Methodology

Public services performance tracker 2026: the NHS

General

Public services spending, including estimates of the total spend on public services

To estimate the real cost of public spending, we deflate government spending figures using the GDP deflators published by the Office for Budget Responsibility (OBR) in the Economic and Fiscal Outlook from October 2026.[1] To better reflect the underlying inflation conditions present in 2020/21, we estimate our own figures by generating a mid-point that averages across values from 2019/20 and 2021/22. We deflate spending figures in our financial analysis across the entire report to 2026/27 prices. There are some instances throughout where we put spending into prices from a year other than 2026/27. Where this is the case, we explain our reasoning in the Methodology below.

In cases where we calculate real-terms changes in figures that relate to individuals – for example, wages or the adult social care means test – we use the consumer price index (CPI) rather than the GDP deflator. The CPI that we use also comes from the OBR's Economic and Fiscal Outlook from October 2026.

Institute for Government interviews

For this report, we conducted around 20 interviews between June and August 2026 with various relevant stakeholders, including subject experts from civil society organisations, civil servants and frontline staff.

Chapter NHS 1 – introduction and overview

Table NHS 1.1: NHS performance against key targets, June 2024 to September 2026

We chose the metrics in this table principally because they are targets in the NHS's '2025/26 priorities and operational planning guidance'[2] and the NHS's 'Medium Term Planning Framework – delivering change together 2026/27 to 2028/29'.[3]

For each metric, we took the published data for every available month since June 2024. For all apart from A&E waiting times and ambulance response times, this is the data to August 2026. For those metrics, it is data to September 2026.

For details on how we calculated "Urgent GP appointments seen on the same day", please see Figure NHS 1.16 below.

For details on how we calculated "GP patient experience", please see Figure NHS 1.17 below.

Chapter NHS 2 – Elective care

Figure NHS 1.3: Elective cases waiting less than 18 weeks for treatment, by trust, October 2017 to August 2026

For this, we include only acute trusts and only those that completed more than 5,000 elective cases in 2025/26. We did this because these are the most comparable trusts. Specialist trusts and trusts with small amounts of elective activity tend to have higher elective performance because they are managing smaller lists. Including them would therefore skew this analysis.

Figure NHS 1.5 Additions to and removals from the NHS elective waiting list in the previous 12 months, March 2017 to August 2026

The number of cases removed from the elective waiting list is the sum of completed admitted pathways, completed non-admitted pathways, and derived unreported removals.

The number of cases added to the elective waiting list is the number of "New RTT periods".

In both cases, we sum them for the previous 12 months to both smooth seasonality and to give a better view of the trend.

Figure NHS 1.7 Appointments delivered in primary care in the previous 12 months, by staff group, August 2019 to August 2026

This data comes from the GP appointment dataset. For each staff group, it is the sum of the appointments that happened in both general practice (table 1a) and primary care networks (table 1b). We then sum the appointments for the previous 12 months, starting from August 2019 (the first month for which there was data for the previous 12 months). We sum appointments over the previous 12 months to smooth seasonality, make the trend clearer, and match the numbers discussed in the text.

Figure NHS 1.8 Unreported removals from the NHS elective waiting list, as a proportion of additions to the waiting list, 2016/17–2026/27*

We sum the number of derived unreported removals and the number of new RTT periods for each financial year and then divide the former by the latter.

For all years apart from 2026/27, this is the full financial year, April to March. For 2026/27 this is only the first five months, April to August.

We chose to use new RTT periods as the denominator because we felt that gave the best comparator of additional need for validation in a given year.

Figure NHS 1.9 Removals from the NHS elective waiting list per working day, by financial year, 2016/17–2026/27

The number of cases removed from the elective waiting list is the sum of completed admitted pathways, completed non-admitted pathways, and derived unreported removals. We then divide that number by the number of working days in each month. We do that to strip out the effects on activity from having different numbers of working days in each month.

Figure NHS 1.10 Proportion of completed cases that had been waiting more than 18 weeks for treatment, by type of case, January 2019 to August 2026

We take the number of completed pathways that took place within 18 weeks from the RTT overview and subtract that from the total number of completed pathways to calculate the number of completed pathways for cases that had been waiting more than 18 weeks. We then divide that by the total number of completed cases in that month to come to the proportion described here. We do this for both admitted and non-admitted pathways and sum the two to find the total.

Figure NHS 1.11 Elective cases waiting less than 18 weeks for treatment, actual and projected, January 2020 to March 2029

This calculates the number of additions and removals (the sum of completed admitted and non-admitted pathways and unreported removals) to the elective per working day between April 2024 and March 2026. We chose these months as we believe they are the months which we believe give the best view of any post-pandemic trend.

We then use those averages to project forward the monthly number of removals and additions to the waiting list between August 2026 (the most recent outturn data) and March 2029.

We take the size of the waiting list in August 2026, add the projected additions and subtract the projected removals for each month to come to an estimate of the size of the waiting list in any given month between August 2026 and March 2029.

That allows us to calculate a "clearance time" for each month. The clearance time is the size of the waiting list divided by the number of removals from the waiting list in that time, effectively the number of weeks it would take to clear the waiting list if there were no further additions.

We then calculated the clearance time for every pre-pandemic month for which there is data and put those results into a linear regression with 18-week performance as the dependent variable. That gave the following equation:

18-week percentile = -0.0337 x clearance time (weeks) + 1.232

We could then apply that equation for all the monthly projected clearance times that we have between August 2026 and March 2029 to calculate the expected 18-week performance for each month.

Table NHS 1.3 Elective cases waiting less than 18 weeks for treatment in March 2029 under different scenarios

We took the methodology described above for Figure NHS 1.11 and then created different scenarios using different assumptions about the growth rate of additions and removals between 2026 and 2029.

For the "additions slowdown" scenario, we applied the average annual growth rate in additions to the waiting list between 2016 (the first full calendar year for which there is data) and 2019 (the last calendar year that was unaffected by the pandemic). This seemed like a fair assumption as it was an additions growth rate which the NHS operated with for many years. We hold the removals assumption unchanged from the central estimate.

For the "removals accelerate" scenario, there was no easy assumption about the growth rate for removals as there was for additions – total removals growth averaged 2.1% per year between 2016 and 2019, below current levels. There is also no easy way to estimate the expected impact of various measures the NHS is implementing (such as elective hubs, PIFU, or Further Faster 20) to improve removals. We therefore chose 4.0% as a reasonable but stretching increase above the 2024 to 2026 trend (3.2%) without reaching a level that would be incredibly difficult to sustain over years. We hold the additions assumption unchanged from the central estimate.

The "optimistic estimate" scenario combines the additions and removals scenarios described in the two paragraphs above.

The "recent trends" scenario extends the period which we use as the baseline for our central estimate from April 2024 to March 2026 to April 2024 to August 2026. That captures both a slowdown in the removals growth rate and an increase in the growth rate of additions in the first five months of 2025/26.

Figure NHS 1.12 Fully qualified GPs working in primary care, by type, September 2015 to September 2026

Data for number of GP partners and GP retainers comes from the NHS Digital GP workforce bulletin tables. The number of salaried GPs combines the total from that data source with the total from the Primary Care Network bulletin tables to calculate the total number of salaried GPs working in primary care.

Figures NHS 1.14 and 1.15 Community health cases waiting less than 18 weeks for treatment, by patient age group, January 2023 to August 2026 & Community health cases waiting more than 52 weeks for treatment, by patient age group, January 2023 to August 2026

We took each month from NHS England's community health waiting list dataset. In that we summed tables 4a, 4b, 4c, 4d, and 4e by specialty to come to the total number of cases waiting less than 18 weeks for care. To calculate the total number of cases waiting more than 52 weeks, we summed tables 4g and 4h. Data for the total size of the waiting list comes from table 4.

We then consolidated every month into a time series starting in January 2023 (the first month for which there is data). We summed the relevant categories to create a total number of adults and children and young people waiting for care. Then we divided the number of cases waiting less than 18 weeks and more than 52 weeks by the total waiting list to come to the totals shown in the chart.

Figure NHS 1.16 GP appointments delivered on the same day they were booked, by severity of appointment, October 2022 to August 2026

The monthly GP appointment CSVs provide a breakdown of appointments at a practice level. It also provides data about how the practice coded those appointments and the length of time between the booking and the appointment.

As a proxy for "urgent appointments", we the classification "general consultation acute", which is how the NHS encourages practices to code appointments that it deems to be urgent.

For each month, we calculated the number of "general consultation acute" appointments that took place on the same day and the number that took place any length of time after that. We divided the former by the total of the two to come to the percentage shown in the chart.

We then did the same for all appointments that were coded as anything other than "general consultation acute". We then summed the "general consultation acute" and non-"general consultation acute" to come to the total line.

We did this for every month since October 2022 (the first month for which this data is available).

Figure NHS 1.17 Patients having a good experience of their GP practice, August 2024 to September 2026

The ONS releases this data every four weeks, but we present our data on a monthly basis. For most months, this doesn't cause an issue; there is one data release in that month. But for some months there are two releases, four weeks apart.

When that happens, we sum the total number of "good" responses for those two releases and divide it by the total number of responses in those releases to create a proportion of people who reported a good experience of general practice in that calendar month.

Figure NHS 1.19 Change in NHS hospital staff numbers, since April 2019, by type of staff

Clinical staff is the sum of HCHS doctors, nurses & health visitors, midwives, and ambulance staff. Non-clinical staff is the sum of scientific, therapeutic & technical staff, clinical support staff, managers, senior managers, staff working in central functions and staff working in hotel, property & estates. 'Total' is the sum of these two.

This excludes staff working in CCGs and ICBs, to provide a clearer picture of staffing patterns in hospital trusts.

This time series starts in April 2019 because that is the start of the NHS Long Term Plan which led to a large acceleration in recruitment between 2019 and 2024.

Figure NHS 1.20 Staff working in Department of Health and Social Care and NHS England, January 2013 to August 2026

The "Department of Health and Social Care and predecessors" line shows staff working in DHSC and DH, before it changed its name.

The "NHS England and predecessor organisations" line is a combination of people working in that organisation and the following organisations:

- Health & Social Care Information Centre
- NHS Digital
- Health Education England
- Monitor
- NHS Trust Development Authority

We aggregate these to show a comparable total over time for the size of NHSE in 2026.

The "Total" line is the sum of the NHSE and DHSC line.

Figure NHS 1.24 Real-terms change in spending on NHS services, by type of service, 2016/17–2025/26

The "Acute, ambulance, and specialist trusts" and "Community trusts" lines show outturn data from NHS England's 'Consolidated NHS provider accounts', and 2016/17 is the first year for which there is data. The spending amount here is expenditure net of depreciation, net finance costs, impairments and transfers by absorption.

For the general practice line, we use outturn data from the NHS's 'Investment in general practice' dataset. That has data for 2016/17 to 2022/23. There is no later outturn data. For the IfG projection between 2022/23 and 2025/26, we apply assumptions about the uplift in funding from the GP contract changes in each year.

For 2022/23 to 2023/24, we sum the PMC allocations and the ARRS funding allocations for both years from NHS England's "Update to the GP contract agreement 2023/24: financial implications" document.[4] This gives us £11.074bn of funding in 2022/23 and £12.024 in 2023/24, with a cash terms increase of 8.6%.

For 2023/24 to 2024/25, we use the same document and process for that year.[5] That gives us a total of £12.024bn in 2023/24 and £12.663bn in 2024/25 – an increase of 5.3% in cash terms.

For 2024/25 to 2025/26, we use NHS England's 'Changes to the GP Contract in 2025/26' document.[6] That shows the "estimated contract value" in 2024/25 as £12.287bn and in 2025/26 as £13.176bn, meaning a 7.2% cash terms growth.

Applying those year-on-year percentage changes to the outturn data from 2022/23 gives as cash terms projection between 2022/23 and 2025/26 and a time series from 2016/17 to 2025/26.

We then deflate those cash terms outturn and projections amounts using the GDP deflator from the 2026 autumn budget.

Figure NHS 1.25 NHS staff, by staff group, December 2018 to August 2026 (index, June 2024 = 100)

All staff are shown in terms of FTEs.

Data for the GP partners, and GP trainees comes directly from the NHS Digital GP workforce bulletin tables. For salaried GPs and nurses, we take data from that source and then staff that are employed in primary care networks. This therefore captures all staff in the wider primary care workforce.

For the direct patient care (DPC) staff, three approaches were used for different time periods:

- Between March 2019 and June 2021, the DPC staff are a combination of the GP workforce bulletin tables DPC staff and those from the primary care network workforce bulletin tables.
- From September 2021 onwards, the DPC staff comes from the primary care workforce – nurses, DPC and admin/non-clinical staff dataset.

Because there is only quarterly data about the number of direct patient care staff (released for March, June, September, and December every year) but the chart requires a monthly amount, we interpolate the missing months on a straight-line basis. As the most recent month for most staff is August 2026, there is no data for the last two months of this time series for DPC staff, meaning the last datapoint is June 2026.

"Hospital nurses" is the sum of adult and children's nurses in NHS England's 'NHS workforce statistics'.

"Hospital doctors" is all HCHS doctors recorded in NHS England's 'NHS workforce statistics'.

"Ambulance staff" is the sum of "Ambulance staff" and "Support to ambulance staff" in NHS England's 'NHS workforce statistics'. We combine these two categories to account for a change in definition of these staff in April 2019, which saw some move ambulance staff reclassified as support staff.

"Non-clinical hospital staff" is the sum of scientific, therapeutic & technical staff, clinical support staff (excluding support to ambulance staff to avoid double counting), managers, senior managers, staff working in central functions and staff working in hotel, property & estates in NHS England's 'NHS workforce statistics'.

"District nurses" is the sum of staff classified as "District nurse – first level" and "District nurse – second level" in NHS England's 'NHS workforce statistics'.

"Other community nurses" is the sum of the following staff groups in NHS England's 'NHS workforce statistics':

- Nurse Consultant
- Modern Matron
- Community Matron
- Nurse Manager
- Children's Nurse
- Other 1st Level Nurse
- Other 2nd Level Nurse
- Post 1st Level Registration Nurse Learner
- Post 2nd Level Registration Nurse Learner

"All NHS staff" is the sum of all these staff. As this is the sum of all these staff groups, it can only go to June 2026, which is the last month for which there is data for DPC staff. This total also includes the interpolation of the monthly estimates for DPC staff, as described above.

Figure NHS 1.26 Average monthly change in NHS staff numbers, by staff group and period, September 2015 to August 2026

The method for calculating these totals is the same as in above figure NHS 1.25, only expressed in absolute terms.

This chart excludes non-clinical hospital staff because it is such a large group that it would distort the y-axis, making it hard to see the variation between other staff groups.

Figure NHS 1.30 Average annual change in vaccination coverage, by vaccine type and time period, 2013/14 to 2025/26

References

[1] Office for Budget Responsibility, 'Economic and Fiscal Outlook', OBR.UK, March 2025, retrieved 8 October 2025, https://obr.uk/efo/economic-and-fiscal-outlook-march-2025/
[2] NHS England, '2025/26 priorities and operational planning guidance', ENGLAND.NHS.UK, August 2025, retrieved 10 November 2026, https://www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/
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[6] NHS England, 'Changes to the GP Contract in 2025/26', ENGLAND.NHS.UK, March 2025, retrieved 10 November 2026, https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/