



National Audit Office

Department of Health & Social Care 2024-25

January 2026

OVERVIEW



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Summary



C&AG introduction

In 2025, we set out our [new five-year strategy](#). In delivering our statutory responsibilities, we aim to maximise our contribution to two outcomes – more productive and resilient public services and better financial management and reporting in government.

Our overviews summarise the key information and insights from our examinations of departments and from their annual report and accounts, and explore departments' progress against these crucial outcomes, highlighting positive examples and opportunities to improve.

If you would like more information about our work, or to arrange a briefing with me or one of my teams, please contact our Parliamentary Relations team at parliament@nao.org.uk.

Background to the Department of Health & Social Care

Objectives The Department of Health & Social Care (DHSC) is responsible for delivering the health and care system in England and for overseeing wider UK health policy, including health security, medicines and vaccinations, and elements of scientific research. In July 2025 the government published its 10 Year Health Plan for England.

Departmental group DHSC has a large and varied departmental group covering many aspects of healthcare, public health, the regulation of healthcare professions, medicines, and research. At the end of 2024-25, the government announced significant changes to several health bodies including NHS England (NHSE), Integrated Care Boards (ICBs), and organisations charged with patient safety.

Key messages against the National Audit Office's (NAO's) themes

Financial management

- In 2024-25 DHSC's net expenditure was £205 billion. The accounts had an unqualified ('clean') audit opinion, the first since 2018-19. They were published five months after the July date Parliament expects.
- Spending on Health is expected to reach almost £250 billion in 2028-29. NAO reports have found that adult social care services are under significant financial pressure. We found that funding increased by 4% (real terms) between 2015-16 and 2023-24, but this had not kept pace with demand.
- The Care Quality Commission, a key healthcare regulator, has had problems implementing a £99 million IT system, disrupting its regulatory work. It has yet to confirm how much of its investment must be written off.

Productivity

- The productivity of acute activity in the NHS in England is around 8% less than it was before the COVID-19 pandemic (2019-20). DHSC does not expect productivity to return to pre-COVID levels until 2028-29.
- Increases in staff numbers, the poor state of many hospitals and differing levels of digitisation across the NHS have all affected levels of productivity.
- To improve productivity and ease pressures, DHSC wants the NHS to use digital tools like AI more, serve more patients online or in communities, and intervene earlier to prevent ill-health.

Risk and resilience

- DHSC faces highly complex and significant risks including several on the National Risk Register.
- DHSC does not publicly define its risks or disclose their likelihood, severity of impact or trajectory, which is not in line with financial reporting good practice.
- Key risks include cyber security, meeting rising demand in health and social care, managing major public health incidents, and the state of the health service estate.



The Department of Health & Social Care (DHSC) is responsible for delivering the health and care system in England and for overseeing wider health policy, including health security, medicines and vaccinations and elements of scientific research in the UK. In 2024-25 DHSC delivered its responsibilities through 19 arm's-length bodies, 42 Integrated Care Boards (ICBs), and over 200 NHS Trusts.

Healthcare is a devolved matter in Scotland, Wales and Northern Ireland and as such these providers are accountable to the Scottish Parliament, the Welsh Parliament (known as the Senedd Cymru), and the Northern Ireland Assembly, respectively.

DHSC has entities which consolidate directly into the department's accounts that are not audited by the National Audit Office. NHS providers are audited by private sector auditors.

NHS England (NHSE) is the largest arm's-length body in the group. It sets the national direction for the NHS, allocates resource and oversees providers of NHS services in England.

Announced changes

In March 2025 the government announced that NHSE would be merged into DHSC within two years. In September 2025, DHSC announced a joint executive team as part of the transition, with some posts being filled by DHSC executives and some by NHSE executives. In addition, NHSE has instructed all 42 ICBs to cut their running costs by 50% in 2025-26, with the target of generating a net surplus going forward.

On 11 November 2025, [DHSC announced](#) that:

- The reforms will see around 18,000 central administrative posts abolished, saving more than £1 billion that will be redirected to frontline patient care.
 - The government has confirmed it will deliver on the planned timetable of bringing NHSE back into the DHSC within two years.
 - ICBs will now have a clear and focused purpose as strategic commissioners. ICBs will be tasked with transforming the NHS into a neighbourhood health service, with a greater focus on preventing illness. It will mean they will be leaner organisations, with half their current posts removed.
- The reintegration of NHSE and restructuring of ICBs will save £1 billion a year by the end of the Parliament.
 - Funding arrangements have been agreed with HM Treasury and will be from within the existing funding settlement. The government said it will not be cutting any investment to the NHS frontline.

The announcement also stated that ICBs would be given permission to go ahead with 50% reductions in headcount. DHSC is aiming to reduce the administrative spending of all ICBs to £19 per capita. For some ICBs this will mean cuts to budgets of more than two-thirds. DHSC has agreed with HM Treasury that redundancies would be funded from its existing financial settlement. It expects savings in future years to cover redundancy costs, with no cuts to NHS or frontline investment.

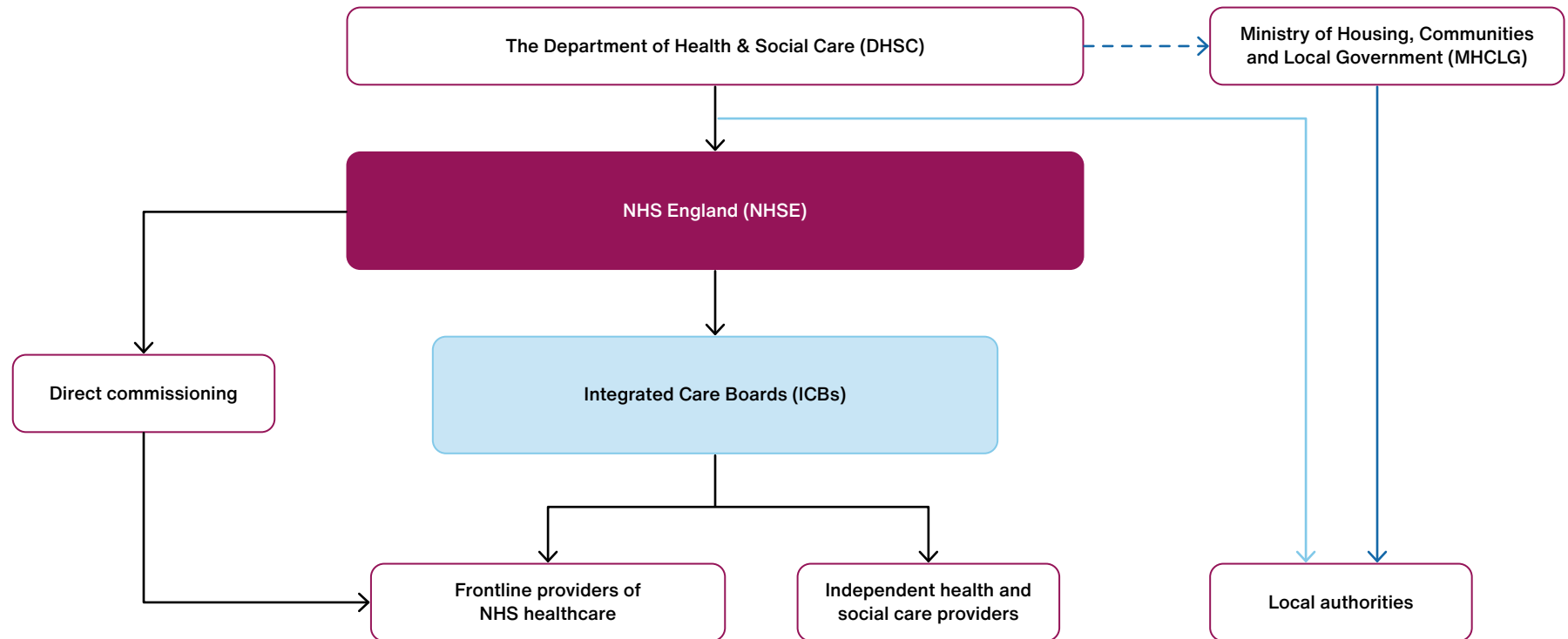
How the DHSC group is structured



Figure 1

The structure of the Department of Health & Social Care (DHSC) group, including funding flows for adult social care, at 31 March 2025

In March and April 2024-25 the government announced the merger of NHS England and DHSC, with a planned 50% reduction in staff numbers and cuts to Integrated Care Boards (ICBs)



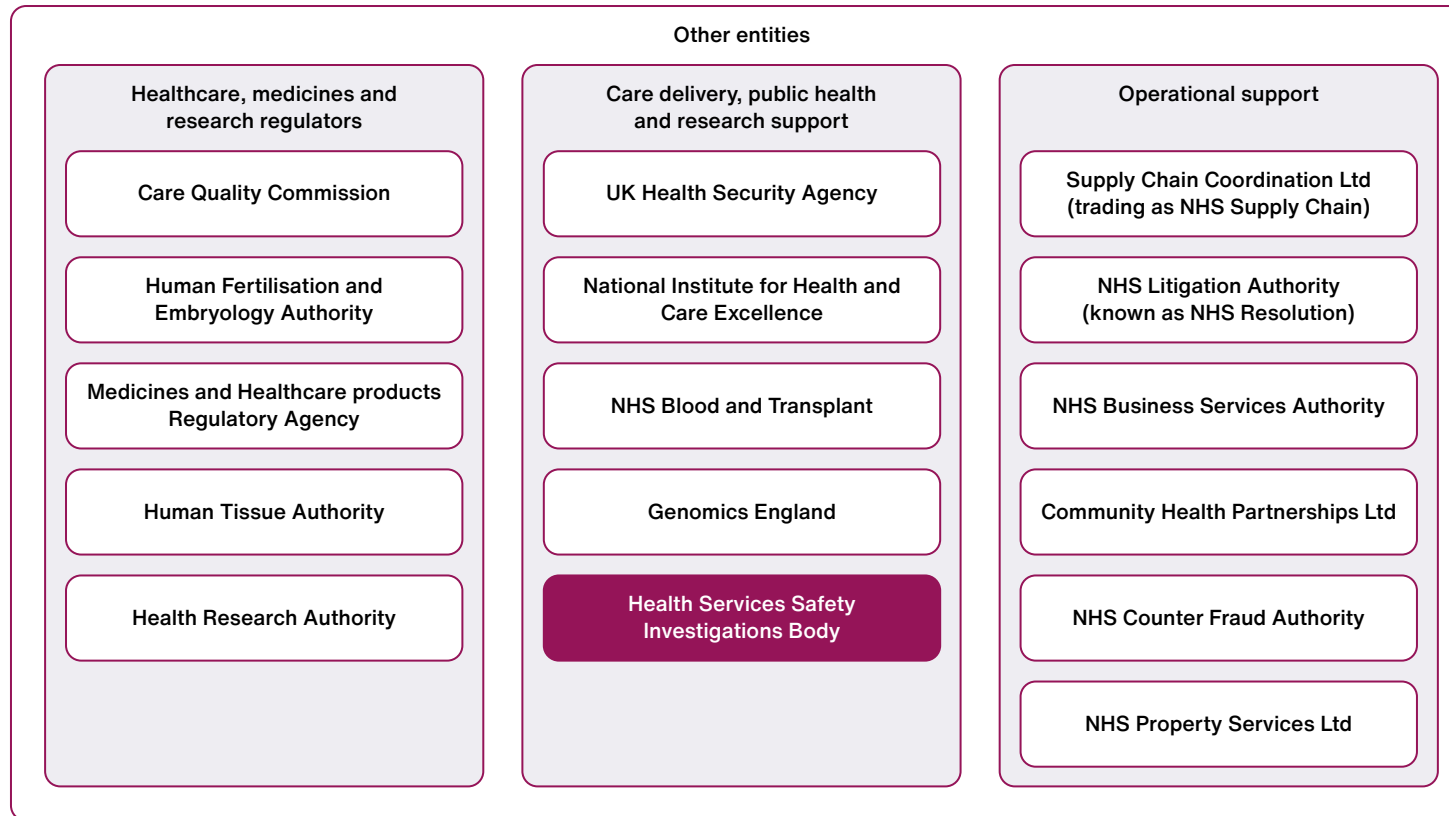
- Abolition of entity announced
- 50% cuts in headcount announced
- Funding and accountability
- Funding
- Adult Social care funding
- Adult social care policy ownership

Continued How the DHSC group is structured



Figure 1 *continued*

The structure of the Department of Health & Social Care (DHSC) group, including funding flows for adult social care



● Abolition of entity announced

Notes

- As part of the restructure of the health sector and the NHS 10 Year Health Plan for England, in March 2025, the government announced that NHS England (NHSE) and the Department of Health & Social Care (DHSC) would merge, and the size of the central organisation would reduce by 50%. In July 2025, it announced the planned abolition of the Health Services Safety Investigations Body.
- Integrated Care Boards (ICBs) were asked by NHSE to cut costs and headcount by 50% in 2025-26.
- DHSC group expenditure recorded in its accounts for other entities totals £10 billion. Regulators are funded through fees, regulatory fines and other forms of trading income. Funding flows for these entities have been excluded to simplify the figure.

Source: National Audit Office analysis of the Department of Health & Social Care, Annual Reports and Accounts 2024-25, relevant legislation and the accounts of the listed arm's-length bodies and other entities

Where DHSC spends its money



In 2024-25 DHSC spent £219.2 billion (£204.7 billion after income). Spending is primarily driven by staff costs (£98,525 million) and clinical supplies and services (£27,508 million), followed closely by the purchase of healthcare from non-NHS bodies (£24,089 million). Non-NHS bodies include independent and voluntary or not-for-profit providers, as well as local authorities, devolved administrations and non-NHS bodies in the departmental group.

Grants to local authorities are primarily the £3,426 million Local Authority Public Health Grant, which is intended to help authorities improve health in their populations. Spending of the grant is reported to the Ministry of Housing, Communities & Local Government (MHCLG) and shared by MHCLG with DHSC.

Beyond 2024-25

Spending levels beyond 2024-25 were set for DHSC at the Spending Review 2025 (SR25) and amended at the Autumn Budget 2025. Over the SR25 period until 2028-29 for day-to-day spending and until 2029-30 for capital spending, spending is set to grow in real terms. Day-to-day spending is planned to increase by £37.9 billion to £231.2 billion and capital spending is planned to increase by £4 billion to £15.2 billion. DHSC has also agreed to save £17.7 billion in efficiencies by 2028-29.



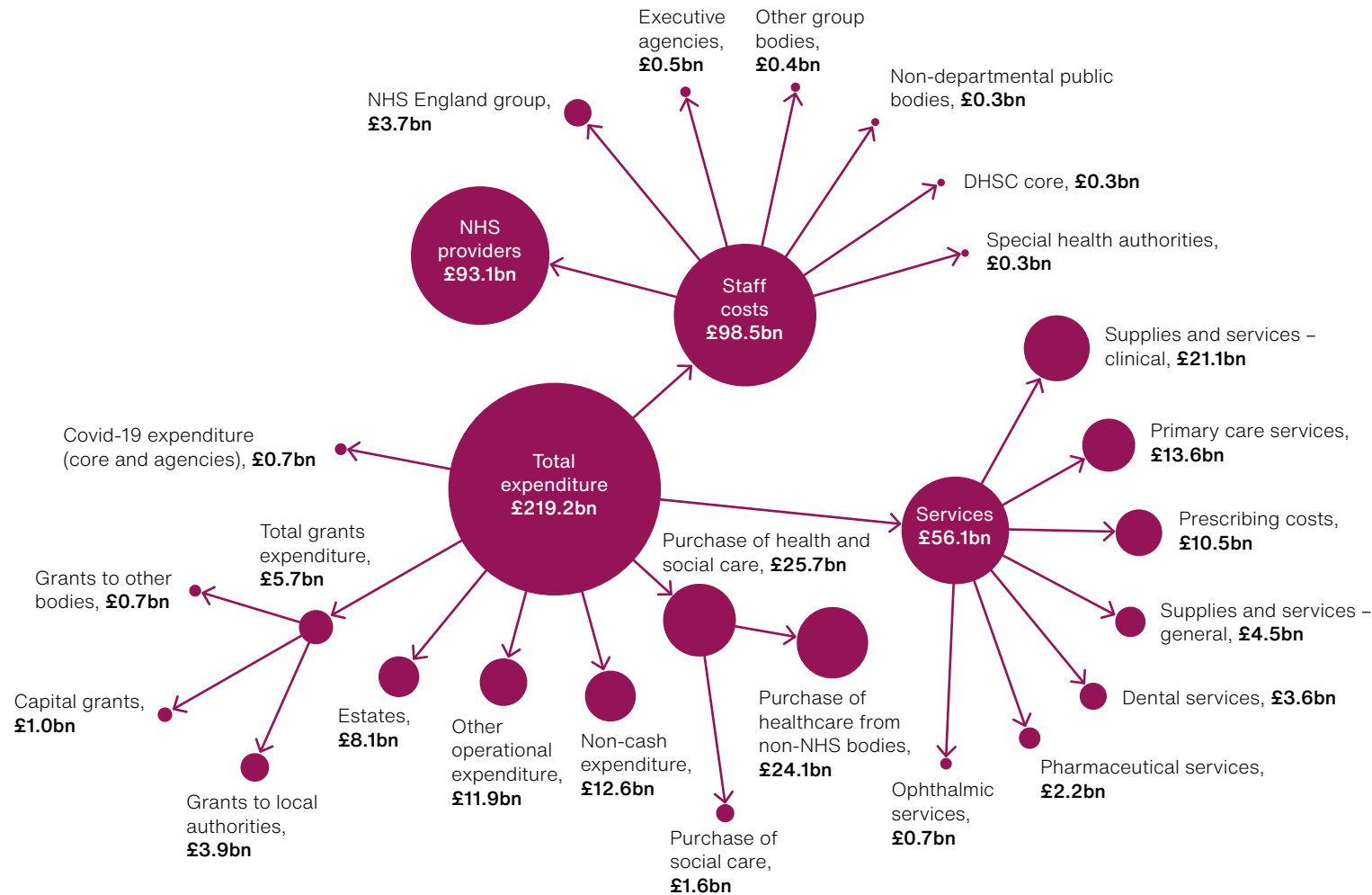
Continued Where DHSC spends its money



Figure 2

Department of Health & Social Care (DHSC) departmental group expenditure, 2024-25

DHSC's expenditure is primarily driven by spending on staff costs and clinical goods and services



Notes

- 1 'Other operational expenditure' includes purchase of good and services from other NHS bodies, interest charges, research and development costs, business rates, training, professional services and consulting, infected blood compensation payments and clinical negligence payments.
- 2 'Supplies and services - clinical' also includes ophthalmic, dental and pharmaceutical services.
- 3 'Non-cash expenditure' includes depreciation and amortisation of assets as well as movements in provisions and impairment costs.
- 4 Spending figures do not match the planned settlement for 2024-25 in Spending Review 2025 as these figures represent actual spend rather than planned spend and because this chart does not take the impact of income into account.
- 5 Staffing costs figures do not add up to the total due to £34mn in staffing costs that are eliminated through the group consolidation process for accounting purposes. That balance has not been included as a sub-total of staffing costs because it does not relate to actual staffing costs but is an accounting adjustment.

Source: National Audit Office analysis of the Department of Health & Social Care, Annual Report and Accounts 2024-25

Performance against key targets



NHS bodies have a large number of performance measures which typically focus on access to treatment rather than the quality of care or patient outcomes. We identified over 60 performance related targets in the 2024-25 annual reports of DHSC and NHSE. Of these, around 43% of targets (26 targets) were met and 44% were not met (27 targets). Performance against the remaining eight targets (13%) was unclear in DHSC's and NHSE's reporting. The majority of the targets relate to access to care, or activity. Transparency of reporting could be improved with clear reporting, with all indicators that are inputs (such as access to care) linked clearly to outcomes such as care quality.

Selected performance targets related to aspects of NHS care

Work area	Performance indicator	Indicator category	Ambition	Performance	Met in 2024-25?
Patient safety	Extra lives saved per year	Care quality	1,000 lives	3,400 lives	Yes
Urgent and emergency care	Improvement of A&E waiting times, compared to 2023-24, with a minimum of 78% of patients seen within four hours in March 2025	Access to care	78%	75%	No
Urgent and emergency care	Improve Category 2 ambulance response times to an average of 30 minutes across 2024-25	Access to care	30 minutes	35 minutes, 22 seconds	No
Elective care	Increase the percentage of patients waiting within six weeks for a key diagnostic test	Access to care	95% by March 2025	81.6%	No
Elective care	Number of additional cancer appointments in the first year of the new government	Access to care	2 million	3 million	Yes
Elective care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest	Access to care	Virtual elimination	22,884 waits over 65 weeks (7,380 at March 2025)	No
Primary and community care	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets seen within two weeks of booking and those who contact their practice urgently are accessed the same or next day according to clinical need	Access to care	2023/24 baseline (83.1%)	82.1%	No
Mental Health	Increase the number of people accessing transformed models of children and young people services	Access to care	840,063 people	829,308 people	No ¹

Note

¹ The national access target was achieved in April 2025, with 842,333 people aged 17 and younger receiving a first contact in 12 months to the end of April 2025.

The 10 Year Health Plan



In July 2025 DHSC published its 10 Year Health Plan for England.

The 10 Year Health Plan follows Lord Darzi's [Independent investigation of the National Health Service in England](#) which found that the NHS "is in serious trouble", facing an ageing population and more people of all ages living with complex health conditions. The Office for Budget Responsibility forecast that, if this trend continues, health spending will increase at twice the growth rate of the economy. Spending on Health is expected to reach almost £250 billion in 2028-29.

To address these issues DHSC intends to make three shifts to how care is delivered.

- Shift 1: From hospitals to local communities.
- Shift 2: From analogue to digital.
- Shift 3: From sickness to prevention.

These shifts will be enabled by several key changes to how the NHS works including:

- a new operating model with power devolved away from central government to local NHS trusts;
- transparency to prevent systematic and avoidable harm;
- a workforce that, by 2035, is smaller than projected in the 2023 Long-Term Workforce Plan, but more motivated and better trained;
- innovation through technology; and
- a more productive and financially sustainable NHS.

Figure 3

Department of Health & Social Care's (DHSC's) 2025-26 to 2028-29 spending period settlement

The vast majority of DHSC's settlement is spent on NHS services in England



Notes

- 1 Planned spending presented here for 2024-25 does not match figures presented for 2024-25 elsewhere in this overview as those figures are actual rather than planned spending taken from the 2024-25 accounts which were not available at the time of the spending review.
- 2 Totals may not sum due to rounding.
- 3 In Spending Review 2025 capital was allocated on a longer timeline than resource (day-to-day) spending.

Source: HM Treasury, *Spending Review 2025*, July 2025

Shift 1: From hospital to community



DHSC intends to create a neighbourhood health service to bring care into local communities, convene patient centred teams, improve access to general practice, and enable hospitals to focus on providing specialist care to those who need it.

Selected key commitments

- Create a multidisciplinary health centre in every community.
- Bring the NHS to communities, including homes and the high street.
- Create teams that integrate different professions, including those working in social care and the voluntary sector.
- Modernise hospitals and reduce long waits.
- Make general practice more flexible and end morning rushes for appointments.
- Roll out new contracts for single- and multi-neighbourhood(s).

To achieve this shift from the hospital to the community, DHSC plans for Neighbourhood Health Centres (NHCs) to operate a minimum of 12 hours per day, six days a week. DHSC aims for NHCs to host medical services, such as diagnostics and post-operative care and rehabilitation, as well as other services such as debt advice, employment support and smoking cessation. NHCs will be delivered through repurposing existing buildings or through new buildings financed by a new public private partnership model.

In our March 2025 report [*NHS England's management of elective care transformation programmes*](#), we found that NHS England had made progress towards elective recovery and had delivered significant additional community diagnostic centres and surgical hubs. However, it had failed to make significant progress to support outpatient transformation. To achieve change, DHSC needs to ensure that stakeholders are fully engaged with the programme of change and that there is appropriate consultation with those who will be delivering change.

Timeline of milestones and ambitions

2026	<ul style="list-style-type: none">• Women and young people who missed out on the human papillomavirus vaccination at school will be able to have it administered at their local pharmacy.• Patient-initiated follow-up is a standard approach.
2027	<ul style="list-style-type: none">• Ensure 95% of people with complex needs have an agreed care plan.• Over financial year 2026-27 dental contract payments will better reflect the cost of treating patients with higher needs.
2028	<ul style="list-style-type: none">• More patients will be supported to book into an appropriate urgent care service via 111 or the NHS App before attending.• Double the number of people offered a Personal Health Budget.
2029	
2030	<ul style="list-style-type: none">• One million people have been offered a Personal Health Budget.
2031	
2032	
2033	
2034	
2035	<ul style="list-style-type: none">• Ensure a Personal Health Budget is a universal offer for all who would benefit.• Most outpatient care will happen outside of hospitals, with effective community based care at home or through NHCs.• Predictive tools to prevent falls will be commonplace among care providers.• The Neighbourhood Health Service will have evolved to fully incorporate genomic data, digital tools and technology.• 120 of the total 250 NHCs the government committed to will have been delivered through a mix of refurbishments and new builds.

Shift 2: From analogue to digital



DHSC plans to replace obsolete computer systems and paper records. It will seek to draw on the economies of scale available to the NHS to make administration and care more efficient and give patients more choice, and visibility of their health data.

Selected key commitments

- Transform the NHS App into a comprehensive service by 2028, with advice, self-referral to tests, appointment booking, and medicine management.
- Create a Single Patient Record for all NHS services that is freely accessible to patients and can reduce duplication between services and patients having to update every new care provider on their health.
- Introduce single sign-on for NHS staff software to reduce time spent using multiple IT systems.
- Use of artificial intelligence (AI) to automate administrative work for staff and clinicians.

In our 2020 report *Digital transformation in the NHS* we highlighted the potential of digital services to enable health and care services to be delivered flexibly and remotely where necessary and provide better information. Over time, more patients should be able to access medical information and advice without face-to-face contact with clinicians, and risks to everyone can be managed more effectively. DHSC and the

NHS should ensure that they are able to collect better data and collate lessons learned from previous digital transformation. The data can underpin clinical decision making, vital research and government planning to help the NHS manage demand and the lessons can inform future work programmes.

Timeline of milestones and ambitions

-
- | | |
|-------------|--|
| 2026 | • Publication of a new regulatory framework for medical devices, including AI. |
| 2027 | • Finish a framework procurement process that can be accessed by all NHS organisations to help with the safe adoption of AI.
• The roll-out of validated AI diagnostic tools begins.
• AI administrative tools are deployed across the NHS. |
| 2028 | • It is DHSC's ambition to have remote monitoring for cardiovascular disease using wearables or similar devices integrated into the NHS App as a standard part of care.
• My NHS GP, an AI-enabled tool in the NHS App, will help people navigate the health system.
• Subject to new legislation, patients are given access to be able to view their Single Patient Record in the NHS App by default. |
| 2029 | • Subject to regulatory approval, AI-enabled digital tools support triage in dermatology as standard practice. |
| 2030 | |
| 2031 | |
| 2032 | |
| 2033 | |
| 2034 | |
| 2035 | • AI to be seamlessly integrated into most clinical pathways, and generative AI to be widely adopted across the NHS.
• Half of all healthcare interactions will be informed by genomic insights and other predictive analytics. |
-

Shift 3: From sickness to prevention



DHSC aims to improve health outcomes through helping people make healthier choices and lead active lives, and secure the financial sustainability of the NHS by reducing demand.

Selected key commitments

- Ban the sale of high-caffeine energy drinks to under 16s.
- Update the standards behind restrictions on advertising and promoting 'less healthy' food and drink.
- Expand access to weight loss medication through the NHS and introduce a health reward scheme to incentivise healthier choices.
- Require nutritional information and health warnings on alcohol labels.
- Expand mental health support teams in schools and colleges.
- Fully roll out lung cancer screening for those with a history of smoking.
- Develop and introduce an AI Health Coach.
- Set targets to increase the healthiness of food sales.

Although prevention is a long-standing priority for the NHS, NAO work has suggested spending on prevention had reduced in years before 2024-25. For example our 2024 report *Progress in preventing cardiovascular disease* found that there is no complete national or local understanding of the effectiveness of services which can help prevent cardiovascular disease (CVD). CVD contributed to a quarter of all

deaths in England in 2022 but preventive public health spending on CVD fell 23% in real terms from £340 million in 2015-16 to £262 million in 2023-24. To gain an understanding of effectiveness and value of prevention efforts, DHSC should compare the value of different commissioning routes, set clear targets and expectations and prioritise groups that are most at risk.

Timeline of milestones and ambitions

2025	<ul style="list-style-type: none">• Restrictions on volume price promotions for certain less healthy products in retailers and online came into force.
2026	<ul style="list-style-type: none">• All children with a parent in receipt of Universal Credit will be eligible for free school meals.• Restrictions on junk food advertising on TV and online come into force.• Launch a consultation on applying updated nutrient profiles to restrictions for promotions and advertising.• The value of the Healthy Start scheme will have been reformed, with children older than one year old but younger than four and pregnant women receiving £4.65 a week and children under the age of one receiving £9.30 a week.
2027	<ul style="list-style-type: none">• People born on or after 1 January 2008 will never legally be able to be sold tobacco products, creating the first smoke-free generation.
2028	
2029	<ul style="list-style-type: none">• Before the end of Parliament in 2029, mandatory food sales reporting for all large companies in the sector will have been introduced.• Full national coverage of mental health support in schools and colleges.
2030	<ul style="list-style-type: none">• Community water fluoridation will have reached 1.6 million more people and existing water fluoridation schemes reaching over 6 million people will have been refurbished.• The government plans to have invested £616 million since 2026-27 in active travel infrastructure, with investment led by the Department for Transport but contributing to DHSC's health aims.• The government's ambition is that new HIV transmissions in England will have been ended by 2030.
2031	
2032	
2033	
2034	
2035	

Financial management and reporting



DHSC's accounts are large and complex, consolidating the results of over 500 individual bodies. The timeliness of DHSC's reporting has been a particular concern since the pandemic. The accounts remain five months behind the date Parliament expects, which delays timely financial accountability.

Key audit findings

DHSC published its accounts for the year ending 31 March 2025 on 11 December 2025. The C&AG gave an unqualified opinion on the financial statements, the first since 2018-19. This means that the accounts give a true and fair view of DHSC's affairs and have been properly prepared in accordance with the Government Resources and Accounts Act 2000; that total spending has not exceeded amounts voted by Parliament; and that the income and expenditure recorded have been applied to the purposes intended by Parliament. The previous qualification was in part for UK Health Security Agency's (UKSHA's) accounts (see right).

Timeliness of reporting

Timely production of accounts is essential for supporting Parliamentary accountability, and the expectation is that accounts are laid before Parliament before the summer recess. The key barrier to pre-recess reporting is the timeliness of financial reporting at some NHS providers, which are part of the local audit system. Careful management will be required to ensure that the restructuring of ICBs and the merger of NHSE and DHSC do not adversely affect the timeliness of the accounts process for 2025-26.

Multi-year budgets

The shift to multi-year budgets for NHS organisations will require care providers and coordinators to undertake financial management and reporting in a new way that may require skills that they do not currently have.

Notable reporting issues

For the first time since it was established in 2021, the C&AG has given the **UKHSA** an unqualified opinion on matters relating to the current financial year. A qualification remains for comparative information relating to prior year transactions, opening balances, and cash flows relating to the Covid Vaccine Unit (CVU). It has not been possible for the C&AG to gain assurance over the CVU in-year transactions and opening balances until the current year.

The unqualified opinion follows several years of the C&AG either not being able to issue an opinion on the accounts (2021-22 and 2022-23), or the opinion being qualified (2023-24). UKHSA was created as a mid-financial year merger of Public Health England's health protection functions, NHS Test and Trace and the Joint Biosecurity Unit in a "volatile" environment during the COVID-19 pandemic. In its first year UKHSA did not operate with sufficient internal controls and did not have a board or Audit Committee in the period, a serious incidence of non-compliance with government governance standards. In future mergers, DHSC should take care that expected controls should be maintained, even in times of crisis.

The **Care Quality Commission (CQC)** has not yet published its 2024-25 annual report and accounts and is working to accelerate the laying date, which has historically been delayed due to Local Government financial reporting and pension scheme audit assurances. In 2023-24, the accounts received a qualified opinion related to intangible asset valuation as well as CQC's share of Teesside Pension Fund assets. The latter issue arose because Teesside Pension Fund could not provide audited accounts by the reporting deadline. External reviews highlighted significant problems with the Regulatory Platform intangible asset, requiring impairment. While CQC calculated an impairment value, it could not complete a full technical review in time due to prioritising timely reporting amid significant pension assurance delays. A technical review is now underway for 2024-25.

Continued Financial management and reporting



Adult social care is vital for supporting people to live their lives, but the system's financial sustainability is at risk.

DHSC sets national policy and is accountable for the performance of the care system as a whole, along with agreeing central government funding. The Ministry of Housing, Communities & Local Government is responsible for the financial framework within which the distribution and management of social care funding occurs. Local authorities are responsible for assessing and providing care for those who are eligible under the Care Act 2014.

Our February 2025 report *Local government financial sustainability* found that adult social care services are under significant strain due to rising demand, increasing complexity of needs, and escalating delivery costs. Despite an overall 4% real-terms funding increase between 2015-16 and 2023-24, resources have not kept pace with population growth or demand for services.

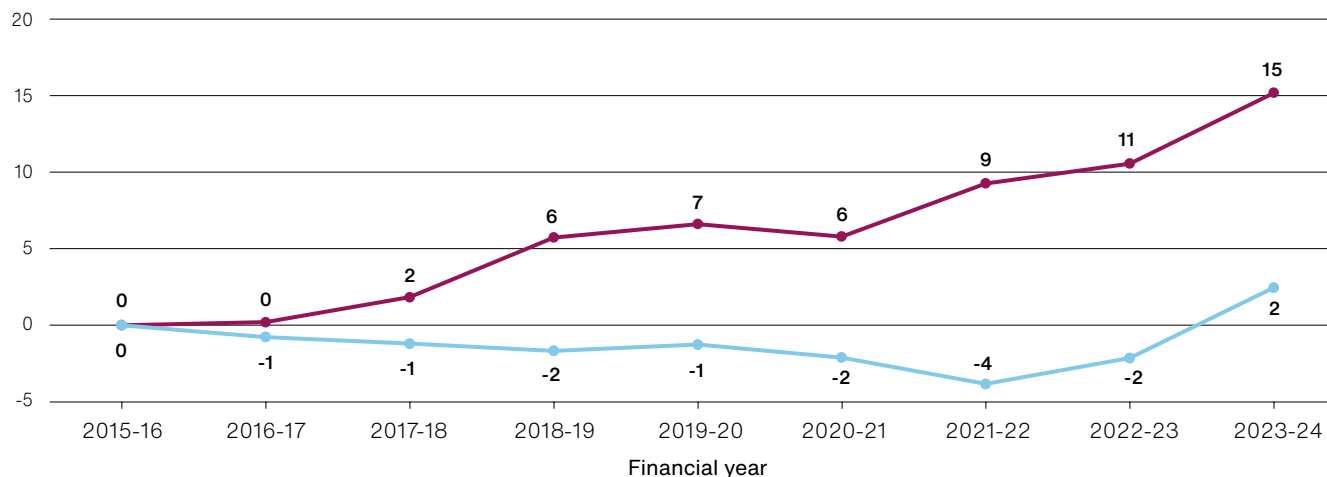
The report found that many local authorities have received exceptional financial support, with overspends in social care being one of the reasons. We found that short-term funding measures have not addressed systemic weaknesses in local government financial sustainability, and that a cross-government approach is needed to ensure financial sustainability and continued delivery of essential care services.

Figure 4

Percentage change in the number of people requesting and accessing publicly funded adult social care support between 2015-16 and 2023-24

The number of requests for publicly funded adult social care has increased by 15% from 2015-16 to 2023-24, while the number of people accessing support increased by 2%

Percentage change compared with 2015-16 (%)



- Percentage change in requests for support
- Percentage change in number of people accessing support

Notes

- 1 Data come from the NHS England Adult Social Care Activity and Finance Report (ASC-FR), England.
- 2 'Requests for support' includes new requests for support for 18- to 64-year-olds and those aged 65 years old and over.
- 3 'Number of people accessing support' include number of episodes of support for long-term support in year and episodes of short-term support to maximise independence (ST-Max support). Some people who receive long-term care may also receive ST-Max within the same financial year. An individual may receive more than one episode of ST-Max within a financial year.
- 4 There are differences in how information on short-term care is collected between the ASC-FR and earlier data returns. NHS England states that some comparisons of general trends can be made, but it does not recommend some direct comparisons.

Source: National Audit Office analysis of NHS England data

NHS staffing increases and productivity



The NHS workforce has grown, but without a corresponding growth in productivity. The balance of spending between workforce spending and other spending, such as capital improvements, needs to be carefully considered to identify the optimal balance for improving productivity.

The productivity of care in the NHS is still recovering from an estimated 22% decline in 2020-21 due to the COVID-19 pandemic. The productivity of NHS care has grown by an average of just over 2% per year over the previous three financial years (2021-22 to 2023-24). The latest analysis produced by NHS England suggests that acute sector productivity is approximately 8% below pre-COVID levels.

Between 2021 and 2025 staffing increased by:

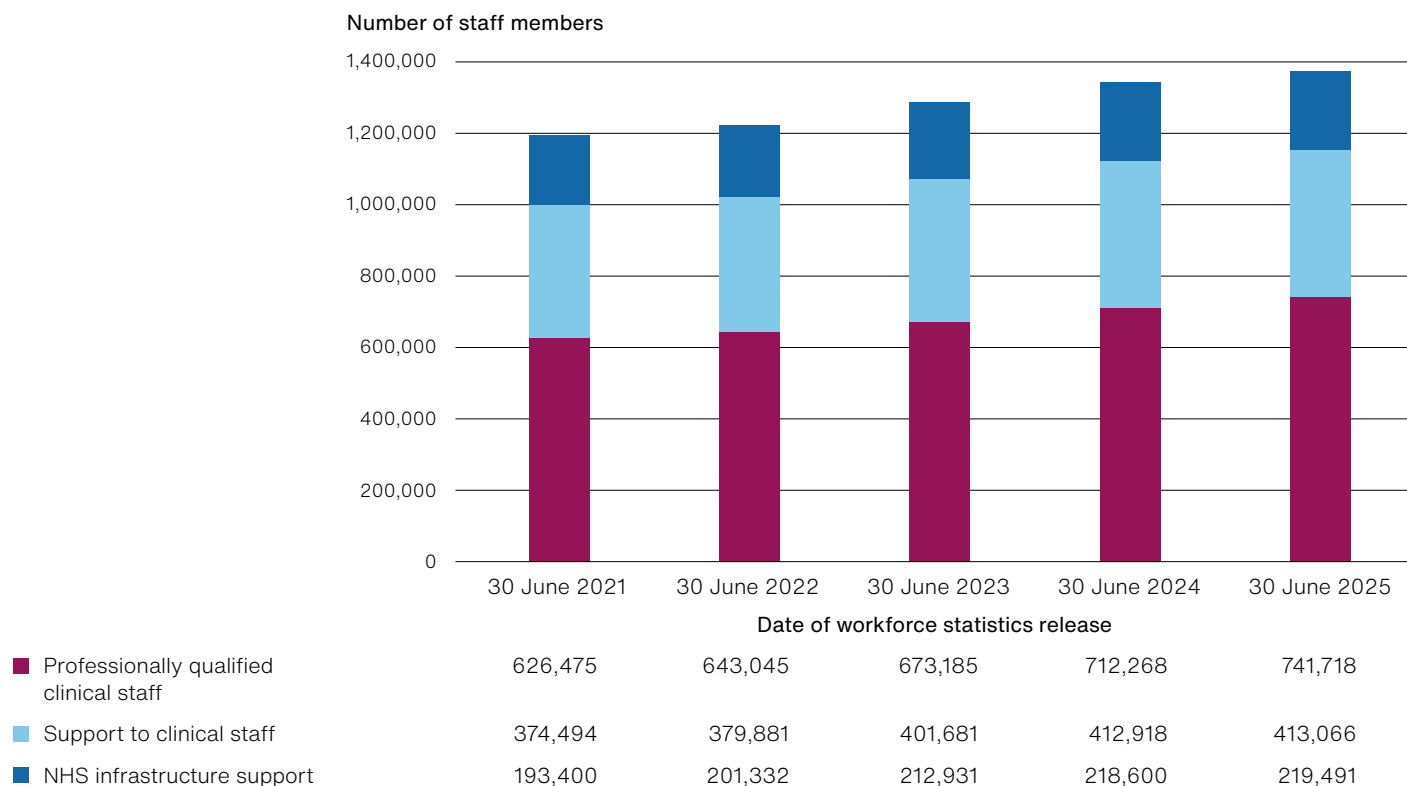
- 18% in professionally qualified clinical staff;
- 10% in support to clinical staff; and
- 13% in NHS infrastructure support.

In our most recent report on *NHS financial management and sustainability* we found that demand for NHS services was also increasing. However, the low rate of productivity suggested that the balance between workforce and capital spending may not be optimal for productivity growth. DHSC needs to identify factors limiting productivity growth, determine which capital investments stand to improve productivity the most and ensure productivity measures capture the full value of NHS activity.

Figure 5

Permanent NHS Hospital and Community Health Service staff by group, June 2021 to June 2025

Full-time equivalent staffing levels in the NHS Hospital & Community Health Service have been increasing since 2021



Notes

- 1 Staff numbers are presented as full-time equivalents, and some staff members may hold roles in multiple categories.
- 2 Professionally qualified staff includes doctors, nurses and health visitors, midwives, ambulance staff and other scientific, therapeutic and technical staff. Support to clinical staff includes healthcare assistants, maternity support workers and technical staff assistants. Infrastructure support includes managers, central functions and property and estates. Staff whose categorisation is unknown have been excluded (281 full-time equivalents in June 2025).
- 3 The data do not include staff working in general practice and other primary care services that have NHS staff.

Source: National Audit Office analysis of NHS Hospital and Community Health Service monthly workforce data produced by NHS England

Plans to develop a new operating model



DHSC has a large and varied workforce. Eliminating duplication of functions and delivering efficiencies will require careful planning, alongside a concerted effort to minimise disruption and retain the staff needed to improve productivity.

DHSC has identified a healthy and motivated workforce as key to improving productivity across the NHS. The DHSC group currently includes:

- 55,665 people working on providing or supporting the delivery of healthcare;
- 5,237 people working at the UK Health Security Agency;
- 1,529 people regulating the healthcare professions; and
- 4,860 people regulating the practice of healthcare and healthcare research.

DHSC's plans to improve NHS productivity include a smaller centre of the system focused on strategic frameworks and partnerships.



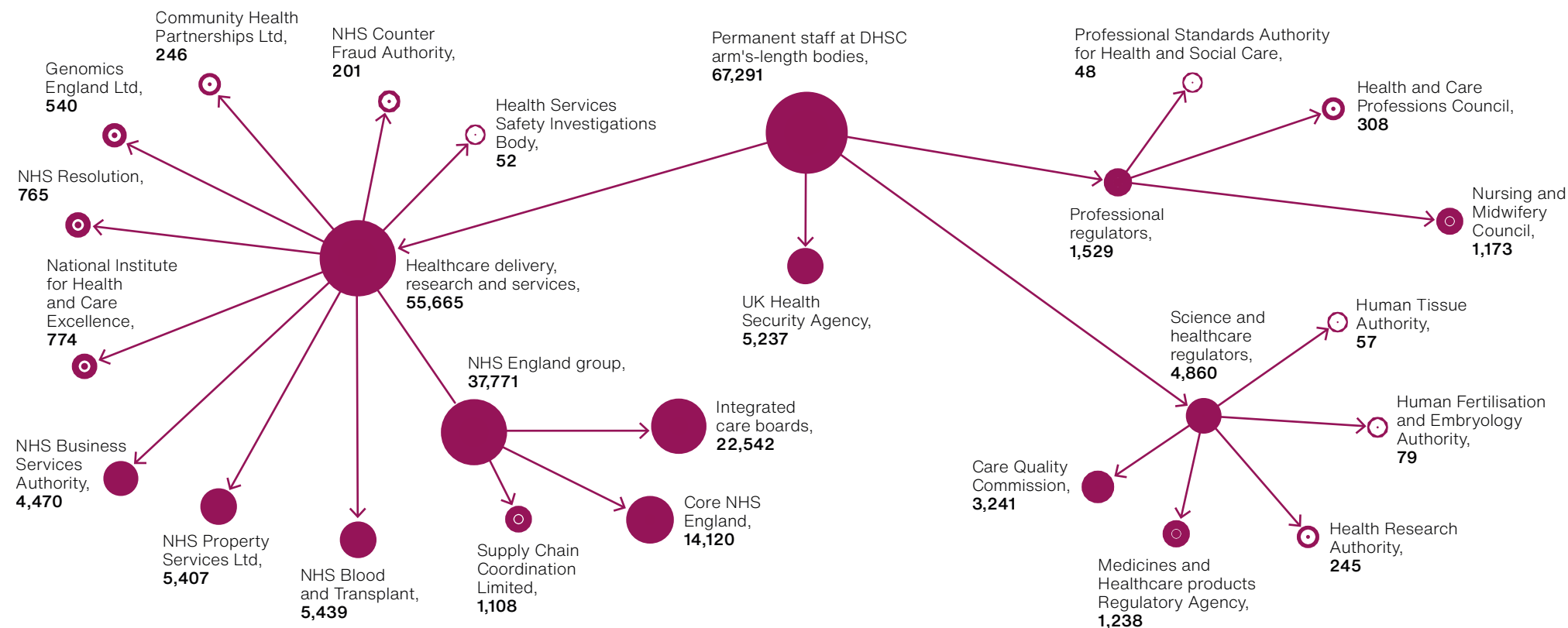
Continued Plans to develop a new operating model



Figure 6

Permanent staff numbers in the Department of Health & Social Care (DHSC) group, as of 31 March 2025

Staff working within the DHSC group work across a wide variety of areas, including research, operational support and regulation



Note

- 1 In March 2025 it was announced that NHS England would be merged into DHSC with a 50% reduction of the combined central organisation.
- 2 DHSC's Annual Report and Accounts does not specify whether the number of staff reported in the source table (Table 66) is the number of people or the full time equivalent.
- 3 Staff numbers for integrated care boards (ICBs) and Supply Chain Coordination Limited (SCCL) are taken from the Annual Reports and Accounts of all ICBs and SCCL and are presented as full-time equivalents. Due to this, NHS England group figures may not sum due to rounding. NHS trusts form a part of DHSC's group but have been excluded here to avoid distorting the graphic. NHS hospital and community care staff numbered 1.38 million full time equivalent on the same date as this figure (31 March 2025).

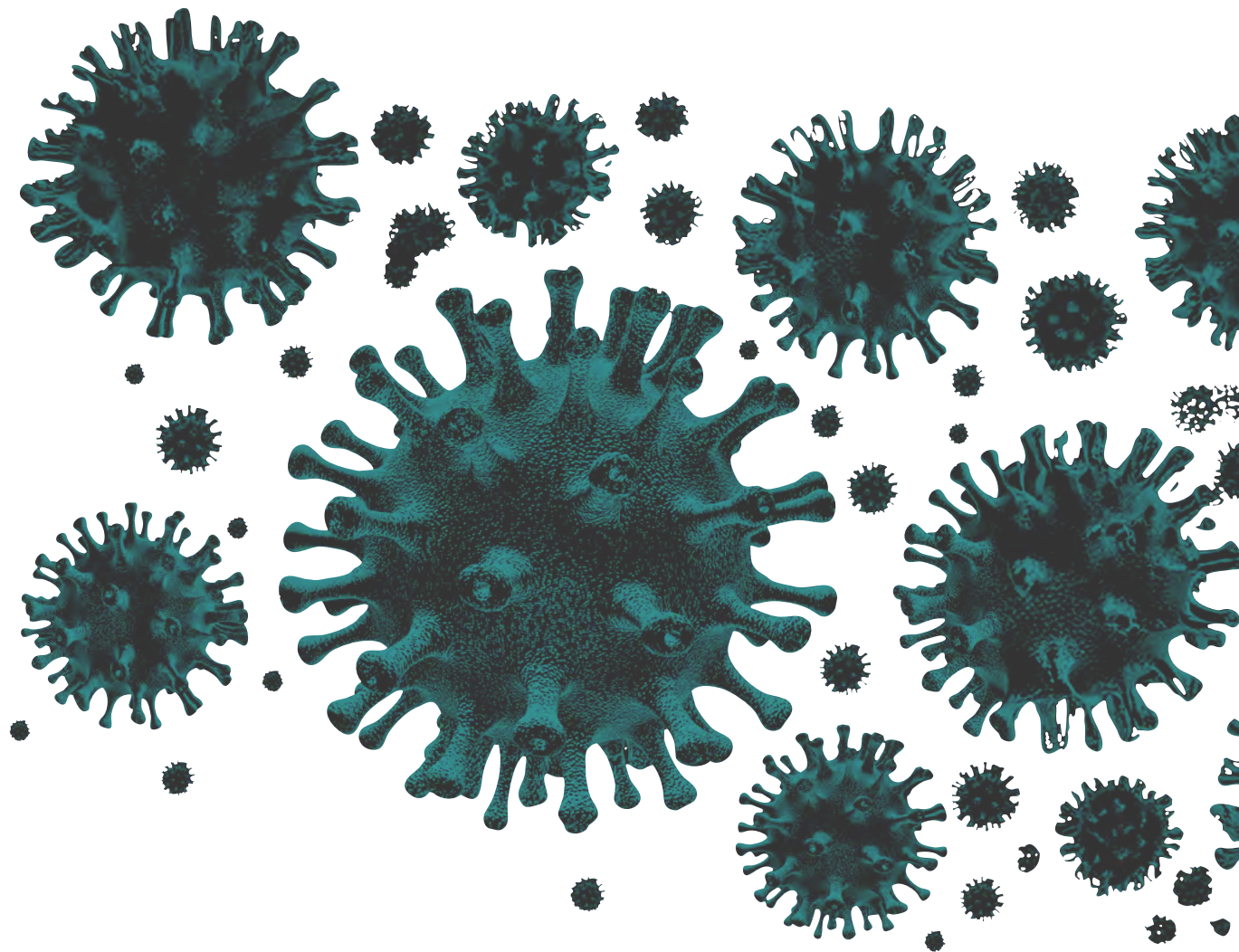
Risk and resilience across DHSC



Robust and effective risk management is essential to securing long-term value for money. Our good practice guide [Overcoming challenges to managing risks in government](#) highlights the need for departments to balance immediate and competing demands with long-term value for money. Resilient public services require a conscious balancing of current and future needs, and improved prevention and preparedness for a range of risks.

Severe risks are monitored by senior leadership committees and are managed locally by senior civil servants at programme or project level. Risks from the wider DHSC family of arm's-length bodies are also managed by DHSC sponsor teams and escalated as required. DHSC's presentation of risk would be clearer if a summary table of risks was presented with a visual indication of the severity of the risk and whether the level of risk had increased, decreased or stayed the same within the year.

Our guide [Good practice in annual reporting](#) includes examples of how public sector entities can clearly report the detail of risk impact and likelihood.



Continued Risk and resilience across DHSC



Figure 7

Risks owned by the Department of Health & Social Care (DHSC) in its 2024-25 accounts

DHSC and its arm's-length bodies are partially or fully responsible for several risks on the National Risk Register (NRR) 2025

Risks reported in DHSC's Annual Report and Accounts (and selected NAO reports)	Referenced in NAO report?	Included on National Risk Register (NRR)?	Reference in NRR
Resilience to cyber-attack	Government cyber resilience (2025)	Yes	National Risk Register 2025: p52
Global threat of antimicrobial resistance and the risk of pandemics or major disease outbreaks	Investigation into how government is addressing antimicrobial resistance (2025)	Yes	National Risk Register 2025: p158
Chemical, biological, radiological or nuclear (CBRN) attack	–	Yes ¹	National Risk Register 2025: p40
Risks to Critical National Infrastructure	Progress with the New Hospital Programme (2023)	No	–
Continuity of supply of medicines and medical products	–	No	–
Demand for NHS services grows beyond assumptions in the NHS long-term plan	NHS England's management of elective care transformation programmes (2025)	No	–
Health disparities	Progress in preventing cardiovascular disease (2025)	No	–
Inadequate levels of funding	NHS financial management and sustainability (2024)	No	–
Industrial action	–	Yes ²	National Risk Register 2025: p175
Staff numbers and skills are not retained and DHSC's workforce lacks sufficient capacity and capability to deliver a quality service	NHS England's modelling for the Long Term Workforce Plan (2024)	No	N/A
The sustainability of adult social care	Local government financial sustainability (2025)	Yes ³	National Risk Register 2025: p65

Notes

- 1 The risk of pandemics or outbreak of an emerging infectious disease is included in the NRR, however antimicrobial resistance has not been included as a main risk in the NRR since 2020. However, it has been included here because DHSC includes it within this risk category and it is included in the NRR as a chronic risk. Chronic risks are managed through a separate risk management process than the acute risks in the NRR.
- 2 Industrial action is recognised in the NRR as a wider risk across the whole of the UK workforce, beyond the healthcare sector.
- 3 The NRR risk is specifically for major adult social care provider failure rather than for the sustainability of the adult social care market as a whole.

Source: National Audit Office analysis of the Cabinet Office, *National Risk Register 2025* and Department of Health & Social Care's *Annual Report and Accounts 2024-25*

Continued Risk and resilience across DHSC



Our recent reports have highlighted a number of examples of some of these risks crystallising or responses to the risk slowing.

Resilience to cyber attack

Our January 2025 report [Government cyber resilience](#) found that a cyber attack on a supplier of pathology services led to over 10,000 acute outpatient appointments being postponed.

Global threat of antimicrobial resistance

Our February 2025 [Investigation into how government is addressing antimicrobial resistance](#) found that the development of new antimicrobials has slowed and is insufficient to withstand or reverse antimicrobial resistance.

Funding not matching service demands

Our October 2025 report [Costs of clinical negligence](#) found that the government's estimated liability for claims has quadrupled to £60 billion since 2006-07 due to more claims and the rising costs of each settlement. Forecasts remain uncertain but it is likely that the costs will continue to grow substantially putting further pressure on the NHS budget.

Our July 2024 report [NHS financial management and sustainability](#) found that the NHS's financial position was worsening because of issues including inflationary pressures, failure to invest in the estate and the cost of post-pandemic recovery.

Demand for NHS services

Our December 2025 report [Primary and community healthcare support for people living with frailty](#) found that there are clear failings and unexplained regional variations in how GPs assess and support people. Whilst DHSC and the NHS have put in place some positive initiatives, these are fragmented and lack holistic evaluation to demonstrate their combined impact.

Our March 2025 report [NHS England's management of elective care transformation programmes](#) found that NHS England's diagnostics, surgical and outpatients transformation programmes had not met their goals to help reduce elective care waiting lists.

End of life care

Our October 2025 report [The financial sustainability of England's adult hospice sector](#) found that DHSC and the NHS do not know how reliant they are on the independent adult hospice sector for the provision of palliative and end-of-life care, and that nearly two-thirds of independent adult hospices recorded a deficit in 2023-24, by far the highest proportion over the preceding ten years, with some hospices reducing the volume or range of services they provide.

The hospital estate

Our January 2025 report [Maintaining public service facilities](#) found that on average, according to NHS England's Estates Returns Information Collection (ERIC) data between 2019-20 and 2023-24 approximately 5,400 clinical service incidents occurred in the NHS every year due to property and infrastructure failures. The latest published data included approximately 5,100 incidents in the same category took place between 2020-2021 and 2024-25.

About the NAO

The National Audit Office (NAO) is the UK's independent public spending watchdog and is responsible for scrutinising public spending for Parliament. We audit the financial accounts of all departments, executive agencies, arm's-length bodies, some companies and charities, and other public bodies. We also examine and report on the value for money of how public money has been spent.

The NAO is independent of government and the civil service. The NAO's wide remit and unique access rights enable us to investigate whether taxpayers' money is being spent in line with Parliament's intention and to respond to concerns where value for money may be at risk.

We support all Members of Parliament to hold government to account, and we use our insights to help those who manage and govern public bodies to improve public services.

We produce reports:

- on the annual accounts of government departments and their agencies;
- on the economy, efficiency and effectiveness with which government has spent public money; and
- to establish the facts where there are concerns about public spending issues.

We do not question government policy objectives. We look at how government has spent money delivering those policies and if that money has been used in the best way to achieve the intended outcome.

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About this report

This report has been produced to provide an overview of the NAO's examination of the spending and performance of the DHSC.

It is intended to support the DHSC Select Committee and Members across the House in their examination of the DHSC.

This report updates our previous report, [An Overview of the Department of Health & Social Care for the new Parliament 2023-24](#), published in February 2025.

How we have prepared this report

The information in this report draws on the findings and recommendations from our financial audit and value for money work, including the annual report and accounts of the DHSC and its partner organisations. In some cases, to provide the most up to date information, we have drawn on information from publicly available documents. We have cited these sources throughout the guide to enable readers to seek further information if required.

Where analysis has been taken directly from our value for money or other reports, details of our audit approach can be found in the Appendix of each report, including any evaluative criteria and the evidence base used. Other analysis in the guide has been directly drawn from publicly available data and includes the relevant source as well as any appropriate notes to help the reader understand our analysis.