ORTENT WHITEPAPER

What NHS boards say, and what they have done

A read of every English health system's 2026 board papers, comparing what each one treats as a priority with what it has delivered.

By Andrew Wyatt, Founder, Ortent Advisory Ltd

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Executive summary

The NHS has a national plan. The 10 Year Health Plan for England, "Fit for the Future", was published on 3 July 2025 and runs to 2035. It is built on three shifts: care from hospital to community, from analogue to digital, and from sickness to prevention.

This paper measures nine themes against that plan. Five come straight from it: care closer to home, the electronic patient record, the single patient record, AI, and prevention. The other four are the standing priorities every board has to report on alongside it: finance, productivity, workforce, and cyber security. For each system, the paper compares how much the board treats each theme as important with how far it has actually got. Both come from the systems' own 2026 board papers.

The work covers all 42 English health systems, the regional bodies that run the NHS, and the organisations inside them: 122 assessed, 119 carrying at least one score. Each of the nine priorities gets two scores out of ten: one for how important the board treats it, one for how far it has been delivered. Each score carries a supporting extract and a citation, and almost every directly scored cell also carries a page reference. There are 911 evidenced scores in all.

This read was taken in July 2026, one year into a plan that runs to 2035. Most of its milestones are still ahead: NHS Online by 2027, the NHS App as the full front door by 2028. So these are early scores. A year in, low delivery is expected across the board, and the value is in the comparison: which systems are further ahead, and where the gap between importance and delivery is widest. We will run it again every quarter, and the picture will get sharper each time. What follows is where things stood in July 2026.

At national level, all nine priorities score higher for importance than for delivery, and the same holds for every system averaged across its evidenced themes. The biggest gap is finance. It is the priority boards rate highest and the one they have delivered least, a gap of almost three points out of ten. Every other gap is between one and two points.

Two other things stand out. AI now shows up in 73 of the 119 organisations, but nearly always as a trial or a purchase, not a full rollout. It appears more often as procurement or a trial than as delivery at scale. And doing well on one priority is a weak guide to the others. A system that has delivered its record has not, by that fact, sorted its money, its productivity or its staffing. Progress is local to each system, not shared across the whole.

The paper explains what the radar measures, how it is scored, where each of the nine priorities stands, and what that means for two groups: companies selling software to the NHS, and the boards themselves. It covers England only, as at July 2026.

The map goes with the paper. At ortent.co/tools/nhs-board-radar you can colour all 42 systems by importance, by delivery, or by the gap between them, switch to a regional view, and open any system to see the evidence behind its scores.

What the radar measures

The radar scores every English health system against nine themes. These are the things the national plan asks the NHS to do, and the things boards report on: care closer to home, digital and the electronic patient record, prevention, the single record, AI, finance, productivity, workforce, and cyber security.

Each theme gets two scores out of ten. Delivery is how far the work has got: from nothing, to a written plan, to a small trial, to a full rollout with results. Importance is how hard the board is pushing it: from no mention, to a stated aim, to a funded plan with money behind it.

The two scores usually differ, and almost always the same way round. Importance sits above delivery, because a priority is something a board wants to do more of. A board can want something a lot and have barely started, which is the normal case here.

The unit is the health system: the 42 regional footprints that planned NHS care across 2022 to 2026. Most are made up of more than one organisation, so the map shows the average for the system and lets you open each organisation underneath. This matters, because one colour on the map can hide big differences inside. Devon, for example, runs from 4.6 to 5.2 across its organisations. The average is honest, but it is not the whole story, and the tool shows both.

How each theme is scored

The delivery score follows a simple ladder. Nothing behind it scores near zero. A written plan with no action scores low. A funded trial scores in the middle. A full rollout with results scores high. So a five is a live trial or a signed contract, not finished work. An eight is something running across the whole organisation with numbers to prove it.

The importance score follows the same ladder. No mention scores zero. A line in a strategy scores low. A funded plan with money attached scores high.

Finance is scored differently, because a deficit is not automatically a fail. A system running a shortfall it was told to run is judged on how well it is handling its position, not simply on whether it is in the black.

The rules that keep the scoring honest

Four rules keep the scores tied to the evidence.

First, every score shows its proof. Each one cites the board pack and gives a supporting extract from the cited page, on almost every directly scored cell. Extracts are drawn from the page they cite; nothing is scored from memory or guessed.

Second, silence is not a low score. If a theme does not appear in a system's papers at all, it is marked "no evidence" and left out of the averages, rather than scored as zero. A theme that shows up in two packs out of five is scored from those two, not padded to look complete.

Third, naming a risk is not the same as dealing with it. A board that lists cyber security as a risk has not, by that act, done anything about it. Themes that show up only as a noted risk score low.

Fourth, nothing is scored without evidence in front of it. Every score carries a supporting extract and a citation, and almost every directly scored cell carries a page reference. The extracts have been through an automated screen against the board packs; sixteen cells still await individual source verification or re-sourcing, and the data records which ones. Where a pack is dated in the future, it is marked as tabled, not approved, so a plan is never counted as a result.

These rules cost coverage. Several themes are scored from fewer than half the packs, and the paper says so.

The overall picture

Delivery sits in a narrow band in the middle of the scale. No theme averages above 5.5 or below 4.4. On their own papers, England's health systems are doing a bit of everything and a lot of almost nothing. Care closer to home and digital lead, both around 5.5. Cyber security trails at 4.4. The rest sit in between.

Importance scores are higher, and they vary more. On finance, the average importance score is 7.6 and the average delivery score is 4.6. That gap, almost three points, is far bigger than any other. Every other gap is between one and two points. Boards feel the most pressure where they have delivered least, which is on money.

That gap affects the other eight priorities too. A board told to close a deficit weighs every other decision, digital and AI included, against what it costs this year.

Finance: the biggest gap between priority and delivery

Finance is the priority boards want fixed most and have fixed least. It has the highest importance score in the data and one of the lowest delivery scores. Nothing else has the same distance between the two.

This affects every other priority. When a board is told to save money this year, a good product is not enough. It has to save money too. Anything that adds cost works against the board. Anything that takes cost out this year works with it.

AI: widely adopted, rarely scaled

AI now appears in the papers of 73 of the 119 organisations. Where it appears, the average delivery score is 5.0, which means a trial or a purchase, not a rollout. In most cases the AI is ambient voice: software that listens to an appointment and writes up the notes, so the clinician does not have to.

The picture splits in two. A growing group of trusts is past the trial stage. West Hertfordshire has rolled the ambient voice tool Heidi out across the whole trust. Great Ormond Street has tested ambient voice across eight sites and 17,000 patients. Derbyshire is running Microsoft Copilot and ambient voice together. Sherwood Forest, the Black Country and Royal Devon have signed contracts at board level. Behind them is a much bigger group where AI is a line in a strategy or a risk register and nothing more.

So across the NHS, AI shows up more often as procurement or a trial than as delivery at scale. Demand is real, and delivery is early. For a company selling AI, the main barrier is not a rival product. It is the trial that never turns into a rollout.

Digital records: nearly everywhere, mostly early

The electronic patient record, the digital system that replaces paper notes, appears in 111 of the 119 packs, more than any theme except finance and productivity. Almost every board is doing something with it. Few are finished.

An average around 5.5 means records that are in place or being installed, with systems that are meant to talk to each other but often do not yet. Only four organisations score at the top of the scale, running a mature version of Epic, one of the leading record systems: University College London Hospitals, Manchester, East Suffolk and North Essex, and Cambridge.

The gap between a trust three years into its record and one still writing the business case is the widest of any theme, and neighbouring trusts sit at opposite ends of it. Most of the NHS is in the middle: it has bought a record and is still learning to use it. That is a different job from starting fresh, and it calls for a different kind of product. The value is in making the record a trust already owns work harder, not in replacing it.

The single patient record: strong in a few systems, missing in most

The single patient record is the plan's goal of one record per patient that follows the person across every service: GP, hospital, community, mental health and social care. It is a different thing from the electronic record above, which digitises one organisation. This one joins every organisation's data around one patient. The government expects people to start viewing their single patient record from 2028. Two things sit underneath it, and boards are building both now: shared care records, which join up a region, and the Federated Data Platform, the national system that links data across NHS organisations. This theme scores that work. It appears in only 49 of the 119 packs, the lowest of any theme.

Where the work is real, it is very real. Dartford and Gravesham has the Federated Data Platform running across the whole trust, with a measured effect on waiting times. Surrey Heartlands, Wye Valley and Northampton are pulling live data from it. But two packs in five is as far as it goes, and the average of 5.1 describes the systems doing the work, not the country. Across the NHS as a whole, the single record is still the exception.

Cyber security: named as a risk, rarely resourced

Cyber security has the lowest delivery score of any theme, 4.4. It shows up mostly as a noted risk, not a funded response. Boards name the threat and set a limit for how much risk they will accept. Far fewer put money behind a plan to deal with it.

A few show real delivery. Devon Partnership holds recognised security accreditations. Sirona has completed a certification and a ransomware audit. These are the exception. For a health service that now depends entirely on its digital records, cyber security is the theme least matched to the risk of getting it wrong. Boards see the finance gap because the regulator tracks it. The cyber gap is harder to see, which is why it carries more risk than it looks.

The themes do not predict each other

I also checked whether doing well on one theme goes with doing well on another. Mostly it does not. The closest link is between digital records and AI, and even that is weak: a trust with a mature record is only a little more likely to be trying AI. No theme is a good guide to any other.

Progress in the NHS is local, not shared. A system that has fixed its record has not, by doing so, fixed its money, its productivity or its staffing. A board that buys one system hoping it drags the others up will be disappointed. A vendor who sells one product as the key to all the rest is selling a link the data does not support.

Why coverage matters as much as the score

Two numbers matter for every theme: how well it scored, and how often it showed up at all. Care closer to home, prevention, finance, productivity and workforce appear in nearly every pack, so their middling scores can be trusted. The single record, in 41 per cent of packs, and AI, in 61 per cent, are different. Those averages describe the systems doing the work. They are not a national estimate, and because a theme is more likely to appear where there is something to report, they probably read higher than the country as a whole.

The less often a theme appears, the better its average looks, because it is worked out only from the systems that had something to report. So a low coverage figure is not a hole in the research. It is a finding about the NHS: on the single record, most systems had nothing to say.

What this means if you sell software to the NHS

The map shows what boards want, in their own words. It points four ways.

Lead with money saved this year. The biggest gap in the system is finance, and it shapes every decision. A board told to close a deficit does not buy features. It buys cost it can take out this year. The pitch that lands names the saving and the timeframe. The one with the best technology and no saving attached does not.

Sell the path to scale, not the trial. AI demand is real and mostly early. The trusts that have moved got past the trial to a funded rollout with a business case. If you sell AI, make that second step believable before the first one starts. The common failure is not a trial that fails. It is a trial that works with no money to scale it.

Make the record they already own work harder. Most trusts have a record and are still learning to use it. Helping them connect systems and get more from what they have bought beats asking a board to rip out and replace something it has just spent years and money installing.

Do not put too much weight on one flagship customer. Because progress is local, a reference travels less far than you would expect. A win in one trust does not pull in its neighbour. Plan to earn each system on its own terms.

What this means if you sit on an NHS board

The gap between importance and delivery is a useful check, not a league table. Three uses stand out.

Watch the quiet gaps, not just the loud one. Every board knows its finance gap, because the regulator makes sure of it. The riskier gaps are the ones no one is forcing into the open. Cyber security is the clearest: named as a risk in most packs, funded in few, in a service that cannot now work without its digital records. A board that has written cyber down as a risk and moved on has not dealt with it.

Drop the idea that one system fixes the rest. The data shows that buying an electronic record will not, on its own, raise productivity, and no single priority pulls the others up. A board that expects one purchase to carry the rest will be disappointed. Treat each priority as its own job.

Treat silence as a signal. If a national priority does not appear in your board papers at all, that gap is worth a question. The radar leaves out what it cannot see, and a board should be more worried than reassured by a theme that never comes up.

What the radar does not tell you

The radar reads board papers, not the ward. A theme missing from the papers may still be happening on the ground, and a theme written up well may be running less well than it reads. This measures what boards report, and how far their own evidence takes it. No more.

Coverage is a sample, not the full set. In numbers, 122 organisations or groups were assessed across 124 footprint assignments; 119 carry at least one score, and after setting aside two organisations that sit in two footprints, the statistics rest on 911 evidenced cells. All 42 footprints are scored, with one to seven organisations each, but not every provider in the country has been read one by one. Where a system is covered by some of its organisations and not all, the paper says so. The averages exclude themes marked no evidence, so the number of organisations behind each theme differs, and the thinly covered ones, the single patient record in 49 organisations and AI in 73, describe the systems doing the work rather than the country.

One boundary note. These are the 42 system footprints used from 2022 to 2026. The legal map of integrated care boards reduced from 42 to 36 in April 2026, part-way through the period these papers cover, and the boards wrote against the older footprints. Papers dated in the future are marked as tabled, not approved. The picture is England only, and it is refreshed every quarter. The July 2026 read is the current one.

Next steps

Read the map at ortent.co/tools/nhs-board-radar. Colour it by the gap between importance and delivery, switch to the regional view, and open a system you know to see the evidence behind its scores.

Then place yourself on it. The companion prompt at ortent.co/tools/nhs-board-radar/prompt takes your own board pack and scores it against the same nine themes, on the same scale, with the same evidence rule, so you can set your own organisation against the national picture.

If you want to talk through what the map says about your market or your board, ortent.co/contact.