Department of Health & Social Care

# Department of Health and Social Care

## Annual Report and Accounts

## 2020-21

**(For the period ended 31 March 2021)**

Accounts presented to the House of Commons pursuant to Section 6(4) of the Government Resources and Accounts Act 2000

Secretary of State's annual report presented to Parliament pursuant to Section 247(D) of the National Health Service Act 2006

Annual Report presented to the House of Commons by Command of Her Majesty

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This is part of a series of departmental publications which - along with the Main Estimates 2020-21 and the document Public Expenditure: Statistical Analyses 2020 - present the Government's outturn for 2020-21 and planned expenditure for 2021-22.



This publication is also available on our website at: www.gov.uk/official-documents

Any enquiries regarding this publication should be sent to us via our Customer Service Centre using the web contact form at: https://contactus.dhsc.gov.uk/

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# Performance Report

## Permanent Secretary's Overview

The Department of Health and Social Care supports its Ministers in leading the nation's health and care system. Our objectives are delivered in conjunction with our Arm's Length Bodies, to help people live more independent, healthier lives, for longer, creating a safe, high-quality health and care system that is financially sustainable.

The Coronavirus (COVID-19) pandemic continues to be the most significant challenge the country and the public sector has faced in a lifetime. Work on COVID-19 is the single most important operational and policy focus for the whole Department and wider health and social care system.

Continuing to be informed by the best available scientific evidence, the Department's programme of work aims to suppress the virus and protect the NHS in order to save lives and provide a route back to normality. This includes; vaccine and therapeutics development and deployment, protecting the UK from global threats and new variants, ensuring the resilience of the NHS and adult social care sectors, maintaining the supply of critical equipment and goods, reducing transmission through non-pharmaceutical interventions, delivery of effective mass testing, contact tracing, and isolation support services through local partnerships, with tailored support for the most vulnerable.

The NHS was able to create capacity to manage the challenges presented by COVID-19, ensuring that urgent and emergency care and COVID-19-related care were not overwhelmed. Whilst waiting time performance and waiting lists have been significantly impacted by COVID-19, the system continues to work hard to address the challenges, striking the right balance across performance, transformation, innovation, quality, safety and living within its financial means.

The pandemic will have lasting consequences for the health and demography of the nation, the economic, social and political context for our work, and the health and care system itself. It has also led to significant changes to the work of the Department through the establishment of NHS Test and Trace, the Joint Biosecurity Centre and the UK Health Security Agency. COVID-19 has also shone a light on the public health challenges facing the UK population such as obesity, and we intend to strengthen our focus on such public health challenges through the establishment of the Office for Health Improvement and Disparities.

It will be critical that the Department and wider health and care system reflect and learn the lessons from the pandemic – both to improve our preparedness and response to health emergencies as well as to embed broader learning. We must also seize any opportunities for change or reform so that we can build back better. This is driving

much of our work including legislative reform such as the Health and Care Bill and the recent announcements regarding Our Plan for Health and Social care.

In this context it has been an incredibly challenging year to produce the Annual Report and Accounts. The Comptroller and Auditor General (C&AG) has qualified the account in several respects. These matters are discussed in more detail in the Governance Statement and the C&AG's certificate and report within these accounts. We are working towards lifting these qualifications and consider the circumstances in which the majority of these qualifications have arisen to be exceptional.

It remains a great privilege to lead the Department and I would like to take this opportunity to thank all the staff both within the Department and across the health and care system for their continued and dedicated hard work, passion and commitment to support the health and care system in such challenging times.

**Sir Chris Wormald KCB**
**Permanent Secretary of the Department of Health and Social Care**

## Performance Overview

1. This section introduces the role and purpose of the Department, how funding flows from Parliament around the health and social care system and provides a high level performance summary against the Department's strategic objectives.

2. Her Majesty's Treasury (HM Treasury) minimum financial reporting requirements, developed during the 2019-20 Annual Report and Accounts (ARA) process, remain in place for the 2020-21 financial year, in light of the unprecedented steps public sector entities are taking in responding to the Coronavirus (COVID-19) outbreak.

3. The revised requirements streamline performance reporting within the 2020-21 ARA. They notably include the removal of the Performance Analysis, which would normally follow the Performance Overview. Where other reporting has been streamlined or omitted in line with the minimum reporting requirements, this is identified in the report.

4. The COVID-19 response has been the overriding priority for the Department of Health and Social Care throughout 2020-21 and has led to both specific and more general impacts on the operations of the Department and the Government more widely. The impact of COVID-19 on the Department is reflected throughout all sections of this ARA accordingly.

5. Specific sections regarding the Department's COVID-19 activities can be found from **paragraph 25** in the Performance Summary, from **paragraph 529** in the Governance Statement, in the Notes to the Departments Annual Report and Accounts, Annex B and Annex C.

## Our Role and Purpose

6. The Department of Health and Social Care (DHSC) supports the Government's Health and Social Care Ministers in leading the nation's health and care to help people live more independent, healthier lives for longer.

7. We support and advise our Ministers to shape policy and set direction, while remaining accountable for delivering the Government's commitments, co-ordinating the legal, financial and policy frameworks in health and social care and, when necessary, we step in as troubleshooters to take action on complex issues, as can be seen in the Department's response to the COVID-19 pandemic. In doing all this, we work closely with our partners in the health and care system, our Arm's Length Bodies (ALBs) and agencies, local authorities, across Government, and with both patients and the public. We are accountable for the health and care system to Parliament and the taxpayer.

8. As a Department of State our strategic priorities in 2020-21 were:
    - A response to COVID-19 and health protection that continues to support health care systems, anticipates future demands and utilises lessons learned to enact wider change and reform to health and social care.
    - A healthier nation that tackles the causes of poor physical and mental health, racial disparities in healthcare, and ongoing efforts to ensure we play a leading role in confronting global health challenges.
    - A transformation in social care that applies lessons learned from COVID-19 and supports the most vulnerable in our community and integrates effectively with healthcare.
    - A stronger and more integrated health and care system driven by system reform, spending review and the ambitions set out in the Long Term Plan that delivers better outcomes, confidence and patient experience.
    - A workforce fit for the future created by recruiting, retaining and developing the people we need, and by making the health and care system a rewarding place to work.
    - A digital revolution which will harness the full potential of data and technology to inform better decisions that improve the delivery of healthcare for the twenty-first century.
    - A well-managed end to European Union transition helping the health and care system to manage the complexity and risk associated with our departure.
    - Building infrastructure for the future to lead on systems reform, build a new relationship between the Department and those delivering care, whilst supporting wider government manifesto commitments.

9. COVID-19 remains the biggest challenge the country and our public sector have faced in a lifetime. DHSC is central to the Government's response and, as a result, the Department has continued to adapt in these unprecedented times. Work on COVID-19 is the single most important operational and policy focus for the whole Department and wider health and social care system in 2020-21.

10. Important wider work continues where we have legal responsibilities to deliver our core corporate functions and to support key commitments beyond COVID-19.

11. The Department works through a number of ALBs, whom we support and hold to account in carrying out their responsibilities. These are set out in further detail in the Accountability Report and include:
    - NHS England and NHS Improvement (NHSE and NHSI) who collectively lead the NHS in England; ensuring patients receive high-quality care in local health systems that are financially sustainable;
    - Health Education England (HEE) who work across England to deliver high-quality education and training to the people who work in the NHS and public health;

- Public Health England (PHE) who provide national leadership, advice and support across the three domains of public health: protecting the public's health, improving the public's health and improving population health. As of October 2021, the Office for Health Improvement and Disparities (OHID), previously announced as the Office for Health Promotion (OHP), incorporated most of PHE's functions that directly support development and delivery of national health improvement policy. PHE's health protection functions have transferred to the new UK Health Security Agency (UKHSA), the UK leader for health protection and ensure the nation can respond quickly and at greater scale to deal with pandemics and future threats. UKHSA was formally established in April 2021 and was fully operational from October 2021.
- The Care Quality Commission (CQC) who monitor, inspect and regulate the health and social care service.
- Medicines and Healthcare products Regulatory Agency (MHRA) who regulate medicines, medical devices and blood components for transfusion in the UK.

12. The Department has prioritised building strong governance and boards in each of these organisations and its other ALBs, and, where necessary, acting as a national co-ordinating mechanism.

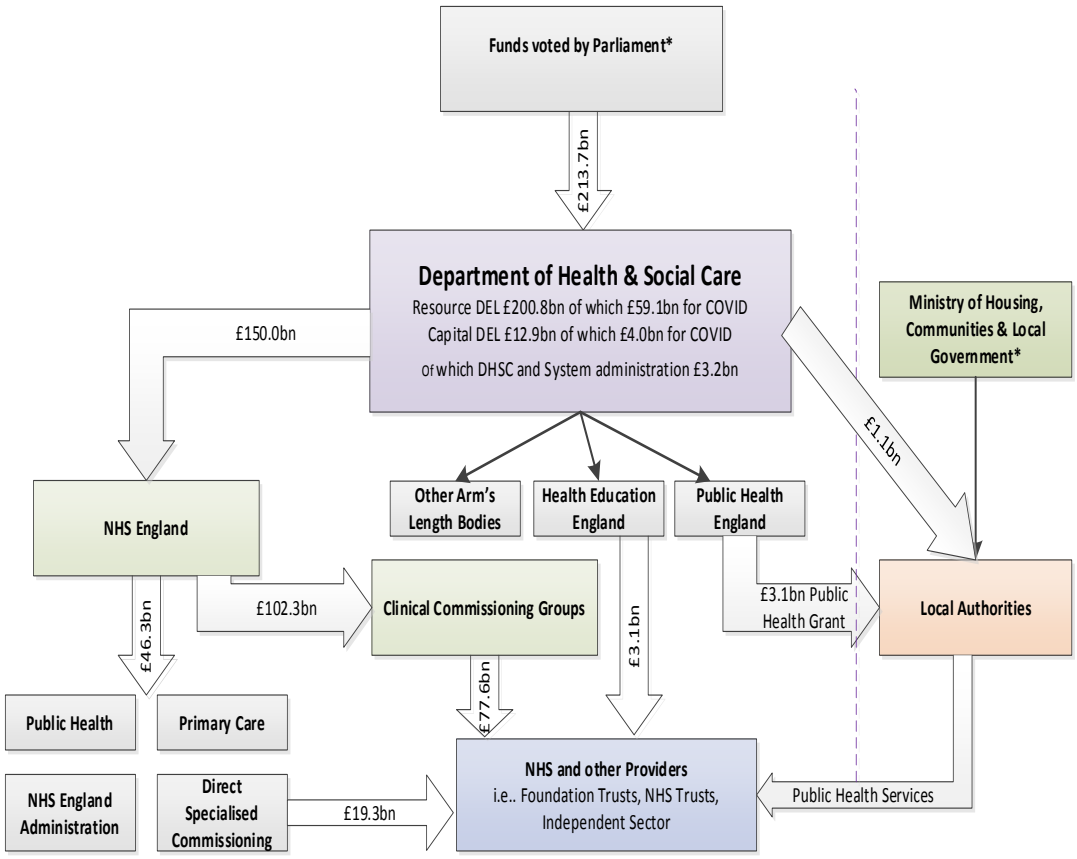
13. The Secretary of State for Health and Social Care and other Departmental Ministers are accountable to Parliament for the provision of the comprehensive health and care service in England. To enable the system to work flexibly, the critical day-to-day operational decisions are made by the professionals working in provider organisations, supported by the strategic and regulatory functions carried out by our ALBs.

14. We secure funds for health and care services and remain accountable for this funding, which is allocated to the most appropriate local level. During the 2020-21 financial year, the Department had a revenue expenditure limit of £200.8 billion and invested a further £12.9 billion in capital funding such as new hospitals and equipment, as detailed in **Table 4** below **paragraph 201**.

15. **Figure 1** demonstrates how funding flows round the system, using agreed budget totals for 2020-21 per the Supplementary Estimate for contextual purposes.

16. Separately, but not shown in **Figure 1**, the Department is responsible for securing funds for adult social care through the Spending Review settlement, albeit the Ministry of Housing, Communities and Local Government (MHCLG), now called the Department for Levelling Up, Housing and Communities, remains accountable for the allocation of those funds to local authorities.

## Figure 1: Funding flows in the health and care system, 2020-21 (per Supplementary Estimate)




*This includes funding from National Insurance Contributions that are not included in the parliamentary vote on DHSC budget. This funding is received directly from HMRC via the National Insurance Fund which is provided for in legislation.
Budgeted figures are used in this presentation with actual figures used by exception where allocations are not included in budgets.
Dashed line indicates boundary of consolidation for DHSC and shows Local Authority funding to Health. MHCLG is now referred to as the Department for Levelling Up, Housing and Communities.

## Our 2020-21 Achievements - At a glance

**COVID-19 vaccination programme**, over 26.7 million vaccinations administered by 31 March 2021

**Universal COVID-19 testing offer**, giving everyone in the UK without symptoms access to weekly testing

Consultation on the first government-led **Women's Health Strategy**

Departmental **commitment to recovery** after COVID-19

99% of GP practices offering **video consultations**

Management of the end of the **EU Transition Period**

Publication of the **White Paper on Integration and Innovation**

Publication of the **NHS People Plan for 2020-21**

Additional **£15bn funding for the NHS** for **2021-22**

Publication of the **Mental Health Act White Paper**

## 2020-21 - Key Finance Facts

**Resources & cash** contained **within all budgets** set by Parliament

**£63bn COVID** funding **secured** to deal with the **pandemic**

**£13bn** (gross) **investment in capital**

**27.7%** spending **growth** in **real terms** over **2019-20**

**Simplified financial framework** ensured focus on **frontline COVID-19 response**

**£18bn COVID-19 funding** to the NHS to support **frontline response** during **2020-21**

**COVID-19 spend 26% lower than funding allocated**

**£7.1bn underspend** against the **AME budgetary control**

## Performance Summary

17. This section provides information about the Department's performance against its strategic priorities during 2020-21.

18. It has been a challenging year for the Department of Health and Social Care as the response to the COVID-19 pandemic was at the forefront of its activities. The Department's programme of work has aimed to suppress the virus and protect the NHS in order to save lives and provide a route back to normality. This programme of work has included; vaccine and therapeutics development and deployment, protecting the UK from global threats and new variants, ensuring the resilience of the NHS and adult social care sectors, maintaining the supply of critical equipment and goods, reducing transmission through non-pharmaceutical interventions, delivery of effective mass testing, contact tracing, and isolation support services through local partnerships, with tailored support for the most vulnerable.

19. The most significant challenges presented at the outset of the pandemic when a national scale emergency response needed to be implemented in the context of relatively limited scientific and clinical evidence. These included: procuring sufficient ventilators, oxygen and PPE to withstand a reasonable worst case scenario; establishing capacity within the NHS to manage the challenges presented by COVID-19; and establishing NHS Test and Trace. The pace and scale of these activities was unprecedented and have allowed the impact of COVID-19 to be managed; however, there has been an impact, most significantly on elective activity, with increasing waiting times and numbers of patients awaiting treatment. Work has begun to tackle this issue, which will require sustained effort over several years.

20. The pandemic has impacted on progress towards implementing many elements of the Long Term Plan in 2020, and will continue to do so during 2021-22. The COVID-19 pandemic also resulted in the publication of a number of key policy documents being rescheduled, and delays to starting some of the Department's annual activities.

21. However, the Department was still able to progress a broad range of other key policies and priorities, including making substantial progress on drafting the Health and Care Bill, establishing the United Kingdom Health Security Agency (UKHSA), and delivering the largest ever flu vaccination programme in England.

22. As the year progressed and the COVID-19 response matured, the Department was able to begin resuming some of its priority programmes.

### Single Departmental Plan

23. The Department's annual Single Departmental Plan (SDP) usually sets out what the Department aims to achieve in order to improve the health and care of the nation over the course of the year. The successful implementation of many of

these priorities is reliant on the Department's Arm's Length Bodies (ALBs) and partner organisations. Where these organisations are accountable for delivery, there is a clear line of sight from the SDP to the organisation's business plan through to commissioners, providers and, ultimately, to patients and the public.

24. Although departments were not required to publish a SDP in 2020, as they focused on the response to the COVID-19 pandemic, as detailed in **paragraph 8**, the Department maintained a planning framework of priorities, objectives and key performance measures for the year ahead. These were linked to the previous SDP and were used to assess the Department's performance during the 2020-21 financial year.

## Coronavirus (COVID-19)

25. The spread of COVID-19 and the global pandemic from early 2020 fundamentally changed the focus of the Department for 2020-21. COVID-19 was the biggest health challenge the country had faced in over a generation and the Department led the Government's health and care-related response. Over the last year the Department acted flexibly, being guided by scientific evidence and advice, and adapted to new challenges such as new variants.

26. By the end of 2020-21, work on the response to COVID-19 remained the single most important operational and policy focus of the Department and wider health and care system.

27. The work of the Department in tackling the virus covers eight areas which are regularly reviewed: NHS Resilience and Recovery; Social Care Resilience; Supply and Distribution of Key Products; NHS Test and Trace; Vaccines and Treatments, Research and Deployment; Non-pharmaceutical Interventions; Protecting the Most Vulnerable; and Global Threats – Protecting the UK.

28. During the initial phases of the pandemic the Department had to adapt quickly, prioritising the COVID-19 response over business-as-usual priorities. There was a sudden increased demand for the supply of personal protective equipment (PPE) for the NHS and adult social care sector, as well as ventilators and oxygen to ensure that those who needed treatment received it across the globe, testing the Department's ability to manage procurement and distribution. There was a need to rapidly design and implement a Test and Trace system from scratch and there were increasing pressures on the NHS and the Adult Social Care system which needed to be addressed.

29. The Coronavirus Act 2020 was introduced, progressed through all stages in the House of Commons and Lords and received Royal Assent in March 2020. The Department also established and published several plans detailing how the entirety of the health and care system would be supported during and after the COVID-19 pandemic. This included the Personal Protective Equipment (PPE) Strategy, the COVID-19 Mental Health and Wellbeing Recovery Action Plan, the

Adult Social Care: Our COVID-19 Winter Plan, the UK COVID-19 Vaccines Delivery Plan and the UK COVID-19 Vaccine Uptake Plan.

30. The Government committed to provide the funding needed to tackle the pandemic and in 2020-21 the Department received additional Total Departmental Expenditure Limit (TDEL) funding of around £63 billion. Further details are set out from **paragraph 205**. This funding mainly comprised:
    - £18 billion revenue and £0.6 billion capital for the NHS to support the frontline response to the pandemic,
    - £23.1 billion for the Test and Trace programme,
    - £14.8 billion for the procurement and supply of PPE,
    - £4.2 billion for the deployment of the COVID-19 vaccine and other COVID-19 treatments,
    - £1.3 billion for the infection control fund and other grants; and
    - £0.6 billion for ventilators and the Critical Care National Stockpile.

31. With this funding the Department aimed to ensure that; the UK had sufficient PPE, the NHS could provide care to those who needed it, NHS Test and Trace were able to identify and mitigate, to some extent, the spread of the virus and COVID-19 vaccines could be rolled out as soon as they were approved for use. Scrutiny into the handling of the COVID-19 pandemic response and use of the funds detailed above has been significant.

32. The NAO and PAC has conducted investigations into numerous areas of the response, including PPE supply and procurement, shielding, Test and Trace and risk management. These reports acknowledged the significant amount of work the Department undertook under considerably pressurised timescales, however they did flag a number of areas for concern. These included a lack of transparency regarding the PPE programme; concerns around the management and distribution of PPE; delays identifying clinical extremely vulnerable people; the initial model choice for Test and Trace delivery and implementation issues preventing Test and Trace from achieving all of its objectives; and a need to strengthen the government's end-to-end risk management process.

33. The speed and severity of the COVID-19 pandemic's impacts on the United Kingdom were wide-ranging. The Department established its COVID-19 Programme in response to the effect on population health, encompassing key delivery workstreams in support of the pandemic response, reporting through established governance routes. Response workstreams were asked to identify and report on 'Programme level' risks as part of a consistent set of delivery plans commissioned by Cabinet Office Taskforce.

34. Within the Department, in May 2020, a COVID-19 High Level Risk Register was set up in line with established risk management principles to monitor and assure the key emerging risks across the response. This has evolved into a 'Strategic Risk

Register', following updates made by established Government Project professionals, with clearer more focussed guidance on how risks are escalated, reviewed and managed. The risk register is reviewed and discussed at an Oversight Board each month.

35. As is detailed from **paragraph 195**, activities were delivered at significantly lower cost than originally anticipated as a result of; lower levels of demand, impact of national lockdowns and in some cases slippage in receipt of goods. Funding and outturn by programme are shown in **Table 5** and **Table 6**.

### NHS Resilience and Recovery

36. As part of the NHS response to COVID-19, £300 million was shared between 117 trusts to upgrade Accident & Emergency facilities and an additional £150 million between 25 individual hospitals, to boost capacity through expanding waiting areas, increasing the number of treatment cubicles, reducing overcrowding and supporting social distancing throughout the pandemic.

37. The Department's plan for building resilience and wellbeing in the NHS workforce for Winter 2020-21 was published on 30 July 2020, followed by the roll out of the 'Looking After Our People' nursing retention programme.

38. Retired nurses were contacted directly to seek their support, international recruits started to arrive, emergency registers were maintained and a strategy to re-engage returners developed. Pre-registration competency tests for internationally trained nursing and medical professionals re-opened in July and August 2020.

39. Funding for the establishment of Infection Protection Control (IPC) improvement support teams was provided to each region across the country. The regional chief nurses supported NHS trusts who reported increased rates of nosocomial infections and shared best practice across organisations.

40. The Ministerial Mental Health Task and Finish Group was established, co-chaired by the Paymaster General, Penny Mordaunt MP and Minister for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries MP, and the Department began development of the Cross-Government Mental Health Action Plan.

41. The Government announced an additional £1 million funding for the Coronavirus Mental Health Response Fund at the Britain's Got Talent Final, in partnership with ITV, to focus on supporting mental health, learning disability and autism charity helplines.

42. More broadly, the Department was committed to supporting everyone's wellbeing and mental health throughout this difficult time. In November 2020, the Department published the Wellbeing and Mental Health Support Plan to strengthen the support and services available to those who need them.

## Social Care Resilience

43. Since the start of the pandemic the Department has worked closely with the adult social care sector and public health experts to put in place guidance and support for adult social care.

44. The Department mobilised regional teams to support local authorities on their implementation of social care COVID-19 policy, with a focus on regions under pressure from new COVID-19 variants.

45. Our priority for adult social care has been for everyone who relies on care to continue getting the care they need throughout the COVID-19 pandemic. The steps we have taken have been designed with care users in mind, to ensure that individuals are treated with dignity and respect and that their individual needs are addressed.

46. We know that staying in hospital when you are fit to leave can impact on wellbeing and affect people's prospects of regaining the level of health and independence they had before admission. Prior to COVID-19, established policy was that, wherever possible, people who are clinically ready should be supported to return to their place of residence, where an assessment of longer-term needs will take place. This approach follows the Discharge to Assess, Home First model, to support timely and appropriate discharge from hospital which has been promoted as good practice for a number of years.

47. In March 2020 modelling suggested that hospital intensive and critical care capacity could be overwhelmed in a matter of weeks. This meant that urgent steps had to be taken to maximise the chances that acutely ill people would have access to beds, respiratory support, and clinical care.

48. It was therefore decided that medically fit patients who no longer required hospital care should be discharged and that patients should be tested before discharge to a care home where a person had had symptoms before or during their hospital stay, in line with the agreed testing prioritisation groups. This policy enabled the NHS to free up beds to care for those with acute health needs. Pandemic response planning has long included plans around management of NHS capacity through the improvement of processes to enable more rapid discharge of individuals from hospital either home or into care settings.

49. At the time of the March 2020 discharge policy, there was only capacity to test 6,000 cases a day. To ensure testing capacity was not breached, testing was prioritised for those who were symptomatic in NHS settings and to support targeted testing in care homes. Isolation advice in March and early April was based on isolating symptomatic residents, staff or contacts of cases, following clinical advice at the time. Once greater testing capacity was available, testing before discharge was introduced during April 2020.

50. An action plan for adult social care was published during April 2020 confirming the move to testing before discharge as well as increased testing of the social care workforce and their wider households. Plans to boost access to PPE across the sector and recommending that all people discharged from hospital should be isolated for 14 days, were also included in the plan, to help reduce outbreaks of COVID-19 in care home settings.

51. Designated settings were established in all local authorities to accept COVID-19 positive residents discharged from hospital to specifically provide safe care in a COVID-19 secure environment, through the Designated Settings Scheme. The Department announced the scheme as part of the Adult Social Care Winter Plan on 18 September 2020 and published detailed guidance on designated settings on 16 December 2020.

52. The scheme ensured that people who were discharged from hospital to a care home, and who had tested positive, move to a 'designated setting' that would be specifically assessed by CQC for that purpose. People would complete a 14-day period of isolation in that setting before moving to a care home that would be a more permanent home for them.

53. Concerns have subsequently been raised about a link between hospital discharge and increased rates of COVID-19 in care homes, particularly prior to testing before to discharge came into full effect in April 2020. During the initial phase of the pandemic, there was no scientific consensus that significant amounts of pre-symptomatic or asymptomatic transmission was taking place. As such asymptomatic patients were not initially thought to be a major route of transmission of COVID-19.

54. The Scientific Advisory Group for Emergencies (SAGE) noted in their 4 February minutes that "asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely", but substantial evidence was not available at the time. Subsequently the Vivaldi study published in July 2020 did find asymptomatic transmission in care home settings. The NAO report on Readying the NHS and adult social care in England for COVID-19 does identify that reported outbreaks in care homes peaked at the start of April 2020. Nevertheless Professor Stephen Powis wrote to the Public Accounts Committee on 30 October 2020, to share reports that do not identify hospital discharge as dominant link to care home outbreaks. Studies are ongoing into this issue.

55. Throughout the pandemic the Government has continued to follow the best scientific advice available at the time and continues to do so. All clinical guidance published received clinical sign off before issue.

56. In February 2021, the Department launched the new 'single named visitor' policy, allowing care home residents to have indoor visits from one, named visitor. This was supported by the implementation of a new testing programme.

57. In 2020-21, the Department made available £1.42 billion of specific funding for adult social care to support the sector through the pandemic and assist them in putting in place crucial measures to minimise the transmission of COVID-19 between and within care settings.

58. Regarding the impact of staff transmissions on COVID rates in care home settings, the Vivaldi study did conclude that infections in staff were a risk factor for infection in residents and that regular use of bank staff, who work temporarily in different settings, was an important risk factor for infections in both residents and other staff in care home settings.

59. The social care action plan took steps to ensure that the only factor, for those working in social care, in their decision to work, isolate or shield themselves, was the same public health advice given to everybody in order to keep individuals, families and the wider public safe. Increased testing capacity for workers and their households and plans to boost access to PPE also played a role in addressing the issue of staff transmissions during the earlier stages of the pandemic.

60. Since March 2021, we have provided almost £980 million of additional funding through the Infection Control and Testing Fund and its subsequent extension, meaning that throughout the pandemic we have made available over £2 billion in specific funding for adult social care.

61. COVID-19 has had a significant impact on adult social care settings in England, and there were large increases in mortality experienced by care homes particularly during the first peak of the pandemic, reflecting increases in both COVID-19 and non-COVID-19 deaths.

62. When comparing care home deaths in various stages of the pandemic to the average of the previous five years in England and Wales (2015 – 2019): In the first wave (March – June 2020), deaths were 78% higher; in Summer 2020 (July – September 2020) deaths were 5% lower, and at the peak of the second wave (November 2020 – February 2021), deaths were 12% higher. Overall, in the 12 months March 2020 to February 2021 there were 26% more deaths from all causes in care homes than the average for the previous 5 years (2015 to 2019).

63. The Social Care Sector COVID-19 Support Taskforce's independent review of the Adult Social Care Winter Plan 2020 to 2021, published by the Department in November 2021, concluded that the actions we took in preparation for - and during - the second wave, were a significant factor in explaining the reduced mortality rate observed, stating that "while COVID-19 accounted for around 40%

of all deaths of care home residents between April and June 2020 in the first wave of the pandemic, it accounted for only a quarter (26%) of all care home resident deaths between September 2020 and February 2021 in the second wave. This compares with a global average of 41% between March 2020 and January 2021. Whilst cause and effect is difficult to unpick, the evidence strongly suggests that the actions taken since the beginning of the pandemic, including those outlined in the Winter Plan, have had a significant impact in reducing risk".

## Supply and Distribution of Key Products

64. The COVID-19 pandemic brought about unprecedented global pressures on supply chains. The rapid rise in international infection rates during the early stages of the pandemic created unparalleled demand for PPE and resulted in a highly competitive global market where many countries imposed export bans.

65. There were significant logistical challenges around sourcing, procuring and distributing PPE to the health and social care sectors and in this unique situation we had to change our approach to procurement and our appetite to risk. The risks that contracts might not perform and that supplies were priced at a premium needed to be balanced against the risk to the health of frontline workers, the NHS and the public if we failed to get the PPE so desperately needed.

66. Prior to the pandemic, there was no nationally centralised model for procuring and distributing PPE to the health and social care sectors. Whilst the majority of supply to the NHS Trusts came through the NHS Supply Chain, the social care and primary care sectors independently procured their own PPE, predominantly buying from a number of established wholesalers within the UK.

67. Amid the significant challenges posed by the pandemic, the Department worked to get PPE to the places where it was needed the most. From scratch, the Department set up a new parallel supply chain to procure, manage and distribute life-saving PPE. This was a cross-government effort, drawing upon expertise from a number of departments together with support from the military and private sector partners.

68. The Department rolled out a PPE Portal in collaboration with eBay, Clipper Logistics, and Royal Mail, through which primary and social care providers could access COVID-19 PPE as part of an 'emergency top-up system'. The PPE Portal became a key distribution route amongst numerous others in the Government's broader PPE strategy. By the end of March 2021 almost 52,000 organisations had registered on the Portal.

69. Through the PPE Portal we have delivered free COVID PPE to the health and social care sector and have committed to doing so until the end of March 2022. During October 2021 we ran a consultation to consider options for extending this provision into 2022-23.

70. At the end of 2020-21, over 11.7 billion items of PPE had been delivered to frontline workers thanks to the efforts of the Government, NHS, industry and the British Armed Forces.

71. Over the course of the pandemic the Department worked to stabilise the UK PPE supply chain and built a robust stockpile. This generates a high level of confidence that we have sufficient stock to cover future COVID-19 related demands including the threat from the new variant omicron.

72. In many cases it has become apparent that we have quantities over and above that we will ultimately need and **Note 8** (Impairments) in our financial statements discloses a £750 million impairment to the value of PPE inventory held at 31 March 2021 to reflect some inventory has an expiry date prior to the expected usage date and is therefore held for resale or donation. This reflects the fact that, in practice, demand turned out to be lower than forecast. This was difficult to predict at the beginning of the pandemic and we therefore planned to the reasonable worst-case scenario.

73. In addition, in a highly competitive global market, our planning had to take into account the likely non-performance of contracts. Our buying activities were more successful than we predicted, both in terms of the amount that actually arrived and met the necessary standards, given the global situation. **Note 16** (Provisions for liabilities and charges) in our financial statements discloses a further £1.2 billion onerous contracts provision for non-cancellable PPE contracts held at 31 March 2021 where the value of inventory yet to arrive at that date is estimated to have reduced below weighted average cost due to a combination of market value fluctuations since the point of purchase, items that cannot be used for their intended purpose and items that have expiry dates prior to the expected usage date.

74. The disruption to the global PPE market, driven by the unprecedented spike in demand, resulted in huge price inflation for goods and intense global competition to secure supply. The estimated £4.7 billion reduction in inventory value reported in **Note 8** in our financial statements, for fluctuations in the market price of PPE between the point of purchase and the balance sheet date, reflects this.

75. Due to the critical nature of the situation there was limited time to fully assess the standard and quality of PPE being purchased (for example, by testing a sample product in advance of contract award). Therefore, before distribution, products not previously purchased were tested, to ensure they conformed to the COVID-19 Pandemic essential technical specifications as issued by the market surveillance authorities, the Health and Safety Executive and the Medicines and Healthcare products Regulatory Agency.

76. Some products unfortunately failed to meet the specified criteria due to failing quality or safety standards, a lack of product documentation or insufficient packaging and labelling. These items are therefore unsuitable for use in health and social care settings as intended. **Note 8** in our financial statements confirms impairments to inventory valuation as follows: £673 million reduction in value for items which have been assessed as not being suitable for any use; and a further £2,581 million for inventory that we do not intend to use for its original intended purpose, either because it was bought as a contingency or has characteristics that prevent its use in a UK healthcare setting, but can be considered for alternative use or resale to maximise value.

77. Where possible the Department has sought to repurpose these items so they can be safely used in different settings (for example, over 115 million face coverings have been supplied to schools). Donations have also been made to Crown Dependencies and Overseas Territories and countries specifically requesting assistance of PPE due to emergencies.

78. In June 2020, the Department introduced a Sales and Operational Planning process which provided the programme with more accurate demand signals and increasingly accurate demand forecasts for PPE. The Department continues to actively pursue options to manage, redistribute or repurpose and, as a last resort, dispose of any excess stock.

79. As mentioned previously, the success of the buying operation by the Department has resulted in significant excess stock in some categories of PPE that are unlikely to be used in the next 18 months. The Department has sold and donated some of this excess to companies and countries respectively. Further donations to countries and the United Nations are expected. While demand exists for PPE the Department will continue to utilise this route to secure best value from the PPE purchased.

80. Despite the efforts to sell or donate PPE to those that require it outside UK shores the Department expects some PPE will need to be recycled. By April 2022 the expectation is that two lead waste providers will be contracted to begin this process for selected PPE items. By recycling PPE the Department will maximise the storage efficiency and reduce overall storage cost. Early indications suggest that some items of PPE will not be suitable for recycling due to the complex mix of materials in the manufacturing process. Our expectation is that these items will need to be disposed of using a waste to energy facility as the Department has adopted a zero-landfill policy for PPE.

81. The supply chain established by DHSC will transfer to Supply Chain Coordination Ltd (SCCL) responsibility from April 2022. This will bring into NHS England's sphere of control the vaccine distribution, PPE, and SCCL supplies. SCCL will continue the process of sales, donations and recycling to maximise the efficiency of the storage facilities.

82. The PPE programme has been subject to significant scrutiny. In November 2020, the NAO published two reports on PPE procurement and supply. These reports cover a number of themes including supply before the pandemic, handling of contracts, use of Regulation 32 – awarding contracts without prior publication, supply to social care, and lessons to be learnt. The reports acknowledge the difficult landscape and credit the Government's work to set up a new PPE supply chain. They do, however, highlight areas that could have been better managed and report a lack of transparency in documentation.

83. Following the publication of the NAO's report, the PAC began their own investigation into PPE. From external witnesses, the Committee was provided with oral evidence of worrying situations on the frontline, although no NHS Trusts reported being stocked out of PPE.

84. In February 2021, the PAC published their report, COVID-19: Government procurement and supply of Personal Protective Equipment, which included a number of recommendations in relation to procurement processes, PPE management and distribution, emergency preparedness plans, ensuring a better understanding of frontline staff experiences and disseminating lessons learned across government.

85. In addition to PPE supply, a reliable supply of ventilators was also critical to the COVID-19 response, and in the early stages of the pandemic the NHS believed it could need far more mechanical ventilators than were available.

86. The Government acted quickly, increasing UK and global procurement, and increasing the UK manufacturing of ventilators and made substantial progress towards achieving its target of obtaining 30,000 ventilators by the end of June 2020, with around 24,000 acquired. The 30,000 target was met in August. In parallel to this the Government acted to boost consumable availability and oxygen contingency arrangements.

87. With regards to medicines, Remdesivir supply was tight during October 2020 in conjunction with increased UK demand. This improved significantly as new manufacturing capacity was released.

88. By the end of 2020-21, the Department had completed work to procure critical COVID-19 supportive medicines to mitigate the risk of insufficient supplies in future waves, and it continued to work with logistics providers on distribution.

### NHS Test and Trace

89. Increasing testing and tracing capability and capacity was key to limiting the spread of the virus with NHS Test and Trace, launched in May 2020, forming a central part of the country's COVID-19 recovery strategy. There were inevitably

significant challenges in establishing a national scale Test and Trace service from scratch, including building organisational capability, a laboratory and testing network and sourcing, procuring, storing and distributing Lateral Flow Tests at pace. This included developing the necessary data capture, financial reporting and operational management and assurance systems, all in the context of rapid demand for services.

90. The Department's Test and Trace capability increased throughout the year, helping inform people whether they needed to self-isolate. Activities also included the establishment of wastewater testing for early warning of COVID-19.

91. The Department rolled out the universal testing offer, giving everyone in the UK without symptoms access to weekly testing, and increased the capacity of polymerase chain reaction (PCR) testing.

92. At the end of 2020-21, there was a lab capacity of 805,000 tests, and for the week ending 31 March 2021, 90% of pillar 2 in-person tests were turned around within 24 hours. By the end of 2020-21, around half of the population in England had been tested at least once since the launch of NHS Test and Trace.

93. The Department also increased the capacity of lateral flow device (LFD) testing, deploying tests across workplaces, health and social care settings, and education settings. By 30 June 2021, over 93 million LFD tests were conducted in education and health and social care settings and, by 24 June 2021, over 3 million tests were conducted across workplaces.

94. Since the launch of Test and Trace and up to 15 December 2021, per the weekly statistics for NHS Test and Trace, the national level trace function reached 87.5% of all cases transferred to the contact tracing system and 78.2% within 24 hours. Contact tracing reached 84.4% of all close contacts and, of those not managed by local health protection teams, 95.5% had been reached within 24 hours. Overall, contact tracing performance improved significantly in 2021 in comparison to the period immediately following the launch of the service. The NAO's interim report on the government's approach to test and trace in England evidences this by referencing tracing performance at 73% in the last week of May 2020.

95. The Department used epidemiological models for estimating the impact on breaking the chains of transmission. The operating model and structure needed to be flexible to meet the everchanging workload based on rates of transmission.

96. The laboratory network for PCR testing was designed to have sufficient flexibility and capacity to operate on a 24/7 basis with a maximum utilisation of 80% to allow for routine training, maintenance and repair.

97. A significant proportion of the laboratory network is contracted on flexible basis, ensuring that costs are only incurred for tests that are processed.

98. The creation of the UKHSA will see the initial necessary use of consultants ramp down and the workforce will be created with permanent civil servants. The formal establishment of the UKHSA will continue to build on the strong relationships with local authorities, the NHS and other partners.

99. Throughout the pandemic, PHE and UKHSA invested in regional teams, whose role is dedicated to working with and supporting local authorities including continuously looking for ways to improve engagement with COVID-19 testing, with a particular emphasis on underrepresented groups.

100. The Department rolled out an improved Outbreak Identification model and established Local Tracing Partnerships in all Local Authorities in England.

101. In September 2020, the Department launched the Test and Trace Support Payment Scheme to help people on low incomes who cannot work from home to self-isolate. This was extended in March 2021 to also include eligible parents and guardians of children required to self-isolate.

102. Under a commitment in the COVID-19 Response Spring 2021 Roadmap, a package of local authority support - providing individuals required to self-isolate with help such as access to food deliveries, emotional support, and wellbeing services - launched on 31 March 2021. This saw funding of £98.4 million being made available to upper tier local authorities to support local delivery, alongside £17.8 million for a free medicines delivery service.

103. The NHS COVID-19 app launched successfully on 24 September 2020, with over 22 million downloads by the end of March 2021.

104. The app anonymously alerts users who have been in contact with a confirmed case of COVID-19 and also enables users to check their symptoms, book tests and check-in to venues by scanning an official NHS QR code poster.

105. The app was proven to work, breaking chains of transmission and saving lives. Analysis from the University of Oxford's Pathogen Dynamics Group at the Big Data Institute showed that, in the first 3 weeks of July 2021, the app averted up to 2,000 cases per day, and reduced the spread of COVID-19 by around 4.3% each week.

106. Previous analysis, published in Nature (The Epidemiological Impact of the NHS COVID-19 App), showed that the app prevented approximately 600,000 cases of coronavirus between September 2020 and January 2021 alone and that for every 1% increase in app users, the number of coronavirus cases in the population could be reduced by 2.3%.

107. The app is regularly updated with new functionality and improvements, for example, in December 2020 it was updated to enable eligible users to apply for the Test and Trace Support Payment, and in August 2021 it was updated to provide advice in line with policy that those aged under 18 or fully vaccinated no longer need to self-isolate if they are identified as a contact, but are encouraged to get tested.

108. After the completion of rigorous field testing such as the Isle of Wight pilot earlier in 2020, on the initial COVID-19 app design, it was announced on 18 June that the focus of work would shift to a design compatible with Google's and Apple's application programming interface, to address the limitations found through the field testing of the initial app design.

### Vaccines and Treatments, Research and Deployment

109. The Department's work on vaccines and treatments started early on in the pandemic, with the Department coordinating and launching, via the National Institute for Health Research (NIHR) and in partnership with UK Research and Innovation (UKRI), a rapid response research call, which funded the Oxford University/AstraZeneca vaccine and the RECOVERY trial in Spring 2020.

110. Through NIHR the Department used the UK's research infrastructure to fund and run studies in vaccine and treatments that changed the global approach. UK trial results proved the Oxford University/AstraZeneca and Novavax vaccines worked, and the RECOVERY trial proved the first treatment, dexamethasone, reduced COVID-19 mortality.

111. The Vaccines Taskforce, led by the Department for Business, Energy and Industrial Strategy, was established in quarter one of 2020-21, to accelerate progress on the development and deployment of COVID-19 vaccines.

112. Following the development of various vaccines, the government authorised the use of Pfizer/BioNTech, Oxford University/AstraZeneca and Moderna vaccines.

113. Significant work led by the NHS was undertaken on vaccination deployment. As of 31 March 2021, 59% of the population had had their first dose and 9% of the population had had their second dose of the vaccine.

114. The Department also worked to ensure vaccine supply could meet demand, ensuring vaccination deployment was initially focused on those at greatest risk: residents in a care home for older adults and their carers, those over 80 years old, frontline health and social care workers and the at-risk population. There were also targeted communications to tackle vaccine hesitancy, particularly amongst high-risk groups.

### Non-Pharmaceutical Interventions

115. To protect the most vulnerable, social distancing regulations were laid on 26 March 2020 as The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 and then reviewed throughout the year.

116. The introduction of a three-tier system of local COVID-19 alert levels in England (Medium, High and Very High) in the middle of the year allowed three packages of measures to be implemented in response to different levels of incidence and risk.

117. This was followed by the introduction of the third national lockdown in January 2021 due to the significant increase in cases of a newer COVID-19 variant across the country, which contributed significantly to the increased prevalence of COVID-19 illness and mortality over the course of the second wave.

118. The Department provided input into the roadmap out of lockdown analysis, providing analytical assessment against the four tests and contributing to the COVID-19 Response – Spring 2021 (Roadmap) which was published on 22 February 2021.

### Protecting the Most Vulnerable

119. The shielding programme introduced at the height of the pandemic supported almost 4 million people identified as clinically extremely vulnerable, providing them with advice to minimise their risk of infection and support to enable people to stay at home.

120. The NAO report - Protecting and supporting the clinically extremely vulnerable during lockdown - published in February 2021, concluded that the shielding programme was a "swift government-wide response to protect clinically extremely vulnerable people against COVID-19", but that it did take time for people to be identified as clinically extremely vulnerable.

121. Both the Department and the NAO agreed that shielding helped to protect clinically extremely vulnerable people and that many people benefited from the Programme provided.

122. Nevertheless the NAO concluded that given the challenges in assessing the impact of shielding on clinically extremely vulnerable people's health, government cannot say whether the £300 million spent on this programme has helped meet its central objective to reduce the level of serious illness and deaths from COVID-19 across clinically extremely vulnerable people.

123. In February 2021, the Department commissioned NHS Digital to apply a new predictive risk model (QCOVID) to patient records to identify those most at risk of serious outcomes from COVID-19 due to a combination of factors.

124. As a result, approximately 1.5 million people were identified and added to the Shielded Patient List as a precautionary measure. They were prioritised for vaccination as a result of this work if they had not already been offered it on account of their age. The Department will continue to work across government to ensure that further COVID-19 policy interventions consider clinical and non-clinical impacts on vulnerable groups.

125. The shielding advice and support was paused in April 2021, following a significant decrease in the prevalence of COVID-19 cases and the Government's priority to ensure clinically extremely vulnerable people were offered the opportunity to receive their first dose of the vaccination against COVID-19 by 15 February 2021.

### Protecting the UK from Global Threats

126. The Department continued to respond to global threats and worked collaboratively with the World Health Organization, industry and other philanthropic foundations on genomics and surveillance of COVID-19 variants. The Department introduced additional health measures at the borders with improvements in self-isolation compliance rates and testing of 'red list' arrivals.

127. In February 2021, the Government announced it would conduct a COVID-Status Certification Review. The review explored whether and how COVID-status certification might be used to reopen the country's economy, reduce restrictions on social contact and improve safety.

128. The Department worked with Cabinet Office to evaluate consultation responses and make recommendations for COVID-status certification. The COVID-Status Certification Review: Report was published in July 2021. Cabinet Office and the Department continue to work together to evaluate and explore options and contingencies for future certification.

### EU Exit

129. During the year, the Department worked with its ALB partners to ensure the health and social care system was as prepared as possible for the end of the Transition Period.

130. Plans for implementing and delivering the Withdrawal Agreement at the end of the Transition Period were developed and refreshed to reflect the impact of the response to COVID-19.

131. The EU-UK Trade and Co-Operation Agreement was agreed on 24 December 2020 and was passed into law on 30 December 2020. The Department communicated the various health aspects to industry and the public.

132. There was a relatively smooth end of the Transition Period with mitigations in place for all EU and Trade Portfolio workstreams, and the EU Exit secondary legislation programme for legal default was completed by 31 December 2020.

133. The Department successfully worked with industry, NHS England, Devolved Administrations, and the National Supply Disruption Response to manage, resolve and mitigate disruption that occurred as a result of the end of the Transition Period. There was almost no clinical trial supply disruption. At the end of 2020-21, the main outstanding issue of concern was the impact of the Northern Ireland Protocol.

134. We will continue to undertake work to manage the changes as a result of the end of the Transition Period, to implement the Northern Ireland Protocol, and to embrace the opportunities presented by the UK's exit from the EU. Further detail regarding EU Exit is detailed from **paragraphs 223** and **711**.

### Spending Review and Budget

135. At the 2020 Spending Review, the Department secured funding to support both its ongoing response to, and recovery from, COVID-19, as well as other Departmental priorities.

136. This support was continued at the March 2021 budget, with the Department receiving further funding for the COVID-19 vaccination rollout, and with the announcement of a £7 billion funding package for health and care services later in March. This is on top of the Department's historic long-term settlement for the NHS, which has been enshrined in law and will see NHS funding increase by £33.9 billion by 2023-24.

### NHS Services and Performance

137. The NHS was able to create capacity to manage the challenges presented by COVID-19, ensuring that urgent and emergency care and COVID-19-related care were not overwhelmed.

138. During Winter 2020-21, the Government ran a significantly expanded seasonal flu vaccination programme to support the most clinically vulnerable and to ease pressure on the NHS. This programme reached over 19 million people from the priority patient groups, making it the largest seasonal flu programme ever in the UK.

139. During the second wave of the pandemic there was a significant impact on hospital bed capacity. A range of interventions were enacted including the use of independent sector capacity; Nightingale Hospitals; enhanced patient discharge arrangements; and the transfer of patients between regions. Work continued to help drive up activity to pre-pandemic levels and reduce long waiting lists, such as through the Elective Recovery Board, which brought programme oversight of the NHS's elective recovery, including the £1 billion Elective Recovery Fund.

140. The pandemic placed considerable strain on planned service delivery, which was already under pressure before the pandemic, and understandably deterred

people from coming forward for care. As of September 2021, the number of people waiting for care was over 5.8 million, up from 4.4 million before the pandemic.

141. In addition to those already on waiting lists, it was estimated that as of September 2021, over 7 million patients who might otherwise have come forward for treatment did not, including a small proportion of these for cancer diagnosis and treatment. There was enormous uncertainty around whether and when these people would seek treatment, making it very difficult to estimate the impact this would have on both their outcomes and the overall waiting list.

142. Under a scenario where all these people came forward, and with no further action to increase activity levels above pre-pandemic rates, the waiting list could increase to 13 million patients.

143. NHS waiting time performance was significantly impacted by increased COVID-19 demand. The following data compares waiting time performance in 2021 with waiting time performance in the same month in both 2020 and 2019. Given that performance in 2020 was significantly impacted by the first wave of COVID-19, more focus is given to the comparison between 2021 and 2019 waiting time performance. Monthly updates of these statistics are published on the statistical work areas section of the NHSE website.

144. In May 2021, referral to treatment (RTT) performance was 67.4% compared to 86.5% in May 2019 (18-week 92% standard, activity within 18 weeks fell from 3,890,000 to 3,576,000). The number of patients waiting more than 52 weeks increased dramatically to 337,000 compared to 1,000 in May 2019.

145. Diagnostic performance remained low at 22.3% compared to 4.1% in May 2019 (no more than 1% waiting 6 weeks, total activity fell 5.3% from 1,996,000 to 1,890,000).

146. The performance against these standards is detailed in **Table 1**.

**Table 1: RTT and Diagnostic standards performance**

| Standard | Referral to Treatment – 18 Weeks (92%) | | | Diagnostics – 6 Weeks (no more than 1% waiting) | | |
|---|---|---|---|---|---|---|
| Month | May-21 | May-20 | May-19 | May-21 | May-20 | May-19 |
| Activity | 3,575,868 | 2,386,214 | 3,809,456 | 1,889,567 | 873,116 | 1,996,365 |
| Performance | 67.4% | 62.2% | 86.9% | 22.3% | 58.5% | 4.1% |

147. In June 2021, A&E performance was 81.3%, compared to 86.4% in June 2019 (against 4-hour, 95% standard), with attendances 2.4% above the June 2019 baseline (total attendances rose from 2,107,987 in June 2019 to 2,159,292 in June 2020), per **Table 2**.

**Table 2: A&E standard performance**

| Standard | A&E 4-hour | | |
|---|---|---|---|
| Month | Jun-21 | Jun-20 | Jun-19 |
| Activity | 2,159,292 | 1,410,602 | 2,107,987 |
| Performance | 81.3% | 92.8% | 86.4% |

148. In cancer performance, in May 2021, the two-week wait (GP referral to specialist) was 87.5% (93% standard) compared to 90.8% in May 2019, with total activity increasing from 201,000 to 207,000 in the same time frame. The 62-day GP referral to first treatment for cancer (standard 85%) was 73.0% in May 2021 compared to 77.6% in May 2019, with total activity decreasing from 14,000 to 13,000 in the same time frame per **Table 3.**

**Table 3: Cancer standards performance**

| Standard | 2-week wait (GP referral to specialist) (93% standard) | | | 62-day GP referral to first treatment for cancer (standard 85%) | | |
|---|---|---|---|---|---|---|
| Month | May-21 | May-20 | May-19 | May-21 | May-20 | May-19 |
| Activity | 207,188 | 106,741 | 200,796 | 12,999 | 8,654 | 13,998 |
| Performance | 87.5% | 94.2% | 90.8% | 73.0% | 70.0% | 77.6% |

149. On 7 September 2021, the government published its new plan for health and social care Build Back Better: Our Plan for Health and Care, which sets out how the government will tackle the electives backlog in the NHS, put the NHS on a sustainable footing, and continue to reform the adult social care system in England.

150. Making the NHS the best place in the world to give birth through personalised, high-quality support, remains a priority for the Department.

151. The joint Department of Health and Social Care and NHS England Safer Maternity Care Progress Report 2021 was published on 25 March 2021 and showed improvements since 2010, including a 25% reduction in the stillbirth rate, a 29% reduction in the neonatal mortality rate for babies born from 24-weeks gestation and a reduced maternal mortality rate for the period 2016-18 (lower than the 2009-11 baseline). This was alongside continued work on the Ockenden Review, the East Kent Independent Investigation and the Pregnancy Loss Review.

152. On the 8 March 2021, the Department published a consultation seeking views of the public to help develop the Government's Women's Health Strategy. This call for evidence sought to collect views on women's health, to inform the priorities, content and actions within the Women's Health Strategy. The Call for Evidence for Women's Health Strategy attracted over 100,000 responses and significant ministerial and public interest.

## Manifesto Commitments

153. Good progress was made against the 2020-21 People Plan. However, faster progress was inhibited by the COVID-19 response efforts.

154. The number of nurses employed by NHS trusts and clinical commissioning groups increased by almost 10,900 in the last year to almost 300,000, bringing the Department closer to the additional 50,000 nurses manifesto commitment.

155. Additionally, nursing numbers for the next academic year remains strong, with a 34% increase seen between last year and this year. Universities and College Admissions Service (UCAS) data indicated a 32% increase in applications for nursing courses and there was continued strong international recruitment despite on-going travel restrictions.

156. Work continued to deliver the Health and Care Bill, with significant progress made on key policies, and the achievement of cross-government clearance to instruct the Office of the Parliamentary Council and engage on Bill proposals.

157. Following ministerial agreement, the White Paper, Integration and Innovation: working together to improve health and social care for all, was published on 11 February 2021, setting out all proposals that would be included in the Bill and a clear narrative on benefits to the sectors. The Bill was subsequently introduced on 6 July 2021.

158. The Department delivered two further manifesto commitments this year (migrant contribution to the NHS in order to receive benefits and resolving tax issues relating to doctors' pensions). The Department will continue to monitor these commitments post-completion.

159. There remain a further 38 manifesto commitments which the Department continued to drive forward in partnership with the relevant ALBs, including delivering 50 million more appointments in general practice, passing legislation to reform the Mental Health Act, extending social prescribing, improving hospital food, and improving the early diagnosis and treatment of major conditions.

160. The Health Infrastructure Plan (HIP) refresh progressed with work undertaken between the Department and NHS England to develop a future Estates Strategy. Work on the manifesto commitment of 40 new hospitals was also ongoing, although delayed by the focus on the COVID-19 response. As of 5 July 2021, 7 out of 40 hospitals were under construction with a further hospital approved and expected to enter construction soon. Additionally, 4 out of 20 upgrades were in construction.

## Public Health

161. COVID-19 shone a light on many of the vulnerabilities in the health of the UK's population – from obesity to mental health. In March 2021, the Department published 'Transforming the Public Health System: Reforming the Public Health

System for the challenges of our times', which set out the Department's plans to reform the public health system.

162. In April 2021, the UKHSA was established to lead on health security and protect the country from infectious diseases and external health threats.

163. The Office for Health Improvement and Disparities (OHID) was established on 1 October 2021. It will sit within the Department, under the professional leadership of a Deputy Chief Medical Officer and the Director General of the Office for Health Improvement and Disparities, and will systematically tackle the top preventable risk factors, improving the public's health and narrowing health disparities.

164. The OHID will embed promotion of good health across the work of the whole government and the NHS and incorporate joint working with the Department for Work and Pensions via the joint Work and Health Unit.

165. The Department's response to the Advancing our Health: Prevention in the 2020s consultation was delayed by the need to focus on the pandemic response. Nevertheless, the Department progressed key work on prevention. In March 2021, the Department published the Suicide Prevention Strategy Progress Report which detailed the steps taken to reduce deaths by suicide.

166. The Department also continued to promote a new Health Disparities Research Initiative, alongside work on a new Tobacco Control Plan which set out the Department's Smokefree 2030 ambitions, whilst carrying out commitments to support the current plan such as the Vaping in England: evidence update that was published in February 2021.

167. The Department also continued to drive forward its obesity reduction strategies. In March 2021, the Department announced the child and family weight management services grant to support children identified as above a healthy weight and their families and increased the value of Healthy Start vouchers from £3.10 to £4.25.

168. The Department committed to developing a new approach to health incentives to support people to eat better and move more. This was in addition to legislation to end advertisements for products high in fat, sugar and salt (HFSS) being shown on TV before 9pm and the placement of HFSS adverts online.

169. In March 2021, the Department published The Best Start for Life: A Vision for the 1,001 Critical Days. The document set out a vision for ensuring families with babies are supported in the period from conception to age two.

170. Dame Carol Black continued to work on part two of her independent review of drugs which will focus on prevention, treatment and recovery, and make

recommendations to the Government on how the nation can turn the tide on drug related deaths. This was published on 8 July 2021.

## Social Care

171. The Department remained committed to supporting high quality and affordable adult social care for all who need it. The objective is to ensure that everyone can get the care they need and for that care to be of a standard that anyone would be happy for their family to receive.

172. The COVID-19 pandemic created unprecedented challenges for the social care sector. The NAO report on Readying the NHS and adult social care in England for COVID-19 identifies a number of these challenges including; the lack of a systematic national data collection process at the outset, regional variations regarding bed capacity, provider sustainability, managing outbreaks, evolving testing and discharging policies and shielding the most vulnerable. The scale of challenge required an equally unprecedented response from the social care sector, its dedicated workforce, the Department and the Government.

173. At the 2020 Spending Review the Government announced that it would enable local authorities to access over £1 billion of additional funding for social care in 2021-22 through £300 million of extra social care grant funding, and the ability to levy a three per cent adult social care precept.

174. This funding sits alongside the £1 billion social care grant provided in 2020-21 which is being maintained, with additional funding agreed to support the COVID-19 response.

175. Alongside significant direct support, such as the provision of free PPE for COVID-19 needs, and free access to regular COVID-19 testing, the Government also made available over £1.4 billion in specific COVID-19 funding for adult social care in 2020-21.

176. Building the capacity of the social care workforce continued to be a priority in 2020-21. The Department delivered the Adult Social Care Recruitment campaign, with 68% of the total target audience recognising the campaign with almost 6 out 10 of those reached acting as a result (April to July 2020).

177. The Call to Care was also successfully launched in February 2021, which led to over 3,000 applications to address short-term capacity issues across the sector.

178. In 2020-21, the Department continued to develop plans for reform of the adult social care system, working with and alongside local and national partners. Build Back Better: Our Plan for Health and Care was published on 7 September 2021 and set out the government's plan for adult social care in England. The white paper People at the Heart of Care: adult social care reform sets out the plan for adult social care sector transformation as part of the Government's 10-year vision.

179. Since March 2020, the Department has made nearly £3.3 billion available via the NHS to support enhanced discharge processes and implementation of the Discharge to Assess model. This approach means people who are clinically ready, and no longer need to be in hospital, are supported to return to their place of residence where possible, where an assessment of longer-term needs takes place so that individuals have the long-term support they need.

180. The funding includes an additional £478 million to continue hospital discharge programmes until March 2022. This will grant staff the resources needed to support patients to leave hospital as quickly and as safely as possible with the right community or at-home support. The programme will not fund care delivered after 31 March 2022.

181. Further detail regarding the COVID-19 challenges and activities of the Department in regards to its COVID-19 programme of work in supporting social care are detailed earlier in the Performance Summary from **paragraph 43**.

**NHSX**

182. NHSX continued to build upon crucial work on connectivity and remote health and social care services that supported the early pandemic response. Scaling of digital transformation was sustained at pace with wider usage of digital services across the country including digital remote monitoring and national data sharing.

183. Additional functionality was added to the NHS App, including to enable pharmacy nominations for repeat prescriptions. Summary Care Records with Additional Information were also made available to clinicians, expanding the amount of information available to them about their patients, enabling better clinical care.

184. In partnership with the seven NHS England Regions, NHSX supported the scale up of remote monitoring services for COVID-19 care, care home residents and patients with key long-term conditions, enabling around 65,000 people to be supported at home.

185. At the end of 2020-21 some 99% of GP practices were able to offer video consultations compared to 3% at the beginning of 2020-21.

186. Improving digital maturity remained a key component of NHSX's work. Its Digital Aspirant programme provided almost 60 trusts with support in developing their core digital capability and cybersecurity competency, boosting some trusts to the equivalent of the best in the world for digitisation.

187. NHSX also targeted care home digital capability with broad success, which included secure access to remote health services.

## Analysis

188. The Department rapidly mobilised the analytical community to respond to COVID-19 and delivered major analytical products, led cross-government modelling of COVID-19 epidemiology through the Scientific Pandemic Influenza Group on Modelling, including modelling of the roadmap.

189. The Department also produced a number of publications including publications about the reproduction number (R) – which in the average number of secondary infections produced by 1 infected person, publication of excess deaths papers, medium-term projections, and the assessment of impact of regulatory changes.

190. The Department achieved a step-change in statistical and data leadership and launched new statistical publications covering Test and Trace, Managed Quarantine Service and Care Homes, as well as correlating developments on vaccination data.

## Research and Innovation

191. In January 2021, the UK Rare Diseases Framework was published, with further work undertaken to support its delivery. The Department also published Saving and improving lives: the future of UK clinical research delivery in March 2021 and, at the end of the year, work was underway to develop the 2021-22 implementation plans to realise the vision through the Recovery, Resilience and Growth Programme.

192. At the end of 2020-21, the Department launched the Medicines and Diagnostics Manufacturing Transformation Fund to increase manufacturing capacity in medicines, medical diagnostics and MedTech.

193. Alongside this, the NIHR Global Health Research Programme continued to invest in areas of unmet need, including addressing the management of multiple long-term conditions in South African primary healthcare and improving outcomes for depression and tuberculosis in Pakistan and Afghanistan.

194. The NIHR also continued to focus efforts on the highest priority COVID-19 research needs, including mental health and minority ethnic group impacts. Alongside UKRI, NIHR funded over £50 million to support studies that will provide a substantial improvement in the understanding of long COVID.

## NHS Financial performance

195. The majority of the DHSC Group budget is spent in the NHS, for which the Government agreed a Long-Term Settlement in 2018. This committed funding increases of £12.4 billion by 2020-21, rising to £33.9 billion by 2023-24, and fully funded the NHS's own Long-Term Plan.

196. The Government provided a further £18 billion in 2020-21 to support the NHS's ongoing COVID-19 response whilst maintaining routine services throughout the pandemic, taking the NHS's total Revenue Departmental Expenditure Limit (RDEL)

budget (excluding depreciation, impairments and other technical adjustments) in 2020-21 to £149.5 billion.

197. In addition to funding support, during 2020-21 the Department set out the following planned measures to support the NHS through the pandemic:
    - We have supported the NHS's approach to allow for maximum operational focus on the COVID-19 response, by agreeing a temporary finance regime across the year that started with guaranteed funding to cover COVID-19 related spending in NHS systems and evolved into fixed allocations for the second half of the year.
    - As part of a financial reset we have eliminated around £13 billion of NHS debt, through the issuance of new Public Dividend Capital, enabling NHS trusts to repay interim revenue and capital debts held with the Department, freeing NHS trusts up to invest in maintaining vital services and longer-term infrastructure improvements.
    - Used significant additional funding to support a series of temporary capacity initiatives such as; extended use of the Independent Sector, an Enhanced Discharge scheme to move patients from acute to community settings, the Nightingale Hospitals programme which added surge capacity to NHS trusts and an extended flu vaccination programme to ease pressure on acute services through the winter.

198. This approach to supporting the NHS through the pandemic has seen a significant improvement in the financial position of frontline NHS organisations, with the NHS provider sector ending the financial year with a healthy aggregate surplus.

199. Against this total budget, the NHS has ended the year with a net underspend of £5.9 billion. This is a material underspend in an unprecedented year, and in general is driven by the uncertainty and volatility of the COVID-19 impact on NHS services.

200. Funding was agreed at prudent levels and has fully funded the direct and indirect costs to the NHS in 2020-21. In addition, savings have arisen in business as usual (BAU) budgets i.e. non-COVID-19 related core NHS services, as the NHS rightly focussed more on the COVID-19 operational response.

### DHSC Group Financial performance

201. The Department is accountable to Parliament for ensuring that total spending by all bodies within the Departmental Group is contained within the overall budgets approved by Parliament per **Table 4**.

**Table 4: DHSC Departmental Outturn 2020-21 against Parliamentary & HM Treasury Controls**

| | Budget £m | Outturn £m | Under/ (Overspend) £m | Key disclosure notes/further detail |
|---|---|---|---|---|
| Resource Departmental Expenditure Limit (RDEL) | 200,755 | 180,199 | 20,556 | SOPS 1.1, Annex B |
| *of which: Resource Administration* | *3,221* | *2,470* | *751* | *SOPS 1.1, Annex B* |
| Capital Departmental Expenditure Limit (CDEL) | 12,918 | 12,683 | 235 | SOPS 1.2, Annex B |
| Resource Annually Managed Expenditure (RAME) | 10,002 | 2,882 | 7,120 | SOPS 1.1 |
| Capital Annually Managed Expenditure (CAME) | 15 | (7) | 22 | SOPS 1.2 |
| Net Cash Requirement | 187,961 | 165,725 | 22,236 | SOPS 3 |
| Further HM Treasury Controls: | | | | |
| Ringfenced Resource DEL | 1,589 | 1,194 | 395 | Annex B |
| Non-ringfenced Resource DEL | 199,166 | 179,006 | 20,161 | Annex B |

202. As referenced in the key finance facts earlier in the Performance Report and in **Table 4**, the Department had underspends of £20.6 billion on its Resource Departmental Expenditure Limit (RDEL) control total, £22.2 billion on its Net Cash Requirement (NCR) control total and £7.1 billion on its Resource Annually Managed Expenditure (AME) control total.

203. AME is demand-led and volatile, being 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. **Note 16** in the Financial Statements section of this report provides further detail.

204. The 2020-21 outturn against the Department's spending controls, is shown in **Table 4**. The following paragraphs, supported by **Table 5** and **Table 6,** provide further information about the nature of the spend and underspends incurred by the Department during 2020-21 in relation to RDEL and CDEL.

## COVID-19 funding and expenditure in 2020-21

205. As part of Government's response to the Coronavirus pandemic the Department received:
    - £58.9 billion additional RDEL funding, including; £18 billion for the NHS to support the frontline response to the pandemic, £20.4 billion for the Test and Trace programme, £14.7 billion for the procurement and supply of personal protective equipment, £4 billion for the deployment of the covid-19 vaccine and other COVID-19 treatments, £1.3 billion for the infection control fund and other grants and £0.1 billion for Ventilators and the Critical Care National Stockpile; and
    - £4 billion additional CDEL funding, including £0.6 billion for the NHS, £2.7 billion for the Test and Trace programme and £0.4 billion for Ventilators and the Critical Care National Stockpile.

## Revenue funding and expenditure analysis

### Table 5: Resource DEL

| | Budget £m | Outturn £m | Under/(over) £m |
|---|---|---|---|
| NHS business as usual activities [1] | 129,632 | 126,119 | 3,513 |
| NHS COVID-19 | 17,995 | 15,749 | 2,246 |
| NHS Test & Trace | 20,369 | 11,070 | 9,300 |
| Personal Protective Equipment | 14,705 | 13,039 | 1,666 |
| Vaccines deployment | 3,045 | 860 | 2,185 |
| Infection Control and other grants [2] | 1,282 | 1,284 | (2) |
| COVID -19 medicines, treatments and R&D | 946 | 328 | 619 |
| Ventilators and Critical Care Stockpile | 145 | 49 | 97 |
| Other COVID-19 | 431 | 550 | (119) |
| Non-NHS Business as usual activities [3] | 12,204 | 11,152 | 1,052 |
| **Total RDEL** | **200,755** | **180,199** | **20,556** |

1. The outturn for COVID-19 Mental Health is included in NHS BAU. The term BAU is used for activities that are non-COVID-19 related core services for the organisation(s).
2. Grants budget includes only HMT funding, whereas outturn includes DHSC 'matched funding' expenditure.
3. Includes EU budget of £115 million and outturn of £75.5 million.

### NHS Response

206. The NHS was allocated COVID-19 revenue funding of £18 billion to support the frontline response to the pandemic. The funding supported specific initiatives to temporarily increase NHS capacity, such as increasing staffing numbers, extending the use of Independent Sector providers, enhancing patient discharge schemes and the Nightingale Hospitals programme. The NHS savings against COVID-19 and business as usual budgets are discussed from **paragraph 195**.

### NHS Test and Trace (NHSTT)

207. NHS Test and Trace (NHSTT) was allocated revenue funding of £20.4 billion and spent £11.1 billion on:
    - Creating daily capacity for tests,
    - Conduction COVID-19 tests since March 2020,
    - Establishing over 880 testing sites,
    - Contacting people to notify them to self-isolate,
    - Creating the NHS COVID-19 app which has been downloaded over 20 million times in England and Wales.

208. £3.3 billion of NHSTT's expenditure relates to inventory, which scores to RDEL on consumption.

209. NHSTT's £9.3 billion saving against budget is mainly due to less than anticipated demand for tests and related activities mainly as a result of the National Lockdown in December 2020. This meant almost all plans for mass and

community testing from January 2021 onwards had to be paused, delayed, or cancelled.

210. The effect of lockdown together with the successful vaccination rollout, meant far fewer people than anticipated took PCR or rapid (LFD) tests. The reduced demand for tests, together with renegotiated contracts, resulted in significant savings in related spend such as consumables, logistics, resources, and laboratory costs.

### Personal Protective Equipment

211. The PPE programme was allocated revenue funding of £14.7 billion and spent £13.0 billion on the procurement, storage and transportation of over 27 billion, (with the Core Department responsible for almost 27 billion of this total) items of PPE, which hit the RDEL budget on purchase. The saving against budget is primarily due to the timing of spend, including contract cancellation and curtailment, and deferment in to 2021-22.

212. As reported in **Note 8** in the financial statements, the Department estimates the value of its investment in PPE inventory reduced by £8.7 billion in 2020-21. This figure comprises the following: £673 million for items not suitable for any use; £2,581 million for items not suitable for use in the NHS but which may be suitable for other uses and therefore held for future sale or donation; £4,701 million as a result of fluctuations in market price between the point of purchase and the balance sheet date (driven by the huge price inflation as a result of the unprecedented spike in global demand); and £750 million for 'excess' inventory which has an expiry date prior to the expected usage date and is therefore held for resale or donation.

213. In addition, the onerous contract provision disclosed in **Note 16** in the financial statements confirms the Department estimates a further £1,231 million diminution in PPE inventory value in future years as a result of the above factors in relation to inventory that had not been delivered at 31 March 2021, but which the Department is committed to purchase under non-cancellable contracts in future years. Please note provisions expenditure scores to the Department's Resource Annually Managed Expenditure budget.

214. At the start of the COVID-19 pandemic, the UK government had to procure PPE at a fast rate and at a time when demand outstripped supply globally, impacting on prices paid.

215. As mentioned above, challenges around such aspects as procurement, technical assurance and quality of PPE across the health and social care system did lead to significant levels of impairment of PPE procured by the Department, as well as losses incurred by the Department. Details pertaining to this can be found in the **Losses Statement** in the **Parliamentary and Accountability Report** and further detail regarding impairments can be found in **Notes 8** and **12** of the **Department's Notes to the Annual Report and Accounts**.

### COVID-19 Vaccine Deployment

216. The COVID-19 Vaccine Deployment Programme was allocated revenue funding of £3.0 billion and spent £0.9 billion on the biggest vaccination programme in NHS history.

217. The Vaccine Deployment Programme £2.2 billion saving against budget is mainly due to timing. The funding allocated in the Supplementary Supply Estimate was based on the best available intelligence at that time and assumed that the majority of spend would fall into financial year 2020-21.

218. The overall cost for the vaccines programme including the booster, and the Children & Young People phases are expected to be around £4 billion, with the balance of costs now expected to fall into 2021-22.

### Other COVID-19 expenditure

219. Grants programmes in relation to COVID-19 were allocated revenue funding of £1.3 billion which was mainly distributed to adult social care providers in England for infection control, prevention and assisting with work force pressures in adult social care.

220. COVID-19 medicines, treatment and Research and Development programme was allocated revenue funding of £0.9 billion and spent £0.3 billion on the research and development and purchase costs of therapeutic COVID-19 treatments. The saving against budget is mainly due to:
    - assumptions on the number of patients and use of therapeutic approved funds were higher than this turned out to be in reality. The successful vaccination programme resulted in less demand for and spend on therapeutic drugs.
    - For Tocilizumab in particular, changed clinical advice resulted in different treatment plans and reduced spend than had been planned at the time of agreeing the funding.

221. Ventilators and critical care stockpile programme was allocated revenue funding of £0.1 billion to cover the cost of ventilators and inventory items that score to RDEL on consumption. The saving against budget is due to consumption being lower than assumed when setting the budget.

222. £0.4 billion was provided for 'other COVID-19' expenditure. Of this, £0.3 billion was incurred on the depreciation and write-off of assets purchased in response to COVID-19. In addition there was £0.3 billion expenditure relating to Community Pharmacy COVID-19 payments.

### EU Exit expenditure

223. In 2020-21 work was still required to minimise disruptions in the early stages of the UK's Departure from the European Union (EU), and to begin to capitalise on the benefits that can be realised outside of the EU. To support this work the Department received £115 million in 2020-21. The outturn was £75.5 million. The largest area of spend was Government Secured Freight Capacity.

224. Further detail on Non-NHS and NHS business as usual financial performance is covered in **Annex B.**

## Capital funding and expenditure analysis

225. The Department's capital funding and outturn is broken down by activity in **Table 6**.

### Table 6: Capital DEL Spending Breakdown by Activity

| | Budget £m | Outturn £m | Under/(over) £m |
|---|---|---|---|
| NHS business as usual activities | 6,722 | 6,756 | (34) |
| NHS COVID-19 | 613 | 594 | 19 |
| NHS Test and Trace | 2,716 | 2,447 | 269 |
| Personal Protective Equipment | 60 | 31 | 29 |
| Vaccine deployment | 10 | 3 | 7 |
| COVID-19 medicines, treatments and R&D | 157 | 68 | 90 |
| Ventilators and Critical Care Stockpile | 439 | 443 | (5) |
| Other COVID-19 | 14 | 14 | 0 |
| Non-NHS Business as usual activities | 2,187 | 2,328 | (141) |
| **TOTAL CDEL** | **12,918** | **12,683** | **235** |

226. NHS capital is discussed in detail in **Annex B**.

### NHS Test and Trace (NHSTT)

227. NHSTT was allocated capital funding of £2.7 billion to cover the purchase of capital assets and net increases in inventory. NHSTT's inventory expenditure, in line with HM Treasury's budgeting classification of large inventory purchases, incurs a charge to capital DEL on purchase and a charge to revenue DEL with an equivalent credit to capital DEL on consumption.

228. The amount scoring to capital DEL reflects the movement between the opening and closing inventory balances over the course of 2020-21.

229. NHSTT spent £2.4 billion mainly on:
    - The net inventory expenditure of c£2.1 billion comprising of c£5.6 billion inventory purchases, such as swabs, chemicals, and lateral flow devices, of which c£3.3 billion was consumed and c£0.2 billion impaired (with the c£2.1 billion being the difference between purchases and consumption); and

- c£0.4 billion on equipment for the local laboratory network.

230. NHSTT's £0.3 billion saving against budget is mainly due lower than anticipated purchases of laboratory equipment. The budget included provision for two Mega Labs. In January 2021, this was reduced to one (the Rosalind Franklin laboratory in Royal Leamington Spa) following a review on the demand for tests. In addition, the opening of the remaining lab was delayed until May 2021 due to construction delays leading to further reductions in expenditure.

### COVID-19 medicines, research, and development

231. COVID-19 medicines, treatments and R&D was allocated capital funding of £0.2 billion and spent £0.1 billion on clinical trials and research and development. The saving against budget is mainly due to a change in HMT budgetary treatment since the Supplementary Supply Estimate when the budgets were set and one of the clinical trials not progressing as forecasted per the Department's expectations.

### Non-NHS business as usual activities

232. The non-NHS business as usual overspend is mainly due to the delayed sale of a financial asset, which completed in April 2021. Further details of this are set out in **Annex B**.

233. Further detail regarding financial performance across the DHSC Group can be found in **Annex B** of this Report.

## Our performance against other required reporting

### Sustainable Development, Sustainable Procurement, Climate Change, Rural Proofing and Sustainable Construction


234. The Government aims to lead by example, managing its estate and activities in a way that supports the principles and objectives of sustainability. All central government departments are required to report on the environmental impact of their operations through the Greening Government Commitments (GGC) reporting.

235. The GGC are a set of targets that cover carbon emissions related to energy use and business travel, water use and waste. The Department is also committed to the elimination of single-use plastics on its estate and reducing the environmental impact of its vehicle fleet.

236. The upcoming GGC report will provide the environmental impact of the Department's operations for 2020-21 in line with the HM Treasury minimum financial reporting requirements for 2020-21 Annual Report and Accounts.

## Parliamentary Questions 2020

237. We remain one of the busiest departments for Parliamentary Questions (PQs) across Government. In 2020 we received 12,043 PQs, almost double the volume compared to the previous year.

238. Due to the high volumes and combined pressures of the pandemic, we were not able to maintain our usual high performance on PQs response times and answered 28.9 per cent on time. We are delivering against our PQ recovery plan and are achieving month on month improvements in performance despite continued exceptionally high levels of parliamentary scrutiny.

## Freedom of Information (FOI) requests

239. We answered 80 per cent of 2,288 FOI requests received in 2020 within the statutory 20 working day deadline (or Public Interest Test extension) which is more than double the volume received compared to the previous year (933). Performance on FOI requests in 2020 is therefore still an impressive achievement considering how high volumes have been during the pandemic.

## Other correspondence

240. As shown in **Table 7**, in 2020 we answered 52,502 letters and emails, more than double the volume compared to the previous year (22,365).

241. Much like PQs, the large increase in volumes caused by the pandemic has impacted on performance, resulting in 39 per cent of cases answered within our target rate of 18 working days. In line with standard correspondence reporting across Government, the data shown is for the calendar year 2020 and not the financial year 2020-21.

### Table 7: Other classes of correspondence 2020

| Case Type | Due in 2020 | Answered On Time | Percentage On Time |
|---|---|---|---|
| Private Office | 30,111 | 5,604 | 19% |
| Treat Official | 1,188 | 799 | 67% |
| Departmental Email | 21,203 | 13,964 | 66% |
| TOTAL | 52,502 | 20,367 | 39% |

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

242. In 2020-21 the Department received no complaints.

243. As shown in **Table 8**, in 2019-20 (the last year for which published results are available), the PHSO received 98 enquiries regarding complaints about the Core Department, of which 21 progressed to assessment. 3 cases progressed to investigation.

### Table 8: PHSO Complaints 2019-20

| Enquiries Received | Assessed | Accepted for Investigation* | Investigations Upheld/Partly Upheld | Investigations not Upheld | Investigations resolved through intervention ** | Investigations resolved without a finding*** |
|---|---|---|---|---|---|---|
| 98 | 21 | 3 | 6 | 0 | 1 | 0 |

* 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 2019-20 but not completed it until the following year 2020-21. Similarly, it may have completed an investigation in 2020-21 which we originally accepted for investigation in the previous year 2019-20.
** Complaints where PHSO starts an investigation but is able to resolve the complaint without having to formally complete the investigation.
*** These are complaints where the PHSO ends the investigation for a variety of reasons, for example at the complainant's request.

244. The Department's complaints process follows the PHSO's Principles of Good Complaint Handling.

245. We have a three-tier process that first aims to resolve the issue at local level by the person who originally dealt with the issue. If this fails, the complaint will be escalated to a senior manager in that area. If there is no resolution at this stage, the complaint may be escalated to the Complaints Manager for investigation. Once the DHSC complaints process has been exhausted, complainants may then ask an MP to refer the complaint to the PHSO on their behalf.

## Prompt Payment of Undisputed Invoices

246. 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 size businesses that may not be able to fully operate with longer payment terms, are not disadvantaged by late payments.

247. **Table 9** details the percentage and value of undisputed invoices paid by NHS provider organisations within the agreed terms over the last 3 years.

### Table 9: Prompt Payment of undisputed invoices

| | NHS providers invoices paid within target | |
|---|---|---|
| Financial Year | Percentage | Value (£m) |
| 2020-21 | 87 | 48,259 |
| 2019-20 | 81 | 40,776[1] |
| 2018-19 | 79 | 37,856 |

1. 2019-20 figure revised from £40,941m due to delayed changes to University Hospital of Leicester NHS Trust's accounts.

248. NHS England and NHS Improvement (NHSE and NHSI) monitor Better Payments Practice Code (BPPC) performance data and other working capital information, as reported by NHS provider Trusts, on a monthly basis to assess and compare provider performance in this area.

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

## Official Development Assistance

250. The Department of Health and Social Care's summary of expenditure on Official Development Assistance (ODA) is included at **Annex D**. This amounted to £247 million in 2020, funding Global Health Research and Global Health Security.

## Better Regulation

251. The Department is committed to the use of better regulation to achieve our objectives of improving the public's health and care while at the same time minimising costs to business. 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.

252. The Department is working in partnership with the Department for Business, Energy and Industrial Strategy's Better Regulation Executive to promote the use of alternative approaches to regulation where appropriate. Where regulation is required our partnership considers how best to develop proportionate and targeted, regulatory solutions through the development of policy.

253. The Department has been contributing to the ongoing regulatory reform work being led by Cabinet Office and the National Economy and Recovery Taskforce (Better Regulation) Committee, chaired by the Chancellor of the Exchequer.

254. We also continue to work closely with our key regulators to ensure their activity contributes to the provision of safe, effective and compassionate care while, at the same time, minimising the burden of bureaucracy on the front line.

## Secretary of State for Health and Social Care Annual Report 2020-21

### Introduction

255. 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 subsection (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.

256. This report comments on services commissioned by the National Health Service Commissioning Board (known as NHS England or NHSE) and clinical commissioning groups (CCGs), as well as those public health services for which the Secretary of State and local authorities are responsible. Social care is not a health service but is covered for completeness.

257. This report includes an assessment of how effectively the Secretary of State has discharged his duties under sections 1A (duty as to improvement in quality of services) and 1C (duty as to reducing health disparities) of the 2006 Act, as required under section 247D (2) of the 2006 Act.

258. The Secretary of State is under a duty in section 1A of the 2006 Act for or in connection with the matters listed at 1(a) (the prevention, diagnosis or treatment of illness) and 1(b) (the protection or improvement of public health), to act with a view to securing continuous improvement in the quality of services provided to individuals, in particular with a view to securing continuous improvement in the outcomes achieved and having regard to quality standards prepared by the National Institute for Health and Care Excellence (NICE), under section 1A (4) of the 2006 Act. Under section 1C 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.

259. The assessments of the discharge of these duties are set out in the following paragraphs specifically in relation to performance of the NHS against key access standards; outcomes frameworks; NICE quality standards; the NHS mandate, and health disparities.

### Performance of the NHS against key access standards

260. There are a number of operational and legal standards that the NHS is required to deliver in terms of access to NHS services. These are reflected as 'rights and pledges' to patients in the NHS Constitution. Details of how the NHS acute sector has delivered against several of these main access standards are given at **Annex C** (NHS Operational Performance).

## Departmental Business Plan

261. Although departments were not required to publish a Single Departmental Plan (SDP) in 2020 as they focused on the response to the COVID-19 pandemic, DHSC worked towards a set of priorities, objectives and key performance measures for the Department for the year ahead. These were linked to the previous SDP and were used to assess progress for the Department during the 2020-21 financial year.

## Outcomes Frameworks

262. While the NHS, public health and adult care and support sectors are funded and structured differently, and have different mechanisms for discharging accountability, they are all covered by a set of outcomes frameworks, describing the outcomes that need to be achieved.

263. Collectively, these three outcomes frameworks provide a way of holding the Secretary of State to account for the results the Department is achieving with its resources, working with and through the health and care delivery system.

264. Together the outcomes frameworks also highlight common challenges across the health and care system at the national and local level, informing local priorities and joint action while reflecting the different ways services are held accountable.

265. As part of the Government and the Department's wider drive to increase the transparency and accountability of public services, data from the three outcomes frameworks is published online for the public to hold their local services to account (see links provided within each outcomes framework section).

266. As in previous years the data published relates to the previous financial year, so for the 2020-21 report most indicators report the 2019-20 position. Therefore the impact of COVID-19 will be more widely reported in relation to these indicators in the 2021-22 Annual Report and Accounts.

## Alignment

267. The importance of integrating services to deliver better care and the need to understand the contributions of different parts of the system is central in supporting local planning and delivery of better outcomes. The three frameworks continue to include shared and complementary measures to support these goals.

268. The Department is committed to increasing the alignment of the outcomes frameworks, where appropriate, to encourage integration, joint working and the coordination of local services. NICE quality standards support alignment across the health and care system by, where appropriate, covering all stages of the care pathway.

## Progress against outcomes

### The NHS Outcomes Framework

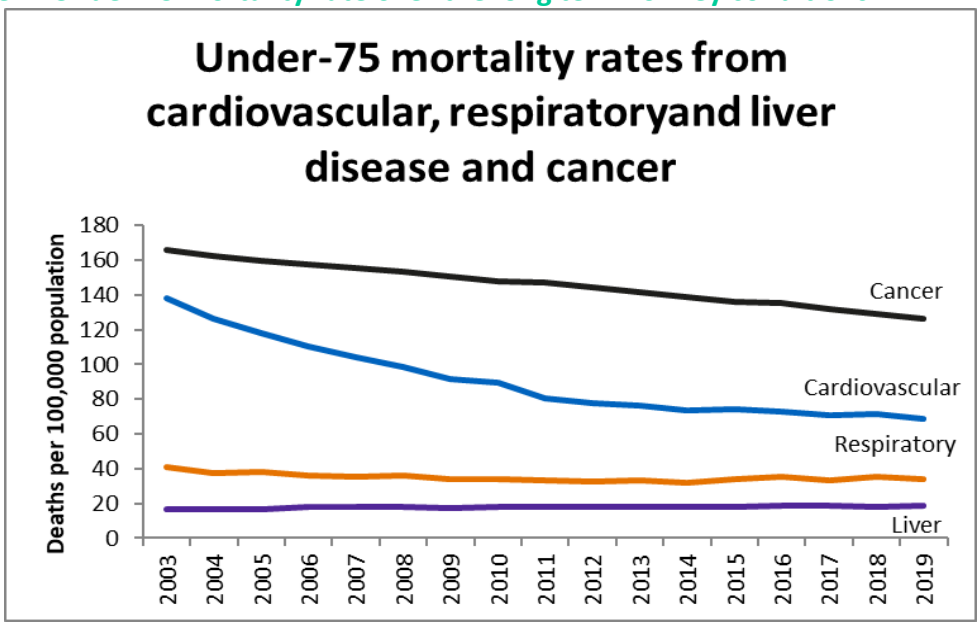
269. The NHS Outcomes Framework (NHSOF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The Framework provides an overview of how the NHS is performing.

270. The NHSOF comprises five domains:
    - preventing people from dying prematurely;
    - enhancing quality of life for people with long-term conditions;
    - helping people to recover from episodes of ill-health or following injury;
    - ensuring people have a positive experience of care; and
    - treating and caring for people in a safe environment and protecting them from avoidable harm.

### Annual indicator data

271. People are living longer due to medical and technological advances and the Government wants to ensure that trend continues. This is why the Government monitors the under-75 mortality rate over the long-term for key conditions, such as cardiovascular disease, cancer and respiratory and liver disease. We have seen significant decreases in the under-75 mortality rate for cardiovascular disease, respiratory disease and cancer between 2003 and 2019. The under-75 mortality rate for liver disease, however, has risen year on year since 2013. See **Figure 2** and following paragraphs.

**Figure 2: Under-75 mortality rate over the long term for key conditions**




Source: NHS Digital

272. In 2020-21, the majority of the 23 indicators where data points were updated remained stable or did not change significantly compared to the previous year, although 9 showed more significant changes.

273. The data in this section comes from various sources, such as NHS Digital and Office of National Statistics and is the latest data available at 31 March 2021. The key changes in each domain are set out below. Full summary details on the indicators can be found on NHS Digital's website.

### Preventing people from dying prematurely

274. The under-75 mortality rates from cardiovascular, respiratory and cancer have significantly decreased between 2004 and 2019. For cardiovascular disease there has been a significant decrease of 45.6%, from 126.5 per 100,000 population in 2004 to 68.8 per 100,000 population in 2019.

275. There has been a significant decrease of 22.3% in under-75 mortality rates from cancer, from 162.5 per 100,000 population in 2004 to 126.3 per 100,000 population in 2019. Respiratory disease also shows a significant decrease of 9.7%, from 37.3 per 100,000 population in 2004 to 33.7 per 100,000 population in 2019.

276. However, the under-75 mortality rate from liver disease has continued to increase. The rate has risen by 10.8%, from 16.7 per 100,000 population in 2004 to 18.5 per 100,000 population in 2019. See **Figure 2.**

### Enhancing quality of life for people with long-term conditions

277. When people do need healthcare, the NHS continues to provide the care people need to live a fulfilling life. There was a significant increase of 6.1% between 2015-16 and 2019-20 in the number of times people with specific long-term conditions - which should not normally require hospitalisation - were admitted to hospital in an emergency. This unfavourable increase was from 812.4 per 100,000 population in 2015-16 to 862.1 per 100,000 population in 2019-20.

278. For the under-19s indicator (asthma, diabetes and epilepsy only), there has been a significant decrease in the asthma rates since 2015-16, from 187.3 admissions per 100,000 population to 148.3 admissions per 100,000 in 2019-20, a decrease of 20.8%. The diabetes rates also show a significant decrease since 2015-16 (from 53.4 per 100,000 population to 49.3 per 100,000 population), a decrease of 7.7%.

### Helping people to recover from episodes of ill health or following injury

279. The NHS continues to support people as they recover from injury or episodes of ill health. The indicator value where children, aged 10 years or under, have been admitted as inpatients to hospital for tooth extractions due to decay has been significantly higher among males than females every year since 2012-13. The indicator value decreased significantly among both males between 2018-19 and

2019-20 (from 426.3 to 401.2) and females (391.7 to 374.1), a 5.9% decrease for males and 4.5% decrease among females.

280. There has been an unfavourable, significant increase in the number of emergency admissions for acute conditions that should not usually require hospital admissions since 2015-16, from 1,318.9 per 100,000 population in 2015-16 to 1,409.4 per 100,000 population in 2019-20, an increase of 6.9%.

### Ensuring that people have a positive experience of care

281. The Government is pleased that most patients are satisfied with their experience of and access to healthcare. In 2019-20, the national indicator value for hospitals' responsiveness to inpatients' personal needs was a score of 67.1 out of 100. The indicator value has fluctuated throughout the time series which started in 2003-04, although results since 2015-16 show an overall downward trend. The 2019-20 score is 2.5 percentage points lower than in 2015-16 (69.6) when the indicator was at its highest.

282. We cannot comment on trends for a number of indicators in this domain as changes to definitions or underlying surveys in previous years mean that NHS Digital cannot provide a time series analysis for these indicators and data has therefore not been published.

### Treating and caring for people in a safe environment and protecting them from avoidable harm

283. There has been a substantial reduction in deaths from venous thromboembolism related events within 90 days post discharge from hospital of 16% from 66.2 deaths within 90 days of discharge per 100,000 related admissions in 2011-12 to 60.4 deaths per 100,000 related admissions in 2019-20.

## The Public Health Outcomes Framework

284. The Public Health Outcomes Framework (PHOF) focuses on the two high-level outcomes we want to achieve across the public health system and beyond:
    - Increased healthy life expectancy (a measure not only of how long we live, our life expectancy, but also whether we are living in good health), and
    - Reduced differences in life expectancy and healthy life expectancy between communities.

285. These outcomes reflect the focus we wish to take, not only on how long we live – our life expectancy, but on how well we live – our healthy life expectancy. Our focus is also on reducing differences between people and communities from different backgrounds.

286. The PHOF comprises a variety of indicators that help track progress toward those two outcomes. These indicators are grouped into overarching indicators and four supporting domains: improving the wider determinants of health, health

improvement, health protection and healthcare, public health and preventing premature mortality.

287. Throughout this section, an assessment of progress on a selection of these indicators is made by comparing the most recent value of an indicator to the value it had in 2014. As there is variation in the baseline year for the indicators, this baseline year has been set at 2014 to ensure that a high number of indicators could be included in this analysis. Depending on the indicator, the values for 2014 refer to the 2014 calendar year itself, or to the 2013-14 financial year or to a 3-year period that ends in 2014. For brevity, these are all referred to as the position in 2014.

288. To date, the COVID-19 global pandemic has had minimal impact on the indicators within the PHOF, as relatively few indicators are reported past March 2020.

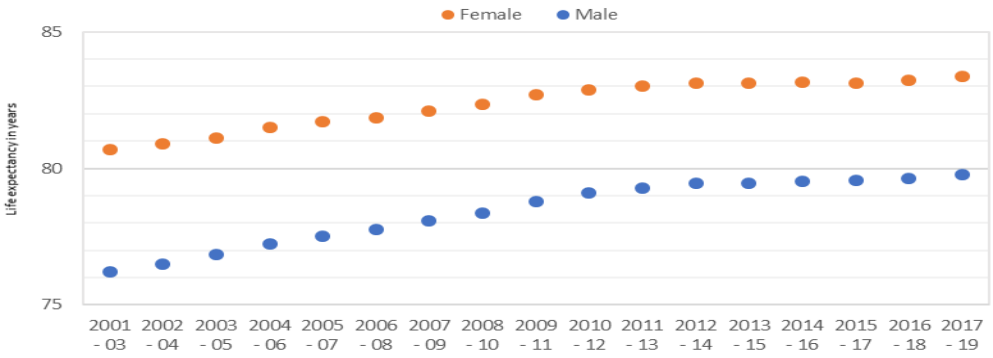
289. A small number of indicators based on programmes delivered in academic settings now report for 2019-20, where data collections and programme delivery may have been impacted due to school closures. Several indicators are being updated later than expected as a result of delays in reporting related to the pandemic. For these indicators, the latest available data is used in this analysis.

290. Of the 108 indicators included in this analysis from the PHOF, 66 (61%) have either improved since 2014 or remained broadly the same and 42 (39%) have deteriorated in comparison with 2014. For most of the indicators there remains considerable variation across local areas. For details on indicators please refer to the Public Health England website.

291. Life expectancy has improved slightly since 2014 (as shown in **Figure 3**) and healthy life expectancy has remained relatively stable since 2014. Although there has been a general improvement in life expectancy over the longer term, the rate of improvement has slowed down since 2011. However, variations exist across different regions and populations in England and for some groups, life expectancy is decreasing.

292. Inequalities in life expectancy have been increasing over time, largely due to low or negative growth in life expectancy in the most deprived areas. This is further discussed in the health disparities section of this report.

**Figure 3: Life Expectancy at birth, Males and females 2001-03 to 2017-19**




## Improving wider determinants of health indicators

293. The majority of the indicators in this domain have improved or remained constant since 2014.

294. In particular, we have seen a decrease in the gap in employment rate between those with a long-term health condition and the overall employment rate (latest data is for financial year 2019-2020). The percentage of working days lost due sick absence (latest data is for 2017-19) has also decreased, showing an improvement in this indicator.

295. Indicators for the proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation and also for the gap in employment rate between those with a learning disability and the overall employment rate have deteriorated (latest data is for the financial year 2019-20).

296. The Community Mental Health Framework, published in September 2019, sets out how systems should move towards a minimum universal standard of high-quality, personalised care for everyone in need of community mental health care. The Government is continuing to engage with local authorities to try and improve best practice to support people with a learning disability into employment.

## Health Improvement Indicators

297. The majority of the indicators in this domain have improved or remained constant since 2014.

298. In particular hospital admissions caused by unintentional and deliberate injuries in children up to the age of 14 years has shown a decrease (latest data for the financial year 2019-20). Smoking prevalence in adults (18+ years), for which our latest data is from 2019, has also fallen.

299. Deteriorating indicators include deaths from drug misuse (latest data is for the period 2017-19) and the number of successful completions of drug treatment for both opiate and non-opiate users (latest data is for 2019).

300. In February 2019, the then Home Secretary appointed Professor Dame Carol Black to undertake an independent review of drugs to inform the government's thinking on what more can be done to tackle the harm that drugs cause. Dame Carol Black's Review of drugs: phase one report was published on 27 February 2020.

301. Part Two of Dame Carol Black's review was published on 8 July 2021. The report made 32 recommendations to government to help overcome the harm drugs have caused to individuals, families and communities across the country, and called for significant investment.

302. On 27 July the Government published an initial response to Part One and Part Two of her review. It set out the recommendations that could be committed to immediately, ahead of providing a full response and setting out a long-term strategy to tackle drugs misuse by the end of this year.

303. The Government has recently consulted on widening access to the lifesaving drug naloxone, which reverses the effects of an opioid overdose and therefore can help to prevent overdose deaths. Naloxone is classified as a prescription-only medicine and the consultation sought views on expanding the list of services and individuals that can give it out without a prescription or other written instruction.

304. The consultation closed on 28 September 2021 and officials are currently analysing the responses. The consultation was launched and developed with our partners in the devolved administrations and future legislative changes would apply across the United Kingdom.

### Health Protection Indicators

305. In contrast to the other three domains, the majority of the indicators in this domain have shown deterioration since 2014.

306. Indicators that have deteriorated since 2014 include the coverage rates for some of the vaccination programmes – for example the population vaccination coverage for flu (those at risk category), (latest data is for the period up to the end of Winter 2019-20) and hib/MenC booster (Haemophilus influenzae type b/meningococcal group C) at 2 years (latest data is for the financial year 2019-20).

307. For the Winter of 2020-21, in light of the increased risk that flu presents alongside COVID-19, the largest flu vaccination programme ever was delivered. GPs and other NHS service providers were asked to prioritise flu vaccination for all those who were in the defined clinically vulnerable groups documented in the national guidance.

308. Plans have been put in place for the systematic restart and recovery of immunisation programmes, including the Hib/Men C booster. These plans are

prioritising those with the highest need and NHSE and NHSI is working with regional commissioners to ensure that all routine immunisations continue to be delivered in primary care settings.

309. An example of an indicator in this domain that improved is the incidence of Tuberculosis (latest data for 2017-19).

### Healthcare, public health and preventing premature mortality indicators

310. The majority of the indicators in this domain have improved or remained unchanged since 2014.

311. Indicators for under-75 mortality rate from cancer considered preventable (latest data 2017-19) and preventable sight loss due to diabetic eye disease (latest data financial year 2019-20) have both shown an improvement.

312. Indicators that have deteriorated include both the mortality rate from a range of communicable diseases (including influenza), and under-75 mortality rate from respiratory disease considered preventable (latest data for both is 2017-19).

313. The number of flu cases and deaths due to flu related complications varies each flu season and many of these deaths were in people with underlying conditions. The Department is committed to working in partnership with its arm's length bodies, agencies and wider government to improve the lives of those with lung disease, and respiratory disease is a clinical priority within the published NHS Long Term plan.

## The Adult Social Care Outcomes Framework (ASCOF)

314. The Adult Social Care Outcomes Framework (ASCOF) fosters greater transparency in the delivery of adult social care, supporting local people to hold their council to account for the quality of the services they provide. ASCOF is divided into 4 'key domains' which are described in the following paragraphs and summarised in **Table 10**.

### Enhancing quality of life for people with care and support needs (ASCOF indicators 1A to 1J)

315. ASCOF indicators measure the quality of life of people who use care services and their experience of care and support including: how safe they feel; the effectiveness of services in supporting them to stay independent for as long as possible; and the choice and control they have over their daily lives. The indicators also include the views of unpaid carers where appropriate.

316. The social care-related quality of life score of people who use services and their overall satisfaction with their care and support has remained steady at 19.1 (out of a possible maximum of 24) since 2014-15. The biennial carer survey was not carried out in 2019-20 due to COVID-19 restrictions, hence the most recent

measure of carer-reported quality of life is from 2018-19, when it was rated at 7.5 (out of a possible maximum of 12), compared to 8.1 in 2012-13.

### Delaying and reducing the need for care and support (ASCOF indicators 2A to 2D)

317. Keeping older people well, out of hospital and helping them to regain their independence after a period of support, is a vital part of enabling them to live full lives and to play an active role in their communities. The effectiveness is best measured by the percentage of older people who were still at home 91 days after discharge from hospital into reablement. In 2019-20, some 82.0% of such people were still at home, this is a similar rate to the rate achieved in 2018-19 which was 82.4%.

318. Making sure people are able to leave hospital as soon as they are medically fit to do so is also important. Latest data shows delayed transfers of care per 100,000 population increased from 10.3 to 10.8 in 2019-20. Whilst delays attributable to social care have remained largely stable moving from 3.1 to 3.2 per day per 100,000 population.

### Ensuring that people have a positive experience of care and support (ASCOF indicators 3A to 3D)

319. Understanding how people who use services, and their carers, feel about the support they receive and the availability of information during a difficult time is crucial to maintaining their wellbeing. The overall satisfaction of people who use services has remained relatively stable and was at 64.2% in 2019-20, although this figure is significantly lower for carers, with 38.6% of carers satisfied with services (when last collected in 2018-19).

### Safeguarding vulnerable adults and protecting from avoidable harm (ASCOF indicators 4A to 4B)

320. Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of service users' experience and their care and support. In 2019-20, 70.2% of people who used services reported that they felt safe; this measure steadily increased to 2016-17 and has been relatively stable since that point.

321. **Table 10** summarises each ASCOF indicator from 2014-15 to 2019-20. Further detail on the ASCOF and all the indicator data can be found at NHS Digital's website.

### Refresh of the ASCOF

322. In 2018 DHSC commissioned the Association of Directors of Adult Social Services (ADASS) to undertake a review of ASCOF. ADASS have worked with the Institute of Public Care (IPC) to engage with key sector stakeholders.

323. DHSC accepted their recommendation to proceed in developing ASCOF in line with the structure of the Care Act 2014. In March 2020, ADASS and IPC submitted their recommended framework to DHSC. DHSC are now considering this recommendation and working to align the framework with ongoing work to improve adult social care data metrics.

## Table 10: ASCOF Indicators

| ASCOF Indicator | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | Maximum score |
|---|---|---|---|---|---|---|
| **Enhancing quality of life for people with care and support needs** | | | | | | |
| 1A: Social care-related quality of life score | 19.1 | 19.1 | 19.1 | 19.1 | 19.1 | 24 |
| 1B: The proportion of people who use services who have control over their daily life | 76.6 | 77.7 | 77.7 | 77.6 | 77.3 | 100 |
| 1C(1A): The proportion of people who use services who receive self-directed support | 86.9 | 89.4 | 89.7 | 89.0 | 91.9 | 100 |
| 1C(1B): The proportion of carers who receive self-directed support | 77.7 | 83.1 | 83.4 | 83.3 | 86.9 | 100 |
| 1C(2A): The proportion of people who use services who receive direct payments | 28.1 | 28.3 | 28.5 | 28.3 | 27.9 | 100 |
| 1C(2B): The proportion of carers who receive direct payments | 67.4 | 74.3 | 74.1 | 73.4 | 77.1 | 100 |
| 1D: Carer-reported quality of life | - | 7.7 | - | 7.5 | - | 12 |
| 1E: The proportion of adults with a learning disability in paid employment | 5.8 | 5.7 | 6.0 | 5.9 | 5.6 | 100 |
| 1F: The proportion of adults in contact with secondary mental health services in paid employment | 6.7 | - | 7.0 | 8.0 | 9.0 | 100 |
| 1G: The proportion of adults with a learning disability who live in their own home or with their family | 75.4 | 76.2 | 77.2 | 77.4 | 77.3 | 100 |
| 1H: The proportion of adults in contact with secondary mental health services living independently, with or without support | 58.6 | - | 57.0 | 58.0 | 58.0 | 100 |
| 1I(1): The proportion of people who use services who reported that they had as much social contact as they would like | 45.4 | 45.4 | 46 | 45.9 | 45.9 | 100 |
| 1I(2): The proportion of carers who reported that they had as much social contact as they would like | - | 35.5 | - | 32.5 | - | 100 |
| 1J: Adjusted Social care-related quality of life – impact of Adult Social Care services | - | 0.4 | 0.4 | 0.4 | 0.4 | |
| **Delaying and reducing the need for care and support** | | | | | | |
| 2A(1): Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population | 13.3 | 12.8 | 14.0 | 13.9 | 14.6 | |
| 2A(2): Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population | 628.2 | 610.7 | 585.6 | 577.6 | 584.0 | |
| 2B(1): The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services | 82.7 | 82.5 | 82.9 | 82.4 | 82.0 | 100 |
| 2B(2): The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital | 2.9 | 2.7 | 2.9 | 2.8 | 2.6 | 100 |
| 2C(1): Delayed transfers of care from hospital, per 100,000 | 12.1 | 14.9 | 12.3 | 10.3 | 10.8 | |
| 2C(2): Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population | 4.7 | 6.3 | 4.3 | 3.1 | 3.2 | |
| 2C(3): Delayed transfers of care from hospital that are jointly attributable to NHS and adult social care, per 100,000 population | - | - | 0.9 | 0.8 | 1.0 | |
| 2D: The outcome of short-term services: sequel to service | 75.8 | 77.8 | 77.8 | 79.6 | 79.5 | 100 |
| **Ensuring that people have a positive experience of care and support** | | | | | | |
| 3A: Overall satisfaction of people who use services with their care and support | 64.4 | 64.7 | 65.0 | 64.3 | 64.2 | 100 |
| 3B: Overall satisfaction of carers with social services | - | 39.0 | - | 38.6 | - | 100 |
| 3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for | - | 70.6 | - | 69.7 | - | 100 |
| 3D(1): Proportion of people who use services who find it easy to find information about services | 73.5 | 73.5 | 73.3 | 69.7 | 68.4 | 100 |
| 3D(2): The proportion of carers who find it easy to find information about support | - | 64.2 | - | 62.3 | - | 100 |
| **Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm** | | | | | | |
| 4A: The proportion of people who use services who feel safe | 69.2 | 70.1 | 69.9 | 70.0 | 70.2 | 100 |
| 4B: The proportion of people who use services who say that those services have made them feel safe and secure | 85.4 | 86.4 | 86.3 | 86.9 | 86.8 | 100 |

1. All indicators are based on 2019-20 data.
2. Correct as at December 2020 (latest available at time of publication).

## NICE Quality Standards

324. NICE quality standards are concise sets of prioritised statements designed to drive and measure quality improvements within a particular area of health or care. They are derived from the 'best available evidence' such as NICE guidance.

325. The Department works closely with NICE, NHS England and NHS Improvement and Public Health England to ensure that NICE's quality standard programme reflects health and care priorities.

326. NICE's quality standard output over the last year has reduced compared with previous years as a result of NICE prioritising work to support the response to the pandemic. From 1 April 2020 to 31 March 2021, NICE published 8 quality standards, covering a range of topics including; decision making and mental capacity, community pharmacies, and abortion care.

327. The Secretary of State for Health and Social Care has to have regard to NICE quality standards when discharging his Section 1A functions.

## Quality and Patient Safety

### Patient Safety

328. The Government is committed to supporting a learning and improvement culture in the NHS so that NHS treatment and care continue to become safer and are provided to the highest possible standards. Internationally, the NHS is identified as one of the safest healthcare systems in the world.

329. In July 2019, NHS England and NHS Improvement (NHSE and NHSI) published the first ever NHS Patient Safety Strategy. This was updated in February 2021.

330. The impact of the COVID-19 pandemic has reached all areas of delivering the Strategy, however progress continues to be made, including on:
    - the creation of the new National Patient Safety Alerts Committee to include oversight of the credentialing and approval of issuers of national patient safety alerts, with the Medicines and Healthcare products Regulatory Agency (MHRA) and Public Health England (PHE) joining the NHSE and NHSI Patient Safety Team in becoming alert issuers;
    - preparation of the first ever Patient Safety Syllabus for the NHS, published in May 2021 following consultation and engagement;
    - identification of over 700 Patient Safety Specialists from over 330 NHS organisations; and
    - publication, in June 2021, of a new Framework for Involving Patients in Patient Safety that sets expectations for ensuring patients and families can contribute to both their own safety and safety leadership in organisations.

331. The Patient Safety Incident Response Framework (PSIRF), an integral part of the Patient Safety Strategy, is currently being piloted. There are 15 Early Adopter pilots currently testing the PSIRF prior to roll out during 2022.

332. During 2020-21, patient safety resources within NHSE and NHSI were repurposed to support the response to COVID-19. This work included:

- Providing expert safety advice for the Nightingale Hospitals and COVID-19 vaccination programme;
- supporting the adoption of early warning systems in non-acute settings to help identify and manage COVID-19 patients at risk of deterioration;
- delivering the COVID oximetry @home programme to implement pulse-oximetry in community settings like care homes;
- supporting the use of validated early warning scores that help identify and manage deterioration of expecting mothers with COVID-19 and their babies; and
- ensuring safe care for COVID-19 patients with a tracheostomy who are looked after outside of intensive care units.

333. Throughout 2020-21, incidents in relation to COVID-19 and the systems, treatments and equipment the NHS used to respond to the pandemic were retrieved from the National Reporting and Leaning System (NRLS), alongside regular clinical review of all serious patient safety incidents, to identify those with potential for national action.

334. National Patient Safety Alerts with the greatest relevance to the pandemic response were prioritised and published. Identified issues were also shared with the National Incident Response command, with specialist cells best placed to take action, and with royal colleges, specialist societies, and MHRA.

335. The NHSE and NHSI Patient Safety Team continued to support colleagues across the system who are not yet accredited issuers of National Patient Safety Alerts, including the DHSC, to strengthen response and alerting systems used to manage issues related to the supply of medicines and medical devices, estates and facilities safety issues, and Therapeutic Alerts for the treatment of COVID-19.

336. The programme to develop new Learn From Patient Safety Events (LFPSE) service to replace the current NRLS, made significant headway in 2020-21 leading to the major milestone of the Public Beta phase of the service being launched in July 2021.

337. The Healthcare Safety Investigation Branch (HSIB) continues to conduct independent investigations of patient safety concerns in NHS-funded care across England with a specific focus on system-wide learning.

338. During 2020-21, HSIB launched 27 investigations, of which 19 progressed to full investigation. Of the 22 reports completed, 18 were published as investigation reports and four were to support NHS bodies in responding to the COVID pandemic. HSIB made a total of 39 safety recommendations to system partners.

339. HSIB's national learning report 'Summary of Themes arising from the Healthcare Safety Investigation Branch Maternity Programme (NLR'), published in March

2020, highlighted eight themes identified from the maternity investigations carried out to date. To further explore these themes, HSIB published two thematic reports which highlighted areas of system-wide learning, and where appropriate, made safety recommendations:

- 'Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection', published in July 2020, focuses on the impact GBS was considered to have in 15 HSIB investigations; and
- 'Neonatal collapse alongside skin-to-skin contact', published in August 2020, focuses on the importance of clinical monitoring to ensure that babies are as safe as possible during skin-to-skin contact following birth.

340. In addition, HSIB published an independent National Learning Report: Maternal death: learning from maternal death investigations during the first wave of the COVID-19 pandemic in February 2021. The report reviewed 19 maternal deaths that occurred between 1 March 2020 and 31 May 2020. It identified seven themes and made three safety observations.

341. The Health Service Safety Investigations Bill (the Bill) provisions have now been brought into the Health and Care White Paper and have been included in the Health and Care Bill. The provisions prohibit disclosure of information held by the proposed new Health Service Safety Investigation Body (HSSIB) in connection with its investigatory function, enabling a 'safe space' whereby participants can provide information in confidence. Amendments extend the remit of the new body to cover healthcare provided in the independent sector, to allow more thorough investigation of patient safety concerns.

342. A power is proposed to enable the Secretary of State to require the HSSIB to investigate particular qualifying incidents, as well as a regulation-making power allowing the Secretary of State to set out additional circumstances when the prohibition on disclosure for information provided under 'safe space' does not apply.

343. A strong framework on learning from deaths is in place to support the NHS. NHS acute, mental health and community trusts are required by law to publish locally, the numbers of deaths thought to be due to problems in care each quarter, and to evidence the learnings and actions taken to prevent recurrence in their annual Quality Accounts.

344. The Care Quality Commission continues to provide strengthened regulation through inspections that assess compliance by trusts with learning from deaths policy set out in national guidance. This includes how well the NHS engages with bereaved families and carers.

345. Medical Examiners are currently being introduced in the NHS in a non-statutory capacity to scrutinise all non-coronial deaths and DHSC is working closely with the National Medical Examiner to achieve full roll out. The Government introduced the Health and Care Bill on 6 July 2021, reinforcing the Government's commitment to introduce a statutory medical examiner system.

346. The National Medical Examiner has published good practice guidelines, and NHSE and NHSI has completed recruitment to regional medical examiner teams to support trusts.

347. The National Medical Examiner's team worked with acute trusts to establish medical examiner offices during 2020-21. By the end of 2020, 130 medical examiner offices had been established. By the end of February 2021, 1,000 senior doctors were trained as medical examiners, with further training planned for 2021-22.

348. The National Medical Examiner contributed to the COVID-19 response through: supporting easements relating to death certification of the Coronavirus Act 2020; publishing guidance for medical practitioners to explain easements during times of excess deaths; and responding to technical queries arising during the COVID-19 response.

349. There is now a standardised process for reviewing the deaths of all children in England, informed by the Child Death Review: Statutory and Operational Guidance (England).

350. Independent scrutiny of every child death is now performed by a local Child Death Overview Panel, or equivalent, to ensure a uniform, high standard of reviews locally. Beginning in April 2019, the National Child Mortality Database programme collates and analyses anonymised information collected from these reviews to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.

351. The Maternity Transformation Programme (MTP) provides the infrastructure for delivering the recommendations from 'Better Births'; the Neonatal Critical Care Review (NCCR) and the Government's National Maternity Safety Ambition. The MTP has made measurable improvements in safety outcomes for women, their babies and families in maternity and neonatal services, with safety as the golden thread running through the programme.

352. The 'Promoting good practice for safer care' workstream within the MTP specifically led the delivery of the Government's national ambition to halve the 2010 rates of stillbirths, neonatal and maternal deaths and intrapartum brain

injuries in babies by 2025, with a 20% reduction by 2020, and to reduce the preterm birth rate from 8% to 6% by 2025.

353. Considerable progress has been made in improving maternity safety and many key achievements have been recognised.

354. There have been reductions in the number of stillbirths (from 5.1 per 1,000 births in 2010 to 3.8 per 1,000 births in 2019), neonatal deaths of babies born after 23 completed weeks of pregnancy onwards (from 2.0 deaths per 1,000 live births in 2010 to 1.4 deaths per 1,000 live births in 2019), and rates of brain injuries occurring at or soon after birth (from 4.7 per 1,000 live births in 2014 to 4.2 per 1,000 live births in 2019) with the rate of infants with hypoxic ischaemic encephalopathy falling by 15% between 2014 and 2019.

355. Further focus is now on addressing disparity in outcomes for women from a black or minority ethnic background and those living in the most deprived areas who are being disproportionally affected.

356. In March 2021 the NHS announced an additional £95 million investment into maternity services to support a step change in the trajectory to meet the national ambition, including to further develop the workforce and strengthen surveillance of the system with support for organisations identified at risk or rated 'inadequate' or 'needs improvement' by the CQC.

357. March 2021 also marked 5 years since the publication of 'Better Births' and the transition of the MTP from its current model into a new governance arrangement. The new model aims to simplify the programme and ensure that it is driven by the core aims of delivering safer, more personalised care, alongside improving equity. It will also encompass relevant commitments from the NHS Long Term Plan (LTP), and where appropriate actions related to the Ockenden review of maternity services.

358. The National Director of Patient Safety has set up a clinically led Valproate Safety Implementation Group (VSIG), following the Independent Medicines and Medical Devices Safety (IMMDS) Review published during 2020-21, to reduce the use of valproate in people who can get pregnant by 50% by 2023 and to prevent unplanned pregnancies in this group. The VSIG has committed to exploring 3 key areas to improve the safe use of valproate in women of childbearing potential;

- Stopping initiation and deprescribing valproate where safer alternatives are available and making dispensing safer;
- Ensuring women of childbearing potential who take valproate have access to highly effective contraception, sexual and reproductive health advice; and
- Ensuring shared decision making is in place wherever valproate is prescribed women of childbearing potential.

359. NHSE and NHSI and the NHS Business Services Authority (NHSBSA) have developed a set of prescribing indicators to monitor the use of valproate medicines among women of childbearing potential. The Valproate Safety Dashboard makes monitoring valproate use straight forward for patients, the public and health professionals.

360. The Department continues to work with other government departments and international governments, as well as the World Health Organization (WHO), to increase global cooperation and action to improve patient safety worldwide. The UK government continues to proactively mark World Patient Safety Day on 17 September each year and in 2020, supported the development of the Global Patient Safety Action Plan 2021-2030 by the WHO.

361. The action plan will support implementation of a UK government-led Resolution on Global Action on Patient Safety adopted by the World Health Assembly in May 2019, by providing strategic direction for concrete actions to be taken by all countries to implement it and the action plan.

### Supporting Patients, Families and Staff to raise concerns

362. The Department is working with stakeholders, including the Parliamentary and Health Service Ombudsman to improve how the NHS responds to complaints and concerns. We are focusing on culture within the NHS to help drive improvements in how feedback and concerns from patients, their families and carers, are dealt with so that the NHS listens, learns and acts.

363. In October 2020, the Minister for Mental Health, Suicide Prevention and Patient Safety supported the National Guardian's Office's (NGO) third 'Speak Up' month to raise awareness of 'Speaking Up' within the NHS.

364. The Freedom to Speak Up Index 2020 described a year-on-year improvement in Speaking Up culture in the NHS. There are now more than 600 Freedom to Speak Up Guardians in place covering every Trust in England who work to drive improvements in Speaking Up culture at a local level.

365. The Government have legislated for a new Patient Safety Commissioner position through the Medicines and Medical Devices Act 2021. The Commissioner will add to existing work that has been done to improve patient safety by acting as a champion for patients.

366. The core role of the Commissioner will be to promote the safety of patients in the context of the use of medicines and medical devices and to promote the importance of the views of patients and other members of the public in relation to the safety of medicines and medical devices. Regulations will be made setting out further details about the appointment and operation of the Commissioner and a

campaign launched in line with the public appointments process to fill the position.

### Infected Blood Inquiry

367. The Infected Blood Inquiry continues to hear evidence, most recently from current and former Ministers as well as campaign groups. The Cabinet Office, as the sponsor department for the inquiry, continues to coordinate work between DHSC and the devolved administrations.

368. The Department is providing the documents that the Inquiry is asking for and has waived its usual right to legal privilege.

369. The Department is committed to working with the support schemes in the Devolved Nations to improve parity of support across the UK. In March 2021, the Paymaster General announced changes across the four schemes which will bring them into broader parity.

### Monitoring and Regulation of Quality of Care

370. The Care Quality Commission (CQC) monitors, inspects and regulates registered health and social care providers in England. In 2020-21, the CQC continued work to roll out a transformation programme, to improve its digital infrastructure and enable it to make improvements in how it registers, monitors and inspects services.

371. In January 2021, the Regulator consulted on a new strategy that will enable it to be more flexible to manage risk and uncertainty. The CQC has said that it learnt from its response to the pandemic and will build on that learning to support services and keep people safe.

372. In October 2020, the CQC's annual State of Care report, which provides an assessment of health and care services, found that the care received by people in England is mostly of 'good quality'.

373. However, in the NHS, improvement in some areas such as emergency care and maternity and mental health, was slower than others and that the social care sector is 'fragile' and in need of greater investment and more workforce planning.

374. During the pandemic, the CQC stopped its routine programme of inspections and introduced regulating health and social care providers on a risk-based approach. It did not stop rating providers but rated where it was required (i.e. where there was a change in quality). **Table 11** shows CQC ratings by type of provider.

**Table 11: Percentage of core services rated by CQC as Good or outstanding by service provider***

| Rating | Outstanding | | Good | | Requires improvement | | Inadequate | |
|---|---|---|---|---|---|---|---|---|
| Year | 2019 | **2020** | 2019 | **2020** | 2019 | **2020** | 2019 | **2020** |
| NHS acute trust core services | 7% | **8%** | 65% | **68%** | 25% | **22%** | 2% | **2%** |
| Adult social care | 4% | **5%** | 80% | **80%** | 15% | **15%** | 1% | **1%** |
| GP practices | 5% | **5%** | 90% | **89%** | 4% | **5%** | 1% | **1%** |
| NHS mental health trust core services | 10% | **11%** | 71% | **71%** | 17% | **15%** | 3% | **3%** |
| Independent mental health core services | 9% | **8%** | 66% | **67%** | 21% | **20%** | 3% | **5%** |

* Ratings taken on 31 July in 2018 and 2019 and published in the CQC State of Care (2018-19) report. Percentage figures may not sum due to rounding.

## Inquiries and Reviews

375. The report of the Independent Medicines and Medical Devices Safety Review chaired by Baroness Julia Cumberlege was published on 8 July 2020 and the report of the Independent Investigation into the life and death of baby Elizabeth Dixon was published on 26 November 2020 and provided system-wide learning.

376. The emerging findings and recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (The Ockenden Review), was published on 10 December 2020. This is the first interim report, following 250 clinical reviews.

377. The Ockenden Review is assessing the quality of investigations relating to new-born, infant and maternal harm at Shrewsbury and Telford Hospitals NHS Trust (SaTH). The original terms of reference for the Review covered the handling of 23 cases.

378. Following the launch of the review in 2017, additional cases have been identified and the final total of cases now being considered is 1,862. The second and final report considering the remaining potential cases, will be published in 2022.

379. In June 2019, Ministers had announced a new independent investigation to review fresh evidence of substandard care at Liverpool Community Health NHS Trust between 2010 and 2014 and its terms of reference were announced in Parliament on 16 July 2020.

380. Following concerns raised about the quality and outcomes of East Kent Hospitals University NHS Foundation Trust maternity and neonatal care, in February 2020, NHSE and NHSI commissioned Dr Bill Kirkup to undertake the East Kent Maternity Independent Investigation. The terms of reference have been agreed and were announced in Parliament by the former Minister of State for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries on 11 March 2021.

381. On 21 January 2021 the Minister of State for Patient Safety, Suicide Prevention and Mental Health announced the establishment of the Essex Mental Health Independent Inquiry into the circumstances of mental health inpatient deaths at the former North Essex Partnership University NHS Foundation Trust, the former South Essex Partnership University Trust and the Essex Partnership University NHS Foundation Trust which took over responsibility for mental health services in Essex from 2017.

### Overall Assessment (section 1A)

382. The Secretary of State's assessment is that, against the challenges of an ageing population and an increase in the complexity and number of patients with long-term conditions, reasonable progress has been made against the duty under section 1A of the 2006 Act, to act to secure continuous improvement in the quality of services provided to individuals, in particular securing continuous improvement in the outcomes achieved.

383. Across the frameworks there are areas where tangible progress has been made, but also areas of concern. For example, while significant progress has been made in reducing the under-75 mortality rate for cardiovascular disease, respiratory disease and cancer between 2003 and 2019, there has been a deterioration across many of the indicators within the domain of health protection. DHSC, working with its ALB partners and other Government Departments, is taking a coordinated set of actions to reverse the decline in vaccination rates.

### Health Disparities

384. The Secretary of State's legal duty to have regard for the need to reduce health disparities includes assessment and reporting requirements. In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.

385. For 2020-21, the criteria for assessment and supporting indicators remained as set out in the Secretary of State's letter to health system leaders in February 2016.

386. Health disparities in access, outcomes and experiences of the health service continue to present a significant challenge. This ongoing challenge has been highlighted and further exacerbated by the COVID-19 pandemic.

387. Over the 2020-21 period, much of the work on reducing health disparities has been focused on addressing the disparities in outcomes for specific groups in relation to COVID-19. Public Health England (PHE) has undertaken in depth analysis of the disparities arising from COVID-19. This work included the Disparities in the Risk and Outcomes of COVID Report published in June 2020,

which confirmed that the impact of COVID-19 replicated and increased existing health disparities.

388. The report found that the risk of dying from COVID-19 was higher in older age groups, males, those living in more deprived areas and some ethnic minority groups.

389. Following PHE's report, the Prime Minister and Secretary of State for Health commissioned the Minister for Equalities, Kemi Badenoch MP, to lead cross-government work to tackle COVID-19 disparities experienced by individuals from an ethnic minority background.

390. The Minister for Equalities has published reports on progress on a quarterly basis, with one final report due later this year. PHE has also been further refining, deploying and assuring its own progress to factor in health disparities through The Health Equity Assessment Tool.

391. In August 2020 NHSE and NHSI published their Phase 3 Implementation Letter which outlined eight urgent actions relating to health disparities and the COVID-19 pandemic, this was issued in relation to the restoration of services and expectations particularly for patients in the 20% most deprived areas and for Black and Asian patients.

392. DHSC has continued to factor addressing health disparities into its work on the COVID-19 vaccination programme and published its UK COVID-19 vaccine uptake plan in February 2021. The programme has focused on encouraging uptake from ethnic minority communities and people living in deprived areas, through the use of tailored approaches, outreach services and providing materials in a variety of languages and formats.

393. Fifteen overarching indicators of how health outcomes differ by area deprivation are drawn from the NHS Outcomes Framework (NHSOF) and Public Health Outcomes Framework (PHOF). They are used in this assessment which seeks to identify both recent change and change since the inequalities duties were introduced under the Health and Social Care Act 2012. This analysis uses NHSOF and PHOF indicator values that have been calculated for each national deprivation decile.

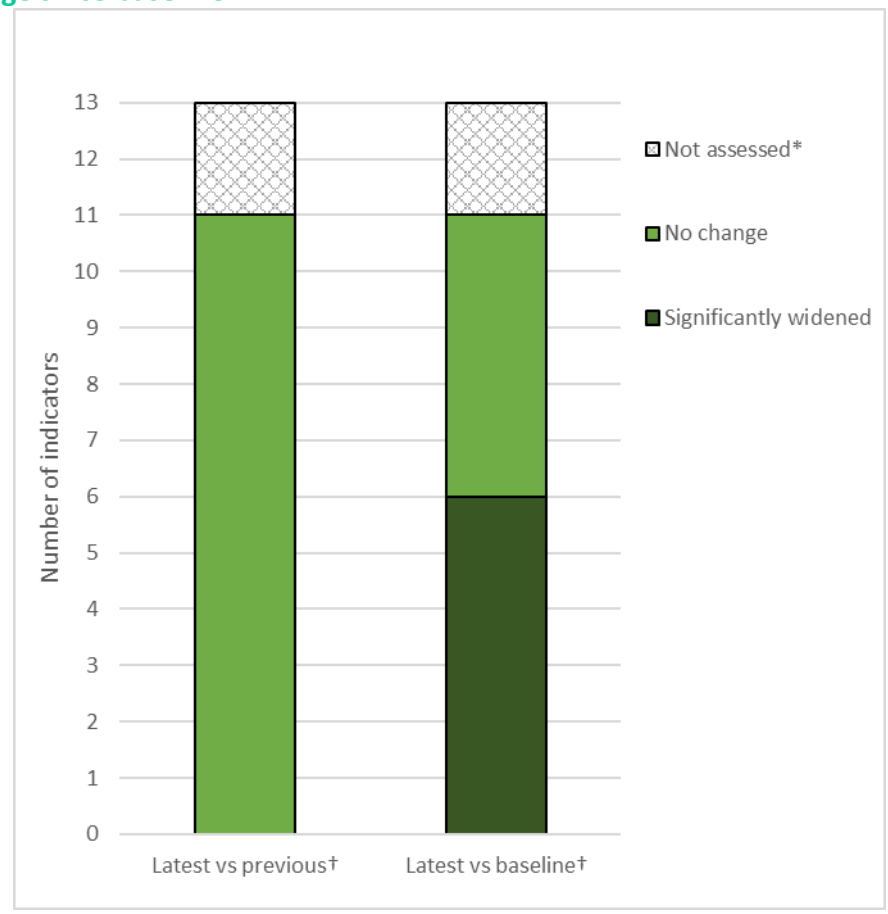
394. Deprivation is measured using the English Index of Multiple Deprivation (IMD), which is the official measure of area-based relative deprivation in England. Deprivation deciles are calculated by ranking Lower-layer Super Output Areas (LSOAs) from most deprived to least deprived based on their IMD score and dividing them into 10 equal groups. These range from the most deprived 10% (Decile 1) of LSOAs to the least deprived 10% (Decile 10) of LSOAs nationally.

395. This analysis uses the IMD 2019 to define deprivation deciles for the most recent time period. In doing this, areas are grouped into deprivation deciles using the IMD that most closely aligns with the most recent indicator data.

396. Impacts from COVID-19 will not be captured in this report as the data analysed is from before the COVID-19 pandemic.

397. **Figure 4** summarises the changes seen across this basket of indicators, comparing the latest data with data from the previous time period.

**Figure 4: Change across the basket of Health Disparities Indicators: recent change and change since baseline**




* Assessment not possible due to data availability
† Previous and baseline years differ across indicators

398. Only eleven of the fifteen indicators are presented in this report. Two of the indicators are no longer updated by NHS Digital ('Potential years of life lost (PYLL) from causes considered amenable to healthcare – adults' and 'Health-related quality of life for people with long-term conditions').

399. A further two indicators were also not analysed due to data availability issues. COVID-19 delays to publication timetables mean that GP survey data was not available. As a result, the indicators 'Access to GP services', 'Patient experience of

primary care - GP services', and 'Infant mortality' will not be updated until next year's report.

400. Of the eleven indicators analysed, six have shown a statistically significant widening of inequality from their baseline time period (see below). None of the eleven indicators have shown any significant change since their previous reporting period.

401. The overarching indicators in the PHOF show that the inequalities between people living in the most deprived areas and the least deprived areas remain:

- in 2017-19, the inequality in life expectancy at birth between the most and least deprived areas was 9.4 years for males and 7.6 years for females.
- in 2017-19 the inequality in healthy life expectancy at birth between the most and least deprived areas was 19.0 years for males and 19.3 years for females.
- inequality in healthy life expectancy at birth has remained stable; however, inequality in life expectancy at birth for males and females significantly widened between the baseline period (2010-12) and 2017-19.

402. The NHSOF covers a wider range of indicators that include health outcomes, access to services and patient experience. These indicators provide a mixed picture:
    - Inequality significantly widened between the baseline period (2011-13) for life expectancy at 75 for males and females but has remained stable since the previous time period (2016-18).
    - Inequality in under 75 mortality rates from cardiovascular diseases has remained broadly stable between the baseline year (2013) and 2019.
    - Inequality in under 75 mortality rates from cancer has not significantly changed from the baseline (2013) or the previous time period (2018).
    - Inequality in emergency admissions for acute conditions that should not usually require hospital admission significantly widened since the baseline (2013-14) but has remained stable since previous time periods (2017-18).
    - Inequality in unplanned hospital admission for chronic ambulatory care sensitive conditions significantly widened from the baseline (2013-14) but has remained stable since the previous time periods (2017-18). This and the above indicator are calculated using indirectly standardised admission rates and estimates may be influenced by the differences in population structures across deprivation deciles.
    - Inequality in infant mortality rates has remained broadly stable between the baseline year (2013) and 2019.

403. The Secretary of State's assessment of how well his health disparities duty has been fulfilled in 2020-21, affirms that reducing health disparities is recognised as a

priority in the health and care sector. The Secretary of State recognises that reducing health disparities is challenging and involves complex drivers, many of which lie outside the health and care sector. However, the Secretary of State recognises that more needs to be done. Over the next year, DHSC will be continuing to drive forward work on addressing health disparities.

404. The new Office for Health Improvement and Disparities (OHID), established in October 2021, will drive our health promotion and prevention agenda. Under the leadership of a Deputy Chief Medical Officer and the Director General Office for Health Improvement and Disparities the Office will help DHSC deliver proactive, predictive and personalised prevention strategies. Alongside the recently announced cross-ministerial board on Prevention, the OHID will put addressing health disparities as a key priority.

405. The Government remains committed to levelling up health outcomes across the country and will publish a landmark Levelling Up White Paper early in 2022, setting out bold new policy interventions to improve livelihoods and opportunity in all parts of the UK.

406. The UK Health Security Agency will contribute to the Government's 'Levelling Up' agenda through a rigorous focus on reducing inequalities in the way different communities experience and are impacted by threats to health, targeting action towards disproportionately affected groups. It will work to understand ever better the needs of citizens, and to build that understanding into the design and continuous improvement of services, contributing to a post COVID-19 health system that is built back better, fairer and more resilient.

### Forward look to 2021-22

407. The Department and its delivery partners across the health and care system are committed to leading the nation's health and social care to help people live more independent, healthier lives for longer. The Secretary of State will continue to report on progress in meeting the Department's priorities over the course of 2021-22.

### Performance Report Accounting Officer Sign-off

28 January 2022
**Sir Chris Wormald KCB**
**Permanent Secretary**

# Accountability Report

## Lead Non-Executive Board Member's Report

### Performance and priorities

Kate Lampard

408. The COVID-19 pandemic has been the greatest challenge to our health and care system in living memory. This has placed extraordinary demands on the Department, and I would like to pay tribute to the staff for their fortitude and dedication to their work over the past year.

409. The Departmental Board met four times in 2020-21 with good attendance from ministers, executives, and non-executive directors. The Board's agenda focused on the Department's response to the COVID-19 pandemic, end of Transition Period preparedness, and winter preparedness.

410. I am grateful for the continued valuable contributions from my fellow non-executive directors. This year saw a change in membership of the Board with three of our non-executive directors finishing their terms with the Department. I thank Professor Dame Sue Bailey, Professor Sir Mike Richards, and Michael Mire for their time and commitment to the Department over their three-year term. We welcomed Gina Coladangelo to the Board from September 2020 to June 2021. Doug Gurr joined the Board on 1 December 2020.

411. The Audit and Risk Committee (ARC) continued with Gerry Murphy as chair and met four times over the year. It regularly discussed the Department's finances and the accounts, internal audit reviews and fraud risk, challenging the Department to improve performance where this was necessary. The network of audit committee chairs from across the Department's arm's length bodies held their annual meeting this year. I thank Gerry for his continuing dedication to his role on the Board.

412. The Nominations and Governance Committee membership was extended to invite Gerry Murphy as a formal member in his capacity as the non-executive leading on talent management. Non-executive directors have also been included as panel members for significant public appointments, including the UK Health Security Agency and the Antiviral Taskforce, as well as Director General roles within the Department.

413. Non-executive directors have also joined the Performance and Risk Committee to provide further external challenge and scrutiny of the Department's performance on key priorities, Long-Term Plan, and manifesto commitments, as well as the departmental risk register.

414. Outside of the formal governance committees, the support and challenge provided by non-executive directors to individual teams continues to be an important part of the role. Individually and collectively we have participated in deep-dive sessions on various aspects of the Department's work as well as offering advice and support to members of staff on a more ad hoc basis. And we have also continued to build on our relationships with the Department's ALBs, through regular attendance at their Board meetings.

415. As the Department's lead non-executive director, it has been an honour to continue to support the work of the Department over the past year and I am grateful to my non-executive team for all their support. I and the rest of the non-executive team are proud of the achievements and the resilience of everyone in the Department and we look forward to continuing our support for them.

## Accountability Report

416. The purpose of the Accountability Report is to meet key accountability requirements to Parliament. It is comprised of three key sections:
    - Corporate Governance Report
    - Remuneration and Staff Report
    - Parliamentary Accountability and Audit Report.

## Corporate Governance Report

417. The purpose of the Corporate Governance Report is to explain the composition and organisation of the Department's governance structures and how they support achievement of our objectives. It is comprised of three sections:
    - Directors' Report
    - Statement of Accounting Officer's Responsibility
    - The Governance Statement.

## Directors' Report

418. The Directors' Report, as per the requirements of the Government Financial Reporting Manual (FReM), requires certain disclosures relating to those having authority or responsibility for directing or controlling the Department including details of their remuneration and pension liabilities. Remuneration and pension information can be found within the Remuneration and Staff Report. Details of our Board and its committees can be found within the Governance Statement.

## Who we are

419. The Department of Health and Social Care is led by a ministerial team and a staff of civil servants. Our non-executive board members are independent of the Department and government and provide advice and challenge to our Ministers and senior staff.

## Our Ministers at 31 March 2021

**The Rt Hon Matt Hancock MP**
Secretary of State for Health & Social Care
Chair of the Departmental Board
Appointed 10 July 2018

**Helen Whately MP**
Minister of State for Care
Appointed 14 February 2020

**Edward Argar MP**
Minister of State for Health
Deputy Chair of the Departmental Board
Appointed 10 September 2019

**Nadine Dorries MP**
Minister of State for Patient Safety, Suicide Prevention and Mental Health
Appointed 27 July 2019 and promoted from Parliamentary Under Secretary in May 2020

**Jo Churchill MP**
Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care
Appointed 26 July 2019

**Lord Bethell of Romford**
Parliamentary Under Secretary of State for Innovation (Lords)
Appointed 9 March 2020

**Nadhim Zahawi MP**
Parliamentary Under Secretary of State for COVID Vaccine Deployment
Appointed 28 November 2020
Remains a Parliamentary Under Secretary of State at the Department for Business, Energy and Industrial Strategy.

## Our Non-Executive Board Members at 31 March 2021

### Kate Lampard

Lead Non-Executive Director

1 October 2017-present

Kate Lampard CBE is chair of GambleAware and works as an independent consultant undertaking investigations and advising organisations on management and service effectiveness and development. Kate is a trustee of the Esmée Fairbairn Foundation and the Royal Horticultural Society.

Previously, Kate Lampard led the NHS investigations into Jimmy Savile and produced a report for the Secretary of State for Health setting out the lessons for today's health service. She was commissioned by the board of Serco Plc to investigate the treatment of residents at Yarl's Wood Immigration Removal Centre and by G4S Plc to undertake an independent investigation into Brook House immigration removal centre. In 2019 to 2020 Kate led a review and produced a report for the Home Office on the Borders, Immigration and Citizenship System.

Kate spent 13 years as a practising barrister before moving into the public sector where she held a number of non-executive appointments. Kate has been the chair of the South East Coast Strategic Health Authority, vice chair of the South of England Strategic Health Authority and a non-executive director and vice chair of the Financial Ombudsman Service Limited. She acted as interim chair of the Independent Advisory Panel on Deaths in Custody.

Kate's daughter is a civil servant at the Foreign, Commonwealth and Development Office.

### Gerry Murphy

Non-Executive Director and Chair of Audit and Risk Committee

1 August 2014-present

Gerry is a co-opted member of the NHS England audit and risk assurance committee. He is also a non-executive director of Currys PLC.

Until 2020 Gerry was Senior Independent Director of Capital & Counties Properties PLC. He is a former Deloitte LLP partner and was leader of its Professional Practices Group with direct industry experience in consumer business, retail and technology, media and telecommunications. He was a member of the Deloitte board and chairman of its audit committee for a number of years and also chairman of the Audit and Assurance Faculty

of the Institute of Chartered Accountants in England and Wales.

**Doug Gurr**

Non-Executive Director with responsibility for the Union

1 December 2020-present

Doug is Director of the Natural History Museum. He is Chair of the Board of Trustees at The British Heart Foundation and Trustee of the Landmark Trust and UK Biobank. He is an advisor for Permira.

Until November 2020, Doug was Country Manager of Amazon UK. He joined Amazon in December 2011 and was President of Amazon China from 2014 to 2016. His previous roles include teaching mathematics and computing at the University of Aarhus in Denmark, working for the UK Government, partner at consultancy firm McKinsey, founder and CEO of internet start-up Blueheath and 5 years on the Board of Asda-Walmart.

**Gina Coladangelo**

Non-Executive Director

1 September 2020- 26 June 2021

Gina is Marketing and Communications Director at Oliver Bonas and a Trustee for Park House School and Tram House School, Independent Special Schools for children and young adults with autism. Gina is a minor shareholder of Luther Pendragon.

Gina has over twenty years' experience in business management and marketing and communications, with a focus on retail, healthcare, the third sector and energy. Marketing expertise across media relations, consumer campaigns, social media, digital strategy, strategic collaborations, internal communications, issues management and public affairs. Previously, Gina completed three-year terms as a Trustee of the Willow Foundation, the only national charity working with seriously ill young adults to fulfil uplifting and unforgettable Special Days. She was Director and Owner of Luther Pendragon, one of the largest independent communications consultancies in London between 2014-2020.

**Other non-executive directors who served in the Department during 2020-21 were:**

- Michael Mire from 1 November 2017- 31 October 2020.
- Prof. Dame Sue Bailey from 1 November 2017 - 31 October 2020.
- Prof. Sir Mike Richards from 1 November 2017- 31 October 2020.

## Our Executive Board Members at 31 March 2021

**Sir Chris Wormald KCB**
Permanent Secretary

**Prof. Chris Whitty**
Chief Medical Officer and DHSC Chief Scientific Adviser

**David Williams CB**
Second Permanent Secretary, Director General for Finance and Group Operations, and Chief Operating Officer

**Matthew Gould**
CEO of NHSX

## Other Senior Officials at 31 March 2021

**Clara Swinson CB**
Director General for Global Health

**Jonathan Marron**
Director General for Public Health

**Lee McDonough**
Director General for NHS Policy and Performance

**Steve Oldfield**
Chief Commercial Officer

**Michelle Dyson**
Director General for Adult Social Care

**Jenny Richardson**
Director of Human Resources

**Hugh Harris**
Director of Ministers, Accountability and Strategy

**Shona Dunn**
SRO, Community Testing Programme

**Other Senior Officials who served in the Department during 2020-21 were:**

- Ros Roughton, Director General for Adult Social Care from 27 April to 1 September 2020.
- Paul Kissack, Director General from 6 April to 8 August 2020.

**Senior Official role changes after 31 March 2021 were:**

- David Williams CB left the Department in April 2021.
- Shona Dunn was appointed Second Permanent Secretary in April 2021.
- Andy Brittain was appointed as interim DG for Finance in April 2021.
- Lee McDonough left the Department in June 2021.
- Lucy Chappell was appointed as Chief Scientific Adviser in August 2021.
- Matthew Styles was appointed as DG for NHS Policy and Performance in November 2021.
- Jonathan Marron became the Director General, Office for Health Improvement and Disparities from October 2021.
- Jeanelle de Gruchy was appointed as a Deputy Chief Medical Officer and co-lead of the Office for Health Improvement and Disparities in October 2021.

**Ministerial changes after 31 March 2021 were:**

- Sajid Javid, Secretary of State for Health and Social Care, was appointed in June 2021.
- Gillian Keegan, Minister of State for Care and Mental Health, was appointed in September 2021.
- Maggie Throup, Parliamentary Under Secretary of State for Vaccines and Public Health, was appointed in September 2021.
- Maria Caulfield, Parliamentary Under Secretary of State for Primary Care and Patient Safety, was appointed in September 2021.
- Lord Kamall, Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences (Lords) was appointed in September 2021.
- Matt Hancock resigned as Secretary of State in June 2021.
- Helen Whately, Nadine Dorries, Jo Churchill, Nadhim Zahawi and Lord Bethell left roles with the Department in September 2021.

420. The composition of the Department's Senior Officials has been extended for the 2020-21 Annual Report and Accounts. Following reconsideration of the matter with the NAO, it was determined that all Board and Executive Committee members should be disclosed as Senior Officials in the Corporate Governance and Remuneration Reports, per the requirements of the Financial Reporting Manual (FReM) to identify those having authority or responsibility for directing or controlling the major activities of the entity during the year. Previously our Director General's had been identified as Other Senior Officials of the Department.

## Our Arm's Length Bodies and Delivery Partners

421. Our Arm's Length bodies (ALBs) are either accountable to Parliament directly or via the Department. We set their strategic direction and hold them to account for delivery of a range of agreed objectives. The ALBs provide a range of diverse functions to support the Department in delivering its objectives, including:
    - delivering high-quality care to reflect what patients and the public value most;
    - regulating the health and care system and workforce;
    - establishing national standards and protecting patients and the public;
    - providing central services to the NHS; and
    - responding to COVID-19 by providing either essential services or health guidance.

422. Our ALBs, detailed in **Annex E**, fall into several distinct types:
    - Executive Non-Departmental Public Bodies (ENDPBs). Established by primary legislation and have their own statutory functions conferred, rather than delegated by the Secretary of State for Health and Social Care.
    - Executive Agencies. Legally part of DHSC but with greater operational independence.
    - Special Health Authorities (SpHAs). These are NHS bodies created by order and subject to direction by the Secretary of State for Health and Social Care.
    - Limited companies incorporated under the Companies Act and included in this Annual Report and Accounts.
    - Other bodies included in the Departmental Group and therefore as part of this Annual Report and Accounts.

423. The Department (DHSC) currently has two Executive Agencies: Public Health England (PHE) and the Medicines and Healthcare products Regulatory Agency (MHRA). Additionally, the UK Health Security Agency (UKHSA) was formed on 1 April 2021 and fully operational from October 2021. The UKHSA brings together functions from PHE, NHS Test and Trace and the Joint Biosecurity Centre. PHE was wound down by 1 October 2021 and continued to deliver its existing functions until then.

424. Our Permanent Secretary is the Principal Accounting Officer for the Departmental Group which as at 31 March 2021 consisted of:
    - Ten ENDPBs (including NHS England and its 135 Clinical Commissioning Groups (CCGs));
    - Four SpHAs;
    - Eight other bodies;
    - 145 NHS Foundation Trusts (FTs);
    - 71 NHS Trusts (NHSTs); and
    - NHS charities.

425. The activities of our ALBs and delivery partners are consolidated and incorporated in this report, with the exception of the MHRA and NHS Blood and Transplant (NHSBT). NHSBT is designated as outside the Departmental Group by the Office for National Statistics. While the Office for National Statistics has now re-categorised MHRA as falling within the Departmental Group, it will not be incorporated into the Department's accounting boundary until its establishing legislation is revoked.

## Departmental Disclosures

426. The Department has a Code for Business Conduct, which incorporates the principles set out in the Civil Service Code and applies to all staff working in the Department, including those who have authority or responsibility for directing or controlling the Department.

427. Information on personal data related incidents are reported to the Information Commissioners office and if applicable are found within the Governance Statement.

## Register of Interests

428. 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.

429. Our Ministers' interests are published on gov.uk website by the Cabinet Office. A Register of Members' Financial Interests also provides information regarding their financial interests, while our Directors General and Directors' record of gifts and hospitality are published as part of the quarterly transparency data also held on gov.uk website.

430. Further to the above, relevant interests of our senior leadership, as identified in the 'who we are' section, are detailed below in the **Register of Interests.**

## Register of Interests for the 2020-21 Financial Year

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Ministers | | | | | |
| Edward Argar MP | Partner | Marie Cure 'charities in the city' fundraising committee | Committee member | Voluanteer - no remunerations | |
| Edward Argar MP | Sister | Duke of Edinburgh Award | London Area Director | Salary | |
| Helen Whately MP | Self | Maidstone Mencap | Vice-President | No salary / fee | Resigned April 20 |
| Helen Whately MP | Self | Campaign for the Protection of Rural England, Kent | Vice-President | No salary / fee | Resigned Oct 19 |
| Helen Whately MP | Self | Family trusts | Trustee/ potential beneficiary | No salary / fee | |
| Helen Whately MP | Cousin | Herne Hill Group Practice | GP | Salary | |
| Lord Bethell of Romford | Self | Hall School Charitable Trust | Governor | Unpaid | Ceased 23 June 2021 |
| Lord Bethell of Romford | Partner | Atairos Management UK LLP (OC421342) | Managing Partner | | |
| Lord Bethell of Romford | Partner | Sadler's Wells Trust Limited (01488786) | Director | | |
| Lord Bethell of Romford | Partner | Sadler's Wells Limited (02907116) | Director | | |
| Lord Bethell of Romford | Partner | Tesco PLC (00445790) | Non-Executive Director | | |
| Lord Bethell of Romford | Partner | Exor N.V | Non-Executive Director | | |
| Lord Bethell of Romford | Partner | Diageo PLC (00023307) | Non-Executive Director | | |
| Lord Bethell of Romford | Self | The Scar Foundation | Director and trustee | Unpaid | Ceased 10 march 2020 |
| Lord Bethell of Romford | Self | Sadler's Wells | Director and trustee | Unpaid | Ceased June 2020 |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Ministers | | | | | |
| Lord Bethell of Romford | Self | International Centre for the Study of Radicalisation and Political Violence | Director and trustee | Unpaid | |
| Lord Bethell of Romford | Self | Jo Cox Foundation | Director and trustee | Unpaid | Ceased June 2021 |
| Jo Churchill MP | Self | Suffolk Philharmonic Orchestra | Member, Council of Reference | unpaid | |
| Jo Churchill MP | Self | Royal British Legion Women's Section – Bury St Edmunds and District Branch | President | unpaid | |
| Jo Churchill MP | Self | Royal Naval Association – Stowmarket Branch | President | Unpaid | |
| Jo Churchill MP | Self | Bury St Edmunds Town Trust | Trustee | Unpaid | |
| Jo Churchill MP | Self | Suffolk Association of Local Councils | Vice President | Unpaid | |
| Jo Churchill MP | Self | South Lincolnshire Scaffolding LTD | Shareholding over 15% | Dividend | Transferred shares to husband 05/05/21 |
| Jo Churchill MP | Self | SLS Pension Fund | Trustee | | Left scheme no longer trustee |
| Jo Churchill MP | Self | SLS Scaffolding Ltd | Directorship and 50% shareholding | Nil dormant company | |
| Nadihim Zahawi MP | Self | BT PLC | Shareholdings | | |
| Nadihim Zahawi MP | Self | SThree PLC | Shareholdings | | |
| Nadihim Zahawi MP | Self | Kissing It Better | Patron | Unpaid | |
| Nadihim Zahawi MP | Partner | Zahawi & Zahawi Ltd | Director | Salary | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Ministers | | | | | |
| Nadihim Zahawi MP | Partner | Warren Medical Limited (12659013) | Director | | |
| Nadihim Zahawi MP | Son | Warren Medical Limited (12659013) | Director | | |
| Nadihim Zahawi MP | Son | Warren Medical Limited (12659013) | Director | | |
| Nadihim Zahawi MP | Partner | Zahawi Wantage Ltd | Director | Salary | |
| Nadihim Zahawi MP | Partner | Zahawi Brierley Hill Ltd | Director | Salary | |
| Nadihim Zahawi MP | Partner | Zahawi Properties Ltd | Director | Salary | |
| Nadihim Zahawi MP | Son | Zahawi & Zahawi Ltd | Director | Salary | |
| Nadihim Zahawi MP | Son | Zahawi Properties Ltd | Director | Salary | |
| Nadihim Zahawi MP | Son | Zahawi & Zahawi Ltd | Director | Salary | |
| Nadihim Zahawi MP | Son | Zahawi Properties Ltd | Director | Salary | |
| Matt Hancock MP | Self | Topwood Ltd | Over 15% shareholding | | |
| Nadine Dorries MP | Self | | | Ms Dorries is a novelist and before her appointment had delivered under contract three book manuscripts for publication from 2019 to 2021 | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Ministers | | | | | |
| Nadine Dorries MP | Daughter | | Civil servant | | |
| Nadine Dorries MP | Daughter | | Civil servant | | |
| Nadine Dorries MP | Daughter | | Senior Parliamentary Assistant | | |
| Nadine Dorries MP | Self | Averbrook Ltd | Director and shareholder | Director and shareholder | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Non Executive Directors | | | | | |
| Doug Gurr | Self | National Gallery Company Limited (02280277) | Director | Salary | Resigned 30 November 2020 |
| Doug Gurr | Self | British Heart Foundation | Chair | Volunteer (not remunerated) | |
| Doug Gurr | Self | The Landmark Trustee Company Limited | Trustee | Volunteer (not remunerated) | |
| Doug Gurr | Partner | Manchester Camerata limited (01128463) | Director | | |
| Doug Gurr | Partner | Manchester Baroque (11666014) | Director | | |
| Doug Gurr | Partner | Scout Road Academy (07717189) | Director | | |
| Doug Gurr | Self | UK Biobank | Director | Volunteer (not remunerated) | |
| Doug Gurr | Self | Permira | Advisor | Fees | |
| Doug Gurr | Self | Amazon EU SARL, UK branch | Country manager, UK | Salary and shareholding | Expired 30 November 2020 |
| Doug Gurr | Self | Roofoods Ltd | Director | Directorship held on behalf of Amazon | resigned 25/9/20 |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Non Executive Directors | | | | | |
| Gina Coladangelo | Self | Luther Pendragon (Communications Consultancy) | Minor Shareholder | No salary; no dividends | Ceased to be an employee in 2014 and resigned as a Director in 2017 |
| Gina Coladangelo | Self | Oliver Bonas (Fashion & homeware retailer) | Marketing and communications director | Salary | Role expired in June 2021 |
| Gina Coladangelo | Partner | Oliver Bonas Limited (03799350) | Shareholder and Director | | |
| Gina Coladangelo | Partner | Oliver Bonas (Property) Limited (08944177) | Director | | |
| Gina Coladangelo | Self | Park House school (Beyond Autism) | Governor | Non-paid | |
| Gina Coladangelo | Self | Tram House school (Beyond Autism) | Governor | Non-paid | |
| Gina Coladangelo | Brother | Partnering Health Holdings Limited (13208108) | Director | | |
| Gina Coladangelo | Brother | PHL Youla Limited (12274169) | Director | | |
| Gina Coladangelo | Brother | Partnering Health Limited (06563486) | Director | | |
| Gina Coladangelo | Brother | Youla LTD (03898770) | Director | | |
| Gina Coladangelo | Father | Rephine Ltd | Director | | |
| Gina Coladangelo | Father | Harrison Life Sciences Group Limited (08488903) | Director | | |
| Gina Coladangelo | Father | MediciSearch LTD (09743483) | Director | | |
| Gina Coladangelo | Father | IX Group Limited (03936262) | Director | | |
| Gina Coladangelo | Father | Youla LTD (03898770) | Director | | |
| Gina Coladangelo | Father | Rephine Limited (04223857) | Director | | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Non Executive Directors | | | | | |
| Gina Coladangelo | Father | Medix UK Limited (03900651) | Director | | |
| Gina Coladangelo | Father | Rephine Sourcng LTD (04394962) | Director | | |
| Gina Coladangelo | Father | PHL Youla Limited (12274169) | Director | | |
| Gerry Murphy | Self | Currys Plc | Non-Executive Director | Remunerated and shares held | Ongoing position |
| Gerry Murphy | Self | Capital & Counties Properties PLC | Senior independent director | Remunerated and shares held | Ceased 1 May 2020 |
| Gerry Murphy | Self and Partner | | | Interests in a diversified portfolio of shares | Indirectly held via nominees, ISAs and a SIPP. These are in large publicly quoted companies quoted on UK and US stock exchanges. Other than in respect of Currys and Capital & Counties as noted above we have no involvement in these companies |
| Kate Lampard | Self | GambleAware | Chair | Salary | |
| Kate Lampard | Self | Esmee Fairbairn Foundation | Trustee | No pecuniary interest | |
| Kate Lampard | Self | | Independent Consultant | Consultancy fees for any work undertaken | |
| Kate Lampard | Daughter | Foreign and Commonwealth Office | employee | | |
| Kate Lampard | Self | Royal Horticultural Society | Trustee | No pecuniary interest | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Non Executive Directors | | | | | |
| Kate Lampard | Self | The Trinity Challenge | Trustee | No pecuniary interest | Ceased to be a trustee in November 2021 |
| Kate Lampard | Self | Rochester Cathedral Trust | Trustee | No pecuniary interest | |
| Kate Lampard | Self | Torry Hill Chestnut Fencing Limited | Director and Shareholder | Shareholding | |
| Kate Lampard | Self | Torry Hill Farm Partnership | Partner | Partnership drawings | |
| Kate Lampard | Self | Yokes Court Consultancy Ltd | Sole Director and shareholder | Shareholding | |
| Kate Lampard | Self | Stone Turn Consultants | Senior Associate | Fees for any work | No work undertaken in 2020/2021 |
| Kate Lampard | Self | Verita Consultants | Senior Associate | Fees for any work | |
| Michael Mire | Self | HM Land Registry Board | Chair | Salary | |
| Michael Mire | Self | Aviva | Non Executive Director | Salary | |
| Mike Richards | Self | Cancer Research UK | Trustee | Unpaid | |
| Mike Richards | Self | GRAIL Bio UK | Clinical Advisor | Paid consultancy | |
| Mike Richards | Self | NHS England | Consultant | Paid | |
| Mike Richards | Self | Pfizer Ltd | Consultant | Paid | Expired 2020-21 |
| Sue Bailey | Self | Centre for Mental Health | Vice Chair | Not remunerated | |
| Sue Bailey | Self | Of new ways of working in mental health HEE mental health programme | Independent chair | Not remunerated | |
| Sue Bailey | Self | Manchester University NHS Foundation Trust | Non-Executive Director | Renumerated | Since October 2017 |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Non Executive Directors | | | | | |
| Sue Bailey | Self | KOOTH plc | Independent Non-Executive Director | Renumerated | |
| Sue Bailey | Self | User carer forum Autistica UK | Chair | Not remunerated | Since 2016 |
| Sue Bailey | Self | Advisory group EDUcation Policy Institute | Member | Not remunerated | Since 2019 |
| Sue Bailey | Self | Bevan Commission | Member | Not remunerated | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Senior Officials | | | | | |
| Clara Swinson | Self | Nil Return | | | |
| Chris Whitty | Self | Gresham College | Professor of Physic | Stipend | |
| Chris Whitty | Self | National fever service, PHE | Honorary member of the national fever service | Unpaid role | |
| Chris Whitty | Self | London School of Hygiene & Tropical Medicine | Honorary Professor | Unpaid role | |
| Chris Whitty | Self | University College London Hospital | Consultant Physician | Unpaid role | |
| Chris Whitty | Self | Sightsavers (aka Royal Commonwealth Society for the Blind) | Trustee | Unpaid role | |
| Chris Whitty | Self | Malawi/Liverpo-ol Wellcome Unit | Advisory Board | Unpaid role | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Senior Officials | | | | | |
| Chris Wormald | Self | Bennett Institute for Public Policy, University of Cambridge | Member of the Advisory Council | Unpaid | |
| Chris Wormald | Self | Economic and Social Research Council | Member | Unpaid | |
| Chris Wormald | Self | Step Up to Serve | Member of the Advisory Council | Unpaid | |
| Chris Wormald | Self | Nuffield College, University of Oxford | Visiting Fellow | Accommodatio-n and dining | |
| Chris Wormald | Brother | Corpus Christi College, Oxford | Academic and member of the Medical Sciences Division Undergraduate Studies Committee and Education Policy and Standards Committee. | Salary | |
| Chris Wormald | Sister in law | Salesforce | Consultant | Salary | |
| David Williams | Partner | East Sussex Healthcare NHS Trust | AfC NHS employee | | |
| Hugh Harris | Self | Nil Return | | | |
| Jonathon Marron | Self | Institute of Lifecourse Development, University of Greenwich | Advisory Board Member | Unpaid | |
| Jonathon Marron | Partner | University of East London | Research Fellow | Salary | This has now expired |
| Jenny Richardson | Self | MHRA | Chief Operating Officer | The MHRA is an executive agency of DHSC | |
| Lee McDonough | Self | Nil Return | | | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Senior Officials | | | | | |
| Michelle Dyson | Brother | Candela Medical, Inc. | Non-executive Director/ Chairman | Indirect shareholding in each company | Company sells medical products or services globally and the NHS is, in some cases, a customer. Michelle Dyson's brother is a Partner at the private equity firm Apax Partners. Funds advised by Apax Partners LLP own majority control of the Comapny. Michelle Dyson's brother has a small financial interest in the Funds, and therefore an indirect interest in each of the companies listed. |
| Michelle Dyson | Brother | Healthium Medtech Limited | Non-executive Director/ Chairman | Indirect shareholding in each company | See above |
| Michelle Dyson | Brother | Rodenstock GmbH | Non-executive Director/ Chairman | Indirect shareholding in each company | See above |
| Michelle Dyson | Brother | Unilabs Holding AB | Non-executive Director/ Chairman | Indirect shareholding in each company | See above |
| Michelle Dyson | Brother | Vyaire Holding Company | Non-executive Director/ Chairman | Indirect shareholding in each company | See above |
| Michelle Dyson | Brother | Advantage Programme – a programme part of West Ham Foundation | Chairman | No interest beyond position | Advantage is a mental health charitable programme which partners with the NHS and football clubs (CCOs) to deliver mental health mentoring for young people. |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Senior Officials | | | | | |
| Matthew Gould | Self | Early Detection of Neurodegenerative Diseases (EDON) initiative | Non-exec board member | Unpaid | The position was agreed in conjunction with Cabinet Office PET and the Perm Sec's office. |
| Matthew Gould | Self | Royal Air Force | Non-executive director | Unpaid | Effective 12 August 21 for three years. |
| Matthew Gould | Mother in law | Laser Skin Clinic | Clinic Manager | Family | |
| Matthew Gould | Sister in law | Camden and Islington Mental Health Trust | Senior Administrator | Family | |
| Matthew Gould | Self | NHS England & Improvement | National Director, Digital Transformation | Executive position | I am jointly employed by DHSC and NHS England in my role as CEO of NHSX, and sit on the NHS England & Improvement Executive |
| Matthew Gould | Niece | University of Cardiff | Medical student | | |
| Matthew Gould | Self | Phico Therapeutics Limited | | Shareholding | |
| Matthew Gould | Self | F2G LTD | | Shareholding | |
| Matthew Gould | Self | Endocrine Pharmaceuticals Limited | | Shareholding | |
| Matthew Gould | Self | Seneca Growth Capital VCT PLC | | Shareholding | |
| Matthew Gould | Self | Oncoprobe Limited | | Shareholding | |
| Matthew Gould | Brother | Locums Nest LTD | Interim CFO | | He has since left this position. |
| Matthew Gould | Brother | Lawrence Gould Consultancy LTD (08277071) | Director | | |
| Matthew Gould | Brother | 11 Alderbrook Road Management Co. LTD (03859637) | Director | | |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Senior Officials | | | | | |
| Matthew Gould | Brother | The One To One Children's Fund (04145357) | Director | | |
| Matthew Gould | Brother | Hoolvale Properties Limited (04112214) | Director | | |
| Matthew Gould | Brother | RCV Engines Limited (03338081) | Director | | |
| Matthew Gould | Brother | OpinionPanel Limited (05013113) | Director | | |
| Matthew Gould | Sister in law | Buckinghamshire | Paediatric District Nurse | | |
| Matthew Gould | Nephew | North Middlesex Hospital | GP in training | | |
| Paul Kissack | Partner | United Kingdom Research and Innovation (UKRI) | Executive Director, Strategy, Performance and Engagement | Salary | |
| Ros Roughton | Self | Sheffield Teaching Hospitals Foundation Trust | Non-executive director | Unpaid | |
| Ros Roughton | Partner | Mike Farrar Consulting LTD (08713749) | Owner and Managing director | Shareholding | Sold during 20/21 and became part shareholder |
| Ros Roughton | Partner | PwC Public Sector Health Board | Chair and advisor to the firm | Fees | |
| Ros Roughton | Partner | The Amateur Swimming Association (Swim England) Limited (10931571) | Chair | Unpaid | Expired during 20-21 |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Senior Officials | | | | | |
| Ros Roughton | Partner | Yorkshire Health Economics Consortium | Non-executive director | Paid | |
| Ros Roughton | Partner | Hanover Communications Ltd | Advisor to the firm | Fees | |
| Ros Roughton | Partner | Vincent Housing Association | Non-executive director | Fees | |
| Ros Roughton | Partner | Spread Innovations Limited (05641515) | Director | | |
| Ros Roughton | Partner | MF Health and Sport LTD (09909103) | Director | | |
| Ros Roughton | Partner | Huddersfield Giants Community Trust LTD (05930465) | Chair | Unpaid | Expired 20-21 |
| Ros Roughton | Partner | Kings College Hospital | Deputy CEO | Unpaid | Expired 20-21 |
| Ros Roughton | Partner | Kings College Hospital | Adviser | Fees | When CEO role expired |
| Ros Roughton | Partner | Rochdale FC Community Sports Trust | Non-executive director | Unpaid | Expired 20/21 |
| Ros Roughton | Partner | Project Rome | Part Owner | Shareholding | Started November 2020 |
| Shona Dunn | Partner | Thales UK | Tax advisor | | |
| Shona Dunn | Self | Alderbrook Primary school Wandsworth | School governor | | |
| Steve Oldfield | Self | Genomics England | Non-executive director | Unpaid role | Directorship of GEL expired on 31 March 2020 (filed 6 April). Representative of the secretery of state. |

| Individual | Family member | Name of company | Position held | Type of interest (salary, fees or shareholding) | Any other relevant information |
|---|---|---|---|---|---|
| Senior Officials | | | | | |
| Steve Oldfield | Self | Sanofi | Shareholder | Share options in previous employer | All remaining shares disposed of in May 2021. |
| Steve Oldfield | Self | Total Oil & Gas | | Minor shareholding | |
| Steve Oldfield | Self | Proctor & Gamble | | Minor shareholding | |
| Steve Oldfield | Self | Gosden House School | Member of their board of governors | Unpaid role (voluntary) | Community governor at a LA school for children with special needs |
| Steve Oldfield | Self | Healthcare UK | Member of their Advisory Board | Unpaid role | Membership of the HCUK Advisory Board expired in March 2021. joint initiative with NHS england and OGD |

## Non-Executive Board Members' Interests

431. A register of interests in maintained which covers non-executive members. 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

432. The Department has reviewed its code of conduct policies, processes and guidance and is content that these are up to date and in line with best practice. These products were refreshed and published in October 2020.

433. Our policy is clear that all declarations of interest should be updated as they cease or arise. Staff are additionally reminded of the policy and its requirements every six months and are asked to review whether any circumstances have changed in that time.

434. Our code of conduct policy was recommunicated to staff through an intranet article in April 2021, including instructions on how to log declarations of interest on D365, the Department's reporting system.

### Declaration of Non-Executive Director Interests

435. The Department ensures that all Non-Executive Director (NED) interests are reviewed and recorded at least annually. The NEDs have been reminded of the importance of declaring any perceived or real conflicts of interest to the Department and they provide in-year updates as necessary.

### Declaration of Special Advisor Interests

436. Special advisers in the Department declare interests to the Permanent Secretary, in line with the Declaration of Interests policy. The personal information which special advisers disclose to the Permanent Secretary is treated in confidence.

437. All special advisers in DHSC have submitted a completed declaration of interests form, including nil returns in instances where there was no actual, potential or perceived conflict of interest. The Permanent Secretary has considered these returns and there are no relevant interests to be published.

438. Where relevant to the role, and to help manage a perception of conflict or to explain how a conflict is being managed, interests will be published on an annual basis in, or alongside, the relevant Annual Report and Accounts. This provides a balance between transparency and privacy.

### Business Appointment Rules

439. The Department continuously reviews business appointment rules (BAR) processes and guidance and is content that these are up to date and in line with best practice. We have updated guidance, communications and documents in 2020-21 to ensure that individuals have the information required to comply with the process. This has included expanding the stakeholders who are informed of any restrictions applied to individuals.

440. Individuals are informed of their responsibilities under BAR. Information is included in individual offer letters, contracts and leavers letters. The policy is available for Department employees to view on the intranet and SCS staff are also reminded of BAR rules 6 and 12 months after leaving the Department.

441. In compliance with BAR, the Department is transparent in the advice given to individual applications for senior staff, including special advisers. Advice provided regarding business appointments can be found on gov.uk on the Department's collection page for business appointment rules advice.

## Statement of Principal Accounting Officer's Responsibilities

442. Under the Government Resources and Accounts Act 2000 (the GRAA), HM Treasury has directed the Department of Health and Social Care to prepare, for each financial year, consolidated resource accounts detailing the resources acquired, held or disposed and the use of resources during the year by the Department (inclusive of its executive agency, Public Health England) 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 2020 no.1530 (together known as the 'Departmental Group', consisting of the Department and sponsored bodies listed at **Note 21** to the accounts).

443. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Department and the Departmental Group and of the net resource outturn, application of resources, changes in taxpayers' equity and cash flows of the Departmental Group for the financial year.

444. In preparing the accounts, the Principal Accounting Officer of the Department is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:
    - observe the Accounts Direction issued by HM Treasury, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
    - ensure that the Department 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 departmental group 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; and
    - confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

445. HM Treasury has appointed the Permanent Secretary of the Department as Principal Accounting Officer of the Department of Health and Social Care. In addition, HM Treasury has appointed a separate Accounting Officer to be accountable for the NHS Pension Scheme and NHS compensation for premature retirement scheme Resource Account. These are produced and published as a separate account.

446. As of March 2020 the Department has had a Second Permanent Secretary as an additional Accounting Officer. The Second Permanent Secretary will assume responsibilities of the Principal Accounting Officer should they be unavailable. The role was initially created to address the operational pressures that have arisen through the Department's COVID-19 pandemic response. The appointment does not detract from the Permanent Secretary's overall responsibility as Principal Accounting Officer for the Department's accounts.

447. 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. The Principal Accounting Officer of the Department is responsible for ensuring that appropriate systems and controls are in place to ensure that any funds that the Department makes available to its sponsored bodies are applied for the purposes intended and that such expenditure and the other income and expenditure of the sponsored bodies are properly accounted for, for the purposes of consolidation within the resource accounts. Under their terms of appointment, the Accounting Officers of the sponsored bodies are accountable for the use, including the regularity and propriety, of the grants received and the other income and expenditure of the sponsored bodies.

448. 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 the Department or non-departmental or other arm's length public body for which the Principal Accounting Officer is responsible, are set out in Managing Public Money published by HM Treasury.

449. The Department published in July 2018 an Accounting Officer System Statement setting out lines of accountability within the Department and the healthcare system bound by the legislative framework of the Health and Social Care Act 2012. This includes the responsibilities and relationships between the Accounting Officers in the Department, its Agencies, Arm's Length Bodies and the NHS.

450. The Principal Accounting Officer confirms that the annual report and accounts as a whole is fair, balanced and understandable and takes personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

451. As far as the Principal Accounting Officer is aware, there is no relevant audit information of which the Department's auditor is unaware and has taken all the steps necessary to make himself aware of any relevant audit information and to establish that the Department's auditor is aware of that information.

# Governance Statement

## Scope of Responsibility

452. This Governance Statement covers the Department of Health and Social Care Group and outlines how responsibility for the management and control of the Department of Health and Social Care's resources were discharged during the year. This statement covers 2020-2021 and is current up to the date this Annual Report was signed.

453. As Principal Accounting Officer for the Departmental 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 the Department complies with the provisions of the Corporate Governance Code for central government departments, published by HM Treasury and the Cabinet Office.

454. The Head of Internal Audit's opinion is that they can give limited assurance to the Department's Principal Accounting Officer in relation to the 2020-21 reporting year regarding the overall adequacy and effectiveness of the Core Department's systems of risk management, governance and internal control for the year as a whole. Further detail regarding the audit opinion is provided from **paragraph 505**. No concerns have been raised about the quality of information received by the Board or its sub-committees.

455. The Departmental Group is described in the Directors' Report within this Annual Report and each body within this group has its own constitution and formal relationship with the Department. Consequently, the nature of control in the Department of Health and Social Care group is different from the concept of a group in the commercial sector. As guardian of the system overall, the Department is responsible for providing oversight and direction, and retains overall accountability for the use of resources and delivery of objectives. The Department does not however, directly control every aspect of the Departmental group.

456. While I am personally accountable for the resources provided to the Department 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), Clinical Commissioning Groups (CCGs), 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.

457. Within the Department there has been the additional support of a Second Permanent Secretary and Accounting Officer since March 2020. The Second Permanent Secretary will assume my responsibilities as Principal Accounting

Officer if I am unavailable. The role was initially created to address the operational pressures that have arisen through the Department's COVID-19 pandemic response.

458. I discharge my responsibility for the governance and control of the Department through the civil service staff based within the Department. Each year I issue formal, written delegations of responsibility to my Directors General and other staff. As part of this delegation, I appoint a Senior Departmental Sponsor for each of our ALBs.

## Departmental Governance

459. The Departmental Board chaired by the Secretary of State brings together Ministerial and Civil Service leadership with Non-Executive Directors from outside Government who provide independent support and challenge.

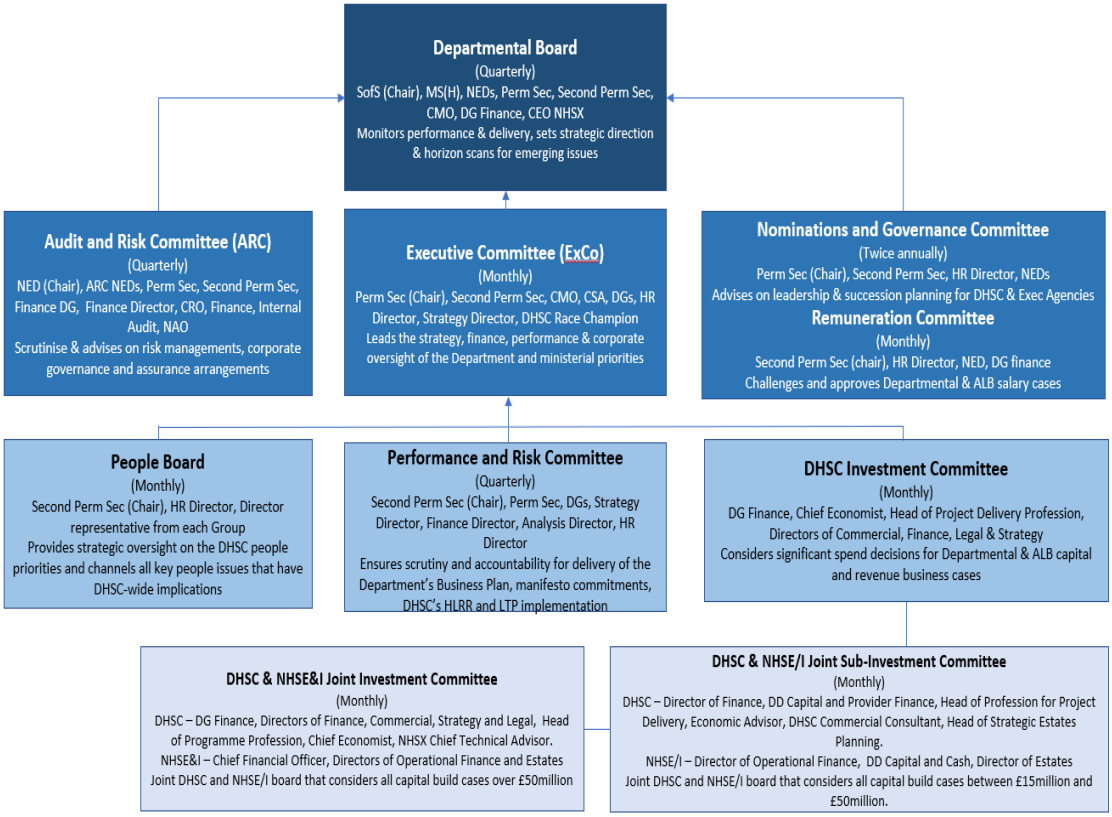
460. The Departmental Board meets on a quarterly basis. The Board met on four occasions during the 2020-21 financial year. Full membership and attendance is outlined in the **Directors' Report**. The composition of the Board changed during 2020-21, with three Non-Executive Directors finishing their three-year term in 2020 and two new Non-Executive Directors appointed.

461. The Board provides the collective strategic and operational leadership of the Department of Health and Social Care, and has responsibility for:
    - supporting Ministers and the Department on strategic issues linked to the development and implementation of the Government's objectives for the health and social care system;
    - horizon scanning for emerging issues;
    - ensuring there is strategic alignment across the health and care system;
    - ensuring that any strategic decisions are based on a collective understanding of evidence, insight and experience;
    - overseeing the sound financial management of the Department;
    - overseeing the management of risks within the Department and its ALBs, including consideration of the Department's risk register; and
    - overseeing the Department's portfolio of major programmes and projects.

462. The Board has responsibility for monitoring performance against objectives and key metrics, including corporate metrics and risks. Discussions have also focused on finance and performance. The Audit and Risk Committee (ARC) also has a role in reviewing the Department's High Level Risk Register and performing scrutiny of individual risks. The ARC regularly makes recommendations that other areas are reviewed and considered for inclusion at future meetings.

463. The Departmental Board is supported by the committees shown in the structure chart at **Figure 5.**

## Figure 5: Departmental Board Structure




464. The Executive Committee oversees strategy, finance, performance and corporate issues in the Department. It reports to the Departmental Board on a quarterly basis including reports from the various sub-committees. Issues discussed at the Executive Committee in 2020-21 included; workplace planning during COVID-19, business planning, financial sustainability, risk and legal risk, and HR items including performance management and pay. The Committee met eleven times this year.

465. The DHSC Remuneration Committee acts on behalf of the Secretary of State and has ultimate accountability for the ALBs' Executive and Senior Manager Pay Framework. Its role and purpose is to ensure ALBs adhere to the Framework, ensure governance processes are followed and challenge and scrutinise the approvals that are presented to them. This role also applies to the approval of senior pay (£150,000 and above) in DHSC's Government-owned companies. The Committee met six times in the year.

466. The Nominations and Governance Committee advises on matters relating to senior leadership and succession planning for the Department. The Nominations and Governance Committee discussed the end-of-year performance assessments and ratings for the Directors General and CEOs for PHE and MHRA, along with a discussion on their talent management and development. The Committee met twice this year.

467. The Audit and Risk Committee advises the Accounting Officer and Departmental Board on risk management, corporate governance and assurance arrangements in the Department and its subordinate bodies and reviews the comprehensiveness of assurances and integrity of financial statements. The Committee met four times this year.

468. The Performance and Risk Committee (PRC) exists to oversee departmental performance and management of the Department's high-level risks. By making a regular assessment of the Department's performance and risks to delivery, the PRC ensures that the Departmental Board and the Executive Committee are supported and held to account for the delivery of the business plan/Outcome Delivery Plan (ODP). Due to conflicting pressures as a result of the COVID-19 pandemic the Committee met twice during the year (quarter one and quarter four), and discussions focussed on achievements and concerns; overall progress towards objectives, milestones and manifesto commitments; and key risks to performance.

469. **Table 12** summarises attendance at the Departmental Board and the four next tier committees.

## Table 12: Committee Attendance

| Name of Board or Committee member[1,2] | Departmental Board<br>Met 4 times | Executive Committee[3]<br>Met 11 times | Audit and Risk Committee<br>Met 4 times | Nominations and Governance Committee<br>Met 2 times | Remuneration Committee[4]<br>Met 6 times |
|---|---|---|---|---|---|
| *Ministers* | | | | | |
| Rt Hon Matt Hancock MP | 3 (out of 4) | - | - | - | - |
| Edward Argar MP | 3 (out of 4) | - | - | - | - |
| *Officials* | | | | | |
| Sir Chris Wormald KCB | 4 | 11 | - | 2 | - |
| Professor Chris Whitty | 4 | 9 | - | - | - |
| David Williams CB | 4 | 11 | 4 | - | 6 |
| Clara Swinson CB | - | 11 | - | - | - |
| Jonathan Marron | - | 11 | - | - | - |
| Lee McDonough | - | 11 | - | - | 4 |
| Steve Oldfield | - | 8 | - | - | - |
| Matthew Gould | 2 (out of 4) | 9 | - | - | - |
| Michelle Dyson[5] | - | 6 (out of 7) | - | - | - |
| Paul Kissack[6] | - | 3 (out of 3) | - | - | - |
| Ros Roughton[7] | - | 1 (out of 3) | - | - | - |
| Jenny Richardson | - | 11 | - | 2 | 4 |
| Hugh Harris | - | 11 | 4 | - | - |
| Andy Brittain[8] | - | - | 2 (out of 2) | - | - |
| Shona Dunn[9] | - | 1(out of 1) | - | - | - |
| *Non-Executive Directors* | | | | | |
| Kate Lampard | 4 | - | - | 2 | 2 |
| Professor Dame Sue Bailey[10] | 1 (out of 2) | - | - | - | - |
| Professor Sir Mike Richards[10] | 2 (out of 2) | - | - | - | - |
| Gina Coladangelo[11] | 3(out of 3) | - | - | - | 1 |
| Doug Gurr[12] | 1 (out of 1) | - | - | - | 1 |
| Michael Mire[10] | 2 (out of 2) | - | 2 (out of 2) | - | - |
| Gerry Murphy[13] | 4 | - | 4 | 1 (out of 1) | 2 |
| *Independent Members* | | | | | |
| Anne Barnard | - | - | 4 | - | - |
| Graham Clarke | - | - | 4 | - | - |
| Richard Hornby | - | - | 2 | - | - |

1. Table represents Committee members attendance only. To note, other officers' attendance is not recorded within the table.
2. Where a number appears in brackets, this is the maximum number of meetings a member could have attended.
3. Where a Director General could not attend, a deputy attended on their behalf.
4. Attendance of the Remuneration Committee is shared amongst our Non-Executive Directors.
5. Michelle Dyson joined the Department in September 2020.
6. Paul Kissack served as a Director General from April 2020 to August 2020.
7. Ros Roughton served as a Director General from April 2020 to September 2020.
8. Andy Brittain was appointed Finance Director in August 2020.
9. Shona Dunn joined the Department as Senior Responsible Officer for NHS Test and Trace in November 2020 and was appointed Second Permanent Secretary in April 2021 following the

departure of David Williams. Shona was invited to attend Executive Committee meetings from January 2021.

10. Professor Dame Sue Bailey, Professor Sir Mike Richards and Mike Mire stood down as non-executive directors on 31 October 2020.
11. Gina Coladangelo was appointed as a non-executive director on 1 September 2020.
12. Doug Gurr was appointed as a non-executive director on 1 December 2020.
13. Gerry Murphy became a member of the Nominations and Governance Committee in February 2021.
14. The DHSC Race Champion referenced in figure 5 joined ExCo in June 2021.

## Assurance Framework, Risk Management and control issues

### Core Department

470. The Department operates an accountability process based on compliance with a set of core assurance standards, including risk management. Each Director General (DG) receives an accountability letter from the Permanent Secretary, setting out their 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 sponsorship responsibilities for ALBs.

471. The Portfolio Management Office tracks the delivery of all DHSC's major programmes on the Government Major Projects Portfolio (GMPP), working closely with the Infrastructure and Projects Authority (IPA). The Department's Audit and Risk Committee has a standing agenda item on major project delivery, with quarterly delivery reports through the GMPP process.

472. New additions this year have been the New Hospital Programme (delivering the 40 new hospitals manifesto commitment), Shared Care Records and the AI Lab Programmes, with 4 programmes having removed from the portfolio as they no longer meet the criteria (Medical Examiners, IT IS, Local Health and Care Record Exemplars and Health and Social Care Network Programme). Following the appointment of a new Head of Project Delivery Profession, the Department is currently considering the case for any further refinements to its project delivery approach, working closely with Profession Heads in our Arm's Length Bodies, as well as the IPA.

473. The DHSC Investment Committee now meets monthly to consider capital and revenue business cases from within DHSC and its ALBs that are above the disclosure threshold limits delegated to DHSC by HM Treasury as set out in the Department's Financial Control Framework. As well as reviewing live cases, the Investment Committee endorses the pipeline of forward cases and sets expectations on the circumstances for resubmission of previously agreed cases. As shown in **Figure 5** the Investment Committee is supported by the DHSC and NHS England and NHS Improvement (NHSE and NHSI) Joint Investment Committee and Joint Sub-Investment Committee, which consider NHS Trust and Foundation Trust business cases over delegated limits, with both committee's meeting on a monthly basis also.

## Three lines of defence

474. The Department applies the 'three lines of defence' principle to its management of risk. At the first line, day-to-day operational risk is managed locally by teams best placed to understand and implement mitigations, including through an effective system of Senior Responsible Officer (SROs), programme and assurance boards and budget managers working with a set of defined financial controls.

475. At the second line, our Governance includes the Performance and Risk and Investment Committees, providing cross-departmental scrutiny and assurance of delivery plans and risk management. The Executive Committee continues to oversee and agree the key strategic risks to the health and social care system, challenging and agreeing proposed mitigations, through the Departmental high-level risk register. This second line of defence is supported by a cross-department quarterly monitoring and reporting framework which brings together an assessment of the Department's progress against Departmental business plan objectives with its most recent assessment of the top risks it faces.

476. The third line of defence comprises the oversight provided by the Departmental Board, which includes independent Non-Executive Directors and the Audit and Risk Committee (ARC). This has provided independent non-executive challenge and assessment of the robustness of arrangements in place. This is further underpinned by the independent oversight and challenge of the Health Group Internal Audit Service (HGIAS), part of the Government Internal Audit Agency (GIAA). The ARC has considered the way in which the Department manages risk at its four meetings during 2020-21 and reviews and discusses the Department's risk register as a standing agenda item at these meetings.

477. Through this scrutiny the ARC has supported the Board to ensure effective systems were in place to deliver high-quality internal control, governance and risk management. The Chair of the ARC, who also sits as a co-opted Non-Executive member of NHS England's Audit and Risk Committee, provides a quarterly update to his fellow members of the Departmental Board on the activities of the ARC. Our third line of defence is further strengthened by other independent assurance processes, such as NAO reviews and the scrutiny of the Health and Social Care Select Committee. Both the NAO and GIAA attend the ARC meetings.

478. Recognising that a number of wider health and care system risks are beyond the direct control of the Department, the ARC regularly challenges Departmental sponsors of ALBs on the risk and accountability of our ALBs. Senior officials from the Department routinely attend audit and risk meetings across our ALBs in order to identify interdependencies between our risks and issues.

479. ARC has a standing meeting agenda for its four meetings which covers papers and updates on Finance, Internal Audit, NAO audits and value for money studies, PAC reports and recommendations, counter fraud, cyber security, high-level risks, the Department's major projects portfolio and GMPP, and EU and Trade as well as the

COVID-19 response. In 2020-21 there were deep dive discussions on the work on the response to COVID-19; personal protective equipment (PPE) finance; New Hospitals Programme (NHP) and NHS winter planning.

480. This year's annual Board Effectiveness Evaluation was led by the Department's lead Non-Executive Board member, Kate Lampard. It also included an independent review by a lead Non-Executive from another Department. The evaluation reflected on progress made in the last year and identified objectives for 2021-22. Overall, the evaluation identified the Board is functioning well. Over the past year, the Non-Executive Directors have become more involved in the day to day business of the Department through their support on COVID-19 governance. This provided for good quality conversations at Board meetings.

481. Going forward there is an opportunity to increase the visibility of the Board across the Department and to continue build on progress to increase the oversight that the Board has of Departmental ALBs.

## Managing Risk

482. The Department's Director of Strategy undertakes the role of Chief Risk Officer (CRO). The quarterly performance and risk process, run by the Chief Risk Officer's risk team maintains the high-level risk register, including agreeing risk scores. This has supported our understanding of our risk exposure and the cross-cutting nature of risks across the system.

483. The Department also has a risk escalation process in place to monitor emerging interdependent risks from other parts of the health system and the risk team engages with ALBs in regular forums where risk is discussed in the round. To ensure effective risk management for COVID-related risks the Department had established a separate COVID risk register, which is regularly reviewed at the COVID Oversight Board and reported to the Performance and Risk Committee through the quarterly performance process.

484. DHSC manages a wide portfolio of risks. Our most severe risks are monitored by our Performance and Risk Committee and Audit and Risk Committee. Below these committees, risks 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.

485. At strategic level DHSC manages a number of different risks across the health and social care landscape. Significant risks actively managed by the Department this year have included:

External risks

- the health and care system's resilience to cyber-attack;
- the health and care system's failure to deliver digital transformation and capability;

- the global threat of antimicrobial resistance; and
- the risk relating to pandemics/major infectious disease outbreaks.

System-wide risks

- the risk of demand for NHS services growing beyond that assumed in the Long Term Plan;
- the failure to maintain internal and external financial control of the health and care system;
- the risk that the system does not recruit and retain the right numbers and skills of staff needed to deliver care, across primary, secondary and social care;
- the growth in demand for NHS services compromises the ability of the system to deliver performance standards within our means;
- the risk that there is a loss of sustainable quality and safety of the care people receive;
- failure to hold partners' organisations to account to deliver our key objectives; and
- the sustainability of the adult social care system.

Change-based risks

- the risk that the Department's workforce has insufficient capacity and/or capability to provide a quality service; and
- the risk that the health and care system is not fully prepared to deliver a smooth and orderly exit from the EU.

486. The COVID-19 pandemic has clearly impacted the risks managed by the Department in areas such as the risk of future or concurrent pandemics, risks associated with the ongoing COVID-19 response and risks to the recovery from this pandemic. These risks are managed as part of the Department's COVID-19 response with the most severe managed by our COVID-19 Oversight Board.

487. Some of the key activities in mitigating these risks are set out in the Performance Report. The Executive Committee, ARC, 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 'deep-dive' examination of particular risks.

488. The Departmental Board discusses the quarterly Performance and Risk packs and receives summaries of ARC, and Performance and Risk Committee meetings to provide assurance and an update on the governance and control system in the Core Department of Health and Social Care. This confirms they have adhered to the Corporate Core Assurance Standards, covering duties expected of ALB sponsors, management of plans and resources, risk management and a range of other requirements incumbent on the Department that we are asked to assure via the Governance Statement.

489. In 2020-21 the Directors General participated in the quarterly Performance and Risk Reporting and Bi-annual Assurance Meeting (BAM) process. In quarter 2 of the financial year, pressures relating to COVID-19 response and EU and Trade meant that BAMs were held for five of the Director General Groups: Adult Social Care; NHS Policy and Performance; Global Health; Public Health and NHSX. At Quarter 4, 6 BAMs have been held. For DG groups where meetings have not taken place, full BAM reports have been shared with senior staff.

490. The BAM reports are part of the Department's system of control, and have contributed to ensuring that where issues have arisen during the year that these are appropriately reported and discussed. The process also contributes to the oversight of the arrangements in place to address identified weaknesses and drive improvement. The internal audit opinion detailed below along with the recommendations made, confirms that improvements can be made to this process to enhance its effectiveness.

491. An outline of the Department's management of the COVID-19 pandemic up to 31 March 2021, including the governance provided by the COVID-19 Oversight Board, is addressed later in the **Governance Statement** and as part of the **Performance Report**.

## Whistleblowing

492. The Department's whistleblowing policy has been in place since August 2015 and includes reporting biannually to the Cabinet Office on all whistleblowing concerns received.

493. The policy offers employees a number of methods to raise a concern and is underpinned by a small network of individuals from various grades, positions and locations, who have been given training on whistleblowing and the Department's policy. The network provides an easily accessible resource for employees to speak to if they have a whistleblowing concern and are uncertain how to address it.

494. The Department also has a Board-level Whistleblowing and Speak Out Champion, which during the reporting period was the Director General for Finance and Group Operations.

495. When a report of a whistleblowing concern is received, the Department conducts initial conversations to establish whether it falls under the whistleblowing policy. If a case of whistleblowing is established, the Department will investigate following the protocols outlined in the policy. In 2020-21 fewer than five formal whistleblowing concerns were raised. Figures of five or less whistleblowing concerns are not published to protect anonymity, but we can say that all cases have been investigated and the investigations have concluded.

496. The Department's HR team uses a Safe to Challenge scorecard to measure progress and identify hotspots and trends. The scorecard is reviewed quarterly at the Department's People Board. DHSC has a programme of work on Safe to Challenge which aims to develop a culture where staff feel safe to give and receive feedback and challenge at all levels.

497. The results of the most recent People Survey showed the percentage of people who felt confident to speak up in the Department was above the Civil Service average. This is suggestive of an effective policy being in place as well as the supporting Safe to Challenge programme of work.

498. Over the course of 2020-21, the priority in this area has been to focus on ensuring all staff are aware of the routes to raise concerns and feel supported to do so, especially when the majority of the Department was working from home. This has included communications on reporting routes and support services, reviewing the corporate induction ensuring this content is clear, releasing toolkits on inclusive conversations, and Speak Out Advisers delivering sessions on speaking up across the Department.

499. The current whistleblowing policy was reviewed, and a decision has been taken to update the policy based on the most recent best practice template developed by Civil Service Employee Policy. The new Raising a Concern policy was launched in 2021.

### Role of Internal Audit

500. The Department's internal audit service continues to be provided by a dedicated Health and Social Care team within the Government Internal Audit Agency (GIAA).

501. The team plays a crucial role in the review of the effectiveness of risk management, controls and governance within the Department by:
    - focusing audit activity on the key business risks;
    - evaluating the design and effectiveness of Departmental processes in achieving your 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.

502. The team operates in accordance with Public Sector Internal Audit Standards and to an Internal Audit Plan, which has been agreed with the Accounting Officer and ARC. With the agreement of ARC, this Plan is updated appropriately throughout the year to reflect changes in risk profile.

503. The Head of Internal Audit submits regular reports to the ARC relating to the adequacy and effectiveness of the Department'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 and includes a timetable for implementation.

504. The status of Internal Audit recommendations and the collection of evidence to verify their implementation are reported to the ARC. The Head of Internal Audit also has direct access to the Department's Permanent Secretary and they meet periodically to review lessons arising from Internal Audit.

### Internal Audit Opinion

505. In considering the overall adequacy and effectiveness of the Department's framework of governance, risk management and control in 2020-21, the Head of Internal Audit has identified significant weaknesses in the framework such that it could be or could become inadequate and ineffective. Her opinion is that she can give 'Limited' Assurance to the Principal Accounting Officer in relation the strength of risk control and governance arrangements within the reporting year.

506. In drawing together her report the Head of Internal Audit observed that "keeping the country safe in the context of a global pandemic became the overriding priority for the Department in 2020-21 with the acknowledgement that this has an impact on delivery of many of its objectives and the government's health and care priorities. The Department's plan for responding to the pandemic was developed at pace within an operating environment subject to significant change. It acted to provide initial clarity of direction in response to the pandemic. The individual components within the plan and associated workstreams have continued to evolve to meet the emerging challenges presented by the coronavirus. This was all completed against a backdrop of the Department doing what was needed to put itself in a good position in respect of the UK's exit from the European Union by making arrangements for continuity of supply, reciprocal healthcare, medicines and devices regulation, the Northern Ireland Protocol and health security. In responding to the challenges outlined above, the Department has nearly tripled in size and expenditure has substantially increased. Importantly, a predominately policy department has now taken on significant operational activity."

507. The Head of Audit reported that the control environment was compromised in some areas during 2020-21 due to the pressure to respond to urgent need in tackling the pandemic. She concluded that the Department had acted appropriately under challenging circumstances to design and implement new systems and processes. She advised that "These had gone some way to manage inherent risks. However, issues in delivering these systems swiftly and effectively had resulted in inconsistent evidencing of the work the Department has delivered, particularly during the early days of the response. We record this as an issue in a number of our reports including pre-employment checks, key financial controls

and due diligence checks in respect of procurement." The Head of Audit reflected that such instances would more likely have been identified and addressed quickly had the Department had a strong cross business assurance framework in place with correctly focused first (management control) and second line (risk and control oversight functions) assurance activity. Other audit and advice work in year where weaknesses were identified included reviews of Personal Protective Equipment handling, NHSX Portfolio delivery management and aspects of Cyber Security.

508. The Head of Audit observed that there is now greater complexity to governance of the Department and that "the existing arrangements in place do not best support the current operating environment". Following an audit of Committees and Governance, she reported that "lines of accountability, interfaces, interdependencies and escalation routes are not clear or fully integrated across the Department and wider health group". She advised that continued action was needed to ensure that existing governance and oversight arrangement relating to the COVID response is aligned or at least working effectively in tandem to ensure optimum achievement of business objectives. Her report also recommended that a more consistent strategic focus should be applied to the achievement of objectives taking full account of all agreed priorities with greater emphasis being placed on performance monitoring.

509. The annual audit opinion report referenced an audit of Risk Management. This noted some good examples of effective risk management in action within the Department, particularly in respect of tactical issues relating to pandemic response. But it was also stated that "the Department does not have a strong organisational risk management culture which is more important given its extended operational remit". The Head of Audit concluded that when considering risk maturity there is more to be done before risk management practices are fully playing their part in enhancing strategic planning and prioritisation, assisting in achieving objectives and strengthening the ability to be agile to respond to the challenges faced.

510. Overall, the Head of Audit judged that the "Department has been operating within a heightened risk setting undertaking activities never previously conducted. Necessary adjustments are required to the framework of risk control and governance arrangements for them to be considered effective in what is a new operating environment. Some of the groundwork has already been laid to facilitate this e.g. the successful introduction of a new enterprise resource planning system for finance, HR and commercial; the exercise to review and refresh governance arrangements and to bolster the risk team."

511. The Department was advised that in the coming year planned transformation activity should have a strong risk control and governance focus taking account of lessons learned during 2020-21. The following recommended areas of improvement were made:

- The Department's transformation road map should clearly outline how DHSC will ensure a more balanced focus in its pandemic response whilst delivering its agreed objectives per Government priorities.
- A root and branch review of its COVID-19 response plan and Business as Usual (BAU) governance arrangements should be completed, to arrive at a new, efficient BAU model, that reflects the current operating environment including the need to work closely with ALBs across the wider health family and cross government. Performance reporting requirements need to be considered in the context of the new arrangements with a stronger focus on metrics.
- An assurance framework for the organisation should be developed, to include production of an assurance map, which will provide a mechanism for objectively evaluating and linking assurances from various sources, to the risks that threaten the achievement of the Department's outcomes and objectives. This should give clarity to where lines of defence checks should operate and who is undertaking them.
- Place a stronger focus on risk management using a maturity model to help the Department move from being 'risk aware' to wholly 'risk enabled'. The setting of risk appetite is particularly key.
- Respond swiftly to recommendations made to address weaknesses in control risk and governance.
- In order to improve compliance with key processes and procedures, particularly as there has been a significant influx of staff, ensure that guidance is updated, is easy to reference and supported by training as necessary, conducting selected first and second line checks to gain comfort that processes are working as intended.

512. The Department has made positive steps to strengthen governance and controls, building on the urgent arrangements that were necessary at the outset of the pandemic. This includes taking appropriate action to address areas for improvement identified during audit. In particular, there has been a strong focus on addressing actions set out in audit reports produced in year. Risk management arrangements have also been strengthened with further work in train to help build a culture of active risk spotting, capturing and mitigating.

513. The launch of the 'Shaping our Future' programme in July by the Second Permanent Secretary has provided a useful reset and includes workstream activity which should also address weaknesses identified. Workstream one 'role and purpose', and workstream three 'Capability and systems and processes' are particularly pertinent, and activity here should act to strengthen governance and the control environment.

### Arm's Length Bodies

514. Each ALB has a Senior Departmental Sponsor at Director General or Director level, with whom they meet at least quarterly in accountability meetings focusing on

operational delivery, financial performance, significant risks and how these are being managed.

515. The Governance Statement for each ALB is published within their own Annual Report and Accounts. In addition, the ALB's Accounting or Accountable Officer provides the Sponsor with a formal, written Annual Governance Statement. There are a number of other organisations which feature in oversight arrangements provided by a Director General, such as Community Health Partnerships Ltd and NHS Property Services Ltd.

516. The objectives and deliverables of the Department's ALBs are set through their annual business planning process. The Department uses ALB mandates, remit letters and business plans to hold its ALBs to account. This year, the collective health system response to COVID-19 has impacted on ALBs' ability to prioritise the publication of their business plans. However, ALBs continue to work closely with the Department to assure their priorities.

### The NHS

517. 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, and in the prevention, diagnosis and treatment of ill-health.

518. In relation to NHS England, the Health and Social Care Act 2012 requires the Department to formally set out in an annual mandate to NHS England its objectives for the health service to be delivered in the financial year. This is one of the formal accountability mechanisms for holding NHS England to account for the money it spends and the outcomes it achieves.

519. NHS England has responsibility for the commissioning of health care in England and, under the mandate to invest its annual budget (of around £144 billion in 2021-22) to bring about measurable improvements in health outcomes for the population.

520. NHS Improvement is the operational name for an organisation that brings together: Monitor, the NHS Trust Development Authority (TDA), the Patient Safety function from NHS England, the Advancing Change team from NHS Improving Quality, the Intensive Support Teams from NHS Interim Management and Support (IMAS) and the NHS Leadership Academy, to make a single integrated enterprise.

521. Since April 2019, NHS England and NHS Improvement (NHSE and NHSI) have adopted a single leadership model under the Chief Executive Officer (CEO) of NHS England and single Chief Operating Officer (COO) who is also the CEO of NHS Improvement, with the single COO post covering both NHSE and NHSI and reporting directly to the CEO of NHSE and NHSI.

522. Both organisations working as one integrated organisation has been reflected in the mandate, which since 2019-20 has included joint objectives for both NHSE and NHSI. As the UK faced the unprecedented challenge of managing the threat of COVID-19 in March 2020, the government's 2020-to-2021 mandate to NHS England and NHS Improvement was a brief one, which focussed on five objectives, including managing COVID-19 and progress on the NHS Long Term Plan. The 2020-21 mandate was republished in March 2021 with revised funding figures.

523. NHSE and NHSI have reported performance to the Secretary of State against each objective in the 2020-21 mandate. The Secretary of State's own assessment of this performance will be set out in an annual assessment for 2020-21, meeting his legal duty to lay in Parliament each year an assessment of NHS England's performance. The assessment is expected to be published at the same time as these Annual Report and Accounts.

524. NHS Commissioners, NHS Trusts and NHS Foundation Trusts are all required to operate risk management procedures. For NHS Commissioners, these processes are set and managed by NHS England and further details are included in NHS England's Governance Statement and published in their annual report and accounts.

525. For NHS Trusts the processes are set by NHS Improvement. 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.

526. The current assurance and accountability process provides Ministers with a number of legislative and non-legislative mechanisms for holding NHSE and NHSI to account. The Framework Agreements for NHSE and NHSI set out the assurance process, roles and responsibilities of the Department and NHSE and NHSI by which accountability will be achieved.

527. This includes an expectation that there will be quarterly accountability meetings between the Secretary of State and the NHS Executive team. Pre-COVID-19, the frequency and form of these meetings were under review to avoid duplication with other senior decision-making forums and during the pandemic other forums have been used for such discussions.

528. The Department is now working with NHSE and NHSI to set up quarterly reporting against headline metrics underpinning the agreed priority commitments set out in the 2021-22 mandate to provide efficient and effective levels of oversight, scrutiny and transparency.

## Key Governance Issues

### Coronavirus (COVD-19)

529. COVID-19 is the biggest challenge the country has faced in a lifetime and DHSC has led the Government's health and social care system's response. Guided by the scientific evidence and advice, and drawing on our emergency preparedness plans, the Department mobilised from an initial emergency operational response to a full Departmental and system-wide response as the initial outbreak of the new virus developed into a pandemic.

530. During the initial phases of the pandemic there was a sudden increased demand for the supply of personal protective equipment (PPE) for the NHS and adult social care sector, as well as ventilators and oxygen to ensure that those who needed treatment received it across the globe, testing the Department's ability to manage procurement and distribution. There was a need to rapidly design and implement a Test and Trace system from scratch and there were increasing pressures on the NHS and the Adult Social Care system which needed to be addressed.

531. Work on the response to COVID-19 became the single most important focus of the whole Department and wider health and care systems, during the final months of 2019-20 and moving into the 2020-21 financial year through a robust governance structure.

532. The Department has had to act in an agile and dynamic manner throughout the outbreak. Activities undertaken in response to the pandemic have adopted a risk based and proportionate approach to the Department's system of internal controls.

533. The objectives of the Department in tackling COVID-19 were initially to deploy phased actions to Contain, Delay and Mitigate the outbreak, using research to inform policy development, working at all times with the Chief Medical Officer for England.

534. The Department produced an Action Plan to provide strategic objectives to tackle the virus and protect life in the initial stages of the pandemic. This represented a consolidation and enhancement of the considerable advice and support that had been provided across the health and social care sector.

535. The Coronavirus Act 2020 which received Royal Assent in March 2020 enabled the Government to respond and manage the effects of the COVID-19 pandemic appropriately.

536. The Department has contributed to ongoing central government response plans including the Winter Plan and Spring 2021 Roadmap. The Department also established and published several plans detailing how the entirety of the health and care system would be supported during and after the COVID-19 pandemic.

This included the Personal Protection Equipment (PPE) Strategy, the COVID-19 Mental Health and Wellbeing Recovery Action Plan, the Adult Social Care: Our COVID-19 Winter Plan, the UK COVID-19 Vaccines Delivery Plan and the UK COVID-19 Vaccine Uptake Plan.

537. Substantial additional resources and expertise were brought in to support the work of the Department. In developing a structured ongoing response to tackling the virus the Department has continued to evolve its internal structure to support the delivery of the strategic objectives, including the establishment of a Second Permanent Secretary role and the prioritisation of COVID-19 work at Director General and Director levels.

538. The COVID-19 Programme was established to coordinate the strategic health and care response across the Department and our ALBs. This included ensuring effective governance arrangements were in place, reporting of performance to the COVID-19 Oversight Board and ensuring that guidance for the public and professionals relating to COVID-19 is timely and accurate.

539. The COVID-19 Oversight Board coordinates and assures the Department's COVID-19 response, supporting and aligning where possible with cross-government response and assurance. Comprised of senior reporting officers and programme director, it scrutinises programme and risk management to assure the deliverables of the Department's response and, ensures the health and social care system's response to COVID-19 is based on robust scenario planning.

540. The portfolio of programmes within the Department's COVID-19 response sits within a governance framework with clear governance structures in place across the workstreams, and assurance is provided through these structures. Senior Reporting Officers provide regular (weekly/fortnightly) returns to the Oversight Board to allow scrutiny of programme and risk management and to assure the deliverables of the workstreams.

541. Escalation routes exist within each of the workstreams and they are able to escalate risks and issues through the COVID-19 Oversight Board, Executive Committee, Performance Committee and Audit & Risk Committee, as relevant and necessary. A quarterly report to both the Performance Committee and Audit & Risk Committee on the COVID-19 response has been provided over the last year.

542. The establishment of the role of Second Permanent Secretary and additional Accounting Officer in the Department has sought to address the operational pressures and create further resilience, as part of the Department's COVID-19 response. The role includes assuming the Principal Accounting Officer responsibilities if the Permanent Secretary is unavailable.

543. On 18 August 2020, the Secretary of State for Health and Social Care announced the establishment of a new Executive Agency, bringing together health protection

elements of Public Health England (PHE) with the NHS Test and Trace service and the Joint Biosecurity Centre (JBC) intelligence and analytical capability.

544. In March 2021 the Secretary of State for Health and Social Care announced the launch of the UK Health Security Agency (UKHSA), which was formally established in April 2021.

545. UKHSA is the UK's permanent standing capacity to plan for, prevent and respond to threats to health. Dr Jenny Harries has been appointed as the new Chief Executive of UKHSA. The Chief Executive is accountable to the Secretary of State for Health and Social Care, through the Permanent Secretary.

546. Ministers are responsible and accountable for policy decisions. They will set public health policy and in doing so will agree the government's priorities for UKHSA and will hold it to account for delivery.

547. Until the formal changes were made, PHE continued to operate and deliver its core functions in line with its Framework Agreement under the leadership of Michael Brodie.

548. From October 2021, the Office for Health Improvement and Disparities (OHID) incorporates most of PHE's functions that directly support development and delivery of national health improvement policy.

549. PHE's health protection functions transferred to UKHSA, which will be the UK leader for health protection and ensure the nation can respond quickly and at greater scale to deal with pandemics and future threats. UKHSA has been fully operational from October 2021.

550. Further information regarding the Department's activities relating to the pandemic response can be found in the Performance Summary at the beginning of these accounts.

### Financial Risk and Sustainability in the NHS

551. Putting the NHS back onto a sustainable financial path is a key priority in the Long Term Plan and is essential to allowing the NHS to deliver the service improvements it sets out. The Government previously announced that the NHS would receive a budget increase equivalent to an extra £33.9 billion in cash terms by 2023-24 (compared to 2018-19) to deliver the commitments set out in the plan and the five financial tests that underpin it.

552. The budget increases were enshrined in law in March 2020 in the NHS funding Act 2020 and the funding and the NHS budget is entrusted to NHS England and NHS Improvement to deliver Long Term Plan.

553. In order to support more effective oversight of delivery of the overall Long-term Plan and the tests, the Government had been working with NHSE and NHSI to determine a set of metrics that reflect the fundamentals and ambitions of the plan.

554. The intention originally was for these metrics to be used to monitor progress against intended outcomes on a regular basis. However, following the onset of COVID-19 pandemic, this process was paused to allow the system to concentrate on the response to the outbreak.

555. The mandate to NHS England and NHS Improvement for 2021-22 sets out a commitment for the Government and NHSE and NHSI to endeavour to agree metrics and trajectories for 2021-22 by July 2021 and in relation to future year trajectories, during Autumn 2021.

556. During the national crisis, £18 billion of additional funding was secured for the NHS in support of the response after extensive discussions with HM Treasury to review the evidence available at the time.

557. Due to the pressures of the pandemic, we have had a higher risk appetite when it comes to financial control. This has led to a limited number of issues where HM Treasury consider the Department's approach irregular. Further detail regarding the regularity opinion is detailed from **paragraph 648**.

558. While the NHS was broadly left to operate and prioritise its activities within existing controls, the uncertainty generated by the pandemic and the need for rapid decision making and increase risk appetite to ensure the NHS was able to operationalise the Covid response at pace. This included committing spending before appropriate approvals were secured, making spending decisions on the best but most immediately available information and investing in additional temporary capacity (such as with the independent sector and creation of the Nightingales hospitals) put in place as precautionary measures which ultimately were not fully utilised.

559. As we return to business as usual financial controls, we are working with HM Treasury to draw any lessons learned that can improve our governance framework and approach to financial forecasting going forward. With the return to business as usual, we have agreed a new set of delegations and spending approval processes with HM Treasury, and the NHS has developed a new System Oversight Framework that seeks to monitor the progress of NHS systems to meet their required standards, including financial and use of resources, and identifies requirements for national intervention where standards are not met.

560. In addition NHSE and NHSI have taken steps to accelerate the move to system working to enable more effective financial co-operation. This includes recasting the financial framework to support system working. These are positive steps in

line with the direction of travel in the Health and Care Bill and will support the return to achieving financial sustainability once the pandemic is over.

561. The Department continues to undertake and regularly review its governance and oversight process to ensure funding is used in the most efficient and effective way; and to hold the NHS to account for delivery of agreed financial objectives.

562. Our monthly Cross System Efficiency & Finance Board with NHSE and NHSI, regular ministerial and HM Treasury engagement have continued to operate throughout the pandemic, providing a regular forum for the senior finance leadership in both organisations to discuss financial issues and support decision making where needed.

563. The impact of the COVID-19 pandemic on the steps being taken towards achieving financial sustainability and the Long Term Plan continues to be assessed.

### Core Performance Standards

564. As set out in this Annual Report, performance against all operational performance standards (covering A&E admissions, Referral to Treatment and Waiting Times) continued to be very challenging in 2020-21. More detail is available in the Performance Summary and Annex C.

565. Performance against these standards was monitored by the Departmental Board and featured as part of the cross-system risk management arrangements.

### Contract Management

566. During 2020-21, the Commercial Capability and Supplier Management (CCSM) Team has maintained work with Director General Groups to ensure that the DHSC Corporate Contracts Register is comprehensive and Directors and Director Generals have corporate visibility of the DHSC contract portfolio. Director Generals have reported on contracts as part of the Biannual Assurance process, helping to ensure contracts and associated risks are identified and managed.

567. The DHSC Contract Management Operating Model is a three-tiered approach based on the proportionate application of resource, governance and process, determined by the strategic importance of each contract. Classifying a contract involves reviewing factors that would have an impact on the Department should the Contract, for any reason, fail. These factors include the total value of the Contract, how many other suppliers are in the market, if the Supplier handles sensitive information, etc. The Department's model of classifying contracts is to differentiate contracts into either a Gold (high risk by either value or impact), Silver (medium risk with a lower value or impact), or Bronze (lowest value/impact).

568. Due to the business concentrating resource on responding to the pandemic, some areas of contract management and assurance activities were deprioritised. The

CCSM team reminded Senior Contract Owners of the highest risk contracts of the importance of contract management and their respective roles and responsibilities through the annual Assurance Framework Attestation process. In ensuring the Contract Management Operating Model was followed and by agreeing revised timescales where needed, this enabled all but one assurance process to be completed for gold and silver contracts in the 'business as usual' (BAU) contract portfolio by 31 March 2021. The final one was completed in April 2021. The BAU portfolio does not include gold or silver contracts which have been awarded relating to COVID-19.

569. Work continues to enrol our Operational Contract Managers (OCMs) on to Contract Management Capability Programme Training. This training is provided by the Cabinet Office and is part of the Government's commitment to invest in training to help OCMs understand all elements of the contract life cycle, manage contracts and relationships with suppliers.

570. The DHSC CM operating model is for operational contract management to be undertaken out in the business. Each contract should have an OCM plus a Senior Contract Owner. The contract management of the contracts awarded for COVID-19 are therefore managed by the respective teams, such as PPE and Test and Trace, and the CCSM team works with the OCMs and SCOs to support them in the management of their contract portfolio. The CCSM team established early links with these teams, however due to high levels of resource changes and lack of initial governance structures, it took longer than usual to identify OCMs and SCOs and make them fully aware of their respective roles and responsibilities. The NAO are currently undertaking an investigation into the contract management of the COVID-19 contracts.

571. Training is based on the Contract Management Professional Standards and accreditation in contract management is offered at three levels: Foundation, Practitioner and Expert. By the end of March 2021, some 972 learners across health (DHSC, ALBs and NHS) had registered for the Foundation Training, of which 450 achieved accreditation. We will continue to encourage all Foundation learners 'in progress' to complete the learning and achieve accreditation. All OCMs managing DHSC gold and silver contracts have been nominated for Practitioner and Expert training as required.

572. A significant number of new contracts have continued to be awarded across COVID-19 workstreams. We have continued to work closely with COVID-19 workstreams and can confirm as of 31 March 2021, over 700 new contracts are still active with a total contract value in excess of £12 billion. This figure relates to contracts across COVID-19 workstreams such as NHS Test and Trace, PPE, Medicines, Logistics and Ventilators.

573. Increased contract management capacity in the Commercial Capability and Supplier Management team has been established to allow us to begin to

undertake our role of governance and oversight of the COVID-19 contract portfolio and to support operational contract managers to ensure they are being managed appropriately.

574. As a result, considerable progress has been made in achieving greater transparency, oversight and assurance within the COVID-19 contract portfolio, with the implementation of more robust contract management and establishing effective working relationships with operational contract managers. This work is ongoing.

575. Whilst OCM capacity has increased, there still remains limited amounts of OCM capacity across some of the COVID-19 workstreams to undertake standard contract management. These risks are recorded in the Commercial and Life Sciences Group risk register.

### Quality Assurance of analysis and models

576. Our Department has a comprehensive framework of assurance for analytical models used in critical areas of our activity, guided by an oversight committee of senior analysts and operating in line with HM Treasury guidance in the Aqua book and the recommendations of the Review of quality assurance of Government analytical models published in 2013.

577. This year we have continued to raise awareness of, and improve the training and materials available to officials engaged in analytical work, to maintain systematic processes to regularly update our list of business-critical models and to ensure that risks are identified, managed and escalated as necessary.

578. To support the increased pace and quantity of analysis being produced during the COVID-19 response, since March 2020 we have maintained a rapid-response facility for analysts from across the Department to advise and undertake time-critical analytical assurance.

579. There has been a major expansion in the number of analysts in the Department this year. These include analytical structures to oversee COVID-19, an expanded central statistics unit, and further analytical expertise on social care. Senior government analysts have been embedded within new units to maintain and promote high standards of quality assurance and analytical rigour.

### Information Risk

580. 2020-21 was an unprecedented year for the Department in terms of information security and data protection following the establishment of NHS Test and Trace and the Joint Biosecurity Centre within DHSC's 'department of state' functions in response to the COVID-19 pandemic.

581. The Department operated throughout the year with an increased risk tolerance as it acted quickly to contain, delay and mitigate the impact of the pandemic, save lives and protect the NHS.

582. Establishing new remote working arrangements and onboarding thousands of new staff at pace posed significant challenges as the Department responded dynamically to the changing situation.

583. The Department has worked with the Information Commissioner's Office (ICO) throughout this period, and continues to do so, to ensure that data protection implications and obligations continue to be considered and met.

584. The Department recorded 122 data-related incidents between April 2020 and March 2021, an increase of almost 500% on the previous year, which is considered to be the result of DHSC's greater operational emphasis at national scale, stronger awareness amongst staff on data incidents, and reflecting the changing nature of the Department's business in response to a national public health emergency.

585. 10 of these incidents were reported to the Information Commissioner's Office, 2 were informal referrals and 1 advisory.

586. These incidents have been dealt with to the satisfaction of the ICO requiring no further follow up. One referral is still under investigation. The Department has ensured that corrective action was taken following these incidents; with internal processes reviewed and updated where appropriate.

587. To provide senior leadership and ensure a focused, agile and robust response to new information risks, a Director of Data and Information Governance was appointed in June 2020. A number of other senior Information Professionals including a new Data Protection Officer, and Heads of Information Risk Management and Information Assurance were also recruited.

588. A new, permanent Information Risk Management and Assurance Directorate was launched on 1 April 2021. It is tasked with developing and delivering a Departmental data and information risk and assurance framework including drafting, publishing and communicating new guidance on data protection and information management to mitigate and manage future information risk and assure compliance.

## Fraud

589. Fraudulent activity in the NHS means that money intended for patient care, and funded by the taxpayer, ends up in the hands of criminals. It means fewer resources are available for frontline health and social care services such as patient care, health and social care facilities, doctors, nurses and other staff. It can lead to a reduced ability to invest in new and improved equipment and technology, fewer

clinical interventions, and a general diminution in the sustainability of an NHS which remains free at the point of delivery.

590. The NHS Counter Fraud Authority (NHSCFA) Strategic Intelligence Assessments show that since 2017, there has been year-on-year reductions in fraud loss estimates.

591. Vulnerability to fraud, bribery and corruption in relation to the NHS leads to an estimated loss of £1.21 billion in 2018-19, down from £1.27 billion in 2017-18 which was a reduction from £1.29 billion in 2016-17. The figure for the latest year, 2019-20, (1 September 2019 to 31 August 2020) is lower still at £1.14 billion.

592. Our work to counter fraud at a national level incorporates the DHSC Anti-Fraud Unit (DHSC AFU). Its goal is to prevent and deter fraud, corruption and bribery by raising awareness and working in partnership with all parts of DHSC, its ALBs and companies.

593. The DHSC AFU sets the counter fraud policy and strategy for the Department and the wider health group, and recently launched the DHSC Counter Fraud Strategy: 2020 to 2023.

594. Fraud is a hidden crime and to fight it, you have to find it. There is no one solution. Addressing fraud needs a holistic response incorporating detection, prevention and redress; underpinned by a strong understanding of risk. It also requires cooperation and a spirit of collaborative working between organisations.

595. Our response to tackling fraud has been, and continues to be, based on the following principles:
    - It is centrally driven and managed, with clear lines of accountability, whether that be in individual NHS bodies themselves or with the Director General Finance or NHS and the Counter Fraud Board.
    - It is reliant on a collaborative approach between organisations as well as a clear commitment by senior management to developing a consistent and organised mechanism for sharing information about risks and best practice.
    - Recognising that reducing fraud/financial loss is the responsibility of all staff. It therefore supports the development of a clear assurance framework that is underpinned by consistent guidance and clear escalation routes. Everyone needs a clear understanding of how and what to report which then allows specialist counter fraud staff to take matters further.
    - By building on previous success and lessons learned, fraud reduction is enhanced by proactively seeking to introduce preventative ways of permanently eradicating whole categories of fraud/financial loss (e.g. prescription fraud) and minimising the opportunity for new categories of fraud to arise.
    - Acknowledging that work on fraud and other types of financial loss is critical to maintaining a sustainable and financially balanced NHS.

596. The DHSC AFU also offers an in-house investigation service to its health group partners on serious and complex cases. It also provides investigatory advice for handling cases which do not meet its prioritisation criteria. Wherever possible, the DHSC AFU seeks to recover funds lost through fraud by making use of its powers under the Proceeds of Crime Act 2002.

597. During the reporting period, our business as usual investigations had been suspended to allow resources to work on COVID-19 post event assurance work. This has placed limitations on our criminal casework. Cases have resumed on a reduced basis since the Autumn of 2020.

598. Also operating at a national level, the NHSCFA spearheads the fight against NHS fraud and implements the Department's strategic plan under the sponsorship of the DHSC AFU. They also launched their own Strategy for 2020 to 2023. NHSCFA has a resource of 164 full time staff.

599. Other bodies with national coverage routinely undertake activity to tackle fraud. The Counter Fraud Board has oversight of DHSC arm's length bodies. This is supported by regular contact at working level between the NHSCFA, NHSBSA and NHSE and NHSI. This will support effort to both identify and consider any gaps in threat coverage and ensure linked actions are aligned and complementary, mitigating the risk of duplication.

600. Local counter fraud work is guided by the NHS Standard Contract, the NHSCFA's Standards for Commissioners and Standards for Providers which require all organisations commissioning and providing NHS services to put in place and maintain appropriate counter fraud arrangements. Following the roll out of Government Counter Fraud Framework Standards, these should be met in everything the NHS does.

601. Local counter fraud specialists support NHSCFA on national issues, get national fraud prevention messages out and identify, report and investigate individual cases (e.g. payroll and procurement and commissioning fraud). As of May 2021, there were 234 Local Counter Fraud Specialists.

602. COVID-19 has clearly had a huge impact on DHSC and the health group as a whole. We have seen spending at an unprecedented scale and pace, exacerbated by the global nature of the pandemic, meaning the UK has had to act fast to secure the resources it needs.

603. To support this, the Cabinet Office has established a COVID-19 Counter Fraud Response Team to proactively monitor the COVID-19 fraud threat utilising expertise, intelligence and analytics from its partnerships across sectors, including law enforcement, the public and private sectors as well as international partners.

604. Shared intelligence and expert fraud risk assessment of the stimulus spend helps understand the risks from fraud and the possible responses. DHSC AFU and NHSCFA are closely involved with this work.

605. In response to the recognised increased risk, DHSC along with government departments have undertaken action to detect fraud and error in their COVID-19 schemes, to recover those losses where it was possible and to understand the extent of fraud and error losses through measurement activity. This is known as Post Event Assurance (PEA) activity.

606. The Department recognised that it was necessary to operate swiftly in responding to the COVID-19 pandemic and that this required a dynamic but inherently higher risk appetite in decision-making and managing transactions, while maintaining reasonable controls in context and ensuring transparency.

607. The Department considers that many of its COVID-19 related programmes and purchases are not necessarily more susceptible to fraud. I.e. there is no reason to believe their fraud risk profiles are significantly dissimilar to BAU activity (including purchasing activity), particularly where we are purchasing goods and services of a nature that is either familiar or easily understood, from suppliers who have history/experience in supplying those goods/services.

608. Personal Protective Equipment (PPE) procurement is the notable exception to this, and the most significant risk of fraud identified, where goods subject to detailed technical requirements were purchased from new suppliers. Some of whom did not have experience in supplying these types of products, and where full physical product quality inspection could not always be done in advance (at least in the early days of purchasing) making paper based product technical assurance all the more important.

609. The spend for PPE of almost £14 billion, in an emergency situation, required an expedited process in order to secure scarce resource amidst a global pandemic. It should be noted that circa £5 billion of this spend was via Supply Chain Coordination Limited, using existing suppliers and therefore significantly less risk than the new suppliers used by the Core Department.

610. DHSC (AFU, Accounts Operations and Commercial) with support from wider counter fraud function and law enforcement partners have recovered / prevented c£162 million in high risk procurement payments. The Department (accounts and purchase to pay teams, the PPE Programme, including quality reviewers and contract managers, and the DHSC Anti-Fraud Unit) has undertaken extensive work to mitigate risks, which, at this time, has led to potentially low levels of fraud being identified.

## Compliance with Equality and Human Rights Legislation

611. The responsibility for meeting the requirements of equality and human rights legislation in policy and decision-making lies with each team in the Department. They are supported by the Policy Assurance and ALB Oversight team who are responsible for raising awareness and capability among staff on equality issues.

612. The Department asked Public Health England to analyse the impact of COVID-19 on different groups in society, and Public Health England published a report on disparities in COVID-19 risks and outcomes in June 2020. The Department has responded to this by considering issues in its work and policies during the pandemic.

613. The Policy Assurance and ALB Oversight team has supported this by delivering more training sessions and updating guidance on the Department's intranet to support staff to understand their responsibilities. There is also a network of Senior Civil Servants who promote good practice and give visibility to equality issues.

614. Directors General are required to consider compliance with the public sector equality duty and evidence of this is provided in submissions to Ministers. The Policy Assurance and ALB Oversight team provide second line assurance on compliance with the duty.

615. The Department has published summary equality information relating to its policies and workforce, including for the pandemic. Previous reports and our current equality objectives can be found under the equality information section of the Department's website.

## National Audit Office

616. As the UK's independent public spending watchdog the National Audit Office (NAO) does much more than audit the accounts of departments and their component bodies. 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.

617. Given the scale of the response to the pandemic across the public sector, the NAO have carried out a substantial programme of audit work in relation to COVID-19 activities. This work provides expert insight to help ensure that appropriate lessons are learned for the future. Given the centrality of the Department to the Government's response to COVID-19, a number of significant reports have been published covering the Department's activities through the pandemic. These have been invaluable in providing external scrutiny and recommendations to guide the Department's ongoing response to the pandemic.

618. **Table 13** provides a summary of the key reports published by the NAO, that reflect on activities of the Department.

**Table 13: Key NAO reports**

| Title of significant NAO report | Date of publication |
|---|---|
| Digital transformation in the NHS | May 2020 |
| Readying the NHS and adult social care in England for COVID-19 | June 2020 |
| Childhood obesity | September 2020 |
| Investigation into how government increased the number of ventilators available to the NHS in response to COVID-19 | September 2020 |
| The supply of personal protective equipment (PPE) during the COVID-19 pandemic | November 2020 |
| Investigation into government procurement during the COVID-19 pandemic | November 2020 |
| The government's approach to test and trace in England – interim report | December 2020 |
| Investigation into preparations for potential COVID-19 vaccines | December 2020 |
| Protecting and supporting the clinically extremely vulnerable during lockdown | February 2021 |
| The adult social care market in England | March 2021 |
| Initial learning from the government's response to the COVID-19 pandemic | May 2021 |

619. The National Audit Office (NAO) seeks to confirm the factual accuracy and provide formal clearance of their reports with the Departmental Finance Director (Director General – Finance), Additional Accounting Officer (Second Permanent Secretary) and the Principal Accounting Officer (Permanent Secretary) where the Department is the primary client.

620. Where the Department is a third-party client, the NAO seeks to confirm the factual accuracy of references to the Department with the Departmental Finance Director. The Permanent Secretaries, Director General of Finance, and other senior officials give evidence to the Public Accounts Committee (PAC) by appearing before hearings in Parliament. They also have responsibility for approving the subsequent Treasury Minute which is the government's response to the recommendations the PAC makes in its report.

621. In 2020-21, DHSC attended nine PAC hearings, details of which can be found via the Committee's website. Updates on NAO and PAC activity are provided at DHSC's Audit and Risk Committee meetings.

### Emergency Preparedness, Resilience and Response

622. The Department works closely with NHSE and NHSI, UKHSA, PHE, other ALBs and other government departments to ensure that the health and social care sector is able to respond to threats and hazards set out in the government's National Risk Register of Civil Emergencies (NRR) and other significant disruptions where they arise. In 2020-21 the Department led the Health and Adult Care Sector's response to COVID-19.

623. The Department scaled up its response capability during this period due to the complexity and scale of incidents. The Department also led the preparation for and management of concurrent risks in Autumn/Winter 2020, including managing significant incidents relating to the supply of critical medical consumables. This additional capacity was augmented by '24/7' on call arrangements which enable the coordination of services in any emergency that occurs. Horizon scanning is used to identify where there are gaps in response capability and bespoke programmes established to address these.

624. The Department is the Lead Government Department (LGD) for preparedness for human disease risks, including an influenza pandemic or outbreak of a High Consequence Infectious Disease (HCID). The plans in place to respond to an influenza pandemic provided the basis for much of the Department's early response to COVID-19.

625. The Department remained focused on the ongoing response to COVID-19 throughout 2020-21, whilst maintaining its preparedness for an influenza pandemic (which remains the Department's highest risk on the National Risk Register) or other HCID and will incorporate learning from COVID-19 in how these preparedness plans are taken forward and developed in the future.

626. As part of its pandemic preparedness planning, the Department ensures that countermeasures are in place to mitigate the risk of an outbreak of pandemic influenza. These countermeasures include stockpiles of Personal Protective Equipment (PPE), medicines (including antivirals and antibiotics), clinical consumables, and an Advanced Purchase Agreement for a pandemic specific influenza vaccine. The Department's stockpiles for pandemic influenza are designed to mitigate the Reasonable Worst-Case Scenario risk of an influenza pandemic as outlined in the National Risk Register, in which up to 50% of the population develop symptomatic infections.

627. Oversight is provided by the Department's Pandemic Influenza Preparedness Programme (PIPP) Board, which reports to the Department's Executive Committee. In 2020-21, Public Health England managed these countermeasures on behalf of the Department and from October 2021 this function transferred to the UK Health Security Agency.

628. Elements of these stockpiles were utilised in our response to COVID-19, where our Pandemic Influenza PPE stockpiles, including aprons, eyewear, facemasks, gloves, and gowns, were released to dentists, trusts, and primary and social case in February and March 2020.

629. This has depleted certain products in the specific pandemic influenza stockpiles, but the Department continues to work with the COVID-19 PPE workstream to assure that there is enough PPE available in the system to cover these shortfalls.

630. In the meantime, the Department is conducting a comprehensive review of its requirements for countermeasures for disease outbreaks and pandemics, in light of the experience of responding to COVID-19. This review, informed by expert scientific advice, is considering the products, volumes, supply, storage and governance arrangements required for a broader set of future pandemic and infectious disease risks, in addition to pandemic influenza. It will also address some of the relevant findings and recommendations contained in the Boardman Review of Government COVID-19 Procurement (December 2020) and the NAO report on The Supply of PPE During the COVID-19 Pandemic (November 2020).

631. In October 2020, the Department published the report from Exercise Cygnus, which was conducted in October 2016 to test preparedness for an influenza pandemic, in light of the focus on the Department's preparedness for a pandemic prior to COVID-19.

632. The Department's response to COVID-19 is outlined earlier in the **Governance Statement** and the **Performance Report**.

### Grant Payments to Non-Public Sector Bodies

633. The Department makes a number of grant payments to non-public sector bodies and Local Authorities each financial year to support delivery in line with governing legislation.

634. The Department's central finance team owns the governance process to ensure that all relevant approvals are given before there is any financial commitment and that the Department adheres to the Cabinet Office Minimum Standards in grant-making. This is described in more detail in the Accounting Officer's System Statement.

### Other Governance Disclosures

635. I confirm a number of other matters as set out in the following paragraphs. The first of these relate to matters initially raised in the 2019-20 accounts which remain issues impacting the 2020-21 ARA. This includes the impairments of the Department's Loans with NHS Providers and the recovery programme being undertaken with regards to the University Hospitals Leicester NHS Trust.

636. Further matters detailed below relate to the Department's response to COVID where it was necessary to adopt an increased risk appetite in the initial stage to ensure that sufficient supplies were procured for a reasonable worst case scenario, e.g. PPE, and resources were allocated swiftly where they were needed. As a consequence, matters have arisen requiring disclosure in the ARA regarding the regularity of spend in a specific number of areas, the extent of approvals regarding indemnities entered into, the value of impairments and losses, and a recent high court ruling.

637. In response, the Department has initiated a programme of work to reset governance and controls across the operating environment including in relation to special payments where delegated authorities have been clarified and the department has commenced a review of the control environment across the Group to establish whether further improvements are required. Additional work regarding the completeness of related party disclosures discussed below, also reflects this move to strengthen processes. The circumstances behind the special exit payment made by Berkshire West CCG that did not have the requisite approvals, mentioned below , will form part of the evaluation of how the control environment can be enhanced.

638. The exceptional impact of the pandemic response on the Department's account has not only led to significant financial reporting challenges, resulting in an account only being laid in the first quarter of 2022, but has increased the number of qualifications on the Department's account. These relate to limitations of scope in relation to stocktakes, accruals and fraud as well as the previously mentioned regularity opinion.

639. Further matters covered below relate to inquiries, reviews and issues that have arisen during 2020-21 up to the time of signing these accounts, for which further information will be provided in the 2021-22 accounts as well as commentary on significant ongoing matters such as cyber security, Carillion, EU Exit, screening programmes and Grenfell.

### Impairment of the Department's Loans with NHS Providers

640. As described in the 2019-20 Annual Report and Accounts, the Department considered the loans it held with NHS providers to be fully recoverable and not credit impaired. During 2020-21, all loans were fully repaid, through the issuance of new Public Dividend Capital and so do not appear in the Department's 2020-21 Statement of Financial Position.

641. As the National Audit Office's Comptroller and Auditor-General (C&AG) did not agree with the Department's impairment approach he chose to qualify his audit opinion on the 2019-20 Financial Statements. As these loans appear in the 2019-20 comparative information, as well as the 2020-21 opening balances, in the 2020-21 Financial Statements, he has qualified his opinion on this basis.

642. While the qualification of the C&AG's opinion remains, no new disagreement has arisen during 2020-21.

### University Hospitals Leicester NHS Trust

643. The ARA for one NHS provider, University Hospitals of Leicester NHS Trust, have not been adopted by the Trust's Board or certified by the Trust's auditor. This also means that the Trust has not published its annual governance statement, which forms part of the annual report.

644. The Trust entered the Special Measures for Finance regime in August 2020. This includes the appointment of a financial improvement director to the Trust, senior monthly oversight meetings, external review of the finance function, and board development.

645. During 2020 the work of the Trust and its external auditor identified significant weaknesses in internal control. Findings included deficiencies in financial systems and control, governance and financial reporting; in particular the use and authorisation of journals in the accounting ledger.

646. In December 2020 the Trust assessed that the weaknesses in underlying accounting records meant that the Board was unable to certify the annual accounts for 2019-20 as true and fair. As a consequence the external auditor did not issue an audit report.

647. During 2021 the Trust has worked to improve its governance and financial control, including work to remedy accounting records for 2019-20 as far as possible. The Trust currently expects to adopt its accounts for 2019-20 and 2020-21 in April 2022.

### C&AG opinion on regularity

648. There are several items of primarily COVID-19 related spend, totalling £1.3 billion, which HM Treasury has concluded are irregular because the Department or the NHS spent without approval, or in breach of previous conditions. These issues arose in the context of Department's emergency response to COVID-19, where the priority was to ensure that critical services were sufficiently resourced. The pace and volume of this activity meant that, in these cases, while information was often shared with HM Treasury, it was only after the spend had been incurred that the Department concluded it should have sought formal approval. Approvals processes and guidance have since been fully revised to prevent a recurrence of these issues in future. The specific items are:

- Community Pharmacy: In March 2020, HM Treasury approved a £300 million cash advance to community pharmacies to help with temporary cash-flow pressures as a result of COVID-19. This was provided on condition that this would be recovered through reductions in subsequent regular payments within the same financial year. By the end of the year, £370 million had been advanced and the Department assessed that the ongoing course of the pandemic meant that it would not be possible to recoup the funding in 2020-21. HM Treasury declined to approve this £370 million payment because the Department had breached the approval conditions. The Department is now recovering the £370 million advance payment made to community pharmacy at the start of the pandemic and this will be concluded by March 2022.
- Dental Charges: If a dentist fails to hit their activity targets, a clawback can be made against future payments. When dentistry reopened on 8 June 2020 with little advance notice, there was insufficient evidence to set safe targets

so a minimum activity level of 20% was recommended, which was later increased to 45%. This low target, plus the fact that practices can avoid a clawback in exceptional circumstances meant that the NHS considered this was unlikely to be possible in practice. Payments made not and not subject to clawback resulted in a £124 million cost pressure. The NHS had considered this routine budget management; however, HM Treasury concluded that the £124 million cost arose a result of a choice to pay dentists at 100% of their contract rather than based on historic levels of delivery, which potentially overfunded the sector relative to business as usual levels of funding. HM Treasury considered this to be a policy decision taken without approval.

- PPE and freight and logistics (£631 million): During routine reporting to HM Treasury, multiple low-level individual PPE contracts were deemed by HM Treasury to be substantively similar and therefore required approval as, in aggregate, they exceeded the delegated threshold of £150 million. The Department believed that these contracts were not substantively similar and, therefore, that approval was not necessary, but did not check this judgment with HM Treasury in advance of entering into the contracts. The approval was declined on the basis that the spend had already been incurred and the spend has been deemed irregular. In addition, extensions and incremental spending to freight and logistics contracts which pushed total spend above £150 million have been deemed irregular on the basis that approval was not sought in advance.
- NHS Test and Trace (£142 million): Extensions to a consultancy contract, which pushed total spend above £150 million, have been deemed irregular on the basis that approval was not sought in advance, and because HM Treasury declined to give retrospective approval to the contract having considered the relevant facts.
- Capital overspend in the NHS (£193 million): The NHS overspent their operational capital budget by c£350 million. Non-ringfenced underspends worth £160 million were identified to offset part of this overspend, since there were legitimate, pre-agreed grounds for relaxing these ringfences. However, HM Treasury did not approve a request to relax further ringfences retrospectively to cover the remainder of this overspend, leaving £193 million as the total unapproved NHS CDEL spend. The Department notified HM Treasury as soon as they were told of this situation by NHSE and NHSI and steps have been taken to guard against a similar overspend in the future; however, it had been communicated by HM Treasury that any requests for relaxation of ringfences had to be made before any spend was incurred, and HM Treasury were not prepared to regularise an overspend in a context where HM Treasury was not assured, at the point the request was made, that the NHS had appropriate control mechanisms in place.

## C&AG opinion on limitation of scope in relation to other accruals

649. The C&AG has limited the scope of his audit opinion in respect of the Other Accruals line of **Note 15** Trade Payables and other current liabilities for the Departmental Group.

650. This limitation of scope results from the aggregation of identified misstatements, projected most likely misstatements and areas of uncertainty where the NAO have been unable to conclude on certain balances. None of these factors are individually material to the Departmental Group but become material in aggregation.

651. No component entity accounts within the DHSC Group have attracted similar limitations of scope, however a Group qualification is still possible as the DHSC Group materiality threshold is significantly below the sum of those of its Group components.

652. The limitation of scope is driven by a combination of factors. Some of these are control weaknesses and are therefore discussed in this Governance Statement.

653. There are also other factors which are not control weaknesses, predominately that the Department was unable to conclude its accounts preparation process in sufficient time to allow us to provide sufficient evidence in all areas which has led to assurance gaps and uncertainties.

654. Whilst immaterial the level of identified accruals misstatement associated with entities within the NHS England Group increased in comparison to prior years. NHS England have started to address specific issues in 2021-22 by undertaking a third party review of pharmacy transactions to improve the process for recording spend and accruals.

655. Additionally, NHS England will undertake a lessons learnt exercise on the work completed on the 2020-21 balances to identify process improvements that can be implemented across the organisation in 2021-22 onwards. They anticipate that these improvements will include a review of regional processes for estimating and approving accruals, additional requirements around the evidence to be provided for accruals, and a clearance of the Goods Received Not invoiced (GRNI) position.

656. The misstatements between lines of the payables note, specifically Other Accruals and Trade Payables, stem from the processes used to register invoices due for payment in the Core Department whilst the department operated heightened purchase to pay controls throughout the COVID-19 pandemic. Under these processes, invoices are not registered as a payable until internal controls in relation to the checking of the validity of the invoice against contract and delivery of goods and services are complete.

657. In 2020-21 the volume of invoices being processed within the Core Department increased substantially, as did the level of scrutiny applied in verification of invoices for payment. This was due to the exceptional nature of much of the Department's COVID-19 expenditure and was considered an essential control over fraud and error. This resulted in an increase in the level of Other Accruals which technically should have been recorded as Trade Payables as the invoice had been received prior to 31 March 2021. In addition, due to the increased value of accruals there was in increased, but immaterial, value of accruals misstatement impacting the outturn of the Core Department.

658. The Department has put additional processes in place as part of its accounts preparation process to identify and separately record similar items as trade payables in future years without reducing levels of control. Additionally, controls around the validation of the value of accruals will be strengthened.

659. Within the Other Accruals balance of £17.2bn there is also an immaterial assurance gap relating to items where we have not been able to provide the NAO with the assurance they require in the time available. These items are primarily new balances within the Core Department which have arisen as a result of the Department's response to COVID-19.

660. Due to the exceptional nature of these COVID-19 related balances at 31 March 2021, the department does not expect these gaps in assurance to persist in future years.

661. The Department's Accounting Officer is therefore satisfied, on the basis of the available evidence, that the value of Other Accruals of £17.2bn in the Departmental Group account would not materially mislead the user of the DHSC Group account, however the assurance gaps that have led to the C&AG limiting the scope of his audit opinion in this regard are acknowledged.

### C&AG opinion on limitation of scope over the regularity of expenditure in respect of the risk of fraud losses

662. The Comptroller and Auditor General has limited the scope of his audit opinion over the regularity of expenditure in respect of the risk of fraud losses. In combination with the Group wide fraud estimate communicated in the Strategic Intelligence Assessment (which the Department considers below the materiality threshold), this is principally a direct consequence of the Department being unable to access, at any given point in time, personal protective equipment (PPE) inventory that is stored in sealed containers, this also being the cause of the related limitation of scope in respect of inventory existence.

663. In addition, due to the pace at which PPE inventory purchasing was stood up, the Department does not have a single integrated inventory management system that provides automated linkage between its purchasing records and the inventory present in the storage network on an order by order basis.

664. The combination of these factors, in particular we could not enable our auditors to be able to view and therefore verify the existence of a significant proportion of the Department's PPE inventory, creates an assurance gap, and whilst management consider, on the basis of the information available, that the Department has not been subject to significant fraud, it is the C&AG's view that having physical access to inventory is a key part of the audit assurances around fraud risk.

665. The limitation of scope over the regularity of expenditure qualification results from gaps in assurance management could provide. We do not believe that there is actual material irregularity arising from fraud.

666. In relation to PPE purchasing, fraud could arise if product either did not arrive in line with the contractual agreement or was subject to quality issues that were indicative of fraud. The Department was well aware of the heightened risk of purchasing PPE from new suppliers and implemented heightened controls in response. These included additional pre-payment banking checks and heightened purchase to pay controls to ensure suppliers were only paid when product arrived in line with contractual requirements, with most payments being dependent upon confirmed proof of receipt.

667. As more than a year has passed since the majority of the PPE arrived, the Department has also had the opportunity to conduct extensive checks to ensure it has not been the victim of fraud. These include reconciling overall purchasing records to inventory in the storage network to a high degree of accuracy, demonstrating that virtually all the inventory the Department ordered has arrived, and contract management activity and/or legal action is ongoing where this is not the case.

668. The Department has also quality checked a sample of all the PPE inventory received covering each distinct product. This includes those items stored in sealed containers, and whilst quality issues have been identified, as reported in **Note 8** Impairments, these have been assessed and with minimal exception, are not considered indicative of fraud.

669. Additionally it should also be noted that the vast majority of the inventory held in sealed containers has been physically observed at some point, mainly during the process of transferring the content of shipping containers into owned and rental containers, this process did not raise any fraud concerns. Robust physical security controls were also in operation throughout the transportation and storage processes to safeguard against theft.

670. In the Department's view, these factors give assurance that the possibility of significant levels of fraud existing in respect of PPE inventory purchasing is remote.

671. The Department's other COVID purchasing, for example that associated with NHS Test and Trace, is considered significantly lower risk (more akin to the fraud risk associated with standard procurement) as products were either: generally purchased in areas with which the Department was familiar, from suppliers with considerable experience of supplying the goods and services purchased or from less complex supply chain arrangements.

672. Additionally there was not a significant volume of NHS Test and Trace inventory held in shipping containers in the period.

673. We recognise the assurance gap that has led to the limitation of scope of the audit.

### Limitation of scope qualification regarding stocktakes

674. As detailed above and throughout this report in regards to the Department's COVID-19 response, we have been focussing on making sure that the PPE flows to those who need it, when they need it.

675. Given the context, we haven't been able, in the time available, to physically stock count every item. Example of stock unable to be physically counted includes stock in transit and stock held in sealed containers. This has led to the C&AG qualifying his opinion in relation to inventory held by the Department.

### COVID-19 Indemnities

676. During the early months of the Department's significant response to the COVID-19 pandemic, it was essential that certain arrangements relating to the NHS Test and Trace programme were put in place at rapid speed. As part of this response, to secure urgent, vital and often novel services during a period when the country was in lockdown, it was necessary to include a relatively broad range of indemnities in some of the contracts awarded.

677. Given the unprecedented urgency required, the Department, in some instances, did not comply with all necessary processes whereby, prior to signing contracts that contain such indemnities, it would seek HM Treasury and Chief Secretary of Treasury approval. There is one indemnity that was entered into by the Department in 2019-20 where such approval had not been obtained.

678. The Department took the action necessary at the time and in a number of instances where contracts included a broad range of indemnities, it has sought to renegotiate these contracts prospectively.

### COVID-19 PPE impairments and losses

679. During the height of the pandemic response the Department purchased large volumes of COVID related inventory at pace and with a heightened risk appetite; most notably personal protective equipment (PPE), test and trace consumables

and ventilators and other capital equipment. At a time of global shortage, the cost of such inventory was inflated, with some products many times their price before the pandemic.

680. In preparing the Department's Annual Report and Accounts the Department is required to value its inventory at the lower of cost and net realisable value (NRV). The assessment of NRV for the Department's COVID-19 inventory is complex because most inventory is either used by the NHS or donated to entities outside the departmental group rather than sold, and because the volume of some inventories held on 31 March 2021 suggest that, based on current usage, not all will be used before their expiry dates.

681. In addition, some inventory received has failed quality testing and/or technical assurance and is either categorised as not fit for any use or not fit for use within the PPE programme. The latter may be suitable for use in other settings but is not suitable for its original intended purpose. As such, from an accounting perspective, this inventory is deemed as being held for sale, donation, or disposal rather than use and must be valued accordingly.

682. Further details regarding the various instances for which losses, have been recognised in the 2020-21 accounts, can be found in the **Losses Statement** in the **Parliamentary and Accountability Report.** Further detail regarding the various instances in which impairments have been recognised can be found in **Notes 8** and **12** of the **Department's Notes to the Annual Report and Accounts**.

### High Court ruling into the awarding of PPE contracts

683. At the start of the COVID-19 pandemic in March 2020, as discussed elsewhere in this report, DHSC introduced a new approach to the procurement of PPE to ensure that adequate supplies were made available to the NHS and other care providers amidst a global shortage. The new approach involved the procurement of over 32 billion items of PPE, with a total value of c£14 billion, purchased through more than one thousand directly negotiated and awarded contracts using Regulation 32(2)(c) of the Public Contract Regulations 2015 (PCR).

684. In January 2022 the High Court published its judgement on a Judicial Review into the awarding of PPE contracts to three suppliers. The claimants, the Good Law Project Limited and Everydoctor, challenged DHSC's decision to award contracts to Crisp Websites Limited (trading as Pestfix), Clandeboye Agencies Limited and Ayanda Capital Limited pursuant to Regulation 32(2)(c) of the PCR. There were five grounds brought by the claimants. The court rejected two of these grounds and of the three tested in court found in favour of DHSC on two. On the remaining ground, the court found that the 'open source' approach to contracting met fairness and transparency rules, but that the operation of the High Priority Lane (HPL) did not. However, the court declined to grant the claimants declaratory relief, and acknowledged it was highly unlikely that the outcome would have been substantially different if a different assessment process had been followed. The

court also found that DHSC did not rely on the referral to the HPL when awarding contracts and concluded that sufficient financial due diligence and technical verification was carried out on contracts processed through this channel.

### Off-payroll engagements

685. In regards to the NHS Digital's senior off-payroll engagements, retrospective approval was sought from HM Treasury for the retention of a member of the core Executive Management Team (EMT) on an off-payroll basis beyond the usual 6 months limit. The individual played a pivotal role in leading the delivery of new critical services in response to the pandemic, and their appointment was extended beyond the usual 6 months to ensure delivery continuity and stability at a senior level. Since the end of the financial year the individual has been replaced in this post by an on-payroll employee of NHS Digital.

686. HM Treasury granted retrospective approval for this individual, and additionally for two other senior officials similarly engaged on an off-payroll basis that were in post at the year end and went beyond the usual 6-month limit during the following financial year, with the proviso that there is a lessons-learned exercise, and that the post holders are on-payroll by February 2022. Additionally, funding provided to NHS Digital is to be reduced by £645,000 for 2021-22 as a penalty for not seeking approval from HM Treasury in advance.

### Improving controls on exit payments

687. Special Severance Payments when staff leave public service employment should be exceptional. They require Treasury approval because they are often novel, contentious and potentially repercussive. Three CCGs approved and paid special severance payments without following the required authorisation process directed by NHS England. CCGs should ensure they have incorporated the requirements of the guidance in their Prime Financial policies and the purpose of the guidance is to ensure that integrity, accuracy, probity, and value for money in the use of resources is maintained in relation to special severance payments. NHS England will consider a proactive control measure to seek adequate assurance from all CCGs of their compliance with the need for CCGs to follow the prescribed process. This will be supported by communication through the year end guidance documents and the year-end finance conferences held.

### Valuation of Core Department Equity Investments

688. The Core Department equity investments are independently revalued every three years, with the latest valuation being at 31 March 2021. Whilst the Department appoints valuation experts to assist in this area it remains the Department's responsibility to ensure the valuation approach adopted is not only reasonable, but the best available estimate at a point in time in the context of the organisation.

689. In 2020-21 the Department has undertaken a more detailed assessment of the markets which could be relevant to the valuation approach adopted. As a result,

the valuation basis for Community Health Partnerships Ltd, NHS Property Services Ltd and Supply Chain Coordination Ltd has been changed to a net asset basis of valuation which the Department considers provides a better estimate of fair value.

690. As part of this reassessment the Department has concluded that this approach should have been adopted previously. Therefore, the prior period financial statements have been restated for the Core Department only. There is no impact on the Group financial statements as all of the affected investments are eliminated on consolidation. Additionally, there is no impact on budgetary outturn for the Departmental Group. Full details of the restatement are provided within Note 11 of the Financial Statements.

### Completeness of related party disclosures

691. As per IAS 24 Related Party Disclosures, as interpreted by the Government Financial Reporting Manual (FReM), the Department should disclose the main entities within government with which the Department has had dealings (no information needs to be given about these transactions), and details of material transactions between the entity and individuals who are regarded as related parties.

692. During the audit of the Department's accounts it became apparent the Department's process for collating and assessing potential related parties and related party transactions under IAS 24 did not provide the necessary completeness assurance over the interests of a number of individuals.

693. The Department has since strengthened its processes, including obtaining direct written confirmation of related parties from Ministers, Non-Executive Directors and Senior Staff and undertaking completeness searches on the results of those confirmations.

694. Whilst the results of these additional processes did not identify additional Core Department related party transactions requiring disclosure under IAS24, it did result in the identification of a number of additional interests for consideration, and for reasons of transparency the department has added some additional disclosure over and above the requirements of IAS 24.

695. We are now satisfied as to the completeness of Note 18 Related Party Transactions to the financial statements and will ensure the enhanced processes for collating and assessing potential related parties are embedded into business as usual process going forwards.

## Data Issues – Data and Cyber Security Programme Data Issues – Data and Cyber Security Programme

696. The work of the cyber security programme has been designed to prevent a similar attack to the 2017 WannaCry incident but has taken on increased significance with the swift digital transformation required to respond to the pandemic.

697. During the COVID-19 response period we have put in place additional cyber security protection for the NHS, including additional incident response capacity, a rapid remediation programme and enhancements to the NHS Digital (NHSD) Cyber security Operations Centre to increase protective monitoring.

698. NHSX and its delivery partners continue to lead a system wide programme to improve cyber resilience across the health and care system. Further progress this year has included supporting NHS organisations to migrate to the Windows 10™ Operating System, which is more secure as well as faster and more efficient to use.

699. Microsoft™ Defender Advanced Threat Protection (ATP) is now deployed and provides central and local visibility of operating systems and applications on most Windows devices in the NHS, with game changing ability to detect and prevent cyber threats.

700. NHSD continues to develop its Cyber Security Operations Centre (CSOC) to provide centralised support, specialist training, advice and threat intelligence to the system to help fill some of the capacity and capability gaps at organisational level and achieve value for money for the system. In addition to this, a separate instance of the CSOC was set up in May 2020 to provide a security monitoring capability to the newly formed NHS Test and Trace capability, this is known as the Cyber Defensive Operations Centre (CDOC).

701. NHSX and NHS Digital have worked with the NCSC to incorporate the requirements of recognised external cyber security standards including Cyber Essentials into the Data Security and Protection Toolkit (DSPT) to form a single data and cyber security standard for the NHS.

702. The DSPT helps organisations understand their data and cyber security risks and measures their compliance with mandatory cyber standards for their type of NHS or social care organisation. NHSX has also used regulatory levers through the Network Information Systems (NIS) Regulations to increase compliance in the NHS with mandated standards such as responses to High Severity Cyber Security Alerts.

703. In total, since WannaCry, over £250 million has been invested nationally to improve cyber security of the health and care system. This excludes monies local organisations have invested themselves and wider national IT investment which supports better security such as the Microsoft Windows 10™ licensing agreement.

704. NHSX has also worked with the Care Providers Alliance and the Local Government Association to invest over £3 million to pilot then deploy support for adult social care providers in every local authority in England, to help those providers adopt and meet the cyber standard set out in the Data Security and Protection Toolkit.

705. This set the foundations for support through 2020-21 that will leverage the regional and local structures established through 2019-20, helping the adult social care sector develop cyber security measures proportionate to the digital growth it experienced through the pandemic.

706. In response to the COVID-19 pandemic, NHSX put in place additional measures through the COVID-19 Cyber Action Plan. The COVID-19 Cyber Action Plan was agreed in Spring 2020, and aimed to provide rapid, additional cyber resilience in the NHS and help protect essential services during the COVID-19 pandemic.

707. In 2020-21, the Cyber Security Capital funding was approved at £11.6 million. NHSX targeted 50% of the total capital fund available (up to £5.8 million) to address remediation of cyber security vulnerabilities identified through penetration tests, back-up reviews and other assessments of cyber risk.

708. NHSX worked closely with NHS Digital to identify the NHS organisations at most risk during the early phase of the pandemic, and to accept and triage Capital funding bids from these organisations in order to resolve any critical vulnerabilities.

709. Following the initial phase associated with the COVID-19 Action Plan, the remaining Cyber Capital Infrastructure Fund (£5.8 million) was allocated to local organisations (Trusts and CCGs) prioritised by regional teams against available regional funding.

710. This funding is helping to build resilience by enhancing on-premises backup capabilities, enabling on-boarding to NHS Secure Boundary and replacing legacy infrastructure and adding to monitoring capabilities within the organisation(s).

### EU Exit

711. During the year, the Department worked across government and with ALB delivery partners to deliver its EU and Trade objectives:
    - Support uninterrupted care at the end of the Transition Period and maintain the quality and safety of health services in the UK;
    - ensure the UK is meeting its commitments in the Transition Period, and that new ways of influencing in Europe are maximised;
    - input to negotiations for the future relationships with the EU and other countries which protect and promote the interests of the UK and support broader health-related Manifesto commitments; and
    - ensure that NHS services and the price the NHS pays for medicines are off the table, and that public health is protected, in any trade negotiations.

712. A Trade and Cooperation Agreement (TCA) with the EU was successfully passed into law on 30 December 2020. The late outcome of negotiations meant that system changes, for example in relation to issuing of the Global Health Insurance Card, could not be optimally implemented for day one, although associated risks were minimal.

713. The majority of DHSC's default delivery plans were always going to be required for the end of the Transition Period and into 2021, regardless of the outcome of the negotiations. At the end of the Transition Period the majority of plans were in place.

714. Key risks remained at the end of the Transition Period and into 2021, including in relation to continuity of supply, reciprocal healthcare and adult social care. Planning assumptions and plans recognised that these would be compounded by concurrent risks around winter pressures and COVID-19.

715. While border disruption at the end of the Transition Period was not at the levels planned for, there are also key outstanding issues from the end of the Transition Period.

716. The highest impact of these is in relation to the potential knock-on implications of the Northern Ireland Protocol and new customs arrangements on the supply of medical products into Northern Ireland from Great Britain. The final quarter of 2020-21 saw extensive work in this area, including taking forward negotiations with the EU.

### Carillion

717. The Department and NHSE and NHSI continue to provide support to NHS organisations where the Carillion group of companies were providing services as part of a Private Finance Initiative (PFI) contract. This is within the Department's PFI Centre of Best Practice programme of support to Trusts with PFI contracts.

718. Prior to their liquidation, members of the Carillion group of companies provided services to a variety of PFI companies that were, in turn, party to PFI contracts with NHS Trusts. Two of these PFI contracts, where the construction of the hospital building was incomplete, were terminated in the 2018-19 financial year. Construction of the facilities at Sandwell and West Birmingham Hospitals NHS Trust and The Royal Liverpool and Broadgreen University Hospitals NHS Trust (now part of the Liverpool University Hospitals NHS Foundation Trust) have resumed.

### Screening Programmes

719. Following the publication on 16 October 2019 of Professor Sir Mike Richards' report on adult screening, the Department published a Written Ministerial

Statement committing to review the recommendations with NHS England, NHS Improvement and Public Health England and publish an implementation plan.

720. The Government is considering the findings of the review alongside the commitments made in the Government responses to the Independent Breast Screening Review, published 14 March 2019, and the Public Accounts Committee report on Health Screening, published on 22 July 2019.

721. COVID-19 has delayed this work and the aim is to publish an overview of progress on actions, reflecting our public health reforms including the dissolution of PHE, movement of functions directly supporting NHS screening services commissioning and delivery to NHSE and NHSI, and the creation of the Office for Health Improvement and Disparities to bring the screening expert advice and policy functions together in one place in 2021.

722. A key recommendation of the Independent Breast Screening Review was for women identified as having missed a screening invitation and who have developed breast cancer, to be assessed to determine whether they have been caused harm by the breast screening incident.

723. NHS England and Public Health England developed a clinical review process which was issued to relevant Trusts in November 2019 to carry out an initial set of 240 reviews in phase one, and in February 2020 to carry out a further 436 reviews in phase two. All follow-up examinations have now been offered and complete.

### Grenfell

724. NHSE and NHSI have continued to support the implementation of remedial measures to improve the safety of properties where appropriate.

725. The full cost of implementing these remedial works has been challenging to calculate as: some are the responsibility of non-NHS landlords and/or contractors; some are the responsibility of the NHS, and some buildings were scheduled for repair and other works.

726. Out of eight Trusts identified as needing remedial work, only one Trust has remediation work ongoing at 31 March 2021 with remediation work in all the other Trusts completed, as shown in **Table 14**.

727. Only one Trust received remediation funding in 2020-21, with Gateshead Health NHS Foundation Trust receiving £360,000.

### Table 14: Grenfell Remedial Work

| Organisation Name | Status |
|---|---|
| Bradford Teaching Hospital NHS Foundation Trust | Remediation Completed |
| Gateshead Health NHS Foundation Trust | Remediation Completed |
| The Royal Wolverhampton NHS Trust | Remediation Completed |
| The Newcastle Upon Tyne Hospitals NHS Foundation Trust | Remediation Completed |
| Kings College NHS Foundation Trust | Remediation Completed |
| Oxford University Hospitals NHS Foundation Trust | Remediation Completed |
| Sheffield Children's NHS Foundation Trust | Remediation Completed |
| Guy's and St Thomas NHS Foundation Trust | Remediation Ongoing |

Source: Ministry for Housing, Communities and Local Government (now called the Department for Levelling Up, Housing and Communities) and NHSE and NHSI.

### Infected Blood Inquiry

728. During 2019, the Infected Blood Inquiry received evidence from people infected and affected by contaminated blood. In February 2020, it heard from expert groups and from senior clinicians. The next set of hearings, originally due to take place in June 2020, were postponed due to COVID-19 but have now resumed. The Cabinet Office, as the sponsor department for the inquiry, continues to coordinate work between DHSC and the devolved administrations.

729. DHSC is providing full disclosure to the inquiry and has waived its usual right to legal privilege. The Secretary of State and DHSC officials gave evidence in May 2021. The Inquiry is expected to conclude in 2022.

730. The Department is committed to working with the support schemes in the Devolved Nations to improve parity of support across the UK. In March 2021, the Paymaster General announced changes across the four schemes which will bring them into broader parity.

731. In England the changes include increases to annual payments for bereaved partners, changes to lump sum bereavement payments, increases to lump sum payments for beneficiaries with Hepatitis C Stage 1 and for those with HIV.

### Independent Medicines and Medical Devices Safety Review

732. The Independent Medicines and Medical Devices Safety Review (IMMDS) looked at what happened when patients raised safety concerns in the cases of Primodos, Sodium Valproate and surgical mesh, and whether the processes pursued to date have been sufficient and satisfactory.

733. Baroness Cumberlege has made recommendations and identified actions for improvement in the report, published during the 2020-21 financial year on 8 July 2020.

734. On 9 July 2020, the Minister of State for Mental Health, Suicide Prevention and Patient Safety, Nadine Dorries MP issued an oral statement in the House of Commons. She apologised, on behalf of the health and care system, to those

women, children and families affected for the time the system took to listen and respond. The Minister committed to considering the Report's recommendations closely.

735. On 11 January 2021, Nadine Dorries MP issued a Written Ministerial Statement, which updated on work responding to the Report's recommendations. The Government responded to the report in July 2021.

### East Kent University NHS Foundation Trust Maternity and Neonatal Services

736. Following concerns raised about the quality and outcomes of East Kent Hospitals University NHS Foundation Trust maternity and neonatal care, in February 2020, NHSE and NHSI commissioned Dr Bill Kirkup to undertake the East Kent Maternity Independent Investigation.

737. The terms of reference have been agreed and were announced in Parliament by the Minister of State for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries on the 11 March 2021.

### Ockenden Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust

738. The Ockenden Review is assessing the quality of investigations relating to new-born, infant and maternal harm at Shrewsbury and Telford Hospitals NHS Trust (SaTH). The original terms of reference for the Review covered the handling of 23 cases.

739. Following the launch of the review in 2017, additional cases have been identified and the final total of cases now being considered is 1,862. The second and final report considering the remaining potential cases will be published no later than 24 March 2022.

### Maidstone & Tunbridge Wells NHS Trust: David Fuller

740. In November 2021, David Fuller pleaded guilty to the murder of two young women in 1987, and to a number of sexual offences in a hospital setting. An independent inquiry has been announced into the circumstances surrounding the offences committed in hospital settings, and their national implications. A more detailed account will be included within the 2021-22 Annual Report and Accounts.

# Remuneration and Staff Report

## Remuneration Report

741. This Remuneration Report provides details of the remuneration and pension interests of Ministers and the most senior management of the Department. This includes Ministers, Non-Executive Directors and Directors General (DGs)/Senior Officials and is compliant with EPN626 guidance.

742. 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.

743. The Constitutional Reform and Governance Act 2010 requires Civil Service appointments to be made on merit 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.

744. 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 2020-21

745. Nadine Dorries was promoted from Parliamentary Under Secretary of State for Mental Health, Suicide Prevention and Patient Safety, to Minister of State for Patient Safety, Suicide Prevention and Mental Health on 6 May 2020.

746. Nadhim Zahawi was appointed as Parliamentary Under Secretary of State (Minister for COVID Vaccine Deployment) and is not remunerated for this role.

## Remuneration of Senior Officials

747. The Directors' Report outlines the senior officials of the Department and their dates of appointment (and departure where appropriate), but their remuneration is detailed in **Table 16**.

## Salary

748. '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 the Department and this is recorded in these accounts.

749. 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. The Department does pay legitimate expenses for Ministers which are not a part of the salary or a benefit in kind.

750. 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 the Department and is therefore shown in full in **Table 15**.

### Non-Consolidated Performance Pay

751. The performance management and reward policy for members of the SCS, including board members, is managed within a central framework set by the Cabinet Office. The framework allows for non-consolidated performance-related awards to be paid to the top performers within the SCS.

752. The Senior Civil Service Performance Management and Reward principles include explanations of how non-consolidated performance awards are determined.

753. SCS non-consolidated performance pay is agreed each year following the Senior Salaries Review Body (SSRB) recommendations, and is expressed as a percentage of the Department's total base pay bill for the SCS. Non-consolidated performance related pay is awarded in arrears.

754. Remuneration frameworks such as that employed by the Government Commercial Organisation operate differently in focussing on a higher base salary, performance related pay and reduced pension benefits.

755. The non-consolidated performance pay included in the 2020-21 figures relates to awards made in respect of the 2019-20 performance year but paid in financial year 2020-21. It was agreed that awards would not be differentiated by grade (SCS Pay Band 1-3). An award of £8,750 was paid to the top performers in each SCS pay band (SCS Pay Band 1-3).

### Benefits in Kind

756. The monetary value of benefits in kind covers any payments or other benefits provided by the Department which are treated by HM Revenue & Customs as a taxable emolument. For its direct employees, the Department pays the individual a net sum and pays tax directly to Her Majesty's Revenue & Customs (HMRC). No benefits in kind were incurred during 2020-21 by Ministers or Senior Officials of the Department.

757. **Tables 15 and 16** provide details of remuneration interests of the Ministers of the Department and senior officials serving on the Departmental Board for the years 2019-20 and 2020-21 and are subject to audit.

## Table 15: Remuneration of Ministers of the Department (subject to audit)

| | 2020-2021 | | | | 2019-2020 | | | |
|---|---|---|---|---|---|---|---|---|
| Ministers | Salary (£)[1] | Gross Benefits in Kind (to nearest £100) | Pension Benefits (to nearest £1000) | Total (to nearest £1000) | Salary (£)[1] | Gross Benefits in Kind (to nearest £100)[4] | Pension Benefits (to nearest £1000)[4] | Total (to nearest £1000) |
| **Rt Hon Matt Hancock MP** *(from 10/07/2018)*<br>Secretary of State | 67,505 | NIL | 17,000 | 84,000 | 67,505 | NIL | 17,000 | 84,000 |
| **Edward Argar MP** *(from 10/09/2019)*[6]<br>Minister of State<br>Full Year Equivalent | 31,680 | NIL | 8,000 | 39,000 | 16,383<br>31,680 | NIL | 5,000 | 21,000 |
| **Helen Whately MP** *(from 14/02/2020)*<br>Minister of State<br>Full Year Equivalent | 31,680 | NIL | 8,000 | 39,000 | 3,068<br>31,680 | NIL | 1,000 | 4,000 |
| **Nadine Dorries MP** *(from 27/07/2019)*<br>Minister of State[5]<br>Full Year Equivalent | 30,780<br>31,680 | NIL | 8,000 | 38,000 | 15,217<br>22,375 | NIL | 4,000 | 19,000 |
| **Jo Churchill MP** *(from 26/07/2019)*<br>Parliamentary Under Secretary of State<br>Full Year Equivalent | 22,375 | NIL | 5,000 | 28,000 | 14,989<br>22,375 | NIL | 6,000 | 21,000 |
| **Lord Bethell of Romford** *(from 09/03/2020)*[2]<br>Parliamentary Under Secretary of State (Lords) | - | NIL | - | - | - | NIL | - | - |
| **Nadhim Zahawi MP** *(from 28/11/2020)*[3]<br>Parliamentary Under Secretary of State | - | NIL | - | - | - | NIL | - | - |
| **Jackie Doyle-Price MP** *(from 14/06/2017 to 26/07/2019)*<br>Parliamentary Under Secretary of State<br>Full Year Equivalent | | | | | 7,158<br>22,375 | NIL | 2,000 | 9,000 |
| **Caroline Dinenage MP** *(from 10/01/2018 to 13/02/2020)*<br>Minister of State<br>Full Year Equivalent | | | | | 29,040<br>31,680 | NIL | 6,000 | 35,000 |
| **Stephen Hammond MP** *(from 16/11/2018 to 25/07/2019)*<br>Minister of State<br>Full Year Equivalent | | | | | 10,049<br>31,680 | NIL | - | 10,000 |
| **Baroness Nicola Blackwood** *(from 10/01/2019 to 13/02/2020)*[4]<br>Parliamentary Under Secretary of State (Lords)<br>Full Year Equivalent | | | | | 65,879<br>74,909 | NIL | 14,000 | 80,000 |
| **Seema Kennedy MP** *(from 04/04/2019 to 26/07/2019)*<br>Parliamentary Under Secretary of State<br>Full Year Equivalent | | | | | 7,272<br>22,375 | NIL | 2,000 | 9,000 |
| **Chris Skidmore MP** *(from 25/07/2019 to 09/09/2019)*<br>Minister of State<br>Full Year Equivalent | | | | | 5,280<br>31,680 | NIL | 0 | 6,000 |

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 waiver any ministerial increases in their salary for the duration of this Parliament.
2. Lord Bethell's role as Parliamentary Under Secretary of State (Lords) is unpaid.
3. The Parliamentary Under Secretary of State (Minister for COVID Vaccine Deployment) is not paid for this role.
4. Baroness Nicola Blackwood's salary for 2019-20 includes the Lords Office-holders allowance. (This is a yearly allowance of £3,940 per annum, paid to Ministers whose primary residence is in London, the allowance is taxable and subject to NI but not pensionable) The allowance paid in 2019-20 includes amounts owed for 2018-19. For further detail see note 4 of table 9 in the 2018-19 ARA.
5. Nadine Dorries MP was appointed as a Minister of State for the Department on 06/05/2020 having been previously serving as a Parliamentary Under Secretary of State for the Department.
6. Edward Argar MP pension beneifts have been restated for 2019-20.

## Table 16: Remuneration of Senior Officials of the Department (subject to audit)

| | 2020-2021 | | | | | 2019-2020 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Officials | Salary (£'000) | Non Consolidated Performance Related Pay (£'000)[1] | Gross Benefits in Kind (to nearest £100) | Pension Benefits (to nearest £1000)[2] | Total (£'000) | Salary (£'000) | Non Consolidated Performance Related Pay (£'000)[1] | Gross Benefits in Kind (to nearest £100) | Pension Benefits (to nearest £1000)[2] | Total (£'000) |
| **Sir Christopher Wormald KCB**<br>Permanent Secretary | 175-180 | NIL | NIL | 94,000 | 270-275 | 170-175 | 15-20 | - | 87,000 | 275-280 |
| **Professor Chris Whitty**<br>Chief Medical Officer | 205-210 | NIL | NIL | 30,000 | 235-240 | 160-165 | NIL | NIL | 36,000 | 200-205 |
| **David Williams CB**<br>Second Permanent Secretary, Director General<br>Full Year Equivalent | 155-160 | 5-10 | NIL | 159,000 | 325-330 | 140-145<br>155-160 | 10-15 | NIL | 55,000 | 210-215 |
| **Clara Swinson CB**<br>Director General | 130-135 | 5-10 | NIL | 68,000 | 205-210 | 125-130 | 10-15 | NIL | 63,000 | 205-210 |
| **Jonathan Marron**[3]<br>Director General | 135-140 | NIL | NIL | 51,000 | 185-190 | 125-130 | NIL | NIL | 50,000 | 175-180 |
| **Lee McDonough**<br>Director General | 130-135 | NIL | NIL | 45,000 | 175-180 | 125-130 | NIL | NIL | 49,000 | 175-180 |
| **Michelle Dyson** *(from 17/09/2020)*[4]<br>Director General<br>Full year equivalent | 60-65<br>120 - 125 | NIL | NIL | 88,000 | 150-155 | | | | | |
| **Steve Oldfield**[5]<br>Chief Commercial Officer | 235-240 | 40-45 | NIL | 7,000 | 285-290 | 235-240 | 45-50 | NIL | 7,000 | 285-290 |
| **Matthew Gould** *(from 20/05/2019)*[3],[6]<br>Chief Executive Officer, NHSX<br>Full Year Equivalent | 25-30<br>125-130 | NIL | NIL | 10,000 | 35-40 | 100-105<br>125-130 | 10-15 | NIL | 36,000 | 150-155 |
| **Hugh Harris**[7]<br>Director<br>Full Time Equivalent | 100-105<br>105-110 | NIL | NIL | 41,000 | 140-145 | 95-100<br>105-110 | 10-15 | NIL | 55,000 | 165-170 |
| **Jenny Richardson**[8]<br>Director | 105-110 | 5-10 | NIL | 44,000 | 160-165 | 105-110 | NIL | NIL | 90,000 | 195-200 |
| **Shona Dunn** *(from 20/11/2021)*[9]<br>COVID-19 workstream SRO<br>Full Year Equivalent | NIL<br>NIL | NIL | NIL | NIL | NIL | | | | | |
| **Paul Kissack** (from 06/04/2020 to 08/08/2020)[10]<br>Director General<br>Full Year Equivalent | NIL<br>NIL | NIL | NIL | NIL | NIL | | | | | |
| **Ros Roughton** *(27/04/2020 to 01/09/2020 )*[11]<br>Director General<br>Full year equivalent | 40-45<br>120-125 | NIL | NIL | 20,000 | 60-65 | | | | | |
| **Professor Dame Sally Davies DBE** *(to 30/09/2019)*<br>Chief Medical Officer<br>Full Year Equivalent | | | | | | 105-110<br>210-215 | NIL | - | N/A | 105-110 |

1. Non Consolidated Performance Pay paid in 2020-21 relates to the 2019-20 performance year.
2. Steve Oldfield and Professor Chris Whitty hold a defined contribution pension therefore figures shown represent the Department's contribution to this scheme.
3. Salary amount disclosed includes overtme paid.
4. Michelle Dyson was appointed interim Director General for Adult Social Care on 17 September 2020.
5. Steve Oldfield was appointed on 7 October 2017 on loan from the Government Commercial Office (GCO). DHSC pay the full employment costs for GCO specialists employed in their departments including pensions, national insurance, PRP and other benefits that can be monetised.
6. The position of Chief Executive Officer of NHSX incorporates the NHS England and NHS Improvement role of National Director of Digital and the DHSC role of Director General. For 2019-20 Matthew was fully remunerated by DHSC as his primary employer, who established his terms of employment on joining the Department on 20 May 2019. For 2020-21 NHSE and NHSI reimbursed DHSC for 80% of Matthew's costs and as such DHSC show only 20% of pay and pension details with NHSE and NHSI disclosing the remaining 80%.
7. Per the detail in the Accountability Report it has been determined that all members of the Department's Board and Executive Committee should be disclosed as senior officials of the Department in accordance with the FReM. As Hugh Harris, Director of Ministers, Accountability and Strategy, was a member of ExCo during 2019-20 and 2020-21, prior year pay and pension details have also been provided.
8. Per the detail in the Accountability Report it has been determined that all members of the Department's Board and Executive Committee should be disclosed as senior officials of the Department in accordance with the FReM. As Jenny Richardson, Director of Human Resources, was a member of ExCo during 2019-20 and 2020-21, prior year pay and pension details have also been provided.
9. Per the detail in the Accountability Report it has been determined that all members of the Department's Board and Executive Committee should be disclosed as senior officials of the Department in accordance with the FReM. Shona Dunn, SRO of the Community Testing Programme became a member of ExCo in 2020 and was subsequntly appointed as Second Permanent Secretary in April 2021. Shona was fully remunerated in her role as Second Permanent Secretary at the Home Office during 2020-21 and as DHSC did not reimburse the Home Office for Shona's work as a workstream SRO during 2020-21, no pay is disclosed.
10. Per the detail in the Accountability Report it has been determined that all members of the Department's Board and Executive Committee should be disclosed as senior officials of the Department in accordance with the FReM. Paul Kissack was a Director General and member of ExCo between April and August 2020. Paul was fully remunerated in his role at the Department for the Environment, Food and Rural Affairs (DEFRA) and as DHSC did not reimburse DEFRA for Paul's work as Director General in DHSC during 2020-21, no pay is disclosed.
11. Ros Roughton was in post as DG for Adult Social Care prior to Michelle Dyson's appointment.

## Department of Health and Social Care's SCS Reward Strategy 2020-21

758. 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. Departments are given some discretion within the broader Cabinet Office pay guidance to develop their pay strategy to meet local needs and these are outlined in an annual reward strategy.

759. The Department's annual SCS Reward Strategy was agreed by the Executive Committee and stated that from 1 April 2020, 1% of the SCS paybill was available for consolidated pay awards and an additional 1% was available to address pay progression and pay anomalies. The Department continued to target the pay award towards those lower in their respective pay range, to address pay equality issues.

760. All eligible SCS members received a 1% consolidated pay award. An additional £1,400 was applied to those whose salary was below the respective DHSC pay band median. An additional award of £1,250 was applied to 'Top Performers' for 2018-19 and 2019-20 with a salary below the respective DHSC pay band median.

761. The non-consolidated performance pay included in the 2020-21 figures relates to awards made in respect of the 2019-20 performance year but paid in financial year 2020-21. It was agreed that awards would not be differentiated by grade (SCS Pay Band 1-3). An award of £8,750 was paid to the top performers in each SCS Pay Band (Band 1-3).

## Median Earnings

762. Departments are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. See **Table 17**.

### Table 17: Median Earnings for Core Department and Public Health England (Executive Agency) (subject to audit)

| Median Earnings 2020-2021 and 2019-2020 | | | | |
|---|---|---|---|---|
| | Core Department | | Department & Executive Agencies [1] | |
| | 2020-2021 | 2019-2020 | 2020-2021 | 2019-2020 |
| Band of Highest Paid Director's Total remuneration (£000)[2] | 280-285 | 280-285 | 280-285 | 280-285 |
| Band of lowest paid (£000) | 15-20 | 15-20 | 15-20 | 15-20 |
| Median Total Remuneration | £41,598 | £40,869 | £40,164 | £39,365 |
| Ratio | 6.8 | 6.9 | 7.0 | 7.2 |

1. The Medicines and Healthcare Products Regulatory Agency is not consolidated within the Department's ARA and therefore is not included in determining the median earnings calculation for either year.

2. The pay multiple uses a median based on civil service pay, i.e. it excludes staff who are paid under arrangements outside the Department's control, e.g. seconded staff.

3. Salaries for senior management are disclosed in bands of £5000, in accordance with EPN626 guidance.

763. The banded remuneration of the highest paid Core Department Director in 2020-21 was £280,000-£285,000 (2019-20 £280,000-£285,000). This was 6.8 times the median remuneration of the workforce of £41,598 (2019-20, £40,869).

764. No DHSC core employees in either 2020-21 or 2019-20 received remuneration in excess of the highest paid Director. Banded remuneration ranged from £15,000 to

£20,000 and £280,000 - £285,000 (2019-20 £15,000-£20,000 and £280,000-£285,000).

765. 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.

766. The median earnings of the Core Department has increased in 2020-21 compared to 2019-20 by £729. This is a larger increase of the median earnings than compared to 2019-20 and 2018-19 in which the increase of median earnings was marginal at £184. Whilst a pay freeze was communicated for the 2021-22 financial year, the civil service pay remit guidance published on 18 May 2020 enabled departments to make average pay awards within the range of 1.5% to 2.5%. In 2019-20 this was limited to 1%, with departments having flexibility to make average pay awards of up to 2%.

767. The banded remuneration of the highest paid director has remained the same from 2019-20 to 2020-21, due to a similarly substantial level of non consolidated performance related pay awarded in 2020-21 as was awarded in 2019-20.

768. The increased median earnings and the static level of remuneration for the highest paid director has resulted in a small decrease in the pay ratio of 0.1 compared to 2019-20. This is significantly lower than the increase in pay ratio between 2018-19 and 2019-20 which increased by 1.1, due to a significant uplift in non consolidated performance related pay between 2018-19 and 2019-20.

769. As detailed in **note 5 to Table 16**, the Department pays the full costs of the Government Commercial Organisation (GCO) specialists it employs which, in this instance, led to a significant increase in ratio in 2019-20 compared to 2018-19.

### Civil Service Pensions

770. Pension benefits are provided through the Civil Service pension arrangements. The Civil Servants and Others Pension Scheme (or Alpha) has been in place since 1 April 2015 and all newly appointed civil servants and the majority of those currently in service are members.

771. The Alpha scheme provides benefits on a career average basis with a normal pension age of 65 or the member's State Pension Age, whichever is the higher.

772. Prior to Alpha, civil servants participated in the Principal Civil Service Pension Scheme (PCSPS), which 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.

773. 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 will switch into Alpha sometime before 1 February 2022 with 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.

774. On 15 July 2019 HMT confirmed that as 'transitional protection' was offered to members of all the main public service pension schemes as part of the 2015 pension reforms, the difference in treatment will need to be remedied across all those schemes. This includes the Civil Service pension arrangements. The remedy will only apply to members who were in service on 31 March 2012 and still in post on 1 April 2015, including those with a break in service of less than five years.

775. A public consultation was conducted and published on 5 February 2021, and the Government will implement the deferred choice underpin (DCU). This will give eligible scheme members a choice at the point their pension becomes payable, whether they wish to receive benefits from the final salary arrangements or benefits equivalent to those that would have been available from alpha in relation to their service between 1 April 2015 and 31 March 2022.

776. The final salary arrangements are set to close on 31 March 2022 following the passing of the Public Service Pensions and Judicial Offices Bill, and from 1 April 2022, all those who remain in service will do so as members of alpha. Benefits built up in the final salary arrangements will be protected.

777. 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 'money purchase' stakeholder pension with an employer contribution (partnership pension account).

778. Employee contributions are salary-related and range between 4.6% and 8.05% of pensionable earnings for members of premium, classic, 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.

779. 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.

780. 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 his 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.

781. 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.

782. The partnership pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 8.0% and 14.75% (depending on the age of the member) into a stakeholder pension product chosen by the employee from a panel of providers. 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).

783. Pension age is 60 for members of classic, premium and classic plus, 65 for members of Nuvos, and either 65 or State Pension Age, whichever is the higher, for members of Alpha. Full details of the Civil Service pension arrangements can be found on the Civil Service Pension website.

### Ministerial Pensions

784. 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.

785. 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 aged 55 or older on 1st April 2013 have transitional protection to remain in the previous final salary pension scheme.

786. 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.

787. **Tables 18** and **19** provide the details of the pension interests for the Department's Officials and Ministers for 2019-20 and 2020-21 and are subject to audit.

### Cash Equivalent Transfer Values

788. 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.

789. A CETV is a payment made by pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown, relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

790. The figures include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the Civil Service pension arrangements. They also include any additional pension benefit accrued to the member as a result of their purchasing additional pension benefits at their own cost.

791. CETVs are worked out 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.

792. Similarly, for Ministers, the pension figures shown related to the benefits that the individual has accrued as a consequence of their total Ministerial service, not just their current appointment as a Minister.

### Real Increase in CETV

793. 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 (i.e. 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.

794. 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 18: Pension Interests of Ministers (subject to audit)

| | Accrued pension at age 65 as at 31/03/21 £'000 | Real increase in pension at age 65 £'000 | CETV at 31/03/21 £'000 | CETV at 31/03/20 £'000 | Real increase in CETV £'000 |
|---|---|---|---|---|---|
| Matt Hancock | 5-10 | 0-2.5 | 58 | 44 | 5 |
| Edward Argar[4] | 0-5 | 0-2.5 | 15 | 9 | 2 |
| Helen Whately | 0-5 | 0-2.5 | 9 | 3 | 3 |
| Nadine Dorries | 0-5 | 0-2.5 | 60 | 49 | 6 |
| Jo Churchill | 0-5 | 0-2.5 | 18 | 11 | 3 |
| Lord Bethell[2] | - | - | - | - | - |
| Nadhim Zahawi[3] | - | - | - | - | - |

1.The figures given are based solely on the individual benefits as a Minister and will not reflect any pension in respect of their MP salary.

2. Lord Bethell's role as Parliamentary Under Secretary of State (Lords) is unpaid.

3. Nadhim Zahawi's role as Parliamentary Under Secretary of State (Minister for COVID Vaccine Deployment) is unpaid.

4. Edward Argar's CETV at 31/03/20 has been restated compared to the 2019-20 disclosure of CETV as at 31/03/20.

## Table 19: Pension Information of Senior Officials of the Department (subject to audit)

| | | Accrued pension at pension age as at 31/03/21 and related lump sum £'000 | Real increase in pension and related lump sum at pension age £ '000 | CETV at 31/03/21 £ '000 | CETV at 31/03/20 £ '000 | Real increase in CETV £'000 | Employer contribution to partnership pension account Nearest £100 |
|---|---|---|---|---|---|---|---|
| Sir Christopher Wormald KCB | Permanent Secretary | 85-90 | 5-7.5 | 1,446 | 1,330 | 60 | - |
| Professor Chris Whitty[1] | Chief Medical Officer | - | - | - | - | - | 30,300 |
| David Williams CB[2] | Second Permanent Secretary, Director General for Finance & Group Operations | 65-70 plus a lump sum of 140-145 | 7.5-10 plus a lump sum of 12.5-15 | 1,242 | 1,075 | 121 | - |
| Clara Swinson CB | Director General for Global Health Group | 40-45 plus a lump sum of 80-85 | 2.5-5 plus a lump sum of 0-2.5 | 653 | 589 | 35 | - |
| Jonathan Marron | Director General for Public Health Group | 20-25 | 2.5-5 | 277 | 233 | 26 | - |
| Lee McDonough | Director General for NHS Policy and Performance Group | 50-55 plus a lump sum of 150-155 | 0-2.5 plus a lump sum of 5-7.5 | 1,176 | 1,088 | 46 | - |
| Michelle Dyson[3] | Director General for Adult Social Care | 30-35 plus a lump sum of 60-65 | 2.5-5 plus a lump sum of 7.5-10 | 559 | 489 | 65 | - |
| Steve Oldfield[1] | Chief Commercial Officer Commercial Group | - | - | - | - | - | 7,100 |
| Matthew Gould[2,8] | Chief Executive Officer, NHSX | 10-15 | 0-2.5 | 183 | 171 | 5 | - |
| Hugh Harris[4] | Director of Ministers, Accountability and Strategy | 35-40 | 0-2.5 | 471 | 432 | 19 | - |
| Jenny Richardson[4] | Director of Human Resources | 35-40 | 2.5-5 | 474 | 435 | 19 | - |
| Shona Dunn[5] | SRO, Community Testing Programme | - | - | - | - | - | - |
| Paul Kissack[6] | Director General | - | - | - | - | - | - |
| Ros Roughton[7] | Director General for Adult Social Care | 0-5 | 0-2.5 | 55 | 39 | 11 | - |

1. Steve Oldfield and Professor Chris Whitty hold a defined contribution pension therefore figures shown represent the Department's contribution to this scheme.
2. CETV balances as at 31/03/20 have been restated. The CETV as at 31/03/20 in the 2019-20 ARA for David Williams was 1,074 and 858 for Matthew Gould.
3. Michelle Dyson was appointed interim Director General for Adult Social Care on 17 September 2020.
4. Jenny Richardson and Hugh Harris were members of ExCo during 2019-20 and 2020-21.
5. Shona Dunn became a member of ExCo during 2020-21 and was appointed as Second Permanent Secretary during April 2021. Shona was fully remunerated in her role as Second Permanent Secretary at the Home Office during 2020-21 and as DHSC did not reimburse the Home Office for Shona's work as a workstream SRO during 2020-21, no pension benefits are disclosed.
6. Paul Kissack was a Director General and member of ExCo between April and August 2020. Paul was fully remunerated in his role at the Department for the Environment, Food and Rural Affairs (DEFRA) and as DHSC did not reimburse DEFRA for Paul's work as Director General in DHSC during 2020-21, no pension benefits are disclosed.
7. Ros Roughton was in post as DG for Adult Social Care prior to Michelle Dyson's appointment.
8. The position of Chief Executive Officer of NHSX incorporates the NHS England and NHS Improvement role of National Director of Digital and the DHSC role of Director General. For 2019-20 Matthew was fully remunerated by DHSC as his primary employer, who established his terms of employment on joining the Department on 20 May 2019. For 2020-21 NHSE and NHSI reimbursed DHSC for 80% of Matthew's costs and as such DHSC show only 20% of pay and pension details with NHSE and NHSI disclosing the remaining 80%.

### Non-Executive Directors

795. Non-Executive Directors are not employees of the Department. 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.

796. Non-Executive Directors also make a significant contribution to Departmental business by working through Committees and with senior officials.

797. The Departmental Board holds positions for six Non-Executive Directors. The Non-Executive Directors sitting on the Departmental Board during 2020-21 are detailed in the Directors' Report. There are also three Independent members of Audit & Risk Committee.

798. One of the Non-Executive Directors chairs the Department's Audit and Risk Committee (4-5 meetings per year). The lead Non-Executive Director chairs the Department's Nominations and Governance Committee, which has an additional Non-Executive Director.

### Table 20: Non-Executive Directors and Members of the Department (subject to audit)

| | | | 2020-2021 | | 2019-2020 | |
|---|---|---|---|---|---|---|
| Non-Executive | Position | Term | Fee Received to nearest £1,000 | Annual Fee Entitlement to nearest £1,000 | Fee Received to nearest £1,000 | Annual Fee Entitlement to nearest £1,000 |
| Gerry Murphy | Non-Executive Board Member & Chair Audit & Risk Committee | 1 Aug 2017 - 31 July 2023 | 20,000 | 20,000 | 20,000 | 20,000 |
| Kate Lampard | Non-Executive Board Member & Lead Non-Executive | 1 Oct 2017 - 30 Sep 2023 | 20,000 | 20,000 | 20,000 | 20,000 |
| Michael Mire | Non-Executive Board Member & Member of Audit & Risk Committee | 1 Nov 2017 - 31 Oct 2020 | 9,000 | 15,000 | 15,000 | 15,000 |
| Prof Sir Mike Richards | Non-Executive Board Member | 1 Nov 2017 - 31 Oct 2020 | 9,000 | 15,000 | 15,000 | 15,000 |
| Prof Dame Sue Bailey | Non-Executive Board Member | 1 Nov 2017 - 31 Oct 2020 | 9,000 | 15,000 | 15,000 | 15,000 |
| Gina Coladangelo | Non-Executive Board Member | 1 Sep 2020 - 31 Aug 2023 | 9,000 | 15,000 | | |
| Doug Gurr | Non-Executive Board Member | 1 Dec 2020 - 30 Nov 2023 | 5,000 | 15,000 | | |
| Anne Barnard | Independent Member of Audit & Risk Committee | 1 Jan 2020 - 31 Dec 2022 | 5,000 | 5,000 | 1,000 | 5,000 |
| Graham Clarke | Independent Member of Audit & Risk Committee | 1 Jan 2020 - 31 Dec 2022 | 5,000 | 5,000 | 1,000 | 5,000 |
| Richard Hornby | Independent Member of Audit & Risk Committee | 1 Jan 2020 - 31 Dec 2022 | | Non-remunerated Civil Servant | | Non-remunerated Civil Servant |
| Sir Ron Kerr* | Non-Executive Board Member | 1 Nov 2017 - 31 Oct 2020 | | | 11,000 | 15,000 |
| Cat Little | Independent Member of Audit & Risk Committee | 1 Nov 2016 - 31 Oct 2019 | | | | Non-remunerated Civil Servant |

*Sir Ron Kerr resigned from Non Executive Director role on 31 December 2019

### Compensation for Loss of Office (subject to audit)

799. 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. No such payments were made during 2020-21.

## Staff Report

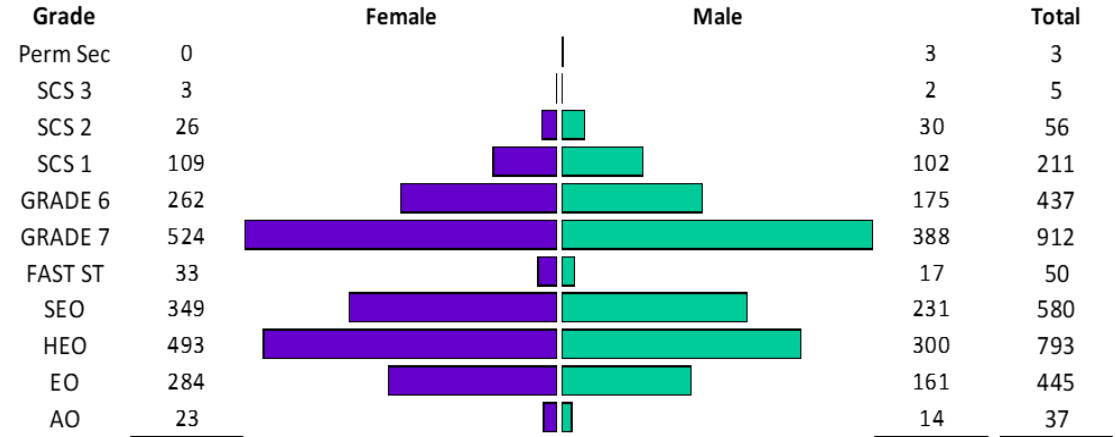
800. This Staff Report summarises the Core Department's key staffing information and policies, with the staff costs, numbers and exit packages disclosures subject to audit.

801. The Core Department employed an average of 2,015 permanent whole time equivalent (WTE) persons during 2020-21 at a total salaries and wages cost of £118.9 million, compared to 1,588 at a cost of £73.8 million in 2019-20. 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 26** and **27**.

### DHSC Staff

802. The Department's staff grading structure is reflective of seniority within the organisation and covers a range of roles; Administrative (AO); Managerial (EO, Fast stream, HEO, SEO); Senior Management (Grade 6 & 7); Senior Civil Service (SCS1 (Deputy Director), SCS2 (Director), SCS3 (Director General)). **Figure 6** outlines the headcount and gender distribution of Core Departmental staff in post as at 31 March 2021 and is consistent with Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment with the Department.

### Figure 6: Gender distribution of Core Department staff (headcount)



| Grade | Female | Male | Total |
|---|---|---|---|
| Perm Sec | 0 | 3 | 3 |
| SCS 3 | 3 | 2 | 5 |
| SCS 2 | 26 | 30 | 56 |
| SCS 1 | 109 | 102 | 211 |
| GRADE 6 | 262 | 175 | 437 |
| GRADE 7 | 524 | 388 | 912 |
| FAST ST | 33 | 17 | 50 |
| SEO | 349 | 231 | 580 |
| HEO | 493 | 300 | 793 |
| EO | 284 | 161 | 445 |
| AO | 23 | 14 | 37 |
| | **2,106** | **1,423** | **3,529** |

### Staff Sickness

803. The Core Department has seen a reduction in the number of days lost to short-term sickness, falling from 1,368 in the rolling calendar year up to 31 December 2019 to 1,043 up to 31 December 2020. There has however, been a rise in days lost to long-term sickness reported over the same period, from 2,782 to 3,377. Over the same rolling calendar year up to 31 December 2020, the average number of working days lost stands at 2.2, down from 3.0 as at December 2019. Some 92 per cent of

**92%** of staff with no recorded sickness in the year ending 31 December 2020

our staff have no recorded sickness in the calendar year up to 31 December 2020, up from 84 percent at the same point the previous year.

## Staff Turnover

804. The Core Department has experienced an 8% turnover of staff during the 2020-21 financial year. This is a decrease on the 2019-20 year for which staff turnover in the Core Department was 9%.

## Staff Redeployment

805. During 2020-21 the Department benefited from a significant number of civil servants loaned from other government departments.

806. These redeployments primarily related to the Departments response to the COVID-19 pandemic. The number and grade of staff re-deployed is shown in **Table 21** below.

### Table 21: Staff redeployment by grade

| Entity | Cost incurred by the Department<br>Number | Cost not incurred by the Department<br>Number | Total<br>Number |
|---|---|---|---|
| AO & EO | 59 | 71 | 130 |
| HEO & SEO | 329 | 244 | 573 |
| G7 & G6 | 377 | 311 | 688 |
| SCS | 112 | 86 | 198 |
| **Total** | **877** | **712** | **1,589** |

807. For those individuals above where the cost was not incurred by the Department, the estimated cost at average cost for the relevant grade is £43 million.

808. Of the above 712 individuals for which the cost was not incurred by the Department, 379 individuals were loaned for 6 months or less and 333 were loaned for more than 6 months.

## Health and Safety

809. The Department of Health and Social Care 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 2020-21, there was one reported accident (which did not result in absence) and one near miss.

## Staff Diversity

810. Information showing how the Department complies with the public sector equality duty as set out in The Equality Act 2010 (Specific Duties and Public

Authorities) Regulations 2017, can be found in Section 2 of the report Equality in 2020: how DHSC met the public sector equality duty. The Report covers the period up to 30 September 2020, the most recent available data. The data presented shows information relating to DHSC's employees by protected characteristic. Information is presented on age, disability, ethnicity, gender, religion or belief and sexual orientation. We have also provided information on working pattern and caring responsibilities of our employees, as we extend protection from discrimination and disadvantage to these groups, amongst others.

## Equal Opportunities Policy

811. The Department is committed to treating all staff fairly and responsibly. The aim of the Department's equal opportunities policies are to promote equality of opportunity whereby no employee or job applicant is discriminated against on the grounds of their race, colour, ethnic or national origin, sex, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy or maternity status, marital or civil partnership status, responsibility for children or other dependents, work pattern.

812. The Department's Strategic Commitments to equal opportunities and diversity incorporate an extensive range of activities and include: goals to strengthen diversity in the more senior grades, focusing on increasing representation of ethnic minority and disabled staff in senior positions; supporting the development, career progression and retention of staff; improving workplace culture by increasing Diversity and Inclusion (D&I) capability; continuing equalities analysis of HR policies and initiatives; developing a comprehensive suite of equality policies; supporting work-life balance, flexible working and mental health initiatives; continuing and improving workforce monitoring by diversity characteristics; and taking targeted action as required. They are set out in the Department's Equality Objectives Action Plan and Equality Objectives: 2019-23.

813. At an operational level, the Department's Equal Opportunities Policy underpins the development and implementation of all policies, guidance and activities. We recognise that our people are at the heart of what we do and proactively creating a culture of inclusion is integral to the Department's values. To support this, we refreshed our DHSC Diversity and Inclusion strategy in the Spring of 2021. This sets out how we will achieve our vision to be a diverse and inclusive place to work, bringing diversity of thought to our policy making and addressing shared challenges faced by under-represented groups. The three themes of our strategy currently are:
    - Engage – drive culture change and ensure that diversity and inclusion are embedded throughout all our work.
    - Develop – ensure all staff have the opportunity to thrive, no matter their background.
    - Attract – lead from the front and establish and support a workforce that reflects the society we serve.

814. Our active staff networks and visible senior Champions have raised the profile of diversity and inclusion in the Department, with an aim of increasing knowledge and awareness and contributing to creating an inclusive environment in which individuals can thrive. The Department hosted a variety of internal events throughout the year, for example on 'National Day for Staff Networks 2020', 'National Inclusion Week 2020' and our first departmental 'Diversity and Wellbeing Day' which was held in January 2021 and attracted over 1,000 DHSC attendees.

815. In the Autumn of 2019, DHSC was the first department in the Civil Service to be awarded the Youth Friendly Employer Mark by Youth Employment UK (YEUK). The DHSC works with Youth Employment UK to encourage more successful Health Policy Fast Track Scheme and DHSC 'entry level' role applications from BAME, disabled and less socially mobile groups. YEUK have been providing the Department with help and assistance in reaching out to our target audience. Their research has assisted us with marketing specifically for BAME individuals and those with mental health issues. We are now looking to advertise all our Executive Officer (EO) grade roles on the YEUK website, as well as some Higher Executive Officer (HEO) roles.

816. The Department uses a range of measures to track progress – including trends in staff surveys (our People Survey) data. Our Engagement Index Score for 2020 has increased, with a 3 percentage point increase from 2019 for the Inclusion and Fair Treatment theme (85 per cent in 2020 against 82 per cent in 2019).

817. In line with its commitment to be a fully diverse and inclusive employer, DHSC has launched a small number of new projects to help achieve this. In September 2020, DHSC launched its Race Equality Action Plan, based on extensive staff engagement following the publication of Public Health England's COVID-19 review of disparities in risks and outcomes and the impact on Black and ethnic minority communities. This plan focuses on three key strategic objectives:
    - Increase representation of ethnic minority staff in senior positions in DHSC, including race diversity in decision making.
    - Work with senior leaders to create an environment where there is no place for racism, where everyone feels safe to challenge and raise concerns.
    - Support the development, career progression and retention of staff from ethnic minorities, with a first focus on junior grades.

818. We are also in the process of creating a Disability Action Plan to support colleagues with disabilities and long-term health conditions.

819. Examples of the targeted work the Department has undertaken to support both the Race and Disability Action Plans, as well as drive wider D&I work forward, include: the launch of a reverse mentoring scheme; refresh of our induction package for new staff; and recruitment workshops aimed at underrepresented

groups. Upcoming initiatives include the launch of a pilot sponsorship scheme and renewing our learning and development offer for all staff.

### Recruitment and Retention of Disabled Persons

820. The Department has a number of policies and activities in place to aid the recruitment and retention of disabled staff. These include: involving the disabled staff network, and other staff networks, in the assessment (by equality) of workforce policies and guidance; a comprehensive suite of flexible working policies; development of specific guidance for managers and staff, (covering such issues as; 'making reasonable adjustments', 'mental health', 'support for carers', 'anti-bullying, harassment and discrimination' and the 'Disability Confident Scheme' (which ensures that all applicants with a disability who meet the minimum criteria for a job are automatically listed for interview)); occupational health support and mental health first aiders; and accessible IT systems, information, accommodation and facilities.

821. In Autumn of 2020, DHSC renewed its Disability Confident Leader benchmarking accreditation. This is in recognition of the Department's commitment to recruiting, developing and engaging disabled individuals and the extensive work we do to promote disability inclusion within working practices and employee opportunities.

822. The Department, under the Equality Act 2010, provides support to employees with a disability or health condition in the form of reasonable workplace adjustments. A workplace adjustment can be a change that removes a barrier or a disadvantage for employees with disability or health condition, which covers both physical, mental and learning disability conditions. This could be a physical feature or a change in working arrangements. What constitutes a workplace adjustment will vary depending on the individual and each request will need to be considered on a case-by-case basis. Equality law recognises that bringing about equality for people with a disability may mean changing the way in which employment is structured, the removal of physical barriers and/or providing extra support. We have an in-house workplace adjustment team and we provide support through our occupational health service for workplace and specialist assessments.

823. Employees also have access to an Employee Assistance Programme for independent advice from qualified professionals on topics such as physical or mental health, stress and depression. Internally, employees have access to over 100 in-house Mental Health First Aiders that can provide support to colleagues and are skilled in how to give appropriate help and support. We also have eight internal Speak Out Advisors, who are DHSC members of staff that are impartial and independent from line management. These individuals act as a source of guidance for those wanting to raise a challenge or concern in work, such as a concern relating to bullying, harassment or discrimination in the workplace.

824. In March 2020, DHSC achieved a Gold Award in the MIND Wellbeing Index, reinforcing our commitment to promoting and delivering Mental Health awareness in the workplace. This resulted in MIND asking us to deliver an external consultation in January 2021 with Mental Healthy Universities to talk about our approach and successes. We also signed the Mental Health Commitment at Work in March 2020, demonstrating that mental health remains a priority for us.

825. The Department has a focus on how best to support staff with disabilities and long-term conditions. This includes work to encourage more people with disabilities to apply for roles in the Department, raise awareness of reasonable adjustments throughout recruitment activity and to improve the existing workplace adjustment process. The Department also has a well-established and active disability network, EnABLE.

826. The Department runs specific targeted information sessions with members of its staff network groups to encourage applicants to apply for Civil Service-wide talent schemes including the Future Leaders Scheme (FLS) and Senior Leaders Scheme (SLS). We also offer additional information sessions with alumni and current participants to candidates who were eligible for the Disability Empowers Leadership Talent (DELTA) scheme or the Minority Ethnic Talent Association (META) scheme, which are integrated into FLS and SLS to support minority ethnic participants or those with a disability.

827. We promote broader leadership schemes to underrepresented groups, e.g. the Interdepartmental Talent Partnership (ITP) for all Grade 6's and 7's, and we promote such schemes to staff networks and underrepresented groups to encourage them to take part by holding targeted information sessions with these groups. In 2020, we undertook diversity monitoring of the ITP scheme to help shape how it's promoted in 2021.

### Trade Union Facility Time

828. Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Department has a statutory requirement to disclose information (see **Tables 22-25**) as prescribed by schedule 2 of the above Regulation. The format of these tables is as prescribed by the Regulations.

829. The disclosure has been compiled in line with the Regulations, therefore the information discloses the trade union facility time utilised by the Core Department and Public Health England staff only. The statutory reporting requirement is met through each entity's underlying Annual Report and Accounts, where an entity is in scope of this requirement.

### Table 22: Relevant Union Officials

| Number of employees who were relevant union officials during the relevant period | Full-time equivalent employee number |
|---|---|
| 64 | 64 |

### Table 23: Percentage of time spent on facility time

| Percentage of time | Number of employees |
|---|---|
| 0% | 0 |
| 1-50% | 64 |
| 51-99% | 0 |
| 100% | 0 |

### Table 24: Percentage of pay bill spent on facility time

| Description | Figures |
|---|---|
| Total cost of facility time | £98,026 |
| Total pay bill | £541,463,421 |
| Percentage of the total pay bill spent on facility time* | 0.018% |

* calculated as: (total cost of facility time ÷ total pay bill) x 100

### Table 25: Paid Trade Union Activities

| Description | Figures |
|---|---|
| Time spent on paid trade union activities as a percentage of total paid facility time hours* | 0% |

* total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

830. With regard to engagement, officials from the Department's HR team meet formally with Departmental Trade Union Side (DTUS) regularly where all 'people matters' are covered. The meetings are 'joint meetings' with MHRA and the Unions represented are PCS, FDA, Prospect, Unite and UCU. The Department also engages directly with DTUS on areas such as pay and reward, policy changes and re-structures and holds formal pay negotiations on an annual basis. In addition to the regular meetings with HR, DTUS also meet quarterly with designated members of the Department's Executive committee.

### Staff Data

831. **Tables 26, 27** and **28** summarise key staff information for the Departmental Group.

## Table 26: Staff costs for the Departmental Group comprise: (subject to audit)

| | | | | | 2020-21 £'000 | 2019-20 £'000 |
|---|---|---|---|---|---|---|
| | Permanently employed staff | Others | Ministers | Special advisors | Total | Total |
| Salaries and wages | 51,447,259 | 6,682,066 | 185 | 36 | 58,129,546 | 51,563,474 |
| Social Security costs | 5,328,572 | 137,721 | 19 | - | 5,466,312 | 4,952,637 |
| NHS Pension | 8,509,702 | 175,256 | - | - | 8,684,958 | 7,984,705 |
| Other pension costs | 113,088 | 5,400 | - | - | 118,488 | 97,231 |
| **Sub-total** | **65,398,621** | **7,000,443** | **204** | **36** | **72,399,304** | **64,598,047** |
| Termination benefits | 21,850 | - | - | - | 21,850 | 44,755 |
| **Sub-total** | **65,420,471** | **7,000,443** | **204** | **36** | **72,421,154** | **64,642,802** |
| Less recoveries in respect of outward secondments | (23,725) | (96,979) | - | - | (120,704) | (105,013) |
| **Total Net Costs** | **65,396,746** | **6,903,464** | **204** | **36** | **72,300,450** | **64,537,789** |

1. Special advisor costs cover the period to August 2019. After this date responsibility for special advisors transferred to the Cabinet Office, with the exception of one special advisor appointed in 2020-21 outside of the arrangement with Cabinet Office.

## Table 27: Average number of whole-time equivalents employed – Departmental Group Restated (subject to audit)

| | | | | | 2020-21 Number | Restated 2019-20 Number |
|---|---|---|---|---|---|---|
| | Permanent staff | Others | Ministers | Special Advisors | Total | Total |
| **Core Department** | | | | | | |
| Core Department | 2,017 | 3,864 | 7 | - | 5,888 | 1,770 |
| **Executive Agencies** | | | | | | |
| Public Health England | 5,545 | 504 | - | - | 6,049 | 5,326 |
| **Other designated bodies** | | | | | | |
| NHS providers | 1,175,126 | 117,918 | - | - | 1,293,044 | 1,224,842 |
| Special Health Authorities | 5,132 | 265 | - | - | 5,397 | 5,061 |
| NHS England Group | 25,188 | 9,330 | - | - | 34,518 | 33,553 |
| Non Departmental Public Bodies | 8,797 | 774 | - | - | 9,571 | 9,446 |
| Others | 8,512 | 384 | - | - | 8,896 | 8,129 |
| **Total** | **1,230,317** | **133,039** | **7** | **-** | **1,363,363** | **1,288,127** |

1. 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 Office for National Statistics categorisation.
2. Professional Standards Authority was an NDPB in the prior year but was classified as an Other Group entity in 2020-21. For comparability purposes, the 2019-20 staff numbers have been restated to reflect this change. 42 staff have been moved from Non Departmental Public Bodies to Others.

Of the figures shown in **Table 27,** staff engaged on capital projects are shown in **Table 28.**

**Table 28: Breakdown of staff engaged on capital projects** (subject to audit)

| | Permanent staff | Others | Ministers | Special Advisors | 2020-21 Number Total | 2019-20 Number Total |
|---|---|---|---|---|---|---|
| Core Dept & Agencies | 77 | 8 | - | - | 85 | 66 |
| Other designated bodies | 3,159 | 412 | - | - | 3,571 | 4,446 |
| **Total** | **3,236** | **420** | **-** | **-** | **3,656** | **4,512** |

832. The increase in the Core Department's staff numbers related to the Department response to the COVID-19 pandemic, including the personal protective equipment procurement programme and the establishment of the Test and Trace function. Salary costs for the Test and Trace function were £524 million for 2020-21 and at 31 March 2021 there were 3,482 whole time equivalents in post.

833. Staff employed in the NHS has increased in 2020-21. This is predominantly due to increased healthcare assistants and support staff, estates and administration and nursing, midwifery and health visiting staff.

834. Further details of staff employed within NHS organisations is available via NHS Digital, who publish on a monthly basis a breakdown of staff employed within the NHS Hospital and Community Health Service (HCHS). The data can be broken down by headcount, WTE, organisation, staff group and is the definitive source for NHS staffing information. Details of each NHS organisation can also be found in their own Annual Report and Accounts.

## Consultancy, Temporary and Agency workers

835. **Table 29** 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 4** of the financial statements.

836. The Department utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. In 2020-21 the Core Department spent £171.6 million on consultancy compared to £15.2 million in 2019-20; and £542.0 million on temporary staff this year compared to £14.8 million last year. Similar to the increase in staff numbers above, these increases predominantly relate to the establishment of programme activity relating to the Department's COVID-19 response, much of which was stood up at pace and/or was temporary in nature.

837. Bodies within the NHS trade with each other in their operations. Such intra-group activity can also include the incurring of expenditure on consultancy services. The overall total spend on consultancy, agency and temporary workers is therefore

presented first as a gross figure and secondly net of any associated elimination of intra-group purchasing of consultancy.

### Table 29: Expenditure on Consultancy, Agency and Temporary Workers

| | 2020-21 | | 2019-20 | |
|---|---|---|---|---|
| | Consultancy £'000 | Temporary Agency £'000 | Consultancy £'000 | Temporary Agency £'000 |
| DHSC Core | 171,613 | 542,021 | 15,203 | 14,842 |
| Executive Agencies | - | 28,242 | - | 13,576 |
| Other Designated Bodies | 314,384 | 4,074,931 | 275,003 | 3,720,978 |
| Gross Total | **485,997** | **4,645,194** | **290,206** | **3,749,396** |
| Eliminations | - | - | - | - |
| Total Departmental Group (after eliminations) | **485,997** | **4,645,194** | **290,206** | **3,749,396** |

1. The numbers reported above for agency include staff categorised as 'bank staff' by NHS providers. These are not included with NHSI's reported measures and agency spending.

### Off-Payroll Engagements

838. In line with HM Treasury requirements, departments must publish information on their highly paid and/or senior off-payroll engagements. This information, contained in **Tables 30a, b** & **c** includes all off-payroll engagements (either during 2020-21 in totality or as at 31 March 2021) for a day-rate of more than £245.

839. A regular dialogue has continued between the Department and HMRC throughout the 2020-21 financial year to ensure ongoing compliance with the IR35 rules - this dialogue ensures that the Department keeps updated with any policy changes implemented during the year and can therefore amend process accordingly if so required. A lot of preparatory work has also gone into ensuring the Department is compliant with the delayed HMRC reporting requirements which came into force on 6 April 2021.

840. 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. Of those who are genuine 'off-payroll' workers, around 50% have been determined as 'inside' IR35 and 50% determined as 'outside' IR35. These determinations have been arrived at using the online HMRC 'Check Employment status for tax' tool and reviewed by the tax team.

841. A communication channel has also been open throughout the year with the Department's ALBs to offer advice and assistance to them in ensuring that they have continued to meet their compliance requirements relating to the IR35 regulations.

842. Whilst the Department had no change of policy relating to the engagement of off-payroll workers during 2020-21 (and continues to utilise them only where it is necessary and prudent to do so) due to the significantly increased workloads for the Department as a result of the COVID-19 pandemic, contractor numbers have

significantly increased during this financial year – by a factor of almost 20, meaning it would simply not be possible to run a lot of the COVID workstreams without a significant number of contractors – in particular NHS Test & Trace which, due to its volatile nature, relies heavily on temporary resources. The lack of enduring roles post pandemic has made it an impossible task to put most new Test & Trace workers onto the Departmental payroll.

843. Other administrative areas relating to COVID (finance, procurement) have also had to use significant temporary resources during the year due to the huge increase in work resulting from the initial Government response to the pandemic back in the Spring & Summer of 2020.

844. Implementation of the Corporate Services Improvement Programme (CSIP) was also delayed as a result of COVID with the go-live date for the new finance, human resources and procurement system delayed from April to December 2020 so contractors working on that programme were engaged for longer than had been anticipated as a result.

845. As a direct result of the pandemic there have been 272 engagements over the 2020-21 financial year where the contractors have been paid at an SCS day-rate and as such are included in **Table 30(c)** as having 'significant financial responsibility'. Of these, 46 were 'off-payroll' appointments and of this subset, 22 were 'outside the scope' of IR35. The reasons for these appointments are very similar to those outlined in the previous paragraph. All COVID response workstreams were set up at very short notice and internal resource to work at the required levels was not available so senior leaders in these programmes are predominantly not DHSC employees. This situation should change as we reach the end of the pandemic and a return to 'business as usual' within DHSC.

846. Across the group, there are seven individuals who are senior 'off-payroll' engagements (see **Table 30(c)**), four of whom are at NHS Digital (NHSD), two are at the Skipton Fund and the last is at the Health Research Authority (HRA). Details are as follows:

- The two individuals who work for the Skipton Fund are both representatives of solicitors Russell-Cooke LLP, who took on the responsibility of running the company until the time comes when it can be formally closed. The company closed in 2017 but these individuals will be kept on until the conclusion of the ongoing public enquiry into the historic infected blood issues. There are no outstanding tax issues in relation to these engagements.

- NHS Digital's Chief Medical Officer took over from an internal interim person in November 2019. During 2020-21, they were on an 18-month secondment to NHSD from United hospitals Bristol NHS Trust and they are paid via the Trust's payroll, so there are no tax issues relevant to this engagement. Since the end

of the financial year, he has been made permanent in post following recruitment through open competition.

- NHS Digital's Product Development Director started in January 2020. He works for a private consultancy firm. The salary is reimbursed to his firm through NHSD's payroll, and his tax is calculated on the basis of being in scope of IR35, and there are no outstanding tax issues. The individual's original engagement was for a 12-month period, which was expected to end on 31 January 2021, but at that point it became clear there was no reduction in new demands to support the COVID response, so a decision was made to keep the individual in place to ensure delivery, continuity, and stability at a senior level. They have now stepped back and are no longer an Executive Director. Their replacement is an on-payroll employee of NHS Digital.

- The role of the Chief Technology Officer in NHS Digital was newly created in December 2019 and was vacant until October 2020 when it was filled on an interim basis for a 12-month contract pending open competition as part of the post pandemic response. There are no outstanding tax issues relevant to this engagement.

- NHS Digital's Head of Platforms permanently employed post holder left the organisation in January 2021. This role was filled on an interim, off-payroll basis during the same month pending permanent recruitment through open competition. There are no outstanding tax issues relevant to this engagement. This engagement is due to conclude November 2021 pending recruitment through open competition.

- The last individual is the Chairman of the Health Research Authority who was appointed in September 2019. As part of the engagement, the individual concerned asked for their host organisation to be reimbursed directly as a recharge rather than receiving their remuneration via the HRA payroll. There are no outstanding tax issues in relation to this engagement.

## Table 30: Off-payroll engagements

| Table a: For all off-payroll engagements as of 31 March 2021, for more than £245 per day[1] | Core Dept | ALBs | Dept Group |
|---|---|---|---|
| **Number of existing engagements as of 31 March 2021** | **1,524** | **1,035** | **2,559** |
| Of which..... | | | |
| Number that have existed for less than one year at time of reporting | 1,503 | 454 | 1,957 |
| Number that have existed for between one and two years at time of reporting | 12 | 279 | 291 |
| Number that have existed for between two and three years at time of reporting | 5 | 91 | 96 |
| Number that have existed for between three and four years at time of reporting | 2 | 45 | 47 |
| Number that have existed for four years or more years at time of reporting | 2 | 166 | 168 |

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

| Table b: For all off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day[1] | Core Dept[3] | ALBs | Dept Group |
|---|---|---|---|
| **Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021** | **1,840** | **1,109** | **2,949** |
| Of which..... | | | |
| Number not subject to off-payroll legislation[2] | 1634 | 341 | 1,975 |
| Number subject to off-payroll legislation and determined as in scope of IR35[2] | 62 | 716 | 778 |
| Number subject to off-payroll legislation and determined as out of scope of IR35[2] | 52 | 52 | 104 |
| Number of engagements reassessed for compliance or assurance purposes during the year | - | 20 | 20 |
| Of which: number of engagements that saw a change to IR35 status following review | - | 5 | 5 |

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

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

3. In the Core Dept figures 92 individuals are highly likely to be on the payroll of their contracting organisation, but it has not been possible to definitively prove this at the time of publication. They appear in the total number provided at the top of table b but not in the further breakdown of the 1,840 engagements.

| Table c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021 | Core Dept | ALBs | Dept Group |
|---|---|---|---|
| Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. | 46 | 7 | 53 |
| 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. | 649 | 414 | 1,063 |

## Exit Packages – Civil Service and Other Compensation Schemes

847. **Table 31** details civil service and other compensation schemes and exit packages. Redundancy and other departure costs have been paid in accordance with the provisions of the Civil Service Compensation Scheme. Where early retirement has been agreed, the additional costs are met by the Department/organisation. 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.

### Table 31: Exit Packages (subject to audit)

| | Core Dept & Agencies | | | | 2020-21 Departmental Group | | | |
|---|---|---|---|---|---|---|---|---|
| Exit package cost band (including any special payment element) | 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 | 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 | 1 | 6 | 7 | - | 164 | 1,482 | 1,646 | 4 |
| £10,001 - £25,000 | 1 | 3 | 4 | - | 154 | 230 | 384 | 5 |
| £25,001 - £50,000 | - | 1 | 1 | - | 138 | 105 | 243 | 6 |
| £50,001 - £100,000 | - | 4 | 4 | - | 95 | 81 | 176 | 2 |
| £100,001 - £150,000 | - | - | - | - | 40 | 22 | 62 | - |
| £150,001 - £200,000 | - | - | - | - | 32 | 8 | 40 | - |
| >£200,000 | - | 1 | 1 | - | 5 | 1 | 6 | - |
| **Total Number** | **2** | **15** | **17** | **-** | **628** | **1,929** | **2,557** | **17** |
| **Total Cost (£)** | **13,067** | **670,735** | **683,802** | **-** | **26,310,856** | **21,458,214** | **47,769,070** | **449,065** |

| | Core Dept & Agencies | | | | 2019-20 Departmental Group | | | |
|---|---|---|---|---|---|---|---|---|
| Exit package cost band (including any special payment element) | 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 | 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 | 9 | 9 | 18 | - | 309 | 1,825 | 2,134 | 2 |
| £10,001 - £25,000 | 3 | 4 | 7 | - | 364 | 336 | 700 | 10 |
| £25,001 - 50,000 | 1 | 4 | 5 | - | 366 | 169 | 535 | 4 |
| £50,001 - £100,000 | - | 6 | 6 | - | 296 | 102 | 398 | 4 |
| £100,001 - £150,000 | - | 4 | 4 | - | 122 | 23 | 145 | - |
| £150,001 - £200,000 | - | - | - | - | 77 | 8 | 85 | 2 |
| >£200,000 | - | - | - | - | 7 | 2 | 9 | - |
| **Total Number** | **13** | **27** | **40** | **-** | **1,541** | **2,465** | **4,006** | **22** |
| **Total Cost (£)** | **123,508** | **1,118,763** | **1,242,271** | **-** | **71,349,820** | **27,947,714** | **99,297,534** | **765,712** |

1. There are no individuals within the Core Department who have received over £95,000 as an exit package due to entitlement on voluntary or compulsory redundancy arrangements in 2019-20 or 2020-21.

## Other Departures

848. **Table 32** 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 32** will not necessarily match the total number in **Table 31**, which will be the number of individuals.

### Table 32: Analysis of Other Departures (subject to audit)

| | 2020-21 Departmental Group | |
|---|---|---|
| | Agreements | Total value of agreements |
| | Number | £000s |
| Voluntary redundancies including early retirement contractual costs | 147 | 6,547 |
| Mutually agreed resignations (MARS) contractual costs | 121 | 3,825 |
| Early retirements in the efficiency of the service contractual costs | 4 | 241 |
| Contractual payments in lieu of notice | 1,625 | 9,510 |
| Exit payments following Employment Tribunals or court orders | 48 | 993 |
| Non-contractual payments requiring HMT approval* | 10 | 342 |
| **Total** | **1,955** | **21,458** |

*Includes any non-contractual severance payments made following judicial mediation, and those relating to non-contractual payments in lieu of notice.

## 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 the Department'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 IFRS (included in the financial statements), the Government Financial Reporting Manual (FReM) requires the Department to prepare a Statement of Outturn against Parliamentary Supply (SOPS) and supporting notes to show resource outturn against the Supply Estimate presented to Parliament, in respect of each budgetary control limit.

The SOPS and related notes present the expenditure of the Department on a basis consistent with the aggregate estimate figures presented in the Parliamentary Supply Estimates and are subject to audit as detailed in the Certificate and Report of the Comptroller and Auditor General to the House of Commons.

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 have 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 (note 1); a reconciliation of outturn to net operating expenditure in the SOCNE, to tie the SOPS to the financial statements (note 2); a reconciliation of outturn to net cash requirement (note 3); and an analysis of income payable to the Consolidated Fund (note 4).

The SOPS reports Departmental expenditure in a way which supports the achievement of macro-economic stability by ensuring that public expenditure is controlled, with the relevant Parliamentary authority, in support of the Government's fiscal framework. Further information regarding the fiscal framework can be found in Chapter 1 of the Consolidated Budgeting Guidance. **Figure 1** at the front of this report helps show how funds flow around the Departmental Group.

## Summary of Resource and Capital Outturn 2020-21

| | | 2020-21 Estimate | | | 2020-21 Outturn | | | 2020-21 | 2019-20 |
|---|---|---|---|---|---|---|---|---|---|
| | SoPS Note | Voted £'000 | Non-Voted £'000 | Total £'000 | Voted £'000 | Non-Voted £'000 | Total £'000 | Voted outturn compared with Estimate: saving/ (excess) £'000 | Outturn Total £'000 |
| **Departmental Expenditure Limit** | | | | | | | | | |
| - Resource | 1.1 | 177,932,014 | 22,823,176 | 200,755,190 | 157,376,168 | 22,823,176 | 180,199,344 | 20,555,846 | 134,183,398 |
| - Capital | 1.2 | 12,917,869 | - | 12,917,869 | 12,682,912 | - | 12,682,912 | 234,957 | 7,015,244 |
| **Annually Managed Expenditure** | | | | | | | | | |
| - Resource | 1.1 | 10,001,880 | - | 10,001,880 | 2,881,760 | - | 2,881,760 | 7,120,120 | 2,848,009 |
| - Capital | 1.2 | 15,000 | - | 15,000 | (7,355) | - | (7,355) | 22,355 | (5,563) |
| **Total Budget** | | 200,866,763 | 22,823,176 | 223,689,939 | 172,933,485 | 22,823,176 | 195,756,661 | 27,933,278 | 144,041,088 |
| **Non-Budget** | | | | | | | | | |
| - Resource | 1.1 | - | - | - | - | - | - | - | - |
| **Total** | | **200,866,763** | **22,823,176** | **223,689,939** | **172,933,485** | **22,823,176** | **195,756,661** | **27,933,278** | **144,041,088** |
| Total Resource | | 187,933,894 | 22,823,176 | 210,757,070 | 160,257,928 | 22,823,176 | 183,081,104 | 27,675,966 | 137,031,407 |
| Total Capital | | 12,932,869 | - | 12,932,869 | 12,675,557 | - | 12,675,557 | 257,312 | 7,009,681 |
| **Total** | | **200,866,763** | **22,823,176** | **223,689,939** | **172,933,485** | **22,823,176** | **195,756,661** | **27,933,278** | **144,041,088** |

1. Explanations of variances between Estimates and Outturn are given in tables a to d below.

## Net cash requirement 2020-21

| | SoPS Note | 2020-21 Estimate £'000 | 2020-21 Outturn £'000 | 2020-21 Outturn compared with Estimate: saving/ (excess) £'000 | 2019-20 Outturn £'000 |
|---|---|---|---|---|---|
| Net cash requirement | 3 | 187,960,883 | 165,725,124 | 22,235,759 | 115,163,740 |

1. Against the 2020-21 Net Cash Requirement of £188.0 billion, DHSC underspent by 11.8% (£22.2 billion).

## Administration Costs 2020-21

| | 2020-21 Estimate £'000 | 2020-21 Outturn £'000 | 2019-20 Outturn £'000 |
|---|---|---|---|
| Administration Costs | 3,221,487 | 2,470,029 | 2,301,082 |

1. Sections outlined in bold are voted totals and/or totals subject to Parliamentary control.

# SOPS 1 Net Outturn

## SOPS 1.1 Analysis of net resource outturn by section

| | 2020-21 £'000 | | | | | | 2020-21 £'000 | 2020-21 £'000 | | 2020-21 £'000 | 2020-21 £'000 | 2019-20 £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Outturn | | | Estimate | | Outturn |
| | Administration | | | Programme | | | Total | Net Total | Virements | Total incl. Virements | Outturn vs Estimate | Total |
| | Gross | Income | Net | Gross | Income | Net | | | | | Savings (Excess) | |
| **Spending in Departmental Expenditure Limits (DEL)** | | | | | | | | | | | | |
| **Voted:** | | | | | | | | | | | | |
| NHS England net expenditure | 1,488,859 | - | 1,488,859 | 24,108,641 | - | 24,108,641 | 25,597,500 | 33,757,461 | (3,374,175) | 30,383,286 | 4,785,786 | 17,186,308 |
| NHS Providers net expenditure | - | - | - | 93,119,985 | - | 93,119,985 | 93,119,985 | 89,240,000 | 3,879,985 | 93,119,985 | - | 81,526,454 |
| DHSC Programme and Administration expenditure | 427,718 | (1,459) | 426,259 | 25,720,268 | (847,591) | 24,872,677 | 25,298,936 | 40,429,676 | (33,899) | 40,395,777 | 15,096,841 | 856,606 |
| Local Authorities | - | - | - | 4,205,920 | - | 4,205,920 | 4,205,920 | 4,205,000 | 920 | 4,205,920 | - | 2,931,555 |
| Public Health England (Executive Agency) | 63,408 | (12,268) | 51,140 | 2,174,764 | (745,071) | 1,429,693 | 1,480,833 | 1,498,768 | - | 1,498,768 | 17,935 | 923,546 |
| Health Education England net expenditure | 58,970 | - | 58,970 | 1,389,670 | - | 1,389,670 | 1,448,640 | 1,545,660 | - | 1,545,660 | 97,020 | 1,444,495 |
| Special Health Authorities expenditure[3] | 253,690 | (60,694) | 192,996 | 2,488,282 | (30,390) | 2,457,892 | 2,650,888 | 3,044,073 | 19,725 | 3,063,798 | 412,910 | 2,743,281 |
| Non Departmental Public Bodies net expenditure[3] | 258,655 | - | 258,655 | 464,924 | - | 464,924 | 723,579 | 858,876 | 3,207 | 862,083 | 138,504 | 628,293 |
| Arm's Length and Other Bodies net expenditure | (6,850) | - | (6,850) | 2,856,737 | - | 2,856,737 | 2,849,887 | 3,352,500 | (495,763) | 2,856,737 | 6,850 | 2,981,221 |
| | **2,544,450** | **(74,421)** | **2,470,029** | **156,529,191** | **(1,623,052)** | **154,906,139** | **157,376,168** | **177,932,014** | **-** | **177,932,014** | **20,555,846** | **111,221,759** |
| **Non-voted:** | | | | | | | | | | | | |
| NHS England expenditure financed by NI Contributions | - | - | - | 22,823,176 | - | 22,823,176 | 22,823,176 | 22,823,176 | - | 22,823,176 | - | 22,961,639 |
| | **2,544,450** | **(74,421)** | **2,470,029** | **179,352,367** | **(1,623,052)** | **177,729,315** | **180,199,344** | **200,755,190** | **-** | **200,755,190** | **20,555,846** | **134,183,398** |
| **Annually Managed Expenditure (AME)** | | | | | | | | | | | | |
| **Voted:** | | | | | | | | | | | | |
| NHS England net expenditure | - | - | - | 86,125 | - | 86,125 | 86,125 | 100,000 | - | 100,000 | 13,875 | 294,489 |
| NHS Providers net expenditure | - | - | - | 1,978,051 | - | 1,978,051 | 1,978,051 | 1,100,000 | 878,051 | 1,978,051 | - | 1,070,401 |
| DHSC Programme and Administration expenditure | - | - | - | 2,010,233 | (12,669) | 1,997,564 | 1,997,564 | 329,314 | 1,668,250 | 1,997,564 | - | 785,506 |
| Public Health England (Executive Agency) | - | - | - | 13,831 | - | 13,831 | 13,831 | 5,000 | 8,831 | 13,831 | - | (2,033) |
| Health Education England net expenditure | - | - | - | 159 | - | 159 | 159 | 5,000 | - | 5,000 | 4,841 | 68 |
| Special Health Authorities expenditure[3] | - | - | - | (1,266,873) | - | (1,266,873) | (1,266,873) | 8,406,566 | (2,572,339) | 5,834,227 | 7,101,100 | 675,203 |
| Non Departmental Public Bodies net expenditure[3] | - | - | - | 23,207 | - | 23,207 | 23,207 | 6,000 | 17,207 | 23,207 | - | 3,536 |
| Arm's Length and Other Bodies net expenditure | - | - | - | 49,696 | - | 49,696 | 49,696 | 50,000 | - | 50,000 | 304 | 20,839 |
| | **-** | **-** | **-** | **2,894,429** | **(12,669)** | **2,881,760** | **2,881,760** | **10,001,880** | **-** | **10,001,880** | **7,120,120** | **2,848,009** |
| **Total** | **2,544,450** | **(74,421)** | **2,470,029** | **182,246,796** | **(1,635,721)** | **180,611,075** | **183,081,104** | **210,757,070** | **-** | **210,757,070** | **27,675,966** | **137,031,407** |
| **Reconciliation to Statement of Comprehensive Net Expenditure** | | | | | | | | | | | | |
| Net gain/(loss) on transfers by absorption | - | - | - | (232) | - | (232) | (232) | | | | | - |
| Capital Grants | 89,064 | - | 89,064 | 849,698 | - | 849,698 | 938,762 | | | | | 809,503 |
| Research and Development[4] | - | - | - | 1,329,778 | - | 1,329,778 | 1,329,778 | | | | | 1,230,741 |
| Income from Consolidated Fund Extra Receipts | - | - | - | - | (365,721) | (365,721) | (365,721) | | | | | (571,133) |
| Utilisation of provisions | (20,090) | - | (20,090) | 20,090 | - | 20,090 | - | | | | | - |
| IFRIC 12 Adjustment | - | - | - | 619,014 | (408,831) | 210,183 | 210,183 | | | | | (105,106) |
| Donated asset/government granted income | - | - | - | - | (162,792) | (162,792) | (162,792) | | | | | (166,275) |
| Expenditure presented on net basis[1] | 193,520 | (193,520) | - | 6,595,351 | (6,595,351) | - | - | | | | | - |
| Other adjustments (mainly COVID-19)[5] | - | - | - | (1,046,941) | (126,827) | (1,173,768) | (1,173,768) | | | | | (30,453) |
| **Net operating cost** | **2,806,944** | **(267,941)** | **2,539,003** | **190,613,554** | **(9,295,243)** | **181,318,311** | **183,857,314** | | | | | **138,198,684** |

1. Under Parliamentary reporting requirements, expenditure for the NHS England Group, NDPBs (including Health Education England), NHS providers and Arm's Length and Other Bodies is shown net of income. This differs from the treatment in the Consolidated Statement of Comprehensive Net Expenditure, where income and expenditure are reported separately on a gross basis.
2. Explanations of variances between Estimates and Outturn are given in tables a to d below.
3. Note 21 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
4. From 2016-17, following the Government's adoption of the 2010 European System of National and Regional Accounts (ESA 2010), the majority of Departmental expenditure on research and development was re-classified from resource to capital expenditure. Further detail is presented in Annex A Core Table 1.
5. Other adjustments in 2020-21 mainly relate to COVID-19 adjustments to reflect the agreed budgetary treatment of COVID-19 expenditure. Included within the £1,174 million adjustment above, £1,065 million relates to the personal protective equipment (PPE) programme and £112 million relates to ventilators, scanners and imaging equipment. The budgetary adjustment for personal protective equipment arises from the HM Treasury agreed budgeting treatment to record this expenditure as RDEL on purchase. The SoCNE reflects utilisation, write downs and impairment of PPE inventory and therefore the budgetary adjustment above reflects the closing value of this inventory at 31 March 2021. This comprises £1,062 million of PPE items and £3 million of Raw Materials for use in the production of PPE as disclosed in Note 12.

## SOPS 1.2 Analysis of net capital outturn by section

| | 2020-21 £'000 | | | 2020-21 £'000 | | 2020-21 £'000 | 2020-21 £'000 | 2019-20 £'000 |
|---|---|---|---|---|---|---|---|---|
| | Outturn | | | | | Estimate | Outturn vs Estimate | Outturn |
| | Gross | Income | Net | Net Total | Virements | Total incl. Virements | Savings (Excess) | Net Total |
| **Spending in Departmental Expenditure Limits (DEL)** | | | | | | | | |
| **Voted:** | | | | | | | | |
| NHS England net expenditure | 330,577 | - | 330,577 | 475,726 | (115,676) | 360,050 | 29,473 | 265,530 |
| NHS Providers net expenditure | 7,281,187 | - | 7,281,187 | 7,165,511 | 115,676 | 7,281,187 | - | 4,498,029 |
| DHSC Programme and Administration expenditure | 4,809,511 | (153,324) | 4,656,187 | 4,701,652 | - | 4,701,652 | 45,465 | 1,811,114 |
| Local Authorities | - | - | - | - | - | - | - | - |
| Public Health England (Executive Agency) | 21,110 | (88) | 21,022 | 235,682 | (56,109) | 179,573 | 158,551 | 140,735 |
| Health Education England net expenditure | 532 | - | 532 | 2,000 | - | 2,000 | 1,468 | 1,557 |
| Special Health Authorities expenditure[2] | 48,477 | (1,157) | 47,320 | 40,530 | 6,790 | 47,320 | - | 24,172 |
| Non Departmental Public Bodies net expenditure[2] | 156,325 | - | 156,325 | 117,263 | 39,062 | 156,325 | - | 118,533 |
| Arm's Length and Other Bodies net expenditure | 189,762 | - | 189,762 | 179,505 | 10,257 | 189,762 | - | 155,574 |
| | **12,837,481** | **(154,569)** | **12,682,912** | **12,917,869** | **-** | **12,917,869** | **234,957** | **7,015,244** |
| Annually Managed Expenditure (AME) | | | | | | | | |
| **Voted:** | | | | | | | | |
| NHS England net expenditure | - | - | - | - | - | - | - | - |
| NHS Providers net expenditure | - | - | - | - | - | - | - | - |
| DHSC Programme and Administration expenditure | (7,355) | - | (7,355) | 15,000 | - | 15,000 | 22,355 | (5,563) |
| Public Health England (Executive Agency) | - | - | - | - | - | - | - | - |
| Health Education England net expenditure | - | - | - | - | - | - | - | - |
| Special Health Authorities expenditure[2] | - | - | - | - | - | - | - | - |
| Non Departmental Public Bodies net expenditure[2] | - | - | - | - | - | - | - | - |
| Arm's Length and Other Bodies net expenditure | - | - | - | - | - | - | - | - |
| | **(7,355)** | **-** | **(7,355)** | **15,000** | **-** | **15,000** | **22,355** | **(5,563)** |
| **Total** | **12,830,126** | **(154,569)** | **12,675,557** | **12,932,869** | **-** | **12,932,869** | **257,312** | **7,009,681** |

1. Explanations of variances between Estimate and outturn are given in tables a to d below.
2. Note 21 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.

## Material variances between the Estimate and Outturn

849. 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 £100 billion (mainly transactions between NHS Commissioners and NHS Providers) is unique to the DHSC.

850. 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.

851. At the start of each financial year, we estimate our income and expenditure, including intra-group transactions, for each of the bodies within our Departmental Group. Due to the size and complexity of our budget, which increased significantly in 2020-21 as a result of the COVID-19 pandemic, there will inevitably be some variances in our Estimate.

852. In setting the Parliamentary Estimate, DHSC takes a pragmatic approach and eliminates only the material transactions between Departmental group bodies.

853. In line with the guidance published by the Parliamentary Scrutiny Unit for Estimates Memoranda, significant variances over £10m and 10% or over £200 million and 5% have been explained in the tables below.

854. Further detail regarding the variances in the following tables can be found in **Annex B.**

## Further Explanation of SOPS 1.1 and 1.2

## Table a: Comparison of Resource DEL Estimate and Outturn

| RESOURCE DEL | | ESTIMATE | OUTTURN | TOTAL VARIANCE | Of which: | | | Explanation of other significant variance |
|---|---|---|---|---|---|---|---|---|
| | | | | | Elimination Variance | Other Variance | Other Variance | |
| | | £m | £m | £m | £m | £m | % | |
| A | NHS England net expenditure | 33,757 | 25,598 | 8,160 | 1,542 | 6,618 | 20% | Funding was agreed at prudent levels to fully fund the direct and indirect costs of the pandemic to the NHS in 2020-21.<br><br>NHSE made significant savings against both their business as usual and COVID-19 budgets and this was, in general is driven by the uncertainty and volatility of the pandemic impact on NHS services.<br><br>The savings in business as usual (BAU) budgets i.e. non-COVID-19 related core NHS services were because the NHS rightly focussed more on the COVID-19 operational response. |
| B | NHS Providers net expenditure | 89,240 | 93,120 | (3,880) | (4,278) | 398 | 0% | |
| C | DHSC Programme and Administration expenditure | 40,430 | 25,299 | 15,131 | 2,626 | 12,505 | 31% | The DHSC core saving predominantly relates to COVID-19.<br><br>Activities were delivered at significantly lower cost than originally anticipated as a result of lower levels of demand, impact of National lockdowns and in some cases slippage in receipt of goods.<br><br>These savings against budget mainly include:<br>1. NHS Test and Trace (circa £9bn) as set out in paragraph 207;<br>2. PPE (circa £1.6bn) as set out in paragraph 211; and<br>3. Vaccine deployment (circa £2bn) as set out in paragraph 216 |
| D | Local Authorities | 4,205 | 4,206 | (1) | | (1) | 0% | |
| E | Public Health England (Executive Agency) | 1,499 | 1,481 | 18 | (2) | 20 | 1% | |
| F | Health Education England net expenditure | 1,546 | 1,449 | 97 | 34 | 63 | 4% | |
| G | Special Health Authorities expenditure | 3,044 | 2,651 | 393 | (407) | 800 | 26% | The saving against budget relates to lower than anticipated clinical negligence scheme settlements due to slow down of court activity due to the pandemic. |
| H | Non Departmental Public Bodies net expenditure | 859 | 724 | 135 | (77) | 212 | 25% | The variance mainly relates to changes in the distribution of the NHS Test and Trace budget after setting the Supplementary Supply Estimate. |
| I | Arm's Length and Other Bodies (Net) | 3,353 | 2,850 | 503 | 562 | (59) | -2% | |
| J | NHS England expenditure financed by NI Contributions | 22,823 | 22,823 | 0 | | 0 | 0% | |
| **Total RDEL** | | **200,755** | **180,199** | **20,556** | **0** | **20,556** | | |

1. Annex B includes a more detailed explanation of the Department's administrative spend.
2. Totals in the table may not sum due to roundings.
3. For elimination variances please see the explanation provided in paragraphs 849 to 852.

## Table b: Comparison of Resource AME Estimate and Outturn

| RESOURCE AME | | ESTIMATE | OUTTURN | TOTAL VARIANCE | | Explanation of significant variances |
|---|---|---|---|---|---|---|
| | | £m | £m | £m | % | |
| K | NHS England net expenditure | 100 | 86 | 14 | 14% | ***See note 1*** |
| L | NHS Providers net expenditure | 1,100 | 1,978 | (878) | -80% | ***See note 1*** |
| M | DHSC Programme and Administration expenditure | 329 | 1,998 | (1,668) | -507% | The variance on this line mainly relates to:<br>1. a circa £1.2bn PPE onerous contract provision as detailed in paragraph 213; and<br>2. the remaining difference relates to changes in DHSC core provisions after the Supplementary Supply Estimate had been set (***See note 1 below)*** |
| N | Public Health England (Executive Agency) | 5 | 14 | (9) | -177% | |
| O | Health Education England net expenditure | 5 | 0 | 5 | 97% | |
| P | Special Health Authorities expenditure | 8,407 | (1,267) | 9,673 | 115% | Underspend relates to lower than forecast clinical negligence provisions. |
| Q | Non Departmental Public Bodies net expenditure | 6 | 23 | (17) | -287% | ***See note 1*** |
| R | Arm's Length and Other Bodies (Net) | 50 | 50 | 0 | 1% | ***See note 1*** |
| **Total RAME** | | **10,002** | **2,882** | **7,120** | | |

1. 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.
2. Totals in the table may not sum due to roundings.

## Table c: Comparison of Capital DEL Estimate and Outturn

| CAPITAL DEL | | ESTIMATE | OUTTURN | TOTAL VARIANCE | | Explanation of significant variances |
|---|---|---|---|---|---|---|
| | | £m | £m | £m | % | |
| A | NHS England net expenditure | 476 | 331 | 145 | 31% | ***See note 1*** |
| B | NHS Providers net expenditure | 7,166 | 7,281 | (116) | -2% | ***See note 1*** |
| C | DHSC Programme and Administration expenditure | 4,702 | 4,656 | 45 | 1% | ***See note 1*** |
| D | Local Authorities | 0 | 0 | 0 | 0% | |
| E | Public Health England (Executive Agency) | 236 | 21 | 215 | 91% | Underspend due to capital credits of around £0.14bn relating to the utilisation of stockpiled emergency preparedness. |
| F | Health Education England net expenditure | 2 | 1 | 1 | 73% | |
| G | Special Health Authorities expenditure | 41 | 47 | (7) | -17% | |
| H | Non Departmental Public Bodies net expenditure | 117 | 156 | (39) | -33% | ***See note 1*** |
| I | Arm's Length and Other Bodies (Net) | 180 | 190 | (10) | -6% | |
| **Total CDEL** | | **12,918** | **12,683** | **235** | | |

1. The Estimate reflects the best estimate of COVID-19 CDEL expenditure for the DHSC Group at a point in time. The distribution of COVID-19 capital across the DHSC Group was revised in Quarter 4 after the Supplementary Supply Estimate had been set.
2. Totals in the table may not sum due to roundings.

## Table d: Comparison of Capital AME Estimate and Outturn

| CAPITAL AME | | ESTIMATE | OUTTURN | TOTAL VARIANCE | | Explanation of significant variances |
|---|---|---|---|---|---|---|
| | | £m | £m | £m | % | |
| J | NHS England net expenditure | 0 | 0 | 0 | 0% | |
| K | NHS Providers net expenditure | 0 | 0 | 0 | 0% | |
| L | DHSC Programme and Administration expenditure | 15 | -7 | 22 | 149% | CAME transactions were lower than anticipated |
| M | Public Health England (Executive Agency) | 0 | 0 | 0 | 0% | |
| N | Health Education England net expenditure | 0 | 0 | 0 | 0% | |
| O | Special Health Authorities expenditure | 0 | 0 | 0 | 0% | |
| P | Non Departmental Public Bodies net expenditure | 0 | 0 | 0 | 0% | |
| R | Arm's Length and Other Bodies (Net) | 0 | 0 | 0 | 0% | |
| **Total CAME** | | **15** | **(7)** | **22** | | |

## SOPS 2 Reconciliation of net resource outturn to net operating expenditure

| | | Note | 2020-21 £'000 Outturn | Restated 2019-20 £'000 Outturn |
|---|---|---|---|---|
| Total resource outturn in Statement of Outturn against Parliamentary Supply | | | | |
| | Budget | SOPS 1.1 | 183,081,104 | 137,031,407 |
| | Non-Budget | SOPS 1.1 | - | - |
| | | | 183,081,104 | 137,031,407 |
| Add: | Capital Grants | | 938,762 | 809,503 |
| | Research and Development | | 1,329,778 | 1,230,741 |
| | PFI/LIFT expenditure under IFRS | | 2,713,451 | 2,326,972 |
| | PFI/LIFT income under IFRS | | (408,831) | (393,331) |
| | | | 4,573,160 | 3,973,885 |
| Less: | Income payable to the Consolidated Fund | SOPS4 | (365,721) | (571,133) |
| | Donated asset/government granted income[3] | | (162,792) | (166,275) |
| | PFI/LIFT expenditure under UK GAAP | | (2,094,437) | (2,038,747) |
| | Loss on transfers by absorption | | (232) | - |
| | Other[2] | | (1,173,768) | (30,453) |
| | | | (3,796,950) | (2,806,608) |
| Net Operating Cost in Consolidated Statement of Comprehensive Net Expenditure after Financing Activities | | | **183,857,314** | **138,198,684** |

1. From 2016-17 government departments were required to capitalise costs that do not meet the criteria to be capitalised in departmental account but meet the ESA10 definition of research and development.
2. Other adjustments in 2020-21 mainly relate to COVID-19 adjustments to reflect the agreed budgetary treatment of COVID-19 expenditure. Of the £1,173.8 million adjustment, £1,065.1 million relates to the personal protective equipment programme and £111.6 million relating to ventilators, scanners and imaging equipment. The budgetary adjustment for personal protective equipment arises from the HM Treasury agreed budgeting treatment (which is a deviation to standard budgetary treatment) to record this expenditure as RDEL on purchase. For further detail please see SOPS 1.1.
3. Donated assets/government granted income does not agree to Note 5.1 as some of this income is included in income received by NHS charities.
4. To improve readability and understanding, other budget adjustments have been netted off in the table above, as a result the prior year comparatives have been restated by £1.4 million to show only a net other adjustments line.

## SOPS 3 Reconciliation of net resource outturn to net cash requirement

| | Note | Estimate | Outturn | 2020-21 £'000 Net total outturn compared with Estimate: Savings/(excess) |
|---|---|---|---|---|
| **Resource Outturn** | SOPS 1.1 | 210,757,070 | 183,081,104 | 27,675,966 |
| **Capital Outturn** | SOPS 1.2 | 12,932,869 | 12,675,557 | 257,312 |
| **Accruals to cash adjustments:** | | | | |
| *Adjustments to remove non-cash items:* | | | | |
| Depreciation | | (1,099,950) | (169,325) | (930,625) |
| New provisions and adjustments to previous provisions | | (12,511,033) | (2,926,024) | (9,585,009) |
| IFRIC12 revenue adjustments | | | 10,575 | (10,575) |
| Adjustment for stockpiled goods | | | 198,113 | (198,113) |
| Non-cash investment additions | | | (24,290) | 24,290 |
| Net gain/loss on transfers by absorption | | | (6,041) | 6,041 |
| Other non-cash items | | - | (1,078,565) | 1,078,565 |
| *Adjustments for NDPBs, NHS Trusts, Foundation Trusts, Charities and Other bodies:* | | | | |
| Remove voted resource and capital Department, and expenditure financed by Parliamentary Funding | | (137,955,502)<br>134,085,452 | (133,835,212)<br>133,959,131 | (4,120,290)<br>126,321 |
| *Adjustments to reflect movements in working balances:* | | | | |
| Increase/(decrease) in inventory | | | 3,834,375 | (3,834,375) |
| less COVID-19 budgeting impacts on non-cash transactions[1] | | | (3,419,841) | 3,419,841 |
| less transfers from non-current assets | | | (41,233) | 41,233 |
| Increase/(decrease) in receivables | | | (12,564,558) | 12,564,558 |
| less movement in current financial assets | | | 13,493,887 | (13,493,887) |
| (Increase)/decrease in payables | | 1,000,000 | (7,985,764) | 8,985,764 |
| less movement in payables to the Consolidated Fund | | | 272,656 | (272,656) |
| Use of provisions | | 3,575,153 | 3,052,069 | 523,084 |
| | | 210,784,059 | 188,526,614 | 22,257,445 |
| **Removal of non-voted budget items:** | | | | |
| National Insurance contributions | | (22,823,176) | (22,823,176) | - |
| Other adjustments | | | | |
| Other cashflow adjustments | | | 21,686 | (21,686) |
| **Net cash requirement** | | **187,960,883** | **165,725,124** | **22,235,759** |

1. COVID-19 adjustments for NCR boundary reflect the non-cash impact of COVID-19 transactions where non-standard budgeting treatments have been agreed with HM Treasury.

For explanations of variances between estimate and resource and capital outturn, please see explanations of material variances from **paragraph 849** onwards.

## SOPS 4 Income payable to the Consolidated Fund

In addition to income retained by the Department, the following income relates to the Department and is payable to the Consolidated Fund (cash receipts being shown in italics).

| | Outturn 2020-21 £'000 | | Outturn 2019-20 £'000 | |
|---|---|---|---|---|
| | **Income** | ***Receipts*** | **Income** | ***Receipts*** |
| Operating income outside the ambit of the Estimate | 365,721 | *365,721* | 571,133 | *571,133* |
| Excess cash surrenderable to the Consolidated Fund | - | - | - | - |
| **Total income payable to the Consolidated Fund** | **365,721** | ***365,721*** | **571,133** | ***571,133*** |

During 2020-21 further income that HM Treasury determined is surrenderable to the Consolidated Fund has been recognised in accordance with IFRS 15, which requires the recognition of income only when it is highly probable the income will be received. The value of income recognised in 2020-21 is £364 million and is included within other contract income.

## Parliamentary Accountability Disclosures (subject to audit)

The following disclosures are all subject to audit.

## Regularity of Expenditure

We are custodian 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 are detailed within the Statement of Accounting Officer Responsibilities and the Governance Statement.

## C&AG opinion on regularity

With regards to the qualified opinion concerning the regularity of expenditure in the Department's Financial Statements, a summary of the matters that the NAO have identified as irregular can be found in the **Governance Statement** from **paragraph 648. The Report of the Comptroller and Auditor General to the House of Commons** also contains information pertaining to this.

## Losses and Special Payments

### Table 33: Losses Statement

| | | 2020-21 | | 2019-20 | |
|---|---|---|---|---|---|
| | | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Total** | Cases | 326 | 60,363 | 306 | 65,602 |
| | £'000 | 1,587,099 | 1,094,364 | 89,564 | 180,994 |
| **Cases over £300,000** | | | | | |
| Cash losses | Cases | 3 | 8 | - | 1 |
| | £'000 | 1,529 | 32,197 | - | 586 |
| Claims abandoned | Cases | - | 3 | - | 2 |
| | £'000 | - | 2,049 | - | 2,327 |
| Cancellation of Public Dividend Capital (PDC) | Cases | 10 | - | - | - |
| | £'000 | 669,229 | - | - | - |
| Administrative write-offs | Cases | - | 1 | - | 2 |
| | £'000 | - | 1,600 | - | 1,019 |
| Fruitless payments | Cases | 101 | 105 | - | 6 |
| | £'000 | 674,967 | 690,855 | - | 10,381 |
| Constructive Loss | Cases | 44 | 50 | 3 | 3 |
| | £'000 | 168,441 | 185,729 | 2,829 | 2,829 |
| Store losses | Cases | - | 4 | - | 2 |
| | £'000 | - | 1,515 | - | 986 |
| Bookkeeping losses | Cases | - | - | - | - |
| | £'000 | - | - | - | - |

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.

### Department of Health and Social Care Share of National Insurance Contribution Losses

Included within its total losses, the Department has recorded a technical loss of £70.7 million which is its share of the overall, cross-government loss relating to National Insurance Contributions (NICs). Such losses occur when contributions cannot be collected because companies have ceased to exist during the year. Her Majesty's Revenue & Customs (HMRC) allocates this category of loss to those Departments which are partially funded from NICs, on a proportional basis. It should be noted that the disclosure of this category of loss is a technical requirement which is completely outside the Department's control.

### Losses resulting from Foreign Exchange Transactions

As part of the Department's response to the COVID-19 pandemic, deposits were paid to suppliers to secure purchases of necessary equipment. Subsequently, some orders were not fulfilled and deposits were returned, which caused exchange rate losses totalling £1,529k.

## Constructive Losses

As part of the Department's response to the COVID-19 pandemic, in September 2020, the combination of an accelerated inbound supply of PPE products, with a lower than expected outbound demand, resulted in a sharp increase of PPE inventory in the UK. The PPE Programme Team secured sufficient storage capacity to hold the increased volume of PPE containers, but it was not possible to move all shipping containers from the port to the storage facility before the grace period, which was typically between 5 and 7 days, before demurrage charges were made. As a consequence, the Department incurred demurrage charges of £111.5 million.

The School Fruit and Vegetable Scheme (SFVS) was temporarily suspended when all schools were closed, except for vulnerable children and the children of key workers, on 5 January 2021, as part of the Government's management of the COVID-19 pandemic. The Department had already contracted to pay for produce to be delivered to schools, as part of the SFVS during this period. The losses incurred during the temporary suspension of the scheme, and during the remainder of the first half of the term totalled £1,247k, which comprised distribution costs of £657k and produce costs of £590k. The Department donated £247k of the produce to food charities.

A constructive loss of £1.1 million has arisen following a negotiated refund amounting to the value of 70 per cent of an undelivered order. As part of the Department's response to the COVID-19 pandemic, the Department had received a part shipment of ventilators which did not fully meet functionality requirements at the time. Consequently, the remainder of the order was cancelled. As the supplier had technically met the contract's specification and had already incurred costs, 30% of the contract value was unable to be recovered.

The Department agreed to pay a supplier a cancellation fee of £790k relating to a contract to supply PPE valued at £2.36 million which was placed as part of the Department's response to the COVID-19 pandemic. The buy-out enabled the Department to avoid further freight and logistics costs of £1.8 million.

As part of the Department's response to the COVID-19 pandemic, medical equipment was purchased to meet urgent requirements. As items were delivered into UK warehouses they were tested for suitability. Following this assessment, items totalling £50.6 million (valued at weighted average cost) were assessed as either not suitable for use or required remedial action and were therefore written off.

During the year, the Department wrote off laboratory equipment, valued at £663k, following the closure of two Regional Testing Sites, there being no alternative options for repurposing or storing these assets.

Due to the unprecedented circumstances of the pandemic, estimates of the level of demand and the continued availability of supply of some consumables had to be made, with some items bought having short lives. As a result, a central stockpile of Protein

Feed was created to avoid any potential shortfall against requirements. Stock valued at £638k was written-off due to reaching its expiry date.

Additionally, a stockpile of Intensive Care Unit consumables was also created to prevent shortages. A small number of items, valued at £313k, reached their expiry date and had to be written off.

### Fruitless Payments

During the height of the pandemic the demand for Personal Protective Equipment (PPE) far outweighed the supply available globally. As a result the Department placed contracts for the purchase of over 32 billion items of Personal Protective Equipment (PPE) centrally to ensure continuity of supply of these critical safety items. These were then distributed onwards to the NHS and wider health and social care settings free of charge.

Due to the critical nature of the situation there was limited time to fully assess the standard and quality of PPE being purchased (for example, by testing a sample product in advance of contract award). Therefore, before distribution, products not previously purchased were rigorously tested to ensure they conformed to the COVID-19 Pandemic essential technical specifications as issued by the market surveillance authorities, the Health and Safety Executive and the Medicines and Healthcare products Regulatory Agency.

Some products unfortunately failed to meet the specified criteria due to failing quality or safety standards, a lack of product documentation or insufficient packaging & labelling. These items are therefore unsuitable for use in health and social care settings as intended. Where possible the Department has sought to repurpose these items so they can be safely used in different settings (for example, over 115 million face coverings have been supplied to schools). The Department has recorded losses of £673 million for items purchased, which following technical assurance, were deemed unsuitable for use in the NHS and could not be repurposed for other uses or sold, this was across 122 contracts.

The fruitless payment of £673 million described above is included at the weighted average cost price of the relevant functionally interchangeable stock categories. This ensures consistency between the impairments disclosed in the financial statements and this losses disclosure.

As disclosed in Note 8, the Department recognised impairments totalling £8,705 million in respect of personal protective equipment, including the £673 million disclosed as a fruitless payment above. The remaining £8,032 million represents the Department's best estimate of the diminution of value of personal protective equipment. Included within this amount is £2,581 million relating to inventory which is not suitable for its original intended use but where the department has assessed that the inventory may be suitable for use in other settings and remains committed to identifying alternative uses and resale where possible, and £750 million relating to inventory which has an expiry

date prior to the expected usage date. These amounts represent the Department's best estimate of the likely loss which may crystalise and therefore become reportable as losses in future accounting periods. Work is ongoing to ensure that the maximum possible value is recovered in respect of these inventory items.

Additionally, impairments in respect of personal protective equipment include £4,701 million arising from fluctuations in market value. In early 2020-21, disruption to the PPE market, coupled with an unprecedented spike in demand, resulted in huge inflation in the price of goods and intense global competition to secure scarce supplies. The PPE market had begun to stabilise by 31 March 2021. A significant diminution in value due to change in market price was acknowledged as a possibility at the point of purchase, but was necessary to secure the required supplies of these vital items during a time of global and national crisis.

Changes in inventory value due to fluctuation in market price do not meet the definition of losses and are therefore not recorded as losses in the table above, but are disclosed as impairments in the financial statements and are referenced here for clarity. The valuation method used to calculate each of the inventory impairments mentioned above is disclosed in **Note 8**.

The Department has impaired NHS Test and Trace consumables totalling £195 million in respect of items for which we have not currently identified a suitable use as described in Note 8. These amounts represent the Department's best estimate of the likely loss which may crystalise and therefore become reportable as losses in future accounting periods. Work is ongoing to ensure that the maximum possible value is recovered in respect of these inventory items. These amounts are therefore not recorded as losses in the current accounting period.

As part of the Department's response to the COVID-19 pandemic, two flights relating to the transportation of PPE from China had to be cancelled due to lack of stock availability at the time, and the £649k deposit for the two flights was taken as a cancellation charge, as per the terms of the contract.

As part of the Department's response to the COVID-19 pandemic, due to changing requirements the Department incurred a cancellation fee of £339k following the cancellation of two contracts for quarantine hotels.

Interest payments were paid to a supplier totalling £1.6 million, resulting from the late payment of invoices. The invoices, for goods purchased as part of the Department's response to the COVID-19 pandemic, were paid late as a result of a contractual dispute with the supplier. It was subsequently agreed that DHSC was contractually obliged to pay the costs and the interest.

## Cancellation of Public Dividend Capital (PDC)

PDC is issued to NHS Trusts and NHS Foundation Trusts under specific statutory powers given to the Department. 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 needs 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 i.e. 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 HM Treasury Minute.

As disclosed in the 2019-20 Annual Report and Accounts, while a Minute for 2019-20 was prepared, it was not laid in Parliament prior to 31 March 2020, due to prioritisation of the COVID-19 response. Therefore no PDC was written off in 2019-20. This is now reflected in the 2020-21 Annual Report and Account accordingly. During 2020-21, the Department gained HM Treasury approval to write off £669.2 million of PDC. The detail for each PDC write off is summarised below.

In relation to PDC expected to be written off in 2019-20, now written off in 2020-21:

- £4.1 million related to the dissolution of Burton Hospitals NHS Foundation Trust on 1 July 2018 when acquired by Derby Teaching Hospitals NHS Foundation Trust, resulting in creation of the University Hospitals of Derby and Burton NHS Foundation Trust;
- £54.5 million related to the dissolution of Ipswich Hospital NHS Trust on 1 July 2018 when acquired by Colchester Hospital University NHS Foundation Trust resulting in creation of the East Suffolk and North Essex NHS Foundation Trust; and
- £9.2 million related to the merger of City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust on 1 April 2019 to form the South Tyneside and Sunderland NHS Foundation Trust.

Regarding further amounts of PDC written off in 2020-21:

- £54.6 million related to the dissolution of Royal Liverpool and Broadgreen University Hospitals NHS Trust on 1 October 2019 when acquired by Aintree University Hospital NHS Foundation Trust, resulting in creation of Liverpool University Hospitals NHS Foundation Trust;
- £202 million related to the dissolution of North Cumbria University Hospitals NHS Trust on 1 October 2019 when acquired by Cumbria Partnership NHS Foundation Trust, resulting in creation of North Cumbria Integrated Care NHS Foundation Trust;

- £1.8 million related to the dissolution of Gloucester Care Services NHS Trust on 1 October 2019 when acquired by 2gether NHS Foundation Trust, resulting in the creation of Gloucestershire Health and Care NHS Foundation Trust;
- £33.2 million related to the dissolution of Basildon and Thurrock University Hospitals NHS Foundation Trust and £181.5 million related to the dissolution of Mid Essex Hospital Services NHS Trust on 1 April 2020 when acquired by Southend University Hospital NHS Foundation Trust, resulting in creation of Mid and South Essex NHS Foundation Trust;
- £71.5m related to the dissolution of Bedford Hospital NHS Trust on 1 April 2020 when acquired by Luton and Dunstable University Hospital NHS Foundation Trust resulting in the creation of Bedfordshire Hospitals NHS Foundation Trust; and
- £56.8m related to the dissolution of Weston Area Health NHS Trust on 1 April 2020 when acquired by University Hospitals Bristol NHS Foundation Trust, resulting in creation of University Hospitals Bristol and Weston NHS Foundation Trust;

### Table 34: Analysis of Losses by Sector Restated

| | 2020-21 | 2019-20 | 2020-21 | 2019-20 |
|---|---|---|---|---|
| | Cases | | Value | |
| | Number | | £'000 | |
| DHSC Core | 283 | 182 | 1,585,406 | 87,686 |
| Public Health England | 43 | 124 | 1,693 | 1,878 |
| NHS England Group | 1,979 | 8,240 | 63,713 | 2,436 |
| NHS Providers | 53,986 | 53,615 | 109,109 | 83,893 |
| NDPBs | 3,751 | 3,344 | 3,599 | 4,605 |
| Special Health Authorities | 331 | 94 | 73 | 110 |
| Other Group entities | - | 3 | - | 386 |
| Eliminations | (10) | - | (669,229) | - |
| **Departmental Group** | **60,363** | **65,602** | **1,094,364** | **180,994** |

1. Professional Standards Authority was an NDPB in the prior year but was classified as an Other Group entity in 2020-21. For comparability purposes, the 2019-20 case numbers and values have been restated to reflect this change.

## Table 35: Special Payments

| | | 2020-21 | | 2019-20 | |
|---|---|---|---|---|---|
| | | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Total** | Cases | 69 | 7,097 | 109 | 7,937 |
| | £'000 | 4,725 | 26,191 | 23,934 | 42,952 |
| **Cases over £300,000** | Cases | 4 | 11 | 28 | 29 |
| | £'000 | 2,898 | 8,625 | 22,107 | 23,014 |

## Special Payments

Special Payments are transactions that Parliament could not have anticipated when passing legislation or approving Supply Estimates for the Department. 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.

There were two payments made of £1.2m and £850k as a result of litigation. This related to the procurement of automated outcome diagnosis software for use by specified laboratories. The choice in the use of the software was challenged through both Judicial Review proceedings and a procurement challenge under the Public Contracts Regulations 2015.

After discussions between legal representatives a negotiated settlement was agreed, and the claimant accepted the Part 36 offer of £1.2m plus costs of £850k. This payment covered the costs proportion of the litigation as agreed by both parties.

All other Core Department cases over £300,000 have not been disclosed on confidentiality grounds. As per paragraph A4.13.7 of HM Treasury's Managing Public Money (MPM) the Department ensures that any proposal to keep a special payment confidential is carefully justified in line with MPM requirements.

NHS England managed the process of obtaining HM Treasury approval for special payments in the NHS resulting from the national settlement of liabilities following the decision of the Employment Appeal Tribunal (EAT) in Flowers and others versus East of England Ambulance Trust and this judgement being applied to all employers. This approval on NHS providers' behalf totalled £159.9 million, in addition to the £1.0 million relating to NHS England group bodies included in the NHS England annual report and accounts.

## Table 36: Special Payments by Sector

| | 2020-21 | 2019-20 | 2020-21 | 2019-20 |
|---|---|---|---|---|
| | Cases | | Value | |
| | Number | | £'000 | |
| DHSC Core | 69 | 105 | 4,725 | 23,925 |
| Public Health England | - | 4 | - | 9 |
| NHS England Group | 111 | 32 | 3,703 | 221 |
| NHS Providers | 6,903 | 7,637 | 17,686 | 18,535 |
| NDPBs | 1 | 9 | 1 | 115 |
| Special Health Authorities | 7 | 149 | 3 | 118 |
| Other Group entities | 6 | 1 | 73 | 29 |
| **Departmental Group** | **7,097** | **7,937** | **26,191** | **42,952** |

## Other Payments

There have been no other payments made by the Core Department for 2020-21 or in 2019-20.

## Fees and Charges

## Table 37: Fees and Charges

| | 2020-21 Departmental Group | | |
|---|---|---|---|
| | Fees and Charges Income | Full Cost of Service | Surplus/(Deficit) |
| | £'000 | £'000 | £'000 |
| Dental | 277,665 | 3,031,109 | (2,753,444) |
| Prescription | 615,251 | 11,451,653 | (10,836,402) |
| Other Fees and Charges for which the cost of providing the service is over £1million | 409,847 | 267,774 | 142,073 |
| **Total** | **1,302,763** | **14,750,536** | **(13,447,773)** |

| | 2019-20 Departmental Group | | |
|---|---|---|---|
| | Fees and Charges Income | Full Cost of Service | Surplus/(Deficit) |
| | £'000 | £'000 | £'000 |
| Dental | 848,292 | 2,958,262 | (2,109,970) |
| Prescription | 614,126 | 10,491,869 | (9,877,743) |
| Other Fees and Charges for which the cost of providing the service is over £1million | 375,149 | 314,484 | 60,665 |
| **Total** | **1,837,567** | **13,764,615** | **(11,927,048)** |

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 are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2020-21, the NHS prescription charge for each medicine or appliance dispensed was £9.15. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £29.65 for three months or £105.90 for a year.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into three bands depending on the level and complexity of care provided. In 2020-21, the charge for Band 1 treatments was £23.80, for Band 2 was £65.20 and for Band 3 was £282.80.

Included in the 'Other fees and charges' (for which the cost of providing the service is over £1.0 million) is £205.2 million (2019-20: £204.0 million) of fees and charges and £196.6 million (2019-20: £199.1 million) of expenditure relating to regulatory income at the Care Quality Commission. The remaining balance relates to the COVID-19 Managed Quarantine Service and services provided by other NDPBs and other ALBs. Further information relating to fees and charges can be obtained from the financial statements of underlying bodies.

## Remote Contingent Liabilities (subject to audit)

In addition to IAS 37 contingent liabilities disclosed within the Accounts, the Department 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 the Department 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

The Department 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.

| | 1 April 2020 | | Increase in year | Liabilities crystallised in year | Obligation expired in year | 31 March 2021 | | Amount reported to Parliament by departmental Minute |
|---|---|---|---|---|---|---|---|---|
| | £'000 | No. | £'000 | £'000 | £'000 | £'000 | No. | £'000 |
| Guarantees | 156 | 1 | 77 | - | - | 233 | 1 | - |
| Indemnities | 1,500 | 1 | 1,620 | - | - | 3,120 | 3 | - |
| Letters of comfort | - | - | - | - | - | - | - | - |
| **Total** | **1,656** | **2** | **1,697** | **-** | **-** | **3,353** | **4** | **-** |

## Unquantifiable

The Department has entered into a number of unquantifiable or unlimited contingent liabilities with various health bodies and private companies. Where the 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.

There were ten unquantifiable indemnities. 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.

1. The 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). This relates to any liability to its employees as defined in section (1) of the Employers' Liability (Compulsory Insurance) Act 1969. The Department would indemnify the Board in the event of any legal act incurring liability for damages, providing the action arose from the proper discharge of its statutory duties.

2. The 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.

3. The 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)

4. The 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 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.

5. The Department holds an insurable risk for professional indemnity or malpractice on behalf of the Human Tissue Authority (HTA).

6. The 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.

7. The Department has undertaken to meet the legal costs of medical, scientific and nursing staff engaged on clinical trials approved by NHS Blood and Transplant.

8. The Department has undertaken to cover any damages arising from NHS Blood and Transplant clinical trials activity.

9. The Department holds liabilities in respect of commercial contract obligations. These liabilities include contractual indemnities the Department has entered into as part of its response to COVID-19.

10. The Department provides an indemnity in respect of an inquiry

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 & 2** and accompanying narrative can be found within **Annex A**.

28 January 2022
Sir Chris Wormald KCB
**Permanent Secretary**
**Department of Health and Social Care**

## The Certificate of the Comptroller and Auditor General to the House of Commons

### Qualified opinion on financial statements

I certify that I have audited the financial statements of the Department of Health and Social Care and of its Departmental Group for the year ended 31 March 2021 under the Government Resources and Accounts Act 2000. The Department comprises the Core Department and its Agency. The Departmental Group consists of the Department and the bodies designated for inclusion under the Government Resources and Accounts Act 2000 (Estimates and Accounts) (Amendment) (No. 2) Order 2020. The financial statements comprise: the Department's and Departmental Group's Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. The financial reporting framework that has been applied in their preparation is applicable law and International Accounting Standards as interpreted by HM Treasury's Government Financial Reporting Manual

I have also audited the Statement of Outturn Against Parliamentary Supply and the related notes, and the information in the Accountability Report that is described in that report as having been audited.

In my opinion, except for the effects of the matters described in the basis for qualified opinions on the financial statements section below, the financial statements:

- give a true and fair view of the state of the Department's and the Departmental Group's affairs as at 31 March 2021 and of the Department's total net expenditure and Departmental Group's total 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.

### Emphasis of Matter – Provision for Clinical Negligence Scheme for NHS Trusts

I draw attention to the disclosures made in note 16 to the financial statements concerning the uncertainties inherent in the claims provision for the Clinical Negligence Scheme for Trusts. As set out in note 16, given the long-term nature of the liabilities and the number and 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.

### Qualified opinion on regularity

In my opinion, except for the effects of the matters described in the basis for qualified opinions on regularity sections below, 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 2021 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 qualified opinions on the financial statements

I have qualified my opinion on the financial statements in three respects.

### 1) Basis for qualified opinion arising from the lack of records in respect of inventory, the onerous contract provision balance and associated transactions

Firstly, in respect of the inventory held by the Department and the Group and related transactions recorded in the financial statements, the evidence available to me was limited as the Department was unable to perform stock takes or provide alternative evidence of the existence, valuation or completeness of inventory held at year end.

Consequently, I was unable to obtain sufficient, appropriate audit evidence to support £3.6 billion of consumables inventory held by the Core Department and represented in the Core Department & Agencies and Group's Statement of Financial Position. In the absence of evidence to support the existence or condition of inventory held, I am unable to assess the completeness and accuracy of the associated transactions in the Core Department & Agencies and Group's Statement of Comprehensive Net Expenditure including impairments recognised of £9.0 billion and inventory consumption of £6.1 billion recorded in note 12.

In addition, I was unable to obtain sufficient, appropriate audit evidence to support the valuation of the Core Department & Agencies and Group's onerous contract provisions of £1.2 billion, or the accuracy of related expenditure, which are based on assumptions of the level of excess inventory holdings at year end.

### 2) Basis of qualified opinion on accruals due to the insufficient evidence available to demonstrate this area is free from material misstatement

Secondly, I was unable to obtain sufficient assurance in respect of the existence and valuation of the Group's Other accruals at 31 March 2021 of £17.2 billion reported in note 15. Cumulatively across the Group, there has been a significant increase in Other liabilities reported, including accruals, compared to 31 March 2020. Through my audit I identified significant but immaterial levels of overstatement of accruals and related expenditure. In addition, I identified significant populations of accruals where the Department were unable to provide and has been unable to obtain adequate records to support the balance included in the financial statements in the timescale required to meet the statutory deadline for reporting of 31 January 2022. The combination of these factors has led me to limit the scope of my opinion in respect of the Group's Other

accruals reported at 31 March 2021, and the associated transactions, including those related to accruals.

### 3) Basis of qualified opinion on opening balance of other financial assets due to disagreement on the application of IFRS 9

While able to support the 31 March 2021 other financial assets balance, I disagreed with the accounting treatment of the loans issued by the Core Department to NHS Trusts and Foundation Trusts, recognised within the Core Department & Agencies Statement of Financial Position as at 31 March 2020, as the requirements of IFRS 9 'Financial Instruments' were not applied. This standard requires that an impairment for expected credit losses is recognised for loans held at amortised cost, considering all reasonable and supportable information, including that which is forward looking. I consider this would have resulted in the opening carrying value being approximately £2.2 billion lower than presented.

### Basis for qualified opinions on regularity

I have qualified my opinion on regularity in two respects.

### 1) Basis for qualified opinion on regularity arising from failure to comply with requirements of Managing Public Money

Firstly, during 2020-21 the Department spent £1.3 billion on projects where they are required to, but did not have, explicit approval from HM Treasury or where the spend breached previous conditions agreed with HM Treasury. The Department is required to comply with the requirements of HM Treasury's Managing Public Money as part of its framework of authorities, including obtaining approval for expenditure where authority has not been delegated. £1.3 billion of expenditure did not, therefore, comply with the framework of authorities and is irregular.

### 2) Basis for qualified opinion on regularity due to insufficient evidence to demonstrate that the spend incurred, particularly on Covid-19 procurement was regular under the framework of authorities

Secondly, I have limited the scope of my opinion on the regularity of expenditure in respect of the risk of losses arising from fraud. Fraud losses arising are always irregular. In any year, the Department is subject to a level of fraud for example through prescription fraud. The level of fraud risk has increased as a result of COVID-19 related procurement. In the context of the limitations in records to support the existence and condition of inventory held and associated transactions I have been unable to perform sufficient procedures to conclude that the overall level of losses arising from fraud are not material. The Department has provided a risk assessment of the level of fraud arising from COVID-19 related expenditure, however, I do not consider that this provides me with adequate assurance that the level of fraud losses are not material when aggregated with the pre-existing fraud risks the Department is exposed to.

## Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. 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 2019. I have also elected to apply the ethical standards relevant to listed entities. I am independent of the Department of Health and Social Care in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

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

## Conclusions relating to going concern

In auditing the financial statements, I have concluded that the Department of Health and Social Care'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 of Health and Social Care'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 of Health and Social Care 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 anticipated that the services which they provide will continue into the future.

## Other Information

The other information comprises information included in the annual report, but does not include the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's certificate thereon. The Accounting Officer is responsible for the other information. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, 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, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements.

### Matters on which I report by exception

In the light of the knowledge and understanding of the Department of Health and Social Care and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Report.

In respect solely of the matters referred to in my basis for qualified opinions on the financial statements section and my basis for my qualified opinions on regularity section above:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; and
- I have not received all the information and explanations I require for my audit.

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

- the financial statements and the parts of the Accountability Report to be audited are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made; 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:

- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error; and
- assessing the Department of Health and Social Care'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 of Health and Social Care 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.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included the following:

- Inquiring of management, the Department of Health and Social Care's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Department of Health and Social Care's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and

- the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Department of Health and Social Care Group's controls relating to Government Resources and Accounts Act 2000, Managing Public Money, Supply and Appropriation (Main Estimates) Act 2020 and the Coronavirus Act 2020.

- discussing among the engagement team including significant component audit teams and involving relevant internal and or external specialists including actuarial support to audit the clinical negligence provisions IBNR, in modelling and statistics and valuation of assets & liabilities, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, posting of unusual journals, bias in management estimates, and claims that feed into clinical negligence provisions;

- obtaining an understanding of Department of Health and Social Care's and group's framework of authority as well as other legal and regulatory frameworks that the Department of Health and Social Care and Group operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Department of Health and Social Care and 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 2020, employment law, tax legislation, health & safety and pension legislation and the Coronavirus Act 2020; and

- specific consideration of the Department's assessment of the level of fraud in COVID-19 expenditure incurred in response to the pandemic.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;

- enquiring of management, the Audit & Risk Committee concerning actual and potential litigation and claims;

- reading minutes of meetings of those charged with governance and the Board;

- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting 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

- reviewing the Department's methodology and assumptions in assessing the level of fraud in COVID-19 expenditure incurred in response to the pandemic.

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and significant 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.

I am required to obtain evidence sufficient to give reasonable assurance that the Statement of Outturn of 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 also required to obtain evidence sufficient 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 that I identify during my audit.

**Gareth Davies** **31 January 2022**

**Comptroller and Auditor General**

National Audit Office

157-197 Buckingham Palace Road

Victoria

London

SW1W 9SP

## The Report of the Comptroller and Auditor General to the House of Commons

### Introduction

1. The Annual Report and Accounts of the Department of Health and Social Care ("the Department") sets out the extraordinary financial impact of an extraordinary event - the COVID-19 pandemic - on the Department. The Departmental Group's total operating expenditure increased to £191.9 billion in 2020-21, a 30 per cent increase on 2019-20 (Figure 1). This included a £20.5 billion (31%) increase in operating expenditure on the purchase of goods and services.

**Figure 1: Analysis of the Department's operating expenditure, 2020-21**

| Area of operating expenditure | 2020-21 Outturn £ billion | 2019-20 outturn £ billion | Increase/ (decrease) % |
|---|---|---|---|
| Staff costs | 72.1 | 64.3 | 12 |
| Purchase of goods and services | 86.5 | 66.0 | 31 |
| Depreciation and impairment charges | 14.0 | 4.1 | 241 |
| Provision expense | 3.9 | 4.6 | (15) |
| Other operating expenditure | 15.4 | 9.1 | 69 |
| Resources expended by NHS charities | 0.1 | 0.1 | 0 |
| Total operating expenditure | 191.9 | 148.1 | 30 |

Source: Department's Annual Report and Accounts 2020-21, Consolidated Statement of Comprehensive Net Expenditure

2. I have previously reported in more detail on the Department's response to the pandemic in a number of my reports, including: Overview of the UK government's response to the COVID-19 pandemic; Readying the NHS and adult social care in England for COVID-19; Investigation into how government increased the number of ventilators available to the NHS in response to COVID-19; The supply of personal protective equipment (PPE) during the COVID-19 pandemic; Investigation into government procurement during the COVID-19 pandemic; The government's approach to test and trace in England – interim report; Investigation into preparations for potential COVID-19 vaccines; Protecting and supporting the clinically extremely vulnerable during lockdown; The adult social care market in England, Initial learning from the government's response to the COVID-19 pandemic; and, Test and trace in England – progress update.

3. In this report, I set out my findings from my audit of the Department's accounts and explain why I have qualified my opinion on a number of matters.

### Key findings

4. The COVID-19 pandemic put the Department under extraordinary pressure. It needed urgently to procure enormous volumes of goods and services in an

overheated global market. The Department has stated that its priority was to ensure that it was able to meet the requirements of a reasonable worst case scenario. In order to do so, it rapidly increased its risk appetite and adapted its normal processes and procedures. The Department was not able to manage adequately some of the elevated risks, resulting in significant losses for the taxpayer. Nearly two years later, it has not fully restored effective control over some of the inventory purchased:

- The Department estimates that there has been a loss in value of £8.7 billion of the £12.1 billion of PPE purchased in 2020-21. Of this £8.7 billion impairment, £4.7 billion relates to reductions in market prices since the goods were purchased.
- The Department's inventory management systems were unable to cope with the significant, rapid increase in procurement and the Department did not maintain adequate records of the location or condition of £3.6 billion of inventory balances recorded in the accounts at the 31 March 2021. Since the year-end, the Department has made progress in improving its records, but significant work remains to be done.
- The level of fraud risk has increased as a result of COVID-19 – related procurement. A significant increase in new suppliers, a lack of timely checks on the quality of goods received and poor inventory management all contributed to this heightened risk. In these circumstances and given the lack of physical checks on the inventory held by the Department, I have not been able to obtain assurance that there has not been a material level of losses due to fraud.
- £1.3 billion of the Department's COVID-19 spending was irregular because it had spent these funds without the necessary HM Treasury approvals or in express breach of conditions set by HM Treasury.
- There are material levels of error and uncertainty in the accruals balance that has been recognised in the group accounts.

5. Accounting for and auditing the Department's spending in the pandemic has been challenging and this has delayed the publication of the Annual Report and Accounts until ten months after the year-end, although this is still within the statutory deadline. Timeliness is a critical element of effective accountability and it is vital that timely audited accounts are restored as soon as possible. I will work with the Department to help achieve that.

## Covid-related procurement

### Introduction

6. **During 2020-21, the Department procured billions of pandemic-related items including personal protective equipment (PPE), lateral flow testing kits (LFTs), and ventilators**. Most of these items were bought at speed early in the pandemic, at a

time when there was a surge in demand in other countries and a temporary decline in global supply. For PPE, the result was an extremely overheated global market – a 'sellers market' – with desperate customers competing against each other, pushing up prices, and buying huge volumes of PPE often from suppliers that were new to the PPE market.

7. **In order to meet the demand for urgent procurement, the Department adapted its normal procurement and inventory management controls. This has contributed to a significant loss of value to the taxpayer and leaving the Department open to the risk of fraud.** The Department has not yet fully evaluated the financial impact of these control adaptions or re-established effective controls in all areas.

8. **The Department estimates that there has been a loss in value of £8.7 billion of the £12.1 billion of PPE purchased in 2020-21**. This impairment relates to:

   - £0.67 billion of PPE which cannot be used, for instance because it is defective;
   - £2.6 billion of PPE which is not suitable for use within the health and social care sector but which the Department considers might be suitable for other uses (although these potential other uses are as yet uncertain);
   - £0.75 billion of PPE which is in excess of the amount that will ultimately be needed; and
   - £4.7 billion of adjustment to the year-end valuation of PPE due to the market price of equivalent PPE at the year-end being lower than the original purchase price

## Inventory management

9. **The Department's inventory management systems were unable to cope with the significant, rapid increase in COVID-related procurement.** This left the Department with incomplete records of the PPE and LFTs it had purchased, what had been used and the location, condition and quality of the remaining items at the year-end. The Department has brought in external accountancy support to remediate these issues, and some progress has been made, but significant weaknesses and gaps in the Department's inventory records remain.

10. **The weaknesses in its inventory records, combined with significant volumes of inventory being locked in containers at ports, other temporary locations or in storage in China, meant the Department was unable to complete its physical stock-counts at the year-end to verify the quantity and quality of the inventory it held**. The Department's records show that as at 31 March 2021, it held 7.5 billion items in 16,000 containers at UK ports plus a further 1.6 billion of items in storage in China; however, because it did not complete its year end stock counts it is unable to confirm this.

11. **Consequently, I have been unable to obtain sufficient, appropriate audit evidence to support £3.6 billion of consumables inventory recorded in the Core Department & Agencies' and Group's Statement of Financial Position**. I am unable to assess the completeness and accuracy of the associated transactions in the Core Department & Agencies and Group's Statement of Comprehensive Net Expenditure including impairments recognised of £9.0 billion (including £8.7 billion for PPE). and inventory consumption stated to be £6.1 billion (including £3.3 billion of Test and Trace consumables) in note 12.

12. **In addition, I have been unable to obtain sufficient, appropriate audit evidence to support the valuation of the Core Department & Agencies' and Group's onerous contract provisions of £1.2 billion**, or the accuracy of related expenditure. These provisions relate to PPE which had been purchased but not received by 31 March 2021 and which the Department has assessed will require impairment on receipt. The Department's assessment is based on assumptions of the level of excess inventory holdings at year end.

13. **In 2022-23, the Department intends to transfer responsibility for managing the supply of PPE to Supply Chain Coordination Limited (SCCL), while oversight of SCCL transferred from the Department to NHS England in October 2021**. Given the scale of the ongoing issues with PPE, the Department will need to stay involved. It has tasked SCCL with selling, donating and recycling PPE to reduce the amount of PPE stored in shipping containers and other temporary locations. This PPE is not accessible and will deteriorate if kept in poor storage conditions. The Department have informed us that it is currently spending in the region of £500k per day on the storage of PPE. The Department will need to ensure that the right balance is struck between minimising ongoing storage costs, maximising the benefits from items which can be used elsewhere and minimising the environmental impact of items which are not fit for purpose.

14. **I will continue to examine this topic and will be reporting later in 2022 on the way that government is managing the relevant contracts and the PPE it has received to date**. This will include actions taken by government if the goods have not been received, are not what was expected, or are no longer required.

## Controls over COVID-19 spending

15. **The Department's changes to its normal procurement processes in the context of an overheated global market for PPE meant it was exposed to a heightened risk of fraud in 2020-21**. A significant increase in new suppliers, a lack of timely checks on the quality of goods received and poor inventory management all contributed to this heightened risk. In these circumstances and given the lack of physical checks on the inventory held by the Department, I have not been able to obtain assurance that there is not a material level of losses due to fraud.

16. **Public bodies in receipt of public funding must comply with conditions that are set as part of their framework of authorities**. This includes obtaining approval for expenditure from HM Treasury where authority has not been delegated. When

granting additional funding to assist with COVID-19 pandemic response activity, HM Treasury set specific conditions that the Department was required to follow. These were in areas such as: advance payments to secure PPE; advance funding for community pharmacies; enhanced discharge payments to Clinical Commissioning Groups; and dental payments.

17. **The Chief Secretary to the Treasury wrote to the Department on 21 December 2021 confirming HM Treasury's view that £1.3 billion of the Department's spending did not have proper HM Treasury consent and was irregular**. He stated that 'in the vast majority of cases' this was because either the Department or NHS England had spent funds without approval or in express breach of the conditions that had been set.

18. **In view of these issues, I have limited the scope of my opinion on regularity in respect of the risk of losses arising from fraud**. Fraud losses are always irregular. In any year, the Department is subject to a level of fraud, for example through prescription fraud. The level of fraud risk has increased as a result of COVID-19 procurement. **In addition, I have qualified my regularity opinion in respect of the £1.3 billion of expenditure that did not comply with the framework of authorities**.

## Accruals

19. **The Department prepares its annual accounts on an 'accruals basis'**. This means the Department recognises the effects of transactions in the period in which the underlying activity occurs, even if any associated cash receipts and payments occur in a different period.

20. **As accruals are estimates of expenditure, they are vulnerable to bias in their estimation**. Where entities are at risk of breaching their budget, they may have an incentive to undervalue the expenditure accrued in the financial statements or to omit these costs altogether. Conversely, where entities are at risk of underspending against their budget, they may have an incentive to overvalue the expenditure accrued in the financial statements or to recognise liabilities which are unsupported. This may occur, for example, when entities funded on an annual basis wish to carry-forward their funding allocation into future years in anticipation of reduced annual settlements.

21. **At 31 March 2021, the Departmental Group recognised £17.2 billion of accruals, an increase of £7.8 billion compared to 31 March 2020**. This increase is partly due to the scale of the Departmental Group's involvement in the Covid-19 response, with almost all components of the group experiencing significant additional demands on their resources and incurring greater expenses to meet the demands of the pandemic. However, the scale of the increase in the Departmental Group's accruals balance is greater than the increase in expenditure during the year. Whereas group operating expenditure has increased by 30 per cent (£43.8 billion), accruals have increased by 83 per cent.

22. **The Department and NHS England changed the funding regime for local NHS bodies during 2020-21 to support the NHS's response to the COVID-19 pandemic**. In 2019-20, commissioners' and providers' funding included a performance-related element associated with the achievement of an agreed financial control total, which risked creating an incentive for NHS bodies to understate their expenditure and associated liabilities. In 2020-21 this performance-related element was removed. Instead, NHS England introduced a system of block contracts with reimbursement of additional COVID-19 expenditure and the amount of cash in the Departmental group has increased by £7.7 billion to £16.8 billion.

23. **With a change in funding regime, the total accruals error in the NHS increased. For NHS providers this switched from a net understatement to a net overstatement**. In 2019-20 and previously, the auditors of NHS providers reported cumulative errors indicating an understatement of accruals and expenditure. In 2020-21 they have reported cumulative errors indicating an overstatement of accruals and expenditure in their clients' accounts. The cumulative error reported by auditors of Clinical Commissioning Groups in 2019-20 showed a small overstatement of accruals, this error has increased substantially in 2020-21. The net error in the provider sector is estimated at £171 million and in the commissioning sector is estimated at £282 million. These errors are not material to the underlying commissioners' and providers' accounts nor to the NHS England Group Accounts or Consolidated NHS Provider Accounts.

24. **I have also identified significant levels of error and uncertainty arising from weaknesses in financial control and difficulties in obtaining adequate accounting records and supporting evidence in the Department and across the group**. These shortcomings have arisen partly because of the necessity of responding at-pace to the demands of the COVID-19 pandemic and the demands that this has placed on finance teams. However, this has exposed weaknesses in the underlying financial systems and controls which pre-date the pandemic. The Department has significant work to do to address these specific deficiencies in its control environment.

25. **While these issues are not material to individual elements of the Departmental Group, their aggregate impact could be material to the consolidated financial statements. Therefore, I am qualifying my audit opinion as the Department has been unable to provide sufficient evidence that the accruals balance recognised in the Departmental Group's Consolidated Statement of Financial Position as at 31 March 2021 is not materially misstated**.

## Opening balance qualification on valuation of loans issued by Core Department to NHS providers

26. **As reported within my report on the 2019-20 accounts, I qualified my opinion on the 'Core Department & Agencies' Statement of Financial Position (SoFP) due to a misstatement in the carrying value of assets held in the 'Core Department & Agencies' SoFP at 31 March 2020 relating to loans to NHS Trusts**. I reported my view that Trusts having negative net assets and, in some cases, agreeing new

repayment plans, was a clear indicator of increased credit risk. I concluded that a £2.2 billion impairment was necessary at 31 March 2020 to avoid these loans being recorded at a value that was materially misstated.

27. **This qualification does not affect the 31 March 2021 balances**. In September 2020, the Department issued new Public Dividend Capital (PDC) to enable Trusts to repay their loans. Where the value of net assets of a Trust fell below the value of the PDC issued to it, the Department appropriately impaired the PDC in its accounts.

## Other key matters

28. During the course of my audit, I identified a number of other issues which were not significant enough to require a qualification of my opinion, but which I wish to bring to the attention of Parliament.

## Financial reporting and governance issues at University Hospitals of Leicester NHS Trust

29. I reported last year that the auditor of University Hospitals of Leicester NHS Trust (UHL) had been unable to complete their audit of UHL's 2019-20 financial statements. The auditor notified me of significant issues that were indicative of management override of control at that Trust in 2018-19, as well as further significant technical issues in UHL's accounting records for 2019-20. As a result of the issues that the auditor identified, UHL's management were not prepared to sign the draft 2019-20 accounts as 'true and fair' and the auditor was of the view that the accounts were not 'true and fair'.

30. When I reported last year, UHL's management had planned to prepare a new set of 2019-20 financial statements. Their objective was to enable the auditor to complete the audit of these by the end of March 2021. As at the date of this report, UHL is yet to sign and publish its financial statements for either 2019-20 or 2020-21. For a second year in a row, an NHS trust has failed to comply with the Secretary of State's directions to prepare 'true and fair' accounts.

31. I have considered the impact of UHL's failure to produce 'true and fair' accounts for my certificate and report. According to the schedules that UHL have provided to NHS Improvement for preparing the Consolidated NHS Provider Accounts and the Department's Annual Report and Accounts in 2020-21, UHL earned £1.3 billion of income in 2020-21.

32. Taking account of alternative procedures that NHS Improvement has been able to perform, and which I have reviewed, I have concluded that the issues are not material to the Consolidated NHS Provider Accounts or the Departmental Group. However, given that this unprecedented failure has continued for a second year, beyond the timescales that UHL initially envisaged, I consider it appropriate to bring this matter to Parliament's attention once again.

## Losses and special payments

33. The Department is required under HM Treasury's Managing Public Money to include a full list of all losses across the Departmental Group. As set out on pages 181-182 of the Annual Report and Accounts, the Department has made impairments of £8.97 billion on PPE and Test and Trace consumable inventory in note 8 that have not yet been recognised as losses in Table 33. It is therefore highly likely that further losses will be recognised in future years

**Gareth Davies** **31 January 2022**
**Comptroller and Auditor General**

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

# Financial Statements

## Consolidated Statement of Comprehensive Net Expenditure

This account summarises the expenditure incurred, and income generated on an accruals basis. It also includes other comprehensive income and expenditure, including changes to the value of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

## For the period ended 31 March 2021

| | Notes | 2020-21 Core Dept & Agencies £'000 | 2020-21 Departmental Group £'000 | 2019-20 Restated Core Dept & Agencies £'000 | 2019-20 Departmental Group £'000 |
|---|---|---|---|---|---|
| Income from contracts | 5 | (1,283,342) | (7,629,690) | (1,614,566) | (9,883,068) |
| Other non-contract operating income | 5 | (1,628,884) | (1,729,699) | (684,731) | (1,285,084) |
| Income received by NHS charities | 19 | - | (174,031) | - | (153,216) |
| **Total operating income** | | **(2,912,226)** | **(9,533,420)** | **(2,299,297)** | **(11,321,368)** |
| Staff costs | 3 | 1,126,645 | 72,075,776 | 441,981 | 64,289,117 |
| Purchase of goods and services | 4 | 13,034,748 | 86,470,730 | 1,035,670 | 65,998,002 |
| Depreciation and impairment charges | 4 | 11,908,893 | 14,032,469 | 421,622 | 4,083,234 |
| Provision expense | 4 | 2,787,560 | 3,912,199 | 1,521,308 | 4,567,520 |
| Other operating expenditure | 4 | 10,865,668 | 15,366,736 | 6,204,810 | 9,077,770 |
| Grant in Aid to NDPBs | | 149,814,029 | - | 127,548,939 | - |
| Funding to Group bodies | | 574,327 | - | 629,036 | - |
| Resources expended by NHS charities | 19 | - | 59,524 | - | 78,644 |
| **Total operating expenditure** | | **190,111,870** | **191,917,434** | **137,803,366** | **148,094,287** |
| **Net operating expenditure for the year ended 31 March 2021** | | **187,199,644** | **182,384,014** | **135,504,069** | **136,772,919** |
| Finance income | | (87,093) | (29,764) | (372,633) | (89,819) |
| Finance expense | | (27,976) | 1,503,064 | 25,438 | 1,515,584 |
| Net (gain)/loss on transfers by absorption | | 6,041 | 232 | - | - |
| **Total Net Expenditure for the year ended 31 March 2021** | | **187,090,616** | **183,857,546** | **135,156,874** | **138,198,684** |
| **Other Comprehensive Net Expenditure** | | | | | |
| **Items that will not be reclassified to net operating costs:** | | | | | |
| Net (gain)/loss on: | | | | | |
| - revaluation of property, plant and equipment | | (26,876) | (871,516) | 2,338 | (1,563,970) |
| - revaluation of intangibles | | (48,056) | (54,388) | (23,830) | (49,200) |
| -revaluation of charitable assets | | - | (54,865) | - | 21,173 |
| - impairments and reversals taken to revaluation reserve | | 781 | 920,647 | 20 | 1,014,048 |
| - equity instruments measured at fair value through OCI | | (53,808) | (307,298) | (314,278) | (111,761) |
| Actuarial (gains)/losses on defined benefit pension schemes | | - | 36,922 | - | (10,540) |
| Other pensions remeasurements | | - | (18,079) | - | 11,068 |
| Other (gains) and losses | | - | 714 | - | 680 |
| **Total Comprehensive Expenditure for the year ended 31 March 2021** | | **186,962,657** | **183,509,683** | **134,821,124** | **137,510,182** |

1. In all material respects, the income and expenditure disclosed in the Consolidated Statement of Comprehensive Net Expenditure relates to activities that are continuing.
2. Per the FReM 8.2 PDC 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 5 income.
3. The net gain on equity instruments measured at fair value through OCI for the Core Department & Agencies has been increased by £188 million to reflect the effect of a prior period adjustment in 2019-20 in respect of the valuation of equity investments held by the Core Department. All of the affected investments are entities within the Departmental Group accounting boundary and there is therefore no impact on the Departmental Group position. See Note 11 for further details relating to the restatement.

## Consolidated Statement of Financial Position

This statement presents the financial position of the Department. It comprises three main components: assets owned or controlled; liabilities owed to other bodies; and equity, the remaining value of the entity.

## As at 31 March 2021

| | | 2020-21 | | 2019-20 Restated | | As at 1 April 2019 Restated | |
|---|---|---|---|---|---|---|---|
| | Notes | Core Dept & Agencies £'000 | Departmental Group £'000 | Core Dept & Agencies £'000 | Departmental Group £'000 | Core Dept & Agencies £'000 | Departmental Group £'000 |
| **Non-current assets** | | | | | | | |
| Property plant and equipment | 6 | 934,133 | 57,447,621 | 1,019,606 | 54,640,754 | 1,091,925 | 53,040,791 |
| Investment Property | | 38,468 | 230,900 | 92,820 | 232,854 | 93,582 | 249,057 |
| Intangible assets | 7 | 228,927 | 2,248,466 | 162,111 | 1,812,382 | 255,989 | 1,689,156 |
| Charitable non-current assets | 19.2 | - | 4,415 | - | 7,080 | - | 11,052 |
| Financial assets- Investments | 11 | 46,960,282 | 914,505 | 27,344,395 | 815,533 | 34,323,351 | 678,673 |
| Charitable investments | 19.3 | - | 361,533 | - | 299,160 | - | 321,692 |
| Other non-current assets | 14 | 256,127 | 761,262 | 251,452 | 868,583 | 210,870 | 771,179 |
| **Total non-current assets** | | **48,417,937** | **61,968,702** | **28,870,384** | **58,676,346** | **35,975,717** | **56,761,600** |
| **Current assets** | | | | | | | |
| Assets classified as held for sale | | 269,693 | 327,380 | - | 53,146 | - | 35,696 |
| Inventories | 12 | 4,085,878 | 5,554,132 | 251,503 | 1,651,737 | 209,860 | 1,496,452 |
| Trade and other receivables | 14 | 797,777 | 3,655,723 | 316,068 | 2,797,324 | 399,910 | 3,183,395 |
| Other current assets | 14 | 761,839 | 2,307,981 | 304,264 | 1,887,509 | 79,820 | 1,447,244 |
| Charitable other current assets | 19.2 | - | 17,909 | - | 22,028 | - | 23,215 |
| Other financial assets | 14 | 230,473 | 853 | 13,724,360 | 17,870 | 3,665,937 | 28,269 |
| Cash and cash equivalents | 13 | 1,576,897 | 16,795,536 | 1,460,785 | 9,111,920 | 1,933,440 | 8,682,028 |
| Charitable cash | 19.2 | - | 256,020 | - | 238,966 | - | 218,242 |
| **Total current assets** | | **7,722,557** | **28,915,534** | **16,056,980** | **15,780,500** | **6,288,967** | **15,114,541** |
| **Total assets** | | **56,140,494** | **90,884,236** | **44,927,364** | **74,456,846** | **42,264,684** | **71,876,141** |
| **Current liabilities** | | | | | | | |
| Trade and other payables | 15 | (878,670) | (9,084,949) | (87,679) | (6,527,633) | (126,090) | (6,422,184) |
| Other liabilities | 15 | (10,562,553) | (23,180,818) | (3,316,237) | (15,018,838) | (3,529,142) | (14,050,394) |
| Charitable liabilities | 19.2 | - | (47,271) | - | (47,078) | - | (35,271) |
| Provisions | 16 | (1,873,407) | (5,548,478) | (494,657) | (3,848,461) | (507,091) | (3,586,672) |
| **Total current liabilities** | | **(13,314,630)** | **(37,861,516)** | **(3,898,573)** | **(25,442,010)** | **(4,162,323)** | **(24,094,521)** |
| **Non-current assets plus/less net current assets/liabilities** | | **42,825,864** | **53,022,720** | **41,028,791** | **49,014,836** | **38,102,361** | **47,781,620** |
| **Non-current liabilities** | | | | | | | |
| Other payables | 15 | (167,181) | (920,180) | (180,135) | (826,931) | (156,343) | (755,913) |
| Charitable liabilities | 19.2 | - | (357) | - | (212) | - | (68) |
| Provisions | 16 | (3,724,593) | (84,838,633) | (3,135,645) | (85,343,056) | (2,359,957) | (83,853,147) |
| Net pension asset/(liability) | 16.1 | - | (158,954) | - | (144,153) | - | (128,661) |
| Financial liabilities | 15 | - | (10,427,527) | - | (10,739,278) | - | (11,080,519) |
| **Total non-current liabilities** | | **(3,891,774)** | **(96,345,651)** | **(3,315,780)** | **(97,053,630)** | **(2,516,300)** | **(95,818,308)** |
| **Total assets less liabilities** | | **38,934,090** | **(43,322,931)** | **37,713,011** | **(48,038,794)** | **35,586,061** | **(48,036,688)** |
| **Taxpayers' equity and other reserves** | | | | | | | |
| General fund | | 33,328,577 | (57,085,015) | 32,192,105 | (61,558,911) | 30,296,520 | (61,127,673) |
| Revaluation reserve | | 712,734 | 12,516,825 | 681,935 | 12,641,317 | 764,848 | 12,314,826 |
| Other Reserves | | 4,892,779 | 653,010 | 4,838,971 | 358,856 | 4,524,693 | 237,297 |
| **Total Taxpayers' Equity** | | **38,934,090** | **(43,915,180)** | **37,713,011** | **(48,558,738)** | **35,586,061** | **(48,575,550)** |
| Charitable funds | 19.2 | - | 592,249 | - | 519,944 | - | 538,862 |
| **Total Reserves** | | **38,934,090** | **(43,322,931)** | **37,713,011** | **(48,038,794)** | **35,586,061** | **(48,036,688)** |

1. The Departmental Group started reporting a net liabilities position in 2015-16 due to a change in the discount rate prescribed by HM Treasury for long term (>10 years) general provisions. More information is given at Note 1 *Statement of Accounting Policies*.
2. Other Reserves in the Core Department relate to fair value gains on equity instruments designated as fair value through other comprehensive income under IFRS 9 Financial Instruments.
3. Financial assets investments and Other Reserves for Core Department and Agencies have been restated on 1 April 2019 and 31 March 2020 to reflect the effect of a prior period adjustment in respect of the valuation of equity investments held by the Core Department. All of the affected investments are entities within the Departmental Group accounting boundary and there is therefore no impact on the Departmental Group position. See Note 11 for further details relating to the restatement.

28 January 2022
**Sir Chris Wormald KCB**
**Permanent Secretary**

## Consolidated Statement of Cash Flows

The Statement of Cash Flows shows the changes in cash and cash equivalents of the Department during the reporting period. The statement shows how the Department generates and uses cash and cash equivalents. The net cash flows arising from the operating activities provide a key indicator of service costs faced by the Department. The investing activities represent the cash inflows and outflows that have been made for resources which are intended to contribute to the Department's future public service delivery. Cash flows arising from financing activities include Parliamentary Supply and other cash flows, including borrowing.

## For the year ended 31 March 2021

| | | 2020-21 | | 2019-20 | |
|---|---|---|---|---|---|
| | | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| | Notes | £'000 | £'000 | £'000 | £'000 |
| **Net cashflow from operating activities** | | | | | |
| Net expenditure for the year | | (187,090,616) | (183,857,546) | (135,156,874) | (138,198,684) |
| Adjustments for non-cash transactions | | 5,847,661 | 9,536,747 | 1,964,229 | 9,103,344 |
| Adjustments for net finance costs | | (84,332) | 981,991 | (371,607) | 890,841 |
| Other non cash movements in Statement of Financial Position items | | - | 234,506 | 6 | (47,180) |
| Movements arising from absorption transfers | | 6,041 | 232 | - | - |
| Adjustments for charities | | - | (15,456) | - | 2,112 |
| (Increase)/decrease in trade and other receivables[2] | | 12,549,928 | (1,154,533) | (10,239,607) | (141,199) |
| (Increase)/decrease in inventories | | (3,834,375) | (3,902,395) | (41,643) | (155,285) |
| Increase/(decrease) in trade and other payables[3] | | 8,024,353 | 10,500,794 | (227,524) | 803,670 |
| Adjustment for working capital balances in the SoFP not flowing through the SoCNE | | (13,713,584) | (1,265,069) | 10,725,531 | 653,570 |
| Use of provisions | | (282,031) | (2,648,281) | (318,745) | (2,831,040) |
| Transfer of provisions to payables | | (507,094) | (540,285) | (463,721) | (487,893) |
| Cash payments in respect of pensions | | - | (18,799) | - | (14,625) |
| Other operating cashflows | | (13,614) | (10,752) | (72,714) | (65,774) |
| **Net cash outflow from operating activities** | | **(179,097,663)** | **(172,158,846)** | **(134,202,669)** | **(130,488,143)** |
| **Cash flows from investing activities** | | | | | |
| Purchase of property, plant and equipment & investment properties | | (344,100) | (6,705,875) | (193,873) | (4,529,563) |
| Purchase of intangible assets | | (165,976) | (921,048) | (111,113) | (614,724) |
| Proceeds of disposal of property, plant and equipment | | 120,596 | 194,389 | 145,499 | 231,084 |
| Proceeds of disposal of intangibles | | (726) | 1,376 | 12 | 1,093 |
| Proceeds of disposal of assets held for sale | | - | 56,744 | 16,314 | 117,337 |
| Purchase of investments | | (22,994,976) | (77,514) | (4,231,723) | (43,113) |
| Proceeds of disposal of investments | | 14,071,885 | 55,630 | 797,371 | 34,517 |
| Interest Received from group bodies | | 72,172 | - | 349,213 | - |
| Interest Received from external bodies | | 170 | 3,814 | 261 | 58,264 |
| Other investing cashflows | | - | 264 | 272 | 23,325 |
| **Net cash outflow from investing activities** | | **(9,240,955)** | **(7,392,220)** | **(3,227,767)** | **(4,721,780)** |
| **Cash flows from financing activities** | | | | | |
| From the Consolidated Fund (Supply) - current year | | 166,203,192 | 166,203,192 | 114,000,000 | 114,000,000 |
| Financing from the National Insurance Fund | | 22,823,176 | 22,823,176 | 22,961,639 | 22,961,639 |
| Net Movements of Capital element of Loans | | - | 59,159 | - | 27,578 |
| Capital element of payments in respect of finance leases and on-balance sheet PFI contracts | | - | (463,914) | - | (436,967) |
| Interest paid to group bodies | | (505) | - | - | - |
| Interest paid to external bodies | | - | (913,856) | - | (896,121) |
| Advances from the Contingencies Fund[4] | | 59,000,000 | 59,000,000 | - | - |
| Repayments to the Contingencies Fund[4] | | (59,000,000) | (59,000,000) | - | - |
| Other financing cashflows | | - | 85,365 | - | 3,380 |
| **Net financing** | | **189,025,863** | **187,793,122** | **136,961,639** | **135,659,509** |
| **Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund** | | **687,245** | **8,242,056** | **(468,797)** | **449,586** |
| Payment of amounts due to the Consolidated Fund | | (571,133) | (571,133) | (3,858) | (3,858) |
| **Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund** | | **116,112** | **7,670,923** | **(472,655)** | **445,728** |
| **Cash and cash equivalents at the beginning of the period** | | 1,460,785 | 9,320,982 | 1,933,440 | 8,875,254 |
| **Cash and cash equivalents at the end of the period** | | **1,576,897** | **16,991,905** | **1,460,785** | **9,320,982** |

1. The 'Other' lines within the Consolidated Statement of Cash Flows include cash flow items recorded by underlying NHS bodies which are not separately identified within the Departmental Annual Report and Accounts format.
2. These amounts reflect the total movements in trade receivables and other current assets in Note 14.
3. These amounts reflect the total movements in trade payables and other liabilities in Note 15.
4. During the year, the Department received advances of £59,000 million. This was due to substantially increased spending resulting from the Department's response to COVID-19 and where this occurred prior to expenditure being approved by Parliament through the Estimates process. Following approval, the full amount was repaid to the Contingencies Fund.

## Consolidated Statement of Changes in Taxpayers' Equity

This statement shows the movement in the year within the different reserve accounts held by the Department, analysed into 'general fund reserves' (i.e. those reserves that reflect a contribution from the Consolidated Fund). Financing and the balance from the provision of services are recorded here. The Revaluation Reserve reflects the change in asset values that have not been recognised as income or expenditure. Other earmarked reserves are shown separately where there are statutory restrictions on their use.

## For the year ended 31 March 2021

| | | Core Dept & Agencies | | | | Departmental Group | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Note | General Fund £'000 | Revaluation Reserve £'000 | Other Reserves | Taxpayers' Equity £'000 | General Fund £'000 | Revaluation Reserve £'000 | Other Reserves £'000 | Taxpayers' Equity £'000 | Charitable Funds £'000 | Total Reserves £'000 |
| **Restated Balance at 1 April 2020** | | 32,192,105 | 681,935 | 4,838,971 | 37,713,011 | (61,558,911) | 12,641,317 | 358,856 | (48,558,738) | 519,944 | (48,038,794) |
| Prior period adjustments in local accounts | | - | - | - | - | 7,425 | 23,340 | (578) | 30,187 | (3,008) | 27,179 |
| Net parliamentary funding - drawn down | | 166,203,192 | | | 166,203,192 | 166,203,192 | | | 166,203,192 | | 166,203,192 |
| Net parliamentary funding - deemed | | 1,045,346 | | | 1,045,346 | 1,045,346 | | | 1,045,346 | | 1,045,346 |
| National Insurance contributions | | 22,823,176 | | | 22,823,176 | 22,823,176 | | | 22,823,176 | | 22,823,176 |
| Supply (payable)/receivable adjustment | 15 | (1,523,414) | | | (1,523,414) | (1,523,414) | | | (1,523,414) | | (1,523,414) |
| CFERs and other amounts payable to the Consolidated Fund | 15 | (365,721) | | | (365,721) | (365,721) | | | (365,721) | | (365,721) |
| Comprehensive Net Expenditure for the Year | | (187,090,616) | | | (187,090,616) | (183,876,521) | | | (183,876,521) | 18,975 | (183,857,546) |
| **Non-cash adjustments:** | | | | | | | | | | | |
| non-cash charges - auditor's remuneration | 4.2 | 2,270 | | | 2,270 | 2,388 | | | 2,388 | | 2,388 |
| **Movements in Reserves** | | | | | | | | | | | |
| Recognised in Statement of Comprehensive Expenditure | | | | | | | | | | | |
| Net gain/(loss) on revaluation of non-current assets | | | 74,932 | - | 74,932 | | 925,904 | - | 925,904 | - | 925,904 |
| Net gain/(loss) on revaluation of charitable assets | | | | | - | | | | - | 54,865 | 54,865 |
| Fair value gains/(losses) on equity instruments designated at FV through OCI | | | | 53,808 | 53,808 | | | 305,802 | 305,802 | | 305,802 |
| Fair value gains/(losses) on other financial assets mandated at FV through OCI | | | | - | - | | | 1,496 | 1,496 | | 1,496 |
| Impairments and reversals | | | (781) | | (781) | | (920,647) | | (920,647) | - | (920,647) |
| Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme | | - | | - | - | (33,414) | | (3,508) | (36,922) | | (36,922) |
| Other pensions remeasurements | | - | | - | - | 25,319 | | (7,240) | 18,079 | | 18,079 |
| Other gains and losses | | - | | - | - | (397) | | (317) | (714) | | (714) |
| Transfers between reserves | | 42,239 | (42,239) | - | - | 162,998 | (163,066) | 68 | - | - | - |
| Other movements | | - | (1,113) | - | (1,113) | 1,675 | 9,977 | 275 | 11,927 | 1,473 | 13,400 |
| Other transfers | | - | - | - | - | 1,844 | - | (1,844) | - | - | - |
| **Balance at 31 March 2021** | | **33,328,577** | **712,734** | **4,892,779** | **38,934,090** | **(57,085,015)** | **12,516,825** | **653,010** | **(43,915,180)** | **592,249** | **(43,322,931)** |

1. The 'Comprehensive net expenditure for the year' figures for the General Fund and Charitable Fund exclude the elimination of intercompany trading between NHS Charities and NHS providers. This ensures the closing Charitable Fund balance reflects the actual reserves held by the NHS Charities sector. There is no overall impact on the total closing reserve balance of the Departmental Group.
2. The General Fund is used in public sector accounting to reflect the total assets less liabilities of an entity, which are not assigned to another special purpose fund.
3. The Revaluation Reserve is a capital reserve used when an asset has been revalued but for which no cash benefit is received. Revaluations are completed periodically to reflect the fair value of an asset owned by an organisation.
4. Other Reserves are used by NHS bodies to account for a difference between the value of non-current assets, taken over by them at establishment, and the corresponding figure in the opening capital debt. This could arise where opening capital debt is set on estimated values or where there has been an error. Additionally, this may arise to reflect pension assets/liabilities in respect of staff in non-NHS defined benefit pension schemes.
5. Charitable Funds are the reserves associated with NHS Charities consolidated into the Departmental Annual Report and Accounts. They include both restricted, £208 million and unrestricted, £384 million funds.
6. CFERs recognised in the year relate to income recognised by DHSC during the year, deemed as surrenderable to the Consolidated Fund by HM Treasury, for which IFRS 15 permits recognition.
7. The opening balance of Other Reserves for the Core Department & Agencies has been increased by £3,759 million to reflect the effect of a prior period adjustment in respect of the valuation of equity investments held by the Core Department. All of the affected investments are entities within the Departmental Group accounting boundary and there is therefore no impact on the Departmental Group position. See Note 11 for further details relating to the restatement.

## For the period ended 31 March 2020

| | Note | Core Department & Agencies | | | | Departmental Group | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | General Fund | Revaluation Reserve | Restated Other Reserves | Restated Taxpayers' Equity | General Fund | Revaluation Reserve | Other Reserves | Taxpayers' Equity | Charitable Funds | Total Reserves |
| **Balance at 31 March 2019** | | 30,296,520 | 764,848 | 953,570 | 32,014,938 | (61,127,673) | 12,314,826 | 237,297 | (48,575,550) | 538,862 | (48,036,688) |
| **Effect of prior period adjustment** | | - | - | 3,571,123 | 3,571,123 | - | - | - | - | - | - |
| **Restated balance at 1 April 2019** | | 30,296,520 | 764,848 | 4,524,693 | 35,586,061 | (61,127,673) | 12,314,826 | 237,297 | (48,575,550) | 538,862 | (48,036,688) |
| Prior period adjustments in local accounts | | - | - | - | - | (1,352) | 855 | 619 | 122 | 1,381 | 1,503 |
| Net parliamentary funding - drawn down | | 114,000,000 | | | 114,000,000 | 114,000,000 | | | 114,000,000 | | 114,000,000 |
| Net parliamentary funding - deemed | | 2,209,086 | | | 2,209,086 | 2,209,086 | | | 2,209,086 | | 2,209,086 |
| National Insurance contributions | | 22,961,639 | | | 22,961,639 | 22,961,639 | | | 22,961,639 | | 22,961,639 |
| Supply (payable)/receivable adjustment | 15 | (1,045,346) | | | (1,045,346) | (1,045,346) | | | (1,045,346) | | (1,045,346) |
| CFERs and other amounts payable to the Consolidated Fund | 15 | (571,133) | | | (571,133) | (571,133) | | | (571,133) | | (571,133) |
| PDC investment adjustment | | (606,125) | | | (606,125) | - | | | - | | - |
| Comprehensive Net Expenditure for the Year | | (135,156,874) | | | (135,156,874) | (138,200,093) | | | (138,200,093) | 1,409 | (138,198,684) |
| **Non-cash adjustments:** | | | | | | | | | | | |
| non-cash charges - auditor's remuneration | 4.2 | 912 | | | 912 | 1,018 | | | 1,018 | | 1,018 |
| **Movements in Reserves** | | | | | | | | | | | |
| Recognised in Statement of Comprehensive Expenditure | | | | | | | | | | | |
| Net gain/(loss) on revaluation of non-current assets | | | 21,492 | - | 21,492 | | 1,613,170 | - | 1,613,170 | - | 1,613,170 |
| Fair value gains/(losses) on equity instruments designated at FV through OCI | | | | 314,278 | 314,278 | | | 111,761 | 111,761 | | 111,761 |
| Net gain/(loss) on revaluation of charitable assets | | | | | - | | | | - | (21,173) | (21,173) |
| Impairments and reversals | | | (20) | | (20) | | (1,014,048) | | (1,014,048) | - | (1,014,048) |
| Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme | | - | | - | - | 8,674 | | 1,866 | 10,540 | | 10,540 |
| Other pensions remeasurements | | - | | - | - | (17,964) | | 6,896 | (11,068) | | (11,068) |
| Other gains and losses | | - | | - | - | (968) | | 288 | (680) | | (680) |
| Transfers between reserves | | 101,530 | (101,530) | - | - | 243,040 | (239,752) | (3,288) | - | - | - |
| Other movements | | (965) | 6 | - | (959) | (17,258) | (30,873) | (25) | (48,156) | (535) | (48,691) |
| Other transfers | | 2,861 | (2,861) | - | - | (581) | (2,861) | 3,442 | - | - | - |
| **Restated Balance at 31 March 2020** | | **32,192,105** | **681,935** | **4,838,971** | **37,713,011** | **(61,558,911)** | **12,641,317** | **358,856** | **(48,558,738)** | **519,944** | **(48,038,794)** |

1. The opening balance of Other Reserves for the Core Department & Agencies has been increased by £3,571 million and the Fair value gains/(losses) on equity instruments designated at FV through OCI has been increased by £188 million to reflect the effect of a prior period adjustment in respect of the valuation of equity investments held by the Core Department. All of the affected investments are entities within the Departmental Group accounting boundary and there is therefore no impact on the Departmental Group position. See Note 11 for further details relating to the restatement.

## Notes to the Department's Annual Report and Accounts

### 1. Statement of accounting policies

The financial statements have been prepared in accordance with the 2020-21 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (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 the Department of Health and Social Care (DHSC) for the purpose of giving a true and fair view has been selected. The policies adopted by the Department of Health and Social Care are described below and have been applied consistently in dealing with items considered material to the accounts.

The 2020-21 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, or written-off on the dissolution of NHS Trusts, is debited or credited, as appropriate, to the General Fund rather than to the Consolidated Statement of Comprehensive Net Expenditure.
- Receipts of National Insurance Contributions from the National Insurance Fund are recognised on a cash basis; and
- Transfers of former Primary Care Trust assets from NHS Property Services to NHS providers under the Asset Transfer Policy announced in May 2019, occured via a modified absorption approach, in which the gain/loss on transfer is recognised directly in reserves.

The Departmental Group has presented a net liabilities position on the Consolidated Statement of Financial Position due to a change in 2015-16 in the HM Treasury prescribed discount rate for long-term (>10 years) general provisions. As the increase in provision value reverses as the date of cash settlement approaches and the discount unwinds, it does not alter the amount of cash ultimately required to settle these liabilities and thus has no bearing on the financial sustainability of the Departmental Group.

Parliament has demonstrated its commitment to fund the Department for the foreseeable future. Therefore, there is no reason to believe funding will not be available to meet the future liabilities of the Departmental Group. Therefore, the Department of Health and Social Care's Annual Report and Accounts are produced on a going concern basis.

### 1.1 Operating segments

Income, expenditure, depreciation and other material items are analysed in the Statement of Operating Costs by Operating Segment (**Note 2**) and are reported in line with management information used within the Department.

### 1.2 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, stockpiled goods and certain financial assets and financial liabilities.

### 1.3 Basis of consolidation

The accounts comprise of a consolidation for the Core Department of Health and Social Care, its Departmental Agency and other bodies that fall within the Departmental boundary as defined by the FReM and make up the 'Departmental Group'. Those other bodies include Arm's Length Bodies, NHS Trusts, NHS Foundation Trusts, Clinical Commissioning Groups, NHS Charities and certain Limited Companies.

The Departmental Group includes all entities designated for inclusion by HM Treasury, which in broad terms equate to those bodies that are classified by the Office of National Statistics to the Central Government sector. Transactions between entities included in the consolidated accounts are eliminated. A list of all those entities within the Departmental boundary is given in **Note 21**.

### 1.4 Employee Benefits

#### 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.

#### Retirement benefit costs:

#### Civil Service Pensions

Past and present employees of the Department are covered by the provisions of the Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and Other Pension Scheme (CSOPS), which are described in **Note 3**.

These schemes are unfunded, defined benefit schemes covering civil servants. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Department of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For defined contribution schemes, such as Civil Service partnership pensions, the Department recognises the contributions payable for the year.

The Department recognises the full cost of benefits paid under the Civil Service Compensation Scheme, including the early payment of pensions.

### NHS Pensions

Past and present employees of the NHS are covered by the provisions of the NHS Pension Schemes.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales.

The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in the scheme is taken as being equal to the contributions payable to the scheme for the accounting period.

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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year. More details can be found in **Note 3**.

## 1.5 Grants payable and Grant-in-Aid

### Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Department recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

### Grant-in-Aid

The provision of Grant-in-Aid by the Department 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 as indicated in **Note 2.2**.

## 1.6 Audit costs

A charge reflecting the cost of audit is included in expenditure. The Department of Health and Social Care 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 Department's Annual Report and Accounts.

With the exception of NHS Foundation Trusts, certain Limited Companies and NHS Charities, other consolidated bodies are audited by the Comptroller and Auditor General or appoint an auditor under local audit arrangements as is the case for NHS Trusts and Clinical Commissioning Groups. Expenditure in respect of audit fees is included in their individual accounts. The accounts of NHS Foundation Trusts are audited by auditors appointed by their board of governors and also include expenditure in respect of audit fees.

### 1.7 Value Added Tax

Most of the activities of the Department 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. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### 1.8 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 the Department relates to the delivery of healthcare. Further detail is provided in **Note 5**. Where NHS providers contract with commissioners to deliver spells of healthcare, these sums are eliminated for the purpose of delivering a DHSC Group position. The amounts of revenue generated and eliminated within the DHSC Group is indicated by **Note 2.1**. The amounts of revenue generated through the provision of healthcare activities external to the DHSC Group is detailed in the 'Revenue from Patient Care activities' section of **Note 5**.

The Department 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.

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 the Standard.

Revenue from the sale of distinct tangible goods such as non-current assets is recognised only when performance obligations under the contract are met, and is

measured as the sums due under the sale contract. Further detail regarding the specific judgements made by individual entities in relation to their material revenue streams can be found in their underlying account.

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 e.g. the issue of a prescription or payment for dental treatment.

There are sources of income that the Department receives which are outside the scope of IFRS 15 as adapted and interpreted by the FReM. Where this is the case the Department recognises the income when it can be measured reliably and it is probable that economic benefit associated with the transaction will flow to the Department in line with the IFRS Conceptual Framework.

Income is Voted on through the Estimates process and Consolidated Fund Extra Receipts (CFERs) which fall outside the Ambit of the Vote and must therefore be returned to HM Treasury, as is confirmed in the 2020-21 Main Supply Estimate paragaph 22, page 9.

The value of the benefit received when the Department accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

National Insurance Contributions are classified as funding rather than income, and are therefore credited to the General Fund upon receipt.

### 1.9 Property, plant and equipment

#### Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Department;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- collectively a number of items have a total cost of at least £5,000 and individually 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.

Expenditure incurred on the remaining Informatics programmes held by the Core Department has been split between capital and revenue using a financial model that analyses contractor costs over the life of the project.

**Valuation of property, plant and equipment (excluding assets relating to remaining Informatics programmes)**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets 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 6**.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. In line with the FReM, specialised assets are therefore valued as their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis.

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.

Valuation guidance issued by the Royal Institution of Chartered Surveyors (RICS) states that valuations are performed net of VAT where the VAT is recoverable by the entity. This commonly applies to schemes procured under a Private Finance Initiative (PFI), where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

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, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase 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.

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.

Gains and losses recognised in the revaluation reserve are reported in the Consolidated Statement of Changes in Taxpayers' Equity.

Where there is a material valuation uncertainty this is disclosed in **Note 1.29**.

### 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 charged to the Consolidated Statement of Comprehensive Net Expenditure in the period in which it is incurred.

### Derecognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met.

The sale must be highly probable and the asset available for immediate sale in its present condition. Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases

to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount.

Assets are derecognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

### 1.10 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 the Department'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, the Department; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible non-current assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent asset basis) and value in use where the asset is income generating.

### Recognition and Valuation of intangible assets relating to Informatics programmes

Informatics, formerly known collectively as NHS Connecting for Health, contains a collection of large infrastructure IT Programmes that are used across the NHS to enable a move towards a single, electronic care record for patients and to connect General Practitioners to hospitals, providing secure and audited access to these records by authorised health professionals.

The intangible assets relating to the DHSC and NHS Digital Informatics programmes, are held at depreciated replacement cost which is calculated by indexing the historic cost of the assets by the movement in appropriate indices between the month of purchase and the Consolidated Statement of Financial Position date. This valuation model is reviewed each year to determine whether it remains appropriate.

### 1.11 Research and development

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to reliably measure the expenditure attributable to the intangible asset during its development.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

### 1.12 Depreciation, amortisation and impairments

Freehold land and investment properties are not depreciated/amortised. Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification.

Assets in the course of construction or development and residual interests in off-Statement of Financial Position Private Finance Initiative (PFI) contract assets are not depreciated until the asset is brought into use or reverts to the Department, respectively.

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment, intangible non-current assets and stockpiled goods, less any residual value, on a straight-line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which the Department expects to obtain economic benefits or service potential from the asset.

The ranges of estimated useful lives have been provided in **Note 6** for property, plant and equipment, and in **Note 7** for intangible non-current assets. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each financial year-end, the Department determines whether there is any indication that its property, plant and equipment 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. Intangible assets not yet available for use are tested for impairment annually at the financial year-end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve. Impairment losses are detailed in **Note 8.**

Inventory is measured at the lower of cost and realisable value per the requirements of IAS 2. Any impairment of inventories as a result of a change in the net realisable value is recognised as an expense in the period in which it occurs. Further detail around the derivation of cost and net realisable value is detailed in **Note 1.17** below.

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. Consequently **Note 8** breaks down the nature of the impairments incurred in relation to the Department's inventory purchased as part of the pandemic response.

### 1.13 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.

Where assets donated do not qualify for capitalisation an amount equivalent to the value of the items is taken to expenses on receipt, unless items are held as inventory, such as personal protective equipment, for which a credit to income is recorded on receipt and the donated inventory will be expensed per the treatment of purchased inventories consumed under IAS 2.

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.

Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Donations of centrally procured items for use in the pandemic response follows the accounting for donated assets detailed above for the receiving DHSC group body, rather than being treated as financing from a controlling body. This approach has been agreed by the Department as relevant authority as permitted by the FReM.

### 1.14 Government grants

Government grant funded assets are capitalised at current 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.

### 1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised at the commencement of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Consolidated Statement of Comprehensive Net Expenditure (CSCNE).

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

### 1.16 Private Finance Initiative (PFI) and NHS Local Improvement Finance Trust (LIFT) transactions

HM Treasury has determined that Government bodies shall account for infrastructure PFI and NHS 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. Consolidated bodies therefore recognise the PFI/LIFT asset as an item of property, plant and equipment, together with a liability to pay for it, on their 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; and
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

### a) Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

### b) PFI and LIFT assets, liabilities, and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. They are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use. A PFI/LIFT liability is recognised at the same time as the assets are recognised. It is measured initially at the same amount as the initial value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to the CSCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.
An element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

### c) 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 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.

### 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.

### Other assets contributed by consolidated bodies to the operator

Other assets contributed (e.g. cash payments, 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.

### 1.17 Inventories and stockpiled goods

Significant volumes of inventories were purchased by the Department as part of the pandemic response.

Inventories are valued at the lower of cost and net realisable value. Cost includes the direct cost of purchase and other costs incurred in bringing the inventories to their present location and condition, such as freight costs. Expenses are recognised on sale, donation, consumption, impairment or write off of the inventory in the period in which the specific event occurs.

Per the application of IAS 2 and given the extent of inventory procured that is able to be identified as ordinarily interchangeable i.e. similar items with a similar use such that a product can be reasonably substituted for another, the Department has employed the weighted average cost (WAC) basis for deriving the cost of its inventory in conjunction with its stock models in place. A WAC was calculated each month for each functionally interchangeable stock (FIS) category.

In determining the appropriate net realisable value, market values were identified for each FIS category. The purpose of holding the inventory was also considered per the requirements of IAS 2. 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 detailed in **Note 8**.

Strategic goods held for use in national emergencies (stockpiled goods) are held as non-current assets within property, plant and equipment at minimum capability levels by replenishment to offset write-offs.

The Department holds a number of different categories of stockpiled goods, however the majority relate to pharmaceuticals and related consumables.

Where there is no active market for partially expired pharmaceuticals and related consumables, or where cost is not materially different to market value, they are held at historic cost as a proxy for fair value and depreciated over their useful life. The remaining categories of stockpiled goods are held at current value in existing use and depreciated over their useful life.

### 1.18 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.

### 1.19 Provisions

Provisions are recognised when the Department has a present legal or constructive obligation as a result of a past event, it is probable that the Department will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of minus 0.95% (2019-20: minus 0.50%) in real terms.

General provisions are subject to four separate nominal discount rates as prescribed by HM Treasury, according to the expected timing of cashflows. A nominal short-term rate of minus 0.02% (2019-20 positive 0.51%) is applied to expected cash flows in a time boundary of between 0 and up to and including 5 years from the Consolidated Statement of Financial Position date. A nominal medium term rate of positive 0.18% (2019-20 positive 0.55%) is applied to the time boundary of after 5 and up to and including 10 years. A nominal long-term rate of positive 1.99% (2019-20 positive 1.99%) is applied to the time boundary of after 10 and up to and including 40 years from the Consolidated Statement of Financial Position date. A nominal very long-term rate of positive 1.99% (2019-20 positive 1.99%) is applied to expected cashflows exceeding 40 years from the Consolidated Statement of Financial Position date.

In using nominal rates there is a need to inflate cashflows as such rates do not take a measure of inflation into account unlike real discount rates. HM Treasury have provided

the Office of Budget Responsibility (OBR) Consumer Price Index (CPI) forecasted inflation rates to be employed to expected cash flows, except where the Department has judged there is a reasoned basis for alternative rates to be employed.

Where such a basis does not exist; an OBR CPI inflation rate of 1.2% (2019-20 1.9%) is applied to all relevant expected cashflows up to and including 1 year from the date of the Consolidated Statement of Financial Position. An OBR CPI inflation rate of 1.6% (2019-20 2.0%) is applied to all relevant expected cashflows in a time boundary of after 1 and up to and including 2 years from the Consolidated Statement of Financial Position date. An OBR CPI inflation rate of 2.0% (2019-20 2.0%) is applied to all relevant cashflows exceeding 2 years from the Consolidated Statement of Financial Position date.

### 1.20 Clinical and non-clinical negligence costs

Clinical and non-clinical negligence costs are managed through schemes run by NHS Resolution (NHSR). The Existing Liability Scheme, Ex-Regional Health Authority Scheme and DHSC clinical and non-clinical schemes are funded by the Department of Health and Social Care, while the Clinical Negligence Scheme for Trusts, Liability to Third Parties Scheme and Property Expenses Scheme are funded from Trust contributions.

In 2019-20 NHSR was commissioned to deliver a future liability scheme established on 1 April 2019 called Clinical Negligence Scheme for General Practice (CNSGP). Additionally NHSR provides management and oversight of arrangements resulting from a transfer of liabilities from Medical Defence Organisations. The transfer of assets and liabilities from the Medical Defence Organisations to the DHSC Group have been accounted for under IFRS 3 Business Combinations, requiring the subsequent measurement of assets and liabilities in accordance with other applicable IFRS.

From 6 April 2020 indemnity for liabilities relating to incidents prior to 1 April 2019 of members of the Medical and Dental Defence Union of Scotland (MDDUS) was provided by Government and administered by NHS Resolution under the Existing Liabilities Scheme for General Practice (ELSGP).

In 2020-21 the interim arrangements continued with the Medical Protection Society (MPS). This is where the legal and operational responsibility of handling claims within scope of those interim arrangements remains with the MDO and NHS Resolution carries out the Secretary of State's oversight and governance responsibilities. This arrangement is known as Existing Liabilities for General Practice (ELGP). From 1 April 2021 indemnity for these claims was provided by Government and administered by NHSR under the Existing Liabilities Scheme for General Practice (ELSGP).

The accounts for the schemes are prepared by NHSR in accordance with IAS 37. Further detail as to the management of the schemes can be found in NHSR's 2020-21 Annual Report and Accounts. A provision for these schemes, disclosed in **Note 16**, is calculated in accordance with IAS 37 by discounting the gross value of all claims received. NHSR

does not consider that any of the indemnity schemes or management and oversight of General Practice claims fall under the definition of an insurance contract as per IFRS 4 Insurance Contracts. This is because significant insurance risk is passed back to the members of risk-pooling schemes through annual contributions, to the GP Contract funding held by NHS England transferred via DHSC as provision of financing, or directly to DHSC through the provision of financing.

NHSR contracts actuarial advisers, the Government Actuary's Department, 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. NHSR'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.

One of the key assumptions used in the production of the estimates reported is outside the formal control of NHSR, as HM Treasury prescribes the discount rates to be used in calculating the provisions. There are other factors that influence the provision that are also outside NHSR's control; for example, patients (and their legal representatives) 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, and is included in contingent liabilities as set out in **Note 17**.

### Existing Liabilities Scheme (ELS), Ex-Regional Health Authorities (Ex-RHA) Scheme and DHSC clinical and non-clinical liabilities schemes

Claims are included in the ELS provision on the basis that the incident occurred on or before 31 March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to NHS Resolution with effect from 1 April 1996. Claims against DHSC clinical and non-clinical liabilities relate to claims against dissolved bodies where there is no successor body and a number of other claims NHSR is managing on behalf of DHSC.

### Clinical Negligence Scheme for Trusts (CNST)

This scheme provides indemnity cover to providers of NHS services, NHS commissioners and Health ALB's for claims arising from incidents involving clinical negligence. Contributions are collected from members to make settlements and administer claims on their behalf. The scheme has been operating since 1 April 1995, and claims are included in the provision where:

- NHS Resolution has assessed the probable cost and time to settlement in accordance with scheme guidelines;
- they are qualifying incidents; and
- the organisation against which the claim is being made remains a member of the scheme.

As at 31 March 2002 all outstanding claims for incidents post 1 April 1995 became the direct responsibility of NHSR. This 'call in' of CNST claims effectively means that member Trusts are no longer reponsible for accounting for claims made against them, although they do remain the legal defendant.

### Property Expenses Scheme (PES) and Liability to Third Parties Scheme (LTPS)

The PES and LTPS schemes were introduced in April 1999 following the Secretary of State's decision that NHS Trusts should not insure with commercial companies for non-clinical risks, other than motor vehicles and other defined areas (e.g. PFI schemes).

These schemes are managed and funded via the same mechanisms as CNST except that specific excesses exist for some types of claims. Thus the provision recorded in these accounts relates only to NHSR's proportion of each claim.

### Clinical Negligence Scheme for General Practice (CNSGP)

The CNSGP is a future liability scheme for general practice, established in 2019-20. The scheme covers claims arising in general practice in relation to incidents that occur on or after 1 April 2019. The accounting for the scheme will follow the accounting treatment and valuation practices employed for NHSR's existing protfolio of indemnity schemes.

During 2019-20 NHSR provided interim management and oversight of arrangements resulting from the transfer of 'in scope' liabilities from specific Medical Defence Organisations to the DHSC Group, as the basis of an existing liability arrangement for GPs, for claims relating to incidents prior to 1 April 2019. These liabilities are accounted for by NHSR under IAS 37. **Note 16** provides further detail regarding the evolution of the claims handling responsibility beyond 2019-20, though this has no impact on the accounting for the liabilities.

### Clinical Negligence Scheme for Coronavirus (CNSC)

Using powers under the Coronavirus Act 2020 and launched on 3 April 2020, the Clinical Negligence Scheme for Coronavirus (CNSC) provides cover for the NHS response to COVID-19 where no other indemnity exists. It constitutes a flexible arrangement to address the fast-paced changes which had to be put in place and extends, for example, to private sector facilities which stepped in to provide overflow capacity for procedures which NHS hospitals were unable to perform owing to the need to give priority to patients with COVID-19.

On the other hand, many new arrangements were picked up by one of our existing schemes, such as retired general practitioners who volunteered to return to give

vaccinations being covered by either CNSGP or CNST, depending upon the contractual arrangement in question.

### The Coronavirus Temporary Indemnity Scheme (CTIS)

The scheme provides state cover for employer's liability and public liability to fill gaps where COVID-19 positive patients have been discharged from the NHS into designated care home settings which have been unable to secure sufficient private insurance cover.

### Incidents Incurred but Not Reported (IBNR)

IAS 37 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to NHSR as at 31 March 2021 where it can be reasonably predicted that:

- an adverse incident has occurred; and
- a transfer of economic benefit will occur; and
- a reasonable estimate of the likely value can be made.

NHSR uses actuaries, the Government Actuary's Department (GAD), to assess the potential value of IBNRs against each of the schemes it operates. The actuaries review existing claims records and, using an appropriate model, calculate values in respect of IBNRs for all schemes. The provisions and contingent liabilities arising are shown in **Notes 16** and **17** respectively. The sums concerned are accounting estimates and, although determined on the basis of information currently available, the ultimate liabilities may vary as a result of subsequent developments.

### Contaminated Blood

The Contaminated Blood payment scheme is for individuals who were infected with HIV and/or hepatitis C following treatment with NHS-supplied blood or blood products before September 1991. These financial statements provide for the future cost of payments for which scheme beneficiaries are eligible. Beneficiaries receive lump sum and annual payments which vary depending on the stage of their condition. On 25 March 2021, a Written Ministerial Statement by Penny Mordaunt, Paymaster General, announced changes across the four separate schemes of the four nations of the United Kingdom to improve their parity. The main change for England to affect the provision, is that bereaved partners will receive the beneficiary's full annual payment for the first year following their death, and subsequently 75% of the payment for the rest of their lifetime, uplifted annually. Contaminated blood payments are linked to increases in the consumer price index.

### 1.21 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Department, or
- 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. Remote contingent liabilities are disclosed elsewhere in the annual report and accounts as part of the Department'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 the Department. A contingent asset is disclosed where an inflow of economic benefits is probable.

### 1.22 Financial instruments

The Department of Health and Social Care 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 rather than generating a financial instrument.

The Department's investment in NHS providers and the Medicines & Healthcare products Regulatory Agency is represented by Public Dividend Capital (PDC) which, being issued under statutory authority, is not classed as being a financial instrument.

PDC is held at historic cost less impairments. Following a review stemming from the transfer of debt to PDC in September 2020 the Department revised its approach to the recognition of impairment against PDC in 2019-20.

PDC is now impaired, on an individual NHS provider basis, where the net assets of those NHS providers is 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 in the Core Department SoCNE.

To allow full elimination of PDC on consolidation, any impairment to the Department's investment must be reversed at group level. This has no overall effect on the consolidation as the losses necessitating the impairment have already been recognised in the provider's financial statements.

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 Department, and no longer appears in the consolidated account.

The Department holds investments in private limited companies and other items such as receivables and payables that arise from its operations and cash resources that do give rise to financial instruments under IFRS 9.

### 1.23 Financial assets

Financial assets are recognised on the Consolidated Statement of Financial Position when the Department 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.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

#### 1.23.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

#### 1.23.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Per the provisions of IFRS 9, the Department has elected to irrevocably designate its equity instruments to be measured at fair value through other comprehensive income. The Department's equity instruments relates to its investment in private limited companies as detailed in **Note 11**. The election ensures that an accounting treatment consistent with prior financial years is maintained under transition to IFRS 9.

### 1.23.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

The Department does not enter into speculative transactions such as interest rate swaps.

### 1.23.4 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, the Department recognises a loss allowance representing expected credit losses on the financial instruments.

The Department adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Department therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. The Department of Health and Social Care, implicitly (so not legally formed), provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in the Consolidated Statement of Comprehensive Net Expenditure as an impairment gain or loss.

**Note 10** provides further detail regarding the Department's limited exposure to different categories of risks in relation to its financial instruments.

### 1.24 Financial liabilities

Financial liabilities are recognised in the Consolidated Statement of Financial Position when the Department 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. The Core Department sets the following de minimis threshold levels for the raising of manual accruals: £2,499 for accruals relating to administration budgets and £9,999 for accruals relating to central programme budgets. 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 bodies, that would be the nominal rate charged on the loan. Such loans are a financial liability measured at amortised cost for NHS bodies, corresponding to the financial asset recognised at amortised cost by the Core Department. Further detail is provided in **Note 11**.

### 1.25 Foreign exchange

The functional and presentational currencies of all consolidated bodies are pounds sterling and figures are expressed in thousands of pounds unless expressly stated otherwise.

The large majority of the Department's foreign currency transactions relate to European Economic Area (EEA) medical costs and COVID-19 purchases in 2020-21. Payments made are valued at prevailing exchange rates. Amounts in the Consolidated Statement of Financial Position at year-end are converted at the exchange rate ruling at the Consolidated Statement of Financial Position date. Exchange rate gains or losses are calculated in accordance with accepted accounting practice.

Due to delays in submission of medical cost claims by member states, the Department 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.

### 1.26 NHS Charities

Following the inclusion of NHS Charities (as defined by section 149 of the Charities Act 2011 as amended) in the 2012 Designation Order, the Department consolidates NHS Charities into the Consolidated Annual Report and Accounts. The transactions and balances associated with NHS Charities are reported as separate items within the consolidated financial statements (e.g. 'Charitable income', 'Charitable cash' etc) due to the unique nature of the transactions and as the majority of those transactions are immaterial in the context of the Group account.

### 1.27 Transfer of Functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the Group are outside the scope of IFRS 3 Business Combinations. When functions transfer between two public sector bodies (except for Department to Department transfers) the FReM requires the application of 'absorption accounting'.

Absorption accounting requires that entities account for their transactions in the period in which those transactions took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Consolidated Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

For transfers between bodies within the Departmental Group, no net impact arises in the Consolidated Annual Report and Accounts as a consequence of the application of absorption accounting as gains and losses are eliminated on consolidation. A non-eliminating net gain or loss is recognised where transfers involve a non-Departmental counter-party that is within the public sector but outside the DHSC Group.

Assets transferred under the Asset Transfer Policy as approved by the SoS have applied a modified form of absorption accounting, with corresponding gains or losses debiting or crediting as appropriate the General Fund rather than the Consolidated Statement of Comprehensive Net Expenditure. This treatment represents an HM Treasury agreed FReM departure, with all other transfers being accounted for in line with the FReM.

### 1.28 Accounting standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2020-21.

IFRS 16 – Leases - The FReM has deferred the Department's adoption of IFRS 16 until 2022-23. The Department continues to liaise closely with HM Treasury to discuss and further refine the impacts of implementing new accounting standards.

- The Departmental Group contains limited companies who report under EU adopted IFRS following the Companies Act 2006. As the Standard is EU adopted those entities implemented IFRS 16 in the 2019-20 financial year. HM Treasury have published criteria for departments to early adopt IFRS 16, for departments whose accounting boundary contains entities who are required to adopt IFRS 16 following the Companies Act 2006. DHSC does not meet this criteria and has not adopted IFRS 16 for the consolidated Annual Report and Accounts in 2020-21. The necessary adjustments have been made, in respect of these limited companies, to disapply IFRS 16 for 2020-21 in the consolidated financial statements.
- Entities are assessing the extent to which arrangements, other than those currently identified as containing a lease per the necessary judgements made under IAS 17 and IFRIC 4, may be identified as a right of use asset under the revised recognition criteria developed under IFRS 16.

- As the Department engages in a number of sub leasing arrangements, it is expected that the finance lease receivable will increase under IFRS 16. On application of IFRS 16 entities are required to reassess subleasing arrangements on the basis of the right of use asset generated by the head lease than with regard to the underlying asset of the arrangement. However as the sub leasing arrangements are predominantly internal to the Group, this impact will eliminate on consolidation.
- The Department currently has commitments under operating leases of almost £3.5 billion, which IFRS 16 requires to be recognised on the Statement of Financial Position as right of use assets with corresponding lease liabilities on transition to the Standard as interpreted by the FReM.
- The new Standard will be applied retrospectively, with the cumulative effect of adopting IFRS 16 being recognised at the date of initial application as an adjustment to the opening balance of the general fund. Prior periods will not be restated. The DHSC Group will be accounting for short-term leases and leases of low-value assets using the practical expedients offered in the Standard. Instead of recognising a right-of-use asset and lease liability, the payments in relation to these are recognised as an expense in income and expenditure on a straight-line basis over the lease term.

IFRS 17 – Insurance Contracts which replaces IFRS 4 Insurance Contracts. The Standard is expected to be effective for accounting periods beginning on or after 1 January 2023, following the International Accounting Standards Board decision to defer the effective date. The standard is still subject to HM Treasury interpretation and adaptation and the Department continues to liaise closely with HM Treasury to discuss and further refine the impacts of implementing the new Standard. It is therefore too early for the Department to provide an estimate of the impact of adopting IFRS 17.

### 1.29 Critical accounting judgements and key sources of estimation uncertainty

Estimates and the underlying assumptions are reviewed on a regular basis by the Department's senior management. Areas of estimation uncertainty or significant judgement made by management are:

- IAS 16 Property, plant and equipment - Assets which are held for their service potential 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.

- Property valuations are based on a number of key assumptions including an estimate of future rental income, anticipated future costs, and a discount rate. The valuers also compare their valuations to market data for other similar assets.

  The outbreak of COVID-19 has significantly affected the UK economy and, while the valuations applied to property, plant and equipment can still be relied upon and are the most appropriate for the Annual Report and Accounts, less certainty can be attached to the valuations than would otherwise be the case at 31 March 2020. Given the unknown future impact of COVID-19, the Department will keep the valuation of its property assets under frequent review.

  The Royal Institute of Chartered Surveyors (RICS), the body setting standards for property valuations, issued guidance to valuers in March 2020 highlighting that the uncertain impact of COVID-19 on markets might cause a valuer to conclude that there is a material uncertainty which the valuer would then declare in their report. As of September 2020 RICS removed their direction to attach a material valuation uncertainty comment to valuations, made in light of the Covid-19 pandemic, however this was after all of the providers had signed off in the PY. This remained the case as at 31 March 2021.

- Useful lives of PPE - as shown in **Note 6**, property plant and equipment (PPE) which is material to these consolidated accounts and where we disclose, for each category of PPE, the lowest minimum and the highest maximum in the ranges of useful lives. They are reviewed regularly to ensure that the assets' useful lives are defined accurately and that the depreciation charges are calculated correctly.

- IAS 36 Impairments - Management makes judgement on whether there are any indications of impairments to the carrying amounts of the Department's assets. During the year management has made significant judgements in relation to the impairment of inventories. Further information including an analysis of key sensitivities is included in **Note 8**, Impairments.

- IFRS 9 impairments – The 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.

- PDC impairment – The 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.

- IAS 37 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. Provisions are discounted according to rates set by HM Treasury, as outlined in **Note 16**.

- Clinical negligence - The Department's most significant provision is for clinical negligence, and estimation is required to calculate the amounts provided for known claims and for IBNR. 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. The value of the provision is sensitive to changes in discount rates, and a sensitivity analysis is provided in **Note 16**.

- IFRS 15 Revenue from Contract with Customers - The Department makes judgement on the timing of income recognised from the delivery of healthcare over time (see **Note 1.8**).

- 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. Any difference between these amounts and the amounts recognised as expenditure and payables are not further adjusted as these net amounts are not material. We are satisfied that the gross mismatches which net together to this immaterial position do not constitute a material error.

## 2. Statement of Operating Costs by Operating Segment

The reportable segments disclosed within this note reflect the current structure of the Departmental Group as defined in legislation, with the activities of each reportable segment thus reflecting the statutory remit of those bodies. These operating segments are reported to the Department of Health and Social Care Departmental Board (Chief Operating Decision Maker) for financial management purposes. They cover the Core Department of Health and Social Care, Public Health England (the Department's executive agency), the NHS (both the NHS commissioning sector and NHS Trusts and NHS Foundation Trusts as providers of healthcare), and all ALBs (both Special Health Authorities and Executive non-Departmental Public Bodies). Other Group Bodies include NHS Property Services Ltd, Community Health Partnerships Ltd, Genomics England Ltd, Nursing and Midwifery Council, Health and Care Professions Council, Skipton Fund Ltd and Supply Chain Coordination Ltd.

Net expenditure by operating segment is regularly reported to the Departmental Board. The information provided to the Departmental Board is presented on a budgeting basis and therefore mirrors the Statement of Outturn against Parliamentary Supply but can be reconciled to the Consolidated Statement of Comprehensive Net Expenditure as shown in the table below. Multiple transactions take place between reportable segments; primarily between commissioning and provider bodies within the NHS. All intercompany transactions are eliminated upon consolidation as shown in the 'Intercompany Eliminations' column of the table below. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure.

## 2.1 Departmental Group Summary

| | | 2020-21 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DHSC Core £000 | Public Health England £000 | Special Health Authorities £000 | NHS Providers £000 | NHS England Group £000 | Non-Departmental Public Bodies £000 | Other Group Bodies £000 | NHS Charities £000 | Inter company Eliminations and Adjustments £000 | Departmental Group £000 |
| Gross expenditure (2.2) | | 189,313,348 | 5,373,147 | 1,935,911 | 106,140,601 | 145,968,752 | 5,383,299 | 4,093,738 | 155,056 | (264,943,354) | 193,420,498 |
| Income (2.3) | | (2,235,247) | (798,630) | (2,825,212) | (105,283,720) | (1,476,832) | (424,982) | (3,679,713) | (174,031) | 107,335,183 | (9,563,184) |
| **Total net expenditure (per CSCNE)** | | **187,078,101** | **4,574,517** | **(889,301)** | **856,881** | **144,491,920** | **4,958,317** | **414,025** | **(18,975)** | **(157,608,171)** | **183,857,314** |
| **Budgeting adjustments per SoPS2** | | | | | | | | | | | |
| Capital Grants | | (856,105) | (2,612) | (4,291) | - | (75,804) | (1,775) | - | - | 1,825 | (938,762) |
| Research and Development | | (1,329,778) | - | - | - | - | - | - | - | - | (1,329,778) |
| Other (mainly COVID-19)[1] | | 1,424,018 | 318 | - | 448,157 | - | (5,723) | (177,940) | - | (196,500) | 1,492,330 |
| **Total adjustments** | | **(761,865)** | **(2,294)** | **(4,291)** | **448,157** | **(75,804)** | **(7,498)** | **(177,940)** | **-** | **(194,675)** | **(776,210)** |
| **Budget outturn per SoPS1, of which:** | | **186,316,236** | **4,572,223** | **(893,592)** | **1,305,038** | **144,416,116** | **4,950,819** | **236,085** | **(18,975)** | **(157,802,846)** | **183,081,104** |
| | *RDEL* | 184,318,672 | 4,558,392 | 373,281 | (679,926) | 144,328,892 | 4,927,407 | 207,202 | (18,975) | (157,815,601) | 180,199,344 |
| | *RAME* | 1,997,564 | 13,831 | (1,266,873) | 1,984,964 | 87,224 | 23,412 | 28,883 | - | 12,755 | 2,881,760 |

1. Included within other budgeting adjustments above are COVID-19 budget adjustments totalling £1,192 million relating to specific budgetary treatments agreed with HM Treasury for certain inventory purchases in the year. Further information can be found in the Statement of Outturn against Parliamentary Supply.

| | | 2019-20 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DHSC Core £000 | Public Health England £000 | Special Health Authorities £000 | NHS Providers £000 | NHS England Group £000 | Non-Departmental Public Bodies £000 | Other Group Bodies £000 | NHS Charities £000 | Inter company Eliminations and Adjustments £000 | Departmental Group £000 |
| Gross expenditure | | 137,715,416 | 4,091,236 | 3,653,288 | 93,934,432 | 125,391,084 | 5,082,701 | 3,864,541 | 151,807 | (224,274,634) | 149,609,871 |
| Income | | (2,426,375) | (243,875) | (2,202,613) | (92,114,440) | (2,143,767) | (420,599) | (3,668,829) | (153,216) | 91,962,527 | (11,411,187) |
| **Total net expenditure (per CSCNE)** | | **135,289,041** | **3,847,361** | **1,450,675** | **1,819,992** | **123,247,317** | **4,662,102** | **195,712** | **(1,409)** | **(132,312,107)** | **138,198,684** |
| **Budgeting adjustments per SoPS2** | | | | | | | | | | | |
| Capital Grants | | (742,181) | (5,124) | - | - | (62,198) | - | - | - | - | (809,503) |
| Research and Development | | (1,230,741) | - | - | - | - | - | - | - | - | (1,230,741) |
| Other | | 558,294 | - | 182,600 | 265,064 | - | - | (165,976) | (1,400) | 34,385 | 872,967 |
| **Total adjustments** | | **(1,414,628)** | **(5,124)** | **182,600** | **265,064** | **(62,198)** | **-** | **(165,976)** | **(1,400)** | **34,385** | **(1,167,277)** |
| **Budget outturn per SoPS1, of which:** | | **133,874,413** | **3,842,237** | **1,633,275** | **2,085,056** | **123,185,119** | **4,662,102** | **29,736** | **(2,809)** | **(132,277,722)** | **137,031,407** |
| | *RDEL* | 133,112,423 | 3,844,269 | 958,072 | 1,028,114 | 122,890,366 | 4,658,497 | (24,331) | (2,809) | (132,281,203) | 134,183,398 |
| | *RAME* | 761,990 | (2,032) | 675,203 | 1,056,942 | 294,753 | 3,605 | 54,067 | - | 3,481 | 2,848,009 |

## 2.2 Departmental Group Detail – Expenditure

| | 2020-21 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | DHSC Core £000 | Public Health England £000 | Special Health Authorities £000 | NHS Providers £000 | NHS England Group £000 | Non-Departmental Public Bodies £000 | Other Group Bodies £000 | NHS Charities £000 | Inter company Eliminations and Adjustments £000 | Departmental Group £000 |
| **Material Expenditure Items** | | | | | | | | | | |
| Staff costs | 722,951 | 403,694 | 285,869 | 67,433,176 | 2,270,582 | 642,296 | 327,331 | - | (10,123) | 72,075,776 |
| Purchase of healthcare from non-NHS bodies[4] | - | - | - | 1,688,925 | 18,379,296 | - | - | - | - | 20,068,221 |
| Goods and Services from other NHS Bodies[5] | - | - | 131 | 75,962 | 91,952,855 | 12 | 6,247 | - | (92,007,832) | 27,375 |
| Utilisation and write down of COVID-19 inventories | - | - | - | 1,145,697 | - | - | - | - | - | 1,145,697 |
| Provider Sustainability Fund | - | - | - | - | (10,921) | - | - | - | 10,921 | - |
| Purchase of social care | - | - | - | 203,427 | 851,720 | - | - | - | - | 1,055,147 |
| General Dental Services (GDS) and Personal Dental Services (PDS) | - | - | - | - | 3,061,746 | - | - | - | (30,637) | 3,031,109 |
| Establishment | 1,075,013 | 38,113 | 16,676 | 1,056,402 | 597,629 | 47,209 | 14,150 | - | (78,491) | 2,766,701 |
| Premises | 449,531 | 28,319 | 26,357 | 3,824,093 | 263,278 | 37,015 | 289,851 | - | (388,888) | 4,529,556 |
| PFI/Lift and other service concession arrangement charges | - | - | - | 1,054,528 | - | - | 88,364 | - | - | 1,142,892 |
| Multi Professional Education and Training (MPET) | - | - | - | - | - | 4,196,173 | - | - | (3,102,673) | 1,093,500 |
| Prescribing Costs | 269,717 | - | - | - | 9,059,707 | - | - | - | (2,055) | 9,327,369 |
| G/PMS, APMS and PCTMS | - | - | - | - | 10,399,491 | - | - | - | (97,146) | 10,302,345 |
| Pharmaceutical Services | - | - | - | - | 2,124,486 | - | - | - | (202) | 2,124,284 |
| Supplies and Services - Clinical | - | - | - | 14,707,579 | 759,132 | 97 | 3,220 | - | (2,336,171) | 13,133,857 |
| Supplies and Services - General | - | 872,370 | 105,557 | 1,857,107 | 1,703,756 | 168,104 | 2,345,170 | - | (833,334) | 6,218,730 |
| Dividends Payable on Public Dividend Capital (PDC) | - | - | - | 736,261 | - | - | - | - | (736,261) | - |
| Rentals under operating leases | 75,989 | 3,423 | 7,410 | 816,233 | 185,414 | 14,657 | 138,396 | - | (467,314) | 774,208 |
| Interest charges | 2,761 | - | - | 920,240 | 33 | - | 159,627 | - | (70,906) | 1,011,755 |
| Research and development | 1,366,658 | 1,997 | 53 | 256,665 | 13,080 | - | 4,477 | - | (759,589) | 883,341 |
| Clinical negligence Costs | - | - | - | 2,253,879 | 220 | 137 | - | - | (2,253,366) | 870 |
| Grant in Aid | 149,814,029 | - | - | - | - | - | - | - | (149,814,029) | - |
| General Ophthalmic Services | - | - | - | - | 590,306 | - | - | - | (26) | 590,280 |
| Business Rates Paid to Local Authorities | 5,079 | 2,166 | - | 484,399 | 962 | 3,350 | 64,528 | - | 3,869 | 564,353 |
| Education, Training and Conferences | 5,222 | 1,355 | 14,521 | 308,725 | 86,952 | 4,519 | 5,628 | - | (12,667) | 414,255 |
| Consultancy Services | 171,613 | - | 4,793 | 232,258 | 51,552 | 2,338 | 23,443 | - | - | 485,997 |
| Legal fees | 39,694 | 721 | 792 | 93,140 | 180,894 | 7,066 | 5,017 | - | (7,098) | 320,226 |
| Funding to Group Bodies | 5,142,370 | - | - | - | - | - | - | - | (5,142,370) | - |
| Funding for additional pensions uplift | - | - | - | - | 2,549,567 | - | - | - | (2,549,567) | - |
| Audit Fees | 2,000 | 472 | 1,515 | 40,900 | 31,774 | 1,444 | 2,049 | - | (1,522) | 78,632 |
| Other | 1,226,683 | 854 | 448,404 | 1,612,543 | 84,360 | 18,938 | 60,207 | - | (42,718) | 3,409,271 |
| Additional support for delivery of healthcare services | (1,164) | - | - | - | - | - | - | - | - | (1,164) |
| **Material expenditure items** | 160,368,146 | 1,353,484 | 912,078 | 100,802,139 | 145,187,871 | 5,143,355 | 3,537,705 | - | (260,730,195) | 156,574,583 |
| Grants to Other Bodies | 663,756 | 26,713 | - | - | 292,772 | - | - | - | (9,558) | 973,683 |
| Grants to Local Authorities | 3,354,394 | 3,076,887 | - | - | - | - | - | - | - | 6,431,281 |
| Capital Grants | 856,105 | 2,612 | - | - | 75,804 | - | - | - | (1,825) | 932,696 |
| **Total Grants expenditure** | 4,874,255 | 3,106,212 | - | - | 368,576 | - | - | - | (11,383) | 8,337,660 |
| Movement in expected credit loss allowance (non credit impaired) | 27,261 | 8 | 114 | 178,368 | 16,752 | 236 | 40,912 | - | 22,527 | 286,178 |
| Depreciation on property, plant and equipment | 7,569 | 44,496 | 7,279 | 2,434,537 | 168,300 | 14,442 | 238,369 | - | 470 | 2,915,462 |
| Amortisation on intangible assets | 92,467 | 2,696 | 14,818 | 285,731 | 4,014 | 67,627 | 4,422 | - | - | 471,775 |
| Impairments and reversals | 2,616,851 | 171,039 | 3,659 | 1,464,236 | 322 | 20,301 | 8,613 | - | (2,613,564) | 1,671,457 |
| Provisions provided for in year | 2,777,913 | 1,864 | 146,247 | 510,185 | 46,884 | 5,186 | (5,012) | - | - | 3,483,267 |
| Non-cash expenditure from movement in pension liability | - | - | - | 8,098 | 67 | 6,947 | 3,502 | - | - | 18,614 |
| Provisions - unwinding of discount | (30,737) | - | 503,375 | (1,010) | 5,137 | 7 | 14,537 | - | - | 491,309 |
| Provisions - Change in discount rate | 7,783 | - | 346,335 | 15,986 | 40,216 | (2) | - | - | - | 410,318 |
| **Non-cash expenditure** | 5,499,107 | 220,103 | 1,021,827 | 4,896,131 | 281,692 | 114,744 | 305,343 | - | (2,590,567) | 9,748,380 |
| **Total non-material expenditure** | 238,867 | 136,456 | 2,006 | 442,331 | 130,613 | 125,200 | 250,690 | 155,056 | (190,226) | 1,290,993 |
| **Covid-19 expenditure (Core and Agencies)[2]** | 18,332,973 | 556,892 | | | | | | | (1,420,983) | 17,468,882 |
| **Total Gross Expenditure** | **189,313,348** | **5,373,147** | **1,935,911** | **106,140,601** | **145,968,752** | **5,383,299** | **4,093,738** | **155,056** | **(264,943,354)** | **193,420,498** |

1. Intercompany trading between bodies within the Departmental Group is eliminated upon consolidation. Where immaterial differences exist between the intercompany income and expenditure reported by Group bodies the Department equalises the amounts via central consolidation adjustments to ensure the net operating cost reported by the Departmental Group remains unaffected. The immaterial differences giving rise to these consolidation adjustments may be present in several income and expenditure categories; however, the consolidation adjustments are made solely to the 'Other' category to ensure all other income and expenditure categories are presented exactly as reported by Group bodies. This may result in the 'Inter Company Eliminations' figure for the 'Other' expenditure and income categories appearing as a positive figure within this note. Further information about expenditure can be found in Note 4 to these accounts.
2. COVID-19 expenditure for Core and Agencies includes the operational costs of the NHS Test and Trace, personal protective equipment and other equipment and consumables procured by the Core Department. The most significant elements of these costs are impairment of inventory (£8,974 million), costs relating to NHS Test and Trace (£6,484 million) and the supply of personal protective equipment to GPs, pharmacies and social care settings (£1,208 million).
3. In addition to the above costs relating to COVID-19 other costs have been incurred across the Departmental Group as a result of the COVID-19 pandemic. These costs are not separately identifiable from the existing operations of those Group bodies.
4. Purchase of Healthcare from Non-NHS bodies within the NHS England Group includes expenditure associated with the COVID-19 pandemic in 2020-21.
5. Goods and Services from other NHS Bodies within the NHS England Group include the national block payments arrangement in place to fund NHS Providers for additional costs associated with the COVID-19 pandemic. The associated income in NHS providers is included in Income from DHSC/ NHS Bodies and Additional Funding Streams within Note 2.3.
6. The Provider Sustainability Fund (PSF) has not been in operation during 2020-21. However, during the year, £10,921k of PSF income awarded in 2019/20 was recovered.

| | 2019-20 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | DHSC Core £000 | Public Health England £000 | Special Health Authorities £000 | NHS Providers £000 | NHS England Group £000 | Non-Departmental Public Bodies £000 | Other Group Bodies £000 | NHS Charities £000 | Inter company Eliminations and Adjustments £000 | Departmental Group £000 |
| **Material Expenditure Items** | | | | | | | | | | |
| Staff costs | 119,849 | 322,132 | 268,279 | 60,584,273 | 2,126,458 | 589,615 | 292,633 | - | (14,122) | 64,289,117 |
| Purchase of healthcare from non-NHS bodies | - | - | - | 1,486,478 | 14,412,050 | - | - | - | - | 15,898,528 |
| Goods and Services from other NHS Bodies | - | - | 137 | 82,953 | 76,696,103 | - | 6,328 | - | (76,761,530) | 23,991 |
| Utilisation of COVID-19 inventories | - | - | - | - | - | - | - | - | - | - |
| Provider Sustainability Fund | - | - | - | - | 2,595,848 | - | - | - | (2,595,848) | - |
| Purchase of social care | - | - | - | 196,159 | 705,362 | - | - | - | - | 901,521 |
| General Dental Services (GDS) and Personal Dental Services (PDS) | - | - | - | - | 3,089,173 | - | - | - | (130,911) | 2,958,262 |
| Establishment | 131,825 | 16,954 | 22,637 | 978,734 | 408,760 | 55,514 | 11,019 | - | (105,510) | 1,519,933 |
| Premises | 4,398 | 28,836 | 18,631 | 2,959,256 | 79,995 | 31,686 | 283,142 | - | (196,175) | 3,209,769 |
| PFI/Lift and other service concession arrangement charges | - | - | - | 1,006,979 | - | - | 86,387 | - | - | 1,093,366 |
| Multi Professional Education and Training (MPET) | - | - | - | - | - | 4,040,435 | - | - | (2,869,572) | 1,170,863 |
| Prescribing Costs | - | - | - | - | 8,540,631 | - | - | - | (7,497) | 8,533,134 |
| G/PMS, APMS and PCTMS | - | - | - | - | 9,153,611 | - | - | - | (45,596) | 9,108,015 |
| Pharmaceutical Services | - | - | - | - | 1,961,271 | - | - | - | (2,536) | 1,958,735 |
| Supplies and Services - Clinical | - | - | - | 14,311,312 | 406,322 | 166 | 5,175 | - | (1,915,955) | 12,807,020 |
| Supplies and Services - General | - | 687,859 | 103,378 | 1,451,363 | 934,232 | 103,281 | 2,318,500 | - | (485,243) | 5,113,370 |
| Dividends Payable on Public Dividend Capital (PDC) | - | - | - | 610,758 | - | - | - | - | (610,758) | - |
| Rentals under operating leases | 20,294 | 4,057 | 8,725 | 751,875 | 311,535 | 14,720 | 136,018 | - | (547,075) | 700,149 |
| Interest charges | 1,026 | - | - | 1,168,738 | 38 | - | 164,003 | - | (353,145) | 980,660 |
| Research and development | 1,182,084 | 435 | 71 | 231,005 | 15,106 | - | 5,014 | - | (775,750) | 657,965 |
| Clinical negligence Costs | - | - | - | 1,952,131 | 240 | 114 | - | - | (1,951,895) | 590 |
| Grant in Aid | 127,548,939 | - | - | - | - | - | - | - | (127,548,939) | - |
| General Ophthalmic Services | - | - | - | - | 547,797 | - | - | - | (296) | 547,501 |
| Business Rates Paid to Local Authorities | 3,962 | 6,659 | - | 464,704 | 1,022 | 4,550 | 86,864 | - | 5,419 | 573,180 |
| Education, Training and Conferences | 5,122 | 2,408 | 34,232 | 287,452 | 95,360 | 8,970 | 4,955 | - | (20,154) | 418,345 |
| Consultancy Services | 15,203 | - | 2,563 | 199,359 | 45,790 | 1,712 | 25,579 | - | - | 290,206 |
| Legal fees | 19,050 | 1,060 | 1,922 | 82,826 | 112,761 | 3,181 | 6,726 | - | (9,842) | 217,684 |
| Funding to Group Bodies | 4,608,564 | - | - | - | - | - | - | - | (4,608,564) | - |
| Funding for additional pensions uplift | - | - | - | - | 2,341,827 | - | - | - | (2,341,827) | - |
| Audit Fees | 710 | 202 | 1,275 | 36,872 | 28,119 | 1,479 | 1,620 | - | (4,560) | 65,717 |
| Other | 1,025,578 | (264) | 97,424 | 1,121,561 | 37,525 | 23,375 | 74,754 | - | (33,756) | 2,346,197 |
| Additional support for delivery of healthcare services | 10,679 | - | - | - | 55,079 | - | - | - | (55,079) | 10,679 |
| **Material expenditure items** | 134,697,283 | 1,070,338 | 559,274 | 89,964,788 | 124,702,015 | 4,878,798 | 3,508,717 | - | (223,986,716) | 135,394,497 |
| Grants to Other Bodies | 189,401 | 4,600 | - | - | 30,722 | - | - | - | - | 224,723 |
| Grants to Local Authorities | 62,430 | 2,931,555 | - | - | - | - | - | - | - | 2,993,985 |
| Capital Grants | 742,181 | 5,124 | - | - | 62,198 | - | - | - | - | 809,503 |
| **Total Grants expenditure** | 994,012 | 2,941,279 | - | - | 92,920 | - | - | - | - | 4,028,211 |
| Movement in expected credit loss allowance (non credit impaired) | 1,799 | (662) | 17 | 100,574 | 913 | 938 | 112,356 | - | (22,107) | 193,828 |
| Depreciation on property, plant and equipment | 17,924 | 33,366 | 7,314 | 2,161,910 | 145,988 | 15,218 | 230,418 | - | 470 | 2,612,608 |
| Amortisation on intangible assets | 179,743 | 3,946 | 19,982 | 238,209 | 3,337 | 48,964 | 2,127 | - | - | 496,308 |
| Impairments and reversals | 155,470 | 31,173 | 1,249 | 927,900 | - | 1,526 | 10,122 | - | (153,122) | 974,318 |
| Provisions provided for in year | 1,491,820 | 426 | 11,933,982 | 129,934 | 330,677 | 649 | (3,699) | - | 428 | 13,884,217 |
| Non-cash expenditure from movement in pension liability | - | - | - | 12,538 | 186 | 7,752 | 4,391 | - | - | 24,867 |
| Provisions - unwinding of discount | 24,412 | - | 507,878 | 2,468 | (538) | 14 | 690 | - | - | 534,924 |
| Provisions - Change in discount rate | 29,062 | - | (9,381,770) | 25,200 | (279) | 32 | (13,809) | - | - | (9,341,564) |
| **Total non-cash expenditure** | 1,900,230 | 68,249 | 3,088,652 | 3,598,733 | 480,284 | 75,093 | 342,596 | - | (174,331) | 9,379,506 |
| **Total non-material expenditure** | 123,891 | 11,370 | 5,362 | 370,911 | 115,865 | 128,810 | 13,228 | 151,807 | (113,587) | 807,657 |
| **Covid-19 Expenditure (Core and Agencies)** | - | - | | | | | | | | - |
| **Total Expenditure** | **137,715,416** | **4,091,236** | **3,653,288** | **93,934,432** | **125,391,084** | **5,082,701** | **3,864,541** | **151,807** | **(224,274,634)** | **149,609,871** |

1. The Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) for providers in deficit are both linked to the achievement of financial controls and performance trajectories. The funding has been included in the NHS England mandate and has been paid to NHS providers from NHS England. Additionally, marginal rate emergency tariff (MRET) funding adjustments were paid to NHS trusts that agreed a control total.

## 2.3 Departmental Group Detail - Income

| | 2020-21 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | DHSC Core £000 | Public Health England £000 | Special Health Authorities £000 | NHS Providers £000 | NHS England £000 | Non-Departmental Public Bodies £000 | Other Group Bodies £000 | NHS Charities £000 | Inter company Eliminations and Adjustments £000 | Departmental Group £000 |
| **Material Income Items** | | | | | | | | | | |
| Income from Local Authorities | - | - | - | (1,804,768) | - | - | (841) | - | - | (1,805,609) |
| Income from Private patients | - | - | - | (375,926) | - | - | - | - | - | (375,926) |
| Income from injury costs recovery | - | - | - | (129,959) | - | - | - | - | - | (129,959) |
| Income from DHSC/NHS bodies | - | - | - | (85,048,091) | - | - | (62,852) | - | 85,000,890 | (110,053) |
| Other non-NHS patient care services | - | - | - | (526,247) | - | - | (186,739) | - | - | (712,986) |
| Income for additional pension uplift | - | - | - | (2,547,728) | - | - | (1,839) | - | 2,549,567 | - |
| Non patient care services to other bodies | (68,357) | - | (74,218) | (596,610) | (262,623) | (38,153) | (2,470,953) | - | 2,804,370 | (706,544) |
| Education, training and research | - | (495) | (208) | (3,898,083) | (12,075) | (139,067) | (2,868) | - | 3,697,726 | (355,070) |
| Provider Sustainability Fund and Financial Recovery Fund Income | - | - | - | 10,921 | - | - | - | - | (10,921) | - |
| Support from DHSC for mergers | - | - | - | (8,374) | - | - | - | - | 8,374 | - |
| Prescription Pricing Regulation Scheme | (490,643) | - | - | - | - | - | - | - | - | (490,643) |
| Fees and Charges | (97,612) | (197,496) | (2,737,608) | (210,109) | (892,916) | (230,086) | (120,270) | - | 3,043,643 | (1,442,454) |
| Additional Funding Streams[2] | - | - | - | (6,865,143) | - | - | - | - | 6,865,143 | - |
| Other Contract Income | (364,894) | - | (11,575) | (1,148,639) | (213,974) | (7,503) | - | - | 556,865 | (1,189,720) |
| Non-material contract income | (67,813) | - | (779) | (238,275) | (7,765) | (3,526) | (2,691) | - | 10,123 | (310,726) |
| **Income from contracts** | (1,089,319) | (197,991) | (2,824,388) | (103,387,031) | (1,389,353) | (418,335) | (2,849,053) | - | 104,525,780 | (7,629,690) |
| **Non-Contract Income** | | | | | | | | | | |
| Rental revenue from operating leases | (14,134) | (5,648) | - | (71,211) | (24) | (452) | (706,329) | - | 523,509 | (274,289) |
| PDC Dividend Received | (736,262) | - | - | - | - | - | - | - | 736,262 | - |
| Charitable and other contributions to expenditure | - | - | - | (69,201) | (11,038) | - | - | - | 16,653 | (63,586) |
| Donation of Assets[3] | - | - | - | (1,404,952) | (1) | - | - | - | 1,404,953 | - |
| Other non-contract income | (28,487) | - | (863) | 10,768 | (75,675) | (3,582) | (99,090) | - | (26,728) | (223,657) |
| Non-material non-contract income | (29,366) | (753) | 39 | (359,975) | (689) | (2,612) | (13,835) | - | 49,290 | (357,901) |
| **Non-contract operating income** | (808,249) | (6,401) | (824) | (1,894,571) | (87,427) | (6,646) | (819,254) | - | 2,703,939 | (919,433) |
| **COVID-19 Income (Core and Agencies)[1]** | (250,858) | (593,966) | | | | | | | 34,558 | (810,266) |
| **Other non-contract operating income** | (1,059,107) | (600,367) | (824) | (1,894,571) | (87,427) | (6,646) | (819,254) | - | 2,738,497 | (1,729,699) |
| Income received by NHS charities | - | - | - | - | - | - | - | (174,031) | - | (174,031) |
| Finance income | (86,821) | (272) | - | (2,118) | (52) | (1) | (11,406) | - | 70,906 | (29,764) |
| **Total income** | **(2,235,247)** | **(798,630)** | **(2,825,212)** | **(105,283,720)** | **(1,476,832)** | **(424,982)** | **(3,679,713)** | **(174,031)** | **107,335,183** | **(9,563,184)** |

1. COVID-19 Income for Core and Agencies relates to donations of vaccines and other COVID-19 consumables and equipment.
2. Income from DHSC/NHS Bodies and Additional Funding Streams in the NHS provider sector includes income from NHS England in relation to the national block payments arrangement in place to fund additional costs associated with the COVID-19 pandemic. The associated expenditure in the NHS England Group is included in Goods and Services from other NHS Bodies within Note 2.2.
3. Income relating to the donation of assets in the NHS provider sector comprises £1,243 million in relation to personal protective equipment and £162 million in relation to ventilators and scanners received for nil consideration from the Core Department and NHS England.

| | DHSC Core £000 | Public Health England £000 | Special Health Authorities £000 | NHS Providers £000 | NHS England Group £000 | Non-Departmental Public Bodies £000 | Other Group Bodies £000 | NHS Charities £000 | Inter company Eliminations and Adjustments £000 | Restated 2019-20 Departmental Group £000 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Material Income Items** | | | | | | | | | | |
| Income from Local Authorities | - | - | - | (2,030,054) | - | - | (667) | - | - | (2,030,721) |
| Income from Private patients | - | - | - | (671,423) | - | - | - | - | - | (671,423) |
| Income from injury costs recovery | - | - | - | (210,132) | - | - | - | - | - | (210,132) |
| Income from DHSC/NHS bodies | - | - | - | (76,190,567) | - | - | (55,952) | - | 76,120,148 | (126,371) |
| Other non-NHS patient care services | - | - | - | (597,655) | - | - | (1) | - | - | (597,656) |
| Income for additional pension uplift | - | - | - | (2,341,827) | - | - | (1,646) | - | 2,343,473 | - |
| Non patient care services to other bodies[1] | (1,430) | - | (101,239) | (761,089) | (291,944) | (45,113) | (2,592,213) | - | 2,935,313 | (857,715) |
| Education, training and research | - | (1,842) | (706) | (3,840,456) | (13,753) | (138,016) | (1,393) | - | 3,527,963 | (468,203) |
| Provider Sustainability Fund and Financial Recovery Fund Income | - | - | - | (2,595,848) | - | - | - | - | 2,595,848 | - |
| Support from DHSC for mergers | - | - | - | (26,940) | - | - | - | - | 26,940 | - |
| Prescription Pricing Regulation Scheme | (722,809) | - | - | - | - | - | - | - | - | (722,809) |
| Fees and Charges | - | (233,370) | (2,096,802) | (221,367) | (1,462,418) | (221,606) | (123,707) | - | 2,423,420 | (1,935,850) |
| Additional Funding Streams | - | - | - | - | - | - | - | - | - | - |
| Other Contract Income | (588,009) | - | (1,540) | (1,730,779) | (272,801) | (7,155) | (160) | - | 725,355 | (1,875,089) |
| Non-material contract income | (70,144) | - | (2,125) | (311,440) | (9,373) | (3,824) | (4,315) | - | 14,122 | (387,099) |
| **Income from contracts** | (1,382,392) | (235,212) | (2,202,412) | (91,529,577) | (2,050,289) | (415,714) | (2,780,054) | - | 90,712,582 | (9,883,068) |
| **Non-Contract Income** | | | | | | | | | | |
| Rental revenue from operating leases | (10,447) | (7,771) | - | (96,671) | (176) | (545) | (755,672) | - | 480,538 | (390,744) |
| PDC Dividend Received | (610,758) | - | - | - | - | - | - | - | 610,758 | - |
| Charitable and other contributions to expenditure | - | - | - | (95,069) | (1,711) | - | - | - | 22,537 | (74,243) |
| Donation of Assets | - | - | - | - | - | - | - | - | - | - |
| Other non-contract income | (18,399) | - | (201) | (54,453) | (91,047) | (2,168) | (97,036) | - | (268,384) | (531,688) |
| Non-material non-contract income | (32,018) | (620) | - | (281,013) | (544) | (2,158) | (23,407) | - | 51,351 | (288,409) |
| **Non-contract operating income** | (671,622) | (8,391) | (201) | (527,206) | (93,478) | (4,871) | (876,115) | - | 896,800 | (1,285,084) |
| **COVID-19 Income (Core and Agencies)** | - | - | | | | | | | - | - |
| **Other non-contract operating income** | (671,622) | (8,391) | (201) | (527,206) | (93,478) | (4,871) | (876,115) | - | 896,800 | (1,285,084) |
| Income received by NHS charities | - | - | - | - | - | - | - | (153,216) | - | (153,216) |
| Finance income | (372,361) | (272) | - | (57,657) | - | (14) | (12,660) | - | 353,145 | (89,819) |
| **Total income** | **(2,426,375)** | **(243,875)** | **(2,202,613)** | **(92,114,440)** | **(2,143,767)** | **(420,599)** | **(3,668,829)** | **(153,216)** | **91,962,527** | **(11,411,187)** |

1. The Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) for providers in deficit are both linked to the achievement of financial controls and performance trajectories. The funding has been included in the NHS England mandate and has been paid to NHS providers from NHS England. Additionally, marginal rate emergency tariff (MRET) funding adjustments were paid to NHS trusts that agreed a control total. These funding streams have not recurred in 2020-21.

## 3. Staff costs

### Staff costs for the Departmental Group comprise:

| | 2020-21 £'000 | 2019-20 £'000 |
|---|---|---|
| | Total | Total |
| Salaries and wages | 58,129,546 | 51,563,474 |
| Social Security costs | 5,466,312 | 4,952,637 |
| NHS Pension | 8,684,958 | 7,984,705 |
| Other pension costs | 118,488 | 97,231 |
| **Termination benefits** | 21,850 | 44,755 |
| **Sub-total** | **72,421,154** | **64,642,802** |
| Less recoveries in respect of outward secondments | (120,704) | (105,013) |
| **Total Net Costs** | **72,300,450** | **64,537,789** |

1. A more detailed analysis of staff costs can be found in the Accountability Report.

| | | | 2020-21 £'000 |
|---|---|---|---|
| | Charged to revenue budgets | Charged to capital | Total |
| Core Dept & Agencies | 1,126,645 | 4,936 | 1,131,581 |
| Other designated bodies | 70,959,325 | 219,738 | 71,179,063 |
| Less elimination of intra-group expenditure | (10,194) | - | (10,194) |
| **Total** | **72,075,776** | **224,674** | **72,300,450** |

| | | | 2019-20 £'000 |
|---|---|---|---|
| | Charged to revenue budgets | Charged to capital | Total |
| Core Dept & Agencies | 441,981 | 3,049 | 445,030 |
| Other designated bodies | 63,861,305 | 245,623 | 64,106,928 |
| Less elimination of intra-group expenditure | (14,169) | - | (14,169) |
| **Total** | **64,289,117** | **248,672** | **64,537,789** |

### Principal Civil Service Pension Scheme (PCSPS)

The Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and Other Pension Scheme (CSOPS) – known as 'Alpha' are unfunded multi-employer defined benefit schemes, but bodies within the Departmental Group are unable to identify their share of the underlying assets and liabilities. The Scheme Actuary valued the PCSPS as at 31 March 2016, this is shown in the Cabinet Office: Civil Superannuation.

For 2020-21, employers' contributions of £30,546,207 were payable to the PCSPS (2019-20: £19,275,399) at one of four rates in the range 26.6% to 30.3% (2019-20: 26.6% to 30.3%) of pensionable earnings, based on salary bands. The Scheme Actuary reviews employer contributions, usually every four years following a full scheme valuation. The

contribution rates are set to meet the cost of the benefits accruing during 2020-21, to be paid when the member retires and not the benefits paid during this period to existing pensioners.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employers' contributions of £176,228 (2019-20: £105,953) were paid to the appointed stakeholder pension provider. Employer contributions are age-related and range from 8% to 14.75% of pensionable earnings.

Employers also match employee contributions up to 3% of pensionable earnings. In addition, employer contributions of £3,925, 0.5% of pensionable pay, (2019-20: £1,483, 0.5% of pensionable pay) were payable to the PCSPS to cover the cost of the future provision of lump sum benefits on death in service or ill health retirement of these employees.

**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 assets and liabilities. The scheme was actuarially valued as at 31 March 2016.

For 2020-21, employers' contributions were payable to the NHS Pension Scheme at the rate of 20.68% (2019-20: 20.68%) of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HM Treasury Valuation Directions, stemming from the latest full scheme valuation.

Of the £8,685.0 million (2019-20: £7,984.7 million) against NHS pension costs, £287.7 million is attributable to NHS England Group (2019-20: £268.7 million), £8,266.0 million is attributable to NHS providers (2019-20: £7,594.7 million) with the balance of £131.3 million (2019-20: £121.3 million) to ALBs.

# 4. Expenditure

## 4.1 Expenditure

| | Note | 2020-21 £'000 Core Dept & Agencies | 2020-21 £'000 Departmental Group | 2019-20 £'000 Core Dept & Agencies | 2019-20 £'000 Departmental Group |
|---|---|---|---|---|---|
| **4.1 (a) Purchase of goods and services** | | | | | |
| Rentals Under Operating Leases | | 78,038 | 774,208 | 23,227 | 700,149 |
| Supplies and services - clinical | | - | 13,133,857 | - | 12,807,020 |
| Supplies and services - general | | 834,126 | 6,218,730 | 684,543 | 5,113,370 |
| Supply of COVID-19 Ventilators to NHS providers | | 161,538 | - | - | - |
| Supply of COVID-19 Ventilators to Devolved Authorities | | 53,989 | 53,989 | - | - |
| Supply of COVID-19 Personal Protective Equipment to NHS providers | | 1,243,415 | - | - | - |
| Supply of Personal Protective Equipment to external bodies | | 1,208,435 | 1,208,435 | - | - |
| Utilisation of COVID-19 specific inventory by NHS providers | | - | 1,092,007 | - | - |
| Cost of COVID-19 equipment | | - | 12,906 | - | - |
| Supply of other vaccines[13] | | 648,949 | 648,949 | - | - |
| Supply of COVID-19 Medicines | | 99,276 | 99,276 | - | - |
| Cost of NHS Test and Trace consumables | | 3,208,911 | 3,208,911 | - | - |
| COVID-19 Statistical Research | | 519,888 | 519,888 | - | - |
| NHS Test and Trace Operational Costs | | 2,771,656 | 2,755,626 | - | - |
| Goods and services from other NHS bodies | | - | 27,375 | - | 23,991 |
| Multi Professional Education and Training (MPET) | | - | 1,093,500 | - | 1,170,863 |
| Additional support for delivery of healthcare services | | (1,164) | (1,164) | 10,679 | 10,679 |
| Purchase of healthcare from non NHS bodies[6] | | - | 20,068,221 | - | 15,898,528 |
| Purchase of Social Care | | - | 1,055,147 | - | 901,521 |
| Expenditure on Drug Action Teams | | - | 805 | - | 240 |
| General Dental Services (GDS) and Personal Dental Services (PDS)[9] | | - | 3,031,109 | - | 2,958,262 |
| Prescribing Costs | | 269,717 | 9,327,369 | - | 8,533,134 |
| G/PMS, APMS and PCTMS[2] | | - | 10,302,345 | - | 9,108,015 |
| Pharmaceutical Services | | - | 2,124,284 | - | 1,958,735 |
| General Ophthalmic Services | | - | 590,280 | - | 547,501 |
| Consultancy services | | 171,613 | 485,997 | 15,203 | 290,206 |
| Establishment | | 1,113,126 | 2,766,701 | 148,843 | 1,519,933 |
| Transport (Business Travel) | | 11,222 | 241,542 | 8,992 | 307,102 |
| Premises | | 477,850 | 4,529,556 | 33,720 | 3,209,769 |
| Education, Training and Conferences (cash) | | 6,571 | 414,255 | 7,530 | 418,345 |
| Insurance | | 178 | 55,083 | 123 | 46,821 |
| Legal fees | | 40,415 | 320,226 | 20,088 | 217,684 |
| NHS Informatics Major Contracts Cost | | 114,527 | 232,685 | 81,810 | 190,417 |
| Audit fees - statutory audit (cash) | | - | 35,659 | - | 29,878 |
| Auditor remuneration - other | | 202 | 40,585 | - | 34,821 |
| **non-cash items** | | | | | |
| Audit fees - statutory audit - non-cash | | 2,270 | 2,388 | 912 | 1,018 |
| **Purchase of goods and services** | | **13,034,748** | **86,470,730** | **1,035,670** | **65,998,002** |
| **4.1 (b) Depreciation and impairment charges** | | | | | |
| **non-cash items** | | | | | |
| Depreciation on property, plant and equipment | | 52,065 | 2,915,462 | 51,290 | 2,612,608 |
| Amortisation on intangible assets | | 95,163 | 471,775 | 183,689 | 496,308 |
| Impairments and reversals[14] | | 11,761,665 | 10,645,232 | 186,643 | 974,318 |
| **Depreciation and impairment charges** | | **11,908,893** | **14,032,469** | **421,622** | **4,083,234** |
| **4.1 (c) Provision expense** | | | | | |
| **non-cash items** | | | | | |
| Non-cash expenditure from movement in pension liability | | - | 18,614 | - | 24,867 |
| Provision provided for in year | | 2,779,777 | 3,483,267 | 1,492,246 | 13,884,217 |
| Provisions change in discount rate[11] | | 7,783 | 410,318 | 29,062 | (9,341,564) |
| **Provision expense** | | **2,787,560** | **3,912,199** | **1,521,308** | **4,567,520** |
| **4.1 (d) Other operating expenditure** | | | | | |
| PFI/LIFT and other service concession arrangements charges | | - | 1,142,892 | - | 1,093,366 |
| Chair and non-executive Directors' costs | | - | 72,841 | - | 79,923 |
| Business rates paid to local authorities | | 7,245 | 564,353 | 11,695 | 573,180 |
| Clinical negligence | | - | 870 | - | 590 |
| Research and development | | 1,368,655 | 883,341 | 1,180,543 | 657,965 |
| Grants to Local Authorities[7] | | 6,431,281 | 6,431,281 | 2,993,985 | 2,993,985 |
| Grants to Other bodies | | 690,469 | 973,683 | 194,001 | 224,723 |
| Capital Grants | | 858,717 | 932,696 | 747,305 | 809,503 |
| DHSC support for mergers | | 8,374 | - | 26,940 | - |
| Prior period adjustments in local accounts | | - | 209,368 | - | (6,557) |
| **non-cash items** | | | | | |
| Loss on disposal of non-current assets and assets held for sale | | 21,873 | 57,617 | 3,202 | 20,466 |
| Movement of expected credit loss allowance (non-credit impaired) | | 27,269 | 286,178 | 1,137 | 193,828 |
| Inventories write down (covid specific) | | 33 | 33 | - | - |
| Inventories write down | | 64,171 | 92,214 | 1,395 | 15,725 |
| COVID-19 - Inventories Write Downs (NHS providers) | | - | 40,784 | - | - |
| Loan Write Off | | - | - | 53 | 53 |
| Capital grants in kind | | - | 6,066 | - | - |
| Apprenticeship training grant (non-cash) | | 929 | 83,392 | 724 | 61,535 |
| Prior period adjustments in local accounts (non-cash) | | 87,801 | 165,099 | - | (4,577) |
| Changes in fair value through SoCNE | | 60,924 | 6,706 | - | 5,787 |
| Other non-cash expenditure | | 10,593 | 13,376 | 12,125 | 12,078 |
| Unrealised Foreign Exchange Rate (Gains)/Losses | | (5,269) | (5,325) | - | - |
| Other[4,5] | | 1,232,603 | 3,409,271 | 1,031,705 | 2,346,197 |
| **Other operating expenditure** | | **10,865,668** | **15,366,736** | **6,204,810** | **9,077,770** |

1. Supply of COVID-19 ventilators, personal protective equipment and medicines represents the donation for nil consideration of inventory purchased centrally by DHSC. Personal protective equipment supplied to external bodies has been donated to health and care sector settings and public bodies outside the DHSC Group. Utilisation of COVID-19 related inventory represents the usage of donated items by recipient bodies.

2. General Medical Services/Personal Medical Services (G/PMS), Alternative Provider Medical Services (APMS) and Primary Care Trust Medical Services (PCTMS) are differing models for providing primary care services.
3. Note 1.6 (audit costs) explains that the Core Department and Agencies audit fee is a notional charge, resulting in its classification as a non-cash item.
4. The Core Department and Agencies 'Other' expenditure figure of £1,232.6 million (£1,031.7 million in 2019-20) includes £480.2 million of revenue policy payments (£170.7 million in 2019-20), £342.6 million in respect of outsourcing contracts (£302.4 million in 2019-20) and £73.6 million of Healthy Start – Welfare Foods payments (£126.6 million in 2019-20). Revenue policy payments have increased as a result of one-off increased awards relating to contaminated blood payments.
5. Other expenditure also includes £601.1 million of transport costs in the provider sector relating to expenditure such as fuel costs, vehicle parts and other fleet related costs.
6. Purchase of healthcare from Non-NHS bodies has increased primarily as a result of COVID-19 costs.
7. Grants to local authorities have increased significantly as a result of the COVID-19 pandemic response. This includes funding to support infection control and local contact tracing.
8. A breakdown of the Departmental Group Other figure by sector is provided in Note 2.2 Departmental Group Detail – Expenditure.
9. General Dental Services (GDS) and Personal Dental Services (PDS) are alternative models for dental care.
10. Core Department and Agencies expenditure figures may be greater than those of the Departmental Group due to the elimination of intercompany trading.
11. For more details on 'Change in discount rate' see Notes 1.19 and 16.
12. Movement of expected credit loss allowance (non-credit impaired) is the impairment of trade and other receivables under the IFRS 9 Expected Credit Loss Model. This shows the movement of the impairment due to changes in credit risk expected in the forthcoming twelve-month period. Any revision to the expected returns due to a triggering event under stage three (e.g. bankruptcy) continue to be recorded as impairments of financial assets under the Impairments and Reversal line. Please see Note 1.23.4 for details of the Department's accounting policy in respect of Expected Credit Losses.
13. Supply of other vaccines includes £558 million COVID-19 vaccines and £91 million of child flu vaccines procured centrally by the Core Department.
14. See Note 8 for further details of impairments during the year.

## Note 4.2 Non-cash transactions

The total of non-cash transactions included in the Reconciliation of Operating Costs to Operating Cash flow in the Consolidated Statement of Cash Flows comprises:

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| Expenditure after financing activities - non-cash items (Note 4 & SOCNE) | 21,560,823 | 25,508,978 | 1,986,890 | 9,491,591 |
| Less non-cash income after financing activities (Note 5 & SOCNE) | (833,667) | (1,065,040) | (20,129) | (178,694) |
| **Total non-cash transactions** | **20,727,156** | **24,443,938** | **1,966,761** | **9,312,897** |
| Movement in expected credit loss allowance | (27,269) | (286,178) | (1,137) | (193,828) |
| Inventories write down | (64,204) | (133,031) | (1,395) | (15,725) |
| Impairment of inventories | (8,973,775) | (8,973,775) | - | - |
| Utilisation of Covid-19 related inventory | (6,624,513) | (6,324,473) | - | - |
| Donations received of Covid-19 related inventory | 810,266 | 810,266 | - | - |
| **Less non-cash movements on SoFP balances analysed separately in the Cash Flow Statement** | **(14,879,495)** | **(14,907,191)** | **(2,532)** | **(209,553)** |
| **Total non-cash transactions as per Consolidated Statement of Cash Flows** | **5,847,661** | **9,536,747** | **1,964,229** | **9,103,344** |

# 5. Income

## 5.1 Income

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Income from contracts** | | | | |
| **Revenue from Patient Care activities** | | | | |
| Income from Local Authorities | - | 1,805,609 | - | 2,030,721 |
| Income from Private patients | - | 375,926 | - | 671,423 |
| Income from Chargeable Overseas Patients | - | 61,328 | - | 93,301 |
| Income from injury costs recovery | - | 129,959 | - | 210,132 |
| Income in respect of EEA claims | 67,813 | 67,813 | 70,144 | 70,144 |
| Income from DHSC/NHS bodies | - | 110,053 | - | 126,371 |
| Other non-NHS patient care services | - | 712,986 | - | 597,656 |
| **Other contract income** | | | | |
| Non-patient care services to other bodies | 68,357 | 706,544 | 1,430 | 857,715 |
| Education, training and research | 495 | 355,070 | 1,842 | 468,203 |
| Prescription Fees and Charges | - | 615,251 | - | 614,126 |
| Dental Fees and Charges | - | 277,665 | - | 848,292 |
| Other Fees and Charges | 291,140 | 549,538 | 230,332 | 473,432 |
| Income in respect of Staff Costs | - | 181,585 | - | 223,654 |
| Voluntary Scheme for Branded Medicines Pricing and Access | 490,643 | 490,643 | 722,809 | 722,809 |
| Other Contract Income[1,2] | 364,894 | 1,189,720 | 588,009 | 1,875,089 |
| **Income from contracts** | **1,283,342** | **7,629,690** | **1,614,566** | **9,883,068** |
| **Other non-contract operating income** | | | | |
| Rental revenue from finance leases | - | 393 | - | 693 |
| Rental revenue from operating leases | 19,782 | 274,289 | 18,405 | 390,744 |
| PDC Dividend Received | 736,262 | - | 610,758 | - |
| Charitable and other contributions to expenditure | - | 63,586 | - | 74,243 |
| Donation of mechanical ventilators[4] | 126,827 | 126,827 | - | - |
| Other donations recognised as inventory[5] | 89,473 | 89,473 | - | - |
| Donation of Covid-19 vaccines[3] | 593,966 | 593,966 | - | - |
| Receipt of donations for capital acquisitions | - | 81,854 | - | 100,905 |
| Receipt of grants for capital acquisitions | - | 18,089 | - | 1,866 |
| Profit on disposal | 11,878 | 53,023 | 7,275 | 67,819 |
| Dividends | 6,718 | 14,565 | 12,509 | 21,862 |
| Other non-cash income | 10,594 | 98,737 | 12,130 | 36,344 |
| Apprenticeship training grant (non-cash) | 929 | 83,392 | 724 | 61,534 |
| Funding from other Government departments | - | 3,231 | - | 5,001 |
| Prior period adjustments in local accounts | - | 4,617 | - | (7,615) |
| Other non contract income | 32,455 | 223,657 | 22,930 | 531,688 |
| **Non-contract income** | **1,628,884** | **1,729,699** | **684,731** | **1,285,084** |

1. Other Contract Income includes £129 million in the provider sector, which represents a proportion of the incidental non-clinical sales and services.
2. During 2019-20 the Department received cash that HM Treasury has determined was surrenderable to the Consolidated fund. The income associated with the transfer of this cash was recognised in accordance with IFRS 15 which requires the recognition of income only when it is highly probable the income will be received. The value of income recognised in 2020-21 was £364 million (2019-20: £571 million) and is included within other contract income.
3. During the year COVID-19 vaccines were procured by the Department for Business, Energy & Industrial Strategy, which were donated to the Departmental group for nil consideration and the fair value of these items are recorded as income.
4. Donations of mechanical ventilators consist of items procured by other government departments and transferred to DHSC for nil consideration.
5. Other donations recognised as inventory includes £68 million of items procured by other government departments and transferred to DHSC for nil consideration and £21 million of items donated from entities outside of government to support the COVID-19 pandemic response.

## 6. Property, plant and equipment

| | Departmental Group 2020-21 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Land | Buildings (excluding dwellings) | Dwellings | Information Technology | Payments on Account & Assets Under Construction | Furniture & Fittings | Plant & Machinery | Transport Equipment | Stockpiled Goods | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Cost or valuation** | | | | | | | | | | |
| **At 1 April 2020** | **5,923,052** | **40,247,728** | **353,871** | **5,217,512** | **3,666,586** | **679,949** | **10,055,098** | **499,831** | **537,535** | **67,181,162** |
| Prior period adjustments in underlying accounts | 4,800 | (25,673) | (88) | (53,360) | (17,599) | (4,116) | (91,819) | (715) | - | (188,570) |
| Additions | 27,400 | 1,393,590 | 2,952 | 824,565 | 3,897,708 | 28,827 | 1,272,875 | 25,227 | 81,755 | 7,554,899 |
| Donations | 115 | 20,143 | - | 5,222 | 81,368 | 737 | 52,812 | 225 | - | 160,622 |
| Impairments and reversals | (1,820) | (2,262,890) | (7,389) | (19,645) | (140,628) | (1,272) | (16,420) | 6 | (156,880) | (2,606,938) |
| Transfers | (1,455) | (3,395) | - | (10,324) | - | (15) | - | - | (41,498) | (56,687) |
| Reclassifications | (26,689) | 1,507,930 | (4,402) | 239,076 | (2,213,239) | 26,596 | 288,761 | 24,642 | - | (157,325) |
| Revaluation and indexation | 148,326 | (436,502) | 7,394 | (1,695) | (474) | (4,931) | (8,173) | (34) | - | (296,089) |
| Disposals | (33,473) | (104,121) | (540) | (460,969) | (8,120) | (38,001) | (490,251) | (20,116) | (24,746) | (1,180,337) |
| **At 31 March 2021** | **6,040,256** | **40,336,810** | **351,798** | **5,740,382** | **5,265,602** | **687,774** | **11,062,883** | **529,066** | **396,166** | **70,410,737** |
| **Depreciation** | | | | | | | | | | |
| **At 1 April 2020** | **8,471** | **1,691,072** | **27,545** | **3,258,088** | **-** | **478,020** | **6,792,955** | **284,257** | **-** | **12,540,408** |
| Prior period adjustments in underlying accounts | - | (71,578) | (432) | (63,384) | - | (4,104) | (90,733) | (717) | 87,801 | (143,147) |
| Charged in year | 89 | 1,432,299 | 10,986 | 657,257 | - | 45,095 | 690,713 | 58,281 | 20,742 | 2,915,462 |
| Impairments and reversals | (3,567) | (91,783) | (187) | (7,638) | - | (193) | (7,147) | 227 | - | (110,288) |
| Transfers | - | - | - | (10,324) | - | (15) | - | - | - | (10,339) |
| Reclassifications | (218) | (16,622) | (1,591) | (5,793) | - | 329 | 4,651 | (3,049) | - | (22,293) |
| Revaluation and indexation | 2,120 | (1,147,321) | (12,445) | (1,602) | - | (566) | (7,748) | (43) | - | (1,167,605) |
| Disposals | - | (52,522) | (63) | (450,784) | - | (36,261) | (479,886) | (19,566) | - | (1,039,082) |
| **At 31 March 2021** | **6,895** | **1,743,545** | **23,813** | **3,375,820** | **-** | **482,305** | **6,902,805** | **319,390** | **108,543** | **12,963,116** |
| **Net book value at 31 March 2021** | **6,033,361** | **38,593,265** | **327,985** | **2,364,562** | **5,265,602** | **205,469** | **4,160,078** | **209,676** | **287,623** | **57,447,621** |
| Net book value at 31 March 2020 | 5,914,581 | 38,556,656 | 326,326 | 1,959,424 | 3,666,586 | 201,929 | 3,262,143 | 215,574 | 537,535 | 54,640,754 |
| **Asset financing:** | | | | | | | | | | |
| Owned - purchased | 5,508,236 | 25,855,229 | 250,648 | 2,309,343 | 4,930,217 | 186,826 | 3,574,373 | 208,081 | 287,623 | 43,110,576 |
| Owned - donated | 87,766 | 1,223,389 | 12,152 | 14,928 | 308,024 | 13,743 | 273,335 | 1,211 | - | 1,934,548 |
| Finance leased | 54,415 | 410,683 | 14,656 | 33,948 | 19,322 | 4,893 | 160,747 | 384 | - | 699,048 |
| On-Statement of Financial Position PFI contracts | 382,944 | 11,103,964 | 48,156 | 6,343 | 8,039 | 7 | 151,623 | - | - | 11,701,076 |
| PFI residual interests | - | - | 2,373 | - | - | - | - | - | - | 2,373 |
| **Net book value at 31 March 2021** | **6,033,361** | **38,593,265** | **327,985** | **2,364,562** | **5,265,602** | **205,469** | **4,160,078** | **209,676** | **287,623** | **57,447,621** |
| **Analysis of property, plant and equipment** | | | | | | | | | | |
| Core Dept & Agencies | 54,812 | 215,214 | - | 19,679 | 307,671 | 5,263 | 43,871 | - | 287,623 | 934,133 |
| Other designated bodies | 5,978,549 | 38,378,051 | 327,985 | 2,344,883 | 4,957,931 | 200,206 | 4,116,207 | 209,676 | - | 56,513,488 |
| **Net book value at 31 March 2021** | **6,033,361** | **38,593,265** | **327,985** | **2,364,562** | **5,265,602** | **205,469** | **4,160,078** | **209,676** | **287,623** | **57,447,621** |

1. Where there is no active market for partially expired pharmaceuticals and related consumables, or where cost is not materially different to market value, they are held at historic cost as a proxy for fair value and are now depreciated over their useful life.
2. The Department leased Wellington House from the Department for Levelling Up, Housing and Communities (formerly the Ministry of Housing, Communities and Local Government (MHCLG)) for no consideration. The Department for Levelling Up, Housing and Communities in turn leases the assets from the HM Treasury UK Sovereign Sukuk plc, for which HM Treasury is paying the lease costs. It was transferred to the Government Property Agency (GPA) on 31 March 2021 and the Department began to pay rent as set out in the terms of the lease between the Department and GPA from 1 April 2021.

| | Departmental Group 2019-20 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Land | Buildings (excluding dwellings) | Dwellings | Information Technology | Payments on Account & Assets Under Construction | Furniture & Fittings | Plant & Machinery | Transport Equipment | Stockpiled Goods | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Cost or valuation** | | | | | | | | | | |
| **At 1 April 2019** | **6,265,568** | **39,717,701** | **364,639** | **4,673,901** | **3,289,739** | **665,497** | **9,502,406** | **477,095** | **506,295** | **65,462,841** |
| Prior period adjustments in underlying accounts | 425 | (140,111) | (3,466) | (256) | (729) | (11,628) | 6,748 | (97) | - | (149,114) |
| Additions | 13,162 | 973,617 | 2,219 | 644,318 | 2,281,371 | 26,549 | 648,393 | 29,581 | 120,153 | 4,739,363 |
| Donations | 175 | 25,782 | 190 | 3,317 | 69,131 | 2,917 | 61,264 | 80 | - | 162,856 |
| Impairments and reversals | (498,494) | (1,374,967) | (9,897) | (21,976) | (40,234) | (107) | (13,603) | - | (29,738) | (1,989,016) |
| Transfers | 10,858 | (137) | - | - | - | - | 2,216 | - | (35,826) | (22,889) |
| Reclassifications | (52,439) | 1,378,384 | 1,135 | 183,581 | (1,930,196) | 27,717 | 189,369 | 22,070 | - | (180,379) |
| Revaluation and indexation | 274,482 | (260,310) | 98 | (500) | 506 | (2,328) | 1,723 | (53) | - | 13,618 |
| Disposals | (90,685) | (72,231) | (1,047) | (264,873) | (3,002) | (28,668) | (343,418) | (28,845) | (23,349) | (856,118) |
| **At 31 March 2020** | **5,923,052** | **40,247,728** | **353,871** | **5,217,512** | **3,666,586** | **679,949** | **10,055,098** | **499,831** | **537,535** | **67,181,162** |
| **Depreciation** | | | | | | | | | | |
| **At 1 April 2019** | **27,780** | **2,130,875** | **34,390** | **2,985,329** | **-** | **471,896** | **6,494,322** | **277,458** | **-** | **12,422,050** |
| Prior period adjustments in underlying accounts | (1,789) | (165,063) | (5,266) | (1,494) | - | (10,602) | 7,214 | (72) | - | (177,072) |
| Charged in year | 87 | 1,345,103 | 11,037 | 539,395 | - | 45,584 | 621,687 | 49,715 | - | 2,612,608 |
| Impairments and reversals | 24,986 | (59,949) | (2,106) | 1,190 | - | (244) | 340 | 840 | - | (34,943) |
| Transfers | - | (147) | - | - | - | - | 2,227 | - | - | 2,080 |
| Reclassifications | - | (50,352) | (1,451) | (2,359) | - | (363) | (3,139) | (15,463) | - | (73,127) |
| Revaluation and indexation | (42,593) | (1,497,859) | (8,623) | (1,661) | - | (390) | 827 | (53) | - | (1,550,352) |
| Disposals | - | (11,536) | (436) | (262,312) | - | (27,861) | (330,523) | (28,168) | - | (660,836) |
| **At 31 March 2020** | **8,471** | **1,691,072** | **27,545** | **3,258,088** | **-** | **478,020** | **6,792,955** | **284,257** | **-** | **12,540,408** |
| **Net book value at 31 March 2020** | **5,914,581** | **38,556,656** | **326,326** | **1,959,424** | **3,666,586** | **201,929** | **3,262,143** | **215,574** | **537,535** | **54,640,754** |
| Net book value at 31 March 2019 | 6,237,788 | 37,586,826 | 330,249 | 1,688,572 | 3,289,739 | 193,601 | 3,008,084 | 199,637 | 506,295 | 53,040,791 |
| **Asset financing:** | | | | | | | | | | |
| Owned - purchased | 5,414,245 | 25,621,154 | 250,448 | 1,906,610 | 3,343,638 | 179,941 | 2,700,775 | 213,430 | 537,535 | 40,167,776 |
| Owned - donated | 78,706 | 1,252,666 | 12,747 | 14,425 | 303,841 | 16,078 | 280,195 | 1,349 | - | 1,960,007 |
| Finance leased | 44,244 | 439,797 | 11,350 | 31,251 | 10,840 | 5,808 | 146,062 | 795 | - | 690,147 |
| On-Statement of Financial Position PFI contracts | 377,386 | 11,243,039 | 49,595 | 7,138 | 8,267 | 102 | 135,111 | - | - | 11,820,638 |
| PFI residual interests | - | - | 2,186 | - | - | - | - | - | - | 2,186 |
| **Net book value at 31 March 2020** | **5,914,581** | **38,556,656** | **326,326** | **1,959,424** | **3,666,586** | **201,929** | **3,262,143** | **215,574** | **537,535** | **54,640,754** |
| **Analysis of property, plant and equipment** | | | | | | | | | | |
| Core Dept & Agencies | 93,194 | 173,944 | - | 17,238 | 164,905 | 4,719 | 28,071 | - | 537,535 | 1,019,606 |
| Other designated bodies | 5,821,387 | 38,382,712 | 326,326 | 1,942,186 | 3,501,681 | 197,210 | 3,234,072 | 215,574 | - | 53,621,148 |
| **Net book value at 31 March 2020** | **5,914,581** | **38,556,656** | **326,326** | **1,959,424** | **3,666,586** | **201,929** | **3,262,143** | **215,574** | **537,535** | **54,640,754** |

1. Richmond House was vacated by the Department on 1 December 2017 and the building was transferred to Parliamentary Estates in September 2019.

Property has been valued as follows:

- Land and buildings held by NHS bodies are valued, by independent valuers, to a modern equivalent basis as required by HM Treasury per the FReM, details of which can be found in the individual body accounts. The value of land and buildings held by NHS providers at 31 March 2021 was £38,238 million.

- The Civil Estate (land and buildings held for use by the Core Department) was valued on 6 March 2020 by independent valuers employed by the Department. Since then, Investment Property Databank indices have been applied, as appropriate, to uplift values as at the year end using IAS 16 revaluation model methodology. The exception to this was Wellington House which was valued via an external exercise prior to its transfer to the Government Property Agency. The value of the Civil Estate at 31 March 2021 was £31.4 million.

- The Retained Estate comprises land and buildings to the value of £26.0 million at 31 March 2021 (£16.3 million within Investment Property and the remaining balance within Land and Buildings) which were primarily intended for use by NHS bodies but which are now surplus to requirements and are therefore held by the Department. The Retained Estate was revalued by professional valuers as at 31 March 2015. Additional valuations are carried out as necessary in circumstances where there were indications that values had substantially changed. No valuations have been carried out in 2020-21 based on materiality and value for money grounds.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 – 169 years
- Information technology: 1 – 25 years
- Furniture and fittings: 1 – 35 years
- Plant and machinery: 1 – 35 years
- Transport equipment: 1 – 15 years

## 7. Intangible Non-Current Assets

Intangible non-current assets comprise Purchased Software Licences and Internally Developed Software, Trade Marks and Development Expenditure relating to both the Department and the entities consolidated within these financial statements.

| | Departmental Group 2020-21 | | | |
|---|---|---|---|---|
| | IT & Software | Development Expenditure | Other | Total |
| | £'000 | £'000 | £'000 | £'000 |
| **Cost or valuation** | | | | |
| **At 1 April 2020** | **3,985,460** | **323,627** | **314,242** | **4,623,329** |
| Prior period adjustments in underlying accounts | (15,370) | (8,821) | 7,920 | (16,271) |
| Additions | 593,244 | 48,039 | 255,411 | 896,694 |
| Donations | 631 | - | 1,539 | 2,170 |
| Impairments and reversals | (47,561) | (4,856) | (34,492) | (86,909) |
| Transfers | (719) | - | - | (719) |
| Reclassifications | 249,914 | (5,569) | (165,179) | 79,166 |
| Revaluation and indexation | 57,982 | (43) | 781 | 58,720 |
| Disposals | (460,835) | (14,535) | (5,822) | (481,192) |
| Other movements | (63) | - | - | (63) |
| **At 31 March 2021** | **4,362,683** | **337,842** | **374,400** | **5,074,925** |
| | | | | |
| **Amortisation** | | | | |
| **At 1 April 2020** | **2,621,799** | **161,026** | **28,122** | **2,810,947** |
| Prior period adjustments in underlying accounts | (9,280) | - | (1,157) | (10,437) |
| Charged in year | 436,173 | 30,711 | 4,891 | 471,775 |
| Impairments and reversals | 5,575 | (580) | (961) | 4,034 |
| Transfers | (719) | - | - | (719) |
| Reclassifications | (3,148) | 748 | (681) | (3,081) |
| Revaluation and indexation | 4,357 | (59) | 34 | 4,332 |
| Disposals | (434,255) | (13,494) | (2,571) | (450,320) |
| Other movements | (72) | - | - | (72) |
| **At 31 March 2021** | **2,620,430** | **178,352** | **27,677** | **2,826,459** |
| | | | | |
| **Net Book Value at 31 March 2021** | **1,742,253** | **159,490** | **346,723** | **2,248,466** |
| Net book value at 31 March 2020 | 1,363,661 | 162,601 | 286,120 | 1,812,382 |

| Analysis of intangible assets | | | | |
|---|---|---|---|---|
| | IT & Software | Development Expenditure | Other | Total |
| | £'000 | £'000 | £'000 | £'000 |
| **Of the total:** | | | | |
| Core Dept & Agencies | 195,849 | 13,252 | 19,826 | 228,927 |
| Other designated bodies | 1,546,404 | 146,238 | 326,897 | 2,019,539 |
| **Net Book Value at 31 March 2021** | **1,742,253** | **159,490** | **346,723** | **2,248,466** |

| | Departmental Group 2019-20 | | | |
|---|---|---|---|---|
| | IT & Software | Development Expenditure | Other | Total |
| | £'000 | £'000 | £'000 | £'000 |
| **Cost or valuation** | | | | |
| **At 1 April 2019** | **3,885,698** | **295,214** | **281,853** | **4,462,765** |
| Prior period adjustments in underlying accounts | (2,286) | (71) | (221) | (2,578) |
| Additions | 355,196 | 42,873 | 185,510 | 583,579 |
| Donations | 926 | - | 2,493 | 3,419 |
| Impairments and reversals | (6,645) | (5,748) | (2,721) | (15,114) |
| Transfers | - | - | - | - |
| Reclassifications | 177,756 | (2,741) | (149,101) | 25,914 |
| Revaluation and indexation | 31,606 | 738 | 1,652 | 33,996 |
| Disposals | (447,772) | (6,638) | (5,223) | (459,633) |
| Other movements | (9,019) | - | - | (9,019) |
| **At 31 March 2020** | **3,985,460** | **323,627** | **314,242** | **4,623,329** |
| | | | | |
| **Amortisation** | | | | |
| **At 1 April 2019** | **2,611,102** | **133,788** | **28,719** | **2,773,609** |
| Prior period adjustments in underlying accounts | (2,139) | 64 | (220) | (2,295) |
| Charged in year | 457,993 | 32,974 | 5,341 | 496,308 |
| Impairments and reversals | 14,687 | (80) | 3 | 14,610 |
| Transfers | - | - | - | - |
| Reclassifications | 2,138 | 8 | (1,761) | 385 |
| Revaluation and indexation | (15,888) | 540 | 144 | (15,204) |
| Disposals | (443,229) | (6,268) | (4,104) | (453,601) |
| Other movements | (2,865) | - | - | (2,865) |
| **At 31 March 2020** | **2,621,799** | **161,026** | **28,122** | **2,810,947** |
| | | | | |
| **Net Book Value at 31 March 2020** | **1,363,661** | **162,601** | **286,120** | **1,812,382** |
| Net Book Value at 31 March 2019 | 1,274,596 | 161,426 | 253,134 | 1,689,156 |

| **Analysis of intangible assets** | | | | |
|---|---|---|---|---|
| | IT & Software | Development Expenditure | Other | Total |
| | £'000 | £'000 | £'000 | £'000 |
| **Of the total:** | | | | |
| Core Dept & Agencies | 123,946 | 23,170 | 14,995 | 162,111 |
| Other designated bodies | 1,239,715 | 139,431 | 271,125 | 1,650,271 |
| **Net Book Value at 31 March 2020** | **1,363,661** | **162,601** | **286,120** | **1,812,382** |

The ranges of estimated useful lives are currently:

- Software licences and Internally Developed Software: 1 – 20 years
- Development expenditure: 1 – 12 years
- Other (licences and trademarks, patents, purchased software etc): 1 – 10 years

The Departmental Group revalues intangible non-current assets associated with Informatics programmes at the end of each financial year, by indexing their original cost using appropriate indices. This valuation method is reviewed annually.

Informatics non-current assets (whether classified as property, plant and equipment or intangible assets) are not added to the relevant organisation's Non-Current Asset Register until confirmation has been received from the appropriate NHS organisation that the relevant system has been deployed successfully.

## 8. Impairments

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Impairments charged to Consolidated Statement of Comprehensive Net Expenditure** | | | | |
| Property Plant and Equipment impairments | 169,442 | 1,576,045 | 29,672 | 940,048 |
| Intangible asset impairments | 1,597 | 90,901 | 1,435 | 29,701 |
| Financial asset impairments | 2,616,851 | 3,537 | 155,536 | 2,847 |
| Non Current Assets Held for Sale impairments | - | 974 | - | 1,722 |
| Inventory impairments | 8,973,775 | 8,973,775 | - | - |
| **Total impairments charged to Consolidated Statement of Comprehensive Net Expenditure** | **11,761,665** | **10,645,232** | **186,643** | **974,318** |
| **Impairments charged to Revaluation Reserve** | | | | |
| Property Plant and Equipment impairments | 781 | 920,605 | - | 1,014,025 |
| Intangible asset impairments | - | 42 | 20 | 23 |
| **Total impairments charged to Revaluation Reserve** | **781** | **920,647** | **20** | **1,014,048** |
| **Impairments charged to General Fund** | | | | |
| PDC impairments | (669,229) | - | 606,125 | - |
| **Total impairments charged to General Fund** | **(669,229)** | **-** | **606,125** | **-** |
| **Total impairments charged in year** | **11,093,217** | **11,565,879** | **792,788** | **1,988,366** |

Financial asset impairments for the Core Department consists of impairments of PDC issued to providers, where the net assets of the individual provider are below the carrying value of the investment. The impairment recognised in 2020-21 has increased due to the reforms to the NHS cash regime as described in Note 11 below.

The above table includes both impairments and impairment reversals. In 2019-20 there was no formal write off of PDC as this process was postponed until 2020-21 due to the COVID-19 pandemic. Therefore, there were no reversals of PDC impairments in 2019-20.

Inventory impairments relate to:

- Personal protective equipment - £8,705 million impairment. This amount can be further analysed as £673 million of items which have been assessed as not being suitable for any use, £2,581 million for items not suitable for use within the health and social care sector but which may be suitable for other uses and are therefore held for future sale or donation. £4,701 million reflects the impairment recognised as a result of fluctuations in the market price of personal protective equipment between the point of purchase and the balance sheet date, and £750 million relates to inventory which has an expiry date prior to the expected usage date and is therefore held for resale or donation. The purchase price of the items which have an expiry date prior to the expected usage date at weighted average cost was £3,322 million. Paragraphs 212 and 213 of the Annual Report contains further information in relation to these impairments.

- Personal protective equipment impairments have been calculated in the order described above as follows: Inventory that cannot be used for its original intended purpose, because it has either been assessed as not suitable for any use or use within the health and social care sector, is impaired upon receipt reflecting the characteristics of the inventory immediately reducing its value. Usable inventory is then subject to an adjustment to its net realisable value where this has dropped below weighted average cost by financial year-end. This impairment reflects a reduction in the market price of these items between the point of purchase and 31 March 2021. A further impairment is subsequently made to the proportion of the usable inventory where the department estimates the items have an expiry date prior to their expected usage date. This impairment reflects a reduction in valuation resulting from the inventory being held for future sale or donation rather than use.

- The impairment ordering and also presents the most transparent view of the individual factors driving the diminution in inventory value. For example, the impairment for items assessed as not being suitable either for any use or for their original intended purpose is expressed at weighted average cost, with the impairment for fluctuations in market value being a year-end valuation adjustment calculated subsequent to this. The impairment of inventory with an expiry date prior to the expected usage date is an estimate, based on estimates of future demand, of losses that will crystalise in future accounting periods and is based on the net realisable value of the inventory at 31 March 2021; i.e. after the impairment for the fluctuations in market value. However, regardless of the order of calculation, the total impairment would remain as calculated above.

- NHS Test and Trace Consumables - £195 million relating to items for which we have not currently identified a suitable use.

- Other COVID-19 related equipment and consumables - £74 million, reflecting impairment (£52 million) due to items being not suitable for their intended use and £22 million relating to market price fluctuations.

The assessment of the level of impairment recognised is subject to a degree of uncertainty predominantly in the following areas:

- Items held for use in the NHS have been impaired to reflect the best estimate of market value using agreed framework prices. If market values used fluctuate by 10%, the total impairment required would change by £91 million.

- The assessment of impairment for inventory which is held for sale or donation would change by £333 million if estimated sales proceeds changed by 10% of cost price.

- In assessing the value of impairments required in respect of personal protective equipment which may become surplus to requirements there is inherent uncertainty in the level of future demand. In order to assess the level of impairment required, the Department has considered the latest available demand led modelling and compared this to inventory held at the year end. A 10% increase in the level of estimated demand across all product lines would reduce the total impairment required by £53 million. A 10% decrease would increase the total impairment required by £106 million.

- The value of impairments in respect of personal protective equipment which may become surplus to requirements is calculated by reference to the shelf life of the relevant FIS category. Due to the volume of stock held, this has necessitated use of an average calculated based on products which are held in palletised storage. The impact of a 6 month increase in average shelf lives would reduce the total impairment required by £80 million and a 6 month reduction would increase the total impairment by £83 million.

**Note 12** provides detail relating to the movement of inventory balances between the start and the end of the financial year due to such activity as addition and consumption of inventory as well as detailing the impact that impairment has on residual balances for inventory at 31 March 2021.

## 9. Commitments

### 9.1 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 the Department to the expenditure as it would be reputationally or politically damaging for the Department to withdraw from the agreement.

Any future capital funding within the Department's accounting boundary does not represent a capital commitment.

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| Contracted capital commitments at 31 March not otherwise included in these financial statements | | | | |
| Property, plant and equipment | 201,628 | 2,318,342 | 188,777 | 2,009,467 |
| Intangible non-current assets | 40,176 | 255,039 | 9,558 | 100,256 |
| | **241,804** | **2,573,381** | **198,335** | **2,109,723** |

## 9.2 Commitments under leases

### 9.2.1 Operating lease payments

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Land:** | | | | |
| Not later than 1 year | 1,189 | 6,123 | - | 10,794 |
| Later than 1 year and not later than 5 years | - | 15,171 | - | 12,504 |
| Later than 5 years | - | 29,630 | - | 20,773 |
| | **1,189** | **50,924** | **-** | **44,071** |
| **Buildings:** | | | | |
| Not later than 1 year | 51,764 | 392,451 | 18,791 | 372,353 |
| Later than 1 year and not later than 5 years | 104,723 | 1,049,900 | 38,963 | 1,015,297 |
| Later than 5 years | 93,611 | 1,385,806 | 28,739 | 1,265,491 |
| | **250,098** | **2,828,157** | **86,493** | **2,653,141** |
| **Other:** | | | | |
| Not later than 1 year | 123 | 199,728 | 387 | 193,984 |
| Later than 1 year and not later than 5 years | 21 | 345,280 | 121 | 369,245 |
| Later than 5 years | - | 65,435 | - | 62,513 |
| | **144** | **610,443** | **508** | **625,742** |

1. Operating lease commitments between bodies with the Departmental Group are eliminated upon consolidation.

### 9.2.2 Operating Lease receipts

Total future minimum lease receipts under operating leases are given in the table below for each of the following periods.

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Land:** | | | | |
| Not later than 1 year | - | 6,546 | - | 4,981 |
| Later than 1 year and not later than 5 years | - | 16,842 | - | 14,362 |
| Later than 5 years | - | 186,583 | - | 199,558 |
| | **-** | **209,971** | **-** | **218,901** |
| **Buildings:** | | | | |
| Not later than 1 year | 16,408 | 139,067 | 16,469 | 126,587 |
| Later than 1 year and not later than 5 years | 29,335 | 455,515 | 30,030 | 419,064 |
| Later than 5 years | 28,947 | 876,038 | 29,894 | 901,076 |
| | **74,690** | **1,470,620** | **76,393** | **1,446,727** |
| **Other:** | | | | |
| Not later than 1 year | - | 10,431 | - | 21,717 |
| Later than 1 year and not later than 5 years | - | 26,887 | - | 31,959 |
| Later than 5 years | - | 13,080 | - | 18,802 |
| | **-** | **50,398** | **-** | **72,478** |

1. Future minimum lease receipts under operating leases between bodies with the Departmental Group are eliminated upon consolidation.

### 9.2.3 Finance lease payments

Total future minimum lease payments under finance leases are given in the table below for each of the following periods.

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Obligations under finance leases for the following periods comprise:** | | | | |
| **Land:** | | | | |
| Not later than 1 year | - | 1,401 | - | 181 |
| Later than 1 year and not later than 5 years | - | 5,565 | - | 727 |
| Later than 5 years | - | 21,444 | - | 1,187 |
| | **-** | **28,410** | **-** | **2,095** |
| Less interest element | - | (14,898) | - | (1,298) |
| **Present Value of obligations** | **-** | **13,512** | **-** | **797** |
| **Buildings:** | | | | |
| Not later than 1 year | - | 48,627 | - | 49,416 |
| Later than 1 year and not later than 5 years | - | 179,848 | - | 188,148 |
| Later than 5 years | - | 429,761 | - | 473,514 |
| | **-** | **658,236** | **-** | **711,078** |
| Less interest element | - | (267,938) | - | (301,024) |
| **Present Value of obligations** | **-** | **390,298** | **-** | **410,054** |
| **Other:** | | | | |
| Not later than 1 year | - | 64,957 | - | 56,830 |
| Later than 1 year and not later than 5 years | - | 143,886 | - | 124,254 |
| Later than 5 years | - | 62,876 | - | 40,222 |
| | **-** | **271,719** | **-** | **221,306** |
| Less interest element | - | (40,146) | - | (29,693) |
| **Present Value of obligations** | **-** | **231,573** | **-** | **191,613** |

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Present Value of obligations under finance leases for the following periods comprise:** | | | | |
| **Land:** | | | | |
| Not later than 1 year | - | 578 | - | 80 |
| Later than 1 year and not later than 5 years | - | 2,752 | - | 452 |
| Later than 5 years | - | 10,182 | - | 265 |
| **Total Present Value of obligations** | **-** | **13,512** | **-** | **797** |
| **Buildings:** | | | | |
| Not later than 1 year | - | 23,198 | - | 24,444 |
| Later than 1 year and not later than 5 years | - | 99,924 | - | 100,156 |
| Later than 5 years | - | 267,176 | - | 285,454 |
| **Total Present Value of obligations** | **-** | **390,298** | **-** | **410,054** |
| **Other:** | | | | |
| Not later than 1 year | - | 57,319 | - | 50,007 |
| Later than 1 year and not later than 5 years | - | 122,869 | - | 108,667 |
| Later than 5 years | - | 51,385 | - | 32,939 |
| **Total Present Value of obligations** | **-** | **231,573** | **-** | **191,613** |

1. Finance lease commitments between bodies with the Departmental Group are eliminated upon consolidation.

### 9.2.4 Finance lease receivables

Total future minimum lease payments receivable under finance leases are given in the table below for each of the following periods.

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Gross investments in leases:** | | | | |
| Not later than 1 year | 545 | 2,119 | 303 | 3,698 |
| Later than 1 year and not later than 5 years | 182 | 5,852 | 424 | 4,414 |
| Later than 5 years | - | 18,473 | - | 18,355 |
| Less future finance income | (43) | (7,948) | (43) | (7,988) |
| **Present Value of minimum lease payments** | **684** | **18,496** | **684** | **18,479** |
| Less cumulative provision for uncollectable payments: | - | - | - | - |
| **Total finance lease receivables recognised in the Consolidated Statement of Financial Position** | **684** | **18,496** | **684** | **18,479** |
| | | | | |
| **Present Value of minimum lease payments:** | | | | |
| Not later than 1 year | 505 | 1,517 | 275 | 3,112 |
| Later than 1 year and not later than 5 years | 179 | 3,672 | 409 | 2,234 |
| Later than 5 years | - | 13,307 | - | 13,133 |
| **Total Present Value of minimum lease payments** | **684** | **18,496** | **684** | **18,479** |
| Less cumulative provision for uncollectable payments: | - | - | - | - |
| **Total finance lease receivables recognised in the Consolidated Statement of Financial Position** | **684** | **18,496** | **684** | **18,479** |
| | | | | |
| included in: | | | | |
| Current finance lease receivables | 505 | 1,517 | 275 | 3,112 |
| Non-current finance lease receivables | 179 | 16,979 | 409 | 15,367 |
| **Sub total** | **684** | **18,496** | **684** | **18,479** |

1. Future minimum lease receipts between bodies with the Departmental Group are eliminated upon consolidation.

## 9.3 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 relevant NHS providers, NHS Property Services Ltd and Community Health Partnerships Ltd.

### 9.3.1 NHS LIFT schemes deemed to be off-Statement of Financial Position

In this financial year, Community Health Partnerships Ltd reported one off-Statement of Financial Position LIFT scheme with an estimated capital value of £0.9 million (2019-20: one scheme, £0.9 million). The assets which make up this capital value were not assets of Community Health Partnerships Ltd.

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Obligations on off-Statement of Financial Position LIFT schemes for the following periods comprise:** | | | | |
| Not later than 1 year | - | 62 | - | 62 |
| Later than 1 year and not later than 5 years | - | 248 | - | 248 |
| Later than 5 years | - | 3,659 | - | 3,721 |
| | **-** | **3,969** | **-** | **4,031** |

### 9.3.2 NHS LIFT schemes deemed to be on-Statement of Financial Position

#### Community Health Partnerships Ltd

In this financial period Community Health Partnerships Ltd reported 298 on-Statement of Financial Position LIFT schemes. (2019-20: 297). The substance of each contract is that Community Health Partnerships Ltd has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The amount included within operating expenses for off-balance sheet LIFT transactions and the service element of on-balance sheet LIFT transactions is £55.2 million (2019-20: £53.9 million).

#### NHS Providers

In this financial year, 6 NHS providers (2019-20: 6 NHS providers), reported on-Statement of Financial Position LIFT schemes. The assets of these schemes are treated as assets of the trusts. The substance of each contract is that the Trust has a finance lease and payments comprise an imputed finance lease charge and a service charge. Details of the individual LIFT schemes are included in the accounts of each NHS provider.

Total obligations for the on-Statement of Financial Position NHS LIFT Schemes due:

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Total obligations under on-Statement of Financial Position LIFT schemes for the following periods comprise:** | | | | |
| Not later than 1 year | - | 165,650 | - | 164,312 |
| Later than 1 year and not later than 5 years | - | 649,289 | - | 646,243 |
| Later than 5 years | - | 2,295,152 | - | 2,432,367 |
| | **-** | **3,110,091** | **-** | **3,242,922** |
| Less interest element | - | (1,389,067) | - | (1,504,991) |
| **Present Value of obligations** | **-** | **1,721,024** | **-** | **1,737,931** |

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Present Value of obligations under on-Statement of Financial Position LIFT schemes for the following periods comprise:** | | | | |
| Not later than 1 year | - | 43,395 | - | 40,127 |
| Later than 1 year and not later than 5 years | - | 188,382 | - | 176,651 |
| Later than 5 years | - | 1,489,247 | - | 1,521,153 |
| **Total Present Value of obligations** | **-** | **1,721,024** | **-** | **1,737,931** |

### 9.3.3 Charges to the Consolidated Statement of Comprehensive Net Expenditure in respect of NHS LIFT Contracts

The total charges in the period to expenditure in respect of off-Statement of Financial Position NHS LIFT contracts and the service element of on-Statement of Financial Position NHS LIFT contracts was £58.8 million (2019-20: £57.4 million).

Community Health Partnerships Ltd and NHS providers with NHS LIFT contracts are committed to the following total charges:

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| Not later than 1 year | - | 59,001 | - | 58,093 |
| Later than 1 year and not later than 5 years | - | 250,857 | - | 247,300 |
| Later than 5 years | - | 603,290 | - | 664,420 |
| | **-** | **913,148** | **-** | **969,813** |

### 9.3.4 PFI Schemes deemed to be off-Statement of Financial Position

#### NHS Providers

In this financial year 7 NHS providers reported off-Statement of Financial Position PFI schemes (2019-20: 7 NHS providers).

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Obligations on off-Statement of Financial Position PFI schemes for the following periods comprise:** | | | | |
| Not later than 1 year | - | 4,647 | - | 5,794 |
| Later than 1 year and not later than 5 years | - | 17,183 | - | 22,607 |
| Later than 5 years | - | 12,780 | - | 20,506 |
| | **-** | **34,610** | **-** | **48,907** |

### 9.3.5 NHS PFI schemes deemed to be on-Statement of Financial Position

#### NHS Property Services Ltd

In this financial period NHS Property Services Ltd reported 27 on-Statement of Financial Position PFI schemes (2019-20: 27 schemes). The amount included in the Consolidated Statement of Comprehensive Net Expenditure in respect of off-Statement of Financial Position PFI transactions and the service element of on-Statement of Financial Position PFI transactions is £33.2 million (2019-20: £32.5 million).

#### NHS Providers

In this financial year, 148 NHS providers reported on-Statement of Financial Position PFI Schemes (2019-20: 151 NHS providers). The assets of these schemes are treated as assets of the NHS provider. The substance of each contract is that the Trust has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The amount included within operating expenses in respect of off-Statement of Financial Position PFI transactions and the service element of the on-Statement of Financial Position PFI transactions is £1,050.9 million. (2019-20: £1,003.5 million).

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Total obligations under on-Statement of Financial Position PFI schemes or other service concession arrangements for the following periods comprise:** | | | | |
| Not later than 1 year | - | 868,865 | - | 860,470 |
| Later than 1 year and not later than 5 years | - | 3,415,109 | - | 3,400,546 |
| Later than 5 years | - | 11,349,754 | - | 12,264,464 |
| | **-** | **15,633,728** | **-** | **16,525,480** |
| Less interest element | - | (7,110,457) | - | (7,703,249) |
| **Present Value of obligations** | **-** | **8,523,271** | **-** | **8,822,231** |

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Present Value of obligations under on-Statement of Financial Position PFI schemes or other service concession arrangements for the following periods comprise:** | | | | |
| Not later than 1 year | - | 327,692 | - | 308,737 |
| Later than 1 year and not later than 5 years | - | 1,391,907 | - | 1,362,879 |
| Later than 5 years | - | 6,803,672 | - | 7,150,615 |
| **Total Present Value of obligations** | **-** | **8,523,271** | **-** | **8,822,231** |

### 9.3.6 Charges to the Consolidated Statement of Comprehensive Net Expenditure in respect of NHS PFI contracts

The total amount charged in the Consolidated Statement of Comprehensive Net Expenditure in respect of off-Statement of Financial Position NHS PFI schemes and the service element of on-Statement of Financial Position NHS PFI schemes was £1,084.1 million (2019-20: £1,036.0 million).

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| Not later than 1 year | - | 971,309 | - | 954,353 |
| Later than 1 year and not later than 5 years | - | 4,132,750 | - | 3,950,932 |
| Later than 5 years | - | 15,174,357 | - | 16,787,049 |
| | - | **20,278,416** | - | **21,692,334** |

### 9.4 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 the Departmental group 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 the Department's accounting boundary does not represent a financial commitment.

Other financial commitments relating to the Core Department primarily include contracts for:

- The Personal Protective Equipment (PPE) programme, for future deliveries of PPE and ongoing storage costs;
- NHS Test and Trace, for costs including laboratory testing, facilities hire and management, outsourced contact tracing and future deliveries of test kits and consumables;
- Future commitments in respect of Research and Development contracts. These contracts are with a number of NHS organisations, universities and private research organisations. The purpose of research and development arrangements varies from the development of the health research workforce and research infrastructure in the NHS and the provision of research support by the NHS to specific research programmes or projects; and
- Other business as usual expenditure such as ongoing estates contracts.

Other financial commitments for the rest of the Departmental Group totalled £1,781 million (2019-20: £2,068 million), of which £823 million (2019-20: £1,022 million) is not later than 1 year, £876 million (2019-20: £943 million) between 2 and 5 years and £82 million (2019-20: 103 million) greater than 5 years.

## 10. Financial Instruments

### 10.1 Risk profile

As the cash requirements of the Department 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 Department's investments in NHS providers and the Medicines & Healthcare products Regulatory Agency are represented by Public Dividend Capital (PDC) which, being issued under statutory authority, are not classed as being a financial instrument.

#### Currency Risk

The Department undertakes certain transactions denominated in foreign currencies, the vast majority of which are transactions relating to European Economic Area (EEA) medical costs.

Due to the lead time in the submission of medical cost claims by member states (as per current EU regulations), the Department estimates annual medical costs and adjusts future years' expenditure when actual costs arise (are claimed). Estimated costs are converted into sterling at average rates calculated using EU published rates. Payments made are valued at prevailing exchange rates. Amounts in the Statement of Financial Position at year-end are converted at the exchange rate ruling at the Statement of Financial Position date, with any exchange rate gains or losses calculated in accordance with accepted accounting practice.

As a result of COVID-19 purchasing, there were a higher number of foreign currency transactions taking place in 2020-21 compared to previous years, although remaining a small proportion of overall expenditure. However, 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 remains low.

#### Liquidity Risk

The income within the Department of Health and Social Care Group mostly originates from Central Government and remains within the group. 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 based either on a tariff for services performed or on assumptions for the amount of work to be carried out. These funding arrangements were replaced in 2020-21 by a system of block contract payments, to enable NHS organisations to respond to COVID-19 without worrying about funding or contract negotiations.

### Interest Rate Risk

The Departmental Group has limited exposure to Interest Rate Risk.

NHS Trusts and NHS Foundation Trusts borrow from government for capital expenditure, subject to affordability. These can take the form of either term loans or maturity loans. The borrowings are for 1 – 25 years. Interest is charged at the National Loans rate prevailing on the date of signing the loan agreement, and the rate is fixed for the life of the loan. NHS Foundation Trusts have the power to enter into loans and working capital facilities with commercial lenders should they wish but this is governed by NHS England and NHS Improvement.

### Credit risk

The vast majority of the Departmental Group's income is generated from public sector bodies and as such is exposed to low credit risk.

From a Core Department perspective, no loans to NHS Trusts or NHS Foundation Trusts have been written off since the re-introduction of loan financing for NHS providers in 2004. The financial performance of NHS Trusts and NHS Foundation Trusts is rigorously managed by NHS England and Improvement (umbrella organisation of the NHS Trust Development Authority and the independent regulator Monitor), not least through their respective powers of intervention.

### Analysis of financial assets

As at 31 March 2021, the financial assets of the Departmental Group amounted to £21,421 million (31 March 2020: £13,293 million) of which £20,741 million (31 March 2020: £12,961 million) was held at amortised cost, £679 million (31 March 2020: £330 million) was designated at fair value through Other Comprehensive Income, and £1 million (31 March 2020: £2 million) was mandated to fair value through profit or loss.

As at 31 March 2021, the financial assets of the Core Department and Agencies amounted to £16,495 million (31 March 2020: £24,996 million), of which £5,728 million (31 March 2020: £5,603 million) was designated at fair value through Other Comprehensive Income and £10,767 million (31 March 2020: £19,393 million) was held at amortised cost.

### Analysis of financial liabilities

As at 31 March 2021, the financial liabilities of the Departmental Group amounted to £41,755 million (31 March 2020: £31,035 million). At both 31 March 2021 and 31 March 2020, all financial liabilities of the group were held at amortised cost.

As at 31 March 2021, the financial liabilities of the Core Department and Agencies amounted to £11,425 million (31 March 2020: £3,110 million). At both 31 March 2021 and 31 March 2020, all financial liabilities of the Core Department and Agencies were held at amortised cost.

## 11. Financial Assets – Investments

| | 2020-21 £'000 | | | | | | 2020-21 £'000 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Core Dept & Agencies | | | | | | Departmental Group | | | |
| | NHS Healthcare Providers | | Other Bodies | | | Total | Other Bodies | | | Total |
| | PDC | Loans | PDC | Loans | Share Capital | | PDC | Loans | Share Capital and Other Investments | |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Restated Balance at 1 April 2020** | **18,154,873** | **2,766,373** | **1,328** | **818,605** | **5,603,216** | **27,344,395** | **1,328** | **295,057** | **519,148** | **815,533** |
| Issued | 17,847,127 | 80,200 | - | 5,017,426 | 74,513 | 23,019,266 | - | 33,255 | 56,980 | 90,235 |
| Disposals | - | - | - | - | - | - | - | - | (12,158) | (12,158) |
| Repaid | (103,099) | (159,218) | - | (88,990) | - | (351,307) | - | (21,779) | (2,410) | (24,189) |
| Transfers to and from current receivables | - | (225,864) | - | (827) | - | (226,691) | - | (827) | - | (827) |
| Written off | (669,229) | - | - | - | - | (669,229) | - | - | - | - |
| Changes in fair value through other comprehensive income | - | - | - | - | 53,808 | 53,808 | - | - | 307,298 | 307,298 |
| Changes in fair value through CSCNE | - | - | - | - | - | - | - | - | 1,481 | 1,481 |
| Other Impairments and reversals | (1,944,335) | - | - | - | (3,287) | (1,947,622) | - | - | (3,537) | (3,537) |
| Reclassifications | - | - | - | (262,338) | - | (262,338) | - | (262,338) | - | (262,338) |
| Transfers | - | - | - | - | - | - | - | - | - | - |
| Other movements | - | - | - | - | - | - | - | - | 3,007 | 3,007 |
| **Balance at 31 March 2021** | **33,285,337** | **2,461,491** | **1,328** | **5,483,876** | **5,728,250** | **46,960,282** | **1,328** | **43,368** | **869,809** | **914,505** |

| | |
|---|---|
| **Investments held by Core Dept & Agencies** | 46,960,282 |
| Less elimination of intra-group investments | (46,296,335) |
| **Investments held by other designated bodies** | 250,558 |
| **Total** | **914,505** |

1. The issued line records the full value of all new loans let in-year and interest arising. These loans will comprise a current and non-current element, with the current element being immediately transferred to receivables via the Transfers to and from current receivables line. Due to reforms to the NHS Cash Regime effective from 1 April 2020, providers were issued £13,548 million of Public Dividend Capital (PDC) to enable the repayment of outstanding loan balances as at 31 March 2020. These loan balances were included in the 'current part of loans repayable transferred from investments' in Note 14.
2. The repaid line records repayments of non-current amounts: i.e. repayments of amounts more than 12 months in advance of the date specified in the relevant loan agreements/schedules. The repayment of the current element of financial assets is accounted for in the receivables note (Note 14).

| | 2019-20 £'000 | | | | | | 2019-20 £'000 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Core Dept & Agencies | | | | | | Departmental Group | | | |
| | NHS Healthcare Providers | | Other Bodies | | | Restated Total | Other Bodies | | | Total |
| | PDC | Loans | PDC | Loans | Share Capital | | PDC | Loans | Share Capital and Other Investments | |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2019** | **18,009,509** | **10,485,812** | **1,328** | **600,792** | **1,654,787** | **30,752,228** | **1,328** | **289,781** | **387,564** | **678,673** |
| **Effect of prior period adjustment** | - | - | - | - | 3,571,123 | 3,571,123 | - | - | - | - |
| **Restated balance at 1 April 2019** | **18,009,509** | **10,485,812** | **1,328** | **600,792** | **5,225,910** | **34,323,351** | **1,328** | **289,781** | **387,564** | **678,673** |
| Issued | 908,379 | 3,146,361 | - | 206,529 | 63,028 | 4,324,297 | - | 28,039 | 29,025 | 57,064 |
| Disposals | - | - | - | - | - | - | - | - | (9,290) | (9,290) |
| Repaid | (1,273) | (313,565) | - | (97,586) | - | (412,424) | - | (21,632) | (2,224) | (23,856) |
| Transfers to and from current receivables | - | (10,552,235) | - | 108,842 | - | (10,443,393) | - | (1,159) | - | (1,159) |
| Written off | - | - | - | (53) | - | (53) | - | (53) | - | (53) |
| Changes in fair value through other comprehensive income | - | - | - | - | 314,278 | 314,278 | - | - | 111,761 | 111,761 |
| Changes in fair value through CSCNE | - | - | - | - | - | - | - | - | (860) | (860) |
| Other Impairments and reversals | (761,742) | - | - | 81 | - | (761,661) | - | 81 | (2,928) | (2,847) |
| Other Movements | - | - | - | - | - | - | - | - | 6,100 | 6,100 |
| **Restated Balance at 31 March 2020** | **18,154,873** | **2,766,373** | **1,328** | **818,605** | **5,603,216** | **27,344,395** | **1,328** | **295,057** | **519,148** | **815,533** |

| | |
|---|---|
| Investments held by Core Dept & Agencies | 27,344,395 |
| **Less elimination of intra-group investments** | (26,726,178) |
| **Investments held by other designated bodies** | 197,316 |
| **Total** | **815,533** |

## Financing of NHS Providers

The Department has two means of financing NHS Trusts and NHS Foundation Trusts:

1. **Public Dividend Capital (PDC)** – issued as either structural capital when NHS Trusts are established, or when the Department needs to provide additional financing to NHS Trusts or NHS Foundation Trusts after establishment for either capital or revenue requirements; and
2. **Loans** – normally made under standard government loan terms, i.e. 6 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.

Loans are held at amortised cost using the effective interest rate method, less impairments.

The Department accounts for the PDC carrying value in the DHSC Core account in line with the Government Financial Reporting Manual (FReM), that requires PDC to be held at historic cost less impairment.

PDC is impaired, on an individual NHS provider basis, where the net assets of those NHS providers is 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 in the Core Department SoCNE. Where the

Department expects that such impairment will result in a write-off of PDC, this element of the impairment is recognised through reserves, reversing any previous impairment taken through the Core Department SoCNE. This treatment mirrors that of the subsequent write-off which is also recognised through reserves in line with an HM Treasury agreed FReM divergence (see Note 1 for further details). The divergence recognises that where net assets are below the value of the PDC reserve in a dissolved Trust, this reflects the existence of historic deficits already recognised in the Statement of Financial Performance for the closing Trust and is not an additional loss to the Taxpayer.

In 2020-21 the value of impairment charged to the SoCNE was £2,613 million and the value of impairments reversed through reserves was £669 million in respect of PDC written off in year. For further details see Note 8 above.

The Department's PDC investment in, and loans to, providers eliminate on consolidation, and so are not shown as consolidated Departmental group investments as they are not with bodies external to the Group. With the exception of MHRA (which is not consolidated into the Department's Annual Report and Accounts) PDC is only issued to bodies within the Departmental Group.

### Reforms to the NHS Cash Regime

On 2 April 2020, the Health Secretary made a public announcement of the Reforms to the NHS Cash Regime effective from 1 April 2020. Interim revenue loans, including eligible working capital facilities and interim capital debt as at 31 March 2020 were repaid during 2020-21. Providers were issued £13,548 million Public Dividend Capital (PDC) to enable the repayment of outstanding balances as at 31 March 2020, these balances were included in the 'current part of loans repayable transferred from investments' included within Note 14 in the 2019-20 accounts.

As a result of the repayment of Interim revenue loans, loan interest receivable by the Core Department have fallen. PDC Dividends receivable have also increased as the net relevant assets held by NHS Trusts and NHS Foundation Trusts have increased.

### Loans to other bodies

Credit Guarantee Finance (CGF) is a loan guaranteed by banks, monolines or other acceptable financial institutions, provided by the sponsoring Department to a PFI project Special Purpose Vehicle on 'market' terms. Aside from one pilot CGF loan with NHS PFI projects in Portsmouth, the Department does not expect to undertake any further CGF loans. The Department's CGF loan was repaid in 2021-22 and the carrying value of £262 million was included as an Asset Held for Sale for 2020-21.

During 2020-21 loans totalling £4,982 million were issued to Supply Chain Coordination Ltd in order to provide a working capital facility.

## Share capital and other investments

The Department's Share Capital investments are measured at fair value.

Community Health Partnerships Ltd, NHS Property Services Ltd, Genomics England Ltd and Supply Chain Coordination Ltd are consolidated into the Departmental accounts; therefore the investments by the Core Department in these companies are eliminated from the Departmental Group figures.

The Department 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 31 March 2021.

As part of this revaluation exercise the Department has reviewed and reconsidered the principal market for these assets. As a result, the measurement basis for NHS Property Services Ltd, Supply Chain Coordination Ltd and Community Health Partnerships Ltd have been changed from a discounted cash flow basis to a net asset basis.

The Department considers that this valuation methodology should have been applied in previous periods, as it results in better estimates of fair value. The prior period financial statements have therefore been restated as required by IAS 8. The opening position on 1 April 2019 has been increased by £3,571 million and the change in fair value through other comprehensive income during 2019-20 has increased by £188 million. The investments impacted by the prior year restatement are consolidated into the Departmental Group accounts and therefore there is no impact on the Departmental Group or the budgetary outturn.

## Valuation classification

The classification of the inputs used to value the Core Department's equity 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. Valuation input classifications for other entities in the Departmental Group can be found in the accounts of underlying bodies where appropriate.

| | | 2020-21 | | | |
|---|---|---|---|---|---|
| | | Core Department | | | |
| Entity | Valuation basis | Level 1 £'000 | Level 2 £'000 | Level 3 £'000 | Total £'000 |
| Community Health Partnerships Ltd | Net assets[1] | - | 826,000 | 374,000 | 1,200,000 |
| NHS Property Services Ltd | Net assets | - | 3,400,000 | - | 3,400,000 |
| Genomics England Ltd | Capital invested | - | 350,000 | - | 350,000 |
| Supply Chain Coordination Ltd | Net assets | - | 159,000 | - | 159,000 |
| NHS Shared Business Services Ltd | Discounted cash flow | - | - | 83,000 | 83,000 |
| NHS Professionals Ltd | Discounted cash flow | - | - | 266,000 | 266,000 |
| Other share capital investments | Various | - | - | 18,400 | 18,400 |
| | | **-** | **4,735,000** | **741,400** | **5,476,400** |

| | | 2019-20 | | | |
|---|---|---|---|---|---|
| | | Core Department | | | |
| Entity | Valuation basis | Level 1 £'000 | Level 2 £'000 | Level 3 £'000 | Total £'000 |
| Community Health Partnerships Ltd | Net assets[1] | - | 851,676 | 348,364 | 1,200,040 |
| NHS Property Services Ltd | Net assets | - | 3,539,672 | - | 3,539,672 |
| Genomics England Ltd | Capital invested | - | 339,200 | - | 339,200 |
| Supply Chain Coordination Ltd | Net assets | - | 202,472 | - | 202,472 |
| NHS Shared Business Services Ltd | Discounted cash flow | - | - | 32,500 | 32,500 |
| NHS Professionals Ltd | Discounted cash flow | - | - | 65,808 | 65,808 |
| Other share capital investments | Various | - | - | 20,313 | 20,313 |
| | | **-** | **4,933,020** | **466,985** | **5,400,005** |

1. The valuation of Community Health Partnerships Ltd is based on net assets. This is adjusted to account for equity investments held by Community Health Partnerships Ltd which are held at cost. This valuation is based on discounted cash flow and this adjustment is therefore classified as level 3.

## 12. Inventories and work in progress

| | Core Dept & Agencies 2020-21 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adult and Childhood Vaccines | Pandemic Flu and Pre Pandemic Flu | Raw materials | COVID-19 Vaccines | Consumables | Other | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2020** | **244,876** | **-** | **-** | **-** | **6,627** | **-** | **251,503** |
| Inventory additions | 703,614 | 17,657 | 12,698 | 593,966 | 18,649,245 | - | 19,977,180 |
| Inventories consumed/disposed of | (485,664) | (17,787) | - | (556,859) | (6,085,576) | (174) | (7,146,060) |
| Write Downs | (64,171) | - | - | (33) | - | - | (64,204) |
| Impairment of inventory | - | - | - | - | (8,973,775) | - | (8,973,775) |
| Transfer (to) / from non-current assets | - | 41,059 | - | - | - | 174 | 41,233 |
| Reclassification | - | (34,558) | (9,316) | - | 43,874 | - | - |
| Other | - | - | - | - | 1 | - | 1 |
| **Balance at 31 March 2021** | **398,655** | **6,371** | **3,382** | **37,074** | **3,640,396** | **-** | **4,085,878** |

1. See Note 8 for details of inventory impairments.
2. In 2020-21 COVID-19 Vaccines were procured by the Department for Business, Energy & Industrial Strategy and then transferred to the Departmental Group for nil consideration.

Consumables can be further analysed as follows:

| | Core Dept & Agencies 2020-21 | | | | |
|---|---|---|---|---|---|
| | Personal Protective Equipment | NHS Test and Trace Consumables | Equipment and other COVID-19 consumables | Other consumables | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2020** | **-** | **-** | **-** | **6,627** | **6,627** |
| Inventory additions | 12,064,577 | 5,597,537 | 877,697 | 109,434 | 18,649,245 |
| Inventories consumed/disposed of | (2,451,849) | (3,311,461) | (215,527) | (106,739) | (6,085,576) |
| Impairment of inventory | (8,705,057) | (194,714) | (74,004) | - | (8,973,775) |
| Reclassification | 43,874 | - | - | - | 43,874 |
| Other | - | - | - | 1 | 1 |
| **Balance at 31 March 2021** | **951,545** | **2,091,362** | **588,166** | **9,323** | **3,640,396** |

| | Core Dept & Agencies 2019-20 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adult and Childhood Vaccines | Pandemic Flu and Pre Pandemic Flu | Raw materials | COVID-19 Vaccines | Consumables | Other | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2019** | **203,401** | **-** | **-** | **-** | **6,459** | **-** | **209,860** |
| Inventory additions | 461,219 | - | - | - | 6,548 | - | 467,767 |
| Inventories consumed/disposed of | (418,349) | (35,764) | - | - | (6,386) | (62) | (460,561) |
| Written down charged to CSCNE | (1,395) | - | - | - | - | - | (1,395) |
| Transfer (to) / from non-current assets | - | 35,764 | - | - | - | 62 | 35,826 |
| Transfers | - | - | - | - | - | - | - |
| Reclassification | - | - | - | - | - | - | - |
| Other | - | - | - | - | 6 | - | 6 |
| **Balance at 31 March 2020** | **244,876** | **-** | **-** | **-** | **6,627** | **-** | **251,503** |

1. Consumables in 2019-20 were all other consumables.

| | Departmental Group 2020-21 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Adult and Childhood Vaccines | Pandemic Flu and Pre Pandemic Flu | Drugs | Raw materials | COVID-19 Vaccines | Consumables | Other | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2020** | **244,876** | **-** | **432,520** | **-** | **-** | **827,871** | **146,470** | **1,651,737** |
| Prior period adjustments in underlying accounts | - | - | (763) | - | - | (1,915) | 13,814 | 11,136 |
| Inventory additions | 703,614 | 17,657 | 6,690,982 | 12,698 | 593,966 | 22,157,643 | 703,911 | 30,880,471 |
| Inventories consumed/disposed of | (485,664) | (17,787) | (6,698,814) | - | (556,859) | (9,272,576) | (695,445) | (17,727,145) |
| Write Downs | (64,171) | - | (12,013) | - | (33) | (55,936) | (878) | (133,031) |
| Impairment of inventory | - | - | - | - | - | (8,973,775) | - | (8,973,775) |
| Transfer (to) / from non-current assets | - | 41,059 | - | - | - | (140,139) | (56,182) | (155,262) |
| Transfers | - | - | - | - | - | (592) | 592 | - |
| Reclassification | - | (34,558) | - | (9,316) | - | 43,874 | - | - |
| Other | - | - | - | - | - | 1 | - | 1 |
| **Balance at 31 March 2021** | **398,655** | **6,371** | **411,912** | **3,382** | **37,074** | **4,584,456** | **112,282** | **5,554,132** |

1. See Note 8 for details of inventory impairments.
2. In 2020-21 COVID-19 Vaccines were procured by the Department for Business, Energy & Industrial Strategy and then transferred to the Departmental Group for nil consideration.

Consumables can be further analysed as follows:

| | Departmental Group 2020-21 | | | | |
|---|---|---|---|---|---|
| | Personal Protective Equipment | NHS Test and Trace Consumables | Equipment and other COVID-19 consumables | Other consumables | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2020** | **-** | **-** | **-** | **827,871** | **827,871** |
| Prior period adjustments in underlying accounts | - | - | - | (1,915) | (1,915) |
| Inventory additions | 12,064,577 | 5,597,537 | 877,697 | 3,617,832 | 22,157,643 |
| Inventories consumed/disposed of | (2,300,441) | (3,311,461) | (75,388) | (3,585,286) | (9,272,576) |
| Write Downs | (40,784) | - | - | (15,152) | (55,936) |
| Impairment of inventory | (8,705,057) | (194,714) | (74,004) | - | (8,973,775) |
| Transfer (to) / from non-current assets | - | - | (140,139) | - | (140,139) |
| Transfers | - | - | - | (592) | (592) |
| Reclassification | 43,874 | - | - | - | 43,874 |
| Other | - | - | - | 1 | 1 |
| **Balance at 31 March 2021** | **1,062,169** | **2,091,362** | **588,166** | **842,759** | **4,584,456** |

| | Departmental Group 2019-20 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Adult and Childhood Vaccines | Pandemic Flu and Pre Pandemic Flu | Drugs | Raw materials | COVID-19 Vaccines | Consumables | Other | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2019** | **203,401** | **-** | **366,063** | **-** | **-** | **815,338** | **111,650** | **1,496,452** |
| Prior period adjustments in underlying accounts | - | - | - | - | - | 31,535 | 1 | 31,536 |
| Inventory additions | 461,219 | - | 6,588,674 | - | - | 4,201,815 | 640,188 | 11,891,896 |
| Inventories consumed/disposed of | (418,349) | (35,764) | (6,512,615) | - | - | (4,179,771) | (641,755) | (11,788,254) |
| Written down charged to CSCNE | (1,395) | - | (9,602) | - | - | (4,670) | (58) | (15,725) |
| Impairment of inventory | - | - | - | - | - | - | - | - |
| Transfer (to) / from non-current assets | - | 35,764 | - | - | - | - | 62 | 35,826 |
| Transfers | - | - | - | - | - | (36,382) | 36,382 | - |
| Other | - | - | - | - | - | 6 | - | 6 |
| **Balance at 31 March 2020** | **244,876** | **-** | **432,520** | **-** | **-** | **827,871** | **146,470** | **1,651,737** |

1. Consumables in 2019-20 were all other consumables.

## 13.1 Cash and cash equivalents

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Balance at 1 April 2020** | **1,460,785** | **9,111,920** | **1,933,440** | **8,682,028** |
| Net change in cash | 116,112 | 7,683,616 | (472,655) | 429,892 |
| **Balance at 31 March 2021** | **1,576,897** | **16,795,536** | **1,460,785** | **9,111,920** |
| The following balances at 31 March were held at: | | | | |
| Government Banking Service | 1,576,783 | 16,463,897 | 1,460,746 | 8,679,337 |
| Commercial banks and cash in hand | 112 | 266,937 | 39 | 227,148 |
| Short term investments | 2 | 64,702 | - | 205,435 |
| **Balance at 31 March 2021** | **1,576,897** | **16,795,536** | **1,460,785** | **9,111,920** |

## 14. Trade Receivables and other current assets

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Amounts falling due within one year:** | | | | |
| Trade receivables | 233,883 | 1,678,196 | 224,097 | 1,993,766 |
| Deposits and advances | - | 374,147 | - | 5,148 |
| Capital receivables | - | 38,417 | 5,693 | 82,355 |
| Interest receivable | - | 4,644 | - | 4,159 |
| Other receivables[4] | 563,894 | 1,560,319 | 86,278 | 711,896 |
| **Trade and other receivables** | **797,777** | **3,655,723** | **316,068** | **2,797,324** |
| Contract Assets | 33,033 | 91,298 | 33,764 | 86,740 |
| Other prepayments and accrued income[3] | 728,806 | 2,078,117 | 270,500 | 1,513,943 |
| Current part of PFI and other service concession arrangements prepayments | - | 24,751 | - | 176,470 |
| Capital Prepayments | - | 96,288 | - | 102,796 |
| Other current assets | - | 17,527 | - | 7,560 |
| **Other current assets** | **761,839** | **2,307,981** | **304,264** | **1,887,509** |
| Current part of loans repayable transferred from investments | 230,473 | 853 | 13,724,360 | 7,870 |
| Other current financial assets | - | - | - | 10,000 |
| **Other financial assets** | **230,473** | **853** | **13,724,360** | **17,870** |
| **Total current receivables** | **1,790,089** | **5,964,557** | **14,344,692** | **4,702,703** |
| **Amounts falling due after more than one year:** | | | | |
| Trade receivables | - | 157,620 | - | 216,860 |
| Deposits and advances | - | 5,571 | - | 9,173 |
| Capital receivables | - | 42,672 | - | 44,587 |
| Contract Assets | - | 4,263 | - | 5,162 |
| Other receivables | 255,978 | 310,444 | 251,452 | 309,375 |
| Other Prepayments and accrued income | 149 | 25,179 | - | 33,648 |
| Non-current part of PFI and other service concession arrangements prepayments | - | 48,772 | - | 47,566 |
| Capital Prepayments | - | 166,741 | - | 202,212 |
| **Total non-current receivables** | **256,127** | **761,262** | **251,452** | **868,583** |
| **Total receivables at 31 March 2021** | **2,046,216** | **6,725,819** | **14,596,144** | **5,571,286** |

1. Trade receivables includes the total expected return arising from items on an entity's sales ledger, as well as contract income recognised in line with IFRS 15 expected on contracts for which obligations have been fulfilled and there is no barrier to receiving the due consideration on the contract except for the passage of time.
2. Trade receivables includes the expected credit loss on receivables under the IFRS 9 expected credit loss model.
3. Other prepayments and accrued income for the department includes £604 million (2019-20: £162 million) in respect of COVID-19 for ventilators, personal protective equipment and testing.
4. Other receivables have increased from £712 million to £1,560 million mainly as a result of VAT being recoverable on increased purchases due to COVID-19 programmes.
5. In advance of the new NHS cash regime being introduced from 2020-21, some loans were moved in 2019-20 to 'current part of loans repayable transferred from investments' which then totalled £13.7 billion in 2019-20. For further information, see the disclosure under Note 11: Investments above.

## 15. Trade payables and other current liabilities

| | 2020-21 £'000 | | 2019-20 £'000 | |
|---|---|---|---|---|
| | Core Dept & Agencies | Departmental Group | Core Dept & Agencies | Departmental Group |
| **Amounts falling due within one year:** | | | | |
| Trade payables | 816,324 | 3,699,241 | 20,441 | 2,904,352 |
| Capital payables | 42,962 | 1,980,582 | 59,892 | 1,178,670 |
| Other payables[2] | 19,384 | 3,405,126 | 7,346 | 2,444,611 |
| **Trade and other payables** | **878,670** | **9,084,949** | **87,679** | **6,527,633** |
| Bank Overdraft | - | 59,651 | - | 29,904 |
| VAT | - | 11,958 | - | 33,786 |
| Other taxation and social security | 13,863 | 1,364,906 | 2,254 | 1,229,190 |
| Deferred tax liability | - | - | - | 17 |
| EEA Medical Costs Accrual | 645,623 | 645,623 | 781,709 | 781,709 |
| Contract liabilities | 28,677 | 1,192,396 | 10,645 | 807,288 |
| Other accruals[3] | 7,837,502 | 17,171,539 | 466,821 | 9,410,573 |
| Deferred income | 147,753 | 212,386 | 438,330 | 531,710 |
| Current part of finance lease | - | 81,095 | - | 74,531 |
| Current part of imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements | - | 371,087 | - | 348,864 |
| Amount issued from the Consolidated Fund for supply but not spent at year end | 1,523,414 | 1,523,414 | 1,045,346 | 1,045,346 |
| Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received[5] | 365,721 | 365,721 | 571,133 | 571,133 |
| Current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary | - | 46,030 | - | 49,761 |
| Pension liabilities | - | 114,456 | - | 92,011 |
| Other current liabilities | - | 20,556 | (1) | 13,015 |
| **Other liabilities** | **10,562,553** | **23,180,818** | **3,316,237** | **15,018,838** |
| **Total current payables** | **11,441,223** | **32,265,767** | **3,403,916** | **21,546,471** |
| **Amounts falling due after more than one year:** | | | | |
| Finance leases | - | 554,288 | - | 527,933 |
| Imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements | - | 9,873,208 | - | 10,211,298 |
| Pension liabilities | - | 31 | - | 47 |
| **Financial liabilities** | **-** | **10,427,527** | **-** | **10,739,278** |
| Trade payables | - | 6,504 | - | 6,655 |
| Contract liabilities | - | 98,909 | - | 83,523 |
| Other accruals | 6,976 | 13,565 | 7,300 | 11,164 |
| Capital payables | 118,737 | 128,751 | 119,226 | 128,998 |
| Other payables | - | 212,563 | - | 192,001 |
| Deferred income | 21,248 | 100,544 | 33,389 | 108,219 |
| Non-current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary | - | 359,344 | - | 296,371 |
| Loans payable by DHSC to group bodies | 20,220 | - | 20,220 | - |
| **Other payables** | **167,181** | **920,180** | **180,135** | **826,931** |
| **Total non-current payables** | **167,181** | **11,347,707** | **180,135** | **11,566,209** |
| **Total payables** | **11,608,404** | **43,613,474** | **3,584,051** | **33,112,680** |

1. Contract Liabilities are recognised where an entity has received consideration from a customer before performance obligations have been fully met.
2. Other payables falling due within one year includes £1,090 million relating to the provider sector and £1,461 million relating to the commissioner sector. These amounts arise from a significant number of entities within each sector and as such are not material individually.
3. Other accruals falling due within one year for the Core Department include £3,915 million due to Supply Chain Coordination Limited, which eliminates on consolidation.
4. Other accruals falling due within one year for the Group includes £6,440 million relating to the provider sector and £6,325 million relating to the commissioner sector. These amounts arise from a significant number of entities within each sector and as such are not material individually. The balances include amounts accrued in relation to the Covid-19 pandemic.
5. Further details are given in Note 5, Income.

## 16. Provisions for liabilities and charges

| | 2020-21 | | | | | | 2019-20 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Core Dept & Agencies | | | | | | Core Dept & Agencies | | | | | |
| | Early departure costs | Injury Benefits | EEA medical costs | Contaminated Blood | Other | Total | Early departure costs | Injury Benefits | EEA medical costs | Contaminated Blood | Other | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2020** | **104,244** | **676,835** | **808,110** | **1,864,269** | **176,844** | **3,630,302** | **107,002** | **711,352** | **867,600** | **968,125** | **212,969** | **2,867,048** |
| Provided in the year | 32,192 | 78,295 | 826,882 | 584,398 | 1,344,944 | 2,866,711 | 17,346 | 29,459 | 526,823 | 940,585 | 22,771 | 1,536,984 |
| Provisions not required written back | (3,344) | (25,196) | - | - | (58,394) | (86,934) | (5,451) | (29,169) | - | - | (10,118) | (44,738) |
| Transfers | - | - | - | - | - | - | - | - | - | - | - | - |
| Provisions utilised in the year | (11,384) | (47,146) | (139,123) | (75,911) | (8,467) | (282,031) | (11,958) | (48,875) | (142,676) | (75,132) | (40,104) | (318,745) |
| Transfer to accruals | - | - | (507,094) | - | - | (507,094) | - | - | (454,782) | - | (8,939) | (463,721) |
| Borrowing costs (unwinding of discount) | (12,360) | (52,252) | 4,121 | 33,374 | (3,620) | (30,737) | 308 | (1,809) | 6,594 | 18,566 | 753 | 24,412 |
| Change in discount rate | 1,705 | 1,302 | 568 | 3,936 | 272 | 7,783 | (3,003) | 15,877 | 4,551 | 12,125 | (488) | 29,062 |
| **Balance at 31 March 2021** | **111,053** | **631,838** | **993,464** | **2,410,066** | **1,451,579** | **5,598,000** | **104,244** | **676,835** | **808,110** | **1,864,269** | **176,844** | **3,630,302** |

| | Early departure costs | Injury Benefits | EEA medical costs | Contaminated Blood | Other | Total | Early departure costs | Injury Benefits | EEA medical costs | Contaminated Blood | Other | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Current | 11,107 | 45,979 | 364,310 | 81,916 | 1,370,095 | 1,873,407 | 11,503 | 48,556 | 298,349 | 88,571 | 47,678 | 494,657 |
| Non Current | 99,946 | 585,859 | 629,154 | 2,328,150 | 81,484 | 3,724,593 | 92,741 | 628,279 | 509,761 | 1,775,698 | 129,166 | 3,135,645 |
| **Expected timing of cash flow** | | | | | | | | | | | | |
| Not later than 1 year | 11,107 | 45,979 | 364,310 | 81,916 | 1,370,095 | 1,873,407 | 11,503 | 48,556 | 298,349 | 88,571 | 47,678 | 494,657 |
| Later than 1 year, not later than 5 years | 45,383 | 190,626 | 629,154 | 323,281 | 20,364 | 1,208,808 | 46,078 | 200,999 | 509,761 | 348,236 | 38,647 | 1,143,721 |
| Later than 5 Years | 54,563 | 395,233 | - | 2,004,869 | 61,120 | 2,515,785 | 46,663 | 427,280 | - | 1,427,462 | 90,519 | 1,991,924 |
| **Total** | **111,053** | **631,838** | **993,464** | **2,410,066** | **1,451,579** | **5,598,000** | **104,244** | **676,835** | **808,110** | **1,864,269** | **176,844** | **3,630,302** |

1. The modelling of the future cash flows for contaminated bloods indicates the majority of future outflows fall in the long term (between 11 and 40 years) and are therefore more sensitive to discount rate changes. The 2019-20 increase in provisions (£941 million) was largely due to an increase in the financial support provided from 1 April 2019 to those infected, together with a change in estimated life expectancy of those infected.

| | 2020-21 | | | | | | | 2019-20 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Departmental Group | | | | | | | Departmental Group | | | | | | |
| | Early departure costs | Injury Benefits | EEA medical costs | Clinical Negligence | Contaminated Blood | Other | Total | Early departure costs | Injury Benefits | EEA medical costs | Clinical Negligence | Contaminated Blood | Other | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Balance at 1 April 2020** | **279,043** | **950,148** | **808,110** | **83,766,855** | **1,864,269** | **1,523,092** | **89,191,517** | **301,131** | **959,622** | **867,600** | **83,070,575** | **968,125** | **1,272,766** | **87,439,819** |
| Prior period adjustments in underlying accounts | (1,585) | 5,441 | - | - | - | (4,590) | (734) | (2,596) | 4,995 | - | - | - | (9,345) | (6,946) |
| Provided in the year | 57,288 | 106,186 | 826,882 | 4,675,047 | 584,398 | 2,266,318 | 8,516,119 | 26,769 | 52,743 | 526,823 | 14,618,037 | 940,585 | 799,728 | 16,964,685 |
| Provisions not required written back | (7,255) | (28,276) | - | (4,657,620) | - | (339,701) | (5,032,852) | (8,844) | (34,927) | - | (2,727,116) | - | (309,581) | (3,080,468) |
| Transfers | - | - | - | - | - | - | - | (9,000) | - | - | - | - | 9,000 | - |
| Provisions utilised in the year | (27,137) | (60,051) | (139,123) | (2,209,346) | (75,911) | (136,713) | (2,648,281) | (29,012) | (62,560) | (142,676) | (2,324,251) | (75,132) | (197,409) | (2,831,040) |
| Transfer to accruals | (10,294) | (3,527) | (507,094) | - | - | (19,370) | (540,285) | (4,035) | (3,703) | (454,782) | - | - | (25,373) | (487,893) |
| Borrowing costs (unwinding of discount) | (12,564) | (53,106) | 4,121 | 503,307 | 33,374 | 16,177 | 491,309 | 1,506 | (721) | 6,594 | 507,811 | 18,566 | 1,168 | 534,924 |
| Change in discount rate | 6,520 | 12,260 | 568 | 344,304 | 3,936 | 42,730 | 410,318 | 3,124 | 34,699 | 4,551 | (9,378,201) | 12,125 | (17,862) | (9,341,564) |
| **Balance at 31 March 2021** | **284,016** | **929,075** | **993,464** | **82,422,547** | **2,410,066** | **3,347,943** | **90,387,111** | **279,043** | **950,148** | **808,110** | **83,766,855** | **1,864,269** | **1,523,092** | **89,191,517** |

| | Early departure costs | Injury Benefits | EEA medical costs | Clinical Negligence | Contaminated Blood | Other | Total | Early departure costs | Injury Benefits | EEA medical costs | Clinical Negligence | Contaminated Blood | Other | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Current | 31,961 | 63,762 | 364,310 | 2,682,695 | 81,916 | 2,323,834 | 5,548,478 | 31,825 | 67,022 | 298,349 | 2,714,960 | 88,571 | 647,734 | 3,848,461 |
| Non Current | 252,055 | 865,313 | 629,154 | 79,739,852 | 2,328,150 | 1,024,109 | 84,838,633 | 247,218 | 883,126 | 509,761 | 81,051,895 | 1,775,698 | 875,358 | 85,343,056 |
| **Expected timing of cash flow** | | | | | | | | | | | | | | |
| Not later than 1 year | 31,961 | 63,762 | 364,310 | 2,682,695 | 81,916 | 2,323,834 | 5,548,478 | 31,825 | 67,022 | 298,349 | 2,714,960 | 88,571 | 647,734 | 3,848,461 |
| Later than 1 year, not later than 5 years | 121,637 | 264,517 | 629,154 | 12,715,195 | 323,281 | 460,731 | 14,514,515 | 124,174 | 270,732 | 509,761 | 12,165,686 | 348,236 | 356,449 | 13,775,038 |
| Later than 5 Years | 130,418 | 600,796 | - | 67,024,657 | 2,004,869 | 563,378 | 70,324,118 | 123,044 | 612,394 | - | 68,886,209 | 1,427,462 | 518,909 | 71,568,018 |
| **Total** | **284,016** | **929,075** | **993,464** | **82,422,547** | **2,410,066** | **3,347,943** | **90,387,111** | **279,043** | **950,148** | **808,110** | **83,766,855** | **1,864,269** | **1,523,092** | **89,191,517** |

1. The modelling of the future cash flows for contaminated bloods indicates the majority of future outflows fall in the long term (between 11 and 40 years) and are therefore more sensitive to discount rate changes. The 2019-20 increase in provisions (£941 million) was largely due to an increase in the financial support provided from 1 April 2019 to those infected, together with a change in estimated life expectancy of those infected.
2. Included within the Clinical Negligence provision above is £76,429 million (31 March 2020: £77,558 million) relating to the Clinical Negligence Scheme for Trusts (CNST).

## Discount Rates

**Note 1.19** Provisions provides information on the discount rates applied by the Department to expected future cashflows. HM Treasury inform departments of the short (with an expected cashflow within 0 to 5 years of the Statement of Financial Position date), medium (with an expected cashflow within 5 to 10 years of the Statement of Financial Position date) long-term and very long-term provisions discount rates to be employed via guidance issued annually.

## Clinical Negligence

The Department of Health and Social Care provides for future costs in a number of cases where it is the defendant in legal proceedings brought by claimants seeking damages for the effects of alleged clinical negligence.

NHS England, NHS Foundation Trusts and NHS Trusts retain legal responsibility for all liabilities covered by the Ex-Regional Health Authority Scheme (ex RHA), Existing Liabilities Scheme (ELS) and Clinical Negligence Scheme for Trusts (CNST), but NHS Resolution (NHSR) accounts for all the liabilities under these separate schemes. Actuaries appointed by NHSR undertake regular reviews to identify movements in the value of likely future settlements under these schemes, and these are recorded in the NHSR's Annual Report and Accounts.

The provision also includes the following liabilities relating to General Practice:

- Clinical Negligence Scheme for General Practice (CNSGP) which covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019.
- Existing Liabilities for General Practice (ELGP), which reflects the interim arrangements under which NHS Resolution carry out the Secretary of State's oversight and governance responsibilities relating to existing liabilities agreed with the Medical Protection Society (MPS), a medical defence organisation.
- Existing Liabilities Scheme for General Practice (ELSGP) which covers claims for historical NHS clinical negligence and other tortious incidents of GP members of participating medical defence organisations occurring at any time before 1 April 2019. This scheme covered members of the Medical and Dental Defence Union of Scotland from 6 April 2020 and was extended to Medical Protection Society members from 1 April 2021.

The coronavirus pandemic has had a significant impact on the NHS this year, which has the potential to affect the value of the liabilities covered by NHS Resolution.

Many of the liabilities arising from healthcare provision in relation to the pandemic are covered by arrangements already in place (i.e. through CNST, CNSGP and LTPS). However, two new schemes have been established during the year to provide indemnity cover for activities related to the response to the coronavirus pandemic. These are:

- The Clinical Negligence Scheme for Coronavirus (CNSC), launched on 3 April 2020, which meets clinical negligence liabilities arising from the special healthcare arrangements that were put in place in response to the pandemic. Any clinical negligence liabilities arising prior to or after this date from these coronavirus-related NHS activities are covered by CNSC by direction from Secretary of State under section 11 of the Coronavirus Act 2020 or, prior to the commencement of that section, under general powers to provide indemnity for clinical negligence.
- The Coronavirus Temporary Indemnity Scheme (CTIS). The scheme will provide state cover for employer's liability and public liability to fill gaps where COVID-19 positive patients have been discharged from the NHS into designated care home settings which have been unable to secure sufficient private insurance cover.

The significant effects of the pandemic only materialised in 2020 and there have not yet been many claims received related to COVID-19. It is therefore challenging to arrive at firm estimates for the impact of the pandemic. A multidisciplinary working group was set up to review the risks and valuation of COVID-19, reviewing an extensive list of risks and multiple sources of data from across the healthcare sector to ascertain the likely impact on the provision. This resulted in the provision being updated to include £0.9 billion across all schemes for claims arising from new risks generated by the pandemic. This is partially offset by the estimated £0.4 billion impact of a reduction in claims resulting from lower levels of usual activity in the NHS. A further allowance for general risk and uncertainty has been included in the claims inflation assumption to cover at present unquantifiable claims risk in relation to the pandemic, as well as other areas of uncertainty. The CNSC and CTIS provisions referred to above together make up £81 million of the total provision.

The high-level approach adopted to quantifying the impact of COVID-19 on the provision separately considers:

- the direct impacts that might arise from new activities related to responding to the pandemic – for example in relation to testing, diagnosis, treating and caring for COVID-19 patients and administering vaccines.
- the direct impacts on core (non-COVID-19) NHS activity and hence the claims that might normally arise – for example in relation to lower clinical activity or the risks of delayed treatment
- the indirect impacts across all other factors that might influence claim costs – for example in relation to lags between incidents, claims and settlement or the economic impact.

Although the pandemic has materially affected activity in 2020-21 and the risk of clinical and non-clinical claims that arise from that activity, the estimated impact on the NHS Resolution provision is fairly limited at this stage because:

- a large share (90%) of the total provision is in relation to incidents that occurred prior to 2020-21. While these claims might still be affected by any potential disruption in

the reporting and settlement of claims, for example due to legal firms furloughing staff, this is not expected significantly to alter the liabilities reported.

- the majority (approximately 65%) of the CNST provision is as a result of claims arising from maternity activity – such as brain damage to babies at birth from negligent care. Although there have been some changes, maternity activities overall have continued during the pandemic and are expected to result in a similar level of claims as in previous years.

Known reported claims are individually valued using likely costs to resolve the claim and probability factors to take account of the potential of a successful defence, while incurred but not reported (IBNR) claims are valued using actuarial models to predict likely values. The value of the provision decreased by £1,344 million in 2020-21 from £83,767 million at 31 March 2020 to £82,423 million at 31 March 2021. The key movements in the provision during the year were as follows:

- An increase of £9 billion relating to another year's worth of activity for all schemes for all incident years
- A decrease of £7.3 billion due to changes in assumptions affecting the IBNR provision. The main drivers of this decrease relate to the CNST IBNR provision, and comprise a decrease of £2.8 billion for inflation and average cost assumptions, a decrease of £1.9 billion for the future Annual Survey of Hours and Earnings (ASHE) inflation assumption, which is used in the valuation of Periodical Payment Orders (PPOs), a decrease of £3.5 billion for the change in the projected number of claims, and a net increase of £0.3 billion for new risks arising from COVID-19. The remaining increase of £0.6 billion relates to the effects of assumption changes on IBNR for the other indemnity schemes.
- A decrease of £1.1 billion in respect of changes in assumptions affecting known claims, primarily due to claims closed during the year either at a lower value than expected or where the claim was repudiated.
- A decrease of £2.3 billion relating to amounts paid out during the financial year to settle claims
- An increase of £0.4 billion due to the reductions in the short- and medium-term discount rates specified for use by HM Treasury under the Public Expenditure System (PES).

Full details of the changes above can be found in the Annual Report and Accounts of NHSR. However, the key changes in assumptions affecting the value of the CNST provision between 31 March 2020 and 31 March 2021 are as follows:

- Both the expected number of future PPO claims and non-PPO claims assumptions have reduced. For non PPOs an adjustment for lower activity due to COVID-19 has been included. The effect of this change is a reduction in the CNST provision of £3.5 billion.
- The average costs per claim assumptions are similar to last year's assumptions which means that they haven't kept pace with the expected level of claims inflation. In

addition, the inflation assumption for PPO damages has decreased by 0.25 pa% from the previous year. The combined impact of these changes is a reduction in the CNST provision of £2.8 billion.

- The ASHE assumption has reduced from CPI+2.0% to CPI+1.75%. The effect of this change is a reduction in the CNST provision of £1.7 billion.

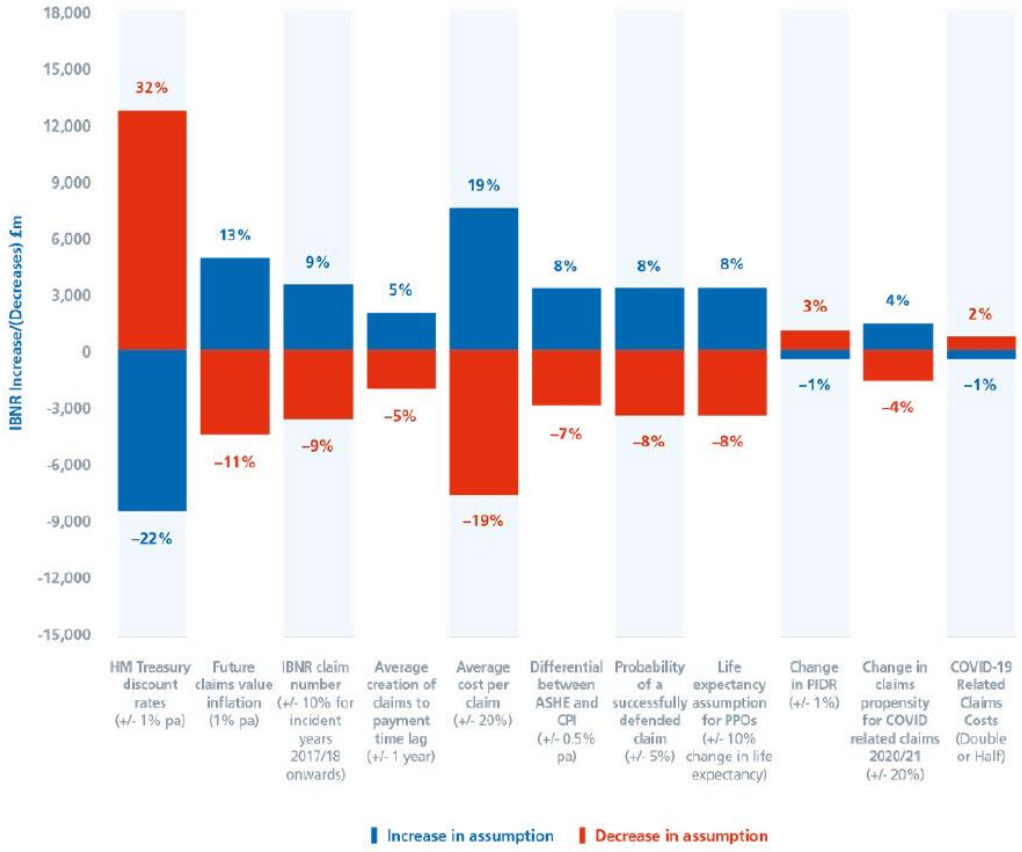
The provisions above are also reported in the accounts of NHSR together with other provisions of £363 million. These represent the English element of the clinical negligence provision as shown in Whole of Government Accounts.

Due to the long-term nature of the liabilities and the assumptions on which the estimate of the provision is based, some uncertainty about the value of the liability remains. This is particularly relevant to the IBNR element of the provision (the largest single element of total provisions, and therefore where uncertainty has the greatest effect).

Claims settling as PPOs also remain a key area of uncertainty, given the high value of PPO settlements, the limited stable past data to base future claim number projections upon and the changing propensity to award PPOs to claimants. PPO claim settlements are paid over the lifetime of the claimant, and consequently there are additional inflation and longevity uncertainties, compared to equivalent lump sum settlements.

The following tables show the impacts of adjusting some of the key assumptions used for the IBNR estimate for CNST.

The ranges of the sensitivity tests shown below are based on the variability observed in past data. They do not represent the maxima or minima of past observed values, nor the range of possible outcomes, but they do capture future values that could plausibly occur. Each change is shown separately, but in practice combinations are possible, as different assumptions can be correlated.




The graph below highlights the sensitivity of the IBNR provision to changes in the HM Treasury discount rates prescribed. The relationship is not purely linear in all cases, as can be seen by the changes outlined in the graph.

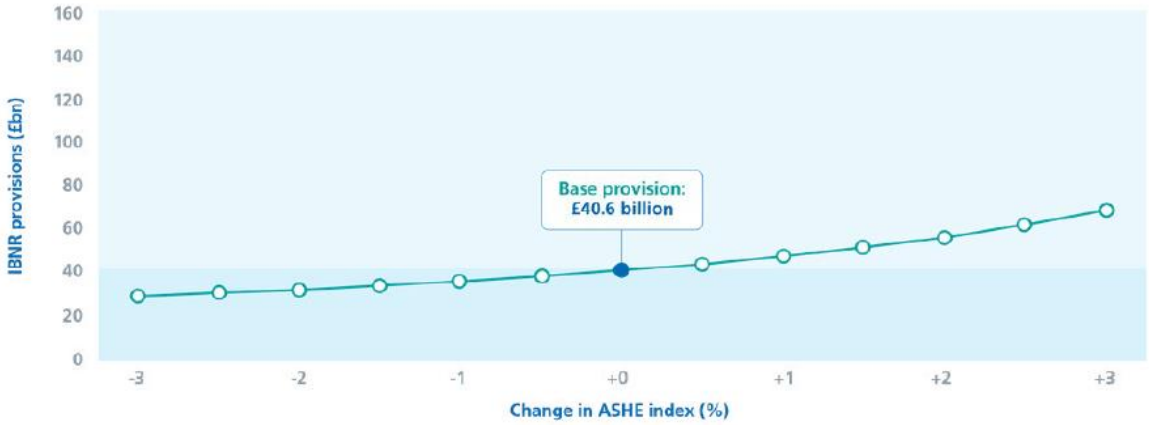

The clinical negligence provision's value is particularly sensitive to changes in the long-term discount rate given its nature. The disclosures above show the impact of percentage changes.

For the clinical schemes, the changes in discount rates this year have had a relatively small impact on the IBNR provisions. This is because a large proportion (by value) of the IBNR provisions are expected to be paid in more than 10 years' time and the long-term discount rate hasn't changed since last year.

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 Annual Hourly Earnings index over the long-term and life expectancy.

The following graph shows the sensitivity of the CNST to the differential between ASHE and CPI.

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 HM Treasury PES discount rate note from December 2020 states that all cash flows should be assumed to increase in line with the Office for Budget Responsibility (OBR) Consumer Price Index (CPI) inflation rates unless three specific conditions are met. NHS Resolution have determined that in relation to Clinical Negligence the three conditions have been met and have therefore used alternative inflation measures for the IBNR provision and settled PPO claims. Further information including additional detail regarding key assumptions and areas of uncertainty is available in NHSR's Annual Report and Accounts.

Clinical negligence claims which may succeed, but are less likely or cannot be reliably estimated, are accounted for as contingent liabilities. (See **Note 17**)

### Early Departure

These financial statements provide for the additional future costs, beyond the normal benefit awards for which employees are eligible under the terms of their pension scheme, arising from compensation payments for termination of employment through

redundancy, severance or early retirement. The provision also takes account of arrangements with pension schemes under which employees can make prepayments to meet future liabilities. On the basis of the age of retirees, expenditure is likely to be incurred over a period of up to nine years.

### Injury Benefits

The Department's Annual Report and Accounts provide for the future costs of permanent Injury Benefits awarded up to April 1997 to NHS staff injured in the course of their duties. From this date, the respective NHS body which employed the injured person has been liable for the costs. The Injury Benefit awards are guaranteed minimum income levels, and are granted for the life of the individual. The award is based on an assessment of the nature of the injury and the effect on the individual's earning capacity which results.

### EEA Medical Costs

EEA Medical Costs refer to medical costs incurred by UK Citizens in other European countries which are accounted for as liabilities payable by the UK to those European countries. The obligation to make payment for historic liabilities under EU regulations in force at the Statement of Financial Position date is unaffected by the United Kingdom's departure from the European Union. Reciprocal healthcare arrangements between the UK and the EU have been agreed within the Protocol on Social Security Coordination of the EU – UK Trade and Cooperation Agreement, in addition to the lifelong reciprocal healthcare entitlements afforded to those in scope of the Withdrawal Agreement.

### Contaminated Blood

The Contaminated Blood payment scheme is for individuals who were infected with HIV and/or hepatitis C following treatment with NHS-supplied blood or blood products before September 1991. These financial statements provide for the future cost of payments for which scheme beneficiaries are eligible. Beneficiaries receive lump sum and annual payments which vary depending on the stage of their condition. On 25 March 2021, a Written Ministerial Statement by Penny Mordaunt, Paymaster General, announced changes across the four separate schemes of the four nations of the United Kingdom to improve their parity. The main change for England to affect the provision, is that bereaved partners will receive the beneficiary's full annual payment for the first year following their death, and subsequently 75% of the payment for the rest of their lifetime, uplifted annually. Contaminated blood payments are linked to increases in the consumer price index.

### Other Provisions

These financial statements disclose other provisions of £3,348 million, which includes the following:

### Onerous Contracts relating to Personal Protective Equipment (PPE)

During 2020-21 the Core Department entered into contracts for the delivery of over 32 billion items of PPE. As described in Note 8, an impairment has been required to reduce the carrying value of PPE delivered during the year to net realisable value.

IAS 37 requires the recognition of an onerous contract provision where the unavoidable costs of meeting the obligations under a contract exceed the economic benefits expected to be received under it.

The Department has assessed all non-cancellable contracts for PPE held on 31 March 2021 using the impairment methodology described in Note 8 considering items which cannot be used for their intended purposes, market value fluctuations and items which have expiry dates prior to the expected usage date.

A provision has been recognised for items which were not delivered by 31 March 2021 under non-cancellable contracts meeting the impairment criteria described above and in Note 8. This provision totals £1,231 million. Deliveries of all outstanding items are contractually due by 31 March 2022, therefore the full amount of this provision is expected to be utilised within one year.

### Clinicians' Pensions

Other provisions include £303 million relating to the clinicians' annual allowance pensions tax scheme. Where a clinician receives an 'annual allowance' pensions tax bill, they can elect to use the 'Scheme Pays' option, where the payment of this tax liability is carried out by the NHS Pension Scheme with a corresponding reduction in clinicians' future pension benefits. Under the 2019-20 annual allowance pension tax scheme, where Scheme Pays was used, NHS England will make a payment to clinicians of equal value to the lost pension benefits from the NHS Pension Scheme arising from a pension tax charge for 2019-20.

Payments to replace the lost pension benefits will be made when clinicians start to draw benefits from the NHS Pension Scheme. None of this provision is expected to be utilised in the next five years.

The commitment to make these payments is made by the employing Trust, with an equivalent commitment from NHS England to fund this obligation.

### NHS Continuing Healthcare

NHS Continuing Healthcare is a package of care arranged and funded by the NHS which can be provided in a range of settings, including a care home or an individual's own home. It is awarded using eligibility criteria depending on whether a person's primary need is a health need. Provisions were previously held with Primary Care Trusts. Following the changes arising from the Health and Social Care Act 2012, these provisions will be accounted for by NHS England Group.

In total, the provision recorded for NHS Continuing Healthcare was £97 million. Of the total, £82 million was expected to be paid within one year, and £15 million between one and five years.

### Other Miscellaneous provisions

The total of other miscellaneous provisions was £1,717 million. These relate to a range of issues, including: HGH (human growth hormone), restructuring, redundancy, lease dilapidations and litigation.

Of the total other miscellaneous provisions £1,011 million is expected to be paid within one year, £446 million in one to five years and £260 million after five years.

## 16.1 Pensions

### Movements in defined benefit obligation and fair value of plan assets

This pension disclosure includes single entity funded defined obligation schemes for Care Quality Commission, a number of NHS Foundation Trusts and NHS England. These are mainly in respect of staff that have transferred from Local Government Pension Schemes to the listed organisations and do not relate to the NHS or Civil Service Pension Schemes disclosed earlier in the account. Further details can be found in the accounts of these bodies.

Reconciliation of movements in the defined obligation and the fair value of plan assets during the year for the amounts recognised in the Statement of Financial Position:

| | 2020-21 £'000 | 2019-20 £'000 |
|---|---|---|
| **Present value of the defined benefit obligation at 1 April 2020** | **(820,628)** | **(880,685)** |
| Prior period adjustments in underlying accounts | 16 | (82) |
| Current Service Costs | (13,810) | (17,132) |
| Past Service Costs | (85) | (2,724) |
| Interest Costs | (18,696) | (21,233) |
| Settlements and curtailments | 8,135 | - |
| Contribution from scheme members | (2,886) | (3,059) |
| Actuarial Gains and (Losses) | (160,169) | 79,896 |
| Benefits paid | 20,182 | 21,294 |
| Scheme transfers | - | (3,599) |
| Transfers to/from other bodies | 7,108 | - |
| Other | 3,651 | 6,696 |
| **As at 31 March 2021** | **(977,182)** | **(820,628)** |
| | | |
| **Plan assets at fair value at 1 April 2020** | **676,475** | **752,024** |
| Prior period adjustments in underlying accounts | (16) | (1,349) |
| Interest income | 13,978 | 16,222 |
| Settlements | (5,783) | (16) |
| Adjustments by the employer | 18,799 | 14,625 |
| Contributions by the plan participants | 2,886 | 3,059 |
| Expected Return on Assets | 22,018 | (8,777) |
| Actuarial Gains and (Losses) | 123,247 | (69,356) |
| Changes in the effect of limiting defined benefit asset to the asset ceiling | (2,203) | (4,639) |
| Benefits paid | (20,182) | (21,294) |
| Transfers to/from other bodies | (7,340) | - |
| Other | (3,651) | (4,024) |
| **As at 31 March 2021** | **818,228** | **676,475** |
| | | |
| **Plan surplus/(deficit) at 31 March 2021** | **(158,954)** | **(144,153)** |

## 17. Contingent Assets and Liabilities disclosed under IAS 37

### 17.1 Contingent Assets

The Core Department has lodged a civil litigation claim seeking damages linked to civil actions around a breach of competition regulations. No further information is disclosed to ensure any prejudice of the position of the entities in relation to this activity is avoided.

NHS providers have contingent assets of £17.2 million (2019-20: £16.6 million).

### 17.2 Contingent Liabilities

Unless there are compelling grounds for non-disclosure due to confidentiality considerations, the contingent liabilities required by IAS37 are detailed below. Further information for all contingent liabilities can be found in the underlying accounts of individual bodies.

#### Clinical Negligence

The Department is the actual or potential defendant in a number of actions regarding alleged clinical negligence, liabilities relating to the 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 the Department's liability and the amounts involved. Possible total expenditure, assuming that damage payments were awarded on all claims rather than taking into account the probability of damages being paid, might be estimated at £45,767 million (2019-20: £48,171 million), although £42,910 million (2019-20: £45,319 million) relating to the Clinical Negligence Scheme for Trusts (CNST) would be expected to be met by payments from NHS providers.

The Clinical Negligence Scheme for Coronavirus (CNSC), was launched on 3 April 2020 in response to the need for government to provide indemnity cover for clinical negligence arising from the NHS healthcare arrangements put in place to respond to the COVID-19 pandemic. Any clinical negligence liabilities arising prior to or after this date from these coronavirus-related NHS activities are covered by CNSC by direction from Secretary of State under section 11 of the Coronavirus Act 2020 or, prior to the commencement of that section, under general powers to provide indemnity for clinical negligence. Contingent liabilities of £43 million are disclosed in the 2020-21 accounts for additional liabilities arising under these indemnity arrangements.

#### Employment Tribunal Cases

The Department is involved in a number of Employment Tribunal cases.

#### Liabilities in respect of the COVID-19 Vaccination Programme

The Department holds a contingent liability relating to the contract signed between Her Majesty's Government and Pfizer/BioNTech for their COVID-19 vaccine.

The Department holds a contingent liability relating to the contract signed between Her Majesty's Government and AstraZeneca/Oxford for their COVID-19 vaccine.

The Department has provided a time limited clinical negligence indemnity to community pharmacy to enable them to engage at pace with the COVID 19 vaccination programme. Community pharmacy are not covered by state indemnity and are obliged to obtain their own commercial insurance. Due to the requirement to provide cover for this risk at such short notice, state indemnity has been agreed.

### Liabilities in respect of medical equipment purchased in response to the COVID-19 Pandemic

The Department has issued a letter of comfort to Supply Chain Coordination Limited to cover COVID-19 related warehousing and stock management costs incurred.

The Department has a contingent liability in respect of a VAT liability to HMRC in respect of medical equipment purchased in response to the COVID-19 pandemic. Equipment was purchased net of VAT from manufacturers in accordance with HMRC legislation on the donation of assets for medical use. If any equipment is not donated, there will be a VAT liability to HMRC.

### Liabilities in respect of contractual obligations

The Department holds contractual liabilities in respect of redundancy payments and entitlements and it also holds liabilities in respect of commercial contract obligations. These liabilities include contractual indemnities the Department has entered into as part of its response to COVID-19

### Aeromedical evacuations of patients

Where there is a requirement for HMG to aeromedically evacuate (MEDEVAC) patients with confirmed or suspected High Consequence Infectious Diseases to the UK for treatment, liability for the costs of these MEDEVAC flights may sit with DHSC. A Memorandum of Understanding exists for the RAF Air Transportable Isolator service between DHSC and MOD. DHSC would be expected to cover the cost of the MEDEVAC in cases where a civilian is involved; where we have initiated the flight; and/or, have a clear duty of care to the patient.

### Expert Advisory Committees

The Department has undertaken to indemnify members of its expert advisory committees:

- New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG);
- The Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO).

The 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.

### Other Contingent Liabilities

Within the NHS England Group account (which incorporates Clinical Commissioning Groups and NHS England) at 31 March 2021, there were contingent liabilities of £32.9 million (2019-20: £43.0 million). These were mainly in respect of continuing care liabilities which transferred from Primary Care Trusts (PCTs) on 1 April 2013.

NHS providers at 31 March 2021 had net contingent liabilities of £23.8 million (2019-20: £52.5 million).

The Department 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.

A designated setting scheme exists for people who are medically fit for discharge from hospital (i.e., they do not require to be in an acute NHS bed) but whose ongoing care and support needs are such that they require full-time residential or nursing care. The Department holds a contingent liability which offers targeted and time-limited state-backed indemnity arrangements to care homes registered, or intending to register, as "designated settings", and which are unable to obtain sufficient insurance cover.

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.

## 18. 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. As disclosed in **Note 21**, the Department acts as the parent of the group of organisations (Public Health England, NHS England, Clinical Commissioning Groups, NHS Trusts, NHS Foundation Trusts, Executive Non-Departmental Public Bodies, Special Health Authorities and certain limited companies) whose accounts are consolidated within this Annual Report and Accounts. It also acts as the sponsor for the trading funds which are not consolidated. These bodies are regarded as related parties with which the Department has had various material transactions during the year.

In addition, the Department had a small number of transactions with other Government Departments and other central Government bodies in 2020-21.

When assessing potential related parties for the purpose of their own underlying financial statement Group bodies are required to consider this from the perspective of both the reporting entity and the parent of the reporting entity (the Core Department).

For this reason, on an annual basis, the Department circulates a list of relevant parent interests to Group bodies for their consideration should they have transactions with those interests.

As disclosed in the Governance Statement, during 2020-21 it became apparent the Department's processes for collating and assessing potential related parties under IAS 24 did not initially provide the necessary completeness assurance over the interests of a number of individuals.

This has since been rectified, with a number of additional interests identified as a result. These interests have been considered in relation to the Core Department and communicated to all Group bodies who had not finalised their accounts at the time the additional interests were identified, however their identification occurred after the majority of the accounts within the departmental Group were finalised and published, meaning the list of interests these entities considered in relation to the parent was incomplete.

This creates a completeness risk over the related party transaction disclosures in those accounts, however due to the number and nature of the newly identified interests, the Department has assessed this risk as limited.

A small number of Ministers, Non-Executive Directors and members of either: The Departmental Board, Executive Committee, People Board or the Audit and Risk Committee, 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, the Department may enter into business transactions with such outside organisations or related parties. In cases where an individual within the Department 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:

| Individual | DHSC role | Organisation | Payables with related party 2020-21 £'000 | Purchases from related party 2020-21 £'000 | Receivables with related party 2020-21 £'000 | Sales to related party 2020-21 £'000 | Payables with related party 2019-20 £'000 | Purchases from related party 2019-20 £'000 | Receivables with related party 2019-20 £'000 | Sales to related party 2019-20 £'000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Prof. Sir Mike Richards | Non Executive Board Member | Cancer Research[1] | - | 461 | - | 166 | - | 461 | 210 | 10 |
| Jenny Richardson | Director of Human Resources | Medicines & Healthcare Products Regulatory Agency[2] | 14 | 38,364 | 46 | 2,831 | - | 68,580 | - | 2,822 |
| Dr Doug Gurr | Non Executive Board Member | British Heart Foundation[3] | - | - | - | - | - | - | 48 | 190 |
| Dr Doug Gurr | Non Executive Board Member | UK Biobank Ltd[4] | - | 2,860 | - | - | - | - | - | - |
| Dr Doug Gurr | Non Executive Board Member | Amazon UK[5] | 5 | 39 | - | - | 1 | 14 | - | - |
| Gerry Murphy | Non Executive Board Member | Currys PLC[6] | - | 4 | - | - | - | - | - | - |

1. Prof. Sir Mike Richards is a trustee of Cancer Research
2. Jenny Richardson's husband is Chief Operating Officer of Medicines & Healthcare Products Regulatory Agency
3. Dr Doug Gurr is Chair of the British Heart Foundation
4. Dr Doug Gurr is a director of UK Biobank Ltd
5. Dr Doug Gurr was Country Manager of Amazon UK
6. Gerry Murphy is a non executive director of Currys PLC

The footnotes above identify 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 Department and the named organisation; not the individuals named in the sub-note who have not benefited from those transactions.

In addition to the above transactions with Amazon UK, the Core Department also had a small number of immaterial transactions with other parts of the Amazon group of companies. These transactions are not required to be disclosed by IAS24 but are mentioned in the interests of transparency.

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 the Department during the year. Compensation paid to management, expense allowances and similar items paid in the normal course of business are disclosed in the notes to the accounts and in the Remuneration Report.
The non-consolidated trading fund and Public Corporations are regarded as related and transactions with the Department have been disclosed along with transactions with NHS Shared Business Services Limited, an equity investment, as set out in the table below: (See **Note 21** for details)

| Related Party Entity | Relationship with DHSC | Payables with related party 2020-21 £'000 | Purchases from related party 2020-21 £'000 | Receivables with related party 2020-21 £'000 | Sales to related party 2020-21 £'000 | Share capital issued/repaid to/by related party 2020-21 £'000 | Loans issued/(repaid to)/by related party 2020-21 £'000 |
|---|---|---|---|---|---|---|---|
| NHS Shared Business Services Ltd. | DHSC Equity investment (50% shareholding) | - | 1,223 | - | 2,326 | - | 271 |
| Medicines & Healthcare Products Regulatory Agency | Non Consolidated Trading Funds | 14 | 38,364 | 46 | 2,831 | - | - |
| NHS Blood & Transplant Agency | Public Corporation | 770 | 169,730 | | 18,845 | - | - |

| Related Party Entity | Relationship with DHSC | Payables with related party 2019-20 £'000 | Purchases from related party 2019-20 £'000 | Receivables with related party 2019-20 £'000 | Sales to related party 2019-20 £'000 | Share capital issued/repaid to/by related party 2019-20 £'000 | Loans issued/(repaid to)/by related party 2019-20 £'000 |
|---|---|---|---|---|---|---|---|
| NHS Shared Business Services Ltd. | DHSC Equity investment (50% shareholding) | 1 | 3,224 | - | 19 | - | 2,906 |
| Medicines & Healthcare Products Regulatory Agency | Non Consolidated Trading Funds | - | 68,580 | - | 2,822 | - | - |
| NHS Blood & Transplant Agency | Public Corporation | - | 78,537 | 8,838 | 9,063 | - | - |

Supply Chain Coordination Limited (SCCL) have yet to publish their financial statements for 2020-21. During the year SCCL transacted with some entities which are related party interests of the Core Department. SCCL made purchases of £340k from Booker Ltd, made sales of 93k to Clinisupplies Limited, made sales of £28k to PHL Integrated Care Limited and made sales of £26k to Vyaire Medical Products Ltd.

## 19. NHS Charities

Following the inclusion of NHS Charities (as defined by section 149 of the Charities Act 2011) as amended in the 2012 Designation Order, the Department consolidates NHS Charities (with the exception of those with full independent status) into the Consolidated Annual Report and Accounts. This note shows the income, expenditure, assets, liabilities and reserves associated with the NHS Charities sector in isolation. As such the 'Total resources expended' figure will not match that in the Consolidated Statement of Comprehensive Net Expenditure, as this statement incorporates the elimination of inter-company trading with other bodies within the Departmental Group.

## 19.1 Charitable Income and expenditure for the period ended 31 March 2021

| | NHS Charities | |
|---|---|---|
| | 2020-21 | 2019-20 |
| | £'000 | £'000 |
| Total resources expended | 155,056 | 151,807 |
| Total incoming resources | (174,031) | (153,216) |
| **Net outgoing / (incoming) resources for the year ended 31 March 2021** | **(18,975)** | **(1,409)** |
| **Other Comprehensive Net Expenditure** | | |
| Net gain/loss on revaluation of charitable assets | (54,865) | 21,173 |
| **Total Comprehensive Expenditure for the year ended 31 March 2021** | **(73,840)** | **19,764** |

## 19.2 Summary Charitable Statement of Financial Position as at 31 March 2021

| | 2020-21 | 2019-20 |
|---|---|---|
| | £'000 | £'000 |
| **Non-current assets** | | |
| Charitable investments | 361,533 | 299,160 |
| Other charitable non-current assets | 4,415 | 7,080 |
| **Total non-current assets** | **365,948** | **306,240** |
| **Current assets** | | |
| Charitable cash | 256,020 | 238,966 |
| Other charitable current assets | 17,909 | 22,028 |
| **Total current assets** | **273,929** | **260,994** |
| **Total assets** | **639,877** | **567,234** |
| **Current charitable liabilities** | (47,271) | (47,078) |
| **Non-current assets plus/less net current assets/liabilities** | **592,606** | **520,156** |
| **Non-current charitable liabilities** | (357) | (212) |
| **Assets less liabilities** | **592,249** | **519,944** |
| **Total charitable reserves** | **592,249** | **519,944** |

## 19.3 Charitable Financial Assets - Investments

| | NHS Charities | |
|---|---|---|
| | 2020-21 | 2019-20 |
| | £'000 | £'000 |
| **Balance as at 1 April** | **299,160** | **321,692** |
| Prior period adjustments in underlying accounts | (1,065) | 1,372 |
| Acquisitions | 41,300 | 47,876 |
| Disposals | (35,697) | (49,310) |
| Net gain/loss on revaluation | 54,735 | (21,671) |
| Transfers | - | (1,377) |
| Other movements | 3,100 | 578 |
| **Balance as at 31 March** | **361,533** | **299,160** |

## 19.4 Other Charitable Non-Current Assets

| | NHS Charities | |
|---|---|---|
| | 2020-21 | 2019-20 |
| | £'000 | £'000 |
| **Balance as at 1 April** | 7,080 | 11,052 |
| Prior period adjustments in underlying accounts | (1,943) | (14) |
| Acquisitions | - | 9 |
| Disposals | - | (4,659) |
| Net gain/loss on revaluation | 130 | 498 |
| Other movements | (852) | 194 |
| **Balance as at 31 March** | **4,415** | **7,080** |

## 20. Events after the Reporting Period

From 1 April 2021 claims arising from the historical liabilities within scope of the interim arrangements with the Medical Protection Society (MPS), have been handled by NHS Resolution on behalf of the Secretary of State.

Indemnity arrangements for designated care settings were extended during the year from the 30 June 2021 to the 31 March 2022.

On 1 April 2021, the UK Health Security Agency was established as an Executive Agency of the Department.

On 1 August 2021, the Vaccine Task Force transferred from the Department for Business, Energy and Industrial Strategy to the Core Department. This will be accounted for as a transfer by merger in accordance with the FReM.

On 1 October 2021, the entire shareholding of Supply Chain Coordination Limited transferred from the Core Department to NHS England. This will be reflected as an absorption transfer in the accounts for 2021-22.

On 1 October 2021, the activities of Public Health England were divided between the Core Department, the UK Health Security Agency, NHS England and NHS Digital. This included the formation of the Office for Health Improvement and Disparities within the Core Department. This will be reflected as an absorption transfer in the accounts for 2021-22.

On 1 October 2021, the activities of NHS Test and Trace were transferred to the UK Health Security Agency. This will be reflected as an absorption transfer in the accounts for 2021-22.

On 1 November 2021, the Vaccine Damage Payments Scheme transferred to the Department from the Department of Work and Pensions. This will be reflected as an absorption transfer in the accounts for 2021-22.

On 22 November 2021 the Secretary of State announced that non-departmental public bodies NHS Digital and Health Education England, and the joint unit NHSX will merge into NHS England.

The Department applied discount rates as notified by HM Treasury to estimated cash flows to calculate the Clinical Negligence provision as at 31 March 2021. In December 2021, HM Treasury published new discount and inflation rates to be applied to estimated cash flows to calculate general provisions as at 31 March 2022. If the revised rates had been applied to estimated cash flows at 31 March 2021, the Clinical Negligence provision would have increased by an amount in the region of £30 billion.

The increase is a non-adjusting event as HM Treasury prescribe the rates to be applied at each year end.

These financial statements were authorised for issue by Sir Chris Wormald KCB on 31 January 2022.

## 21. Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2020-21.

| (a) Consolidated in the Department's Annual Report and Accounts | Website |
|---|---|
| **Supply Financed Agencies** | |
| Public Health England | https://www.gov.uk/government/organisations/public-health-englanc |
| **Other Bodies** | |
| Clinical Commissioning Groups | Available on the website of the relevant organisation. |
| NHS Providers (NHS Trusts and NHS Foundation Trusts) | Available on the website of the relevant organisation. Additionally the Consolidated Account of NHS providers is available at: https://improvement.nhs.uk/ |
| Skipton Fund Limited | http://www.skiptonfund.org/home.php |
| NHS Charities[1] | Available on the website of the relevant organisation. |
| Health and Care Professions Council | https://hcpc-uk.org |
| Wiltshire Health and Care LLP[2] | http://wiltshirehealthandcare.nhs.uk/ |
| Community Health Partnerships Limited | http://www.communityhealthpartnerships.co.uk/home-page |
| The Nursing and Midwifery Council | http://www.nmc.org.uk/ |
| NHS Property Services Limited | http://www.property.nhs.uk/ |
| Genomics England Limited | http://www.genomicsengland.co.uk/ |
| Professional Standards Authority for Health and Social Care (formerly included as an Executive Non-Departmental Public Body) | https://www.professionalstandards.org.uk/home |
| Supply Chain Coordination Limited | https://www.supplychain.nhs.uk/sccl/ |
| **Special Health Authorities** | |
| NHS Business Services Authority | https://www.nhsbsa.nhs.uk |
| NHS Counter Fraud Authority | https://cfa.nhs.uk/ |
| NHS Litigation Authority[4] | https://resolution.nhs.uk |
| National Health Service Trust Development Authority[5] | http://www.ntda.nhs.uk/ |
| **Executive Non-Departmental Public Bodies** | |
| Human Fertilisation and Embryology Authority | https://www.hfea.gov.uk |
| Care Quality Commission | http://www.cqc.org.uk/ |
| Monitor[5] | https://www.gov.uk/government/organisations/monitor |
| National Institute for Health and Care Excellence | https://www.nice.org.uk/ |
| Human Tissue Authority | https://www.hta.gov.uk/ |
| NHS Commissioning Board[6] | https://www.england.nhs.uk/ |
| The Health and Social Care Information Centre[7] | http://www.hscic.gov.uk/home |
| Health Research Authority | http://www.hra.nhs.uk/ |
| Health Education England | https://hee.nhs.uk/ |

These advisory bodies/advisory NDPBs are not separate legal entities, rather they are part of the Core Department or Public Health England accounts. As such they are not separately consolidated into these 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 Excellence Awards
- Advisory Committee on Dangerous Pathogens (DH)
- Advisory Group on Hepatitis
- Advisory Committee on Safety of Blood, Tissues and Organs
- 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 Mutagenicity of Chemicals in Food, Consumer Products and the Environment
- Committee on the Medical Effects of Air Pollutants (DH)
- Expert Advisory Group on AIDS
- Healthwatch England
- Independent Reconfigurations Panel
- Joint Committee on Vaccination and Immunisation
- Office of the National Data Guardian for Health & Social Care
- The NHS Pay Review Body
- Review Body on Doctors' and Dentists' Remuneration
- Scientific Advisory Committee on Nutrition
- UK Nutrition & Health Claims Committee[3]

| (b) Non-Consolidated | Website |
|---|---|
| **Trading Funds** | |
| Medicines & Healthcare Products Regulatory Agency | http://info.mhra.gov.uk/ |
| **Public Corporation** | |
| NHS Blood and Transplant | http://www.nhsbt.nhs.uk/ |
| **DH Equity Investments** | |
| NHS Shared Business Services (50% holding) | https://www.sbs.nhs.uk/ |

1. Charitable trusts, the trustees of which are an NHS Foundation Trust (as established under section 30 of the National Health Service Act 2006(a)), charitable trusts, the trustees of which are appointed for NHS Foundation Trusts in pursuance of an order under section 51 of the National Health Service Act 2006 and English NHS charities as defined by section 149(7) of the Charities Act 2011(c), with the exception of those with full independent status which are not subject to consolidation.
2. Wiltshire Health and Care LLP is a partnership formed by three Foundation Trusts.
3. UK Nutrition & Health Claims Committee has been added to the designation order in 2020-21. This committee is included as part of the Public Health England accounts
4. The NHS Litigation Authority is known as NHS Resolution.
5. As of 1 April 2016, Monitor and the NHS Trust Development Authority, operate as a single organisation, NHS Improvement (NHSI) under a shared executive leadership and Board membership.
6. NHS Commissioning Board is known as NHS England.
7. The Health and Social Care Information Centre is known as NHS Digital.

The Department of Health & Social Care'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

£'000

| | | 2016-17 Outturn | 2017-18 Outturn | 2018-19 Outturn | 2019-20 Outturn | 2020-21 Outturn | 2021-22 Plan |
|---|---|---|---|---|---|---|---|
| **Resource DEL** | | | | | | | |
| A | NHS Commissioning Board | 16,449,871 | 16,232,918 | 16,598,249 | 17,186,308 | 25,893,520 | 32,592,834 |
| B | NHS Providers | 68,492,416 | 70,750,505 | 75,607,340 | 81,526,454 | 94,565,010 | 86,000,000 |
| C | DHSC Programme and Administration | 1,579,373 | 1,747,178 | 1,107,488 | 856,606 | 25,279,332 | 23,278,677 |
| D | Local Authorities (Public Health) | 3,433,394 | 3,090,533 | 3,011,064 | 2,931,555 | 4,205,920 | 3,526,500 |
| E | Public Health England | 877,056 | 822,586 | 1,026,301 | 923,546 | 1,480,833 | 872,506 |
| F | Health Education England | 2,153,292 | 2,056,903 | 1,819,177 | 1,444,495 | 1,448,640 | 1,568,119 |
| G | Special Health Authorities | 3,489,248 | 4,034,160 | 2,718,887 | 2,743,281 | 2,650,893 | 2,808,574 |
| H | Non Departmental Public Bodies | 530,669 | 576,362 | 624,829 | 628,293 | 723,579 | 337,960 |
| I | Arm's Length Bodies [1] | - | - | 838,583 | 2,981,221 | 1,128,441 | 3,386,200 |
| J | NHS Commissioning Board financed from National Insurance contributions (non voted) | 20,025,641 | 21,338,869 | 21,926,343 | 22,961,639 | 22,823,176 | 23,443,279 |
| **Total Resource DEL** | | **117,030,960** | **120,650,014** | **125,278,261** | **134,183,398** | **180,199,344** | **177,814,649** |
| | Adjusted for classification change under ESA10 moving Research and Development to Capital DEL. For 2016-17 onwards the outturn/plans already include the reclassification adjustment. | | | | | | |
| **Total Resource DEL (adjusted for classification changes)** | | **117,030,960** | **120,650,014** | **125,278,261** | **134,183,398** | **180,199,344** | **177,814,649** |

£'000

| | | 2016-17 Outturn | 2017-18 Outturn | 2018-19 Outturn | 2019-20 Outturn | 2020-21 Outturn | 2021-22 Plan |
|---|---|---|---|---|---|---|---|
| **Capital DEL** | | | | | | | |
| A | NHS Commissioning Board | 227,416 | 227,820 | 221,233 | 265,530 | 330,577 | 300,654 |
| B | NHS Providers | 2,865,338 | 3,045,549 | 3,928,404 | 4,498,029 | 7,281,187 | 5,921,000 |
| C | DHSC Programme and Administration | 1,355,172 | 1,782,811 | 1,658,348 | 1,811,114 | 4,656,187 | 1,822,154 |
| D | Local Authorities (Public Health) | 9,325 | 15,456 | - | 0 | 0 | 0 |
| E | Public Health England | 51,679 | 70,695 | (70,475) | 140,735 | 21,022 | 179,000 |
| F | Health Education England | 476 | 628 | 467 | 1,557 | 532 | 2,000 |
| G | Special Health Authorities | 14,726 | 16,738 | (49,815) | 24,172 | 47,320 | 59,312 |
| H | Non Departmental Public Bodies | 31,947 | 78,155 | 95,246 | 118,533 | 156,325 | 20,465 |
| I | Arm's Length Bodies [1] | - | - | 157,836 | 155,574 | 189,762 | 225,005 |
| **Total Capital DEL** | | **4,556,079** | **5,237,852** | **5,941,244** | **7,015,244** | **12,682,912** | **8,529,590** |
| | Adjusted for Classification change under ESA10 moving Research and Development to Capital DEL. For 2016-17 onwards the outturn/plans already includes the reclassification adjustment. | | | | | | |
| **Total Capital DEL (adjusted for classification changes)** | | **4,556,079** | **5,237,852** | **5,941,244** | **7,015,244** | **12,682,912** | **8,529,590** |

£'000

| | | 2016-17 Outturn | 2017-18 Outturn | 2018-19 Outturn | 2019-20 Outturn | 2020-21 Outturn | 2021-22 Plan |
|---|---|---|---|---|---|---|---|
| **Resource AME** | | | | | | | |
| K | NHS Commissioning Board | (307,784) | 17,784 | (19,733) | 294,489 | 86,125 | 100,000 |
| L | NHS Providers | 1,025,251 | 662,491 | 1,134,119 | 1,070,401 | 1,978,051 | 1,100,000 |
| M | DHSC Programme and Administration | 223,184 | 491,136 | (437,113) | 785,506 | 1,997,564 | 329,313 |
| N | Public Health England | 2,223 | 4,623 | (2,181) | (2,033) | 13,831 | 5,000 |
| O | Health Education England | 4,817 | (17,647) | (44) | 68 | 159 | 5,000 |
| P | Special Health Authorities | 8,557,599 | 11,990,518 | 6,405,024 | 675,203 | (1,266,873) | 8,406,566 |
| Q | Non Departmental Public Bodies | 2,628 | 3,406 | 6,373 | 3,536 | 23,207 | 6,000 |
| R | Arm's Length Bodies [1] | - | - | (72,480) | 20,839 | 49,696 | 50,000 |
| **Total Resource AME** | | **9,507,918** | **13,152,311** | **7,013,965** | **2,848,009** | **2,881,760** | **10,001,879** |

£'000

| | | 2016-17 Outturn | 2017-18 Outturn | 2018-19 Outturn | 2019-20 Outturn | 2020-21 Outturn | 2021-22 Plan |
|---|---|---|---|---|---|---|---|
| **Capital AME** | | | | | | | |
| K | NHS Commissioning Board | 0 | 0 | 0 | 0 | 0 | 0 |
| L | NHS Providers | 0 | 0 | 0 | 0 | 0 | 0 |
| M | DHSC Programme and Administration | 13,349 | 0 | (4,801) | (5,563) | (7,355) | 15,000 |
| N | Public Health England | 0 | 0 | 0 | 0 | 0 | 0 |
| O | Health Education England | 0 | 0 | 0 | 0 | 0 | 0 |
| P | Special Health Authorities | 0 | 0 | 0 | 0 | 0 | 0 |
| Q | Non Departmental Public Bodies | 0 | 0 | 0 | 0 | 0 | 0 |
| R | Arm's Length Bodies [1] | - | - | - | - | 0 | 0 |
| **Total Capital AME** | | 13,349 | 0 | (4,801) | (5,563) | (7,355) | 15,000 |

1.The structure of the Estimate changed in 2018-19 with the creation of an additional line in order to provide greater transparency for its reader.

## Core Table 2: Administration Budgets

£'000

| | | 2016-17 Outturn | 2017-18 Outturn | 2018-19 Outturn | 2019-20 Outturn | 2020-21 Outturn | 2021-22 Plan |
|---|---|---|---|---|---|---|---|
| **Administration Budgets** | | | | | | | |
| A | NHS Commissioning Board | 1,497,776 | 1,560,979 | 1,508,274 | 1,545,410 | 1,488,859 | 1,773,000 |
| B | NHS Providers | - | - | - | - | - | - |
| C | DHSC Programme and Administration | 353,927 | 208,067 | 230,029 | 230,249 | 426,259 | 1,010,116 |
| D | Local Authorities (Public Health) | - | - | - | - | - | - |
| E | Public Health England | 58,925 | 50,661 | 48,778 | 49,134 | 51,140 | 54,674 |
| F | Health Education England | 70,783 | 65,304 | 59,943 | 61,296 | 58,970 | 59,119 |
| G | Special Health Authorities | 153,922 | 159,191 | 178,184 | 180,884 | 192,996 | 184,465 |
| H | Non Departmental Public Bodies | 259,119 | 259,311 | 248,219 | 239,886 | 258,655 | 228,022 |
| I | Arm's Length Bodies | - | - | (739) | (5,777) | (6,850) | 1,200 |
| **Total Administration Budget** | | **2,394,452** | **2,303,513** | **2,272,688** | **2,301,082** | **2,470,029** | **3,310,596** |

Supporting narrative for the core tables can be found within performance section and **Annex B.**

## Annex B – Financial Performance Detail

855. The Department 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.

**Largest DEL Budget in Government**

856. Spending for all Government Departments is measured against a set of metrics as agreed in HM Treasury's Spending Review. **Table 38** provides a breakdown of the consolidated budgets for all bodies in the Departmental group into the main spending metrics.

### Table 38: DHSC Departmental Expenditure – Spending Metrics

| Total Department Expenditure Limit (TDEL) | Total Annually Managed Expenditure (TAME) |
|---|---|
| **£212.08bn** | **£8.92bn** |
| Total spending by DHSC, excluding AME and DEL depreciation & impairments. | Total AME spending by DHSC, excluding depreciation & impairments. |

| Resource Departmental Expenditure Limit (RDEL) | Capital Departmental Expenditure Limit (CDEL) | Annually Managed Expenditure - Resource (RAME) | Annually Managed Expenditure - Capital (CAME) |
|---|---|---|---|
| **£200.76bn** | **£12.92bn** | **£10.00bn** | **£0.02bn** |
| The control total for which current resource expenditure, net of income, must be contained.<br><br>Of which COVID-19: £58.92bn | The control for which capital expenditure, e.g. fixed assets additions and capital grants, net of capital disposals must be contained.<br><br>Of which COVID-19: £4.0 bn | A technical control for items that HM Treasury have deemed to be demand-led or exceptionally volatile or that have no real impact on the fiscal framework, requiring no taxes be raised to cover. | A technical control for items that HM Treasury have deemed to be demand-led or volatile. For DHSC, entirely relates to costs associated with the sale of Plasma Resources UK and the Credit Guarantee Finance scheme. |

| Administration (Admin) |
|---|
| **£2.88bn** |
| Administration budgets cover the costs of all central government administration, excluding depreciation and the costs of direct frontline service provision.<br><br>Of which COVID-19:£0.43 bn |

### Total Departmental Expenditure Limit

857. The Department's Total DEL (TDEL); a spending measure, not formally managed, consistent with the presentation of spending in HM Treasury publications, calculated as the sum of Resource Departmental Expenditure Limit (RDEL) plus Capital Departmental Expenditure Limit (CDEL) less depreciation.

858. TDEL spending continues to grow cumulatively since SR15 and was significantly impacted by COVID-19 spending in 2020-21.

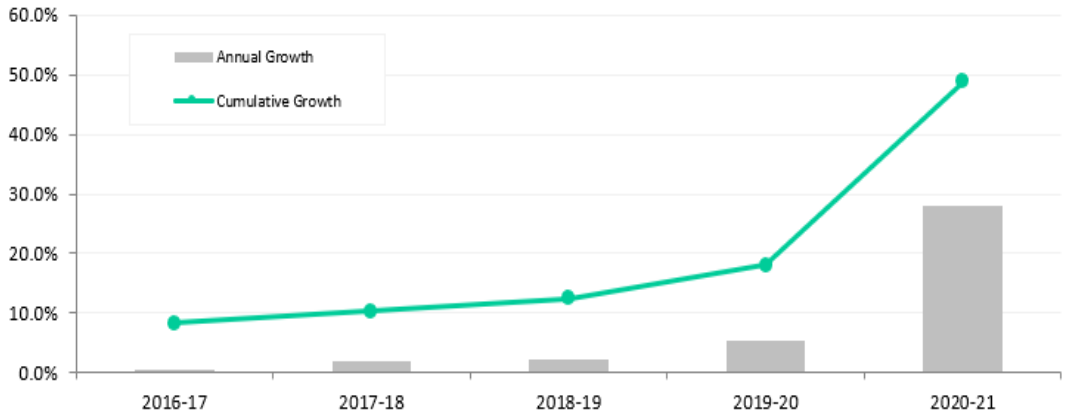
859. **Table 39** details 2020-21 TDEL spending outturn and compares that to previous years.

### Table 39: Total Departmental Expenditure Limit Spending

| | 2016-17 £m | 2017-18 £m | 2018-19 £m | 2019-20 £m | 2020-21 £m |
|---|---|---|---|---|---|
| **TDEL spending** | **120,584** | **125,154** | **130,300** | **140,498** | **191,688** |
| *Growth Nominal (£)* | *3,336* | *4,570* | *5,146* | *10,198* | *51,190* |
| *Growth Nominal (%)* | *2.8%* | *3.8%* | *4.1%* | *7.8%* | *36.4%* |

860. As shown in **Figure 7**, in 2020-21, the Departmental real-terms spending was 27.7% greater than in 2019-20 and 48.6% greater than in 2016-17.

### Figure 7: Real Terms Spending Growth




1. Cumulative growth figures are against the 2016-17 baseline
2. GDP Deflators at 30st June 2021 used to calculate real terms growth

861. The TDEL expenditure growth results from:
- The funding secured in the 2015 Spending Review and 2019 Spending Round,
- the NHS Long Term Plan multi-year funding commitment and additional capital allocations made in the 2017 Budget and later in Summer 2019: and
- the significant increase in 2020-21 TDEL expenditure is a result of the Department's response to the coronavirus pandemic which increased TDEL expenditure by £46.2 billion in 2020-21.

862. The Department contained its resources within all budgets authorised by Parliament as shown in **Table 40**.

### Table 40: Parliamentary DEL and AME control totals

| | Budget £m | Outturn £m | Under/ (Overspend) £m |
|---|---|---|---|
| Resource Departmental Expenditure Limit (RDEL) | 200,755 | 180,199 | 20,556 |
| *of which: Resource Administration* | *3,221* | *2,470* | *751* |
| Capital Departmental Expenditure Limit (CDEL) | 12,918 | 12,683 | 235 |
| Resource Annually Managed Expenditure (RAME) | 10,002 | 2,882 | 7,120 |
| Capital Annually Managed Expenditure (CAME) | 15 | (7) | 22 |
| Net Cash Requirement | 187,961 | 165,725 | 22,236 |
| Further HM Treasury Controls: | | | |
| Ringfenced Resource DEL | 1,589 | 1,194 | 395 |
| Non-ringfenced Resource DEL | 199,166 | 179,006 | 20,161 |

863. 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)

**£200.8bn RDEL Budget**

864. The Department's total 2020-21 Resource DEL (RDEL) represents the consolidated resource spending of all bodies within the NHS and non-NHS sectors of the Departmental group i.e. NHS healthcare providers and commissioners and the Department plus; its Arm's Length Bodies (ALBs).

865. The spending plans for all Government Departments are submitted to Parliament for scrutiny and approval as part of the Estimates process. The Department receives the majority of its revenue funding via this Estimates 'vote' process, but also receives an element of funding from National Insurance Contributions, which are not voted on by Parliament in the supply estimates process.

866. In 2020-21, our National Insurance Contributions receipts were in line with the funding set out in the Parliamentary Estimate.

867. **Table 41** summarises the RDEL outturn against budget since 2016-17; highlighting the £20.6 billion underspend in 2020-21.

### Table 41: Resource DEL

| | 2016-17 £m | 2017-18 £m | 2018-19 £m | 2019-20 £m | 2020-21 £m |
|---|---|---|---|---|---|
| RDEL Budget | 117,594 | 121,342 | 125,924 | 134,628 | 200,755 |
| **RDEL Spending Outturn** | **117,031** | **120,650** | **125,278** | **134,183** | **180,199** |
| *Underspends / (Overspends) (£m)* | *563* | *692* | *646* | *444* | *20,556* |
| *Underspends / (Overspends) (%)* | *0.479%* | *0.570%* | *0.513%* | *0.330%* | *10.239%* |

## RDEL: Funding Flows and Sector Breakdown

868. Of the Department's total £200.8 billion 2020-21 RDEL budget, £149.6 billion was allocated directly to NHS commissioners, with the remaining £51.2 billion funding allocated to ALBs and the Department's central budgets, i.e. the non-NHS sector.

869. NHS healthcare providers are not directly funded, instead they generate income to cover their spending via trading activity with commissioners i.e. 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. However in 2020-21 these financial arrangements were suspended to respond to the outbreak of Covid-19, where block contracts were put in place for the first half of the year and trusts able to claim a top-up for any COVID-19 costs. This block payment arrangement was continued into the second half of the year, however the retrospective top-up was removed to provide greater financial control.

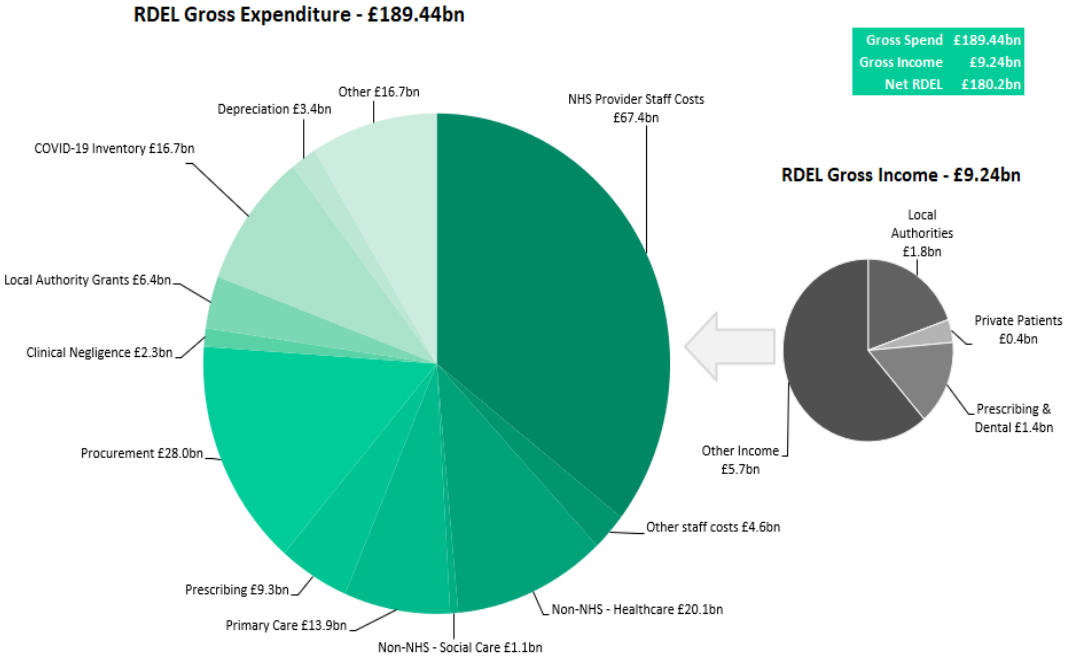
870. Across Government, this 'Internal Market' is unique to the Department of Health and Social Care and adds an additional layer of complexity as all inter-group trading needs to be eliminated on consolidation when preparing the Departmental Group account (via an 'Agreement of Balances' exercise).

871. Approximately £94.7 billion of resource expenditure in the Departmental Group sits 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.

872. The RDEL budget is set net of income and in 2020-21 the Departmental Group received around £9.2 billion of RDEL income from varying sources. This was mainly received by NHS providers and included prescribing and dental charges, trading with Local Authorities and income from treating private patients. Donation income of £594 million was received from the Department of Business Energy and Industrial Strategy on receipt of donated COVID-19 vaccines.

873. A breakdown of RDEL expenditure can be found in **Figure 8**.

## Figure 8: Resource DEL – spending breakdown (also see SOPS 1.1)




1. The figures in the illustrations above detail the gross RDEL expenditure and RDEL income for the DHSC Group. This differs from the presentation in the Statement of outturn against Parliamentary Supply (SOPS) note 1.1 as not all DHSC Group bodies are detailed on a gross expenditure and income basis.
2. COVID-19 inventory is detailed in the chart above as a 'type' of expenditure, however further detail is provided in the Performance Overview regarding the treatment of inventory in budgets.

## NHS Bodies - Financial Performance Revenue DEL (RDEL) Spending

874. The following section provides detail on the financial performance of the NHS in 2020-21. The NHS ended the financial year with an overall underspend position of £5.9 billion. Of this total underspend, £2.6 billion related to underspends against COVID-19 ringfences.

875. **Table 42** provides a summary of the spending position against the total agreed NHS budget of £149 billion, which includes additional funding provided to cover costs relating to COVID-19.

### Table 42: Financial Performance – NHS Commissioners & NHS Providers

| | £m |
|---|---|
| **Net Outturn against NHS Budget** | |
| NHS England group | 144,100 |
| NHS providers net Sector Reported Position Surplus | (655) |
| **Net Outturn** | **143,445** |
| *Of which Covid-19* | *17,422* |
| **NHS Budget** | **149,474** |
| ***Under / (over) spend*** | ***6,029*** |
| | |
| Additional NHS provider technical RDEL adjustment | (77) |
| **NHS RDEL Position as per SoPS** | **149,396** |

## Financial Performance – NHS Commissioners

876. The Financial Directions to the Government's revised NHS mandate for 2020-21 separately sets out NHS England's resource and capital funding limits against spending controls. These spending controls stem from the same controls that HM Treasury apply to the Department of Health and Social Care. In addition, a further £20 billion was provided to fund the costs of COVID-19 of which £12.2 billion was separately ringfenced by HM Treasury. **Table 43** provides a breakdown of that spending.

### Table 43: Financial Performance – NHS Commissioners

| | RDEL (excluding depreciation & impairments) | RDEL RF (depreciation & impairments) | AME | *£m* Technical |
|---|---|---|---|---|
| NHS England Budget | 149,474 | 174 | 100 | 200 |
| Total NHS England spending outturn | 144,100 | 173 | 87 | 86 |
| ***Net Variance against Resource Limits*** | ***5,374*** | ***1*** | ***13*** | ***114*** |
| *Of which Covid-19* | | | | |
| *Budget* | *19,988* | | | |
| *Outturn* | *17,422* | | | |
| *Variance*[1] | *2,566* | | | |

1. Variance relates to underspend on agreed Covid-19 ringfences of £12.168 billion as per the Financial Directions to the 2020-21 NHS mandate.

877. The vast majority of healthcare services are purchased from NHS providers (NHS Trusts and Foundation Trusts); however, £18 billion of these types of services were purchased from non-NHS healthcare providers in 2020-21, of which £2.2 billion was spent on Covid-19 related activity. These non-NHS providers include Local Authorities, voluntary sector/not for profit organisations, Devolved Administrations and private sector providers. **Table 44** provides a breakdown of this spending and compares to 2019-20.

### Table 44: NHS England's Purchase of healthcare from non-NHS Providers

| | 2019-20 £m | 2020-21 £m |
|---|---|---|
| Independent Sector Providers | 9,692 | 12,170 |
| Voluntary sector/Not for profit | 1,705 | 1,866 |
| Local authorities | 2,984 | 4,312 |
| Devolved Administrations | 49 | 36 |
| Total NHSE spend on all non-NHS bodies | 14,430 | 18,384 |
| Total DHSC RDEL | 134,183 | 180,199 |
| Spend with private sector as a % of total RDEL | 7% | 7% |
| Spend on all non-NHS bodies as a % of total RDEL | 11% | 10% |

1. The numbers above have been collected separately from audited accounts data and may include estimates.
2. Numbers shown in the table have been adjusted to show the DEL impact of the spending. This adjustment specifically relates to Continuing Health Care provisions which are attributed to expenditure in accounts as provisions arise but only impact on the DEL when paid.
3. Totals in the table may not sum due to roundings.

878. Further commentary, together with the consolidated accounts of the NHS England group, is published on NHS England's website.

## NHS Financial Performance – NHS Providers

879. At the 2020-21 financial year-end, there were 219 provider organisations producing accounts during the year. Together these providers ended 2020-21 with a net financial surplus of circa £0.7 billion. **Table 45** details the reported net position, plus Resource DEL scoring adjustments relating to the categorisation of provisions, PFI, donated assets and prior period adjustments.

### Table 45: NHS Providers RDEL Breakdown

*£m*

| | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|---|
| **NHS providers' RDEL Outturn as per SoPS1[1]** | **2,548** | **935** | **1,038** | **826** | **1,008** | **(732)** |
| Provisions Adjustment | (74) | (43) | (39) | 23 | 50 | 418 |
| Other Adjustments[2] | (27) | (101) | (8) | (22) | (159) | (341) |
| **Aggregate Net Deficit (impact on RDEL)** | **2,448** | **791** | **991** | **827** | **899** | **(655)** |
| Unallocated sustainability funding | 0 | 0 | (25) | 0 | (144) | 0 |
| Adj for Covid-19 impact on providers' deficit | 0 | 0 | 0 | 0 | (85) | 0 |
| ***Reported Net Deficit / (Surplus) (impact on RDEL)*** | ***2,448*** | ***791*** | ***966*** | ***827*** | ***669*** | ***(655)*** |

1. Excludes RDEL Depreciation ringfence.
2. Other adjustments – these include adjustments to reflect the correct DEL scoring of income and depreciation of donated assets and of PFI spending.
3. All expenditure incurred by providers relating to COVID-19 was fully funded from NHS England central budgets.

880. Throughout 2020-21, NHS providers have been supported with funding cover and a simplified financial framework which has allowed them to focus on their operational response to the COVID-19 pandemic. This has resulted in a healthy year-end surplus position across the sector.

881. The majority of providers, 179 (82%) continue to report a year-end position that is in surplus or in financial balance.

882. **Table 46** provides a breakdown of the reported deficit and position against control totals.

### Table 46: Summary of NHS Provider's surplus / (deficit)

| | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| Gross Deficit | (1,824) | (2,433) | (2,755) | (1,560) | **(158)** |
| Gross Surplus | 914 | 1,337 | 1,889 | 567 | **363** |
| Adjustments [1] | 120 | 105 | 39 | 323 | **450** |
| ***Net (Deficit) / Surplus*** | ***(790)*** | ***(991)*** | ***(827)*** | ***(670)*** | ***655*** |
| Number of trusts in deficit | 105 | 101 | 107 | 53 | **42** |
| Number of trusts in surplus / balance | 133 | 133 | 123 | 173 | **177** |

1. Other adjustments relate to minor reporting adjustments relating to differences between control totals and reported surplus/(deficit), where reported surplus/(deficit) includes items such as donated asset income and depreciation, changes in provisions discount rates and prior period adjustments not included in control totals.

## NHS Total Departmental Expenditure Limit

883. The majority of the Department of Health and Social Care's budget is allocated to fund the NHS. In June 2018, the Prime Minister set out a new multi-year funding plan for the NHS to regain core performance, lay the foundations for service improvements and provide the financial security to develop a 10-year plan.

884. **Table 47** provides an explanation of the adjustments made to the NHS budget since the 2015 Spending Review (SR).

## Table 47: NHS Outturn versus SR Baseline

| | 2014-15 £m | 2015-16 £m | 2016-17 £m | 2017-18 £m | 2018-19 £m | 2019-20 £m | 2020-21 £m | 2021-22 £m | 2022-23 £m | 2023-24 £m |
|---|---|---|---|---|---|---|---|---|---|---|
| **1. NHS Funding as announced in SR 2015** | | | | | | | | | | |
| NHS RDEL Budget (exc Depreciation) | 97,800 | 101,018 | 106,451 | 109,854 | 112,374 | 115,451 | 119,598 | | | |
| NHS CDEL Budget | 300 | 300 | 260 | 260 | 260 | 260 | 305 | | | |
| **NHS TDEL measure at SR15 [1]** | **98,100** | **101,318** | **106,711** | **110,114** | **112,634** | **115,711** | **119,903** | | | |
| *Nominal cumulative **NHS TDEL** Growth v 2014-15 baseline* | | *3,218* | *8,611* | *12,014* | *14,534* | *17,611* | ***21,803*** | | | |
| **2. Additional NHS RDEL funding adjustments announced in a) Autumn Budget 2017, b) NHS Mandate and c) HM Government Long Term Settlement** | | | | | | | | | | |
| **NHS RDEL Budget (exc Depreciation) at SR15** | **97,800** | **101,018** | **106,451** | **109,854** | **112,374** | **115,451** | **119,598** | | | |
| (a) 2017-18 Autumn Budget [2] | 0 | 0 | 0 | 337 | 1,601 | 901 | 0 | | | |
| (b) NHS Mandate Adjustments [3, 4] | (702) | (446) | (749) | (655) | (172) | (736) | (793) | | | |
| **NHS RDEL as per NHS Mandate** | **97,098** | **100,572** | **105,702** | **109,536** | **113,803** | **115,616** | **118,805** | | | |
| (c) Additional NHS funding as per LTS | | | | | 800 | 5,191 | 8,202 | 133,283 | 139,990 | 148,467 |
| **NHS RDEL Budget (exc Depreciation) at LTS [5]** | | | | | **114,603** | **120,807** | **127,007** | **133,283** | **139,990** | **148,467** |
| *Nominal cumulative **NHS RDEL** Growth v 2018-19 baseline (excluding pensions)* | | | | | | *6,204* | *12,404* | *18,680* | *25,387* | ***33,864*** |
| **3. Further budget changes since LTS** | | | | | | | | | | |
| **NHS RDEL Budget (exc Depreciation) at LTS** | | | | | **114,603** | **120,807** | **127,007** | **133,283** | **139,990** | **148,467** |
| Adjustment for NHS Pensions [5] | | | | | 0 | 2,851 | 2,851 | 2,851 | 2,851 | 2,851 |
| NHS Mandate Adjustments [6] | | | | | (182) | (281) | (373) | 108 | | |
| Additional Covid-19 funding [7] | | | | | | | 19,988 | 8,123 | | |
| **NHS RDEL Budget at per NHSE Mandate** | | | | | **114,421** | **123,377** | **149,473** | **144,365** | **142,841** | **151,318** |
| **4. Latest reported outturn (exc Depreciation)** | Actual | | | | | | | Plan | | |
| **NHS RDEL Budget** | **97,098** | **100,572** | **105,702** | **109,536** | **114,421** | ***123,377*** | ***149,473*** | ***144,365*** | ***142,841*** | ***151,318*** |
| Plus NHS provider sector net RDEL outturn | | | 935 | 1,038 | 826 | 1,009 | (732) | | | |
| Plus Net commissioner and NHSE underspend | | | (902) | (970) | (916) | (636) | (5,374) | | | |
| **Net NHS RDEL Outturn [3]** | **97,098** | **100,572** | **105,735** | **109,605** | **114,331** | ***123,750*** | ***143,367*** | ***144,365*** | ***142,841*** | ***151,318*** |
| NHSE CDEL | 189 | 182 | 240 | 228 | 221 | 266 | 331 | 301 | | |
| **NHS TDEL** | **97,287** | **100,754** | **105,975** | **109,833** | **114,552** | **124,016** | **143,698** | **144,666** | | |

Notes to table:

1. Paragraph 11.6 of the Spending Review and Autumn Statement 2015 publication – https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015
2. Paragraph 7.2 of the Autumn Budget 2017 publication: https://www.gov.uk/government/publications/autumn-budget-2017-documents/autumn-budget-2017
3. In order to be comparable with SR15 (i.e. 2016-17 to 2020-21), NHS RDEL NRF outturns for 2013-14 to 2015-16 have been adjusted to apply a transfer of function from NHSE to Local Authorities for 0-5 years commissioning that occurred halfway through 2015-16, across all years; and net NHS overspends have been removed as these did not form part of the SR baseline.
4. Mandate adjustments are as published in the annual Financial Directions to NHS England.
5. NHS Long Term Settlement and pensions funding details are set out in the 2019-20 Financial Directions to NHS England - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803055/financial-directions-to-nhs-england-2019-to-2020.pdf
6. Details of 2018-19 changes are set out in the 2018-19, 2019-20 and 2020-21 Financial Directions to NHS.
7. Covid-19 funding of £19.988 billion was added to NHSE's financial directions in 2020-21 and £8.123 billion in 2021-22.

## Non-NHS Bodies - Financial Performance Resource DEL Spending

885. Outside of the NHS sector, the Department's non-NHS sector contained resource expenditure within DEL spending limits. The non-NHS's activities, particularly the Core Department's, changed significantly during 2020-21 in response to the Coronavirus Pandemic.

**20%**
**Of DHSC RDEL expenditure**

886. The non-NHS sector's outturn was around £14.5 billion lower than the allocated funding, of which £13.4 billion relates to Non-NHS COVID-19 savings, explanations on DHSC Group COVID-19 savings are detailed in the **Performance Summary**.

887. £0.4 billion of the saving relates to ring-fenced funding for depreciation and the remaining £0.7 billion mainly relates to business as usual activities as follows:
    - NHS Resolution's outturn was £0.5 billion lower than planned primarily driven by a lower than anticipated clinical negligence scheme settlements due to slow down of court activity due to the pandemic;
    - Health Education England's outturn was £0.1 billion lower than planned because of the disruption of the pandemic which resulted in decreased placement activity;
    - Public dividend and interest income from NHS Providers was around £0.2 billion lower than planned due to the impact of increased provider cash balances on the dividend calculation which reduced dividend payments; and
    - Other budgets were around £0.4 billon lower than planned, of which around £0.3 billion related to lower than planned workforce expenditure for seasons including slippage in recruitment timelines.

888. The summarised RDEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 48**.

**Table 48: Summarised Financial Position for DHSC's ALBs in 2020-21**

| | Plan £m | Outturn £m | Variance £m |
|---|---|---|---|
| **RDEL Non Ring-fenced Spending -** | | | |
| Public Health England | 813 | 794 | 19 |
| Public Health Local Authority Grants | 3,066 | 3,066 | 0 |
| Health Education England | 4,390 | 4,283 | 107 |
| NHS Resolution | 430 | (15) | 445 |
| NHS Property Services | (60) | (21) | (39) |
| Community Health Partnerships (CHP) | 20 | 9 | 11 |
| NHS Digital | 393 | 387 | 7 |
| Other ALBs | 518 | 453 | 65 |
| European Economic Area (EEA) medical costs | 720 | 698 | 22 |
| PPRS | (465) | (490) | 25 |
| Other DHSC Central Budgets | 2,279 | 2,069 | 210 |
| Public dividend capital (PDC) payments and loan interest | (1,023) | (816) | (208) |
| NHS Charities | 0 | (19) | 19 |
| **DHSC - business as usual** | **11,081** | **10,396** | **685** |
| **DHSC COVID-19:** | | | |
| PPE | 14,184 | 12,588 | 1,596 |
| Test & Trace | 19,958 | 10,743 | 9,215 |
| Medicines , vaccines & R&D | 834 | 299 | 535 |
| Vaccine deployment | 2,096 | (7) | 2,102 |
| Ventilators & related products | 145 | 49 | 97 |
| Infection Control and other grants | 1,295 | 1,284 | 11 |
| Other COVID-19 | 99 | 285 | (186) |
| **DHSC - COVID-19** | **38,611** | **25,241** | **13,370** |
| **Total Non-NHS Non Ring-fence** | **49,693** | **35,637** | **14,055** |
| RDEL depreciation ring-fence | 1,416 | 1,021 | 395 |
| **Total RDEL** | **51,109** | **36,659** | **14,450** |

## RDEL Administration

889. 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 and Clinical Commissioning Groups) and all the Department's central government Arm's Length Bodies (ALBs).

890. In 2020-21, DHSC underspent by £0.8 billion against the total Resource Administration limit of £3.2 billion. This underspend mainly related to ring-fenced budgets as follows:
- c£0.3 billion underspend on depreciation and impairments; and
- c£0.3 billion underspend on admin budgets for the response to the coronavirus pandemic.

891. **Table 49** shows the administration outturn (excluding depreciation and impairments) between 2016-17 and 2020-21. Spending on administration increased in 2020-21 by c£160 million (7.2%) compared to 2019-20, this is mainly explained by expenditure incurred in response to the coronavirus pandemic.

### Table 49: DHSC Administration

| | 2016-17 £m | 2017-18 £m | 2018-19 £m | 2019-20 £m | 2020-21 £m |
|---|---|---|---|---|---|
| Administration Outturn | 2,275 | 2,222 | 2,189 | 2,212 | 2,382 |

1. 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 (£2,470m).

## Capital Departmental Expenditure Limit (CDEL)

**£12.6bn CDEL spend**

892. The Department's total 2020-21 CDEL outturn is the consolidated net capital spending of all bodies within the Departmental group.

893. **Table 50** summarises the CDEL outturn against budget since 2016-17; highlighting the £0.24 billion (1.82%) underspend in 2020-21.

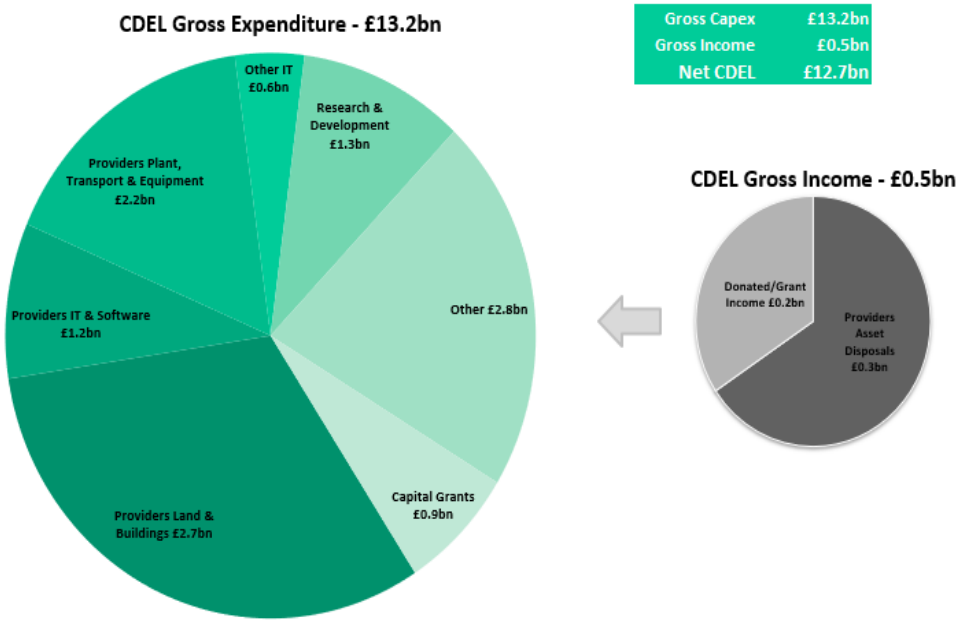
### Table 50: Capital DEL Outturn[1]

| | 2016-17 £m | 2017-18 £m | 2018-19 £m | 2019-20 £m | 2020-21 £m |
|---|---|---|---|---|---|
| CDEL Budget | 4,616 | 5,598 | 5,983 | 7,125 | 12,918 |
| **CDEL Spending Outturn, of which:** | **4,556** | **5,238** | **5,941** | **7,015** | **12,683** |
| *COVID-19* | | | | | *3,600* |
| *Business as usual* | | | | | *9,084* |
| *CDEL Underspend* | *60* | *360* | *42* | *110* | *235* |
| *CDEL Underspend %* | *1.30%* | *6.43%* | *0.70%* | *1.54%* | *1.82%* |

1. Totals in the table may not sum due to rounding.

894. **Figure 9** provides a breakdown of 2020-21 capital spend (CDEL) by expenditure type.

### Figure 9: Capital DEL - spending breakdown (also see SOPS 1.2)




## NHS Bodies - Financial Performance Capital DEL (CDEL) Spending

895. The summarised DEL outturn compared to plan for key elements of the NHS sector are shown in **Table 51**.

### Table 51: NHS Capital DEL Spending Breakdown by Activity

| | Budget £m | Outturn £m | Under/(over) £m |
|---|---|---|---|
| NHS England business as usual activities | 288 | 239 | 49 |
| NHS Providers business as usual activities | 6,434 | 6,517 | (83) |
| NHS COVID-19 | 613 | 589 | 24 |
| NHS Test and Trace | 57 | 61 | (4) |
| Ventilators and Critical Care Stockpile | 41 | 56 | (15) |
| **TOTAL NHS CDEL,** *of which:* | **7,433** | **7,462** | **(28)** |
| *NHS Providers* | | *7,131* | |
| *NHSE* | | *331* | |

## NHS Providers Capital Expenditure:

896. **Table 52** provides a breakdown of NHS Provider capital expenditure.

### Table 52: NHS Provider Capital DEL Spending Breakdown by Activity

| | 2019-20 £m | 2020-21 £m |
|---|---|---|
| **Capital DEL Outturn** [1] | **4,503** | **7,131** |
| Of which | | |
| Operational Capital Expenditure [2] | 3,449 | 3,867 |
| National Programmes | 829 | 2,479 |
| COVID-19 (National Funding) | 67 | 614 |
| PFI Residual Interest [3] | 158 | 171 |

1. NHS CDEL in the table above does not include the net capital investment of NHS Charities
2. Operational Capital Expenditure is self-financed spending by Trusts, loans, and emergency capital.
3. HMT's budgeting framework requires PFI residual interest on assets to score to CDEL.

897. NHS Provider CDEL expenditure was £7.1 billion in 2020-21 (exclusive of net capital investment of NHS Charities). CDEL increased by 58% from 2019-20 to 2020-21, primarily due to an increase in spending on national programmes.

898. Funding for national programmes, such as Health Infrastructure Plan (HIP) and Sustainability and Transformation Partnerships (STP) infrastructure, is provided as direct funding issued by the Department in the form of Public Dividend Capital (PDC) to cover Trusts' expenditure. 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.

## Operational Capital

899. Operational capital includes emergency capital issued to NHS Providers, and self-financed CDEL expenditure, i.e. where NHS Providers use the income they receive for depreciation, their own cash reserves, and loans. As part of the new capital regime implemented in 2020-21 the majority of operational capital budgets were allocated at system level to the Integrated Care Systems (ICS) to improve the coordinated planning, allocation and delivery of investment, and the join up of services within ICSs.

900. NHS Providers were required to set their operational budgets within those envelopes and reflect system-wide priorities. In-year emergency applications and re-prioritisation or rephasing of capital spend are made at a local level through ICS/provider discussions.

## COVID-19

901. As part of the response to COVID-19, the Secretary of State for Health confirmed in February 2020 that the NHS would have immediate access to the capital funding it required. This ensured the NHS had the necessary means to combat the

pandemic. Public Dividend Capital (PDC) was issued directly to NHS providers for clinical equipment, build infrastructure, infection control adaption, oxygen supply infrastructure, IT (including laptops to support remote working) and Test and Trace for laboratories and rapid testing. PDC was also issued to dental teaching hospitals to facilitate more clinical experience of students whose studies had been disrupted by COVID-19.

## National Programmes

902. **Table 53** provides details of National Programmes, the detail of which is described in the following paragraphs.

### Table 53: NHS Provider National Programmes

| | 2020-21 Total £m |
|---|---|
| Critical Infrastructure Risk Schemes | 588 |
| A&E Improvements | 438 |
| Strategic Investments made following the collapse of Carillion | 310 |
| Sustainability and Transformation Partnerships (STP) Build Schemes | 224 |
| Health Infrastructure Plan Schemes | 205 |
| Health System Led Investment | 138 |
| Investment in the Mental Health Estate | 106 |
| Diagnostics | 99 |
| Other PDC for Local Investments | 95 |
| Car Parking | 48 |
| Digital Aspirants | 54 |
| Other PDC Programmes | 44 |
| Other NHS Technology | 36 |
| E Prescribing | 25 |
| E Rostering | 21 |
| Global Digital Exemplars | 16 |
| Local Health Care Records Exemplars | 16 |
| Energy Efficiency Fund | 16 |
| **NHS Providers National PDC Total** | **2,479** |

903. The delivery of 40 new hospitals by 2030, as part of the Health Infrastructure Plan (HIP) was announced in October 2020 by the Prime Minister. He confirmed a £3.7 billion national funding allocation over the next 4 years.

904. Additionally, 8 schemes secured investment through the previous Government to deliver new hospitals and have been included in the Health Infrastructure Plan. Cumberland Cancer Hospital was one of these and opened in August 2021.

905. The Sustainability and Transformation Partnerships (STPs) programme was announced in the 2017 Autumn Budget, to modernise and transform the NHS's buildings and services.

906. Since July 2017, approximately £3.3 billion has been provisionally awarded to over 170 STP schemes and hospital upgrades. In 2020-21, 25 STP schemes were completed, and 77 schemes commenced, alongside 3 hospital upgrades.

907. To help eradicate Critical Infrastructure Risk (CIR) in NHS hospitals, the Secretary of State for Health announced £600 million in December 2020. The funding was awarded to 178 NHS trusts to cover almost 1,800 critical maintenance projects. Investment was targeted towards a range of works including building new or refurbished buildings to deliver key services, upgrades to electrical infrastructure, improvements to ventilation systems and works to improve fire safety and replacing hospital lifts.

908. Investment was made in cancer diagnostic equipment more than 10 years old. In continuing with the two-year programme, £100 million was allocated in 2020-21 for 139 diagnostic assets across 54 Trusts, including CT scanners, MRI machines, digital mammography units, and breast screening trailers.

909. To upgrade of A&E facilities ahead of Winter 2020-21, funding was awarded to over 115 separate trusts and over 190 urgent treatment sites, primarily for emergency departments. As of 31 March 2021, 142 of the 175 smaller capital schemes were completed. This has created 2,065 additional waiting spaces, 692 treatment spaces for patients with major conditions, 181 resuscitation spaces, and 1,183 extra Same Day Emergency Care spaces into the system to improve capacity.

910. To improve mental health facilities, the Government has committed more than £400 million over the next 4 years to eradicate dormitory accommodation across the country. This will improve the safety, privacy and dignity of patients suffering with mental illness. As of 31st March 2021, 9 schemes had been completed and 28 were under construction, with over £100 million invested.

## Non-NHS Bodies - Financial Performance Capital DEL Spending

911. Outside of the NHS sector, the Department's non-NHS sector contained capital expenditure within DEL spending limits.

912. The non-NHS's activities, particularly the Core Department's, changed during 2020-21 in response to the Coronavirus Pandemic.

913. Detail regarding the Department's utilisation of CDEL in its pandemic response is given in the **Performance Summary.**

914. The non-NHS sector's outturn was around £0.3 billion lower than the allocated funding, of which £0.4 billion relates to COVID-19. The non-NHS sector's business as usual capital outturn was £0.1 billion higher than planned, mainly due to:
    - Planned financial asset proceeds being received a couple of weeks into the 2021-22 financial year, instead of 2020-21 as planned. This financial asset sale generated capital receipts for Government of around £0.35 billion; offset by;
        - Capital credits of around £0.14 billion relating to the utilisation of stockpiled emergency preparedness inventories; and
        - Other capital expenditure was around £0.1 billion lower than planned.

915. The summarised DEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 54**.

**Table 54: Summarised Financial Position for 2020-21 Non-NHS**

| | Plan £m | Outturn £m | Variance £m |
|---|---|---|---|
| **CDEL** | | | |
| NHS Digital | 90 | 75 | 15 |
| NHS Property Services | 85 | 87 | (2) |
| Genomics England Ltd | 60 | 57 | 3 |
| NHS Business Services Authority | 49 | 41 | 8 |
| Other ALBs | 82 | 76 | 6 |
| Research & Development | 1,042 | 1,059 | (18) |
| Disabled Facilities Grant | 573 | 573 | 0 |
| NHSX | 97 | 94 | 2 |
| NHS Charities | | 10 | (10) |
| Other DHSC Central Budgets | 103 | 255 | (152) |
| **DHSC - business as usual** | **2,181** | **2,328** | **(147)** |
| **DHSC COVID-19:** | | | |
| PPE | 60 | 31 | 29 |
| Test & Trace | 2,659 | 2,386 | 273 |
| Medicines , vaccines & R&D | 157 | 68 | 90 |
| Vaccine deployment | 10 | 3 | 7 |
| Ventilators & related products | 398 | 387 | 11 |
| NHS COVID-19 | 5 | 5 | 0 |
| Other COVID-19 | 14 | 14 | 0 |
| **DHSC - COVID-19** | **3,303** | **2,894** | **409** |
| **Total Non-NHS CDEL** | **5,484** | **5,222** | **262** |

## Annually Managed Expenditure (AME)

**£2.9bn**
**AME spend**

916. Details of the Department's total 2020-21 AME budget and expenditure are set out in **Table 55**, which shows the Department underspent by £7.1 billion (71.2%) against its final Resource AME budget.

### Table 55: Annually Managed Expenditure plans, outturns and under/ (over) spends

| | 2016-17 £m | 2017-18 £m | 2018-19 £m | 2019-20 £m | 2020-21 £m |
|---|---|---|---|---|---|
| Resource AME Budget | 16,150 | 27,940 | 12,926 | 11,420 | 10,002 |
| **RAME Outturn** | **9,508** | **13,152** | **7,014** | **2,848** | **2,882** |
| *Underspend/(Overspend) £m* | *6,642* | *14,788* | *5,912* | *8,572* | *7,120* |
| *Underspend/(Overspend) %* | *41.1%* | *52.9%* | *45.7%* | *75.1%* | *71.2%* |
| | | | | | |
| Capital AME Budget | 15 | 15 | 15 | 15 | 15 |
| **Capital AME Outturn** | **13** | **0** | **(5)** | **(6)** | **(7)** |
| *Underspend/(Overspend) £m* | *2* | *15* | *20* | *21* | *22* |
| *Underspend/(Overspend) %* | *13.3%* | *100.0%* | *132.0%* | *137.1%* | *149.0%* |

917. The Department's AME provision (Resource and Capital) is set annually outside the Spending Review and 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 Department's AME spending is not typical to most government Department's AME spending, which normally will impact on the fiscal framework in the same way as DEL spending.

918. Additionally, the Department's AME is demand-led and volatile, being subject to many variables outside the Department's direct control, such as changes to the discount rates to measure the value of long-term provisions liabilities. **Note 16 within the Financial Statements**, provides further detail and analysis of variables.

919. The final AME budget in 2020-21 was set at £10.0 billion. The main element of DHSC's AME relates to clinical negligence expenditure in NHS Resolution (NHSR). The AME budget for NHSR was re-set as part of the Supplementary Estimates and included an estimate of expenditure based on the mid-range of several scenarios produced by NHSR's actuarial advisors.

920. As a result of favourable reductions, including assumptions around inflationary costs, the estimated quantum of future clinical negligence expenditure was lower than had been forecast.

# Financial Information by Arm's-length body (ALB)

921. As of the 2020-21 reporting cycle, HM Treasury require the presentation of ALB income and expenditure figures alongside detail pertaining to staff costs and numbers to aide users of the accounts of government departments.

922. Each ALB consolidated into the Department's Group ARA, produces its own of ARA which provides information in relation to income, expenditure staff numbers and staff costs as part of those accounts. Equally the Department consolidates the ALB information to produce its Group ARA. The below table provides the necessary information.

923. The websites for each of our ALBs (excluding individual NHS provider and Commissioners) can be found in **Annex E**.

924. **Table 56** provides the required income, expenditure, staff cost and staff number information required by HM Treasury. Notes to the table aide the users' interpretation of the figures presented.

## Table 56: Financial information by ALB

| | | | | 2020-21 | | | |
|---|---|---|---|---|---|---|---|
| | | | | Permanently employed staff | | Other Staff | |
| | Total Operating Income | Total Operating Expenditure | Net Expenditure for the year (including financing) | Number of employees | Staff costs | Number of employees | Staff costs |
| | £'000 | £'000 | £'000 | Number | £'000 | Number | £'000 |
| DHSC Core | (2,235,247) | 189,313,348 | 187,083,824 | 2,017 | 163,862 | 3,864 | 562,007 |
| Public Health England | (798,630) | 5,373,147 | 4,574,835 | 5,545 | 383,156 | 504 | 28,242 |
| NHS England Group | (1,476,832) | 145,968,752 | 144,491,920 | 25,188 | 1,705,096 | 9,330 | 565,486 |
| National Health Service Trust Development Authority | (16,398) | 237,204 | 220,806 | 1,478 | 130,721 | 156 | 6,952 |
| NHS Providers | (105,293,784) | 106,158,368 | 864,498 | 1,175,126 | 62,007,324 | 117,918 | 5,712,826 |
| Monitor | (3,776) | 42,520 | 38,744 | 110 | 14,628 | 6 | 499 |
| Care Quality Commission | (206,893) | 225,324 | 18,431 | 3,067 | 166,767 | 16 | 8,719 |
| National Institute for Health and Care Excellence | (19,275) | 69,019 | 49,744 | 664 | 42,237 | 7 | 742 |
| NHS Digital | (45,298) | 593,660 | 542,639 | 2,480 | 172,004 | 452 | 47,734 |
| Human Fertilisation and Embryology Authority | (4,431) | 6,790 | 2,359 | 63 | 4,284 | 4 | 674 |
| Human Tissue Authority | (4,549) | 5,375 | 826 | 47 | 3,272 | 1 | 87 |
| Health Research Authority | (321) | 16,520 | 16,199 | 210 | 10,070 | 12 | 1,041 |
| Health Education England | (144,680) | 4,428,332 | 4,283,652 | 2,156 | 134,436 | 276 | 53,015 |
| NHS Counter Fraud Authority | (259) | 13,433 | 13,174 | 164 | 9,055 | 4 | 162 |
| NHS Business Services Authority | (499,166) | 657,964 | 158,798 | 3,116 | 110,765 | 78 | 5,224 |
| NHS Resolution | (2,309,526) | 1,027,447 | (1,282,079) | 374 | 25,120 | 27 | 1,326 |
| NHS Property Services Ltd | (731,972) | 864,438 | 132,466 | 5,619 | 147,394 | 30 | 5,106 |
| Community Health Partnerships Ltd | (425,103) | 607,374 | 182,271 | 204 | 11,363 | - | - |
| Supply Chain Coordination Ltd | (2,329,918) | 2,384,040 | 54,122 | 381 | 24,586 | 127 | 9,523 |
| Genomics England Ltd | (9,769) | 65,122 | 55,353 | 182 | 14,379 | 50 | 7,572 |
| Skipton Fund Ltd | (1) | 135 | 134 | - | - | - | - |
| Nursing & Midwifery Council | (92,005) | 80,435 | (11,570) | 893 | 44,764 | 71 | 2,458 |
| Health & Care Professions Council | (27,851) | 29,424 | 1,573 | 213 | 9,897 | 49 | 2,403 |
| Wiltshire Health and Care LLP | (61,991) | 61,815 | (176) | 979 | 41,031 | 56 | 3,361 |
| Professional Standards Authority for Health and Social Care | (5,091) | 4,943 | (148) | 41 | 3,442 | 1 | 52 |

1. Net expenditure for the year is net operating expenditure after financing, and therefore comprises total operating income, less total operating expenditure, plus finance income less finance expenditure.
2. The requirement to report disaggregated information does not apply to public corporations that are not trading funds, NHS Trusts, NHS Foundation Trusts and Clinical Commissioning Groups (CCGs). For completeness, however, the above table includes NHS providers and CCGs.
3. The amounts above do not include any central adjustments the Department has made, the results of NHS Charities (as these are disclosed separately within the Annual Report and Accounts in Note 19) or intragroup eliminations.

## Annex C – NHS Operational Performance

### NHS Operational Performance against waiting time standards

925. The COVID-19 pandemic has applied additional and unprecedented pressure on the NHS. Responding to the large numbers of people infected with COVID-19 required a scale of response not seen during peacetime.

926. On 30 January 2020, the first phase of the NHS's preparation and response to COVID-19 was triggered with the declaration of a Level 4 National Incident. On 17 March 2020 NHS England and NHS Improvement wrote to all NHS trusts and requested the temporary postponement of all non-urgent elective operations from 15 April 2020. This prevented the NHS from becoming overwhelmed as it sought to treat patients with COVID-19, as well as continuing to provide urgent and emergency care. Despite the best efforts of hardworking NHS staff, the pressures on beds, staff and equipment, combined with enhanced infection prevention and control measures necessary to keep people safe, significantly disrupted non-urgent care.

927. On 29 April 2020, guidance went out to trusts on the second phase of the NHS response to COVID-19. It advised the continuation of the Level 4 National Incident, recommended retaining surge capacity, asked systems to step up non-COVID-19 urgent services, and asked them to consider capacity for elective care. Again, the impact was felt on elective care services, with outpatient services delivered virtually where possible and significant volumes of planned patient treatment postponed.

928. On 31 July 2020, further guidance was issued to local NHS providers and commissioners outlining the third phase of the NHS response. The focus was on accelerating the return of non-COVID-19 health services, fully restoring cancer services, and making full use of available capacity between July 2020 and winter, whilst preparing for winter demand pressures. The guidance advised that clinically urgent patients would continue to be treated first, with priority then given to the longest waiting patients. Trusts, working with GP practices, were asked to ensure that every patient whose planned care had been disrupted by COVID-19 received clear communication about their treatment. Continued access to independent sector capacity was put in place to support the recovery and restoration of elective services.

929. On 4 November 2020, the NHS returned to an Incident Level 4. While COVID-19 continued to put pressure on healthcare services, the NHS worked hard to deliver elective care as much as possible, with priority given based on clinical urgency and then length of wait. Since that time, despite a further COVID-19 peak in January 2021, the NHS continued to deliver urgent and elective services, with increased activity to try and tackle the backlog.

930. In the early stages of the pandemic, referral activity reduced dramatically. GP referrals in Q1 2020-21 were 63% lower than in Q1 2019-20. This was concurrent with the pause in elective treatment. There were concerns about patients not presenting with symptoms, particularly those which could be related to cancer, and this led to the 'Help Us, Help You' media campaign that encouraged the public to seek medical attention. However, elective activity levels fell by more than demand levels, despite the drop in referrals, creating an imbalance. This meant that alongside referrals moving towards usual levels by the end of 2020-21, there was a significant increase in the number of patients experiencing longer waits for surgery. Patient waiting lists reached a record high of 4.95 million people in March 2021.

931. On 18 March 2021, we announced an additional £7 billion funding for healthcare services, in recognition that the pandemic has continued to have a severe impact on care. However, by taking action to keep non-COVID services going, the NHS has been able to deliver more than 12 million planned operations and procedures and over 19 million key diagnostic tests throughout the pandemic.

### A&E Waiting Times

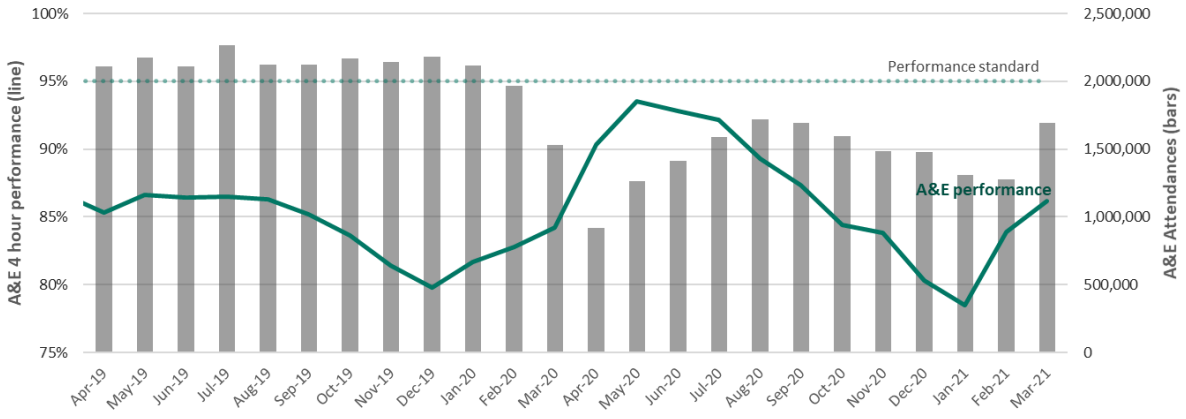
932. National performance for A&E waiting times in 2020-21 was disrupted during the pandemic, at 86.9% against the standard that 95.0% of patients should be admitted, transferred or discharged within four hours of arrival in an A&E department.

933. However, the average performance was still higher than 2019-20, which was 84.2%. The standard has not been met since July 2015.

934. The improvement in performance as shown in **Figure 10** should be seen in the context of a decrease in demand for non-elective services. A&E attendances in 2020-21 were 30.3% lower than in 2019-20, decreasing to 17.4 million from 25 million in 2019-20. Over the same period, the total number of emergency admissions from A&E decreased by 16.4% from 6.41 million in 2019-20 to 5.36 million in 2020-21.

935. Data for trusts undertaking the Clinical Review of Standards (CRS) field testing have been removed from the whole of the A&E time series. As a result the time series here is on a comparable 'like for like' basis across the full period of the data reported.

**Figure 10: A&E waiting times and activity against the 4-Hour standard (95% threshold) April 2019 – March 2021.**




Standard - 95% patients admitted, transferred or discharged within 4 hours of arrival

## Ambulance Response Programme

936. **Figure 11** and **Table 57** show data against the ambulance response time categories for the 11 ambulance trusts. In March 2021, five of the six national response time standards were met and ambulance services received a 24,025 daily 999 calls. The year started in April 2020 with a sharp reduction in the number of incidents where a patient was transported to an Emergency Department, suggesting that alternatives to A&E were being used in order to avoid taking patients to hospitals facing increased pressures due to the COVID-19 pandemic. However, by March 2021 this had returned to almost pre-COVID levels.

937. In the year 2020-21, performance against national response time standards has varied. The Category 1 mean standard has been met 5 times and the Category 4 90th centile standard of 3 hours was met seven times. Both category 1a and 1b were met in March 2021.

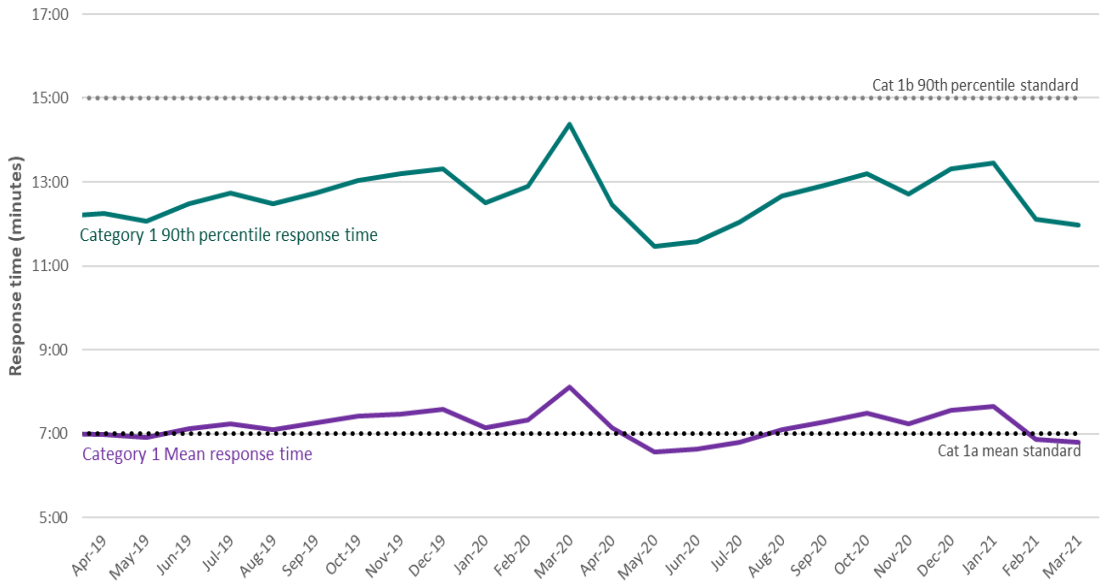
938. The NHS operational priorities for 2021–22 set out in NHS England and Improvement's planning guidance were published on 25 March 2021. This included guidance to transform community and urgent and emergency care, to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients, and reduce length of stay.

939. The NHS Long Term Plan focuses on safely reducing conveyance to A&E in order to reduce pressure on emergency departments. This is achieved through increased rates of 'hear and treat' (advising patients over the phone) and 'see and treat' (treating patients at the scene), as well as transporting patients to alternative locations, such as urgent treatment centres. Ambulance dispatchers can also directly refer patients to a wide range of community-based services via the CAS (clinical assessment service) integrated urgent care system and other digital tools. There is also a focus on reducing handover delays to free up vehicles to attend to new 999 calls, through intensive support to the poorest performing acute hospitals.

## Table 57: Ambulance Response Performance – April 2020 to April 2021

| Performance | Apr-21 | Apr-20 | Change |
|---|---|---|---|
| **Category 1a**: Mean response time ≤ 7 minutes | **07m00** | 07m08 | ▲ -00m08 |
| **Category 1b**: 90th percentile ≤ 15 minutes | **12m26** | 12m27 | ▲ -00m01 |
| **Category 2a**: Mean response time ≤ 18 minutes | **20m16** | 18m28 | ▼ 01m48 |
| **Category 2b**: 90th percentile ≤ 40 minutes | **00h40** | 00h38 | ▼ 02m05 |
| **Category 3**: 90th percentile ≤ 120 minutes | **02h18** | 01h29 | ▼ 49m03 |
| **Category 4**: 90th percentile ≤ 180 minutes | **03h48** | 02h25 | ▼ 01h23 |

## Figure 11: Ambulance response times (mins) for category 1a and 1b

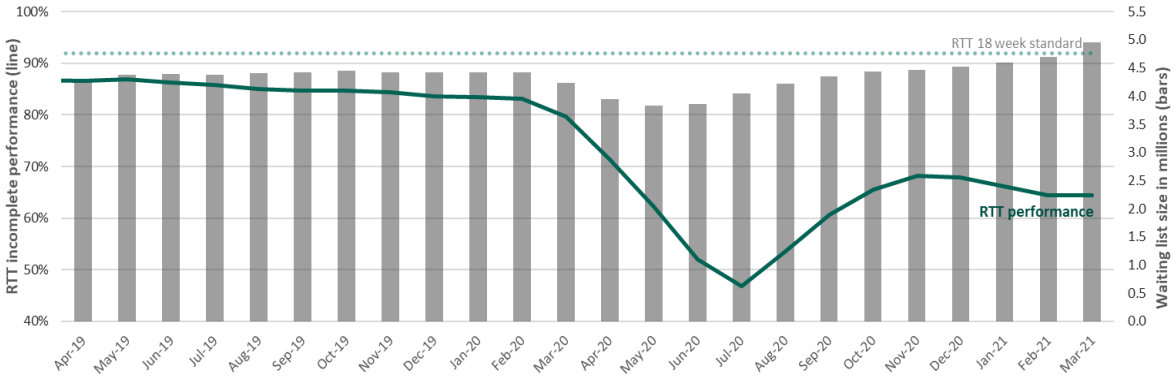



Standard - Category 1 incidents are the most urgent ambulance incidents and have the shortest response time standards, with category 4 being the least urgent. Category 1a is the mean response time for category 1 incidents and this has a standard of 7 minutes or less, Category 1b is the 90th percentile response time and this has a standard of 15 minutes or less.

### Referral to Treatment Waiting Times

940. Elective waiting times are monitored against the referral to treatment (RTT) incomplete pathway standard, in that a minimum of 92% of patients still waiting to start consultant-led treatment for non-urgent conditions at the end of the month, should have been waiting less than 18 weeks from referral. As shown in **Figure 12** published performance was 64.4% in March 2021, compared to 79.7% in March 2020 (partially impacted by COVID-19), and 83.2% in February 2020. The standard was last met in February 2016.

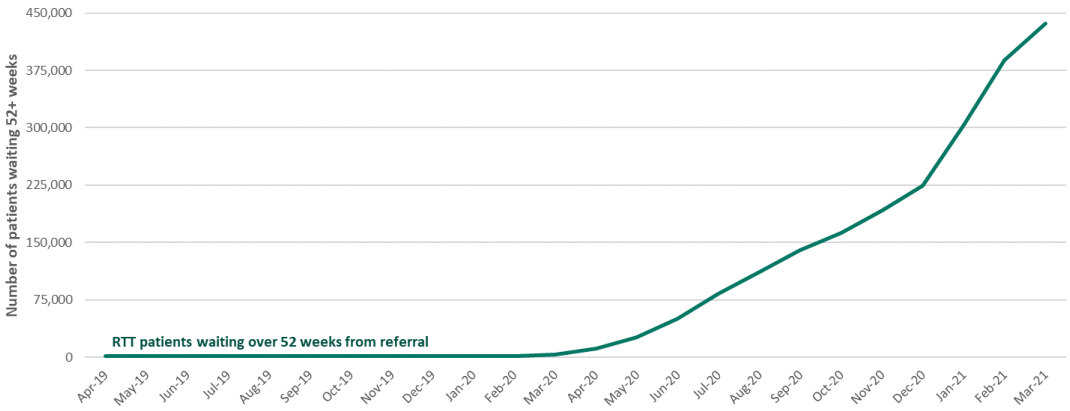
### Figure 12: Percentage of patients on RTT incomplete pathways waiting within 18 weeks from referral and waiting list, 2019-20 and 2020-21




Standard – 92%, Patients with incomplete pathways waiting to start consultant led treatment within 18 weeks.

941. Deteriorating performance against the standard is a result of a continued mismatch between demand and activity, which has been amplified by COVID-19 and the measures taken by the NHS to respond to COVID-19 during the first wave. As shown in **Figure 13**, this is more evident from the growth in the number of patients waiting for more than 18 weeks which, by March 2021, had more than doubled, and the number of patients waiting for more than 52 weeks, which increased by 433,000, compared to March 2020. Addressing the elective waiting list has become a government priority.

### Figure 13: Number of patients waiting over 52 weeks from referral, April 2019 to March 2021




## Cancer Waiting Times

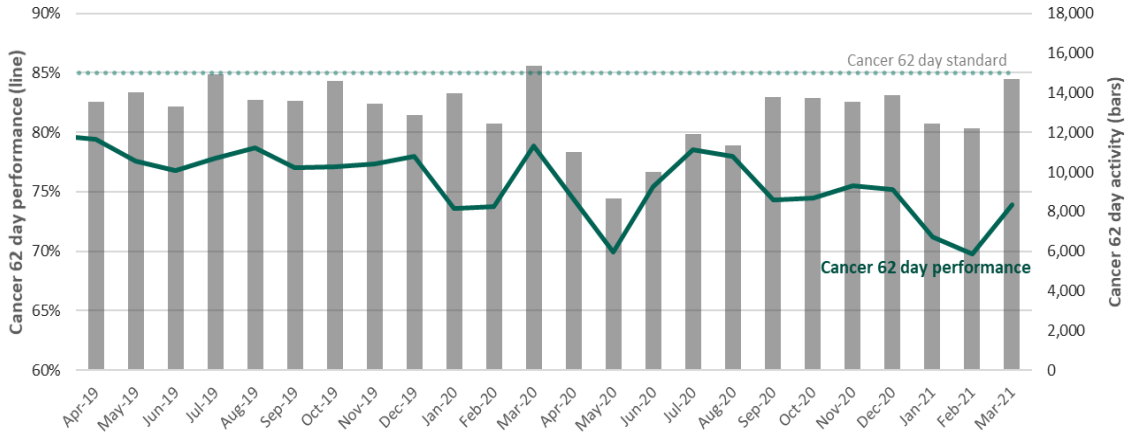
942. Early diagnosis and treatment are crucial to improving survival rates for cancer. The key cancer waiting time standards cover different elements of the pathway, to ensure patients benefit from better access to cancer services. Increasing the number of people coming forward with cancer symptoms has been highlighted as part of the 'Help Us Help You' campaign. Consequently, following a dip in cancer referrals during the early stages of the pandemic, urgent GP referrals for cancer were the highest ever recorded in March 2021 with over 200,000 referrals, on

average, over 10,000 patients each working day. This is 26.4% higher than March 2020.

943. NHS England's Cancer Recovery Plan set out the aims and actions needed to recover from the impact of COVID-19, while the NHS Long Term Plan remains the detailed strategy for cancer services and will continue to apply after the pandemic. The NHS Long Term Plan sets out an ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half to three-quarters of cancer patients.

944. As shown in **Figure 14**, the standard - that 85% of patients begin first treatment within 62 days of an urgent GP referral for suspected cancer - was not met in any month of 2020-21 or 2019-20 and was last met in December 2015.

**Figure 14: 62-day GP Referral to First Treatment of Cancer Performance, April 2019 to March 2021**



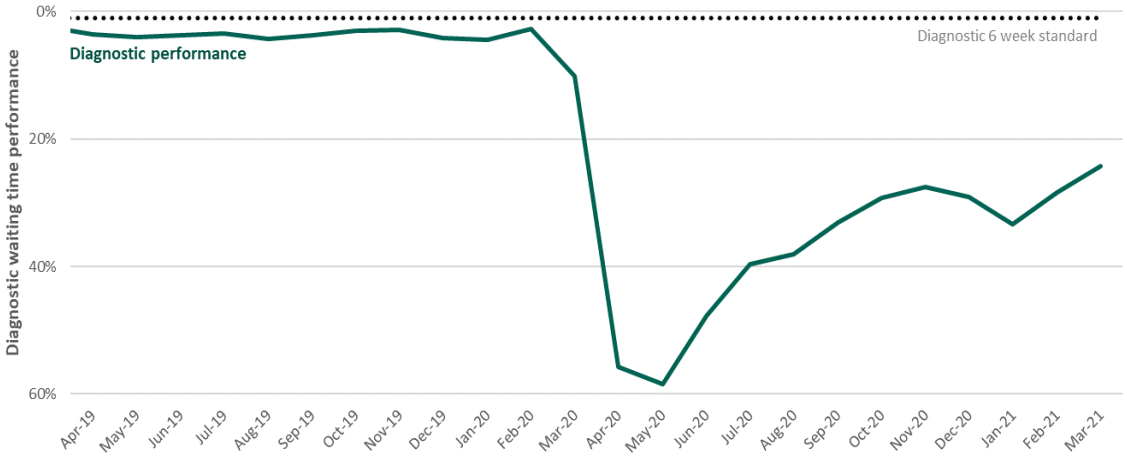

Standard – 85% of patients receiving a first treatment for cancer following a GP urgent referral.

## Diagnostic Tests

945. Waiting times for diagnostic tests are an important contributor to all NHS (including cancer) treatment, because most patients require a diagnostic test to determine whether and what treatment is necessary. As shown in **Figure 15**, the standard that less than 1% of patients should be waiting more than six weeks for a diagnostic test at the end of the month was not met in any month in 2020-21 for the 15 diagnostic tests measured. However, the majority of patients were seen within the diagnostic standard of six weeks, despite the pressures of the pandemic.

946. The number of tests carried out decreased by 22.9% from 23.2 million in 2019-20 to 17.9 million in 2020-21. The drop in performance can be attributed to the impact of COVID-19 and the resulting decrease in tests over the pandemic period. Going forward, steps are being taken to improve this with additional capital and revenue funding made available to deliver diagnostic capacity.

**Figure 15: Diagnostic test wait times performance, April 2019 to March 2021**




Standard is less than 1% of patients wait more than 6 weeks for a diagnostic test.

## Delayed Transfers of Care

947. A delayed transfer of care (DTOC) is defined as when a patient is ready to depart from hospital care but is still occupying a bed. This government is clear that no-one should stay in a hospital bed longer than necessary.

948. Due to COVID-19 and the need to release capacity across the NHS to support the response, NHSE and NHSI paused the collection and publication of some of their official statistics, including on Delayed Transfers of Care. More information can be found on the NHS England and NHS Improvement website.

949. NHSE and NHSI are keeping the list of affected data under review to establish whether further collections should be reinstated or paused.

## Annex D – Department of Health and Social Care Official Development Assistance

950. The following section focusses on Official Development Assistance (ODA) spend. 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 30 different DAC members including the UK.

951. The rules set by the OECD ensure international comparability and consistency in the reporting of ODA among the DAC members. Under the rules, spend must be reported on a calendar-year basis to provide comparable data (and take account of the fact that financial years vary across members). The rules also state that ODA spend must be recorded on a cash basis (not accruals).

952. **Table 58** shows how the Department spent ODA funding in the 2020 calendar year.

### Table 58: Official Development Assistance

| |
|---|
| The Department of Health and Social Care provided £247 million of Official Development Assistance (ODA) in 2020. Figures are provisional, taken from Statistics on International Development: Provisional UK Aid Spend 2020 |
| The Department of Health and Social Care did not spend any cross-government ODA funds in 2020. |
| In support of the UK Aid Strategy, Department of Health and Social Care's (DHSC's) ODA activities focused on the areas of global health research, global health and health security.<br><br>The National Institute for Health Research (NIHR) Global Health Research (GHR) portfolio was established to support high-quality applied health research for the direct and primary benefit of people in low and middle-income countries (LMICs). The portfolio aims are delivered through a mix of researcher-led and commissioned calls delivered by NIHR and through partnerships with other global health research funders, through initiatives to develop and advance global health research and career pathways both in LMICs and in the UK. Together these activities have positioned the NIHR as a key player in supporting high-quality global health research.<br><br>Throughout 2020 the impact of the COVID-19 pandemic was seen across the existing portfolio and a number of ongoing NIHR funded research teams were able to rapidly pivot their activities to provide evidence for local, national and international COVID response.<br><br>We joined UKCDR COVID-circle to co-ordinate funding efforts, connect networks of researchers, and collate learnings to inform future epidemic and pandemic responses with a focus on lower-resource settings.<br><br>We also provided new contributions to funding schemes to address COVID-19 research: |

- The new rapid response Global Effort on COVID-19 (GECO) calls with UKRI, aimed at supporting applied health research that will address COVID-19 knowledge gaps by understanding the pandemic and mitigating its health impacts in LMIC contexts.
- Contribution to the Mobilisation of funding for COVID-19 research in sub-Saharan Africa – 2020 with European and Developing Countries Clinical Trials Partnership (EDCTP) to support research activities in sub-Saharan Africa to manage and/or prevent the spread of the current COVID-19 outbreak.
- Research for Health in Humanitarian Crises COVID-19 rapid response call, funded by FCDO, Wellcome and DHSC through ELRHA - see here for more information.

The GHR funding portfolio continued to expand in 2020, with the following highlights:

**NIHR Global Health Research Units and Groups** – The NIHR continues to support 13 Global Health Research Units and 40 Global Health Research Groups to generate high quality global health research focusing on health issues that affect the poorest people in LMICs, through equitable partnerships between UK and LMIC researchers.

The NIHR Research and Innovation for Global Health Transformation (RIGHT) programme funds interdisciplinary applied health research in key areas in ODA-eligible countries where a strategic and targeted investment can result in a transformative impact. In 2020, the programme's second call awarded six new research contracts for applied research on the development and evaluation of interventions to improve outcomes for those affected by mental health issues.

The NIHR Global Health Policy and Systems Research (Global HPSR) programme was launched in 2019 with the aim to support research into health systems which is directly and primarily of benefit to people in LMICs. In 2020 the first Global HPSR Commissioned Awards began: five projects were funded with a focus on improving access to appropriate and affordable health services across the lifespan. This built on the 17 active Global HPSR Development Awards which fund developing equitable partnerships, engaging stakeholders and identifying research priorities.

**NIHR Global Health Research Partnerships**
In 2020, the NIHR worked in partnership with 15 other global funders to address health challenges relevant to people in LMIC settings in areas of unmet need.

Key highlight areas include:
- With the Medical Research Council (MRC), NIHR supported joint funding for two research calls in 2020 to address the burden of maternal and neonatal mortality and morbidity (7 full projects and 13 seed projects), and adolescent health in LMICs (11 projects).
- With the World Bank to fund the Global Road Safety Facility (GSRF) which aims to address the growing public health crisis of road traffic deaths and injuries in LMICs through supporting the scale-up of scientific, technological and managerial capacities to effectively manage road safety.
- With Research for Health in Humanitarian Crises - Elrha (R2HC) to deliver phase 4

of funding, aimed at developing more effective responses to humanitarian challenges by providing significant funding for high-quality research on the effectiveness of health interventions in humanitarian crises.

- With Grand Challenges Canada (GCC), NIHR supported three new Transition to Scale (TTS) mental health projects in India, Liberia and Peru which aim to support bold solutions that provide evidence-based, person-centred mental health services in community-based settings. The NIHR also supported 12 seed funding awards aiming to provide proof-of-concept grants focused on new ideas that have the potential to transform mental health services available for youth in LMICs.
- With MRC, Wellcome and the Foreign, Commonwealth and Development Office (FCDO) funded 5 full trials and 6 development awards through the Joint Global Health Trials in 2020, on topics including menstrual health, malaria and nutrition.

**Supporting research capacity building and training in LMICs:**

- NIHR Global Research Professorships –This programme funds research leaders of the future with a position affiliated to a UK university to promote effective translation of research and to strengthen research leadership at the highest academic levels, providing support for a small team as the building blocks of an independent academic research career in global health. In 2020, two Professorships continued, and a third Global Professorship was contracted, focussing on preventing invasive salmonella disease in Africa.
- With the Royal Society of Tropical Medicine and Hygiene (RSTMH) small grants scheme, 102 awards were supported for early career researchers. All of these awards were granted to LMIC nationals, covering 23 different countries across sub-Saharan Africa, Latin America and southeast Asia and researching topics such as neglected tropical diseases and chronic respiratory disease.
- With the WHO Special Programme for Research and Training in Tropical Diseases (TDR), the AMR SORT IT programme aims to build sustainable operational research capacity to generate and utilize evidence on the emergence, spread and health impact of antimicrobial resistance, in order to limit this public health problem.
- The NIHR-Wellcome Global Health Research partnership jointly funded eight new International Fellowships directly to LMIC applicants and three new policy awards with areas of global health research priority including mental health, multimorbidity, non-communicable diseases, nutrition and snakebite.

**NIHR provides support funding for established alliances that underpin global health research:**

- As an Associate Member of the Global Alliance for Chronic Diseases (GACD), the Department of Health and Social Care (DHSC) pays an annual fee to support the activities of the GACD and supports the GACD secretariat. Awards are ongoing across previous calls focused on mental health and scaling up interventions tackling prevention of diabetes, hypertension and heart disease.

These strategic investments contribute to the portfolio of high-quality global health research focused on health issues of people living in LMICs and pandemic response

supported through the Global Health Research ODA budget in 2020.

The Global Health Security programme contributes to the UK Aid Strategy, specifically, 'strengthening resilience and response to crises', to ensure a world safe and secure from infectious disease threats and promotion of Global Health as an international security priority.

Assistance was focused on:

The Fleming Fund - This project supports low- and middle-income countries (LMICs) in Africa and Asia to generate, share and use anti-microbial resistance (AMR) data, to enable countries to optimise the use of antibiotics and reduce drug resistance. Fleming Fund is improving laboratory capacity and diagnosis and building sustainable surveillance systems at a country level through a One Health approach, covering human and animal health and agriculture sectors, in places where drug resistant infections have a disproportionate effect. In 2020, the most significant areas of ODA spend were:

- **Surveillance and data:** development of country grants in 22 priority countries, of which 22 country grants and 11 regional grants were active in supporting the collection of AMR data. 240 labs supported (including human, animal and environmental); 13 FF countries submitting data into the Global Antimicrobial Resistance Surveillance System ( GLASS). GLASS promotes and supports a standardised approach to the collection, analysis and sharing of AMR data at a global level by encouraging and facilitating the establishment of national AMR surveillance systems that are capable of monitoring AMR trends and producing reliable and comparable data.
- **Global guidance, protocols and governance:** support to the key tripartite multilateral organisations: the World Health Organization (WHO), the World Organisation for Animal Health (OIE), and the Food and Agriculture Organization (FAO). Nine global protocols and guidance for AMR surveillance were developed and implemented in countries with the direct support of the Fund.
- **Awareness and advocacy:** In 2020 the Global Research on Antimicrobial resistance (GRAM) Project submitted 4 articles to peer reviewed journals including a significant output on trends in global Antimicrobial Consumption.
- **Partnerships, capacity building and technical assistance:** 131 professional and policy fellows have been selected and the Commonwealth Partnerships for Antimicrobial Stewardship scheme trained and tested 1024 clinical staff in 4 countries who demonstrated improved Antimicrobial Stewardship knowledge after the training.
- **Adaptive management, learning and evaluation:** The third evaluation report was produced by the independent evaluation supplier supporting DHSC and the Management Agent is to adapt and improve programme delivery based on learning to date.

UK Vaccine Network – This project is focused on targeted investments to support the development of new vaccines and vaccine technologies for diseases of epidemic potential in LMICs. It provides DHSC ODA-funding to support a portfolio of research

projects, with investments guided by a multi-disciplinary advisory group. In 2020, the most significant areas of spend were:

- Pre-clinical and Clinical stage vaccine development projects funded through three Small Business Research Initiative (SBRI) competitions managed by Innovate UK.
- Clinical-stage vaccine development projects funded through a Biotechnology and Biological Sciences Research Council (BBSRC) / Medical Research Council (MRC) Intramural Centre competition and managed by the National Institute for Health Research (NIHR, NETSCC).
- Two vaccine manufacturing research hubs funded through an Engineering and Physical Sciences Research Council (EPSRC) managed competition.
- A financial commitment to the Coalition for Epidemic Preparedness Innovations (CEPI).
- A research competition run by BBSRC to support One Health approaches to accelerate vaccine development.
- An Epidemiology for Vaccinology competition run by NIHR (CCF) which seeks to develop epidemiological models, tools and technologies to assist with development and clinical trialling of vaccines in outbreak situations in LMICs.
- Re-orienteering existing UKVN-funded research projects to support the COVID-19 response, provided this research was ODA-eligible.

An early success of the UKVN was highlighted in 2020, as the UKVN's 2016 investment in Middle East respiratory syndrome (MERS) research through Oxford University proved instrumental to the development of the UK's Oxford COVID-19 vaccine. Using domestic NIHR funding, our partner institution, Oxford University, was able to rapidly re-orient their vaccine technologies, which they developed for MERS, to work on COVID-19.

**UK Public Health Rapid Support Team (UK-PHRST)** – The UK Public Health Rapid Support Team (UK-PHRST) is funded by DHSC and delivered as a partnership between Public Health England and the London School of Hygiene and Tropical Medicine. It works to address the threat posed by outbreaks of infectious disease within ODA-eligible countries through an integrated triple remit, incorporating outbreak response, innovative research to inform best practice in disease interventions, and capacity development to help improve countries' preparedness and response.

Under the response element of its remit, the UK-PHRST identifies situations where deployment of specialist expertise can mitigate threats and can rapidly deploy a team of multidisciplinary public health professionals and researchers to an ODA-eligible country. It aims to be ready to deploy a team in as little as 48 hours of a requirement being identified. Early in 2020, deployments were made to support preparedness and response for COVID-19, to the Philippines and Nepal, the WHO African Regional Office, and the headquarters of Africa Centres for Disease Control and Prevention. Limitations on physical deployments imposed by international travel restrictions then led to the development of new and innovative ways of continuing UK-PHRST support with partners remotely. Later in the year, deployments were made to support the COVID response in Tajikistan, Bangladesh (the Rohingya refugee camps in Cox's Bazar) and The

Gambia.

Research and capacity development activities have also continued throughout 2020. Research projects have included those focused on COVID response, as well those focused on other diseases that continue to threaten developing countries, like Lassa Fever and Ebola, and outbreak response more generally. Capacity development activities have included the training of local public health staff whilst on physical deployment and the development of online training materials.

**International Health Regulations (IHR) Strengthening Project** - The International Health Regulations (IHR) Strengthening Project is funded by DHSC and delivered by Public Health England. It works with six partner countries (Ethiopia, Myanmar, Nigeria, Pakistan, Sierra Leone and Zambia) as well as regional organisations (such as Africa Centres for Disease Control and Prevention, and the Eastern Mediterranean Public Health Network) to improve compliance with the WHO International Health Regulations (IHR 2005) by helping to build the capacity and capability of health systems to prepare, detect and respond to public health emergencies.

In 2020 the Project continued to provide expert public health support to partner countries and regional organisations, helping to strengthen systems, workforces and leadership, both specifically in relation to the COVID-19 threat and for broader IHR compliance. At times when direct in-country support had to be withdrawn due to international travel restrictions effective support continued to be provided remotely.

**Global AMR Innovation Fund (GAMRIF)** – This project is focused on developing new international research and development (R&D) partnerships to support early-stage AMR R&D that will advance novel One Health AMR solutions for the benefit of people in LMICs.

In 2020, GAMRIF's spend included disbursement to:

- **Bilateral research partnerships**. This includes a programme between the UK and China, to support 14 projects delivered and managed by Innovate UK, which advances innovations for AMR. Additionally, there is a partnership between the UK and Argentina to support five research projects that are advancing research on AMR and the environment. Funding was disbursed to BBSRC for the management of this programme for the UK.
- Three **global research initiatives**, where GAMRIF partners with research institutions that will support international research competitions. This includes 14 projects with CARB-X to advance research on vaccines and alternatives for humans, 11 projects under the InnoVet AMR programme with Canada's International Development Research Centre (IDRC) on vaccines and alternatives for animals, and finally, 17 bacterial vaccinology projects with the BactiVac Network.
- Two **product development partnerships** (PDPs), including to the Foundation for Innovative New Diagnostics (FIND) and the Global Antimicrobial Research and Development Partnership (GARDP).
- Research success from GAMRIF during 2020 include: progression of GARDP Phase III

Zoliflodacin clinical trials (announced late 2019), and the FIND One Health Connectivity Pilot being installed in the government-approved hosting environment in Zambia in January 2020.

**Contribution to the Strategic Preparedness and Response Plan (SPRP) for the 2019 Novel Coronavirus (COVID-19) Outbreak -** In March 2020, DHSC provided a one-off contribution of £5m to WHO towards the Strategic Preparedness and Response Plan (SPRP) for the COVID-19 Outbreak. On 4 February 2020 WHO released their SPRP to the novel coronavirus COVID-19 and requested a UN system-wide scale up to assist countries to prepare for and respond to the outbreak. Most urgently, funding was required to cover the initial 3 months of the global response. At a country level, WHO identified 34 countries with low levels of preparedness, and therefore needed significant levels of support to ensure they were able to detect and respond to this outbreak. It was agreed that DHSC contribution would be spent in ODA-eligible countries only.

**ODA admin** – This budget funds all DHSC staff supporting ODA funded activities and their associated costs, and legal support costs as required.

**The Framework Convention on Tobacco Control 2030 (FCTC 2030) Project**

Tobacco use is the world's single most preventable cause of death and disease, and by 2030, over 80% of the world's tobacco-related mortality will be in LMICs.

The FCTC 2030 project has completed five years and is directly supporting the implementation of the WHO Framework Convention on Tobacco Control in 24 LMICs. The project is led by the WHO FCTC Secretariat based in Geneva.

Year 5 countries:

**Phase 1 countries (from years 1-5)**: Cabo Verde, Cambodia, Chad, Colombia, Egypt, El Salvador, Georgia, Jordan, Madagascar, Myanmar, Nepal, Samoa, Sierra Leone, Sri Lanka and Zambia.

**Phase 2 countries (added in year 4-5):** Armenia, Costa Rica, Eswatini, Fiji, Lao Peoples Democratic Republic. Mozambique, Serbia, Suriname and Tunisia.

The project support is helping to reduce the burden of death and disease from tobacco, and enable countries to make better use of health system resources to improve health and well-being of their populations.

The project continues to receive praise from the countries participating, the global public health and development communities, and continues to help raise the UK's profile as global leaders in tobacco control and strengthens its global reach.

Delivery plans for year 5 of the project (2020-2021) were revised due to the COVID-19

pandemic and the project delivered on the high-level objectives set by DHSC at the beginning of the year.

In 2020 the most significant areas of ODA spend were related to:

- Delivering key objectives in accordance with the agreed FCTC 2030 year five work programme.
- Funding activities at country level with Partner Parties working to their own individual workplans depending on their focus areas.
- Financial resources allocated for WHO Regional Offices on projects to advance FCTC 2030 priorities at regional level.

**The Elton John AIDS Foundation - Promoting HIV Self-testing for Young Men in Kenya project**

Kenya has the joint fourth largest HIV/AIDS epidemic in the world. Evidence has shown that men of 18 to 24 years are an important target group when tackling the epidemic.

Funded through one-year ODA spend, this Elton John AIDS Foundation project started in March 2020 and aims to close the HIV testing gap among men in Kenya by promoting HIV Self-Testing. Its objectives are:

- To innovate service delivery models linking public and private sectors through design of HIV Self-Testing promotion tools targeting young people;
- To increase uptake of HIV Self-Testing through awareness raising on self-testing services for at-risk men ages 20-34;
- To create a sustainable supply of HIV Self-Testing kits that are conveniently available and accessible for men in need of HIV Self-Testing; and
- To create an enabling environment for HIV Self-Testing scale up and sustainability by adapting and running the intervention through existing health system and structures.

**Other**

The Department of Health and Social Care pays an annual subscription to the World Health Organisation (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 agreed in New York. These scales are negotiated by the FCDO in accordance with the UN Charter and UK membership obligations. The Department of Health and Social Care has funded the first twelve months of asylum seekers healthcare costs following their arrival in the UK. These are the estimated healthcare costs of asylum seekers classified as 'Section 95', 'Section 98' and Unaccompanied Asylum- Seeking Children by the Home Office.

## Annex E – Our Arm's Length Bodies and Delivery Partners

| Organisation | Status | Website |
|---|---|---|
| **Our Executive Agencies** | | |
| Public Health England | Executive Agency | https://www.gov.uk/government/organisations/public-health-england |
| Medicines and Healthcare products Regulatory Agency[1] | Executive Agency | https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency |
| **Our Executive non-Departmental Public Bodies (NDPBs)** | | |
| NHS Commissioning Board (known as NHS England)[2] | NDPB | https://www.england.nhs.uk/ |
| NHS Improvement[2] | NDPB | https://improvement.nhs.uk/ |
| Monitor[2] | NDPB | https://improvement.nhs.uk/ |
| Care Quality Commission | NDPB | https://www.cqc.org.uk/ |
| National Institute for Health and Care Excellence | NDPB | https://www.nice.org.uk/ |
| NHS Digital | NDPB | https://digital.nhs.uk/ |
| Human Fertilisation and Embryology Authority | NDPB | https://www.hfea.gov.uk/ |
| Human Tissue Authority | NDPB | https://www.hta.gov.uk/ |
| Health Research Authority | NDPB | https://www.hra.nhs.uk/ |
| Health Education England | NDPB | https://www.hee.nhs.uk/ |
| **Our Special Health Authorities** | | |
| NHS Counter Fraud Authority | Special Health Authority | https://cfa.nhs.uk/ |
| NHS Trust Development Authority[2] | Special Health Authority | https://improvement.nhs.uk/ |
| NHS Business Services Authority | Special Health Authority | https://www.nhsbsa.nhs.uk/ |
| NHS Resolution | Special Health Authority | https://resolution.nhs.uk/ |
| NHS Blood and Transplant[1] | Special Health Authority | https://www.nhsbt.nhs.uk/ |
| **Other bodies included within the Departmental Group** | | |
| NHS Property Services Ltd | Limited company owned by DHSC | https://beta.companieshouse.gov.uk/company/07888110 |
| Community Health Partnerships Ltd | Limited company owned by DHSC | https://beta.companieshouse.gov.uk/company/04220587 |
| Supply Chain Coordination Ltd | Limited company owned by DHSC | https://beta.companieshouse.gov.uk/company/10881715 |
| Genomics England Ltd | Limited company owned by DHSC | https://beta.companieshouse.gov.uk/company/08493132 |
| Skipton Fund Ltd[3] | Limited company operated by third party | https://beta.companieshouse.gov.uk/company/05084964 |
| Nursing & Midwifery Council | Professional regulator | https://www.nmc.org.uk/ |
| Health & Care Professions Council | Professional regulator | https://www.hcpc-uk.org/ |
| Professional Standards Authority for Health and Social Care | Independent body accountable to parliament | https://www.professionalstandards.org.uk/home |

Notes

1.NHS Blood and Transplant is not included in this Annual Report and Accounts as it is designated as outside the Departmental Group by the Office for National Statistics. MHRA has now been re-categorised as falling within the Departmental Group but it will not be incorporated into the Department's accounting boundary until its establishing legislation is revoked.

2.Monitor and the NHS Trust Development Authority remain legal entities. However, since 1 April 2016, they have operated as a single organisation, NHS Improvement. In April 2019, NHS England and NHS Improvement moved to a single leadership model under the Chief Executive Officer of NHS England and single Chief Operating Officer, who is also the CEO of NHS Improvement.

3.Partners of Russel-Cooke LLP took over as Directors of Skipton Fund Ltd in September 2018, in agreement with the Department, to provide any outstanding legal and administrative functions. The Skipton Fund retained its £500,000 reserve fund, originally provided by the Department, to cover these operational costs, and it provides quarterly reports to the Department.

## Annex F - Commonly used Acronyms

| Acronym | Term |
|---|---|
| **A&E** | Accident and Emergency |
| **ALB(s)** | Arm's Length Body/Bodies |
| **AME** | Annually Managed Expenditure |
| **ARA** | Annual Report and Accounts |
| **ARC** | Audit and Risk Committee |
| **ASCOF** | Adult Social Care Outcomes Framework |
| **ATP** | Advanced Threat Protection |
| **BAM** | Bi-annual Assurance Meeting |
| **BAME** | Black and Minority Ethnic |
| **BAR** | Business Appointment Rules |
| **BAU** | Business as usual |
| **BPPC** | Better Payments Practice Code |
| **C&AG** | Comptroller and Auditor-General |
| **CAS** | Clinical assessment Service |
| **CCG** | Clinical Commissioning Group |
| **CCSMT** | Commercial Capability and Supplier Management Team |
| **CDEL** | Capital Departmental Expenditure Limit |
| **CDOC** | Cyber Defensive Operations Centre |
| **CETV** | Cash Equivalent Transfer Value |
| **CFERs** | Consolidated Fund Extra Receipts |
| **CGF** | Credit Guarantee Finance |
| **CIR** | Critical Infrastructure Risk |
| **CNSC** | Clinical Negligence Scheme for Coronavirus |
| **CNSGP** | Clinical Negligence Scheme for General Practice |
| **CNST** | Clinical Negligence Scheme for Trusts |
| **COO** | Chief Operating Officer |
| **CPA** | Consolidated Provider Accounts |
| **CPI** | Consumer Price Index |
| **CQC** | Care Quality Commission |
| **CRO** | Chief Risk Officer |
| **CRS** | Clinical Review of Standards |
| **CSCNE** | Consolidated Statement of Comprehensive Net Expenditure |
| **CSOC** | Cyber Security Operations Centre |
| **CSOPS** | Civil Servant and Other Pension Scheme |
| **CTIS** | Coronavirus Temporary Indemnity Scheme |
| **D&I** | Diversity and Inclusion |
| **DAC** | Development Assistance Committee |
| **DEL** | Departmental Expenditure Limit |
| **DELTA** | Disability Empowers Leadership Talent scheme |
| **DG** | Director General |
| **DHSC** | Department of Health and Social Care |
| **DHSC AFU** | DHSC Anti-Fraud Unit |

| | |
|---|---|
| **DRC** | Depreciated Replacement Cost |
| **DSPT** | Data Security and Protection Toolkit |
| **DTOC** | Delayed Transfer of Care |
| **DTUS** | Departmental Trade Union Side |
| **ED** | Emergency Department |
| **EEA** | European Economic Area |
| **ELS** | Existing Liabilities Scheme |
| **ENDPB** | Executive Non-Departmental Public Body |
| **EU** | European Union |
| **EXCO** | Executive Committee |
| **FIS** | Functionally Interchangeable Stock |
| **FLS** | Future Leaders Scheme |
| **FOI** | Freedom of Information |
| **FReM** | Financial Reporting Manual |
| **FT** | Foundation Trust |
| **GAD** | Government Actuary's Department |
| **GCO** | Government Commercial Organisation |
| **GIAA** | Government Internal Audit Agency |
| **GMPP** | Government Major Projects Portfolio |
| **GPA** | Government Property Agency |
| **GRAA** | Government Resources and Accounts Act 2000 |
| **HCHS** | NHS Hospital and Community Health Service |
| **HCID** | High Consequence Infectious Disease |
| **HEE** | Health Education England |
| **HFSS** | High in Fat, Sugar and Salt |
| **HGIAS** | Health Group Internal Audit Service |
| **HIP** | Health Infrastructure Plan |
| **HMRC** | HM Revenue & Customs |
| **HMT** | HM Treasury |
| **HRA** | Health Research Authority |
| **HSIB** | Healthcare Safety Investigation Branch |
| **HTA** | Human Tissue Authority |
| **IBNR** | Incidents Incurred but Not Reported |
| **ICS** | Integrated Care Systems |
| **IFRS** | International Financial Reporting Standards |
| **IMAS** | Interim Management and Support |
| **IMD** | Index of Multiple Deprivation |
| **IMMDS** | Independent Medicines and Medical Devices Safety Review |
| **IPA** | Infrastructure and Projects Authority |
| **IPC** | Infection Protection Control |
| **ISAs** | International Standards on Auditing |
| **ITP** | Interdepartmental Talent Partnership |
| **LFD** | Lateral Flow Device |
| **LGD** | Lead Government Department |
| **LIFT** | Local Improvement Finance Trust |
| **LSOA** | Lower-layer Super Output Area |

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| **LTPS** | Liability to Third Parties Scheme |
| **MEA** | Modern Equivalent Asset |
| **META** | Minority Ethnic Talent Association |
| **MHCLG** | Ministry of Housing, Communities and Local Government |
| **MHRA** | Medicines and Healthcare products Regulatory Agency |
| **MPM** | Managing Public Money |
| **MTP** | Maternity Transformation Programme |
| **NAO** | National Audit Office |
| **NCR** | Net Cash Requirement |
| **NDPBs** | Non-Departmental Public Bodies |
| **NED** | Non-Executive Director |
| **NERVTAG** | New and Emerging Respiratory Virus Threats Advisory Group |
| **NGO** | National Guardian's Office |
| **NHS** | National Health Service |
| **NHSBSA** | NHS Business Services Authority |
| **NHSBT** | NHS Blood and Transplant |
| **NHSCFA** | NHS Counter Fraud Authority |
| **NHSD** | NHS Digital |
| **NHSE and NHSI** | NHS England and NHS Improvement |
| **NHSOF** | NHS Outcomes Framework |
| **NHSR** | NHS Resolution |
| **NHSTT** | NHS Test and Trace |
| **NIBSC** | National Institute of Biological Standards and Control |
| **NICE** | National Institute for Health and Care Excellence |
| **NICs** | National Insurance Contributions |
| **NIHR** | National Institute for Health Research |
| **NRR** | National Risk Register of Civil Emergencies |
| **OBR** | Office of Budget Responsibility |
| **OCM** | Operational Contract Managers |
| **ODA** | Official Development Assistance |
| **OECD** | Organisation for Economic Co-operation and Development |
| **OHID** | Office for Health Improvement and Disparities |
| **OHP** | Office for Health Promotion |
| **ONS** | Office for National Statistics |
| **OSCAR** | Online System for Central Accounting and Reporting |
| **PAC** | Public Accounts Committee |
| **PCPF** | Parliamentary Contributory Pension Fund |
| **PCSPS** | Principal Civil Service Pension Scheme |
| **PCT** | Primary Care Trust |
| **PDC** | Public Dividend Capital |
| **PES** | Property Expenses Scheme |
| **PFI** | Private Finance Initiative |
| **PHE** | Public Health England |
| **PHOF** | Public Health Outcomes Framework |
| **PHSO** | Parliamentary and Health Service Ombudsman |
| **PPE** | Personal Protective Equipment |

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|---|---|
| **PQ** | Parliamentary Question |
| **PRC** | Performance and Risk Committee |
| **PYLL** | Potential years of life lost |
| **R&D** | Research and Development |
| **RDEL** | Resource Departmental Expenditure Limit |
| **RICS** | Royal Institution of Chartered Surveyors |
| **RTT** | Referral to Treatment |
| **SaBTO** | The Advisory Committee on the Safety of Blood Tissues and Organs |
| **SAGE** | Scientific Advisory Group for Emergencies |
| **SCCL** | Supply Chain Coordination Limited |
| **SCS** | Senior Civil Servant |
| **SDP** | Single Departmental Plan |
| **SFVS** | School Fruit and Vegetable Scheme |
| **SLS** | Senior Leaders Scheme |
| **SoCNE** | Statement of Comprehensive Net Expenditure |
| **SoFP** | Statement of Financial Position |
| **SOPS** | Statement of Outturn against Parliamentary Supply |
| **SpHA** | Special Health Authorities |
| **SR** | Spending Review |
| **SRO** | Senior Responsible Officer |
| **STP** | Sustainability and Transformation Partnership |
| **TCA** | Trade and Cooperation Agreement |
| **TDA** | NHS Trust Development Authority |
| **TDEL** | Total Departmental Expenditure Limit |
| **UCAS** | Universities and College Admissions Service |
| **UKHSA** | UK Health Security Agency |
| **UKRI** | UK Research and Innovation |
| **VSIG** | Valproate Safety Implementation Group |
| **WAC** | Weighted Average Cost |
| **WHO** | World Health Organisation |
| **WTE** | Whole Time Equivalent |
| **YEUK** | Youth Employment UK |

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