a fairer Britain for all.

Public health funding

Public health services commissioned by upper-tier local authorities in England are mainly funded through a ringfenced public health grant. In 2025-26, funding for all local authorities through the public health grant, and the 100% retained business rates arrangement for

local authorities in Greater Manchester, increased by 6.1% in cash terms relative to 2024-25, taking total funding to £3.884 billion.

In addition to the public health grant, DHSC also provided £436.8 million of targeted funding to local authorities in England to support improvements in the quality and capacity of drug and alcohol treatment and Start for Life services, and new investment in local authority-led stop smoking services.

All upper tier and unitary local authorities must report on how they spend their grant funding and the Section 151 Officer and the Director of Public Health must provide an annual written statement confirming that the grant has been spent in accordance with the public health grant conditions. On behalf of the Secretary of State, DHSC Regional Directors of Public Health undertake assurance activity with local authorities to ensure principally that the public health grant has been spent in line with the associated conditions and spend is appropriately reported.

Tobacco and vaping

As part of the shift from sickness to prevention, we are delivering our ambition for a smoke-free UK and tackling youth vaping. In 2025-26, the landmark Tobacco and Vapes Act progressed through Parliament and achieved Royal Assent on 29 April 2026. The Act will help to create a smoke-free generation by making it illegal for anyone born on or after 1 January 2009 to be sold tobacco products, breaking the cycle of addiction and disadvantage. The Act bans the advertising and sponsorship of vapes from 1 June 2027. Subject to consultation, the Act enables government to regulate the display and marketing of vapes and nicotine products as well as to expand smoke-free places and introduce vape-free and heated tobacco-free places. In 2026-27, we will continue to oversee the implementation of the Act.

We have continued to invest in support to help adult smokers to quit. In 2025-26, we provided an additional £70 million to local authority-led Stop Smoking Services in England. Further investment was made in national smoking cessation programmes, including the National Smoke-free Pregnancy Incentives Scheme and the Swap to Stop scheme. From 2026-27, funding for stop smoking services is now ringfenced in the Public Health Grant, protecting at least £150 million per year for these services. In parallel, to further reduce smoking prevalence we continue to work with the NHS to embed opt-out smoking cessation support in routine hospital care.

Obesity

We set an ambition to end the obesity epidemic, tackle the childhood obesity crisis, and raise the healthiest generation of children ever. To address obesity and improve children's diets, we have implemented restrictions on volume price promotions for less healthy food and drink, fulfilled the government's manifesto commitment to restrict junk food advertising on TV and online, announced an extension to the Soft Drinks Industry Levy, and confirmed

we will ban the sale of high-caffeine energy drinks to children under 16 years in England. We are also supporting families who need it most through our Healthy Start scheme for which we uplifted the value of weekly payments by 10% in April 2026.

To go further, we have launched a consultation on our proposals to apply the new Nutrient Profiling Model (NPM 2018) to the advertising and promotions restrictions for less healthy food and drink products. We consulted, and updated School Food Standards in collaboration with the Department for Education. As set out in the 10 Year Health Plan, we will launch a consultation on requiring all large food businesses to report against standardised metrics on healthiness of food sales.

To support those already living with obesity, NHS England plans to make tirzepatide available to 220,000 people over the first three years of a new rollout, prioritised based on clinical need, and expand access to the NHS Digital Weight Management Programme to 125,000 more people per year. As of June 2026, the Obesity Pathway Innovation Programme, funded in partnership with industry, has selected 12 NHS led projects to pilot innovative obesity care pathways and treatment delivery models.

Physical inactivity

The 10 Year Health Plan committed to working cross-sector to reduce the high levels of physical inactivity present across adults and children. We continue to work on the development of a national movement campaign to motivate millions to walk, and where possible run, on a regular basis. We have continued our school sports funding contribution throughout the 2025-26 academic year. We have also committed funding (over financial years 2026-27, 2027-28 and 2028-29) towards – and have continued to work with the Department for Education and Department for Digital, Culture, Media and Sport on the development of - the new PE and School Sport Partnerships Network, which will provide more opportunities for the least active children to build healthy habits early and reap the benefits of movement. In 2026, we celebrated 10 years of NHS Couch to 5K, which through our partnership with the BBC continues to help millions of people walk, jog and run. We also updated the UK Chief Medical Officer's Physical Activity guidelines and teamed back up with Joe Wicks to help families and children enjoy an active summer through the Activate workouts.

Alcohol harms and alcohol and drug treatment

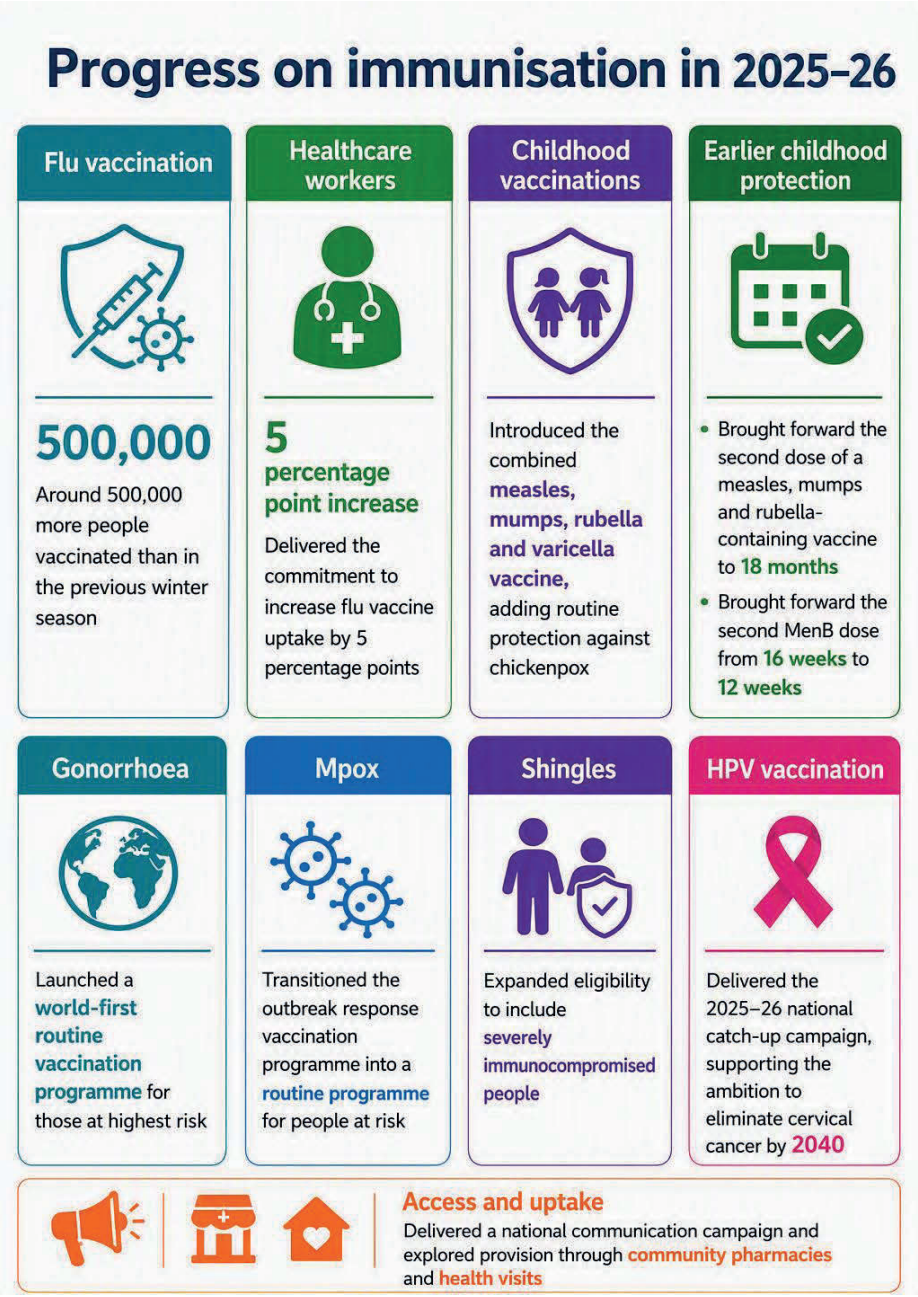
As outlined in the 10 Year Health Plan, we are working to deliver a mandatory requirement for alcoholic drinks to display consistent nutritional information and health warning messages. We are working towards opening a consultation, setting out the options under consideration, for the public and businesses to respond to. No- and low-alcohol products have the potential to reduce alcohol consumption through substitution, and the government supports market growth where this delivers public health benefits. We are engaging with relevant stakeholders on whether changes to how product strength is communicated could better support substitution, alongside access restrictions to prevent

under-18 consumption. We continue to work across government to explore further, evidence-based measures to reduce population-level alcohol harm.

Through the Public Health Grant, we are providing local authorities with £3.4 billion in ringfenced funding over the next three years to deliver vital drug and alcohol treatment and recovery services. Between April 2024 and March 2025, 329,646 adults were in contact with drug and alcohol treatment services in England - the highest level on record. To improve joined-up care, we, jointly with NHS England, have published the Co-occurring Mental Health and Substance Use Delivery Framework, setting out how drug and alcohol services and mental health services should work together more effectively. We have also developed and published the first ever UK clinical guidelines for alcohol treatment, which will promote and support good practice and improve the quality of alcohol treatment. 2026-27 will see a greater focus on improving the quality of treatment and coverage of the high-performing Individual Placement and Support employment support model move closer to total coverage of England.

Immunisations

During 2025-26, DHSC strengthened the national immunisation programme through changes to the childhood schedule, wider vaccine eligibility and new approaches to improving access and uptake.

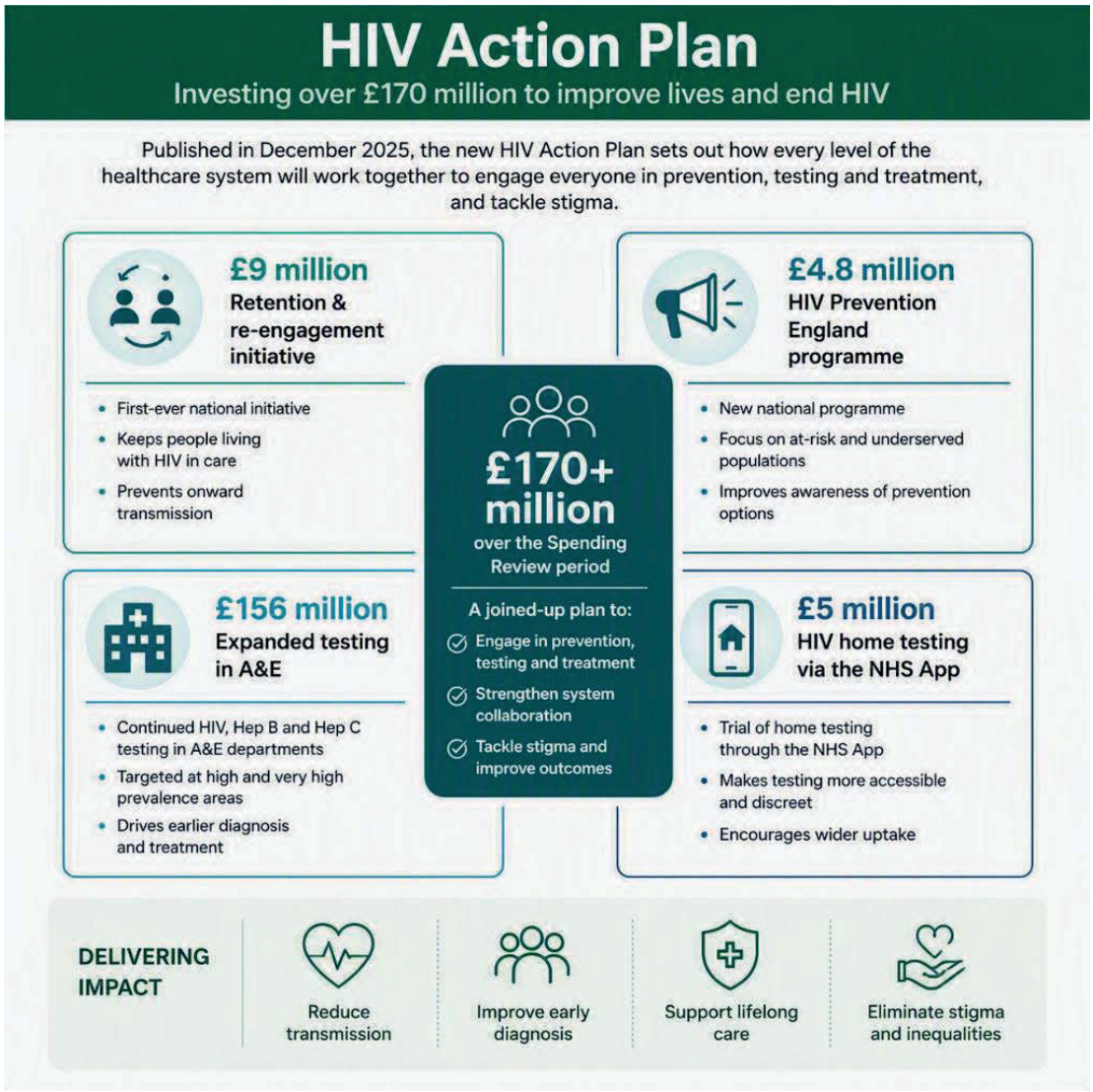


Sexual and reproductive health

The government is committed to ensuring good sexual and reproductive health for everyone.

As set out in the government's manifesto, it is united with its partners in the ambition to end new HIV transmissions in England by 2030. To support this, DHSC published the new HIV Action Plan in December 2025, backed by over £170 million over the three-year Spending Review period, setting out how the government will enable every level of the healthcare system to work together to engage everyone in prevention, testing and treatment, and tackle stigma.

Figure 17: HIV Action Plan



The government committed to supporting everyone in England through the HIV Action Plan. It also recognised that inequalities persist and therefore focused attention on five key population groups that are disproportionately affected by HIV, including all gay and bisexual men and heterosexual men and women from ethnic minorities.

The government has committed to monitoring how actions at national and local levels support the improvements needed for these groups and the key priorities in the plan. It will adopt a flexible approach, using surveillance data to assess progress and adjust where necessary, with a dedicated mid-plan review point in 2028.

Other initiatives in 2025-26 to promote good sexual and reproductive health included:

- expanding access to HIV prevention by rolling out injectable PrEP (cabotegravir) from October 2025 for people unable to take oral PrEP

- rolling out the world's first gonorrhoea vaccination programme from summer 2025, delivered through DHSC, the NHS and local partners

- publishing clinical guidelines supporting the use of doxycycline as post-exposure prophylaxis to help prevent syphilis

- continuing to fulfil statutory responsibilities under the Abortion Act 1967, including approving places for the purpose of treatment for termination of pregnancy

Work and health

The Joint Work and Health Directorate (a joint Directorate of the Department for Work and Pensions and DHSC) led cross-government efforts in 2025-26 to improve health and employment outcomes by aligning strategy, funding, and delivery. It worked with local and national partners to integrate health and employment support, helping disabled people and those with long-term health conditions to start, stay, and thrive in work.

The insertion of employment advisers in NHS Talking Therapies integrates tailored employment support into psychological therapy to help patients being treated for mental health conditions. National coverage was achieved by March 2026, with employment support available across all NHS integrated care boards. Delivery continued through 2025-26 with further research assessing health and work outcomes and value for money. NHS official statistics indicate 85,000 people received employment support during 2025-26.

By offering early, integrated health and employment support, and delegating funding to local health systems to lead, design and deliver that support, we are breaking down the health-related barriers that prevent people from entering or staying in work. The WorkWell programme provides a single gateway approach enabling partnerships across the NHS, local authorities, Jobcentre Plus and the voluntary and community sector. 34,000 people across the 15 pilot ICB sites have passed through the service since launch in October 2024. Rollout across England began during 2026-27.

NHS Health and Growth Accelerators (West Yorkshire ICB, South Yorkshire ICB and North East Cumbria ICB) are testing how NHS systems increase and are then held accountable for the impact they have on a person’s work status through early intervention and prevention. Offering a broad range of over 230 preventative services to achieve their outcome targets, the Accelerators are actively looking for the evidence of what interventions succeed in helping people remain in or return to work.

Aiming to reduce waiting times for community musculoskeletal(MSK) appointments, the **GIRFT (Getting It Right First Time) Musculoskeletal Community Delivery Programme** enhances access to treatment and improves pathways to wider support services. Evaluation of the seven ICBs participating in cohort 1 (December 2024 and March 2025), suggested a statistically significant reduction of around 20% (or over 8,000 people) in the

18+ week waiting lists. The qualitative findings demonstrated the programme was widely seen as a timely and effective solution. Local clinical advisers are being deployed across all health systems as a priority in 2026-27 to drive best practice, standardise care, and routinely connect patients to employment support alongside treatment.

Secondary prevention

Cardiovascular disease (CVD)

Too many lives are lost prematurely to heart disease and stroke.

In 2024, 29.2% of all CVD related deaths in England occurred in people under the age of 75. In 2025-26, DHSC delivered the following key actions with the following outcomes:

Figure 18: Cardiovascular disease prevention

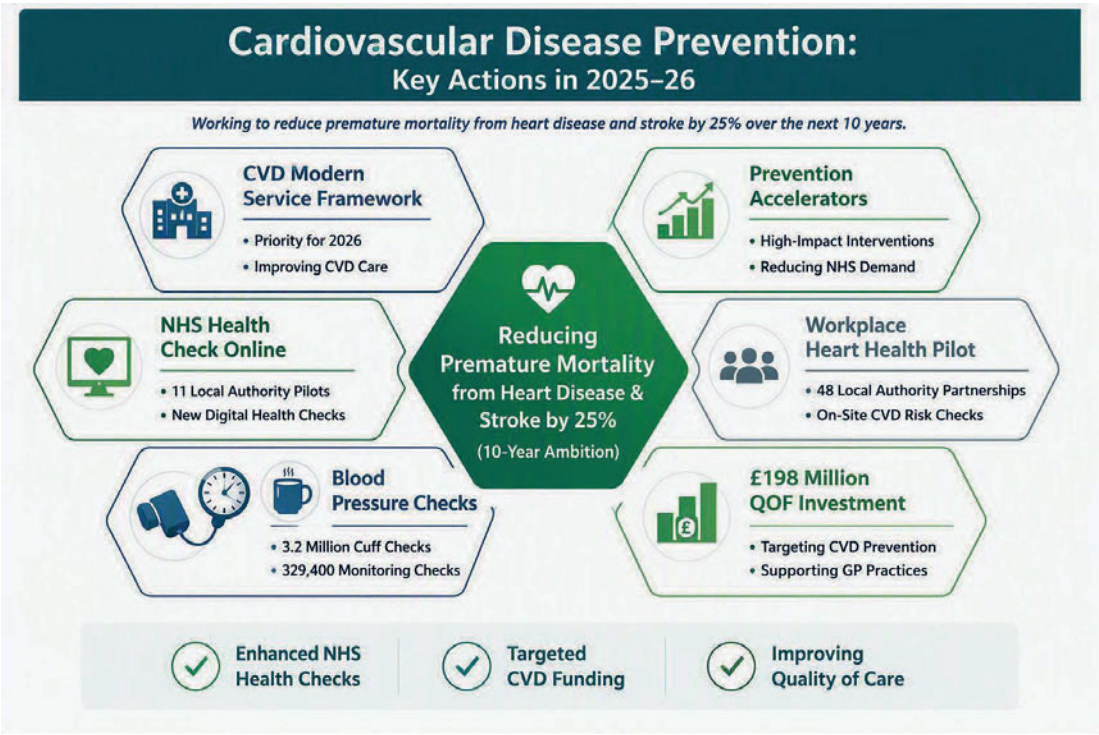
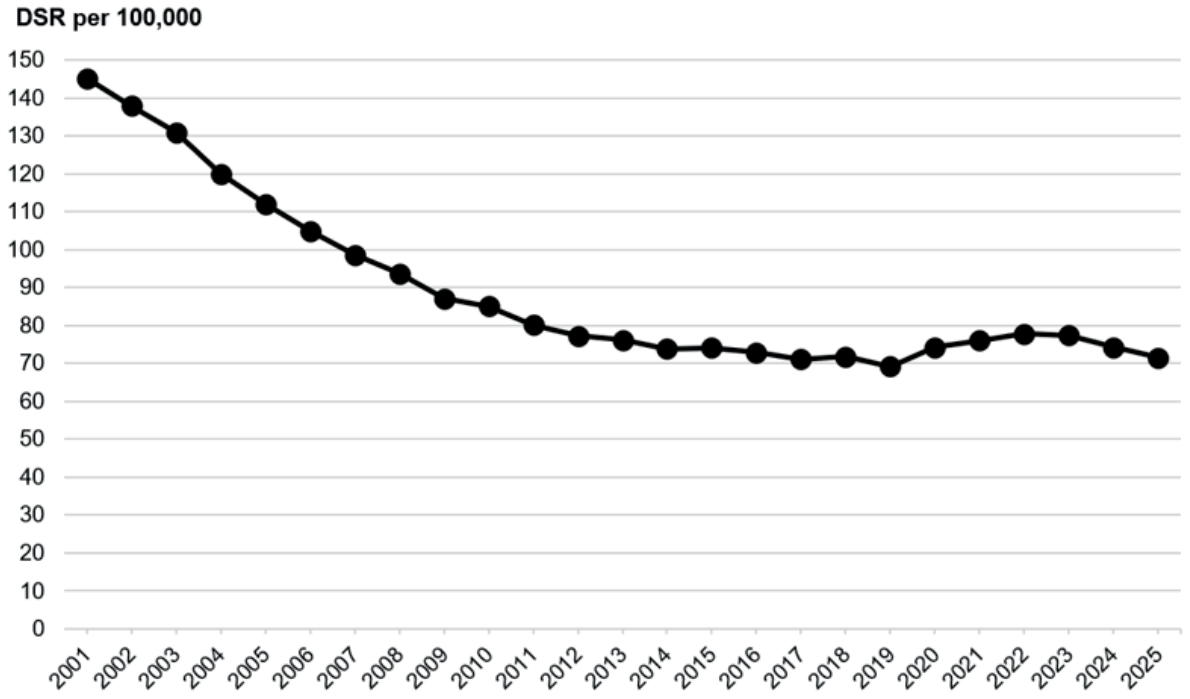


Figure 19: Age-standardised annual mortality rate in England from cardiovascular disease, all in persons under 75 years, from 2001 to 2025



Source: Mortality Profile - Data | Fingertips | Department of Health and Social Care (Accessed on 1st October 2026 – provisional data for 2025)

Cardiovascular disease modern service framework

Publication of the CVD Modern Service Framework was identified as an early priority in the 10 Year Health Plan. To this end, a CVD Task and Finish Group was established in October 2025 with membership comprising of a wide range of representatives from 31 stakeholder organisations, including, charities, professional bodies, patient and public voices, and NHS England, related to cardiovascular disease and associated conditions.

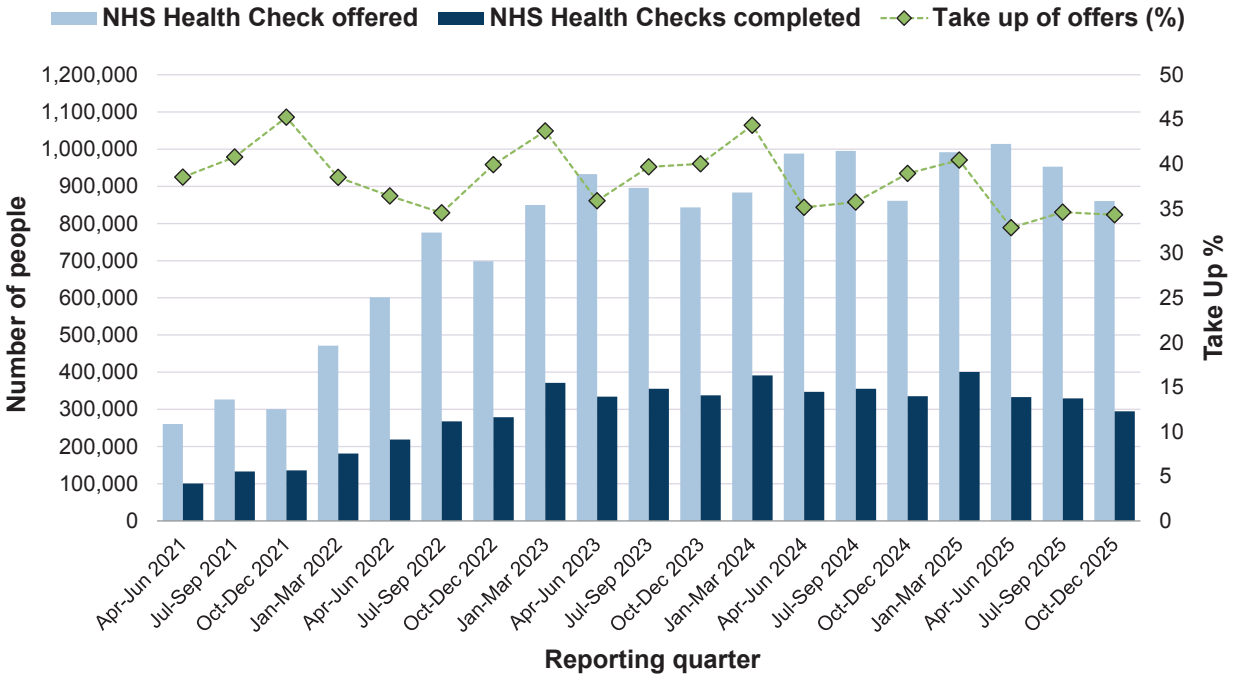
The CVD framework identifies and sets standards for the best evidenced interventions, driving innovation, and reducing unwarranted variation in healthcare.

NHS health check programme

The NHS Health Check programme is a core component of England's CVD prevention programme. It aims to detect people at risk of heart disease, stroke, type 2 diabetes and kidney disease by assessing the top risk factors for CVD in adults aged between 40-74.

The current five-year cycle (April 2021 – March 2026) was impacted by the COVID-19 pandemic as local authorities paused the NHS Health Check programme during 2020-22. A total of 3,799,126 NHS Health Checks were offered in 2025-26 and 1,316,481 were delivered. The number of checks delivered in 2025-26 is 8.5% lower compared to the same period in 2024-25.

Figure 20: Quarterly activity in England since April 2021: number of NHS Health Checks offered, number delivered and percentage take-up of offers.



Source: NHS Health Check – Data | Fingertips | Department of Health and Social Care

The NHS Health Check programme engages over 1.4 million people a year and, through behavioural and clinical interventions, prevents around 300 premature deaths, and 500 heart attacks or strokes each year. Annually, the NHS Health Check identifies over 340,000 people with high blood pressure, over 330,000 people living with obesity and over 900,000 people with raised cholesterol. Six years after attending an NHS Health Check, individuals are, on average, likely to have a reduced average body mass index (BMI), reduced smoking intake, and reduced blood pressure.

To improve access and uptake, DHSC continued developing the NHS Health Check online service, allowing people to assess and act on their cardiovascular disease risk at home. Following a limited private beta testing phase in June 2025, extended beta testing began in October 2025 across 11 local authorities, working with local general practices to prepare and deliver the service.

Strategic outcome three

Fairer Britain, where everyone lives well for longer: reduce the number of years people spend in ill-health

Key areas of work

- Health inequalities
- Adult social care
- Palliative care and end-of-life care
- Maternity
- Women's health
- Children, early years, and families
- Men's health
- Quality and patient safety
- Science, research and evidence

Key achievements

- Baroness Casey's independent commission into adult social care began its work
- Published first Men's Health Strategy for England
- Invested in maternity and neonatal safety improvements
- 10 Year Health Plan published with ambitions to improve life expectancy and reduce inequalities
- Published renewed Women's Health Strategy

Health inequalities

DHSC, together with its partners across national and local government and the healthcare system, remains determined to address the stark inequalities that blight our nation's health. This was reinforced by the most recently available ONS data, based on measures of self-reported health and mortality rates, showing increased inequality in the preceding period to 2022-24, including:

- the gap in healthy life expectancy at birth for males between the most and least deprived increased by 1.5 years to 19.4 years between the last pre-pandemic period 2017-19 and the latest period 2022-24

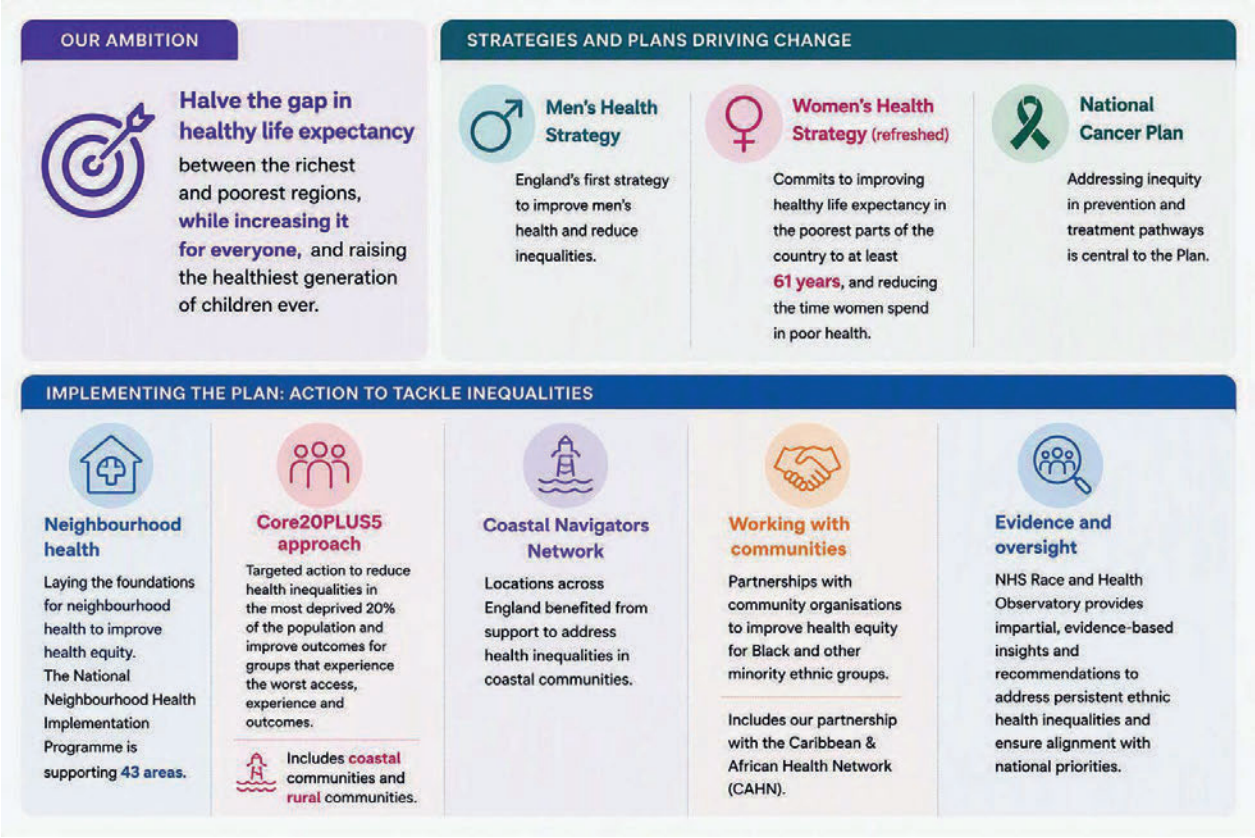
- the gap in healthy life expectancy at birth for females between the most and least deprived increased from 19.4 years to 20.3 years between 2017-19 and 2022-24

- healthy life expectancy at birth fell below 50 years in the most deprived decile for both females and males for the first time since the data series began in 2013-15.

Source: Healthy life expectancy by national area deprivation, England and Wales: between 2013-15 and 2022-24.(Office for National Statistics)

Against this backdrop, the 10 Year Health Plan set out a reimagined service designed to tackle inequalities in both access and outcomes, as well as to give everyone, no matter who they are or where they come from, the means to engage with it on their own terms.

Central to this ambition is the overall goal to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and raising the healthiest generation of children ever. Achievements are as follows:



During 2025-26, NHS England continued to discharge its statutory, governance and delivery support responsibilities for health inequalities, realigning its programme delivery into five priority workstreams, prioritising 10 Year Health Plan implementation. Highlights included:

- embedding the 'Framework for NHS Action on Inclusion Health', with a suite of national resources: a self-assessment tool for the framework; a data intelligence dashboard, and a service mapping tool

- publishing a 'Community Languages and Translation Framework for Action' and supporting implementation through a community of practice

- developing a Digital Exclusion Risk Atlas; an NHS analytical tool that identifies patterns of digital exclusion across England by combining indicators into a single risk index

- launching an 'Ethnicity Recording Improvement Plan' setting out actions to improve the quality of ethnicity data in health datasets

NHS England also strengthened national accountability for reducing health inequalities by embedding scored metrics within the NHS Oversight Framework resulting in clear and transparent accountability for key outcomes linked to Core20PLUS5, and 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. Further information is available in NHS England's Annual Report and Accounts.

To help empower regional and local action, DHSC worked with the Ministry of Housing, Communities and Local Government (MHCLG) to introduce a new health improvement and health inequalities duty for combined authorities and combined county authorities through the English Devolution and Community Empowerment Act 2026. The new duty requires these authorities, and their elected Mayors, to have regard to the need to both improve the health of the people living in their areas and reduce health inequalities between the people living in their areas, when considering how to exercise their functions.

DHSC committed to supporting the homelessness strategy target set by MHCLG that no one eligible for homelessness assistance is discharged to the street after a hospital stay. This will be achieved by embedding best practice across NHS and local systems. As part of supporting those experiencing homelessness, DHSC has also committed to measures including improving access to mental health and substance misuse services and updating statutory guidance to strengthen safeguarding responsibilities for people experiencing homelessness.

These steps, as well as ensuring integrated working across health, social care and housing services as part of the £442 million Rough Sleeping Programme, will support the new Prime Minister's ambition to end rough sleeping at the earliest opportunity. These steps recognise that homelessness is not an issue of housing alone. Someone's physical health, mental health and care needs are both impacted by, and impact, their ability to access and remain in housing.

Adult social care

Adult social care makes an important contribution to healthier, longer lives by helping people to live independently, maintain relationships, contribute to their communities, and live the lives they want. The government's vision for a National Care Service is about building a social care system that gives people greater choice, control, dignity, and independence.

The independent commission into adult social care, chaired by Baroness Louise Casey, began its work in April 2025. Its objective is to deliver public and political consensus on clear recommendations for how to reform the adult social care system to meet the current and future needs of the population. In July 2026, the new Prime Minister announced that he has asked the chair of the Independent Commission to complete its work more quickly, and that it would now report in summer 2027.

In March 2026, Baroness Casey made specific early recommendations in three key areas: safeguarding, dementia, and motor neurone disease. The government responded in March 2026 setting out plans to drive progress on Baroness Casey's recommendations and in June 2026, Ministers wrote to Baroness Casey to update her on progress in implementing these initial recommendations.

Alongside the work of the Commission, DHSC took forward action on a range of reforms to improve adult social care and support the workforce.

These reforms support three core government objectives for adult social care: improving the quality of care, including legislating for the first ever Fair Pay Agreement for adult social care; strengthening join-up between health and care services, including through the development of neighbourhood health; and enabling people to have more choice and control over their care, including increased investment in the Disabled Facilities Grant.

Progress against these objectives is helping develop a more resilient and sustainable adult social care system and is supporting delivery of the 10 Year Health Plan. Following the 2025 Spending Review, the government announced an increase in available funding for adult social care of over £4.6 billion in 2028-29 compared with 2025-26, including an additional £500 million to support implementation of the first Fair Pay Agreement for adult social care.

System performance, capacity and resilience

Adult social care resilience

DHSC continues to work closely with cross-government and sector partners to monitor emerging and ongoing risks to operational resilience in the adult social care sector. The most significant risk is major provider failure (MPF), which appears on the National Risk Register overseen by the Cabinet Office. Contingency planning for MPF remained an

important element of DHSC's work on adult social care throughout 2025–26. DHSC also led an exercise to test the sector response to MPF, and participated in other exercises designed to test DHSC's capability to respond to various incidents, including Exercise Pegasus, strengthening preparedness and response arrangements. DHSC continued to monitor and plan contingencies for a wider set of acute risks, including cyber-attacks, water shortages, national power outages and infectious disease outbreaks, working with key sector and government partners, developing the government's Pandemic Preparedness Strategy, and responding to incidents in the sector where government intervention was required. We have well-established channels for communicating with the adult social care sector to coordinate a system response and gather intelligence to respond to emerging risks. Further details of DHSC's activity in respect of emergency planning are set out at pages 95 and 96 of this Performance Report.

Local authority assessments

Under the Health and Care Act 2022, the Care Quality Commission (CQC) was given a new statutory duty to assess how local authorities deliver their adult social care responsibilities under Part 1 of the Care Act 2014. This provides, for the first time, an independent assessment of local authority performance across England.

During 2025-26, CQC continued delivery of its national baselining programme for all 153 local authorities in England, publishing 90 assessment reports. These assessments provide a comprehensive view of system performance across nine quality statements, covering areas such as needs assessments, care provision, safeguarding, and leadership. Initial findings indicate that the assessment process is strengthening transparency and accountability across the sector and driving improvements in local authority practice.

Over 2026-27, CQC will complete publication of its 'baseline' assessment reports and will begin reassessing local authorities in line with their recently published longer-term assessment approach and guidance.

Table 1: Distribution of CQC local authority assessment ratings in 2025-26 (%)

Local authority rating	%
Outstanding	3
Good	59
Requires Improvement	36
Inadequate	2

Provider assessments

It is not possible to directly compare this year's CQC overall ratings of adult social care providers with previous years as a means of understanding performance in the sector. CQC introduced its Single Assessment Framework (SAF) in November 2023, with phased rollout across all regions during late 2023 and early 2024, replacing the previous

inspection model. As a result, ratings from inspections using the SAF reflect a different inspection methodology.

In the State of Care report 2024-25 published in October 2025, CQC only reports ratings from inspections for active locations conducted under the SAF, giving 69.5% of locations a rating of Good/Outstanding. CQC's 2024-25 data therefore exclusively capture CQC inspections carried out under the SAF between January 2024 and August 2025, meaning the sample size is much smaller than previous years. Given CQC uses a risk-based approach (that is, prioritising for inspection those providers it has reason to believe may be poorer performing), this data is therefore not representative of the sector as a whole. Neither is it comparable to previous years. In 2023-24, CQC used all inspections for active locations including those pre-SAF, giving 82.4% of locations Good/Outstanding.

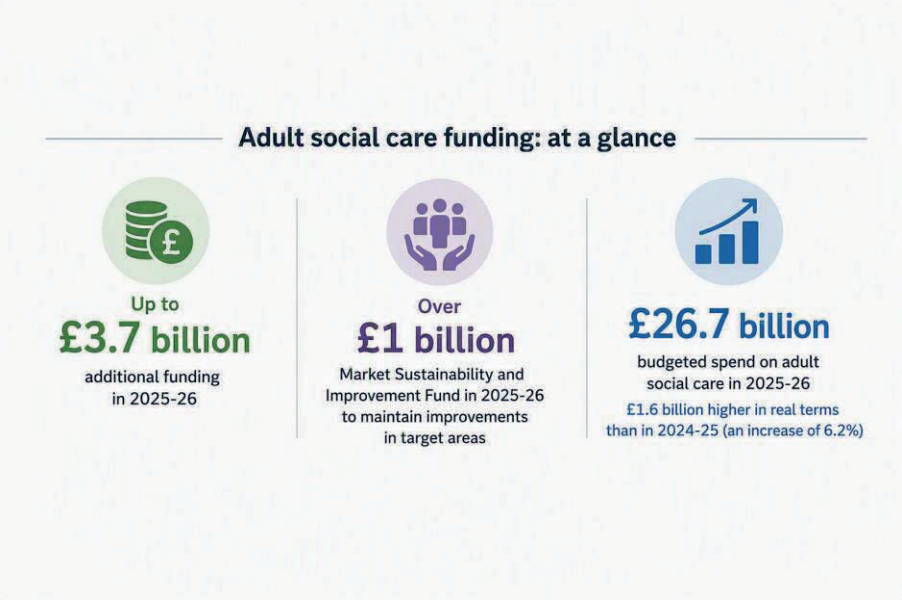
Table 2: Percentage of CQC regulated social care settings with overall rating of good or outstanding

Year	Proportion of social care settings rated Good or Outstanding
1 August 2024 (2023-24 report)	82.4%
1 August 2023 (2022-23 report)	83.4%
3 August 2022 (2021-22 report)	83.3%

Source: CQC State of Care annual reports Note: the 2024-25 report data is not directly comparable to previous years, as per above.

Adult social care funding

Key funding details can be highlighted as follows:



At the Autumn Statement 2024, the government set budgets for 2025-26 which made available up to £3.7 billion of additional funding for social care authorities. This included an £880 million increase in the Social Care Grant and allowance to increase the adult social care precept by 2% which raised £654 million.

Alongside the £3.7 billion in additional funding, social care authorities also received over £1 billion of grant funding through the Market Sustainability and Improvement Fund to maintain improvements achieved in target areas since the fund was created in 2023-24. The additional funding provided by the government supported local authorities to increase their budgeted spend on adult social care to £26.7 billion in 2025-26, £1.6 billion (an increase of 6.2%) higher in real terms than in 2024-25.

The 2025 Spending Review announced a three-year local government settlement, that will make over £4.6 billion of additional funding available to adult social care in 2028-29 compared to 2025-26. The 2026-27 Local Government Finance Settlement confirmed the government's plans to simplify adult social care funding to give local government more flexibility, and to redistribute it to where it is needed most. As part of this the government published adult social care notional funding allocations for the first time, alongside a document setting out priority outcomes and expectations for local authorities' delivery of adult social care from 2026-27.

The government also introduced a new funding formula for adult social care to redistribute funding to where it is needed most.

Improvement support

In 2025-26, £16.4 million was provided to sector partners (Local Government Association, Association of Directors of Adult Social Services, Think Local Act Personal, and Care Providers Alliance) to deliver a programme of support to local authorities. The programme helped local authorities and their partners to meet their statutory duties, improve services and tackle operational challenges. Following the rollout of CQC baselining, the programme delivered tailored, intensive and universal support to local authorities to tackle specific problems in response to their CQC assessment and to support improvement of adult social care delivery. 43 local authorities received intensive/targeted support in 2025-26 due to a CQC rating of 'requires improvement' or 'inadequate'. The programme also included networks and groups to support the collaboration of Directors of Adult Social Services and their teams, training and best practice resources.

Where CQC considers that a local authority is failing to discharge its functions to an acceptable standard, it is under a duty to inform the Secretary of State. In those local authorities in respect of which CQC has to date notified SoS of failure, non-statutory improvement advisers have been appointed to provide intensive support and challenge, while providing ministers with robust oversight. Should an authority fail to demonstrate sufficient progress, the Secretary of State may exercise the intervention powers introduced by the Health and Care Act 2022. In addition, during 2025-26, we further expanded our pool of sector experts to deliver this specific type of support.

Improved quality of care

Safeguarding

In March 2026, DHSC set up an Adult Safeguarding Challenge Group to provide more routine and robust arrangements for scrutiny of Safeguarding Adult Reviews that local authorities have escalated nationally. In March 2026, the previous Secretary of State also agreed to recommendations made by Baroness Casey, chair of the Independent Commission into adult social care, to establish a new national board for adult safeguarding and to undertake an urgent review of the legal framework for adult safeguarding. Progress is already being made against these recommendations, with the first National Adult Safeguarding Board taking place in June 2026.

Digitising social care

DHSC, in partnership with NHS England, made significant progress during the year towards delivering the government's ambition for a fully digitised adult social care sector by the end of this Parliament, and improving the integration of health and care data services.

By the end of March 2026, 83% of CQC-registered care providers had a digital social care record, supporting over 91% of people drawing on care. In March 2026, the programme completed initial work to develop national data infrastructure for social care and began testing the feasibility of data sharing between digital social care record suppliers. This will inform how social care information connects to the Single Patient Record. DHSC strengthened the evidence base for care technology by completing evaluations for eight pilot projects, which will be published before the end of 2026.

Alongside this, the programme improved Care Act assessment journeys by supporting local authorities to appropriately use digital and data systems. In 2025-26, DHSC published the Adult Social Care Assessments Improvement Toolkit in October 2025 to direct local authorities to tailored support and practical resources to help strengthen local assessment processes.

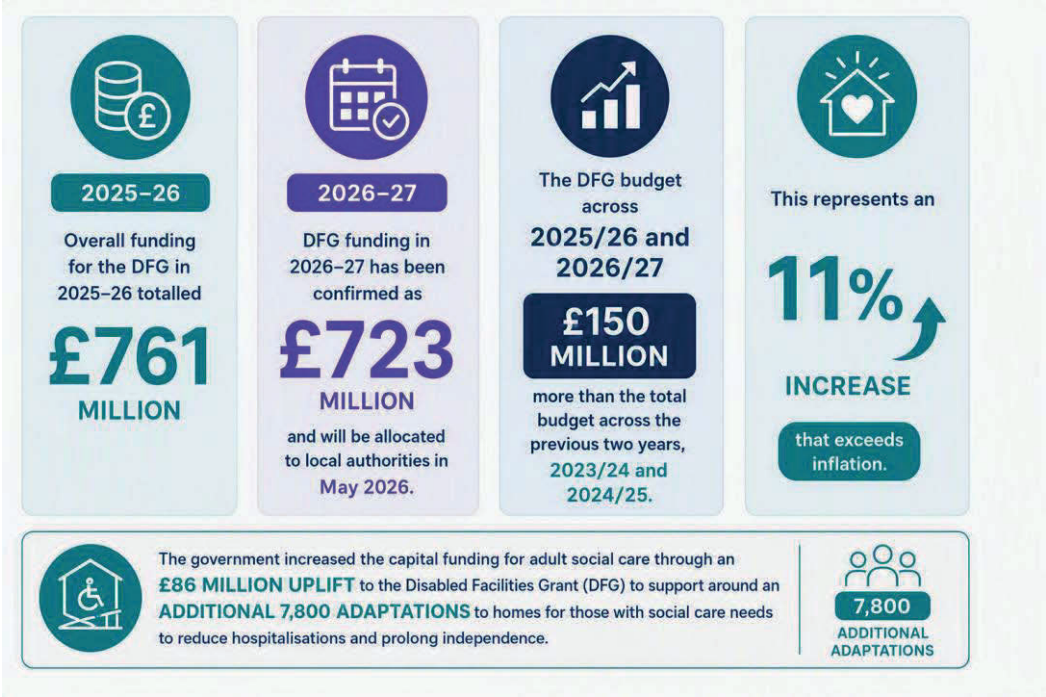
In parallel, DHSC also progressed a programme to establish the foundations for efficient, user-centred and interoperable case management systems. This included publishing a Foundational Specification, setting out expectations for modern case management systems, and beginning, jointly with the Department for Education, initial testing of data and technology standards to support future efficiencies and integration across the care sector.

Greater choice and control

Housing/disabled facilities grant (DFG)

The government increased the capital funding for home adaptations through the Disabled Facilities Grant (DFG) to support more older and disabled people, thereby reducing hospitalisations and prolonging independence. Overall funding for the DFG in 2025-26 totalled £761 million. This included an in-year uplift of £50 million.

Figure 21: Disabled facilities grant (DFG) funding 2025-26



Visiting regulations

During 2025–26, DHSC reviewed CQC Regulation 9A, which introduced visiting and accompanying as a CQC fundamental standard in health and care settings. The review found that Regulation 9A has reinforced the principle that visiting is integral to care, by clarifying expectations and giving families greater confidence to challenge restrictions. However, it has not delivered consistent change across the system. Awareness and understanding remain variable, and there are gaps in data, monitoring and escalation.

Building on this evidence, the government has committed to strengthening visiting rights in practice. In 2026–27, DHSC will focus on improving awareness of Regulation 9A, supporting clearer and more consistent local decision making, and strengthening data and oversight with CQC. In parallel, DHSC will continue to explore potential legislative changes to better recognise the role of families and carers as partners in care.

Social care allowances uplift

In 2025-26, as part of the annual review of social care allowances, DHSC announced an increase to the amount that working-age adults who receive social care must be able to keep after paying for home care (known as the minimum income guarantee) by 7%. This change took effect from April 2026, strengthening this safety net to ensure that people have enough for daily expenses and helping to ease financial pressures.

This is the largest above-inflation uplift in more than a decade and means working-age adults receiving care in the community will have more money left over for everyday essentials such as food, heating and bills. DHSC estimates that working age disabled adults will keep at least £400 more each year.

Joined up services

Better Care Fund

The Better Care Fund (BCF) is a framework for ICBs and local authorities to make joint plans and pool budgets for the purposes of delivering better joined-up care.

In 2025-26, ICBs and local authorities were required to pool around £9 billion through the BCF. The BCF framework for 2025-26 set ICBs and local authorities the objectives of supporting the shift from sickness to prevention and supporting people to live independently, and the shift from hospital to home. Local areas were asked to set goals for unplanned hospital admissions in people aged 65 and over, delayed discharges and long-term care home admissions.

On 17 February 2026, the government published guidance for ICBs, local authorities and health and wellbeing boards setting out the new arrangements for the BCF in 2026-27.

Neighbourhood health

Neighbourhood health will refocus the system on improving people's access, experience and outcomes; and organising services to meet their needs, closer to the places they live. Adult social care has an important part to play in realising this vision, as articulated in the Neighbourhood Health Framework which was published in March 2026 to provide clarity and consistency and to support joined-up working between ICBs, local authorities and other relevant local partners.

Data transformation

High-quality data is essential to ensure that people receive the right care, supporting effective commissioning, enabling better service delivery, and helping health and care services to work better together.

Progress during the year included:

Figure 22: Adult social care data highlights 2025-26



Dementia

We will publish the first-ever Modern Service Framework (MSF) for Frailty and Dementia to deliver rapid and significant improvements in quality of care and productivity. This will be informed by phase one of the independent commission into adult social care, which is expected this year. We are committed to feeding into NHS and local government planning cycles in September and will aim to publish the full MSF recommended by Baroness Casey as soon as the necessary preparatory work is complete.

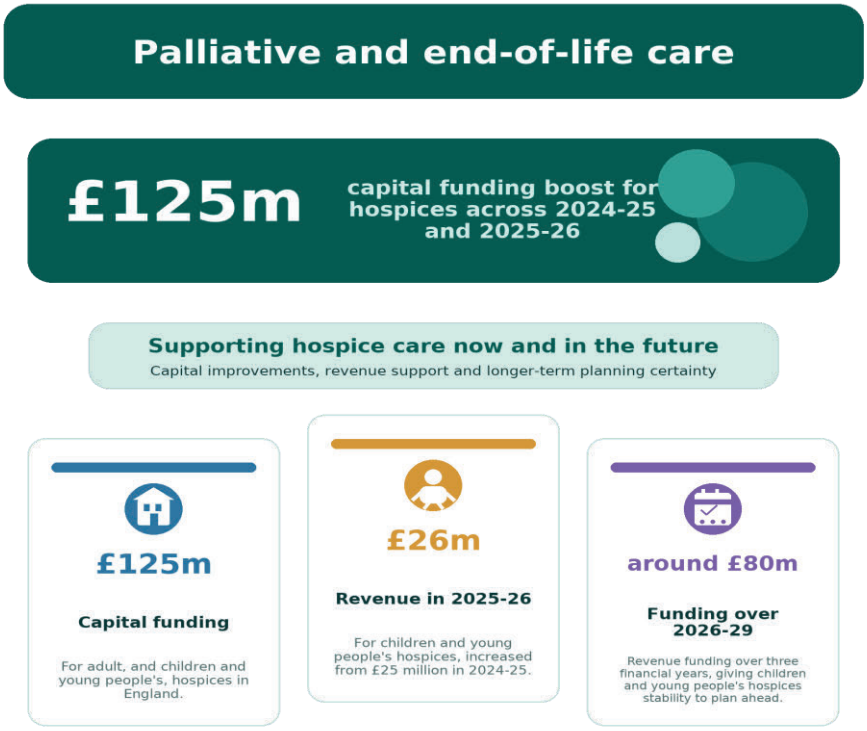
The framework will be shaped by the Frailty and Dementia Modern Service Framework Task and Finish Group, an advisory body to offer insight and guidance drawing on their experience across the health and social care system. The first meeting took place in March 2026, and meetings will take place monthly.

Palliative care and end-of-life care

The NHS, alongside the independent sector, continued to provide palliative care and end-of-life care throughout 2025-26. The percentage of people identified on the supportive palliative care register in primary care has risen from 0.46% of the population (290,433) in 2022-23 to 0.6% (356,543) in 2024-25, the final year for which data against this indicator was published. (Palliative and End of Life Care Profiles | Fingertips | Department of Health and Social Care).

Palliative care and end-of-life care are broad, holistic approaches provided through a range of professionals and providers - generalist and specialist - across the NHS, social care and voluntary sector organisations. Therefore, the cost of provision is difficult to measure because relevant consultations and tasks are not always coded as palliative care or end-of-life care.

Whilst the majority of palliative care and end-of-life care is provided by NHS staff and services, we recognise the vital part that voluntary sector organisations, including hospices, also play in providing support to people at the end of life and their loved ones. We have supported the hospice sector with funding as follows:



In February 2026, NHS England wrote to all ICBs requesting an update on the financial stability of hospices within their footprint. We are now repeating this exercise, triangulating data also received from independent hospices via Hospice UK. This will allow us to make an up-to-date assessment on the financial situation of every hospice in England, as well as risks and potential mitigations. NHS England will continue to support ICBs where risks are identified.

The government is developing a Modern Service Framework (MSF) for Palliative Care and End-of-Life Care for England, with a planned publication date of later this year. This will be aligned with the ambitions set out in the 10 Year Health Plan and those set out in the recently published Neighbourhood Health Framework.

The MSF will drive improvements in the services that patients and their families receive at the end of life and enable integrated care boards to address challenges in access, quality and sustainability through the delivery of high-quality, personalised care.

Social prescribing

Social prescribing is a key component of the NHS's universal personalised care and is a way for GPs, other statutory services and local agencies to refer people to a social prescribing link worker. Social prescribing seeks to address the wider determinants of health (for example, social, economic, and environmental) which impact on an individual's wellbeing. Social prescribing activities are commissioned locally, utilising community assets often in the voluntary, community and social enterprise sector.

As of the end of March 2026, the number of social prescribing link workers recruited was 3,371 full-time equivalents since the beginning of the national rollout in 2019. In September 2024 there had been over 2.8 million referrals (rolling referral numbers are no longer measured beyond this date). There is a growing evidence base for the effectiveness of social prescribing and research by the National Academy for Social Prescribing suggests social prescribing schemes can deliver between £2.14 and £8.56 in social and economic value for every £1 invested. Further details are in their Building the economic case for social prescribing report.

Maternity

Maternity and neonatal outcomes

Whilst the vast majority of births in England are safe, there are a series of systemic issues affecting maternity and neonatal care, including women and families not being listened to consistently, a lack of accountability and learning when things go wrong and insufficient oversight and regulation of the system. In addition, despite some improvement in rates of stillbirth and neonatal mortality, maternal mortality in the UK increased between 2009-11 and 2022-24, while inequalities relating to ethnicity and social deprivation have persisted.

In June 2025, the then Secretary of State commissioned a National Independent Investigation into Maternity and Neonatal Care and committed to establish and chair a National Maternity and Neonatal Taskforce. Separate local reviews into maternity services at University Hospitals Sussex NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust were announced subsequently, highlighting growing concerns around maternity and neonatal safety. Further detail is provided at page 178 in the Governance Statement of this Annual Report.

Progress continues to be made on improving outcomes, experience, and quality for those accessing maternity and neonatal services. Actions implemented in the 2025-26 year include:

- investing over £145 million to address critical safety risks on the maternity and neonatal estate, and a £25 million boost for trusts to tackle causes of maternal death, enhance bereavement facilities and improve triage services

- implementing a new programme to reduce the two leading causes of avoidable brain injury during labour

- launching a package of initiatives and interventions to reduce stillbirths, neonatal brain injury, neonatal death, and preterm birth

- delivering an anti-discrimination programme in all trusts to tackle inequalities. This will help ensure all NHS service users and their families receive care, free from discrimination and racism, and all NHS staff experience a work environment free from discrimination and racism

- beginning the expansion of Martha's Rule to all maternity and neonatal units in England, following a successful pilot in 14 trusts across six regions, to give patients and families the right to request a second opinion

- rolling out a Maternal Care Bundle to tackle the leading causes of maternal death, and produce a decline in deaths and harm

- extending the Baby Loss Certificate scheme to include all historic losses. As of 31 March 2026, 122,941 certificates had been issued

- publishing an equity and equality data dashboard to help support real-time quality improvement – showing data on maternity and neonatal care services for every trust in the country, with breakdowns by ethnicity and deprivation, to strengthen transparency and accountability. This can be used by local NHS trusts to identify areas where specific populations, including Black women, face the greatest disparities, to develop specific, tailored interventions and improved support for their local populations

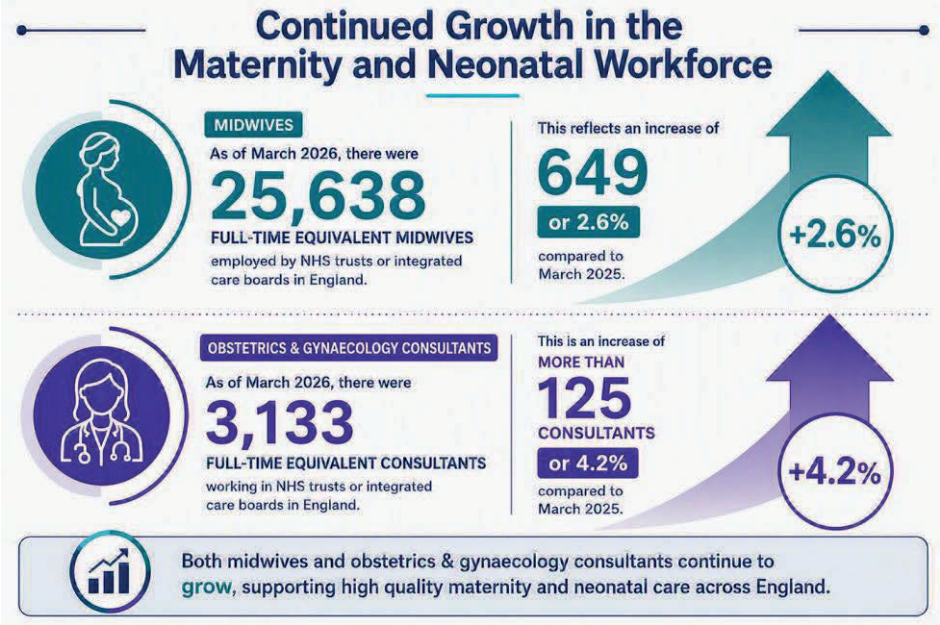
- delivering the manifesto commitment to strengthen national support to struggling trusts through the national maternity and neonatal intensive support team

- launching a new Maternity Outcome Signalling System (MOSS) to better identify safety concerns, by immediately flagging unusually high rates of term stillbirth, neonatal death and brain injury to prompt a rapid review of any safety concerns

- expanding specialist perinatal mental health support to provide greater access to women in different areas of the country

- offering a 7-day-a-week bereavement service across maternity settings in all ICB areas in England

Figure 23: Maternity and neonatal workforce 2025-26



Women's health

Free emergency hormonal contraception in pharmacies

From October 2025, emergency hormonal contraception was made available free of charge to women across the country without needing to see their GP or get an appointment at a sexual health clinic. This service is another example of how the NHS is delivering on the 10 Year Health Plan commitment to shift care into the heart of communities.

Between its launch in October 2025 and March 2026, over 305,000 emergency hormonal contraception consultations were delivered through the service and as of March 2026, the service was being delivered by over 7,800 pharmacies across England.

Women's health research

Through the National Institute for Health and Care Research (NIHR), DHSC committed £85.5 million in 2025-26 for new research projects into women's health. This includes conditions that are unique to women, such as endometriosis, and health topics that are relevant to women such as the impact of domestic violence.

DHSC also invests significantly in research expertise, facilities, and collaborations to support and deliver research in England, known as NIHR infrastructure. An additional £53.6 million was committed in 2025-26 to infrastructure to support research into women's health. For example, the NIHR's Research Delivery Network supported the delivery of 453

studies in conditions that are unique to women and enabled 275,500 participants to take part in potentially life-changing research in women's health.

As part of our ambition and commitment to becoming a more inclusive funder of research, DHSC introduced inclusive research design as a condition of NIHR funding in November 2024. Building on this, the introduction of the sex and gender in research policy in November 2025 marks a further step forward. This policy ensures that sex and gender are considered across all stages of research so that women are better represented not only in women's health studies, but in all research that shapes health and care for everyone.

Examples of investments during this period include:

- the extension of the contract of the Policy Research Unit in Reproductive Health until 2028 to enable continued research to better understand contraceptive attitudes and decisions, and data for reproductive health

- new funding calls focused on topics including support for women and girls impacted by domestic abuse, and interventions to prevent health issues associated with period poverty and menstruation

- the world-leading EDITH trial to test how cutting-edge AI tools can be used to catch breast cancer cases earlier

- a new Public Health Research Programme to improve the evidence base relating to which health interventions exist for servicewomen and female veterans in the UK, how they operate, and what impact they have

Children, early years, and families

Healthiest generation ever

DHSC wants every child in England to have the opportunity for a healthy, happy childhood. That means making sure children can get high-quality and timely treatment and support when they need it, with action also taken to ensure that all children are safe and well cared for.

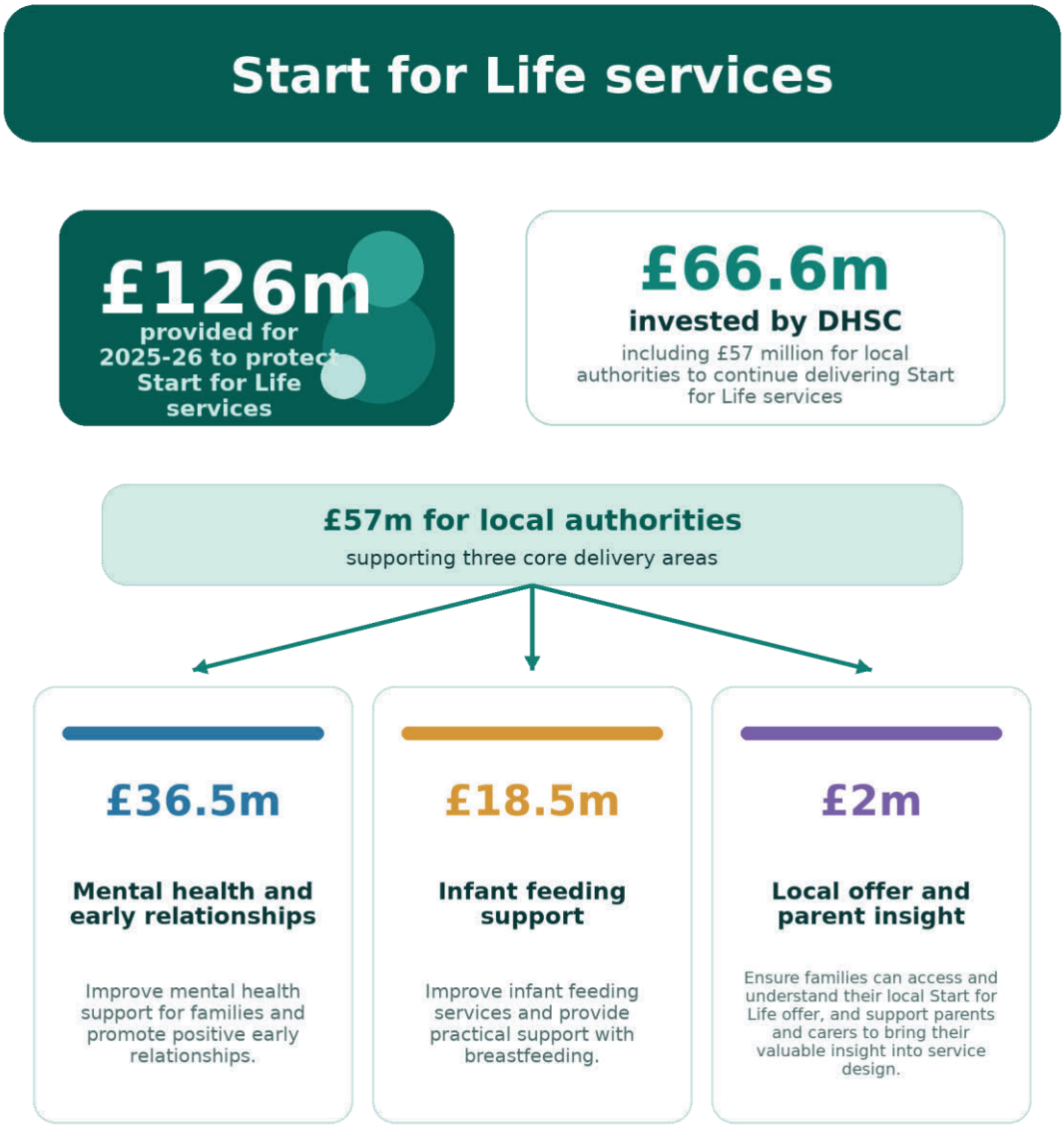
The government is committed to raising the healthiest generation of children ever. We continue to work in close partnership across government, taking action to strengthen support for children and their families.

We are focused on delivering for children through the 10 Year Health Plan, the Opportunity Mission, the National Youth Strategy and the Child Poverty Strategy. Improving child health goes hand-in-hand with our wider priorities, such as the move to a Neighbourhood Health Service and the three big shifts, hospital to community, analogue to digital and sickness to prevention.

Family Hubs and Start for Life programme

The jointly managed DHSC and Department for Education Family Hubs and Start for Life programme delivers a community-based, prevention-led model supporting the shifts from hospital to community and from treating sickness to prevention.

From April 2025, £126 million was provided for 2025-26 to continue to protect Start for Life services and to support the local authorities to embed their models. Funds were invested as follows:



Almost £30 million was also allocated to deliver national initiatives to complement local delivery, including the National Breastfeeding Helpline with an extension to operating hours so that infant feeding support is available round-the-clock every day of the year.

In March 2026, funding of £200 million was announced for the continued delivery of Healthy Babies (formerly Start for Life) for 2026-27 – 2028-29 in the 75 funded local authorities. In addition, the 10 Year Health Plan has committed to expanding funding for Start for Life (now Healthy Babies) services to all areas over the lifetime of the plan.

In April 2026, the Family Hubs and Start for Life programme transitioned to Best Start Family Hubs and Healthy Babies.

Vulnerable children and families

To provide access to high-quality health and care, in the Violence Against Women and Girls (VAWG) Strategy published in December 2025, DHSC committed to rolling out the 'Steps to Safety' domestic abuse and sexual violence referral service across ICBs from April 2026. This will give general practices the tools and ability to identify and refer victims and survivors into support services. The Strategy also committed to investing up to £50 million to transform support for victims of child sexual abuse and exploitation across every NHS region in England, starting from April 2026 so that children and young people affected by these horrific crimes can access the specialist care they need.

In December 2025, DHSC announced that tens of thousands of care leavers will receive free prescriptions, dental and eyecare services up to age 25 by the end of 2026. These changes to improve access to healthcare services come alongside pilots to improve mental health support for children in care and families, and paid NHS internships for care leavers to break down barriers to opportunity.

The Children's Wellbeing and Schools Act 2026 introduces the expansion of corporate parenting responsibilities, including to DHSC, NHS England and other health bodies, to strengthen the role of public services in promoting the wellbeing and life chances of children in care and care leavers.

Men's health

On 19 November 2025, to coincide with International Men's Health Day, the government published the first ever Men's Health Strategy for England. This sets out the ambition to improve the health of all men and boys in England via a whole system approach with a range of activities supported by partners from the NHS, local government, academia, the voluntary sector and industry.

The strategy includes tangible actions to improve access to healthcare, provide the right support to enable men to make healthier choices, develop healthy living and working conditions, foster strong social, community and family networks and address societal norms. It also considers how to prevent and tackle the biggest health problems affecting men of all ages, which include mental health and suicide prevention, respiratory illness, prostate cancer, and heart disease.

The strategy supports the government's overarching ambition to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, as well as the delivery of the government's commitment to raise the healthiest generation of children ever. It also contributes to broader government missions on economic growth, safer streets and opportunity.

Since its launch, significant work and focus has been on implementing the commitments set out in the strategy. For example, in March 2026, the Men's Health Community Fund, a £6.3 million programme, was launched in partnership with Movember and the People's Health Trust. We have also established the Men's Health Academic Network and Men's Health Stakeholder Group to provide advice to DHSC on implementation.

In 2026-27 we will continue to implement the Men's Health Strategy, including delivery of the Men's Health Community Fund. We will also work with the Men's Health Academic Network, voluntary sector and wider stakeholders to develop and publish a one-year-on report, highlighting the improvements made and where future efforts will need to be targeted. We expect this will be published during 2026-27.

Patient safety and quality

During 2025-26, DHSC and NHS England have continued to enhance patient safety and a learning culture in the NHS. The changes we are making as part of the 10 Year Health Plan and Dr Penny Dash's report on the patient safety landscape will improve quality and safety by clarifying where responsibility and accountability sit at all levels of the system. This work is now led by the relaunched National Quality Board and further strengthened with the publication of the new Quality strategy.

Highlights include improved systems of surveillance and learning, as well as the rollout of Martha's Rule to every acute hospital in the country, empowering patients and their families to raise concerns about their condition, which has seen more than 13,000 escalation calls leading to changes in treatment for more than 1,900 patients.

Strengthening patient safety systems and learning

In 2025-26, NHS England's Patient Safety Strategy continued with key programmes that are focused on improving the NHS's systems, capability and capacity to improve safety, such as the Patient Safety Incident Response Framework, the NHS Patient Safety Syllabus, and the Framework for Involving Patients in Patient Safety. NHS England's centralised, real-time reporting system, the Learn From Patient Safety Events (LFPSE) service, gives us greater ability to learn from more than 3 million patient safety incidents reported annually, including through the development of machine learning and AI tools for analysis. The national patient safety team reviews hundreds of incidents reported through LFPSE each week, looking for new and under-recognised risks that can be acted on. In 2025-26 NHS England issued the following three National Patient Safety Alerts, which are informed by data from LFPSE, direct providers to take specific actions to improve safety:

- Risk associated with adult breathing circuits lacking a patent exhalation route – 11 December 2025
- Harm from incorrect recording of penicillin allergy as penicillamine allergy – 20 November 2025
- Harm from delayed administration of rasburicase for tumour lysis syndrome – 9 September 2025

Other work in 2025-26 included system-wide action in collaboration with partners to address safety issues (see case studies), as well as the publication of the Being Fair tool, a replacement for the 'just culture guide' and developed by NHS England in collaboration with a wide range of stakeholders to better support NHS staff after a patient safety event.

Improving outcomes for patients

The strategy is in its seventh year and NHS England estimates that it is now achieving the impact that was estimated in 2019, saving around 1,000 lives and over £100 million in care costs each year. By focusing national patient safety programmes in priority areas, the strategy can now demonstrate over 1,900 neonatal lives saved through safer care bundle interventions, including improvements in optimal cord management and the administration of antenatal steroids, and over 600 fewer cerebral palsy cases in premature babies (which saves £600 million in lifetime care costs) due to the administration of magnesium sulphate during pre-term labour. In 2025-26, NHS England expanded Martha's Rule into every acute hospital in England, following evidence of significant patient benefit. Over 13,000 escalation calls led to changes in treatment for more than 1,900 patients, including over 570 who required enhanced care. In February 2026, an evaluation demonstrated the impact of the medicines improvement programme for chronic pain and opioid prescribing over a five-year period.

Strengthening the medical examiner system

2025-26 marked the first full year of the statutory medical examiner system, independently reviewing every death in England and Wales not referred to a coroner (over half a million annually). Medical examiners initiated discussions with bereaved families in more than 97% of cases, improving their understanding and experience of the death certification process, and providing a route to feedback on their experience of care. The system has also improved the quality of referrals to coroners, so that fewer cases are referred (Ministry of Justice coroner statistics for 2025 indicate the number of deaths referred to coroners fell by a quarter since 2023), while those cases that are referred are more relevant (the proportion of cases referred that lead to an inquest being opened has increased by almost 25%).

Reforming the patient safety landscape

In 2025, Dr Penny Dash's review of the patient safety landscape found that there are multiple bodies with overlapping responsibilities, which can lead to confusion and inefficiency. The Dash report made nine recommendations, the majority of which were accepted in full by the government. We are in the process of implementing the recommendations which include:

- the revitalisation of the National Quality Board (NQB). In September 2025, the NQB was revamped and relaunched and is now operating under interim arrangements with refreshed leadership, new membership and new terms of reference. It brings together senior leaders from across NHS England, DHSC and key arm's-length bodies – such as Care Quality Commission, the National Institute for Health and Care Excellence and the Medicines and Healthcare products Regulatory Agency

- the NQB is to develop a hub to enable the prioritisation and effective oversight of recommendations

- transfer of the hosting of the Patient Safety Commissioner from DHSC to the MHRA occurred in November 2025

- the closure of the National Guardian's Office, incorporating responsibilities into provider organisations and functions aligned with other staff voice functions in NHS England

DHSC and NHS England continue to implement the recommendations, working collaboratively with the organisations. Where legal changes are required, these are being undertaken through the passage of the NHS Bill.

Applying evidence-based, fair, and effective patient safety principles as part of broader quality efforts is now more crucial than ever. On 14 July 2026, NHS England published an overarching Quality Strategy, setting out a structured approach to making quality the organising principle for all NHS activity in England over the next decade.

Cross-cutting work area 1 – Workforce



Cross-cutting work area 1: Workforce

NHS workforce

Workforce numbers

In recent years the NHS has seen very fast growth in workforce – with the workforce as a whole growing by 21% between 2020 and 2025. This is not sustainable. In 2025-26 we have seen slower growth reflecting the fiscal reality and the need to fund technology which will improve productivity in the medium to long term.

Table 3 presents data on the number of full-time equivalent (FTE) staff employed by NHS provider trusts and ICBs in England. As of March 2026, there are almost 1.38 million full-time equivalent (FTE) staff, 1,200 (0.1%) more compared to March 2025. Within the workforce there were over 5,500 more doctors and over 4,400 more nurses and health visitors working than in March 2025.

The 2025-26 NHS Priorities and Operational Planning Guidance asked trusts to review workforce growth and reduce expenditure on support functions back to April 2022 levels. This has in part driven the slowing of workforce growth over 2025-26.

Table 3: FTE workforce numbers since 2021

	Doctors	Nurses and Health Visitors	All Staff
Mar-21	124,078	311,137	1,197,747
Mar-22	128,392	321,624	1,226,677
Mar-23	133,807	334,132	1,280,350
Mar-24	140,774	355,283	1,345,047
Mar-25	147,931	369,449	1,378,470
Mar-26	153,487	373,883	1,379,670

Source: NHS England workforce statistics

As of March 2026, vacancy rates in NHS providers are lower than pre-pandemic rates. Data published by NHS England showed that there were over 97,400 vacancies in NHS provider trusts as of March 2026, equivalent to 6.5% of the workforce. This is slightly less than the 6.7% vacancy rate in March 2025 (over 100,100 vacancies) and below the 8.1% in March 2019, when there were over 96,300 vacancies but a smaller overall workforce.

In 2025, a total of 1,693 applications were submitted for new awards under the National Clinical Impact Award scheme for NHS consultant doctors, dentists and academic general practitioners. Overall, 539 awards were granted — 502 in England and 37 in Wales.

NHS staff standards, staff retention and experience

As part of the 10 Year Health Plan, we committed to developing a set of staff standards that would articulate national minimum expectations of employment in the NHS. During 2025-26, we have worked closely with the Social Partnership Forum, system leaders and external experts to develop the standards and an accompanying composite metric in the NHS Oversight Framework. The NHS staff standards were published on 6 July 2026.

Work continues on retaining skilled and experienced NHS staff with NHS England continuing their work to strengthen the staff experience through targeted, evidence-based interventions. These interventions focus on the issues that are important for staff experience and retention and address health and wellbeing, flexible working, career development, staff engagement and morale.

2025-26 also saw considerable work undertaken by NHS England and DHSC, in partnership with NHS trade unions and employers, to implement the improvement recommendations arising from the 2023 Agenda for Change Non-pay Agreement. This includes the mandating of the Violence Prevention and Reduction standard; supporting prevention, risk assessment and responses to incidents.

Medical and clinical expansion

In the 10 Year Health Plan we committed to several measures to dramatically improve access to the medical profession for those from disadvantaged backgrounds, as well as exploring options to improve financial support to students from the lowest socio-economic background so that they are able to thrive at medical school.

In April 2026, we announced a comprehensive package to break down long-standing barriers into NHS careers and open up opportunity to people from every background. This includes 2,000 new nursing apprenticeships concentrated in areas that need it most, 2,000 places on access to medicine programmes and a pledge to increase the number of students who received free school meals into medicine by 50% in the next decade.

£5 million was made available for a Widening Access Demonstrators programme pilot which was established in July 2025, providing funding to 10 ICBs to widen access to NHS and social care careers. The first year of programme delivery concluded at the end of March 2026, with more than 1,000 people successfully supported into pre-employment programmes.

In the 10 Year Health Plan we also committed to creating 1,000 new specialty training posts over the next three years, with a focus on specialties where there is greatest need. We have also expanded GP training posts by 250 places for 2025-26, taking the total to 4,250.

The subsequent 2026 Resident Doctors Deal in England committed to significantly expanding specialty training posts by up to 4,500 in England over the next three years, including 1,000 additional training places in 2027. We have since exceeded delivery of these 1,000 training places. Over 680 new places were made available on 22 October 2026 for doctors starting in August 2027, which followed 380 places being made available in August 2026 for doctors starting in February 2027.

Leadership and professional regulation

There is a significant programme of work underway to strengthen and professionalise NHS leadership, which builds on the recommendations arising from the Kark (2019) and Messenger (2022) reviews. This includes the government's manifesto commitments to introduce professional regulation for NHS managers, wider work to develop professional standards, a national code of practice, and a core training curriculum for NHS managers at all levels. In addition, the NHS College of Leadership and Management, launched in July 2026, will be the new national home for NHS leadership, management and talent excellence. The College will bring a more consistent approach to leadership and management development across the NHS, supporting the aims of the 10 Year Health Plan.

As a first step towards delivering this commitment, DHSC launched a consultation in November 2024 on options for regulating NHS managers in England. Our response, published on 21 July 2025, sets out plans to regulate NHS managers via a statutory barring system. We will take forward legislative changes so that the Health and Care Professions Council (HCPC) can operate a barring mechanism for NHS board level managers and their direct reports within this Parliament. These measures will ensure that managers and leaders are equipped to deliver transformation in the NHS and to build a positive and compassionate culture.

Following publication of the Leng Review in July 2025, DHSC has worked with NHS England and system partners to progress implementation of its recommendations, including the development of national clinical protocols to support the safe and effective deployment of physician associates and anaesthesia associates within multidisciplinary teams.

In October 2025, the government also launched a rapid review into antisemitism and other forms of racism in healthcare, as part of wider efforts to tackle discrimination in the health service. Lord John Mann was commissioned to lead the review, examining how the regulatory system for healthcare professionals tackles antisemitism and other forms of racism at every stage, from employment through to professional oversight. The review considered regulatory processes, transparency in investigations, reporting mechanisms, and how guidance and policies can be more effectively and consistently implemented across the health service.

Medical Training (Prioritisation) Act 2026

The Medical Training (Prioritisation) Act 2026, which was commenced on 6 March 2026, implemented our commitment in the 10 Year Health Plan to prioritise UK medical graduates for foundation training places, and to prioritise UK medical graduates and other doctors with significant NHS experience for specialty training places. The Act will support a sustainable medical workforce that can meet population health needs, reduce the UK's reliance on an unpredictable international labour market, and ensure we make best use of the substantial taxpayer investment in medical training. It will reduce competition for places and give homegrown talent a path to become the next generation of NHS doctors.

The Act has had an immediate impact. Competition ratios for applications to specialty training this year have halved, prioritised doctors have filled 98% of roles, and in some specialties, like General Practice, all posts have been filled by prioritised doctors.

In summary, 33,953 applications successfully met the required appointable level for one of 9,315 specialty training posts starting in 2026. This is a competition ratio of 4:1. 16,066 applications were from prioritised candidates, reducing the competition ratio to 2:1. This means 98% of posts were filled by priority candidates compared to 72% in 2025. In round 1 only 1.80% of offers accepted to date are from non-prioritised applicants compared to 27.95% last year, a reduction from 2,168 to 163 in one annual cycle. The non-prioritised applicants accepted roles only in specialties or geographies prioritised applicants did not want.

Furthermore, for the first time ever, 100% of GP training places were accepted by UK graduates or applicants working in the NHS. This compares to 62% last year.

International recruitment

The Code of Practice for international recruitment of health and social care personnel in England is designed to ensure stringent ethical standards when recruiting health and social care staff from overseas. The Code was last republished in March 2025 with minor updates to streamline and improve the guidance. The Code follows the latest guidance from the World Health Organization and active recruitment from 'red list' countries with the most vulnerable health systems is prohibited.

Health and care worker visa data published by the Home Office shows that the number of visas granted to health professionals has been declining over the past two years. The average number of visas granted to health professionals in each quarter of 2023 was almost 9,000; this has fallen to only 1,500 granted in the last quarter of 2025. The decrease in health and care worker visa grants is likely due to a number of factors including the end of the centrally supported nurse international recruitment programme and changes in demand for international staff.

Industrial relations

DHSC continued to work closely with trade unions and key stakeholders in 2025-26 to improve the working conditions of NHS staff. This work includes:

- getting the basics right for resident doctors through the 10 Point Plan being delivered by NHS England. As part of this, a reformed exception reporting system for resident doctors went live on 4 February 2026 to ensure resident doctors are fairly compensated for the additional work they do, and unsafe working practices can be identified and resolved quickly

- continuing to deliver the non-pay workstreams from the Agenda for Change deal agreed in 2023. This includes measures to improve reporting and prevention of violence and aggression in the workplace and supporting local employers to correctly and consistently implement the NHS Job Evaluation scheme, and

- a new commitment to nursing, that provides fairer recognition, stronger support and a clearer future for the profession. This includes work to review the work of every band 5 nurse and establishing a single national nursing preceptorship standard.

In 2025-26, the British Medical Association Resident Doctor Committee (BMA RDC) entered into dispute over pay and jobs and subsequently secured mandates for industrial action. During 2025-26, the BMA RDC took 15 days of strike action from 25 to 30 July, 14 to 19 November and 17 to 22 December 2025, followed by a further six days of strike action in 2026-27 (7 to 13 April 2026). On 29 June 2026, the government agreed a deal with the BMA RDC which resolved the dispute. The agreement covered pay scale reform, the creation of up to 4,500 additional specialty training posts over three years and a range of wider measures to support and improve the working lives of resident doctors.

In March 2026, the governments in England, Wales and Northern Ireland provided a joint mandate to the NHS staff Council to negotiate changes to the Agenda for Change pay structure. This followed recommendations from the NHS Pay Review Body in 2024 and 2025. The pay structure changes took effect on 1 April 2026.

Pay round

The government accepted the 2025-26 headline pay recommendations in full. NHS staff on Agenda for Change Terms and Conditions received a 3.6% uplift and doctors received a 4% uplift. Resident doctors also received an additional £750 consolidated payment. We funded pay rises of 4% for GPs and the pay elements of the NHS dental contract increased by 4%.

We are committed to improving the pay round timetable and we remitted the Pay Review Bodies (PRBs) for recommendations on pay for 2026-27 on 22 July 2025, much earlier than in previous years. We received the NHS PRB report on 5 February 2026 and the

Review Body on Doctors' and Dentists' Remuneration report on 17 March 2026 and responded to both PRBs more quickly than in previous years.

The government accepted the 2026-27 headline pay recommendations in full meaning Agenda for Change staff received an increase of 3.3% in April 2026. This is the first time pay has been in pay packets (without the need for retrospective backpay) in April for six years. Doctors will receive an increase of 3.5% backdated to 1 April 2026 and the pay elements of the NHS dental contract will increase by 3.75%.

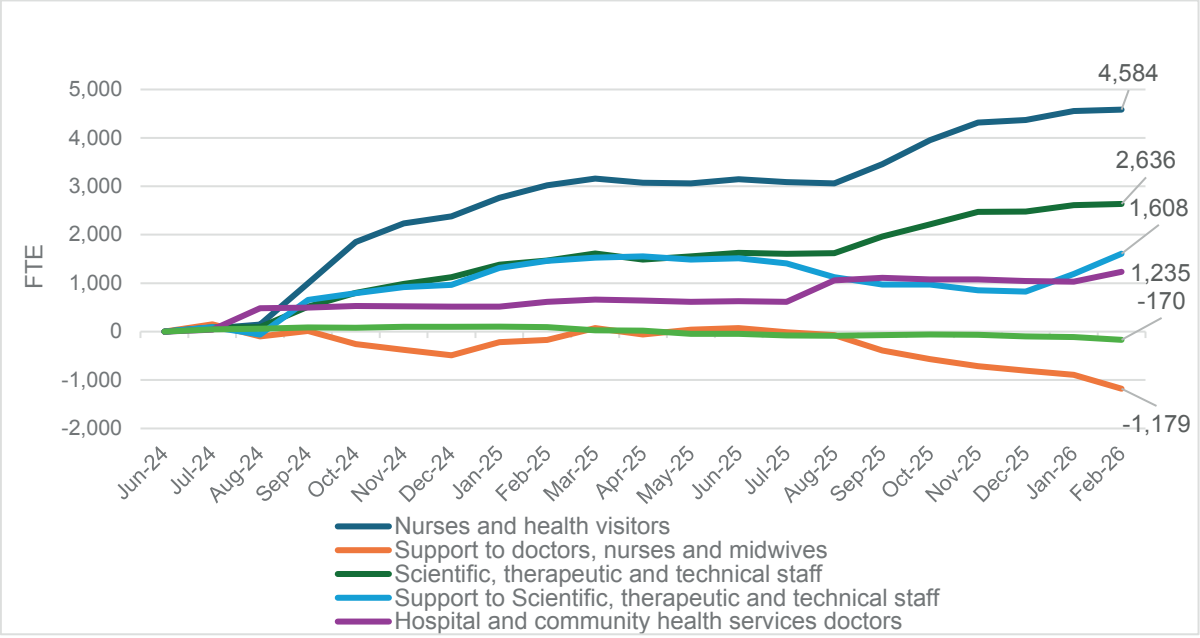
NHS PeoplePortal

In October 2025, the NHS Business Services Authority awarded Infosys a £1.2 billion contract to deliver NHS PeoplePortal, which replaced the Electronic Staff Record. Infosys took over the running of the existing system on 1 September 2026, alongside designing and building the new shared workforce platform for NHS organisations across England and Wales. Over the 15-year contract, NHS PeoplePortal aims to improve colleague experience, support workforce transformation, simplify processes and reduce reliance on local workforce systems, with the potential to generate significant efficiencies and financial savings.

Mental health workforce

In February 2026, the government met its commitment to recruit an additional 8,500 mental health workers. These new staff included more than 1,200 doctors, over 4,500 nurses and a wide range of other staff, helping to reduce pressure on services and strengthen support for patients. While the number of support staff recorded in this period decreased, this is likely to reflect seasonal workforce variation, training flows and movement of staff into qualified clinical roles, rather than a sustained reduction in workforce capacity.

Figure 24: Growth in mental health workforce by staff group, since June 2024



GP workforce data

The number of doctors in general practice has continued to grow in 2025-26. As of March 2026, in England, there were 40,129 full time equivalent (FTE) doctors in general practice, including 30,071 FTE fully qualified GPs, which is the highest number of fully qualified GPs since the introduction of the current methodology in September 2015. Funding for PCNs to recruit recently qualified GPs via the Additional Roles Reimbursement Scheme continued throughout 2025-26, totalling £160 million in funding since October 2024. As of March 2026, this has prevented over 3,580 GPs (by headcount) from graduating into unemployment, with over 2,300 individual GPs actively in post through the scheme.

Adult social care (ASC) workforce

Workforce capacity in ASC has grown. Skills for Care data shows in 2025-26 there were just under 1.59 million filled posts, an increase of 20,000 (1.27%) from 2024-25.

Table 4: ASC workforce by job roles, by year

	Direct care for example, care workers, personal assistants	Managers	Regulated professions	Other	Total workforce filled posts
2025-26	1,195,000	127,000	64,000	202,000	1,588,000
2024-25	1,185,000	122,000	62,000	199,000	1,568,000

Source: Skills for Care, Trended data download – 2016-17 to 2025-26

We are strengthening the adult social care workforce through actions to attract, develop, support and retain staff. These include:

Recruitment campaigns

The 2025-26 ASC recruitment campaign launched on 6 October 2025 and ran until 15 March 2026. Advertising ran via radio, TV and social media and drove people with the right skills and values to apply for paid vacancies in the sector.

International recruitment

Care workers became eligible for the Health and Care visa in February 2022 with international recruitment driving workforce growth. Following rule changes on 22 July 2025, employers can no longer recruit care workers and senior care workers from overseas. A transition period to 2028 allows in-country applications (including from other visa routes) where individuals are already working in the adult social care sector.

DHSC made £12.5 million available in 2025-26 to fund 15 regional partnerships to support international care workers impacted by employer sponsor non-compliance into new jobs. We are making up to £7.5 million available in 2026-27 to continue this support.

Skills and qualifications

In 2025-26, DHSC supported adult social care workforce skills and development to enable high-quality care. This included over £12 million through the Learning and Development Support Scheme, up to £2.3 million for newly qualified social workers and up to £1 million for Individual Employers and their Personal Assistants. In addition, we refreshed Care Certificate Standards (April 2025) and launched the health and care foundation apprenticeship (May 2025).

We also invested over £48 million in Social Work training via the social work bursary and education support grant and consulted on both schemes in early 2026 to improve their effectiveness.

Fair pay agreements

The ambition to implement a fair pay agreement (FPA) was set out in the government's Next Steps to Make Work Pay plan in October 2024. On 18 December 2025, the Employment Rights Act 2025 received Royal Assent, establishing a framework through which an agreement for the adult social care sector can be negotiated and reached.

The public consultation on Fair pay agreement processes in adult social care was launched on 30 September 2025 and ran until 16 January 2026 alongside a full engagement programme with sector partners. A response to the consultation was published on 16 July 2026. Secondary legislation is now in development to enable the new adult social care negotiating body to be established.

£500 million has been earmarked at the last Spending Review for local authorities to implement improvements to pay and terms and conditions as set out in the first Fair Pay

Agreement, which will come into force in 2028. The £500 million forms part of an increase of over £4.6 billion of additional funding available for adult social care in 2028-29, compared to 2025-26.

Adult social care workforce pathway

In April 2025, in partnership with Skills for Care, DHSC published the expanded and revised Care Workforce Pathway, including additional role categories for registered and deputy managers, personal assistants, and a new enhanced care worker role category.

DHSC worked with Skills for Care in 2025-26 to deliver an implementation programme supporting providers interested in adopting the Pathway. More than 125 providers became Pathway Pioneers, and six regional systems came together to use the pathway. Taken together, this work encompassed a workforce of over 200,000.

Cross-cutting work area 2 – New Hospital Programme



Cross-cutting work area 2: New Hospital Programme

New Hospital Programme

The New Hospital Programme (NHP) was established in October 2020 to address the crumbling, outdated hospital estate. Following a review, the government published a revised, costed Plan for Implementation in January 2025, setting out delivery through five-year waves of investment. The programme's delivery waves and schemes are shown in **Figure 25**.

The appointment of the programme delivery partner in April 2025 has strengthened the capacity to deliver the programme. The Health Delivery Partnership is working closely with NHP to provide the expertise needed, including technical design support, commercial functions, programme delivery capability and other specialist skills, processes, and tools necessary to support the successful delivery of the NHP.

Through the programme's bespoke commercial framework, the Hospital 2.0 Alliance, Trusts will acquire contractors to deliver their scheme. In March 2026, the NHP appointed ten construction partners to the Alliance framework. The Hospital 2.0 Alliance establishes a different way of contracting for building hospitals which will secure market appetite, provide commercial flexibility and enable efficiencies through the standardised design.

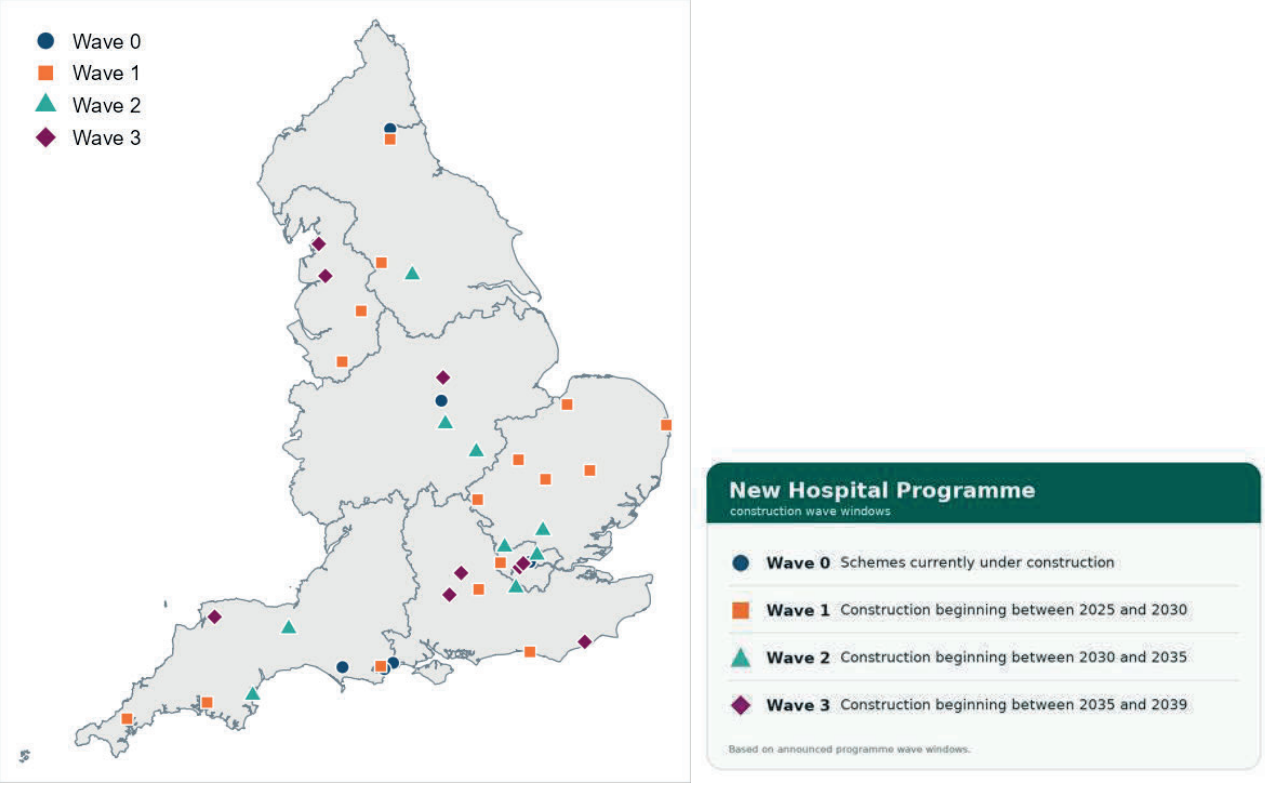
As at 31 March 2026, the NHP had funded, supported and delivered seven hospitals which are now complete and open to patients: the Northern Centre for Cancer Care; Royal Liverpool University Hospital; Dyson Cancer Centre, Bath; Greater Manchester Major Trauma Hospital; Midland Metropolitan University Hospital; Brighton 3Ts Hospital (Stage 1); and the CEDAR (Care Environment Development and Re-provision) programme which delivers state-of-the-art mental health and learning disability facilities in the North East of England.

One of these schemes, Brighton 3Ts, has additional phases, for the new Sussex Cancer Centre, and is being supported by the NHP to complete these.

Three schemes, Alumhurst Road Children's Mental Health Unit (Seastone); St Ann's Hospital; and the National Rehabilitation Centre were open to patients as of September 2026.

Four more NHP schemes are in main construction: Oriel Eye Hospital; Dorset County Hospital; Royal Bournemouth Hospital; and Derriford Emergency Care Hospital, with enabling works being delivered at some Wave 1, Wave 2 and Wave 3 schemes.

Figure 25: Location of NHP schemes per wave



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Source: Office for National Statistics

Five of the seven hospital schemes replacing hospitals built wholly or mainly from reinforced autoclaved aerated concrete (RAAC) are now at Outline Business Case stage having had their Strategic Outline Cases approved. The programme continues to prioritise the RAAC schemes to protect patient and staff safety.

The NHP continues to work with trusts to progress schemes in line with the published Plan for Implementation. By bringing together industry expertise, staff and patients, its standardised approach aims to deliver modern, sustainable hospitals more quickly and cost-effectively, while reflecting the needs of individual schemes.

Cross-cutting work area 3 – Technology and innovation

Cross-cutting work area 3: Technology and Innovation

Federated Data Platform

The NHS Federated Data Platform (FDP) is a national platform developed by NHS England that enables NHS organisations to securely connect, access and use operational data held across multiple local systems. The platform supports faster and more coordinated care by bringing together data that has historically been fragmented, while maintaining local data controllership for each organisation.

The FDP's role was reinforced in the Medium Term Planning Framework 2026-27–2028-29, which set out the expectation that all providers across acute, community and mental health, and ICBs onboard to the FDP and start making use of core products, data capabilities and population health management tools by 2028-29.

FDP is a key enabler of the NHS's long-term ambition to move from analogue to digital processes, support a shift from hospital-centric care to community-based models, and place greater emphasis on prevention.

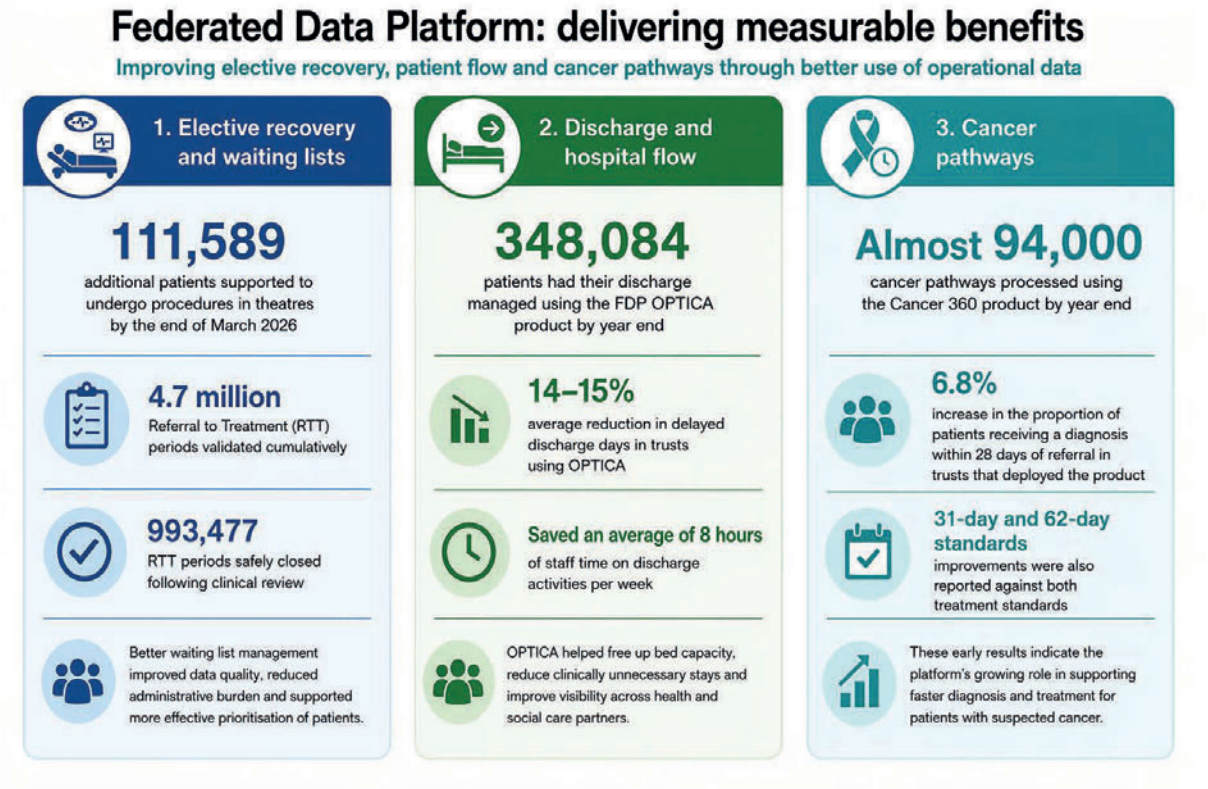
Delivery exceeded the original programme plan, which anticipated adoption of 100 organisations as FDP expanded to more trusts and ICBs than expected, including supporting national reporting and delivery of the vaccination programmes.

During 2025-26, the FDP programme scaled significantly in both adoption and impact. As of 31 March 2026, 171 NHS Trusts and 41 ICBs were part of the programme, with participation spanning acute, mental health, community and ambulance providers. Uptake was strengthened as organisations expanded their use of FDP by adopting additional products, resulting in 96 additional product deployments entering delivery during the year. These products included:

- **Strategic Commissioning Tool:** Data-driven strategic commissioning of Population Health Management interventions
- **System Co-ordination Centre:** Enables secure, scalable data integration, empowering local health and care organisations working within an Integrated Care System to make data-driven decisions for improved patient flow and proactive risk mitigation

The programme continued to mature its product portfolio with 10 local products in general availability by the end of the year.

Figure 26: Federated data platform: delivering measurable benefits



Note: Benefits reflect 2025-26 Quarter 4

Beyond acute care, FDP supported progress towards more preventative and community-based models of care. The programme enabled deployment of the Crisis Response product to support people experiencing mental health crises to be assessed and treated outside Urgent and Emergency Care settings. Population Health Management and Strategic Commissioning tools were also used by ICBs to identify higher-risk cohorts, plan services more proactively and help prevent avoidable admissions. These developments align directly with the NHS's ambition to reduce health inequalities, and the number of years people spend in ill health.

The lifetime cost of the FDP programme includes both revenue and capital expenditure, with costs associated with product development, deployment and the creation of enduring assets.

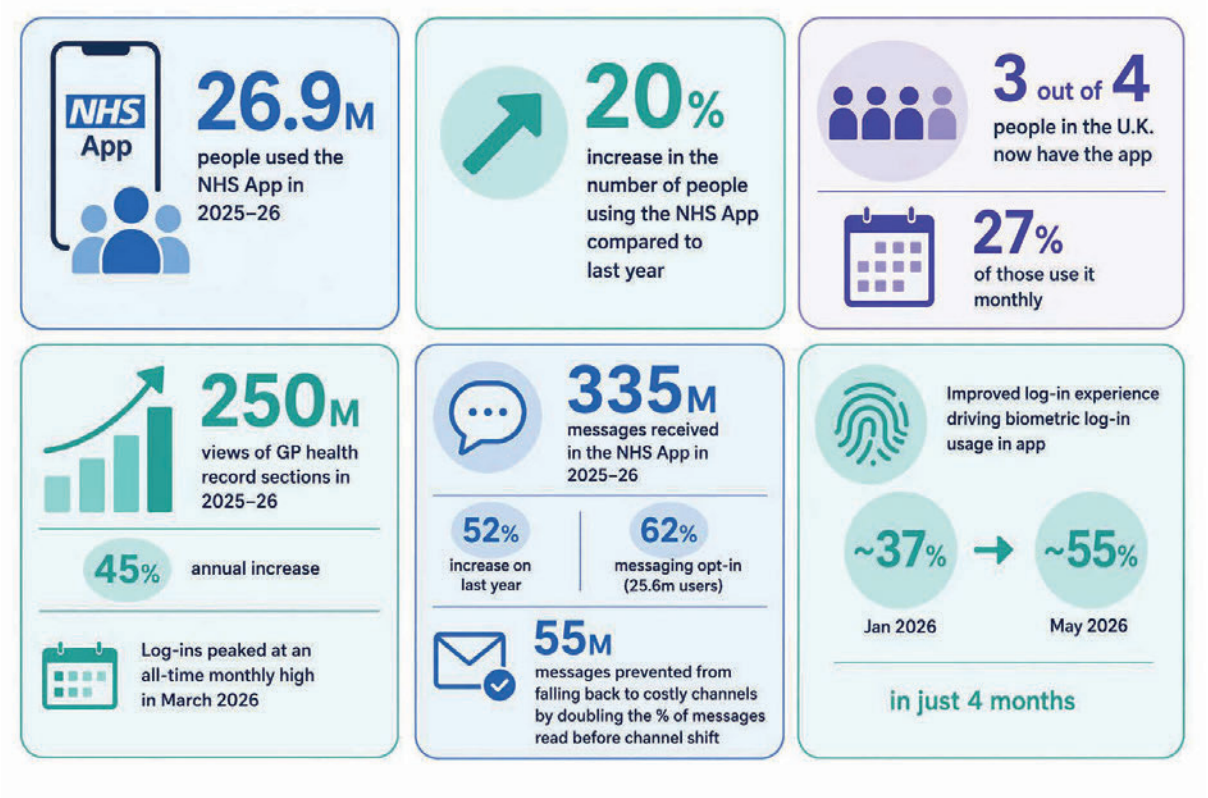
Overall, FDP continued to demonstrate strong value for money during 2025-26. The programme's latest lifetime benefits forecast continues to show FDP benefits delivery considerably exceeding FBC targets. Delivery during the year remained within approved budgets and was supported by established financial, commercial and delivery controls. Independent evaluation has been commissioned to assess the programme's impact, delivery and value for money.

The programme continued to face challenges during the year, including workforce and capacity pressures, increasing demand for FDP products, and the need to balance rapid scale-up with product assurance and service stability. These risks were actively managed through strong programme governance, prioritisation and phased delivery approaches.

In line with best practice and the programme's commitment to ensure the NHS FDP achieves maximum impact, Imperial College Projects has now been commissioned to conduct an independent evaluation. The evaluation will assess the programme's impact, effectiveness and value for money and help ensure the programme's aims are being achieved.

NHS App

Figure 27: NHS App usage



Supporting elective recovery

Transforming access to hospital and specialist appointments through the NHS App

We are making it easier for patients to manage their care through the NHS App: all 134 NHS acute and specialist acute trusts commissioned for adult services are now connected to the NHS App for referral and appointment management, as well as 15 NHS mental health and community trusts, enabling patients to view and manage their hospital and specialist appointments in one place.

Over 100 trusts also now offer patients under their care additional capabilities such as receiving appointment reminders, viewing appointment letters, and completing pre-appointment information via the NHS App.

Patients used these services 75 million times in 2025-26 – a 97% year-on-year increase, improving patient experience and freeing up NHS capacity by helping to reduce missed appointments, avoidable queries and administrative burden.

Supporting primary care access

All pharmacies can now access real-time GP records, reducing clinical risk for over 80,500 patients since April 2025.

In the biggest change to sexual health services since the 1960s, the Emergency Contraception Service was launched nationally, supporting over 146,000 women.

More than 7.8 million patient registrations were completed via the GP Registration service, with over 130,000 patient registrations automatically accepted via The Phoenix Partnership GP IT integration. 93.5% of eligible submissions are now completed within 30 minutes of submission.

Sickness to prevention

National screening programmes have undergone major digital transformation, introducing services that free up staff time and give participants more flexible options. This year, digital communications (via the NHS App or text message) for cervical screening replaced more than 5.6 million paper letters, sending results out to people faster and more securely and cutting costs.

The Record a Vaccination Service is live across over 1,250 sites, including community pharmacies and maternity units. It has replaced manual data entry, saving clinicians time administering vaccinations. Manage Vaccinations in Schools (Mavis) is now used by over 40% of school-aged immunisation teams, replacing paper processes with digital consent. In pilot areas this has contributed to over a 25% increase in consent and over 10% increase in vaccine uptake. These services ensure real-time data sharing with GP practices, creating a safer, more accurate national record for patients.

The NHS Health Check online service has been introduced in 10 local authority areas and 28 GP practices, making it easier for people to complete checks that support early detection of cardiovascular disease and strokes. This service is a first of its kind for the NHS App and includes at-home blood testing and risk calculations.

Increasing NHS efficiency and reducing costs

75 million repeat prescription orders were undertaken in the NHS App. This represents a 35% increase on the previous financial year, saving significant processing time for general practices and patients.

Over 75 million patient letters have been replaced this year with messages via digital channels, providing significant savings and improving the patient experience.

Addressing digital exclusion

The app strengthened its accessible design through external audits and partnerships with charities including the Royal National Institute for Deaf People, Royal National Institute for Blind People and Mencap. User research was updated so every round includes people with accessibility needs and those from areas of high deprivation, helping ensure services work for all.

A new Accessibility Lab opened in London, building on the success of the initiative in Leeds. The Lab provides teams with the tools, expertise and support to improve accessibility and inclusive design across NHS services.

Work also focused on groups facing barriers linked to deprivation and limited digital skills. The Public Libraries Partnership was expanded to better connect health services with libraries, helping more people get online and access digital health tools.

Engagement with community organisations continued, including Smartlyte in Birmingham and the Good Things Foundation. During Get Online Week, NHS App teams worked in community settings to support people to use the App.

The NHS App Ambassador network grew to over 3,000 NHS staff volunteers. Through a partnership with the Good Things Foundation, they offered free data SIM cards to the public. Pilot programmes with Boots and Virgin Media O2, supported locally in Leeds, trained staff to provide in-person help and access to free data. Further collaboration is underway with all the major mobile networks to make sure people do not use up their data to access the NHS website and App, including video content that is shown to be especially helpful for groups with lower levels of literacy.

Artificial intelligence

2025-26 saw a pivotal shift in DHSC’s approach to artificial intelligence, moving from the time-limited NHS AI Lab programme to a sustained, operational AI capability delivered through the NHS AI Team. This transition signals a clear move beyond experimentation and pilot initiatives towards scaling solutions, driving adoption, and embedding AI into routine health and care delivery.

The NHS AI Lab programme, which closed in March 2025 and had a lifetime spend of £144 million, laid important groundwork across areas such as infrastructure, evidence generation, governance, and wider ecosystem development. In 2025-26, the NHS AI Team had a budget of £2 million and focused on building on this legacy, placing particular emphasis on enabling adoption pathways, strengthening national coordination, and supporting the safe and effective deployment of AI technologies across the health system.

As AI adoption expands, it is important to address known implementation challenges, including data quality, the risk of algorithmic bias, workforce readiness, and barriers to deployment. In response, the NHS AI team has taken forward a range of measures to support the safe, effective and responsible adoption of AI across priority use cases, including developing implementation guidance, strengthening governance arrangements, supporting evaluation, and improving organisational readiness for adoption.

The NHS AI team has published national guidance on Ambient Voice Technology (AVT) to address common barriers to adoption, including uncertainty around clinical safety, information governance, procurement, assurance and implementation. This was supported by a national supplier registry, supplementary guidance and communities of practice to help organisations adopt AVT safely, consistently and at scale.

In May 2025, the Responsible AI Adoption Committee was established to support NHS England teams in the design and implementation of AI projects. The committee brings together expertise across legal, technical, information governance, user and patient experience, and evaluation disciplines. By March 2026, the committee had reviewed and supported 18 projects, including the national Copilot rollout and an AI-Assisted Discharge Tool.

Further work is underway to support the responsible adoption of AI across health and care, including guidance on AI in triage and autonomous AI systems, a refresh of the AI Buyer's Guide, development of an AI Readiness Checklist, and initiatives to strengthen evidence generation and evaluation. NHS England has also continued to support the development of evaluation and monitoring approaches for large language model technologies to help ensure AI systems are safe, effective and appropriate for deployment in clinical settings.

Following the publication of the AI Opportunities Action Plan in early 2025, the same year also saw the release of the 10 Year Health Plan in which AI is a central theme. The plan highlights the transformative potential of AI in delivering improved outcomes for patients, particularly through the three strategic shifts from analogue to digital, from hospital to community care, and from sickness to prevention.

The DHSC AI Team is developing tools to drive productivity, support better quality policy-making, and enable more data-driven decision making such as supporting in-depth intelligent analysis of governance data across the care sector. AI pilots have been run in collaboration with OGDs and external organisations as well as on the DHSC Data

Analytical Cloud. Work is underway to build AI capability across the department. The DHSC AI Team recently delivered the Cabinet Office-led One Big Thing initiative 'AI for All' to over 5,000 attendees across the health and care system resulting in a 56% increase in confidence using generative AI.

In parallel, the NHS AI Team is translating this momentum into practice by supporting the safe, effective, and scalable adoption of AI through guidance, governance, and real-world implementation across priority use cases.

In this context, work has been taken forward across a range of priority areas where AI can support patients, clinicians, and the wider health and care system, with a strong focus on practical delivery and real-world impact. Examples of this work are: -

- **the AI Ambassador Network:** established in 2025, the AI Ambassador Network has grown to over 15,600 members, providing a learning forum for sharing AI use cases and influencing adoption across health and care. It meets monthly with average attendance of 1,711 and has helped promote wider AI communities while shaping strategy and policy in response to the 10 Year Health Plan

- **AI Digital Regulations Service:** The AI Digital Regulations Service was developed to simplify the complex regulatory landscape for AI in health and care. It provides a trusted, centralised platform where users can access clear, authoritative guidance directly from source, supporting both developers and adopters with varying levels of experience

- **AI Readiness Checklist:** The £99,000 AI Readiness Checklist initiative, supported by NHS England, the Health Foundation, and MHRA, enables safe and equitable AI adoption by promoting robust governance, infrastructure, and workforce readiness. It defines a practical standard for "AI readiness," reducing variation, mitigating risks, and supporting scalable deployment across the NHS

- **Ambient Voice Technology:** The NHS AI Team is supporting the safe and scalable adoption of Ambient Voice Technology through national guidance, regulatory clarity, procurement support, and coordinated pilots. As a priority use case, it aims to reduce administrative burden and improve patient experience, while ensuring strong governance and clinical safety

- **AI Triage Guidance:** Work on AI-assisted triage focuses on developing national guidance, assurance mechanisms, and policy clarity to support safe adoption. It also addresses regulatory challenges, particularly for generative AI tools, which require new approaches to classification, oversight, and incident management

- **Automated retinal image analysis systems:** With a budget of £240,000, the NHS AI team and partners have developed a 'revolutionary platform' to deliver the

world's first fair, equitable and transparent evaluation of AI systems to detect sight-threatening diabetic eye disease. In total, 202,886 screening visits were evaluated, representing 1.2 million images from various ethnic groups. Each screening visit took just 240 milliseconds to 45 seconds to analyse across all eight AI systems, compared with up to 20 minutes for a trained human

- **BRIDGE-AI Pilot (AI Monitoring in breast screening):** The £97,000 BRIDGE-AI pilot examined how changes in imaging and algorithm versions affect AI performance in breast screening. Its findings have informed requirements for monitoring and data access, supporting policy development to manage performance degradation in large-scale deployment

AI has been adopted in a safe and scalable way, moving from pilot activity to operational delivery in line with the 10 Year Health Plan. It translates policy into practice through guidance, assurance, and capability-building initiatives, acting as a bridge between innovation, policy, and frontline delivery.

Data

DHSC's mission is to shape an innovative data-led culture that unlocks the potential of our health and care data assets in a secure, legal and ethical way, enhancing our data science, analysis and research capabilities to enable decision-making that helps people to live more independent, healthier lives for longer.

In 2025-26, major achievements included:

- **Health statistics data provision and publishing:** The Fingertips service is providing access to public health data, analysis and insights to inform the Public Health Outcomes Framework and a range of Official Statistics, with access via Application Programming Interfaces, downloads and managed reports, now being rebuilt as a modern, fully compliant GOV.UK digital service. We are securing the future of data-led public health and ill health prevention through migrating from outdated systems to resilient cloud provision

- **DHSC Analytical Cloud (DAC) Platform:** This Azure data platform is built in-house and provides data pipelines from NHS England and wider data sources with tools for analysts, including compute clusters and dashboarding abilities, and this year safely launched the capability to host internal and external facing data products for sharing

Cross-cutting work area 4 – Pandemic preparedness



Cross-cutting work area 4: Emergency preparedness, resilience and response

DHSC is the lead government department for preparedness for human disease risks including pathogens with pandemic potential, emerging infectious disease including an outbreak of a high-consequence infectious disease, and antimicrobial resistance.

DHSC published on 26 March 2026 the Pandemic Preparedness Strategy which set out how the UK intends to rebuild readiness for future pandemics through a whole-of-government approach that prioritises the needs of the most vulnerable. The strategy includes actions to implement improvements to pandemic preparedness in England by 2030, building on lessons identified from the COVID-19 pandemic and the UK COVID-19 Inquiry and initial findings from Exercise Pegasus (the 2025 national pandemic preparedness exercise).

Exercise Pegasus was held in autumn 2025 to test our ability to respond to a pandemic, involving all nations of the UK and thousands of participants. The final exercise phase focusing on recovery concluded in summer 2026.

DHSC is embedding a new strategic approach to pandemic preparedness, including learning from COVID-19 and initial findings from Exercise Pegasus. This approach is based on having a range of response capabilities that are adaptable, flexible, and scalable and can be applied to a pandemic threat regardless of the route of disease transmission (respiratory; oral; sexual/blood; contact; and vector).

The range of capabilities required to respond to a pandemic includes equipment (for example stockpiles and countermeasures, such as medicines and vaccines), skilled people (for example research, science, and laboratory staff) and infrastructure (for example laboratory, testing, and treatment facilities). These resources are represented in the core capabilities of the UK Health Security Agency (UKHSA), such as surveillance and diagnostics, and the response capabilities of the wider health and care system, in particular the NHS and adult social care.

DHSC continues to explore innovative options for access to countermeasures which may provide additional resilience, provide better value for public money, and reduce the levels of stock that need to be held.

In March 2026, DHSC supported NHS England, UKHSA and local partners to respond to the meningococcal group B outbreak in Kent.

Local NHS teams and national public health experts worked closely with businesses, universities, schools and colleges to protect students, families and the wider community. This was done through:

- providing clear advice on symptoms and when to seek medical attention
- alerting frontline clinicians to ensure early recognition of cases
- deploying 50,000 doses of stockpiled antibiotics to the local area to ensure rapid access for those at highest risk
- targeted meningitis B vaccination has also been introduced to provide longer-term protection for students and young people in the area. Vaccination was offered to all those who have received preventative antibiotics, and students in years 12 and 13 in schools and colleges in Kent where confirmed or probable cases were identified

The Joint Committee on Vaccination and Immunisation was requested to re-examine eligibility for meningitis vaccines to assess, for example, an expanded offer to older children and/or young adults. Updated advice was issued and in June 2026 a time-limited Meningitis B vaccine offer was made available this summer for Year 13 students and people aged under 25 who would be starting university as undergraduates or moving into residential further education settings for the first time in autumn 2026.

Cross-cutting work area 5 – Science, research and evidence



Cross-cutting work area 5: Science, research and evidence

DHSC leads and funds a highly productive research programme, delivered primarily through the National Institute for Health and Care Research (NIHR), the research operational arm of DHSC. NIHR research is one of the core delivery mechanisms through which the 10 Year Health Plan and its three major shifts will be delivered. The government's plan explicitly recognises research, life sciences and innovation as critical to creating an NHS that is fit for the future and capable of moving from hospital to community, analogue to digital, and sickness to prevention.

The digital transformation of the NHS depends on research into AI, genomics, digital therapeutics, diagnostics, health data and real-world evidence. Research determines which technologies are safe and cost-effective before they are adopted at scale.

Research generates the evidence needed to redesign care pathways, test new models of community-based care, and identify which interventions deliver the best outcomes outside acute settings. Clinical trials, health services research, digital monitoring technologies and implementation science enable care to be delivered close to home, reducing pressure on hospitals and improving patient experience.

Prevention is fundamentally evidence driven. Research identifies risk factors, evaluates preventive interventions, improves screening programmes and enables earlier diagnosis. Advances in genomics, predictive analytics and population health research allow earlier intervention before illness develops, supporting longer, healthier and more productive lives.

The Life Sciences Sector Plan is built around strengthening the UK's position as a global leader in health innovation. It seeks to make the UK the leading life sciences economy in Europe and a global leader in attracting investment, developing new treatments and commercialising innovation. DHSC funding of research through the NIHR is the foundation of this ambition because it provides the discoveries that become future medicines, diagnostics, devices and digital technologies. DHSC, through the NIHR, funds the clinical trials infrastructure that allows innovations to be tested and adopted, gives awards to maintain the talent pipeline of scientists, clinicians, data scientists and innovators of the present and the future and funds the evidence that attracts domestic and international investment.

NIHR research is a powerful engine for economic growth, delivering over £13 in economic and social benefit for every £1 invested, over 60 years. Initial estimates suggest that

activity funded or enabled by the NIHR in 2025-26 will contribute £8.8 billion of Gross Value Add to the UK economy.

In 2025-26, 86% of guidelines from NICE (the National Institute for Health and Care Excellence) included evidence from NIHR research.

In 2025-26, 878,698 participants took part in 4,536 recruiting studies supported by the NIHR Research Delivery Network, delivered by the NHS and social care sector. NIHR research is informed by the public; in 2025-26 over 10,000 public contributors have helped us shape and prioritise our research.

Key work included supporting the 10 Year Health Plan as follows:

- **Shifting from analogue to digital:** In December 2025, NIHR launched a trial for localised prostate cancer treatment in the UK. The international trial is investigating whether a novel therapy using robotics, AI and real-time imaging is as effective as traditional surgery. The therapy can help deliver precise treatment that is less invasive and improve a man's quality of life following surgery. This study is a great example of how NIHR is supporting the government's landmark Men's Health Strategy which places a strong focus on improving prostate cancer care

- **Shifting from hospital to community:** Co-developed by NIHR and the National Association of Primary Care, the Community Health and Wellbeing Workers (CHWWs) programme was recognised in the 10 Year Health Plan as a blueprint for prevention and integrated community care. In this pioneering approach CHWWs bring care to people where they are, visiting around 100 homes each and connecting with more than 500 residents in their local communities. They provide tailored support, helping people navigate healthcare services, access screenings and immunisations, and connect with social support networks. Their role is designed to tackle health inequalities and ensure that no one is left behind. Communities supported by CHWWs have seen substantial increases in immunisation, screening, and NHS Health Check uptake, alongside reductions in hospital admissions and emergency visits

- **Shifting from sickness to prevention:** NIHR enabled the world's first participant testing of a 'fridge-free' vaccine for tetanus and diphtheria. This innovation will have a significant impact on global health, dramatically reducing vaccine wastage and the costs of storage and transport, with the potential to make vaccines far more accessible in parts of the world where refrigeration is limited and the need is greatest

- **Driving economic growth:** NIHR launched the Life Sciences Industry Hub, a single, nationally coordinated front door for industry and the operational backbone for commercial clinical research in England. The Hub supports life science

companies around the country to make the UK a faster, more predictable, and higher-performing environment for global commercial research

On 7 April 2025, the then Prime Minister announced up to £500 million of government funding, alongside a £100 million investment from Wellcome, to establish a Health Data Research Service (HDRS). HDRS will provide a single point of access to health data for multiple sources, supercharging research to deliver significant health and growth benefits to the UK. It will also help accelerate discoveries that lead to better treatments and outcomes for patients. DHSC, with support from the Department for Science, Innovation and Technology and NHS England, led the set-up of the HDRS to ensure that it is ready to be operational by the end of 2026.

In 2025-26, NIHR supported 707 commercially-sponsored studies in the UK, the highest in a decade – and more than 100 global or European 'first participants' were recruited by UK sites. A global (or European) first means a UK site was the first in the world (or Europe) to enrol a patient into an international study, demonstrating the UK's leadership in new and innovative medical treatments.

Clinical trials

DHSC has worked with partners across the NHS, regulators and research system to make clinical trial delivery much faster, more predictable and more competitive for the life science sector, supporting economic growth and greater patient access to new medicines. The UK is making strong progress towards faster clinical trial set-up. For commercial interventional trials beginning set-up in the first half of the year, the median time to set up a study fell to 122 days from 169 days in the equivalent period the previous year, while the proportion completing set-up within 150 days increased from 45% to 73%.

In the latest reported months, every eligible study met the target - helping patients access potentially groundbreaking treatments sooner and strengthening the UK's offer to the global life sciences sector. This progress was supported by action to reduce bureaucracy and streamline national processes, the new NIHR Industry Hub's work to help companies navigate the system, and substantial government-industry investment under the Voluntary Scheme for Branded Medicines Pricing, Access and Growth Investment Programme. This included the launch of 35 new Commercial Research Delivery Centres in hospitals and primary care settings across the UK.

DHSC group financial performance

DHSC is accountable to Parliament for ensuring that total spending by all bodies within DHSC group is contained within the overall budgets approved by Parliament as set out in **Table 5** (note: table may not cast due to rounding).

Table 5: DHSC Departmental Outturn 2025-26 against Parliamentary and HM Treasury Controls

	Budget £m	Outturn £m	Underspend/ (overspend) £m	Key disclosure notes/further detail
Parliamentary Controls:				
Resource Departmental Expenditure Limit (RDEL)	210,676	208,981	1,695	SOPS 1.1, Annex B
of which: Resource Administration	3,839	2,895	944	SOPS 1.1, Annex B
Capital Departmental Expenditure Limit (CDEL)	13,625	13,316	309	SOPS 1.2, Annex B
Resource Annually Managed Expenditure (RAME)	10,000	3,226	6,774	SOPS 1.1, Annex B
Capital Annually Managed Expenditure (CAME)	549	266	283	SOPS 1.2, Annex B
Net Cash Requirement	194,029	183,588	10,441	SOPS 3
Further HM Treasury Controls:				
Ringfenced Resource DEL	6,207	4,920	1,287	Annex B
Non-ringfenced Resource DEL	204,469	204,060	409	Annex B

Resource departmental expenditure limit (RDEL)

DHSC's 2025-26 budgets were agreed as part of the 2025 Spending Review (SR25). During 2025-26, DHSC faced challenges in managing inflationary pressures and rising costs within SR25 funding. However, through careful prioritisation and financial management, expenditure was contained within budget.

DHSC underspent the available total RDEL funding by £1.7 billion, comprising of a £0.4 billion underspend against the RDEL non-ringfenced budget, and a £1.3 billion underspend against the RDEL ringfenced budget.

The non-ringfenced RDEL underspend of £0.4 billion (0.2% of the budget) comprised a £75 million underspend in the NHS, and a £334 million net underspend across DHSC and its non-NHS arm's-length bodies. This partially reflects DHSC's prudent management of financial risks arising from industrial action. Contingency funding was held centrally to ensure DHSC could respond to potential cost pressures without seeking additional funding from HM Treasury. As the position on industrial action remained uncertain throughout until late in the financial year and was only resolved in March 2026, there was limited opportunity to redeploy this contingency funding before year end, resulting in an underspend. Additional underspends arose due to higher-than-forecast income relating to

the Voluntary Scheme for branded medicines Pricing, Access and Growth (VPAG) and Public Dividend Capital (PDC) receipts.

The circa £1.3 billion ringfenced RDEL underspend (21% of the budget) reflects lower-than-forecast depreciation and impairment charges compared with the assumptions agreed at the Supplementary Supply Estimate. DHSC completed a commissioning exercise for HM Treasury in September 2025 to set ringfenced RDEL budgets for 2025-26 to 2028-29, as they were not agreed at SR25. The exercise modelled future depreciation and impairment requirements using the agreed SR25 capital envelopes and historical depreciation trends. During 2025-26, actual depreciation and impairment charges were lower than forecast, principally reflecting lower depreciation arising from differences in the timing and scale of capital additions, together with lower impairment charges than anticipated. As a result, the expected growth in non-cash expenditure did not materialise to the extent assumed when the ringfenced budget was set.

Further detail on the RDEL outturn is set out in **Annex B**.

Capital departmental expenditure limit (CDEL)

DHSC's 2025-26 budgets were agreed as part of the SR25. £13.3 billion of capital funding was spent during the year, including on modernising and transforming the NHS estate (including the New Hospital Programme and estate upgrades), supporting the return to constitutional standards (including through improvements in elective and emergency care), and expanding the use of innovative digital technologies.

DHSC underspent the available capital funding by circa £0.3 billion (2.3% of the capital budget). The underspend reflects a combination of lower-than-expected IFRS 16 lease-related capital costs, which were around £0.1 billion below forecast, and a net underspend across other capital budgets of circa £0.2 billion. The latter includes the impact of disposal proceeds and other capital receipts, which are recorded as reductions to capital expenditure.

Further detail on the CDEL outturn is set out in **Annex B**.

Annually managed expenditure (AME)

Expenditure which HM Treasury has deemed demand-led and volatile is treated as Annually Managed Expenditure (AME). DHSC's AME is subject to many variables outside the department's direct control, such as changes to the discount rates in measuring the value of long-term provisions liabilities.

The final Resource AME (RAME) budget in 2025-26 was £10 billion and DHSC underspent against the RAME limit by circa £6.8 billion. This was primarily driven by lower-than-planned costs within NHS Resolution and the core department. In particular, updated

assumptions, including changes in discount rates and inflation, reduced the estimated cost of future clinical negligence liabilities, resulting in a £5.1 billion underspend in NHS Resolution and £1.7 billion underspend in the core department.

Further detail on the AME outturn is set out in **Annex B**.

Capital Annually managed expenditure (CAME)

DHSC's capital AME expenditure has included specific budgeting relating to IFRS 16, the accounting standard for leases, since its implementation in 2022-23. Since 2024-25, capital AME budgets and outturn also include Infected Blood Inquiry interim compensation payments, relating to payments for infected blood support schemes, announced by the government on 21 May 2024.

In 2025-26 DHSC underspent against the CAME limit by £0.3 billion, mainly due to lower-than-expected IFRS 16 lease related capital costs.

Further detail on the CAME outturn is set out in **Annex B**.

Net cash requirement

DHSC underspent against its cash limit by circa £10.4 billion (5.4%). The cash limit was set as part of the Supplementary Supply Estimates and included cash to support the resource and capital budgets, as well as an estimate of working capital required. Around £0.7 billion of the underspend is explained by the resource non-ringfenced and capital DEL underspends of circa £0.4 billion and circa £0.3 billion, respectively. The remaining balance is mainly due to working capital requirements being lower than estimated. The variance arose mainly because the timing of actual payments across the DHSC group were later than expected, meaning less cash was needed in-year than forecast at Supplementary Estimates. Estimating working capital is inherently complex, particularly around year-end, when relatively small shifts in activity or supplier payment behaviour can produce large swings.

Unlike previous years, DHSC did not seek to reduce the Net Cash Requirement (NCR) provision at the Supplementary Estimate to retain additional headroom to mitigate the risk of breaching the Parliamentary Control. This reflected a cautious approach in the context of significant uncertainty around year-end cash requirements and organisational change. As those risks did not subsequently materialise, a larger proportion of the available NCR remained unused at year end.

It should be noted that NCR is primarily a cash management and Parliamentary control measure rather than a measure of underlying expenditure. Changes in the NCR do not necessarily indicate a change in the fiscal position, as they often reflect the timing of cash

receipts, payments and other working capital movements. Accordingly, variances in the NCR may arise without any corresponding change in underlying spending or income.

Notwithstanding the higher NCR underspend, DHSC continued to perform strongly against HM Treasury's principal operational cash forecasting metrics, remaining well within agreed tolerances.

NHS financial sustainability

Financial foundations and governance

Ensuring the financial sustainability of the NHS remained a central priority in 2025-26, supporting the government's ambition to build an NHS fit for the future and the wider reform agenda set out in the 10 Year Health Plan. The plan also set out plans for a new financial foundation for the NHS, with Lord Darzi and others recognising that the existing financial model was becoming increasingly unsustainable.

Throughout the year, financial recovery and operational improvement continued, with a sharp focus on restoring financial discipline, increasing productivity and reducing unwarranted variation in performance.

NHS England's 2025-26 priorities and operational planning guidance, published on 30 January 2025, placed clear emphasis on improving access to timely care for patients, increasing productivity, living within allocated budgets and driving reform. Earlier publication of planning guidance and allocations gave NHS systems a stronger basis for local planning than in previous years, and all systems agreed financially balanced plans at the start of the financial year. Building on this approach, planning frameworks for 2026-27 were shared during summer 2025, with planning guidance and allocation issued in October, enabling all plans to be agreed before 1st April 2026.

During 2025-26, DHSC and NHS England continued to drive and monitor financial discipline, grip and transparency across trusts and integrated care systems. This approach built on the response to the National Audit Office's 2024 report on NHS financial management and sustainability, including a renewed emphasis on timely planning, stronger oversight and more consistent intervention where organisations faced persistent financial or operational challenges. This strengthened approach contributed to improved financial performance across the NHS, with 80% of providers and 67% of systems reporting a break-even position by year end. In addition, reliance on deficit support reduced by more than £700 million compared to the previous year; again, a positive sign of financial recovery.

Notwithstanding this progress, 2025-26 remained financially demanding. NHS organisations continued to face cost pressures associated with demand growth, workforce requirements, service recovery and the condition of the estate. As a result, the overall picture during the year was one of tighter control and stronger governance, but with

continued underlying risk to financial sustainability if reform, productivity gains and service transformation are not maintained over the medium and longer term.

A number of governance and oversight changes were taken forward during 2025-26, including the implementation of updated oversight arrangements and provider improvement support intended to enhance accountability and improve organisational performance. In March 2026, NHS England announced the Intensive Recovery Programme, providing targeted oversight, challenge and support to NHS organisations facing significant financial and operational difficulties to deliver immediate in-year improvements and longer-term sustainability. Alongside this, NHS England continued to emphasise the importance of publishing clearer productivity information and of linking operational recovery more explicitly to financial improvement and value for money.

Financial governance and oversight of NHS finances is evolving to reflect increasingly joint working arrangements between DHSC and NHS England, ahead of the formal planned merger in April 2027. In 2025-26, this included the establishment of a single Director General-Finance role across the two organisations and the development of Joint Finance Committee arrangements to support more aligned decision-making, clearer accountability and closer coordination of financial planning, performance oversight and risk management. These changes are also intended to end any duplication between national bodies and strengthen the link between policy, financial control and delivery.

Productivity and efficiency improvements

Productivity improvements

The impact of the COVID-19 pandemic on NHS productivity was severe, with an estimated decline of between 22% and 25% in 2020-21, according to Office for National Statistics (ONS) and NHS England data. Since 2020-21, NHS productivity has been recovering each year, but NHS England's analysis suggests that acute sector productivity remained around 7% to 8% below pre COVID-19 levels as at the end of 2025-26.

As Lord Darzi’s independent investigation of the NHS in England concluded, driving up productivity through better operational management, capital investment in buildings and equipment, re-engaging and empowering staff and exploiting technology are essential to reducing waiting lists, improving patient care and the financial sustainability of the NHS. Therefore, improving NHS productivity is a cornerstone of the 10 Year Health Plan; Chapter 9 sets out the plans for driving up NHS productivity alongside those for reinventing the NHS financial model.

During 2025-26, the NHS continued to prioritise improvements in productivity and efficiency through the ongoing delivery of the NHS Productivity Plan.

Acute hospital sector productivity has grown by an average of just over 2% per year over the last three financial years. In 2025-26, acute sector productivity grew by 2.6%,

outperforming the 2% target agreed with the HM Treasury in Spending Review 25. This builds upon the 2.7% growth between financial years 2023-24 and 2024-25 and is significantly above the long-term average of 0.6% per year (annual average between 1995-96 and 2018-19 ONS), demonstrating progress towards the NHS's productivity commitments and continued recovery.

These improvements have been supported by interventions across four key areas:

Four drivers of productivity and efficiency improvement	
Operational and clinical excellence Better patient flow, shorter stays and less unwarranted clinical variation.	**Workforce** Better planning, retention and culture to reduce bank and agency spending.
Technology Modern IT, including the Federated Data Platform, the NHS App and digital tools that free up staff time and improve patient experience. The Single Patient Record will also be critical to supporting productivity.	**Reducing waste** Efficiencies in medicines, procurement and automation of corporate services.

Improvements across 2025-26 were associated with changes in operational and clinical performance, including improvements in patient flow, more effective use of clinical capacity, and continued improvement to outpatient services and urgent and emergency care to support more consistent delivery across providers.

Workforce related measures have been a further contributing factor. Reduced reliance on temporary staffing has led to lower levels of agency and bank expenditure compared to the previous year. This has been supported by improvements in workforce deployment to enable more effective use of existing staff resources.

There has also been major investment in IT infrastructure across the current Spending Review period, aimed specifically at digital infrastructure and technologies that will optimise workflows, reduce administrative burdens, and unlock staff time. This includes rolling out Electronic Patient Records to all trusts, enhancing cyber security, and expanding the NHS App.

Work has also continued to support a shift in care towards community-based models. Over time this is expected to improve outcomes and contribute to productivity. NHS England's final figure for acute sector productivity growth in 2025-26 was 2.6%.

NHS England has also developed measures of productivity for non-acute services (community, mental health and ambulance services). While the data quality is less mature than for acute services, when combined these data also show improvements of over 2%.

Further coverage of the impact of productivity and efficiency improvements across specific service areas is set out elsewhere in this performance report.

Efficiency

Under the most ambitious programme of efficiencies and savings ever pursued in the NHS, systems delivered some £10.2 billion of efficiencies and savings in 2025-26, equivalent to 5.2% of budgets. Activity included a wide range of actions to reduce waste and drive greater value for money, such as reducing temporary staffing, improving procurement, delivering service redesign and making improvements in clinical and operational services.

Across the wider DHSC group, the core department and non-NHS arm's length bodies delivered an additional £114 million of efficiencies in 2025-26 through a range of initiatives including estates and procurement improvements, digital transformation, and workforce initiatives. This reflects continued progress in identifying, measuring, and reporting efficiencies across the group, supporting a stronger focus on value for money and productivity.

Sustainability

This section summarises DHSC's sustainability progress and key activity in 2025-26, our environmental performance at a group level alongside our ALBs, our compliance with the 'Task Force on Climate-related Financial Disclosures' recommendations, and how our departmental work supports the global UN Sustainable Development Goals

We recognise that the climate and nature crisis is also one of health, which threatens DHSC's vision to help people live more independent, healthier lives for longer. We are, therefore, committed to minimising the environmental footprint of our own departmental estate and operations, ensuring that we are resilient to projected climate impacts and embedding sustainability at the heart of our work that we do.

Progress and key activity

Highlights



Installed LED lighting and 90 solar panels at our Nottingham office, funded by Government Property Agency (GPA).



Completed our Nottingham office refurbishment using 98% reused furniture, saving 43 tonnes of CO_2e overall.



Agreed new actions to drive net zero, waste minimisation and energy and water efficiency across DHSC's estate.



Increased our proportion of DHSC's ICT waste that is sent for reuse, from 14% to 51% (with the remainder recycled).

Energy

- At DHSC's Nottingham office (our highest priority property for sustainability, due to its long lease length), we switched to LED lighting, installed 90 solar panels and designed a heating electrification scheme, funded by the Government Property Agency.
- In collaboration with our facilities management provider, we agreed a series of new, planned actions to drive energy efficiency and net zero across DHSC's estate.

Waste

- We completed a refurbishment of DHSC's Nottingham office using 98% reused furniture from across the government estate, saving an estimated total of 43 tonnes of CO_2 and £140,000 for the public purse compared to if we purchased new items.
- We donated 120 items of DHSC's own surplus furniture to others for reuse, preventing around four tonnes of waste from arising.
- We avoided around 35,000 single-use plastic stationery items by supplying our staff with a new, sustainable product selection in communal stores at our headquarters offices - an 83% reduction compared to the year prior to implementation.
- At our two staff canteens, we swapped all plastic drinks bottles for glass or can alternatives, to save an estimated 13,000 single-use plastics per year.

Water

- At DHSC's two largest offices in London, we continued to operate water monitoring systems, providing flow rates, temperatures levels and 24-hour major leak detection.
- In collaboration with our facilities management provider, we agreed a series of new, planned actions to drive water efficiency across DHSC's estate.

Nature

- DHSC has an urban office estate with no significant landholdings (this does not include the NHS estate, which is reported on separately by NHS England). However, we recognise that everyone has a role to play in nature's recovery and so we have continued to explore how we can support this at our properties.
- For example, at one of DHSC's London offices, we used our courtyard garden to plant an array of wildlife-friendly plant species.

Food

- At our two staff canteens, we launched a new menu including a variety of plant-based meals and 30% plant-based proteins overall, reducing the environmental impacts of our food and being more inclusive of those with dietary requirements.

Travel

- We evaluated a policy previously introduced within DHSC to restrict domestic business flights to specific exceptional circumstances only and, over 18 months, our related emissions fell by 32% compared to the same period pre-implementation.
- We established a new service whereby DHSC staff can now hire electric vehicles for business purposes, where rail travel is not possible.
- Our Active Travel Staff Group continued to help DHSC colleagues wishing to cycle, run, walk or incorporate other physical activity into their commute, alongside a written guide outlining the relevant provisions and facilities available at our offices.

Climate change adaptation

- In line with our climate change risk assessment and adaptation plan for DHSC's office estate, we set up flood warning alerts for all properties and, where required, upgraded and maintained heating and cooling systems to reduce overheating risk.

Digital

- With 12 tonnes of information and communications technology (ICT) waste requiring disposal (a total of 5,589 items), 51% was reused through resale and charitable donation, and 49% was recycled.
- Whilst we cannot disaggregate our associated spend on ICT waste disposal (as this was incorporated into a broader service charge from our ICT services provider), any costs were offset by £352,576 returned to DHSC from the above device resales.
- In collaboration with our ICT services provider, we held two events for staff where we collected a further 1,800 items of unwanted personal technology for recycling.
- We embedded sustainability into DHSC's new AI guidance for staff, encouraging colleagues to use AI only where needed and to do so efficiently, applying 'green prompting' techniques to reduce its environmental impacts. We also engaged 350 staff on this topic via a webinar plus two in-person training workshops.

Staff engagement

- We continued to run one-day Carbon Literacy training courses (now having trained a total of 77 colleagues), to educate staff on climate change and its interaction with health and to empower them to take meaningful action within their own work areas.
- We promoted a series of practical sustainability actions to DHSC's wider workforce through two engagement sessions spanning several staff directorates.
- Around 40 DHSC staff volunteered to support environmental causes, including litter picking, tree planting and redistributing surplus food to charitable causes.

Procurement

- DHSC's sustainable procurement policy, covering net zero, social value and modern slavery, was updated to reflect the latest policy and legislative landscape, and enable the application of a less burdensome, more common-sense set of requirements for suppliers.
- We continued to use prompts within our standard commercial templates (business cases and procurement strategies etc.) to ensure that sustainability is considered from the outset of procurement activity. This includes a requirement to confirm compliance with the relevant Government Buying Standards.
- We continued to embed the Greening Government Commitments in DHSC's contracts via our standard terms and conditions, with the option to add further environmental clauses where deemed relevant to the specific goods or service.

Policymaking

- In accordance with DHSC's legal duty to have due regard to the Environmental Principles Policy Statement, we continue to provide materials and training to assist our policymakers and ministers to effectively consider the environmental impacts of their policies. We also support continuous improvement work, alongside the Department for Environment, Food and Rural Affairs (Defra) and other government departments, to share lessons learnt and improve our related practices.

Projects

- We continue to factor sustainability considerations into DHSC's programme and project management assurance processes (gateway reviews etc.) as appropriate.
- For construction, net zero requirements are considered in investment appraisals.
- DHSC began to integrate guidelines from government's Teal Book chapter on the environment and sustainability and the Whole Life Carbon Management Handbook, on measuring, mitigating and reporting the carbon impacts of infrastructure projects.
- In line with new, mandatory requirements for the Government Major Projects Portfolio (GMPP), we captured data on carbon reduction targets, biodiversity net gain and environmental and climate risk assessments in DHSC's GMPP reporting and included sustainability considerations in our evaluation planning.

Group-level performance

Tables 6 to **10** below provide data on our group-level environmental performance, covering both DHSC and the following arm's-length bodies (ALBs): Care Quality Commission (CQC), Health Research Authority (HRA), Human Fertilisation and Embryology Authority (HFEA), Human Tissue Authority (HTA), Medicines and Healthcare products Regulatory Agency (MHRA), NHS Business Services Authority (NHSBSA), NHS Counter Fraud Authority (NHSCFA), NHS England (NHSE), NHS Resolution (NHSR), National Institute for Health and Care Excellence (NICE) and UK Health Security Agency (UKHSA).

Whilst this data would typically be compared to cross-government environmental targets, the latest targets (for 2025 to 2030) were not yet published at the time of writing. In the interim, we have continued to report against the relevant areas and included comparative data from previous years to provide transparency on the trajectory of our performance.

However, both DHSC and our ALBs have made a series of reporting improvements during 2025-26, including by providing a more complete picture of our estate and incorporating additional waste categories and so on. Whilst this is a positive development, improving the completeness and accuracy of the data presented, this may affect the trends observed, with reported performance in 2025-26 appearing less favourable than if we were to compare on an exact, like-for-like basis with previous years.

Where actual data is unavailable and has not been provided by landlords or suppliers, we have generated estimates using appropriate methodologies, relying on, for example, industry standards, suitable proxies and historical data.

Where available, accompanying spend data is also provided. However, these figures are partial, as some data is incorporated into broader property service charges or project costs, and so cannot be disaggregated to this level of detail.

Table 6: Greenhouse gas emissions (tonnes of CO_2 equivalent)

		Previous years			Current
		2022-23	2023-24	2024-25	2025-26
Scope 1	Estate	6,024	6,078	5,297	6,025
	Fleet	110	125	126	72
Scope 2		8,099	8,442	8,424	9,102
Scope 3		3,955	4,620	4,696	4,581
Total		**18,188**	**19,265**	**18,543**	**19,780**

Table 6 distinguishes between scope 1, 2 and 3 emissions, as defined by the Greenhouse Gas Protocol. Scope 1 are direct emissions from sources that our organisations own or control, divided here into those related to our estate and fleet vehicles. Scope 2 are indirect emissions from the generation of energy that our organisations purchase. Scope 3 are other indirect emissions that occur in our organisations' value chains; for the purposes of this table, this figure includes emissions related to domestic business travel and energy transmission and distribution only. However, scope 3 emissions related to international

business travel are also deemed to be material and these are disclosed separately in **Table 10** below. All emissions have been calculated using our activity data and the UK government conversion factors for company reporting of greenhouse gas emissions.

Our organisations spent an associated £917,258 on emissions reduction projects. Our organisations did not use any accredited carbon offsets.

Table 7: Energy use (kWh)

	Previous years			Current 2025-26	
	2022-23	2023-24	2024-25	kWh	Spend
Purchased energy					
Electricity	41,883,125	40,770,048	40,686,136	51,154,542	£11,067,278
Gas	30,355,246	29,430,465	27,938,535	32,273,394	£1,803,280
Gas oil	1,509,385	856,865	480,816	68,966	£5,702
Diesel	-	10,571	7,642	9,643	£4,057
District heating	-	-	-	270,439	-
Hydrotreated Vegetable Oil	-	50,000	100,000	-	-
Self-generated energy					
Electricity from renewable sources	1,316,825	1,333,778	1,450,826	1,756,283	-
Total	**75,064,581**	**72,451,727**	**70,663,955**	**85,533,267**	**£12,880,317**

Table 8: Municipal waste (tonnes)

	Previous years			Current 2025-26	
	2022-23	2023-24	2024-25	Tonnes	Spend
Recycling	1,418	997	917	1,169	-
Anaerobic digestion	32	37	41	67	-
Composting				15	-
Incineration with energy recovery	551	458	377	482	-
Incineration without energy recovery	150	150	153	149	-
Landfill	21	17	16	29	-
Total	**2,172**	**1,659**	**1,504**	**1,911**	**£360,327**

ICT waste is included within this municipal waste data.

Table 9: Water (m^3)

Previous years			Current 2025-26	
2022-23	2023-24	2024-25	m^3	Spend
161,212	149,226	147,245	197,851	£1,253,294

Table 10: International travel (tonnes of CO_2 equivalent)

Previous years			Current
2022-23	2023-24	2024-25	2025-26
785	1,628	2,014	2,728

Task Force on Climate-related Financial Disclosures (TCFD)

DHSC has reported on climate-related financial disclosures consistent with HM Treasury's TCFD-aligned disclosure application guidance, which interprets and adapts the framework for the UK public sector. DHSC has complied with the TCFD recommendations and disclosures around:

- governance – recommended disclosures (a) and (b)
- risk management – recommended disclosures (a) to (c), and
- metrics and targets – recommended disclosure (b)

DHSC, however, has not complied with the required disclosures under the TCFD on strategy (a) to (c) or metrics and targets (a) and (c). DHSC's Leadership Group considered whether climate change should be escalated to a principal risk, however it was agreed that, given its broad scope, climate-related risks would be best managed through the mitigation of risks already present in our High-Level and Group-Level Risk Register. Our Leadership Group decided that, by managing aspects within these existing risks, DHSC can capture the cross-cutting nature of climate change and mitigate it most effectively. Compliance with the TCFD will be kept under continuous review as part of those arrangements.

However, as climate change affects various principal risks held by DHSC where those risks relate to NHS operations, the relevant information has been disclosed in the NHS England Annual Report and Accounts. In particular, these describe Greener NHS Programme and set out that reporting on most TCFD disclosures, and related emergency readiness assurance, is the responsibility of NHS organisations.

The following disclosures relate to DHSC only and do not cover our ALBs, as there is a varied landscape across our organisations that cannot currently be captured in a singular statement. In scope ALBs are responsible for providing their own TCFD-aligned disclosures within their Annual Report and Accounts.

Governance (a) and (b)

Health and social care system

Our Executive Committee and Leadership Group discussed DHSC's principal risk profile throughout the year, with climate change discussed on various occasions and agreements reached on where this is best placed and how DHSC can most effectively manage and mitigate its impacts. The Audit and Risk Committee (ARAC), as part of DHSC's challenge function, ratified and supported Executive Committee and Leadership Group's decision-making on climate-related risks.

DHSC estate

Our Sustainability Team aims to minimise the climate impacts of DHSC's own office estate and operations, directly overseen by the Director for Workspace, Information, Security and Technology. Progress is monitored through our Sustainability Delivery Board, co-chaired by two director-level sponsors and bringing together relevant teams from across DHSC for a holistic view of the work taking place, including representatives on property, travel, procurement, technology and internal communications. Whilst this board did not convene in 2025-26, a board meeting was held in April 2026 to review progress made during the year. Following each meeting, written updates are shared with DHSC's Leadership Group to summarise the key issues that were discussed.

For information on DHSC's broader governance structures, please see page 150.

Risk management

Health and social care system

Under the government's third National Adaptation Plan (NAP3), DHSC looks to mitigate risks to health and social care delivery from climate change, risks to UK public health from climate change overseas and risks to health from vector-borne diseases. DHSC's progress against these actions is reported into the wider government NAP3 reporting process, as led by Defra. DHSC is working alongside other 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 fourth National Adaptation Plan (NAP4), which will set out the government's approach to improve preparedness to the impacts of climate change.

Within DHSC, climate-related risks are identified and managed through existing risk management procedures, as set out in the governance statement from page 156 using the Orange Book and Three Lines of Defence model. The significance of climate-related risks is assessed using standard DHSC risk scoring methodology (likelihood x impact), enabling direct comparison with other risks and supporting prioritisation through the High-Level Risk Register and governance processes. DHSC considers relevant regulatory and external

factors and assesses the size and scope of impacts within existing risk categories, using established definitions and frameworks rather than separate climate-specific terminology.

DHSC's devolved risk management system means that teams can adapt best practice guidance and risk management frameworks supplied by the Central Risk Team, to mitigate and manage risk in the most effective way. The Central Risk Team conduct regular risk management training sessions, highlighting frameworks for risk owners to aid their management of climate-related risks. The team also design and commission the risk registers used by teams to record their risks, incorporating crucial elements to ensure that teams are thoroughly and effectively understanding and mitigating their risks. Additionally, the team encourages use of the '5 T's' approach when responding to risks (treating the risk, terminating, transferring, tolerating or taking the opportunity). Risk training takes place at all levels, up to and including Senior Civil Servants in DHSC.

DHSC estate

DHSC developed a climate change risk assessment and adaptation plan in 2024-25, focused on office buildings under the DHSC's operational control. This risk assessment was conducted using the Office of Government Property's Estates Adaptation Framework and data from the UK Climate Change Committee's Independent Assessment of Climate Risk. Priority risks were identified based on likelihood and impact, with climate hazards judged to pose a greater threat to our estate than future regulatory requirements. Our adaptation plan sets out the steps that DHSC will take to mitigate these priority risks. Our climate change adaptation progress is also tracked by DHSC's Sustainability Delivery Board and as part of our reporting to Defra against cross-government environmental targets.

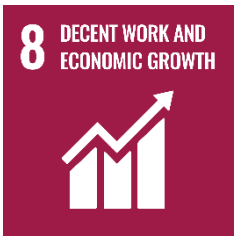
Metrics and targets (b)

DHSC's emissions during 2025-26 are detailed in **Table 6**. This data covers both DHSC and our ALBs, in line with our relevant reporting against cross-government environmental targets). Scope 3 emissions are provided where deemed material.

UN Sustainable Development Goals

DHSC advances the United Nations Sustainable Development Goals (SDGs) by pursuing delivery objectives, implementing the 10 Year Health Plan for England, and reforming adult social care so as to align with recommendations arising from Baroness Louise Casey's independent commission. These efforts promote better population health, reduce inequalities and help build a sustainable health and care system, as summarised in the table below. A more comprehensive update on progress can be found in the performance analysis section of this report.

SDG 3: Ensure healthy lives and promote well-being for all at all ages. 	**10 Year Health Plan focus** • Prevention over sickness • Care closer to home • Digital transformation **What we're doing** • Prevention across the life course (smoking, obesity, alcohol harm, vaccination and screening) • Earlier diagnosis • Targeted investment in areas with the lowest healthy life expectancy • Neighbourhood Health Services providing proactive, preventative care **Outcome** • Better population health • Reduced health inequalities • A more sustainable NHS
SDG 5: Achieve gender equality and empower all women and girls. 	**10 Year Health Plan focus** • Improving outcomes and safety for women **What we're doing** • Reforming maternity and neonatal services • Expanding women's health hubs • Improving access and choice via neighbourhood services • Strengthening accountability in maternity care • Recognising and supporting carers and unpaid caring roles **Outcome** • Safer, more responsive services for women • Reduced inequalities in access and experience

SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.  	**10 Year Health Plan focus** • Better health as a driver of economic participation **What we're doing** • Prevention and early intervention to help people stay in or return to work • Improved management of long-term conditions • Workforce reforms promoting wellbeing, skills and fair employment • Adult social care reform to support fair pay and workforce sustainability **Outcome** • Reduced economic inactivity • Stronger, more productive health and care workforce • Inclusive economic growth
SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation.  	**10 Year Health Plan focus** • A modern, resilient health and care system **What we're doing** • Investing in digital infrastructure, Artificial Intelligence, genomics and data platforms • Developing Neighbourhood Health Centres • Partnering with life sciences and technology sectors • Strengthening research and innovation • Integrating health and social care reform **Outcome** • More resilient infrastructure • Improved productivity and innovation

SDG 10: Reduce inequality within and among countries.  	**10 Year Health Plan focus** • Reducing health inequalities in access, experience and outcomes • Supporting people and places facing the greatest disadvantage **What we're doing** • Designing the NHS to tackle inequalities in both access and outcomes • Establishing Neighbourhood Health Centres, beginning in places where healthy life expectancy is lowest • Supporting the Core20PLUS5 approach to focus action on the most deprived 20% of the population and groups with the worst access, experience and outcomes • Improving inclusion health support for people affected by multiple disadvantage and displacement • Strengthening data, accountability and local assurance on health inequalities **Outcome** • Narrower gaps in healthy life expectancy • Fairer access to health and care services • Better outcomes for communities experiencing the greatest disadvantage

Other performance reporting

Parliamentary questions

Between April 2025 and March 2026, DHSC responded to 14,134 Parliamentary Questions (PQs), almost double the number responded to in 2024-25 (8,131) and more than any other government department. The rise in volumes observed during the latter part of 2024-25 continued into 2025-26 and is expected to remain at this level.

In the first quarter of 2025-26, our Ordinary PQ on-time rate was 65 per cent against the 85 per cent target set by Parliament, with Named Day PQs being answered on-time at a rate of 57 per cent. This on-time rate fell further as the financial year has progressed, sitting at 52 per cent and 47 per cent for Ordinary and Named Day PQs respectively in July to November 2025, and 53 per cent and 41 per cent during the period from December 2025 to the end of the Parliamentary session in April 2026.

Following the appearance of Minister Smyth and the then Second Permanent Secretary, Tom Riordan, before the House of Commons Procedure Committee in May 2025, the Committee wrote again to Minister Smyth in April 2026 regarding the latest performance data for DHSC on the timeliness of responses to PQs. Minister Smyth's response highlighted the considerable increase in PQ volumes and outlined the continued work being undertaken to improve performance. While the higher volumes of PQs received into DHSC has proven to be challenging, we continue to work on further supporting DHSC's PQ processes and exploring further avenues for performance improvement.

Freedom of information requests

In the calendar year 2025, DHSC responded to 1,767 Freedom of Information (FOI) requests. This was a 6% increase in total volume compared to 2024 (1,668). DHSC answered 92 per cent of these within the statutory 20 working day deadline (or Public Interest extension), maintaining our performance from 2024. The Information Commissioner's Office's minimum target is 90 per cent.

Source: Freedom of Information statistics: www.gov.uk/government/statistics/freedom-of-information-statistics-annual-2025

Correspondence and complaints

As shown in **Table 11**, DHSC answered 38,960 pieces of correspondence due in 2025, compared to 38,315 in the previous year. Receipts of ministerial correspondence increased in 2025 following the launch of several high-profile government initiatives, including the 10 Year Health Plan.

In line with standard correspondence reporting across government, the data shown below is for the calendar year 2025. The cross-government target across all correspondence is to

respond to 80 per cent of cases within 20 working days. DHSC is committed to bringing performance on ministerial correspondence in line with this target.

Data comparing DHSC's performance to that of other government departments is published by the Cabinet Office at www.gov.uk/government/collections/data-on-responses-to-correspondence-from-mps-and-peers.

Table 11: Other classes of correspondence 2025

Case Type	Due in 2025	Answered on time	Percentage on time
Ministerial	14,715	7,328	49.8%
Public	24,245	20,923	86.3%
Total	**38,960**	**28,251**	**72.5%**

Complaints to DHSC and the Parliamentary and Health Service Ombudsman (PHSO)

In 2025-26, DHSC received 20 complaints about the work of DHSC. These were handled in line with the DHSC complaints policy available on our website at www.gov.uk/government/organisations/department-of-health-and-social-care/about/complaints-procedure.

As shown in **Table 12**, in 2024-25 (the last year for which published results are available), the PHSO received 22 enquiries regarding complaints about the core department, of which 4 progressed to assessment (primary investigation). No cases were accepted for detailed investigation. Full details of PHSO complaints can be found at www.ombudsman.org.uk/organisations-we-investigate/annual-data-complaints.

Table 12: PHSO complaints 2024-25

Enquiries Received	Assessed	Accepted for Investigation[1]	Investigation Upheld/Partly Upheld	Investigations not Upheld	Investigations resolved through intervention[2]	Investigations resolved without a finding[3]
22	4	0	0	0	0	0

1. The number of cases accepted for investigation by the PHSO in a financial year differs from the number of investigations completed in the same year. This is because the statistics only provide a snapshot of the casework flow at a given time. For example, the PHSO may have accepted a complaint for investigation in 2022-23 but not completed it until the following year 2023-24. Similarly, it may have completed an investigation in 2023-24 which we originally accepted for investigation in the previous year 2022-2023.
2. These are complaints where PHSO starts an investigation but can resolve the complaint without having to formally complete the investigation.
3. These are complaints where the PHSO ends the investigation for a variety of reasons, for example at the complainant's request.

Prompt payment of undisputed invoices

The Public Contracts Regulations 2015 state that contracting authorities must have regard to guidance in relation to the payment of valid and undisputed invoices within 30 days. This requirement has been designed to help ensure that small and medium sized businesses that may not be able to fully operate with longer payment terms are not disadvantaged by late payments.

Table 13 details the percentage and value of undisputed invoices paid by NHS provider organisations within the agreed terms over the last three years.

Table 13: Prompt payment of undisputed invoices

	NHS provider invoices paid within target	
Financial Year	**Percentage**	**Value (£m)**
2025-26	90	70,048
2024-25	90	68,283
2023-24	91	66,925

Source: NHS provider accounts

NHS England monitors Better Payments Practice Code performance data and other working capital information, as reported by NHS provider trusts monthly in order to assess and compare provider performance in this area. The target set out in the code is to pay 95 per cent of undisputed invoices within 30 days.

NHS England discusses performance with providers with poor or deteriorating working capital position and supports individual providers in seeking ways to improve this position.

Data for the core department's performance against this standard is published quarterly. In April to June 2025, the core department paid 99% of invoices within 30 days, and in July to September 2025 (the latest quarter for which data has been published), the core department paid 97% of invoices within 30 days.

Fraud and error analysis

Fraud

DHSC has a comprehensive Counter Fraud Strategy for 2023-26 in place, with a vision of 'A system-wide approach to tackling fraud which protects taxpayers' money for better patient care'. It focuses on four key areas - proactivity and prevention, utilising digital and data analytics, collaboration and coordination, and response and enforcement.

The Strategic Intelligence Assessment (SIA) 2026 estimates that the financial vulnerability to fraud in the NHS, in England, is £1.301 billion.

The DHSC Anti-Fraud Unit (AFU) has developed an enterprise and thematic Fraud Risk Assessment (FRA), to expand the oversight and understanding of fraud risk across departmental activity and groups. We have improved the fraud risk template to contribute greater detail to the enterprise and thematic processes. DHSC AFU has worked with teams across DHSC, including Government Major Projects Portfolio (GMPP) and Investment Appraisals, to strengthen guidance and oversight of Initial Fraud Impact Assessments (IFIAs). Guidance has been published encouraging the use of IFIAs for capital spend above £30 million and emphasising mandatory completion for all GMPP programmes. The New Hospitals Programme (NHP) is an active DHSC GMPP programme and is listed on the Public Sector Fraud Authority (PSFA) High Fraud Risk Portfolio. DHSC AFU is proactively engaged with stakeholders including PSFA, NHS England, DHSC programme leads and the NHS Counter Fraud Authority to manage fraud risks within the programme. Further details, including on the Counter Fraud Strategy for 2023-26 are set out at pages 165 to 169 of the Governance Statement of this Annual Report and Accounts.

Error

DHSC participates in the quarterly Consolidated Data Return (CDR) process, overseen by the Public Sector Fraud Authority (PSFA), which requires it to record the levels of error it has detected, prevented and recovered during each quarter. This process is participated in by all group bodies except for ICBs and NHS providers.

Review of the CDRs for 2025-26 has confirmed that there are no areas of activity where the level of error detected is significant to the area of activity, where the area of activity is significant to the organisation as a whole.

Isolated errors which have resulted in the core department incurring losses over £300,000 are set out on the losses report on pages 219 to 221.

Details of losses incurred by group bodies can be found in the underlying annual reports and accounts.

Official development assistance

The definition of ODA is set by the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) and spend data is collected from 33 different DAC members including the UK.

DHSC’s expenditure on official development assistance (ODA) totalled £315.6 million in the 2025-26 financial year (2024-25: £316.6 million).

DHSC's 2025-26 expenditure on ODA delivered a targeted set of high-ambition programmes to reduce the impact of devastating health threats on low- and middle-income countries and - in turn - reduce the risk of those health threats increasing in a way that would endanger the UK and its citizens. DHSC's expenditure was focused primarily on Global Health Security (GHS) and Global Health Research (GHR). In addition, ODA funding also supported tobacco control and workforce capacity-building in low- and middle-income countries (LMICs), including through work to support implementation of the World Health Organization's (WHO's) Framework Convention on Tobacco Control.

In 2025-26, the GHS programme consisted of five projects: the Fleming Fund, the UK Vaccine Network, the Global Antimicrobial Resistance Innovation Fund, the International Health Regulations Strengthening Project and the UK Public Health Rapid Support Team. The portfolio of activities strengthens the ability of developing countries to prepare, prevent, detect and respond to the threat of infectious diseases of epidemic and pandemic potential and antimicrobial resistance (AMR). Notably, the GHS portfolio supported the first new antibiotic for drug-resistant gonorrhoea in 30 years to achieve US Food and Drugs Administration approval and funded a quarter of all vaccine candidates entering clinical development for specific diseases impacting the poorest countries since 2016. In part thanks to DHSC-funded data on AMR, the UN committed to reducing deaths due to AMR by 10% by 2030.

DHSC also pays an annual membership fee to WHO and takes the overall lead for the government's engagement with the organisation. The annual contribution to WHO's budget is linked to the UN Scales of Assessment. These scales are in accordance with the UN Charter and UK membership obligations and based on factors including members' share of the global gross national income.

The GHR portfolio funds high-quality applied (near-patient) research and capacity strengthening, including through clinical trials, to build the evidence base needed to impact health policy and practice, and ultimately improve service delivery and health outcomes of people in LMICs. This is delivered through the world-class expertise of the National Institute for Health and Care Research and strategic partnerships with global funders and international organisations. In 2025-26, the portfolio aims were delivered through a mix of researcher-led and targeted, thematic calls to support equitable partnerships. These included areas across research on pandemic preparedness, vaccines for pathogen and AMR control, virus genomics for outbreak response, non-communicable diseases and health system strengthening, and through initiatives to strengthen research capacity in LMICs to develop the research leaders of tomorrow.

In addition to DHSC's ODA programme, and in line with the OECD rules, the first 12 months of asylum seekers' healthcare costs following their arrival in the UK are reported as ODA via the Foreign, Commonwealth and Development Office (FCDO). These healthcare costs relate to asylum seekers and individuals within the Afghanistan and Ukraine Support Schemes. A proportion of DHSC ODA was also used to support the

evacuation of sick and injured children from Gaza to the UK for specialist medical treatment.

Overall, DHSC's 2025-26 ODA expenditure remained closely aligned to departmental objectives and was managed with a high degree of budgetary control. While DHSC's ODA envelope reduced from 2024-25 to 2025-26, a further substantial reduction to ODA budgets is expected from 2026-27 onwards across the remainder of the Spending Review 25 period, reflecting the wider fiscal context of lower UK government ODA spending as a proportion of gross national income. Within this constrained environment, DHSC's ODA portfolio continued to support delivery across global health security, global health research and in-donor refugee costs, contributing to the UK's wider global health commitments, our international obligations, and our protection against transnational health threats.

DHSC received a reduced ODA allocation in the 2025 Spending Review due to reductions in the government's ODA budget overall. For instance, funding was not provided for a further phase of the Fleming Fund following the completion of Phase 2, and some research and development activity was scaled back. Continued funding constraints could require further programme trade-offs in future years. DHSC continues to work with FCDO to support the sustainability and impact of our prior investments, including through the Fleming Fund to tackle AMR, and to ensure continuing investments in global health security deliver value for money.

Performance Report Accounting Officer Sign-Off

27 October 2026
Samantha Jones OBE
Permanent Secretary

Accountability report

Structure of the Accountability Report

This accountability report sets out how DHSC meets its accountabilities to Parliament. It includes:

- The report of the lead Non-Executive Board Member
- Names of ministers and directors with oversight of DHSC and their interests, and the statement of Principal Accounting Officer responsibilities **(Corporate Governance Report)**
- An explanation of the governance of DHSC (the **Governance Statement**)
- Information about staff numbers and costs and the remuneration of our ministers and directors (**Remuneration and Staff report**)
- Information about expenditure against budgets set by Parliament

Lead Non-Executive Board Member's Report 2025-26



The 2025–26 financial year was a period of delivery for the Department of Health and Social Care (DHSC). DHSC progressed its priorities as set out in the 10 Year Health Plan and supported early implementation across the health and care system. Alongside delivery of its priorities, DHSC continued work to strengthen alignment between DHSC and NHS England ahead of the new DHSC being formed in 2027.

Throughout the year, non-executive board members (NEBMs) continued to engage across DHSC, providing independent advice, support, and challenge to ministers and senior leaders. Beyond collectively supporting the Board, NEBMs were active in specific areas of departmental work, and their breadth of experience supported informed discussion and constructive challenge across a wide range of issues. Drawing on experience from across the public and private sectors, they engaged with senior leadership and policy teams on matters including health and care system performance, adult social care, workforce and productivity, digital and data transformation, and the continued development and implementation of the 10 Year Health Plan.

In addition, at the request of the then Secretary of State, I, alongside the Chair of NHS England, supported oversight of the DHSC/NHS England transformation programme to create the new DHSC, enabled by the legislation which was introduced to Parliament in May

2026. As the programme developed, revised governance arrangements were subsequently put in place to oversee the next phase of the transformation.

The Audit and Risk Assurance Committee (ARAC) continued to play a central role in supporting the Departmental Board and the Principal Accounting Officer, with four meetings taking place over the year. Under the chairmanship of Sir Richard Douglas and with NEBM support from Naomi Eisenstadt CB, ARAC considered DHSC's financial position, key risks, accounts, and internal audit findings. Through targeted discussion and challenge, ARAC provided assurance on priority risk areas and supported the preparation and sign-off of the Annual Report and Accounts.

The Nominations and Governance Committee, which manages the talent pipeline for DHSC, provides further support and met three times this year under my Chairmanship. The Remuneration, Exits and Governance Committee met monthly and was also chaired by Sir Richard.

We have had one change to the departmental NEBMs as, in June 2025, Samantha Jones left her role as a departmental NEBM to take up the role of Permanent Secretary. I would like to thank her for her tenure as a NEBM as we continue to work together on the Board and in DHSC more widely.

As Lead NEBM, it has been a privilege to support the work of DHSC during 2025–26. I am grateful to my fellow NEBMs for their continued commitment, insight and professionalism, and to ministers and the Executive Team for their openness and engagement. The NEBM team remains proud of the progress made during the year, and we look forward to continuing to support DHSC as it takes forward its priorities in the year ahead.

The Rt Hon Alan Milburn
Lead Non-Executive Board Member

Corporate governance report

Directors' report

DHSC is led by a ministerial team and a staff of civil servants. Our non-executive board members are independent of DHSC and government and provide advice and challenge to our ministers and senior staff.

Our ministers at 31 March 2026



Rt Hon Wes Streeting MP
Secretary of State for Health and Social Care
Chair of Departmental Board



Stephen Kinnock MP
Minister of State for Care



Karin Smyth MP
Minister of State for Health (Secondary Care)



Baroness Gillian Merron
Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health



Sharon Hodgson MP
Parliamentary Under-Secretary of State for Public Health and Prevention



Dr Zubir Ahmed MP
Parliamentary Under Secretary of State

Ministers appointed since 1 April 2026

Rt Hon Yvette Cooper MP
Secretary of State for Health and Social Care and Chair of Departmental Board

Rt Hon James Murray MP (until 20 July 2026)
Secretary of State for Health and Social Care and Chair of Departmental Board

Preet Kaur Gill MP (until 20 July 2026)
Parliamentary Under-Secretary of State for Health Innovation and Safety

Rt Hon Dame Diana Johnson DBE MP
Minister of State

Alison McGovern MP
Minister of State

Chris McDonald MP
Minister of State

James Frith MP
Parliamentary Under-Secretary of State

Other ministers who served in DHSC during 2025-26 were:

Ashley Dalton MP
Parliamentary Under-Secretary of State for Public Health and Prevention

Our non-executive board members at 31 March 2026

The Rt Hon Alan Milburn

Lead non-executive board member since 8 November 2024



Alan Milburn was a Member of Parliament from 1992 to 2010. He served as Chief Secretary to the Treasury from 1998 to 1999, Secretary of State for Health from 1999 to 2003, and Chancellor of the Duchy of Lancaster from 2004 to 2005. He was the Independent Reviewer on Social Mobility and Child Poverty under the Coalition Government and became Chair of the Social Mobility and Child Poverty Commission between 2012 and 2017. He is currently leading the independent review into young people and work established by the government. He is also Chancellor of Lancaster University, chair of the Social Mobility Foundation and runs his own consultancy firm AM Strategy Ltd.

Sir Richard Douglas

Chair of Audit and Risk Assurance Committee



Richard's current roles include chair of the NHS South East London Integrated Care Board, an advisory role with Incisive Health, trustee for the children's mental health charity, Place2be, as well as a trustee of Demelza Hospice Care for Children. He has previously held NED roles with both NHS England and NHS Improvement. Prior to this he was a director general at DHSC and has held various financial roles in the Civil Service. Richard held the role of Acting Permanent Secretary at DHSC for a brief period in 2010.

Naomi Eisenstadt CB



Naomi Eisenstadt CB also serves as a Non-Executive Board Member for the Department for Education. Beginning her career in the voluntary sector, she was Chief Executive of a child poverty charity before joining the Civil Service. She became the first Director of Sure Start in 1999. After seven years, she served for three years as director of the Social Exclusion Task Force. She has served as an adviser on Poverty and Inequality to the First Minister of Scotland, held trustee roles on several charity boards, and served as a non-executive director of an NHS primary care trust. From 2020 to 2025 she served as chair of the Northamptonshire Integrated Care Board.

Phil Jordan



Phil Jordan had an executive career as Chief Information Officer (CIO) leading global business, digital and data transformations across a range of sectors, including telecoms, media and retail. He recently retired as Group CIO at Sainsbury's and, prior to that, was Global CIO at Telefonica and CIO for Vodafone UK and Ireland. He now has a non-executive and adviser portfolio that has included clients such as Sainsbury's, TalkTalk, HSBC, AND Digital, and Deloitte.

Baroness Camilla Cavendish



Baroness Camilla Cavendish is Contributing Editor and Columnist for The Financial Times, a Research Fellow at Harvard University's Kennedy School and a crossbench peer in the House of Lords. She has a background in policy with expertise in health and care. She is a former Head of the Downing Street Policy Unit under Prime Minister David Cameron, author of two independent reviews for government into health and social care, a former non-executive director of the Care Quality Commission and former chair of the national social work charity, Frontline: Changing Lives.

Other non-executive board members who served in DHSC during 2025-26 were:

- Samantha Jones OBE served on the Departmental Board as a Non-Executive Board Member from 14 February 2023 until appointment as DHSC Permanent Secretary on 14 June 2025

Our executive board members at 31 March 2026



Samantha Jones OBE
DHSC Permanent Secretary



Professor Sir Chris Whitty KCB
Chief Medical Officer



Elizabeth O'Mahony
Director General Finance



Matthew Style
Interim Second Permanent Secretary and Chief Operating Officer

Other senior officials at 31 March 2026

Professor Lucy Chappell	Chief Scientific Officer and Director General, Science and Research
Catherine Frances CB	Director General for Global and Public Health
Sally Warren	Director General of 10 Year Health Plan (until 29 October 2025) and Director General Adult Social Care
Andrew Brittain	Director General for Finance and Operations (until 30 October 2025) and Director General of Corporate Services
Julian Hunt	Interim Director General, Technology, Digital and Data
Paul Dinkin	Director General, Strategy and Healthcare Policy
Lorraine Jackson CBE	Director, DWP and DHSC Joint Work and Health Directorate
Paul Macnaught	Director, Ministers, Accountability and Strategy
Juliette Cammaerts	Principal Private Secretary to the Secretary of State
Toni Court	Director, Human Resources
Antony Tiernan	Director, Transformation and Internal Communications
Danny Mortimer	Director General, People
Rachel Carr	Director of Communications

Other senior officials who served in DHSC in 2025-26 were:

Tom Riordan CBE	Second Permanent Secretary
Jonathan Marron CB	Director General for Primary Care and Prevention
Michelle Dyson	Director General for Adult Social Care
Jenny Richardson	Director of Human Resources
Gila Sacks	Interim Director General for Primary Care and Prevention

NHS England officials who served on Leadership Group during 2025-26 were:

Fiona Bride	Director General, Commercial and Growth
Duncan Burton	Chief Nursing Officer for England
Dr Claire Fuller/ Professor Meghana Pandit	Medical Director
David Probert	Director General, Performance and Delivery

Departmental disclosures

DHSC has a code of business conduct, which incorporates the principles set out in the Civil Service Code and applies to all staff working in DHSC, including those who have authority or responsibility for directing or controlling DHSC.

Personal data related incidents

Information relating to personal data-related incidents is reported to the Information Commissioner's Office (ICO). There were two personal data breaches formally notified to the ICO this year, both of which related to data being emailed to the incorrect recipient. The ICO did not take any further action on any of these cases.

Register of interests

All staff are required to record and regularly review any potential or actual conflicts of interest or to confirm a 'nil return', alongside any gifts or hospitality declared on the electronic register of interests.

Our ministers' interests are published on gov.uk by the Cabinet Office. A Register of Members' Financial Interests also provides information regarding their financial interests, while DHSC's directors general and directors' record of gifts and hospitality is published as part of the quarterly transparency data also published on the gov.uk website.

Any remunerated outside employments held by DHSC's senior civil servants are also published online.

Further relevant interests of DHSC's senior leadership are detailed in the following register of interests table. Interests of Claire Fuller, Professor Meghana Pandit, Elizabeth O'Mahony and Duncan Burton, who sit on the Board of NHS England, are set out in the NHS England Board members' Register of Interests. Elizabeth O'Mahony, Director General – Finance had a nil return.

Register of interests for 2025-26

Senior Official	Held by	Name of Company	Position Held	Type of Interest	Other Information
Samantha Jones	Spouse	Milton Keynes University Hospital NHS Foundation Trust	Chief Executive	Salaried	
Samantha Jones	Spouse	NHS England	Director of Digital Channels	Remunerated	Ended August 2025
Samantha Jones	Spouse	Bedfordshire, Luton and Milton Keynes Integrated Care Board	Member	Not remunerated	Ended April 2026
Samantha Jones	Spouse	NHS Employers Policy Board	Chair	Not remunerated	
Samantha Jones	Spouse	NHS Confederation	Trustee	Not remunerated	
Samantha Jones	Spouse	National Association of Primary Care	Council Member	Not remunerated	
Samantha Jones	Spouse	Health Innovation Oxford and Thames Valley	Member	Not remunerated	
Samantha Jones	Spouse	NHS Advisory Board for Procurement and Supply	Chair	Remunerated	
Samantha Jones	Spouse	NHS Elect Advisory Board	Member	Not Remunerated	
Samantha Jones	Spouse	Pharmacy 2U	Advisor	Remunerated	Ended August 2026
Samantha Jones	Spouse	G Square Capital	Advisor	Remunerated	Ended August 2026
Samantha Jones	Spouse	Samantha Jones Ltd	Director	Not Remunerated	
Samantha Jones	Spouse	Asterix Health Advisory Board (also known as Remote Duty Doctor)	Advisor	Remunerated	

Senior Official	Held by	Name of Company	Position Held	Type of Interest	Other Information
Samantha Jones	Self	National Association of Primary Care	Advisor	Remunerated	Ended early June 2025
Samantha Jones	Self	G Square Capital	Advisor	Remunerated	Ended early June 2025
Samantha Jones	Self	Keys Group	Non-Executive Director	Salaried/fees	Ended early June 2025
Samantha Jones	Self	Bain Consulting Group	Advisor	Remunerated	Ended early June 2025
Samantha Jones	Self	CeraCare	Advisory Board Member	Minor shareholding	Ended early June 2025
Samantha Jones	Self	Huma	Shareholder	Minor shareholding	Ended early June 2025
Samantha Jones	Self	Accurx	Advisory and Board Member	Remuneration and minor shareholding	Ended early June 2025
Samantha Jones	Self	HSBUK	Advisor	Remunerated	Ended early June 2025
Samantha Jones	Self	PA Consulting	Advisor	Remunerated	Ended early June 2025
Samantha Jones	Self	System C	Advisor	Minor shareholding	Ended early June 2025
Samantha Jones	Self	Samantha Jones Ltd	Director	Shareholding	Ended early June 2025
Samantha Jones	Self	HCA Healthcare UK	Advisor	Remunerated	Ended early June 2025
Samantha Jones	Self	XLinks Ltd	Chief Operating Officer	Salaried	Ended early June 2025

Senior Official	Held by	Name of Company	Position Held	Type of Interest	Other Information
Catherine Frances	Partner	Senior Clinician at King's College Hospital NHS Foundation Trust	Employee	Salaried	
David Probert	Self	University College London Hospitals NHS Foundation Trust	Chief Executive	Salaried	
David Probert	Self	UCL Global Business School for Health	Honorary Professor	Not Remunerated	
David Probert	Self	St Dunstan's College	Director	Not Remunerated	
David Probert	Spouse	Homerton NHS Trust	Chief Nurse and Director of Clinical Governance	Salaried	
Fiona Bride	Spouse	ALK	Vice-President	Salaried	
Jonathan Marron	Self	Institute of Lifecourse Development, University of Greenwich	Advisory Board Member	Not Remunerated	
Jonathan Marron	Self	Downing Battock Institute	Advisory Board Member	Not Remunerated	
Julian Hunt	Spouse	Isle of Wight Youth Trust	Chair	Not Remunerated	
Julian Hunt	Spouse	Care Quality Commission	Board Member, Senior Independent Director, Audit and Risk Committee Chair	Salaried	
Julian Hunt	Spouse	Eakin Healthcare Group Ltd	Non-Executive Director, Chair of Remuneration Committee	Salaried	
Julian Hunt	Spouse	London Fire Brigade	Independent Audit Committee Member	Salaried	
Julian Hunt	Spouse	Medicine Research Council, UK Research and Innovation	Senior Independent Member	Salaried	

Senior Official	Held by	Name of Company	Position Held	Type of Interest	Other Information
Julian Hunt	Spouse	Ashlar Advisory Ltd	Director	Shareholder	
Lorraine Jackson	Self	Charity for Civil Servants	Trustee	Not remunerated	
Lucy Chappell	Self	Medical Research Council	Member	Non-remunerated	
Matthew Style	Partner	Macmillan Cancer Support	Chief Executive	Salaried	
Michelle Dyson	Brother	Advantage Mentoring Community Interest Corporation	Member and Director		
Michelle Dyson	Brother	Healthcare team at Apax Partners UK Ltd	Partner	Shareholding	Until June 2025
Michelle Dyson	Self	Norwood Ravenswood (charity)	Committee Member		
Sir Chris Whitty	Self	London School of Hygiene and Tropical Medicine	Honorary Professor	Not remunerated	
Sir Chris Whitty	Self	Pembroke and Wolfson Colleges, Oxford; Gresham College; Royal College of Defence Studies.	Honorary Fellow	Not remunerated	
Sir Chris Whitty	Self	Sightsavers (Royal Commonwealth Society for the Blind)	Trustee	Not remunerated	
Sir Chris Whitty	Brother	EN Projects Limited Health Consultants International Ltd (from 12 March 2025)	Director	Salaried and shareholding	
Sir Chris Whitty	Self	University College London Hospitals and Hospital for Tropical Diseases	Consultant physician	Not remunerated	
Sir Chris Whitty	Self	University College London	Honorary Professor	Not remunerated	

Senior Official	Held by	Name of Company	Position Held	Type of Interest	Other Information
Tom Riordan	Self	Middlesbrough Football Club Foundation	Trustee and Director	Not remunerated	
Tom Riordan	Self	National Wealth Fund	Non-Executive Director	Salaried	
Antony Tiernan	Self	NHS Charities Together	Trustee	Not remunerated	
Jenny Richardson	Self	The Whitehall and Industry Group	Member of Advisory Group - People	Not remunerated	

Non-executive board members' interests

A register of interests covering non-executive board members is maintained by DHSC. This ensures that any perceived or real conflicts of interest can be identified. This register is updated annually and when relevant changes occur.

Declaration of interests

DHSC is content its code of conduct policies, processes and guidance are up to date and in line with best practice.

Our policy is clear, in that all declarations of interest should be updated as they cease or arise. All members of the senior civil service (SCS) need to confirm on an annual basis that their declarations of interest are up to date (including a nil return). Delegated grades complete the declaration on appointment and maintain the record.

Annual reminders are sent to employees via our HR system, D365. In addition, a reminder was issued to all staff in DHSC in January 2026 through an intranet article, including instructions on how to log declarations of interest on D365.

DHSC is required to publish the relevant interests of its Permanent Secretary, and other SCS who are board members at least annually within its annual report and accounts alongside all board member interests. Any outside employment, work, or appointment, (paid or otherwise remunerated) held by a member of the SCS that has been agreed through the process for the declaration and management of outside interests can be accessed by viewing the register of senior civil servants' secondary employment. This does not include voluntary roles.

Declaration of non-executive board member interests

DHSC ensures that all non-executive board member (NEBM) interests are reviewed and recorded at least annually. They are published as part of the register of board members' interests. The NEBMs have been reminded of the importance of declaring any perceived or real conflicts of interest to DHSC and they provide in-year updates as necessary.

Declaration of special adviser interests

In line with the current declaration of interests policy for special advisers, all special advisers have declared any relevant interests or confirmed they do not consider they have any relevant interests. The Permanent Secretary considers all returns, and relevant interests are set out in public:

Special adviser name	Details of interest
Sam Forster	**Interest:** Sam Forster held a part-time paid role with the Labour Party between 2 February and 26 February 2026. Mr Forster's work for this organisation was performed outside their hours as a Special Adviser in DHSC. Mr Forster's work as a Special Adviser was under a temporary part-time contract during this period.
Ed Jones	**Interest:** Ed Jones' mother is owner and Managing Director of Cragg Ross Dawson Limited, a market research recruitment agency. **Mitigation:** Ed Jones is recused from involvement in discussions or matters relating to Cragg Ross Dawson Limited.
Kirsty O'Brien	**Interest:** Kirsty O'Brien's husband is Director of the Social Market Foundation. **Mitigation:** Kirsty O'Brien is recused from involvement in discussions or matters relating to the Social Market Foundation.
Will Prescott	**Interest:** Will Prescott's father-in-law is Chair of Cancer Research Horizons and Chair of Immatics N.V. He was previously a trustee of Cancer Research UK. **Mitigation:** Will Prescott is recused from involvement in discussions or matters relating to Cancer Research Horizons. Will Prescott is recused from involvement in discussions or matters relating to Immatics NV. Will Prescott is recused from involvement in discussions or commercial matters relating to Cancer Research Organisations.

Other Special Advisors in post during 2025-26 (Thomas Gardiner, Sarah Harrison, and Heather Iqbal) do not have any interests to declare.

Business appointment rules

DHSC continuously reviews business appointment rules (BAR) processes and guidance and is content that these are up to date and in line with best practice and Cabinet Office guidance. In compliance with BAR, DHSC is transparent in the advice given to individual applications for senior staff, including special advisers. Advice provided regarding business appointments can be found on the DHSC collection page for BAR advice.

DHSC has a clear conduct policy in place that applies to all staff and incorporates the principles of the Civil Service Code and Civil Service Management Code. Staff in the Department are reminded of their obligations under these codes as well as the need to comply with the Cabinet Office's BAR when leaving the Civil Service.

Under the application of BAR to civil servants (including special advisers) leaving Crown Service in DHSC, the number of exits from Crown Service (civil servants and special advisers) in the past year was 888 of which 62 were senior civil servants. This figure excludes individuals who have transferred to other government departments, returned to other government departments after loan periods or returned to private organisations after secondment periods.

BAR rules apply to all civil servants who leave the Civil Service. However, it is an individual's responsibility to follow BAR policy and procedures. As seen in **Table 14**, DHSC set BAR conditions for 11 individuals in the past year. No BAR applications were found to be unsuitable for the applicant to take up and there was one breach of the rules in the preceding year.

Table 14: BAR applications in DHSC 2025-26

Grade	Number of BAR applications assessed	Number of BAR conditions set	Number of applications from civil servants to which DHSC advised no conditions
AO	0	0	0
EO	0	0	0
HEO	0	0	0
SEO	0	0	0
Grade 7	2	2	0
Grade 6	3	3	0
SCS 1	2	2	0
SCS 2	5	4	1
Special Adviser	0	0	0
Minister	0	0	0

DHSC's policy is that employees have the responsibility to submit BAR applications either before or after their departure from DHSC. For delegated grades, the rules apply for one year post departure and for SCS the rules apply for two years. Individuals are required to submit BAR applications to their line manager prior to them accepting an outside appointment. Line managers are required to review this information and provide advice on any concerns, issues, or associated risks. They should also confirm that the information provided is accurate, add any further detail they feel is relevant and suggest conditions to be set. HR Operations review the application and confirm that enough detail has been provided for consideration.

For SCS3 applications, the HR Director reviews and sets conditions and these are then forwarded to the Civil Service Commission to confirm the conditions. The outcome of the Commission's consideration is published on the website. For SCS1 and SCS2 applications, the HR Director reviews the application and applies conditions. For delegated grades, HR deputy directors review the applications and set conditions. To ensure consistency is applied to each application submitted, previous applications and decisions are taken into account and for staff below SCS3 level DHSC writes to individuals confirming the conditions set.

DHSC implements and monitors BAR applications across all grades and increases awareness amongst employees by informing all new starters and leavers of their contractual obligations under the BAR. Full guidance is also published on the DHSC intranet and sets out that line managers and HR will make judgements on what might represent a conflict of interest. Additionally, leavers letters are issued to all leavers from DHSC. These letters remind individuals of their obligations under the BAR after they leave the Crown Service. The line manager's checklist for leavers includes a request for managers to discuss BAR on departure. DHSC also sends notifications to any Senior Civil Servant leavers 12 months after their leaving date, reminding them of their duty under the BAR in addition to information provided in their employment contracts, DHSC's published policy and leavers' letters to all employees.

Statement of Principal Accounting Officer's Responsibilities

Under the Government Resources and Accounts Act 2000 (the GRAA), HM Treasury (HMT) has directed DHSC to prepare, for each financial year, consolidated resource accounts detailing the resources acquired, held, or disposed of, and the use of resources during the year by DHSC (inclusive of its executive agencies, Medicines and Healthcare products Regulatory Agency (MHRA) and UK Health Security Agency (UKHSA)) and its sponsored non-departmental and other arm's-length public bodies (including NHS bodies) designated by order made under the GRAA by statutory instrument amendment Order (SI 2025 no.1336) (together known as the 'departmental group', consisting of DHSC and sponsored bodies listed at **Note 19** to the accounts).

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of DHSC and the departmental group and of the income and expenditure, statement of financial position and cash flows of the departmental group for the financial year.

HMT has appointed the Permanent Secretary of DHSC as Principal Accounting Officer of DHSC. In preparing the accounts, the Principal Accounting Officer of DHSC is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by HMT, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- ensure that DHSC has in place appropriate and reliable systems and procedures to carry out the consolidation process
- make judgements and estimates on a reasonable basis, including those judgements involved in consolidating the accounting information provided by non-departmental and other arm's-length public bodies
- state whether applicable accounting standards, as set out in the Government Financial Reporting Manual, have been followed, and disclose and explain any material departures in the accounts
- prepare the accounts on a going concern basis
- confirm that the annual report and accounts as a whole, is fair, balanced, and understandable and take personal responsibility for the annual report and account and the judgements required for determining that it is fair, balanced, and understandable

The Principal Accounting Officer has also appointed the chief executives, or equivalents, of its sponsored non-departmental and other arm's-length public bodies as accounting officers of those bodies. These appointments do not detract from the Principal Accounting Officer's overall responsibility to be accountable for those parts of the department's accounts relating to specified requests for resources and the associated assets, liabilities and cash flows.

Under their terms of appointment, the accounting officers of the sponsored bodies are accountable for the use, including the regularity and propriety, of funds received and the other income and expenditure of the sponsored bodies.

The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Principal Accounting Officer is answerable, for keeping proper records and for safeguarding the assets of DHSC or non-departmental or other arm's-length public bodies for which the Principal Accounting Officer is responsible, are set out in Managing Public Money published by HM Treasury.

As the Principal Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that DHSC'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. I also confirm that this Annual Report and Accounts is fair, balanced and understandable.

Governance statement

This section includes areas of DHSC's core governance where decisions are made about the key risks and challenges faced by DHSC. The following sections include an overview of the major boards and committees within DHSC, the nature of their operations, and key decisions on risk assurance made throughout the year.

Scope of responsibility

This governance statement covers the DHSC group and outlines how responsibility for the management and control of DHSC's resources were discharged during the year. This statement covers 2025-26 and is current up to the date this annual report was signed.

As Principal Accounting Officer for the DHSC group, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible. This statement sets out how DHSC complies with the provisions of the corporate governance code for central government departments, published by HM Treasury and the Cabinet Office.

The Head of Internal Audit's opinion is that they can provide 'moderate' assurance regarding the overall adequacy and effectiveness of DHSC's systems of risk management, governance, and internal control for the year. This classification means that 'some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control'. Further detail regarding the Government Internal Audit Agency's audit opinion is provided at page 170.

The departmental group is described at pages 315 to 318 of this Annual Report and Accounts. Each body within this group has its own constitution and formal relationship with DHSC. As guardian of the system overall, DHSC is responsible for providing oversight and direction, and retains overall accountability for the use of resources and delivery of objectives.

While I am personally accountable for the resources provided to DHSC and ensuring there is a high standard of financial management across the departmental group, I am supported by an accounting or accountable officer who has been appointed to each of the arm's-length bodies (ALBs), integrated care boards (ICBs), NHS trusts and NHS foundation trusts. The process for appointment of these accounting and accountable officers is set out in the relevant legislation and guidance.

I discharge my responsibility for the governance and control of DHSC through the DHSC staff. Each year I issue formal, written delegations of accountability to my directors general who in turn send such delegations to their directors. Each accountability letter sets out

responsibilities for identifying, assessing, communicating, managing, and escalating risk in their directorates. These letters also outline accountability for their allocated budget, delivery of business plan objectives, and departmental sponsorship responsibilities for each of our ALBs.

Ministerial directions

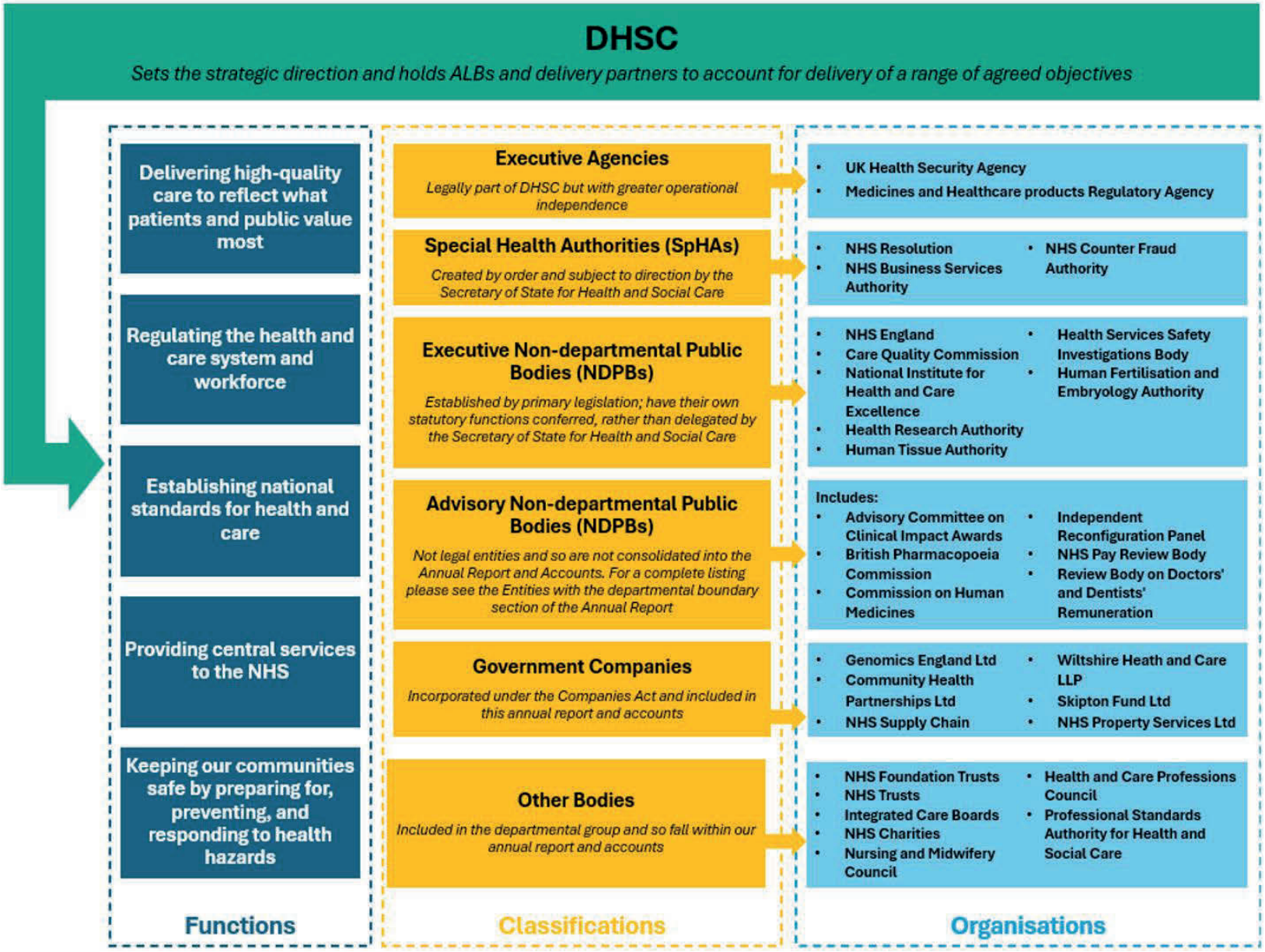
The Accounting Officer is accountable to Parliament for ensuring that all expenditure complies with the standards set out in Managing Public Money (MPM). If the Accounting Officer concludes that one or more of the four standards – regularity, propriety, value for money and feasibility – cannot be met, they must seek a written direction from the senior departmental minister before the expenditure is committed. No written directions were sought in respect of DHSC during 2025-26.

Arm's-length bodies and delivery partners

DHSC's ALBs and delivery partner organisations are either accountable to Parliament directly or via DHSC. We set their strategic direction and hold them to account for delivery of a range of agreed objectives and deliverables. These are set through their annual business planning process. DHSC uses ALB mandates, remit letters and business plans to hold its ALBs to account.

This process is managed by senior departmental sponsors (directors general or directors) who oversee DHSC's relationship with their ALBs. They are responsible for ensuring that activities across the six capabilities outlined in the Cabinet Office ALB Sponsorship Code of Good Practice are met. Senior sponsors are supported in delivering this responsibility by a sponsorship team, in addition to DHSC corporate teams.

The ALBs provide a range of diverse functions to support DHSC in delivering its objectives, as can be seen in the infographic below:


DHSC
Sets the strategic direction and holds ALBs and delivery partners to account for delivery of a range of agreed objectives
Delivering high-quality care to reflect what patients and public value most
Regulating the health and care system and workforce
Establishing national standards for health and care
Providing central services to the NHS
Keeping our communities safe by preparing for, preventing, and responding to health hazards
Functions
Executive Agencies
Legally part of DHSC but with greater operational independence
Special Health Authorities (SpHAs)
Created by order and subject to direction by the Secretary of State for Health and Social Care
Executive Non-departmental Public Bodies (NDPBs)
Established by primary legislation; have their own statutory functions conferred, rather than delegated by the Secretary of State for Health and Social Care
Advisory Non-departmental Public Bodies (NDPBs)
Not legal entities and so are not consolidated into the Annual Report and Accounts. For a complete listing please see the Entities with the departmental boundary section of the Annual Report
Government Companies
Incorporated under the Companies Act and included in this annual report and accounts
Other Bodies
Included in the departmental group and so fall within our annual report and accounts
Classifications
UK Health Security Agency
Medicines and Healthcare products Regulatory Agency
NHS Resolution
NHS Business Services Authority
NHS Counter Fraud Authority
NHS England
Care Quality Commission
National Institute for Health and Care Excellence
Health Research Authority
Human Tissue Authority
Health Services Safety Investigations Body
Human Fertilisation and Embryology Authority
Includes:
Advisory Committee on Clinical Impact Awards
British Pharmacopoeia Commission
Commission on Human Medicines
Independent Reconfiguration Panel
NHS Pay Review Body
Review Body on Doctors' and Dentists' Remuneration
Genomics England Ltd
Community Health Partnerships Ltd
NHS Supply Chain
Wiltshire Heath and Care LLP
Skipton Fund Ltd
NHS Property Services Ltd
NHS Foundation Trusts
NHS Trusts
Integrated Care Boards
NHS Charities
Nursing and Midwifery Council
Health and Care Professions Council
Professional Standards Authority for Health and Social Care
Organisations

Departmental governance

Departmental Board

The Departmental Board chaired by the Secretary of State for Health and Social Care brings together ministerial and Civil Service leadership with Non-Executive Board Members from outside government who provide independent support and challenge. It is the most senior DHSC forum and operates in an advisory capacity but does not make decisions.

The board is supported by the committees shown at page 150. Updates were provided to the Departmental Board on the activities of the Executive Committee and Leadership Group and the Joint Executive Team (JET), the Audit and Risk Assurance Committee (ARAC – known as ARC until November 2025) and other major subcommittees.

To manage any conflicts of interest, DHSC maintains a register of board member interests. Board members are required to declare any potential conflicts that arise. Where a potential conflict is identified, board members are not involved in discussions or decisions on the matter in question.

The board and its committees consider management information covering a variety of disciplines, including financial data and information on departmental strategies and risks. High level risks were regularly reviewed by ARAC throughout the reporting year and by the Performance and Risk Committee up until May 2025 after when it was subsumed by the Executive Committee. DHSC risks are now reviewed quarterly at Leadership Group.

Attendance of the two Departmental Board meetings held during 2025-26 was as follows:

Departmental Board member	Attendance	Departmental Board member	Attendance
Ministers		*Non-Executive Board Members*	
Rt Hon Wes Streeting MP	1 (out of 2)	Rt Hon Alan Milburn	2 (out of 2)
Stephen Kinnock MP	0 (out of 2)	Sir Richard Douglas	2 (out of 2)
Baroness Gillian Merron	0 (out of 2)	Naomi Eisenstadt CB	1 (out of 2)
Karin Smyth MP	0 (out of 2)	Phil Jordan	2 (out of 2)
Ashley Dalton MP	0 (out of 1)	Baroness Camilla Cavendish	1 (out of 2)
Sharon Hodgson MP	0 (out of 1)		
Dr Zubir Ahmed	0 (out of 1)		
Officials			
Samantha Jones OBE	2 (out of 2)		
Professor Sir Chris Whitty	2 (out of 2)		
Tom Riordan CBE	1 (out of 1)		
Andy Brittain	1 (out of 1)		
Matthew Style	0 (out of 1)		
Elizabeth O'Mahony	1 (out of 1)		

Corporate governance code compliance

In 2025–26, DHSC continued to align its governance approach with the principles set out in Corporate Governance in Central Government Departments (2017). The Departmental Board and its Non-Executive Board Members remained committed to promoting high standards of corporate governance and providing strategic oversight and challenge, supporting delivery of DHSC's objectives.

Departmental Board meetings took place in April 2025 and March 2026. In light of the changes to departmental governance arrangements during the year, including the planned integration of NHS England and DHSC into a new single organisation and the establishment of new governance structures to support this transition, the intention is to undertake an external Board Effectiveness Evaluation in 2026-27, to ensure meaningful insight into the effectiveness of the Board and the governance arrangements supporting it.

Non-Executive Board Members continued to engage across DHSC throughout the year, providing independent advice, support and challenge to ministers and senior leaders. Their oversight role was strengthened through participation in DHSC/NHS England transformation governance, the 10 Year Health Plan governance arrangements and key assurance committees, bringing additional external expertise and challenge to DHSC.

The Board's sub-committees continued to benefit from strong Non-Executive Board Member oversight and engagement throughout the year and further strengthened their contribution to DHSC's governance framework during a period of significant organisational change and transformation.

The Nominations and Governance Committee, chaired by a Non-Executive Board Member, supported oversight of senior leadership capability, succession planning and wider governance effectiveness. The Audit and Risk Assurance Committee, also chaired by a Non-Executive Board Member, continued to provide independent assurance and challenge on the effectiveness of the DHSC's governance, risk management, internal control and audit arrangements. The Committee met regularly throughout the year and worked closely with its NHS England counterpart to strengthen alignment of risk, audit and financial assurance arrangements, helping to ensure robust oversight and assurance throughout the transformation process.

DHSC Leadership Group

During the reporting year, Leadership Group (or its predecessor, ExCo) has subsumed the functions of the Performance and Risk Committee, the Organisational Design Board and People Board. Performance-related, organisational design and DHSC people matters continue to be considered within Leadership Group, as required. People matters relating to the transformation programme remain within the remit of established transformation governance arrangements reporting to the JET.

Leadership Group has replaced the DHSC Executive Committee (previously known as ExCo) and is DHSC's highest-level executive decision-making forum. It provides oversight of strategy, finance (including strategic finance), people and capability, performance, risk management, and wider corporate matters, to deliver organisational plans effectively. It supports the Permanent Secretary, in her capacity as Principal Accounting Officer, in discharging her responsibilities.

Joint Executive Team

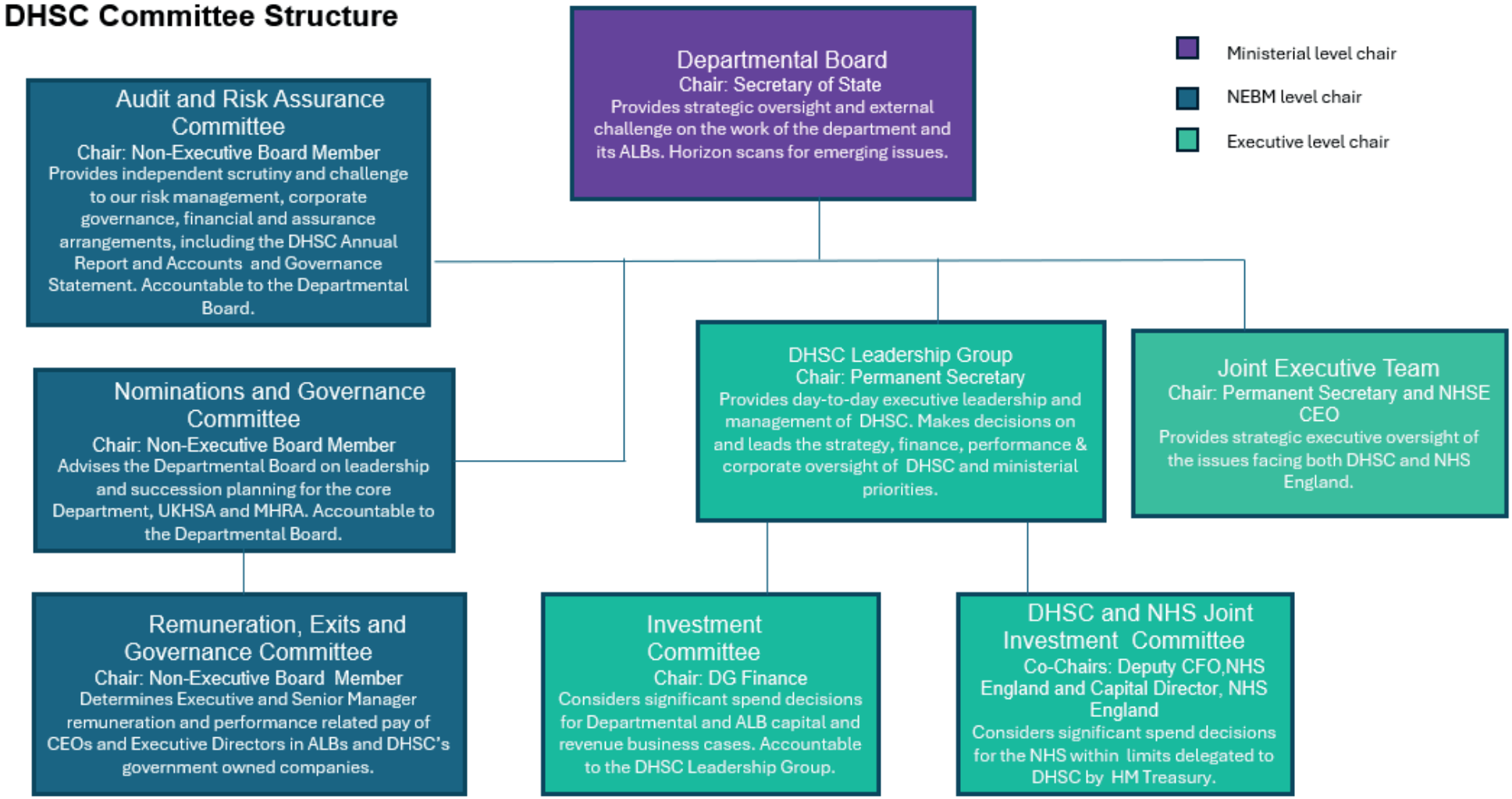
The Joint Executive Team (JET) was established to set out the shared vision and strategic priorities for health and social care as we move towards a single organisation from 1 April 2027. It ensures alignment between DHSC, NHS England, and ministerial objectives.

The JET is chaired jointly by the Permanent Secretary and the CEO of NHS England. Its membership also includes the interim Second Permanent Secretary, Chief Medical Officer, Chief Scientific Advisor, Medical Directors of NHS England, and DHSC Director Generals.

While DHSC and NHS England remain legally distinct, NHS England continues to operate separate governance arrangements, including the NHS England Board and NHS Executive, in accordance with statutory requirements until its planned abolition.

DHSC also has the following other major committees:

DHSC Committee Structure



The committees are responsible for the following:

Executive Committee: DHSC's major decision-making body and oversees strategy, finance, performance, and corporate issues in DHSC. It reports to the Departmental Board quarterly, with reports from various sub-committees. The Executive Committee met monthly until the end of October 2025, when it was superseded by the **Leadership Group.**	Met 6 times in the reporting year between April 2025 and October 2025.
Discussed: Executive Committee discussed capital spending, pandemic preparedness, delegated (non-senior civil service) and senior civil service grades pay awards; supply chain risks of medicines and medical products, Spending Review, DHSC risk (twice) and departmental workforce strategy.	

Leadership Group: Replaced the Executive Committee as the highest-level executive forum. In addition to taking on the previous remit of the Executive Committee, it subsumed the responsibilities of the former Performance and Risk Committee, Organisational Design Board and People Board. **Leadership Group** has met on a weekly basis since 3 November 2025 and held a formal monthly "Business Meeting" in March 2026. It has continued to meet in both weekly and monthly business meeting formats to July 2026, with the business meeting replacing the weekly format for one week per month.	The Leadership Group met weekly during 2025-26.
Discussed: Leadership Group discussed DHSC risk, business continuity, devolution, business planning and workforce strategy and priorities.	

Joint Executive Team: Sets out the shared vision and strategic priorities for health and social care as DHSC and NHS England move towards becoming a single organisation.	Met 3 times in the reporting year between November 2025 and January 2026.
Discussed: Issues relating to both organisations including cyber, legislation, the Chief Medical Officer's Annual Report 2025 and transformation programme matters.	

Remuneration, Exits and Governance Committee (previously the Remuneration Committee): has authority for the remuneration over £174,000 and performance related pay elements for any Executive in DHSC's arm's-length bodies (ALBs) and government owned companies including high-value contractual exit payments, including voluntary and compulsory redundancy payments, and all non-contractual Special Severance Payments from ALBs, Government owned Companies and NHS system organisations.	Met 10 times in reporting year

Nominations and Governance Committee: responsible for the performance and talent of DHSC, UKHSA and MHRA senior leaders and for their succession planning.	Met three times in reporting year
Discussed: end-of-year performance assessments and ratings for the directors general and CEOs for the UK Health Security Agency and Medicines and Healthcare products Regulatory Agency and their talent management and development.	

Audit and Risk Assurance Committee: has a standing meeting agenda for its four full committee meetings which covers finance, internal and NAO audits, value-for-money studies, departmental risk appetite and the board assurance framework. It also regularly discusses Public Accounts Committee reports and recommendations, counter fraud, cyber security, DHSC's major projects portfolio and the Government Major Projects Portfolio.	Met four times in reporting year
Discussed: In 2025–26, the ARAC held discussions on the DHSC/NHS England transformation programme, DHSC's financial position and outlook, audit findings and delivery, and DHSC's principal risks and risk culture. The committee also reviewed DHSC's Annual Report and Accounts. ARAC has held two joint sessions with the NHS England'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.	

Table 15 summarises respective committee or board member attendance at the Departmental Board and the four next-tier committees.

Table 15: Committee attendance

Committee member	Executive Committee	Leadership Group	Joint Executive Committee	Audit and Risk Assurance Committee	Nominations and Governance Committee	Remuneration, Exit and Governance Committee
	Met 6 times	Met 15 times	Met 3 times	Met 4 times	Met 3 times	Met 10 times
Senior Officials						
Samantha Jones OBE	4 (out of 4)	15 (out of 15)	3 (out of 3)	-	2 (out of 2)	-
Professor Sir Chris Whitty	4 (out of 6)	12 (out of 15)	2 (out of 3)	-	3 (out of 3)	-
Tom Riordan	6 (out of 6)	3 (out of 7)	2 (out of 3)	-	3 (out of 3)	-
Jonathan Marron	3 (out of 3)	-	-	-	-	-
Professor Lucy Chappell	6 (out of 6)	8 (out of 15)	2 (out of 3)	-	-	-
Michelle Dyson	3 (out of 3)	-	-	-	-	-
Sally Warren	2 (out of 6)	5 (out of 15)	3 (out of 3)	-	-	-
Andrew Brittain	5 (out of 6)	8 (out of 15)	-	2 (out of 2)	-	5 (out of 6)
Matthew Style	5 (out of 6)	10 (out of 15)	3 (out of 3)	-	-	7 (out of 10)
Catherine Frances	6 (out of 6)	8 (out of 15)	3 (out of 3)	-	-	-
Gila Sacks	1 (out of 1)	-	-	-	-	-
Jenny Richardson	6 (out of 6)	4 (out of 6)	-	-	2 (out of 3)	6 (out of 6)
Lorraine Jackson	6 (out of 6)	0 (out of 1)	-	-	-	-
Paul Macnaught	5 (out of 6)	11 (out of 13)	-	-	-	-
Danny Mortimer	-	5 (out of 5)	-	-	-	-
Elizabeth O'Mahony	-	9 (out of 15)	2 (out of 3)	1 (out of 2)	-	-
David Probert	-	3 (out of 15)	3 (out of 3)	-	-	-
Julian Hunt	1 (out of 1)	11 (out of 15)	3 (out of 3)	-	-	-
Duncan Burton	-	0 (out of 4)	3 (out of 3)	-	-	-
Professor Meghana Pandit	-	2 (out of 4)	3 (out of 3)	-	-	-
Dr Claire Fuller	-	0 (out of 4)	2 (out of 3)	-	-	-
Paul Dinkin	-	9 (out of 10)	1 (out of 1)	-	-	-
Fiona Bride	-	8 (out of 8)	-	-	-	-

Committee member	Executive Committee	Leadership Group	Joint Executive Committee	Audit and Risk Assurance Committee	Nominations and Governance Committee	Remuneration, Exit and Governance Committee
	Met 6 times	Met 15 times	Met 3 times	Met 4 times	Met 3 times	Met 10 times
Toni Court	-	8 (out of 11)	-	-	1 (out of 3)	3 (out of 4)
Juliette Cammaerts	-	3 (out of 4)	-	-	-	-
Antony Tierman	-	10 (out of 15)	-	-	-	-
Rachel Carr	-	6 (out of 13)	-	-	-	-
Non-Executive Board Members						
Rt Hon Alan Milburn	-	-	-	-	3 (out of 3)	-
Sir Richard Douglas	-	-	-	4 (out of 4)	-	10 (out of 10)
Naomi Eisenstadt CB	-	-	-	1 (out of 1)	-	-
Phil Jordan	-	-	-	-	-	-
Baroness Camilla Cavendish	-	-	-	-	-	-
Independent Members						
Anne Barnard	-	-	-	3 (out of 3)	-	-
Graham Clarke	-	-	-	3 (out of 3)	-	-
Chris Young	-	-	-	4 (out of 4)	-	-

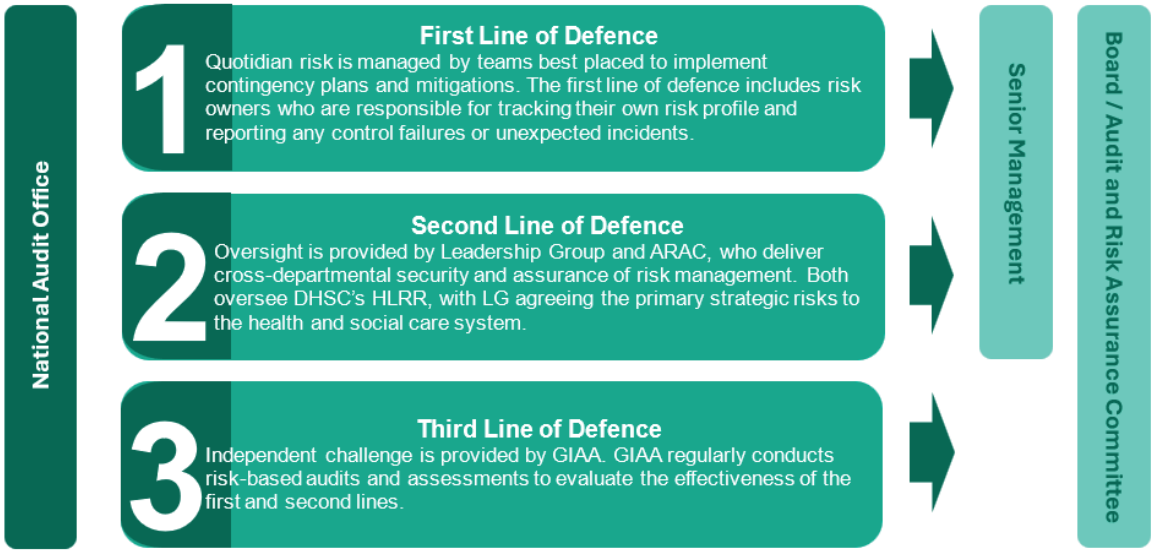
Core assurance framework, risk management and control

Three lines of defence

DHSC applies the 'three lines of defence' principle to its management of risk (illustrated below). At a departmental level we maintain a High Level Risk Register (HLRR) of the top strategic risks. Currently the HLRR contains four risks that are on the National Risk Register (NRR). They include:

DHSC High Level Risk	Risk on National Risk Register
Chemical, biological, radiological, and nuclear (CBRN) risk to public health and the health and social care system's preparedness and response capability.	(Chemical, biological, radiological, and nuclear (CBRN) attacks)
Cyber incident	Cyber-attack: health and social care system
Adult social care major provider failure	Major adult social care provider failure
Pandemic preparedness	Pandemic

Where risks are on both DHSC's HLRR and the NRR, they are indicated as such to ensure sufficient coverage, prioritisation, and attention. The HLRR is reviewed on a quarterly basis by Leadership Group and receives independent quarterly review by the ARAC. Through this scrutiny ARAC has supported the Departmental Board to ensure effective systems were in place to deliver high-quality internal control, governance and risk management.



Managing risk

DHSC's principal risks are set out at pages 8 and 9 of this Annual Report and Accounts.

The management of risks in DHSC complies with the guidance set out in HM Treasury's Orange Book setting the principles and concepts of risk management. which ARAC regularly considers the High-Level Risk Register and the quality of DHSC's assessment of risks and ensures that risk management and internal control systems remain effective. The committee supports the Departmental Board, Leadership Group, and the Joint Executive Team. In doing so, it provides independent challenge, non-executive scrutiny, and holds DHSC's senior leadership to account. This includes:

- challenging and assessing the robustness of how DHSC manages financial and strategic risk,
- reviewing and providing the final sign off of DHSC's Annual Report and Accounts (ARA), and
- ensuring DHSC is delivering recommendations from the NAO and Public Accounts Committee reports and investigations;

Given the ongoing transformation programme, the ARAC has been actively involved in assessing and conducting risk deep dives into the programme's key risks and mitigations.

The system of internal control for identifying, evaluating, and managing risks has been in place for the full year. DHSC's risk management approach supports understanding of its risk exposure and the cross-cutting nature of risks across the system. A key position within this system is DHSC's Director of Ministers, Accountability, and Strategy, who undertakes the role of Chief Risk Officer.

DHSC manages a wide portfolio of risks. The most severe are monitored by ARAC and Leadership Group. Below these committees, risks are managed by Senior Civil Servants. Risks from the wider DHSC family of arm's-length bodies are also monitored by DHSC sponsor teams and escalated as required.

The management of risk can be visualised as follows:

PROGRESS OF RISK MANAGEMENT IN DHSC

ANNOUNCED CHANGES

The amount of change DHSC and the system has experienced throughout the financial year, due to several big announcements, has led to a significant increase in the risk profile of DHSC. This has required a consistent and hands on approach to risk management, ensuring DHSC is well-equipped to react to sudden and large-scale changes.

RISK DISCUSSIONS

Various risk discussions took place at ARAC, Executive Committee (ExCo), and Leadership Group (LG). For instance, ARAC considered, in several meetings, the principal risks facing DHSC as well as the risk profile of the transformation programme. Similarly, ExCo and LG also held talks on the organisation's principal risks, leading to important revisions to DHSC's High Level Risk Register.

RISK REPORTING

Several changes have been made to risk reporting frameworks, used internally by DHSC. These changes have ensured increased effectiveness of risk management and incorporated recommendations made by the Government Internal Audit Agency to progress DHSC's risk maturity.

RISK CULTURE

DHSC has undertaken targeted training throughout the year for staff of all grades. This, alongside our improvements to risk reporting, is part of an initiative to increase DHSC's risk maturity.

Figure 28 below highlights the routes for escalation of risks



Biannual assurance meetings

During 2025-26, DHSC held assurance meetings on a biannual basis. They serve as an opportunity for directors to discuss and raise new and emerging risks with their director general and the Permanent Secretary, providing the Permanent Secretary with an opportunity to evaluate each director general's risk profile at a more granular level. In

2026-27 Group Business Reviews replaced biannual assurance meetings; these will also be held twice a year for each director general group.

Major projects

The Major Projects Portfolio (MPP) continues to manage the oversight of the delivery of DHSC's key programmes and projects delivering priorities and manifesto commitments.

Governance, scrutiny and challenge continue to be delivered through the Portfolio Oversight Board which has further refined its data set for reporting over the past year.

The MPP at March 2026 comprised 15 programmes and projects, with criteria for inclusion in the MPP based on HM Treasury's definition of a 'major project', including manifesto commitments and programmes or projects which feature in the Government Major Projects Portfolio (GMPP). The MPP team continues to track the delivery of all DHSC's major programmes on the GMPP, working closely with the National Infrastructure and Service Transformation Authority (NISTA).

In line with other government departments, DHSC provides an updated delivery confidence assessment for inclusion in the NISTA's annual report reflecting the position as at Quarter 4. It should be noted that the MPP in its entirety is not included in this return, only those programmes and projects that are commissioned on the GMPP. The latest report can be found here.

Since 1 April 2026 the GMPP has been refocused in order to boost delivery of national priorities. Consequently a number of programmes and projects will leave the MPP as they will have delivered and or be out of business case cover. These are:

- Ambulance Radio Programme
- Community Diagnostic Centres (CDC)
- Digital Transformation of Screening (DTOS)
- Drug Strategy
- Family hubs/ Start for Life
- Integrated Single Financial Environment (ISFE)
- NHS Tech: Frontline Digitisation Programme
- Targeted Investment Funding (TIF)

The reforms announced as part of Autumn Budget 2025 and summarised in the Office for Value for Money publication, Reforming the spending control and accountability framework are now being implemented in DHSC and other government departments. Under these reforms, the DHSC elements of the GMPP will evolve, reflecting a revised set of criteria for such programmes and changes in the composition of the department's own MPP.

Better regulation

DHSC is committed to the use of better regulation principles to achieve our objectives of improving the public's health and care while at the same time minimising costs to business and promoting growth. When we do regulate, it is where necessary to protect public health and to ensure we provide safe, effective, and compassionate care. We support the recognition of wider impacts of regulation beyond the costs to business.

DHSC continues to promote the use of alternative approaches to regulation where appropriate. Where regulation is required DHSC's Better Regulation Unit works closely with teams to consider how best to develop proportionate and targeted regulatory solutions through the development of policy.

We measure our progress in achieving the aims and objectives as set out in the Better Regulation Framework and its core principles through our regular interaction with policy teams and our key stakeholders such as the Regulatory Policy Committee. DHSC monitors its regulatory policies and reports regularly to the Department for Business and Trade (DBT) on qualifying regulatory measures. DBT is also leading the cross-Whitehall regulatory reforms into which DHSC is contributing.

Whistleblowing

DHSC's whistleblowing policy has been in place since August 2015 and includes reporting biannually to the Cabinet Office on all whistleblowing concerns received. The policy is regularly reviewed. The most recent version was revised and updated in April 2025. We are in the process of reviewing our policy to reflect the changes set out in the Employment Rights Act 2025 with regards to protections for workers who make a disclosure in relation to workplace sexual harassment.

In 2025-26, no formal whistleblowing cases were raised in DHSC. In comparison, during 2024-25, DHSC completed an internal whistleblowing health check in line with Cabinet Office guidance. This provided DHSC with an additional mechanism to assess whether effective processes are in place for raising whistleblowing concerns safely, and whether a strong culture exists in which staff feel confident to speak up. Building on this, during 2025-2026 DHSC underwent an audit of its Speak Up service. Six recommendations were made (five medium priority and one low priority), including one recommendation relating to our Raising a Concern Policy, which will be completed by Q4 2026-27.

DHSC's HR team continues to use a 'safe to challenge' scorecard to measure progress against the aims of the programme and identify hotspots and trends through data and insights. The scorecard is reviewed by DHSC's Leadership Group and the HR Director on a quarterly basis.

Key departmental operational governance

This section includes areas which relate to DHSC's key operations during the reporting year. Issues disclosed below may have covered more than one reporting year and, where that is the case, will have been first raised in the 2024-25 ARA or in earlier reports. Where matters have arisen during the reporting year and are not yet resolved, they will continue to feature in future reports.

Finalisation of group entities' accounts

DHSC is committed to laying its ARA in as timely a manner as is possible as this is critical for Parliamentary scrutiny and is implementing a multi-year plan which aims to bring forward the publication of the DHSC group ARA each year.

Under this plan, we published last year's 2024-25 ARA on 11 December 2025. This year we have published the 2025-26 ARA before the end of October 2026, some six weeks earlier.

NHS audit timescales remain highly dependent on the capacity of the private sector firms undertaking them and the regulatory requirements and standards to which the firms must work, which is further impacted by the application of the international accounting standard ISA 600 Group Audits. In addition, accounts preparers have a role to play to support the audit timetable with variability in the timeliness and quality of the NHS bodies' financial statements and supporting working papers also being contributing factors. However, these factors are largely outside DHSC's control and remain the key risks to our multi-year plan.

The Consolidated Provider Accounts for 2025-26 were finalised without five NHS provider audits completed. Of these five, two NHS provider audits remain outstanding for 2024-25. One of these is Croydon Health Services NHS Trust, which received a disclaimed audit opinion on its 2023-24 accounts. Further details are given in the Consolidated Provider Accounts 2025-26 ARA.

It is also imperative that DHSC continues to work in partnership with the private sector audit firms to set achievable audit timescales. DHSC has therefore engaged with audit firms to agree stretching but deliverable deadlines for NHS audits each year, alongside work with all key stakeholders to reform and build capacity in the local audit market. Our aspiration is that, over the longer-term, capacity and resilience of the private sector audit market will be strengthened for NHS bodies and support accelerated audit timescales. DHSC is also working closely with the Ministry of Housing, Communities and Local

Government on the relevant elements of its work to reform the local audit market, including its establishment of the Local Audit Office.

DHSC information risk management and assurance

Information risk management and assurance expertise continued to provide DHSC advice throughout 2025-26, ensuring information is effectively used, lawful, kept securely, and shared responsibly to support DHSC in decision-making and improving services. Reporting into the Information Governance Committee which acts as supervisory and strategic decision-making body and escalation route for information governance and data protection across DHSC. The Committee holds overall accountability for the management of DHSC's information and data protection risks and reports into the Senior Information Risk Owner.

DHSC recorded 190 data-related incidents between April 2025 and March 2026, an increase of 97 on the previous year. Of the 190 reported incidents, two met the criteria to be referred to the Information Commissioner's Office (ICO) (compared to one in the previous year). We continue to work with the ICO, to ensure that data protection implications and obligations are considered and met.

Compliance with equality and human rights legislation

The overall responsibility for meeting the requirements of equality and human rights legislation in policy and decision-making lies with individuals in DHSC. Staff are encouraged to consider equality from the perspective of improving outcomes for people, rather than as a legal duty or process, to ensure that equality is put at the heart of all policy and decision-making. Training sessions on the public sector equality duty and how it applies to DHSC are made available. Staff are also encouraged to engage with lawyers during the policy and decision-making process to ensure that legal duties are met.

Equality and human rights compliance is considered through the DHSC biannual assurance meetings with each director general group so that where issues arise during the year, they are appropriately reported and discussed. It also addresses identified weaknesses to drive improvements.

Staff are required to consider compliance with the public sector equality duty and evidence of this is provided in submissions to ministers which include a checklist that highlights the duty as something that must be considered by the lead policy team developing the policy. The most current information on how DHSC complies with the duty can be found in the report Equality in 2025: how DHSC met the public sector equality duty report published in July 2026.

Quality Assurance of analysis and models

DHSC has a comprehensive framework of assurance for analytical models used in critical areas of our activity, guided by an oversight committee of senior analysts. DHSC operates in line with HM Treasury guidance in the AQuA Book and the recommendations of the Review of quality assurance of government models published in 2013.

During 2025-26, DHSC's internal Quality Assurance Working Group has continued to raise awareness of, and improve, the training and materials available to officials engaged in analytical work. In addition, the group has carried out reviews of governance and quality assurance processes in place across DHSC's business-critical models. This helps maintain systematic processes to regularly update our list of business-critical models, and to ensure that risks are identified, managed, and escalated as necessary.

DHSC has continued to publish a list of business-critical models on an annual basis, covering the models in DHSC, its arm's-length bodies and executive agencies. This supports transparency and encourages good practice in quality assurance. DHSC has continued to run a Community of Practice with membership from executive agencies and arm's-length bodies with the goal of sharing best practice and ensuring quality assurance standards are upheld in each organisation.

Data issues – cyber security programme

The UK health and social care sector is considered an attractive target to a range of threat actors because of the quantity and sensitivity of health data available. The future of the NHS and social care relies on using digital technology to provide safer, more efficient, more personalised care. Throughout 2025-26 we have continued to increase cyber resilience across the health and care sector.

The aim of the Cyber Improvement Programme is to deliver the ambitions of the Cyber Security Strategy for Health and Social Care to 2030. In the last financial year, the programme has further developed capabilities and services that will enable the Health and Care Sector to better manage their Cyber Risks.

This included implementation of an Operational Data Platform providing the technical means of transforming a number of key risk identification data sources into one asset that can be holistically and powerfully analysed; onboarding more than 900 users across 270 organisations to the Threat Intelligence Sharing Platform, enabling healthcare organisations to rapidly receive and share threat intelligence to enable an informed cyber threat response; maturing cyber incident response processes through implementation of an incident response toolkit for National Teams and Adult Social Care; development of the cyber exercise strategy and running a national incident response exercise to test preparedness to contain a cyber incident and build muscle memory; direct support to the frontline stepped up, with £2.7 million investment in technical remediation with 18% of this

investment used to assess local infrastructure vulnerabilities and 82% directed at reducing vulnerabilities; over £40m direct funding to close other known cyber vulnerabilities at the frontline and increase resilience; and, an increased cyber awareness amongst Health and Care workforce through cyber school training, upskilling 500 people and embedding 23 cyber apprentices in the frontline contributing to building the talent pipeline.

The programme has mobilised to deliver against a four-year business case covering financial years 2026-2030, with the aim of raising the cyber resilience of all local health and care organisations to a consistent and assured standard by enabling the successful implementation of the Cyber Assessment Framework.

COVID-19 Inquiry

The UK COVID-19 Inquiry was set up to examine the UK's response to the COVID-19 pandemic, assess its impact and identify lessons to guide future preparedness. In early 2026, the final public hearings were completed and reports are being drafted by the Inquiry for Modules 5 (procurement), 6 (care sector), 7 (test, trace and isolate), 8 (children and young people), 9 (economic response) and 10 (impact on society).

The government responded to the Inquiry's Module 1 report on resilience and preparedness in January 2025. The first update on the implementation of the recommendations was published on 8 July 2025. The second progress update was published on 16 January 2026 via the Cabinet Office website and further updates will be published at six-month intervals.

The Inquiry's Module 2 report on core UK decision-making and political governance was published on 20 November 2025. The government published its response to the Module 2 report on 25 March 2026, outlining how departments have improved decision-making processes since the pandemic. The response includes measures to strengthen protections for vulnerable groups and enhance cooperation with devolved governments to enable a fairer, faster and more coordinated crisis response.

The Inquiry's Module 3 Report on the impact of the pandemic on the healthcare systems of the United Kingdom was published on 19 March 2026 and the Module 4 Report on vaccines and therapeutics was published on 16 April 2026. The government published its response to the Module 4 report on 16 October 2026.

The Module 5 Report on procurement was published on 14 July 2026. The Module 6 Report on the impact of the pandemic on the adult social care sector was published on 20 October 2026. We are considering the Inquiry's findings and recommendations and will respond in due course.

DHSC remains committed to responding to the Inquiry with openness and transparency. At the end of April 2026, DHSC had submitted more than 58,000 pieces of evidence to the

Inquiry, including written individual witness and corporate statements, and has supported 35 witnesses, including then serving and former ministers and senior civil servants to give evidence at the hearings.

Clinical negligence

The total of payments made by NHS Resolution (NHSR) for clinical negligence claims in 2025-26 was £3.2 billion, up from £3.1 billion in 2024-25. Repeated inquiries and investigations have highlighted significant issues with patient safety, and DHSC is clear in its ambition to restore public confidence.

The NHS Resolution Annual Report and Accounts 2025-26 outlines some of the measures being taken by NHSR to improve patient safety, including sharing data and insights as a catalyst to improve service delivery, identifying emerging patient safety risks and supporting a greater understanding of the causes of incidents. Additionally, collaboration to improve maternity outcomes has been a strategic priority for NHS Resolution and has included an Early Notification scheme and Maternity Incentive scheme, as well as launching an e-learning module designed to support clinicians working in maternity services.

The rising costs of clinical negligence claims against the NHS in England are of great concern to the government. In 2025-26, total payments for damages (compensation) for clinical claims was £2.5 billion with total legal costs for clinical claims costing £0.8 billion.

The causes of the overall cost rise are complex and there is no single fix - costs are likely to be rising because of a range of factors, including higher compensation payments and legal costs rather than more claims or a decline in patient safety. Recent reports from the National Audit Office in October 2025 and the Public Accounts Committee report in January 2026 highlighted the disproportionate legal costs of low value claims as a key concern. DHSC is examining how best to address some of the problems.

The government is of the view that ever-increasing levels of compensation and legal costs is not in the wider public interest and agrees with the Public Accounts Committee that this issue should be tackled. As set out in the 10 Year Health Plan, David Lock KC is providing expert advice on the rising costs of clinical negligence and how we can improve patients' experience of claims. The results of David Lock's work will inform future policy making in this area.

Fraud prevention

DHSC anti-fraud unit

DHSC remains committed to ensuring that public funds are used effectively and transparently to deliver on the Secretary of State's priorities. Fraud diverts resources from

patients and frontline services and undermines public trust. Preventing and responding to fraud is integral to ensuring we have an NHS fit for the future.

Over the past year, the DHSC Anti-Fraud Unit (DHSC AFU) has continued to strengthen its counter fraud framework at a national level, aligned with the Government Counter-Fraud Functional Standard (GCFFS also known as 'GovS 013') and taken a risk-based approach to protecting funds across core priority areas. The DHSC AFU has worked in partnership with all parts of DHSC, its ALBs and owned companies.

2025-26 was the final year of the 2023-26 DHSC Counter Fraud Strategy, which has the vision 'A system-wide approach to tackling fraud that protects taxpayers' money for better patient care'. It focuses on four key areas as follows:

Four key areas of focus			
Proactivity and prevention	Using digital and data analytics	Collaboration and co-ordination	Response and enforcement

The first two years of the strategy have delivered £381 million of counter fraud savings across the health group, including prevented, detected and recovered with year 3 savings for 2025-26 to be confirmed. It is expected that the £500 million three-year target will be exceeded.

A new DHSC Counter Fraud Strategy 2026-29 is being developed.

The DHSC AFU continues to maintain a close working relationship with the Public Sector Fraud Authority, reporting quarterly action plan updates to them, along with quarterly performance metrics. A close relationship with the Public Sector Fraud Authority ensures we are at the forefront of any government counter fraud developments and a counter fraud response that is aligned with the wider system.

The DHSC AFU has developed an enterprise and thematic Fraud Risk Assessment (FRA) to expand the oversight and understanding of fraud risk across departmental activity. The AFU has improved the fraud risk template to contribute greater detail to those processes, as well as emphasise risk ownership and responsibility. The AFU also advises colleagues across DHSC on how to complete full FRAs for specific spend areas and offer assurance on these assessments.

The DHSC AFU has worked with teams across DHSC, including Investment Appraisals, to strengthen guidance and oversight of Initial Fraud Impact Assessments (IFIAs). This has included emphasising mandatory completion for all Government Major Projects Portfolio (GMPP) programmes in accordance with Managing Public Money. Guidance has been published encouraging the use of IFIAs for capital spend above £30 million. This ensures

that fraud is considered at an early stage for large spend, rather than just major spend. DHSC had no GMPP programmes which necessitated an IFIA in 2025-26.

The New Hospitals Programme (NHP) is an active DHSC GMPP programme and is listed on the PSFA High Fraud Risk Portfolio. The DHSC AFU continues to be proactively engaged with stakeholders, including PSFA and NHS England, DHSC programme leads and the NHSCFA to manage fraud risks within the programme.

DHSC has a comprehensive programme of engagement and counter fraud improvement work in place with health ALBs. From March 2026, the operational remit of the NHS Counter Fraud Authority was expanded to enable it to provide further support to NHS facing ALBs. This change removes duplication and gives NHS facing ALBs access to a national body with the consistency, appropriate skills and expertise needed to support them in their counter fraud work. The DHSC AFU will continue to work with departmental ALBs: UK Health Security Agency (UKHSA), the Medicines and Healthcare products Regulatory Agency (MHRA), Health Services Safety Investigations Body (HSSIB) and NHS Business Services Authority (NHSBSA).

DHSC, and several of its ALBs, also contributed to the PSFA's counter fraud Workforce and Performance Review 2025, which provides detailed insight into counter fraud capability across government.

NHS Counter Fraud Authority (NHSCFA)

The NHSCFA is a special health authority established in November 2017, with DHSC AFU its departmental sponsor. In respect of counter fraud, it is responsible for preventing, detecting and investigating fraud, corruption or other unlawful activities, carried out against or otherwise affecting the NHS and the wider health sector in England.

The NHSCFA had an average staff of 227 (full-time equivalents) during the reporting period which includes 48 fixed-term contracts and three contractors/temporary staff. NHSCFA implements DHSC's strategic plan under the sponsorship of DHSC AFU.

NHSCFA publishes an annual Strategic Intelligence Assessment (SIA) which estimates the potential vulnerability to fraud in the NHS in England. The SIA does not indicate actual fraud losses but rather an estimate of fraud vulnerability. This informs the NHSCFA and its stakeholders of the priorities for the year ahead by capturing established, emerging and potential future threats. The SIA has ensured, and will continue to, ensure, a coordinated response to fraud and protect funding to aid delivery of the 10 Year Health Plan, modernise the NHS and protect funds meant for patient care.

The Strategic Intelligence Assessment (SIA) 2026 (using 2024-2025 financial data and 2025-2026 reporting data) estimates the financial vulnerability to fraud in the NHS, in England, is £1.301 billion (not actual fraud losses) compared to £1.346 billion for 2024-

2025. This is a reduction of £45.06 million compared with the previous year and we saw an overall decrease in the percentage of the budget vulnerable to fraud. The fraud vulnerability estimate equated to 0.66% of the total NHS budget for 2025-26. This demonstrates an effective counter fraud approach across the health sector in England.

There will always be a gap between the level of fraud against the government that is detected and the amount that is estimated, given the use of extrapolation across samples in estimates.

DHSC committed £10 million investment in the NHSCFA over two years to support enhanced counter fraud capability, including Project Athena. This funding has now been mainstreamed into the NHSCFA budget, embedding the activity as business as usual. Project Athena was a project aiming to both prevent fraud and deliver a dedicated response by identifying patterns in data on a scale that has not been done before across the NHS for counter fraud purposes. It provided the NHSCFA with specialist expertise to focus on priority areas using data analytics, enabling more fraud to be detected and prevented. In its first year, Project Athena supported the sector in demonstrating a counter fraud financial impact of £28.5 million (in respect of all fraud prevented) in 2024-25 and £42.3 million in 2025-26 (£70.8 million over two financial years).

Local counter fraud work

The NHS Standard Contract requires all organisations commissioning and providing NHS services to put in place and maintain appropriate counter fraud arrangements. NHS England has also published statutory guidance for ICBs on their counter fraud responsibilities.

Local Counter Fraud Specialists (LCFS) support the NHSCFA on national issues, ensure national fraud prevention messages are widely circulated and identify, report, and investigate individual cases. As of March 2026, there were 256 LCFSs. Other NHS-facing ALBs with national coverage routinely undertake activity to tackle NHS fraud such as fraud awareness, prevention and detection.

Counter fraud oversight

The Counter Fraud Board maintains oversight and coordination of the response to fraud by key national health organisations. Board members include NHSCFA, NHS England, NHSBSA, UK Health Security Agency (UKHSA) as well as the PSFA.

The NHSCFA chairs a quarterly control strategy and strategic tasking and coordination group consisting of key stakeholders across the health group (DHSC, NHS England, NHSBSA, and UKHSA) to collectively agree priorities and areas for counter fraud activity for the forthcoming financial year and/or strategic planning cycle.

COVID-19 pandemic fraud

With support from the wider counter fraud function and law enforcement partners, DHSC has prevented and recovered a total of £238 million in high-risk procurement payments. This is comprised of £163 million prevented before payment and £75 million recovered. This figure relates to fraud prevention and recovery activity and excludes recoveries achieved through commercial contract dissolution processes.

The COVID-19 Counter Fraud Commissioner (CCFC), Tom Hayhoe, was appointed in December 2024 to provide independent external assurance that the government has done as much as possible to identify, pursue and recover public money lost to COVID-19 related fraud or under-performing contracts.

His final report was published on 9 December 2025 and included the following assessment: “Overall, I can provide assurance to the Chancellor about the efforts that have been and continue to be made by DHSC’s Contracts Dissolution Team and Anti-Fraud Unit to recover public money lost through problems with the procurement of PPE during the pandemic and suspected fraud. They have been tenacious and resourceful in seeking satisfactory resolution and appear to have left no stone unturned”.

Civil litigation

On behalf of DHSC, NHS England and the devolved governments, DHSC AFU engages in civil litigation cases when anti-competitive behaviour is suspected in the pharmaceutical industry. We continue to develop our approach to these civil litigation cases by engaging with pharmaceutical companies at an early stage and, on a without prejudice basis, seeking settlement without lengthy and costly litigation where possible. Any settlement, less legal fees, is returned to the NHS or devolved government.

Departmental financial and audit governance and quality assurance

This section includes reviews and disclosures of areas relating to financial and audit governance and quality assurance in DHSC.

Role of internal audit

DHSC’s internal audit service continues to be provided by a dedicated health and social care team within the Government Internal Audit Agency (GIAA). The team plays a crucial role in the review of the effectiveness of risk management, controls, and governance within DHSC by:

- focusing audit activity on the key business risks
- evaluating the design and effectiveness of departmental processes in achieving business objectives

- being available to guide managers and staff through improvements in internal controls
- auditing the application of risk management and control as part of internal audit reviews of key systems and processes, and
- providing advice to management on internal control implications of proposed and emerging changes.

The team operates in accordance with the Global Internal Audit Standards and to an internal audit plan, which has been agreed with the Accounting Officer and the DHSC ARAC. With the agreement of ARAC, this plan is updated appropriately throughout the year to reflect changes in risk profile, including those relating to the planned integration of NHS England with DHSC.

The Head of Internal Audit submits regular reports to the ARAC relating to the adequacy and effectiveness of DHSC's systems of internal control, and the management of key business risks, together with recommendations for improvement. These recommendations have been discussed, and the resulting action plan is agreed by management which includes a timetable for implementation.

The status of internal audit recommendations and the collection of evidence to verify their implementation are reported to the ARAC. The Head of Internal Audit also has direct access to DHSC's Director General for Finance, and they met periodically during the year to review lessons arising from internal audit.

Since September 2021, functional standards have set expectations for the consistent management of 13 central functions across government departments and their ALBs. DHSC internal audit reviews DHSC compliance with these functional standards where they are relevant to any audit subject on a case-by-case basis – as agreed in the DHSC internal audit plan. In 2025-26, DHSC completed both the Government Finance Function Continuous Improvement Assessment Framework and the End of Year Assessment, improving its rating to "Good", which is the target maturity level set by the Government Finance Function.

Internal audit opinion

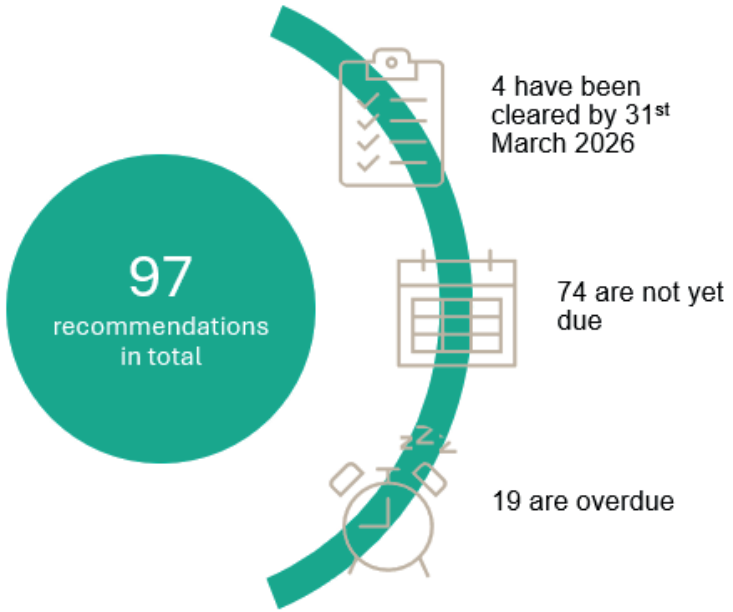
The Head of Internal Audit provided an opinion of 'moderate' assurance on the adequacy and effectiveness of the risk management, control and governance arrangements within the core department in 2025-26, which remains the same as for the last three years, demonstrating the continued progress, and consolidation, since the COVID-19 pandemic. No evidence was found of significant pervasive control weaknesses.

In forming the opinion of ‘moderate’ assurance, the Head of Internal Audit observed that, overall, DHSC had adequate governance structures and processes. DHSC has continued to observe appropriate departmental oversight via, for example, the Stockpile Board Governance and the Analytical Oversight Committee. The Head of Internal Audit also considered, on an advisory basis, work performed in relation to the DHSC/NHS England transformation programme. ARAC has continued to provide robust challenge and oversight of DHSC activities, including in relation to the planned integration of NHS England with DHSC.

The Head of Internal Audit confirmed that the work of his team throughout the year has continued to see the strengthening of the control environment, such as in relation to key financial controls and, following on from good progress in the past two years, risk management. In addition, significant improvements have been made to DHSC’s integrated approach to providing assurance over major change activity.

The Head of Internal Audit concluded that in their judgement, during 2025-26, DHSC has maintained an adequate system of governance, risk management and internal control. Their opinion reflects that whilst DHSC has now returned to a more settled ‘business as usual’ state of operation post pandemic, it is now increasingly focused on ensuring it maintains, and, where necessary, develops, appropriate ways of working that will enable it to deliver the planned integration of NHS England and DHSC.

A summary of the internal audit engagements reported on in 2025-26 as at March 2026 is shown below:



Engagement	Report date
DHSC Voucher Scheme	23/12/2025
DHSC Data Protection Officer role (MHRA)	06/03/2026
Analytical Governance arrangements in Health Group ALBs	22/05/2026
IT Asset Management	28/04/2026
Compliance with Commercial Policies and Procedures	24/04/2026
Partners in Care & Health Continuous Improvement & Support Programme - Adult Social Care	27/04/2026
New Hospitals Programme - governance	11/08/2025
Analytical Oversight Committee	11/09/2025
Stockpile Board governance arrangements	16/09/2025
NIHR Research Delivery Network Coordinating Centre	13/10/2025
Speak Up	10/02/2026
Risk management effectiveness	01/11/2025
Delivery of NIHR commitments to climate, health and sustainability	16/03/2026
Joint Work and Health Directorate	18/03/2026
Key Financial Controls	06/05/2026
Arms-Length Body Sponsorship	29/04/2026
Sustainability Reporting	26/03/2026
Manual and foreign currency payments	18/03/2026
Integrated assurance: Action plans, recommendation tracking and assurance mapping	12/12/2025
Validation of Grant Administration Cost Baselining	17/04/2026
Emergency Planning, Resilience and Response	21/04/2026
Anti-Fraud Unit Referrals process	15/10/2025
Portfolio Management – Adult Social Care Reform	21/01/2026
DHSC & NHSE Transformation Programme – advisory	31/03/2026

National Audit Office and Public Accounts Committee

As the UK's independent public spending watchdog, the National Audit Office (NAO) both audits the accounts of departments and their component bodies and, through the Comptroller and Auditor General (C&AG), has the statutory authority to examine and report to Parliament on whether departments and the bodies they fund have used their resources efficiently, effectively and with economy.

Table 16 provides a summary of the key reports published by the NAO in 2025-26, that reflect on activities of DHSC:

Table 16: Key NAO reports

Title of significant NAO report	Date of publication
Cost of clinical negligence	17 October 2025
The financial sustainability of England's adult hospice sector	29 October 2025
Primary and community healthcare support for people living with frailty	5 December 2025
Department of Health and Social Care Accounts 2024-25	11 December 2025
Update on the New Hospital Programme	16 January 2026
The costs of tackling drug harms in prisons	4 February 2026

Table 17: Key PAC reports

Title of PAC report	Date of publication
Fixing NHS Dentistry	4 April 2025
DHSC Annual Report and Accounts 2023-24	14 May 2025
Antimicrobial resistance: addressing the risks	13 June 2025
Reducing NHS waiting times for elective care	19 November 2025
Costs of clinical negligence	30 January 2026
Financial sustainability of adult hospices in England	18 March 2026

The NAO seeks to confirm the factual accuracy and provide formal clearance of their reports with the departmental Director General of Finance and the Principal Accounting

Officer (Permanent Secretary) where DHSC is the primary client. DHSC reports on the implementation status of the NAO's recommendations on a bi-annual basis. These are published by the NAO in its Recommendations Tracker.

The Accounting Officers, Director General of Finance, and other senior officials give evidence to the Public Accounts Committee (PAC) by appearing at hearings in Parliament.

Accounting Officers also have responsibility for approving the subsequent Treasury minutes which are the government's response to the recommendations the PAC makes in its reports. DHSC reports on the implementation status of the PAC's recommendations on a bi-annual basis. They are commissioned centrally by the Treasury Office of Accounts in HM Treasury and are published in the Treasury Minute Progress Reports. In 2025-26, DHSC officials attended five PAC hearings, the details of which can be found via the Committee's website. A quarterly update paper on the department's NAO and PAC activity is provided to DHSC's ARAC.

Grant funding

DHSC currently awards grants to private and voluntary sector organisations using a range of statutory grant awarding powers. The governance process for grant-making is overseen by an expert functional resource, ensuring a consistent approach to assurance and approvals during the grant's life cycle. Material grant awards are also subject to DHSC's standard spending decision processes and approved by the Investment Committee. Appropriate Ministerial, Secretary of State and HM Treasury approval is sought, as determined by the underpinning legal power and grant value. This governance model embeds the Government Functional Standard for Grants and HM Treasury's Managing Public Money, with which DHSC is compliant.

Grants are funded through grant agreements which specify the terms, conditions and key performance indicators the grant recipient must adhere to. Financial returns are required to ensure grant expenditure is in line with budget and is incurred as intended. For multi-year awards, there is annual scrutiny to determine whether to continue in line with existing plans, make adjustments, or terminate the grant. Any surplus funding may be recovered.

DHSC has a variety of measures in place to ensure that all grants awarded constitute value for money. For example, the system covering grants issued to voluntary organisations under section 64 of the Health Services and Public Health Act 1968, requires that prior to their award they are approved by HM Treasury to ensure they offer value for money, and fit with DHSC's priorities.

Evaluation takes place at the end of the activities to determine how and where the project was successful, and how value for money has been achieved.

As described at pages 38 and 39 of the Performance Report, the public health grant is subject to assurance arrangements by Regional Directors of Public Health. DHSC accounts for the outcomes achieved through the Social Care grant awarded to local authorities as part of its overall approach to monitoring performance in adult social care.

NHS governance

The NHS

NHS England shares responsibility with the Secretary of State for Health and Social Care for promoting a comprehensive health system in England, designed to secure improvement in physical and mental health of the people of England, and in the prevention, diagnosis, and treatment of physical and mental illness.

In relation to NHS England, the National Health Service Act 2006, as amended, requires DHSC to formally set out its objectives for the health service in a mandate to NHS England, and any requirements considered necessary to achieve those objectives. This is one of the formal accountability mechanisms for holding NHS England to account for the money it spends and the outcomes it achieves. A new mandate to NHS England was published on 30 January 2025. Other accountability mechanisms include regular reporting, particularly on priority issues and strategies, and regular conversations between DHSC and NHS England at all levels to work together on delivering a comprehensive health service.

NHS England has responsibility for the commissioning of healthcare in England and to invest its annual budget (of around £198 billion in 2025-26) with a view to bringing about measurable improvements in health outcomes for the population.

ICBs, NHS trusts and NHS foundation trusts are all required to operate risk management procedures. For ICBs and NHS trusts, these processes are set and managed by NHS England. NHS foundation trusts are required, under the terms of their establishment, to maintain adequate systems of internal control and report these in their annual report and accounts.

The current assurance and accountability process provides ministers with several legislative and non-legislative mechanisms for holding NHS England to account. Following the then Prime Minister’s announcement of plans to abolish NHS England in March 2025, DHSC and NHS England have been working closely to ensure continued effective accountability, joint working and the removal of duplication. The NHS England Chief Operating Officer is SRO for NHS England closedown and related NHS England transition work.

NHS England/DHSC integration oversight and governance

The Health Bill, introduced to Parliament on 14 May 2026, started the process formally to abolish NHS England and transfer the majority of its functions to DHSC. This is a significant transformation, and DHSC, with NHS England, is managing the risks to business continuity and the organisations' capacity and capability that arise. The interim Second Permanent Secretary is in place as Senior Responsible Owner (SRO) and reports to the Transformation Executive Group, which is jointly chaired by the Permanent Secretary and the NHS England Chief Executive. In addition, as described in the Departmental Governance section above, the DHSC Board and its Committees are monitoring the programme and considering transition risks. The DHSC ARAC is doing so in close collaboration and on occasion jointly with NHS England's Audit and Risk Committee.

Special severance payments

Any proposed non-contractual special severance payment in the NHS requires formal approval from DHSC and HMT. At the time of finalising the disclosures in the consolidated provider accounts on 9 October 2026, there were 18 outstanding cases where payments were made without prior authorisation. The majority of these have been submitted to HMT retrospectively and HMT's view is awaited. NHS England will continue to reinforce the requirement that such payments be approved by HM Treasury in advance of offers being made.

There was one further non-contractual payment during 2025-26 for which the relevant Trust sought approval from DHSC through the appropriate process, but were incorrectly informed that HMT approval was not required. This case is not included in the figure of 18 cases disclosed above.

These cases, while currently irregular, have been judged as individually and collectively not material by nature to both the consolidated provider accounts and the departmental group accounts.

Other special payments

There were two cases for 2025-26 at two NHS providers where non-severance special payments above £95,000 were made without prior authorisation. A further case, paid in 2024-25 without prior authorisation, was identified after the finalisation of the 2024-25 consolidated accounts. These have been submitted for retrospective approval. These cases, while currently irregular, have been judged as individually and collectively not material by nature to both the consolidated provider accounts and the departmental group accounts.

Inquiries and reviews

DHSC currently oversees a range of inquiries and investigations, which are discussed further below. At the end of 2025-26, DHSC was sponsoring two independent statutory public inquiries: the Lampard Inquiry (formerly the Essex Mental Health Independent Inquiry) and the Thirlwall Inquiry into the Countess of Chester Hospital. NHS England commissions investigations, which can generate recommendations for DHSC as well as the wider health and care system. This includes the continuing investigation into maternity services at the Nottingham University Hospital NHS Trust.

The Cabinet Office-sponsored Infected Blood Inquiry reported on 20 May 2024. In June 2024, DHSC established a response programme board, coordinating the response to health specific recommendations for inclusion in the government's overall response that was published on 14 May 2025.

Lampard inquiry (formerly the Essex mental health independent inquiry)

The Lampard Inquiry is a statutory inquiry investigating mental health inpatient deaths in Essex. On 27 October 2023, DHSC issued a formal notice of conversion, confirming the Inquiry's statutory status and formally appointing Baroness Lampard as chair. Oral hearings covering evidence from affected families, the South Essex Partnership Trust, the North Essex Partnership Trust and the Essex Partnership University Trust took place throughout 2025 and are expected to conclude in autumn 2026. DHSC anticipates giving evidence to the Inquiry during 2026.

The Thirlwall inquiry

The Thirlwall Inquiry was established in October 2023 following the trial and subsequent convictions of former neonatal nurse Lucy Letby. The Inquiry, chaired by Lady Justice Thirlwall, examined the wider circumstances of what happened at the Countess of Chester Hospital, including the handling of concerns and governance. It also looked at what actions were taken by regulators and the NHS, and the NHS culture.

The Inquiry's hearings ran from September 2024 to March 2025. The Inquiry heard evidence from the infants' families, and staff and management from the Countess of Chester Hospital, including former executives and board members. It also heard evidence from national oversight and regulatory bodies and a range of experts. DHSC gave evidence to the Inquiry in January 2025.

The report and its recommendations were published on 15 September 2026. The Secretary of State announced a number of immediate actions in response to strengthen NHS safeguarding, accountability and neonatal safety, including work on 'cot cams'. Responsibility for any outstanding work in respect of the recommendations will transfer to DHSC as co-recipient when NHS England ceases to exist, ensuring there is no shortfall in accountability.

Independent inquiry into issues raised by the David Fuller case

In November 2021, an independent inquiry was established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in mortuaries at the Maidstone and Tunbridge Wells NHS Trust.

The first phase of the inquiry, on matters relating to Maidstone and Tunbridge Wells NHS Trust, concluded in November 2023 with the publication of the phase 1 report. The report identified failures of management governance, regulation and processes and a persistent lack of curiosity which all contributed to an environment in which Fuller could offend unnoticed and unchecked.

Phase 2 of the inquiry, which looked at the broader national picture concluded with a report published on 15 July 2025 which considered if procedures and practices in other hospital and non-hospital settings where deceased people are kept safeguard the security and dignity of the deceased. The Phase 2 report sets out 75 recommendations for NHS England, NHS trusts, Local Authorities, independent hospitals, medical education, hospices, ambulance services, care homes, the funeral sector and faith organisations, making specific recommendations to improve the care of the deceased. The overarching recommendation is for the UK government to establish an independent statutory regulatory regime for the care of the deceased across all sectors in England. The government published an interim update on progress on 16 December 2025 and committed to publish an update on progress in responding to the Fuller Inquiry Phase 2 report in July 2026.

Maternity services reviews and investigations

National maternity and neonatal services investigation and taskforce

In June 2025, the then Secretary of State announced a national independent investigation into NHS maternity and neonatal care to help us understand the systemic issues behind why so many women, babies and families experience unacceptable care.
The investigation, led by Baroness Amos, brought together the findings from past reviews, from local investigations of maternity and neonatal services in selected trusts and evidence from families and staff into one clear national set of recommendations. Baroness Amos' final report was published on 30 June 2026. The investigation found that women and families are not being listened to, that there is a lack of accountability when things go wrong, that racism and discrimination are driving inequalities in outcomes, and that the current system is fragmented, overly complex and too slow to learn. Over 11,000 women and families and over 9,000 staff shared their experiences for this investigation.

The National Maternity and Neonatal Taskforce will translate the investigation's final recommendations into action. It will tackle the recurrent systemic issues identified and hold the system to account for improving outcomes and experiences for women, babies and families. The Taskforce is chaired by the Secretary of State for Health and Social

Care. It is comprised of experts and key stakeholders from across the maternity and neonatal sector, and wider health sector. This includes families, clinicians, academics, royal colleges, international expertise and those who can speak to health equity. The Taskforce is supported by eight expert reference groups to ensure that it is informed by a breadth of perspectives. The Taskforce held its first meeting in March, and further meetings were held in May and July 2026.

Local reviews into maternity and neonatal care

The government announced an independent review into maternity and neonatal services at Leeds Teaching Hospitals NHS Foundation Trust on 20 October 2025. Donna Ockenden has been appointed as the Chair of the review. Terms of Reference have been developed with families and the review is expected to conclude by 2029.

The government also announced an independent review into the maternity and neonatal care received by families at University Hospitals Sussex NHS Foundation Trust. Donna Ockenden was also announced as Chair of this review on 15 April 2026. The full terms of reference will be developed with Donna Ockenden and families in the coming months and will start later in 2026.

Both reviews will examine the maternity and neonatal care that women and families received at each trust over a number of years, identify failings and recommend actions for improvement.

Donna Ockenden's independent review of maternity and neonatal care at Nottingham University Hospitals Trust was published on 24 June 2026, having heard evidence from over 2,500 families and over 800 staff members. It identified significant and sustained failings in maternity and neonatal care, as well as a failure to listen to women and families, a lack of senior accountability, clear evidence of racism and discrimination and deeply concerning issues with mortuary practices. The Maternity and Neonatal Taskforce will consider the national recommendations from this review when developing the national action plan.

Infected blood inquiry

Following the publication of the infected blood inquiry's final report on 20 May 2024, the then government announced a proposed compensation scheme for infected and affected victims of infected blood to be delivered through the Infected Blood Compensation Authority (IBCA). The first set of regulations to establish the Infected Blood Compensation Scheme (IBCS) and the core compensation route for the infected were made on 24 August 2024. On 31 March 2025 a second set of regulations came into force to extend the scheme to people who are affected (family members), and to establish the supplementary compensation route for people who are both infected and affected. The IBCA has already

contacted all the registered infected people to begin a claim and has now expanded its service to the affected community from December 2025.

These regulations also made provisions for the transfer to IBCA of the England Infected Blood Support Scheme (EIBSS). While the IBCA and compensation scheme are being established, DHSC remains responsible for making payments under the EIBSS, administered by NHS Business Services Authority. Responsibility for making support scheme payments for EIBSS beneficiaries is planned to transfer to IBCA in March 2027. Regulations were updated to reflect the new transfer dates which came into effect at the end of 2025.

The government to date has paid over £1.4 billion in interim compensation payments to infected blood victims.

On 14 May 2025, the government published its full response to the recommendations made by the Infected Blood Inquiry in its May 2024 report and continues to provide progress updates against the recommendations on the government's Reporting Integration Platform website, run by Cabinet Office. DHSC is committed to learning from the findings identified in the inquiry to ensure that nothing like this can happen again.

Remuneration report

This remuneration report provides details of the remuneration and pension interests of ministers and the most senior management of DHSC. This includes ministers, non-executive directors and directors general (DGs)/senior officials and is compliant with EPN746 guidance.

The following elements of the remuneration report are subject to audit:

- salaries (including non-consolidated performance pay, pay multiples) and allowances
- compensation for loss of office
- non-cash benefits
- pension increases and values, and
- Cash Equivalent Transfer Values (CETV) and increases.

The Constitutional Reform and Governance Act 2010 requires civil service appointments to be made on merit and on the basis of fair and open competition. The Recruitment Principles published by the Civil Service specify the circumstances when appointments may otherwise be made.

Unless otherwise stated in the following paragraphs, the officials covered by this report hold appointments which are open-ended. Early termination, other than for misconduct, would result in the individual receiving compensation as set out in the Civil Service Compensation Scheme.

Ministerial changes during 2025-26

- Dr Zubir Ahmed MP was appointed Parliamentary Under-Secretary of State for Health Innovation and Safety on 7 September 2025.
- Ashley Dalton MP resigned as Parliamentary Under-Secretary of State for Public Health and Prevention on 2 March 2026.
- Sharon Hodgson MP was appointed Parliamentary Under-Secretary of State for Public Health and Prevention on 3 March 2026.

Remuneration of ministers and senior officials

The Directors' report outlines the ministers and senior officials of DHSC and their dates of appointment (and departure where appropriate), but their remuneration is detailed in **Table 18**, with senior officials in **Table 19**.

Salary

'Salary' includes: gross salary; performance pay, or non-consolidated performance pay; overtime; reserved rights to London Weighting or London allowances; and any other allowance to the extent that it is subject to UK taxation. This report is based on accrued payments made by DHSC, and this is recorded in these accounts.

In respect of ministers in the House of Commons, departments bear only the cost of the additional ministerial remuneration; the salary for their services as an MP and various allowances to which they are entitled are borne centrally. DHSC does pay legitimate expenses for ministers which are not a part of the salary or a benefit in kind.

However, the arrangement for ministers in the House of Lords is different, in that they do not receive a salary but rather an additional remuneration which cannot be quantified separately from their ministerial salaries. This total remuneration, as well as the allowances to which they are entitled, is paid by DHSC and is therefore shown in full in **Table 18.**

The remuneration of senior civil servants is determined in accordance with the rules set out in the Civil Service Management Code and in line with the annual SCS framework guidance issued by Cabinet Office.

Non-consolidated performance pay

SCS non-consolidated performance pay is agreed each year following the Senior Salaries Review Body (SSRB) recommendations and is expressed as a percentage of DHSC's total base pay bill for the SCS. Non-consolidated performance related pay is awarded in arrears.

Remuneration frameworks, such as that used by the Government Commercial Organisation, operate differently by focusing on a higher base salary, performance-related pay and reduced pension benefits.

The non-consolidated performance pay included in DHSC's 2025-26 figures relates to awards made in respect of the 2024-25 performance year but paid in the 2025-26 financial year. Awards of £7,500 were paid to officials at grades SCS1 and SCS2 receiving an 'Exceeding' performance rating and awards of £4,000 were paid to SCS1 and SCS2 receiving a 'High Performing' performance rating. There was one SCS3 (DG) award made for an 'Exceeding' rating at £12,500. This figure is centrally set by Cabinet Office.

Benefits in kind

The monetary value of benefits in kind covers any payments or other benefits provided by DHSC which are treated by His Majesty's Revenue and Customs (HMRC) as a taxable emolument. For its direct employees, DHSC pays the individual a net sum and pays tax

directly to HMRC. DHSC's Second Permanent Secretary, Tom Riordan received £35,100 in benefits in kind during 2025-26, to cover dual location of his role. Julian Hunt, DG for Technology, Digital and Data and Sally Warren, DG for Adult Social Care received £9,100 and £2,600 respectively for the same purpose. These are shown in **Table 19**.

Tables 18 and **19** provide details of remuneration interests of the ministers of DHSC and senior officials who served on the Executive Committee and the DHSC Leadership Group during 2025-26.

Table 18: Remuneration of ministers of DHSC (subject to audit)

Ministers	2025-26 Salary (£)[1]	2025-26 Gross benefits in kind (to nearest £100)	2025-26 Pension benefits (to nearest £1000)	2025-26 Total (to nearest £1000)	2024-25 Salary (£)[1]	2024-25 Gross benefits in kind (to nearest £100)	2024-25 Pension benefits (to nearest £1000)	2024-25 Total (to nearest £1000)
Rt Hon Wes Streeting MP (from 05/07/2024)	67,505		17,000	85,000	49,903		13,000	63,000
Secretary of State								
Full year equivalent	67,505				67,505			
Karin Smyth MP (from 08/07/2024)	31,680		8,000	40,000	23,164		6,000	29,000
Minister of State								
Full year equivalent	31,680				31,680			
Stephen Kinnock MP (from 08/07/2024)	31,680		8,000	40,000	23,164		6,000	29,000
Minister of State								
Full year equivalent	31,680				31,680			
Baroness Gillian Merron (from 09/07/2024)[2]	107,335		20,000	127,000	78,193	100	13,000	92,000
Parliamentary Under-Secretary of State								
Full year equivalent: Lords Office-Holder	36,366				36,366			
Full year equivalent: Parliamentary Under-Secretary of State	70,969				70,969			
Dr Zubir Ahmed MP (from 07/09/2025)	12,679	-	3,000	16,000	-	-	-	-
Parliamentary Under-Secretary of State								
Full year equivalent	22,375							
Sharon Hodgson MP (from 03/03/2026)	1,744	-	-	2,000	-	-	-	-
Parliamentary Under-Secretary of State								
Full year equivalent	22,375							
Ashley Dalton MP (from 10/02/2025 - 02/03/2026)[3]	26,224		5,000	31,000	3,130	-	1,000	4,000
Parliamentary Under-Secretary of State								
Full year equivalent	22,375				22,375			

1. The government has determined that ministers should receive salaries at the same rate as claimed by equivalent ministers in previous governments since 2010. Therefore, the serving ministers have agreed to waive any ministerial increases in their salary for the duration of this Parliament. Figures include any severance payment/compensation in lieu of notice payment received by ministers
2. The remuneration for Baroness Gillian Merron comprises £36,366 in respect of her role as Lords Office-Holder and £70,969 in respect of her role as Parliamentary Under-Secretary of State
3. Ashley Dalton MP's salary includes a severance payment of £5,594

Table 19: Remuneration of senior officials of DHSC (subject to audit)

Officials	2025-26 Salary (£'000)	2025-26 Non consolidated performance related pay (£'000)[1]	2025-26 Gross benefits in kind (to nearest £100)	2025-26 Pension benefits (to nearest £1000)[2,3]	2025-26 Contribution to external pension scheme (to nearest £1,000)	2025-26 Total (£'000)	2024-25 Salary (£'000)	2024-25 Non consolidated performance related pay (£'000)[1]	2024-25 Gross benefits in kind (to nearest £100)	2024-25 Pension benefits (to nearest £1000)[2,3]	2024-25 Contribution to external pension scheme (to nearest £1,000)	2024-25 Total (£'000)
Samantha Jones OBE (from 15/06/2025) Permanent Secretary Full year equivalent	245-250 310-315	-	-	94,000	-	340-345	-	-	-	-	-	-
Professor Sir Chris Whitty Chief Medical Officer for England & Interim Permanent Secretary (16/12/2024 - 14/06/2025)	235-240	-	-	89,000	-	325-330	230-235	-	-	89,000	-	320-325
Jonathan Marron (until 21/07/2025) Director General Primary Care and Prevention Full year equivalent	45-50 150-155	-	-	50,000	-	95-100	145-150	-	-	80,000	-	225-230
Matthew Style Director General System Development Interim Second Permanent Secretary and Chief Operating Officer (from 23/03/2026)	170-175	10-15	-	61,000	-	245-250	165-170	0-5	-	90,000	-	260-265
Andrew Brittain Director General, Finance	150-155	-	-	46,000	-	195-200	145-150	-	-	95,000		240-245
Sally Warren (from 08/07/2024) Director General Adult Social Care Full year equivalent	150-155	-	2,600	58,000	-	210-215	105-110 145-150	-	-	27,000	4,000	135-140
Catherine Frances (from 07/01/2025) Director General Global, Public Health and Emergencies Full year equivalent	150-155	-	-	43,000	-	195-200	35-40 150-155	-	-	48,000	-	80-85
Professor Lucy Chappell[4] Chief Scientific Adviser	135-140	-	-	63,000	-	195-200	130-135	-	-	-	-	130-135
Lorraine Jackson Director, DWP and DHSC Joint Work and Health Unit	110-115	5-10	-	55,000	-	175-180	105-110	0-5	-	58,000	-	170-175
Paul Macnaught (from 01/05/2024) Director Ministers, Accountability and Strategy Full year equivalent	125-130	5-10	-	80,000	-	210-215	105-110 115-120	5-10	-	93,000	-	205-210
Julian Hunt (from 06/10/2025) Director General, Technology, Digital and Data Full year equivalent	100-105 210-215	-	9,100	40,000	-	150-155	-	-	-	-	-	-
Paul Dinkin (from 12/01/2026) Director General, Strategy and Healthcare Policy Full year equivalent	35-40 170-175	-	-	16,000	-	50-55	-	-	-	-	-	-
Daniel Mortimer (from 23/02/2026) Director General, People Full year equivalent	15-20 190-195	-	-	9,000	-	25-30	-	-	-	-	-	-
Tom Riordan (23/09/2024 - 01/02/2026) Second Permanent Secretary Full year equivalent	175-180 205-210	-	35,100	64,000	-	275-280	100-105 200-205	-	18,000	40,000	-	160-165

Officials	2025-26 Salary (£'000)	2025-26 Non consolidated performance related pay (£'000)[1]	2025-26 Gross benefits in kind (to nearest £100)	2025-26 Pension benefits (to nearest £1000)[2,3]	2025-26 Contribution to external pension scheme (to nearest £1,000)	2025-26 Total (£'000)	2024-25 Salary (£'000)	2024-25 Non consolidated performance related pay (£'000)[1]	2024-25 Gross benefits in kind (to nearest £100)	2024-25 Pension benefits (to nearest £1000)[2,3]	2024-25 Contribution to external pension scheme (to nearest £1,000)	2024-25 Total (£'000)
Jenny Richardson (to 31/01/2026)[5] Director of Human Resources	110-115	5-10	-	39,000	-	155-160	135-140	0-5	-	133,000	-	270-275
Full year equivalent	140-145											
Michelle Dyson (to 01/08/2025)[6] Director General Adult Social Care	140-145	-	-	16,000	-	155-160	145-150	-	-	86,000	-	230-235
Full year equivalent	150-155											
Gila Sacks (21/07/2025 - 12/09/2025)[5] Director General, Primary Care and Prevention	20-25	10-15	-	21,000	-	50-55	-	-	-	-	-	-
Full year equivalent	130-135											
Antony Tiernan (from 04/08/2025)[7] Director, Transformation and Internal Communications	90-95	-	-	-	-	90-95	-	-	-	-	-	-
Full year equivalent	135-140											
Juliette Cammaerts (from 09/03/2026)[9] Principal Private Secretary to the Secretary of State	5-10	-	-	2,000	-	10-15	-	-	-	-	-	-
Full Year Equivalent	135-140											
Toni Court (from 19/01/2026) Director of Human Resources	25-30	-	-	14,000	-	40-45	-	-	-	-	-	-
Full year equivalent	145-150											
Rachel Carr (from 29/10/25)[5] Director of Communications	65-70	-	-	10,000	-	75-80	-	-	-	-	-	-
Full year equivalent	130-135											
NHS England officials who have served on DHSC Leadership Group during 2025-26												
Fiona Bride (from 30/01/2026)[8] Director General, Commercial and Growth	195-200	-	-	51,000	-	250-255	-	-	-	-	-	-
Elizabeth O'Mahony (Director General, Finance), David Probert (Director General, Performance & Delivery), Dr Claire Fuller (Medical Director), Professor Meghana Pandit (Medical Director). Duncan Burton (Chief Nursing Officer for England) served on DHSC Leadership Group since 29 October 2025[9].												

1. Non-consolidated performance pay paid in 2025-26 relates to the 2024-25 performance year.
2. The value of pension benefits accrued during the year is calculated as: (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to a transfer of pension rights.
3. Where final salary members have transitioned to the alpha pension scheme, the final salary pension of a person in employment is calculated by reference to their pay and length of service. The pension will increase each year by virtue of any pay rise during the year. Where there is no or a small pay rise, the increase in pension due to extra service may not be sufficient to offset the inflation increase. In real terms, the pension value can reduce which can result in negative values.
4. Professor Lucy Chappell was appointed on 1 August 2021 on secondment from Kings College, London, for four days a week. The figures in the table represent the proportion DHSC paid only, not the full salary. DHSC contributes to her pension scheme with Kings College, London. The salary figure for 2024-25 has been restated to show the amount paid by DHSC on an accruals basis.
5. The salary disclosed for Jenny Richardson, Rachel Carr and Gila Sacks only includes the amounts paid in the period of sitting on the Executive Committee or DHSC's Leadership Group
6. Michelle Dyson's salary includes an exit payment. **Table 34** discloses costs of departures across the departmental group, including exit payments.
7. Antony Tiernan is on secondment from NHS Blood and Transplant.
8. Fiona Bride's salary and pension costs were wholly retained by NHS England. Her remuneration is shown as full-year to align with disclosures in NHS England's Annual Report and Accounts made for senior NHS England officials serving on DHSC Leadership Group who are part of NHS England's Board. Senior NHS England officials who served on DHSC Leadership Group were seconded into DHSC from NHS England. Their salary and pension costs were wholly retained by NHS England.
9. Senior NHS England officials who served on DHSC Leadership Group were seconded into DHSC from NHS England Their salary and pension costs were wholly retained by NHS England. Details of their remuneration can be found in NHS England's Annual Report and Accounts.

Fair pay disclosure (subject to audit)

Departments are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median, and upper quartile remuneration of the organisation's workforce. See **Table 20**.

Table 20: Pay ratios for core department and executive agencies

	Core department 2025-26	Core department 2024-25	Core department and executive agencies 2025-26	Core department and executive agencies 2024-25
25th Percentile pay ratio	7.2:1	5.7:1	8.1:1	6:4:1
Median pay ratio	5.4:1	4.1:1	6.4:1	5:1
75th Percentile pay ratio	4.8:1	3.7:1	4.9:1	3.8:1

1. Pay ratio compares the percentile pay benefits to the highest paid director.

Table 21: Total remuneration and salary element for core department and executive agencies

	Core department 2025-26	Core department and executive agencies 2025-26
25th Percentile total remuneration (salary element)	43,236 (42,486)	38,549 (38,147)
Median total remuneration (salary element)	58,382 (57,757)	48,708 (47,891)
75th Percentile total remuneration (salary element)	64,502 (63,170)	63,612 (62,302)

1. Total remuneration includes salary, non-consolidated performance pay and benefits-in-kind for each employee on the percentile. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

In 2025-26 the median earning of the core department has increased by 4.2%, or £2,346, compared to 2024-25, where the increase of median earnings was £773. Core department staff, excluding the highest-paid director, had an average increase in pay and benefits of 4.4%. See **Table 22**.

The increase in median earnings of the core department can be attributed to changes in the composition of the workforce in 2025-26 such as grade distribution and implementation of the 2025-26 pay award (in line with Civil Service Pay Guidance). It is consistent with the pay, reward, and progression policies for the core department.

Table 22: Percentage change in remuneration from 2024-25

	Core department		Core department and executive agencies	
Percentage change in total remuneration	Highest paid director	Average of total employees	Highest paid director	Average of total employees
Change from 2024-25	34.4%	4.4%	34.4%	4.0%
Salary and allowances	34.4%	4.0%	34.4%	3.8%
Bonus	0.0%	30.9%	0.0%	20.9%

In 2025-26, the banded remuneration of the highest-paid director increased to £310,000–£315,000 (see **Table 23**). The highest paid individual changed during the year following the appointment of the new Permanent Secretary. Banded remuneration for the core department staff remained the same in 2025-26 for the lowest paid, ranging between £20,000 - £25,000. No employees received remuneration at a higher level than the highest-paid director in 2025-26 or 2024-25.

While bonuses as a percentage of overall payroll costs remained broadly in line with the prior year, this was split between a smaller number of employees, resulting in a higher average bonus year on year.

Table 23: Banded remuneration range for core department and executive agencies

	Core department		Core department and executive agencies	
	2025-26	2024-25	2025-26	2024-25
Band of highest paid director's total remuneration (£000)[1]	310-315	230-235	310-315	230-235
Band of lowest paid	20-25	20-25	20-25	20-25

1. Salaries for senior management disclosed in bands of £5,000, in accordance with EPN737 guidance.
2. Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Civil service pensions

Pension benefits are provided through the civil service pension arrangements. From 1 April 2015 a new pension scheme for civil servants was introduced. This was the Civil Servants and Others Pension Scheme, known as alpha, which provides benefits on a career average basis with a normal pension age equal to the member's State Pension Age (or 65 if higher). From that introduction date, all newly appointed civil servants and the majority of those already in service joined alpha. Prior to that date, civil servants participated in the Principal Civil Service Pension Scheme (PCSPS). The PCSPS has four sections: three providing benefits on a final salary basis (classic, premium, or classic plus) with a normal pension age of 60; and one providing benefits on a whole career basis (nuvos) with a normal pension age of 65.

These statutory arrangements are unfunded with the cost of benefits met by monies voted by Parliament each year. Pensions payable under classic, premium, classic plus, nuvos and alpha are increased annually in line with Pensions Increase legislation. Existing members of the PCSPS who were within 10 years of their normal pension age on 1 April 2012 remained in the PCSPS after 1 April 2015. Those who were between 10 years and 13 years and 5 months from their normal pension age on 1 April 2012 switched into alpha sometime between 1 June 2015 and 1 February 2022. Because the government plans to remove discrimination identified by the courts in the way that the 2015 pension reforms were introduced for some members, it is expected that, in due course, eligible members with relevant service between 1 April 2015 and 31 March 2022 may be entitled to different pension benefits in relation to that period (and this may affect the Cash Equivalent Transfer Values (CETV) shown in this report – see below). All members who switch to alpha have their PCSPS benefits 'banked', with those with earlier benefits in one of the final salary sections of the PCSPS having those benefits based on their final salary when they leave alpha. (The pension figures quoted for officials show pension earned in PCSPS or alpha – as appropriate. Where the official has benefits in both the PCSPS and alpha the figure quoted is the combined value of their benefits in the two schemes). Members joining from October 2002 may opt for either the appropriate defined benefit arrangement or a defined contribution (money purchase) pension with an employer contribution (partnership pension account).

Employee contributions are salary-related and range between 4.6% and 8.05% for members of classic, premium, classic plus, nuvos and alpha. Benefits in classic accrue at the rate of 1/80th of final pensionable earnings for each year of service. In addition, a lump sum equivalent to three years initial pension is payable on retirement. For premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike classic, there is no automatic lump sum. Classic plus is essentially a hybrid with benefits for service before 1 October 2002 calculated broadly as per classic and benefits for service from October 2002 worked out as in premium. In nuvos, a member builds up a pension based on their pensionable earnings during their period of scheme membership. At the end of the scheme year (31 March) the member's earned pension account is

credited with 2.3% of their pensionable earnings in that scheme year and the accrued pension is uprated in line with Pensions Increase legislation. Benefits in alpha build up in a similar way to nuvos, except that the accrual rate is 2.32%. In all cases members may opt to give up (commute) pension for a lump sum up to the limits set by the Finance Act 2004.

The partnership pension account is an occupational defined contribution pension arrangement which is part of the Legal & General Mastertrust. The employer makes a basic contribution of between 8% and 14.75% (depending on the age of the member). The employee does not have to contribute, but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.5% of pensionable salary to cover the cost of centrally provided risk benefit cover (death in service and ill health retirement).

The accrued pension quoted is the pension the member is entitled to receive when they reach pension age, or immediately on ceasing to be an active member of the scheme if they are already at or over pension age. Pension age is 60 for members of classic, premium, and classic plus, 65 for members of nuvos, and the higher of 65 or State Pension Age for members of alpha.

Further details about the civil service pension arrangements can be found at the Civil Service Pensions website.

Ministerial pensions

Pension benefits for ministers are provided by the Parliamentary Contributory Pension Fund (PCPF). The scheme is made under statute and the rules are set out in the Ministers Pension Scheme 2015.

Those ministers who are Members of Parliament may also accrue an MP's pension under the PCPF (details of which are not included in this report). A new MP's pension scheme was introduced from May 2015, although members who were MPs and aged 55 or older on 1 April 2013 have transitional protection to remain in the previous MP's final salary pension scheme.

Benefits for ministers are payable from State Pension age under the 2015 scheme. Pensions are re-valued annually in line with Pensions Increase legislation both before and after retirement. The contribution rate from May 2015 is 11.1% and the accrual rate is 1.775% of pensionable earnings.

The figure shown for pension value includes the total pension payable to the member under both the pre- and post-2015 ministerial pension schemes.

Tables 24 and **25** provide details of the pension interests for DHSC's officials and ministers for 2024-25 and 2025-26 and are subject to audit.

Cash equivalent transfer values (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised 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 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 pension benefits they have accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total ministerial service, not just their current appointment as a minister. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

Real increase in CETV

Remuneration reports show the CETVs of senior staff at the start and end of the reporting year, together with the real increase during that period. The real increase is the increase due to additional benefit accrual (that is, as a result of salary changes and service) that is funded by the employer or the Exchequer (in the case of ministers) and uses common market valuation factors for the start and end periods.

Real increases in CETVs will be smaller than the difference between the start and end CETVs because it does not include any increase in the value of the pension due to inflation or due to the contributions paid by the member or the value of any benefits transferred from another pension scheme. Nor does it include any increases (or decreases) because of any changes during the year in the actuarial factors used to calculate CETVs.

Table 24: Pension interests of ministers (subject to audit)

	Accrued pension at age 65 as at 31/03/26 £'000	Real increase in pension at age 65 £'000	CETV at 31/03/26 £'000	CETV at 31/03/25 £'000	Real increase in CETV £'000
Rt Hon Wesley Streeting MP	0-5	0-2.5	29	12	9
Karin Smyth MP	0-5	0-2.5	18	8	7
Stephen Kinnock MP	0-5	0-2.5	17	7	6
Baroness Gillian Merron	0-5	0-2.5	47	19	20
Dr Zubir Ahmed MP From 07/09/2025	0-5	0-2.5	3	-	2
Sharon Hodgson MP From 03/03/2026	0-5	0-2.5	1	-	-
Ashley Dalton MP 10/02/2025 - 02/03/2026	0-5	0-2.5	7	1	4

The figures given are based solely on individual benefits as a Minister and will not reflect any pension in respect of their MP salary.

Table 25: Pension information of senior officials of DHSC (subject to audit)

		Accrued pension at pension age as at 31/03/26 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/03/26	CETV at 31/03/25 (Restated)	Real increase in CETV	Employer contribution to external pension scheme Nearest £100
Samatha Jones OBE	Permanent Secretary	5-10	5-7.5	86	-	67	-
Professor Sir Chris Whitty	Chief Medical Officer for England & Interim Permanent Secretary	10-15	5-7.5	228	138	68	-
Jonathan Marron	Director General Primary Care and Prevention	35-40	2.5-5	697	624	31	-
Matthew Style	Director General Systems Development and Interim Second Permanent Secretary	60-65	2.5-5	1,020	926	33	-
Andy Brittain	Director General Finance	65-70 plus a lump sum of 160-165	2.5-5 plus a lump sum of 0	1,518	1,402	30	-
Sally Warren	Director General Adult Social Care	5-10	2.5-5	66	21	34	-
Catherine Frances	Director General Global, Public Health and Emergencies	50-55	2.5-5	975	894	23	-
Professor Lucy Chappell[2]	Chief Scientific Advisor	80-85 plus a lump sum of 90-95	2.5-5 plus a lump sum of 0-2.5	1,500	1,386	90	-
Lorraine Jackson	Director, DWP and DHSC Joint Work & Health Unit	55-60	2.5-5	1,164	1,058	43	-
Paul Macnaught	Director Ministers, Accountability and Strategy	50-55 plus a lump sum of 115-120	2.5-5 plus a lump sum of 2.5-5	1,071	949	64	-
Julian Hunt	Director General, Technology, Digital and Data	0-5	0-2.5	34	-	27	-
Paul Dinkin	Director General, Strategy and Healthcare Policy	0-5	0-2.5	13	-	11	-
Daniel Mortimer	Director General, People	0-5	0-2.5	7	-	6	-
Tom Riordan	Second Permanent Secretary	5-10	2.5-5	99	37	47	-
Jenny Richardson	Director of Human Resources	55-60	0-2.5	985	932	21	-
Michelle Dyson	Director General for Adult Social Care	50-55 plus a lump sum of 120-125	0-2.5 plus a lump sum of 0	1,149	1,102	9	-

		Accrued pension at pension age as at 31/03/26 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/03/26	CETV at 31/03/25	Real increase in CETV	Employer contribution to external pension scheme
Gila Sacks	Director General Primary Care and Prevention	20-25	0-2.5	270	255	11	-
Antony Tiernan[3]	Director, Transformation and Internal Communications	40-45 plus a lump sum of 90-95	-	861	929	-	-
Juliette Cammaerts	Principal Private Secretary to the Secretary of State	20-25	0-2.5	239	238	1	-
Toni Court	Director of Human Resources	20-25	0-2.5	297	286	8	-
Rachel Carr	Director of Communications	45-50	0-2.5	807	777	1	-
NHS England officials who have served on DHSC Leadership Group during 2025-26							
Fiona Bride[4]	Director General, Commercial & Growth	5-10	2.5-5	146	84	60	-

Elizabeth O'Mahony (Director General, Finance), David Probert (Director General, Performance & Delivery), Dr Claire Fuller (Medical Director), Professor Meghana Pandit (Medical Director). Duncan Burton (Chief Nursing Officer for England) served on DHSC Leadership Group since 29 October 2025[5].

1. Where the real increase in CETV is disclosed as a negative figure this means that, taking account of inflation, the CETV funded by the employer has decreased in real terms.
2. Professor Lucy Chappell was appointed on 1 August 2021 on secondment from King's College, London (KCL) for four days per week. Her pension is with the NHS Pension Scheme and DHSC contributes 80% of the costs paid into the scheme by KCL. Her full pension accrual is shown the table above.
3. Antony Tiernan is on secondment from NHS Blood and Transplant.
4. Fiona Bride's salary and pension costs were wholly retained by NHS England . Her remuneration is shown as full-year to align with disclosures in NHS England's Annual Report and Accounts made for senior NHS England officials serving on DHSC Leadership Group who are part of NHS England's Board.
5. Senior NHS England officials who served on DHSC Leadership Group were seconded into DHSC from NHS England. Their pension costs were wholly retained by NHS England.

Non-executive board members

Non-executive board members (NEBMs) (see **Table 26**) are not employees of DHSC. They are appointed for a fixed term of three years initially, with the possibility of extension, and their fees are not pensionable. They are appointed primarily to support and provide an external source of challenge to government departments and take up roles in departmental governance. As such they attend and contribute to departmental board meetings, which involve a monthly commitment of meetings, and occasional overnight events per year. NEBMs also make a significant contribution to departmental business by working through committees and with senior officials.

The Departmental Board holds positions for six NEBMs. The non-executive directors sitting on the Departmental Board during 2025-26 are detailed in the Directors' Report. There were also three independent members of Audit and Risk Assurance Committee. For two NEBMs, their terms of office ended 31 December 2025. The third position is non-remunerated.

Table 26: NEBMs and independent committee members (subject to audit)

Non-Executive	Position	Term	2025-26 Fee received to nearest £1,000	2025-26 Annual fee entitlement to nearest £1,000	2024-25 Fee received to nearest £1,000	2024-25 Annual fee entitlement to nearest £1,000
Rt Hon Alan Milburn	Non-Executive Board Member & Lead Non-Executive	8 November 2024 - 8 November 2027	20,000	20,000	8,000	20,000
Samantha Jones OBE	Non-Executive Board Member & Lead Non-Executive (to 07/11/24)	14 February 2023 - 15 June 2025	3,000	15,000	18,000	20,000
Sir Richard Douglas	Non-Executive Board Member	7 March 2024 - 6 March 2027	20,000	20,000	19,000	20,000
Baroness Camilla Cavendish	Non-Executive Board Member	13 January 2025 - 12 January 2028	15,000	15,000	3,000	15,000
Phil Jordan	Non-Executive Board Member	13 January 2025 - 12 January 2028	15,000	15,000	3,000	15,000
Naomi Eisenstadt CB	Non-Executive Board Member	13 January 2025 - 12 January 2028	15,000	15,000	3,000	15,000
Chris Young	Non-Executive Member of Audit & Risk Committee	1 February 2025 - 31 January 2028	Non-remunerated role	Non-remunerated role	-	-
Anne Barnard	Independent Member of Audit & Risk Assurance Committee	1 January 2020 - 31 December 2025	4,000	5,000	5,000	5,000
Graham Clarke	Independent Member of Audit & Risk Assurance Committee	1 January 2020 - 31 December 2025	4,000	5,000	5,000	5,000

Compensation for loss of office (subject to audit)

In accordance with the Ministerial and Other Pensions and Salaries Act 1991, on leaving office, ministers who have not attained the age of 65, and are not appointed to a relevant ministerial or other paid office within three weeks, are eligible for a severance payment of one quarter of the annual ministerial salary being paid. These payments are exempt from tax under the provision of section 291 of the Income Tax (Earnings and Pensions) Act 2003 and the payments are also not pensionable.

Ashley Dalton MP received a severance payment of £5,593.75.

In line with the Constitutional Reform and Governance Act 2010 and the Model Contract for Special Advisers, a special adviser's appointment automatically ends when their appointing minister leaves office. Special advisers are not entitled to a notice period but receive contractual termination benefits to compensate for this. Termination benefits are based on length of service and capped at six months' salary. If a special adviser returns to work for HM Government following the receipt of a severance payment, the payment is required to be repaid, less a deduction in lieu of wages for the period until their return. Termination costs for special advisers are reported in the Cabinet Office Annual Report and Accounts.

Staff report

This staff report summarises the core department's key staffing information and policies, with the staff costs, numbers and exit packages disclosures subject to audit.



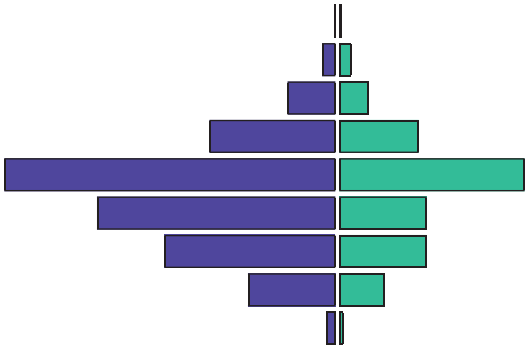
A breakdown of staff numbers and associated costs for the core department together with its executive agencies and for the overall departmental group are included in **Tables 29** and **30**. The rise in staff salaries and wages reflects the uplift in pay under the pay award for 2025-26.

DHSC structure

DHSC's staff grading structure is as follows; Administrative (AO); Managerial (EO, Fast stream, HEO, SEO); Senior Management (Grade 6 and 7); Senior Civil Service (SCS1 (Deputy Director), SCS2 (Director), SCS3 (Director General)). **Figure 29** below outlines the headcount and gender distribution of Core Departmental staff in post at 31 March 2026 and is consistent with Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment into DHSC.

Figure 29: Gender distribution of core department staff (headcount)

Grade	Female		Male	Total
Perm Sec	1	1		2
SCS 3	2	6		8
SCS 2	28	24		52
SCS 1	97	61		158
GRADE 6	260	163		423
GRADE 7	682	381		1063
SEO	490	247		737
HEO	351	180		531
EO	181	92		273
AO	18	8		26
	2110	**1163**		**3273**



Staff sickness

71% of staff with no recorded sickness in the year ending 31 December 2025

The core department has seen an increase in the number of days lost to short-term sickness, rising from 6,432 in the rolling calendar year up to 31 December 2024 to 7,140 up to 31 December 2025. There has also been an increase in days lost to long-term sickness reported over the same period, from 9,790 to 11,769. Over the same rolling calendar year up to 31 December 2025, the average number of working days lost stands at 5.3, an increase from 4.9 as at December 2024. Some 71% of our staff have no recorded sickness in the calendar year up to 31 December 2025, slightly down from 72% at the same point in the previous year.

Staff turnover

The core department has experienced a 12% turnover of staff during the 2025-26 financial year. This has been calculated in line with Cabinet Office guidance. This is an increase from the 2024-25 year where staff turnover in the core department was 7%. Turnover was higher during 2025-26 due to leavers through DHSC's Voluntary Exit Scheme.

Staff redeployment

During 2025-26, DHSC benefited from a number of civil servants loaned from other government departments.

The number and grade of staff redeployed is shown in **Table 27**.

Table 27: Staff redeployment by grade

Grade	Cost incurred by DHSC Number	Cost not incurred by DHSC Number	Total Number
EO	2	0	2
HEO and SEO	31	0	31
G7 and G6	14	0	14
SCS	6	0	6
Totals	**53**	**0**	**53**

1. For those individuals where the cost was incurred by DHSC, the estimated average cost was £60,427

Health and safety

DHSC recognises its responsibilities, under the Health and Safety at Work Act 1974, for ensuring, so far as is reasonably practicable, the health, safety and welfare of its employees, temporary staff, and visitors to its premises and to others who may be affected by its operations and/or activities. In 2025-26, there were 10 reported accidents (one of which resulted in absence) and five near misses.

Staff engagement

The annual Civil Service People Survey looks at civil servants' attitudes to, and experience of working in government departments. Every year, a Civil Service benchmark report is published alongside a summary of main department scores.

DHSC's response rate this year was 76% (2,883 respondents out of c.3,700 staff members who were invited). This is above the civil service average of 59%, but lower than DHSC's response rate last year of 83%.

Overall, we have seen a reduction in employee engagement from 62% last year to 57%. This is the same engagement score held by DHSC in 2023 but sits below the Civil Service benchmark of 65% (an increase this year from 64% in 2024). While going through significant transformation this reduction is not unexpected with overall decreases across the core themes.

There are nine 'core themes' included in the People Survey. In DHSC, there have been decreases across all of the core themes this year:

a. My manager (-2pp)
b. My team (-2pp)
c. My pay and benefits (-3pp)
d. Inclusion and fair treatment (-3pp)
e. Resources and workload (-3pp)
f. My work (-4pp)

g. Organisational objectives and purpose (-4pp)
h. Learning and development (-11pp)
i. Leadership and managing change (-13pp).

DHSC is lower than the Civil Service benchmark in six of the core themes, in line with two of the themes ('My Team' and 'Inclusion and Fair Treatment') and higher in the 'My Manager' theme.

Equal opportunities policy

DHSC is committed to promoting and supporting inclusion in the workplace and to treating all staff fairly and responsibly, in line with DHSC values and our legal duties as a public sector body. DHSC's refreshed Equality Objectives: 2023-27. are underpinned by the Civil Service Diversity and Inclusion (D and I) Strategy 2022-2025, and our internal equal opportunities policies and are delivered in collaboration with our leaders, staff networks, and employees.

The Departmental Inclusion Plan and its actions are designed to fulfil its commitments under the refreshed equality objectives above and are stress-tested and supported by DHSC governance. Equality, Diversity and Inclusion (EDI) is discussed quarterly by Leadership Group.

In recognition of the importance of championing EDI visibly at senior leadership level, during 2025-26, the Second Permanent Secretary acted as DHSC's Senior EDI Sponsor and was supported by a group of DG Sponsors and SCS Champions. These leaders work with our staff networks and focus on areas including:



DHSC staff networks provide support to employees, increase knowledge and awareness of specific EDI topics or experiences, provide insight to aid the development of HR policy and initiatives, and contribute to creating an inclusive environment in which individuals can thrive. DHSC has eight recognised staff networks which align with characteristics protected under the Equality Act 2010 and/or characteristics particularly important to our organisational demographic, with other staff groups working to support activity relating to grades, professions and other workplace matters.

DHSC refreshed its performance management framework for all departmental Senior Civil Servants (SCS) during 2025-26, including the introduction of minimum standards covering EDI and leadership standards. This framework supports members of the SCS to identify and set their ambition and goals on the leadership of EDI in DHSC and guides them on what to include in their plans for meeting the minimum standards, required for all SCS across the wider Civil Service.

Additionally, during 2025-26, DHSC:

- developed a new staff networks policy to ensure activity is in line with the Civil Service Code
- restructured our staff networks to strengthen employee voice for underrepresented groups
- completed an audit of our Speak Up service which identified key areas of improvement
- brought together our senior leaders and staff network leads for open discussions on world events affecting staff
- increased office facilities in Leeds to accommodate disability requirements
- launched a team coaching pilot to tackle bullying, harassment and discrimination
- developed policy knowledge and capability on EDI matters through the line manager programme
- introduced mandatory training on antisemitism for all members of the SCS
- maintained compliance with Civil Service EDI expenditure guidance to provide greater transparency and deeper assurance and alignment with government priorities

DHSC strives to embed an evidence-based and outcome-focused approach in all that we do to progress equality, diverse representation and inclusion. Diversity data is regularly

monitored, helping to identify areas for improvement and to measure progress in making DHSC a more inclusive workplace. DHSC uses a range of measures to track progress, including self-declaration data in the HR management system, recruitment data and trends in staff survey data (Civil Service People Survey). DHSC's last published diversity data set is available on the Civil Service Diversity and Inclusion Dashboard.

Recruitment and retention of under-represented groups

DHSC has several policies and activities in place to aid the recruitment and retention of under-represented groups and works closely with staff networks and forums when reviewing. This includes guidance in relation to workplace adjustments, health and wellbeing support, support for carers and anti-bullying, harassment and discrimination.

All employees have access to an Employee Assistance Programme for independent advice from qualified external professionals on topics including physical or mental health, stress, and depression. Internally, employees have access to in-house Mental Health First Aiders who are trained in how to give appropriate help and support, and internal Speak Up Advisers who are DHSC members of staff who are impartial and independent from line management. These individuals act as a source of guidance for those wanting to raise a challenge or concern at work, such as a concern relating to bullying, harassment, or discrimination in the workplace.

During 2025-26, DHSC operated tight recruitment controls as part of broader commitment to significantly reduce the size of DHSC. As a result, greater use was made of temporary secondments with NHS England and of the internal labour market, including small-scale internal panels. Where roles were advertised externally, DHSC continued to attract diverse candidates from outside DHSC. For advertised campaigns, selection panels at delegated grades (AA to G6) must have at least one panel member from an underrepresented group and Senior Civil Servant campaigns include a diverse panel member, supporting fair, evidence based decision-making and reducing bias in recruitment outcomes.

DHSC has reached Disability Confident Leader level 3 status under the Disability Confident Scheme, guaranteeing an interview for disabled candidates who demonstrate the minimum requirement at sift.

DHSC, under the Equality Act 2010, provides support to employees with a disability or health condition in the form of reasonable workplace adjustments. DHSC recognises that bringing about equality for disabled people may mean changing the way in which employment is structured, the removal of physical barriers and/or providing extra support. To support this commitment, DHSC has a dedicated health and safety team, created a Workplace Adjustment Advisor role in 2023, as well as providing support through our occupational health service for workplace and specialist assessments.

DHSC uses a range of talent and apprenticeship schemes to attract and develop diverse talent, including those employees and underrepresented candidates from lower socio-

economic backgrounds, who might otherwise not have access to formal education or training. This includes a departmental care leavers internship scheme, offering 18-month work placements to care leavers aged between 18 and 30, and the annual cross-Government Beyond Boundaries development programme, targeted at developing delegated grades AA to SEO talent and careers within the Civil Service. For the latter, DHSC reserved 66% of places in its 2025 cohort for those with a disability, long-term condition, who were from an ethnic minority background, and/or were from a lower-socio-economic background.

Staff data

Tables 28, **29** and **30** summarise key staff information for the departmental group.

Table 28: Staff costs for the departmental group (subject to audit)

	2025-26 Permanently employed staff £'000	2025-26 Others £'000	2025-26 Ministers £'000	2025-26 Total £'000	2024-25 Total £'000
Salaries and wages	74,043,709	5,765,936	272	79,809,917	76,998,081
Social security costs	10,052,027	229,761	38	10,281,826	8,047,304
NHS pension	14,424,795	269,021	-	14,693,816	13,775,455
Other pension costs	202,975	5,151	-	208,126	205,501
	98,723,506	**6,269,869**	**310**	**104,993,685**	**99,026,341**
Termination benefits	737,873	62,104	6	799,983	45,169
	99,461,379	**6,331,973**	**316**	**105,793,668**	**99,071,510**
Less income in respect of secondments	(42,798)	(142,432)	-	(185,230)	(153,130)
Total staff costs	**99,418,581**	**6,189,541**	**316**	**105,608,438**	**98,918,380**

Special advisers are temporary civil servants. In order to improve efficiency, the administration of staff costs for all special advisers across government is managed by the Cabinet Office, with corresponding budget cover transfers. Therefore, all special adviser costs are reported in the Cabinet Office Annual Report and Accounts. Special advisers remain employed by the respective department of their appointing minister.

Table 29: Average number of whole-time equivalents employed – departmental group (subject to audit)

	2025-26 Permanent staff	2025-26 Others	2025-26 Ministers	2025-26 Total	2024-25 Total
Core department and agencies	9,977	773	6	10,756	10,834
Other designated bodies	1,432,230	118,565	-	1,550,795	1,555,581
Total	**1,442,207**	**119,338**	**6**	**1,561,551**	**1,566,415**

Staff numbers are calculated in line with public sector accounts disclosure requirements using a financial year average (using the number of staff at the end of each quarter and averaging them over the year) and using ONS categorisation.

Of the figures shown in **Table 29**, staff engaged on capital projects are shown in **Table 30**.

Table 30: Breakdown of staff engaged on capital projects (subject to audit)

	2025-26 Permanent staff	2025-26 Others	2025-26 Ministers	2025-26 Total	2024-25 Total
Core department and agencies	914	-	-	914	216
Other designated bodies	4,331	575	-	4,906	4,521
Total	**5,245**	**575**	**-**	**5,820**	**4,737**

Consultancy, temporary and agency workers

Table 31 provides details of expenditure on consultancy, agency and temporary workers by the core department and bodies within the departmental accounting boundary. The definition for consultancy and temporary agency workers is in line with HM Treasury guidance. The consultancy values are reported on a resource basis, consistent with the accounts and reconcile to the figures reported in **Note 3** of the financial statements.

DHSC utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. In 2025-26 the core department spent £4.6 million on consultancy compared to £2.0 million in 2024-25; and £2.3 million on temporary staff compared to £3.7 million in 2024-25. The increase in consultancy spend in the core department is primarily a result of increased reliance on external expertise to support delivery of the DHSC/NHS England transformation programme, alongside reductions in substantive headcount. The increase in consultancy spend in DHSC's executive agencies relates primarily to a technical adjustment in the UK Health Security Agency to reclassify previously capitalised consultancy expenditure on a project that was subsequently transferred to another government department.

Table 31: Expenditure on consultancy, agency and temporary workers

	2025-26 Consultancy £'000	2025-26 Temporary agency £'000	2024-25 Consultancy £'000	2024-25 Temporary agency £'000
DHSC core	4,602	2,345	1,990	3,651
Executive agencies	25,665	14,835	14,887	12,083
Other designated bodies	228,865	3,091,733	235,066	3,977,648
Gross total	**259,132**	**3,108,913**	**251,943**	**3,993,382**
Eliminations	3	-	(21)	-
Total after eliminations	**259,135**	**3,108,913**	**251,922**	**3,993,382**

The numbers reported above for agency include staff categorised as 'bank staff' by NHS providers. These are not included within NHS England's reported measures and agency spending.

Off-payroll engagements

In line with HM Treasury requirements, departments must publish information regarding their highly paid and/or senior off-payroll engagements. This information, contained in

Table 32, includes all off-payroll engagements (either during 2025-26 in totality or 'as at' 31 March 2026) for a day-rate of more than £245.

A regular dialogue has continued between DHSC and the Tax Centre of Excellence throughout the 2025-26 financial year to ensure ongoing compliance with the IR35 rules. This dialogue ensures that DHSC remains informed of any policy changes implemented during the year and can therefore amend process accordingly if so required.

The figures for the core department show most contractors are either on the payroll of their agency or an umbrella company, and so the IR35 rules are not a consideration. For workers to whom the IR35 rules do apply, determinations have been arrived at using the online HMRC 'Check Employment Status for Tax' tool by the tax team.

The core department has not paid any penalties for non-compliance.

Table 32: Off-payroll engagements

Table 32a: For all off-payroll engagements as of 31 March 2026, for more than £245 per day

	Core department	ALBs	Total
Number of existing engagements as of 31 March 2026	**14**	**1,103**	1,117
Of which:			
Number that have existed for less than one year at time of reporting	7	515	522
Number that have existed for between one and two years at time of reporting	2	268	270
Number that have existed for between two and three years at time of reporting	1	155	156
Number that have existed for between three and four years at time of reporting	-	153	153
Number that have existed for four years or more years at time of reporting	4	12	16

Table 32b: For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day

	Core department	ALBs	Total
Number of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	**29**	**1,628**	**1,657**
Of which:			
Number not subject to off-payroll legislation	20	1,565	1,585
Number subject to off-payroll legislation and determined as in scope of IR35	-	45	45
Number subjected to off payroll legislation and determined as out of scope of IR35	9	18	27
Number of engagements reassessed for compliance or assurance purposes during the year	3	1	4
Of which: number of engagements that saw a change to IR35 status following review	3	1	4

Table 32c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026

	Core department	ALBs	Total
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-	-	-
Number of individuals that have been deemed 'board members, and /or senior officials with significant financial responsibility' during the financial year. This figure includes both off-payroll and on-payroll engagements.	269	563	832

Exit packages – civil service and other compensation schemes (subject to audit)

Table 33 details Civil Service and other compensation schemes and exit packages. Redundancy and other departure costs for civil servants have been paid in accordance with the provisions of the Civil Service Compensation Scheme, a statutory scheme made under the Superannuation Act 1972. Where early retirement has been agreed, the additional costs are met by the group.

Ill-health retirement costs are met by the pension scheme and are not included in the table. The figures disclosed relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure cost may have been accrued or provided for in a previous period. The information in this disclosure note is therefore presented on a different basis to the staff cost and other expenditure notes in the accounts.

Since March 2025, we have been working towards reducing our headcount. To support this, we have put in place recruitment restrictions. In 2025-26 DHSC launched an organisation-wide Voluntary Exit Scheme (VES), with 265 colleagues leaving by 31 March 2026 and further VES exits expected through FY 2026-27. No individuals within the core department have received over £95,000 as an exit package due to entitlement on voluntary or compulsory redundancy arrangements in either 2025-26 or 2024-25. Additional disclosure for group entities can be found in the ARA of the individual bodies as set out in **Note 19**.

Table 33a: Exit packages (subject to audit)
Core department and agencies for the year ended 31 March 2026

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
£10,000 or less	4	11	15	-
£10,001 to £25,000	8	78	86	-
£25,001 to £50,000	-	98	98	-
£50,001 to £100,000	-	225	225	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	1	-	1	-
More than £200,000	-	-	-	-
Total number	**13**	**412**	**425**	**-**
Total cost (£)	**306,323**	**23,162,300**	**23,468,623**	**-**

Table 33b: Exit packages (subject to audit)
Core department and agencies for the year ended 31 March 2025

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
£10,000 or less	13	17	30	-
£10,001 to £25,000	18	2	20	-
£25,001 to £50,000	5	4	9	-
£50,001 to £100,000	2	3	5	-
£100,001 to £150,000	-	3	3	-
£150,001 to £200,000	-	4	4	-
More than £200,000	-	5	5	-
Total Number	**38**	**38**	**76**	**-**
Total Cost (£)	**615,092**	**2,885,943**	**3,501,035**	**-**

Table 33c: Exit packages (subject to audit)
Departmental group for the year ended 31 March 2026

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
£10,000 or less	499	4,110	4,609	25
£10,001 to £25,000	644	3,354	3,998	33
£25,001 to £50,000	552	2,997	3,549	10
£50,001 to £100,000	499	3,495	3,994	6
£100,001 to £150,000	236	1,004	1,240	1
£150,001 to £200,000	111	587	698	-
More than £200,000	9	8	17	2
Total number	**2,550**	**15,555**	**18,105**	**77**
Total cost (£)	**118,949,191**	**668,819,461**	**787,768,652**	**3,269,902**

Table 33d: Exit packages (subject to audit)
Departmental group for the year ended 31 March 2025

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
£10,000 or less	437	2,369	2,806	22
£10,001 to £25,000	429	649	1,078	33
£25,001 to £50,000	381	341	722	10
£50,001 to £100,000	333	243	576	9
£100,001 to £150,000	112	69	181	1
£150,001 to £200,000	60	23	83	-
More than £200,000	2	6	8	1
Total Number	**1,754**	**3,700**	**5,454**	**76**
Total Cost (£)	**70,517,500**	**63,181,970**	**133,699,470**	**2,706,789**

Other departures

Table 34 outlines the detail of other departures. A single exit package can be made up of several components, each of which will be counted separately. Therefore, the total number in **Table 34** will not necessarily match the total number in **Table 33**, which represents the number of individuals where exit packages have been agreed.

Table 34: Analysis of other departures (subject to audit)

	2025-26 Departmental group Number	2025-26 Departmental group £'000
Voluntary redundancies including early retirement costs	8,035	525,306
Mutually agreed resignation schemes (MARS)	4,283	111,419
Early retirements in the efficiency of the service	-	-
Contractual payments in lieu of notice	3,301	28,036
Exit payments following Employment Tribunals or court	44	2,326
Non contractual payments requiring HMT approval	67	1,733
Total	**15,730**	**668,820**

Parliamentary accountability and audit report

The Parliamentary accountability and audit report brings together the key Parliamentary accountability documents within these annual report and accounts. The report establishes DHSC's compliance with principles relating to supply and Parliamentary control over income and expenditure incurred.

Statement of Outturn against Parliamentary supply (subject to audit)

In addition to the primary statements prepared under International Financial Reporting Standards (IFRS), the Government Financial Reporting Manual (FReM) requires DHSC to prepare a Statement of Outturn against Parliamentary Supply (SOPS) and supporting notes.

The SOPS and related notes are subject to audit, as detailed in the Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament.

The SOPS is a key accountability statement that shows, in detail, how an entity has spent against their Supply Estimate. Supply is the monetary provision (for resource and capital purposes) and cash (drawn primarily from the Consolidated Fund), that Parliament gives statutory authority for entities to utilise. The Estimate details supply and is voted on by Parliament at the start of the financial year.

Should an entity exceed the limits set by their Supply Estimate, called control limits, their accounts will receive a qualified opinion.

The format of the SOPS mirrors the Supply Estimates, published on gov.uk, to enable comparability between what Parliament approves and the final outturn.

The SOPS contain a summary table, detailing performance against the control limits that Parliament has voted on, cash spent (budgets are compiled on an accruals basis and so outturn won't exactly tie to cash spent) and administration.

The supporting notes detail the following: outturn by estimate line, providing a more detailed breakdown (**SOPS 1**); a reconciliation of outturn to net operating expenditure in the statement of comprehensive net expenditure, to tie the SOPS to the financial statements (**SOPS 2**); a reconciliation of outturn to net cash requirement (**SOPS 3**); and an analysis of income payable to the Consolidated Fund (**SOPS 4**).

Explanations of variances between Estimates and Outturn are given in **Tables A** to **D**.

The SOPS and Estimates are compiled against the budgeting framework, which is similar to, but different to, IFRS. Further information regarding the fiscal framework can be found in chapter 1 of the Consolidated Budgeting Guidance. Further information on the Public Spending Framework and the reasons why budgeting rules are different to IFRS can also

be found in chapter 1 of the Consolidated Budgeting Guidance. **Figure 1** at page 6 of this Annual Report and Accounts helps show how funds flow around the departmental group.

The SOPS provides a detailed view of financial performance, in a form that is voted on and recognised by Parliament. The financial review, in the Performance Report, provides a summarised discussion of outturn against estimate and functions as an introduction to the SOPS disclosures.

Summary of resource and capital outturn 2025-26

	SOPS note	Outturn Voted £'000	Outturn Non-voted £'000	Outturn Total £'000	Estimate Voted £'000	Estimate Non-voted £'000	Estimate Total £'000	Outturn vs estimate: saving / (excess) Voted £'000	Outturn vs estimate: saving / (excess) Total £'000	Prior year outturn total £'000
Departmental expenditure limit										
Resource	1.1	177,520,195	31,460,545	208,980,740	179,215,371	31,460,545	210,675,916	1,695,176	1,695,176	198,192,223
Capital	1.2	13,316,138	-	13,316,138	13,624,735	-	13,624,735	308,597	308,597	11,471,292
Total		**190,836,333**	**31,460,545**	**222,296,878**	**192,840,106**	**31,460,545**	**224,300,651**	**2,003,773**	**2,003,773**	**209,663,515**
Annually managed expenditure										
Resource	1.1	3,225,960	-	3,225,960	10,000,000	-	10,000,000	6,774,040	6,774,040	2,387,981
Capital	1.2	266,229	-	266,229	548,827	-	548,827	282,598	282,598	660,486
Total		**3,492,189**	**-**	**3,492,189**	**10,548,827**	**-**	**10,548,827**	**7,056,638**	**7,056,638**	**3,048,467**
Total budget										
Resource	1.1	180,746,155	31,460,545	212,206,700	189,215,371	31,460,545	220,675,916	8,469,216	8,469,216	200,580,204
Capital	1.2	13,582,367	-	13,582,367	14,173,562	-	14,173,562	591,195	591,195	12,131,778
Total budget expenditure		**194,328,522**	**31,460,545**	**225,789,067**	**203,388,933**	**31,460,545**	**234,849,478**	**9,060,411**	**9,060,411**	**212,711,982**

Net cash requirement 2025-26

	SOPS Note	Outturn £'000	Estimate £'000	Outturn vs estimate: saving/ (excess) £'000	Prior year outturn £'000
Net cash requirement	3	183,588,212	194,029,051	10,440,839	176,287,546

Administration costs 2025-26

	Outturn £'000	Estimate £'000	Outturn vs estimate: saving/ (excess) £'000	Prior year outturn £'000
Administration costs	2,895,261	3,838,983	943,722	2,554,116

Figures within the areas outlined by thick lines cover the voted control limits voted by Parliament. Refer to the Supply Estimates guidance manual, available on gov.uk, for detail on the control limits voted by Parliament. Although not a separate voted limit, any breach of the administration budget will also result in an excess vote.

SOPS 1 Outturn detail, by estimate line

SOPS 1.1 Analysis of net resource outturn by estimate line

	Resource outturn							Estimate			Outturn vs estimate: saving / (excess)	Prior year outturn total
	Administration			Programme								
	Gross £'000	Income £'000	Net £'000	Gross £'000	Income £'000	Net £'000	Total £'000	Total £'000	Virements £'000	Total incl. Virements £'000	£'000	£'000
Departmental expenditure limit (DEL)												
Voted expenditure												
NHS England net expenditure	2,084,559	-	2,084,559	33,261,190	-	33,261,190	35,345,749	39,475,750	(4,130,001)	35,345,749	-	32,394,795
NHS providers net expenditure	-	-	-	131,796,950	-	131,796,950	131,796,950	127,345,976	4,450,974	131,796,950	-	125,147,653
DHSC programme and administration expenditure	437,483	(1,697)	435,786	2,118,107	(2,575,860)	(457,753)	(21,967)	2,573,148	(937,036)	1,636,112	1,658,079	447,660
Local authorities	-	-	-	3,632,376	-	3,632,376	3,632,376	3,607,176	25,200	3,632,376	-	3,425,796
Executive agencies	150,308	(5,049)	145,259	2,179,873	(404,252)	1,775,621	1,920,880	1,733,638	210,856	1,944,494	23,614	2,110,378
Special health authorities expenditure	297,303	(165,606)	131,697	3,578,217	(52,690)	3,525,527	3,657,224	3,360,173	297,051	3,657,224	-	3,430,552
Non-departmental public bodies net expenditure	101,237	-	101,237	121,600	-	121,600	222,837	163,461	65,535	228,996	6,159	210,490
Arm's length and other bodies net expenditure	(3,277)	-	(3,277)	969,423	-	969,423	966,146	956,049	17,421	973,470	7,324	860,870
	3,067,613	**(172,352)**	**2,895,261**	**177,657,736**	**(3,032,802)**	**174,624,934**	**177,520,195**	**179,215,371**	**-**	**179,215,371**	**1,695,176**	**168,028,194**
NHS England expenditure financed by NI contributions	-	-	-	31,460,545	-	31,460,545	31,460,545	31,460,545	-	31,460,545	-	30,164,029
Total spending in DEL	**3,067,613**	**(172,352)**	**2,895,261**	**209,118,281**	**(3,032,802)**	**206,085,479**	**208,980,740**	**210,675,916**	**-**	**210,675,916**	**1,695,176**	**198,192,223**
Annually managed expenditure (AME)												
Voted:												
NHS England net expenditure	-	-	-	238,378	-	238,378	238,378	250,000	-	250,000	11,622	(28,442)
NHS providers net expenditure	-	-	-	2,753,184	-	2,753,184	2,753,184	2,500,000	253,184	2,753,184	-	2,260,251
DHSC programme and administration expenditure	-	-	-	439,282	-	439,282	439,282	2,168,800	(253,184)	1,915,616	1,476,334	(1,733,781)
Executive agencies	-	-	-	(165,832)	-	(165,832)	(165,832)	1,000	-	1,000	166,832	(23,213)
Special health authorities expenditure	-	-	-	(66,925)	-	(66,925)	(66,925)	5,002,000	-	5,002,000	5,068,925	1,844,846
Non-departmental public bodies net expenditure	-	-	-	(1,367)	-	(1,367)	(1,367)	2,000	-	2,000	3,367	180
Arm's length and other bodies net expenditure	-	-	-	29,240	-	29,240	29,240	76,200	-	76,200	46,960	68,140
Total spending in AME	**-**	**-**	**-**	**3,225,960**	**-**	**3,225,960**	**3,225,960**	**10,000,000**	**-**	**10,000,000**	**6,774,040**	**2,387,981**
Total resource	**3,067,613**	**(172,352)**	**2,895,261**	**212,344,241**	**(3,032,802)**	**209,311,439**	**212,206,700**	**220,675,916**	**-**	**220,675,916**	**8,469,216**	**200,580,204**

The total estimate columns include virements. Virements are the reallocation of provision in the estimates that do not require Parliamentary authority (because Parliament does not vote to that level of detail and delegates to HM Treasury). Further information on virements is provided in the Supply Estimates Manual, available on gov.uk. The outturn vs estimate column is based on the total including virements. The estimate total before virements have been made is included so that users can tie the estimate back to the estimates laid before Parliament.

SOPS 1.2 Analysis of net capital outturn by estimate line

	Outturn			Estimate			Outturn vs estimate: savings / (excess) £'000	Prior year outturn total £'000
	Gross £'000	Income £'000	Net total £'000	Net Total £'000	Virements £'000	Total incl. Virements £'000		
Departmental expenditure limits (DEL)								
Voted expenditure								
NHS England net expenditure	669,494	-	669,494	573,276	96,218	669,494	-	598,247
NHS providers net expenditure	9,098,125	-	9,098,125	9,698,663	(447,780)	9,250,883	152,758	7,710,874
DHSC programme and administration expenditure	3,085,005	(59,285)	3,025,720	2,674,158	351,562	3,025,720	-	2,752,268
Executive agencies	190,806	(9,508)	181,298	252,930	-	252,930	71,632	81,638
Special health authorities expenditure	35,675	(142)	35,533	54,350	-	54,350	18,817	22,735
Non-departmental public bodies net expenditure	14,170	-	14,170	23,788	-	23,788	9,618	11,287
Arm's length and other bodies net expenditure	291,798	-	291,798	347,570	-	347,570	55,772	294,243
Total spending in DEL	**13,385,073**	**(68,935)**	**13,316,138**	**13,624,735**	**-**	**13,624,735**	**308,597**	**11,471,292**
Annually managed expenditure (AME)								
Voted expenditure								
NHS England net expenditure	5,010	-	5,010	15,000	-	15,000	9,990	241
NHS providers net expenditure	9,569	-	9,569	20,000	-	20,000	10,431	6,299
DHSC programme and administration expenditure	250,507	-	250,507	513,827	(1,143)	512,684	262,177	662,260
Executive agencies	227	-	227	-	227	227	-	1,575
Special health authorities expenditure	2	-	2	-	2	2	-	40
Arm's length and other bodies net expenditure	914	-	914	-	914	914	-	(9,929)
Total spending in AME	**266,229**	**-**	**266,229**	**548,827**	**-**	**548,827**	**282,598**	**660,486**
Total capital	**13,651,302**	**(68,935)**	**13,582,367**	**14,173,562**	**-**	**14,173,562**	**591,195**	**12,131,778**

The total estimate columns include virements. Virements are the reallocation of provision in the estimates that do not require Parliamentary authority (because Parliament does not vote to that level of detail and delegates to HM Treasury). Further information on virements is provided in the Supply Estimates Manual, available on gov.uk. The outturn vs estimate column is based on the total including virements. The estimate total before virements have been made is included so that users can tie the estimate back to the estimates laid before Parliament.

Material variances between the estimate and outturn

HM Treasury designates that Estimates are prepared on a consolidated basis, meaning that all intra-group transactions are removed. Across government, the DHSC 'internal market' of circa £130 billion (mainly transactions between NHS Commissioners and NHS Providers) is unique to the DHSC Group.

To give an example, if NHS England purchase a service from an NHS provider to the value of £20 million, on consolidation, the expenditure of NHS England would be reduced by £20 million, and the income of the NHS provider would be equally reduced by £20 million.

At the start of each financial year, we estimate our income and expenditure, including intra-group transactions, for each of the bodies within the DHSC group. Due to the size and complexity of our budget, there will inevitably be some variances in our Parliamentary Estimate.

In setting the Estimate, DHSC takes a pragmatic approach and eliminates only the material transactions between DHSC group bodies.

In line with the guidance published by the Parliamentary Scrutiny Unit for Estimates Memoranda, significant variances over £10 million and 10% or over £200 million and 5% have been explained in the tables below.

Further detail regarding the variances in the following tables can be found in **Annex B**.

Estimates in tables A to D below are stated before virements.

Further explanation of SOPS 1.1 and 1.2

Table A: Comparison of resource DEL estimate and outturn

	Resource DEL	Estimate £m	Outturn £m	Variance £m	Variance %	Explanation of significant variances
A	NHS England net expenditure	39,476	35,346	4,130	10%	The £0.3 billion variance across NHS England and NHS Providers mainly reflects lower than forecast net intra-group eliminations. This was partially offset by the timing of intra-group budget transfers and an underspend on ringfenced RDEL (depreciation and impairments).
B	NHS providers net expenditure	127,346	131,797	(4,451)	-3%	
C	DHSC programme and administration expenditure	2,573	(22)	2,595	101%	The £2.6bn variance mainly reflects an underspend on ringfenced RDEL (depreciation and impairments), higher-than-forecast intra-group eliminations, the timing of intra-group budget transfers, and additional income, including the Voluntary scheme for branded medicines pricing, access and growth (VPAG) and Public Dividend Capital (PDC) receipts.
D	Local authorities (public health)	3,607	3,632	(25)	-1%	-
E	Executive agencies	1,734	1,921	(187)	-11%	The £0.2bn variance mainly reflects an underspend in UKHSA, driven by lower than expected covid-19 vaccine expenditure due to demand and timing of vaccination programmes, alongside higher than forecast intragroup eliminations.
F	Special health authorities expenditure	3,360	3,657	(297)	-9%	The £0.3bn variance mainly relates to higher than forecast intragroup income eliminations.
G	Non departmental public bodies net expenditure	163	223	(60)	-37%	The £0.1bn variance mainly relates to higher than forecast intragroup income eliminations.
H	Arm's length and other bodies (net)	956	966	(10)	-1%	-
I	NHS England expenditure financed by NI contributions	31,461	31,461	0	0%	-
Total	**RDEL**	**210,676**	**208,981**	**1,695**		

Annex B includes a more detailed explanation of DHSC's administrative spend.

Totals in the table may not sum due to rounding.

For elimination variances, please see the explanation provided in **Annex B**.

Table B: Comparison of resource AME estimate and outturn

	Resource AME	Estimate £m	Outturn £m	Variance £m	Variance %	Explanation of significant variances
J	NHS England net expenditure	250	238	12	5%	-
K	NHS providers net expenditure	2,500	2,753	(253)	-10%	Net provisions expenditure was higher than forecast when setting the final budget.
L	DHSC programme and administration expenditure	2,169	440	1,729	80%	Net provisions expenditure was lower than forecast when setting the final budget.
M	Executive agencies	1	(166)	167	16683%	Net provisions expenditure was lower than forecast when setting the final budget.
N	Special health authorities expenditure	5,002	(67)	5,069	101%	The variance on this line relates to lower than forecast provisions in NHS Resolution - mainly clinical negligence provisions. This was due to favourable changes in assumptions and methodology, including inflationary costs and the estimated quantum of future clinical negligence claims.
O	Non departmental public bodies net expenditure	2	(1)	3	168%	-
P	Arm's length and other bodies (net)	76	29	47	62%	Net provisions expenditure was lower than forecast when setting the final budget.
Total	**RAME**	**10,000**	**3,226**	**6,774**		

The Estimate reflects the best estimate of provisions and impairment expenditure for the DHSC group. This type of expenditure is demand led and can result in significant variances at year end.

Totals in the table may not sum due to rounding.

Table C: Comparison of capital DEL estimate and outturn

Capital DEL		Estimate	Outturn	Variance	Variance	Explanation of significant variances
		£m	£m	£m	%	
A	NHS England net expenditure	573	669	(96)	-17%	The £0.1 billion variance mainly relates to underspends arising on Technology, Digital and Data.
B	NHS providers net expenditure	9,699	9,098	601	6%	The majority of the outturn variance against the Supplementary Estimate is attributable to intra-group transfers from NHS Providers to NHSE ahead of year-end.
C	DHSC programme and administration expenditure	2,674	3,026	(352)	-13%	The variance mainly reflects a combination of in-year funding reallocations, including increased R&D expenditure and additional support for the Disabled Facilities Grant funded from wider underspends, alongside the impact of centrally managed budget assumptions, which result in higher outturn relative to the initial plan.
D	Local authorities (public health)	0	0	0	0%	-
E	Executive agencies	253	181	72	28%	The underspend mainly reflects lower-than-planned capital expenditure in UKHSA, including delays to laboratory estate projects, covid-19 testing stockpiles and asset-related adjustments.
F	Special health authorities expenditure	54	36	18	33%	The underspend mainly reflects lower expenditure in NHS Business Services Authority, following updated plans for the Future Workforce Solution.
G	Non departmental public bodies net expenditure	24	14	10	42%	The underspend reflects lower-than-planned capital expenditure across non-departmental public bodies, mainly the Care Quality Commission and Health Research Authority.
H	Arm's length and other bodies (net)	348	292	56	16%	The underspend reflects a range of lower-than-planned expenditure across bodies, including PFI accounting impacts, changes in investment activity, and reduced capital requirements across research and development programmes.
Total CDEL		**13,625**	**13,316**	**309**		

Totals in the table may not sum due to rounding.

Table D: Comparison of capital AME estimate and outturn

Capital AME		Estimate	Outturn	Variance	Variance	Explanation of significant variances
		£m	£m	£m	%	
J	NHS England net expenditure	15	5	10	67%	IFRS 16 dilapidations provisions expenditure was lower than forecast when setting the final budget.
K	NHS providers net expenditure	20	10	10	50%	IFRS 16 dilapidations provisions expenditure was lower than forecast when setting the final budget.
L	DHSC programme and administration expenditure	514	250	264	51%	IFRS 16 dilapidations provisions expenditure was lower than forecast when setting the final budget.
M	Executive agencies	0	0	0	0%	-
N	Special health authorities expenditure	0	0	0	0%	-
O	Non departmental public bodies net expenditure	0	0	0	0%	-
P	Arm's length and other bodies (net)	0	1	(1)	0%	-
Total CAME		**549**	**266**	**283**		

SOPS 2 Reconciliation of net resource outturn to net operating expenditure

	SOPS note	2025-26 Outturn £'000	2024-25 Outturn £'000
Total resource outturn	1.1	**212,206,700**	**200,580,204**
Add: Capital Grants		1,179,737	1,024,638
Research and development expenditure		2,139,649	2,020,554
Infected blood compensation payments		250,428	663,240
Service concession arrangement expenditure under IFRS		3,296,124	3,495,614
Service concession arrangement income under IFRS		(576,352)	(530,757)
Other		27,120	16,887
		6,316,706	**6,690,176**
Less: Income payable to the Consolidated Fund	4	(145)	(1,076)
Donated asset and government grant income		(451,768)	(446,131)
Service concession arrangement expenditure under UK GAAP		(2,710,969)	(2,660,764)
Loss on transfers by absorption		-	(1,801)
		(3,162,882)	**(3,109,772)**
Net operating cost in consolidated statement of comprehensive net expenditure before absorption transfers		**215,360,524**	**204,160,608**

As noted in the introduction to the SOPS above, outturn and estimates are compiled against the budgeting framework, which is similar to, but different from, IFRS. Therefore, this reconciliation bridges the resource outturn to net operating expenditure, linking the SOPS to the financial statements. The main reconciling items are described below:

- Capital grants and research and development expenditure are budgeted for as capital DEL, but accounted for as expenditure in the financial statements, and therefore function as reconciling items between resource outturn and net operating expenditure.

- Infected blood compensation payments in the year score to the capital AME budget in line with HM Treasury classification, but are accounted for as expenditure in the financial statements and therefore are reconciling items between resource outturn and net operating expenditure. This amount will not agree to note 3.1 due to the utilisation of the prior year provision, already recognised in expenditure.

- As noted in note 1.14 below, HM Treasury has determined that government bodies shall account for infrastructure PFI and LIFT schemes, where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement, as service concession arrangements, following the principles set out in IFRIC 12. DHSC therefore recognises the PFI or LIFT asset as an item of property, plant and equipment, together with a liability to pay for it, on its statement of financial position. In line with Consolidated Budgeting Guidance,

service concession arrangements which are subject to IFRIC 12 in accounts, are measured according to ESA10 standards set out in the Manual on Government Deficit and Debt. The reconciling items above reflect this differing treatment and impact on resource outturn.

- Donated assets and government grant income do not agree to note 4 as some of this income is included in income received by NHS charities. This income functions as a reconciling item between resource outturn and net operating expenditure as it is accounted for as income in the financial statements but recognised as capital DEL in outturn.

SOPS 3 Reconciliation of net resource outturn to net cash requirement

	SOPS note	Outturn £'000	Estimate £'000	Outturn vs estimate: savings / (excess) £'000
Total resource outturn	1.1	**212,206,700**	**220,675,916**	**8,469,216**
Total capital outturn	1.2	**13,582,367**	**14,173,562**	**591,195**
Adjustments for ALBs:				
Remove voted resource and capital		(181,440,197)	(181,447,733)	(7,536)
Add cash grant-in-aid, PDC, loans and share capital from core department, and expenditure financed by parliamentary funding		171,707,408	178,424,807	6,717,399
Adjustments to remove non-cash items:				
Depreciation		(251,680)	(1,060,156)	(808,476)
New provisions and adjustments to previous provisions		(3,133,288)	(11,807,370)	(8,674,082)
PPE leased additions		-		-
Service concession arrangement revenue adjustments		100,593	-	(100,593)
Adjustment for stockpiled goods		25,980	-	(25,980)
Non-cash investment additions		(9,750)	-	9,750
Net gain/loss on transfers by absorption		-	-	-
Other non-cash items		(1,697,218)	-	1,697,218
Adjustments to reflect movements in working balances:				
Increase / (decrease) in inventories		(194,760)	-	194,760
COVID-19 budgeting impacts on non-cash transactions		39	-	(39)
Transfers to non-current assets		(20,225)	-	20,225
Increase / (decrease) in receivables		(190,239)	2,000,000	2,190,239
Movement in Consolidated Fund receivables		(126)	-	126
Movement in current financial assets		21,333	-	(21,333)
Movements in finance lease receivables		14,987	-	(14,987)
Capital element of finance lease receivables		(10,570)	-	10,570
(Increase) / decrease in payables		(1,655,812)	-	1,655,812
Movement in payables to the Consolidated Fund		1,410,899	-	(1,410,899)
Movement in finance lease/PFI payables		33,688	-	(33,688)
Capital element of finance lease/PFI payables		37,018	-	(37,018)
Use of provisions		4,489,068	4,530,570	41,502
		215,026,215	**225,489,596**	**10,463,381**
Removal of non-voted budget items:				
National Insurance contributions		(31,460,545)	(31,460,545)	-
Other adjustments		22,542	-	(22,542)
Net cash requirement		**183,588,212**	**194,029,051**	**10,440,839**

As noted in the introduction to the SOPS above, outturn and the estimates are compiled against the budgeting framework, not on a cash basis. Therefore, this reconciliation bridges the resource and capital outturn to the net cash requirement.

For explanations of variances between estimate and resource and capital outturn, please see explanations of material variances from page 211 onwards.

SOPS 4 Analysis of income payable to the Consolidated Fund

In addition to income retained by DHSC, the following income is payable to the Consolidated Fund (cash receipts being shown in italics).

	2025-26 Outturn		2024-25 Outturn	
	Accruals £'000	*Cash basis £'000*	Accruals £'000	*Cash basis £'000*
Income outside the ambit of the Estimate	145	*19*	1,076	*1,034*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total amount payable to the Consolidated Fund	**145**	***19***	**1,076**	***1,034***

Parliamentary accountability disclosures

Regularity of expenditure (subject to audit)

We are custodians of taxpayers' funds and have a duty to Parliament to ensure the regularity and propriety of our activities and expenditure. We manage public funds in line with HM Treasury's Managing Public Money. The disclosures made within the Parliamentary Accountability and Audit Report are indicative of this.

The importance of operating with regularity and the need for efficiency, economy, effectiveness, and prudence in the administration of public resources to secure value for public money, is the responsibility of our Accounting Officer whose responsibilities are also set out in Managing Public Money. The manner in which the Accounting Officer and the wider department discharges its responsibilities in the administration of public resources is detailed within the Statement of Principal Accounting Officer Responsibilities and the Governance Statement.

Losses (subject to audit)

Table 35: Losses statement

		Core department and agencies		Departmental group	
		2025-26	2024-25	2025-26	2024-25
Total losses	**Cases**	**337**	**327**	**553,479**	**158,000**
	£'000	**458,216**	**2,084,720**	**502,673**	**1,999,364**
Cases over £300,000					
Cash losses	Cases	6	1	6	1
	£'000	18,903	586	18,903	586
Claims abandoned	Cases	6	6	6	10
	£'000	59,281	38,087	59,281	40,955
Cancellation of public dividend capital	Cases	1	2	-	-
	£'000	97,769	226,724	-	-
Administrative write-offs	Cases	-	-	1	-
	£'000	-	-	475	-
Fruitless payments	Cases	-	-	28	5
	£'000	-	-	16,726	21,866
Constructive losses	Cases	7	5	7	6
	£'000	277,601	1,817,474	277,601	1,817,862
Store losses	Cases	-	-	9	7
	£'000	-	-	3,893	4,063

The narrative disclosures below relate to the core department only. Further disclosures of losses and special payments for other bodies can be found within the accounts of those entities.

Claims waived and abandoned

DHSC recognised a loss of £1.35 million in relation to a COVID-19-era contract for the development and supply of medical devices. Following legal advice, DHSC agreed a settlement and the resulting loss has been recorded as a claim abandoned.

A claim of £5.3 million was abandoned in relation to reciprocal healthcare agreements with an EU member state where the claims were not submitted within the appropriate timescales.

During 2025–26, DHSC abandoned VAT claims totalling £1.3 million. As invoices from suppliers were not processed before the deadline, no VAT could be recovered from HMRC under section 41 of the Value Added Tax Act 1994.

DHSC waived or abandoned claims of £82 million against 8 PPE suppliers during 2025-26. These have not been included in the table above as losses have already been disclosed in previous financial years in relation to the associated inventory. The COVID-19 Counter-Fraud Commissioner (CCFC), appointed in December 2024 by the Chancellor of the Exchequer, has reviewed these cases and has agreed with the claims waived or abandoned loss position and course of action taken by DHSC in each of these cases.

Constructive losses

There were two constructive losses in 2025-26, of £122 million and £12 million respectively, relating to two COVID-19 medicines which reached their expiry dates during the year. The bulk of these items were procured in response to the emergence of the Omicron variant at a time when its severity and potential impact on vaccine efficacy were uncertain. The actual impact was less severe than previous variants and as a result, not all medicines purchased were used prior to their expiry dates, which were extended where possible.

The vast majority of these medicines had already been impaired in the financial statements in previous years to reflect that they were not expected to be used, but the reportable loss only crystallises when the expiry date of the medicines is actually reached. This occurred during the 2025-26 financial year.

Cash losses

DHSC has recorded a loss relating to business-as-usual foreign exchange rate movements on the settlement of reciprocal healthcare medical costs liabilities, which are paid as they fall due at the prevailing exchange rate. These losses reflect the movement in exchange rates between the prior year end and the settlement date on accruals denominated in foreign currency. The loss on 6 payments exceeded £300k individually, comprising £18.9 million in total, and these are included within the table above.

The exchange rate gain/loss from these payments is highly susceptible to periodic fluctuations in the exchange rate. In the prior year, an overall gain of £14.7 million was made in relation to reciprocal healthcare medical costs payments and therefore no loss disclosure was required. DHSC identifies and measures foreign currency losses, but has not adopted a more extensive FX strategy as it is not currently exposed to material exchange rate risk.

Cancellation of Public Dividend Capital

PDC is issued to NHS Trusts and NHS Foundation Trusts under specific statutory powers given to DHSC. When functions transfer between NHS Trusts and NHS Foundation Trusts and other group bodies, the outstanding PDC balance and the net assets and liabilities of the closing Trusts need to be transferred to the successor organisation(s).

At this point, the Department may conclude that where the PDC balance is greater than the value of net assets transferring, the excess should be written off. This write off of the PDC represents the final accounting transaction, reflecting the existence of the historic deficits already recognised in the Statement of Financial Performance for the closing Trust, meaning it is not an additional loss to the taxpayer. PDC with a value in excess of £20 million can only be written off with the agreement of HM Treasury by formal notice to Parliament, known as a Minute.

In 2025-26, the Department wrote off £98 million of public dividend capital relating to the dissolution of North Middlesex University Hospital NHS Trust when acquired by the Royal Free London NHS Foundation Trust on 1 January 2025.

Special payments (subject to audit)

Table 36: Special payments

		Core department and agencies		Departmental group	
		2025-26	2024-25	2025-26	2024-25
Total special payments	**Cases**	**22**	**54**	**6,699**	**8,358**
	£'000	**100,717**	**790**	**130,661**	**25,013**
Cases over £300,000	Cases	1	-	7	5
	£'000	100,000	-	117,722	7,910

Special payments are transactions that Parliament could not have anticipated when passing legislation or approving supply estimates for DHSC. Examples include extra contractual payments to contractors, ex-gratia payments to contractors, other ex-gratia payments, compensation payments, and extra-statutory and extra-regulatory payments.

All cases over £300,000 in 2025-26 relate to agencies. There were no core department special payments over £300,000 in 2025-26.

Other payments (subject to audit)

There have been no gifts over £300,000 made by the core department for 2025-26 or in 2024-25.

Table 37: Fees and charges (subject to audit)

Fees and charges for the year ended 31 March 2026

	Fees and charges income £'000	Full cost of service £'000	Surplus/(deficit) £'000
Dental	848,169	3,712,786	(2,864,617)
Prescription	732,752	13,293,022	(12,560,270)
Other fees and charges for which the cost of providing the service is over £1million	534,350	487,824	46,526
Total	**2,115,271**	**17,493,632**	**(15,378,361)**

Fees and charges for the year ended 31 March 2025

	Fees and charges income £'000	Full cost of service £'000	Surplus/(deficit) £'000
Dental	796,508	3,552,908	(2,756,400)
Prescription	730,413	12,776,122	(12,045,709)
Other fees and charges for which the cost of providing the service is over £1million	502,561	487,050	15,511
Total	**2,029,482**	**16,816,080**	**(14,786,598)**

The fees and charges information in this note is provided in accordance with the HM Treasury Financial Reporting Manual. NHS England receives income in respect of prescription and dental charges to patients. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges, as per The National Health Service (Charges for Drugs and Appliances) (Amendment) Regulations 2024, 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 items 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.

Those who are not eligible for exemption are required to pay NHS dental charges, as per The National Health Service (Dental Charges) (Amendment) Regulations 2025, which fall into three bands depending on the level and complexity of care provided. In 2025-26, the charge for Band 1 treatments was £27.40, for Band 2 was £75.30 and for Band 3 was £326.70.

Remote contingent liabilities (subject to audit)

In addition to IAS 37 contingent liabilities disclosed within the Accounts, DHSC discloses for Parliamentary reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to Parliament in accordance with the requirements of Managing Public Money. These comprise:

- items over £300,000 (or lower, where required by specific statute) that do not arise in the normal course of business and which are reported to Parliament by Departmental Minute prior to DHSC entering into the arrangement; and,

- all items (whether or not they arise in the normal course of business) over £300,000 (or lower, where required by specific statute or where material in the context of the Annual Report and Accounts) which are required by the Financial Reporting Manual to be noted in the Annual Report and Accounts.

Quantifiable remote contingent liabilities

The DHSC Group has entered into the following quantifiable contingent liabilities by offering indemnities and guarantees. HM Treasury's guidance Managing Public Money requires that the full potential costs of such contracts be reported to Parliament. Quantifiable remote contingent liabilities are as shown below:

Indemnities (£m)		
1	The core department holds an indemnity relating to the two contracts signed between His Majesty's Government (HMG) and the medicine supplier Pfizer for the COVID-19 antiviral drug PF-07321332+ritonavir (co-packaged and marketed as Paxlovid).	N/A[1]
2	The core department has issued an indemnity in respect of a Department of Health and Social Care established statutory, independent inquiry into the care and treatment pathways and the circumstances and practices surrounding the deaths of mental health inpatients in Essex.	3.0
3	The core department holds an indemnity provided to Oxford University for unexpected tax implications as a result of the National Institute for Health Research (NIHR) National Biosample Centre transfer to DHSC.	3.2
4	The core department holds a general indemnity provided to Oxford University in relation to the National Institute for Health Research (NIHR) National Biosample Centre transfer to DHSC.	15.0

5	The core department holds an indemnity relating to use of a monoclonal antibody, Sotrovimab, developed for the treatment of COVID-19 to bring expired stock back into circulation by relabelling the stock.	N/A[1]
6	The core department has issued an indemnity in respect of a DHSC established independent inquiry into the issues raised by the David Fuller case.	3.0
7	The core department holds an obligation to indemnify reasonable capital and operating costs incurred by the following water companies that fluoridate water in England: • Anglian Water • Northumbrian Water • Severn Trent Water • South Staffs Water • United Utilities	N/A[1]
8	The core department holds an indemnity in relation to the collaboration agreement between DHSC and the Premier League in relation to the Men's Mental Health strategy.	0.05
9	The core department holds an indemnity in relation to GambleAware's contractual obligations with Wellset Repro covering any post transfer liabilities or costs arising from its own non-performance during the transition period until GambleAware ceases operations in March 2026.	0.1
10	DHSC indemnified GSK, the manufacturer of the Pandemrix vaccine, for the cost of any personal injury claims resulting from the use of the Pandemrix during the 2009/10 H1N1 swine flu pandemic. There is one outstanding claim remaining, although the claim is currently dormant, having stalled at an early procedural stage.	N/A[1]
Other remote contingent liabilities (£m)		
11	The Department holds a remote contingent liability relating to potential historic claims for reimbursement of prescription and medical costs.	10.0
12	The Department holds a contingent liability relating to the provision of professional clinical indemnity cover.	N/A[1]
13	The department may incur costs in relation to potential injury to feelings awards arising from the 2018 McCloud pension judgement.	N/A[1]

1. Due to the sensitive nature of these contingent liabilities, the value has not been disclosed.

Unquantifiable remote contingent liabilities

The DHSC Group has entered into a number of unquantifiable or unlimited contingent liabilities with various health bodies and private companies. Where the core department has chosen to indemnify another organisation within the departmental group, entering into these arrangements does not increase the overall exposure of the group to potential liabilities.

None of these are a contingent liability within the meaning of IAS 37 since the possibility of a transfer of economic benefit in settlement is too remote.

Unquantifiable contingent liabilities are described below:

Indemnities	
1	The core department has undertaken to indemnify members of its expert advisory committees: • Advisory Committee on Dangerous Pathogens (ACDP) and their associated working groups • Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) • New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) • The Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO)
2	The core department has undertaken to indemnify members of the following committees: • Committee for Carcinogenicity • Committee for Mutagenesis • Committee for Medical Effects of Radiation • Committee for Medical Aspects of Air Pollution • Administration of Radioactive Substances Advisory Committee

	The core department would pay the legal costs and damages of any member who was personally subjected to any action arising out of the business activities of these committees and associated sub-committees.
3	The core department has undertaken to meet the cost of compensation payments arising from injury claims in relation to the immunisation of voluntary donors with specialised immunoglobulin.
4	The core department has undertaken to meet the legal costs of medical, scientific and nursing staff engaged on clinical trials approved by NHS Blood and Transplant.
5	The core department has undertaken to cover any damages arising from NHS Blood and Transplant clinical trials activity.
6	The core department holds an indemnity in relation to the Mpox vaccine.
7	The Department has provided the Official Receiver with a legal indemnity to protect them against financial loss or legal claims incurred while carrying out their duties in respect of the insolvency of NRS Healthcare Ltd.
8	Sensitive contingent liabilities nature not disclosed.
Other Remote Unquantifiable Contingent Liabilities	
9	UKHSA maintains a stockpile of medical countermeasures for responding to Chemical, Biological, Radiological and Nuclear (CBRN) incidents. Some of these products are unlicensed because no licensed alternatives are available in the UK. Similarly, UKHSA also holds stocks of unlicensed anti-venoms and anti-toxins. If any recipients were to suffer an adverse reaction to using these products UKHSA would be liable.
10	UKHSA holds remote contingent liabilities relating to contract disputes, primarily relating to contracts let in response to the COVID-19 pandemic.
11	UKHSA holds liabilities in respect of commercial contract obligations. These liabilities include contractual indemnities DHSC has entered into as part of its response to COVID-19. UKHSA has provided a letter of comfort to local authorities participating in the COVID-19 Community Testing Programme, offering a route to manage potential clinical negligence claims, should they arise in the course of testing conducted by local authorities. While this testing has now completed, the limitation of claims relating to these has not yet expired.

These liabilities are unquantifiable due to their underlying nature and uncertainty around future events that may lead to the remote obligation crystallising.

Government Core Tables 1 and **2** and accompanying narrative can be found within **Annex A**.

NHS Blood and Transplant (disclosure subject to audit)

In 2025-26, DHSC had lead policy responsibility for NHS Blood and Transplant. As a public corporation the results of NHS Blood and Transplant are not consolidated into the group financial statements.

Accountability report Sign-Off

27 October 2026
Samantha Jones OBE
Permanent Secretary

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSE OF COMMONS

Opinion on financial statements

I certify that I have audited the financial statements of the Department of Health and Social Care (DHSC) and of its Departmental Group for the year ended 31 March 2026 under the Government Resources and Accounts Act 2000. The Department comprises the core Department and its agencies. The Departmental Group consists of the Department and the bodies designated for inclusion under the Government Resources and Accounts Act 2000 (Estimates and Accounts) Order 2025. The financial statements comprise the Department's and the Departmental Group's:

- Consolidated Statement of Financial Position as at 31 March 2026;
- Consolidated Statement of Comprehensive Net Expenditure, Consolidated Statement of Cash Flows and Consolidated 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 Department and the Departmental Group's affairs as at 31 March 2026 and their net expenditure for the year then ended; and
- have been properly prepared in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects:

- the Statement of Outturn against Parliamentary Supply properly presents the outturn against voted Parliamentary control totals for the year ended 31 March 2026 and shows that those totals have not been exceeded; and
- 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 the Department 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.

The framework of authorities described in the table below has been considered in the context of my opinion on regularity.

Framework of authorities	
Authorising legislation	Government Resources and Accounts Act 2000
Parliamentary authorities	Supply and Appropriations Act
HM Treasury and related authorities	Managing Public Money

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the Department 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 Department or 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 the Department 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.

Overview of my audit approach

Key audit matters

Key audit matters are those matters that, in my professional judgment, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditor, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of the audit of the financial statements as a whole, and in forming my opinion thereon. I do not provide a separate opinion on these matters.

This is not a complete list of all risks identified through the course of my audit but only those areas that had the greatest effect on my overall audit strategy, allocation of resources and direction of effort. I have not, for example, included information relating to the work I have performed in response to the presumed audit risks of management override of controls or of fraud in revenue recognition, for which I did not identify any matters to report. I have also not included information related to the work I have performed in response to other risks identified arising from the processing of the consolidation and completeness and accuracy of disclosures in the consolidated Annual Report and Accounts, and in relation to the completeness and accuracy of intra-group transactions and balances.

The key audit matters were discussed with the Audit and Risk Assurance Committee; their report on matters that they considered to be significant to the financial statements is set out on page 153.

In this year's report the following changes to the risks identified have been made compared to my prior year report:

- I identified a new significant risk in respect of the implementation of the Integrated Single Financial Environment 2 (ISFE2) system upgrade to Oracle Fusion, which

went live on 1 October 2025. This is a major IT change implemented across the NHS England Group, affecting the parent body and all Integrated Care Boards.

- I removed the key audit matter and significant risk previously reported in respect of the infected blood provision. The legislation establishing the Infected Blood Compensation Authority (IBCA), an arms-length body of the Cabinet Office, means that the Department is now only responsible for making payments under the English Infected Blood Support Scheme up to 23 March 2027. The value of the provision has, therefore, reduced to £0.1 billion as at 31 March 2026 and no longer presents a risk of material misstatement in the context of my audit.

Valuation and disclosure of the NHS Resolution clinical negligence provisions

Description of risk *The Departmental Group recognised provisions in relation to clinical negligence totalling £59.9billion billion at 31 March 2026 (31 March 2025: £60.0 billion). See note 15 to the financial statements.*

There are significant judgements implicit in the valuation of the clinical negligence provisions. The valuation requires the support of actuarial experts and involves the use of actuarial assumptions, models, and data held within the NHS Resolution claims management systems. The 'incurred but not reported' (IBNR) provision includes a greater level of estimation uncertainty, as judgements are required by management in respect of the level of claims that will be received for incidents that occurred prior to the reporting date but have not yet been reported to NHS Resolution.

The highly material value of the provisions and the level of judgement and estimation uncertainty inherent in the calculation presents a significant risk of material misstatement to the Departmental Group's financial statements.

How the scope of my audit responded to the risk	I issued group instructions to the NHS Resolution component audit team, and reviewed the work performed in response. I directed the component audit team to complete testing which included: • evaluating the design and implementation of the controls in place in respect of management's review of the valuation prepared by the actuarial adviser (the Government Actuary's Department); • assessing the independence, objectivity and expertise of the actuarial adviser used in developing the valuation; • assessing and testing the completeness and accuracy of the incident data which forms the basis of the input data; • testing the arithmetic accuracy and the logic of the model;

- evaluating whether management had taken appropriate steps to understand and reduce estimation uncertainty; and
- engaging an actuarial specialist to review the actuarial valuation report to confirm the appropriateness of the methodology and assumptions utilised by the actuarial adviser; and challenging NHS Resolution management in respect of key assumptions applied, including the use of relevant indices.

I have assessed the adequacy of the financial statements disclosure, set out on pages 303 to 308.

Key observations

I draw attention to the uncertainties inherent in the claims provision for the Clinical Negligence Scheme for Trusts. As set out in note 15, given the long-term nature of the assumptions on which the estimate of the provision is based, a considerable degree of uncertainty remains over the value of the liability recorded by the Department. Significant changes to the liability could occur as a result of subsequent information and events that are different from the current assumptions adopted by the Department. My opinion is not modified in respect of this matter.

I did not identify material misstatements in the valuation or disclosure of the NHS Resolution clinical negligence provisions as a result of the work I have performed.

Property valuations across the Departmental Group

Description of risk

The Departmental Group reported property recognised under IAS 16: Property, Plant and Equipment *with a net book value of £54.9 billion and property recognised under* IFRS 16: Leases as right-of-use assets *with a net book value of £3.8 billion at 31 March 2026 (31 March 2025: Property recognised under IAS 16 £54.4 billion and property recognised as right-of-use assets under IFRS 16 £3.7 billion). See notes 5 and 7 to the financial statements.*

The net book value of property is highly material to the Departmental Group's financial statements and is owned by individual NHS providers, mainly consisting of hospitals and other healthcare buildings. NHS providers are required by the Department to value their specialised property assets on a depreciated replacement cost (DRC) basis using the modern equivalent asset (MEA) approach. The valuation of these property assets represents a significant accounting estimate in each NHS provider's accounts, which is

sensitive to key assumptions made by management at each NHS provider. Due to the complexities involved, support is often sought from external valuers, operating in line with guidance issued by the Royal Institute of Chartered Surveyors (RICS). Valuers needed to consider the impact of factors such as the presence of reinforced autoclaved aerated concrete (RAAC) and movements in the inflation rate in reaching their valuations as at 31 March 2026.

There is a high level of judgement involved in the selection and application of the assumptions used in estimating the value of these property assets. There is also a risk that estimates may be manipulated by NHS provider management in response to NHS system incentives to achieve a desired valuation outcome.

How the scope of my audit responded to the risk

I issued group instructions to the Consolidated NHS Provider Accounts, Community Health Partnerships Limited, and NHS Property Services Limited component audit teams, and reviewed the work performed in response. I directed the component audit teams to complete testing which included:

- evaluating the design and implementation of controls in operation at NHS England (for its production of the Consolidated NHS Provider Accounts), Community Health Partnerships Limited and NHS Property Services Limited in respect of property valuations;
- obtaining specific information on NHS provider's valuation methodologies and approach, and key assumptions in respect of properties;
- evaluating this information in aggregate to establish the appropriateness and consistency of the valuation bases applied at Departmental Group level for NHS providers;
- selecting a risk-based sample of NHS provider audit files and reviewed substantive procedures performed by the NHS provider auditors to address the risk around valuation of property assets, including consideration of the method used for depreciation;
- assessing the appropriateness of the methodology and assumptions, and substantively tested the data inputs, used in the valuation of NHS Property Services Limited's property portfolio; and
- assessing the appropriateness of the methodology and assumptions, and substantively tested the data inputs,

used in the valuation of Community Health Partnerships Limited's property portfolio.

Key observations

I did not identify material misstatements in the valuation of property as a result of the work I have performed.

Classification, existence, rights and obligations, presentation, and valuation of financial assets

Description of risk

The Department held financial assets valued at £48.4 billion as at 31 March 2026 (31 March 2025: £45.3 billion). See note 10 to the financial statements. The Department holds four categories of financial assets, three of which had material, or near material balances at 31 March 2026:

- *Public Dividend Capital (PDC) to NHS providers of £42.5billion (31 March 2025: £39.4 billion);*
- *Share capital investments of £4.0 billion (31 March 2025: £3.9 billion);*
- *Loans to NHS providers of £1.8 billion (31 March 2025: £1.8 billion); and*
- *Loans to other bodies of £0.2 billion (31 March 2025: £0.2 billion).*

This key audit matter is in relation to the Department's Public Dividend Capital (PDC) to NHS providers and its share capital investments.

The Department is required to value its share capital investments at 'fair value', which results in a level of inherent uncertainty in estimating the value as at 31 March 2026.The Department undertook a desk-based valuation exercise of its share capital investments as at 31 March 2026 with the assistance of an investments expert. I identified a risk of misclassification between PDC and loans to NHS providers, and inherent risks regarding the existence and rights and obligations of all of the financial assets. I also identified the subsequent measurement of PDC as a risk which includes the impairment of PDC. I identified a further risk that the presentation of the Department's financial assets may not be in accordance with the requirements of the reporting framework.

The majority of the Department's financial assets are held in the NHS providers, Community Health Partnerships Limited, Genomics England Limited, and NHS Property Services Limited and are eliminated on consolidation in the Departmental Group financial statements.

How the scope of my audit responded to the risk

I have:

- reviewed the design and implementation of controls around the valuation of financial assets including PDC, loans to NHS providers and share capital investments. I tested in-year PDC additions, PDC assets and Loans to NHS providers as at 31 March 2026 to confirm that the assets exist and that the rights and obligations of the assets were held by the Department.
- assessed and confirmed the appropriateness of the Department's impairment policy for PDC. I tested the PDC impairment calculations to ensure that they had been applied in line with the Department's accounting policy as set out on page 267.
- engaged a valuations expert to assist me in:
  - assessing and challenging the valuation methodology applied by the Department for each of its share capital investments to ensure that these were appropriate, reasonable, and consistently applied;
  - assessing and challenging management's assumptions applied in the valuations, including the discount rate applied, to ensure that these were appropriate; and
  - assessing the relevance and reliability of the data used by the Department in valuing its share capital investments.

I concluded that the methodology used in the valuation of the Department's share capital investments was appropriate.

I have assessed the adequacy of the disclosures made in respect of the Department's financial assets, including their classification, set out on pages 290 to 292.

Key observations

I did not identify material misstatements in the classification, existence, rights and obligations, presentation, or valuation of the Department's financial assets as a result of the work I have performed.

ISFE2 – Implementation of Oracle Fusion by NHS England

Description of risk

The Integrated Single Financial Environment 2 (ISFE2) is the system upgrade to the Oracle Fusion finance system which went live on 1 October 2025. This is a major IT change occurring across the NHS England Group, affecting NHS England and all Integrated Care Boards.

ISFE2 is considered to be critical national infrastructure, with implementation delayed since April 2024 due to the system changes not being ready.

Given the significance of the NHS finance function to Departmental financial statements, I identified the implementation of ISFE2 as a significant risk for my audit of the Departmental Group.

As a result of this IT change, the financial statements could be materially misstated due to:

- inaccurate or incomplete data transfer;
- inaccurate or inappropriate specification, design or configuration as part of the IT change; or
- inaccurate or incomplete scoping or specification of the data migration of an existing IT system.

How the scope of my audit responded to the risk

I issued group instructions to the NHS England component audit team and reviewed the work performed in response. I directed the component audit team to complete testing which included:

- evaluating the of the design and implementation of controls relating to the implementation of Oracle Fusion with the assistance of internal IT audit experts. The assessment included:
  - Programme and project governance processes;
  - Functional and technical specification;
  - Solution and user acceptance testing;
  - Data conversion and migration;
  - Go/no-go decision;
  - Post implementation review; and
  - Privileged users

- reviewing substantive testing of other audit areas to obtain assurance over the accuracy of data within the two systems with respect to purchases and sales invoices;
- reviewing component auditor group returns to address the risk around completeness and accuracy of data migration at the ICB level.

Key observations

I did not identify material misstatements to the financial statements as a result of the work I performed.

Application of materiality

Materiality

I applied the concept of materiality in both planning and performing my audit, and in evaluating the effect of misstatements on my audit and on the financial statements. This approach recognises that financial statements are rarely absolutely correct, and that an audit is designed to provide reasonable, rather than absolute, assurance that the financial statements are free from material misstatement or irregularity. A matter is material if its omission or misstatement would, in the judgement of the auditor, reasonably influence the decisions of users of the financial statements.

Based on my professional judgement, I determined overall materiality for the Department and its Group's financial statements as a whole as follows:

	Departmental Group	Department (parent)
Materiality	£2.2 billion	£2.1 billion
Basis for determining materiality	Approximately 1% of Departmental Group gross expenditure (£219.2 billion). The basis for determining materiality for the 2025-26 financial statements remains the same as that used in 2024-25, when materiality was £1.9 billion.	Approximately 1% of core and agencies gross expenditure (£205.9 billion). The basis for determining materiality for the 2025-26 financial statements remains the same as that used in 2024-25, when materiality was £1.9 billion.
Rationale for the benchmark applied	As a public sector department responsible for the provision of	The rationale for the benchmark applied is

	health and social care services, the Departmental Group is primarily funded by amounts drawn down from the Consolidated Fund. Gross expenditure is the primary driver of the Departmental Group financial statements; the provision of health and social care in England is the Department's primary purpose and a focus of both Parliamentary and public interest. In line with user interest, I have, therefore, chosen gross expenditure as the appropriate benchmark to apply.	consistent with that of the Departmental Group.

Performance Materiality

I set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality of the financial statements as a whole. Group performance materiality was set at 75% of Group materiality for the 2025-26 audit (2024-25: 75%). In determining performance materiality, we have also considered the uncorrected misstatements identified in the previous period.

Other Materiality Considerations

Apart from matters that are material by value (quantitative materiality), there are certain matters that are material by their very nature and would influence the decisions of users if not corrected. An example is any errors reported in the Related Parties note in the financial statements Assessment of such matters needs to have regard to the nature of the misstatement and the applicable legal and reporting framework, as well as the size of the misstatement.

I applied the same concept of materiality to my audit of regularity. In planning and performing my audit work to support my opinion on regularity and in evaluating the impact of any irregular transactions, I considered both quantitative and qualitative aspects that would reasonably influence the decisions of users of the financial statements.

Error Reporting Threshold

I agreed with the Audit and Risk Assurance Committee that I would report to it all uncorrected misstatements identified through my audit in excess of £1 million, as well as differences below this threshold that in my view warranted reporting on qualitative grounds. I also report to the Audit and Risk Assurance Committee on disclosure matters that I identified when assessing the overall presentation of the financial statements.

Total unadjusted audit differences reported to the Audit and Risk Assurance Committee would have increased net expenditure by £0.054 billion and decreased net assets by £0.054 billion.

Audit scope

The scope of my Group audit was determined by obtaining an understanding of the Department and its Group and their environment, including Department/Group-wide controls, and assessing the risks of material misstatement at the Group level.

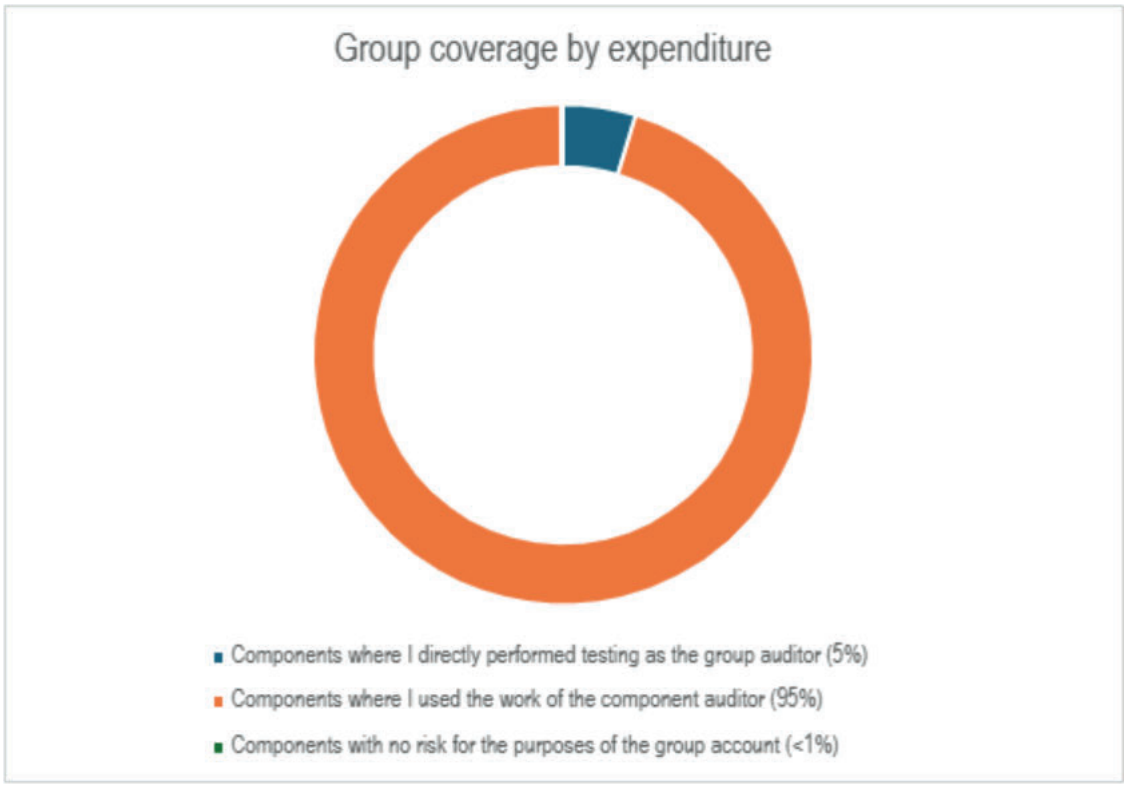
In line with *ISA (UK) 600 - Audits of Group Financial Statements (Including the Work of Component Auditors)* I developed my audit approach with consideration of the risks of material misstatement given the magnitude, estimation, and complexity of the classes of transactions, account balances and disclosures reported in the Department and the Departmental Group financial statements. I applied this risk assessment in determining the audit procedures required to be performed under my direction, supervision and review.

The Department for Health and Social Care Group recognised net expenditure of £215.4 billion in 2025-26, the majority spent by NHS providers who consolidated into the Group through the NHS Consolidated Provider Accounts. The Group had assets of £106.5 billion, of which £71.1 billion was Property, Plant and Equipment, mostly held either by NHS providers, NHS Property Services Limited, and Community Health Partnerships Limited. It had liabilities of £121.1 billion, the largest element of which being provisions for clinical negligence (£59.9 billion) held by NHS Resolution, and Service Concession Arrangements (being contracts with private companies to build, upgrade, operate, and maintain public infrastructure) (£16.9 billion) mostly held by NHS providers and by Community Health Partnerships Limited.

In applying ISA 600 revised ‘Special Considerations – Audits of Group Financial Statements (Including the Work of Component Auditors)’ I also deemed some transactions and balances at NHS England, NHS Business Services Authority and the UK Health Security Agency in scope of review by the Group engagement team. These consist of balances exceeding the respective component materialities, but which do not represent significant risks at the group level.

I have audited the full financial information of the Core Department, as well as the Group consolidation. As group auditor, I have gained assurance from the auditors of the components in scope of my review and engaged regularly on the Group significant risks.

My audit included coverage of 99.9% of the Departmental Group’s expenditure and 99.7% of its assets through the work performed directly as a Group auditor and through work performed by component auditors.



I audited the core Department component as part of my audit of the Departmental Group. I have had direct involvement in the audit strategy with all component auditors. I issued group audit instructions which enabled me to direct component auditors to carry out the procedures required for my audit opinion on the Department's and the consolidated Departmental Group's financial statements. I am the appointed auditor for all of the components of the Department and of the Departmental Group, with the exception of Community Health Partnerships Limited and a small number of bodies that are consolidated but we do not require assurance from the component auditor based on my risk assessment. For Community Health Partnership Limited I obtain assurance through review of relevant aspects of the component auditor's work. Audit procedures in accordance with UK adaptations of International Standards on Auditing have been conducted for classes of transactions, account balances and disclosures included in the scope of my audit and I have satisfied myself that sufficient work has been undertaken to provide the necessary assurances for my audit opinion on the Department's and on the Departmental group's consolidated financial statements.

I have audited the Statement of Outturn against Parliamentary Supply. I have assessed the appropriateness of the Supply classifications of different classes of transaction, and of reconciling items between the Statement of Comprehensive Net Expenditure and the Statement of Outturn Against Parliamentary Supply. I have recalculated the Statement of Outturn against Parliamentary Supply and its supporting notes to ensure that they are accurate.

Other Information

The other information comprises the information included in the Annual Report, but does not include the financial statements and my auditor's certificate and report 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 HM Treasury directions issued under the Government Resources and Accounts Act 2000.

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 HM Treasury directions issued under the Government Resources and Accounts Act 2000;

- 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 the Department and its Group and 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 Department 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 Accounting Officer for the financial statements

As explained more fully in the Statement of Principal Accounting Officer's Responsibilities, the Accounting Officer is 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 the Department 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 and are in accordance with HM Treasury directions issued under the Government Resources and Accounts Act 2000;

- preparing the annual report, which includes the Remuneration and Staff Report, in accordance with HM Treasury directions issued under the Government Resources and Accounts Act 2000; and

- assessing the Department 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 the Department 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 Government Resources and Accounts Act 2000.

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 the Department and its Group's accounting policies;
- inquired of management, the Department's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Department and its Group's 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 the Department and its Group's controls relating to the Department's compliance with the

Government Resources and Accounts Act 2000, Managing Public Money, and the Supply and Appropriation (Main Estimates) Act 2025;

- inquired of management, the Department'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 components within the scope of my group audit and relevant external specialists, including those engaged as valuation experts in respect of share capital investments, 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 Department 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 Department and Group's framework of authority and other legal and regulatory frameworks in which the Department 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 Department and its Group. The key laws and regulations I considered in this context included the Government Resources and Accounts Act 2000, Managing Public Money, Supply and Appropriation (Main Estimates) Act 2025, Local Government Act 2003, the Infected Blood Compensation Scheme Regulations 2025, employment law, tax legislation, health and safety legislation and pension legislation

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 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; and

- I reviewed the Department's assessment of the level of fraud across the NHS and non-NHS bodies in the Group.

I communicated relevant identified laws and regulations and potential risks of fraud to all engagement team members 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 appropriate evidence sufficient to give reasonable assurance that the Statement of Outturn against Parliamentary Supply properly presents the outturn against voted Parliamentary control totals and that those totals have not been exceeded. The voted Parliamentary control totals are Departmental Expenditure Limits (Resource and Capital), Annually Managed Expenditure (Resource and Capital), Non-Budget (Resource) and Net Cash Requirement.

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
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Date: 28 October 2026

Financial statements

Structure of the financial statements

The financial statements set out the DHSC group's financial position and performance. It includes:

- The Consolidated Statement of Comprehensive Net Expenditure
- The Consolidated Statement of Financial Position
- The Consolidated Statement of Cash Flows
- The Consolidated Statement of Changes in Taxpayers' Equity

Consolidated statement of comprehensive net expenditure

This statement summarises the expenditure incurred and income generated on an accruals basis. It also includes other comprehensive income and expenditure, which includes changes to the values of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

Other comprehensive net expenditure includes items which will not be reclassified to net operating costs.

In all material respects, the income and expenditure disclosed in the consolidated statement of comprehensive net expenditure relates to activities that are continuing.

Consolidated statement of financial position

This statement presents the financial position of DHSC. It comprises three main components: assets owned, controlled, or receivable from other bodies; liabilities owed to other bodies; and equity, the remaining value of the entity.

Consolidated statement of cash flows

The statement shows the changes in cash and cash equivalents of the department during the reporting period. The statement shows how DHSC generates and uses cash and cash equivalents by classifying cash flows as operating, investing and financing activities. The amount of net cash flows arising from operating activities is a key indicator of service costs and the extent to which these operations are funded by way of income from the recipients of services provided by DHSC. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to DHSC's future public service delivery.

Consolidated statement of changes in taxpayers' equity

These statements show the movement in the year on the different reserves held by the department and its agencies, analysed into 'general fund reserves' (that is, those reserves that reflect a contribution from the Consolidated Fund). The revaluation reserve reflects the change in asset values that have not been recognised as income or expenditure. Other reserves represents unrealised gains on financial assets held at fair value through other comprehensive income, the differences between the value of non-current assets taken over by NHS bodies at establishment and the corresponding figure recorded as the initial capital funding provided by government and to reflect pension assets/liabilities in respect of staff in non-NHS defined benefit pension schemes. The general fund represents the total assets less liabilities of the department, to the extent that the total is not represented by other reserves and financing items.

Consolidated statement of comprehensive net expenditure for the year ended 31 March 2026

	Note	Core department and agencies 2025-26 £m	Core department and agencies 2024-25 £m	Departmental group 2025-26 £m	Departmental group 2024-25 £m
Income from contracts	4	(2,957)	(2,632)	(13,631)	(12,575)
Non-contract income	4	(1,198)	(1,121)	(1,475)	(1,718)
Income received by NHS charities		-	-	(146)	(138)
Total operating income		**(4,155)**	**(3,753)**	**(15,252)**	**(14,431)**
Staff costs	2	870	814	105,159	98,525
Purchase of goods and services	3	1,602	2,045	98,318	94,004
Depreciation and impairment charges	3	2,875	999	8,024	6,291
Provision expense	3	1,439	(790)	3,501	3,001
Other operating expenditure	3	9,064	10,466	12,804	14,126
Grant in aid to NDPBs		200,444	191,590	-	-
Funding to group bodies		664	581	-	-
Resources expended by NHS charities		-	-	100	71
Total operating expenditure		**216,958**	**205,705**	**227,906**	**216,018**
Net operating expenditure		**212,803**	**201,952**	**212,654**	**201,587**
Finance income		(69)	(72)	(553)	(650)
Finance expense	3	70	147	3,260	3,223
Net (gain)/loss on transfers by absorption		-	(1)	-	2
Net expenditure for the year		**212,804**	**202,026**	**215,361**	**204,162**
Other comprehensive net expenditure					
Net (gain)/loss on:					
- revaluation of property, plant and equipment	5	(16)	(19)	(1,318)	(1,180)
- revaluation of intangibles	6	-	-	-	(1)
- revaluation of right of use assets	7	-	-	(17)	(9)
- revaluation of charitable assets		-	-	(12)	2
- net impairments taken to revaluation reserve	3.3	3	10	1,434	1,158
- equity instruments measured at fair value	10	88	581	12	113
- other financial assets mandated at fair value	10	-	-	3	-
Actuarial (gains)/losses on pension schemes		-	-	1	(29)
Other pension remeasurements		-	-	(5)	46
Other (gains) and losses		-	-	26	417
Comprehensive net expenditure for the year		**212,879**	**202,598**	**215,485**	**204,679**

Consolidated statement of financial position as at 31 March 2026

	Note	Core department and agencies 2025-26 £m	Core department and agencies 2024-25 £m	Departmental group 2025-26 £m	Departmental group 2024-25 £m
Non-current assets					
Property, plant and equipment	5	919	926	71,147	69,520
Investment property		2	42	248	262
Intangible assets	6	233	190	3,879	3,226
Right of use assets	7	173	122	4,533	4,458
Net pension asset		-	-	8	32
Non-current investments	10	48,436	45,326	492	524
Charitable investments		-	-	281	325
Other non-current assets	13	243	277	928	850
Total non-current assets		**50,006**	**46,883**	**81,516**	**79,197**
Current assets					
Assets held for sale		1	5	94	101
Inventories	11	481	676	2,219	2,385
Trade and other receivables	13	348	328	4,154	3,980
Other current assets	13	1,048	1,226	3,389	3,529
Other financial assets (investments)	13	198	220	44	136
Cash and cash equivalents	12	3,312	1,927	14,929	13,509
Charitable cash		-	-	199	177
Total current assets		**5,388**	**4,382**	**25,028**	**23,817**
Total assets		**55,394**	**51,265**	**106,544**	**103,014**
Current liabilities					
Trade and other payables	14	(91)	(76)	(9,585)	(9,080)
Other liabilities	14	(5,863)	(4,279)	(25,618)	(22,188)
Provisions	15	(569)	(702)	(5,871)	(5,285)
Total current liabilities		**(6,523)**	**(5,057)**	**(41,074)**	**(36,553)**
Total assets less current liabilities		**48,871**	**46,208**	**65,470**	**66,461**
Non-current liabilities					
Other payables	14	(29)	(29)	(1,253)	(1,273)
Provisions	15	(1,986)	(1,520)	(58,912)	(59,109)
Financial liabilities	14	(250)	(219)	(19,877)	(20,193)
Total non-current liabilities		**(2,265)**	**(1,768)**	**(80,042)**	**(80,575)**
Total assets less liabilities		**46,606**	**44,440**	**(14,572)**	**(14,114)**
Taxpayers' equity and other reserves					
General fund		43,591	41,323	(29,637)	(29,632)
Revaluation reserve		326	342	14,487	14,855
Other reserves		2,689	2,775	140	173
Total equity		**46,606**	**44,440**	**(15,010)**	**(14,604)**
Charitable funds		-	-	438	490
Total reserves		**46,606**	**44,440**	**(14,572)**	**(14,114)**

27 October 2026
Samantha Jones OBE
Permanent Secretary

Consolidated statement of cash flows for the year ended 31 March 2026

	Note	Core department and agencies 2025-26 £m	Core department and agencies 2024-25 £m	Departmental group 2025-26 £m	Departmental group 2024-25 £m
Net cashflow from operating activities					
Net expenditure for the year		(212,804)	(202,026)	(215,361)	(204,162)
Adjustments for non-cash transactions	3.2	4,542	2,012	13,173	12,378
Adjustments for net finance costs		(60)	(65)	1,086	1,101
Other non-cash movements in statement of financial position items		3	(24)	(24)	3
Adjustments for charities		-	-	44	17
(Increase)/decrease in trade and other receivables	13	214	(143)	(20)	(704)
(Increase)/decrease in inventories	11	195	16	166	(74)
Increase/(decrease) in trade and other payables	14	1,630	(761)	3,599	(1,017)
Movements arising from absorption transfers		-	-	-	2
Working capital movements not in net expenditure		(1,461)	234	(1,776)	290
Use of provisions	15	(542)	(446)	(4,082)	(3,872)
Transfer of provisions to payables/ inventories	15	(651)	(699)	(690)	(747)
Cash payments in respect of pensions		-	-	(3)	(4)
Other operating cashflows		(19)	(1)	(19)	(28)
Net cash outflow from operating activities		**(208,953)**	**(201,903)**	**(203,907)**	**(196,817)**
Cash flows from investing activities					
Purchase of property, plant, equipment and investment properties		(192)	(204)	(8,056)	(7,664)
Purchase of intangible assets		(116)	(64)	(1,321)	(961)
Purchase of investments		(6,347)	(4,845)	(12)	(12)
Proceeds of disposal of property, plant and equipment		59	5	160	84
Proceeds of disposal of intangibles		-	-	-	1
Proceeds of disposal of right of use assets		-	-	(1)	-
Proceeds of disposal of assets held for sale		1	1	61	64
Proceeds of disposal of investments		443	435	70	21
Receipts in respect of finance leases		11	14	13	11
Interest received from group bodies		56	61	-	-
Interest received from external bodies		-	-	531	640
Non-cash disposals of financial assets		-	-	1	1
Payment of direct costs in respect of obtaining right of use assets		(1)	-	(1)	(4)
Other investing cashflows		-	5	9	35
Net cash outflow from investing activities		**(6,086)**	**(4,592)**	**(8,546)**	**(7,784)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year	SoCTE	185,000	175,940	185,000	175,940
Net financing from the National Insurance Fund	SoCTE	31,461	30,164	31,461	30,164
Net movements of capital element of loans		-	-	(34)	(44)
Payments in respect of leases		(34)	(37)	(813)	(793)
Capital payments in respect of PFI contracts		-	-	(751)	(756)
Interest paid to group bodies		(1)	(1)	-	-
Interest paid to external bodies		-	-	(979)	(994)
Other financing cashflows		(1)	-	-	(2)
Net cash outflow from financing activities		**216,425**	**206,066**	**213,884**	**203,515**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**1,386**	**(429)**	**1,431**	**(1,086)**
Payment of amounts due to the Consolidated Fund		(1)	(14)	(1)	(14)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**1,385**	**(443)**	**1,430**	**(1,100)**
Cash and cash equivalents at the beginning of the period		1,927	2,370	13,667	14,767
Cash and cash equivalents at the end of the period		**3,312**	**1,927**	**15,097**	**13,667**

Consolidated statement of changes in taxpayers' equity: core department and agencies

For the year ended 31 March 2026

	Note	General fund £m	Revaluation reserve £m	Other reserves £m	Taxpayers' equity £m
Balance at 1 April 2025		**41,323**	**342**	**2,775**	**44,440**
Prior period adjustments in local accounts		20	(25)	-	(5)
Parliamentary and other funding					
Parliamentary funding - drawn down	SoCF	185,000	-	-	185,000
Parliamentary funding - deemed		2,712	-	-	2,712
Parliamentary funding - amounts unspent at period end	14	(4,123)	-	-	(4,123)
National Insurance Fund contributions	SoCF	31,461	-	-	31,461
Comprehensive net expenditure for the year					
Net expenditure for the year	SoCNE	(212,804)	-	-	(212,804)
Non-cash auditor's remuneration	3.1	2	-	-	2
Net gain/(loss) on revaluation of non-current assets		-	16	-	16
Net impairments	3.3	-	(3)	-	(3)
Fair value gains/(losses) on equity instruments	10	(3)	-	(85)	(88)
Other movements					
Transfers between reserves		3	(3)	-	-
Transfer of revaluation reserve (Intangible Assets) to General Fund		1	(1)	-	-
PDC impairments	3.3	98	-	-	98
PDC written off		(98)	-	-	(98)
Other movements		(1)	-	(1)	(2)
Balance at 31 March 2026		**43,591**	**326**	**2,689**	**46,606**

For the year ended 31 March 2025

	Note	General fund £m	Revaluation reserve £m	Other reserves £m	Taxpayers' equity £m
Balance at 1 April 2024		**36,999**	**330**	**3,352**	**40,681**
Prior period adjustments in local accounts		(3)	4	-	1
Parliamentary and other funding					
Parliamentary funding - drawn down	SoCF	175,940	-	-	175,940
Parliamentary funding - deemed		3,059	-	-	3,059
Parliamentary funding - amounts unspent at period end	14	(2,712)	-	-	(2,712)
Amounts payable to the Consolidated Fund	14	(1)	-	-	(1)
National Insurance Fund contributions	SoCF	30,164	-	-	30,164
Comprehensive net expenditure for the year					
Net expenditure for the year	SoCNE	(202,026)	-	-	(202,026)
Non-cash auditor's remuneration	3.1	2	-	-	2
Net gain/(loss) on revaluation of non-current assets		-	19	-	19
Fair value gains/(losses) on equity instruments	10	(3)	-	(578)	(581)
Net impairments	3.3	-	(10)	-	(10)
Other movements					
PDC impairments	3.3	129	-	-	129
PDC written off		(227)	-	-	(227)
Other movements		2	(1)	1	2
Balance at 31 March 2025		**41,323**	**342**	**2,775**	**44,440**

Consolidated statement of changes in taxpayers' equity: departmental group

For the year ended 31 March 2026

	Note	General fund £m	Revaluation reserve £m	Other reserves £m	Taxpayers' equity £m	Charitable funds £m	Total reserves £m
Balance at 1 April 2025		**(29,632)**	**14,855**	**173**	**(14,604)**	**490**	**(14,114)**
Prior period adjustments in local accounts		9	10	(3)	16	-	16
Parliamentary and other funding							
Parliamentary funding - drawn down	SoCF	185,000	-	-	185,000	-	185,000
Parliamentary funding - deemed		2,712	-	-	2,712	-	2,712
Parliamentary funding - amounts unspent at period end	14	(4,123)	-	-	(4,123)	-	(4,123)
National Insurance Fund contributions	SoCF	31,461	-	-	31,461	-	31,461
Net expenditure for the year	SoCNE	(215,301)	-	-	(215,301)	(60)	(215,361)
Non-cash auditor's remuneration	3.1	2	-	-	2	-	2
Other comprehensive net expenditure							
Net gain/(loss) on revaluation of non-current assets		-	1,335	-	1,335	-	1,335
Fair value gains/(losses) on equity instruments	10	12	-	(24)	(12)	-	(12)
Net gain/(loss) on revaluation of charitable assets		-	-	-	-	12	12
Fair value gains/(losses) on other financial assets	10	-	-	(3)	(3)	-	(3)
Net impairments	3.3	-	(1,434)	-	(1,434)	-	(1,434)
Net actuarial gain/(loss) on defined benefit pension scheme		(1)	-	-	(1)	-	(1)
Other pensions remeasurements		4	-	1	5	-	5
Other gains and losses		(26)	-	-	(26)	-	(26)
Other movements							
Transfers between reserves		210	(207)	(3)	-	-	-
Transfer of intangible asset revaluation reserves to general fund		50	(50)	-	-	-	-
Other movements		(14)	(22)	(1)	(37)	(4)	(41)
Balance at 31 March 2026		**(29,637)**	**14,487**	**140**	**(15,010)**	**438**	**(14,572)**

For the year ended 31 March 2025

	Note	General fund £m	Revaluation reserve £m	Other reserves £m	Taxpayers' equity £m	Charitable funds £m	Total reserves £m
Balance at 1 April 2024		**(32,286)**	**15,410**	**307**	**(16,569)**	**515**	**(16,054)**
Prior period adjustments in local accounts		40	130	(8)	162	2	164
Application of IFRS 16 measurement principles to PFI liability		-	-	-	-	-	-
Parliamentary and other funding							
Parliamentary funding - drawn down	SoCF	175,940	-	-	175,940	-	175,940
Parliamentary funding - deemed		3,059	-	-	3,059	-	3,059
Parliamentary funding - amounts unspent at period end	14	(2,712)	-	-	(2,712)	-	(2,712)
Amounts payable to the Consolidated Fund	14	(1)	-	-	(1)	-	(1)
National Insurance Fund contributions	SoCF	30,164	-	-	30,164	-	30,164
Net expenditure for the year	SoCNE	(204,137)	-	-	(204,137)	(25)	(204,162)
Non-cash auditor's remuneration	3.1	3	-	-	3	-	3
Other comprehensive net expenditure							
Net gain/(loss) on revaluation of non-current assets		-	1,190	-	1,190	-	1,190
Net gain/(loss) on revaluation of charitable assets		-	-	-	-	(2)	(2)
Fair value gains/(losses) on equity instruments	10	-	-	(113)	(113)	-	(113)
Net impairments	3.3	-	(1,158)	-	(1,158)	-	(1,158)
Net actuarial gain/(loss) on defined benefit pension scheme		29	-	-	29	-	29
Other pensions remeasurements		(30)	-	(16)	(46)	-	(46)
Other gains and losses		(417)	-	-	(417)	-	(417)
Other movements							
Transfers between reserves		713	(715)	2	-	-	-
Other movements		3	(2)	1	2	-	2
Balance at 31 March 2025		**(29,632)**	**14,855**	**173**	**(14,604)**	**490**	**(14,114)**

Notes to the financial statements

1. Statement of accounting policies

The accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) as adapted and interpreted by the 2025-26 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply IFRS as adapted or interpreted for the public sector context.

Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the circumstances of DHSC for the purpose of giving a true and fair view has been selected. The policies adopted by DHSC are described below and have been applied consistently in dealing with items considered material to the accounts.

The 2025-26 annual report and accounts includes three departures from the FReM, all of which have been agreed with HM Treasury:

- public dividend capital issued by the core department on the creation of new NHS trusts, any subsequent impairment, or that is written off on dissolution, are recognised as movements in the general fund.
- receipts of National Insurance contributions from the National Insurance Fund are recognised on a cash basis.
- The revised FReM valuation-cycle requirements for property, plant and equipment have not been adopted for 2025-26. With HM Treasury agreement, the Group has continued to apply the valuation approach used in previous years. The departure does not apply to intangible assets, which are measured under the revised FReM requirements from 1 April 2025

The FReM requires DHSC's annual report and accounts to be produced on a going concern basis. Parliament has demonstrated its commitment to fund DHSC for the foreseeable future. There is no reason to believe funding will not be available to meet the future liabilities of DHSC. Therefore, the use of the going concern basis is appropriate.

1.1 Accounting convention

The accounts have been prepared under the historical cost convention with modification, to account for the revaluation of investment property, property, plant and equipment, intangible assets, right of use assets, stockpiled goods and certain financial assets and financial liabilities.

1.2 Basis of consolidation

The accounts comprise a consolidation of the core department, its executive agencies and other bodies designated for inclusion within the departmental accounting boundary

by HM Treasury under the Government Resources and Accounts Act 2000. These bodies make up the 'departmental group' and include arm's-length bodies, NHS trusts, NHS foundation trusts, integrated care boards, NHS charities and certain limited companies.

The departmental group includes all entities designated for inclusion within the DHSC departmental accounting boundary by HM Treasury. Transactions and balances between entities included in the consolidated accounts are eliminated on consolidation. A list of entities within the departmental accounting boundary is provided in note 19, together with details of entities controlled by DHSC but not consolidated.

1.3 Employee benefits

1.3.1 Recognition of short-term benefits

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. Where material, non-consolidated performance pay and annual leave earned but not taken by the year end are recognised on an accruals basis in the financial statements.

1.3.2 Retirement benefit costs - NHS Pensions

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.

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 four years, with approximate assessments in intervening years".

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 of the Actuary, which forms part of the 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 contribution rates 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 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.

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 NHS body commits itself to the retirement, regardless of the method of payment.

Figures relating to NHS pensions cost for DHSC can be found in **Note 2**.

1.4 Grants payable and grant-in-aid

1.4.1 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, DHSC recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.4.2 Grant-in-aid

The provision of grant-in-aid by DHSC to its non-departmental public bodies (NDPBs), 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 NDPBs' operating expenditure. These transactions are eliminated at the DHSC group level.

1.5 Audit costs

A charge reflecting the cost of audit is included in expenditure. DHSC is audited by the Comptroller and Auditor General. No cash charge is made for this service but a notional charge representing the cost of the audit is included in the accounts. This charge covers the audit costs in respect of the DHSC Annual Report and Accounts.

Other consolidated bodies are either audited by the Comptroller and Auditor General or they appoint an auditor under the relevant statutory provisions. Expenditure in respect of audit fees is included in their individual accounts.

Total audit remuneration for the departmental group, including the notional charge in respect of the audit of the DHSC Annual Report and Accounts and audit fees incurred by other consolidated bodies, is disclosed in **Note 3**.

1.6 Value added tax

Most of the activities of DHSC are outside the scope of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets, with the exception of leases under IFRS 16, where the FReM requires that irrecoverable VAT is expensed on a straight-line basis over the life of the lease. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.7 Revenue

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. Where consideration is received for performance obligations to be satisfied in the following year, revenue is deferred with a contract liability being recognised.

A significant source of revenue from services provided by DHSC relates to the delivery of healthcare. Further detail is provided in **Note 4**. DHSC has judged the delivery of healthcare to predominantly involve the satisfaction of performance obligations over a period of time under IFRS 15, as healthcare is received and consumed simultaneously by the patient as the services are being provided. Subsequently revenue is recognised on the basis of measuring the progress made towards the complete satisfaction of the delivery of the spell of healthcare being administered at a local level.

A significant source of revenue for the core department relates to the voluntary scheme for branded medicines pricing, access and growth (VPAG). DHSC has judged that the scheme's performance obligations are satisfied over a period of time, as the benefit is received and consumed simultaneously. Most payments are due within one month of the end of each quarter. Where revenue has been recognised but the related payment has not yet been received, the amount is recorded as accrued income.

Where revenue includes amounts subject to uncertainty, estimates are constrained to levels that would not entail a significant reversal of revenue being recognised per the requirements of IFRS 15. DHSC uses historic knowledge and experience, as well as comparison with actual payments received after the reporting date in constraining the estimate.

DHSC acts as agent in respect of the share of VPAG income attributable to the devolved administrations (DAs), collecting and transferring amounts on their behalf where the DAs retain responsibility for the relevant devolved healthcare activities, access arrangements and commercial decisions; accordingly.

IFRS 15 is applicable to revenue in respect of fees and charges (such as 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.

There are sources of income that DHSC receives which are outside the scope of IFRS 15 as adapted and interpreted by the FReM. Where this is the case, DHSC recognises the income when it can be measured reliably, and it is probable that economic benefit associated with the transaction will flow to DHSC in line with the IFRS Conceptual Framework.

Income is voted on through the estimates process and any consolidated fund extra receipts (CFERs) which fall outside the ambit of the vote must therefore be returned to HM Treasury, as is confirmed in the 2025-26 Main Supply Estimate paragraph 23, page 9.

National Insurance contributions are classified as funding rather than income and are therefore credited to the general fund upon receipt.

Public dividend capital dividend income should be presented as a form of finance income.

However, dividend income has been included under operating income, so it can be separately identified as shown in **Note 4** income.

1.8 Property, plant, and equipment

1.8.1 Recognition

Property, plant and equipment are 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, DHSC
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item costs at least £5,000 or collectively a number of items have a total cost of at least £5,000 and individually a cost of more than £250, the assets are functionally interdependent, purchase dates are broadly simultaneous, disposal dates are anticipated to be simultaneous, and assets 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.

1.8.2 Valuation of property, plant, and equipment

All property, plant and equipment are 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 in use that are held for their service potential are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date. Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Further detail is provided in **Note 5**.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost (DRC), modern equivalent asset basis (MEA)

The MEA method assumes that the existing asset would be replaced with a modern asset of equivalent capacity and function. This asset need not be restricted to the current location and thus, where it would meet the contractual location requirements of the service being provided, an alternative site may instead be used as the basis of valuation.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, furniture and fittings, and plant and machinery (including transport equipment) held for operational use are valued at depreciated historic cost. This approach is applied where the assets have short useful economic lives, low values, or both, as depreciated historic cost is not considered to be materially different from current value in existing use.

1.8.3 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 written out and charged to operating expenses.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is expensed in the period in which it is incurred.

1.9 Intangible non-current assets

Intangible non-current assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of DHSC’s business or which 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 DHSC where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software that is integral to the operation of hardware is capitalised as part of the relevant item of PPE. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

From 1 April 2025, intangible assets are measured at cost less accumulated amortisation and accumulated impairment losses. This reflects the change in the 2025-26 FReM from the previous revaluation approach to a cost-based subsequent measurement approach for intangible assets. For intangible assets previously measured under a revaluation approach, the net carrying amount at 31 March 2025 is treated as deemed historical cost from 1 April 2025.

Prior to 1 April 2025, following initial recognition, intangible assets were carried at current value in existing use where an active market existed. Where no active market existed, assets were measured at the lower of depreciated replacement cost on a modern equivalent asset basis and value in use for income-generating assets.

1.10 Research and development

Expenditure on research activity is not capitalised and is recognised as an operating expense in the period in which it is incurred.

Expenditure on development activity can be capitalised subject to meeting the specific recognition criteria for internally generated intangible assets. The sum of the expenditure incurred from the date when the criteria for recognition are initially met, represents the initial recognition value for such an intangible asset. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.11 Depreciation, amortisation, revaluation and impairments of property, plant and equipment and intangible assets

1.11.1 Depreciation and amortisation

Freehold land and investment properties are not depreciated.

Assets in the course of construction or development are not depreciated until the asset is brought into use.

Otherwise, depreciation or amortisation, as appropriate, is charged to record the costs or valuation of PPE, right of use assets and intangible non-current assets, less any residual value, in expenditure on a straight-line basis over their estimated remaining useful lives, or lease term, whichever is shorter. The estimated useful life of an asset is the period over which DHSC expects to obtain economic benefits or service potential from the asset.

Estimates of the useful life of assets and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.11.2 Revaluation and impairments

An increase to an asset's value arising on revaluation is taken to the revaluation reserve, except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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.

A revaluation decrease is only recognised as an impairment charged to the revaluation reserve when it does not result from a loss in the economic value or service potential, to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure.

At each financial year-end, DHSC determines whether there is any indication that its PPE, right of use assets or intangible non-current assets have suffered an impairment loss. If there is an 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.

Gains and losses recognised in the revaluation reserve are reported in the consolidated statement of changes in taxpayers' equity.

1.12 Donated assets

Donated non-current assets are capitalised at the value in existing use if they will be held for service potential, or otherwise, at 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.

Donated assets are valued, depreciated, and impaired in the same way as purchased assets. Gains and losses on revaluations, impairments and sales are also treated in the same way as purchased assets.

Where assets donated do not qualify for capitalisation an amount equivalent to the value of the items is taken to expenses on receipt.

1.13 Leases

1.13.1 General approach of IFRS 16

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. In applying IFRS 16 DHSC has applied the following expedients and elections:

- Right of use assets and corresponding lease liabilities have not been recognised for leases with a term of 12 months or less, with such short-term arrangements being expensed on a straight-line basis.

- Right of use assets and corresponding lease liabilities have not been recognised for leases where the underlying asset is below £5,000, with such low value assets being expensed on a straight-line basis.

- DHSC has chosen not to apply IFRS 16 to any new leases of intangible assets.

HM Treasury has 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:

- DHSC 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 but may not be enforceable in their legal form. Prior to accounting for such arrangements under IFRS 16 DHSC has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

- DHSC 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. The accounting for peppercorn arrangements aligns to the treatment of donated assets.

1.13.2 Acting as a lessee

At the commencement date for the leasing arrangement a lessee recognises a right of use asset and corresponding lease liability.

DHSC employs a revaluation model for the subsequent measurement of its right of use assets, across all categories of right of use assets disclosed in **Note 7**, 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.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the statement of comprehensive net expenditure.

HM Treasury incremental borrowing rates have been applied in accounting for lease liabilities where the lessee cannot readily determine the interest rate implicit in the lease unless another discount rate would more accurately represent the incremental borrowing

rate. The incremental borrowing rate was 4.81% for leases entered into, or appropriately modified or remeasured, from 1 January 2025 and 5.32% from 1 January 2026.

Where changes in future lease payments result from a change in an index or rate or rent review, lease liabilities are remeasured using an unchanged discount rate. Where there is a change in a lease term or change to an option to purchase the underlying asset, DHSC will apply a revised rate for calculating the remeasured lease liability. Where existing leases are modified DHSC determines whether the arrangement constitutes a separate lease.

1.14 Service concession arrangements

HM Treasury has determined that government bodies shall account for infrastructure PFI and LIFT schemes, where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement, as service concession arrangements, following the principles set out in IFRIC 12. DHSC therefore recognises the PFI or LIFT asset as an item of property, plant and equipment, together with a liability to pay for it, on its statement of financial position.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received
- Payment for the PFI asset, including finance costs
- Payment for the replacement of components of the asset during the contract ‘lifecycle replacement’

1.14.1 PFI and LIFT assets, liabilities, and finance costs

PFI and LIFT assets are recognised as property, plant and equipment (PPE) when they come into use.

Service concession assets and related liabilities are initially measured in accordance with the principles of IFRS 16. This includes recognition of a right of use asset and a corresponding lease liability based on the present value of future lease payments.

Subsequently, PFI and LIFT assets are measured at current value in existing use, as detailed in **Note 1.8.2**.

An annual finance cost is recognised in expenditure, calculated by applying the interest rate implicit in the lease to the lease liability for the period. Variable lease payments that depend on an index or rate are included in the measurement of the lease liability and updated when the relevant index or rate changes.

Service concession liabilities are remeasured when cash flows change as a result of change in an index or rate. The net change in lease liabilities from such remeasurement is charged to finance costs within expenditure.

1.14.2 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the consolidated bodies' criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value. The component being replaced is derecognised at that point, through disposal, write-off, or impairment, as appropriate.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.14.3 Assets contributed by consolidated bodies to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment.

1.14.4 Other assets contributed by consolidated bodies to the operator

Other assets contributed (for example cash payments and surplus property) by the consolidated bodies to the operator before the asset is brought into use, where these are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the consolidated body, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value. Expenses are recognised on sale, donation, consumption, impairment or write off of the inventory in the period in which the specific event occurs.

Impairment of inventories result from a fall in their estimated net realisable value. Estimating a net realisable value takes into consideration not only the amount that may be expected to be realised from a sale of the inventory, so factoring in such matters as fluctuations of price or market value, but also the purpose for which inventory is held. Exercises such as identifying damaged stock, stock that is not suitable, excess stock or stock close to expiry, have all impacted on the level of impairment of inventory.

1.16 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 which are readily convertible to known amounts of cash with insignificant risk of change in value.

In the consolidated 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.

1.17 Provisions

Provisions are recognised when DHSC has a present legal or constructive obligation as a result of a past event, it is probable that DHSC 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. These discount rates are published in the DHSC Group Accounting Manual.

1.17.1 Clinical negligence costs

Clinical negligence costs are managed through schemes run by NHS Resolution.

The accounts for the schemes are prepared by NHS Resolution (NHSR) in accordance with IAS 37. Further detail as to the management of the schemes can be found in NHS Resolution's Annual Report and Accounts 2025-26. A provision for these schemes, disclosed in **Note 15**, includes obligations relating to claims that have been received together with actuarial estimates of obligations arising from incidents that have occurred but for which claims have not yet been received. The provision is measured in accordance with IAS 37 and, where the effect of the time value of money is material, expected future cash flows are discounted using the applicable HM Treasury discount rates.

NHS Resolution contracts actuarial advisers, the Government Actuary's Department (GAD), to assist with the preparation of financial statements through analysis and modelling of claims data. This is combined with information provided by management on the current economic and claims environment in order to provide estimates in relation to determining the valuation of the liabilities for the accounts. NHS Resolution's Reserving and Pricing Committee is responsible for making decisions on the key judgements and estimates, drawing on advice of the Government Actuary's Department.

Some key assumptions used in the production of the estimates reported are outside the formal control of NHS Resolution. For instance, HM Treasury prescribes the discount rates to be used in calculating the provisions. Patients (and their legal representatives) also have an element of control over the timing of the reporting of claims.

The Reserving and Pricing Committee keeps all of the factors affecting the calculation of provisions under review to ensure that the final provisions reflect the experience of the organisation and are adjusted in a timely manner.

The difference between the gross value of claims and the amount of the provision calculated above is also discounted, taking into account the likely time to settlement.

The schemes NHS Resolution manage are detailed in NHS Resolution's Annual Report and Accounts. All the schemes relate to the management of claims for clinical negligence.

1.18 Contingent liabilities and contingent assets

A contingent liability is either:

- 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 DHSC

- 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. **Note 16** provides details of DHSC's contingent liabilities. Remote contingent liabilities are disclosed elsewhere in the Annual Report and Accounts as part of DHSC's Parliamentary accountability disclosures.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts.

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 DHSC. A contingent asset is disclosed where an inflow of economic benefits is probable.

1.19 Public dividend capital, funding, and interaction with financial instruments

DHSC mainly relies on Parliamentary voted funding and receipt of a proportion of National Insurance contributions to finance its operations. Such transactions are accounted for as funding and do not generate a financial instrument.

DHSC's investment in NHS providers is represented by public dividend capital (PDC) which, being issued under statutory authority, is not classed as a financial instrument under IFRS 9. PDC is held at historic cost less impairments.

PDC is impaired, on an individual NHS provider basis, where the net assets of those NHS providers are below the level of PDC issued to that trust or foundation trust, irrespective of whether subsequent PDC write-offs are likely to occur. Where such adjustment is made the impairment is expensed by the core department.

Following closure of a provider, any PDC balance not transferred to a successor body is formally written off in the books of both the provider and the core department.

DHSC holds investments in private limited companies and other items such as receivables and payables that arise from its operations and cash resources that are financial instruments under IFRS 9.

1.20 Financial assets

Financial assets are recognised when DHSC becomes party to the financial instrument contract and the right to receive or pay cash is unconditional 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. Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques in line with IFRS 13.

Financial assets are classified into the following categories where the classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and determined at the time of initial recognition.

1.20.1 Financial assets at amortised cost

Financial assets measured at amortised cost includes trade receivables, loans receivable, and other simple debt instruments.

1.20.2 Financial assets at fair value through other comprehensive income

On transition to IFRS 9 DHSC elected to irrevocably designate its equity instruments to be measured at fair value through other comprehensive income. DHSC's equity instruments relate to its investment in private limited companies as detailed in **Note 10**.

1.20.3 Financial assets at fair value through profit and loss

Financial assets not otherwise measured at amortised cost or fair value through other comprehensive income fall into this category, such as financial assets acquired principally for the purpose of selling in the short term.

1.20.4 Impairments of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated per the irrevocable election), lease receivables and contract assets, DHSC recognises a loss allowance representing expected credit losses on the financial instruments.

DHSC adopts the simplified approach to impairment 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).

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 as an impairment gain or loss in income or expenditure.

Note 9 provides further detail regarding DHSC's limited exposure to different categories of risks in relation to its financial instruments.

1.21 Financial liabilities

Financial liabilities are recognised when DHSC 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. In the case of loans from DHSC to NHS providers, that would be the nominal rate charged on the loan. Such loans are a financial liability measured at amortised cost for NHS providers, corresponding to the financial asset recognised at amortised cost by the core department. Further detail is provided in **Note 10**.

1.22 Foreign exchange

The functional and presentational currencies of all consolidated bodies are pounds sterling and figures are expressed in millions of pounds unless expressly stated otherwise.

The large majority of DHSC's foreign exchange transactions relate to reciprocal healthcare medical costs. Payments made are valued at prevailing exchange rates. Outstanding balances at year end are converted at the closing exchange rate.

Due to delays in submission of medical cost claims by member states, DHSC estimates annual medical costs and adjusts future years' expenditure when actual costs are claimed. Estimated costs are converted into sterling at average rates calculated using EU published rates.

1.23 NHS charities

The transactions and balances associated with NHS charities are reported as separate items within the consolidated financial statements (for example 'income received by NHS charities, 'charitable cash' and so on) due to the unique nature of the transactions.

1.24 Initial application of reporting standards during 2025-26

IFRS 17 (Insurance Contracts)

IFRS 17 Insurance Contracts is effective for the DHSC Group from 1 April 2025 in accordance with the Financial Reporting Manual (FReM), replacing IFRS 4. IFRS 17 requires insurance contract liabilities to be valued based on the discounted estimate of future cash flows arising from the insurance obligations. The overall impact of IFRS 17 on the Group financial statements is not material.

The Group has assessed its arrangements against the definition of an insurance contract, including the requirement for the transfer of significant pre-existing insurance risk.

The Group has concluded that:

- Clinical negligence and other indemnity schemes administered by NHS Resolution on behalf of the Secretary of State for Health and Social Care do not meet the definition of insurance contracts as set out under IFRS 17.

- A small number of remote contingent liabilities (RCLs) have been assessed as meeting the definition of an insurance contract under IFRS 17. The expected impact of these arrangements have been assessed as demonstrably immaterial to the Group financial statements. Accordingly, no insurance contract assets or insurance contract liabilities have been recognised in respect of these arrangements under IFRS 17. The relevant arrangements continue to be reported as remote contingent liabilities where required for Parliamentary accountability reporting.

- Financial guarantee contracts are accounted for under IFRS 9 where applicable.

1.25 Accounting standards, amendments and interpretations that have been issued but have not yet been adopted

IFRS 18 Presentation and disclosure in financial statements

IFRS 18 was issued in April 2024 and will replace IAS 1 Presentation of Financial Statements for reporting periods beginning on or after 1 January 2027. The standard introduces revised requirements for presenting and explaining an entity's financial performance and position.

Key changes under IFRS 18 include:

- a mandatory structure for the statement of financial performance, requiring income and expenses to be grouped into operating, investing, financing, tax and discontinued operations categories;

- the presentation of specified totals and subtotals based on this classification structure; and

- disclosure of certain management-defined performance measures that are used in public reporting but are not otherwise required by IFRS.

HM Treasury interpretation and adaptation of the Standard is yet to be finalised, and the Department continues to liaise closely with HM Treasury to discuss and further refine the proposed approach to implementing the new standard. It is therefore too early for the Department to provide an estimate of the impact of adopting IFRS 18.

IFRS 19 Subsidiaries without Public Accountability: Disclosures

Application is required for accounting periods beginning on or after 1 January 2027 and provides reduced disclosure requirements for certain subsidiaries when preparing their financial statements. The standard is not yet adopted by the FReM. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 20 Regulatory Assets and Regulatory Liabilities

Application is required for accounting periods beginning on or after 1 January 2029. The standard is not yet UK-endorsed and not yet adopted by the FReM.

1.26 Critical accounting judgements and key sources of estimation uncertainty

Estimates and the underlying assumptions are reviewed on a regular basis by DHSC's senior management. Areas of estimation uncertainty or significant judgement made by management are:

Valuation approach for property, plant and equipment

IAS 16 valuation approach - assets which are held for their operational capacity and are in use, are held at their current value in existing use. For non-specialised assets, this is interpreted as market value in existing use, defined in the Royal Institution of Chartered Surveyors (RICS) Red Book as Existing Use Value (EUV). For specialised assets, this is interpreted as depreciated replacement cost on a modern equivalent asset basis. Where this applies, underlying bodies may perform a valuation based on an alternative site if this is consistent with the body's requirements to serve the local population. Where a body has taken this approach, it discloses the fact in its own accounting policies.

Useful lives of property, plant and equipment (PPE)

DHSC's judgements as to the useful economic lives of PPE impacts the amount of annual depreciation charged to expenditure. Those judgements are reviewed regularly to ensure that they are appropriate. **Note 5** discloses for each category of PPE, the lowest minimum, and the highest maximum in the ranges of useful lives.

Valuation of shareholdings

Share capital valuations are determined by applying the most appropriate methodology in line with IFRS 13. DHSC uses experts to assist with determining the fair value of its investments. Further details are given in **Note 10**.

Impairments of non-current assets

The management makes judgement on whether there are any indications of impairments to the carrying amounts of DHSC's assets. Further information is included in **Note 3.3**.

Impairments of financial assets

The core department considers the level of credit risk in NHS providers to be low and, as such, has not impaired loans between the core department and NHS providers.

Public dividend capital (PDC) impairment

The core department estimates the value of PDC impairment with reference to the net assets of NHS providers as a proxy for carrying value of the PDC investment in the

DHSC core account. Further information regarding the core department's approach to PDC impairment can be found in **Note 1.19**.

Clinical negligence provision

DHSC's most significant provision is for clinical negligence, and significant estimation is required to calculate the amounts provided. Resolution of claims is difficult to predict as many factors can lead to delay during the settlement and/or resolution process, and emerging evidence can alter valuation. The estimates and underlying assumptions are reviewed on an ongoing basis by NHS Resolution, supported by its actuaries, the Government Actuary's Department (GAD). Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of the revision and future periods, if the revision affects both current and future periods. In line with NHS Resolution, DHSC has assessed the applicability of IFRS 17 and concluded that clinical negligence provisions are outside the scope of the standard; accordingly, provisions will continue to be accounted for under IAS 37. Further detail on the sensitivities of the various assumptions is outlined in **Note 15** and in the NHS Resolution Annual Report and Accounts.

Other provisions

Judgement is made on the best estimate that 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. Further details on other provisions are outlined in **Note 15**.

Timing of income recognition

DHSC has made the judgement that the income recognised from the delivery of healthcare is over time (see **Note 1.7**).

Intra-group transactions and balances

Intra-group transactions and balances between group bodies are eliminated upon consolidation. Where differences are identified in the amounts recorded, adjustments are made to these amounts to ensure all intragroup balances eliminate. These adjustments may result in classification errors, for example between different types of expenditure. However, these differences are not material both on a net and gross basis and therefore cannot constitute a material misstatement in the group financial statements. DHSC coordinates extensive agreement of balances exercises across the group, where counterparties to intra-group transactions and balances are required to discuss and agree those amounts, with the aim of minimising residual mismatches. It is not feasible to further resolve these differences due to the significant number of individual entities which contribute to the difference identified.

2. Staff costs

Staff costs for the departmental group comprise:

	2025-26 £m	2024-25 £m
Salaries and wages	79,810	76,999
Social security costs	10,282	8,047
NHS pension	14,694	13,775
Other pension costs	208	206
Termination benefits	800	45
	105,794	**99,072**
Less: income in respect of secondments	(186)	(154)
Total staff costs	**105,608**	**98,918**
Less: amounts charged to capital	(449)	(393)
Total staff costs recognised in expenditure	**105,159**	**98,525**

Further information on staff costs and staff numbers is provided in the Remuneration and Staff Report within the Accountability Report.

NHS Pension Scheme

The NHS Pension Scheme is an unfunded, multi-employer defined benefit scheme. Individual NHS bodies are therefore unable to identify their shares of the underlying scheme liabilities. The FReM interpretation of IAS 19 states that the NHS Pension Scheme should be accounted for as a defined contribution scheme.

Employer contribution rates payable to the NHS Pension Scheme in 2026-27 remain the same as those payable in 2025-26 therefore we do not expect overall NHS pension costs in 2026-27 to be materially different from 2025-26.

3. Expenditure

3.1 Analysis of expenditure

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
3.1 (a) Purchase of goods and services				
Cash items				
Healthcare supplies and services				
Purchase of healthcare from non-NHS bodies	-	-	25,673	24,089
Supplies and services - clinical	11	-	22,055	21,066
Supplies and services - general	952	951	4,448	4,480
COVID-19 vaccines	287	711	287	711
Other COVID-19 expenditure	4	48	5	56
Goods and services from other NHS bodies	-	-	18	15
Direct commissioning and prescriptions				
Primary care services	-	-	14,698	13,616
Prescribing costs	-	-	10,688	10,543
Dental services	-	-	3,713	3,553
Pharmaceutical services	-	-	2,606	2,234
Ophthalmic services	-	-	675	655
Estates costs				
Establishment	210	187	2,536	2,550
Premises	41	60	4,900	4,945
Transport (business travel)	8	8	379	379
Rentals under leases	1	-	214	190
Other goods and services				
Purchase of social care	-	-	1,712	1,610
Multi professional education and training	-	-	1,969	1,637
Consultancy	30	17	259	252
Education, training and conferences	10	9	526	497
Insurance	-	-	146	123
Legal fees	46	52	579	535
NHS informatics	-	-	129	172
Audit fees - statutory audit (cash)	-	-	70	63
Auditor remuneration - other	-	-	31	30
Non-cash items				
Audit fees - statutory audit - non-cash	2	2	2	3
Purchase of goods and services	**1,602**	**2,045**	**98,318**	**94,004**

Analysis of expenditure (continued)

	Notes	Core department and agencies 2025-26 £m	Core department and agencies 2024-25 £m	Departmental group 2025-26 £m	Departmental group 2024-25 £m
3.1 (b) Depreciation and impairment charges					
Non-cash items					
Depreciation on property, plant and equipment	5	164	152	3,998	3,867
Amortisation on intangible assets	6	38	25	734	663
Depreciation on right of use assets	7	20	22	681	682
Impairments and reversals	3.3	2,653	800	2,611	1,079
Depreciation and impairment charges		**2,875**	**999**	**8,024**	**6,291**
3.1 (c) Provision expense					
Non-cash items					
Movement in pension liability		-	-	2	4
Net provisions arising	15	1,438	(781)	7,932	4,063
Provisions - change in discount rate	15	1	(9)	(4,433)	(1,066)
Provision expense		**1,439**	**(790)**	**3,501**	**3,001**
3.1 (d) Other operating expenditure					
Cash items					
Grants					
Grants to local authorities		4,134	3,949	4,134	3,949
Grants to other bodies		665	674	683	690
Capital grants		935	811	1,172	1,024
Other costs					
Service concession arrangements		-	-	1,388	1,335
Research and development		2,017	1,922	1,216	1,149
Infected blood compensation payments		209	640	209	640
Business rates paid to local authorities		1	1	681	641
Chair and non-executive directors' costs		-	-	42	43
Clinical negligence		-	-	-	2
Prior period adjustments in local accounts		(14)	-	(43)	(107)
Realised foreign exchange rate (gains)/losses		6	9	6	9
Other cash expenditure		903	828	2,796	2,669
Non-cash items					
Inventories write down					
COVID-19 inventories write downs		134	1,532	136	1,534
Inventories write down		7	46	31	69
Other costs					
Movement in expected credit loss allowances		(4)	1	127	187
Apprenticeship training grant		1	-	191	175
Prior period adjustments in local accounts		42	41	92	57
Loss on disposal of assets		10	12	32	34
Unrealised foreign exchange rate (gains)/losses		5	-	5	-
Changes in fair value		7	1	(41)	29
Capital grants in kind		8	1	8	1
Other non-cash expenditure		(2)	(2)	(61)	(4)
Other operating expenditure		**9,064**	**10,466**	**12,804**	**14,126**
3.1 (e) Finance expense					
Service concession arrangements					
Remeasurement of liabilities		-	-	539	659
Interest on obligations		-	-	970	982
Provisions					
Unwinding of discount		61	140	1,622	1,472
Other costs					
Interest on obligations under leases		8	6	115	98
Interest on loans and overdrafts		-	-	-	-
Interest on late payment of commercial debt		-	-	1	1
Other interest expense		1	1	13	11
Finance expense		**70**	**147**	**3,260**	**3,223**

Other cash expenditure in the departmental group comprises several items for which information would not be material. The largest balance included in other cash expenditure related to transport costs in the provider sector of £689 million (2024-25: £755 million), made up of expenditure such as fuel costs, vehicle parts and other fleet related costs.

Grants to local authorities include £3,632 million (2024-25: £3,426 million) relating to the Local Authority Public Health Grant.

3.2 Non-cash transactions

The total of non-cash transactions included in the reconciliation of operating costs to operating cashflow in the consolidated statement of cash flows comprises:

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Non-cash expenditure after financing activities	4,877	2,743	13,961	13,615
Non-cash income after financing activities	(28)	(2)	(323)	(290)
Total non-cash transactions	**4,849**	**2,741**	**13,638**	**13,325**
Movement in expected credit loss allowances	4	(1)	(127)	(187)
Inventories write down	(141)	(1,578)	(167)	(1,603)
Impairment of inventories	121	1,609	121	1,610
Utilisation of COVID-19 related inventory	(291)	(759)	(292)	(767)
Less non-cash movements analysed separately in the cash flow statement	**(307)**	**(729)**	**(465)**	**(947)**
Total non-cash transactions as per consolidated statement of cash flows	**4,542**	**2,012**	**13,173**	**12,378**

3.3 Impairments

	Notes	Core department and agencies 2025-26 £m	Core department and agencies 2024-25 £m	Departmental group 2025-26 £m	Departmental group 2024-25 £m
Impairments charged to consolidated statement of comprehensive net expenditure					
Property, plant and equipment impairments	5	4	6	2,632	2,464
Intangible asset impairments	6	37	-	73	70
Right of use asset impairments	7	(3)	38	15	129
Non-current investments impairments	10	2,736	2,365	(1)	25
Assets held for sale impairments		-	-	13	1
Inventory impairments	11	(121)	(1,609)	(121)	(1,610)
		2,653	**800**	**2,611**	**1,079**
Impairments charged to revaluation reserve					
Property, plant and equipment impairments	5	3	10	1,429	1,149
Right of use asset impairments	7	-	-	5	9
		3	**10**	**1,434**	**1,158**
Impairments charged to general fund					
Non-current investments impairments	10	(98)	(129)	-	-
		(98)	**(129)**	**-**	**-**
Total impairments charged in year		**2,558**	**681**	**4,045**	**2,237**

The table above includes both impairments and impairment reversals.

Non-current investments impairments

Non-current investments impairments include public dividend capital impairments (included in **Note 10**).

Public Dividend Capital (PDC)

Financial asset impairments for the core department include impairments of PDC issued to providers, where the net assets of the individual provider are below the carrying value of the investment. The impairment charged to expenditure in 2025-26 was £2,737 million (2024-25: £2,341 million).

As part of an agreed departure from the FReM, as detailed in **Note 1**, impairments arising or reversed in relation to demising NHS trusts or foundation trusts are charged to the general fund. In 2025-26 an impairment reversal of £98 million (2024-25: £129 million) was recognised.

4. Income

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Revenue from patient care activities				
Income from local authorities	-	-	2,372	2,302
Income from private patients	-	-	835	783
Income from overseas patients	-	-	166	142
Income from injury costs recovery	-	-	211	213
Income in respect of reciprocal healthcare claims	74	43	74	43
Income from DHSC/NHS bodies	-	-	164	167
Other non-NHS patient care services	-	-	1,010	1,018
Other contract income				
Non-patient care services to other bodies	1	21	1,273	940
Education, training and research	3	4	770	623
Prescription fees and charges	-	-	733	730
Dental fees and charges	-	-	848	797
Other fees and charges	330	301	637	604
Income in respect of staff costs	-	-	144	169
Branded medicines income	2,407	2,087	2,407	2,087
Other contract income	142	176	1,987	1,957
Income from contracts	**2,957**	**2,632**	**13,631**	**12,575**
Rental revenue from finance leases	-	-	1	1
Rental revenue from operating leases	2	4	334	410
PDC dividend received	1,121	1,085	-	-
Charitable and other contributions to expenditure	-	-	131	96
Receipts of donations for capital acquisitions	-	-	222	223
Receipt of grants for capital acquisitions	-	-	180	156
Profit on disposal	25	2	72	57
Dividends	-	-	17	16
Other non-cash income	2	-	36	34
Apprenticeship training grant (non-cash)	1	-	191	175
Funding from other government departments	-	-	2	2
Prior period adjustments in local accounts	(1)	-	(28)	20
Other non-contract income	48	30	317	528
Non-contract income	**1,198**	**1,121**	**1,475**	**1,718**

Other contract income includes £1,512 million relating to the provider sector. These amounts arise from a significant number of entities and as such are not material individually.

5. Property, plant and equipment

Departmental group for the year ended 31 March 2026

	Land £m	Buildings (excluding dwellings) £m	Dwellings £m	Information technology £m	Assets under construction £m	Furniture and fittings £m	Plant and machinery £m	Stockpiled goods £m	Total £m
Cost or valuation									
At 1 April 2025	**5,652**	**49,362**	**372**	**6,503**	**6,536**	**785**	**12,813**	**536**	**82,559**
Prior period adjustments in underlying accounts	1	(52)	-	(62)	(64)	(8)	(79)	-	(264)
Additions	84	1,667	8	585	4,867	44	977	114	8,346
Donations	-	98	-	1	283	2	61	-	445
Impairments and reversals	(382)	(3,435)	(16)	(8)	(61)	(4)	(3)	(6)	(3,915)
Transfers	2	5	-	3	(36)	10	15	(20)	(21)
Reclassifications	6	3,234	(10)	279	(4,226)	21	467	-	(229)
Revaluation and indexation	142	(793)	5	1	-	1	(8)	23	(629)
Disposals	(30)	(64)	(1)	(815)	(15)	(76)	(844)	(31)	(1,876)
Derecognition due to finance leasing	-	(2)	-	-	-	-	-	-	(2)
At 31 March 2026	**5,475**	**50,020**	**358**	**6,487**	**7,284**	**775**	**13,399**	**616**	**84,414**
Depreciation									
At 1 April 2025	**-**	**992**	**6**	**3,991**	**-**	**459**	**7,310**	**281**	**13,039**
Prior period adjustments in underlying accounts	-	(28)	-	(37)	-	(6)	(71)	-	(142)
Charged in year	-	1,838	14	848	-	65	1,127	106	3,998
Impairments and reversals	27	123	(3)	1	-	(1)	-	-	147
Transfers	-	(1)	1	-	-	-	-	-	-
Reclassifications	-	(15)	(1)	(7)	-	(16)	(30)	-	(69)
Revaluation and indexation	(22)	(1,904)	(11)	-	-	-	(10)	-	(1,947)
Disposals	-	(55)	(1)	(813)	-	(75)	(790)	(25)	(1,759)
At 31 March 2026	**5**	**950**	**5**	**3,983**	**-**	**426**	**7,536**	**362**	**13,267**
Net book value at 31 March 2026	**5,470**	**49,070**	**353**	**2,504**	**7,284**	**349**	**5,863**	**254**	**71,147**
Net book value at 31 March 2025	5,652	48,370	366	2,512	6,536	326	5,503	255	69,520
Asset financing									
Owned - purchased	5,015	34,759	274	2,461	6,749	332	5,205	254	55,049
Owned - donated	75	1,971	15	34	502	17	466	-	3,080
PFI contracts	380	12,340	61	9	33	-	192	-	13,015
PFI residual interests	-	-	3	-	-	-	-	-	3
Net book value at 31 March 2026	**5,470**	**49,070**	**353**	**2,504**	**7,284**	**349**	**5,863**	**254**	**71,147**

Departmental group for the year ended 31 March 2025

	Land £m	Buildings (excluding dwellings) £m	Dwellings £m	Information technology £m	Assets under construction £m	Furniture and fittings £m	Plant and machinery £m	Stockpiled goods £m	Total £m
Cost or valuation									
At 1 April 2024	**5,864**	**47,488**	**409**	**6,596**	**7,332**	**754**	**12,419**	**439**	**81,301**
Prior period adjustments in underlying accounts	(9)	6	(9)	(91)	(54)	(10)	(147)	-	(314)
Additions	22	1,440	6	494	4,295	42	720	112	7,131
Donations	1	63	-	2	270	1	88	16	441
Impairments and reversals	(217)	(2,923)	(35)	(7)	(396)	(6)	(8)	(6)	(3,598)
Transfers	-	(3)	(1)	(1)	(5)	4	6	2	2
Reclassifications	(42)	3,891	-	294	(4,902)	52	516	-	(191)
Revaluation and indexation	54	(533)	2	(14)	4	1	1	-	(485)
Disposals	(21)	(71)	-	(770)	(8)	(53)	(781)	(27)	(1,731)
Recognition due to termination of sub-leasing	-	4	-	-	-	-	-	-	4
Derecognition due to finance leasing	-	-	-	-	-	-	(1)	-	(1)
At 31 March 2025	**5,652**	**49,362**	**372**	**6,503**	**6,536**	**785**	**12,813**	**536**	**82,559**
Depreciation									
At 1 April 2024	**9**	**1,035**	**16**	**4,024**	**-**	**451**	**7,181**	**198**	**12,914**
Prior period adjustments in underlying accounts	(9)	(108)	(9)	(94)	-	(12)	(183)	-	(415)
Charged in year	-	1,791	14	844	-	66	1,064	88	3,867
Impairments and reversals	4	(4)	2	(1)	-	(1)	5	9	14
Transfers	-	(1)	(1)	-	-	(1)	-	1	(2)
Reclassifications	-	(23)	-	-	-	7	(5)	-	(21)
Revaluation and indexation	(4)	(1,633)	(16)	(14)	-	2	-	-	(1,665)
Disposals	-	(65)	-	(768)	-	(53)	(752)	(15)	(1,653)
At 31 March 2025	**-**	**992**	**6**	**3,991**	**-**	**459**	**7,310**	**281**	**13,039**
Net book value at 31 March 2025	**5,652**	**48,370**	**366**	**2,512**	**6,536**	**326**	**5,503**	**255**	**69,520**
Net book value at 31 March 2024	5,855	46,453	393	2,572	7,332	303	5,238	241	68,387
Asset financing:									
Owned - purchased	5,184	34,096	286	2,481	6,087	310	4,871	255	53,570
Owned - donated	88	1,811	15	25	435	16	446	-	2,836
PFI contracts	380	12,463	62	6	14	-	186	-	13,111
PFI residual interests	-	-	3	-	-	-	-	-	3
Net book value at 31 March 2025	**5,652**	**48,370**	**366**	**2,512**	**6,536**	**326**	**5,503**	**255**	**69,520**

Land and buildings held by NHS bodies are valued by independent valuers to a modern equivalent asset basis as required by HM Treasury per the FReM, details of which can be found in the individual body accounts. NHS bodies are required to prepare annual reports and accounts in accordance with the DHSC Group Accounting Manual reporting framework, which requires disclosures relating to property valuations, including the dates of the most recent valuations and the names and qualifications of the valuers. The value of land and buildings held by NHS providers at 31 March 2026 was £47.7 billion.

Property, plant and equipment disclosed in this note includes assets which are subject to operating leases where group entities grant the use of these assets to third parties. The majority of total property, plant and equipment assets in the departmental group are held in the NHS provider sector.

The ranges of estimated useful lives are currently:

- Buildings and dwellings 1 – 169 years
- Information technology 1 – 21 years
- Furniture and fittings 1 – 35 years
- Plant and machinery 1 – 38 years

Prior period adjustments in underlying accounts are consolidation timing adjustments which represent differences between provisional balances included in the prior year group consolidation and final audited balances subsequently reported by group entities after completion of the consolidation process. Where final audited information from group entities is unavailable by the reporting deadline, the group consolidation incorporates the most recent information available at that date. Any subsequent differences between those provisional amounts and the final audited balances are recognised as current year movements within the relevant asset category.

6. Intangible assets

Departmental group for the year ended 31 March 2026

	IT & software £m	Development expenditure £m	Other £m	Total £m
Cost or valuation				
At 1 April 2025	**5,013**	**748**	**764**	**6,525**
Prior period adjustments in underlying accounts	38	(18)	46	66
Additions	373	334	593	1,300
Donations	-	-	4	4
Impairments and reversals	(1)	-	(37)	(38)
Transfers	44	-	(42)	2
Reclassifications	426	23	(344)	105
Disposals	(335)	(62)	(5)	(402)
Other movements	(8)	-	3	(5)
At 31 March 2026	**5,550**	**1,025**	**982**	**7,557**
Amortisation				
At 1 April 2025	**2,886**	**370**	**43**	**3,299**
Prior period adjustments in underlying accounts	14	(11)	(1)	2
Charged in year	560	170	4	734
Impairments and reversals	26	-	9	35
Transfers	2	(1)	-	1
Reclassifications	-	2	-	2
Disposals	(334)	(50)	(4)	(388)
Other movements	(9)	-	2	(7)
At 31 March 2026	**3,145**	**480**	**53**	**3,678**
Net book value at 31 March 2026	**2,405**	**545**	**929**	**3,879**
Net book value at 31 March 2025	2,127	378	721	3,226

Departmental group for the year ended 31 March 2025

	IT & software £m	Development expenditure £m	Other £m	Total £m
Cost or valuation				
At 1 April 2024	**5,093**	**473**	**610**	**6,176**
Prior period adjustments in underlying accounts	(19)	16	(4)	(7)
Additions	232	299	403	934
Donations	1	-	1	2
Impairments and reversals	(11)	(4)	(40)	(55)
Transfers	19	1	(21)	(1)
Reclassifications	237	23	(172)	88
Revaluation and indexation	(7)	-	(10)	(17)
Disposals	(528)	(60)	(7)	(595)
Other movements	(4)	-	4	-
At 31 March 2025	**5,013**	**748**	**764**	**6,525**
Amortisation				
At 1 April 2024	**2,918**	**275**	**43**	**3,236**
Prior period adjustments in underlying accounts	(9)	(4)	-	(13)
Charged in year	503	155	5	663
Impairments and reversals	5	-	10	15
Reclassifications	1	3	-	4
Revaluation and indexation	(8)	-	(10)	(18)
Disposals	(524)	(59)	(5)	(588)
At 31 March 2025	**2,886**	**370**	**43**	**3,299**
Net Book Value at 31 March 2025	**2,127**	**378**	**721**	**3,226**
Net Book Value at 31 March 2024	2,175	198	567	2,940

From 2025–26, intangible assets are measured at cost, rather than under the revaluation model previously applied. This change has been applied prospectively, with the carrying amount at 1 April 2025 deemed to be historical cost (see further details in **Note 1.9**).

The ranges of estimated useful lives are currently:

- Software licences and internally developed software 1 – 30 years
- Development expenditure 1 – 20 years
- Other 1 – 20 years

Prior period adjustments in underlying accounts are consolidation timing adjustments which represent differences between provisional balances included in the prior year group consolidation and final audited balances subsequently reported by group entities after completion of the consolidation process. Where final audited information from group entities is unavailable by the reporting deadline, the group consolidation incorporates the most recent information available at that date. Any subsequent differences between those provisional amounts and the final audited balances are recognised as current year movements within the relevant asset category.

7. Right of use assets

Departmental group for the year ended 31 March 2026

	Property £m	Information technology £m	Furniture and fittings £m	Plant and machinery £m	Intangible assets £m	Total £m
Cost or valuation						
At 1 April 2025	**4,972**	**151**	**13**	**1,379**	**7**	**6,522**
Prior period adjustments in underlying accounts	(42)	(2)	-	-	-	(44)
Additions	425	10	-	221	-	656
Rerecognition due to termination of finance sub-lease	20	-	-	-	-	20
Remeasurements	152	-	-	20	-	172
Disposals and derecognitions	(143)	(13)	-	(89)	-	(245)
Capital provisions and reversals	19	-	-	-	-	19
Impairments and reversals	(15)	-	-	-	-	(15)
Revaluation and indexation	(2)	-	-	-	-	(2)
Transfers	(2)	1	-	-	-	(1)
Reclassifications	16	(3)	-	(8)	-	5
At 31 March 2026	**5,400**	**144**	**13**	**1,523**	**7**	**7,087**
Depreciation						
At 1 April 2025	**1,271**	**86**	**8**	**694**	**5**	**2,064**
Prior period adjustments in underlying accounts	(6)	(2)	-	1	-	(7)
Charged in year	431	20	2	228	-	681
Rerecognition due to termination of finance sub-lease	5	-	-	-	-	5
Disposals and derecognitions	(76)	(10)	-	(83)	-	(169)
Impairments and reversals	6	-	-	(1)	-	5
Revaluation and indexation	(19)	-	-	-	-	(19)
Reclassifications	(3)	-	-	(4)	1	(6)
At 31 March 2026	**1,609**	**94**	**10**	**835**	**6**	**2,554**
Net book value at 31 March 2026	**3,791**	**50**	**3**	**688**	**1**	**4,533**
Net book value at 31 March 2025	3,701	65	5	685	2	4,458

Departmental group for the year ended 31 March 2025

	Property £m	Information technology £m	Furniture and fittings £m	Plant and machinery £m	Intangible assets £m	Total £m
Cost or valuation						
At 1 April 2024	**4,777**	**148**	**12**	**1,254**	**11**	**6,202**
Prior period adjustments in underlying accounts	8	(1)	-	(30)	-	(23)
Additions	353	30	1	236	-	620
Rerecognition due to termination of finance sub-lease	5	-	-	-	-	5
Remeasurements	159	(1)	-	29	-	187
Disposals and derecognitions	(159)	(21)	-	(94)	(4)	(278)
Capital provisions and reversals	(1)	-	-	-	-	(1)
Impairments and reversals	(144)	-	-	(3)	-	(147)
Revaluation and indexation	(20)	-	-	(4)	-	(24)
Transfers	-	-	-	-	-	-
Reclassifications	(6)	(4)	-	(9)	-	(19)
At 31 March 2025	**4,972**	**151**	**13**	**1,379**	**7**	**6,522**
Depreciation						
At 1 April 2024	**956**	**81**	**6**	**575**	**9**	**1,627**
Prior period adjustments in underlying accounts	-	-	-	(11)	-	(11)
Charged in year	436	23	2	221	-	682
Rerecognition due to termination of finance sub-lease	1	-	-	-	-	1
Disposals and derecognitions	(83)	(14)	-	(84)	(4)	(185)
Impairments and reversals	(8)	-	-	-	-	(8)
Revaluation and indexation	(29)	-	-	(4)	-	(33)
Transfers	-	-	-	-	-	-
Reclassifications	(2)	(4)	-	(3)	-	(9)
At 31 March 2025	**1,271**	**86**	**8**	**694**	**5**	**2,064**
Net book value at 31 March 2025	**3,701**	**65**	**5**	**685**	**2**	**4,458**
Net Book Value at 31 March 2024	3,821	67	6	679	2	4,575

8. Commitments

8.1 Capital commitments

This note discloses commitments to future capital expenditure, not otherwise disclosed elsewhere in the financial statements. Included within capital commitments are non-cancellable contracts and purchase orders which commit the departmental group to capital expenditure in a future period. Commitments to expenditure under other forms of agreement such as Memorandums of Understanding may be considered as a capital commitment if they, in exceptional circumstances, effectively commit DHSC to the expenditure as it would be reputationally or politically damaging for DHSC to withdraw from the agreement.

Any future capital funding within the DHSC's accounting boundary does not represent a capital commitment.

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Property, plant and equipment	27	24	2,137	2,533
Intangible non-current assets	7	7	204	114
	34	**31**	**2,341**	**2,647**

8.2 Operating lease receipts

Total future minimum lease receipts under operating leases are given in the tables below for each of the following periods.

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Not later than 1 year	1	1	183	178
Later than 1 year and not later than 2 years	1	1	151	151
Later than 2 years and not later than 3 years	1	1	133	135
Later than 3 years and not later than 4 years	1	1	122	122
Later than 4 years and not later than 5 years	(1)	1	106	113
Later than 5 years	2	4	776	876
	5	**9**	**1,471**	**1,575**

8.3 Commitments under PFI and LIFT contracts

PFI contracts are held by NHS Property Services Ltd and NHS providers. LIFT contracts are held by Community Health Partnerships Ltd and NHS providers. Details of PFI and LIFT contracts in respect of each of the following categories are recorded in the individual accounts of the relevant group body.

8.3.1 LIFT schemes deemed to be on-statement of financial position

In this financial period there were 304 on-statement of financial position LIFT schemes (2024-25: 304). The substance of each contract is that DHSC has a finance lease, and payments comprise an imputed finance lease charge and a service charge.

Total future obligations in respect of LIFT contracts are given in the table below:

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Not later than 1 year	-	-	292	286
Later than 1 year and not later than 5 years	-	-	1,650	1,212
Later than 5 years	-	-	2,841	3,510
	-	**-**	**4,783**	**5,008**
Less interest element	-	-	(1,703)	(1,909)
Present value of obligations	**-**	**-**	**3,080**	**3,099**

8.3.2 Charges to the consolidated statement of comprehensive net expenditure in respect of LIFT contracts

The total charges in the period to expenditure in respect of off-statement of financial position LIFT contracts and the service element of on-statement of financial position LIFT contracts was £78 million (2024-25: £76 million).

Total future obligations in respect of these charges are given in the table below:

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Not later than 1 year	-	-	80	78
Later than 1 year and not later than 5 years	-	-	327	327
Later than 5 years	-	-	312	383
	-	**-**	**719**	**788**

8.3.3 PFI schemes deemed to be on-statement of financial position

In this financial period there were 155 on-statement of financial position PFI schemes (2024-25: 161). The substance of each contract is that DHSC has a finance lease, and payments comprise an imputed finance lease charge and a service charge.

Total future obligations in respect of PFI finance leases are given in the table below:

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Not later than 1 year	-	-	1,420	1,371
Later than 1 year and not later than 5 years	-	-	5,467	5,450
Later than 5 years	-	-	13,336	14,230
	-	**-**	**20,223**	**21,051**
Less interest element	-	-	(6,413)	(6,988)
Present value of obligations	**-**	**-**	**13,810**	**14,063**

8.3.4 Charges to the consolidated statement of comprehensive net expenditure in respect of PFI contracts

The total charges in the period to expenditure in respect of off-statement of financial position PFI schemes and the service element of on-statement of financial position PFI schemes was £1,309 million (2024-25: £1,260 million).

Total future obligations in respect of these charges are given in the table below:

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Not later than 1 year	-	-	1,228	1,255
Later than 1 year and not later than 5 years	-	-	4,738	5,013
Later than 5 years	-	-	11,043	12,469
	-	**-**	**17,009**	**18,737**

8.4 Other financial commitments

This note discloses commitments to future expenditure not otherwise disclosed elsewhere in the financial statements. Included within other financial commitments are non-cancellable contracts and purchase orders which commit DHSC to revenue expenditure in a future period. Commitments to expenditure under other forms of agreement such as Memorandums of Understanding may be considered as commitments if they would be reputationally or politically damaging for departmental group bodies to withdraw from the agreement.

Any future funding within DHSC's accounting boundary does not represent a financial commitment.

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Not later than 1 year	2,513	1,884	4,701	3,993
Later than 1 year and not later than 5 years	4,460	4,176	6,502	6,439
Later than 5 years	932	1,459	1,435	1,970
	7,905	**7,519**	**12,638**	**12,402**

Included within the core department and agencies and departmental group figures for 2025-26 are financial commitments of £4,327 million relating to UKHSA (2024-25: £3,803 million). The majority of these commitments relate to non-cancellable contracts that commit the agency to future expenditure in the procurement of vaccines as well as any milestone payments relating to the Moderna Strategic Partnership. Whilst these contracts are non-cancellable, in some instances the future expenditure is dependent on conditions being met and as such the commitment disclosed is an estimate of maximum future expenditure.

9. Financial instruments

9.1 Risk profile

As the cash requirements of DHSC are met through the estimates process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body of a similar size. The majority of financial instruments relate to contracts for non-financial items in line with DHSC's expected purchase and usage requirements and DHSC is therefore usually exposed to little credit, liquidity or market risk.

The core department's investments in NHS providers are represented by public dividend capital which, being issued under statutory authority, are not classed as being a financial instrument.

Currency risk

DHSC undertakes certain transactions denominated in foreign currencies, the vast majority of which are transactions relating to reciprocal healthcare medical costs. Due to the lead time in the submission of medical cost claims by member states DHSC estimates annual medical costs and adjusts future years' expenditure when actual costs are claimed. DHSC is therefore exposed to a limited amount of currency risk in relation to these expected claims before they can be settled.

As the NHS sector is made up principally of domestic organisations with the great majority of transactions, assets and liabilities being in the UK and sterling based, exposure to currency rate fluctuations is low.

Liquidity risk

The income within the group mostly originates from central government. Due to the continuing service provider relationship that health bodies have with each other, they are not exposed to the degree of financial risk faced by business entities. NHS trusts and foundation trusts, for example, generate their income from contractual arrangements with their commissioners.

Interest rate risk

DHSC has limited exposure to interest rate risk.

Credit risk

The vast majority of the group's income is generated from public sector bodies and as such is exposed to low credit risk.

9.2 Analysis of financial assets

Core department and agencies

	31 March 2026 £bn	31 March 2025 £bn
Financial assets	10.9	9.8
of which:		
held at amortised cost	6.9	5.9
held at fair value through other comprehensive expenditure	4.0	3.9

Departmental group

	31 March 2026 £bn	31 March 2025 £bn
Financial assets	21.4	20.1
of which:		
held at amortised cost	20.9	19.5
held at fair value through other comprehensive expenditure	0.5	0.6

9.3 Analysis of financial liabilities

Core department and agencies

	31 March 2026 £bn	31 March 2025 £bn
Financial liabilities	6.1	4.5

Departmental group

	31 March 2026 £bn	31 March 2025 £bn
Financial liabilities	53.0	49.7

At both 31 March 2026 and 31 March 2025, all financial liabilities were held at amortised cost.

10. Non-current investments

Core department and agencies for the year ended 31 March 2026

	Public dividend capital issued to NHS providers £m	Loans issued to NHS providers £m	Loans issued to other bodies £m	Share capital issued to other bodies £m	Total £m
Balance at 1 April 2025	**39,381**	**1,843**	**212**	**3,890**	**45,326**
Issued	5,909	82	177	189	6,357
Repaid	(85)	(8)	(175)	-	(268)
Net transfer to current receivables	-	(152)	(2)	-	(154)
Written off	(98)	-	-	-	(98)
Changes in fair value through other comprehensive income	-	-	-	(88)	(88)
Other impairments and reversals	(2,639)	-	-	-	(2,639)
Balance at 31 March 2026	**42,468**	**1,765**	**212**	**3,991**	**48,436**

Core department and agencies for the year ended 31 March 2025

	Public dividend capital issued to NHS providers £m	Loans issued to NHS providers £m	Loans issued to other bodies £m	Share capital issued to other bodies £m	Total £m
Balance at 1 April 2024	**37,404**	**1,943**	**198**	**4,267**	**43,812**
Issued	4,467	47	136	204	4,854
Repaid	(51)	(9)	(119)	-	(179)
Net transfer to current receivables	-	(138)	(3)	-	(141)
Written off	(227)	-	-	-	(227)
Changes in fair value through other comprehensive income	-	-	-	(581)	(581)
Other impairments and reversals	(2,212)	-	-	-	(2,212)
Balance at 31 March 2025	**39,381**	**1,843**	**212**	**3,890**	**45,326**

Departmental group for the year ended 31 March 2026

	Loans £m	Share capital and other investments £m	Total £m
Balance at 1 April 2025	**5**	**519**	**524**
Issued	-	12	12
Disposals	-	(48)	(48)
Repaid	-	(2)	(2)
Net transfer to current receivables	(2)	(1)	(3)
Changes in fair value through other comprehensive income	-	(15)	(15)
Changes in fair value through net expenditure	-	2	2
Other movements	-	22	22
Balance at 31 March 2026	**3**	**489**	**492**
Investments held by core department and agencies			48,436
Less elimination of intra-group investments			(48,333)
Investments held by other group bodies			389
Total			**492**

Departmental group for the year ended 31 March 2025

	Loans £m	Share capital and other investments £m	Total £m
Balance at 1 April 2024	**3**	**636**	**639**
Issued	5	8	13
Disposals	-	(16)	(16)
Repaid	-	(3)	(3)
Net transfer to current receivables	(2)	(1)	(3)
Changes in fair value through other comprehensive income	-	(113)	(113)
Changes in fair value through net expenditure	-	2	2
Other impairments and reversals	-	(1)	(1)
Other movements	(1)	7	6
Balance at 31 March 2025	**5**	**519**	**524**
Investments held by core department and agencies			45,326
Less elimination of intra-group investments			(45,209)
Investments held by other group bodies			407
Total			**524**

Financing of NHS providers

DHSC finances NHS providers by issuing public dividend capital and loans.

Public dividend capital (PDC) is issued when DHSC needs to provide additional financing to NHS providers for either capital or revenue requirements. PDC is a form of government financing provided to public sector organisations. PDC issued by DHSC is recorded as equity on the statement of financial position of providers and as an investment asset for the core department. The rules governing PDC for NHS trusts and NHS foundation trusts are provided in the NHS Act 2006. This allows for the use of PDC as originating capital for NHS trusts, and initial PDC for NHS foundation trusts. Providers pay dividends to the core department based on the provider's average relevant net assets. The current dividend rate for PDC is 3.5% of average relevant net assets. PDC is repayable to the core department but does not have a set repayment schedule.

In 2025-26 the value of impairment in respect of public dividend capital charged to expenditure was £2,737 million (2024-25: £2,341 million) and the value of impairments credited to reserves was £98 million (2024-25: £129 million). For further details see **Note 3.3**.

Loans are normally made under standard government loan terms, that is six-monthly equal instalments of principal and interest charged on outstanding balances. National Loan Fund rates of interest (as published by the UK Debt Management Office) are applied to all loans.

Share capital and other investments

The core department's share capital investments are measured at fair value. DHSC reviews the values of its financial investments each year with independent valuations carried out at intervals of no more than three years. The last such external valuation was undertaken on 31 March 2024.

Valuation classification

The classification of the inputs used to value the core department's share capital investments as level 1, level 2 or level 3 within the fair value hierarchy as required by IFRS 13 is shown below, these are all recurring valuations.

For the year ended 31 March 2026

Entity	Valuation basis	Level 1 £m	Level 2 £m	Level 3 £m	Total £m
Community Health Partnerships Ltd	Net assets	-	-	-	-
NHS Property Services Ltd	Net assets	-	2,993	-	2,993
Genomics England Ltd	Capital invested	-	898	-	898
NHS Professionals Ltd	Discounted cash flow	-	-	78	78
Porton Biopharma Ltd	Discounted cash flow	-	-	13	13
Other share capital investments	Various	-	-	9	9
		-	**3,891**	**100**	**3,991**

For the year ended 31 March 2025

Entity	Valuation basis	Level 1 £m	Level 2 £m	Level 3 £m	Total £m
Community Health Partnerships Ltd	Net assets	-	-	-	-
NHS Property Services Ltd	Net assets	-	3,041	-	3,041
Genomics England Ltd	Capital invested	-	738	-	738
NHS Professionals Ltd	Discounted cash flow	-	-	102	102
Other share capital investments	Various	-	-	9	9
		-	**3,779**	**111**	**3,890**

11. Inventories

Core department and agencies for the year ended 31 March 2026

	Notes	Vaccines £m	COVID-19 medicines £m	COVID-19 vaccines £m	Consumables £m	Other £m	Total £m
Balance at 1 April 2025		**395**	**16**	**228**	**7**	**30**	**676**
Prior period adjustments in underlying accounts		2	-	-	1	(1)	2
Inventory additions		569	-	235	6	7	817
Inventory consumed/disposed of		(608)	(4)	(287)	(7)	(5)	(911)
Write downs		(36)	(134)	30	1	(2)	(141)
Impairments and reversals	3.3	-	121	-	-	-	121
Transfers		20	-	-	-	1	21
Other		1	1	(107)	(2)	3	(104)
Balance at 31 March 2026		**343**	**-**	**99**	**6**	**33**	**481**

Core department and agencies for the year ended 31 March 2025

	Notes	Vaccines £m	COVID-19 medicines £m	COVID-19 vaccines £m	Consumables £m	Other £m	Total £m
Balance at 1 April 2024		**439**	**46**	**172**	**9**	**26**	**692**
Prior period adjustments in underlying accounts		(11)	-	-	(1)	1	(11)
Inventory additions		595	-	829	35	9	1,468
Inventory consumed/disposed of		(583)	(37)	(711)	(44)	(9)	(1,384)
Write downs		(46)	(1,249)	55	(338)	-	(1,578)
Impairments and reversals	3.3	-	1,257	-	352	-	1,609
Transfers		(5)	-	-	-	2	(3)
Transfers from provisions		-	-	(118)	(8)	(1)	(127)
Other		6	(1)	1	2	2	10
Balance at 31 March 2025		**395**	**16**	**228**	**7**	**30**	**676**

Departmental group for the year ended 31 March 2026

	Notes	Vaccines £m	Drugs £m	COVID-19 medicines £m	COVID-19 vaccines £m	Consumables £m	Other £m	Total £m
Balance at 1 April 2025		**395**	**575**	**16**	**228**	**1,048**	**123**	**2,385**
Prior period adjustments in underlying accounts		2	-	-	-	-	-	2
Inventory additions		569	10,610	-	235	5,358	643	17,415
Inventory consumed/disposed of		(608)	(10,598)	(4)	(287)	(5,318)	(640)	(17,455)
Write downs		(36)	(16)	(134)	30	(9)	(2)	(167)
Impairments and reversals	3.3	-	-	121	-	1	(1)	121
Transfers		20	-	-	-	-	1	21
Other		1	-	1	(107)	(1)	3	(103)
Balance at 31 March 2026		**343**	**571**	**-**	**99**	**1,079**	**127**	**2,219**

Departmental group for the year ended 31 March 2025

	Notes	Vaccines £m	Drugs £m	COVID-19 medicines £m	COVID-19 vaccines £m	Consumables £m	Other £m	Total £m
Balance at 1 April 2024		**439**	**534**	**46**	**172**	**1,009**	**111**	**2,311**
Prior period adjustments in underlying accounts		(11)	5	-	-	(8)	3	(11)
Inventory additions		595	10,164	-	829	5,044	634	17,266
Inventory consumed/disposed of		(583)	(10,112)	(37)	(711)	(4,995)	(629)	(17,067)
Write downs		(46)	(15)	(1,249)	55	(347)	(1)	(1,603)
Impairments and reversals	3.3	-	-	1,257	-	353	-	1,610
Transfers		(5)	-	-	-	-	2	(3)
Transfers from provisions		-	-	-	(118)	(8)	(1)	(127)
Other		6	(1)	(1)	1	-	4	9
Balance at 31 March 2025		**395**	**575**	**16**	**228**	**1,048**	**123**	**2,385**

12. Cash and cash equivalents

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Balance at 1 April 2025	**1,927**	**2,370**	**13,509**	**14,592**
Net change in cash	1,385	(443)	1,420	(1,083)
Balance at 31 March 2026	**3,312**	**1,927**	**14,929**	**13,509**
The following balances at 31 March were held at:				
Government Banking Service	3,312	1,927	14,347	13,017
Commercial banks and cash in hand	-	-	308	314
Short term investments	-	-	274	178
Balance at 31 March 2026	**3,312**	**1,927**	**14,929**	**13,509**

13. Trade receivables and other assets

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Amounts falling due within one year:				
Trade receivables	89	55	2,710	2,652
Deposits and advances	-	-	5	6
Capital receivables	1	8	76	81
Interest receivable	-	-	24	21
Other receivables	258	265	1,339	1,220
Trade and other receivables	**348**	**328**	**4,154**	**3,980**
Contract assets	5	8	7	10
Other prepayments and accrued income	1,043	1,218	3,162	3,322
Service concession arrangement prepayments	-	-	25	24
Capital prepayments	-	-	166	138
Other current assets	-	-	-	3
Charitable other current assets	-	-	29	32
Other current assets	**1,048**	**1,226**	**3,389**	**3,529**
Loans receivable	198	220	4	4
Other current financial assets	-	-	40	132
Other financial assets	**198**	**220**	**44**	**136**
Total current receivables	**1,594**	**1,774**	**7,587**	**7,645**
Amounts falling due after more than one year:				
Trade receivables	1	1	188	185
Deposits and advances	-	-	5	7
Capital receivables	-	-	4	4
Contract assets	-	-	5	5
Other receivables	233	227	398	297
Other prepayments and accrued income	9	49	41	80
Service concession arrangement prepayments	-	-	58	52
Capital prepayments	-	-	227	218
Charitable non-current assets	-	-	2	2
Other non-current assets	**243**	**277**	**928**	**850**
Total receivables	**1,837**	**2,051**	**8,515**	**8,495**

14. Trade payables and other liabilities

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Amounts falling due within one year:				
Trade payables	71	51	4,498	4,691
Capital payables	3	10	2,794	2,103
Other payables	17	15	2,293	2,286
Trade and other payables	**91**	**76**	**9,585**	**9,080**
Bank overdrafts	-	-	31	19
VAT	-	-	69	68
Other taxation and social security	29	26	2,188	1,918
Deferred tax liability	-	-	2	2
Reciprocal healthcare payables	832	735	832	735
Contract liabilities	15	16	1,681	1,497
Other accruals	733	668	13,669	12,345
Deferred income	94	88	252	296
Lease liabilities	37	33	584	590
Service concession arrangements	-	-	768	682
Amount issued from the Consolidated Fund for supply but not spent at year end	4,123	2,712	4,123	2,712
Consolidated Fund extra receipts due to be paid to the Consolidated Fund - Received	-	1	-	1
Loans payable to entities outside the group	-	-	36	35
Pension liabilities	-	-	1,302	1,230
Other current liabilities	-	-	10	12
Charitable liabilities	-	-	71	46
Other liabilities	**5,863**	**4,279**	**25,618**	**22,188**
Total current payables	**5,954**	**4,355**	**35,203**	**31,268**
Amounts falling due after more than one year:				
Lease liabilities	250	219	3,755	3,713
Service concession arrangements	-	-	16,122	16,480
Financial liabilities	**250**	**219**	**19,877**	**20,193**
Trade payables	-	-	2	2
Contract liabilities	6	6	91	127
Other accruals	-	-	-	1
Capital payables	-	-	4	7
Other payables	-	-	875	815
Deferred income	3	3	86	95
Loans payable to entities outside the group	-	-	194	226
Loans payable by DHSC to group bodies	20	20	-	-
Charitable liabilities	-	-	1	-
Other payables	**29**	**29**	**1,253**	**1,273**
Total non-current payables	**279**	**248**	**21,130**	**21,466**
Total payables	**6,233**	**4,603**	**56,333**	**52,734**

Other payables and other accruals for the departmental group consist of a large number of individual balances from bodies across the group. None of these other payables bodies' balances is individually material. Other accruals includes £6,907 million relating to NHS England and £5,822 million relating to the provider sector.

14.1 Lease liabilities

Total expected future lease payments under leases (excluding service concession arrangements which are disclosed in **Note 8.3**) are given in the table below:

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Current lease liabilities	37	33	584	590
Non-current lease liabilities	250	219	3,755	3,713
Total lease liabilities	**287**	**252**	**4,339**	**4,303**

Maturity analysis

	Core department and agencies		Departmental group	
	2025-26 £m	2024-25 £m	2025-26 £m	2024-25 £m
Undiscounted lease payments falling due in:				
Not later than 1 year	46	40	735	702
Later than 1 year and not later than 5 years	128	116	2,020	1,959
Later than 5 years	187	156	2,511	2,447
Sub-total	**361**	**312**	**5,266**	**5,108**
Less interest element	(74)	(60)	(927)	(805)
Total lease liabilities	**287**	**252**	**4,339**	**4,303**

DHSC has a diverse range of leasing arrangements. The vast majority of DHSC's leases relate to property, these include office premises and a range of health sector specialised assets.

DHSC does not have significant exposure to future cash outflows which are not reflected in the measurement of lease liabilities.

Further detail on the nature of the group's leases can be found in the accounts of individual departmental bodies, in particular NHS Property Services Limited and the Consolidated Provider Accounts.

15. Provisions for liabilities and charges

Core department and agencies for the year ended 31 March 2026

	Infected blood £m	Reciprocal healthcare costs £m	Injury benefits £m	Early departure costs £m	Other £m	Total £m
Balance at 1 April 2025	**152**	**1,350**	**415**	**61**	**244**	**2,222**
Prior period adjustments in underlying accounts	-	-	-	-	25	25
Provided in the year	112	1,380	17	8	6	1,523
Provisions not required written back	-	-	(16)	(4)	(64)	(84)
Provisions utilised in the year	(146)	(227)	(44)	(10)	(115)	(542)
Transfers to accruals	-	(640)	-	-	(11)	(651)
Borrowing costs (unwinding of discount)	-	41	15	1	4	61
Change in discount rate	-	4	(1)	(1)	(1)	1
Balance at 31 March 2026	**118**	**1,908**	**386**	**55**	**88**	**2,555**
Included in						
Current provisions	118	384	43	10	14	569
Non-current provisions	-	1,524	343	45	74	1,986
Total	**118**	**1,908**	**386**	**55**	**88**	**2,555**
Expected timing of cash flow						
not later than 1 year	118	384	43	10	14	569
later than 1 year, not later than 5 years	-	1,524	161	33	31	1,749
later than 5 years	-	-	182	12	43	237
Total	**118**	**1,908**	**386**	**55**	**88**	**2,555**

Core department and agencies for the year ended 31 March 2025

	Infected blood £m	Reciprocal healthcare costs £m	Injury benefits £m	Early departure costs £m	Other £m	Total £m
Balance at 1 April 2024	**1,968**	**1,164**	**434**	**65**	**350**	**3,981**
Prior period adjustments in underlying accounts	-	-	-	-	37	37
Provided in the year	24	909	29	9	129	1,100
Provisions not required written back	(1,760)	-	(19)	(4)	(98)	(1,881)
Transfers	-	-	-	-	(1)	(1)
Provisions utilised in the year	(153)	(186)	(47)	(10)	(50)	(446)
Transfers to accruals and inventories	-	(571)	-	-	(128)	(699)
Borrowing costs (unwinding of discount)	84	33	17	1	5	140
Change in discount rate	(11)	1	1	-	-	(9)
Balance at 31 March 2025	**152**	**1,350**	**415**	**61**	**244**	**2,222**
Included in						
Current provisions	152	334	45	10	161	702
Non-current provisions	-	1,016	370	51	83	1,520
Total	**152**	**1,350**	**415**	**61**	**244**	**2,222**
Expected timing of cash flow						
not later than 1 year	152	334	45	10	161	702
later than 1 year, not later than 5 years	-	1,016	166	35	37	1,254
later than 5 years	-	-	204	16	46	266
Total	**152**	**1,350**	**415**	**61**	**244**	**2,222**

Departmental group for the year ended 31 March 2026

	Clinical negligence £m	Infected blood £m	Reciprocal healthcare costs £m	Injury benefits £m	Early departure costs £m	Other £m	Total £m
Balance at 1 April 2025	**59,984**	**152**	**1,350**	**638**	**173**	**2,097**	**64,394**
Prior period adjustments in underlying accounts	-	-	-	-	-	21	21
Provided in the year	8,510	112	1,380	29	21	901	10,953
Provisions not required written back	(2,511)	-	-	(21)	(11)	(458)	(3,001)
Provisions utilised in the year	(3,238)	(146)	(227)	(60)	(25)	(386)	(4,082)
Transfers to accruals	-	-	(640)	(3)	(3)	(45)	(691)
Borrowing costs (unwinding of discount)	1,528	-	41	21	5	27	1,622
Change in discount rate	(4,401)	-	4	(9)	(3)	(24)	(4,433)
Balance at 31 March 2026	**59,872**	**118**	**1,908**	**595**	**157**	**2,133**	**64,783**
Included in							
Current provisions	4,206	118	384	62	27	1,074	5,871
Non-current provisions	55,666	-	1,524	533	130	1,059	58,912
Total	**59,872**	**118**	**1,908**	**595**	**157**	**2,133**	**64,783**
Expected timing of cash flow							
not later than 1 year	4,206	118	384	62	27	1,074	5,871
later than 1 year, not later than 5 years	13,794	-	1,524	238	91	372	16,019
later than 5 years	41,872	-	-	295	39	687	42,893
Total	**59,872**	**118**	**1,908**	**595**	**157**	**2,133**	**64,783**

Departmental group for the year ended 31 March 2025

	Clinical negligence £m	Infected blood £m	Reciprocal healthcare costs £m	Injury benefits £m	Early departure costs £m	Other £m	Total £m
Balance at 1 April 2024	**58,156**	**1,968**	**1,164**	**656**	**186**	**2,354**	**64,484**
Prior period adjustments in underlying accounts	-	-	-	-	-	62	62
Provided in the year	8,202	24	909	49	24	815	10,023
Provisions not required written back	(3,533)	(1,760)	-	(26)	(10)	(632)	(5,961)
Transfers	-	-	-	-	-	(1)	(1)
Provisions utilised in the year	(3,088)	(153)	(186)	(63)	(28)	(354)	(3,872)
Transfers to accruals and inventories	-	-	(571)	(3)	(3)	(170)	(747)
Borrowing costs (unwinding of discount)	1,301	84	33	23	5	26	1,472
Change in discount rate	(1,054)	(11)	1	2	(1)	(3)	(1,066)
Balance at 31 March 2025	**59,984**	**152**	**1,350**	**638**	**173**	**2,097**	**64,394**
Included in							
Current provisions	3,648	152	334	63	28	1,060	5,285
Non-current provisions	56,336	-	1,016	575	145	1,037	59,109
Total	**59,984**	**152**	**1,350**	**638**	**173**	**2,097**	**64,394**
Expected timing of cash flow							
not later than 1 year	3,648	152	334	63	28	1,060	5,285
later than 1 year, not later than 5 years	12,137	-	1,016	243	99	356	13,851
later than 5 years	44,199	-	-	332	46	681	45,258
Total	**59,984**	**152**	**1,350**	**638**	**173**	**2,097**	**64,394**

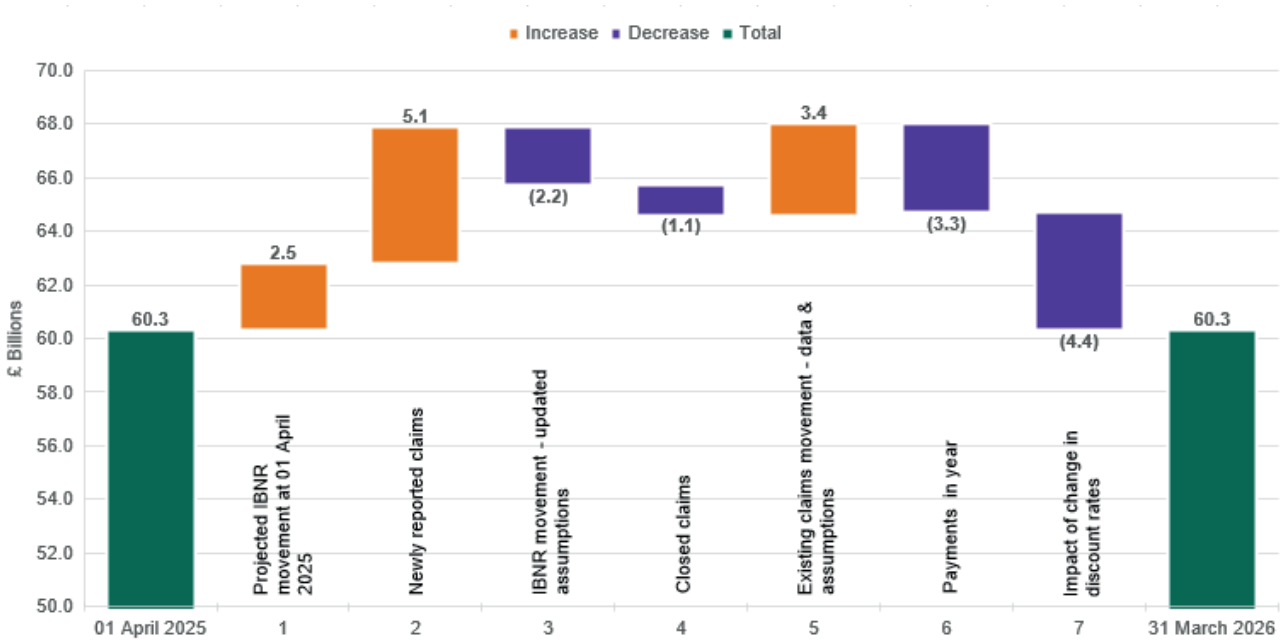
Clinical negligence

The departmental group, through the operations of several schemes under NHS Resolution, recognises a clinical negligence provision. The provision represents the best estimate of future obligations from clinical negligence as a result of incidents up to 31 March 2026. The three key elements of the provision are:

- Known claims – where a claim has been received by NHS Resolution but not yet settled.
- Settled claims – where a claim has been settled in the past but involves ongoing future payments.
- Incurred but not reported (IBNR) claims– claims that have not been received but where it can be reasonably predicted that:
    - an adverse incident has occurred, and
    - a transfer of economic benefits will occur, and
    - a reasonable estimate of the likely value can be made.

Key movements in the provision

The value of the clinical negligence provision remained broadly stable during 2025–26, decreasing marginally from £60.0 billion at 31 March 2025 to £59.9 billion at 31 March 2026, reflecting several offsetting movements during the year. The below diagram and accompanying table show the key movements of total clinical negligence and non-clinical provisions held by NHS Resolution, including £0.3 billion at 1 April 2025 and £0.4 billion at 31 March 2026 for non-clinical negligence schemes.



Item(s)	Commentary
1,2	Increase from another year's worth of activity in 2025-26 for all schemes for all incident years is £7.6 billion.
3	Net decrease of £2.2 billion due to changes in assumptions affecting the IBNR provision across all schemes. The main drivers relate to the clinical negligence scheme for trusts (CNST) which makes up £20.8 billion of the total IBNR provision of £22.4 billion. The most material components of the decrease in the CNST are updates to Annual Survey of Hours and Earnings (ASHE) indexation assumptions to align with the latest long-term historical averages and a decrease in respect of claim number projections for IBNR, this being driven by a change in approach for estimating claim numbers for the Early Notification scheme, which utilises the latest experience data for these cases.
4	Reduction of £1.1 billion in respect of claims closed during this financial year.
5	Increase of £3.4 billion in respect of changes in data and assumptions affecting known claims.
6	Decrease of £3.3 billion from amounts paid out during the financial year in relation to claims.
7	There is a decrease in the provision of £4.4 billion due to updates to the discount rates specified for use by HM Treasury (HMT). Further details are provided below.

Further information can be found in the NHS Resolution Annual Report and Accounts.

Effect of change in discount rate

One of the key assumptions used in calculating the provisions is the discount rate used to place a present value on projected future cashflows. Since the discount rates are prescribed by HMT, the rates are outside the formal control of DHSC and NHS Resolution.

The clinical negligence provision is particularly sensitive to the long-term and very long-term discount rates. This reflects the long-term nature of the liabilities which is driven by the reporting and settlement delays as well as the fact that many high-value claims are settled as a periodical payment order (PPO) with payments provided over the remaining lifetime of the claimant.

In 2025-26, there was a notable increase to long-term and very long-term discount rates prescribed by HMT. This update has decreased the clinical negligence provision by £4.4 billion.

Discount rate term	31 March 2026 nominal rates	31 March 2025 nominal rates	Change
Short-term (up to 5 years)	3.64%	4.03%	-0.39%
Medium-term (after 5 and up to 10 years)	4.22%	4.07%	+0.15%
Long-term (after 10 and up to 40 years)	5.32%	4.81%	+0.51%
Very long-term (after 40 years)	5.07%	4.55%	+0.52%

Although the change in discount rates affects the value of the provision, it does not alter the cost of settling claims, which is driven by the frequency and severity of claims and the legal environment in which the claims are settled (for example, the personal injury discount rate). As such, the decrease in the provision reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

The table below details the movements in the provision if the same discount rates as 2024-25 had been applied.

At 1 April 2025 £ billion	Provided in year £ billion	Provisions not required written back £ billion	Provisions utilised in year £ billion	Borrowing cost £ billion	At 31 March 2026 £ billion
60.0	8.5	(2.5)	(3.2)	1.5	64.3

Key areas of uncertainty

Due to the long-term nature of the liabilities and the assumptions on which the estimate of the clinical negligence provision is based, some uncertainty about the value of the liability remains. This is particularly relevant to the IBNR element of the provision, as the method used to calculate these provisions assumes future experience will be in line with past experience, making adjustments for emerging risks and changes where relevant.

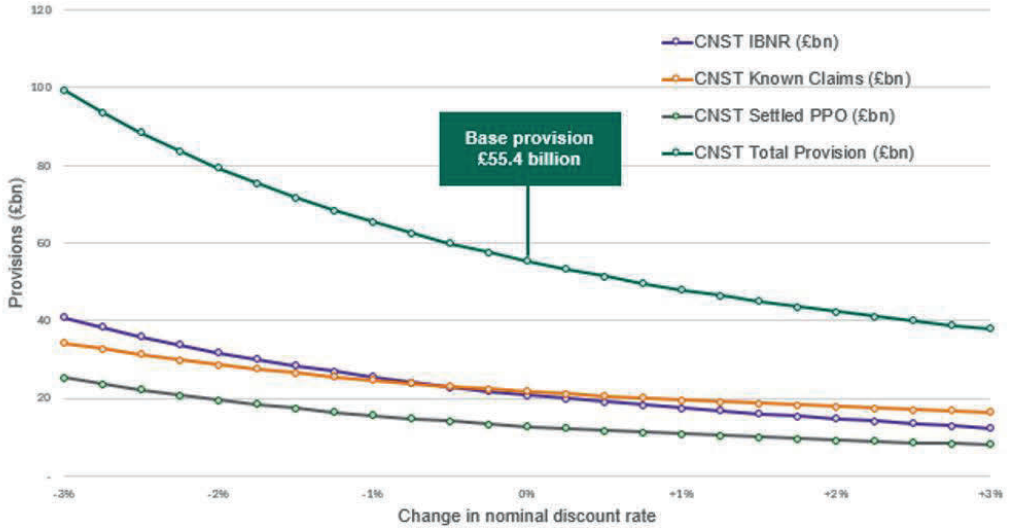
The largest scheme within the clinical negligence provision is the CNST which accounts for £55.4 billion of the total provision of £59.9 billion. Changes to the assumptions underpinning this element have the greatest potential to affect the estimate of the total provision. The table below outlines the key assumptions in the CNST provision along with the degree of uncertainty and sensitivity of the provision value based on changes to the assumptions.

Assumption	Approach	Degree of uncertainty	Sensitivity to changes
Nominal discount rates	HMT prescribed	**Prescribed**	**High**
Personal Injury Discount Rate (PIDR)	Prescribed by Lord Chancellor	**Prescribed**	**Medium**
Ultimate number of claims and propensity to settle as PPO	Derived from past claim numbers and development patterns and assumptions that the level of risk will be similar to prior years, adjusted for levels of activity	**Medium**	**High**
	Value threshold derived from recent years' settled claims data	**Medium**	**Medium**
Average cost per claim*	Derived from past settled claims – set separately for damages, NHE legal costs and claimant costs.	**High**	**High**
Claims inflation	Long-term claims inflation: derived from past settled claims Short-term claims inflation: derived from short-term HMT prescribed CPI forecasts	**High**	**High**
PPO indexation - ASHE	Based on earnings increases over the longer term	**Medium**	**High**
Probability of paying damages	Derived from past settled claims, adjusted for incomplete development	**Medium**	**Medium**
Creation to payment lags	Derived from past settled claims	**Low**	**Low**
Life expectancy for PPO payments	Based on analysis of past settled PPO claims	**Medium**	**Low**
Claims Evolution Programme	Based on expected future savings profile	**Medium**	**Low**

*The average cost per claim assumptions that are used to set the IBNR have increased broadly in line with the rates previously assumed (high degree of uncertainty and sensitivity to changes). There has been an update to the standard reserve held for claims relating to children born with cerebral palsy or brain damage (medium degree of uncertainty and sensitivity to changes).

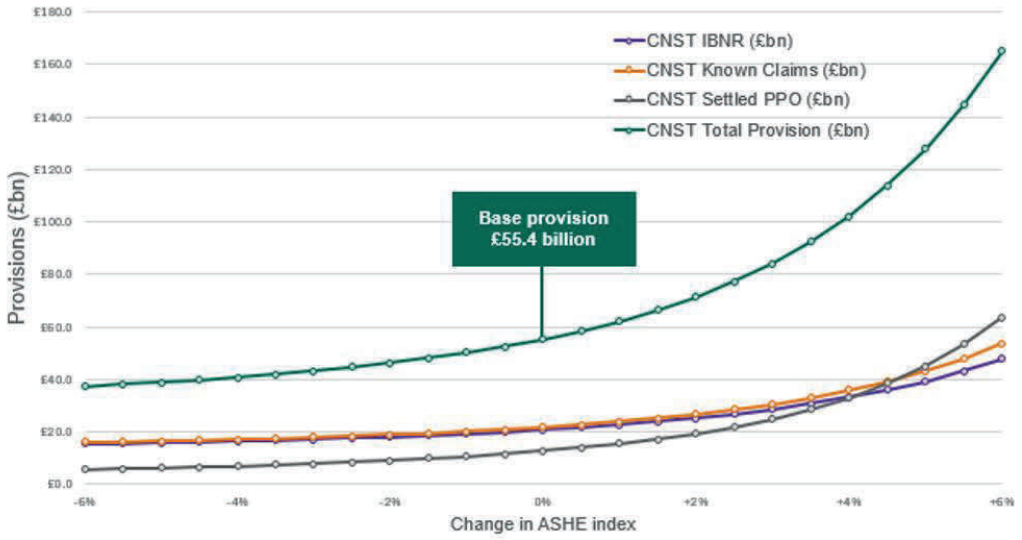
Further information is provided in the NHS Resolution Annual Report and Accounts 2025-26, including sensitivity analysis and details of key estimation uncertainties relating to the clinical negligence provision.

As mentioned above, the clinical negligence provision's value is particularly sensitive to changes in the discount rate given its nature. The graph below shows the impact of percentage changes in the discount rate for the CNST provision. The graph highlights the sensitivity of the IBNR provision, especially, to changes in the discount rate.



Other factors affecting the value of the clinical negligence liability which are subject to estimation and assumption include patterns of delay in reporting incidents, assumptions regarding the severity, frequency and/or value inflation of claims, and the differential between the Consumer Price Index (CPI) and the ASHE, a wage inflation index, over the long-term and life expectancy.

The ASHE index, used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers. The following graph shows the sensitivity of the CNST provision to the differential between ASHE and CPI.



Interaction between the clinical negligence provision and contingent liability

As well as the clinical negligence provision detailed above, the DHSC group also holds a contingent liability for clinical negligence (See **Note 16**).

The provision represents the best estimate, as at 31 March 2026, of the cost to settle clinical negligence cases taking into consideration the probability that damage payments will be awarded. The contingent liability represents the best estimate, as at 31 March 2026, of the costs to settle all clinical negligence without reflecting the probability of damages being awarded, in excess of the provision amount. In both cases the amount represents the present value, and therefore amounts are inflated and discounted to the present value of the claim based on the expected settlement dates.

When taken as a whole, the total balance reflects the position if damage payments were awarded on all clinical negligence cases. In 2025-26, there has been an increase in this total balance of £220 million representing a 0.3% increase.

	Departmental group	
Clinical negligence:	**31 March 2026 £m**	**31 March 2025 £m**
Provision	59,872	59,984
Contingent liability	25,355	25,023
Total	**85,227**	**85,007**

Further information regarding both the provision and contingent liability can be found in the NHS Resolution Annual Report and Account.

Infected blood

The infected blood support scheme is for individuals who were infected with HIV and/or hepatitis C following treatment with NHS supplied blood or blood products, and their bereaved partners. These financial statements provide for the expected future cost of payments to be made by DHSC for which scheme beneficiaries are eligible. Beneficiaries receive lump sum and annual payments which vary depending on the stage of their condition. Infected blood payments are linked to increases in the CPI.

DHSC has assessed that, as at 31 March 2026, the department has a constructive obligation for payments made under the England Infected Blood Support Scheme (EIBSS), up to March 2027, the date when the Infected Blood Compensation Authority (IBCA) is expected to assume responsibility for these payments.

Reciprocal healthcare costs

Reciprocal healthcare arrangements provide mutual healthcare assistance for those accessing healthcare in partner countries. The UK has a number of reciprocal healthcare agreements which allow UK residents to access state-funded healthcare when visiting,

studying, working or moving to partner countries. In return, residents of partner countries can access the NHS across the UK under the same terms.

The Department's reciprocal healthcare liabilities cover the expected healthcare costs of UK residents and pensioners living, working, or travelling in the member states within the European Union, EEA-EFTA countries and Switzerland. The settlement of healthcare claims can take up to four years under the terms of our agreements and therefore the liability is split between an accrual and a provision depending on the certainty of individual liabilities.

The provision at 31 March 2026 reflects the costs the Department expects to pay for healthcare provided by EU member states, EEA-EFTA countries and Switzerland to patients whose healthcare is the responsibility of the UK, where the final settlement position remains to be finalised. Amounts provided are estimates derived from forecasts based on historical data which are adjusted to account for changes in variables such as numbers of visitors to the relevant states, numbers of pensioners residing in relevant states, and inflation rates of healthcare costs in the relevant states.

Liabilities are transferred to accruals when the associated claims have been received and accepted by the Department. For some countries, there are agreements in place whereby the UK makes payments on account based on estimated costs for a given year. These payments on account are accrued when they become due. Further payments are then made, or amounts reimbursed, as and when the amounts owing to the relevant state are finalised.

Other provisions

Other provisions are made up of several small provisions from bodies within the departmental group. None of the provisions within the other provisions amount is individually material.

16. Contingent assets and liabilities disclosed under IAS 37

16.1 Contingent assets

The core department has lodged several civil litigation claims seeking damages linked to civil actions around a breach of competition regulations. The core department has also lodged claims linked to commercial regulation breaches. No further information is disclosed to ensure any prejudice of the position of the entities in relation to this activity is avoided.

Providers have several VAT related contingent assets totalling £21.8 million.

16.2 Contingent liabilities

Unless there are compelling grounds for non-disclosure due to confidentiality considerations, the contingent liabilities required by IAS 37 are detailed below. Further information for all contingent liabilities can be found in the underlying accounts of individual bodies.

Contingent liabilities under IAS 37		31 March 2026 £m	31 March 2025 £m
Clinical negligence			
1	DHSC is the actual or potential defendant in a number of actions regarding alleged clinical negligence, liabilities relating to NHS property or third parties. In some cases, costs have been provided for or otherwise charged to the accounts. In other cases, there is a large degree of uncertainty as to DHSC's liability and the amounts involved. This contingent liability discloses possible total expenditure, assuming that damage payments were awarded on all claims, rather than taking into account the probability of damages being paid. See **Note 15** for further details.	25,355.1	25,023.1
Legal Cases			
2	Employment tribunal cases Not disclosed due to sensitive nature of the contingent liabilities.	n/a	n/a
3	The Department holds a contingent liability for potential legal costs in relation to a breach of contract claim.	n/a[1]	n/a

4	The Department holds a contingent liability for potential legal costs in relation to proceedings against pharmaceutical companies over anti-competitive “pay-for-delay” agreements.	n/a[1]	n/a
5	The Department is involved in various legal claims related to individuals who received human growth hormone treatment between 1959 and 1985.	n/a[1]	n/a
6	Litigation relating to the Infected Blood Inquiry – DHSC as defendant. There are uncertainties around timings and expected costs which have meant the core department is unable to quantify these contingent liabilities.	n/a	n/a
7	The department is potentially liable for claims brought forward in relation to the March Discharge Policy 2020 guidance and April Admission 2020 guidance over care homes in the COVID-19 pandemic.	n/a[1]	n/a
8	Legal cases – DHSC as defendant Not disclosed due to sensitive nature of the contingent liabilities.	n/a	n/a
Liabilities in respect of the COVID-19 vaccination programme			
9	Indemnities for COVID-19 vaccines purchases Not disclosed due to sensitive nature of the contingent liabilities.	n/a	n/a
NHS England Group and Consolidated Provider Account			
10	There were contingent liabilities within the NHS England Group account (which incorporates ICBs, Supply Chain Coordination Ltd, Health Education England and NHS England). These were mainly in respect of an off-payroll liability to HMRC.	74.3	94.2
11	There were contingent liabilities of NHS providers at 31 March 2026.	134.6	126.8
NHS Resolution			
12	At 31 March 2026, NHS Resolution had other non-clinical contingent liabilities. These related to non-clinical claims such as public and employers’ liability for incidents on or after 1 April 1999, and non-clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies.	238.7	219.2

Other IAS 37 Contingent Liabilities			
13	Contractual liability for redundancy payments. There are uncertainties around timing and likelihood of redundancies covered by the contract, as well as the payments expected as a result.	0.3	0.5
14	Provision of life assurance cover for individuals transferred to DHSC. There are uncertainties around timing and likelihood of payments being required, as well as the expected payments.	1.1	1.1
15	Compensation payments due to individuals unable to be traced. There are uncertainties around timing, likelihood and expected costs.	0.4	0.4
16	Sensitive contingent liability. Not disclosed due to sensitive nature of the contingent liabilities.	n/a	n/a
17	Contractual liability for voluntary redundancy payments There are uncertainties around instances where voluntary redundancy has been offered but the employee has not yet decided on accepting the offer.	1.9	-
18	UKHSA is involved in a variety of material contract disputes, two over £300,000 which UKHSA believe constitute contingent liabilities, primarily relating to contracts let in response to the COVID-19 pandemic. These have associated financial risks, which constitute a contingent liability for the organisation. Not disclosed due to sensitive nature of the contingent liabilities.	n/a	n/a
19	UKHSA holds unquantifiable contingent liabilities in relation to potential remedial works relating to radiological contamination at its radiological scientific sites at the end of their lifespans. This is unquantifiable because until the sites are vacated (which is not currently planned) the extent of any contamination cannot be determined and therefore no calculation of potential liabilities can be made.	n/a	n/a
20	The Nursing and Midwifery Council has an unquantifiable contingent liability for potential additional liabilities following the High Court's ruling on Virgin Media's pension scheme. There is uncertainty with regards to monetary value of the potential additional liabilities.	n/a	n/a

21	NHS Property Services has disclosed a contingent liability regarding its entitlement to claim capital allowances on qualifying fixtures and integral features within properties transferred to the company from Primary Care Trusts and Strategic Health Authorities in 2013. The amount and timing of any liability or cash outflow, if any, cannot currently be estimated reliably. Further details are given in the NHS Property Services 2025-26 Annual Report and Accounts.	n/a	n/a

1. The values of these contingent liabilities have not been disclosed due to their sensitivity

17. Related party transactions

Related party transactions associated with the core department are disclosed within this note. Details of related party transactions associated with other bodies within the departmental group are disclosed in their underlying statutory accounts.

The core department is the parent of the group of organisations and sponsor of the non-departmental public bodies shown in **Note 19**. These bodies (including their subsidiaries, joint ventures, and associates) are regarded as related parties with which the core department has had various material transactions during the year.

In addition, the core department had a small number of transactions with other government departments and other central government bodies in 2025-26. Most of these transactions have been with local authorities (in relation to the Public Health Grant and other grant funding) and the Government Property Agency (in relation to leasing arrangements).

A small number of ministers, non-executive directors, and senior officials have connections with a wide range of outside organisations for reasons unrelated to their work in the department. In the normal course of its business during the year, DHSC may enter into business transactions with such outside organisations or related parties.

In cases where an individual within DHSC has an outside connection with one of these related parties, the department is obliged to disclose the extent of its own transactions with those organisations, as set out in the table below:

Organisation	Payables with related party 2025-26 £'000	Purchases from related party 2025-26 £'000	Receivables with related party 2025-26 £'000	Sales to related party 2025-26 £'000	Payables with related party 2024-25 £'000	Purchases from related party 2024-25 £'000	Receivables with related party 2024-25 £'000	Sales to related party 2024-25 £'000
The Alan Turing Institute	-	-	-	-	-	125	-	-
NHS Confederation	-	10,402	-	-	-	10,132	-	-
Alzheimer's Society	-	-	-	-	-	-	-	482
Place2Be	-	-	-	-	-	400	-	-
Lancaster University	41	2,736	-	-	31	3,043	-	-

1. Doug Gurr held the position of Chair at the Alan Turing Institute on a remunerated basis. Doug Gurr resigned as a non-executive board member on 10 January 2025.
2. An individual related to Samantha Jones is a Trustee at the NHS Confederation on a non-remunerated basis.
3. Samantha Jones held the position of Trustee at Alzheimer's Society during 2024-25.
4. Richard Douglas holds the position of Trustee at Place2Be.
5. Alan Milburn holds the position of Chancellor of Lancaster University.

The accountability report identifies those individuals with outside connections to the organisations listed in the table. It is important to note that the financial transactions disclosed were between the core department and the named organisation; not the individuals named in the sub-note who have not benefited from those transactions.

Apart from where disclosed in this note, no other minister, board member, member of the key management personnel or other related party has undertaken any material transactions with DHSC during the year. Compensation paid to management, expense allowances and similar items paid in the normal course of business are disclosed in the remuneration report.

DHSC occupy space in the NAO headquarters building, through a lease entered into by the Secretary of State for Levelling Up, Housing and Communities on behalf of GPA, in order to accommodate the Lampard Inquiry. The rental value is immaterial for both the NAO and the tenant and reflects normal market conditions. The amount relating to this lease was £211k for 2025-26.

18. Events after the reporting period

UK Health Data Research Service

On 26 June 2026, Health Data Research Service Limited (HDRS) was incorporated. HDRS is a private company limited by shares held by the Secretary of State for Health and Social Care.

Hantavirus response and indemnity

After the reporting date, UKHSA responded to a hantavirus incident. The Japanese government supplied treatment medicines for use in the response, and UKHSA provided an indemnity in respect of potential impacts associated with those medicines. The event does not relate to conditions existing at 31 March 2026. DHSC will recognise a contingent liability in respect of the indemnity in the 2026-27 accounts. The financial effect cannot currently be estimated reliably because potential impacts are unknown. No claims had been received as at 26 October 2026.

None of the above are adjusting events after the reporting period and will be reflected in future years.

These financial statements were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller & Auditor General.

19. Entities within the departmental boundary

The entities within the boundary comprise supply financed agencies and those entities listed in the designation and amendment orders presented to Parliament. They are:

Supply financed agencies

Entity	Website
Medicines and Healthcare products Regulatory Agency	Medicines and Healthcare products Regulatory Agency - GOV.UK (www.gov.uk)
UK Health Security Agency	UK Health Security Agency - GOV.UK (www.gov.uk)

Special health authorities

Entity	Website
NHS Business Services Authority	Welcome | NHSBSA
NHS Counter Fraud Authority	Welcome to the NHS Counter Fraud Authority (NHSCFA) public website | NHS Fraud? See it. Stop it. Report it.
NHS Litigation Authority (known as NHS Resolution)	Home - NHS Resolution

Executive non-departmental public bodies

Entity	Website
Care Quality Commission	Care Quality Commission (cqc.org.uk)
Human Fertilisation and Embryology Authority	HFEA: UK fertility regulator
Health Research Authority	Health Research Authority (hra.nhs.uk)
Health Services Safety Investigations Body	Health Services Safety Investigations Body (HSSIB)
Human Tissue Authority	Home | Human Tissue Authority (hta.gov.uk)
National Institute for Health and Care Excellence	NICE | The National Institute for Health and Care Excellence
NHS England	NHS England

Other bodies

Entity	Website
Integrated care boards	Accounts for integrated care boards are available on the websites of the individual bodies
NHS trusts and NHS foundation trusts (collectively referred to as NHS providers)	Accounts for NHS providers are available on the websites of the individual bodies
NHS charities (see note below)	Accounts for NHS charities are available on the websites of the individual bodies

Community Health Partnerships Limited	Community Health Partnerships - Helping to build healthier communities
Genomics England Limited	Homepage | Genomics England
Health and Care Professions Council	The Health and Care Professions Council (HCPC) | (hcpc-uk.org)
Medicines Manufacturing Centre LLP	See note below
NHS Property Services Limited	NHS Property Services | Home | NHS Property Services
Professional Standards Authority for Health and Social Care	Healthcare Regulation | Professional Standards Authority
Skipton Fund Limited	Available at Companies House
The Nursing and Midwifery Council	The Nursing and Midwifery Council - The Nursing and Midwifery Council (nmc.org.uk)
Wiltshire Health and Care LLP	Available at Companies House
Supply Chain Coordination Limited (known as NHS Supply Chain)	Supply Chain Coordination Limited: Home

NHS charities are charitable trusts where the trustees are an NHS foundation trust (as established under section 30 of the National Health Service Act 2006) and English NHS charities as defined by section 149(7) of the Charities Act 2011, excluding those with full independent status which are not subject to consolidation.

Medicines Manufacturing Centre LLP is a partnership set up by eight acute NHS trusts within the North East of England and North Cumbria region. It was incorporated in 2025-26, however it was not active in this year. The LLP will produce its own accounts to be filed with Companies House.

Non-executive non-departmental public bodies

These non-executive NDPBs are not separate legal entities, rather they are part of the accounts of the entities listed above. As such they do not prepare separate financial statements.

- Administration of Radioactive Substances Advisory Committee
- Advisory Committee on Antimicrobial Prescribing, Resistance and Healthcare Associated Infection
- Advisory Committee on Borderline Substances
- Advisory Committee on Clinical Impact Awards
- Advisory Committee on Dangerous Pathogens

- Advisory Committee on the Safety of Blood, Tissues and Organs
- Advisory Group on Hepatitis
- British Pharmacopoeia Commission
- Commission on Human Medicines
- Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment
- Committee on the Medical Aspects of Radiation in the Environment
- Committee on the Medical Effects of Air Pollutants
- Committee on Mutagenicity of Chemicals in Food, Consumer Products and the Environment
- Expert Advisory Group on AIDS
- Healthwatch England
- Independent Reconfiguration Panel
- Joint Committee on Vaccination and Immunisation
- The NHS Pay Review Body
- Office of the Commissioner for Patient Safety
- Office of the National Data Guardian for Health and Social Care
- Review Body on Doctors' and Dentists' Remuneration
- Scientific Advisory Committee on Nutrition
- UK Nutrition and Health Claims Committee

In addition to the bodies listed above DHSC is the sponsoring department for NHS Blood and Transplant. As a Public Corporation the results of NHS Blood and Transplant are not consolidated into the group financial statements.

DHSC's registered office is 39 Victoria Street, London, SW1H 0EU.

Annexes: Not subject to audit - presented for further information

Annex A – regulatory reporting – government core tables

The figures in **Core Tables 1** and **2** are from HM Treasury's public expenditure database OSCAR. This is consistent with HM Treasury publications.

Core table 1: public spending

	2021-22 Outturn £'000	2022-23 Outturn £'000	2023-24 Outturn £'000	2024-25 Outturn £'000	2025-26 Outturn £'000	2026-27 Plan £'000	2027-28[2] Plan £'000	2028-29[2] Plan £'000	2029-30[2] Plan £'000
Resource DEL									
A NHS England	23,371,789	14,524,033	27,857,107	32,394,795	35,345,749	40,843,792			
B NHS providers	99,849,097	107,932,134	114,691,376	125,147,653	131,796,950	128,018,846			
C DHSC programme and administration	13,268,380	5,065,263	453,477	447,660	(21,967)	1,845,152			
D Local authorities (public health)	4,217,325	3,195,761	3,301,393	3,425,796	3,632,376	3,680,291			
E Executive agencies	10,181,091	3,737,212	2,629,150	2,110,378	1,920,880	1,107,129			
F Health Education England [1]	1,595,487	1,789,611	-	-	-	-			
G Special health authorities	2,868,350	2,969,741	3,771,079	3,430,552	3,657,224	3,353,457			
H Non departmental public bodies	875,334	769,729	203,613	210,490	222,837	143,653			
I Arm's length bodies	2,124,627	844,324	855,900	860,870	966,146	707,879			
J NHS England financed from National Insurance contributions (non voted)	25,196,757	36,266,858	29,055,511	30,164,029	31,460,545	32,600,208			
Total Resource DEL	**183,548,237**	**177,094,666**	**182,818,606**	**198,192,223**	**208,980,740**	**212,300,407**	**221,269,449**	**231,163,591**	**N/A**

	2021-22 Outturn £'000	2022-23 Outturn £'000	2023-24 Outturn £'000	2024-25 Outturn £'000	2025-26 Outturn £'000	2026-27 Plan £'000	2027-28[2] Plan £'000	2028-29[2] Plan £'000	2029-30[2] Plan £'000
Capital DEL									
A NHS England	291,416	238,684	376,068	598,247	669,494	852,000			
B NHS providers	6,833,740	7,537,572	7,753,801	7,710,874	9,098,125	9,726,000			
C DHSC programme and administration	1,795,522	1,987,401	2,143,363	2,752,268	3,025,720	2,823,981			
D Local authorities (public health)	-	-	-	-	-	-			
E Executive agencies	(221,171)	(274,232)	(93,031)	81,638	181,298	135,200			
F Health Education England [1]	1,119	1,889	-	-	-	-			
G Special health authorities	30,623	23,715	24,172	22,735	35,533	25,936			
H Non departmental public bodies	187,746	129,542	20,804	11,287	14,170	24,810			
I Arm's length bodies	200,041	203,379	294,067	294,243	291,798	349,766			
Total Capital DEL	**9,119,036**	**9,847,950**	**10,519,244**	**11,471,292**	**13,316,138**	**13,937,693**	**13,829,045**	**14,769,009**	**15,304,206**

	2021-22 Outturn £'000	2022-23 Outturn £'000	2023-24 Outturn £'000	2024-25 Outturn £'000	2025-26 Outturn £'000	2026-27 Plan £'000	2027-28[2] Plan £'000	2028-29[2] Plan £'000	2029-30[2] Plan £'000
Resource AME									
K NHS England	119,445	10,693	(80,093)	(28,442)	238,378	912,000			
L NHS providers	1,100,553	962,326	2,158,520	2,260,251	2,753,184	7,204,000			
M DHSC programme and administration	3,115,133	(3,519,936)	(466,781)	(1,733,781)	439,282	2,874,931			
N Executive agencies	269,629	(483,838)	(160,517)	(23,213)	(165,832)	116,000			
O Health Education England [1]	596	(856)	-	-	-	-			
P Special health authorities	43,308,197	(58,933,071)	(11,132,970)	1,844,846	(66,925)	5,039,000			
Q Non departmental public bodies	25,429	16,508	(50,717)	180	(1,367)	21,500			
R Arm's length bodies	31,745	(23,742)	2,525	68,140	29,240	338,200			
Total Resource AME	**47,970,727**	**(61,971,916)**	**(9,730,033)**	**2,387,981**	**3,225,960**	**16,505,631**	**16,265,127**	**16,913,080**	**N/A**

	2021-22 Outturn £'000	2022-23 Outturn £'000	2023-24 Outturn £'000	2024-25 Outturn £'000	2025-26 Outturn £'000	2026-27 Plan £'000	2027-28[2] Plan £'000	2028-29[2] Plan £'000	2029-30[2] Plan £'000
Capital AME									
K NHS England	-	-	(1,237)	241	5,010	15,000			
L NHS providers	-	16,807	16,843	6,299	9,569	20,000			
M DHSC programme and administration	-	2,654	5,060	662,260	250,507	172,746			
N Executive agencies	-	-	-	1,575	227	-			
O Health Education England [1]	-	-	-	-	-	-			
P Special health authorities	-	-	-	40	2	-			
Q Non departmental public bodies	-	-	-	-	-	-			
R Arm's length bodies	-	868	10,989	(9,929)	914	-			
Total Capital AME	**-**	**20,329**	**31,655**	**660,486**	**266,229**	**207,746**	**105,600**	**105,600**	**N/A**

1. In April 2023 NHS England and Health Education England legally merged to create a new, single organisation to lead the NHS in England.
2. Resource DEL control totals to 2028-29 and Capital DEL control totals to 2029-30 were agreed as part of Spending Review 2025. Resource AME and Capital AME control totals to 2028-29 were agreed with HMT in November 2025. Detailed allocations below Departmental level have not yet been finalised for financial years beyond 2026-27.

Core table 2: administration budgets

		2021-22 Outturn £'000	2022-23 Outturn £'000	2023-24 Outturn £'000	2024-25 Outturn £'000	2025-26 Outturn £'000	2026-27 Plan £'000	2027-28[2] Plan £'000	2028-29[2] Plan £'000
Administration Budgets									
A	NHS England	1,474,998	1,789,448	1,851,566	1,750,184	2,084,559	2,383,000		
B	NHS providers	-	-	-	-	-	-		
C	DHSC programme and administration	522,365	390,591	352,766	432,007	435,786	677,576		
D	Local authorities (public health)	-	-	-	-	-	-		
E	Executive agencies	174,753	201,661	169,540	166,489	145,259	122,457		
F	Health Education England [1]	60,183	60,709	-	-	-	-		
G	Special health authorities	167,127	121,647	112,112	114,973	131,697	102,181		
H	Non departmental public bodies	280,647	241,300	89,600	94,318	101,237	102,005		
I	Arm's length bodies	(5,461)	3,003	(4,302)	(3,855)	(3,277)	0		
Total Administration Budget		**2,674,612**	**2,808,359**	**2,571,282**	**2,554,116**	**2,895,261**	**3,387,219**	**2,958,000**	**2,815,191**

1. In April 2023 NHS England and Health Education England legally merged to create a new, single organisation to lead the NHS in England.
2. Resource DEL control totals to 2028-29 and Capital DEL control totals to 2029-30 were agreed as part of Spending Review 2025. Resource AME and Capital AME control totals to 2028-29 were agreed with HMT in November 2025. Detailed allocations below Departmental level have not yet been finalised for financial years beyond 2026-27.

Supporting narrative for the core tables can be found within the Performance Report of this Annual Report and Accounts and **Annex B.**

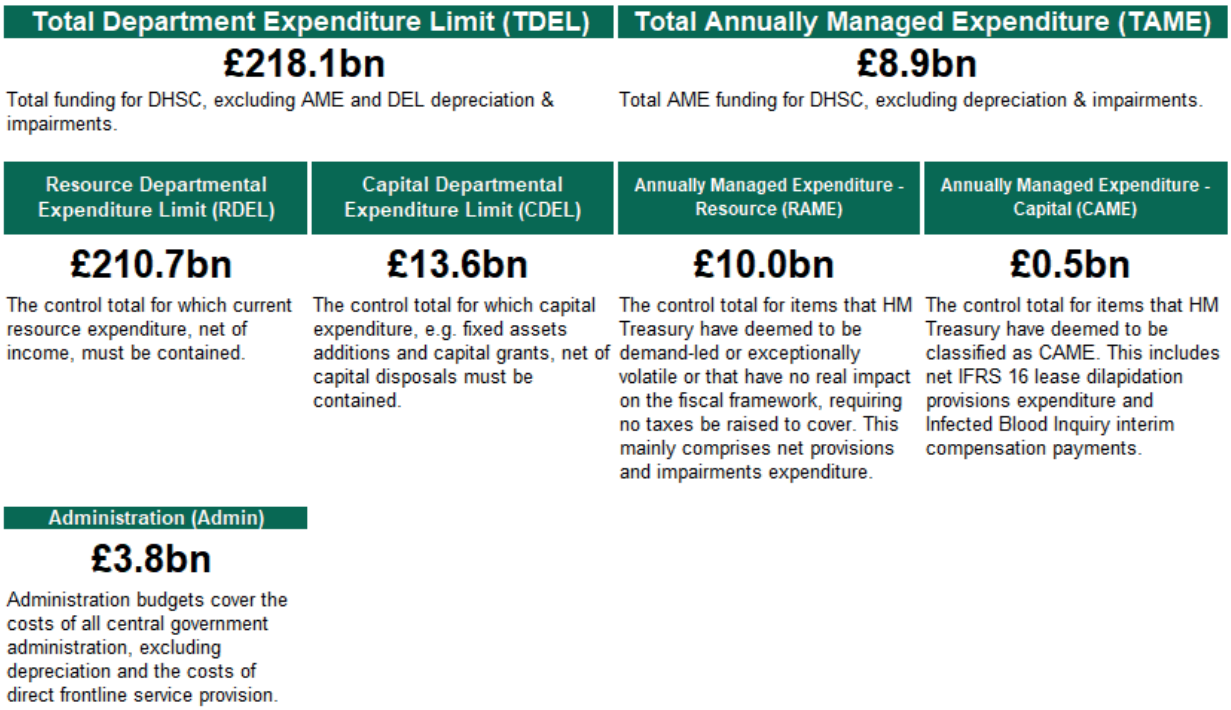
Annex B (i) – Financial performance detail

Largest DEL
Budget in Government

The DHSC group has the largest departmental expenditure limit (DEL) in government. We consolidate the spending of around 400 health and care organisations and cover a wide range of activities: from front-line treatment of patients, training of medical professionals, public health and social care, through to the running costs of each organisation within the group.

Spending for all government departments is measured against a set of metrics as agreed in HM Treasury's spending review. **Figure 30** provides a breakdown of the consolidated budgets for all bodies in the DHSC group into the main spending metrics.

Figure 30: DHSC group budget – spending metrics



Total departmental expenditure limit

The DHSC group's total DEL (TDEL) is a measure of overall spending used for comparability with HM Treasury publications. It is calculated as the sum of resource departmental expenditure limit (RDEL) plus capital departmental expenditure limit (CDEL) less depreciation. TDEL is not a control total but provides a consistent view of overall spending across government.

Table 38 details TDEL spending outturn from 2021-22 to 2025-26.

Table 38: Total departmental expenditure limit spending outturn

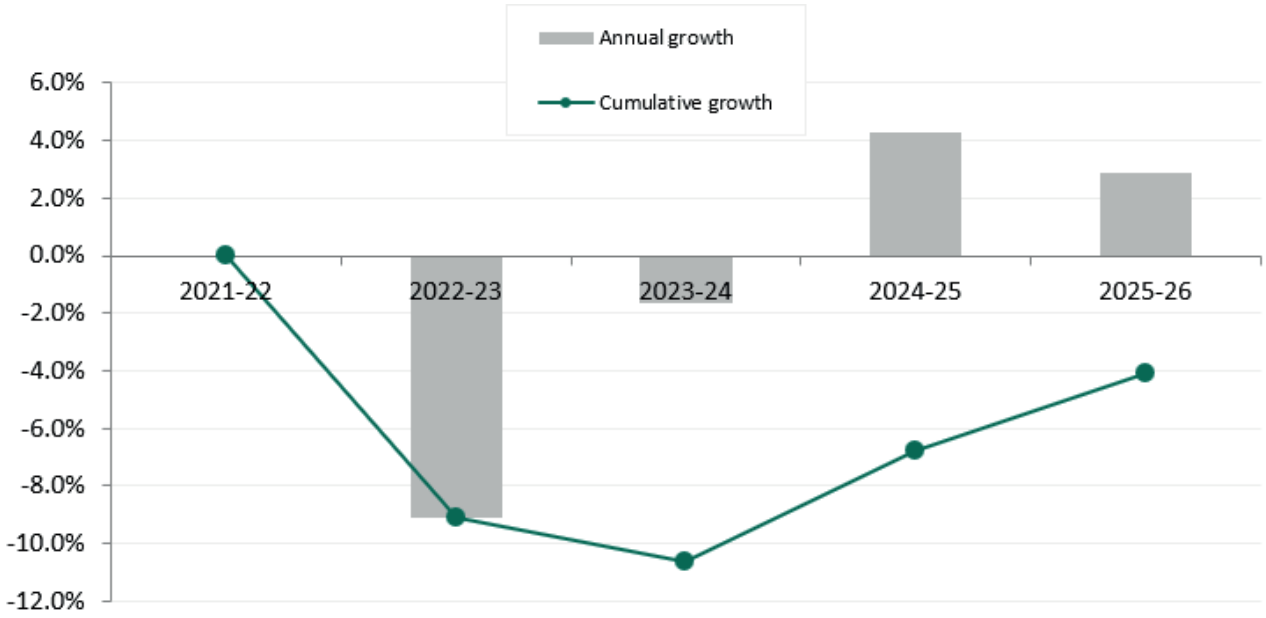
	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
TDEL spending	**187,274**	**182,131**	**188,614**	**204,710**	**217,376**
Nominal growth (£)		(5,143)	6,483	16,095	12,666
Nominal growth (%)		(2.7%)	3.6%	8.5%	6.2%

This table has been adjusted to reflect the reclassification of NHS provider depreciation to RDEL RF.

TDEL spending decreased in 2022-23 following a significant reduction in COVID-19 spending compared with the previous year. Since 2023-24, spend has increased each year, with outturn now at the highest level since 2020-21. This growth reflects the funding settlements agreed at SR21 and SR25.

Figure 31 shows TDEL spending in real terms over 2021-22 to 2025-26. In 2025-26 DHSC real-terms annual growth was 2.9% higher than in 2024-25, and cumulative growth was 4.1% lower than in 2021-22.

Figure 31: Real terms spending growth



1. Cumulative growth figures are from 2021-22.
2. GDP deflators at March 2026 used to calculate real terms growth.

The DHSC group's outturn against the budgets authorised by Parliament is detailed in **Table 39** below:

Table 39: Parliamentary DEL and AME control totals

	Budget £m	Outturn £m	Under/ (Overspend) £m
Parliamentary controls:			
Resource departmental expenditure limit (RDEL)	210,676	208,981	1,695
of which: resource administration	3,839	2,895	944
Capital departmental expenditure limit (CDEL)	13,625	13,316	309
Resource annually managed expenditure (RAME)	10,000	3,226	6,774
Capital annually managed expenditure (CAME)	549	266	283
Net cash requirement	194,029	183,588	10,441
Further HM Treasury controls:			
Ringfenced resource DEL	6,207	4,920	1,287
Non-ringfenced resource DEL	204,469	204,060	409

The following narrative, with commentary and supporting tables, provides an explanation of the financial performance of the system, including financial outturn against the department's own spending controls.

Resource departmental expenditure limit (RDEL)

£209 billion RDEL spend – 5% higher than 2024-25

£1.7 billion (0.8%) RDEL underspend

96% of total DHSC RDEL allocated to the NHS

DHSC's total 2025-26 resource DEL (RDEL) represents the consolidated resource spending of all bodies within the NHS and non-NHS sectors of the DHSC group, that is, NHS healthcare providers and commissioners and the core department plus its arm's-length bodies (ALBs).

The spending plans for all government departments are submitted to Parliament for scrutiny and approval as part of the Parliamentary supply estimates process – these budgetary limits are known as voted limits. DHSC receives the majority of its resource funding via this process, but also receives an element of funding from National Insurance contributions, which are not voted on in the Parliamentary supply estimates.

In 2025-26, National Insurance contributions receipts of £31.5 billion were in line with the non-voted funding set out in the Parliamentary estimate.

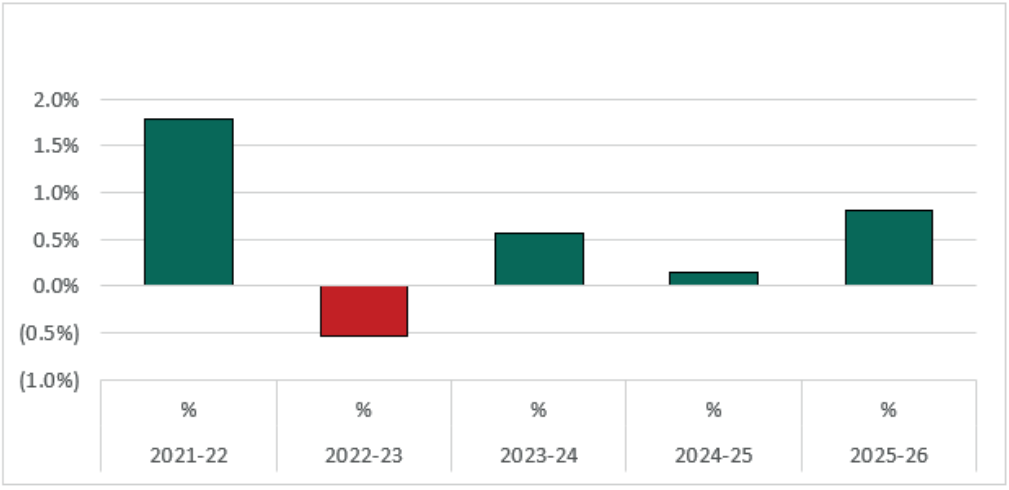
Table 40 summarises the RDEL outturn against budget since 2021-22; highlighting the £1.7 billion, 0.8% underspend in 2025-26.

Table 40: Resource DEL outturn against budget

	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
RDEL budget	186,895	176,148	183,861	198,491	210,676
RDEL spending outturn	**183,548**	**177,095**	**182,819**	**198,192**	**208,981**
Underspends / (overspends) (£m)	*3,347*	*(947)*	*1,042*	*299*	*1,695*
Underspends / (overspends) (%)	*1.8%*	*(0.5%)*	*0.6%*	*0.2%*	*0.8%*

Figure 32 shows the difference between outturn and budget, expressed as a percentage of the budget.

Figure 32: RDEL underspend / overspend (% of budget)



RDEL: Funding flows and sector breakdown

Of DHSC's total £210.7 billion 2025-26 RDEL budget, £203.0 billion was allocated directly to NHS commissioners, with the remaining £7.7 billion funding allocated to ALBs and DHSC's central budgets, that is, the non-NHS sector.

NHS healthcare providers are not directly funded, instead they generate income to cover their spending via trading activity with commissioners, for example, commissioners pay providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs, under a national tariff system.

Across government, this 'internal market' is unique to the DHSC group and adds an additional layer of complexity as all inter-group trading needs to be eliminated on consolidation when preparing the Departmental Group account (via an 'Agreement of Balances' exercise).

Approximately £143.6 billion of resource expenditure in the DHSC group is in the NHS provider sector, spent on staff costs, drugs, clinical negligence and procurement of supplies and services to deliver healthcare. Other significant expenditure includes primary care (including general practice, dentistry, ophthalmology, pharmaceutical),

public health (including grants to local authorities), plus other administration costs from the other sectors within the group.

The RDEL budget is set net of income and in 2025-26 the DHSC group received around £15.0 billion of RDEL income from varying sources. This was mainly received by NHS providers and included prescribing and dental charges, income from trading with local authorities and from treating private patients.

RDEL: DHSC group

Table 41 details the DHSC group resource DEL outturn by sector against budgets.

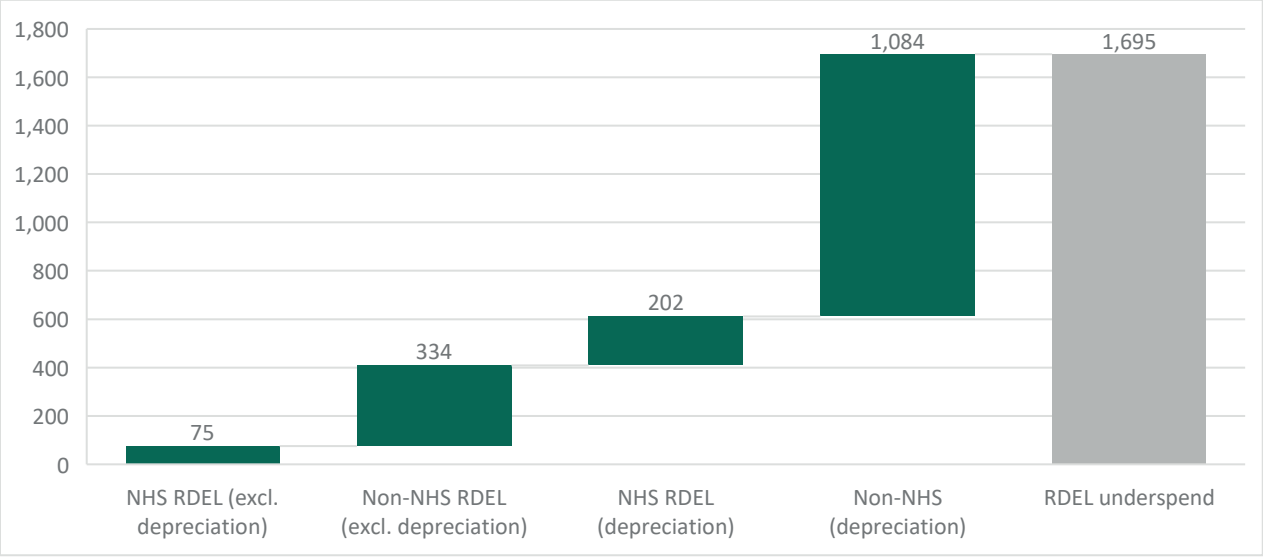
Table 41: DHSC group resource DEL

	Budget £m	Outturn £m	Underspend/ (overspend) £m
NHS RDEL (excl. depreciation)	198,095	198,020	75
Non-NHS RDEL (excl. depreciation)	6,374	6,040	334
DHSC group RDEL (excl. depreciation)	**204,469**	**204,060**	**409**
NHS RDEL (depreciation)	4,868	4,666	202
Non-NHS (depreciation)	1,339	255	1,084
DHSC group RDEL (incl. depreciation)	**210,676**	**208,981**	**1,695**

Table may not sum due to rounding.

Figure 33 shows the main components contributing to the £1.7 billion RDEL underspend.

Figure 33: Components of the RDEL underspend



As set out in DHSC group financial performance section (page 100), DHSC underspent against the RDEL by circa £1.7 billion. The net underspend mainly comprised:

- **RDEL non-ringfenced**: DHSC underspent the available RDEL non-ringfenced funding by circa £0.4 billion (0.2% of the budget). Further details of the NHS and non-NHS performance is set out below.

- **RDEL ringfenced**: DHSC underspent the available RDEL budget ringfenced for depreciation and impairments by circa £1.3 billion because actual expenditure was lower than the forecasts available when agreeing the final budget in the supplementary supply estimate. These forecasts were increased following an HM Treasury led exercise to set ringfenced RDEL budgets for the SR25 period. As part of this exercise, DHSC reviewed projected depreciation based on expected capital investment (CDEL), updated asset valuations, reassessed asset lives, and identified potential impairment charges for 2025–26. This led to an uplift in the budgeted level of depreciation and impairments. However, as these non cash costs did not materialise to the extent anticipated, the higher budget was not required, resulting in the underspend.

RDEL NHS: Overall NHS performance against NHS financial directions – resource limits

The following section provides detail on the financial performance of the NHS in 2025-26.

The Financial Directions to the government's revised NHS mandate for 2025-26 separately sets out the resource and capital funding limits against spending controls for the NHS. These spending controls stem from the same controls that HM Treasury apply to DHSC. NHS England must exercise its duties with a view to ensuring that spending across integrated care boards, NHS providers and their own centrally managed budgets is contained within the funding limits set out in Annex 1 of those Directions. **Table 42** below summarises the performance against those limits.

Table 42: Financial performance – NHS England, integrated care boards and NHS providers

	RDEL NRF £m	RDEL RF £m
NHS England central	30,373	329
Integrated care boards	170,911	-
Net NHS England group outturn	**201,284**	**329**
NHS trusts and foundation trusts	(3,300)	4,337
NHS charities	36	-
Net NHS outturn as per SOPS	**198,020**	**4,666**
Budgets as per 2025-26 financial directions	**198,095**	**4,868**
Under/ (overspend)	**75**	**202**

The RDEL non-ringfenced budget of £198.1 billion is used to fund the costs of healthcare services delivered in England. In 2025-26, the NHS have ended the year with a small underspend against the RDEL non-ringfence budget.

The majority of the NHS RDEL budget is allocated to integrated care boards (ICBs), who together with their partners in integrated care systems (ICS) will use that to fund healthcare services in their respective local areas. In 2025-26, ICBs and NHS providers, known collectively as "NHS systems", reported a year-end overspend of circa £0.7 billion. This overspend was offset by underspends on other NHS England centrally managed budgets, but these pressures were not fully mitigated, resulting in the small underspend reported above. **Table 43** provides a further breakdown of the NHS' outturn by sector.

Table 43: Breakdown of NHS spending outturn against revenue DEL budget, excluding depreciation and impairments[1]

	Plan £m	Outturn £m	Under/ (overspend) £m
NHS England central	31,304	30,373	932
NHS systems (ICBs + NHS providers)	171,166	171,831	(665)
Classification adjustments	(4,375)	(4,220)	(155)
NHS charities	-	36	(36)
Net NHS outturn as per SOPS	**198,095**	**198,020**	**75**

1. As per 2025-26 financial directions to NHS England Annex A1: Directions Under Section 223D of the 2006 Act.

Table 44: Breakdown of NHS England spending outturn against revenue DEL budget

	Plan £m	Outturn £m	Under/ (overspend) £m
Revenue departmental expenditure limit (excluding depreciation and impairments)	**202,470**	**201,284**	**1,187**
Of which,			
Individual placement support	111	111	-
NHS England administration limit	2,315	2,047	268
Revenue departmental expenditure limit (depreciation and impairments)	**393**	**329**	**64**

As per 2025-26 financial directions to NHS England Annex A2: Directions under section 223E(1) and (3) of the 2006 Act.

Table 45: NHS systems breakdown

	Plan £m	Outturn £m	Under/ (overspend) £m
Integrated care boards		170,911	
NHS providers adjusted financial performance		920	
Total adjusted financial performance	**171,166**	**171,831**	**(665)**

	Plan	Outturn	*Variance*
Number of NHS systems in balance/surplus	42	27	(15)
Number of NHS systems in deficit	-	15	(15)

Further commentary, together with the consolidated accounts of the NHS England group, is published on NHS England's website.

RDEL non-NHS: financial performance resource DEL spending

The DHSC group's non-NHS sector contained resource expenditure within DEL spending limits. The non-NHS sector is the core department and its non-NHS ALBs.

The summarised RDEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 46**.

Table 46: Summarised financial position for the non-NHS in 2025-26

	Plan £m	Outturn £m	Under/ (Overspend) £m
Non-NHS RDEL (excl. depreciation) -			
UK Health Security Agency	1,727	1,636	91
Other ALBs	668	661	7
Public health local authority grants	3,632	3,632	-
Voluntary scheme for branded medicines pricing access and growth	(2,274)	(2,407)	133
Public dividend capital (PDC) payments and loan interest	(1,210)	(1,269)	59
European Economic Area (EEA) medical costs	876	877	(1)
Adult social care	227	209	18
Other DHSC central budgets	2,728	2,701	27
Total non-NHS RDEL (excl. depreciation)	**6,374**	**6,040**	**334**
Non-NHS (depreciation)	1,339	255	1,084
Non-NHS RDEL (incl. depreciation)	**7,713**	**6,295**	**1,418**

Excluding depreciation, the non-NHS sector's RDEL outturn was around £0.3 billion lower than the allocated funding. Details of the main components of the outturn and resultant underspend are set out below:

UK Health Security Agency

The resource underspend of £91 million in UK Health Security Agency was primarily from the COVID-19 vaccine unit which has been responsible for the purchase of COVID-19 vaccines since October 2022. The demand for vaccines in the financial year is influenced by policy decisions and the timing of the Spring campaign. As a result there was an underspend in 2025-26 compared to the spending review budget allocation.

Public dividend capital (PDC) payments and loan interest

Income received in the core department was around £0.1 billion higher than estimated when agreeing opening budgets.

RDEL administration

Within the overall RDEL control limit sits a separate RDEL administration limit, which covers the running costs of the core department, commissioning sector (NHS England group) and all DHSC's central government arm's-length bodies (ALBs).

Against the total resource administration limit of £3.8 billion the DHSC group underspent by £0.9 billion, and this mainly comprised:

- circa £0.3 billion underspend on depreciation and impairments
- circa £0.6 billion underspend RDEL excluding depreciation and impairments

Table 47 shows the DHSC group administration outturn (excluding depreciation and impairments) between 2021-22 and 2025-26.

Table 47: DHSC administration

	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
Administration outturn	2,575	2,665	2,428	2,374	2,770

Figures do not include depreciation and as a result will not directly reconcile to the admin outturn in the Statement of Outturn against Parliamentary Supply £2.9 billion.

Administration expenditure increased by circa £0.4 billion in 2025-26 compared with 2024-25. This increase reflects additional funding agreed at Autumn Budget 2025, which provided a £0.4 billion uplift in 2025–26 and 2026-27 in return for a reduced budget in 2027-28 and 2028-29 to facilitate DHSC, NHS England and wider NHS restructuring and reform.

Capital departmental expenditure limit (CDEL)

£13.3 billion CDEL spend – 16% higher than 2024-25

£0.3 billion (2.3%) CDEL underspend

75% of total DHSC CDEL allocated to the NHS

DHSC's 2025–26 budgets were agreed as part of the Spending Review 2025. The DHSC group's total 2025-26 CDEL outturn is the consolidated net capital spending of all bodies within the DHSC group.

Table 48 summarises the CDEL outturn against budget since 2021-22, highlighting the £0.3 billion (2.3%) underspend in 2025-26.

Table 48: Capital DEL

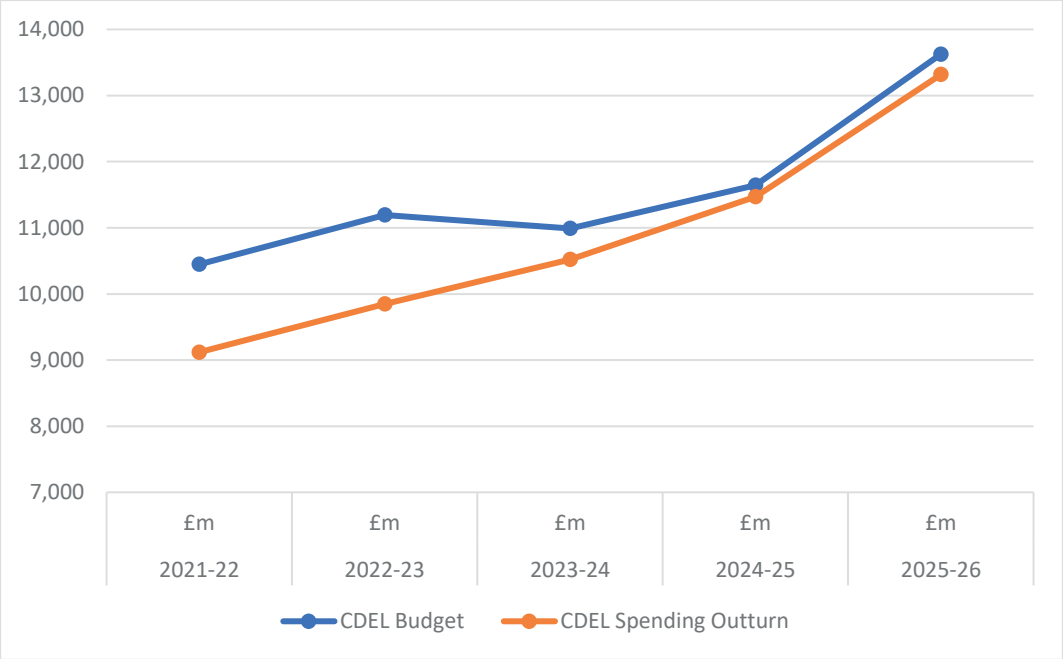
	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
CDEL budget	10,447	11,193	10,989	11,644	13,625
CDEL spending outturn, of which:	**9,119**	**9,848**	**10,519**	**11,471**	**13,316**
CDEL underspend	1,328	1,345	470	173	309
CDEL underspend %	12.7%	12.0%	4.3%	1.5%	2.3%

The £0.3 billion (2.3%) underspend in 2025-26 was mainly due to:

- **IFRS 16**: DHSC has followed the accounting standard for leases IFRS 16 since 2022–23. Additional capital funding was secured for its impact, however the associated capital costs in 2025-26 were around £0.1 billion lower than expected
- **Other capital**: net underspends of circa £0.2 billion occurred across a range of capital budgets. This includes the impact of disposal proceeds and other capital receipts, which scored as reductions to capital expenditure

Figure 34 demonstrates how the total DHSC CDEL outturn has increased year-on-year over the past five years, rising from £9.1 billion in 2021-22 to £13.3 billion in 2025-26, with underspends reducing overall over this period.

Figure 34: CDEL budget and outturn



CDEL: DHSC group

Table 49 details the DHSC group capital DEL outturn by sector against budgets:

Table 49: DHSC group capital DEL

	Budget £m	Outturn £m	Underspend/ (Overspend) £m
NHS capital DEL	10,182	9,769	413
Non-NHS capital DEL	3,443	3,547	(104)
TOTAL CDEL	**13,625**	**13,316**	**309**

As shown in **Table 49**, DHSC underspent against its Capital DEL (CDEL) by circa £0.3 billion. This comprises an underspend of £413 million within the NHS, alongside a further £104 million overspend across DHSC and its non-NHS arm's-length bodies. Further detail on the NHS and non-NHS positions is set out on pages 333 to 340.

CDEL NHS: financial performance CDEL spending

Summary

During the year, the NHS capital funding was invested in key priorities including:

- modernising and transforming the NHS estate (including the New Hospital Programme and estate upgrades)
- supporting the return to constitutional standards (including through improvements in elective and emergency care)
- expanding the use of innovative digital technologies

The NHS CDEL outturn for 2025-26 was £9,769 million against a budget of £10,182 million, as set out in **Table 50**.

Table 50: NHS capital DEL

	Budget £m	Outturn £m	Under/ (overspend) £m
NHS providers	9,414	9,099	315
NHS England	768	670	98
TOTAL NHS CDEL, of which:	**10,182**	**9,769**	**413**

NHS providers

NHS provider CDEL expenditure was £9.1 billion in 2025-26, including net capital investment by NHS charities IFRS 16 spend. This is around £1.2 billion higher than the equivalent net investment in 2024-25 (£7.9 billion). Capital budgets are allocated to NHS providers via operational capital and various national programmes.

The NHS provider capital outturn is set out in **Table 51** below. This reflects continued investment at provider level, supported by both local operational funding and nationally directed capital programmes.

Table 51: NHS provider capital DEL

	2025-26 £m
Capital DEL outturn [1]	**9,099**
Of which	
Operational capital expenditure [2]	4,600
National programmes	4,255
PFI residual interest [3]	244

1. NHS CDEL in the table above includes the net capital investment of NHS charities.
2. Operational capital expenditure is self-financed spending by trusts, loans, and system capital support. Although locally financed, this expenditure remains within providers' agreed capital allocations and forms part of the overall NHS capital control total.
3. HMT's budgeting framework requires PFI residual interest on assets to score to CDEL.

Operational capital

Operational capital funding supports the NHS's routine investment requirements, including the replacement and renewal of plant and equipment, information technology investments, minor estate works, and projects that enable the delivery of core clinical strategies. For 2025-26, the majority of the NHS operational capital budget was allocated at system level across the 42 Integrated Care Systems (ICSs), with providers expected to develop and manage capital programmes within these allocations and align spending with wider system priorities.

System capital support is available to NHS providers who do not have sufficient cash resources to fund their operational capital programmes and other self-financed CDEL spending. This includes expenditure funded through depreciation income, cash reserves or borrowing. Applications for in-year system capital support, as well as requests to re-prioritise or reprofile capital expenditure, are managed locally through discussions between NHS England and ICSs/NHS providers.

Funding was also allocated to systems to provide CDEL cover for right-of-use leases which score as capital following DHSC's adoption of the IFRS 16 accounting standard, as required across government.

National programmes

Public dividend capital (PDC) is issued by DHSC to support approved national capital programmes investment by NHS providers. This includes funding on estate safety, infrastructure renewal and service transformation programmes. Further details of these investments can be found in the report 'Financial Assistance under Section 40 of the National Health Service Act 2006' which is published alongside this annual report.

Table 52 sets out capital funding allocated to national programmes in 2025-26, with further detail provided below.

Table 52: National programmes capital DEL

	2025-26 £m
Estate safety fund	1,014
Diagnostics	624
New hospital programme	599
NHS technology and digital	484
Urgent and emergency care	348
Reinforced autoclaved aerated concrete (RAAC)	264
Electives	230
Hospital Upgrades	191
GB energy solar partnership	132

Ambulances	75
NHS decarbonisation scheme	66
Reducing out of area mental health placements	55
Genomics (NHS non-R&D)	29
Clinical decontamination	27
Maternity	26
Electric vehicle charging	17
Eradicating mental health dormitories	17
Other strategic investments	57
NHS providers national PDC total	**4,255**

Estates safety fund

Capital funding was issued to NHS trusts to address critical infrastructure (the most severe categories of backlog maintenance) and safety risks in NHS buildings. Over 1,700 schemes identified by systems as local priorities were funded to target urgent estates risks, improving safety and reducing risks of service disruption. The schemes delivered relatively small scale but important building safety works, for example, fixes to leaking roofs, upgrades to faulty electrical wiring and addressing fire safety requirements, across a range of different types of facility, including maternity and mental health.

New hospital programme

The New Hospital Programme (NHP) was established in October 2020 to address the crumbling, outdated hospital estate. The NHP covers 46 schemes.

In January 2025, the government announced the outcome of a review of the programme, publishing a new, costed plan and timeline in the New Hospital Programme: plan for implementation. This set out that hospitals will be delivered through five-year waves of investment which will increase to up to £15 billion over each consecutive five-year wave, averaging around £3 billion a year from 2030. The exact profile of funding will be confirmed in rolling five-year waves at regular spending reviews.

Return to constitutional standards

£1.65 billion of capital funding was allocated in 2025-26 to support the return to NHS constitutional performance standards. This funding supported delivery of key national targets, including referral to treatment (RTT), diagnostic waiting times, urgent and emergency care performance, and expanded access to mental health crisis services.

Diagnostics

Funding has been committed to increase the volume of diagnostic activity to help clear the backlog of people waiting for clinical tests, such as magnetic resonance imaging (MRI), ultrasound, and computerised tomography (CT) scans. A significant proportion of

the diagnostic funding has enabled the rollout of Community Diagnostic Centres (CDCs). There are 170 CDC sites operational as of March 2026. CDCs increase diagnostic capacity, supporting faster, earlier diagnosis and reduced waiting times for better patient outcomes.

Other programmes within the scope of this funding included purchasing of diagnostic equipment for endoscopy, imaging, physiological sciences and screening.

Urgent and emergency care (UEC)

UEC investment focuses on improving patient experience and outcomes by supporting better patient flow, reducing waiting times in emergency departments and improving ambulance response times. This funding has supported the NHS to deliver schemes that contribute to restoring performance against the constitutional standards, namely 4-hour Emergency Department performance and/or ambulance Category 2 response times.

Schemes supported through this funding included the expansion or creation of co-located Urgent Treatment Centres, Same Day Emergency Care Services, Acute Assessment Units, Ambulance Services, Emergency Department refurbishments, and new or replacement medical equipment.

Elective care

This investment supports the government's commitment of achieving the NHS constitutional standard that 92% of patients should wait no longer than 18 weeks from referral to treatment, by the end of this Parliament.

The aims of this elective care capital investment build on investment from previous years to deliver further increased levels of resilience through separation of elective and emergency services, to increase elective capacity, theatre utilisation, efficiency, and productivity. Outcomes from the funding include supporting the expansion or creation of elective hubs, additional procedure and outpatient clinic rooms to allow elective activity to move away from main theatres, the creation of additional protected elective inpatient beds, the reconfiguration of day case and outpatient spaces, additional theatre lists, and additional diagnostic activity.

Ambulances

Ambulance trusts received £75 million of Return to Constitutional Standards funding to purchase a total of 486 brand new replacement ambulances featuring the latest vehicle and patient safety features. The newer ambulances have contributed to improved fleet reliability so that more ambulances can be kept on the road in front line service to help paramedics respond to patients faster. These more modern ambulances are also equipped with more up to date technology, improving protection for patients and staff while supporting paramedics to deliver urgent care more effectively.

Approximately £10 million of this funding was used to purchase 53 electric ambulances, accelerating the NHS's necessary transition to an all-electric ambulance fleet by 2040. Each ambulance trust in England now has at least one of the new zero emission electric ambulances, which will start to reduce the level of CO_2 and NO_2 emissions breathed in by patients outside our emergency departments.

NHS technology schemes

Successful digital transformation in the NHS delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. Funding issued to NHS providers in 2025-26 for NHS technology programmes totalled £484 million. The funds have ensured improvements in infrastructure for managing and sharing digital patient records between health care providers across the country, transforming remote monitoring of patients, and raising digital and cybersecurity maturity. This has included investment in the NHS frontline digitisation programmes, strengthening the implementation of digital capabilities across secondary care, and enabling infrastructure to meet core standards.

Reinforced autoclaved aerated concrete (RAAC)

£264 million was issued to NHS trusts to manage NHS estates affected by RAAC, supporting these trusts to mitigate immediate risks and eradicate RAAC from hospital sites, protecting staff and patient safety. This includes a programme of fail-safe measures in seven hospitals constructed predominantly from RAAC which will be fully replaced through the New Hospital Programme.

Hospital upgrades

Capital funding has been awarded to over 170 upgrade schemes since July 2017, with total investment of nearly £3.8 billion. These investments have supported the modernisation of NHS buildings and services across the country, including development of new urgent care centres, integrated care hubs that bring together primary and community services, and new mental health facilities.

As at the end of March 2026, over 130 schemes are now operationally and patient ready. This funding has been used to upgrade facilities, expand capacity to treat more patients and support a greater emphasis on prevention and community-based care, including increased investment in mental health and integrated care services.

Energy efficiency and resilience investment

DHSC collaborated with the Department for Energy Security and Net Zero (DESNZ) to deliver the Great British (GB) energy solar programme, funding solar photovoltaic and battery storage projects. Capital was allocated to projects covering 260 NHS sites across all NHS regions.

DHSC also worked with DESNZ to invest in energy efficiency focused projects including Building Management Systems, LED lighting upgrades, and a small number of solar installations through the NHS Decarbonisation Fund. It is projected that the investment could save up to £30 million a year on trusts' energy bills.

Funding was also invested in electric vehicle charging infrastructure across NHS trusts, supporting the installation of charging infrastructure across NHS sites and enabling the electrification of ambulance and medical fleets.

Mental health

Reducing mental health out of area placements

The NHS is committed to reducing inappropriate out-of-area placements for mental health patients due to the associated risks, including higher rates of suicide following discharge and the susceptibility of out-of-area care to a closed culture. To support this, £55 million was invested in 2025-26, with 20 projects delivered, supporting the establishment and expansion of local inpatient capacity across acute mental health, psychiatric intensive care unit, rehabilitation and secure services. The funding also enabled improvements to mental health facilities, helping providers deliver care closer to patients' homes and reduce reliance on out-of-area placements.

Eradicating mental health dormitories

Between 2020-21 and 2025-26, circa £600 million has been invested to replace dormitory beds with single en-suite accommodation in mental health inpatient wards across England, of which £17 million was invested in 2025-26.

This has improved safety, privacy and the quality of care for patients, with potential reductions in length of stay.

Primary care

The primary care utilisation and modernisation fund supported targeted investment in primary care infrastructure in 2025-26, with approximately £100 million allocated across 790 projects. This funding enabled improvements to the existing GP estate, increasing capacity for face-to-face and virtual appointments and making better use of available space.

Emergency preparedness and health protection

Capital funding was allocated to support the development of NHS preparedness and response capabilities for CBRN (Chemical, Biological, Radiological and Nuclear) incidents.

This included procurement of updated clinical decontamination equipment by ambulance and hospital trusts in England, procurement of Hazardous Area Response Team personal protective equipment for ambulance trusts in England, and the improvement of CBRN training facilities at the NHS Resilience Emergency Capabilities Unit.

CDEL non-NHS: financial performance capital DEL spending

Outside of the NHS sector, DHSC's non-NHS sector capital expenditure was around £104 million higher than the allocated funding.

The summarised DEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 53**.

Table 53: Summarised CDEL financial position for 2025-26 non-NHS

Non-NHS Capital DEL	Plan	Outturn	Under/ (Overspend)
	£m	£m	£m
UK Health Security Agency	206	142	64
Other ALBs	324	227	97
Research and development	2,137	2,164	(27)
Disabled facilities grant	711	761	(50)
Other DHSC central budgets	65	253	(188)
Total non-NHS CDEL	**3,443**	**3,547**	**(104)**

Details of the main components of the overspend are set out below.

UK Health Security Agency

The capital underspend of £64 million in UK Health Security Agency was due to delays in planned maintenance of the laboratory estates. Capital portfolios were not fully delivered due to the volume of projects. Additional underspends were from the delay in receiving COVID-19 testing stockpiles and adjustments to fixed assets disposals and revaluations which were reviewed at year end.

Other ALBs

The £97 million underspend reflects a number of variances across arm's-length bodies. Key drivers include lower expenditure in the Nursing and Midwifery Council, primarily relating to the disposal of long-term investments, underspends within the Medicines and Healthcare products Regulatory Agency and NHS Business Services Authority, including programme-related efficiencies and reduced costs in Community Health Partnerships linked to PFI accounting treatment.

Research and development

The £27 million overspend reflects increased R&D expenditure within SRE compared to the initial budget allocation, supported by in-year funding from departmental capital

underspends and transfers from NHS England, as well as the use of available headroom from wider underspends across the R&D portfolio.

Disabled Facilities Grant

The variance reflects in-year decisions to increase funding for the Disabled Facilities Grant using underspends elsewhere in the group, which were not reflected in the budget baseline and therefore result in an apparent overspend.

Other DHSC central budgets

The variance reflects the application of a centrally held opening over-commitment, which reduces the initial budget and results in higher outturn relative to plan. This over-commitment was managed down over the course of the year, resulting in the overall underspend across the group.

Annually managed expenditure (AME)

Details of the DHSC group's total 2025-26 AME budget and expenditure are set out in **Table 54**, which shows that the group underspent by £6.8 billion against its final resource AME budget, and £0.3 billion against its capital AME budget.

£3.5 billion AME outturn

Table 54: Annually managed expenditure

	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
Resource AME Budget	49,000	(35,957)	(2,272)	8,780	10,000
RAME Outturn	**47,971**	**(61,972)**	**(9,730)**	**2,388**	**3,226**
Underspend/(Overspend) £m	1,029	26,015	7,458	6,392	6,774
Underspend/(Overspend) %	2.1%	(72.3%)	(328.3%)	72.8%	67.7%
Capital AME Budget	15	106	106	813	549
CAME Outturn	**-**	**20**	**32**	**660**	**266**
Underspend/(Overspend) £m	15	85	74	153	283
Underspend/(Overspend) %	100.0%	80.7%	70.0%	18.8%	51.5%

The DHSC group's AME provision (resource and capital) is set annually outside of the spending review. The resource related spending is purely impairments and provisions, which have no real impact on the fiscal framework or need for taxes to be raised to cover the spending. The DHSC group's AME spending is not typical to most government departments' AME spending, which normally will impact on the fiscal framework in the same way as DEL spending.

Additionally, the DHSC group's AME is demand-led and volatile, being subject to many variables outside DHSC's direct control, such as changes to the discount rates used to measure the value of long-term provisions liabilities. **Note 16** within the financial statements provides further detail and analysis of variables.

The main elements of the DHSC group's resource AME (RAME) £3.2 billion outturn and resultant £6.8 billion underspend are due to:

- NHS Resolution's (NHSR) AME outturn of £(0.1) billion was £5.1 billion lower than anticipated when setting the budget due to favourable changes in assumptions and methodology, claims inflation and the estimated quantum of future clinical negligence claims was lower than had been forecast

- the remaining non-NHS sector's AME outturn, comprising net provisions movement and impairments expenditure was around £2 billion lower than anticipated when setting the final budget

DHSC's capital AME expenditure has included specific budgeting relating to IFRS 16, the accounting standard for leases, since its implementation in 2022-23. Since 2024-25, capital AME budgets and outturn also include infected blood inquiry interim compensation payments, relating to payments for infected blood support schemes, announced by the government on 21 May 2024.

Annex B (ii) – Supplementary time-series information

In addition to the core tables and financial performance detail, the tables below provide further timeseries breakdowns of key spending numbers of regular interest to Parliament and the wider public.

NHS total departmental expenditure limit

The majority of the DHSC group's budget is allocated to fund the NHS. **Table 55** sets out the NHS outturn for 2019-20 to 2025-26, and planned NHS spend for 2026-27 to 2028-29, as per the Spending Review (SR) 2025.

Table 55: NHS outturn versus budget – timeseries

	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	2027-28 £m	2028-29 £m
(a) NHS RDEL (excl depreciation), of which:	**126,442**	**146,018**	**152,317**	**160,939**	**171,271**	**186,894**	**198,020**	**204,905**	**215,386**	**226,131**
Spending Outturn as per SOPS[1,3]	126,442	146,018	152,317	160,939	171,271	186,894	198,020			
Planned spending as per SR25[2]								204,905	215,386	226,131
(b) NHSE CDEL, of which:	**371**	**411**	**394**	**384**	**388**	**609**	**670**	**-**	**-**	**-**
Spending Outturn as per SOPS[1,4]	371	411	394	384	388	609	670			
Planned spending as per SR25[2]										
NHS TDEL (a+b)	**126,813**	**146,429**	**152,711**	**161,323**	**171,659**	**187,503**	**198,689**	**N/A**	**N/A**	**N/A**

1. The NHS' spending outturn has been adjusted to reflect spending in entities that were merged with NHS England during 2022-23 and from 2023-24, to allow for consistency across all years.
2. Full details of budgets and planned spending can be found in the government's financial directions to the NHS.
3. Table 42 of DHSC's Annual Report and Accounts 2025-26.
4. Table 50 of DHSC's Annual Report and Accounts 2025-26.

NHS financial performance – NHS providers (NHS trusts and foundation trusts) and integrated care boards (ICBs)

Table 56 provides a timeseries of the aggregate surplus/(deficit) position in NHS providers, plus the further adjustments to that surplus/(deficit) needed to calculate the impact on the resource DEL.

Table 56: NHS providers (NHS trusts and foundation trusts) RDEL breakdown – timeseries

NHS providers financial performance - timeseries	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
NHS providers - adjusted financial performance	**(655)**	**(556)**	**450**	**1,312**	**776**	**920**
Plus additional RDEL adjustment	(77)	(39)	528	69	293	120
Depreciation classification adjustment	(2,341)	(2,641)	(3,293)	(3,874)	(4,368)	(4,339)
Net NHS providers RDEL NRF	**(3,073)**	**(3,236)**	**(2,315)**	**(2,492)**	**(3,299)**	**(3,300)**

Table 57 provides a timeseries of the aggregate surplus/(deficit) position across NHS systems (ICBs and NHS providers). 2022-23 was the first year that commissioners and providers worked together as ICS to manage to an agreed financial plan and therefore prior year comparators are not available.

Table 57: ICS financial performance – timeseries

NHS systems financial performance - timeseries	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
Integrated care boards/clinical commissioning groups	119,088	133,632	150,872	170,911
NHS providers adjusted financial performance	450	1,312	776	920
NHS providers reporting adjustments	252	-	-	-
Net outturn	**119,790**	**134,944**	**151,648**	**171,831**
Plan	**119,273**	**133,566**	**151,044**	**171,166**
Under /(overspend)	**(517)**	**(1,378)**	**(604)**	**(665)**

Purchase of healthcare from non-NHS providers

Most healthcare services are purchased from NHS providers (NHS trusts and foundation trusts); however, £22 billion of these types of services were purchased from non-NHS healthcare providers in 2025-26. These non-NHS providers include local authorities, voluntary sector/not for profit organisations, devolved administrations and private sector providers. **Table 58** provides data between 2020-21 and 2025-26.

Table 58: NHS England's purchase of healthcare from non-NHS providers

Purchase of healthcare from non-NHS providers	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
Independent sector providers	12,139	10,854	11,015	12,357	14,136	15,228
Voluntary sector / not for profit	1,866	1,791	1,734	1,841	1,992	2,347
Local authorities	4,312	4,318	3,805	3,825	4,141	4,301
Devolved administrations	36	48	59	56	63	69
Other group bodies	31	35	28	27	31	23
Sub-total	**18,384**	**17,046**	**16,640**	**18,108**	**20,363**	**21,967**
Total DHSC RDEL	**181,441**	**183,548**	**177,095**	**182,819**	**198,192**	**208,981**
Spend with private sector as a % of total RDEL	7%	6%	6%	7%	7%	7%
Spend on all non-NHS bodies as a % of total RDEL	10%	9%	9%	10%	10%	11%

1. The numbers above have been collected separately from audited accounts data and may include estimates.
2. Totals in the table may not sum due to rounding.

Financial information by arm's-length body (ALB)

The table below discloses ALB income and expenditure figures alongside detail pertaining to staff costs and numbers. The table reflects the data reported to DHSC and included within these consolidated financial statements and does not include any central adjustments, the results of NHS charities or intragroup eliminations.

Table 59: Financial information by ALB

	Total operating income	Total operating expenditure	Net expenditure for the year (including financing)	Permanently employed staff Employees	Permanently employed staff Staff costs	Other staff Employees	Other staff Staff costs
	£'000	£'000	£'000	Number	£'000	Number	£'000
DHSC core	(3,754,583)	216,758,130	213,003,547	3,359	299,665	216	18,790
UK Health Security Agency	(302,881)	1,931,872	1,628,991	5,219	395,269	374	36,391
Medicines and Healthcare products Regulatory Agency	(175,730)	265,438	89,708	1,374	113,670	182	11,023
NHS England group	(6,882,315)	208,976,018	202,093,703	37,694	3,859,304	6,744	588,193
NHS providers	(148,662,015)	152,002,319	3,339,967	1,376,914	93,484,807	112,793	5,918,731
Care Quality Commission	(232,486)	295,098	62,612	3,529	220,444	66	18,060
National Institute for Health and Care Excellence	(28,107)	90,541	62,434	792	64,901	11	475
Human Fertilisation and Embryology Authority	(6,937)	8,558	1,621	82	5,983	1	200
Human Tissue Authority	(6,153)	6,600	447	60	4,734	-	6
Health Research Authority	(697)	20,703	20,006	260	17,208	2	258
Health Services Safety Investigations Body	(211)	6,553	6,342	49	4,907	2	66
NHS Counter Fraud Authority	(296)	21,664	21,368	224	16,134	1	57
NHS Business Services Authority	(786,327)	1,080,423	294,096	5,047	244,931	78	4,181
NHS Resolution	(3,059,102)	3,307,532	248,430	830	63,750	8	871
NHS Property Services Ltd	(830,391)	985,397	155,343	3,686	200,138	263	6,428
Community Health Partnerships Ltd	(571,556)	616,038	44,482	258	18,606	13	809
Genomics England Ltd	(30,563)	166,767	136,204	525	53,751	-	1,704
Skipton Fund Ltd	-	-	-	-	-	-	-
Nursing & Midwifery Council	(107,027)	133,171	26,144	1,244	78,344	31	2,075
Health & Care Professions Council	(43,507)	42,480	(1,027)	329	19,434	37	345
Wiltshire Health and Care LLP	-	521	521	-	-	-	-
Professional Standards Authority for Health and Social Care	(6,506)	6,125	(381)	47	4,167	1	211

Annex C - Reconciliation of contingent liabilities included in the Supply Estimate to the accounts (not subject to audit)

Quantifiable contingent liabilities

	Description of contingent liability	Supply Estimate £'000	Amount disclosed in ARA £'000	Variance £'000
1	NHS England group contingent liabilities.	94,200	74,276	19,924
2	The department is the actual or potential defendant in a number of actions regarding alleged clinical negligence. There is a large degree of uncertainty as to the Department's liability and the amounts involved. This includes the Clinical Negligence Scheme for Coronavirus (CNSC).	25,023,100	25,355,137	(332,037)
3	DHSC holds a contingent liability for the provision of life assurance cover for individuals transferred to DHSC.	1,100	1,100	-
4	The core department holds an indemnity provided to Oxford University for unexpected tax implications as a result of the National Institute for Health Research (NIHR) National Biosample Centre transfer to DHSC.	3,200	3,200	-
5	The core department holds a general indemnity provided to Oxford University in relation to the National Institute for Health Research (NIHR) National Biosample Centre transfer to DHSC.	14,900	15,000	(100)

6	The core department holds a contingent liability for compensation payments due to individuals unable to be traced.	400	400	-
7	The core department holds a contractual liability for redundancy payments.	500	290	210
8	NHS Resolution non-clinical contingent liabilities.	219,200	238,726	(19,526)
9	Legal cases – DHSC as defendant	-	N/A[1]	N/A
10	The core department has issued an indemnity in respect of a Department of Health and Social Care established independent inquiry into the issues raised by the David Fuller case.	N/A	3,000	N/A
11	Legal cases – DHSC as claimant	-	N/A[1]	N/A
12	NHS Providers at 31 March 2026 had net contingent liabilities.	126,800	134,630	(7,830)
13	The core department has issued an indemnity in relation to the operations of the Human Fertilisation and Embryology Authority (HFEA).	1,500	N/A	-
14	DHSC is involved in a number of Employment Tribunal cases	N/A	N/A[1]	N/A
15	The core department holds an indemnity relating to use of a monoclonal antibody, Sotrovimab, developed for the treatment of COVID-19 to bring expired stock back into circulation by relabelling the stock.	N/A	N/A[1]	N/A

16	The core department has issued an indemnity in respect of a DHSC established statutory, independent inquiry into the care and treatment pathways and the circumstances and practices surrounding the deaths of mental health inpatients in Essex.	N/A	3,000	N/A
17	The core department holds a contingent liability relating to the two contracts signed between His Majesty's Government and the medicine supplier Pfizer for their COVID-19 antiviral drug PF-07321332+ritonavir, co-packaged and marketed as Paxlovid.	N/A	N/A[1]	N/A
18	The core department holds indemnities for COVID-19 vaccines purchases.	N/A	N/A[1]	N/A
19	The core department holds an indemnity in relation to the collaboration agreement between DHSC and the Premier League in relation to the Men's Mental Health strategy.	-[2]	50	(50)
20	The core department holds an indemnity in relation to GambleAware's contractual obligations with Wellset Repro covering any post transfer liabilities or costs arising from its own non-performance during the transition period until GambleAware ceases operations in March 2026.	-[2]	100	(100)
21	Sensitive contingent liabilities	-	N/A[1]	N/A
22	Contractual liability for voluntary redundancy payments.	-[2]	1,900	N/A

23	A letter of comfort has been issued to the Care Quality Commission (CQC) in respect of potential future pension liabilities that may arise in respect of early cessation costs or inherited deficits.	N/A[3]	N/A[3]	N/A
24	The Department holds a contingent liability for potential legal costs in relation to a breach of contract claim.	-[4]	N/A[1]	N/A
25	The Department holds a contingent liability for potential legal costs in relation to proceedings against pharmaceutical companies over anti-competitive “pay-for-delay” agreements.	-[4]	N/A[1]	N/A
26	The Department is involved in various legal claims related to individuals who received human growth hormone treatment between 1959 and 1985.	-[5]	N/A[1]	N/A
27	The Department holds a remote contingent liability relating to potential historic claims for reimbursement of prescription and medical costs.	-	10,000	N/A
28	DHSC indemnified GSK, the manufacturer of the Pandemrix vaccine, for the cost of any personal injury claims resulting from the use of the Pandemrix during the 2009/10 H1N1 swine flu pandemic. There is one outstanding claim remaining, although the claim is currently dormant, having stalled at an early procedural stage.	-[5]	N/A[1]	N/A
29	The department may incur costs in relation to potential injury to feelings awards arising from the 2018 McCloud pension judgement.	-[5]	N/A[1]	N/A

30	The department is potentially liable for claims brought forward in relation to the March Discharge Policy 2020 guidance and April Admission 2020 guidance over care homes in the COVID-19 pandemic.	-[5]	N/A[1]	N/A
31	The Department holds a contingent liability relating to the provision of professional clinical indemnity cover. No further details are disclosed due to sensitivity.	-	N/A[1]	N/A

1. Due to the sensitive nature of these liabilities, the value has not been disclosed.
2. Not included in the supplementary supply estimate, as DHSC was not aware of this obligation at the time of agreement of the estimate.
3. Not included in the Annual Report and Accounts as this is an intragroup liability
4. Previously included in item 11, now disclosed separately in this Annual Report and Accounts
5. Previously included in item 9, now disclosed separately in this Annual Report and Accounts

DHSC is required by the Government Financial Reporting Manual (FReM) to provide an explanation for material variances only. There are no material variances requiring explanation.

The value for the items 9, 11, 14, 15, 17, 18, 21, 24, 25, 26, 28, 29, 30 and 31 have not been disclosed due to the sensitive nature of the contingent liabilities. DHSC does not determine the variances for the individual items to be material.

Unquantifiable contingent liabilities

	Description of contingent liability	Included in the Supply Estimate	Disclosed in ARA	Explanation of difference
1	The core department is bearing an insurable risk for professional indemnity or malpractice on behalf of the Human Tissue Authority.	Yes	No	Intragroup indemnity not disclosed in ARA

2	The core department has undertaken to meet the legal costs of medical, scientific and nursing staff engaged on clinical trials approved by NHS Blood and Transplant.	Yes	Yes	N/A
3	The core department has undertaken to cover any damages arising from NHS Blood and Transplant clinical trials activity.	Yes	Yes	N/A
4	The core department has undertaken to indemnify members of its expert advisory committees: a. Advisory Committee on Dangerous Pathogens (ACDP) (and their associated Working Groups); b. Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI); c. New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG); d. The Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO).	Yes	Yes	N/A
5	The core department has undertaken to indemnify members of the: a) Committee for Carcinogenicity; b) Committee for Mutagenesis; c) Committee for Medical Effects of Radiation; d) Committee for Medical Aspects of Air Pollution; e) Administration of Radioactive Substances Advisory Committee.	Yes	Yes	N/A

6	The core department would need to meet the costs of damages awarded in litigation involving MHRA actions or decisions in carrying out its functions and activities on behalf of the Secretary of State for Health and Social Care.	Yes	No	Intragroup indemnity not disclosed in ARA
7	The core department has an exemption certificate in place with the Medicines and Healthcare products Regulatory Agency (MHRA) regarding the National Institute of Biological Standards and Control (NIBSC).	Yes	No	Intragroup indemnity not disclosed in ARA
8	The core department has undertaken to meet the cost of compensation payments arising from injury claims in relation to the immunisation of voluntary donors with specialised immunoglobulin.	Yes	Yes	N/A
9	UK Health Security Agency maintains a stockpile of medical countermeasures for responding to Chemical, Biological, Radiological and Nuclear (CBRN) incidents. Some of these products are unlicensed because no licensed alternatives are available in the UK. Similarly, UKHSA also holds stocks of unlicensed anti-venoms and anti-toxins. If any recipients were to suffer an adverse reaction to using these products UKHSA would be liable. The associated contingent liability is unquantifiable.	Yes	Yes	N/A
10	The core department holds a contingent liability relating to contracts signed between His Majesty's Government and Pfizer/BioNTech for their COVID-19 vaccine.	Yes	Yes	N/A
11	The core department holds a contingent liability relating to the contracts signed between His Majesty's Government and Moderna for their COVID-19 vaccine.	Yes	Yes	N/A

12	UK Health Security Agency has provided a letter of comfort to local authorities participating in the COVID-19 Community Testing Programme, offering a route to manage potential clinical negligence claims, should they arise in the course of testing conducted by local authorities.	Yes	Yes	N/A
13	The core department holds an indemnity in relation to the Mpox vaccine.	Yes	Yes	N/A
14	The core department entered into contracts for the supply of PPE during the COVID-19 pandemic, which were found to be not suitable. Legal proceedings have been initiated against DHSC for the balance of the contract and damages.	Yes	No	See below
15	Legal cases – DHSC as defendant.	No	Yes	See below
16	The Nursing and Midwifery Council has an unquantifiable contingent liability for potential additional liabilities following the High Court's ruling on the Virgin Media pension scheme.	Yes	Yes	N/A
17	UKHSA holds contingent liabilities relating to contract disputes, primarily relating to contracts let in response to the COVID-19 pandemic.	Yes	Yes	N/A
18	UKHSA holds unquantifiable contingent liabilities in relation to potential remedial works relating to radiological contamination at its radiological scientific sites at the end of their lifespans.	Yes	Yes	N/A
19	Potential future liabilities arising from the insolvency of NRS Healthcare.	No	Yes	See below

20	The core department holds an obligation to indemnify reasonable capital and operating costs incurred by the following water companies that fluoridate water in England: • Anglian Water • Northumbrian Water • Severn Trent Water • South Staffs Water • United Utilities	Yes	Yes	N/A
21	Sensitive contingent liabilities nature not disclosed.	No	Yes	See below
22	Litigation relating to the Infected Blood Inquiry – DHSC as defendant.	No	Yes	See below
23	NHS Property Services has disclosed a contingent liability regarding its entitlement to claim capital allowances on qualifying fixtures and integral features within properties transferred to the company from Primary Care Trusts and Strategic Health Authorities in 2013. The amount and timing of any liability or cash outflow, if any, cannot currently be estimated reliably.	Yes	Yes	N/A

Item 14 has expired and therefore is not disclosed in the ARA. Items 15 and 21 are part of the normal course of business and therefore not subject to Parliamentary approval. Item 22 was previously included as part of item 15 but is now disclosed separately in the ARA.

Items 19 was not included in the supplementary supply estimate, as it was identified during compilation of the review of contingent liabilities for the end of the financial year.

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