Department of Health & Social Care

Department of Health and Social Care

Annual Report and Accounts 2017-18

(For the period ended 31 March 2018)

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

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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 2017-18 and the document Public Expenditure: Statistical Analyses 2017 - present the Government's outturn for 2017-18 and planned expenditure for 2018-19.

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Permanent Secretary's Overview

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

This year has again been challenging for the health and care system, treating a record number of patients, with the system working to strike the right balance across performance, transformation, quality and safety and living within its financial means.

The health and care system, despite the challenge, has once again delivered financial balance by building on the financial rigour and efficiency measures set in 2016-17, with the majority of NHS provider organisations meeting their control totals in 2017-18.

Despite the endeavours of those working in the NHS many of the key waiting time and performance targets have not been achieved in 2017-18. Focus on measures to recover performance has begun, with additional funding to support urgent and emergency care secured in the spring. Long-term sustainable improvements, maximising resources, minimising waste to improve services will be essential to balance the health and care needs over the coming years whilst maintaining financial balance.

As the NHS reaches its 70th birthday, additional funding has been secured, with the NHS receiving an average of 3.4 per cent real terms funding increase over the next five years, helping to secure the long term future of the health service.

2017-18 has seen the Department of Health become the Department of Health and Social Care, with the move of long-term social care strategy back to the Department. We have made good progress towards our vision for the Department's future, enhancing our role as a great Department of State leading the health and care system effectively.

I would like to take this opportunity to extend my personal thanks to 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 Department and the wider health and care system.

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

Our Role and Purpose

1. The Department of Health and Social Care (DHSC) supports the Government's Health Ministers in leading the nation's health and care to help people live healthier lives for longer ensuring that people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.

2. As a Great Department of State, we support the NHS to ensure efficient, productive, safe, timely and high quality hospital care; whilst transforming out of hospital care to keep people living better for longer in their community. Additionally, we stay at the cutting edge of medicine and support the outstanding work of over 1.2 million staff within the health and care system, whilst training the workforce of tomorrow. In doing this, we remain accountable for the health and care system to Parliament and the taxpayer, getting the most out of every taxpayer pound spent.

3. We support and advise our Ministers to shape policy, set direction and to lead key strategic debates, while remaining accountable for delivering our commitments, acting as guardians of the health and care framework and as trouble-shooters (to take action when necessary to solve complex issues). 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, ensuring that we are all working with one focus – the people who use our services.

4. 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 (NHSE) and NHS Improvement (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 for a better health and care workforce;
    - Public Health England (PHE) who protect and improve the nation's health and wellbeing, and reduce health inequalities; and
    - The Care Quality Commission (CQC) who monitor, inspect and regulate the health and social care service.

5. 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.

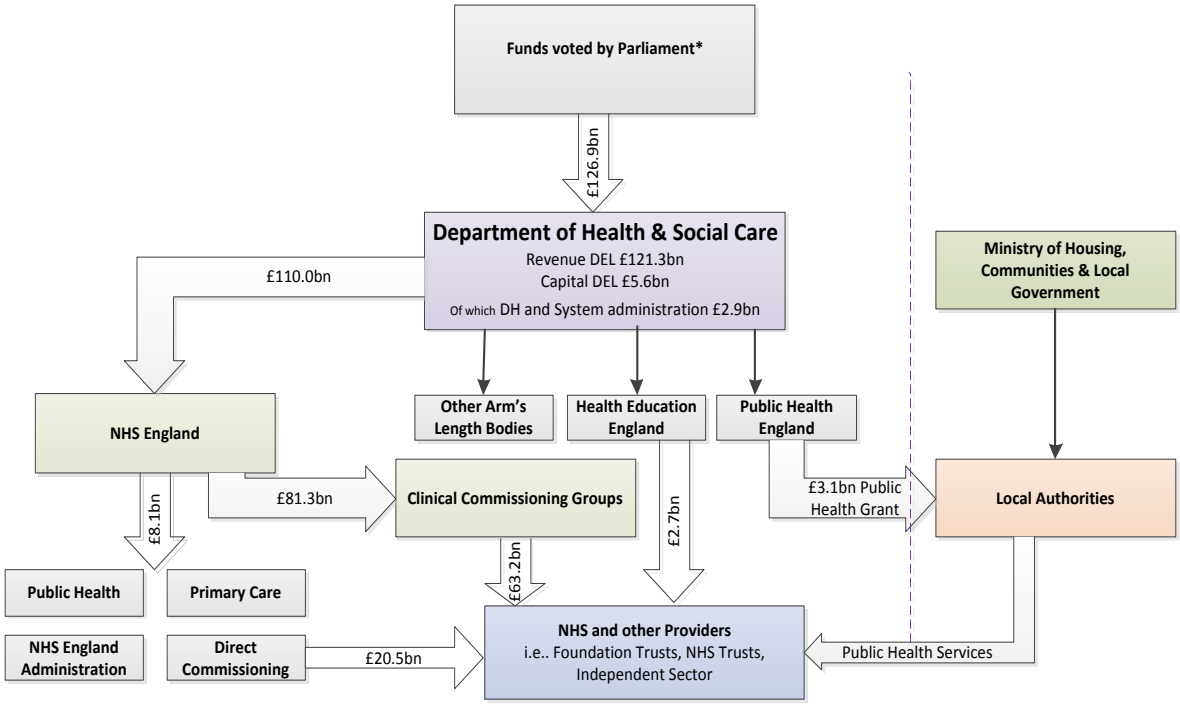
6. The Secretary of State for Health and Social Care and other Departmental Ministers are accountable to Parliament for the provision of the comprehensive health and care service in England. To enable the system to work flexibly; the critical day-to-day operational decisions are made by the professionals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

7. The Department's Counter Fraud Strategic Plan sets out work to tackle fraud across the healthcare system through to 2020, as we move towards raising standards and improving care for all. The Counter Fraud Strategic Plan is supported by a dedicated network of counter fraud professionals across the health group.

8. We secure funds for health and care services and remain accountable for this funding, which is allocated to the most appropriate local level. In the last financial year, the Department has allocated revenue of £120.7 billion and invested a further £5.2 billion in capital funding such as new hospitals and equipment. **Figure 1** demonstrates how funding flows round the system, using budgeted figures for 2017-18 for contextual purposes.

9. 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) remains accountable for the allocation of those funds to local authorities.

Figure 1: Flow of funding in the health and care system, 2017-18 (Budgeted Position)



*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.
Dashed line indicates boundary of consolidation for DHSC and shows Local Authority funding to Health.

Our 2017-18 Achievements - At a glance

Over 500,000 more A&E attendances managed than in 2016-17

Published **Children and Young People's Mental Health** Green paper December 2017

88.3% of GP practices offering partial or fully extended opening hours

*(On target for **100%** by **2020**)*

£7.38bn of health and social care budgets pooled into **Better Care Fund**

95% uptake of MMR vaccination in England for the first time

54,790 genomes sequenced by March 2018. On track for 100,000 by December 2018)

80% of social care providers rated as **Good** or **Outstanding** by CQC

Over **725,000** participants recruited for vital health research through NIHR Clinical Research Network

1.8% increase in NHS workforce. (Jan 17 – Jan 18)

Introduced Soft Drinks Industry Levy in support of Childhood Obesity Plan

2017-18 - Key Finance Facts

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

£2.1bn funding increase in NHS sector

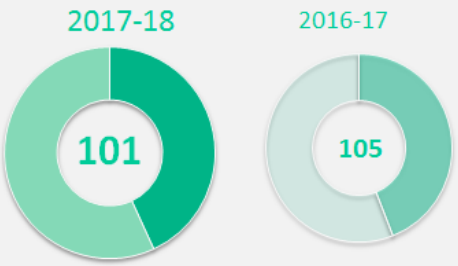
(Compared to 2016-17)

The NHS broadly delivered overall **financial balance**

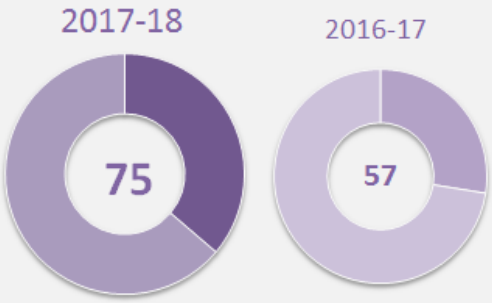
£1.8bn Sustainability and Transformation Fund

helping to sustain NHS Providers

Number of **providers** in **deficit**

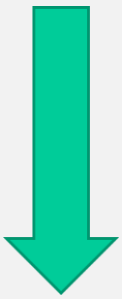


£5.5bn (gross) **investment in capital**



Number of CCGs with overspends
(after the release of the 0.5% risk reserve)

£14.8bn underspend against the **AME budgetary control**



Performance Summary

10. This performance summary and the role and purpose section provide information about the Department, our purpose and how we have performed during 2017-18.

11. The Department has a Single Departmental Plan (SDP)[1], which sets out the work we are committed to achieving to improve the health and social care system over the course of this Parliament but which has a particular focus on the actions we have committed to in 2017-18. The Department's national partner organisations are key to the successful implementation of many of these priorities and where they 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, patients and the public. An updated SDP has subsequently been published setting out our focus for 2018-19 and beyond[2].

12. The SDP was developed in conjunction with our ministerial team and sets out the strategic direction for the health and social care system with clear objectives, milestones and metrics to deliver the Secretary of State's priorities and the NHS Five Year Forward View[3]. It provides the foundation for how we measure our progress and the structure for our quarterly reporting to our Departmental Board and its sub-committees.

Single Departmental Plan 2017-18 Objectives

The Department of Health and Social Care supports Ministers in leading the nation's health and social care and helping people live more independent, healthier lives for longer by:

1. **Keeping people healthy and supporting economic productivity and sustainable public services**
2. **Transforming out-of-hospital care to keep people living better for longer in their community**
3. **Supporting the NHS to deliver high quality, safe and sustainable hospital care and securing the right workforce**
4. **Research and innovation to maximise health and economic productivity**
5. **Ensuring accountability of the health and care system to Parliament and the taxpayer; and creating an efficient and effective Department of Health and Social Care**

13. The SDP is focussed both on the short-term objectives that we are committed to deliver across the year, and on the long-term ambitions that they underpin. In this report we will give an overview of performance in 2017-18 against both the short and long-term progress on our five strategic objectives.

14. The success of the health and social care system is judged against a range of measures spanning multiple domains. In the simplest form, the key to success is to strike the right balance across performance, transformation, quality and safety, and finance.

15. The challenges we face in delivering our objectives and achieving the right balance in doing so are well known and are shared by health and care systems across the world. An

[1] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan
[2] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan/department-of-health-and-social-care-single-departmental-plan
[3] https://www.england.nhs.uk/ourwork/futurenhs/

ageing population coupled with the increasing complexity of illness, contributes to rising demand for services across the system. Rapid medical and technological advances allow us to treat more people but historically has often been at greater cost. Recent breakthroughs offer the potential for technology to both improve outcomes and reduce costs. We must therefore respond to these challenges but we do so against the backdrop of ongoing EU exit negotiations, bringing both challenge and opportunity.

16. The demand for services continues to rise above what would be expected from population growth and demographics alone, with a record number of patients treated this year, placing unprecedented pressure on the NHS. In 2017-18, 23.9 million people attended an A&E in England, an increase of 2.2% on 2016-17. 70,000 more people received an urgent GP referral for cancer, and 120,000 more calls were placed to NHS 111 every month from December to March. Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2017-18, including A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards.

17. Throughout 2017-18 we have developed and put in place measures to improve performance, including £100 million additional funding in the 2017 Spring Budget to support improvements in urgent and emergency care, in the short term and allow us to focus on the long-term solutions needed for sustainable improvement, including work to reduce waste in NHS spending.

18. On 18 June 2018, the Prime Minister announced a new 5-year funding settlement for the NHS, supported by a new 10-year long-term plan. We look forward to seeing the NHS plan in response to this announcement later this year.

19. The NHS will receive increased funding of £20.5 billion in real terms per year by the end of the 5 years compared to today – an average 3.4 per cent per year overall – in a move to secure the future of the health service as it approaches its 70th birthday.

20. This year a number of steps have been taken towards keeping people healthier to support sustainable public services**.** Smoking prevalence is now at the lowest rate since records began and we have put in place plans to reduce it even further. The Government has also introduced a Soft Drinks Industry Levy alongside other actions to implement the Childhood Obesity Plan.

21. January 2018 saw the Department of Health become the Department for Health and Social Care, with an additional Ministerial position for Social Care created, to help the Department deliver an even clearer focus on adult social care. The change signals the move of long-term social care strategy back to the Department with the upcoming Green Paper, and is a reminder of the challenge to work across organisational boundaries so we can make the links work better across the health and care system, including working more closely with Local Authorities to deliver social care

22. The safety and quality of care that patients received has remained a priority. The Care Quality Commission (CQC) continued to inspect NHS acute hospitals, GP practices and social care provider locations this year. This year also saw the launch of the new Health and Safety Investigation Branch which is described under Objective 3 at page 20.

23. Despite increasing activity during the year, the NHS balanced its financial budget through continuing focus on financial rigour and efficiency, with the majority of Trusts once again meeting their control totals. This contributed to the Department delivering the 2017-18 financial outturn within the Parliamentary vote. This level of rigour will need to continue in future years to support long-term financial sustainability.

24. A more detailed analysis of the Department's performance in 2017-18 is presented in the following section, including further analysis on the delivery of our key objectives and progress against the objectives set out in our SDP. The SDP includes some longer term objectives meaning some areas are more mature in terms of deliverables than others and the presentation of analysis that follows reflects this. Details of our performance against outcomes frameworks is contained in the Secretary of State's Annual Report.

Performance Analysis

25. This performance review covers the performance of the health and care system in 2017-18, including delivery of our five objectives and progress against the SDP.

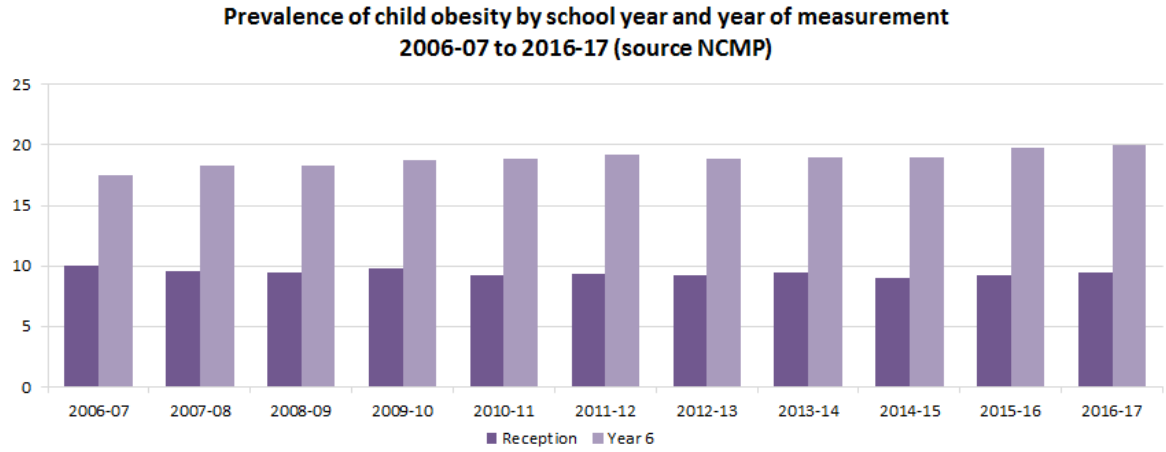
Objective 1: Keeping people healthy and supporting sustainable public services

26. The Department continues to look at how to keep people healthy for as long as possible and the health improvement and prevention programmes remain key to this objective. Considering the long-term sustainability of public services to support long-term health also remains a key part of this objective, particularly in the context of exiting the EU.

27. Smoking prevalence has continued to decline with the latest smoking prevalence amongst adults standing at 15.5%. The Department published the Tobacco Control Plan for England in July 2017[4], which included a number of ambitions for reductions in prevalence over the five year lifetime of the plan, including to reduce adult smoking from 15.5% to 12% or less; reduce smoking in pregnancy from 10.7% to 6% or less; reduce smoking amongst 15 year olds from 8% to 3% or less; and to reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.

28. The latest available data shows that the prevalence of child obesity is continuing to rise. Efforts to reverse this trend have continued, including work to implement the Childhood Obesity Plan[5], with new baseline data published and targets for sugar reformulation agreed. Further measures introduced by the Government this year have included a Soft Drinks Industry Levy[6], the launch of a food calorie reduction programme, the appointment of a Policy Research Unit into Childhood Obesity, and the doubling of the school sports premium.

Figure 2: Prevalence of child obesity



[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022__2_.pdf
[5] https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action
[6] https://www.gov.uk/guidance/soft-drinks-industry-levy

29. The Government delivers several Healthy Food Schemes – Healthy Start, School Fruit & Vegetable and the Nursery Milk schemes, which aim to provide children with nutritional support and to encourage good eating habits from an early age.

Healthy Food Schemes
319,000 people taking up Healthy Start vouchers
7,000 Pregnant women, new mothers and children under 4 in receipt of Healthy Start Vitamins
47,000 Childcare settings registered for the nursery milk scheme
445 million pieces of fruit & veg distributed to **2.3 million** children across 16,000 schools

30. In December 2017, we published our consultation on a new system for organ and tissue donation[7], in which people would be considered willing to be an organ donor after their death unless they have 'opted out' in order to address the shortage of donors in this country for the around 6,000 people waiting for a transplant. We particularly sought views on the role of the family when someone has decided to donate their organs and tissues, what safeguards we should put in place, and how a new system might affect certain groups depending on age, disability, race or faith. We expect to publish our response to the consultation later in summer 2018.

31. In October 2017, Government published the Race Disparity Audit[8], building on work across 12 departments, including the Department of Health and Social Care, ensuring that the health sector is fully represented in this powerful new dataset, which will inform future policy across Government. Following publication of the Audit, the Department has identified key actions to address inequalities in organ donation, mental health, childhood obesity, and in the NHS workforce.

32. To further protect and improve people's health in the UK and internationally, we have maintained our focus on delivering excellent vaccinations programmes. Uptake for most of our national immunisation programmes, which protect against 16 different diseases, remains high and there have been positive developments such as increases in uptake for the childhood flu programme for those aged 2-4 years, and in meeting the World Health Organisation (WHO) target on measles, mumps and rubella (MMR), achieving the 95% uptake target for MMR vaccine first doses for the first time in England[9].

33. The delivery of some national screening and immunisation programmes continues to present a mixed picture. There has been continued progress in rolling out the national bowel scope screening programme and the child flu immunisation programme. There have however, been declines in uptake of some screening and immunisation programmes, including new-born infant physical examination screening and cervical cancer screening. The Department is working with NHS England and Public Health England (PHE) to reverse these declines wherever possible.

[7] https://www.gov.uk/government/consultations/introducing-opt-out-consent-for-organ-and-tissue-donation-in-england
[8] https://www.gov.uk/government/publications/race-disparity-audit
[9] https://digital.nhs.uk/article/7712/Measles-mumps-and-rubella-vaccination-target-for-five-year-olds-in-England-has-been-met-for-the-first-time

34. In May 2018, the Secretary of State informed Parliament[10] of a serious failure in the national breast screening programme in England and as result a significant number of women aged between 68 and 71 were not invited to their final breast screening appointments. In an update to Parliament on 4 June, it was confirmed that analysis of data by PHE, who oversee the programme, had identified that 174,000 women were affected by this issue.

35. Ministers took advice from PHE and NHS England to ensure appropriate support for those women affected, NHS England has expanded the capacity of screening services to ensure all women who wish to be screened will receive an appointment within six months. Further detail is set out in the Governance Statement.

36. As part of preparations for what proved to be an incredibly challenging winter and a severe flu season internationally, we successfully delivered flu vaccinations to 1.5 million people, more than ever before.

37. The UK has maintained its commitment to slowing the growth and spread of antibiotic resistance which poses a threat to keeping people healthy in the future. The Advisory Committee on Antimicrobial Prescribing, Resistance and Healthcare Associated Infection (APRHAI) provided formal recommendations to the Government regarding the reduction in inappropriate prescribing in primary care, a new national target for primary care antibiotic prescribing in England has been included in the 2018-19 NHS England CCG Improvement Assessment Framework and CCG Quality Premium[11].

38. Antimicrobial resistance remains a global challenge, but we have seen positive steps in the UK through the delivery of the Government commitment to reduce veterinary prescribing two years early, led by the Department for Environment, Food and Rural Affairs (Defra), and a significantly reduced year-on-year increase of 2% in *E.coli* blood stream infections, compared to yearly increases of around 6-8% in previous years.

39. Our continued work on Global Health Security received an amber/green rating from the Independent Commission for Aid Impact (ICAI) Review[12] with the final report noting that the UK has responded rapidly to learning from the Ebola crisis to address weaknesses in the international response system and that we have been influential in encouraging World Health Organisation (WHO) reform and securing global policy commitments to tackling antimicrobial resistance. As the report notes, we have more to do and in our response accepted or partially accepted all recommendations[13].

40. The NHS Business Services Authority became the scheme administrator for the reformed infected blood payment schemes[14] from November 2017, following a period of transition from the previous five schemes into a single scheme. In 2017-18, a total of 676 applications for the special category mechanism payment were received with 498 approved. The Authority is responsible for administering completely new enhanced elements of the scheme.

10 https://hansard.parliament.uk/commons/2018-05-02/debates/BE9DB48A-C9FF-401B-AC54-FF53BC5BD83E/BreastCancerScreening
11 https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/anti-dash/
12 https://icai.independent.gov.uk/report/global-health-threats/
13 https://www.gov.uk/government/publications/hm-government-response-to-icai-recommendations-on-the-uk-aid-response-to-global-health-threats
14 https://www.gov.uk/government/news/infected-blood-scheme-reform

41. This year saw unprecedented levels of activity for the Department's Emergency Preparedness, Resilience and Response team. The Department and the health system has been actively involved in the response to a number of major incidents this year, ensuring that the NHS and wider system has been able to provide rapid and high quality support to people affected by terrorist attacks at Westminster Bridge, the Manchester Arena and London Bridge, in addition to the response to the WannaCry ransomware attack, the fire at Grenfell Tower and the chemical weapon attack in Salisbury.

42. The Department for Work and Pensions and the Department of Health and Social Care published Improving Lives: the Future of Work, Health and Disability on 30 November 2017[15], following the consultation launched as part of October 2016's Green Paper. It set out the Government's ambition to see one million more disabled people in work over the next ten years, and the next steps we plan to take to deliver our vision across three key settings; the welfare system, the workplace, and the healthcare system.

43. To deliver the transformational change needed to achieve this goal, the Department's Work and Health Unit is taking forward a programme of work to deliver the right balance of incentives and expectations for employers to recruit and retain disabled people and those with long-term health conditions; as well as how to shape effective occupational health services that can support all in work. Supported by the Work and Health Unit's Innovation Fund, we are working with research partners and academics, end-users, and delivery partners to build a comprehensive evidence base to inform decision making and implementation. The Office for National Statistics will publish new data later this year, enabling further comment on changes in disability employment in 2017-18.

44. In December 2017, the Government set out its intention to roll the public health grant into a new system of retained business rate funding from April 2020, on the understanding that the move will not take place until important mitigating actions are in place, including secondary legislation. These additional measures will be designed to promote a continuing focus on health outcomes.

45. The UK also continued to play a leadership role on international engagement in health, with Secretary of State and other members of our ministerial team, as well as the Chief Medical Officer attending, G7 and G20 meetings throughout the year to ensure that UK interests were effectively represented. As a result each of those groups has retained a focus on tackling antimicrobial resistance – a key UK goal.

46. We have continued to work closely with Public Health England, Department for International Development, Department for Environment Food and Rural Affairs, Department for Business Energy & Industrial Strategy, Healthcare UK and others to develop our approach to cross-government working on global health. Throughout 2017-18, we have continued work to implement a new overseas healthcare payment system, making it easier for UK citizens to be registered for state-provided healthcare in European Economic Area countries and Switzerland (and vice versa), while also bringing in tighter processes to reduce fraud and error, maximising income received.

47. The DHSC EU Exit Programme has been established to deliver a smooth and orderly exit from the European Union in such a way that the delivery of healthcare to UK citizens is

[15] https://www.gov.uk/government/publications/improving-lives-the-future-of-work-health-and-disability

maintained throughout and that the health and care system continues to focus on improving outcomes and efficiencies as set out in the DHSC Single Departmental Plan.

48. Working closely with other government departments, including the Department for Exiting the European Union, work continues to ensure readiness for 'exit day', this work will continue over the coming year. Preparatory work has included potential arrangements for paying for and recovering payment for health care provided to UK citizens in the remaining member states and vice-versa; developing a robust system for regulation of medicines and clinical trials after exit; extent of the UK's continuing participation in EU-wide science and innovation programmes; and ensuring a reliable supply chain for the health and care system. DHSC has been allocated £21.1 million for staff to support these essential EU exit preparations in 2018-19.

Objective 2: Transform out of hospital care to keep people living healthier for longer in their community

49. We have continued to make good progress on keeping the long term health of the nation on the right track. However, where our work focuses on transforming care to stay in the community for longer – through the use of community services such as GP surgeries, mental health support and social care access, there are a number of challenges that remain.

50. General Practice Forward View[16] (April 2016) set a target of 5,000 more doctors in general practice by 2020-21. The difficulty in building on the number of GPs in practice has continued; as at December 2017 there were 33,890 full time equivalent (FTE) doctors (including locums) working in General Practice, equating to a net loss of 702 FTE GPs since September 2015.

GP Training places offered by HEE
3,250 GP training places each year
3,151 GP training places filled in 2017-18 (4.4% up on 2016-17)
500 Doctors return to practice by 2020-21

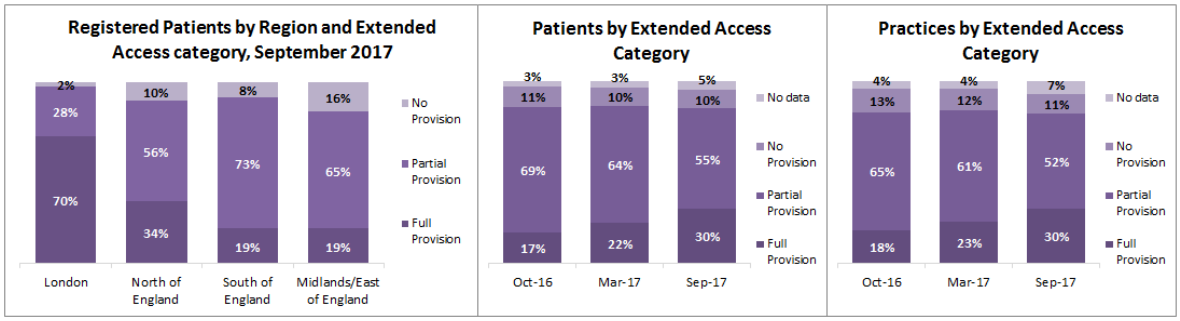
51. The core issue remains the retention of those working in primary care. In October 2017 the Government announced a new state-backed indemnity scheme designed to provide a more stable and affordable system for GPs. This builds on other actions this year designed to improve retention of GPs, including the GP Retention Scheme (opened on 1 April 2017) and the GP Career Plus pilot, developed by NHS England with the Royal College of General Practitioners, British Medical Association and Health Education England. There are also ongoing actions to recruit more GPs by increasing GP training places to 3,250 each year (3,157 places filled in 2017) and by a new focus on international GP recruitment, expanding the pilot programme from 500 to at least 2,000 international GPs by 2020. Despite these initiatives, our ambition of 5,000 more doctors in general practice remains extremely challenging.

52. We have made more encouraging progress towards delivering the Government commitment that by 2019 everyone will be able to 'get routine weekend or evening appointments at either their own GP surgery or one nearby'. The latest NHS planning

[16] https://www.england.nhs.uk/gp/gpfv/

guidance, issued by NHS England in February 2018, requires Clinical Commissioning Groups to provide extended access to general practice to their whole population by 1 October 2018, to ensure additional capacity is in place ahead of winter 2018. This includes ensuring that access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods. The bi-annual GP Extended Access Survey published by NHS England[17] suggests that 88.3% of practices are now offering either partial or full extended access to their patients, covering 51.6 million registered patients.

Figure 3: GP Access Metrics



Source: NHS England

53. Alongside increasing the number of doctors working in primary care, the Government is committed to ensuring a minimum of 5,000 additional staff working in general practice by 2020-21 to broaden the mix of skills and specialisms available to patients and support the work of GPs. As at December 2017, there were 92,200 FTE non-GP staff - an increase of 3,925 FTE since Sept 2015 - putting us on track to exceed the target of an additional 5,000 other staff working in general practice by 2020. The majority of this increase (2,639) has been seen in staff with direct patient care responsibilities including pharmacists and physician associates. Over this period, the number of nurses increased by 449 and the number of admin/non-clinical staff increased by 837.

Additional staff to support GPs by 2020 includes:
3,000 Mental health therapists
1,000 Physician Associates
Piloting **491** clinical pharmacists in 658 practices

54. Through 2017-18 work has continued to deliver dental contract reform, a key enabler of increased access and improved oral health. In May 2018, we published an evaluation of the first year of the trial of the potential new system (Dental Prototype Agreement Scheme[18]), testing new ways of providing NHS dental care with an increased emphasis on preventing future dental disease. This found that the preventative-focussed approach is widely agreed to be effective. Further work will take place over the next two years to fully test the remuneration system to ensure successful delivery of a reformed contract for NHS dentists, part of wider work to address concerns about recruitment and existing contract viability.

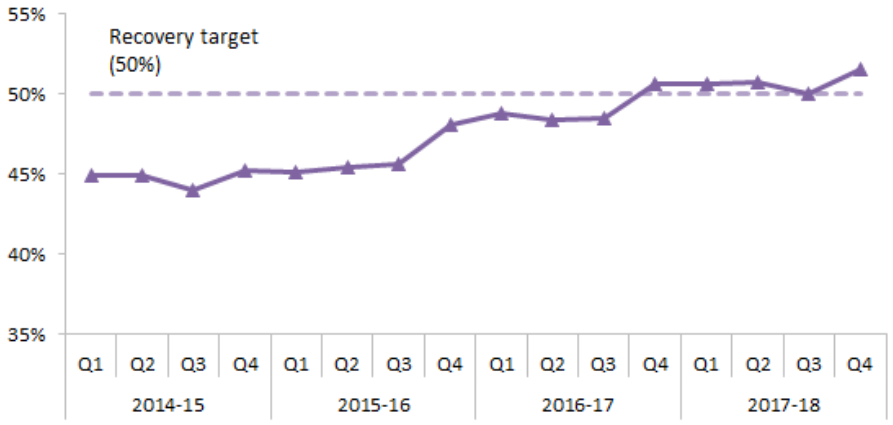
[17] https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/extended-access-to-general-practice-bi-annual-data-collection/
[18] https://www.gov.uk/government/publications/dental-prototype-agreements-directions-and-patient-information

55. Overall, the quarterly performance data published by NHSE[19] shows that significant progress in delivering on commitments in the Five Year Forward View for Mental Health[20] has been made. We have continued to make progress towards delivering parity of esteem, with the Mental Health Investment Standard met by 85% of CCGs in 2016-17. 2017-18 data is to be published later in the year, and all agreed access standards are either being delivered or on track to be delivered by 2020. This includes:

Investment in mental health:
£9.98bn spent by CCGs on mental health in 2017-18
£255m increase on 2016-17

- Improving Access to Psychological Therapies (IAPT) waiting time standards both consistently being met (75% referral to treatment within 6 weeks and 95% referral to treatment within 18 weeks).
- Early Intervention in Psychosis (EIP) standard (50% referral to treatment in 2 weeks) has been met since introduction in April 2016.
- Eating disorder access and waiting time standard for Children and Young Persons (CYP) on track to deliver 95% by 2020-21 (73% of urgent cases already being seen within 1 week, and 79% of routine cases being seen within 4 weeks).
- Perinatal care with expanded specialist perinatal care with over 5,000 additional women accessing these services between April and December 2017.

Figure 4: IAPT Recovery Rate



Source: NHS England

56. However, there is still more work to be done, particularly around out of area placements and crisis care. Whilst progress has been made on both reporting of out of area placements and on reducing the number of such placements, there is still more to do. NHSE and NHSI now have a comprehensive national programme supporting reductions in out of area placements, and every local area is currently developing a trajectory towards ending out of area placements in non-specialist, acute care by no later than 2021. We will maintain focus on our commitment to eliminate such placements through continued support to local systems and investment in Crisis Resolution and Home Treatment Teams offering in-home treatment as an alternative to admission.

[19] https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/
[20] https://www.england.nhs.uk/mental-health/taskforce/imp/

57. The Children and Young People's Green Paper[21] was published on 4 December 2017, with the consultation closing on 2 March 2018. The core policy package includes designated senior mental health leads in schools, mental health support teams able to go into schools and provide interventions for those with mild to moderate needs, and pilots of a 4-week wait for specialist services.

58. Good progress has been made on the treatment of offenders with mental health issues, through joint working between the Department, Ministry of Justice, the Home Office, NHS England and Public Health England. 2017-18 saw a continuing increase in the number of liaison and diversion cases across both adult and children and young people. Between April 2014 and December 2017, 193,600 people have used liaison and diversion services, (167,900 adult and 25,700 children and young people), with 82% of the population covered by the end of 2017-18. We remain on track to achieve full rollout by 2020-21.

59. Implementation of the Government's Dementia 2020 challenge has continued and we continued to meet the commitment of a diagnosis rate of two thirds, at 67.3% at the end of April 2018. As at March 2018 there were 2.4 million Dementia Friends. Our delivery partner, The Alzheimer's Society, is developing plans to improve the trajectory to ensure we have 4 million Dementia Friends by 2020. We have also maintained focus on the delivery of dementia research commitments, more detail of which is included under Objective 4.

60. There has been a renewed focus by the Department on enabling an affordable and sustainable adult social care system, emphasised by the change in our name to the Department of Health and Social Care, with the addition of a new Minister for Social Care.

61. A strong and effective social care system is essential for supporting people in their communities to maintain their wellbeing and independence, to avoid unnecessary hospital admissions, and ease pressure on the NHS, but the context remains challenging. The Adult Social Care Outcomes Framework (ASCOF) provides more detail on performance in this area and can be found in the Secretary of State's Annual Report.

62. Whilst we have not reached the ambition in the NHS England mandate of losing no more than 3.5% of NHS bed days to delayed discharges by September 2017, progress has been made this year in reducing Delayed Transfers of Care. In March 2018, there were 4,987 delayed days per day, representing a 25% decrease against a peak in delayed days in February 2017, and a reduction of 1,673 against our target of 2,500. Within this, 31% of delayed days were due to social care, down from 36% in February 2017. There are significant local and regional variations and work will continue to implement the Budget package and Better Care Fund[22] (BCF) to improve the situation.

63. In 2017 the Care Quality Commission commenced Local System Reviews[23] to find out how services are working together to care for people aged 65 and older, addressing the challenges at the interface of health and social care in many of the most poorly performing areas.

[21] https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper
[22] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[23] http://www.cqc.org.uk/publications/themes-care/our-reviews-local-health-social-care-systems

64. The Better Care Fund (BCF) requires local authorities and clinical commissioning groups to pool budgets for the purposes of integrated care. They can also make voluntary contributions to the BCF pool. In 2017-18 the total minimum contribution of the BCF was £1.5 billion. Local areas voluntarily planned to pool more than the minimum required, taking the total to £7.3 billion.

65. The social care system has come under increasing scrutiny this year with growing concern over the financial pressures on local authorities and social care providers. An extra £2 billion funding was announced at the 2017 Spring Budget to support local councils to deliver adult social care, supporting an increase in the budget for social care to £15.62 billion in 2017-18. However, the situation remains challenging, with local variation in the level of funding available to meet social care needs.

66. While the July 2017 Association of Directors of Adult Social Services (ADASS) budget survey suggests that the vast majority of Local Authorities have used some of the additional funding to increase fee payments to providers, the adult social care market remains fragile, with reports of providers handing unsustainable contracts back to commissioners.

67. The Competition and Markets Authority (CMA) published a report in November 2017[24], arguing that those requiring care need greater support in choosing a care home, greater consumer protections, and the current model of service provision cannot be sustained without additional public funding. The Department published its response on 5 March 2018[25], accepting CMA recommendations on consumer protection and information, and will consider recommendations on capacity and market sustainability in the forthcoming Green Paper on care and support for older people.

68. However, despite challenges around funding market fragility, quality in adult social care remains good overall; the October 2017 State of Care report[26] found that 80% of adult social care settings had been rated as good or outstanding.

69. Community pharmacy has a vital role in supporting NHS and care services, and public health, enabling people to access appropriate health advice and care closer to home. Through 2017-18 we have continued work to develop the sector to provide a more efficient service whilst maintaining access and quality, and better integrating community pharmacy within the NHS. Key developments this year have included:
    - Quality payments, introduced for the first time in 2017-18, have been successful in incentivising quality and especially the digital enablement of community pharmacy – 93% plus of community pharmacies now have four digital enablers essential for better integration with NHS – Electronic Prescription Service, NHS Mail, NHS 111 Directory of Services and Summary Care Record.
    - Further integration is being driven through the Pharmacy Integration Fund with 38,900 out of hours GP time saved through urgent medicine requests being met directly through community pharmacy, (from December 2016 to December 2017) and the piloting of NHS 111 referral to pharmacies for people with minor illness.

[24] https://www.gov.uk/cma-cases/care-homes-market-study
[25] https://www.gov.uk/government/publications/cma-care-homes-market-study-government-response
[26] http://www.cqc.org.uk/publications/major-report/state-care

- Though subject to judicial review, the Government's reforms to community pharmacy funding were upheld, with an appeal heard on 22-24 May 2018. The funding for 2017-18 was £2.592 billion.

70. Action was taken in August to reduce reimbursement prices for some generic medicines due to an over-delivery in previous years on the level of medicine margin which makes up some of the payment for the community pharmacy contractual payment. Further actions were taken in the autumn firstly to mitigate potential cash flow issues for community pharmacies and secondly in response to a significant increase in number and of value of products needing concessionary pricing.

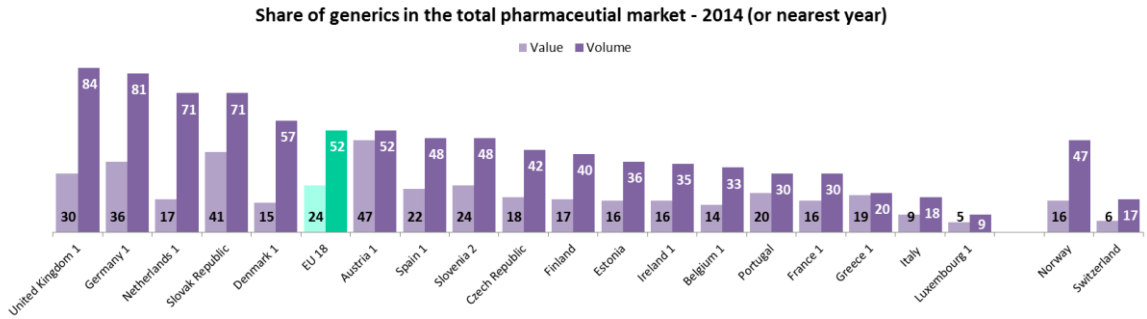
71. In 2016-17, the cost of medicines to the NHS was £15.4 billion, representing the largest area of spend after NHS staff pay. Through 2017-18, the Department and the NHS have focussed efforts on ensuring that the medicines budget is used as efficiently as possible, whilst ensuring that patients continue to have access to safe and cost effective medicines.

72. The Pharmaceutical Price Regulation Scheme (PPRS), a voluntary agreement to control the prices of branded drugs sold to the NHS, saw companies pay over £400 million back to the Department as part of the agreement to control medicines spend by health services across the UK in 2017-18, which was apportioned over the four UK countries, and reinvested in the NHS for patients' benefit.

73. This year we have also consulted on and put in place Regulations[27] for a new statutory medicines pricing scheme from 1 April 2018, designed to support and sit alongside the current voluntary PPRS, and expected to realise around £33 million of further savings for the NHS in 2018-19.

74. On the most recent available data, the NHS continues to perform well at both use and pricing of generic medicines. The Department is working with the Competition and Markets Authority and industry to develop its approach to investigating and taking action on high priced generic medicines, where appropriate, with work to continue next year to ensure that the NHS is able to purchase medicines at the best reasonable price. Information relating to share of generics in the total pharmaceutical market, 2014 is shown in **Figure 5**.

Figure 5: Share of generics in total pharmaceutical market



Source: OECD Health Statistics 2016
1. Reimbursed pharmaceutical market.
2. Community pharmacy market.

[27] https://www.gov.uk/government/consultations/statutory-scheme-to-control-cost-of-branded-medicines-consultation

75. Alongside keeping people healthy in their communities for longer, there remains a focus on the ability to access data digitally and to provide further support to people to personalise their healthcare. We are responsible for setting the strategic direction and developing the policy for technology, data and digitally enabled health and care. Over the last year we have strengthened our assurance of the over £4 billion Digital Transformation Portfolio (Personalised Health and Care 2020), including through the appointment of a new Chief Executive at NHS Digital, and a new Chief Clinical Information Office for the health and care system. Working with NHSE England and NHS Digital we have reviewed and reprioritised the portfolio to create the capacity to tackle new priorities, including strengthening the cyber security of the health and care system.

76. Cyber security is critical in ensuring that clinicians, services and patients are able to access healthcare data in a safe, legal and secure way, and that they feel confident in doing so. Since the Wannacry ransomware attack in May 2017, we have significantly bolstered our cyber security programme and continue to actively review it in light of the developing threat, including investment of an additional £60 million in local infrastructure to address key cyber weaknesses, including major trauma centres and ambulance trusts. We have also released an additional £150 million for cyber security between 2018-19 and 2020-21, including for the CareCERT service. This service, provided by NHS Digital, is how we were first made aware of the cyber-attack in May 2017.

77. We also published the Government response to the National Data Guardian's Review of Data Security, Consent and Opt-outs in July 2017[28] and accepted all of the recommendations to embed data security standards and a new national data opt-out. We are on track to launch the national data opt-out in 2018-19.

78. In response to the Wachter review[29] recommendations we are providing funding for local investment in 16 acute (up to £10 million matched funding) and 7 mental health trusts (up to £5 million matched funding), supporting some of the most digitally developed hospitals to develop their services further so they can become world class, and develop 'blueprints' that will allow other NHS trusts to learn from their experience so that they can adopt the same digital technologies more quickly and effectively.

Objective 3: Support the NHS to deliver high quality, safe and sustainable hospital care and secure the right workforce

79. As the NHS continues to treat record numbers of people, maintaining and improving the standards of care remains crucial. This year, we have continued to focus on ensuring the services it provides are of the safest and highest quality.

80. The Care Quality Commission (CQC) continues to inspect hospitals, GP surgeries and care home providers across the country and in 2017-18 carried out 107 inspections of NHS Acute Trusts, 215 inspections of Independent Acute Hospitals, 2,383 inspections of GP Practices and 12,281 inspections of providers of Adult Social Care locations. In addition to

[28] https://www.gov.uk/government/publications/review-of-data-security-consent-and-opt-outs
[29] https://www.england.nhs.uk/digitaltechnology/info-revolution/wachter-review/

continuing delivery of inspections, in March 2018 the CQC has developed its approach to begin to consider how well NHS Trusts use the resources available to them, publishing a joint response to consultation with NHS Improvement in March 2018[30] and beginning to issue assessments using the new approach from 5 March 2018.

Providers inspected by CQC since 2014: • **141** NHS Acute Trusts • **16** Specialist NHS Trusts • **7,982** GP Surgeries • **28,726*** Adult Social Care	**51** NHS Acute Trusts rated during 2017-18: • **10%** rated inadequate • **63%** rated as needing improvement • **25%** rated as good • **2%** rated as outstanding

*Includes hospices from April 2017

81. A particular area of focus for this year has been safety in maternity care, following the publication in November 2017 of Safer Maternity Care: progress and next steps[31] bringing forward from 2030 to 2025 the ambition to halve rates of stillbirths, neonatal and maternal deaths, and brain injuries during or soon after birth. Further detail on perinatal mortality is included within the NHS Outcomes Framework section of the Secretary of State's Annual Report.

82. The Healthcare Safety Investigation Branch (HSIB) – an independent Expert Advisory Group set up to make recommendations to the then Department of Health on how the new Independent Patient Safety Investigation Service would work - became operational from 1 April 2017, to conduct its own independent investigations into safety incidents. These investigations will focus on generating lessons to reduce patient harm and build capability to raise the standards of local investigations, sharing learning across the whole healthcare system.

83. During its first full year, HSIB initiated 12 investigations of which 9 have gone on to become full investigations. Its first investigation report into the implantation of wrong prostheses during joint replacement surgery[32] was published on 21 June with further reports to be published in the coming months. HSIB will require written responses to its recommendations to agreed timescales. It will be for healthcare providers themselves to put in place actions to fully meet the recommendations. The Care Quality Commission which monitors, inspects and regulates providers can then take into account these actions in its inspections. NHS Improvement can also support trusts to meet the recommendations, to ensure system improvements to patient safety are implemented.

84. In addition, supporting our focus on improving safety in maternity care and in line with the NHS Five Year Forward View, HSIB remit was extended to deliver approximately 1,000 maternity investigations annually. HSIB established maternity investigators in the South East Region in April 2018 and there is a phased roll out of the programme to other areas. These maternity investigations, unlike HSIB's national investigations, will have a dual purpose. As well as system learning, they will also provide the family of the baby or mother who was harmed with a full account of what happened in the individual case.

[30] http://www.cqc.org.uk/get-involved/consultations/consultation-reporting-rating-nhs-trusts-use-resources
[31] https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps
[32] https://www.hsib.org.uk/investigations-cases/implantation-wrong-prostheses-during-joint-replacement-surgery/

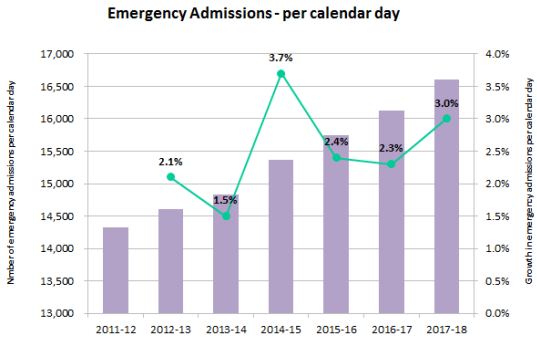
85. The 'Learning from Deaths' programme'[33] was established in response to the CQC report Learning, Candour and Accountability[34]. It found that Learning from Deaths needed higher priority in the NHS to avoid missing opportunities to improve patient care. Guidance was issued in March 2017 to all Trusts on how to learn from in-patient deaths and this learning will be captured in Trusts' annual quality accounts. By March 2018, all acute, mental health and community NHS Trusts had published their updated policies on learning from deaths and their second set of quarterly avoidable mortality data.

86. In December 2017, the Government established an Independent Inquiry into the issues raised by the conviction of surgeon Ian Paterson on counts of wounding with intent and unlawful wounding, whilst employed by the Heart of England NHS Foundation Trust and practicing in the independent sector at Spire Parkway and Spire Little Aston. The Inquiry, chaired by the Bishop of Norwich, will examine the lessons that the NHS should learn from the case, and will report its conclusions and recommendations in summer 2019.

Performance standards

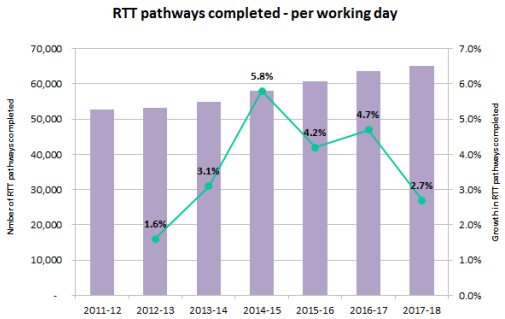
87. Demand for services provided in the health and care system continues to rise above population and demographic growth as better diagnosis and medical advancement means more treatment is possible. To meet this demand the NHS continues to deliver more activity than ever before - as evidenced in **Figures 6 and 7** - by the growth in emergency admissions and elective (i.e. non-emergency) treatments over the last 6 years.

Figure 6: Emergency Admissions



Source: Hospital Episode Statistics for Admitted Patient Care -2017-18 figures.

Figure 7: Elective Treatments



Source: NHS England Consultant Led Referral to Treatment Statistics. Data adjusted for non-submitting Trusts and exclusion of sexual health services from 2013.

88. Compared with 2016-17, the NHS managed just over half a million more A&E attendances in 2017-18, an increase of 3.8% in people seen by a specialist for suspected cancer and performed more 528,000 more diagnostic tests. Although the NHS treated more patients than ever, and despite the fantastic efforts of everyone working the NHS, core performance targets were not met (further details in Annex C).

89. This year 23.9 million people attended an A&E in England, with 21.1 million people being either admitted, transferred, or discharged within four hours of attending – more than ever before in the history of the NHS. This activity, including increases this year in the number of patients admitted to hospital, has put pressure on hospital bed capacity.

[33] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
[34] http://www.cqc.org.uk/content/learning-candour-and-accountability

During 2017-18, cross-system action was successful in reducing the number of hospital beds occupied by patients with a delayed transfer of care (DTOC). However, although up to 1,900 beds were freed-up through action on DTOC, pressure on beds, particularly from increases in beds occupied by patients suffering from flu and norovirus, meant bed occupancy[35] rose to over 95% during the winter period.

90. This increase in activity and pressure on bed capacity has meant increasing difficulty for the NHS in meeting the A&E waiting times national standard. In 2017-18, national performance is 88.4%, not meeting the standard that 95% of patients should be admitted, transferred or discharged within four hours of arrival in an A&E department, nor meeting the NHS mandate expectation that the majority of Trusts should meet the standard by March 2018.

National A&E waiting time	2017-18	2016-17
A&E attendances (million)	23.9	23.4
of which: Emergency Admissions (million)	4.5	4.3
National Standard* (%)	95.0	95.0
Actual performance (%)	88.4	89.1

**95% of patients admitted, transferred or discharged within four hours of arrival*

91. There has been an ongoing review of the way the ambulance service responds to calls through the Ambulance Response Programme (ARP). Following an independent evaluation of extensive trials covering 14 million emergency 999 calls, in July 2017 the Secretary of State approved NHS England's recommendation to implement an improved ambulance performance framework.

92. The previous Red1/Red2/A19 standards have been replaced by six standards over the new call categories of C1 to C4. All mainland Ambulance Trusts have reported against the new response standards from December 2017, with Isle of Wight expected to commence from September 2018. Trust performance against the standards is improving as they adapt to the new framework. Three out of six response time standards were met nationally in April 2018. Further details of the new standards and performance against them can be found in Annex C. NHS Planning guidance for 2018-19 includes a requirement that Ambulance Trusts meet the performance standards by September 2018, and there is confidence that the majority of Trusts will achieve this.

93. Performance against the elective waiting time standard - referral to treatment (RTT) incomplete pathway standard was 87.2% in March 2018 compared to 90.3% in March 2017. The standard was last met in February 2016. We remain fully committed to the RTT standard and expect the NHS to deliver the actions set out in the *Refreshing NHS Plans for 2018-19*[36], in full, as key steps towards fully recovering performance against core access standards including RTT. Whilst activity has increased, the waiting list stands at 4.09 million and more people are waiting longer for treatment than in 2016-17.

[35] https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/
[36] https://www.england.nhs.uk/publication/refreshing-nhs-plans-for-2018-19/

Referral to treatment for non-urgent conditions	2017-18	2016-17
Total number of completed pathways (million)	15.75	15.70
Waiting List –including estimates for non-reporting trusts (million)	4.09	3.9
National Standard* (%)	92	92
Actual performance (%)	87.2	90.3

**95% of patients on RTT incomplete pathways waiting within 18 weeks from referral to start consultant-led treatment*

94. As part of ongoing work to support the NHS to respond to increasing demand for services, planning for winter started earlier than before, delivering:
    - a reduction in delayed transfers of care of up to 1,900 bed days per day (December 2017 compared to February 2017) ;
    - a 16% increase in calls to NHS 111 from last winter (Dec – Mar), over 120,000 extra calls each month, with 40% of these calls – more than ever - receiving clinical input;
    - primary care streaming at 98.5% of Type 1 A&E's by December 2017, diverting people with more minor illnesses to more appropriate services better suited to their needs, supported by £100 million of funding announced in the 2017 Spring Budget;
    - Over 1 and a half million more people vaccinated against flu as part of our expanded reach to at risk groups and health and care workers. The highest ever uptake amongst healthcare workers at 68.7%;
    - Extended access to GP appointments which were available 8am to 8pm across the country throughout the Christmas period; and;
    - The establishment of the clinically-led National Emergency Pressures Panel (NEPP) to further ensure patient safety. The NEPP brought together clinical leaders and experts from health and social care including the Royal College of Surgeons, the Royal College of Physicians, the Royal College of GPs, the Royal College of Nursing, Public Health England and the CQC.

95. Despite this, the increased demand for non-elective services over winter led to the National Emergency Pressures Panel issuing guidance on 2 January 2018, which advised the NHS to defer all non-urgent inpatient elective care until 31 January 2018, and that day-case procedures and routine follow-up and outpatient appointments should also be deferred or dealt with in different ways, for example telephone consultation. This clinically-led recommendation meant that Trusts were able to prioritise emergency care and continue to deliver safe care to those in most urgent need.

96. Beyond these shorter-term responsive measures, a focus on preventing ill health and transforming care in the community remains a key priority in delivering a high quality and sustainable health and care system.

97. The eight cancer waiting time standards are crucial to support improvements in cancer care and survival rates through early diagnosis and treatment and the majority of these standards were met this year, including that 96% of patients should begin first treatment within 31 days of a decision to treat which was met every month in 2017-18 and saw 97.5% of patients treated within 1 month across the year.

98. There has been a continuing rise in demand for cancer services, with urgent GP referrals rising by over 70,000 compared to last year, which itself saw 200,000 referrals compared

to the year previously. Whilst there was a slight improvement on 2016-17, the target of 85% of patients beginning first treatment within 62 days of urgent GP referral for suspected cancer was not met in any month of 2017-18, with performance for the year at 82.3%. Recovery of the 62 day standard remains a key objective for NHS England, and a joint plan with NHS Improvement has been put in place. The target of 93% of symptomatic breast patients (where cancer was not initially suspected) being seen by a consultant within two weeks of an urgent GP referral was also narrowly missed, at 92.8%.

Cancer	2017-18	2016-17
Urgent GP referrals for suspected cancer (million)	1.95	1.88
Patients starting treatment for cancer in year (thousand)	295	290
National Standard* (%)	96	96
Actual annual performance (%)	97.5	98.0

*

96% of patients to begin 1st treatment within 31 days of decision to treat

99. Further detail on cancer mortality and survival after diagnosis are set out in the NHS Outcomes Framework section of the Secretary of State's Annual Report.

100. The Secretary of State launched the HEE Cancer Workforce Plan in December 2018[37]. The Plan has three main strands; the first focuses on immediate and ongoing actions to make better use of the existing cancer workforce. The second strand focuses on the expansion of clinical skills over the next three years to transform and support growth of the cancer workforce. The final strand of the plan sets out HEE's longer-term ambition to increase the numbers of medical and post-graduate trainees over the next 3 to 15 years.

101. Following the launch of the National Diabetes Prevention Programme[38] in June 2016, with an aim of coverage of the whole country by 2020, at the end of March 2018, total referrals into the programme stood at 182,846, with 140,068 referrals across 2017-18. 78,326 people have now attended an initial assessment, and the programme is on track to reach full coverage by 2020.

Workforce

102. The commitment and expertise of the health and social care workforce means that the NHS and adult social care system are able to continue delivering high quality, safe and effective services. Between January 2017 and January 2018, the size of the 1 million Full Time Equivalents (FTE) strong NHS workforce increased 1.8%, including around 3,400 more doctors and 500 more nurses and midwives. The social care workforce, at 1.4 million people in 1.1 million FTE posts is even larger.

103. However, more needs to be done to support the people who work in health and social care and ensure the workforce of the future is able to meet demand. In December 2017, Health Education England launched a draft workforce strategy, Facing the Facts, Shaping

[37] https://www.hee.nhs.uk/our-work/workforce-strategy-england/cancer-workforce-plan
[38] https://www.england.nhs.uk/diabetes/diabetes-prevention/

the Future[39], on the future of health and adult social care in England – the first step to securing a proper plan that stretches beyond any electoral cycle and secures the supply of staff for future generations. The consultation closed on 23 March 2018, the responses and associated analysis will be published later this year.

104. There are currently over 155,000 staff from EU27 countries making an important and valued contribution to our health and care system. Securing their position has been made a priority in negotiations on exiting the European Union. At the same time, the Department and its ALBs are putting in place measures to enable England to be more self-sufficient in securing the staff it needs in the future.

105. In 2017-18, we have maintained a significant focus on ensuring we have the right number of staff to deliver quality care. In March 2018, the Secretary of State announced the allocation of 1,000 new undergraduate medical school places, including places at five brand new medical schools, in addition to the 500 new places already allocated to existing schools. These additional 1,500 places, 630 of which will start in September this year, will mean a record number of undergraduates will begin training by 2020 and will deliver one of the biggest ever increases to the medical workforce in England.

106. We have also made progress towards increasing the supply of non-medical trainees across nursing, midwifery and allied health professionals. In 2017, we announced additional funding for clinical placements to make available 5,000 more nursing student places per year from 2018-19 to 2020-21 – a 25% increase over the number of nursing students in 2016-17. Following this, in March 2018 plans were announced to make available more than 3,000 extra midwifery training places over 4 years, starting with 650 more places in August 2019.

107. Our reforms to healthcare education funding started to take effect from 1 August 2017, with students moving from a bursary-based funding model to loans-based. This has removed an artificial cap on the number of training places that can be provided, and initial data shows that there remains strong demand, with more applicants than available training places.

108. At the end of December 2017, the NHS has employed 8,781 apprentices towards an annual target of 27,500, meaning the NHS has not met the annual target in 2017-18. NHS employers have prioritised resources, in the first year the target is in operation to build the infrastructure to employ apprentices and embed apprenticeships into local workforce planning which should see figures improve in 2018-19. Apprenticeships offer an important means to increasing the number of routes in to practice and the range of advanced practitioner roles our most talented staff can move in to. The launch of new roles, such as the Nursing Associate (NA), increases the mix of skills in the NHS and creates opportunities for staff to concentrate on the tasks they are best qualified to carry out. These measures mean that the NHS is a more attractive place to work which will help

2,000 new Trainee Nursing Associates on HEE pilot
Over 1,100 Nursing Associates on the apprenticeship programme
3,000 Nurses back on the front line since 2014

[39] https://hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%2C%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf

ensure health and care continue to be able to recruit and retain the most talented and caring staff.

109. The Nursing Associates programme will be expanded to deliver 12,500 associates in training by 2019, starting with 5,000 in 2018 followed by a further 7,500 in 2019. The consultation on the draft Nursing and Midwifery Council (NMC) order to regulate NAs has been published and the Department is on track to lay the new order on time for regulation by 2019.

110. Since September 2014, around 4,800 nurses have started HEE's Nursing Return to Practice Programme, with 3,000 completing the programme, with an additional 1,800 working towards completion.

111. The 2016 contract for doctors and dentists in training has now been implemented. This includes a range of measures aimed at improving the wellbeing of our training workforce. It puts in place new, stronger limits on working hours and patterns and has ensured the appointment of a Guardian of Safe Working in every trust, a Code of Practice for the timely notification of placements. Many changes have already been made and work includes a pilot of less-than-full-time training in emergency medicine, support for doctors returning to training and a review of the appraisal process. NHS Employers and the British Medical Association are working in partnership on the review of the 2016 contract.

112. In autumn 2017, the Chancellor committed to make additional pay investment for NHS staff employed under the Agenda for Change contract if agreement was reached on reforms that support recruitment and retention and help boost productivity. NHS trade unions announced in June 2018 that the majority of their members had voted in favour of the deal. The multi-year pay and contract reform deal means nearly one million employees on Agenda for Change contracts, including the lowest paid NHS workers will receive well deserved pay rises in summer 2018.

113. The deal will help deliver better value for money from the £36 billion Agenda for Change pay bill, with some of the most important changes to working practices in a decade. Reforms will put learning and development at the centre of local appraisal processes, ensuring staff demonstrate that they meet the required standards for their role before moving to the next pay point, a key driver in our ambitions to be the safest health care system in the world; employers will commit to supporting staff to maintain their physical and mental health and well-being, reducing sickness absence to the best levels in the public sector, increasing capacity for patient care.

114. The adult social care workforce is absolutely vital and the Department recognises the incredible contribution care workers make to our society. Improving the capability of the workforce through continued skills development is a vital investment in the future, and helps other people to recognise social care as a skilled career option. The Department continues to fund Skills for Care[40], to deliver initiatives to build sector capability and skills in these areas.

[40] https://www.skillsforcare.org.uk/Home.aspx?gclid=EAIaIQobChMI7fmI2MDl2wIVUzPTCh35EguPEAAYASAAEgIWOPD_BwE

115. During 2017-18 the Department has continued its partnership with Think Ahead[41], a graduate training programme to attract high potential graduates and career changers into social workers in mental health services. In each of its first two annual intakes, it has attracted more than 2,300 applications for 80-100 places, making it one of the most competitive graduate schemes in the country, and this year ranked 62 in the Times Top 100 graduate employers list.

Efficiency

116. Work to deliver improved quality and performance, and a sustainable workforce for the future, is underpinned by a continuing focus on efficiency, seeking out and realising opportunities to reduce variation and waste in how the system uses it resources.

117. One important route for the NHS to use its resources as efficiently as possible is to ensure that where it treats people who are not entitled to free NHS care, those costs are recovered for the benefit of the NHS. In 2017-18, the NHS recovered £392 million from overseas visitors and migrants not entitled to free NHS care, through the healthcare surcharge, recovery of payments from EEA countries for treatment of their citizens by the NHS and direct charges.

118. This year, building on the publication of the Carter Review in February 2016[42], the system has made progress in implementing the Operational Productivity programme, aimed at reducing unwarranted variation in the NHS. Across 2017-18, this programme has delivered £1.45 billion of efficiency savings for the NHS across the NHS, including hospital pharmacy and medicines, the clinical workforce, procurement, back-office services and estates. This is a promising start, but we recognise the challenge going forward to ensure that learning and best practice is spread across the NHS so that the full benefits of this work are felt everywhere.

119. Alongside this, we have made progress in reducing the reliance on the use of agency staff within the NHS, reducing spending on agency workers to the targeted level of £2.5 billion and increasing the use of bank staff, who are typically more committed to their Trusts, bringing better continuity, safer care and value for money for the taxpayer. Bank staff are more cost effective than agency staff, and increasing bank fill rates has contributed to total savings in spend on temporary staffing of circa £100 million. The focus on reducing as far as possible spend on temporary staff will be complemented by an improved offer for staff who wish to work flexibly, and the Secretary of State announced in October a new pilot scheme to help nurses work more flexibly where they want to, scheduled to begin in 12 Trusts in 2018-19.

Objective 4: Research and innovate to maximise health and economic productivity

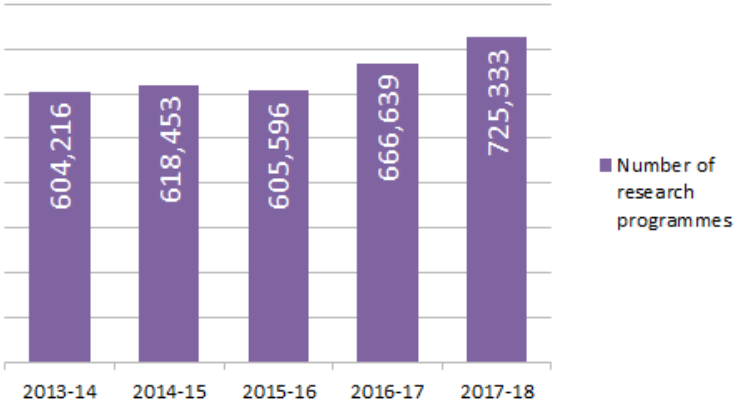
120. The efforts to improve how our health and care system delivers better outcomes to be most effective, these must be underpinned by a strong culture of evidence-based innovation. Throughout 2017-18 the Department has maintained its focus on investing in infrastructure and research.

[41] https://thinkahead.org/
[42] http://www.nhsemployers.org/news/2016/02/carter-report

121. The Department has a shared ambition with the National Institute for Health Research (NIHR), NHS England, NHS Improvement, the Health Research Authority and the Office of Life Sciences for the NHS to offer a simple, coordinated and cost-effective process for contracting research which will support improvement and innovation in the NHS. NHS England and NIHR have set out 12 actions to further support and apply research in the NHS. As part of this work, in December 2017, NHS England launched a consultation[43] aimed at simplifying NHS research proposals, managing excess treatment costs better and improving commercial clinical research set-up and reporting.

122. The NIHR continues to provide the funding, support and facilities the NHS needs to conduct first-class research into delivering the highest quality of care. This also plays an important role in maintaining the UK's competiveness as a global destination for research. The NIHR enables and facilitates recruitment of patients and other participants into research through its funded research infrastructure in the NHS, which includes NIHR Biomedical Research Centres, NIHR Clinical Research Facilities and through the NIHR Clinical Research Network. See **Figure 8**.

Figure 8: Summary of NIHR Research Programmes



123. The number of people taking part in clinical research supported by the NIHR Clinical Research Network has increased to over 725,000 in 2017-18.

124. The Department supports and funds the 100,000 Genomes Project, which is enabling the foundations of the world's first mainstream genomics health service to be established and encourages investment in the Life Sciences industry.

125. Thirteen NHS Genomic Medicine Centres (GMCs) have been set up by NHS England. Genomics England has created a unique semi-automated pipeline to help researchers understand the large amount of data contained within the sequenced genomes. This has meant that 25% of patients with rare diseases who participated in the project received a diagnosis for the first time. At March 2018, Genomics England reported 80,370 DNA samples collected from patients with rare diseases and cancer, with 54,790 genomes successfully sequenced, and we remain on track to deliver the full 100,000 genomes by December 2018.

[43] https://www.nihr.ac.uk/news/nhs-england-launches-consultation-on-supporting-research-in-the-nhs/7590

126. We have also made progress on our work on rare diseases, publishing our implementation plan for the UK Strategy for Rare Diseases in January 2018[44], which was followed by a progress report from the UK Rare Diseases Policy Board in February[45].

127. The Department, through the NIHR, is committed to developing the health and life sciences sector through training the next generation of health researchers. At the end of 2017-18, through its infrastructure, personal and institutional awards, and research schools, the NIHR was supporting 5,000 trainees undertaking NIHR-supported academic research.

128. In line with the Government's Challenge on Dementia, and the commitment to maintain spending on dementia research at £60 million annually to March 2020, we have maintained spending on dementia research. In 2016-17, a total of £83.1 million was spent through the NIHR, Medical Research Council and the Economic and Social Research Council, and we are on course to deliver the aspiration for funding for dementia research from all sources (including charity and industry) to double by 2025. In addition, UK Dementia Research Institute (UKDRI) has invested £40 million into research.

129. Supporting world-class global health research, funded by DHSC, NIHR commissions via three different strands: programmes, research partnerships and people. This year, the Department has seen:
    - Research Programmes: £120 million to fund 13 Global Health Research Units (universities and research institutes with an existing track-record of delivering internationally recognised research) and 20 Global Health Research Groups (existing specialist academic groups who wish to expand into the field of global health, especially in shortage areas of research).
    - Research Partnerships: NIHR has committed over £100 million in partnerships with a number of funding bodies that run high-quality schemes for commissioning global health research. These funding bodies have a strong history and track record of supporting research that aims to improve health in low and middle income countries.
    - People: A recruitment exercise has been launched for up to 2 NIHR Global Health Professorships and has attracted a significant number of applications. The 33 Groups and Units will between them create around 90 PhD student positions.

130. The Life Sciences Industrial Strategy & Sector Deal was announced in the Industrial Strategy White Paper on 27 November 2017[46] , supported by the creation of a new Life Sciences Council and over £350 million of Government support through the first and second waves of the Industrial Strategy Challenge Fund. As part of the Deal, Merck & Co (known as MSD outside the U.S.) announced a new major investment to build a new discovery centre in London.

131. Our Exit from the European Union creates both risks and opportunities for the life sciences industry in the UK. Through the Office of Life Sciences, a joint unit with Department for Business, Energy and Industrial Strategy, we are continuing to work across Government and with industry to understand the key issues and ensure a smooth

[44] https://www.gov.uk/government/publications/uk-strategy-for-rare-diseases-implementation-plan-for-england
[45] https://www.gov.uk/government/publications/uk-rare-disease-policy-board-second-progress-report
[46] https://www.gov.uk/government/topical-events/the-uks-industrial-strategy

transition that delivers on the public principles that: patients should not be disadvantaged; innovators should be able to get their products into the UK market as quickly and simply as possible; and the UK should continue to play a leading role promoting public health.

Objective 5: Ensure accountability of the health and care system to Parliament and the taxpayer; and create an efficient and effective Department of Health and Social Care

132. As a Department of State, one of our core functions is to ensure that we, and the health and care system as a whole, are accountable to Parliament and the public for the work we do and the outcomes delivered for patients and services. In 2017 we continued to manage the biggest direct post-bag of all Government Departments and answered 93% of all correspondence within 18 working days, receiving twice as many Parliamentary Questions as the next busiest Department, with over 99% answered within deadline, putting us amongst the top performers across Government on both measures.

Parliamentary and Public Accountability
6,452 written parliamentary questions
99.8% answered on time
32,346 letters and emails to Ministers and the Department
93% responded to within 18 working days of receipt

133. As part of holding ourselves accountable to patients, service users and the public, in May 2018, we also published a statement setting out how the Department of Health and Social Care had complied with the public sector equality duty in 2017[47].

134. Continuing the work to make the Department more efficient and effective, London-based staff completed a move to 39 Victoria Street in December 2017. This move has enabled a move to a new modern working environment that fully supports smarter working. The move has also enabled the Department to reduce its estate footprint in London by up to 50% and will deliver significant cost savings over the life of the lease.

Considerate and Sustainable construction
93.85% of site team lived within 40 miles of 39 Victoria Street, minimising carbon foot print
40/50 score under Code of Considerate Practice for Construction
100% of sub-contractors were SMEs, supporting Government policy
100% of sub-contractors paid within 19 days of invoice
92.88% of spend within 40 miles of 39 Victoria Street
96.6% of non-hazardous waste diverted from landfill – 408 m^3

135. Work to drive improvement in the Department's commercial capability has continued throughout 2017-18, ensuring that across the Department we are well placed to deliver value-for-money, commercial outcomes for the NHS and the taxpayer.

136. One example of the benefits of a high-performing function is in procurement. The NHS spends approximately £5.7 billion on goods across everyday hospital consumables, common goods, high value healthcare consumables and capital equipment. The delivery

[47] https://www.gov.uk/government/publications/dhsc-public-sector-equality-duty-compliance-2017

of the NHS Supply Chain service is currently contracted to DHL, which concludes, after extension of the current Master Service Agreement, in March 2019. The Procurement Transformation Programme (PTP) is the means by which we are implementing a new and improved supply chain model. The model is based on leveraging the collective purchasing power of the NHS to deliver increased value and savings. The aim is to increase market share of the current centralised procurement function, improving bulk procurement practice and reducing the number of Trusts purchasing from other providers. At the end of 2017-18, the NHS Supply Chain Programme has released more than £290 million of cash releasing savings for the NHS since April 2013.

137. The remaining parts of this objective are covered within the following section; delivering a financially sustainable system.

Delivering a Financially Sustainable System

138. The money we spend is used to help people stay in good health and live independent lives. However we must live within our means, which means managing spending within agreed annual funding levels.

139. The Department is therefore accountable to Parliament for ensuring that total spending by all bodies within the departmental group is contained within the overall budget authorised by Parliament.

140. During 2017-18, the Department contained its resources within all budgets authorised by Parliament, and the NHS broadly delivered financial balance for the sector as a whole. **Table 1** details the Parliamentary controls against which performance is measured, with further details provided in the SOPS and Annex B within this Annual Report.

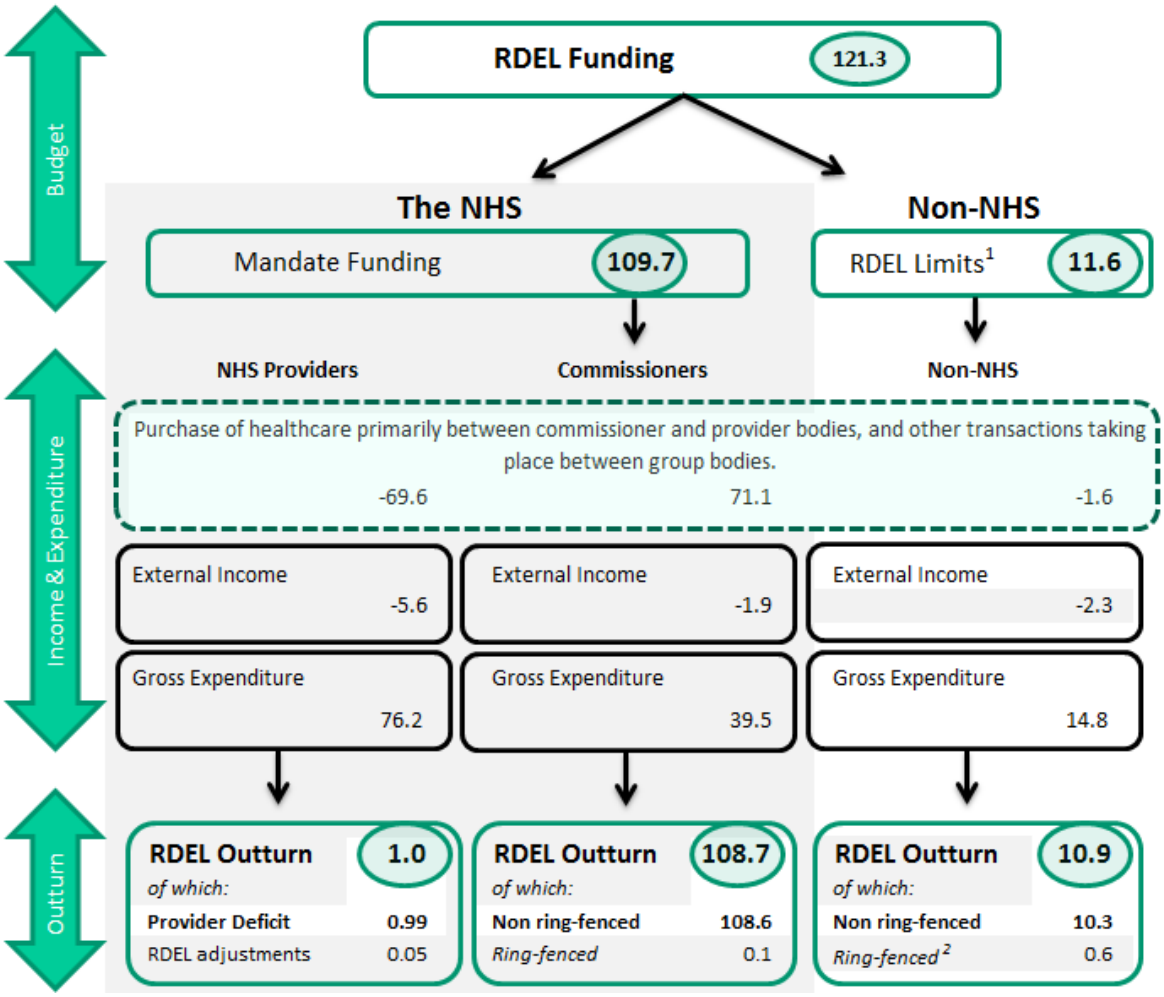
Table 1: Departmental Outturn 2017-18 against Parliamentary Controls

	Budget £m	Outturn £m	Under/ (Overspend) £m	Key disclosure notes/further detail
Revenue Departmental Expenditure Limit (RDEL)	121,342	120,650	692	SOPS 1.1, Annex B
of which: Revenue Administration	*2,940*	2,304	*636*	*Annex B*
Capital Departmental Expenditure Limit (CDEL)	5,598	5,238	360	SOPS 1.2, Annex B
Revenue Annually Managed Expenditure (RAME)	27,940	13,152	14,788	SOPS 1.1, Note 16
Capital Annually Managed Expenditure (CAME)	15	0	15	SOPS 1.2
Net Cash Requirement	105,424	102,010	3,414	SOPS 1.3

Revenue Departmental Expenditure Limit (RDEL)

141. **Figure 9** provides an overview of how the Department's net revenue funding moves around the system. Further detail is provided in the Accountability Statements and Financial Statements within this Annual Report and Annex B.

Figure 9: Flow of RDEL around the Health & Care System



Figures above are in billions. The Department is funded and expenditure recorded on a net basis.

[1] Includes the Public Health Grant

[2] In this presentation, the non-NHS figures included provider ring-fenced spend as this does not form part of the NHS Mandate.

142. The majority of the Department's revenue budget is allocated to the NHS to fund healthcare services in England. This budget funds the spending of all NHS commissioning and provider organisations. To support delivery of the broader accountability requirement to Parliament, the Department has made NHS England and NHS Improvement responsible for ensuring the NHS overall balances its budget.

143. As part of the annual budget setting process, the available funding and resulting expenditure controls are set out in the financial directions that accompany the Government's Mandate to the NHS. This Mandate also sets out the outcomes that are to be achieved.

144. The Department therefore needs to work with NHS leadership to ensure that the demand for healthcare and adult social care services and associated spending is managed within the available budget to ensure a financially sustainable healthcare sector, and at the same time supporting the NHS to successfully transform in order to meet the challenges of the future.

145. The broad challenge facing healthcare was set out by the NHS in its Five Year Forward View plan in 2014. The Government signalled its clear support for this plan through the

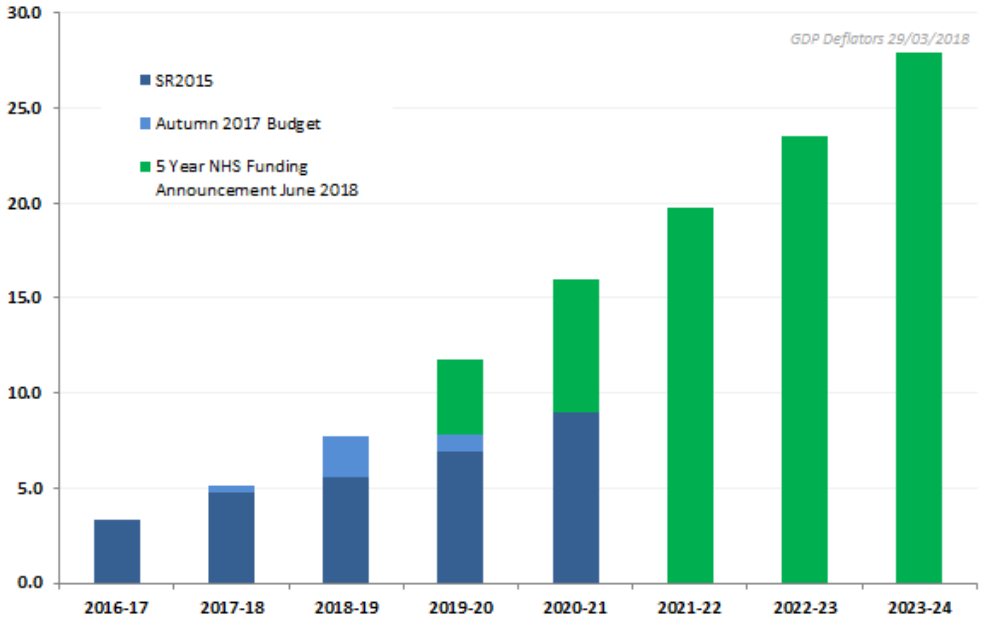
2015 Spending Review settlement with a commitment to increase NHS funding by more than £8 billion per year by 2020-21 compared to 2015-16 (and £10 billion compared to 2014-15), and it has subsequently continued this support with additional funding increases.

146. Further new funding announced in the 2017 Autumn Budget has helped to relieve some of the pressure on the system during a particularly difficult winter, allowing trusts to focus on the operational challenges whilst helping to manage finances within agreed controls, in 2017-18 and providing further increases into 2018-19 and 2019-20.

147. And in June 2018, the Prime Minister set out a new multi-year funding plan for the NHS, setting the real terms growth rate for spending in return for the NHS agreeing a new long-term plan with the Government later this year.

148. All of this means that the NHS is seeing real growth in its budget despite the continuing challenging economic conditions. **Figure 10** provides a time-series of NHS funding growth.

Figure 10: NHS Funding Cumulative Growth in real terms over 2015-16 (£billion)



149. The Government's Mandate to the NHS includes a clear objective for the NHS to balance its budget; for NHS England and NHS Improvement (which has responsibility for financial control in NHS providers) to work together to stabilise finances across the system; and, to increase financial sustainability through improved efficiency and productivity in the provision of healthcare.

150. To meet this objective, the NHS developed its own financial strategy for delivering financial balance and sustainability into future years as part of the 'financial re-set' in July 2016. The aspiration and financial levers of this reset have remained in place throughout 2017-18 and this has resulted in a continued stabilisation of finances in the majority of NHS providers.

151. The following controls and incentives have been key to the financial management regime across the NHS during 2017-18:

- Control totals: setting a minimum financial performance target for NHS providers.
- Sustainability and Transformation Fund (STF): deploying a £1.8 billion budget aimed at helping improve NHS providers' financial positions and incentivising improved efficiency and performance management.
- Agency controls and targets: continuing with the successful programme that has seen a sizeable reduction in the cost of using expensive agency staff (both nursing and medical).
- Fines: removing national fine sanctions from those providers agreeing to control total conditions to avoid them from both being fined and losing STF payment at the same time should they fail to meet agreed performance targets.

152. To support the financial levers and incentives, there has been a continuation of programmes to improve the efficiency and productivity of the system, as set out in the NHS' 10-Point Efficiency Plan[48], that includes:
    - Operational Productivity Programme[49]: reducing variation in clinical practice and improving management of resources in NHS acute, community, mental health, and ambulance providers, following the recommendations of the 2016 Carter Review of operational productivity.
    - Getting it Right First Time[50]: driving quality and productivity improvement in over 30 clinical specialities, helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes.
    - Other cost improvement initiatives: such as RightCare[51] which is supporting commissioners to reduce unwarranted variations in care; and NHS Improvement's Financial Improvement Programme which is providing central support combined with sharing learning and guidance to help raise levels of achievement against plans.

153. Finally, a series of contingency and mitigation strategies were in place to ensure that where things might go wrong, financial balance and sustainability is achievable, alongside continued delivery of high-quality healthcare services, these include:
    - System risk reserve: securing a central risk reserve within the NHS budget, available to deploy to offset cost pressures across the NHS.
    - Special Measures for Finance: supporting those NHS providers who show signs of growing financial struggle with intensive and dedicated help.
    - Capped expenditure process: providing extra targeted support to health economies with the greatest gap between their planned expenditure and their budget to help them achieve financial balance.
    - Interim finance support: providing financial support to NHS providers where things do go wrong and they require access to cash to continue the delivery of affordable, safe, quality healthcare.

154. The NHS continues to work incredibly hard to manage its finances in a challenging period. Since the financial re-set of July 2016, the NHS has gripped the financial challenge with the significant step forward made in 2016-17 maintained into 2017-18.

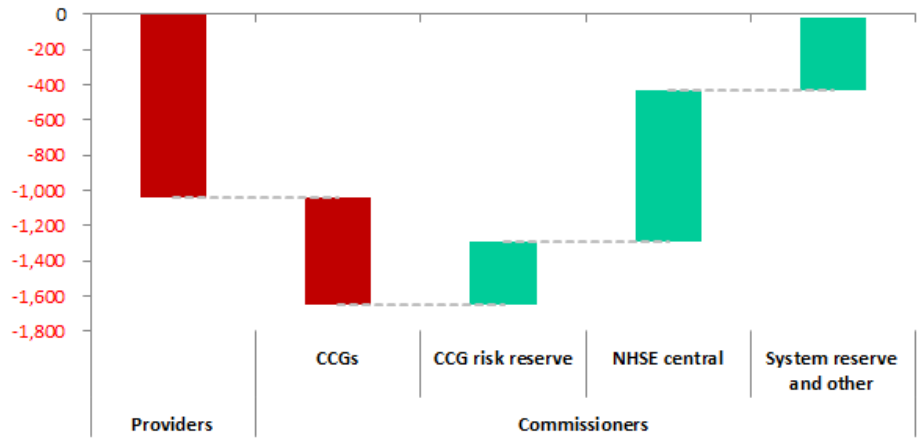
[48] https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/funding-and-efficiency/
[49] https://www.gov.uk/government/publications/productivity-in-nhs-hospitals
[50] http://gettingitrightfirsttime.co.uk/
[51] https://www.england.nhs.uk/rightcare/what-is-nhs-rightcare/

155. NHS providers reported an aggregate deficit of just under £1 billion in 2017-18, however this overall deficit, the size of individual deficits and the number of trusts reporting a deficit have all significantly improved since 2015-16 and the NHS financial reset.

156. In addition, CCGs reported financial pressures, but by deploying the contingency measures described previously and achieving underspends in NHS England centrally managed programmes, the NHS reported a broadly balanced position. The difference between the aggregate provider deficit and net commissioner underspend equating to only circa £20 million. See **Figure 11**.

Figure 11: Net NHS Financial Balance 2017-18

Pressures and savings across providers and commissioners (£m)



157. A number of exceptional events described earlier in this report, occurred during the year leading to further financial pressure on the system. These include: the impact of terrorist attacks, cyber-attacks on NHS infrastructure, and other such incidents; pressures relating to concessionary prices for generic drugs; all in addition to the pressure faced by the system in an extraordinarily challenging winter period.

158. NHS England achieved an under spend of almost £1 billion of which £0.6 billion relates to the planned release of system reserves and contingencies, to offset overspends in the provider sector of the NHS. CCGs collectively overspent by £0.6 billion (reducing to £0.2 billion after the release of the CCG proportion of the risk reserve), resulting from a range of financial challenges including pressures on generic drug prices; a degree of shortfall in meeting quality, innovation, productivity and prevention targets (QIPP) (despite delivering an unprecedented level of efficiencies compared to previous years); higher than planned complex activity in the acute hospital sector; plus pressures on Continuing Healthcare budgets. The CCG overspending was offset, and the surplus achieved, through a combination of: centrally managed efficiency measures; re-phasing of centrally-managed expenditure; plus benefits from unplanned receipts.

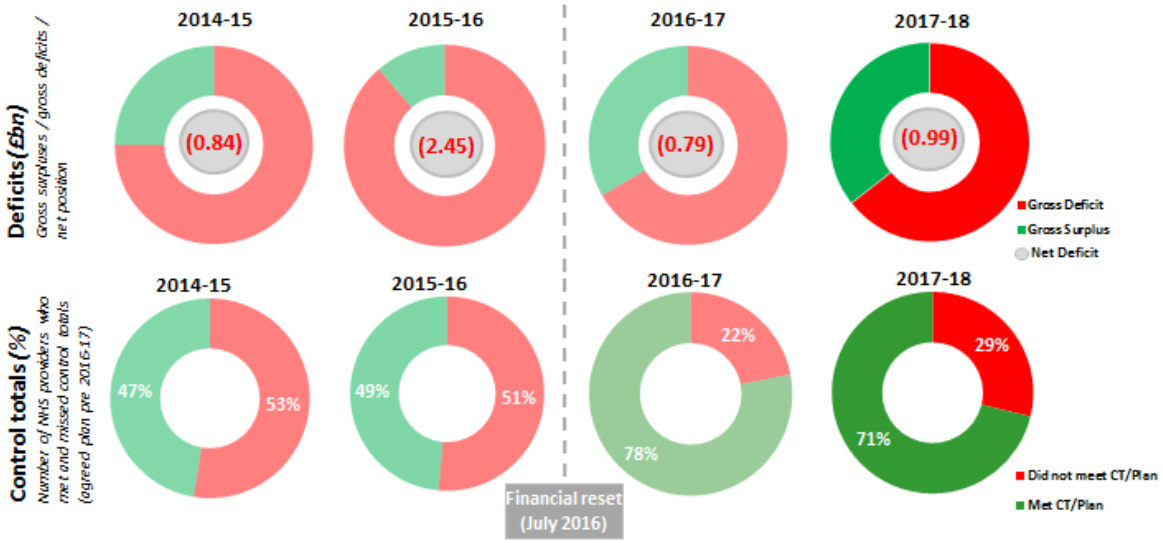
159. NHS providers have reported an aggregate net deficit of just under £1 billion. This is c£0.5 billion over plan and, in addition, to the exceptional challenges outlined above, the main underlying drivers of this deficit are:

- Lower income receipts because of a need to prioritise a higher level of urgent and emergency care cases in A&E at the expense of planned hospital procedures.

- Lower cost improvement compared with plans, which, in part can be attributed to operational issues (for example, a lack of bed capacity to support theatre productivity), but also due to wider variance across the sector on efficiency.
- Overspends against pay plans caused by increased demand, vacancies and staff sickness/absence that were partially offset by savings achieved on agency staff spending.

160. Despite the challenging environment, NHS providers continue to demonstrate that strong, effective and sustainable financial management is possible. The growing deterioration in the aggregate deficit reported by trusts was reversed and stabilised in 2016-17 and maintained into 2017-18 as shown in **Figure 12**. And the majority of trusts have gripped their finances and continue to deliver within controls.

Figure 12: NHS provider deficit time series



161. Despite these successes, there remains a minority of organisations reporting significant deterioration against their agreed controls. For example, 15% of providers are disproportionately driving the aggregate variance to plan, together reporting around a £0.7 billion variance to plan. And of those, four trusts have reported overspends of more than £30 million. These trusts rely heavily on short-term financing support from the Department to pay their staff and bills, enabling the continued delivery of patient care.

162. As discussed in the NHS's own *Next Steps on the Five Year Forward View*[52], it is critical that those geographies that are significantly out of balance now confront the difficult choices they have to take. Where necessary this may mean explicitly scaling back spending on locally unaffordable services, so that they go in to the future with viable and balanced plans. NHS Improvement is intervening in all of these organisations to provide additional support to get them back on track. This includes tackling underlying structural issues, improving patient flow to reduce delayed transfers of care, resolving disputes with commissioners, maximising operational productivity opportunities or undertaking reconfiguration, to make best use of services across local areas, and placing those with most need into financial special measures. Measures taken by NHS Improvement to

[52] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

address the financial challenges faced in these organisations are vital to the success of the long-term NHS financial strategy.

163. The NHS must also become an increasingly efficient system to make sure that the funding it receives is used in the most effective manner to achieve best value. The overall efficiency challenge is set out in the joint NHS' 10 Point Efficiency Plan – a single, agreed plan of action as to how the NHS will deliver the necessary savings to ensure it lives within its means. NHS England and NHS Improvement have joint oversight over the programme and monitor its progress. They provide expert central support and combine this with the sharing of learning and guidance to help raise levels of achievement against plans. Each NHS organisation has been set a stretching efficiency target as their contribution to this plan.

164. NHS England and NHS Improvement have worked with commissioners and providers and aligned annual savings plans – Commissioners' Quality Innovation Productivity and Prevention (QIPP) plans and providers' cost improvement programme (CIP) plans – with the NHS' 10-Point Efficiency Plan. In 2017-18 current expectations will see commissioners and providers collectively deliver efficiency savings of over £6 billion.

165. At this moment the NHS is not yet seeing the level of sustainable efficiencies that it needs, and organisations need to address this and deliver more recurrent efficiencies and reduce reliance on one-off short-term solutions.

166. In addition, of all public services, the NHS has been afforded the most priority by this Government. At the 2015 Spending Review the Government committed to increase funding by £8 billion per year in real terms by 2020-21, compared to 2015-16 (and £10 billion compared to 2014-15). At Autumn Budget 2017 a further £2.8 billion for frontline services was announced, and the Government announced that it was lifting the pay cap and funding a pay award for those staff working in the NHS under Agenda for Change Contract terms and conditions. And on 18 June 2018, the Prime Minister announced a new five-year budget settlement for the NHS, a further increase of over £20 billion a year in real terms by 2023-24. This all means that the NHS is properly funded to ensure it can meet the growing demands of the service.

167. The NHS will now produce its own ten-year strategic plan, led by doctors, that will set out how this money will be best spent to get the NHS back on track delivering core performance standards, and take forward the reforms that will ultimately deliver a better and more sustainable NHS with improved care for patients

168. Outside of the NHS sector, the Department's non-NHS sector contained revenue expenditure within DEL spending limits, absorbing a material starting over-commitment, primarily as a result of the contributions made as part of the 2015 Spending Review (SR15) to mitigate pressures in the NHS. This was extremely challenging and some hard decisions were taken to reduce the non-NHS risk without compromising the support of the wider system, whilst safeguarding the interests of patients and the wider public.

169. During the year, further unmanageable pressures emerged relating to lower than anticipated drugs receipts and higher expenditure relating to reciprocal healthcare arrangements in the European Economic Area. Despite our efforts, this gap could not be closed in totality and HM Treasury awarded additional Reserve Claim funding of c£0.3 billion via the 2017-18 Supplementary Estimate.

Capital Departmental Expenditure Limit (CDEL)

170. The Department's Capital Departmental Expenditure Limit for 2017-18 was £5.6 billion; including a transfer of £1 billion to the Revenue DEL budget authorised by Parliament via the in-year Supplementary Estimate process. This transfer was agreed with HM Treasury at the time of Spending Review 2015 as part of a planned, time limited and reducing transfer of capital across the current Spending Review period.

171. Approximately £3.1 billion of the Department's total CDEL is spent by NHS providers (net of charities) to cover their operational (e.g. maintaining existing estate) and strategic (e.g. digitalisation, transformation, new builds) investment needs - demonstrated in Annex B, Capital DEL Spending Breakdown by Sector. This expenditure is financed primarily through providers own self-generated cash for which there is currently little central leverage available to the Department. This is further supported by DHSC financing in the form of Public Dividend Capital and/or repayable capital loans. This is demonstrated in Annex B, Financing of Capital DEL.

172. The remainder of the group CDEL budget is utilised on Research and Development, the Disabled Facilities Grant payable to the Ministry of Housing, Communities and Local Government, the Department's and ALB's central and strategic investments, investment in primary care, community and social care (£0.2 billion), and informatics. This is demonstrated in Annex B, Capital DEL – spending.

173. Contributing to the provider capital envelope was additional funding provided at the 2017-18 Spring and Autumn Budgets (£209 million and £506 million respectively), which allowed the Department to:
    - Invest in streamlining patient flow in A&E effectively, helping ensure all patients get the right treatment, in the right place as quickly as possible.
    - Support trusts facing with the most urgent critical backlog maintenance.

174. Overall DHSC net capital expenditure during the year was £5.2 billion resulting in a circa £0.4 billion underspend against the capital budget. This underspend arose predominantly due to NHS providers' capital spend being significantly lower than they planned and forecast. This does not mean the capital requirements of the system fall below the current CDEL budget, but instead demonstrates the challenge the Department faces in ensuring the maximum consolidated capital spend is delivered within an annual voted limit.

175. Recognising that the current capital regime presents challenges both nationally and locally in effectively planning and forecasting capital investment, the Department is working closely with NHS Improvement to review the regime over the coming year to minimise future unnecessary underspends and ensure the maximum funding is deployed in the most effective manner.

Sustainability and Transformation Plans supporting the move towards Integrated Care Systems

176. In 2017-18 we announced 77 STP schemes to transform patient care and invest in new facilities, with 40 schemes announced in March 2018 – including a £300 million major scheme for Shrewsbury and Telford NHS Trust.

177. By necessity, in more recent years there has been a requirement to prioritise both revenue and capital funding towards financial sustainability over transformation in the interest of securing patient services.

178. However, the pace of transformation work now needs to pick up. While speeding this up is necessary it is important that this is done with the involvement and buy-in from patients, public and staff; and through creating partnership working between the NHS, local authority and voluntary sectors. It is about changing attitudes and approach as much as changing service delivery and physical structures.

179. Through the 2017 Autumn Budget, we have committed to £3.5 billion of new capital investment by 2022-23 to transform the NHS estate and drive further efficiency savings, with;
    - £2.6 billion for STPs 'to deliver transformation schemes that improve their ability to meet demand for local services. This funding will enable them to deliver more integrated care for patients, more care out of hospital and reduce waiting times'.
    - £700 million to 'support turnaround plans in the individual trusts facing the biggest performance challenges, and tackle the most urgent and critical maintenance issues that trusts are facing – to help ensure every patient is treated in a safe environment, conducive to the highest quality of care'.
    - £200 million to 'support efficiency programmes that will, for example, help reduce NHS spending on energy, and fund technology that will allow more money and staff time to be directed towards treating patients'.

180. This investment crystallises the government's commitment to transforming the NHS estate to deliver improved services for patients as recommended by Sir Robert Naylor's review. The response to the review[53] sets out the steps the government will be taking, including increasing the skills and capability in the system, so that NHS Estates strategies are focused on the delivery of clinical priorities, while also addressing backlog maintenance and taking advantage of the opportunities presented by surplus land.

Investment in enabling technology and mitigating Cyber risks

181. The Department funded a programme of capital investment in cyber security totalling around £61 million during 2017-18. The funding was awarded following a bidding process co-ordinated by NHS England with input from NHS Digital, NHS Improvement and the Department.

182. Capital investment funding was also awarded to NHS providers as part of the Personalised Health and Care 2020 Informatics Strategy. A total of around £94 million was invested into a range of Provider Digitisation schemes, mainly Global Digital Exemplar sites who will ultimately share their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible.

183. Following a Secretary of State commitment to provide patient Wi-Fi access across secondary care, allowing patients and the public to download health apps, browse the internet and access health and care information NHS England identified a number of pilot sites who received a total of £11 million of capital investment in 2017-18 in order to put in

[53] https://www.gov.uk/government/publications/naylor-review-government-response

place an updated Wi-Fi infrastructure involving 33 trusts selected to take part in the second stage of delivery.

Annual Managed Expenditure (AME)

184. The Department's Annually Managed Expenditure (AME) budget is set annually outside the Spending Review and has no immediate impact on the fiscal framework[54] or need for taxes to be raised to cover spending.

185. Expenditure that scores to this budget is demand-led, can be volatile and subject to many variables outside of the Department's direct control. The budget is materially affected by the need to provide for future costs in cases where the Department is the defendant in legal proceedings brought by claimants seeking damages for the effects of alleged clinical negligence.

186. The final AME budget in 2017-18 was set at £27.9 billion. This included a cautious estimate of expenditure, provided by NHS Resolution (NHSR), based on an early analysis of variables impacting future clinical negligence costs undertaken by their actuarial advisors.

187. As a result of favourable reductions, including the number of clinical negligence claims and claims inflation, the estimated quantum of future clinical negligence expenditure at the end of 2017-18 was significantly lower than had been forecast at the time of budget setting. DHSC therefore underspent by £14.8 billion on its AME budget of £27.9 billion.

188. This is the second year that there have been significant variances between NHSR's forecast at the point of setting the AME budget and final estimated provision expenditure. DHSC will be working with NHSR to make the necessary changes in order to minimise these fluctuations in future years.

[54] https://www.gov.uk/government/publications/charter-for-budget-responsibility-autumn-2016-update

Our performance against other required reporting

Sustainable Development, Sustainable Procurement, Climate Change and Rural Proofing

189. 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 their progress in terms of reducing the environmental impact of their operations, through the Greening Government Commitments (GGC)[55]. The GGC are a set of agreed targets that cover carbon emissions related to energy use and business travel, water use and waste.

190. We are committed to long-term sustainable development. At 2017-18 (against a 2009-10 baseline) the Department and its in-scope ALBs have reduced our carbon emissions by 53%, our waste tonnage by 28% (with only 4% to landfill) and our water use by 16%. We also reduced the number of domestic flights taken by staff by 62%. More detail around our performance in these areas is included within Annex D.

53% reduction in greenhouse gas emissions by DHSC in last 8 years

191. We work closely with other government departments, and also support the health and social care system via the NHS Sustainable Development Unit (SDU)[56]. The SDU assists the health and care system to develop Sustainable Development Management Plans (SDMP) and links sustainability to healthcare improvement. Published in 2014, the Sustainable Development Strategy for the Health, Public Health and Social Care System 2014-2020[57] outlines the vision for the health system.

192. We have continued to promote sustainable procurement, which engages and influences procurement practice on a number of key sustainability issues including consideration of the Public Services (Social Value) Act and the Small Medium Enterprise (SME) Agenda. We have maintained a good level of compliance with Government Buying Standards and work continues under the facilities management contract to support energy efficiency and carbon reduction.

193. A percentage of our expenditure is contracted through pan-government frameworks and contracts managed by the Crown Commercial Services (CCS) and the Department supports the use of sustainable procurement within these frameworks. For large, strategic procurement projects, sustainable procurement is considered through a procurement strategy.

194. Within the wider civil service, planning for the delivery of the Sustainable Development Goals is embedded into the Single Departmental Plan (external) and the Departmental Business Plan (internal) for each department. In both the internal and external business plans, each department outlines how planned activity will support the delivery of the Goals. Departmental reporting against Single Departmental Plans includes evidence of progress in implementing the Goals, allowing the Department for International Development (DFID) and the Cabinet Office to track delivery.

[55] https://www.gov.uk/government/publications/greening-government-commitments-2015-to-2016-annual-report
[56] http://www.sduhealth.org.uk/
[57] http://www.sduhealth.org.uk/search/resources.aspx?q=sustainable+development+strategy&zoom_query=sustainable+development+strategy

195. Single Departmental Plans, showing how planned activity will contribute to the delivery of the Goals, are made available on GOV.UK. The Departmental Business Plan sets out each department's medium-term objectives, including how departmental activity will deliver the Goals. They enable a department's contribution to delivery of the Goals to be reported publicly in the Departments' Annual Report and Accounts, and enable progress to be scrutinised by parliament and the public.

196. The Department (DHSC) has identified how policies in its Single Departmental Plan[58] support the Sustainable Development Goals and identified suitable metrics will be reported upon. A Sustainable Development Management Plan (SDMP) for DHSC has been drafted and will be submitted to the Management Committee for approval. The Management Committee will have oversight of progress on the commitments in the SDMP.

197. The DHSC National Adaptation Steering Group feeds into the development of the Climate Change Risk Assessment and National Adaptation Programme, monitors actions from health and social care and reports to Defra under the Climate Change Act. The Steering Group is chaired by DHSC and has members from Public Health England (PHE), NHS England, NHS Improvement and Defra.

198. The Department and PHE participate in the Domestic Adaptation Board, the Cross Whitehall Sustainable Development Group, and the Cabinet Office led Sustainable Development Goal Planning and Performance Group. DHSC also engages with the Cross System Health and Social Care Sustainable Development Group with the Secretariat provided by the NHS England/PHE funded Sustainable Development Unit.

199. DHSC has a sustainability toolkit to assist its policy teams assess sustainability questions in Impact Assessments. There are sections in the DHSC impact assessment guidance to cover the sustainability 'specific impact tests', based on and consistent with, the Better Regulation Framework Manual advice to Government Departments[59], and The Green Book: Appraisal and Evaluation in Central Government[60], published by HM Treasury.

Climate Change Adaptation

200. We are looking at how best to take our sustainable development and climate change work forward, building on the Greening Government Commitments and the UN's 2030 Sustainable Development Goals. The Department and its ALBs have worked to make sure that health is represented in cross Government strategies seeking to develop our society in a healthy and sustainable manner, including the Clean Growth Strategy[61] and the 25 Year Environment Plan[62]. We are working closely with the Department for Environment, Food and Rural Affairs (Defra) on a new Clean Air Strategy to be published later in 2018.

201. We encourage all staff to think about sustainability, including climate change, in all our policies and in engagement and interactions with our stakeholders and supply chains and

[58] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan/department-of-health-single-departmental-plan
[59] https://www.gov.uk/government/publications/better-regulation-framework
[60] https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent
[61] https://www.gov.uk/government/publications/clean-growth-strategy
[62] https://www.gov.uk/government/publications/25-year-environment-plan

will be using the Sustainable Development Goals to help our staff identify how sustainable development and climate change can be addressed in their everyday work.

202. In conjunction with Defra, we have produced a second National Adaptation Programme (NAP)[63], which sets out what government, businesses and society are doing in response to the top risks identified in the second Climate Change Risk Assessment (CCRA), which was laid before Parliament in January 2017[64]. We are currently finalising the objectives in health-related areas, covering actions to ensure public health protection plans take account of climate change risks, and improve resilience of health and social care facilities in the NAP.

203. A key part of the Department's national adaption planning to reduce the public health impacts of climate change, is in the preparation of climate proof plans to protect public health from the effects of extreme weather and climate change which will lead to an increase in the severity of these extreme weather health impacts. In the second NAP these will be combined into a single adverse weather plan for the health and Social Care Sector.

Rural Proofing

204. We have been working with Defra to develop and promote the Rural Health Proofing tool[65], designed to share good practice on health and health services in rural areas, with a view to its greater use in the NHS. We have collaborated with Defra and NHS England about Lord Cameron's rural proofing review and shared with Defra relevant NHS policy developments, such as the GP's Minimum Practice Income Guarantee (MPIG). In his review report, Lord Cameron emphasised that all Government policies need to make rural issues a routine policy consideration. The Government's response to the review published in December 2015[66], supported this approach and committed to strengthen departmental rural proofing guidance.

Correspondence and Complaints to the Parliamentary Ombudsman

205. As shown in **Table 2**, in 2017 we answered 32,346 letters and emails, responding to over 93 per cent within our target rate of 18 working days. This firmly positions us as one of the top performing departments in Government, with the highest volume of correspondence received. In line with standard correspondence reporting, the data shown is for the calendar year 2017 and not the financial year 2017-18.

93% of DHSC correspondence cases responded to within 18 days target in 2017

Table 2: Correspondence Cases 2017

Case type	Due in 2017	Completed On Time	Percentage On Time
Private Office	12,348	11,242	91.0%
Treat Official	6,446	6,101	94.6%
Departmental Email	13,552	12,816	94.6%
TOTAL	32,346	30,159	93.2%

NB: Excludes Freedom of Information (FOI) cases

[63] https://www.gov.uk/government/publications/adapting-to-climate-change-national-adaptation-programme
[64] http://www.defra.gov.uk/environment/climate/government/risk-assessment/
[65] https://www.gov.uk/rural-proofing-guidance
[66] https://www.gov.uk/government/publications/rural-proofing-government-response-to-lord-camerons-review

206. As shown in **Table 3**, in 2016-17 (the last year for which published results are available) the core Department received 22 complaints. One complaint was accepted for investigation by the Parliamentary and Health Service Ombudsman (PHSO) and one complaint was partially upheld. The PHSO made one recommendation in relation to the partially upheld complaint, which the Department complied with in full.

Table 3: PHSO Complaints core Department 2016-17

Enquiries Received	Assessed	Accepted for Investigation*	Investigation Upheld/partly Upheld	Investigations not Upheld	Investigations resolved without completion of investigation**	Investigations resolved without a finding***
22	1	0	1	4	0	7

* The number of cases accepted for investigation by the PHSO in a financial year differs from the number of investigations completed in the same year. This is because the statistics only provide a snapshot of the casework flow at a given time. For example, the PHSO may have accepted a complaint for investigation in 2016-17 but not completed it until the following year 2017-18. Similarly, it may have completed an investigation in 2016-17 which we originally accepted for investigation in the previous year 2015-16.

** 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.

207. The Department's complaints process follows the PHSO's Principles of Good Complaint Handling[67]. 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

208. The Public Contracts Regulations 2015[68] states 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.

209. **Table 4** details the percentage and value of undisputed invoices paid by NHS provider organisations within the agreed terms.

Table 4: Prompt Payment of undisputed invoices

	NHS Providers invoices paid within target [1,2]	
Financial Year	Percentage	Value (£m)
2017-18	77	34,505

1. 2017-18 data includes NHS Foundation Trusts for the first time as this data was not collected by NHS Improvement or the Department of Health and Social Care prior to 2017-18
2. 2016-17 data was only available for NHS Trusts and is not shown in the table as it is not directly comparable with 2017-18. (2016-17 NHS Trust only 78%, £11,036m)

[67] https://www.ombudsman.org.uk/about-us/our-principles/principles-good-complaint-handling
[68] http://www.legislation.gov.uk/uksi/2015/102/contents/made

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

211. 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 (ODA)

212. The Department of Health and Social Care's summary of expenditure on ODA is included at Annex E. This amounted to £101 million in 2017, funding Global Health Research and Global Health Security.

Better Regulation

213. 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.

214. We support Government's policy on regulatory efficiency (as outlined in the manifesto) and are committed to putting the Industrial Strategy at the heart of our better regulation approach and building regulatory regimes to support innovation.

215. The Small Business, Enterprise and Employment (SBEE) Act 2015[69] requires Government to set a Business Impact Target (BIT) for the length of the Parliament. A £9 billion target to regulate more efficiently has already been announced in the manifesto. An interim target for the first three years of the Parliament (i.e. up to June 2020) will be set. The Government intend to take the same approach as during the last Parliament and have set this at the midpoint of the overall target (i.e. a net saving of Ê4.5 billion to business). The Government have confirmed that departments will not be set a target of deregulatory savings for this Parliament.

216. We are working closely with our key regulators to understand how their activity will contribute to the provision of safe, effective and compassionate care.

217. The Department is working in partnership with the Better Regulation Executive to promote the consideration and use of alternatives to and ways of regulating across the Health & Social Care System and delivery of high quality, proportionate, and targeted, regulatory solutions through the use of our policy profession.

[69] http://www.legislation.gov.uk/ukpga/2015/26/contents/enacted

Secretary of State for Health and Social Care Annual Report 2017-18

Introduction

218. The Secretary of State is required by section 247D[70] of the National Health Service Act 2006, (the 2006 Act), to publish an annual report 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.

219. This report comments on services commissioned by the National Health Service Commissioning Board (known as NHS England) and clinical commissioning groups (CCGs), as well as those public health services for which the Secretary of State and local authorities are responsible[71]. 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 inequalities) of the 2006 Act[72].

220. The Secretary of State is under a duty in section 1A of the 2006 Act 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)[73]. 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 get from the health service. The assessments of the discharge of these duties are set out below specifically in relation to performance of the NHS against key access standards; outcomes frameworks; NICE quality standards; and health inequalities.

Performance of the NHS against key access standards

221. There are a number of operational 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. During 2017-18, the Secretary of State held regular performance and accountability meetings with the chief executives of NHS England and NHS Improvement, to account for their management of the NHS, seeking assurances on delivery of the constitutional standards, and what action they are taking where the standards are not being met. Details of how the NHS acute sector has delivered against several of these main access standards are given in the main body of this Annual Report under 'NHS Operational Performance' at Annex C.

Single Departmental Plan

222. In line with the process other government departments have followed to agree their single departmental plans, the Department's Single Departmental Plan (SDP)[74] highlights the priorities, objectives, accountabilities and measures that will guide the work of the health and social care system in the coming years. During financial year 2017-18, progress for the Department and the wider system was assessed via the SDP.

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[70] Secretary of State for Health Annual Report on the performance of the health service in England is presented to Parliament pursuant to section 247D subsection (3).
[71] Social care is not a health service but is covered for completeness.
[72] The assessment is required under section 247D (2) of the National Health Service Act 2006
[73] The NICE quality standards duty relates to section 1A(4)
[74] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan/department-of-health-and-social-care-single-departmental-plan

223. The SDP is aligned with the outcomes frameworks. In particular, where the SDP is focussed specifically on outcomes, it draws on metrics already included in the outcomes frameworks, a review of performance is included in the 'Performance Analysis' section of this Annual Report.

Outcomes Frameworks

224. 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 outcome frameworks, describing the outcomes that need to be achieved.

225. Collectively, these three outcome 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. Together the outcome frameworks also highlight common challenges across the health and care system at the national and local level, informing local priorities and joint action whilst reflecting the different ways services are held accountable.

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

Alignment

227. 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. The Department is committed to increasing the alignment of the outcome 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 (NHSOF)

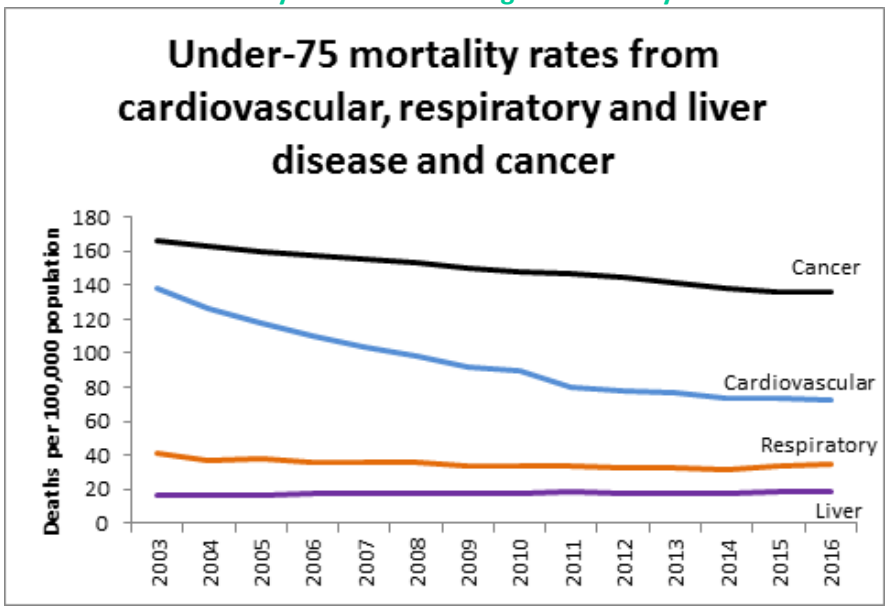
228. The NHS Outcomes Framework (NHSOF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The Framework provides an overview of how the NHS is performing. The NHSOF comprises five domains: preventing people from 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; treating and caring for people in a safe environment and protecting them from avoidable harm.

229. New data has been published for 32 of the 69 indicators in the Framework in the last year. In 2017-18, the majority of indicators remained stable or did not change significantly compared to the previous year, although a number showed more significant changes. The data in this section comes from various sources and is the latest data available. The key

changes in each domain are set out in the following paragraphs. Full details on the indicators can be found on NHS Digital's website[75].

230. Medical and technological advances mean that people are living longer 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. See **Figure 13**.

Figure 13: Under-75 mortality rate over the long-term for key conditions



Source: NHS Digital

Preventing people from dying prematurely

231. The under-75 mortality rates for cardiovascular disease (CVD) and for cancer continue to improve steadily.

232. However, there has been a significant increase in the under-75 mortality rate for respiratory disease for the second year running following a downward trend between 2003 and 2014. The rate climbed to 35.3 deaths per 100,000 of population in 2016 from 34.0 in 2015 – an increase of 3.8%. Deaths from liver disease have shown little change over the last decade.

233. To ensure improvements across all of these areas, the NHS Health Check programme targets seven of the top eight behavioural and physiological risk factors driving premature death and ill health in England, therefore not only targeting CVD but also other non-communicable diseases such as cancer, respiratory and liver disease and dementia.

Enhancing quality of life for people with long-term conditions

234. When people do need healthcare, the NHS continues to provide the care people need to live a fulfilling life. In 2016, there were large, significant reductions to the unplanned admission rate for 0-18 year olds for asthma, diabetes and epilepsy, with the largest

75 https://digital.nhs.uk/search/category/nhs-outcomes-framework--nhs-of-/category/clinical-indicators-team?sort=relevance&area=data

decrease occurring in the one-year age group. The rate reduced from 312 admissions per 100,000 of population in 2015-16, to 304 admissions per 100,000 of population in 2016-17, a decrease of 2.6%.

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

235. The NHS continues to support people as they recover from injury or episodes of ill health. There has been a significant improvement in the proportion of patients recovering from their previous level of mobility following hip fracture after 120 days since 2015 and in each of the years the indicator has covered so far (since 2011). It rose from 61.2% in 2015 to 63.9% in 2016.

236. An indicator that demonstrates significant change in this area is the increase in the number of emergency admissions for children with lower respiratory tract infections. The total has risen from 422.7 per 100,000 of population in 2015-16 to 446.4 per 100,000 of population in 2016-17, representing a 5.6% increase. There has been a significant increase of 43.1% from 2003-04's figure of 311.9 per 100,000 of population. There are many socio-economic factors driving this increase that has meant we are now working even closer with parents, children and clinicians to monitor and support respiratory tract conditions and in turn reduce hospital admissions.

Ensuring that people have a positive experience of care

237. The Government is pleased that most patients are satisfied with the healthcare that they are receiving. Between the last two years, inpatients report a 2.2% drop in responsiveness to their personal needs. This follows annual increases from 2009-10 to 2015-16. However, changes to the sampling methodology for patient experience of A&E services may have affected comparability.

238. There was a reduction in the percentage of people reporting a 'very good' or 'fairly good' experience of their GP surgery and experience of making an appointment, although satisfaction remains high. After a slight increase in 2015-16, the percentage reporting a 'very good' or 'fairly good' experience of their GP surgery fell from 85.2% to 84.8% in 2016-17, and satisfaction with making an appointment fell from 73.4% to 72.7% in the same period.

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

239. The Department is committed to ensuring that English hospitals and GP surgeries are the safest in the world. Overall, patient safety incidents have been increasing over the last 14 years. However, rates are more likely to be due to there being a more open culture, where staff can learn from incidents, rather than genuine changes in the number of patient safety incidents.

240. There has been a large reduction in cases of both Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium Difficile* since 2008-09. The number of cases has been more stable in recent years, but there was a 9% fall in the number of cases of *Clostridium difficile* in 2016-17.

The Public Health Outcomes Framework (PHOF)

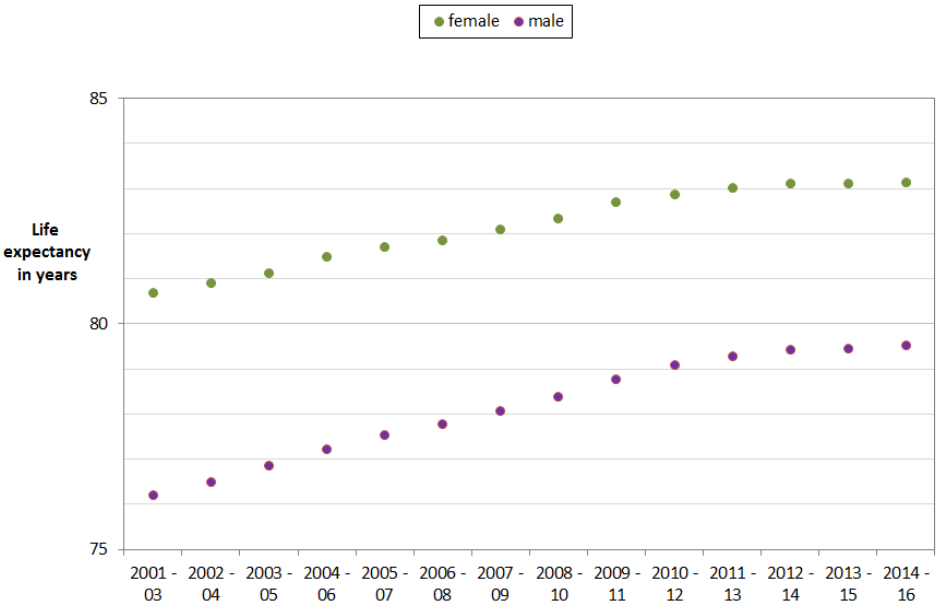
241. The strategic vision for public health in England concentrates on two high-level outcomes:

- Increased healthy life expectancy[76].
- Reduced differences in life expectancy and healthy life expectancy between communities.

242. Throughout this section assessment of progress on indicators is made by comparing the most recent value of an indicator to the value it had in 2014[77].

243. Life expectancy and healthy life expectancy at birth have remained relatively stable since 2014[78]. However, there has been a general improvement in life expectancy over the longer term as shown in **Figure 14**.

Figure 14: Life Expectancy at birth, Males and females 2001-03 to 2014-16



244. As a whole, for the majority of indicators in the Public Health Outcomes Framework, the trends in England are either broadly constant or have improved in comparison with 2014. However, for most indicators there remains considerable variation across local authorities. For details on indicators please refer to the Public Health England (PHE) website[79].

Improving wider determinants of health indicators

245. The majority of the indicators in this domain have improved or remained constant.

246. In particular we have seen an increase in children achieving a good level of development at the end of reception. Also, the percentage of Year-1 pupils achieving the expected level

[76] Is about not only how long we live, our life expectancy, but also on how well we live, our healthy life expectancy at all stages of the life course; helping people live healthy lives.
[77] For simplicity and topicality we have chosen a fairly recent year 2014 for our assessment of *subsequent* progress. Depending on the indicator, the values for 2014 refer to the 2014 calendar year itself, or to the 2014/15 financial year or to the 3 year period 2013-15. For brevity these are all referred to as the position in 2014.
[78] Only statistically significant changes are described as improvements or deteriorations in sections 4 to 16.
[79] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

in the phonics screening check has increased. Both indicators are continuing a longer term upward trend.

247. The Government's strategy 'Improving Lives: The Future of Work, Health and Disability'[80] includes measures to increase employment among people with a learning disability and people with mental health conditions. We would expect these measures to have a positive impact on deteriorating indicators in the 'wider determinants of health' domain such as:
    - the gap in employment rate between those with a learning disability and the overall employment rate, and
    - the gap in employment rate between those in contact with secondary mental health services and the overall employment rate.

Health Improvement Indicators

248. The majority of the indicators in this domain have improved or remained constant.

249. In particular smoking prevalence among adults has declined substantially. Smoking is a known risk factor for many diseases including Chronic Obstructive Pulmonary Disease (COPD), heart disease and numerous cancers.

250. However, further work is needed in seeking improvement across indicators showing deterioration, such as the coverage for the screening programmes for breast and cervical cancer, the indicator for child excess weight and the indicator for completion of drug treatment. The Department is working with NHS England and PHE to reverse the declines in screening coverage wherever possible. We are delivering a world-leading Childhood Obesity Plan which focuses on the areas that are likely to have the biggest impact on preventing childhood obesity. Similarly, for completion of drug treatment, we are working with the Care Quality Commission (CQC) to improve the quality of treatment services. From autumn 2018 CQC will commence rating this area.

Health Protection Indicators

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

252. The indicators that have deteriorated are the chlamydia detection rates and the coverage rates for some of the vaccination programmes. PHE commissioned an external peer review of the chlamydia screening programme which made recommendations to increase the efficiency of the programme and to ensure local programmes are targeting those at highest risk. PHE is also working with NHS England to improve vaccination performance for example by promoting the importance of vaccinations to the public and healthcare professionals, employing a set of targeted communications actions.

253. However some indicators have improved. These are the incidence of Tuberculosis (TB), population vaccination coverage for MMR (measles, mumps and rubella) 1 dose at 5 years, Hib/MenC booster at 5 years (haemophilus influenza type B and meningococcal C), Flu (2-4 years), and NHS organisations with a board-approved sustainable development management plan. Indicators that have shown no change are the population vaccination

[80] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF

coverage rate for Pneumococcal Polysaccharide Vaccine (PPV), human immunodeficiency virus (HIV) late diagnosis and treatment completion for TB.

Healthcare, public health and preventing premature mortality indicators

254. The majority of the indicators in this domain have improved or remained unchanged.

255. In particular, rates of cardiovascular disease and cancer mortality, two of the major causes of deaths in the under-75s, have decreased.

256. The only indicator in this domain that has deteriorated is the measure of excess winter deaths for all ages when comparing single years. There are three other measures of excess winter deaths in this domain which have all improved or stayed the same. The causes of excess winter deaths are complex and vary from year to year, depending on the interplay of factors such as outdoor winter temperatures and how much circulating influenza there is. The winter of December 2014 to March 2015 had unusually high excess deaths whereas in the previous winter the number was unusually low.

The Adult Social Care Outcomes Framework (ASCOF)

257. The 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.

258. **Table 5** shows selected data. Further detail on the ASCOF and all of the indicator data can be found at NHS Digital's website[81].

Table 5: ASCOF Indicators

Rating	Enhancing quality of life for people with care and support needs	Delaying and reducing the need for care and support	Ensuring that people have a positive experience of care and support	Safeguarding vulnerable adults and protecting from avoidable harm
Better than or on trajectory	8	3	2	2
Worse than trajectory	3	4	3	0
Rated indicators that are better than or on trajectory (%)	72.7%	42.9%	40%	100%

1. All indicators are based on 2016-17 data.
2. Correct as at May 2017

Enhancing quality of life for people with care and support needs

259. ASCOF measures cover 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 measures also cover the informal carers where appropriate. The social care-related quality of life of people who use services and

[81] https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current

their overall satisfaction with their care and support remains at the high level of the last two years.

Delaying and reducing the need for care and support

260. Keeping older people well and out of hospital and supporting them to regain their independence after a period of support is a vital part of supporting older people 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 2016-17, 82.5% were still at home, down from 82.7% in the previous year. Despite 2016-17 data showing delayed transfer of care rising, we know from more recent data that local authorities working with local health partners have successfully reduced overall numbers of delayed transfers of care. January 2018 data shows that since February 2017 delayed transfers of care due to adult social care had come down 34%.

Ensuring that people have a positive experience of care and support

261. The proportion of people who use services who say that those services have made them feel safe and secure has increased in 2016-17 to 86.4%. The proportion has increased each year since 2014-15. This may reflect the ongoing work of the Care Quality Commission and providers to raise quality and provide care users with a positive experience.

Safeguarding vulnerable adults and protecting from avoidable harm

262. 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 2016-17, 70.1% of people who used services reported that they felt safe; an increase from 69.2% in 2015-16.

NICE Quality Standards

263. 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. The Department works closely with NICE, NHS England and Public Health England to ensure that NICE's quality standard programme reflects health and care priorities. Over the past year, NICE has published 28 new and updated quality standards covering a range of topics, including HIV testing, end of life care for children and sepsis. The Secretary of State has to have regard to NICE quality standards when discharging his section 1A functions.

Quality

264. In 2017 the Secretary of State for Health and Social Care restated his commitment to the NHS "being the safest healthcare system in the world". In July 2017 the US-based Commonwealth Fund said the NHS was the best and safest healthcare system of a study of the healthcare systems of 11 developed countries.

265. Considerable progress has been made through a sustained focus on:
    - Learning from deaths and incidences of avoidable harm
    - A new national maternity safety strategy
    - Further development of the healthcare inspection and regulation model
    - Greater transparency for the public and protection for whistle blowers.

266. In 2017-18, the NHS became the first healthcare system in the world to publish estimates of how many patients may have died because of problems in their care, under the Learning from Deaths programme. Individual Trusts began publishing quarterly data of all patient deaths thought, more likely than not, to be due to problems in care from October 2017. New Regulations require Trusts to include evidence of learning and improvements to prevent such deaths in their annual Quality Accounts from June 2018. This new level of transparency is fundamental to a culture of learning and ensuring the safety of NHS services.

267. The draft Employment Rights Act 1996 (NHS Recruitment - Protected Disclosure) Regulations 2018[82] were laid before Parliament in March 2018. The draft Regulations provide a new protection from discrimination for health service job applicants who have spoken up about potential risks to patient safety and other concerns in the public interest. Subject to Parliamentary approval, the regulations are expected to come into force in 2018. These draft Regulations will fulfil the Government's commitment in responding to the recommendations in Sir Robert Francis' 'Freedom to Speak Up' review report to strengthen the protections afforded to people who speak up in the NHS.

268. The work builds on Sir Robert Francis QC's historic and ground-breaking inquiry into failings at the Mid Staffordshire NHS Foundation Trust.

269. The Care Quality Commission (CQC) was reset in 2013-14 to 'bring clarity to quality' and now operates a comprehensive and robust inspectorate regime. The organisation is in 'steady state', with inspections completed of all NHS hospitals, adult social care providers and GP practices, providing a baseline of the quality of services across England. It is also engaged in transforming its inspection model onto a digital platform.

270. The CQC report from July 2017, 'The state of health care and adult social care in England 2016-17'[83], recognised that the vast majority of patients in England are getting good care and that many parts of the NHS have improved thanks to the hard work of staff.

Patient Experience

271. Patient satisfaction for inpatient care was rated higher in 2016-17 (76.7%) than in 2009-10 (75.6%). Only two previous surveys (2013-14 and 2015-16) have returned higher scores, since 2010. The Overall Patient Experience Scores (OPES) as shown in **Table 6**, (from the 2016 Adult Inpatient Survey[84]) reflect those in the CQC's Report.

272. The scores show a small improvement in patients' experiences of the NHS with regards to building closer relationships. Overall, patients' experience of the standards of care hospital cleanliness remained at 81.1% in 2016-17.

273. However, the slightly lower scores for access and waiting; involvement in decisions about their care and treatment; and safe and co-ordinated care over the previous year, indicate there is room for improvement in these areas.

82 http://www.legislation.gov.uk/ukdsi/2018/9780111167519/contents
83 https://www.cqc.org.uk/sites/default/files/20171011_stateofcare1617_summary.pdf
84 https://www.gov.uk/government/statistics/inpatient-survey-2016

Table 6: OPES Headlines – Adult inpatient survey

Survey Year	Access & waiting	Safe, high quality , co-ordinated care	Better information, more choice	Building closer relationships	Clean, friendly, comfortable place to be	Overall patient experience score
2016-17	82.9	66.1	68.0	85.5	81.1	**76.7**
2015-16	84.5	66.3	69.3	85.4	81.1	**77.3**

Source: *Overall Patient Experience Scores: 2016 adult inpatient survey update* (NHS England)

Speaking out and learning

274. A key priority of the Secretary of State is to instil a learning culture across the NHS and to reduce the incidence of avoidable harm. All acute, mental health and community Trusts are expected to have proper arrangements for learning from deaths and CQC inspections now assess their compliance against the national guidance.

275. The Healthcare Safety Investigation Branch (HSIB) began its work in April 2017 to conduct independent investigations of serious patient safety incidents in the NHS in England with a specific focus on system-wide learning and improvement.

276. In September 2017, the Government laid a draft Bill in Parliament to establish a new independent Health Service Safety Investigations Body to take forward HSIB's work with legal protections.

277. The Secretary of State's commitment to improving openness in the NHS has resulted in more than 500 appointments of 'Freedom to Speak Up' Guardians, Champions or Ambassadors across all trusts, helping to raise more than 1,000 patient safety issues.[85]

278. The Department is working with the adult social care sector to implement the Quality Matters initiative, launched in July 2017, which is a shared commitment to achieve high quality adult social care for everyone who uses, works in and supports adult social care through six actions. These include acting on feedback; measuring and using data more effectively; and commissioning for outcomes.

279. Over the course of the year, one inquiry and two reviews were launched:
    - In December 2017, the Government announced an independent non-statutory inquiry into the circumstances and practices surrounding the malpractice of former breast surgeon Ian Paterson in both NHS and private practice.
    - On 6 February 2018 the Secretary of State for Health announced a rapid policy review into gross negligence manslaughter in healthcare, chaired by Professor Sir Norman Williams. The review was set up to consider the wider patient safety impact resulting from concerns among healthcare professionals that any errors could result in prosecution for gross negligence manslaughter, even in the face of broader organisation and system failings. The report *Gross negligence manslaughter in healthcare: The report of a rapid policy review*[86] was published on Gov.uk on 11 June.

85 National Guardian's Office Annual Report 2017

86 https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare

- In February 2018, the Secretary of State announced a review, to be chaired by appointed Baroness Julia Cumberlege, into how the health system responds to reports from patients about side effects from treatments.

280. The Gosport panel, chaired by Bishop James Jones KBE, has continued its work into the care of older people at Gosport War Memorial Hospital and has reported87.

A safer environment

281. Patient safety and sustaining the health service in England as a safe environment for all patients remain key priorities for the Department. In November 2017, the Secretary of State announced that from April 2018, HSIB would also investigate all cases of early neonatal deaths, term-intrapartum stillbirths, severe brain injury in babies, and maternal deaths, as part of a new strategy to improve maternity safety.

282. The Secretary of State's ambition to reduce gram-negative blood stream infections by 50% by 2020-21 through a 10% reduction in 2017-18 in *E.coli* infections, which account for more than half of all healthcare associated (HCA) infections, continues to have a positive impact.

283. Since the Government set out its commitment on seven-day hospital services, we have worked with NHS England to ensure consistent standards of care for patients needing urgent and emergency treatment. Hospitals made progress implementing the four priority standards during 2017-18 but there is more to do, and we will continue to work with the NHS to roll out seven-day services to 100% of the population by 2020-21.

Overall Assessment (section 1A)

284. 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 2016 Act, to act to secure continuous improvement in the quality of services provided to individuals, in particular securing continuous improvement in the outcomes achieved.

285. Across the frameworks there are areas where tangible progress has been made but also areas of concern. For example, whilst under-75 mortality rates for cardiovascular disease (CVD) and for cancer continue to improve steadily, there has been a significant increase in the number of emergency admissions for children with lower respiratory tract infections

Health Inequalities

286. The Secretary of State's legal duty to have regard to the need to reduce health inequalities includes assessment and reporting requirements[88]. For 2017-18 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[89].

287. This made clear that the Department's aim is to bring about measurable and sustained reductions in health inequalities and that assessment would put stronger and increasing

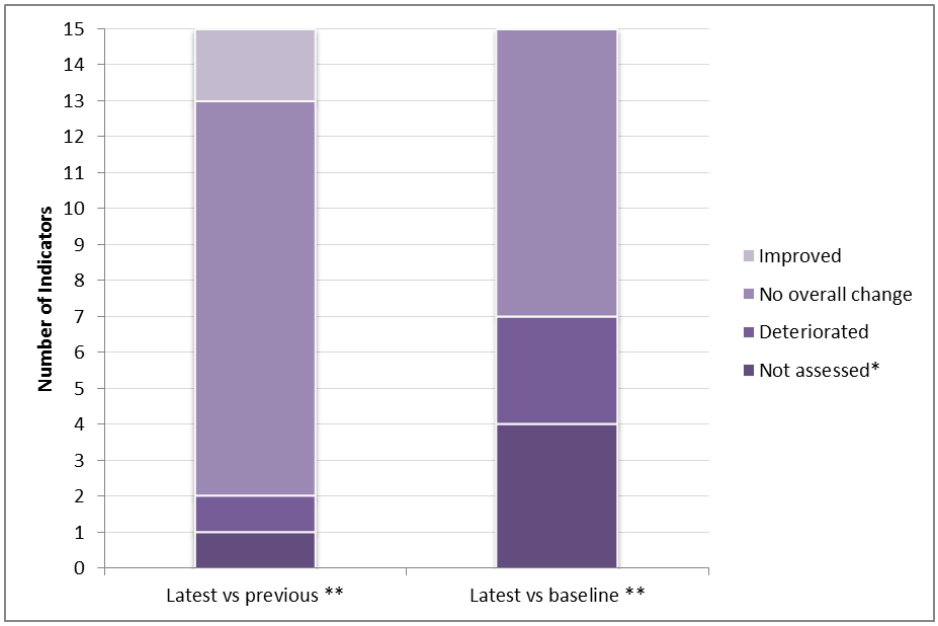
[87] https://www.gosportpanel.independent.gov.uk/
[88] In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service. Health and Social Care Act 2012
[89] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/506771/SofS_letter_health_inequalities_acc.pdf

focus on action taken to reduce inequalities in access, outcomes and experience shown by the data for the selected indicators. This ambition is reflected in important strategic documents including the mandate to NHS England and the PHE Remit Letter for 2017-18 as well as the NHS Constitution. However, the Department knows that reducing health inequalities is hugely challenging, there are complex drivers and some interventions take time to impact.

288. Fifteen overarching indicators of how outcomes differ by area deprivation are drawn from the NHS Outcomes Framework (NHSOF) and Public Health Outcomes Framework (PHOF).[90] 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. In 2017-18 a number of methodological improvements have been made to ensure consistency of reporting of inequalities across PHE, NHS England and DHSC including use of an agreed baseline for each indicator and standardised significance testing.[91]

289. **Figure 15** summarises the changes seen across this basket of indicators comparing the latest data with data from the previous time period, i.e. looking at recent change, and when comparing with the baseline period. The full data table is available in Annex D.

Figure 15: Change across the basket of Health Inequalities Indicators: recent change and change since baseline



* Assessment not possible due to data availability or changes in the Indices of Multiple Deprivation used
** Previous and baseline years differ across indicators – see Indicator Table (Annex D)

290. For most of the indicators there has been neither recent statistically significant change (11 out of 15) nor statistically significant change since the baseline year (9 out of 15).

[90] No new data has been collected on one of the selected indicators (Potential years of life lost (PYLL) from causes considered amenable to healthcare - adults) and this is the last reporting year that Health Related Quality of Life data will be available from the current survey source.

[91] The baseline year for measurement will be fixed at the closest year to the introduction of the health inequalities legal duties under the Health and Social Care Act 2012. Significance testing has also been standardised using the methodology developed by PHE for use in the Public Health Outcomes Framework. Details of this methodology are given in the Technical user guide for the PHOF overarching indicators. https://fingertips.phe.org.uk/documents/PHOF_Overarching_user_guide_Feb_2018_updated%20FINAL.pdf

291. In relation to inequalities by area deprivation, the overarching indicators in the PHOF show that the gaps between people living in the most deprived areas and the least deprived areas remain:
    - These inequalities are broadly stable since the baseline year and the previous time period. However, inequality in life expectancy at birth for females significantly increased between 2010-12 (b) and 2014-16.[92]
    - Life expectancy at birth: in 2014-16, the gap in life expectancy at birth between the most and least deprived areas was 9.3 years for males, and 7.3 years for females.
    - Healthy life expectancy at birth: in 2014-16 the gap in healthy life expectancy at birth between the most and least deprived areas was 19.1 years for both males and females.

292. The NHSOF covers a wider range of health outcomes, access to services and patient experience. These indicators provide a mixed picture:
    - For unplanned hospitalisation for chronic ambulatory care sensitive conditions and emergency admissions for acute conditions that should not usually require hospital admission inequalities were significantly reduced between 2015-16 and 2016-17.
    - Inequalities significantly increased between 2011-13 and 2014-16 for life expectancy at 75 for males and females.
    - For access to GP services and experience of GP services there is a notable increase in the slope index of inequality between the baseline year (2013/14) and the most recent time period (2016-17); however, it is not possible to accurately assess the statistical significance of this change as they use different indices of multiple deprivation.

293. Where data are available, through the GP Patient Survey, an assessment can also be made for other dimensions of inequality: these are ethnic group, sexual orientation and age[93]. In 2016-17:
    - There remain inequalities in experience for the different ethnic groups with the majority reporting poorer scores than White British for each of the three available measures – access to GP services, experience of GP services and health-related quality of life score.
    - For access to GP services and experience of GP services:
        i. Younger ages generally report lower scores than older people.
        ii. Individuals who identify as heterosexual report higher scores than those who identify as gay/lesbian or bisexual.

294. The Secretary of State's assessment of how well his duty to have regard to the need to reduce health inequalities between the people of England has been discharged in 2017-18 is that there has continued to be progress, particularly in relation to focused action, evidence and insight and support to local areas. This has included making national and local level data highlighting health inequalities available; through provision of a central repository for a wide range of online guides and resources for local authorities and through the NHS National Cancer and Diabetes Prevention Programmes.

[92] These estimates for the Slope Index of Inequality (SII) for Life Expectancy (LE) and Healthy Life Expectancy (HLE) are not comparable to those used in the 2015-16 Report. In 2017 new estimates of LE and HLE and for the SII were added to the PHOF; these were based on the 2015 Indices of Multiple Deprivation rather than 2010 IMD.
[93] https://indicators.hscic.gov.uk/webview/

295. However, given that key health inequalities indicators remain largely unchanged, and some are widening, a greater focus on reducing health inequalities within key priority programmes of work is required with clearly defined expected outcomes and supporting metrics.

Forward look to 2018-19

296. Over the course of 2018-19, the Department will further develop the use of data and insight to assist improvement in quality and efficiency, and help hospital leaders at Board level to understand what more needs to be done in their organisation to earn the title of 'learning organisation'. As set out in the Department's SDP for 2016-20[94], the Department and its delivery partners across the health and care system are committed to creating the safest, highest quality care healthcare services. The Secretary of State will continue to report on progress in meeting these priorities over the course of 2016-20.

Rt Hon Matt Hancock MP was appointed as the new Secretary of State for Health and Social Care in July 2018, replacing Rt Hon Jeremy Hunt MP who was appointed to Secretary of State for Foreign and Commonwealth Affairs.

The new Secretary of State for Health and Social Care has approved this Secretary of State Annual Report.

Performance Report Accounting Officer Sign-off

5 July 2018
Sir Chris Wormald KCB
Permanent Secretary

[94] https://www.gov.uk/government/publications/department-of-health-shared-delivery-plan-2015-to-2020

Accountability Report

Lead Non-Executive Board Member's Report

Kate Lampard

Performance and priorities

297. This year, I joined the Department as the new lead non-executive Director. I was appointed alongside four other new non-executive Directors: Dame Sue Bailey, Sir Ron Kerr, Michael Mire and Sir Mike Richards. We have joined Gerry Murphy who has been reappointed for a further term to form a new non-executive Director team. Between us, we bring wide expertise to the Department including clinical, financial and legal experience. My thanks go out to the out-going lead non-executive Director, Peter Sands, who stood down in April having served in this capacity for six years.

298. The Board meetings are chaired and led by the Secretary of State and have covered a range of topics from a deep dive into the top risks facing the Department and wider system to the Single Departmental Plan for the financial year 2018-19. A summary of items discussed at Board meetings in 2017-18 can be found on gov.uk website. Non-executive Directors have also utilised their significant experience through providing insight and support on the development of the Children and Young People's Mental Health Green Paper, challenging the Department's approach to leaving the EU and attending Secretary of State meetings on a range of priority policy areas for the Department.

299. Given the significant changes in the composition of the Board membership this year, we have chosen to conduct a 'light touch' Board Effectiveness Evaluation, focused around and reflecting upon the changes that have been made to the way the Board operates and how we should best spend our time from October, once the Board has been in place for a year.

Accountability Report

300. 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

301. 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

302. 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.

Who we are

303. The Department of Health and Social Care is led by a ministerial team and a staff of civil servants. Our ministers and senior staff are advised by non-executive board members; independent of the Department and government.

Our Ministers at 31 March 2018

Rt Hon Jeremy Hunt MP*
Secretary of State for Health and Social Care

Chair of the Board
3/3 Board meetings attended

Stephen Barclay MP
Minister of State for Health

Not a formal member of the Board
1/1 Board meetings attended

Caroline Dinenage MP
Minister of State for Care

Deputy chair of the Board
1/1 Board meetings attended

Jackie Doyle-Price MP
Parliamentary Under Secretary of State (Mental Health and Inequalities)

Not a formal member of the Board.

Steve Brine MP
Parliamentary Under Secretary of State (Public Health and Primary Care)

Not a formal member of the Board.

Lord O'Shaughnessy
Parliamentary Under Secretary of State for Health (Lords)

Not a formal member of the Board.

***** Rt Hon Matt Hancock MP was appointed as the new Secretary of State for Health and Social Care in July 2018, replacing Rt Hon Jeremy Hunt MP who was appointed to Secretary of State for Foreign and Commonwealth Affairs.

Former ministers who served during 2017-18

- **Philip Dunne MP,** Minister of State for Health until 9 January 2018. 2/2 Board meetings attended.
- **David Mowat MP**, Parliamentary Under Secretary of State for Community Health & Care until 8 June 2017. 0/0 Board meetings attended.
- **Nicola Blackwood MP,** Parliamentary Under Secretary of State for Public Health and Innovation until 8 June 2017. 0/0 Board meetings attended.

Our Non-Executive Board Members 2017-18

Peter Sands
Lead Non-Executive Director 0/0 Board meetings attended
1 April 2011- 30 April 2017

Kate Lampard
Lead Non-Executive Director 1/2 Board meetings attended
1 October 2017-Present

Gerry Murphy
Non-Executive Director
1 August 2014- Present
3/3 Board meetings attended

Prof. Dame Sue Bailey
Non-Executive Director 2/2 Board meetings attended
1 November 2017-Present

Sir Ron Kerr
Non-Executive Director 2/2 Board meetings attended
1 November 2017- Present

Prof. Sir Mike Richards
Non-Executive Director 2/2 Board meetings attended
1 November 2017-Present

Michael Mire
Non-Executive Director 2/2 Board meetings attended
1 November 2017- Present

Our Executive Board Members

Sir Chris Wormald KCB
Permanent Secretary

3/3 Board meetings attended

Prof. Dame Sally Davies DBE
Chief Medical Officer and lead for Research and Development

0/3 Board meetings attended

David Williams
Director General for Finance and Group Operations

2/3 Board meetings attended

Clara Swinson
Director General for Global and Public Health

2/3 Board meetings attended

Jonathan Marron
Interim Director General for Community and Social Care
(from 26 June 2017)

3/3 Board meetings attended

Lee McDonough
Director General for Acute Care and Workforce

3/3 Board meetings attended

Other Board Members who served during 2017-18

- **Tamara Finkelstein - Director General for Community and Social Care,** (Seconded to the former Department for Communities and Local Government from 19 June 2017. Left Department of Health and Social Care to join Department for Environment, Food and Rural Affairs in March 2018). 0/0 Board meetings attended.

Other Senior Officials

Professor Chris Whitty
Chief Scientific Officer

Not a formal member of the Board.

Steve Oldfield
Chief Commercial Officer
(from 9 October 2017)

Not a formal member of the Board.

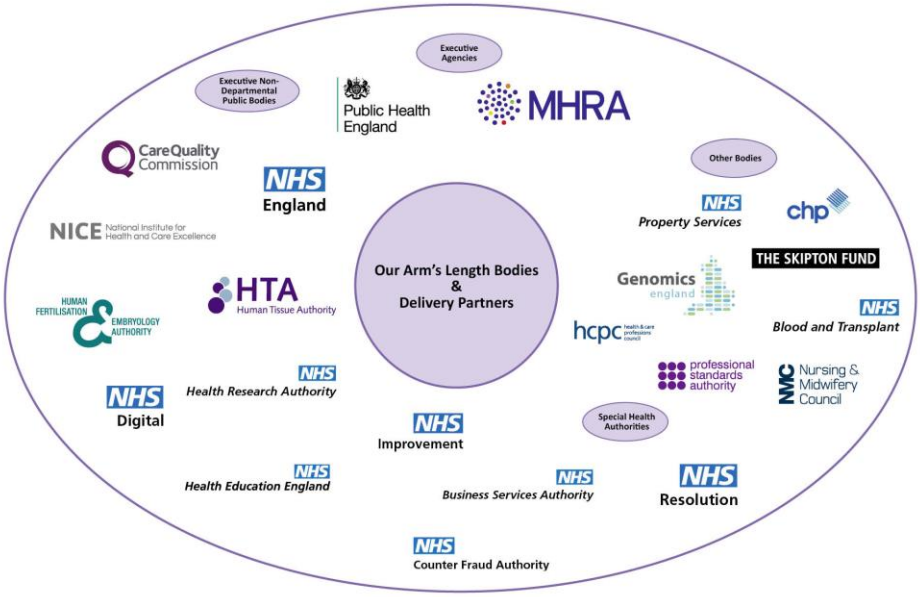
Our Arm's Length Bodies and Delivery Partners

304. The Department includes two Executive Agencies: Public Health England (PHE) and The Medicines and Healthcare products Regulatory Agency (MHRA), which are legally part of the Department but have greater operational independence.

305. 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; and
- providing central services to the NHS.

306. Our ALBs, detailed in Annex F, fall into several distinct types as shown in **Figure 16**.
- 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.
- 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 not included in this Annual Report and Accounts because they receive their funding from other sources.

Figure 16: Our Arm's Length Bodies and Delivery Partners



Note: Since April 2016, Monitor and NHS TDA operate as NHS Improvement.

307. Our Permanent Secretary is the Principal Accounting Officer for the Departmental Group which as at 31 March 2018 consisted of:
    - Ten ENDPBs (including NHS England and its 207 Clinical Commissioning Groups (CCGs));
    - Four SpHAs;
    - Seven other bodies;
    - 154 NHS Foundation Trusts (FTs);
    - 80 NHS Trusts (NHSTs); and
    - NHS charities.

308. The activities of our ALBs and delivery partners are consolidated and incorporated in these accounts, with the exception of the MHRA and NHS Blood and Transplant (NHSBT), both of whom are designated as outside the Departmental Group by the Office for National Statistics.

Departmental Disclosures

309. The Department has a Code for Business Conduct, which incorporates the principles set out in the Civil Service Code[95] and applies to all staff working in the Department, including those who have authority or responsibility for directing or controlling the Department.

310. 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

311. 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.

312. Our Ministers' interests are published on Gov.Uk website by the Cabinet Office[96] whilst 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[97].

313. Note 18 of the financial statements also details any related party transactions with organisations whom our Ministers, Non-Executive Directors or board members have connections.

[95] https://www.gov.uk/government/publications/civil-service-code/the-civil-service-code
[96] https://www.gov.uk/government/publications/list-of-ministers-interests
[97] https://www.gov.uk/government/publications/dh-senior-officials-business-expenses-2016-to-2017

Statement of Principal Accounting Officer's Responsibilities

314. Under the Government Resources and Accounts Act 2000[98] (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 2017 no. 1256 (together known as the 'Departmental Group', consisting of the Department and sponsored bodies listed at note 21 to the accounts).

315. 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.

316. 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 the 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; and
    - prepare the accounts on a going concern basis.

317. HM Treasury has appointed the Permanent Secretary of the Department as Principal Accounting Officer of the Department of Health and Social Care.

318. 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.

319. 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

[98] https://www.legislation.gov.uk/ukpga/2000/20/contents

propriety, of the grants received and the other income and expenditure of the sponsored bodies.

320. 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[99] published by HM Treasury.

321. Alongside this Annual Report, the Department has also published an Accounting Officer System Statement[100] setting out lines of accountability within the Department and the healthcare system bound by the legislative framework of the 2012 Health and Social Care Act[101]. This includes the responsibilities and relationships between the Accounting Officers in the Department, its Agencies, Arm's Length Bodies and the NHS.

322. 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.

323. 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.

99 https://www.gov.uk/government/publications/managing-public-money
100 https://www.gov.uk/government/publications/department-of-health-accounting-officer-system-statement
101 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Governance Statement

Scope of Responsibility

324. 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 2017-18 and is current up to the date this Annual Report was signed.

325. 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, whilst 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[102] published by HM Treasury and the Cabinet Office.

326. 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 guardians 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.

327. Whilst 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.

328. 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, who in turn issue formal written delegations to these bodies.

Departmental Governance

329. The Departmental Board, chaired by the Secretary of State brings together Ministerial and civil service leadership with Non-Executives from outside government who can provide independent support and challenge.

330. The Departmental Board meets at a frequency agreed by members, with meetings taking place at least quarterly. The Board met on three occasions during the 2017-18 financial year, with a meeting also held in March 2017. Full membership and attendance is outlined in the Directors' Report. For a period of six months, the Board had only one non-

[102] https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments-2017

executive in post as the recruitment exercise for the remaining positions was postponed during the pre-election period in 2017. The DHSC Board met once during this time period. As the terms of reference for the DHSC Board do not require a certain number of non-executive directors to be quorate, this was considered a formal quarterly meeting. In addition to the Departmental Board, the Secretary of State gained assurance over the running of the Department through weekly meetings with the Permanent Secretary and the additional focused meetings on his priorities with senior colleagues from our ALBs.

331. The Board advises the Secretary of State and Permanent Secretary and in particular 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, ensuring that any strategic decisions are based on a collective understanding of evidence, insight and international experience;
    - ensuring there is strategic alignment across the health and care system;
    - overseeing the sound financial management of the Department, in the context of the Single Departmental Plan;
    - 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.

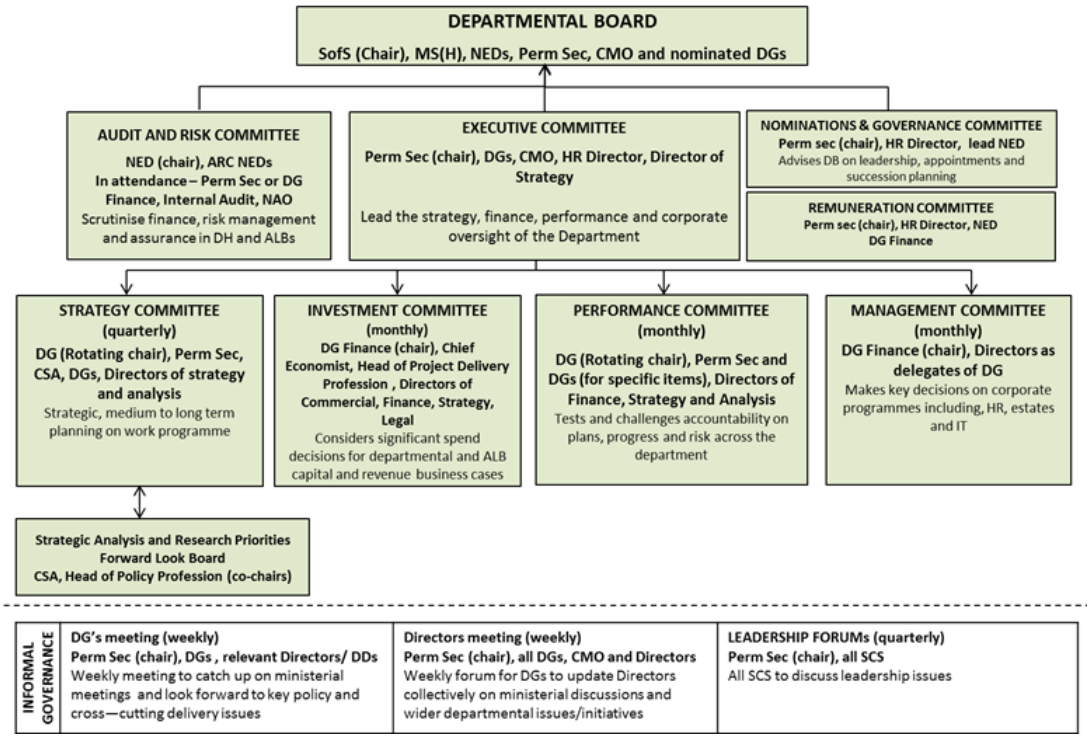
332. All information presented to the Board and its sub-committees is accompanied by a cover note which is cleared by a Senior Civil Servant who has responsibility for the subject matter. Further, the Board and its sub-committees undertake deep dives of specific issues, with the purpose both of improving understanding of an issue and challenging the information with which they are presented.

333. The Board also has responsibility for monitoring performance against key metrics, including efficiency metrics, corporate risks and seeking assurance over performance of the Department's ALBs. Discussions have also focused on finance and performance. The Audit and Risk Committee (ARC) also has a role in reviewing the risk register and performing scrutiny of individual risks. The ARC regularly makes recommendations that other areas are reviewed and considered for inclusion.

334. There were a number of changes at the Department of Health and Social Care over 2017-18, with the appointment of five new Non-Executive Directors (NEDs) in the autumn including a new Lead Departmental NED. Given the significant changes in the composition of the Board membership this year, we have chosen to conduct a 'light touch' Board Effectiveness Evaluation, focused around and reflecting upon the changes that have been made to the way the Board operates and how we should best spend our time from October, once the Board has been in place for a year.

335. The Departmental Board is supported by the committees shown in the structure chart at **Figure 17**. A number of new Committees were established in 2017-18 including the Performance Committee, Strategy Committee and Investment Committee.

Figure 17: Departmental Board Structure



336. 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 2017-18 include business planning, financial sustainability, risk and legal risk, and a number of HR items including performance management and pay. The Committee met 12 times this year.

337. 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. The Committee met 10 times in the year

338. The Nominations and Governance Committee advises on matters relating to leadership and succession planning for the Department. The Committee met once this year.

339. 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 review the comprehensiveness of assurances and integrity of financial statements. The Committee met 4 times this year.

340. **Table 7** summarises attendance at the four committees outlined above.

Table 7: Committee Attendance

		Executive Committee	Remuneration Committee[2]	Nominations and Governance Committee	Audit and Risk Committee
Sir Chris Wormald KCB	Permanent Secretary	13/13	10/10	1/1	
Professor Dame Sally Davies DBE	Chief Medical Officer	2/13			
David Williams	Director General for Finance and Group Operations	13/13	10/10		4/4
Clara Swinson	Director General for Global and Public Health	11/13			
Lee McDonough	Director General for Acute Care and Workforce	13/13			
Professor Christopher Whitty	Chief Scientific Officer	13/13			
Tamara Finkelstein	Director General for Community and Social Care	3/4			
Jonathan Marron	Interim Director General for Community and Social Care	9/9			
Steve Oldfield	Chief Commercial Officer	5/5			
Kate Tilley	Director of HR	12/13	10/10	1/1	
Kathy Hall	Director of Strategy	13/13			
Gerry Murphy	Non-Executive Member/Chair of ARC		1/1	1/1	4/4
Michael Mire	Non-Executive Member		1/1		
Jacqui Burke	Independent Member				4/4
Cat Little	Independent Member				2/4

1. Table represents Committee members attendance only. To note, other officer's attendance is not recorded in the above table.
2. Membership of the Remuneration Committee required the attendance of a Non-Executive from January 2018. Attendance is shared amongst our Non-Executives.
3. Where a DG could not attend, a deputy attended on their behalf

Assurance Framework, Risk Management and control issues

Core Department

341. 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.

342. DGs and Directors are required to identify and record the key risks to successful delivery of their business plans and to report on their risks as part of Biannual Assurance Meetings (BAMs), to which all Senior Civil Servants contribute. These reviews are designed to strengthen individual accountability within the Department for the stewardship of resources and ensure the delivery of corporate objectives.

343. The Department continued to work with the Infrastructure and Projects Authority in the management of programmes and projects on the Government Major Projects Portfolio and strengthened the support provided to Senior Responsible Owners (SROs) and programmes through the Major Projects Leadership Academy and Project Leadership Programme, which has seen a steady increase in uptake throughout the year.

344. The setup of a new Investment Committee, which held its first meeting in November 2017, has strengthened the management of the approval of major investment. It will also monitor delivery of major projects and will complement the oversight offered through the BAM process.

345. The DHSC Investment Committee now meets monthly to consider capital and revenue business cases above the disclosure threshold limits delegated to DHSC by HM Treasury as set out in the Department's Standing Financial Instructions (SFIs). 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.

Three lines of defence

346. 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. This is supported by the use of Group-specific risk registers to identify, escalate and manage risk.

347. At the second line our Governance structure has been strengthened this year by the addition of Strategy, Performance 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 business plan objectives with its most recent assessment of the top risks it faces.

348. The third line of defence comprises the oversight of the Departmental Board, which includes independent Non-Executive Directors and is provided by 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. The ARC has considered the way in which the Department manages risk at its four meetings during 2017-18 and has scrutinised the Department's risk register as a standing agenda item at these meetings. Through this scrutiny the Committee 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 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 Committee. Our third line of defence is further strengthened by other independent assurance processes, such as NAO reviews and the scrutiny of the Health Select Committee.

349. 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. In 2017-18, three ALBs presented to the Departments ARC on key issues and approaches to risk management. Meetings have included discussions around financial sustainability of the NHS, Sustainability and Transformation Plans, the NHS Cyber Security Incident and NHS Winter planning.

Managing Risk

350. During 2017-18, the Department further strengthened how it assures and governs risk through the appointment of a Director to the role of Chief Risk Officer (CRO), effective from 1 April 2017. As part of discharging responsibility for ensuring an appropriate approach to risk management within the Department, the CRO holds at least quarterly discussions with each DG and their Directors to discuss and challenge their identification, assessment and management of risks within their Group, ensuring a consistent approach across the Department.

351. These challenge meetings have contributed to closer link-up between the central teams and DG Groups across the Department, leading to an improved and more accurate

understanding of our risk exposure and the cross-cutting nature of risks across the system.

352. The nature of the health system is that risks can be inherent, fast-evolving and unpredictable, for example incidents such as cyber-attacks. The Department's overall approach to risks is based on constant intelligence and preparation for the unexpected. The Department has continued to apply this approach throughout 2017-18 to manage a developing portfolio of risks, both within the Department and in the wider system. Significant risks actively managed by the Department this year have included:

External risks

- the health and care system's resilience to cyber-attack;
- the risk that health inequalities continue to rise leading to higher morbidity and demand on NHS services;
- the global threat of antimicrobial resistance; and
- the risk relating to pandemics/major infectious disease outbreaks.

System-wide risks

- the financial performance and sustainability of the health and care system;
- the risk that 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;
- system readiness to respond to major infectious disease outbreaks;
- the growth in demand for NHS services compromises the ability of 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;
- the risk that our partnerships with ALBs are insufficient 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.

353. 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.

354. My governance team have prepared summary reports of the governance and control system in the core Department of Health and Social Care. These reports provided information on the key issues for each Directorate and was were drawn from material supplied for the BAM and DGs' assessments of internal control. In 2018-19 we will develop further year end reporting of DGs and directors against Accountability Letters and are refreshing assurance mapping across the Department. The BAM reports confirmed that the Department has adequate and effective systems of control in place, and that where issues have arisen during the year assurance arrangements were in place to validate that weaknesses were addressed. There were a number of changes at the Department of Health and Social Care over 2017-18, with the appointment of five new

Non-Executive Directors (NEDs) in the autumn including a new Lead Departmental NED. A Board Effectiveness Evaluation is being finalised over the summer and will reflect on the major changes that have been made in the Department's approach to the Board and how early successes with the new NED team can be taken forward into the way the Board works in 2018-19.

Whistleblowing

355. The Department's whistleblowing policy has been in place since August 2015, and is based upon best practice in the Civil Service Employee Policy including reporting biannually on all whistleblowing concerns received to the Cabinet Office. The policy offers individuals 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 individuals to speak to if they have a whistleblowing concern and are uncertain how to address it.

356. The Department also has a Board-level whistleblowing Champion in the Director General for Finance and Group Operations. When a report of a whistleblowing concern is received, the Department establishes an investigation to establish if it falls under whistleblowing. If a case of whistleblowing is established, the Department will investigate following usual protocols. Figures of five or less whistleblowing concerns are not published to protect anonymity.

357. The Department has expanded the Speak Out strategy by appointing a Director General as 'Speak Out Champion' to provide visible leadership in this area and twelve Speak Out advisers have also been appointed. The Department has strengthened the employee offer and HR reviewed, refreshed and published; whistleblowing, bullying and harassment, and grievance policies - which included a new offer on mediation - by joining the cross-government mediation service in September 2017. This also included tool kits for line managers who are dealing with bullying and harassment issues. The Department's HR team has created a scorecard to measure progress and identify any hotspots or trends which will be discussed regularly at Executive Committee meetings.

Role of Internal Audit

358. The Department's internal audit service continues to be provided by the Health Group Internal Audit Service (HGIAS). HGIAS delivers a shared internal audit service for the Department and 13 of its Arm's Length Bodies, with the exception of NHS England.

359. HGIAS 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;
    - 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.

360. The HGIAS team operates in accordance with Public Sector Internal Audit Standards and to an agreed Internal Audit Plan, which has been agreed with the Accounting Officer and

the Audit and Risk Committee (ARC). With the agreement of ARC, this Plan is updated appropriately throughout the year to reflect changes in risk profile.

361. 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 plan - agreed by management - includes an agreed timetable for implementation. 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

362. Following completion of planned audit work for 2017-18 for the Department, the Head of Internal Audit has objectively considered the adequacy and effectiveness of the Department's systems of risk management, governance and internal control throughout the year. As such, the Head of Internal Audit's opinion is that he can give Moderate Assurance to the Department's Principal Accounting Officer in relation to the 2017-18 reporting year. A Moderate Assurance means that in the Head of Internal Audit's opinion some improvements are required to enhance the adequacy and effectiveness of the framework of risk management, governance and control.

Arm's Length Bodies

363. 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. These risks are considered by the Senior Departmental Sponsor and will also be referenced as appropriate in the overall Departmental Risk Register.

364. 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.

365. The objectives and deliverables of the Department's ALBs are set through their annual business planning process. The Department uses the ALB mandates, remit letters and business plans to hold its ALBs into account. A number of key 2018-19 ALB business planning documents were published in March 2018, with good progress on publishing the rest.

366. In relation to NHS England, the Health and Social Care Act 2012 requires the Department to formally set out in a 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. Continuing the multi-year approach first established in 2016-17 following a public consultation, a mandate to NHS England for 2018-19 was published on 20 March 2018. It again sets out NHS England's objectives, and its budget, to 2020.

The NHS

367. 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. The 2012 Act establishes the relationship through a Mandate, through which the Secretary of State specifies the objectives that NHS England is expected to deliver.

368. NHS England has responsibility for the commissioning of health care in England and, under the Mandate, to invest its annual budget (of approximately £110 billion) to bring about measurable improvements in health outcomes for the population. The Mandate is reviewed annually, and may not be amended during the year without special reason.

369. The 2018-19 Mandate[103] continues the multi-year approach first established in 2016-17 following public consultation, maintaining the objectives, 2020 goals and annual deliverables from the 2017-18 mandate. The main substantial change is to extend an existing objective to include support for implementation of EU Exit with regards to health and care. Along with the provision of an additional £2.8 billion of funding for the NHS in Budget 2017, the Government's decision to maintain a stable mandate for 2018-19 will support NHS England, and the wider NHS, to recover performance on important patient access standards.

370. NHS England is required to report performance against the mandate to the Secretary of State every six months. Performance is assessed against each objective and correlated into the mandate assurance report. The assessment of performance is then considered at regular accountability meetings between the Secretary of State and the Chair of NHS England, and the respective executive teams from each organisation. The Framework Agreement between the Department of Health and Social Care and NHS England[104], which sets out respective roles, responsibilities, governance and accountability arrangements, sets out that these accountability meetings are the highest decision-making forum that focus on key strategic, financial and delivery issues and ensure NHS England is carrying out its statutory functions to an agreed standard. These meetings take place each quarter and the agenda and the minutes are published.

371. 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, and the Intensive Support Teams from NHS Interim Management and Support (IMAS), to make a single integrated enterprise. Monitor and the TDA remain as separate legal entities but the boards of Monitor and TDA have identical membership, and meet jointly as one NHS Improvement Board. NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. Rules of Procedure set out NHS Improvement's governance arrangements.

[103] https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019
[104] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/280889/20140206_DH_and_NHS_England_Framework_Agreement.pdf

372. 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. 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.

373. Through its sponsorship discussions the Department assesses the risks and issues and considers these for inclusion in the overall Departmental risk register. The Department and NHS Improvement regularly discuss those providers with significant risks. NHS Trusts and Foundation Trusts now benefit from a more consistent and proactive approach to managing strategic and operational risks under the Single Oversight Framework[105] published in autumn 2016.

374. The Department sends an annual remit letter to NHS Improvement which sets out their objectives for the coming year for which they are held to account. The Framework Agreement sets out the assurance process, roles and responsibilities of the Department and NHS Improvement by which accountability will be achieved. NHS Improvement and the Department have a programme of accountability meetings, four at Ministerial level every year.

375. From September 2018, NHS England and NHS Improvement will increase integration and alignment of national programmes and activities. They will integrate respective regional teams, to be led in each case by one regional director working for both organisations, and will move to seven regional teams to underpin this new approach.

376. Strategic oversight on future collaboration will be provided by having a degree of cross-membership between the NHS England and NHS Improvement boards. Non-voting, Associate Non-Executive Directors (NEDs) were appointed in February 2018 to attend the corresponding board to facilitate faster progress towards shared management of financial performance across the system and to provide greater oversight of shared national and regional functions. One associate NED from each organisation will lead on a joint Financial Advisory Group to focus on alignment and reporting into each respective board.

377. To improve the mechanism for monitoring NHS finances and ensuring the system works better as a whole, NHS England and NHS Improvement are undertaking a programme of work to review areas of closer alignment. This will look at options to tighten financial controls and propose more productive system design and transformation between the two organisations. The review will operate within the current legislative framework and report recommendations to Ministers by July 2018.

378. NHS England and NHS Improvement have also reflected in their planning guidance for 2018-19, greater expectations for improved financial management at local system level.

[105] https://improvement.nhs.uk/resources/single-oversight-framework/

Key Governance Issues

Financial Risk and Sustainability

379. The NHS has taken a number of steps to tackle the financial challenges seen over recent years, restore financial discipline, improve financial sustainability, manage and mitigate financial risk and continue to improve the efficiency of the system.

380. In July 2016, NHS England and NHS Improvement published a joint plan to restore financial rigour in 2016-17, and beyond that confirmed a series of actions to cut the annual trust deficit and sharpen the direct accountability of Trusts and CCGs to live within available resources. Measures are detailed in the financial performance section of this Annual Report.

381. NHS England and NHS Improvement took further in-year action to control the financial risk in the commissioner and provider sectors, with NHS England focussing activity to manage down CCG risks and NHS Improvement putting in place further controls on provider expenditure. This included a targeted approach for those CCGs and trusts at risk of missing their control totals with a 'hands on approach' for the most challenged – those trusts who were in Financial Special Measures (FSMs), or who were part of the Financial Improvement Programme – to review all areas of efficiency.

382. An improved monthly monitoring and governance process has been implemented, with a detailed data collection from individual providers and commissioners collated by NHS Improvement and NHS England and returned to the Department within tight timescales. This has informed a monthly governance process. This includes our 'Cross System Efficiency & Finance Board' with NHS England and NHS Improvement, and ministerial engagement including Secretary of State's 'Finance and Efficiency Delivery' meetings. These meetings have resulted in improved and effective reporting to senior officials and ministers. This has allowed for increased transparency on emerging risks and pressures, and supported decision making where needed. A particular theme has been the extent to which financial pressures are disproportionately in a small number of challenged organisations, and we now have a series of deep dives underway – led by the Minister of State for Health – to review the causes of deficits or variance from plan in those organisations and to help identify solutions.

383. The Department and the NHS continue to work on efficiency-related activities to put the NHS on a financially sustainable footing by enabling the NHS to live within its means, eliminate organisational deficits and ensure a balanced NHS budget in each year. The *Next Steps on the Five Year Forward view* published March 2017 set out the joint NHS' 10 Point Efficiency Plan setting out how the action being taken to deliver this. To support the implementation of NHS England's Five Year Forward View and its goals for sustainable finances, local health and social care systems, including NHS organisations and local councils, have developed STPs which include proposals for transforming health and social care and proposals have now been published for all STP areas.

384. The plan focusses on:
    - making better use of NHS providers' resources – money, technology, estates and people (this will account for the most substantial savings);

- reducing the growth in demand for healthcare services through public health measures and providing services that better meet people's needs, including better services out of hospital and smarter, data-driven commissioning;
- reducing some NHS costs by limiting pay increases and improving purchasing, increasing income to the NHS through existing charges and commercial opportunities; and
- reducing the cost of the architecture that leads and manages the NHS.

Core Performance Standards

385. 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 2017-18 and a number were missed, more detail is available in the performance summary and Annex C.

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

Contract management

387. During 2017-18, Directors General have reported on contracts as part of the Biannual Assurance process. This is helping to ensure we have corporate visibility of all contracts and that associated risks are identified and managed. The Contract Management Team has been working throughout the year with Groups to ensure that the DHSC Corporate Contracts Register is comprehensive and we continue to engage Directors and Directors General to ensure we have visibility of the DHSC contract portfolio. All Contract Management recommendations from previous Internal Audit reports have been actioned. We have formally communicated to the Senior Contract Owners of the highest risk contracts, the importance of Contract Management and their respective roles and responsibilities.

Macpherson Review and Quality Assurance

388. The Macpherson Review[106] published in 2013, made a number of recommendations to ensure that analytical models used in critical areas of our activity are subject to appropriate quality assurance, within an appropriate framework. We implemented a comprehensive framework of assurance across the Department and its ALBs to support high quality data models, guided by an oversight committee to maintain systematic on-going processes to regularly update our list of business critical models and to ensure that risks are identified, managed and escalated as necessary. These processes were considered in full by our Audit and Risk Committee in the development phase and they are now embedded in routine business process.

Information Risk

389. The Department has not identified any major information risk control issues in 2017-18.

390. The Department reported two personal data breaches to the Information Commissioner's Office in 2017-18. There were eight data-related incidents. The Department ensured appropriate corrective action was taken following these incidents, reviewing internal processes and updating them where necessary.

[106] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206946/review_of_qa_of_govt_analytical_models_final_report_040313.pdf

DH 2020

391. DHSC has now completed its organisational change programme (DH 2020). The programme was rigorous and was delivered over a relatively short time period, throughout 2016 and early 2017. It aimed at ensuring the Department was fit to achieve the ambitions set out in the Single Departmental Plan, living within our Spending Review settlement – delivering a 30 per cent cost reduction by 2019-20.

392. In July 2017, the DH 2020 programme closed and a new phase of the Department's Plan for Change was launched as the 'Great Department of State'. This supported the key elements of being a Brilliant Civil Service, focussing on enabling ongoing changes (such as those in the workplace and IT); embedding new ways of working and delivering the cultural change required in order to be a streamlined and efficient department.

393. In September 2017, the Department's Management Committee agreed a continuous improvement approach should be embedded into departmental ways of working. This aims to support becoming a great department of state, with a focus on getting the basics right.

Fraud, including prescription charge fraud

394. The DHSC Anti-Fraud Unit (AFU) investigates allegations of fraud, bribery and corruption, as well as looking at ways in which it can be prevented. The AFU is also the sponsor branch for the NHS Counter Fraud Authority (NHSCFA), successfully launched on 1 November 2017. The NHSCFA, a new Special Health Authority, aligns with the DHSC counter fraud strategy and acts as the principal lead for counter fraud activity in the NHS in England, the organisation that investigates fraud, bribery and corruption in the NHS in England. The AFU has developed a comprehensive fraud investigation capability and also looks to prevent and deter fraud by raising awareness of the problem and working in partnership with all parts of DHSC to build fraud prevention in to all work. The AFU offers an in-house investigative capacity across DHSC and to its non-NHS facing ALBs. This is in line with Cabinet Office cross-government initiatives to reduce fraud.

395. The NHSCFA works collaboratively with the DHSC and other key stakeholders to deliver a full range of counter fraud functions. This includes the prevention, deterrence and detection of serious and organised NHS fraud. NHSCFA seeks the recovery of funds lost from the NHS by making use of its unique powers under the Proceeds of Crime Act 2002[107] to recover funds and assets from those found to be defrauding the NHS. Counter fraud standards for the NHS in England are also set and monitored by the NHSCFA and it will produce, on an annual basis, an estimate of fraud losses.

396. The NHSCFA produce an annual Strategic Intelligence Assessment, which based on historic intelligence provides a high-level estimate of fraud in the NHS in England. The NHSCFA will shortly publish an update for 2016-17, which as outlined in their latest Business Plan estimates the quantum of fraud to be £1.29 billion (compared to a figure of £1.25 billion for 2015-16).

397. NHS Business Services Authority (NHSBSA) continues to build on its programme of work to combat patient prescription charge fraud which was launched in September 2014. Through a phased programme of post-dispensing checking on behalf of NHS England and

[107] https://www.legislation.gov.uk/ukpga/2002/29/contents

issuing Penalty Charge Notices (PCNs) where exemption cannot be confirmed. By March 2018, 2.71 million PCNs have been issued to patients, of which 1 million PCNs were issued during 2017-2018. Each PCN seeks to recover the original NHS prescription plus a penalty, the penalty is five times the original amount owed, up to a maximum of £100. There are plans to increase PCNs volumes to 1.4 million during 2018-2019 and together with targeted publicity campaigns this programme aims to achieve a reduction in overall losses.

398. NHSBSA is also responsible for undertaking eligibility checking on patients' entitlement to free NHS dental treatment. Since September 2014, some 1.12 million dental PCNs have been issued to patients claiming exemption through schemes relating to low income, tax credits, income-based Jobseeker's Allowance, income-related Employment and Support Allowance, Income Support, Pensions Credit and Universal Credit, of which 427,241 PCNs were issued in 2017-18.

399. On dental contractor fraud, NHS England and NHSBSA are working on a number of programmes to maximise behavioural change amongst dentists and take positive action where there is evidence of fraud and/or excessive and inappropriate claiming. Since July 2015, a £24 million reduction in claims for short duration (28-day re-attendance) courses of treatment (known as splitting) has been achieved, with continuing reductions of around 20 per cent per year. The overall recurring claims reduction for the three years of all programmes was £49 million by March 2018 in addition to financial recoveries of £1.8 million. This will continue during 2018-19 and further recoveries of around £1.5 million are forecast. An exercise to audit claims for reimbursement of business rates has yielded around £1.5 million in recoveries and changes to increase checks resulted in a £3 million reduction in claims made during 2017-18.

400. Following the success of the 28-day re-attendance challenge exercise and the Statement of Financial Entitlement (SFE) Business Rates audit, the NHSBSA and NHS England have identified ways to audit dental activity, provide assurances about the quality and probity of treatment claimed and manage debt arising from underperformance. These include assessment of potential risk areas, providing additional clinical support and leadership to progress cases to resolution, and management of the mid-year and year end contract reconciliation process.

Compliance with Equality and Human Rights Legislation

401. 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 System Oversight, Performance and Legislation team who are responsible for raising awareness and capability among staff through a policy certificate training module and signposting to up to date and authoritative guidance on the Department's intranet. There is also a lead Senior Civil Servant (SCS) for each of the protected characteristics to further support staff in making equalities decision making.

402. Directors General are required to consider compliance with the public sector equality duty, the Secretary of State for Health and Social Care's inequalities duties and human rights as part of the Quarterly Performance Returns and Biannual Assurance process, to which all Senior Civil Servants contribute.

403. Regular meetings with the Equality and Human Rights Commission are held to discuss respective priorities and the Department's performance in meeting its statutory equality

duties. Information about substantive equality issues are also shared with the Health and Wellbeing Alliance.

404. The Department continues to publish summary equality information relating to its policies and workforce annually. This information, along with our current equality objectives, can be found under the 'Equality and Diversity' section of the Department's website.

National Audit Office and Public Accounts Committee

405. The National Audit Office (NAO) seeks to confirm the factual accuracy of their value for money and other major reports with the Departmental Finance Director (Director General – Finance) and Accounting Officer (Permanent Secretary) where the Department is the primary or third party client. The Finance Director General, the Accounting Officer and other senior officials also give evidence to the Public Accounts Committee (PAC) as well as approving the subsequent Treasury Minute which represents the government's response to the PAC's report. Updates on NAO and PAC activity are provided to the Audit and Risk Committee at its meetings.

Emergency Preparedness, Resilience and Response

406. The Department works closely with NHS England and Public Health England to ensure that the health sector is able to respond to threats and hazards set out in the government's National Risk Register. The Department has in place '24/7' arrangements to be able to coordinate services in any emergency that occurs. In 2017-18, the Department has responded to a number of high-profile incidents including the Grenfell Tower fire, terrorist attacks in London and Manchester, the poisoning incident in Salisbury, and to hurricanes in overseas territories. The Department participates in health and cross-government exercises to maintain our skills and response arrangements.

General Data Protection Regulation

407. The Department and the ALBs are engaged in a broad-ranging programme of activity (encompassing the wider health sector) to ensure compliance with the General Data Protection Regulation (GDPR), which came into effect on 25 May 2018. Activity is being co-ordinated across government by the Department for Digital, Culture, Media & Sport, and within Health by the NHS England-led National GDPR Working Group. The Permanent Secretary is fully sighted on this programme of activity which (for DHSC and the executive agencies for which DHSC is the data controller) is led at Director level. The Department and all of its ALBs have been audited in respect of their 'state of preparedness' and we are confident we are in a positive position as we approach the implementation date.

Grant Payments to Non-Public Sector Bodies

408. 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. 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 published alongside this Annual Report.

Other Governance Disclosures

409. I confirm a number of other matters as set out in the following paragraphs.

Data Issues – NHS Primary Care Clinical Correspondence (including NHS Shared Business Services)

410. In March 2016 a serious incident was identified when NHS Shared Business Services (NHS SBS), who provided primary care support services to NHS England in several geographical areas, reported a large backlog comprising around 709,000 items of unprocessed correspondence relating to patients.

411. In October 2016 NHS England discovered that general practitioners (GPs) had been incorrectly forwarding misdirected mail to the new provider of primary care support services (Capita). The new services did not include mail redirection and no further action had been taken by Capita. So far 374,000 additional items have been identified by NHS England. All clinical correspondence within the backlog has been reviewed. As of February 2018, no harm to patients had been identified.

412. The National Audit Office (NAO) published a report following their investigations on 27 July 2017 and 2 February 2018. Public Accounts Committee (PAC) hearings were held on 16 October 2017 and 26 March 2018.

Data Issues - WannaCry ransomware attack

413. As well as affecting services in many other countries worldwide, the WannaCry ransomware attack in May 2017 was the largest ransomware incident to affect the health and care system to date. Having first been alerted on 12 May 2017, the coordinated NHS response to this incident focussed on protecting clinical safety with all NHS service diverts subsequently lifted on 16 May and the major incident officially closed on 19 May 2017. For the health and care sector, a significant programme of work was already underway to mitigate data and cyber security risks in addition to increased security for legacy and out of support systems. Lessons from this incident have informed the on-going national programme.

United Kingdom Leaving the European Union

414. Since the result of the referendum on the UK's membership of the European Union on 23 June 2016, the Department has been working closely with other government departments, and its Arm's Length Bodies, on the Government's strategy for securing an orderly withdrawal from, and agreeing a 'deep and special partnership' with, the European Union. The Departmental Board and Executive Committee will continue to monitor these developments through the governance process to ensure that emerging consequences on the health and care system are managed in an effective manner.

Carillion

415. On 15 January 2018, Carillion plc entered into liquidation. NHS bodies had a variety of direct and indirect business arrangements with the Carillion group of companies. The Department and NHS Improvement continue to manage the impact upon the NHS, and we are working with other government departments to coordinate the response. There have been no material issues reported by any of the NHS bodies who held direct contracts with members of the Carillion group of companies or under the operational Private Finance Initiative (PFI) contracts. The Department and NHS Improvement continue to provide support to NHS organisations to ensure that arrangements are transferred to an appropriate replacement.

416. Officials from the Department and NHS Improvement are also working with all parties in respect of the two PFI hospitals under construction by a Carillion group company to

ensure that they are finished as quickly as possible and to do this in a way that secures best value for the tax payer.

417. Carillion group companies also provided maintenance services to a number of Local Investment Finance Trust (LIFT) Companies, who in turn provide accommodation services to NHS bodies. The LIFT companies had their own contingency plans in place to source maintenance services from other companies and already have put in place alternative arrangements.

Screening Programmes

418. In March 2018, ministers were alerted to a serious failure in the national breast screening programme in England. The programme, which is overseen by Public Health England (PHE) and delivered by the NHS, screens 2 million women a year between the ages of 50 and 70 years of age. As a result up to 174,000 women aged between 68 and 71 were not invited to their final breast screening appointment.

419. Ministers took advice from PHE and NHS England to ensure appropriate support for those affected would be available as promptly as practicable, without overwhelming the ongoing screening programme. The failure has not affected any women after 1 April 2018. Parliament and the public were informed on 2 May 2018 as soon as remedies, including a helpline and clear plans to inform those who may have been affected, were in place. NHS England has expanded the capacity of screening services to ensure all women who wish to be screened will receive an appointment within six months. Further detail is set out in the Performance Report.

Grenfell

420. Following the Grenfell Tower tragedy, the Department, NHS Improvement, NHS England and the NHS property companies set out immediately to provide assurance to the Government and the public as to the safety of the NHS estate, with particular emphasis on those buildings considered to be at the highest risk – over two storeys, overnight inpatient accommodation, and with cladding that could be of the type used in Grenfell Tower. NHS Improvement coordinated a large-scale effort to check cladding where necessary, with the help of the local fire and rescue service, and supported the implementation of remedial measures to improve the safety of properties where appropriate.

Gosport

421. On 20 June 2018, the Gosport Independent Panel published its report on events at Gosport War Memorial Hospital from the late 1980s to 2001. This report follows four years of work by the Chair, Bishop James Jones KBE and his Panel and it has drawn on previous reviews and also on important new material unearthed by the Panel. The report found that, over the period, the lives of more than 450 patients were shortened by clinically inappropriate use of opioid analgesics, with an additional 200 lives also likely to have been shortened if missing medical records are taken into account. Given the gravity of issues and the content and scale of the report, the Government will to consider its findings with great care and thoroughness across Government and once that work is done the relevant agencies will decide what steps to take next.

TPP

422. NHS Digital has recently identified a supplier defect in processing historical patient objections to the sharing of their confidential health data. This error has occurred where 150,000 Type 2 objections set between March 2015 and June 2018 in GP practices running TPP systems, have not been sent to NHS Digital. As a result, these objections have not been upheld by NHS Digital in its data disseminations between April 2016, when the NHS Digital process for enabling them to be upheld was introduced, and 26 June 2018.

423. Since being informed of the error by TPP, NHS Digital acted swiftly and it has now been rectified. TPP has apologised unreservedly for its role in this matter and has committed to work with NHS Digital so that errors of this nature do not occur again. There is, and has never been, any risk to patient care as a result of this error. NHS Digital has made the Information Commissioner's Office and the National Data Guardian for Health and Care aware. A letter to affected GP practices has been sent and all affected patients will be written to by the end of July 2018.

Remuneration and Staff Report

Remuneration Report

424. This Remuneration Report provides details of the remuneration and pension interests of Ministers and the most senior management (Board Members) of the Department. This includes Ministers, Non-Executive Directors and Directors General (DGs)/Senior Officials and is compliant with EPN 536 guidance.

425. 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.

426. The Constitutional Reform and Governance Act 2010 require Civil Service appointments to be made on merit on the basis of fair and open competition. The Recruitment Principles[108] published by the Civil Service specify the circumstances when appointments may otherwise be made.

427. 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[109].

Remuneration of Ministers 2017-18

428. Lord O'Shaughnessy was unpaid by the Department up to 13 June 2017, instead paid as a Government Whip (Lord in Waiting), by Her Majesty's Treasury. Lord O'Shaughnessy was paid by the Department from 14 June 2017.

429. Following the General Election in June 2017, David Mowat and Nicola Blackwood both lost their seats and were replaced as DHSC Ministers by Steve Brine, as Parliamentary Under Secretary of State (Public Health and Primary Care) and Jackie Doyle-Price as Parliamentary Under Secretary of State (Mental Health and Inequalities), from 14 June 2017.

430. Following a Cabinet re-shuffle, Philip Dunne left his post as Minister of State for Health on 9 January 2018. Stephen Barclay was appointed as Minister of State for Health and Caroline Dinenage was appointed as Minister of State for Care, from 10 January 2018.

Remuneration of Senior Officials on the Departmental Board

431. The Directors' Report outlines the officials sitting on the Departmental Board and their dates of appointment (and where appropriate departure), but their remuneration is detailed in **Table 9**.

[108] http://civilservicecommission.independent.gov.uk/civil-service-recruitment/
[109] www.civilservicepensionscheme.org.uk/civil-service-compensation-scheme.

Salary

432. '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.

433. 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.

434. 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 8**.

Non-Consolidated Performance Pay

435. 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 a maximum of the top 25 per cent of performers within the SCS. The Senior Civil Service Performance Management and Reward principles include explanations of how non-consolidated performance awards are determined.

436. 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.

437. The non-consolidated performance pay included in the 2017-18 figures relates to awards made in respect of the 2016-17 performance year but paid in financial year 2017-18. It was agreed that awards would not be differentiated by grade. An award of £10,500 was paid to the top 25 per cent performers in each SCS pay band.

Benefits in Kind

438. 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).

439. Dame Sally Davies has occasional use of an official car and taxis for the journey between her home and office. The benefit in kind amounted to £290 in 2017-18.

440. **Tables 8 and 9** provide details of remuneration interests of the Ministers of the Department and senior officials serving on the Departmental Board for the years 2016-17 and 2017-18 and are subject to audit.

Table 8: Remuneration of Ministers of the Department (subject to audit)

	2017-2018				2016-2017			
Ministers	Salary (£)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits to nearest (£'000)	Total to nearest (£'000)	Salary (£)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits to nearest (£'000)	Total to nearest (£'000)
Jeremy Hunt MP	67,505	Nil	16,000	84,000	67,505	Nil	19,000	87,000
Secretary of State								
Lord O'Shaughnessy[2] *(from 14/06/2017)*	55,273	Nil	16,000	71,000	-	-	-	-
Parliamentary Under Secretary								
Full year equivalent	72,530							
Steve Brine MP *(from 14/06/2017)*	19,702	Nil	5,000	25,000	-	-	-	-
Parliamentary Under Secretary								
Full year equivalent	22,375							
Jackie Doyle-Price MP *(from 14/06/17)*	16,992	Nil	5,000	22,000	-	-	-	-
Parliamentary Under Secretary								
Full year equivalent	22,375							
Caroline Dinenage MP *(from 10/1/2018)*	5,830	Nil	2,000	8,000	-	-	-	-
Minister of State								
Full year equivalent	31,680							
Stephen Barclay MP *(from 10/1/2018)*	7,154	Nil	2,000	9,000	-	-	-	-
Minister of State								
Full year equivalent	31,680							
Philip Dunne MP *(from 15/07/2016 to 9/1/2018)*	24,526	Nil	-	25,000	21,120	Nil	-	21,000
Minister of State								
Full year equivalent	31,680				*31,680*			
Nicola Blackwood *(from 16/07/2016 to 8/6/2017)*	4,226	Nil	1,000	5,000	15,897	Nil	4,000	20,000
Parliamentary Under Secretary								
Full year equivalent	22,375				*22,375*			
David Mowat *(from 16/07/2016 to 8/6/2017)*	4,226	Nil	1,000	5,000	15,897	Nil	4,000	20,000
Parliamentary Under Secretary								
Full year equivalent	22,375				22,375			
Lord David Prior of Brampton[3] *(from 12/05/2015 to 8/1/2017)*	-	-	-	-	87,563	Nil	18,000	106,000
Parliamentary Under Secretary								
Full year equivalent	-				*105,076*			
Alistair Burt MP *(from 12/5/2015 to 14/7/2016)*	-	-	-	-	9,112	Nil	10,000	19,000
Minister of State								
Full year equivalent	-				*31,680*			
Ben Gummer *(from 12/5/2015 to 13/07/2016)*	-	-	-	-	7,458	Nil	2,000	9,000
Parliamentary Under Secretary								
Full year equivalent	-				22,375			
Jane Ellison *(from 7/10/13 to 13/07/2016)*	-	-	-	-	7,458	Nil	10,000	17,000
Parliamentary Under Secretary								
Full year equivalent	-				22,375			
George Freeman MP[4] *(from 15/7/2014 to 13/7/2016)*	-	-	-	-	-	-	-	-
Parliamentary Under Secretary								

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 O'Shaughnessy's salary for 2017-18 includes the Lords Office-holders allowance. (This is a yearly allowance of £3,820 per annum, paid to Ministers whose primary residence is in London, the allowance is taxable and subject to NI but not pensionable). Up to 13 June 2017 he received no salary from the Department and was paid as a Government Whip by Her Majesty's Treasury.

3. Lord Prior's salary for 2016-17 includes the Lords Office-holders allowance. In 2016-17, he received £57,258 Ministerial Salary and £30,305 Lords office-holders allowance for the period 1/4/2016-8/1/2017.

4. The Minister was shared with the Department for Business , Innovation and Skills (BIS) now known as Department for Business, Energy & Industrial Strategy(BEIS), His full costs were met by BEIS and were disclosed in their annual accounts.

Table 9: Remuneration of Senior Officials on the Departmental Board (subject to audit)

	2017-2018					2016-2017				
Officials	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[2]	Gross Benefits in Kind (to nearest £100)	Pension Benefits to nearest (£'000)	Total (£'000)	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits to nearest (£'000)[3]	Total (£'000)
Sir Christopher Wormald *(from 1/6/2016)* Permanent Secretary Full year equivalent	165-170	Nil	Nil	58,000	225-230	135-140 165-170	Nil	Nil	44,000	180-185
Professor Dame Sally Davies Equivalent of Permanent Secretary	210-215	Nil	300	N/A	210-215	205-210	Nil	100	23,000	230-235
David Williams Director General	135-140	10-15	Nil	25,000	175-180	140-145	Nil	Nil	52,000	190-195
Clara Swinson *(from 7/11/2016)* Director General Full year equivalent	105-110	5-10	Nil	122,000	235-240	90-95 105-110	5-10	Nil	79,000	180-185
Tamara Finkelstein *(to 19/06/17)*[5] Director General Full year equivalent	25-30 120-125	Nil	Nil	6,000	30-35	120-125	10-15	Nil	54,000	185-190
Jonathan Marron *(from 26/06/17)* Director General Full year equivalent	95-100 125-130	10-15	Nil	41,000	145-150	-	-	-	-	-
Lee McDonough *(from 28/11/2016)* Director General Full year equivalent	120-125	5-10	Nil	195,000	325-330	30-35 120-125	Nil	Nil	103,000	135-140
Professor Christopher Whitty *(from 1/1/2016)* 3,4 Chief Scientific Officer	-	-	-	-	-	120-125	Nil	Nil	232,000	350-355
Will Cavendish *(to 2/10/2016)* Director General Full year equivalent	-	-	-	-	-	60-65 120-125	Nil	Nil	13,000	70-75
Felicity Harvey *(to 30/06/2016)* Director General Full year equivalent	-	-	-	-	-	30-35 135-140	Nil	Nil	4,000	35-40
Charles Massey *(to 30/10/2016)* Director General Full year equivalent	-	-	-	-	-	75-80 130-135	Nil	Nil	29,000	105-110
Una O'Brien *(to 30/4/2016)* Permanent Secretary Full year equivalent	-	-	-	-	-	10-15 160-165	Nil	Nil	0	10-15
Jonathan Rouse *(to 22/07/2016)* Director General Full year equivalent	-	-	-	-	-	40-45 140-145	10-15	Nil	17,000	70-75

1. Non Consolidated Performance Related Pay is paid in arrears and disclosed on an accruals basis. Therefore the Non Consolidated Performance Pay paid in 2016-17 relates to the 2015-16 performance year.

2. Non Consolidated Performance Related Pay is paid in arrears and disclosed on an accruals basis. Therefore the Non Consolidated Performance Pay paid in 2017-18 relates to the 2016-17 performance year.

3. Professor Whitty was appointed on 1 January 2016 on secondment from the London School of Hygiene and Tropical Medicine for four days per week. The figures in the table represent the proportion the department pays only not his full salary. In addition, the Department also contributes towards his pension scheme and NI costs which are not included above. For 2017-18, Professor Whitty works 2 days per week for the Department. He is not formally a member of the Departmental Board, as such his remuneration benefits are not included.

4. Steve Oldfield (Chief Commercial Officer) and Professor Chris Whitty's remuneration benefits do not appear in the table for 2017-18 as they are not formal members of the Departmental Board.

5. Seconded to Ministry of Housing, Communities and Local Government. Subsequently left DHSC to join DeFRA.

Department of Health and Social Care's SCS Reward Strategy 2017-18

441. The remuneration of Senior Civil Servants is determined in accordance with the rules set out in the Civil Service Management Code[110] 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.

442. The Department's annual SCS Reward Strategy was agreed by the Executive Board and ratified by the Nominations and Governance Committee and stated that from 1 April 2017, one per cent of the SCS paybill was available for consolidated pay awards. The Department continued to target the pay award towards those lower in their respective pay range by applying 'breakpoints' in each SCS Pay Band and differentiating the consolidated increases based on where staff were positioned in relation to the respective breakpoint. The breakpoints remained at the levels as set for 2016-17, which for Directors General (SCS3 Pay Band) was £140,000.

[110] http://civilservicecommission.independent.gov.uk/civil-service-code/

443. The pay award was paid as a flat cash rate increase rather than a percentage uplift; this delivered a higher reward to those who earned less in comparison with their peers. SCS below the breakpoint for their respective grade received a consolidated pay award of £1,000 and those above the breakpoint received no reward. In line with Cabinet Office guidance, staff in the bottom 10 % performance group were ineligible for an award.

Median Earnings

444. 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 10**.

Table 10: Median Earnings for Core Department and Public Health England (Executive Agency)

(subject to audit)

Median Earnings 2016-2017 and 2017-2018				
	Core Department		Combined [1]	
	2017-18	2016-2017	2017-18	2016-2017
Band of Highest Paid Director's Total remuneration (£000)[2]	210-215	205-210	215-220	220-225
Band of lowest paid	15-20	15-20	15-20	15-20
Median Total Remuneration	£39,584	£44,800	£38,589	£38,207
Ratio	5.4	4.6	5.6	5.8

1. The Medicines and Healthcare Products Regulatory Agency is designated out of scope by the Office for National Statistics and therefore is not included in determining the median earnings calculation for either year.
2. Salaries for senior management are disclosed in bands of £5000, in accordance with EPN536 guidance.

445. The banded remuneration of the highest paid core Department Director in 2017-18 was £210,000-£215,000 (2016-17 £205,000-£210,000). This was 5.4 times the median remuneration of the workforce of £39,584 (2016-17, £44,800).

446. No DHSC core employees in either 2017-18 or 2016-17 received remuneration in excess of the highest paid Director. Banded remuneration ranged from £15,000 to £20,000 and £210,000 - £215,000 (2016-17 £15,000-£20,000 and £205,000-£210,000).

447. The median earnings for the core Department have decreased in 2017-18 compared to 2016-17. This variance is directly related to the change in distribution of the earnings of staff, which has affected the ratio.

448. The higher ratio between the median earnings to the highest earner between 2016-17 and 2017-18 is due to the change in distribution of earnings and numbers of staff following the completion of the Department's DH2020 change programme.

Civil Service Pensions

449. 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. 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.

450. 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.

451. These statutory arrangements are unfunded with the cost of benefits met by monies voted by Parliament each year. Pensions payable under classic, premium, classic plus, Nuvos and Alpha are increased annually in line with Pensions Increase legislation. Existing members of the PCSPS who were within 10 years of their normal pension age on 1 April 2012 remained in the PCSPS after 1 April 2015. Those who were between 10 years and 13 years and 5 months from their normal pension age on 1 April 2012 will switch into Alpha sometime between 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. 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).

452. 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. For premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike classic, there is no automatic lump sum. Classic plus is essentially a hybrid with benefits for service before 1 October 2002 calculated broadly as per classic and benefits for service from October 2002 worked out as in premium. In nuvos a member builds up a pension based on 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. Benefits in Alpha build up in a similar way to nuvos, except that the accrual rate in 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.

453. 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).

454. 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 website[111].

Ministerial Pensions

455. 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.[112]

[111] http://www.civilservicepensionscheme.org.uk/members/the-new-pension-scheme-alpha/
[112] http://qna.files.parliament.uk/ws-attachments/170890/original/PCPF%20MINISTERIAL%20SCHEME%20FINAL%20RULES.doc

456. 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.

457. 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.

458. **Tables 11 and 12** provide the details of the pension interests for the Department's Officials and Ministers for 2016-17 and 2017-18 and are subject to audit.

Cash Equivalent Transfer Values

459. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by 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.

460. 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. 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.

461. 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

462. 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.

463. 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 11: Pension Interests of Ministers (subject to audit)

	Accrued pension at age 65 as at 31/03/18	Real increase in pension at age 65	CETV at 31/03/18	CETV at 31/03/17	Real increase in CETV
	£'000	£'000	£'000	£'000	£'000
Jeremy Hunt	10-15	0-2.5	178	155	7
Lord O'Shaughnessy[2]	0-5	0-2.5	15	5	4
Steve Brine[2]	0-5	0-2.5	4	0	2
Jackie Doyle-Price[2]	0-5	0-2.5	12	7	2
Caroline Dinenage[3]	0-5	0-2.5	13	12	1
Stephen Barclay[3]	0-5	0-2.5	11	10	1
Philip Dunne[4]	-	-	-	-	-
Nicola Blackwood[5]	0-5	0-2.5	5	4	0
David Mowat[5]	0-5	0-2.5	6	5	1

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. Reflects Ministerial pension for the period 14 June 2017-31 March 2018

3. Reflects Ministerial pension for the period 10 January 2018-31 March 2018.

4. Minister does not contribute to the Pension scheme

5. Reflects Ministerial pension for the period 1 April 2017- 8 June 2017

Table 12: Pension Information of Senior Officials on the Departmental Board (subject to audit)

		Accrued pension at pension age as at 31/03/18 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/03/18	CETV at 31/03/17	Real increase in CETV	Employer contribution to partnership pension account
		£'000	£ '000	£ '000	£ '000	£'000	Nearest £100
Christopher Wormald *(from 1/6/2016)*	Permanent Secretary	65-70	2.5-5	1,013	925	23	N/A
Professor Dame Sally Davies[1]	Chief Medical Officer	-	-	-	430	-	N/A
David Williams[2]	Director General for Finance & Group Operations	50-55 plus a lump sum of 125-130	0-2.5 plus a lump sum of 0-2.5	865	807	2	N/A
Clara Swinson *(from 7/11/2016)*	Director General for Global & Public Health	30-35 plus a lump sum of 75-80	5-7.5 plus a lump sum of 10-12.5	435	342	66	N/A
Tamara Finkelstein *(to 19/6/2017)*	Director General for Community Care	50-55	0-2.5	809	780	2	N/A
Jonathan Marron *(from 26/6/17)*	Director General for Community Care	10-15	0-2.5	137	107	17	N/A
Lee McDonough *(from 28/11/2016)*	Director General for Acute Care & Workforce	45-50 plus a lump sum of 140-145	7.5-10 plus a lump sum of 25-27.5	969	741	175	N/A
Professor Christopher Witty[3,4]	Chief Scientific Officer	-	-	-	734	-	N/A

1. Member opted out of the pension scheme as at 6/04/2016. Reflects pension to that period.

2. The member also transferred to new pension scheme. The final salary pension of a person in employment is calculated by reference to their pay and length of service. The pension will increase from one year to the next by virtue of any pay rise during the year. Where there is no or a small pay rise, the increase in pension due to extra service may not be sufficient to offset the inflation increase – that is, in real terms, the pension value can reduce, hence the negative values.

3. Professor Whitty was appointed on secondment from the London School of Hygiene and Tropical Medicine for four days per week. The figures govern are based solely on the individual benefits he receives from the 80% proportion that that the Department contributes towards and not his full pension entitlement .

4. Steve Oldfield (Chief Commercial Officer) and Professor Chris Whitty's remuneration benefits do not appear in the table for 2017-18 as they are not formal members of the Departmental Board.

Non-Executive Directors

464. 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. The Non-Executive Directors also make a significant contribution to Departmental business by working through Committees and with senior officials.

465. The Departmental Board holds positions for six Non-Executive Directors. The Non-Executive Directors sitting on the Departmental Board during 2017-18 are detailed in the Directors' Report. There are also two Independent members of Audit & Risk Committee.

466. 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 13: Non-Executive Directors and Members of the Department (subject to audit)

Non-Executive	Position	Date of Appointment	Term	Annual Fee
Peter Sands	Non-Executive Board Member & Lead Non-Executive	1 May 2014 - 30 April 2017	re-appointed 3 Years	Waived fees
Gerry Murphy	Non-Executive Board Member & Chair Audit & Risk Committee	1 Aug 2017 - 31 July 2020	re-appointed as Chair of Audit & Risk Committee	£15,000 £5,000
Kate Lampard	Non-Executive Board Member & Lead Non-Executive	1 Nov 2017 - 30 Sep 2020	3 Years	£15,000 £5000
Michael Mire	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	3 Years	£15,000
Prof Sir Mike Richards	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	3 Years	£15,000
Prof Dame Sue Bailey	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	3 Years	£15,000
Sir Ron Kerr	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	3 Years	£15,000
Jacqueline Burke	Independent Members of Audit & Risk Committee	1 Sep 2016 - 31 Aug 2019	re-appointed Member of Audit & Risk Committee	£5,000
Cat Little	Independent Members of Audit & Risk Committee	1 Nov 2016 - 31 Oct 2019	Member of Audit & Risk Committee	Non-remunerated Civil Servant

Compensation for Loss of Office (subject to audit)

467. 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.

468. There were three payments for loss of office during 2017-18 to Ministers. David Mowat and Nicola Blackwood, who lost their seats following the General Election in June 2017, both received payments of £5,594 following their departure on 8 June 2017. Philip Dunne, who left his post following the Cabinet re-shuffle, received a payment of £7,920, following his departure on 9 January 2018.

Staff Report

469. 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.

470. The core Department employed an average of 1,369 permanent whole time equivalent (WTE) persons during 2017-18 at a total salaries and wages cost of £62.1 million, compared to 1,733 at a cost of £79.4 million in 2016-17. A breakdown of staff numbers and associated costs for the Core Department and Agencies and the overall Departmental Group is included in **Tables 18 and 19**.

DH 2020 change programme

471. Following the announcement in the 2015 Spending Review of the plan to reduce the Department's running costs by 30 per cent by 2019-20, the Department completed its organisational change programme (DH 2020) in February . This programme focused on restructuring to ensure the right skills were retained or brought in to lead the health and care system effectively, whilst delivering the scale of savings necessary to meet the Spending Review target.

472. The programme was rigorous, delivering a restructuring and job selection process by February 2017. This included a voluntary exit scheme where 577 staff were given approval to leave the Department. The scheme was designed to ensure we did not approve the exit of any staff believed to have the right skills and behaviours needed for the future Department.

473. The Department identified the need to recruit a range of new staff across all grades and professions with the requisite skills and capability to populate the new structures and began a bulk recruitment process in December 2016, following completion of the selection process for existing staff.

474. Between April 2017 and March 2018, 121 external candidates were recruited. The Civil Service core competencies remain at the heart of our approach to any new recruitment and candidates must demonstrate a range of professional expertise with particular emphasis on world-class policy making, project and implementation skills, purposeful and disciplined management, and inspiring and confident leaders.

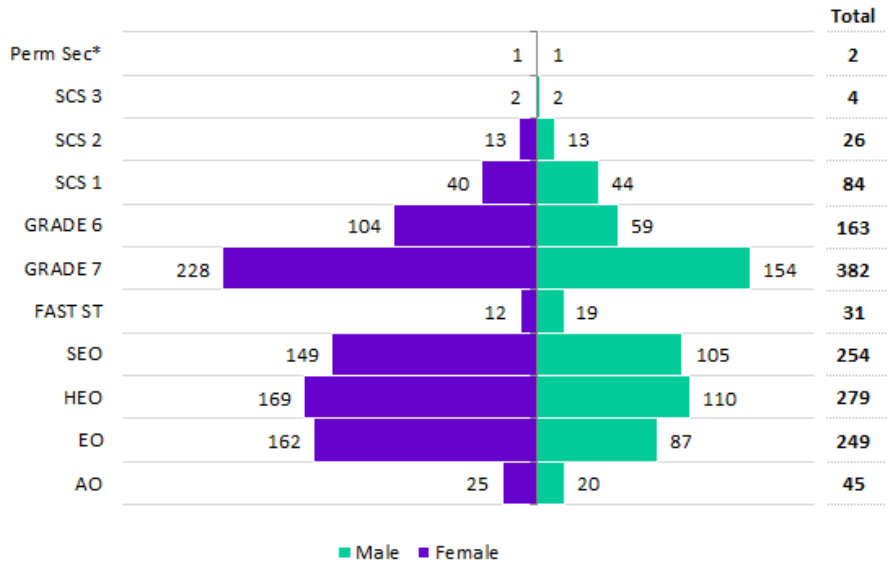
475. In July 2017, the DH 2020 programme formally closed and a new phase of the Department's Plan for Change was launched as the 'Great Department of State'. This supports the key elements of being a Brilliant Civil Service, focussing on: enabling ongoing workplace and IT changes; embedding new ways of working; and delivering the cultural change required in order to be a streamlined and efficient department. A continuous improvement approach was also adopted, with a focus on sustained effort to 'get the basics right'.

476. In October 2017, in London, the Department of Health and Social Care rationalised its estate significantly, consolidating staff from Richmond House and Wellington House into a newly refurbished building in Victoria Street. This London site - with all the space, flexibility and digital infrastructure supports modern ways of working - has resulted in far greater efficiency of the workspace, helping us work towards our $8m^2$ per WTE outlined in the Government Estates Strategy 2015.

DHSC Staff

477. 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 18** outlines the headcount and gender distribution of core Departmental staff in post as at 31 March 2018 and is consistent wth Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment with the Department.

Figure 18: Gender distribution of core Department staff (headcount) as at 31st March 2018



*Dame Sally Davies is classified as Permanent Secretary in this presentation, appearing alongside Chris Wormald. Chris Whitty and Steve Oldfield are not shown as SCS3 due to their hosted (seconded in) status.

Staff Sickness

478. The core Department has continued to reduce the number of days lost to short-term and long-term sickness, falling from 3,103 and 4,312 days respectively in 2016 to 1,600 and 3,333 in 2017. Our average number of days lost due to sickness of 3 days is significantly below the civil service average of 7.1 days.

3 days sickness compared to 7.1 days across Civil Service

Health and Safety

479. The Department of Health and Social Care recognises its responsibilities, under the Health and Safety at Work Act 1974[113], 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 2017-18, there were 12 reported accidents; one of which resulted in absence, and one near miss.

Equal Opportunities Policy

480. The Department is committed to treating all staff fairly and responsibly. The aim of the Department's equal opportunities policy is to promote equality of opportunity whereby

[113] http://www.hse.gov.uk/legislation/hswa.htm

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, membership or activity.

481. 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, HEO and above; equalities analysis of HR policies and initiatives; a comprehensive suite of equality policies; work-life balance and mental health initiatives; workforce monitoring by diversity characteristics; and targeted action such as career progression support for staff in historically underrepresented groups. They are set out in the Department's Equality Objectives Action Plan[114] and Annual Equalities Information Report[115].

482. 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 a key strand of our Departmental People strategy. To support this element of our People strategy we have launched our DHSC Diversity and Inclusion strategy setting out how we will achieve our vision to be a diverse and inclusive place to work where everyone can achieve their potential. The five themes of our strategy are:
    - Culture - creating an inclusive culture where difference is valued , the power of diversity is harnessed and everyone has equal opportunity to achieve their potential;
    - Capability - to build diversity capability and confidence across our workforce to ensure DHSC is a trusted, diverse organisation for which people are proud to work and leaders are inclusive by instinct;
    - Data and insight - we encourage everyone to provide diversity information to support more evidence based solutions to our diversity;
    - Talent - we identify and act to remove barriers to progress to ensure everyone has equal opportunity to fulfil their potential; and
    - Social Mobility – we take action to support improved diversity and social mobility in our workforce.

483. The Department uses a range of measures to track progress – including trends in staff survey (our People Survey) data, and participation in Civil Service wide and external benchmarking exercises such as the cross-sector Stonewall Workplace Equality Index and expert advice from organisations such as the Business Disability Forum. We have seen an increase in our staff engagement index to 62% (a 17% rise from last year) and on the specific People Survey theme of 'Inclusion and Fair Treatment' - which most closely relates to equality, diversity and inclusion - we have an engagement score of 82% (a 16% rise from last year).

[114] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401180/DH_equalities_2015_acc.pdf
[115] https://www.gov.uk/government/collections/dh-workforce-equality-information

484. The Department also implements the recommendations from the Civil Service Diversity and Inclusion strategy entitled 'A Brilliant Civil Service: becoming the UK's most inclusive employer'[116].

Recruitment and Retention of Disabled Persons

485. 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 'Guaranteed Interview 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.

486. The Department provides support to employees with a disability or health condition in the form of a workplace adjustment. 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.

487. The Department is obliged to provide 'reasonable adjustments' under the Equality Act 2010 to employees with a disability. This is to ensure that employees with a disability are able to develop, prosper and fulfil their potential on a level playing field with non-disabled colleagues.

488. The Department is taking part in a cross-government talent programme to develop the skills required of all staff for progression to higher grades, and we also make Unconscious Bias training a required piece of learning for all staff, which includes all those taking part in recruitment and selection. We have also been recognised as being a Disability Confident Leader organisation.

489. The Department runs specific targeted information sessions with members of our staff network groups - including our disability network 'Enable' - to encourage applicants to apply for the Civil Service-wide talent schemes – 'Future Leaders Scheme' and 'Senior Leaders Scheme', and the Civil Service wide development scheme 'Positive Action Pathway'.

Trade Union Facility Time

490. Under The Trade Union (Facility Time Publication Requirements) Regulations 2017[117] , the Department has a statutory requirement to disclose information (see **Tables 14, 15, 16**

[116] https://www.gov.uk/government/publications/a-brilliant-civil-service-becoming-the-uks-most-inclusive-employer
[117] http://www.legislation.gov.uk/uksi/2017/328/made

and **17**) as prescribed by schedule 2 of the above Regulation. The format of these tables is as prescribed by the Regulations.

491. The disclosure has been compiled in line with the Regulations. It is for this reason that 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 14: Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
31	31

Table 15: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	1
1-50%	30
51-99%	0
100%	0

Table 16: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£98,847
Total pay bill	£367,331,584
Percentage of the total pay bill spent on facility time*	0.03%

* calculated as: (total cost of facility time ÷ total pay bill)

Table 17: 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)

Staff Data

492. **Tables 18, 19 and 20** summarise key staff information for the Departmental Group.

Table 18: Staff costs for the Departmental Group comprise: (subject to audit)

					2017-18 £'000	2016-17 £'000
	Permanently employed staff	Others	Ministers	Special advisors	Total	Total
Salaries and wages	41,025,497	4,984,115	203	144	46,009,959	44,839,638
Social Security costs	4,275,050	90,395	23	18	4,365,486	3,958,408
NHS Pension	4,893,603	86,395	-	-	4,979,998	4,784,513
Other pension costs	60,667	1,422	1	23	62,113	67,998
Sub-total	**50,254,817**	**5,162,327**	**227**	**185**	**55,417,556**	**53,650,557**
Termination benefits	50,108	5,449	8	9	55,574	99,563
Sub-total	**50,304,925**	**5,167,776**	**235**	**194**	**55,473,130**	**53,750,120**
Less recoveries in respect of outward secondments	(31,887)	(54,542)	-	-	(86,429)	(72,478)
Total Net Costs	**50,273,038**	**5,113,234**	**235**	**194**	**55,386,701**	**53,677,642**

1. The Apprenticeship Levy is a levy on UK employers to fund new apprenticeships and is a new charge for 2017-18. It is

charged at a rate of 0.5% of an employer's paybill. Each employer receives an allowance of £15,000 to offset against their levy payment. This has been included in Social Security costs.

Table 19: Average number of whole-time equivalents employed – Departmental Group (subject to audit)

	Permanent staff	Others	Ministers	Special Advisors	2017-18 Number Total	2016-17 Number Total
Core Department						
Core Department	1,369	149	6	2	1,526	1,879
Executive Agencies						
Public Health England	4,966	317	-	-	5,283	5,345
Other designated bodies						
NHS Providers	1,057,352	100,195	-	-	1,157,547	1,144,229
Special Health Authorities	3,624	241	-	-	3,865	3,267
NHS England Group	22,408	9,302	-	-	31,710	31,017
Non Departmental Public Bodies	9,158	540	-	-	9,698	9,925
Others	4,758	155	-	-	4,913	5,290
Total	**1,103,635**	**110,899**	**6**	**2**	**1,214,542**	**1,200,952**

493. Of the figures shown in **Table 19**, the following staff were engaged on capital projects:

Table 20: Breakdown of staff engaged on capital projects (subject to audit)

Of the above, the following staff were engaged on capital projects:					2017-18 Number	2016-17 Number
Core Dept & Agencies	40	6	-	-	46	34
Other designated bodies	3,417	476	-	-	3,893	3,357

494. Further details of staff employed within NHS organisations is available via NHS Digital[118], 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

495. **Table 21** 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.

496. The Department utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. In 2017-18 the 'Core' Department has spent £12.4 million on consultancy compared to £4.5 million in 2016-17; and £21.9 million on temporary staff this year compared to £14.2 million last year. This increase relates to programmes of a short term nature that require specialist support not available within the department. These resources primarily support the Corporate Services Improvement Programme

[118] http://content.digital.nhs.uk/article/7028/NHS-workforce-new-analysis-shows-NHS-workforce-figures-over-time

(CSIP) and the development and implementation of a new supply chain model to produce procurement efficiency and value for money for NHS services.

497. Bodies within the NHS trade with each other in their operations and this is applicable to consultancy. The overall totals therefore are presented gross and net of the associated elimination.

Table 21: Expenditure on Consultancy, Agency and Temporary Workers

	2017-18		2016-17	
	Consultancy £'000	Temporary Agency £'000	Consultancy £'000	Temporary Agency £'000
Total DHSC Core	12,402	21,932	4,485	14,219
Executive Agencies	-	17,702	-	3,681
Other Designated Bodies	358,619	3,403,310	384,816	3,699,483
Gross Total	**371,021**	**3,442,944**	**389,301**	**3,717,383**
Eliminations	(51)	(478)	(148)	-
Total Departmental Group (after eliminations)	**370,970**	**3,442,466**	**389,153**	**3,717,383**

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

498. 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 22 a, b & c** includes all off-payroll engagements as at 31 March 2018 for a day-rate of more than £245 and which have duration of more than six months.

499. New rules relating to the engagement of off-payroll workers came into force on 5 April 2017. Regular correspondence has been undertaken between the Department and HMT, HMRC & Crown Commercial Services to ensure the new requirements have been understood and implemented in a fair and reasonable manner both by the Department and its ALBs. As a result of these discussions, HMRC have confirmed that the Departments processes are compliant with the new rules. The Department has also conducted a re-review of a proportion of its longer serving off-payroll worker population to ensure their IR35 status has not changed since the start of their engagement.

500. Regular communication has also been undertaken with the Departments ALBs to provide advice and assistance to them in ensuring that they have met their compliance requirements relating to the new rules. Presentations have been made by the Departments Head of VAT & Tax to ALB HR & Finance Directors to ensure the changes have been understood and acted upon. All appointments across the core Department, its agencies & ALBs have been subject to a risk based assessment regarding the payment of the correct tax by our combined contractor and off-payroll worker base.

501. On the advice of HMT, secondments have been included within the off-payroll figures for the core Department. Secondees engaged as at 31 March 2018 accounted for 15 of the off-payroll workers with none of these having reached their initial six month duration during financial year 2017-18. The Department had no change of policy relating to the engagement of off-payroll workers during 2017-18 and continues to utilise them only where it is necessary and prudent to do so.

Table 22: Off-payroll engagements

Table a: For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months	Core Dept & Agencies	ALBs
Number of existing engagements as of 31 March 2018	72	832
Of which.....		
Number that have existed for less than one year at time of reporting	21	562
Number that have existed for between one and two years at time of reporting	19	159
Number that have existed for between two and three years at time of reporting	13	61
Number that have existed for between three and four years at time of reporting	4	24
Number that have existed for four years or more years at time of reporting	15	26

Table b: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months	Core Dept & Agencies	ALBs
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	25	718
Of which.....		
Number assessed as caught by IR35	1	126
Number assessed as not caught by IR35	24	592
Number engaged directly (via PSC contracted to department) and are on the departmental payroll		2
Number of engagements reassessed for consistency / assurance purposes during the year		186
Number of engagements that saw a change to IR35 status following the consistency review		5

Table c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	Core Dept & Agencies	ALBs
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.		0
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	141	448

1. Changes outlined in Chapter 10, Part 2, Income Taxes (Earnings and Pensions) Act 2003
2. For Senior Officials the core Department has included all officials at SCS1 payband or above with significant financial responsibility for budget(s) of £500,000 or more

Exit Packages – Civil Service and Other Compensation Schemes

502. **Table 23** 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[119]. 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 23: Exit Packages (subject to audit)

				Core Dept & Agencies				2017-18 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	12	11	23	-	475	1,872	2,347	17
£10,001 - £25,000	6	6	12	-	556	456	1,012	5
£25,001 - £50,000	5	1	6	-	413	318	731	4
£50,001 - £100,000	3	6	9	-	253	167	420	2
£100,001 - £150,000	2	-	2	-	76	23	99	2
£150,001 - £200,000	1	-	1	-	50	13	63	-
>£200,000	-	-	-	-	5	1	6	-
Total Number	**29**	**24**	**53**	**-**	**1,828**	**2,850**	**4,678**	**30**
Total Cost (£)	**1,008,803**	**642,548**	**1,651,351**	**-**	**63,222,683**	**41,076,539**	**104,299,222**	**653,735**

				Core Dept & Agencies				2016-17 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	2	25	27	-	434	1,914	2,348	15
£10,001 - £25,000	2	101	103	1	487	760	1,247	7
£25,001 - 50,000	4	210	214	-	429	632	1,061	3
£50,001 - £100,000	6	361	367	-	243	570	813	2
£100,001 - £150,000	4	5	9	-	85	53	138	1
£150,001 - £200,000	2	4	6	-	51	17	68	-
>£200,000	-	3	3	-	2	4	6	-
Total Number	**20**	**709**	**729**	**1**	**1,731**	**3,950**	**5,681**	**28**
Total Cost (£)	**1,422,479**	**37,605,917**	**39,028,396**	**17,161**	**61,791,027**	**91,691,723**	**153,482,750**	**479,778**

1. Within the total above, there were 6 exit packages during 2017-18 relating to the DH 2020 restructure programme. (5 Voluntary exits, 1 compulsory redundancy), these occurred as individuals failed to secure a post during 2016-17 and were entitled to a redeployment period of 3 months and subsequent notice period.
2. There are no individuals within the Department who have received over £95,000 as an exit package due to entitlement on voluntary or compulsory redundancy arrangements in 2017-18. 8 individuals received payments over £95,000 were in 2016-17.

[119] http://www.civilservicepensionscheme.org.uk/civil-service-compensation-scheme/

Other Departures

503. **Table 24** 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 24** will not necessarily match the total number in **Table 23**, which will be the number of individuals.

Table 24: Analysis of Other Departures

	2017-18 Departmental Group	
	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	366	14,943
Mutually agreed resignations (MARS) contractual costs	582	14,172
Early retirements in the efficiency of the service contractual costs	15	531
Contractual payments in lieu of notice	1,819	9,807
Exit payments following Employment Tribunals or court orders	66	1,215
Non-contractual payments requiring HMT approval*	18	409
Total	**2,866**	**41,077**

*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

Statement of Parliamentary Supply

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 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.**

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.

Summary of Resource and Capital Outturn 2017-18 (subject to audit)

		2017-18 Estimate			2017-18 Outturn			2017-18	2016-17
	SoPS Note	Voted £'000	Non-Voted £'000	Total £'000	Voted £'000	Non-Voted £'000	Total £'000	Voted outturn compared with Estimate: saving/ (excess) £'000	Total £'000
Departmental Expenditure Limit									
- Resource	1.1	100,003,230	21,338,869	121,342,099	99,311,145	21,338,869	120,650,014	692,085	117,030,960
- Capital	1.2	5,597,681	-	5,597,681	5,237,852	-	5,237,852	359,829	4,556,079
Annually Managed Expenditure									
- Resource	1.1	27,939,879	-	27,939,879	13,152,311	-	13,152,311	14,787,568	9,507,918
- Capital	1.2	15,000	-	15,000	-	-	-	15,000	13,349
Total Budget		133,555,790	21,338,869	154,894,659	117,701,308	21,338,869	139,040,177	15,854,482	131,108,306
Non-Budget									
- Resource	1.1	-	-	-	-	-	-	-	-
Total		**133,555,790**	**21,338,869**	**154,894,659**	**117,701,308**	**21,338,869**	**139,040,177**	**15,854,482**	**131,108,306**
Total Resource		127,943,109	21,338,869	149,281,978	112,463,456	21,338,869	133,802,325	15,479,653	126,538,878
Total Capital		5,612,681	-	5,612,681	5,237,852	-	5,237,852	374,829	4,569,428
Total		**133,555,790**	**21,338,869**	**154,894,659**	**117,701,308**	**21,338,869**	**139,040,177**	**15,854,482**	**131,108,306**

Net cash requirement 2017-18 (subject to audit)

Net Cash Requirement 2017-18		2017-18	2017-18	2017-18	2016-17
	SoPS Note	Estimate £'000	Outturn £'000	Outturn compared with Estimate: saving/ (excess) £'000	Outturn £'000
Net cash requirement	3	105,423,780	102,009,695	3,414,085	99,049,454

Administration Costs 2017-18 (subject to audit)

Administration Costs 2017-18	2017-18 Estimate £'000	2017-18 Outturn £'000	2016-17 Outturn £'000
Administration Costs	2,939,885	2,303,513	2,394,452

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 (subject to audit)

	2017-18 £'000			2017-18 £'000			2017-18 £'000	2017-18 £'000			2016-17 £'000
							Outturn			Estimate	Outturn
	Administration			Programme			Total	Net Total	Net total compared to Estimate Savings /(excess)	Net total compared to Estimate, adjusted for virements	Total
	Gross	Income	Net	Gross	Income	Net					
Spending in Departmental Expenditure Limits (DEL)											
Voted:											
NHS England net expenditure	1,560,979	-	1,560,979	14,671,939	-	14,671,939	16,232,918	24,265,428	8,032,510	15,735	16,449,871
NHS Trusts net expenditure	-	-	-	-	-	-	-	-	-	-	25,259,577
NHS Foundation Trusts net expenditure	-	-	-	-	-	-	-	-	-	-	43,232,839
NHS Providers net expenditure	-	-	-	70,750,505	-	70,750,505	70,750,505	63,919,697	(6,830,808)	-	-
DHSC Programme and Administration expenditure	254,445	(46,378)	208,067	2,331,870	(792,759)	1,539,111	1,747,178	2,779,582	1,032,404	676,313	1,579,373
Local Authorities	-	-	-	3,090,533	-	3,090,533	3,090,533	3,090,570	37	37	3,433,394
Public Health England (Executive Agency)	55,485	(4,824)	50,661	951,902	(179,977)	771,925	822,586	766,533	(56,053)	-	877,056
Health Education England net expenditure	65,304	-	65,304	1,991,599	-	1,991,599	2,056,903	1,853,202	(203,701)	-	2,153,292
Special Health Authorities expenditure	224,140	(64,949)	159,191	4,154,867	(279,898)	3,874,969	4,034,160	2,848,193	(1,185,967)	-	3,489,248
Non Departmental Public Bodies net expenditure	259,311	-	259,311	317,051	-	317,051	576,362	480,025	(96,337)	-	530,669
	2,419,664	**(116,151)**	**2,303,513**	**98,260,266**	**(1,252,634)**	**97,007,632**	**99,311,145**	**100,003,230**	**692,085**	**692,085**	**97,005,319**
Non-voted:											
NHS England expenditure financed by NI Contributions	-	-	-	21,338,869	-	21,338,869	21,338,869	21,338,869	-	-	20,025,641
	2,419,664	**(116,151)**	**2,303,513**	**119,599,135**	**(1,252,634)**	**118,346,501**	**120,650,014**	**121,342,099**	**692,085**	**692,085**	**117,030,960**
Annually Managed Expenditure (AME)											
Voted:											
NHS England net expenditure	-	-	-	17,784	-	17,784	17,784	100,000	82,216	82,216	(307,784)
NHS Trusts net expenditure	-	-	-	-	-	-	-	-	-	-	296,447
NHS Foundation Trusts net expenditure	-	-	-	-	-	-	-	-	-	-	728,804
NHS Providers net expenditure	-	-	-	662,491	-	662,491	662,491	1,400,162	737,671	737,671	-
DHSC Programme and Administration expenditure	-	-	-	491,136	-	491,136	491,136	293,110	(198,026)	-	223,184
Local Authorities	-	-	-	-	-	-	-	-	-	-	-
Public Health England (Executive Agency)	-	-	-	4,623	-	4,623	4,623	22,928	18,305	18,305	2,223
Health Education England net expenditure	-	-	-	(17,647)	-	(17,647)	(17,647)	4,679	22,326	22,326	4,817
Special Health Authorities expenditure	-	-	-	11,990,518	-	11,990,518	11,990,518	26,119,000	14,128,482	13,927,050	8,557,599
Non Departmental Public Bodies net expenditure	-	-	-	3,406	-	3,406	3,406	-	(3,406)	-	2,628
	-	-	-	**13,152,311**	-	**13,152,311**	**13,152,311**	**27,939,879**	**14,787,568**	**14,787,568**	**9,507,918**
Total	**2,419,664**	**(116,151)**	**2,303,513**	**132,751,446**	**(1,252,634)**	**131,498,812**	**133,802,325**	**149,281,978**	**15,479,653**	**15,479,653**	**126,538,878**
Reconciliation to Statement of Comprehensive Net Expenditure											
Net gain/(loss) on transfers by absorption	-	-	-	(7,521)	-	(7,521)	(7,521)				-
Capital Grants	12,868	-	12,868	576,120	-	576,120	588,988				554,812
Research and Development	-	-	-	1,132,586	-	1,132,586	1,132,586				1,056,049
Income from Consolidated Fund Extra Receipts	-	-	-	-	(13,126)	(13,126)	(13,126)				(1)
Utilisation of provisions	(23,499)	-	(23,499)	23,499	-	23,499	-				-
IFRIC 12 Adjustment	-	-	-	255,998	(366,680)	(110,682)	(110,682)				363,414
Donated asset/government granted income	-	-	-	-	(155,038)	(155,038)	(155,038)				(182,078)
Expenditure presented on net basis[1]	137,855	(137,855)	-	8,132,755	(8,132,755)	-	-				-
Other adjustments	-	-	-	262,012	-	262,012	262,012				186,131
Net operating cost	**2,546,888**	**(254,006)**	**2,292,882**	**143,126,895**	**(9,920,233)**	**133,206,662**	**135,499,544**				**128,517,205**

1. Under Parliamentary reporting requirements, expenditure for the NHS England Group, NDPBs (including Health Education England) and NHS Providers 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 Annex B.
3. Note 21 to the accounts provide details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
4. Other adjustments include £262.0 million of expenditure representing the loss relating to the net assets transferred outside the Department's accounting boundary for the six charities that have gained independent status during 2017-18. Further details can be found in note 19.1.
5. 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 revenue to capital expenditure. Further detail is presented in Annex A Core Table 1.

6. NHS Trusts' and NHS Foundation Trusts' 2016-17 outturns are not permitted to be re-categorised as a single NHS Providers Estimate line. This is consistent with the 2016-17 Supplementary Estimates, where they were reported on separate lines. 2017-18 outturns are presented as a single NHS Providers Estimate line.
7. The total Revenue DEL underspend of £692 million consist of a £777 million underspend against the ringfence control. This is not cash backed, and cannot be used to fund healthcare services.

SOPS 1.2 Analysis of net capital outturn by section (subject to audit)

	2017-18 £'000 Outturn			2017-18 £'000 Estimate			2016-17 £'000 Outturn
	Gross	Income	Net Total	Net Total	Net total compared to Estimate Savings /(excess)	Net total compared to Estimate adjusted for virements	Net Total
Spending in Departmental Expenditure Limits (DEL)							
Voted:							
NHS England net expenditure	227,820	-	227,820	251,450	23,630	23,630	227,416
NHS Trusts net expenditure	-	-	-	-	-	-	1,049,501
NHS Foundation Trusts net expenditure	-	-	-	-	-	-	1,815,837
NHS Providers net expenditure	3,045,549	-	3,045,549	3,615,459	569,910	297,779	-
DHSC Programme and Administration expenditure	1,880,324	(97,513)	1,782,811	1,572,319	(210,492)	-	1,355,172
Local Authorities	15,456	-	15,456	-	(15,456)	-	9,325
Public Health England (Executive Agency)	74,560	(3,865)	70,695	90,900	20,205	20,205	51,679
Health Education England net expenditure	628	-	628	2,036	1,408	1,408	476
Special Health Authorities expenditure	16,881	(143)	16,738	33,545	16,807	16,807	14,726
Non Departmental Public Bodies net expenditure	78,155	-	78,155	31,972	(46,183)	-	31,947
	5,339,373	**(101,521)**	**5,237,852**	**5,597,681**	**359,829**	**359,829**	**4,556,079**
Annually Managed Expenditure (AME)							
Voted:							
NHS England net expenditure	-	-	-	-	-	-	-
NHS Trusts net expenditure	-	-	-	-	-	-	-
NHS Foundation Trusts net expenditure	-	-	-	-	-	-	-
NHS Providers net expenditure	-	-	-	-	-	-	-
DHSC Programme and Administration expenditure	-	-	-	15,000	15,000	15,000	13,349
Local Authorities	-	-	-	-	-	-	-
Public Health England (Executive Agency)	-	-	-	-	-	-	-
Health Education England net expenditure	-	-	-	-	-	-	-
Special Health Authorities expenditure	-	-	-	-	-	-	-
Non Departmental Public Bodies net expenditure	-	-	-	-	-	-	-
	-	-	-	**15,000**	**15,000**	**15,000**	**13,349**

1. Explanations of variances between Estimate and outturn are given in the Annex B.
2. Note 21 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
3. NHS Trusts' and NHS Foundation Trusts' 2016-17 outturns are not permitted to be re-categorised as a single NHS Providers Estimate line. This is consistent with the 2016-17 Supplementary Estimates, where they were reported on separate lines. 2017-18 outturns are presented as a single NHS Providers Estimate line.

SOPS 2 Reconciliation of net resource outturn to net operating expenditure (subject to audit)

		Note	2017-18 £'000 Outturn	2016-17 £'000 Outturn
Total resource outturn in Statement of Parliamentary Supply				
	Budget	SOPS 1.1	133,802,325	126,538,878
	Non-Budget	SOPS 1.1	-	-
			133,802,325	126,538,878
Add:	Capital Grants		588,988	554,812
	Research and Development[2]		1,132,586	1,056,049
	PFI/LIFT expenditure under IFRS		2,164,246	2,538,697
	PFI/LIFT income under IFRS		(366,680)	(373,801)
	Other[1]		262,012	239,737
			3,781,152	4,015,494
Less:	Income payable to the Consolidated Fund	SOPS4	(13,126)	(1)
	Donated asset/government granted income		(155,038)	(182,078)
	PFI/LIFT expenditure under UK GAAP		(1,908,248)	(1,801,482)
	Loss on transfers by absorption		(7,521)	-
	Other		-	(53,606)
			(2,083,933)	(2,037,167)
Net Operating Cost in Consolidated Statement of Comprehensive Net Expenditure after Financing Activities			**135,499,544**	**128,517,205**

1. The 'Other' line relates predominantly to a loss generated on recognition of the net assets of six NHS Charities that have converted to independent status during 2017-18. HMT have confirmed that effective transfer of assets to a fully independent charity is treated as a capital grant in kind and is budget neutral. This is therefore a reconciling item between the net resource outturn and Net operating costs in the Statement of Comprehensive Net Expenditure.
2. From 2016-17, government departments were required as part of ESA10 to categorise R&D expenditure as capital.

SOPS 3 Reconciliation of net resource outturn to net cash requirement (subject to audit)

	Note	2017-18 £'000 Estimate	Outturn	Net total outturn compared with Estimate: Savings/(excess)
Resource Outturn	SOPS 1.1	149,281,978	133,802,325	15,479,653
Capital Outturn	SOPS 1.2	5,612,681	5,237,852	374,829
Accruals to cash adjustments:				
Adjustments to remove non-cash items:				
Depreciation		(1,205,086)	(175,802)	(1,029,284)
New provisions and adjustments to previous provisions		(28,624,600)	545,221	(29,169,821)
IFRIC12 revenue adjustments			30,595	(30,595)
Adjustment for stockpiled goods			60,227	(60,227)
Non-cash investment additions			(13,082)	13,082
Other non-cash items[1]		-	(16,410,087)	16,410,087
Adjustments for NDPBs, NHS Trusts, Foundation Trusts, Charities and Other bodies:				
Remove voted resource and capital		(95,924,110)	(94,441,934)	(1,482,176)
Add cash grant-in-aid, PDC, loans and share capital from Core Department, and expenditure financed by Parliamentary		94,339,138	91,535,905	2,803,233
Adjustments to reflect movements in working balances:				
Increase/(decrease) in inventory			19,072	(19,072)
less transfers from non-current assets			(146)	146
Increase/(decrease) in receivables		-	1,053,566	(1,053,566)
less movement in current financial assets			(922,004)	922,004
(Increase)/decrease in payables		1,000,000	(503,453)	1,503,453
less movement in payables to the Consolidated Fund			107,658	(107,658)
less movement in finance lease/PFI payables			(3,222)	3,222
add capital element of finance lease/PFI payables			3,028	(3,028)
Use of provisions		2,282,648	3,400,069	(1,117,421)
		126,762,649	**123,325,788**	**3,436,861**
Removal of non-voted budget items:				
National Insurance contributions		(21,338,869)	(21,338,869)	-
Other adjustments				
Other cashflow adjustments			22,776	(22,776)
Net cash requirement		**105,423,780**	**102,009,695**	**3,414,085**

1.The 'Other non-cash items' line relates predominantly to the change in discount rate relating to Provisions as described in Note 16.

SOPS 4 Income payable to the Consolidated Fund (subject to audit)

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 2017-18 £'000		Outturn 2016-17 £'000	
	Income	*Receipts*	Income	*Receipts*
Operating income outside the ambit of the Estimate	17,354	*17,354*	1	*1*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total income payable to the Consolidated Fund	**17,354**	***17,354***	**1**	***1***

Parliamentary Accountability Disclosures

The following disclosures are subject to audit.

Losses and Special Payments

Table 25: Losses Statement (subject to audit)

		2017-18		Restated[1] 2016-17	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	91	58,081	71	61,936
	£'000	195,083	294,901	154,063	217,205
Cases over £300,000					
Cash losses	Cases	-	2	-	1
	£'000	-	981	-	668
Claims abandoned	Cases	1	2	-	1
	£'000	391	14,913	-	338
Cancellation of Public Dividend Capital (PDC)	Cases	2	2	2	2
	£'000	65,735	65,735	5,884	5,884
Administrative write-offs	Cases	-	1	-	1
	£'000	-	13,804	-	572
Fruitless payments	Cases	-	1	-	1
	£'000	-	832	-	604
Constructive Loss	Cases	3	3	4	5
	£'000	39,446	39,446	37,380	39,780
Store losses	Cases	-	1	-	1
	£'000	-	457	-	651

1. Prior year has been restated to include loss on foreign exchange. More detail can be found below.

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 £78.9 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

Included within its total losses, the Department has recorded a loss of £10 million relating to losses realised on the settlement of EEA liabilities. Prior year figures have been restated to include £23m of losses in 2016-17. These losses represent the accounting entries required to reflect the movement in exchange rates between the prior year end and the settlement date on EEA accruals denominated in foreign currency. It is not practicable to identify the individual number of cases and therefore 1 loss has been recorded in the total losses category above but it is highly unlikely that the amount relating to any individual case would be above the £300,000 threshold for individual disclosure. It should be noted that the disclosure of this category of loss is a technical requirement which is completely outside the Department's control.

Constructive Loss

The constructive losses relate to stockpiled drugs and vaccines where the use-by date has expired.

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.

During 2017-18, the Department has written off a total of £65.7 million of PDC. Peterborough & Stamford Hospitals NHS Foundation Trust acquired Hinchingbrooke Healthcare NHS Trust on 1 April 2017 to form North West Anglia NHS Foundation Trust, which resulted in a write off of £63.2 million. In addition, £2.5 million relates to the dissolution of Mid Staffordshire NHS Foundation Trust on 1 November 2017.

Claims waived and abandoned

The Department incurred a loss of £391k that relates to the reversal of a legacy receivable from 2013-14 that is now deemed irrecoverable due to insufficient supporting evidence. There is no loss to the DHSC Group.

Other Losses

The above narrative disclosures relate to the Core and Agencies only. Further disclosures of losses and special payments for other bodies can be found within the accounts of those entities.

Table 26: Analysis of Losses by Sector

	2017-18	2016-17	2017-18	2016-17
	Cases		Value	
	Number		£'000	
DHSC Core	36	47	155,249	116,278
Public Health England	55	24	39,834	37,785
NHS England Group	488	436	21,285	10,653
NHS Providers	52,665	57,367	75,125	47,527
NDPBs	4,461	3,500	2,815	1,656
Special Health Authorities	377	533	984	780
Other Group entities	-	29	-	2,526
Eliminations	(1)	-	(391)	-
Departmental Group	**58,081**	**61,936**	**294,901**	**217,205**

Table 27: Special Payments (subject to audit)

		2017-18		2016-17	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	43	15,428	43	17,252
	£'000	26,260	55,137	4,914	26,907
Cases over £300,000	Cases	15	25	3	4
	£'000	25,003	35,858	3,444	3,944

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.

Certain Core Department cases over £300k 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.

One compensation payment was made in August 2017 totalling £0.51 million relating to historical human growth hormone treatment offered by the NHS. Due to the Morland Judgement, which means that patients whose treatment commenced after 1 July 1977 would be successful, the claim was settled.

The above narrative disclosures 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.

Table 28: Special Payments by Sector

	2017-18	2016-17	2017-18	2016-17
	Cases		Value	
	Number		£'000	
DHSC Core	38	34	26,191	4,872
Public Health England	5	9	69	42
NHS England Group	6,983	7,366	5,914	3,615
NHS Providers	8,299	9,606	22,701	18,133
NDPBs	-	2	-	11
Special Health Authorities	97	228	157	84
Other Group entities	6	7	105	150
Departmental Group	**15,428**	**17,252**	**55,137**	**26,907**

Other Payments

There have been no other payments made by the Core Department for 2017-18 (three donations totalling £1.9 million in 2016-17.)

Fees and Charges

Table 29: Fees and Charges (subject to audit)

	2017-18 Departmental Group		
	Fees and Charges Income	Full Cost of Service	Surplus/(Deficit)
	£'000	£'000	£'000
Dental	807,333	2,811,569	(2,004,236)
Prescription	575,963	10,455,670	(9,879,707)
Other Fees and Charges for which the cost of providing the service is over £1million	346,284	302,986	43,298
Total	**1,729,580**	**13,570,225**	**(11,840,645)**

	2016-17 Departmental Group		
	Fees and Charges Income	Full Cost of Service	Surplus/(Deficit)
	£'000	£'000	£'000
Dental	776,812	2,767,908	(1,991,096)
Prescription	554,935	10,515,464	(9,960,529)
Other Fees and Charges for which the cost of providing the service is over £1million	291,511	313,902	(22,391)
Total	**1,623,258**	**13,597,274**	**(11,974,016)**

The fees and charges information in this note is provided in accordance with the HM Treasury Financial Reporting Manual. The Core Department does not provide services for which a fee is charged, therefore all disclosures relate to consolidated bodies. 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 2017-18, the NHS prescription charge for each medicine or appliance dispensed was £8.60. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £29.10 for three months or £104.00 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 2017-18, the charge for Band 1 treatments was £20.60, for Band 2 was £56.30 and for Band 3 was £244.30.

Included in the 'Other fees and charges' (for which the cost of providing the service is over £1.0 million) is £193.7 million (2016-17: £149.6 million) of fees and charges and £197.0 million (2016-17: £197.0 million) of expenditure relating to regulatory income at the Care Quality Commission. The remaining balance relates to 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 of Health and Social Care 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 2017		Increase in year	Liabilities crystallised in year	Obligation expired in year	31 March 2018		Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	£'000	No.	£'000
Guarantees	-	-	156	-	-	156	1	-
Indemnities	1,400	2	5,829	-	(1,300)	5,929	4	-
Letters of comfort	-	-	-	-	-	-	-	-
Total	**1,400**	**2**	**5,985**	**-**	**(1,300)**	**6,085**	**5**	**-**

Unquantifiable

The Department of Health and Social Care has entered into a number of unquantifiable or unlimited contingent liabilities with various health bodies and private companies. There were 13 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. A summary of these can be found in the Department's Supplementary Estimates.

Government Core Tables 1 & 2 and accompanying narrative can be found within Annex A.

5 July 2018
Sir Chris Wormald KCB
Permanent Secretary
Department of Health and Social Care

The Certificate and Report of the Comptroller and Auditor General to the House of Commons

Opinion on financial statements

I certify that I have audited the financial statements of the Department of Health and Social Care and of its Departmental Group for the year ended 31 March 2018 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) Order 2017. 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.

I have also audited the Statement of 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:

- 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 2018 and of the Department's total net expenditure and Departmental Group's total net expenditure for the year then ended; and
- the financial statements 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

Without qualifying my opinion, 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 NHS Resolution. Significant changes to the liability could occur as a result of subsequent information and events which are different to those used to inform the current assumptions adopted by NHS Resolution

Opinion on regularity

In my opinion, in all material respects:

- the Statement of Parliamentary Supply properly presents the outturn against voted Parliamentary control totals for the year ended 31 March 2018 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 of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) 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 2016. I am independent of the Department of Health and Social Care in accordance with the ethical requirements that are relevant to my audit and 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.

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 and for being satisfied that they give a true and fair view.

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.

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. 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.

As part of an audit in accordance with ISAs (UK), I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the group's and the Department of Health and Social Care's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and

the Department of Health and Social Care's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.

- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the group financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

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.

I am required to obtain evidence sufficient to give reasonable assurance that the Statement 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.

Other Information

The Accounting Officer is responsible for the other information. The other information comprises information included in the annual report, other than the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and 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, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the 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;

- in the light of the knowledge and understanding of the group and the parent and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report or the Accountability Report; 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

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Accountability Report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse **12 July 2018**

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 2018

For the year ended 31 March 2018				Restated[4]	
		2017-18		2016-17	
	Notes	Core Dept & Agencies £'000	Departmental Group £'000	Core Dept & Agencies £'000	Departmental Group £'000
Income from sale of goods and services	5	(124,405)	(5,540,067)	(167,319)	(5,333,347)
Other operating income	5	(1,416,611)	(4,443,324)	(1,657,502)	(4,937,002)
Income received by NHS charities	19	-	(151,638)	-	(207,838)
Total operating income		**(1,541,016)**	**(10,135,029)**	**(1,824,821)**	**(10,478,187)**
Staff costs	3	404,965	55,201,860	450,440	53,529,306
Purchase of goods and services	4	880,101	61,720,027	985,125	60,664,112
Depreciation and impairment charges	4	234,850	3,469,590	450,984	4,329,242
Provision expense	4	1,533,753	15,436,029	943,785	11,487,086
Other operating expenditure	4	5,707,323	8,064,046	6,050,846	8,008,886
Grant in Aid to NDPBs		112,888,699	-	109,751,742	-
Funding to Group bodies		749,321	-	331,212	-
Resources expended by NHS charities	19	-	304,692	-	308,592
Total operating expenditure		**122,399,012**	**144,196,244**	**118,964,134**	**138,327,224**
Net operating expenditure for the year ended 31 March 2018		**120,857,996**	**134,061,215**	**117,139,313**	**127,849,037**
Finance income		(227,652)	(39,210)	(210,386)	(66,759)
Finance expense		(37,964)	1,477,539	(22,985)	734,927
Net (gain)/loss on transfers by absorption		-	7,521	35,936	-
Total Net Expenditure for the year ended 31 March 2018		**120,592,380**	**135,507,065**	**116,941,878**	**128,517,205**
Other Comprehensive Net Expenditure					
Items that will not be reclassified to net operating costs:					
Net (gain)/loss on:					
- revaluation of property, plant and equipment		(73,261)	(2,200,182)	(12,107)	(794,364)
- revaluation of intangibles		(6,209)	(6,358)	(5,838)	(7,419)
- revaluation of investments		(782,054)	(47)	-	-
-revaluation of charitable assets		-	(7,184)	-	(49,705)
- impairments and reversals taken to revaluation reserve		3,143	516,480	16,818	1,235,954
Actuarial (gains)/losses on defined benefit pension schemes		-	(13,350)	-	17,724
Other pensions remeasurements		-	(592)	-	(10,275)
Other (gains) and losses		-	852	-	(4,806)
Total Comprehensive Expenditure for the year ended 31 March 2018		**119,733,999**	**133,796,684**	**116,940,751**	**128,904,314**

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 6.2 PDC dividend income should be presented as a form of finance income. It has been included under operating income, so it can be separately identified as shown in Note 5 Income.
3. The change in the Personal Injury Discount Rate requirements has led to an increase in Funding to Group Bodies.
4. Inventories consumed expenditure has been allocated to other more specific expenditure categories. Prior year analysis has been restated to ensure comparability. An amount of £9.9 billion has been reallocated from other operating expenditure to purchase of goods and services.

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 2018

		2017-18		2016-17	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Non-current assets					
Property plant and equipment	6	1,237,947	52,371,283	1,178,425	50,397,679
Investment Property		16,870	224,491	9,613	142,645
Intangible assets	7	236,431	1,442,861	231,415	1,293,732
Charitable non-current assets	19.2	-	79,944	-	106,222
Financial assets- Investments	11	38,069,358	750,366	34,679,999	683,342
Charitable investments	19.3	-	398,585	-	657,154
Other non-current assets	14	223,932	895,752	150,893	650,185
Total non-current assets		**39,784,538**	**56,163,282**	**36,250,345**	**53,930,959**
Current assets					
Assets classified as held for sale		2,899	75,184	72,320	155,122
Inventories	12	161,348	1,321,990	144,843	1,242,477
Trade and other receivables	14	158,736	1,879,730	184,877	2,021,510
Other current assets	14	286,760	2,012,382	206,580	1,802,178
Charitable other current assets	19.2	-	31,025	-	39,699
Other financial assets	14	1,784,501	22,210	862,497	20,261
Cash and cash equivalents	13	1,709,068	7,562,137	1,877,074	6,789,286
Charitable cash	19.2	-	230,219	-	252,609
Total current assets		**4,103,312**	**13,134,877**	**3,348,191**	**12,323,142**
Total assets		**43,887,850**	**69,298,159**	**39,598,536**	**66,254,101**
Current liabilities					
Trade and other payables	15	(142,063)	(5,507,774)	(143,997)	(5,360,556)
Other liabilities	15	(3,381,420)	(13,173,813)	(2,923,876)	(11,807,456)
Charitable liabilities	19.2	-	(43,740)	-	(82,103)
Provisions	16	(408,335)	(3,670,948)	(651,342)	(3,954,364)
Total current liabilities		**(3,931,818)**	**(22,396,275)**	**(3,719,215)**	**(21,204,479)**
Non-current assets plus/less net current assets/liabilities		**39,956,032**	**46,901,884**	**35,879,321**	**45,049,622**
Non-current liabilities					
Other payables	15	(19,296)	(431,678)	(9,892)	(416,850)
Charitable liabilities	19.2	-	(6,858)	-	(17,660)
Provisions	16	(2,887,680)	(77,858,429)	(2,263,132)	(65,250,495)
Net pension asset/(liability)	16.1	-	(114,834)	-	(115,779)
Financial liabilities	15	-	(11,401,073)	-	(11,660,902)
Total non-current liabilities		**(2,906,976)**	**(89,812,872)**	**(2,273,024)**	**(77,461,686)**
Total assets less liabilities		**37,049,056**	**(42,910,988)**	**33,606,297**	**(32,412,064)**
Taxpayers' equity and other reserves					
General fund		35,248,195	(56,375,479)	32,646,301	(44,735,412)
Revaluation reserve		1,800,861	12,619,978	959,996	11,211,334
Other Reserves		-	155,338	-	156,093
Total Taxpayers' Equity		**37,049,056**	**(43,600,163)**	**33,606,297**	**(33,367,985)**
Charitable funds	19.2	-	689,175	-	955,921
Total Reserves		**37,049,056**	**(42,910,988)**	**33,606,297**	**(32,412,064)**

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*. This net liabilities position has increased in 2017-18 mostly due to a further change in discount rate.

Sir Chris Wormald KCB
Permanent Secretary 5 July 2018

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 period ended 31 March 2018

		2017-18		2016-17	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Net cashflow from operating activities					
Net operating cost including financing activities	CSCNE	(120,592,380)	(135,499,544)	(116,905,942)	(128,517,205)
Adjustments for non-cash transactions	4.2	1,731,231	19,094,081	1,243,349	15,389,656
Non-cash movements arising from absorption transfers/FT authorisations		-	(11,465)	13,578	210
Adjustments for charities		-	243,933	-	183,329
Other non-cash movements in Statement of Financial Position items		-	6,296	-	8,162
(Increase)/decrease in trade and other receivables	14	(1,049,082)	(315,940)	(85,805)	(327,953)
less movements in receivables relating to items not passing through the CSCNE	14	943,910	186,492	263,140	79,145
(Increase)/decrease in inventories	12	(16,505)	(79,513)	34,436	(20,294)
less transfers to inventories from non-current assets	12	146	146	55,886	55,886
Increase/(decrease) in trade and other payables	15	465,014	1,268,574	(761,047)	(662,714)
less movements in payables relating to items not passing through the CSCNE	15	(114,823)	(227,367)	809,363	996,267
Use of provisions	16	(493,999)	(2,955,692)	(286,131)	(2,349,778)
Transfer of provisions to payables	16	(620,040)	(651,906)	(445,246)	(464,792)
Cash payments in respect of pensions	16.1	-	(13,925)	-	(10,668)
Other operating cashflows		796	10,374	1	(10,679)
Net cash outflow from operating activities		**(119,745,732)**	**(118,945,456)**	**(116,064,418)**	**(115,651,428)**
Cash flows from investing activities					
Purchase of property, plant and equipment & investment properties	6, 15	(116,790)	(3,577,991)	(211,745)	(3,532,652)
Purchase of intangible assets	7, 15	(112,021)	(453,254)	(100,769)	(373,714)
Proceeds of disposal of property, plant and equipment		7,295	302,143	5,792	123,117
Proceeds of disposal of intangibles		470	5,225	951	2,088
Proceeds of disposal of assets held for sale		9,435	191,820	261,632	422,890
Purchase of investments	11	(4,200,428)	(16,409)	(3,779,469)	(47,561)
Proceeds of disposal of investments	11, 14	573,269	30,105	743,972	224,738
Other investing cashflows		-	197,434	-	132,004
Net cash outflow from investing activities		**(3,838,770)**	**(3,320,927)**	**(3,079,636)**	**(3,049,090)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year		102,100,000	102,100,000	98,200,000	98,200,000
Financing from the National Insurance Fund		21,338,869	21,338,869	20,025,641	20,025,641
Movement in loans received from DHSC and Other Bodies		-	24,476	-	19,051
Capital element of payments in respect of finance leases and on-SOFP PFI/LIFT contracts		(3,028)	(416,529)	(3,664)	(440,015)
Other financing cashflows		(19,344)	(24,827)	(5,052)	(30,772)
Net financing		**123,416,497**	**123,021,989**	**118,216,925**	**117,773,905**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**(168,005)**	**755,606**	**(927,129)**	**(926,613)**
Payment of amounts due to the Consolidated Fund		(1)	(1)	(106)	(106)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**(168,006)**	**755,605**	**(927,235)**	**(926,719)**
Cash and cash equivalents at the beginning of the period		1,877,074	7,024,807	2,804,309	7,951,526
Cash and cash equivalents at the end of the period	13, 15, 19.2	**1,709,068**	**7,780,412**	**1,877,074**	**7,024,807**

1. The 'Other' lines within the Consolidated Statement of Cash Flows include cash flow items recorded by underlying NHS bodies not separately identified within the Resource Account format. This line also includes an adjustment for a deferred tax liability to ensure the internal consistency of the Resource Account Consolidated Statement of Cash Flows.
2. Due to the immateriality of interest paid and received and dividends received, these are not separately disclosed on the face of the cash flow. Interest payable of £964 million (2016-17: £941 million), interest receivable of £45 million (2016-17: £70 million) and dividend income of £32 million (2016-17: £12 million) have been included in net operating cost.

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 period ended 31 March 2018

		Core Dept & Agencies			Departmental Group					
	Note	General Fund £'000	Revaluation Reserve £'000	Taxpayers' Equity	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Taxpayers' Equity	Charitable Funds £'000	Total Reserves £'000
Balance at 1 April 2017		32,646,301	959,996	33,606,297	(44,735,412)	11,211,334	156,093	(33,367,985)	955,921	(32,412,064)
Prior period adjustments in local accounts		-	-	-	5,764	4,434	(7)	10,191	3,478	13,669
Net parliamentary funding - drawn down		102,100,000		102,100,000	102,100,000			102,100,000		102,100,000
Net parliamentary funding - deemed		2,086,363		2,086,363	2,086,363			2,086,363		2,086,363
National Insurance contributions		21,338,869		21,338,869	21,338,869			21,338,869		21,338,869
Supply (payable)/receivable adjustment	15	(2,176,668)		(2,176,668)	(2,176,668)			(2,176,668)		(2,176,668)
CFERs and other amounts payable to the Consolidated Fund	15	(17,354)		(17,354)	(17,354)			(17,354)		(17,354)
PDC investment adjustment		(159,346)		(159,346)	-			-		-
Comprehensive Net Expenditure for the Year		(120,592,380)		(120,592,380)	(135,230,078)			(135,230,078)	(276,987)	(135,507,065)
Non-cash adjustments:										
non-cash charges - auditor's remuneration	4.1	824		824	919			919		919
Movements in Reserves										
Recognised in Statement of Comprehensive Expenditure										
Net gain/(loss) on revaluation of non-current assets			861,524	861,524		2,206,587	-	2,206,587	-	2,206,587
Net gain/(loss) on revaluation of charitable assets				-				-	7,184	7,184
Impairments and reversals			(3,143)	(3,143)		(516,480)		(516,480)	-	(516,480)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme		-		-	12,500		850	13,350		13,350
Other pensions remeasurements		-		-	(1,877)		2,469	592		592
Other gains and losses		-		-	(416)		(436)	(852)		(852)
Transfers between reserves		21,716	(21,716)	-	241,174	(240,212)	(962)	-	-	-
Other movements		(130)	4,200	4,070	7,726	(45,188)	(10,169)	(47,631)	(555)	(48,186)
Other transfers		-	-	-	(6,989)	(497)	7,500	14	134	148
Balance at 31 March 2018		**35,248,195**	**1,800,861**	**37,049,056**	**(56,375,479)**	**12,619,978**	**155,338**	**(43,600,163)**	**689,175**	**(42,910,988)**

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 Department's Resource Account. They include both restricted, £340.1 million and unrestricted, £349.1 million funds.

For the period ended 31 March 2017

	Note	Core Department & Agencies			Departmental Group					
		General Fund	Revaluation Reserve	Taxpayers' Equity	General Fund	Revaluation Reserve	Other Reserves	Taxpayers' Equity	Charitable Funds	Total Reserves
Restated balance at 1 April 2016		30,399,188	1,133,026	31,532,214	(35,864,671)	12,110,852	147,898	(23,605,921)	1,128,499	(22,477,422)
Prior period adjustments in local accounts		-	-	-	(6,304)	(100,031)	2,428	(103,907)	639	(103,268)
Net parliamentary funding - drawn down		98,200,000		98,200,000	98,200,000			98,200,000		98,200,000
Net parliamentary funding - deemed		2,935,817		2,935,817	2,935,817			2,935,817		2,935,817
National Insurance contributions		20,025,641		20,025,641	20,025,641			20,025,641		20,025,641
Supply (payable)/receivable adjustment	15	(2,086,363)		(2,086,363)	(2,086,363)			(2,086,363)		(2,086,363)
CFERs and other amounts payable to the Consolidated Fund	15	(1)		(1)	(1)			(1)		(1)
PDC investment adjustment		(71,892)		(71,892)	(183)			(183)		(183)
Comprehensive Net Expenditure for the Year		(116,941,878)		(116,941,878)	(128,293,756)			(128,293,756)	(223,449)	(128,517,205)
Non-cash adjustments:										
non-cash charges - auditor's remuneration	4.1	824		824	919			919		919
Movements in Reserves										
Recognised in Statement of Comprehensive Expenditure										
Net gain/(loss) on revaluation of non-current assets			17,945	17,945		801,783	-	801,783	-	801,783
Net gain/(loss) on revaluation of charitable assets				-				-	49,705	49,705
Reclassification adjustment on disposal of available for sale financial assets			-	-		-	-	-		-
Impairments and reversals			(16,818)	(16,818)		(1,235,954)		(1,235,954)	-	(1,235,954)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme		-		-	(16,701)		(1,023)	(17,724)		(17,724)
Net gain/(loss) on transfers by modified absorption		-		-	-			-		-
Other pensions remeasurements		-		-	7,662		2,613	10,275		10,275
Other gains and losses		-		-	3,659		1,147	4,806		4,806
Transfers between reserves		169,187	(169,187)	-	347,710	(346,596)	(1,114)	-	-	-
Other movements		10,808	-	10,808	14,189	(13,750)	(3,856)	(3,417)	(384)	(3,801)
Other transfers		4,970	(4,970)	-	(3,030)	(4,970)	8,000	-	911	911
Balance at 31 March 2017		**32,646,301**	**959,996**	**33,606,297**	**(44,735,412)**	**11,211,334**	**156,093**	**(33,367,985)**	**955,921**	**(32,412,064)**

Notes to the Department's Annual Report and Accounts

1. Statement of accounting policies

The financial statements have been prepared in accordance with the 2017-18 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 particular circumstances of the Department of Health and Social Care (DHSC) for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Department of Health and Social Care are described below. The policies have been applied consistently in dealing with items considered material to the accounts.[120]

As in previous years the 2017-18 Annual Report and Accounts includes two departures from the FReM, both of which have been agreed with HM Treasury:

- Public Dividend Capital issued by the 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; and
- Receipts of National Insurance Contributions from the National Insurance Fund are recognised on a cash basis.

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.

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 (formerly Department of Health), 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

[120] In Line with the guidance offered in IFRS Practise Statement 2: Making Materiality Judgements published September 2017.

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 Going Concern

The Department of Health and Social Care's Annual Report and Accounts are produced on a going concern basis. As detailed in Note 1, the Department is supply financed and thus draws the majority of its funding from the Consolidated Fund. Parliament has demonstrated its commitment to fund the Department for the foreseeable future.

1.5 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.[121]

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.

[121] www.nhsbsa.nhs.uk/pensions

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.

1.6 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.

1.7 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.

1.8 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.

1.9 Income

Income principally comprises fees and charges for services provided on a full cost basis, investment income and public repayment work. It includes income Voted during 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. Income in respect of services provided is recognised when the service is rendered, stage of completion of the transaction at the end of the reporting period can be measured reliably and it is probable that economic benefit associated with the transaction will flow to the Department. Income is measured at fair value of the consideration receivable. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The value of the benefit received when the Department accesses funds from the Government's apprenticeships 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 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.

1.10 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. 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.

Assets held at depreciated replacement cost may be valued on an alternative site basis where this would meet the location requirements of the service being provided.

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.

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.

1.11 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.

Since 2006 the Department has used a financial model to apportion expenditure on the Local Service IT Provider contracts for the North, Midlands and East. The model is reviewed regularly, with the latest such review carried out in March 2016.

Applying the financial model, the remaining Informatics programmes assets held by the Core Department are capitalised by reference to the remaining contract and not individual assets. In terms of valuing these Local Service Provider assets, the financial model output alone is used.

No Local Service capital expenditure is apportioned between tangible and intangible non-current assets. The Department therefore makes a judgement that, unless the tangible element is significant, all the non-current IT assets should be accounted for as intangible, as it concludes that the intangible element is more significant.

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 method is reviewed each year to determine whether it remains the most appropriate index to use.

1.12 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.

1.13 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, investment properties, stockpiled goods and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, 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. 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.

1.14 Donated assets

Donated non-current 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. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are 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.

1.15 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.

1.16 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 inception 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 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.

1.17 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.

1.18 Inventories and stockpiled goods

Inventories are valued at the lower of cost and net realisable value. Stockpiled goods are held at current value in existing use.

Strategic goods held for use in national emergencies (stockpiled goods) are held as non-current assets within property, plant and equipment. These stocks are maintained at minimum capability levels by replenishment to offset write-offs and so are not depreciated, as agreed with HM Treasury.

1.19 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. Cash, bank and overdraft balances are recorded at current values.

1.20 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 positive 0.10% (2016-17: positive 0.24%) in real terms. All other provisions (general provisions) are subject to three separate discount rates according to the expected timing of cashflows. A short-term rate of *negative 2.42%* (2016-17: *negative 2.70%*) 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 medium term rate of *negative 1.85%* (2016-17: *negative 1.95%)* is applied to the time boundary of after 5 and up to and including 10 years and a long-term rate of *negative 1.56%* (2016-17: negative 0.80%) is applied to expected cashflows exceeding 10 years (all percentages are in real terms).

1.21 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, whilst the Clinical Negligence Scheme for Trusts, Liability to Third Parties Scheme and Property Expenses Scheme are funded from Trust contributions. The accounts for the schemes are prepared by NHSR in accordance with IAS 37. 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.

Calculation of the provision for each scheme is made using:

- probability factors. The probability of a claim having to be settled is assessed between 10% and 94%. This probability is applied to the gross value to give the probable cost of each claim; and
- a discount factor calculated using HM Treasury's real discount rates noted in Note 1.20 above (i.e. short-term *negative 2.42%,* medium term *negative 1.85%* and long term *negative 1.56%*), RPI of 3.45% and claims inflation (varying between schemes) of between 4.45% and 8.95%, is applied to the probable cost to take into account the likely time to settlement.

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 NHS Resolution 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.

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 2018 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.

1.22 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.

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.

1.23 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. The Department holds investments in private limited companies and other items such as trade receivables and payables that arise from its operations and cash resources. It does not enter into speculative transactions such as interest rate swaps.

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. The decision to impair the Department's PDC investment is taken when the following criteria are met:

- a decision has been taken by the regulatory body to cease provision of healthcare by a Provider;
- the net assets of the Provider have fallen below the total of PDC issued to it; and
- the Provider is still providing healthcare services at the financial year end (i.e. formal write off, where required, of the Provider's PDC has yet to be completed).

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.

1.24 Financial assets

Financial assets are recognised on the Consolidated Statement of Financial Position when the Department becomes party to the financial instrument contract 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.

As available for sale financial assets, the Department's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the Consolidated Statement of Comprehensive Net Expenditure on de-recognition. For details of the Core Department's valuation of investments, refer to Note 11 Financial Assets – Investments.

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. This is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset.

At the Consolidated Statement of Financial Position date, the Department assesses whether any financial assets are impaired. Financial assets are impaired, and impairment losses recognised, if there is objective evidence of impairment as a result of one or more triggering events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Consolidated Statement of Comprehensive Net Expenditure.

1.25 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.

Derivatives are measured at fair value with changes in value recognised in the Consolidated Statement of Comprehensive Net Expenditure.

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. This approach to valuing financial instruments is intended to reflect the value at which such instruments could be traded. In the case of loans from DHSC to NHS bodies, neither party is involved in trading its interest in the loan and as such these loans are measured at historic cost with any unpaid interest at the reporting date accrued separately and not added to the carrying value of the loan.

1.26 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. 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. 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.

1.27 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.

1.28 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.

1.29 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 2017-18. IFRS 9 and IFRS 15 have been interpreted and adapted through the FReM ready for implementation in 2018-19. IFRS 16 is still subject to HM Treasury interpretation and upon which HMT are currently consulting across government and is for implementation in 2019-20. The Department continues to liaise closely with HM Treasury to discuss and further refine the impacts of implementing the new accounting standards.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018. IFRS 9 introduces changes to the classification and measurement of financial instruments. In relation to the scope of IFRS 9, the Departmental Group holds investments of around £750 million, as well as total receivables of around £5 billion and total payables of around £30 billion. The Department does not have complex financial instruments, and has identified no significant classification issues.
- The Core Department has two two specific methods of financing NHS Providers, via Public Dividend Capital of nearly £27 billion and £11.1 billion of Provider loans, split between £9.3 billion non current and around £1.8 billion classified as current assets. Both methods of financing are held at historic cost under existing accounting treatment. Whilst treatment of PDC will remain the same as under IAS 39, per the continuing FReM interpretations for PDC, provider loans as of 2018-19 will be accounted for at amortised cost using the effective interest rate. The Department has modelled the impact of applying the effective interest rate to the gross carrying amount of the provider loans and has concluded that no material impacts arise from this change in accounting treatment. It is also important to note that the financing of NHS providers is eliminated on consolidation.
- The Core Department, which holds the material qualifiying equity instruments, intends to make the irrevocable election to measure these at fair value through other comprehensive income. This means changes in fair value will not pass through income and expenditure. Whilst entailing the same valuation basis as under IAS 39, the election under IFRS 9 restricts even further the scenarios in which changes to fair value impact on income and expenditure. There will be no material changes to financial liabilities under IFRS 9.
- IFRS 9 also introduces a new expected losses model of impairments. Dependent on the level of credit risk, IFRS 9 requires a loss allowance to be recognised at an amount equal to either 12-month or lifetime expected credit losses. The Department has considered the potential impact of this on intra-group balances. There is significant internal trading within the NHS resulting in receivables balances between NHS providers and commissioners. The Department intends to provide a guarantee for such balances between all Group bodies. This will bring such balances within the scope of an adaption to IFRS 9 in HM Treasury's Financial Reporting Manual for Crown entities with zero 'own credit risk' which will remove the need to recognise expected credit losses (stage 1 and stage 2 impairments) within the Departmental Group.This will ensure standardisation of approach across the Group regarding the adoption of the new impairment model. It will still be necessary to recognise such expected credit losses against bodies external to the Group. In recent years, the cost of impairing receivables has been under £180 million. In light of the above commentary the impact of implementing IFRS 9 is not expected to be material for the Departmental Group.
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018. IFRS 15 introduces changes to the timing of revenue recognition for contracts, matching revenue to performance obligations, and changes to revenue disclosure requirements. Within the scope of IFRS 15, the Department earns external revenue of around £10 billion, with over £80 billion of intra-group revenue eliminated on consolidation. The majority of this revenue relates to contracts that are completed with the financial year, or the delivery of services such as ongoing health care where revenue must be recognised over time as the service is delivered and performance obligations satisfied. The Department has not identified significant changes in how its revenue will be recognised and as such the impact of implementing IFRS 15 is not expected to be material.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The Department currently has commitments under operating leases of approximately £3 billion, which IFRS 16 requires to be recognised on balance sheet as right of use assets with corresponding lease liabilities.

1.30 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 significant judgement made by management are:

- 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. 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.

- 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.

- IAS 36 Impairments - Management make judgement on whether there are any indications of impairments to the carrying amounts of the Department's assets.

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 for financial management purposes. They cover the core Department of Health and Social Care (which includes Informatics programmes), 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 and Skipton Fund 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 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

		2017-18									
		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 £000	Departmental Group £000
Gross expenditure (2.2)		122,176,127	4,150,281	16,404,909	82,371,399	110,941,269	5,697,704	1,485,953	428,625	(197,982,484)	145,673,783
Income (2.3)		(1,530,736)	(246,624)	(3,908,234)	(80,809,995)	(2,178,882)	(383,770)	(1,342,103)	(151,638)	80,377,743	(10,174,239)
Total net expenditure (per CSCNE)		**120,645,391**	**3,903,657**	**12,496,675**	**1,561,404**	**108,762,387**	**5,313,934**	**143,850**	**276,987**	**(117,604,741)**	**135,499,544**
Budgeting adjustments per SoPS2											
Capital Grants		(533,242)	(866)	-	-	(54,917)	-	-	-	37	(588,988)
Research and Development		(1,132,586)	-	-	-	-	-	-	-	-	(1,132,586)
Prior period adjustments		-	-	-	-	-	-	-	-	-	-
Other		(17,469)	-	-	315,454	-	-	(11,618)	(262,012)	-	24,355
Total adjustments		**(1,683,297)**	**(866)**	**-**	**315,454**	**(54,917)**	**-**	**(11,618)**	**(262,012)**	**37**	**(1,697,219)**
Budget outturn per SoPS1, of which:		**118,962,094**	**3,902,791**	**12,496,675**	**1,876,858**	**108,707,470**	**5,313,934**	**132,232**	**14,975**	**(117,604,704)**	**133,802,325**
	RDEL	118,538,318	3,898,168	506,157	1,215,258	108,689,686	5,328,175	63,981	14,975	(117,604,704)	120,650,014
	RAME	423,776	4,623	11,990,518	661,600	17,784	(14,241)	68,251	-	-	13,152,311

		2016-17									
		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 £000	Departmental Group £000
Gross expenditure		118,692,498	4,508,874	12,290,299	80,920,733	106,893,041	5,785,144	1,427,884	431,287	(191,887,609)	139,062,151
Income		(1,806,207)	(236,228)	(3,455,995)	(78,616,765)	(2,233,568)	(304,238)	(1,235,767)	(207,838)	77,551,660	(10,544,946)
Total net expenditure (per CSCNE)		**116,886,291**	**4,272,646**	**8,834,304**	**2,303,968**	**104,659,473**	**5,480,906**	**192,117**	**223,449**	**(114,335,949)**	**128,517,205**
Budgeting adjustments per SoPS2											
Capital Grants		(473,285)	(10,880)	-	-	(70,647)	-	-	-	-	(554,812)
Research and Development		(1,056,049)	-	-	-	-	-	-	-	-	(1,056,049)
Prior period adjustments		-	-	-	-	-	-	-	-	-	-
Other		7,794	-	-	(104,188)	-	(35,936)	(49,005)	(239,737)	53,606	(367,466)
Total adjustments		**(1,521,540)**	**(10,880)**	**-**	**(104,188)**	**(70,647)**	**(35,936)**	**(49,005)**	**(239,737)**	**53,606**	**(1,978,327)**
Budget outturn per SoPS1, of which:		**115,364,751**	**4,261,766**	**8,834,304**	**2,199,780**	**104,588,826**	**5,444,970**	**143,112**	**(16,288)**	**(114,282,343)**	**126,538,878**
	RDEL	115,205,343	4,259,543	276,705	1,174,529	104,896,610	5,437,525	79,336	(16,288)	(114,282,343)	117,030,960
	RAME	159,408	2,223	8,557,599	1,025,251	(307,784)	7,445	63,776	-	-	9,507,918

2.2 Departmental Group Detail – Expenditure

	2017-18									
	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 £000	Departmental Group £000
Material Expenditure Items										
Staff costs	106,371	298,594	176,755	52,029,780	1,843,108	576,723	182,298	-	(11,769)	55,201,860
Purchase of healthcare from non-NHS bodies	-	-	-	1,106,065	13,096,155	-	-	-	-	14,202,220
Sustainability and Transformation Fund Expenditure	-	-	-	-	1,800,000	-	-	-	(1,800,000)	-
Purchase of social care	-	-	-	181,890	599,274	-	-	-	-	781,164
Expenditure on Drugs Action Teams	-	-	-	-	712	-	-	-	-	712
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	2,944,521	-	-	-	(132,952)	2,811,569
Consultancy Services	12,402	-	141	247,470	85,476	1,555	23,977	-	(51)	370,970
Establishment	59,275	-	19,635	879,495	366,933	50,192	8,640	-	(91,676)	1,292,494
Transport (Business Travel)	2	9,116	3,886	191,694	43,073	17,497	4,087	-	(12,862)	256,493
Premises	14,431	31,700	11,359	2,565,557	69,460	39,741	242,440	-	(228,168)	2,746,520
PFI/Lift and other service concession arrangement charges	-	-	-	919,873	-	-	79,470	-	-	999,343
Business Rates Paid to Local Authorities	9,860	-	-	422,887	782	4,742	39,676	-	180	478,127
NHS Informatics Major Contracts Costs	74,747	-	-	-	-	81,139	-	-	(2,543)	153,343
Clinical negligence Costs	-	-	-	1,945,373	189	139	-	-	(1,945,842)	(141)
Education, Training and Conferences	6,256	3,358	980	255,104	150,834	6,366	3,208	-	(15,753)	410,353
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,715,198	-	-	(2,941,896)	1,773,302
Prescribing Costs	-	-	-	-	8,560,895	-	-	-	(7,818)	8,553,077
G/PMS, APMS and PCTMS	-	-	-	-	8,274,354	-	-	-	(32,146)	8,242,208
Pharmaceutical Services	-	-	-	-	1,906,991	-	-	-	(4,398)	1,902,593
General Ophthalmic Services	-	-	-	-	556,015	-	-	-	(195)	555,820
Supplies and Services - Clinical	-	-	(2)	13,509,327	225,588	44	2,368	-	(1,624,408)	12,112,917
Supplies and Services - General	-	634,584	1,770,240	1,386,737	821,514	82,876	139,516	-	(272,846)	4,562,621
Grants to Other Bodies	164,774	-	-	-	26,038	-	-	-	(70,700)	120,112
Grants to Local Authorities	59,098	3,090,533	-	-	-	-	-	-	-	3,149,631
Capital Grants	533,242	866	-	-	54,917	-	-	-	(37)	588,988
Movement in provision for impairment of receivables	62	798	-	123,420	19,774	1,053	33,876	-	(1,656)	177,327
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	687,324	-	-	-	-	(687,324)	-
Rentals under operating leases	21,407	10,746	3,658	672,378	326,071	17,045	133,054	-	(533,608)	650,751
Interest charges	209	-	-	1,022,838	43	-	167,013	-	(225,951)	964,152
Research and development	1,118,264	592	-	197,335	11,856	-	2,417	-	(744,492)	585,972
Depreciation on property, plant and equipment	19,060	26,611	6,480	1,982,766	97,308	12,908	206,097	-	-	2,351,230
Amortisation on intangible assets	106,444	4,926	12,281	199,309	5,985	35,150	280	-	-	364,375
Impairments and reversals	37,330	40,479	(1,006)	606,107	23	121	70,931	-	-	753,985
Provisions provided for in year	1,327,427	2,329	(1,874,977)	117,264	49,853	(15,214)	(21,403)	-	-	(414,721)
Non-cash expenditure from movement in pension liability	-	-	-	8,876	144	8,362	-	-	-	17,382
Grant in Aid	112,888,699	-	-	-	-	-	-	-	(112,888,699)	-
Funding to Group Bodies	4,705,464	-	-	-	-	-	-	-	(4,705,464)	-
Provisions - Change in discount rate	203,997	-	15,599,270	6,084	(291)	(30)	24,338	-	-	15,833,368
Other	635,854	(9,251)	121,343	895,100	42,357	39,348	61,513	-	124,829	1,911,093
Goods and Services from other NHS Bodies	-	-	-	93,337	68,784,452	-	42,613	-	(68,884,133)	36,269
Additional support for delivery of healthcare services	-	-	-	-	-	-	-	-	-	-
DHSC support for mergers	83,942	-	-	-	-	-	-	-	(83,942)	-
Resources expended by NHS charities	-	-	-	-	-	-	-	428,625	(123,933)	304,692
Non material expenditure categories	(12,490)	4,300	554,866	118,009	176,865	22,749	39,544	-	(32,231)	871,612
Total Gross Expenditure	**122,176,127**	**4,150,281**	**16,404,909**	**82,371,399**	**110,941,269**	**5,697,704**	**1,485,953**	**428,625**	**(197,982,484)**	**145,673,783**

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. The Sustainability and Transformation Fund (STF) is linked to the achievement of financial controls and performance trajectories for required A&E 4 hour performance and the required milestones on Primary care front door streaming. The funding has been included in the NHS England mandate and has been paid to NHS Providers from NHS England.

	Restated[1]									2016-17
Material Expenditure Items	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 £000	Departmental Group £000
Staff costs	148,553	301,887	139,367	50,428,834	1,781,455	577,036	162,539	-	(10,365)	53,529,306
Purchase of healthcare from non-NHS bodies	-	-	-	1,068,066	12,636,738	-	-	-	-	13,704,804
Sustainability and Transformation Fund Expenditure	-	-	-	-	1,800,000	-	-	-	(1,800,000)	-
Purchase of social care	-	-	-	282,276	388,461	-	-	-	-	670,737
Expenditure on Drugs Action Teams	-	-	-	-	325	-	-	-	-	325
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	2,909,509	-	-	-	(141,601)	2,767,908
Consultancy Services	4,485	-	6	259,727	101,264	2,038	21,781	-	(148)	389,153
Establishment	51,890	4,243	16,720	887,157	313,116	64,071	20,295	-	(82,167)	1,275,325
Transport (Business Travel)	15	9,043	2,875	356,331	33,317	17,410	5,262	-	(3,432)	420,821
Premises	12,766	22,230	13,330	2,532,594	82,480	35,354	256,052	-	(306,904)	2,647,902
PFI/Lift and other service concession arrangement charges	-	-	-	870,335	-	-	74,925	-	-	945,260
Business Rates Paid to Local Authorities	7,011	4,426	-	320,781	1,137	4,679	68,771	-	-	406,805
NHS Informatics Major Contracts Costs	168,598	-	-	-	-	35,378	-	-	(8,745)	195,231
Clinical negligence Costs	-	-	-	1,648,896	338	153	-	-	(1,648,782)	605
Education, Training and Conferences	1,589	2,731	534	246,274	140,244	8,381	3,308	-	(14,019)	389,042
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,822,164	-	-	(2,924,741)	1,897,423
Prescribing Costs	-	-	-	-	8,534,616	-	-	-	(8,202)	8,526,414
G/PMS, APMS and PCTMS	-	-	-	-	7,971,342	-	-	-	(32,085)	7,939,257
Pharmaceutical Services	-	-	-	-	1,992,230	-	-	-	(3,180)	1,989,050
General Ophthalmic Services	-	-	-	-	554,399	-	-	-	(299)	554,100
Supplies and Services - Clinical	-	-	-	13,397,606	113,428	124	1,917	-	(1,574,119)	11,938,956
Supplies and Services - General	-	643,736	1,647,002	1,199,005	959,486	56,923	122,474	-	(338,944)	4,289,682
Grants to Other Bodies	132,649	34	-	-	27,225	-	-	-	-	159,908
Grants to Local Authorities	43,861	3,387,958	-	-	-	-	-	-	-	3,431,819
Capital Grants	473,285	10,880	-	-	70,647	-	-	-	-	554,812
Movement in provision for impairment of receivables	(1)	248	-	120,340	6,514	3,415	(12,633)	-	(2,133)	115,750
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	754,962	-	-	-	-	(754,962)	-
Rentals under operating leases	16,867	11,838	2,955	663,945	291,407	17,061	121,151	-	(456,013)	669,211
Interest charges	462	-	-	942,169	471	1	171,279	-	(173,573)	940,809
Research and development	1,055,618	653	-	197,499	12,937	-	3,665	-	(596,250)	674,122
Depreciation on property, plant and equipment	27,834	27,904	6,612	2,014,467	82,091	10,999	187,354	-	-	2,357,261
Amortisation on intangible assets	354,611	4,635	12,181	179,995	5,857	28,851	767	-	-	586,897
Impairments and reversals	755	35,245	(1,971)	1,307,835	1,839	(24)	41,405	-	-	1,385,084
Provisions provided for in year	868,400	2,940	10,008,115	123,732	(172,193)	6,441	(7,998)	-	-	10,829,437
Non-cash expenditure from movement in pension liability	-	-	-	4,191	104	7,898	-	-	-	12,193
Grant in Aid	109,751,742	-	-	-	-	-	-	-	(109,751,742)	-
Funding to Group Bodies	4,584,207	-	-	-	-	-	-	-	(4,584,207)	-
Provisions - Change in discount rate	72,445	-	492,701	43,113	256	132	36,809	-	-	645,456
Other	744,831	(85)	125,006	645,834	39,790	41,329	44,690	-	(215,090)	1,426,305
Goods and Services from other NHS Bodies	-	-	-	122,116	66,027,029	-	31,907	-	(66,138,766)	42,286
Additional support for delivery of healthcare services	8,450	-	-	-	-	-	-	-	(8,450)	-
DH support for mergers	154,138	-	-	-	-	-	-	-	(154,138)	-
Resources expended by NHS charities	-	-	-	-	-	-	-	431,287	(122,695)	308,592
Non material expenditure categories	7,437	38,328	(175,134)	302,653	185,182	45,330	72,164	-	(31,857)	444,103
Total Expenditure	**118,692,498**	**4,508,874**	**12,290,299**	**80,920,733**	**106,893,041**	**5,785,144**	**1,427,884**	**431,287**	**(191,887,609)**	**139,062,151**

1. Inventories consumed expenditure has been allocated to other more specific expenditure categories. Prior year analysis has been restated to ensure comparability. An amount of £9.9 billion has been reallocated from inventories consumed to Supplies and Service - Clinical (£8.0 billion) and Supplies and Services - General (£1.9 billion).

2.3 Departmental Group Detail - Income

	2017-18									
	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 £000	Departmental Group £000
Material Income Items										
Income from Local Authorities	-	-	-	(2,114,236)	-	-	-	-	-	(2,114,236)
Income from Private patients	-	-	-	(614,367)	-	-	-	-	-	(614,367)
Income from DHSC/NHS bodies	-	-	847	(68,299,282)	-	-	(45,228)	-	68,220,469	(123,194)
Additional income for delivery of healthcare services	-	-	-	-	-	-	-	-	-	-
Sustainability and Transformation Fund Income[1]	-	-	-	(1,800,000)	-	-	-	-	1,800,000	-
Other non-NHS patient care services	-	-	-	(555,487)	-	-	-	-	-	(555,487)
Interest revenue	(224,324)	(9,265)	-	(19,581)	-	(18)	(15,804)	-	223,845	(45,147)
Prescription Pricing Regulation Scheme	(409,723)	-	-	-	-	-	-	-	-	(409,723)
Prescription Fees and Charges	-	-	-	-	(575,963)	-	-	-	-	(575,963)
Dental Fees and Charges	-	-	-	-	(807,333)	-	-	-	-	(807,333)
Other Fees and Charges	-	(224,916)	(2,159,502)	-	-	(215,290)	(103,681)	-	2,210,266	(493,123)
PDC Dividend Received	(686,799)	-	-	-	-	-	-	-	686,799	-
Education, training and research	-	(1,923)	(154)	(3,653,604)	(177,657)	(120,593)	-	-	3,596,823	(357,108)
Income from injury costs recovery	-	-	-	(201,905)	-	-	-	-	-	(201,905)
Charitable and other contributions to expenditure	-	-	-	(105,839)	(2,695)	-	-	-	56,655	(51,879)
Rental revenue from operating leases	(24,009)	-	-	(88,058)	(267)	(567)	(1,013,181)	-	675,746	(450,336)
Non patient care services to other bodies	(39,852)	-	(1,748,254)	(745,849)	(326,041)	(37,057)	(4,722)	-	1,929,847	(971,928)
Support from DHSC for mergers	-	-	-	(75,975)	-	-	-	-	75,975	-
Other	(54,608)	-	(34)	(1,854,945)	(281,953)	(9,496)	(101,183)	-	821,276	(1,480,943)
Apprenticeship training grant (non-cash)	-	(70)	-	(6,255)	(98)	(76)	-	-	-	(6,499)
Income received by NHS charities	-	-	-	-	-	-	-	(151,638)	-	(151,638)
Non-material income categories	(91,421)	(10,450)	(1,137)	(674,612)	(6,875)	(673)	(58,304)	-	80,042	(763,430)
Total Gross Income	**(1,530,736)**	**(246,624)**	**(3,908,234)**	**(80,809,995)**	**(2,178,882)**	**(383,770)**	**(1,342,103)**	**(151,638)**	**80,377,743**	**(10,174,239)**

1. The Sustainability and Transformation Fund (STF) is linked to the achievement of financial controls and performance trajectories for required A&E 4 hour performance and the required milestones on Primary care front door streaming. The funding has been included in the NHS England mandate and has been paid to NHS Providers from NHS England.

	2016-17									
	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 £000	Departmental Group £000
Material Income Items										
Income from Local Authorities	-	-	-	(2,341,140)	-	-	(13)	-	-	(2,341,153)
Income from Private patients	-	-	-	(583,983)	-	-	-	-	-	(583,983)
Income from DHSC/NHS bodies	-	-	(846)	(66,243,101)	-	-	(31,275)	-	66,148,881	(126,341)
Additional income for delivery of healthcare services	-	-	-	(8,450)	-	-	-	-	8,450	-
Sustainability and Transformation Fund Income	-	-	-	(1,800,000)	-	-	-	-	1,800,000	-
Other non-NHS patient care services	-	-	-	(497,612)	-	-	-	-	-	(497,612)
Interest revenue	(213,034)	(409)	-	(13,996)	-	(4)	(13,478)	-	171,105	(69,816)
Prescription Pricing Regulation Scheme	(489,295)	-	-	-	-	-	-	-	-	(489,295)
Prescription Fees and Charges	-	-	-	-	(554,935)	-	-	-	-	(554,935)
Dental Fees and Charges	-	-	-	-	(776,812)	-	-	-	-	(776,812)
Other Fees and Charges	-	(209,176)	(1,830,193)	(185,106)	-	(172,261)	(116,438)	-	1,935,462	(577,712)
PDC Dividend Received	(754,962)	-	-	-	-	-	-	-	754,962	-
Education, training and research	-	(12,298)	(135)	(3,637,638)	(202,160)	(78,627)	-	-	3,597,033	(333,825)
Income from injury costs recovery	-	-	-	(205,653)	-	-	-	-	-	(205,653)
Charitable and other contributions to expenditure	-	-	-	(96,840)	(2,889)	-	-	-	39,190	(60,539)
Rental revenue from operating leases	(20,503)	(8,500)	-	(74,712)	(437)	(442)	(866,553)	-	732,884	(238,263)
Non patient care services to other bodies1	(44,887)	-	(1,623,937)	(657,593)	(362,848)	(41,436)	(18,881)	-	1,912,555	(837,027)
Support from DHSC for mergers	-	-	-	(140,585)	-	-	-	-	140,585	-
Other	(63,843)	-	(16)	(1,598,004)	(328,403)	(10,639)	(171,023)	-	215,880	(1,956,048)
Apprenticeship training grant (non-cash)	-	-	-	-	-	-	-	-	-	-
Income received by NHS charities	-	-	-	-	-	-	-	(207,838)	-	(207,838)
Non-material income categories	(219,683)	(5,845)	(868)	(532,352)	(5,084)	(829)	(18,106)	-	94,673	(688,094)
Total Income	**(1,806,207)**	**(236,228)**	**(3,455,995)**	**(78,616,765)**	**(2,233,568)**	**(304,238)**	**(1,235,767)**	**(207,838)**	**77,551,660**	**(10,544,946)**

3. Staff costs

Staff costs for the Departmental Group comprise:

	2017-18 £'000	2016-17 £'000
	Total	Total
Salaries and wages	46,009,959	44,839,638
Social Security costs	4,365,486	3,958,408
NHS Pension	4,979,998	4,784,513
Other pension costs	62,113	67,998
Termination benefits[2]	55,574	99,563
Sub-total	**55,473,130**	**53,750,120**
Less recoveries in respect of outward secondments	(86,429)	(72,478)
Total Net Costs	**55,386,701**	**53,677,642**

1. The Apprenticeship Levy is a new charge for 2017-18 and this has been included in Social Security Costs.
2. £31,568k of the termination benefits in 2016-17 noted above related to payments made to staff exiting the Core Department as part of the DH 2020 change programme.
3. A more detailed analysis of staff costs can be found in the Accountability Report.

Of which:			2017-18 £'000
	Charged to revenue budgets	Charged to capital	Total
Core Dept & Agencies	404,965	2,259	407,224
Other designated bodies	54,808,694	182,582	54,991,276
Less elimination of intra-group expenditure	(11,799)	-	(11,799)
Total	**55,201,860**	**184,841**	**55,386,701**

			2016-17 £'000
	Charged to revenue budgets	Charged to capital	Total
Core Dept & Agencies	450,440	2,302	452,742
Other designated bodies	53,147,789	146,034	53,293,823
Less elimination of intra-group expenditure	(68,923)	-	(68,923)
Total	**53,529,306**	**148,336**	**53,677,642**

Staff numbers in the Staff Report 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 use Office for National Statistics categorisation.

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 2012, this is shown in the Cabinet Office: Civil Superannuation[122].

[122] http://www.civilservicepensionscheme.org.uk/about-us/resource-accounts/

For 2017-18, employers' contributions of £12,816,861 were payable to the PCSPS (2016-17: £16,685,066) at one of four rates in the range 20.0% to 24.5% (2016-17: 20.0% to 24.5%) 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 2017-18, 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 £nil, (2016-17: £123,342) were paid to one or more of the panel of three appointed stakeholder pension providers. 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 £2,115, 0.5% of pensionable pay, (2016-17: £4,520, 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 2012[123].

For 2017-18, employers' contributions were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014.

Of the £4,980.0 million (2016-17: £4,784.5 million) against NHS pension costs, £164.8 million is attributable to NHS England Group (2016-17 £151.7 million), £4,744.4 million is attributable to Providers (2016-17: £4,565.3 million) with the balance of £70.8 million (2016-17 £67.5 million) to ALBs.

[123] www.nhsbsa.nhs.uk/pensions

4 Expenditure

4.1 Expenditure

	Note	2017-18 £'000 Core Dept & Agencies	2017-18 £'000 Departmental Group	Restated[9] 2016-17 £'000 Core Dept & Agencies	2016-17 £'000 Departmental Group
4.1 (a) Purchase of goods and services					
Rentals Under Operating Leases		30,071	650,751	24,512	669,211
Supplies and services - clinical		-	12,112,917	-	11,938,956
Supplies and services - general		629,940	4,562,621	642,659	4,289,682
Goods and services from other NHS bodies		-	36,269	-	42,286
Multi Professional Education and Training (MPET)		-	1,773,302	-	1,897,423
Additional support for delivery of healthcare services		-	-	8,450	-
Purchase of healthcare from non NHS bodies		-	14,202,220	-	13,704,804
Purchase of Social Care		-	781,164	-	670,737
Expenditure on Drug Action Teams		-	712	-	325
General Dental Services (GDS) and Personal Dental Services (PDS)		-	2,811,569	-	2,767,908
Prescribing Costs		-	8,553,077	-	8,526,414
G/PMS, APMS and PCTMS		-	8,242,208	-	7,939,257
Pharmaceutical Services		-	1,902,593	-	1,989,050
General Ophthalmic Services		-	555,820	-	554,100
Consultancy services		12,402	370,970	4,485	389,153
Establishment		59,277	1,292,494	56,140	1,275,325
Transport (Business Travel)		9,118	256,493	9,058	420,821
Premises		40,724	2,746,520	35,129	2,647,902
Education, Training and Conferences (cash)		9,620	410,353	4,320	389,042
Insurance		285	42,480	84	41,227
Legal fees		13,049	190,615	30,862	228,769
NHS Informatics Major Contracts Cost		74,769	153,343	168,598	195,231
Audit fees - statutory audit (cash)		-	27,857	4	32,318
Other auditor's remuneration		22	42,760	-	53,252
non-cash items					
Audit fees - non-cash		824	919	824	919
Purchase of goods and services		**880,101**	**61,720,027**	**985,125**	**60,664,112**
4.1 (b) Depreciation and impairment charges					
non-cash items					
Depreciation on property, plant and equipment		45,671	2,351,230	55,738	2,357,261
Amortisation on intangible assets		111,370	364,375	359,246	586,897
Impairments and reversals		77,809	753,985	36,000	1,385,084
Depreciation and impairment charges		**234,850**	**3,469,590**	**450,984**	**4,329,242**
4.1 (c) Provision expense					
non-cash items					
Non-cash expenditure from movement in pension liability		-	17,382	-	12,193
Provision provided for in year		1,329,756	(414,721)	871,340	10,829,437
Change in discount rate[8]		203,997	15,833,368	72,445	645,456
Provision expense		**1,533,753**	**15,436,029**	**943,785**	**11,487,086**
4.1 (d) Other operating expenditure					
PFI/LIFT and other service concession arrangements charges		-	999,343	-	945,260
Chair and non-executive Directors' costs		-	82,597	-	81,543
Business rates paid to local authorities		10,035	478,127	11,437	406,805
Clinical negligence		-	(141)	-	605
Research and development		1,117,135	585,972	1,055,448	674,122
Grants to Local Authorities		3,149,631	3,149,631	3,431,819	3,431,819
Grants to Other bodies		164,774	120,112	132,683	159,908
Capital Grants		534,108	588,988	484,165	554,812
DHSC support for mergers		83,942	-	154,138	-
Prior period adjustments in local accounts		-	(33,495)	-	120,238
non-cash items					
Loss on disposal of non-current assets and assets held for sale		2,075	13,818	34,895	57,971
Movement in provision for impairment of receivables		860	177,327	247	115,750
Inventories write down		1,434	13,588	2,217	12,647
Apprenticeship training grant (non-cash)		70	6,499	-	-
Prior period adjustments in local accounts (non-cash)		-	37,721	-	70,206
Changes in fair value through SoCNE		-	(76,905)	-	(48,787)
Other non-cash expenditure		12,224	9,771	326	(318)
Other[3, 4]		631,035	1,911,093	743,471	1,426,305
Other operating expenditure		**5,707,323**	**8,064,046**	**6,050,846**	**8,008,886**

1. 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.
2. Note 1.7 (audit costs) explains that the Core Department and Agencies audit fee is a notional charge, resulting in its classification as a non cash item.
3. The Core Department & Agencies 'Other' expenditure figure of £646.0 million (£743.5 million in 2016-17) includes £122.3 million of revenue policy payments (£237.0 million in 2016-17), £162.0 million in respect of outsourcing contracts (£153.1 million in 2016-17) and £114.5 million of Healthy Start – Welfare Foods payments (£123.9 million in 2016-17).
4. Other expenditure also includes £472 million of transport costs in the Provider sector relating to expenditure such as fuel costs, vehicle parts and other fleet related costs.
5. A breakdown of the Departmental Group Other figure by sector is provided in Note 2.2 Departmental Group Detail – Expenditure.
6. General Dental Services (GDS) and Personal Dental Services (PDS) are alternative models for dental care.
7. Core Department and Agencies expenditure figures may be greater than those of the Departmental Group due to the elimination of intercompany trading.
8. For more details on 'Change in discount rate' see notes 1.20 and 16.
9. Inventories consumed expenditure has been allocated to other more specific expenditure categories. Prior year analysis has been restated to ensure comparability. An amount of £9.9 billion has been reallocated from inventories consumed to Supplies and Service - Clinical (£8.0 billion) and Supplies and Services - General (£1.9 billion).

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:

	2017-18 £'000	2016-17 £'000 Restated
	Departmental Group	Departmental Group
Expenditure after financing activities - non-cash items (Note 4 & SOCNE)	19,601,744	15,818,834
Less non-cash income after financing activities (Note 5 & SOCNE)	(316,748)	(300,781)
Total non-cash transactions	**19,284,996**	**15,518,053**
Movement in provision for impairment of receivables	(177,327)	(115,750)
Inventories write down	(13,588)	(12,647)
Less non-cash movements on SoFP balances analysed separately in the Cash Flow statement	**(190,915)**	**(128,397)**
Total non-cash transactions as per Consolidated Statement of Cash Flows	**19,094,081**	**15,389,656**

1. Inventories consumed expenditure has been allocated to other more specific expenditure categories. Prior year analysis has been restated to ensure comparability. The amount of the adjustment is £9.9 billion.

5. Income

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Income from sale of goods and services				
Revenue from Patient Care activities				
Income from Local Authorities	-	2,114,236	-	2,341,153
Income from Private patients	-	614,367	-	583,983
Income from Chargeable Overseas Patients	-	86,836	-	81,402
Income from injury costs recovery	-	201,905	-	205,653
Income in respect of EEA claims	62,717	62,717	86,066	86,066
Income from DHSC/NHS bodies	-	123,194	-	126,341
Additional income for delivery of healthcare services	-	-	-	-
Other non-NHS patient care services	-	555,487	-	497,612
Other Non Trading Income				
Rental revenue from finance leases	-	1,953	-	2,022
Rental revenue from operating leases	20,192	450,336	24,443	238,263
Non-patient care services to other bodies	39,573	971,928	44,512	837,027
Education, training and research	1,923	357,108	12,298	333,825
Income from sale of goods and services	**124,405**	**5,540,067**	**167,319**	**5,333,347**
Other operating income				
Prescription Pricing Regulation Scheme	409,723	409,723	489,295	489,295
Prescription Fees and Charges	-	575,963	-	554,935
Dental Fees and Charges	-	807,333	-	776,812
Other Fees and Charges	221,805	493,123	206,315	577,712
PDC Dividend Received	687,324	-	754,962	-
Charitable and other contributions to expenditure	-	51,879	-	60,539
Receipt of donations for capital acquisitions	-	66,479	-	35,378
Receipt of grants for capital acquisitions	-	8,057	-	63,318
Profit on disposal	8,662	275,037	124,881	238,874
Dividends	24,831	32,158	7,356	12,401
Income in respect of Staff Costs	-	201,463	-	189,319
Other non-cash income	11,598	34,070	10,282	16,979
Apprenticeship training grant (non-cash)	70	6,499	-	-
Funding from other Government departments	-	205	-	176
Prior period adjustments in local accounts	-	392	-	(34,784)
Other[1]	52,598	1,480,943	64,411	1,956,048
Other operating income	**1,416,611**	**4,443,324**	**1,657,502**	**4,937,002**

1. Other Income also includes £344m in the Provider sector, which represents a proportion of the incidental non-clinical sales and services.

6. Property, plant and equipment

Departmental Group
2017-18

	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 2017	**6,317,332**	**39,016,572**	**387,566**	**3,887,576**	**1,984,995**	**675,704**	**8,986,625**	**457,621**	**721,519**	**62,435,510**
Prior period adjustments in underlying accounts	(52,298)	(388,649)	(2,624)	(276)	(683)	(4,687)	(3,730)	(5)	-	(452,952)
Additions	23,757	723,331	2,662	470,606	1,748,537	22,044	465,460	25,040	26,829	3,508,266
Donations	-	29,592	350	2,900	58,635	2,584	49,248	758	-	144,067
Impairments and reversals	(231,808)	(1,050,407)	(29,256)	(11,178)	(81,542)	(727)	(16,691)	(1)	(60,081)	(1,481,691)
Transfers	(5,495)	(45,148)	-	-	(178)	178	(19)	-	(146)	(50,808)
Reclassifications	(75,852)	790,433	(1,804)	67,931	(1,242,372)	3,549	137,206	20,302	(805)	(301,412)
Revaluation and indexation	402,455	859,029	3,250	(10,844)	1,796	(2,322)	(6,513)	(74)	(11,190)	1,235,587
Disposals	(54,283)	(66,678)	(3,609)	(206,982)	(3,100)	(42,778)	(464,926)	(41,471)	(6,336)	(890,163)
At 31 March 2018	**6,323,808**	**39,868,075**	**356,535**	**4,199,733**	**2,466,088**	**653,545**	**9,146,660**	**462,170**	**669,790**	**64,146,404**
Depreciation										
At 1 April 2017	**93,362**	**2,558,210**	**40,121**	**2,484,634**	**-**	**454,484**	**6,114,113**	**292,907**	**-**	**12,037,831**
Prior period adjustments in underlying accounts	(49,958)	(403,732)	(2,627)	(273)	-	(3,065)	(7,443)	(9)	-	(467,107)
Charged in year	28	1,187,414	10,340	439,614	-	50,077	619,492	44,265	-	2,351,230
Impairments and reversals	2,379	(282,841)	3,516	(354)	-	(305)	(1,448)	361	-	(278,692)
Transfers	-	(45,164)	-	-	-	-	(4)	-	-	(45,168)
Reclassifications	(31)	(65,376)	(1,091)	(19,498)	-	(4,864)	(18,070)	(7,907)	-	(116,837)
Revaluation and indexation	(7,908)	(908,559)	(11,444)	(10,831)	-	(2,623)	(8,015)	(76)	-	(949,456)
Disposals	-	(24,993)	(388)	(204,389)	-	(42,069)	(444,207)	(40,634)	-	(756,680)
At 31 March 2018	**37,872**	**2,014,959**	**38,427**	**2,688,903**	**-**	**451,635**	**6,254,418**	**288,907**	**-**	**11,775,121**
Net book value at 31 March 2018	**6,285,936**	**37,853,116**	**318,108**	**1,510,830**	**2,466,088**	**201,910**	**2,892,242**	**173,263**	**669,790**	**52,371,283**
Net book value at 31 March 2017	6,223,970	36,458,362	347,445	1,402,942	1,984,995	221,220	2,872,512	164,714	721,519	50,397,679
Asset financing:										
Owned - purchased	5,794,852	25,060,882	231,196	1,470,529	2,253,069	186,260	2,326,030	170,023	669,790	38,162,631
Owned - donated	101,951	1,267,067	13,853	12,213	67,915	14,746	279,742	1,555	-	1,759,042
Finance leased	47,089	436,559	17,568	23,339	7,228	743	144,124	1,685	-	678,335
On-Statement of Financial Position PFI contracts	342,044	11,088,607	53,665	4,749	137,876	161	142,346	-	-	11,769,448
PFI residual interests	-	1	1,826	-	-	-	-	-	-	1,827
Net book value at 31 March 2018	**6,285,936**	**37,853,116**	**318,108**	**1,510,830**	**2,466,088**	**201,910**	**2,892,242**	**173,263**	**669,790**	**52,371,283**
Analysis of property, plant and equipment										
Core Dept & Agencies	168,626	257,086	-	12,695	81,384	6,318	42,048	-	669,790	1,237,947
Other designated bodies	6,117,310	37,596,030	318,108	1,498,135	2,384,704	195,592	2,850,194	173,263	-	51,133,336
Net book value at 31 March 2018	**6,285,936**	**37,853,116**	**318,108**	**1,510,830**	**2,466,088**	**201,910**	**2,892,242**	**173,263**	**669,790**	**52,371,283**

1. Stockpiled goods are not depreciated, as agreed with HM Treasury.
2. The Department leases both Richmond House and Wellington House buildings from the Ministry of Housing, Communities and Local Government (MHCLG) for no consideration. MHCLG in turn leases the assets from the HM Treasury UK Sovereign Sukuk plc, for which HMT is paying the lease costs. As the Department retains control of these properties their value is included in the 'Buildings (excluding dwellings)' column above.
3. Richmond House was vacated by the Department on 1 December 2017 and the building will be transferred to Parliamentary Estates in July 2019.

Property has been valued as follows:

- The Civil Estate (land and buildings held for use by the core Department) was valued on 1 September 2015 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.

- Land and buildings held by NHS bodies are valued, by independent valuers, to a modern equivalent basis as required by HM Treasury, details of which can be found in the individual body accounts.
- All valuations have been undertaken according to Royal Institute of Chartered Surveyors (RICS) guidelines.
- The Retained Estate comprises land and buildings (£13.2m at 31 March 2018) 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 were carried out as necessary in circumstances where there were indications that values had substantially changed.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 – 193 years
- Information technology: 1 – 21 years
- Furniture and fittings: 1 – 41 years
- Plant and machinery: 1 – 65 years
- Transport equipment: 1 – 20 years

	Land	Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture & Fittings	Plant & Machinery	Transport Equipment	Stockpiled Goods	Departmental Group 2016-17 Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation										
At 1 April 2016	**6,672,579**	**39,950,365**	**392,177**	**3,711,594**	**1,831,052**	**643,419**	**8,775,794**	**452,583**	**682,028**	**63,111,591**
Prior period adjustments in underlying accounts	(467)	(114,015)	(664)	(8,038)	(1,408)	201	(19,069)	(161)	-	(143,621)
Additions	2,173	786,622	2,044	391,216	1,498,542	29,903	443,236	13,976	164,644	3,332,356
Donations	15	28,381	-	1,955	100,152	1,001	45,602	246	-	177,352
Impairments and reversals	(424,744)	(2,068,726)	(5,896)	(21,663)	(29,123)	(3,576)	(9,956)	(3,017)	(35,245)	(2,601,946)
Transfers	-	(11)	-	(985)	-	-	-	-	(55,886)	(56,882)
Reclassifications	(23,202)	905,733	(1,426)	110,912	(1,410,926)	40,963	101,550	18,441	-	(257,955)
Revaluation and indexation	122,541	(380,747)	4,068	(6,516)	25	(7,092)	(24,436)	(454)	-	(292,611)
Disposals	(31,563)	(91,030)	(2,737)	(290,899)	(3,319)	(29,115)	(326,096)	(23,993)	(34,022)	(832,774)
At 31 March 2017	**6,317,332**	**39,016,572**	**387,566**	**3,887,576**	**1,984,995**	**675,704**	**8,986,625**	**457,621**	**721,519**	**62,435,510**
Depreciation										
At 1 April 2016	**81,794**	**2,618,658**	**39,340**	**2,394,769**	**-**	**423,053**	**5,889,700**	**280,442**	**-**	**11,727,756**
Prior period adjustments in underlying accounts	(3,945)	(61,635)	(573)	(7,433)	-	(991)	(16,444)	(195)	-	(91,216)
Charged in year	65	1,203,836	11,280	413,031	-	50,792	633,416	44,841	-	2,357,261
Impairments and reversals	53,328	(88,815)	2,008	(4,012)	-	(1,453)	(3,737)	(2,305)	-	(44,986)
Transfers	-	-	-	(507)	-	-	-	-	-	(507)
Reclassifications	(178)	(79,136)	(338)	(25,774)	-	18,904	(48,369)	(6,052)	-	(140,943)
Revaluation and indexation	(32,052)	(1,001,434)	(11,054)	(6,697)	-	(7,447)	(27,836)	(455)	-	(1,086,975)
Disposals	(5,650)	(33,264)	(542)	(278,743)	-	(28,374)	(312,617)	(23,369)	-	(682,559)
At 31 March 2017	**93,362**	**2,558,210**	**40,121**	**2,484,634**	**-**	**454,484**	**6,114,113**	**292,907**	**-**	**12,037,831**
Net book value at 31 March 2017	**6,223,970**	**36,458,362**	**347,445**	**1,402,942**	**1,984,995**	**221,220**	**2,872,512**	**164,714**	**721,519**	**50,397,679**
Net book value at 31 March 2016	6,590,785	37,331,707	352,837	1,316,825	1,831,052	220,366	2,886,094	172,141	682,028	51,383,835
Asset financing:										
Owned - purchased	5,745,470	24,272,384	250,467	1,374,342	1,862,436	206,020	2,310,938	161,808	721,519	36,905,384
Owned - donated	98,950	1,171,989	12,178	9,734	110,866	13,235	278,477	1,100	-	1,696,529
Finance leased	55,586	417,589	21,784	13,006	-	1,121	164,272	1,806	-	675,164
On-Statement of Financial Position PFI contracts	323,964	10,596,400	61,358	5,860	11,693	844	118,825	-	-	11,118,944
PFI residual interests	-	-	1,658	-	-	-	-	-	-	1,658
Net book value at 31 March 2017	**6,223,970**	**36,458,362**	**347,445**	**1,402,942**	**1,984,995**	**221,220**	**2,872,512**	**164,714**	**721,519**	**50,397,679**
Analysis of property, plant and equipment										
Core Dept & Agencies	141,067	195,544	-	17,573	48,169	5,832	48,721	-	721,519	1,178,425
Other designated bodies	6,082,903	36,262,818	347,445	1,385,369	1,936,826	215,388	2,823,791	164,714	-	49,219,254
Net book value at 31 March 2017	**6,223,970**	**36,458,362**	**347,445**	**1,402,942**	**1,984,995**	**221,220**	**2,872,512**	**164,714**	**721,519**	**50,397,679**

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 2017-18			
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2017	**3,024,076**	**192,936**	**183,767**	**3,400,779**
Prior period adjustments in underlying accounts	(1,757)	348	383	(1,026)
Additions	295,279	33,153	143,308	471,740
Donations	431	-	10,540	10,971
Impairments and reversals	(34,771)	(204)	(13,406)	(48,381)
Transfers	(9)	-	-	(9)
Reclassifications	149,229	28,953	(101,415)	76,767
Revaluation and indexation	23,377	532	97	24,006
Disposals	(107,660)	(9,059)	(938)	(117,657)
Other movements	(59)	-	-	(59)
At 31 March 2018	**3,348,136**	**246,659**	**222,336**	**3,817,131**
Amortisation				
At 1 April 2017	**2,000,014**	**86,328**	**20,705**	**2,107,047**
Prior period adjustments in underlying accounts	(478)	(897)	30	(1,345)
Charged in year	332,857	27,777	3,741	364,375
Impairments and reversals	(1,479)	(110)	284	(1,305)
Transfers	(6)	-	-	(6)
Reclassifications	(3,347)	6,681	6	3,340
Revaluation and indexation	17,167	393	88	17,648
Disposals	(105,631)	(9,033)	(762)	(115,426)
Other movements	(58)	-	-	(58)
At 31 March 2018	**2,239,039**	**111,139**	**24,092**	**2,374,270**
Net Book Value at 31 March 2018	**1,109,097**	**135,520**	**198,244**	**1,442,861**
Net book value at 31 March 2017	1,024,062	106,608	163,062	1,293,732

Analysis of intangible assets				
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Of the total:				
Core Dept & Agencies	222,714	4,588	9,129	236,431
Other designated bodies	886,383	130,932	189,115	1,206,430
Net Book Value at 31 March 2018	**1,109,097**	**135,520**	**198,244**	**1,442,861**

	Departmental Group 2016-17			
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2016	**3,704,060**	**160,829**	**142,804**	**4,007,693**
Prior period adjustments in underlying accounts	4,847	(5,706)	2,009	1,150
Additions	281,672	23,453	108,502	413,627
Donations	1,821	-	2,905	4,726
Impairments and reversals	(17,302)	(96)	(11,369)	(28,767)
Transfers	(4,288)	111	(111)	(4,288)
Reclassifications	113,869	15,112	(59,085)	69,896
Revaluation and indexation	14,498	2,412	355	17,265
Disposals	(1,075,099)	(3,181)	(2,243)	(1,080,523)
Other movements	(2)	2	-	-
At 31 March 2017	**3,024,076**	**192,936**	**183,767**	**3,400,779**
Amortisation				
At 1 April 2016	**2,518,830**	**69,865**	**17,684**	**2,606,379**
Prior period adjustments in underlying accounts	3,730	(5,020)	(112)	(1,402)
Charged in year	559,836	22,858	4,203	586,897
Impairments and reversals	(2,743)	27	153	(2,563)
Transfers	(4,548)	-	-	(4,548)
Reclassifications	3,997	1	(135)	3,863
Revaluation and indexation	8,514	1,083	249	9,846
Disposals	(1,073,034)	(2,486)	(1,337)	(1,076,857)
Other movements	(14,568)	-	-	(14,568)
At 31 March 2017	**2,000,014**	**86,328**	**20,705**	**2,107,047**
Net Book Value at 31 March 2017	**1,024,062**	**106,608**	**163,062**	**1,293,732**
Net Book Value at 31 March 2016	1,185,230	90,964	125,120	1,401,314

Analysis of intangible assets				
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Of the total:				
Core Dept & Agencies	225,328	-	6,087	231,415
Other designated bodies	798,734	106,608	156,975	1,062,317
Net Book Value at 31 March 2017	**1,024,062**	**106,608**	**163,062**	**1,293,732**

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 - 15 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

	2017-18 £'000		2016-17 £'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	77,688	704,801	35,245	1,340,841
Intangible asset impairments	-	44,689	-	19,771
Financial asset impairments	121	(885)	755	19,806
Non Current Assets Held for Sale impairments	-	5,380	-	4,666
Total impairments charged to Consolidated Statement of Comprehensive Net Expenditure	**77,809**	**753,985**	**36,000**	**1,385,084**
Impairments charged to Revaluation Reserve				
Property Plant and Equipment impairments	-	513,337	-	1,216,119
Intangible asset impairments	2,387	2,387	3,416	6,433
Financial asset impairments	756	756	13,402	13,402
Total impairments charged to Revaluation Reserve	**3,143**	**516,480**	**16,818**	**1,235,954**
Impairments charged to General Fund				
PDC impairments	93,611	-	65,634	-
Total impairments charged to General Fund	**93,611**	**-**	**65,634**	**-**
Total impairments charged in year	**174,563**	**1,270,465**	**118,452**	**2,621,038**

The above table includes both impairments and impairment reversals.

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.

	2017-18 £'000		2016-17 £'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	37,546	1,338,696	33,604	1,530,895
Intangible non-current assets	26,875	117,391	67,522	144,544
	64,421	**1,456,087**	**101,126**	**1,675,439**

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.

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	4,006	-	5,296
Later than 1 year and not later than 5 years	-	8,310	-	9,040
Later than 5 years	-	21,019	-	15,640
	-	**33,335**	**-**	**29,976**
Buildings:				
Not later than 1 year	11,065	318,978	18,832	298,262
Later than 1 year and not later than 5 years	35,540	879,758	38,294	796,646
Later than 5 years	41,719	966,326	48,475	1,009,937
	88,324	**2,165,062**	**105,601**	**2,104,845**
Other:				
Not later than 1 year	474	193,114	204	186,590
Later than 1 year and not later than 5 years	806	324,255	193	304,703
Later than 5 years	-	75,110	-	42,498
	1,280	**592,479**	**397**	**533,791**

1. Operating lease commitments between bodies with the Departmental Group are eliminated upon consolidation.
2. The Department's operating leases includes one for £72.5m at 39 Victoria Street, London. It expires in September 2029 and has rent reviews in 5 year intervals.

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.

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	3,192	-	2,470
Later than 1 year and not later than 5 years	-	11,247	-	9,219
Later than 5 years	-	155,603	-	143,925
	-	**170,042**	**-**	**155,614**
Buildings:				
Not later than 1 year	551	97,069	13,572	75,900
Later than 1 year and not later than 5 years	1,349	289,974	35,521	244,709
Later than 5 years	-	758,759	25,500	561,727
	1,900	**1,145,802**	**74,593**	**882,336**
Other:				
Not later than 1 year	-	17,357	-	25,309
Later than 1 year and not later than 5 years	-	21,534	-	32,142
Later than 5 years	-	56,482	-	74,052
	-	**95,373**	**-**	**131,503**

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.

	2017-18 £'000		2016-17 £'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	-	185	-	295
Later than 1 year and not later than 5 years	-	741	-	1,225
Later than 5 years	-	1,742	-	3,658
	-	**2,668**	-	**5,178**
Less interest element	-	(1,689)	-	(3,268)
Present Value of obligations	-	**979**	-	**1,910**
Buildings:				
Not later than 1 year	-	43,025	-	44,586
Later than 1 year and not later than 5 years	-	167,047	-	177,165
Later than 5 years	-	478,001	-	518,743
	-	**688,073**	-	**740,494**
Less interest element	-	(314,164)	-	(332,756)
Present Value of obligations	-	**373,909**	-	**407,738**
Other:				
Not later than 1 year	-	46,352	3,418	47,912
Later than 1 year and not later than 5 years	-	109,799	-	107,064
Later than 5 years	-	23,549	-	24,920
	-	**179,700**	**3,418**	**179,896**
Less interest element	-	(23,949)	(196)	(24,609)
Present Value of obligations	-	**155,751**	**3,222**	**155,287**

1. Finance lease commitments between bodies with the Departmental Group are eliminated upon consolidation.

	2017-18 £'000		2016-17 £'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	-	61	-	67
Later than 1 year and not later than 5 years	-	344	-	483
Later than 5 years	-	574	-	1,360
Total Present Value of obligations	-	**979**	-	**1,910**
Buildings:				
Not later than 1 year	-	18,113	-	17,864
Later than 1 year and not later than 5 years	-	76,425	-	79,028
Later than 5 years	-	279,371	-	310,846
Total Present Value of obligations	-	**373,909**	-	**407,738**
Other:				
Not later than 1 year	-	40,121	3,222	41,390
Later than 1 year and not later than 5 years	-	95,891	-	91,198
Later than 5 years	-	19,739	-	22,699
Total Present Value of obligations	-	**155,751**	**3,222**	**155,287**

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.

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Gross investments in leases:				
Not later than 1 year	-	1,211	-	1,001
Later than 1 year and not later than 5 years	-	3,777	-	554
Later than 5 years	-	20,062	-	2,345
Less future finance income	-	(9,205)	-	(1,593)
Present Value of minimum lease payments	**-**	**15,845**	**-**	**2,307**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**-**	**15,845**	**-**	**2,307**
Present Value of minimum lease payments:				
Not later than 1 year	-	595	-	961
Later than 1 year and not later than 5 years	-	1,465	-	395
Later than 5 years	-	13,785	-	951
Total Present Value of minimum lease payments	**-**	**15,845**	**-**	**2,307**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**-**	**15,845**	**-**	**2,307**
included in:				
Current finance lease receivables	-	595	-	961
Non-current finance lease receivables	-	15,250	-	1,346
Sub total	**-**	**15,845**	**-**	**2,307**

1. Future minimum lease receipts under finance leases 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 (2016-17: one scheme, £0.9 million). The assets which make up this capital value were not assets of Community Health Partnerships Ltd.

	2017-18 £'000		2016-17 £'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	-	77	-	77
Later than 1 year and not later than 5 years	-	329	-	329
Later than 5 years	-	4,213	-	4,213
	-	**4,619**	**-**	**4,619**

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 295 on-Statement of Financial Position LIFT schemes. (2016-17: 295). 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 PFI transactions and the service element of on-balance sheet PFI transactions is £50.0 million (2016-17: £48.4 million).

NHS Providers

In this financial year, 6 NHS Providers (2016-17: 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 NHST/NHSFT.

Total obligations for the on-Statement of Financial Position NHS LIFT Schemes due:

	2017-18 £'000		2016-17 £'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	-	165,494	-	166,794
Later than 1 year and not later than 5 years	-	648,633	-	652,562
Later than 5 years	-	2,715,227	-	2,877,505
	-	**3,529,354**	**-**	**3,696,861**
Less interest element	-	(1,744,468)	-	(1,875,215)
Present Value of obligations	**-**	**1,784,886**	**-**	**1,821,646**

	2017-18 £'000		2016-17 £'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	-	37,358	-	36,256
Later than 1 year and not later than 5 years	-	160,771	-	154,606
Later than 5 years	-	1,586,757	-	1,630,784
Total Present Value of obligations	**-**	**1,784,886**	**-**	**1,821,646**

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 £53.0 million (2016-17: £51.1 million).

Community Health Partnerships Ltd and NHS Providers with NHS LIFT contracts are committed to the following total charges:

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	54,615	-	52,639
Later than 1 year and not later than 5 years	-	234,116	-	225,582
Later than 5 years	-	782,742	-	834,660
	-	**1,071,473**	**-**	**1,112,881**

9.3.4 PFI Schemes deemed to be off-Statement of Financial Position

NHS Providers

In this financial year 8 NHS Providers reported off-Statement of Financial Position PFI schemes (2016-17: 7 NHS Providers).

	2017-18 £'000		2016-17 £'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	-	6,425	-	5,144
Later than 1 year and not later than 5 years	-	25,131	-	20,567
Later than 5 years	-	36,417	-	34,157
	-	**67,973**	**-**	**59,868**

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 (2016-17: 26 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 £29.5 million (2016-17: £26.6 million).

NHS Providers

In this financial year, 153 NHS Providers reported on-Statement of Financial Position PFI Schemes (2016-17: 152 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 £916.8 million. (2016-17: £867.6 million).

	2017-18 £'000		2016-17 £'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	-	872,363	-	861,321
Later than 1 year and not later than 5 years	-	3,431,408	-	3,366,438
Later than 5 years	-	14,025,967	-	14,625,174
	-	**18,329,738**	**-**	**18,852,933**
Less interest element	-	(8,885,205)	-	(9,199,731)
Present Value of obligations	**-**	**9,444,533**	**-**	**9,653,202**

	2017-18 £'000		2016-17 £'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	-	289,408	-	269,318
Later than 1 year and not later than 5 years	-	1,265,931	-	1,173,324
Later than 5 years	-	7,889,194	-	8,210,560
Total Present Value of obligations	**-**	**9,444,533**	**-**	**9,653,202**

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 £946.3 million. (2016-17: £894.1 million).

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	919,727	-	875,898
Later than 1 year and not later than 5 years	-	3,871,709	-	3,580,918
Later than 5 years	-	18,168,124	-	18,322,339
	-	**22,959,560**	**-**	**22,779,155**

9.4 Other Financial Commitments

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	1,678,115	2,169,532	1,711,732	2,126,917
Later than 1 year and not later than 5 years	2,019,596	2,908,664	1,780,927	2,638,069
Later than 5 years	141,184	296,928	127,880	303,453
	3,838,895	**5,375,124**	**3,620,539**	**5,068,439**

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 reputational 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.

In this financial year, the Department is committed to expenditure of £2,293.9 million (2016-17: £2,112.5 million) on 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. The overall purpose of the work is to develop an evidence base for improved health care, public health and social care, so leading to better health outcomes, and also promoting economic growth.

10. Financial Instruments

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, is 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.

The NHS sector is made up principally of domestic organisations with the great majority of transactions, assets and liabilities being in the UK and sterling based. Exposure to currency rate fluctuations is therefore 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.

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 and working capital requirements for the normal course of business, subject to affordability. These can take the form of either term loans or maturity loans. The borrowings are for 1 – 25 years for capital borrowings and 1 – 7 years for working capital borrowings. For capital loans and normal course of business revenue loans, 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. A range of factors are taken into account when setting the interest rates for interim revenue support loans. NHS Foundation Trusts have the power to enter into loans and working capital facilities with commercial lenders should they wish but the amounts NHS Foundation Trusts can borrow are governed by Monitor.

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 Improvement.

11. Financial Assets – Investments

	2017-18 £'000						2017-18 £'000			
	Core Dept & Agencies						Departmental Group			
	NHS 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
Balance at 1 April 2017	**26,199,628**	**7,483,010**	**1,328**	**305,064**	**690,969**	**34,679,999**	**1,328**	**397,013**	**285,001**	**683,342**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	4,617	4,617
Issued[1]	622,325	3,435,666	-	63,483	92,036	4,213,510	-	13,483	16,008	29,491
Disposals	-	-	-	-	-	-	-	-	(2,700)	(2,700)
Repaid[2]	(2,467)	(252,254)	-	(25,065)	-	(279,786)	-	(25,065)	(1,526)	(26,591)
Transfers to and from current receivables	-	(1,349,220)	-	133,733	-	(1,215,487)	-	3,733	(1,690)	2,043
Written off	(65,735)	-	-	-	-	(65,735)	-	-	-	-
Revaluation	-	-	-	-	782,054	782,054	-	-	47	47
Changes in fair value through CSCNE	-	-	-	-	-	-	-	-	2,651	2,651
Impairments and reversals	(93,611)	-	-	-	(877)	(94,488)	-	1,006	(877)	129
Reclassifications	-	-	-	-	49,291	49,291	-	-	49,291	49,291
Transfers	-	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	8,046	8,046
Balance at 31 March 2018	**26,660,140**	**9,317,202**	**1,328**	**477,215**	**1,613,473**	**38,069,358**	**1,328**	**390,170**	**358,868**	**750,366**

Investments held by Core Dept & Agencies	38,069,358
Less elimination of intra-group investments	(37,597,842)
Investments held by other designated bodies	278,850
Total	**750,366**

1. The issued line records the full value of all new loans let in-year. 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.
2. The Repaid line records repayments of non-current amounts: i.e. repayments of amounts 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.

	Restated[1]				2016-17 £'000				2016-17 £'000	
	Core Dept & Agencies						Departmental Group			
	NHS 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
Balance at 1 April 2016	**25,832,424**	**5,018,223**	**1,328**	**602,872**	**684,140**	**32,138,987**	**1,328**	**683,120**	**310,595**	**995,043**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	(800)	(800)
Issued	468,371	4,151,961	-	31,931	67,928	4,720,191	-	31,931	47,561	79,492
Disposals	-	-	-	-	-	-	-	-	(80)	(80)
Repaid	(29,458)	(1,058,848)	-	(181,794)	-	(1,270,100)	-	(181,794)	(1,172)	(182,966)
Transfers to and from current receivables	-	(628,326)	-	(17,477)	-	(645,803)	-	(7,477)	-	(7,477)
Written off	(6,258)	-	-	(269)	-	(6,527)	-	(269)	-	(269)
Revaluation	-	-	-	-	-	-	-	-	-	-
Changes in fair value through CSCNE	-	-	-	-	-	-	-	-	295	295
Impairments and reversals	(65,634)	-	-	(38)	(13,908)	(79,580)	-	1,663	(34,660)	(32,997)
Reclassifications	-	-	-	(130,161)	(54,791)	(184,952)	-	(130,161)	(54,791)	(184,952)
Transfers	-	-	-	-	-	-	-	-	-	-
Other Movements	183	-	-	-	7,600	7,783	-	-	18,053	18,053
Balance at 31 March 2017	**26,199,628**	**7,483,010**	**1,328**	**305,064**	**690,969**	**34,679,999**	**1,328**	**397,013**	**285,001**	**683,342**

Investments held by Core Dept & Agencies	34,679,999
Less elimination of intra-group investments	(34,263,304)
Investments held by other designated bodies	266,647
Total	**683,342**

1. Prior year Core Department and Agency balances relating to NHS Trusts and NHS Foundation Trusts have been restated to reflect the combined NHS Provider sector.

The Department's PDC investment in, and loans to, NHS 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, PDC is only issued to bodies within the Departmental Group.

Community Health Partnerships Ltd, NHS Property Services Ltd and Genomics England Ltd are consolidated into the Departmental accounts; therefore the investment by the Core Department in these companies are eliminated from the Departmental Group figures.

The Department's Share Capital investments are measured at fair value. Where the difference between fair value and depreciated historic cost is insignificant, the Department may use depreciated historic cost as a proxy, for example the valuation of MHRA.

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 Department's investments in Genomics England Ltd, NHS Shared Business Services, NHS Property Services Ltd and Community Health Partnerships Ltd were all subject to independent valuations in 2017-18. The Core Department and Agencies share capital of £1.6 billion includes £974.5 million in respect of NHS Property Services Ltd and £284.0 million in Community Health Partnerships Ltd.

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.

During 2017-18, the Department increased its shareholding in Genomics England Ltd by £75.0 million, £2.8 million in Community Health Partnerships and £1.6 million in Dementia Discovery Fund.

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; and
2. **Loans** – normally made under standard government loan terms, i.e. 6 monthly equal instalments of principal and interest charged on outstanding balances. The primary exception is the Department's revolving working capital loan facilities under which the full obligation for providers to repay the loans falls due at the end of the loan term. National Loan fund rates of interest (as published by the UK Debt Management Office) are applied.

PDC is held at historic value less impairments. With the exception of loans from DHSC to NHS bodies, loans are held at amortised cost using the effective interest rate method, less impairments. In the case of loans from DHSC to NHS bodies, neither party is involved in trading its interest in the loan and as such these loans are measured at historic cost with any unpaid interest at the reporting date accrued separately and not added to the carrying value of the loan. The Department judges that there is no material credit risk associated with either form of investment. The financial performance of NHS Trusts and NHS Foundation Trusts is rigorously managed by NHS Improvement (umbrella organisation of the NHS Trust Development Authority and the independent regulator Monitor), not least through their respective powers of intervention. 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.

Investments held by other NHS bodies in 2017-18

The Departmental Group figure for loans to other bodies at 31 March 2018 contains a £93.0 million (2016-17 £91.9 million) working capital loan made by NHS Business Services Authority in support of the outsourcing Supply Chain arrangement. The primary purpose of the working capital loan is to facilitate aggregated capital purchases (and cost savings) for the NHS. Further details relating to investments can be found in the accounts of underlying bodies.

12. Inventories and work in progress

	Departmental Group 2017-18					
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2017	**140,709**	**-**	**322,819**	**711,744**	**67,205**	**1,242,477**
Prior period adjustments in underlying accounts	-	-	612	3	18	633
Additions	411,380	-	6,088,413	3,167,696	316,420	9,983,909
Consumed/Disposed of	(393,754)	(4)	(6,064,076)	(3,144,168)	(289,576)	(9,891,578)
Written down charged to CSCNE	(1,434)	-	(8,234)	(3,820)	(100)	(13,588)
Transfer (to) / from non-current assets	-	4	-	-	142	146
Transfers	-	-	-	-	-	-
Reclassification	-	805	-	855	(855)	805
Other	-	(805)	-	(9)	-	(814)
Balance at 31 March 2018	**156,901**	**-**	**339,534**	**732,301**	**93,254**	**1,321,990**

Analysis of Inventories

Of the total:	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Core Dept & Agencies	156,901	-	-	4,447	-	161,348
Other designated bodies	-	-	339,534	727,854	93,254	1,160,642
	156,901	**-**	**339,534**	**732,301**	**93,254**	**1,321,990**

	Departmental Group 2016-17					
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2016	**175,157**	**-**	**321,651**	**672,362**	**53,013**	**1,222,183**
Prior period adjustments in underlying accounts	-	-	366	14	438	818
Additions	359,239	-	5,934,712	3,334,044	208,026	9,836,021
Consumed/Disposed of	(391,470)	(55,528)	(5,926,356)	(3,292,113)	(194,317)	(9,859,784)
Written down charged to CSCNE	(2,217)	-	(7,554)	(2,563)	(313)	(12,647)
Transfer (to) / from non-current assets	-	55,528	-	-	358	55,886
Transfers	-	-	-	-	-	-
Reclassification	-	-	-	-	-	-
Other	-	-	-	-	-	-
Balance at 31 March 2017	**140,709**	**-**	**322,819**	**711,744**	**67,205**	**1,242,477**

Analysis of Inventories

Of the total:	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Core Dept & Agencies	140,709	-	-	4,134	-	144,843
Other designated bodies	-	-	322,819	707,610	67,205	1,097,634
	140,709	**-**	**322,819**	**711,744**	**67,205**	**1,242,477**

13. Cash and cash equivalents

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Balance at1 April 2017	**1,877,074**	**6,789,286**	**2,804,309**	**7,680,408**
Net change in cash	(168,006)	772,851	(927,235)	(891,122)
Balance at 31 March 2018	**1,709,068**	**7,562,137**	**1,877,074**	**6,789,286**
The following balances at 31 March were held at:				
Government Banking Service	1,709,068	7,093,321	1,875,958	5,977,551
Commercial banks and cash in hand	-	301,629	1,116	319,518
Short term investments	-	167,187	-	492,217
Balance at 31 March 2018	**1,709,068**	**7,562,137**	**1,877,074**	**6,789,286**

14. Trade Receivables and other current assets

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade receivables	23,638	752,724	34,065	445,245
Deposits and advances	-	4,176	-	6,472
Capital receivables	8,208	78,469	-	63,248
Interest receivable	41,368	7,767	23,705	6,889
Other receivables	85,522	1,036,594	127,107	1,499,656
Trade and other receivables	**158,736**	**1,879,730**	**184,877**	**2,021,510**
Pension prepayments maturing in one year	-	-	-	-
Consolidated Fund Extra Receipts receivable	-	-	-	-
Other prepayments and accrued income	286,760	1,827,176	206,580	1,613,652
Current part of PFI and other service concession arrangements prepayments	-	118,870	-	138,714
Capital Prepayments	-	62,388	-	38,286
Other current assets	-	3,948	-	11,526
Other current assets	**286,760**	**2,012,382**	**206,580**	**1,802,178**
Current part of loans repayable transferred from investments	1,784,501	7,210	862,497	5,261
Other current financial assets	-	15,000	-	15,000
Other financial assets	**1,784,501**	**22,210**	**862,497**	**20,261**
Total current receivables	**2,229,997**	**3,914,322**	**1,253,954**	**3,843,949**
Amounts falling due after more than one year:				
Trade receivables	-	116	-	13,666
Deposits and advances	-	4,214	-	-
Capital receivables	13,698	34,429	-	24,961
Other receivables	210,234	465,022	150,893	359,667
Interest Receivable	-	-	-	-
Pension prepayments maturing after one year	-	-	-	-
Other Prepayments and accrued income	-	50,905	-	65,521
Non-current part of PFI and other service concession arrangements prepayments	-	35,386	-	83,424
Capital Prepayments	-	305,680	-	102,946
Total non-current receivables	**223,932**	**895,752**	**150,893**	**650,185**
Total receivables at 31 March 2018	**2,453,929**	**4,810,074**	**1,404,847**	**4,494,134**

15. Trade payables and other current liabilities

	2017-18 £'000		2016-17 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade payables	25,129	2,947,924	33,462	3,139,541
Capital payables	103,956	899,710	103,837	710,629
Other payables	12,978	1,660,140	6,698	1,510,386
Trade and other payables	**142,063**	**5,507,774**	**143,997**	**5,360,556**
Bank Overdraft	-	11,944	-	17,088
VAT	-	29,536	-	11,938
Other taxation and social security	1,917	1,086,669	1,849	1,120,888
Deferred tax liability[1]	-	148,023	-	-
Early retirement costs payable within one year	-	-	-	105
EEA Medical Costs Accrual	769,238	769,238	459,364	459,364
Other accruals	360,756	7,665,026	301,412	6,902,147
Deferred income	55,487	745,671	71,665	697,107
Current part of finance lease	-	58,295	3,222	59,321
Current part of imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	326,766	-	313,114
Amount issued from the Consolidated Fund for supply but not spent at year end	2,176,668	2,176,668	2,086,363	2,086,363
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received	17,354	17,354	1	1
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Receivable	-	-	-	-
Other amount payable to the Consolidated Fund	-	-	-	-
Current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	27,800	-	18,742
Pension liabilities	-	102,473	-	100,654
Other current liabilities	-	8,350	-	20,624
Other liabilities	**3,381,420**	**13,173,813**	**2,923,876**	**11,807,456**
Total current payables	**3,523,483**	**18,681,587**	**3,067,873**	**17,168,012**
Amounts falling due after more than one year:				
Finance leases	-	498,345	-	505,614
Imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	10,902,653	-	11,155,186
Pension liabilities	-	75	-	102
Financial liabilities	**-**	**11,401,073**	**-**	**11,660,902**
Trade payables	-	3,681	-	12,134
EEA Medical Costs Accrual	-	-	-	-
Other accruals	9,028	23,978	9,892	18,400
Capital payables	10,268	13,421	-	2,972
Other payables	-	18,681	-	43,072
Deferred income	-	182,350	-	166,123
Non-current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	189,567	-	174,149
Other payables	**19,296**	**431,678**	**9,892**	**416,850**
Total non-current payables	**19,296**	**11,832,751**	**9,892**	**12,077,752**
Total payables	**3,542,779**	**30,514,338**	**3,077,765**	**29,245,764**

1. The Deferred Tax liability (2017-18: £148.0m) has been separately analysed from 2017-18. In 2016-17 it was included in the Other Taxation and Social Security line. (2016-17: £102.9m)

16. Provisions for liabilities and charges

	2017-18					2016-17				
	Core Dept & Agencies					Core Dept & Agencies				
	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2017	**124,195**	**836,087**	**736,501**	**1,217,691**	**2,914,474**	**126,217**	**861,855**	**658,044**	**1,079,397**	**2,725,513**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	-	-
Provided in the year	7,095	35,902	840,537	555,453	1,438,987	5,791	21,367	683,345	213,933	924,436
Provisions not required written back	(4,282)	(19,119)	-	(85,830)	(109,231)	(4,735)	(18,231)	-	(30,130)	(53,096)
Transfers	-	-	-	-	-	-	-	-	-	-
Provisions utilised in the year	(12,463)	(49,589)	(235,162)	(196,785)	(493,999)	(12,553)	(50,870)	(169,248)	(53,460)	(286,131)
Transfer to accruals	-	-	(620,040)	-	(620,040)	-	-	(445,246)	-	(445,246)
Borrowing costs (unwinding of discount)	295	(7,849)	(19,885)	(10,734)	(38,173)	1,716	(7,044)	(10,200)	(7,919)	(23,447)
Change in discount rate	943	32,501	(4,679)	175,232	203,997	7,759	29,010	19,806	15,870	72,445
Balance at 31 March 2018	**115,783**	**827,933**	**697,272**	**1,655,027**	**3,296,015**	**124,195**	**836,087**	**736,501**	**1,217,691**	**2,914,474**

	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current	11,934	50,325	247,714	98,362	408,335	12,623	51,431	260,656	326,632	651,342
Non Current	103,849	777,608	449,558	1,556,665	2,887,680	111,572	784,656	475,845	891,059	2,263,132
Expected timing of cash flow										
Not later than 1 year	11,934	50,325	247,714	98,362	408,335	12,623	51,431	260,656	326,632	651,342
Later than 1 year, not later than 5 years	47,355	213,890	449,558	265,095	975,898	48,839	220,224	475,845	158,354	903,262
Later than 5 Years	56,494	563,718	-	1,291,570	1,911,782	62,733	564,432	-	732,705	1,359,870
Total	**115,783**	**827,933**	**697,272**	**1,655,027**	**3,296,015**	**124,195**	**836,087**	**736,501**	**1,217,691**	**2,914,474**

1. Further details on the Contaminated Blood supplies provision included in 'Other' can be found below.

	2017-18						2016-17					
	Departmental Group						Departmental Group					
	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
Balance at 1 April 2017	**459,673**	**836,087**	**736,501**	**64,676,682**	**2,495,916**	**69,204,859**	**446,257**	**861,855**	**658,044**	**56,082,162**	**2,692,959**	**60,741,277**
Prior period adjustments in underlying accounts	3,926	-	-	-	(3,844)	82	2,742	-	-	-	6,399	9,141
Provided in the year	28,526	35,902	840,537	1,792,647	1,016,599	3,714,211	23,760	21,367	683,345	11,668,935	639,504	13,036,911
Provisions not required written back	(13,169)	(19,119)	-	(3,678,093)	(418,551)	(4,128,932)	(11,860)	(18,231)	-	(1,676,486)	(500,897)	(2,207,474)
Transfers	-	-	-	-	-	-	-	-	-	-	-	-
Provisions utilised in the year	(41,857)	(49,589)	(235,162)	(2,227,542)	(401,542)	(2,955,692)	(38,334)	(50,870)	(169,248)	(1,707,166)	(384,160)	(2,349,778)
Transfer to accruals	(12,702)	-	(620,040)	-	(19,164)	(651,906)	(2,985)	-	(445,246)	-	(16,561)	(464,792)
Borrowing costs (unwinding of discount)	1,722	(7,849)	(19,885)	552,103	(12,704)	513,387	5,467	(7,044)	(10,200)	(177,091)	(17,014)	(205,882)
Change in discount rate	4,925	32,501	(4,679)	15,586,994	213,627	15,833,368	34,626	29,010	19,806	486,328	75,686	645,456
Balance at 31 March 2018	**431,044**	**827,933**	**697,272**	**76,702,791**	**2,870,337**	**81,529,377**	**459,673**	**836,087**	**736,501**	**64,676,682**	**2,495,916**	**69,204,859**

	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
Current	38,455	50,325	247,714	2,598,231	736,223	3,670,948	41,092	51,431	260,656	2,620,466	980,719	3,954,364
Non Current	392,589	777,608	449,558	74,104,560	2,134,114	77,858,429	418,581	784,656	475,845	62,056,216	1,515,197	65,250,495
Expected timing of cash flow												
Not later than 1 year	38,455	50,325	247,714	2,598,231	736,223	3,670,948	41,092	51,431	260,656	2,620,466	980,719	3,954,364
Later than 1 year, not later than 5 years	155,576	213,890	449,558	12,885,310	533,858	14,238,192	159,523	220,224	475,845	14,829,681	448,253	16,133,526
Later than 5 Years	237,013	563,718	-	61,219,250	1,600,256	63,620,237	259,058	564,432	-	47,226,535	1,066,944	49,116,969
Total	**431,044**	**827,933**	**697,272**	**76,702,791**	**2,870,337**	**81,529,377**	**459,673**	**836,087**	**736,501**	**64,676,682**	**2,495,916**	**69,204,859**

Discount Rates

Note 1.20 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) and long term provisions discount rates to be employed via guidance issued annually.

Contaminated Blood supplies

The Department of Health and Social Care holds provisions for the future support of patients affected by contaminated blood supplies. The contaminated blood supplies provision total value of the provision is included within the 'other' category and is made up of as follows:-

	2017-18	2016-17
	£'000	£'000
Balance at 1 April 2017	**634,947**	**623,973**
Prior period adjustments in underlying accounts	-	-
Provided in the year	542,074	61,598
Provisions not required written back		(21,545)
Provisions utilised in the year	(34,475)	(37,038)
Borrowing costs (unwinding of discount)	(5,172)	(4,983)
Change in discount rate	129,477	12,942
Balance at 31 March 2018	**1,266,851**	**634,947**
Current	45,387	23,498
Non Current	1,221,464	611,449
Expected timing of cash flow		
Not later than 1 year	45,387	23,498
Later than 1 year, not later than 5 years	184,487	93,793
Later than 5 Years	1,036,977	517,656
Total	**1,266,851**	**634,947**

Most of the increase is accounted for by the reforms to the Scheme that were announced by the Prime Minister in July 2016. These reforms introduced annual payments for all Stage 1 HCV recipients. They also introduced the "Special Categories Mechanism" (SCM), which allows higher annual payments for Stage 1 HCV claimants who have certain HCV-related conditions. The reforms also increased all the pre-existing annual payments made to Stage 2 HCV recipients and HIV recipients.

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 clinical negligence schemes: the Ex-Regional Health Authority Scheme (ex RHA), Existing Liabilities Scheme (ELS) and Clinical Negligence Scheme for Trusts (CNST), but 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 accounts.

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, whilst incurred but not reported (IBNR) claims are valued using actuarial models to predict likely values. The value of the provision increased by £12,026 million in 2017-18 from £64,677 million at 31 March 2017 to £76,703 million at 31 March 2018. £15,587 million of this increase is related to a change in the HMT discount rate, offset by a £3,561 million net movement on provisions created and written back in the year, utilised, and unwinding of discount. These provisions are also reported in the accounts of NHSR together with other provisions of £285 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. The table below provides a sensitivity analysis to highlight the impact on IBNR provisions were HM Treasury discount rates to be further adjusted by +/- 1.0%. The relationship is not purely linear in all cases, as can be seen by the changes outlined in the table. The clinical negligence provision for IBNR claims recorded in the Statement of Financial Position would reduce by £10,172 million if the discount rate was increased by 1.0%. If the discount rate were to be decreased by 1.0%, the value of IBNR claims would increase by £15,296 million.

Discount rate: sensitivity to change	**Estimated IBNR provision £m**	**Change to original IBNR estimate**	
		£m	**%**
1.0% decrease in the real discount rate	58,997	15,296	35
Tiered real discount rate structure	43,701	0	0
1.0% increase in the real discount rate	33,529	(10,172)	-23

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 a change of 1.0%, however the potential change in the discount rates applied could be significantly more in the long-term meaning the uncertainty surrounding the valuation of this liability could be significantly greater than the numerical values presented.

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, the differential between Retail Price Index (RPI) and Annual Hourly Earnings index over the long-term and life expectancy. The following tables show the impacts of adjusting these other key assumptions used for the IBNR estimate for CNST. In each case the base assumption used for the accounting estimates is shown in the middle row of the table. 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. Each change is shown separately, but in practice combinations are possible. Again it should be noted that the

relationship between changes in the value of assumptions and the IBNR provision is not always linear.

Claims value inflation : sensitivity to change	Estimated IBNR provision	Change to original IBNR estimate	
	£m	£m	%
All rates -2%	34,378	(9,323)	-21
Base assumptions	43,701	0	0
All rates +2%	56,348	12,647	29

Average costs of claim : sensitivity to change	Estimated IBNR provision	Change to original IBNR estimate	
	£m	£m	%
Reduction in average claim values of 20%	35,167	(8,534)	-20
Base assumptions	43,701	0	0
Increase in average claim values of 20%	52,341	8,640	20

Probability of a successfully defended claim : sensitivity to change	Estimated IBNR provision	Change to original IBNR estimate	
	£m	£m	%
All probabilities -5%	47,656	3,955	9
Base assumption	43,701	0	0
All probabilities +5%	39,852	(3,849)	-9

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 per current EU regulation has not changed in light of the Prime Minister triggering Article 50 in the European Union's (EU) Lisbon Treaty on 29 March 2017.

Other Provisions

These financial statements disclose other provisions of £2,870.3 million, which relate to the following:

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 £90.2 million, of which £86.5 million was accounted for by NHS England Group. Of the total, £84.0 million was expected to be paid within one year, and £6.2 million between one and five years.

Provision for Support

The Department of Health and Social Care holds provisions for future support of patients affected by contaminated blood supplies.

The provision for future support of patients who contracted Hepatitis C through blood and blood products in the course of treatment by the NHS and future support of patients who contracted HIV from contaminated blood supplies totalled £1,266.9 million of which £45.4 million is expected to be paid within one year, £184.5 million in one to five years and £1,037.0 million after five years.

Other Miscellaneous provisions

The total of other miscellaneous provisions was £1,513.2 million. These relate to a range of issues, including: HGH (human growth hormone), restructuring, redundancy, onerous leases, lease dilapidations and litigation. Of the total other miscellaneous provisions £606.8 million is expected to be paid within one year, £343.1 million in one to five years and £563.3 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 early 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:

	2017-18 £'000	2016-17 £'000
Present value of the defined benefit obligation at 1 April 2017	**(748,374)**	**(578,706)**
Prior period adjustments in underlying accounts	1,730	-
Current Service Costs	(17,243)	(12,181)
Past Service Costs	(277)	(272)
Interest Costs	(19,973)	(20,334)
Settlements and curtailments	387	2,157
Contribution from scheme members	(3,264)	(3,002)
Remeasurement of the defined benefit obligation:		
Actuarial Gains and (Losses)	8,940	(91,026)
Benefits paid	19,702	18,565
Scheme transfers	-	-
Transfers to/from other bodies	(49,883)	(42,030)
Other	-	(21,545)
As at 31 March 2018	**(808,255)**	**(748,374)**
Plan assets at fair value at 1 April 2017	**632,595**	**484,961**
Prior period adjustments in underlying accounts	(833)	(2)
Interest income	15,232	16,961
Settlements	(192)	(1,784)
Adjustments by the employer	13,925	10,668
Contributions by the plan participants	3,264	3,002
Remeasurement of the defined benefit asset:		
Expected Return on Assets	3,159	9,938
Actuarial Gains and (Losses)	4,410	76,283
Changes in the effect of limiting defined benefit asset to the asset ceiling	(798)	-
Benefits paid	(19,702)	(18,565)
Scheme transfers	-	-
Transfers to/from other bodies	42,361	35,318
Other	-	15,815
As at 31 March 2018	**693,421**	**632,595**
Plan surplus/(deficit) at 31 March 2018	**(114,834)**	**(115,779)**

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 £29.4 million (2016-17: £18.1 million).

17.2 Contingent Liabilities

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, or 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 might be estimated at £46,119.2 million (2016-17: £35,254.9 million), although £44,298.6 million (2016-17: £33,643.5 million) relating to the Clinical Negligence Scheme for Trusts (CNST) would be expected to be met by payments from NHS Providers.

Other Contingent Liabilities

Within the NHS England Group account (which incorporates Clinical Commissioning Groups and NHS England) at 31 March 2018, there were net contingent liabilities of £42.4 million (2016-17: £43.5 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 2018 had net contingent liabilities of £47.6 million (2016-17: £59.7 million).

Injury Benefit Scheme

An investigation into the administration of the Injury Benefits Scheme began in 2006 following a decision by the Pensions Ombudsman. As a result of the review, monies were due to be paid to some 10,000 people who had not received the correct payments due to irregularities in the administration of the Injury Benefits Scheme between 1972 and 2006. Due to difficulties in contacting beneficiaries, it has not been possible to make full payment to all the affected individuals in this financial year. There are still people for whom the Department retains a financial liability but who currently cannot be traced. This financial liability is estimated to be £2.6 million. Although at this stage the Department cannot estimate how many of these claims will be successful or how much benefit will eventually be owed.

Employment Tribunal Cases

The Department is involved in a number of Employment Tribunal cases, following the transfer of functions between the Department and the Departmental Group.

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 Account. 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 2017-18.

A small number of Ministers, Non-Executive Directors and members of either: the Departmental Board, Department of Health and Social Care Management Committee 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	Purchases from related party	Receivables with related party	Sales to related party
			2017-18 £'000	2017-18 £'000	2017-18 £'000	2017-18 £'000
Cat Little	Audit & Risk Committee Member	Ministry of Justice[1]	-	175	125	123
Cat Little	Audit & Risk Committee Member	Ministry of Defence[2]	-	1,377	-	100
Phillip Dunne	Former Minister	Serco PLC[3]	-	3,326	-	-
Jackie Doyle-Price	Minister	Thurrock Borough Council[4]	-	538	-	-
Sue Bailey	Non Executive Board Member	Manchester University NHS Foundation Trust[5]	42	23,426	26	26
Sue Bailey	Non Executive Board Member	Centre for Mental Health[6]	-	21	-	-
Ron Kerr	Non Executive Board Member	Guy & St Thomas NHS Foundation Trust[7]	-	62,754	-	-
Ron Kerr	Non Executive Board Member	University of Bristol[8]	-	6,720	-	-
Professor Chris Whitty	Chief Scientific Advisor	London School of Hygiene & Tropical Medicine[9]	-	11,653	-	-
Dame Sally Davies	Chief Medical Officer	Cambridge University[10]	8	8,746	-	-

1. Cat Little was the Group Finance Director for the Ministry of Justice until September 2017
2. Cat Little is the Director General for the Ministry of Defence from September 2017
3. Phillip Dunne's brother -in-law is the CEO of Serco PLC
4. Jackie Doyle-Price's husband is a member of Thurrock Borough Council
5. Sue Bailey is a Non Executive Director for Manchester University NHS Foundation Trust
6.Sue Bailey is Vice Chair for the Centre for Mental Health
7. Ron Kerr is a Special Advisor to the Board of Guy & St Thomas NHS Foundation Trust
8. Ron Kerr is a member of the Board of Trustees for the University of Bristol
9. Professor Chris Whitty is employed by the London School of Hygiene & Tropical Medicine
10. Dame Sally Davies' husband is an employee of Cambridge University

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 whom have not benefited from those transactions.

Apart from where disclosed in this note, no other Minister, Board member, member of the key management personnel or other related party has undertaken any material transactions with 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, an equity investment, as set out in the table below: (See note 21 for details)

Related Party Entity	Payables with related party	Payables with related party	Purchases from related party	Receivables with related party	Sales to related party	Share capital issued/repaid to/by related party	Loans issued/repaid to/by related party
		2017-18 £'000	2017-18 £'000	2017-18 £'000	2017-18 £'000	2017-18 £'000	2017-18 £'000
NHS Shared Business Services	DHSC Equity investment (50% shareholding)	109	1,907	1	51	-	2,170
Medicines & Healthcare Products Regulatory Agency	Non Consolidated Trading Funds	-	31,398	-	2,639	-	-
NHS Blood & Transplant Agency	Public Corporation	-	76,119	-	17,817	-	-

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. The inter-company transactions eliminated between NHS Charities and other Group bodies totalled £123.9 million in 2017-18 (£122.7 million in 2016-17).

During 2017-18, six NHS Charities with net assets totalling £262.0 million converted to independent status; a change analogous to the loss of control of a subsidiary (as described in IFRS 10).

The net assets of those charities have been derecognised and a corresponding loss recorded (this can be seen in the Resources expended by NHS charities line in the Consolidated Statement of Comprehensive Net Expenditure (CSCNE)).

From a budgetary perspective, HMT have confirmed that effective transfer of assets to a fully independent charity is treated as a capital grant in kind and is removed from resource budget with the expense scored to capital, the corresponding disposal of the same assets generates a capital credit, meaning the net impact on capital budgets is also nil.

19.1 Charitable Income and expenditure for the period ended 31 March 2018

	NHS Charities	
	2017-18	2016-17
	£'000	£'000
Total resources expended[1]	428,625	431,287
Total incoming resources	(151,638)	(207,838)
Net outgoing / (incoming) resources for the year ended 31 March 2018	**276,987**	**223,449**
Other Comprehensive Net Expenditure		
Net gain/loss on revaluation of charitable assets	(7,184)	(49,705)
Total Comprehensive Expenditure for the year ended 31 March 2018	**269,803**	**173,744**

1. Includes £262.0 million of expenditure representing the loss relating to the net assets transferred outside the Department's accounting boundary for the six charities that have gained independent status in the year.

19.2 Summary Charitable Statement of Financial Position as at 31 March 2018

	2017-18 £'000	2016-17 £'000
Non-current assets		
Charitable investments	398,585	657,154
Other charitable non-current assets	79,944	106,222
Total non-current assets	**478,529**	**763,376**
Current assets		
Charitable cash	230,219	252,609
Other charitable current assets	31,025	39,699
Total current assets	**261,244**	**292,308**
Total assets	**739,773**	**1,055,684**
Current charitable liabilities	(43,740)	(82,103)
Non-current assets plus/less net current assets/liabilities	**696,033**	**973,581**
Non-current charitable liabilities	(6,858)	(17,660)
Assets less liabilities	**689,175**	**955,921**
Total charitable reserves	**689,175**	**955,921**

19.3 Charitable Financial Assets - Investments

	NHS Charities 2017-18 £'000	2016-17 £'000
Balance as at 1 April 2017	**657,154**	**832,335**
Prior period adjustments in underlying accounts	883	(11,543)
Acquisitions	59,912	86,713
Disposals	(75,974)	(100,376)
Net gain/loss on revaluation	5,109	65,310
Impairment	-	-
Transfers[1]	(240,930)	(216,693)
Other movements	(7,569)	1,408
Balance as at 31 March 2018	**398,585**	**657,154**

1. Includes £240.9 million relating to investments transferred outside the Department's accounting boundary for the six charities that have gained independent status in the year.

19.4 Other Charitable Non-Current Assets

	NHS Charities 2017-18 £'000	NHS Charities 2016-17 £'000
Balance as at 1 April 2017	106,222	93,080
Prior period adjustments in underlying accounts	15	9,879
Acquisitions	79	16,489
Disposals	(1,500)	(3)
Net gain/loss on revaluation	2,075	932
Impairment	(17)	(954)
Transfers[1]	(26,680)	(13,341)
Other movements	(250)	140
Balance as at 31 March 2018	**79,944**	**106,222**

1. Includes £26.7 million relating to Non-Current Assets transferred outside the Department's accounting boundary for the six charities that have gained independent status in the year.

20. Events after the Reporting Period

The Accounts were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller & Auditor General.

In March 2018, NHS England announced jointly with Monitor and NHS TDA (NHS Improvement) to plan to work in a more integrated way to deliver better outcomes for patients, whilst improving performance and efficiency. The organisations are working together on an effective model of joint working but the underlying legal entities of NHS England, Monitor and NHS TDA will remain in place.

On 2 May 2018, the Secretary of State for Health and Social Care informed the House of Commons of a serious failing in the national breast screening programme in England and a series of subsequent actions that would be taken by the health and care system. Further details are provided on page 86 of the Governance Statement.

Since the Annual Report & Accounts were signed by the Accounting Officer On 5th July 2018, the Rt Hon Matt Hancock MP was appointed as the new Secretary of State for Health and Social Care, replacing the Rt Hon Jeremy Hunt MP who was appointed to Secretary of State for Foreign and Commonwealth Affairs.

21. Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2017-18.

(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-england
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	http://www.hcpc-uk.co.uk/
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/
Special Health Authorities	
NHS Business Services Authority	http://www.nhsbsa.nhs.uk/Index.aspx
NHS Counter Fraud Authority[3]	https://cfa.nhs.uk/
NHS Litigation Authority[4]	http://www.nhsla.com/Pages/Home.aspx
National Health Service Trust Development Authority[5]	http://www.ntda.nhs.uk/
Executive Non-Departmental Public Bodies	
Human Fertilisation and Embryology Authority	http://www.hfea.gov.uk/index.html
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/
Professional Standards Authority for Health and Social Care	https://www.professionalstandards.org.uk/home
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/
DHSC Expert Committees/Advisory NDPBs	
These advisory bodies/advisory NDPBs are not separate legal entities, rather they are part of the Core Department account. 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	
The NHS Pay Review Body	
Review Body on Doctors' and Dentists' Remuneration	
Scientific Advisory Committee on Nutrition	
(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) NHS charities, as defined by section 43 of the Charities Act 1993, 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) The NHS Counter Fraud Authority was established on 1 Nov 2017. Its predecessor NHS Protect was part of NHS Business Services Authority.

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.

8) The Department of Health & Social Care registered office is 39 Victoria Street, London, SW1H 0EU

Annexes – Not subject to audit

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

	2007-08 Outturn	2008-09 Outturn	2009-10 Outturn	2010-11 Outturn	2011-12 Outturn	2012-13 Outturn	2013-14 Outturn	2014-15 Outturn	2015-16 Outturn	2016-17 Outturn	2017-18 Outturn	2018-19 Plans	2019-20 Plans	2020-21 Plans
Original Resource DEL	84,207,717	90,156,640	97,075,200	100,285,421	101,591,758	103,948,229	106,495,326	110,554,300	114,730,499	118,028,960	121,712,514	124,596,099	126,774,869	129,772,000
Adjustments -														
Spending Review 2010 transfer to DCLG re - PSS (from 2011-12)	-1,782,416	-1,280,872	-1,363,966	-1,471,058	0	0	0	0	0	0	0	0	0	0
Machinery of Government transfer to DCLG - re Learning Disability and Health Reform Grant (from 2013-	-1,206,234	-1,253,164	-1,288,752	-1,345,000	-1,325,914	-1,378,364	0	0	0	0	0	0	0	0
Classification change under ESA 10 moving Research and Development to Capital DEL				-886,623	-897,721	-925,357	-1,018,037	-1,020,561	-1,020,481	-998,000	-1,062,500	-1,078,000	-1,093,000	-1,108,000
Revised Resource DEL1,2,3,4	**81,219,067**	**87,622,604**	**94,422,482**	**96,582,740**	**99,368,123**	**101,644,508**	**105,477,289**	**109,533,739**	**113,710,018**	**117,030,960**	**120,650,014**	**123,518,099**	**125,681,869**	**128,664,000**
of which depreciation	*717,673*	*951,571*	*1,185,285*	*1,209,702*	*1,193,265*	*1,131,512*	*1,069,928*	*1,160,382*	*1,114,742*	*1,002,687*	*733,608*	*1,531,000*	*1,531,000*	*1,531,000*
Resource AME	**3,679,949**	**1,588,034**	**3,699,212**	**3,206,771**	**3,193,101**	**5,775,113**	**4,261,086**	**3,418,733**	**29,206,503**	**9,507,918**	**13,152,311**	**10,526,334**	**9,315,879**	**10,001,879**
of which depreciation	*548,759*	*386,765*	*2,499,236*	*1,000,777*	*716,384*	*1,145,927*	*1,133,780*	*956,669*	*964,956*	*1,077,584*	*805,957*	*1,745,000*	*2,065,640*	*2,065,640*
Total Resource (revised)	**84,899,016**	**89,210,638**	**98,121,694**	**99,789,511**	**102,561,224**	**107,419,621**	**109,738,375**	**112,952,472**	**142,916,521**	**126,538,878**	**133,802,325**	**134,044,433**	**134,997,748**	**138,665,879**
Capital DEL	3,966,103	4,368,533	5,182,275	4,158,605	3,771,268	3,782,882	4,348,909	3,950,694	3,631,849	3,558,079	4,175,352	5,286,359	5,648,359	5,669,000
Classification change under ESA 10 moving Research and Development to Capital DEL				886,623	897,721	925,357	1,018,037	1,020,561	1,020,481	998,000	1,062,500	1,078,000	1,093,000	1,108,000
Revised Capital DEL4	**3,966,103**	**4,368,533**	**5,182,275**	**5,045,228**	**4,668,989**	**4,708,239**	**5,366,946**	**4,971,255**	**4,652,330**	**4,556,079**	**5,237,852**	**6,364,359**	**6,741,359**	**6,777,000**
Capital AME	37,142	13,831	6,441	7,876	0	0	-69,813	-4,938	37,880	13,349	0	15,000	15,000	15,000
Total Capital	**4,003,245**	**4,382,364**	**5,188,716**	**5,053,104**	**4,668,989**	**4,708,239**	**5,297,133**	**4,966,317**	**4,690,210**	**4,569,428**	**5,237,852**	**6,379,359**	**6,756,359**	**6,792,000**
Total departmental spending (revised)	**87,635,829**	**92,254,666**	**99,625,889**	**102,632,136**	**105,320,564**	**109,850,421**	**112,831,799**	**115,801,738**	**145,527,033**	**129,028,035**	**137,500,612**	**137,147,792**	**138,157,467**	**141,861,239**
Of which -														
Total DEL	*84,467,497*	*91,039,566*	*98,419,472*	*100,418,266*	*102,843,847*	*105,221,235*	*109,774,307*	*113,344,612*	*117,247,606*	*120,584,352*	*125,154,258*	*128,351,458*	*130,892,228*	*133,910,000*
Total AME	*3,168,332*	*1,215,100*	*1,206,417*	*2,213,870*	*2,476,717*	*4,629,186*	*3,057,493*	*2,457,126*	*28,279,427*	*8,443,683*	*12,346,354*	*8,796,334*	*7,265,239*	*7,951,239*

1. The revised TDEL calculated in this table excludes spending for functions that have transferred out of DHSC that were originally included within either the Plans or Spending Outturns. This presentation is consistent with HM Treasury publications.
2. SR10 Transfer for Personal Social Services spending has been transferred to Ministry of Housing, Communities and Local Government. This transfer was effective from 2011-12.
3. Machinery Of Government change relating to the Learning Disability and Health Reform Grant which has been transferred to the Department for Communities and Local Government. This transfer was effective from 2013-14.
4. Research and Development was subject to a classification change and now scores as part of the Capital DEL.

Core Table 2: Administration Budgets

£'000

	2010-11 Baseline	2011-12 Outturn	2012-13 Outturn	2013-14 Outturn	2014-15 Outturn	2015-16 Outturn	2016-17 Outturn	2017-18 Outturn	2018-19 Plans	2019-20 Plans	2020-21 Plans
Total administration budget	5,425,184	3,540,726	3,670,052	3,121,751	2,872,450	2,553,806	3,292,393	2,303,513	2,845,985	2,767,000	2,767,000

1 The extended administration control began in 2010-11

2 The 2010-11 administration figure is as per the baseline used for the Spending Review

3 These figures include depreciation

Supporting narrative for the core tables can be found within performance section and Annex B.

Annex B – Financial Performance Detail

504. The Department has the largest Departmental Expenditure Limit in government. We consolidate the spending of over 450 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

505. Spending for all government departments is measured against a set of metrics that are agreed in HM Treasury's Spending Review. **Table 30** provides a breakdown of the consolidated spending outturn for all bodies in the Departmental group into the main spending metrics.

Table 30: DHSC Departmental Expenditure – Spending Metrics

Total Department Expenditure Limit (TDEL)	Total Annually Managed Expenditure (TAME)
£125.43bn	£27.12bn
Total spending by DHSC, excluding AME and DEL depreciation & impairments.	Total AME spending by DHSC, excluding depreciation & impairments.

Revenue Departmental Expenditure Limit (RDEL)	Capital Departmental Expenditure Limit (CDEL)	Annually Managed Expenditure - Revenue (RAME)	Annually Managed Expenditure - Capital (CAME)
£121.34bn	£5.60bn	£27.94bn	£0.02bn
The control total for which current revenue expenditure, net of income, must be contained.	The control for which capital expenditure, e.g. fixed assets additions and capital grants, net of capital disposals must be contained.	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)
£2.53bn
Administration budgets cover the costs of all central government administration, excluding depreciation and the costs of direct frontline service provision.

506. The Department contained its resources within all budgets authorised by Parliament as shown in **Table 31**.

Table 31: Parliamentary DEL and AME control totals

	2017-18		
	Budget £m	Outturn £m	Underspend £m
RDEL	121,342	120,650	692
CDEL	5,598	5,238	360
RAME	27,940	13,152	14,788
CAME	15	0	15

507. 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.

Total Departmental Expenditure Limit (TDEL)

508. The Department's Total DEL (TDEL); a spending measure consistent with the presentation of spending in HM Treasury publications, calculated as the sum of Revenue Departmental Expenditure Limit (RDEL) plus Capital Departmental Expenditure Limit (CDEL) less depreciation.

509. TDEL spending continues to grow, both over the previous year and cumulatively over 2010-11. **Table 32** confirms the 2017-18 TDEL spending outturn and compares that to previous years.

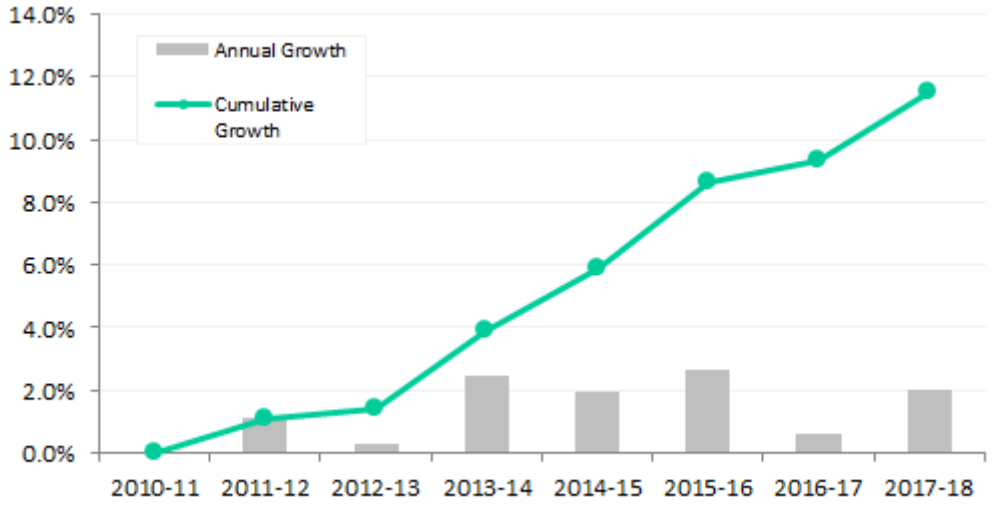
Table 32: Total Departmental Expenditure Limit Spending

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m
TDEL spending	**100,418**	**102,844**	**105,221**	**109,774**	**113,345**	**117,248**	**120,584**	**125,154**
Growth Nominal (£)	-	*2,426*	*2,377*	*4,553*	*3,570*	*3,903*	*3,336*	*4,570*
Growth Nominal (%)	-	*2.4%*	*2.3%*	*4.3%*	*3.3%*	*3.4%*	*2.8%*	*3.8%*

510. As shown in **Figure 19**, in 2017-18, the Departmental real-terms spending was 2.0% greater than in 2016-17 and 11.5% greater than in 2010-11.

2.0%
Spending growth in real terms over 2016-17

Figure 19: Real Terms Spending Growth



1. Cumulative growth figures are against the 2010-11 baseline
2. GDP Deflators at 31st March 2018 used to calculate real terms growth

NHS Total Departmental Expenditure Limit TDEL

511. The majority of the Department of Health and Social Care's budget is allocated to fund the NHS and in the 2015 Spending Review the government committed to increasing that funding by £8 billion in real terms by 2020-21 compared to 2015-16 (and £10 billion compared to 2014-15).[124]

512. Since that point, the NHS has seen:
- Further funding commitments by the Government, with extra budget being allocated in the Autumn 2017 Budget; and
- Adjustments to the NHS budget to reflect agreed transfers of functions between the NHS and other parts of the Health and Social Care system; and
- The Prime Minister's recent announcement in June 2018 setting out a five year funding plan for the NHS (see the next section).

513. The real terms funding commitment set out in SR15 was calculated with reference to the Summer Budget 2015 GDP deflators. However, since that point, HM Treasury have refined deflator calculations to reflect more accurately an equivalent spending basis across the years.

514. **Table 33** provides an explanation of the adjustments made to the NHS budget since the 2015 Spending Review announcement and recalculates the equivalent real terms funding growth using the latest available GDP Deflators.

Table 33: NHS Outturn versus SR Baseline

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS RDEL NRF SR15 Budget				106,451	109,854	112,374	115,451	119,598			
Mandate Adjustments				-749	-655	-172	-736	-793			
2017 Autumn Budget					337	1,601	901				
5-Year Funding Announcement (June 18) adjustments (1)						800	4,934	8,107	133,146	139,825	147,759
Pensions funding							1,250	1,250	1,250	1,250	1,250
NHS RDEL NRF Budget				**105,702**	**109,536**	**114,603**	**121,800**	**128,162**	**134,396**	**141,075**	**149,009**
NHSE CDEL SR15 Budget				260	260	260	305	305			
Mandate Adjustments				0	-13	-4	0	0			
NHSE CDEL Budget				**260**	**247**	**256**	**305**	**305**	**0**	**0**	**0**
NHS TDEL Budget				**105,962**	**109,783**	**114,859**	**122,105**	**128,467**	**134,396**	**141,075**	**149,009**
Commissioner RDEL NRF Underspend				-902	-970						
Provider RDEL deficit				791	991						
Provider technical				144	47						
NHS RDEL NRF Outturn (3)	**93,696**	**97,098**	**100,572**	**105,735**	**109,605**	**114,603**	**121,800**	**128,162**	**134,396**	**141,075**	**149,009**
Commissioner CDEL Underspend				-20	-19						
NHSE CDEL Outturn (4)	**180**	**189**	**182**	**240**	**228**	**256**	**305**	**305**	**0**	**0**	**0**
Total TDEL Outturn (5)	**93,876**	**97,287**	**100,754**	**105,975**	**109,833**	**114,859**	**122,105**	**128,467**	**134,396**	**141,075**	**149,009**
NHS TDEL nominal growth £m			**3,467**	**5,221**	**3,858**	**5,026**	**7,246**	**6,362**	**5,929**	**6,679**	**7,934**
NHS TDEL nominal growth %			3.6%	5.2%	3.6%	4.6%	6.3%	5.2%	4.6%	5.0%	5.6%
Cumulative NHS TDEL real terms growth £m			2,839	5,904	7,986	11,345	16,704	20,901	24,419	28,353	32,771
NHS TDEL real terms growth %			2.8%	5.6%	7.4%	10.3%	14.8%	17.6%	19.9%	22.5%	25.2%
Cumulative NHS RDEL real terms growth (excluding pensions) £m							4,083	8,306	12,140	16,095	20,538
NHS RDEL real terms growth (excluding pensions) %							3.6%	3.6%	3.1%	3.1%	3.4%

1. Figures are as per the 18th June 2018 5 year funding announcement for the NHS, subject to the NHS agreeing a new long-term plan with the Government late this year. The final plan and settlement will be confirmed at a future fiscal event, subject to an NHS plan that meets the tests that the Government has set out. Figures include funding for Agenda for Change pay costs.

2. Pensions funding refers to the expected increase to NHS employer pension contributions from 2019-20 onwards.

3. In order to be comparable with SR15 (i.e 2016-17 to 2020-21 years), 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 to 5 years commissioning, that occurred halfway through 2015-16, across all years in the table; and 2. net NHS overspends have been removed as these did not form part of the SR baseline.

4. June 2018 funding announcement only covered NHSE RDEL. CDEL funding will be settled in line with the Spending Review process.

5. In line with NHS figures in the SR15 publication, NHS TDEL in this table is defined as NHSE TDEL (NHS RDEL NRF plus CDEL) plus NHS Providers RDEL NRF

6. Totals in the table may not sum due to rounding.

[124] https://www.gov.uk/government/news/department-of-healths-settlement-at-the-spending-review-2015

NHS Five-year funding plan

515. On 18 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. The final settlement and plan will be confirmed at a future fiscal event, subject to an NHS plan that meets the five tests set out in the publication[125].

Revenue Departmental Expenditure Limit (RDEL)

516. The Department's total 2017-18 Revenue DEL (RDEL) represents the consolidated revenue 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).

£121.3bn RDEL Budget

517. 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.

518. In 2017-18, our National Insurance Contributions receipts were in line with the funding set out in the Parliamentary Estimate.

519. **Table 34** summarises the RDEL outturn against budget since 2010-11; highlighting the £0.7 billion underspend in 2017-18.

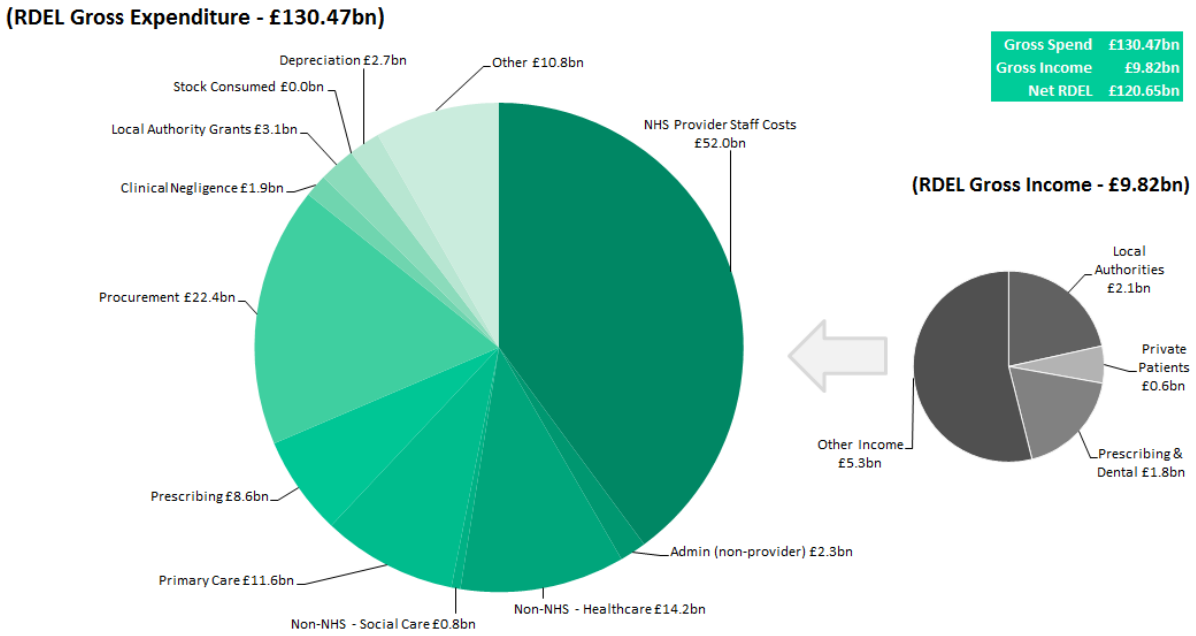
Table 34: Revenue DEL

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m
RDEL Budget	98,567	101,092	104,097	106,801	110,556	114,523	117,594	121,342
RDEL Spending Outturn	**97,469**	**100,266**	**102,570**	**106,495**	**110,554**	**114,730**	**117,031**	**120,650**
Underspends / (Overspends) (£m)	*1,098*	*826*	*1,527*	*305*	*1*	*(207)*	*563*	*692*
Underspends / (Overspends) (%)	*1.114%*	*0.817%*	*1.467%*	*0.286%*	*0.001%*	*-0.181%*	*0.479%*	*0.570%*
Of which:								
RDEL Depreciation Ring Fence Outturn	*1,210*	*1,193*	*1,132*	*1,070*	*1,160*	*1,115*	*1,003*	*734*
RDEL Non Ring Fence Outturn	*96,260*	*99,073*	*101,438*	*105,425*	*109,394*	*113,616*	*116,028*	*119,916*

520. A breakdown of RDEL expenditure can be found in **Figure 20.**

[125] https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan

Figure 20: Revenue DEL – spending breakdown (also see SoPS 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 Parliamentary Supply (SOPS) note 1.1 as not all DHSC Group bodies are detailed on a gross expenditure and income basis.

RDEL: Funding Flows and Sector Breakdown

521. Of the Department's total 2017-18 RDEL budget (£121.3 billion), £109.7 billion was allocated directly to NHS commissioners, with the remainder (£11.6 billion) funding ALBs and the Department's central budgets i.e. the non-NHS sector.

522. 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.

523. 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).

524. Approximately £76 billion of revenue 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.

525. The RDEL budget is set net of income and in 2017-18 the departmental group received around £10 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.

RDEL: Outturn

526. The Government's Mandate to the NHS set a clear expectation that financial balance for the NHS sector as a whole was to be achieved during 2017-18. NHS providers planned for a small deficit during the year, therefore NHS England put aside a risk reserve to offset this and further unplanned deficits that may arise. During the year this contingency was utilised, ensuring the NHS was able to broadly deliver financial balance.

NHS Financial Performance – NHS Commissioners

527. The Government's mandate to NHS England in 2017-18 separately set out NHS England's revenue and capital resource 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. NHS England must ensure that spending is contained within each of these funding limits. **Table 35** provides a breakdown of that spending.

90%
of total DHSC RDEL

Table 35: NHS RDEL

	Limit £m	Spending Outturn £m	*Under/ (Over) spend £m*
NHS England RDEL	109,536	108,567	*970*
NHS England Depreciation (RF RDEL)[1]	166	123	*43*
Total NHS England RDEL	**109,702**	**108,690**	***1,013***
of which Admin	*1,805*	*1,583*	*222*
Total NHS England AME	**100**	**18**	***82***

1. Funding for depreciation costs are ring-fenced under HM Treasury spending rules, and cannot be used to fund other "non-ring-fenced" spending.

528. As part of their own plan to balance the NHS financial position in 2017-18, to allow for effective risk management and build in flexibility, NHS England created a £0.6 billion 'risk reserve' to cover pressures across the system. At year-end, this system reserve was released and further savings of £0.4 billion were achieved across commissioner budgets, resulting in a combined underspend of circa £1 billion against the agreed RDEL spending control.

529. The vast majority of healthcare services are purchased from NHS providers (NHS Trusts and Foundation Trusts); however £13 billion of these types of services were purchased from non-NHS healthcare providers in 2017-18. These non-NHS providers include Local Authorities, voluntary sector/not for profit organisations, Devolved Administrations and private sector providers. **Table 36** provides a breakdown of this spending and compares to 2016-17.

Table 36: Purchase of healthcare from non-NHS providers

	2016-17 £m	2017-18 £m
Independent Sector Providers	9,007	8,765
Voluntary sector/Not for profit	757	1,564
Local authorities	2,909	2,737
Devolved Administrations	73	43
Total Spend on all non-NHS bodies	**12,746**	**13,109**
Total RDEL	**117,031**	**120,638**
Spend with private sector as a % of total RDEL	*7.7%*	*7.3%*
Spend on all non-NHS bodies as a % of total RDEL	*10.9%*	*10.9%*

1. The numbers above have been collected separately from audited accounts data and may include estimates.
2. Numbers shown in the table above 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. The 2017-18 figures reflect improvements in identifying spend with Community Interest Companies, and allocating such spend to the Voluntary/Not for Profit category, rather than to Independent Sector Providers.

530. Further commentary, together with the consolidated accounts of the NHS England group, is published on NHS England's website.

NHS Financial Performance – NHS Providers

531. At the 2017-18 financial year-end, there were 234 provider organisations producing accounts during the year. Together these providers ended 2017-18 with a net financial pressure on the overall Revenue DEL outturn of circa £1 billion, £0.5 billion over plan. **Table 37** details the reported net deficit, plus Revenue DEL scoring adjustments relating to the categorisation of provisions, PFI, donated assets and prior period adjustments.

Table 37: NHS providers RDEL Breakdown

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m
Total Provider Deficit	**(458)**	**(476)**	**(544)**	**107**	**842**	**2,448**	**791**	**991**
Provisions Adjustment	(106)	(163)	(120)	53	121	74	43	39
Other Adjustments	(183)	3	68	(11)	(47)	27	101	8
Total Revenue DEL	**(748)**	**(636)**	**(596)**	**149**	**916**	**2,548**	**935**	**1,038**

1. Other adjustments – these include adjustments to reflect the correct DEL scoring of income and depreciation of donated assets and of PFI spending.
2. Totals in the table may not sum due to rounding.

532. This position includes the benefit of income from the Sustainability and Transformation Fund (STF). This £1.8 billion fund is designed to help providers move to a sustainable financial footing and has been primarily allocated to providers of emergency care that have been under the greatest financial pressure.

533. At the beginning of 2017-18, NHS Improvement used the control framework and the related STF incentive to implement a plan aimed at delivering a net deficit of c£0.5 billion in 2017-18, with 212 trusts (91%) signing up to the controls.

534. Despite the challenging environment, the majority of providers continue to demonstrate that strong, effective and sustainable financial management is possible. Whilst trusts

ultimately reported a position that exceeded NHSI's plan, the step change to stabilise financial performance that occurred in 2016-17 has continued.

535. In addition, the step change we saw in 2016-17 has continued into 2017-18 with the majority of providers, 151 (65%), reporting a year-end position that is equal to or better than their agreed control totals.

536. **Table 38** provides a breakdown of the reported deficit and position against control totals.

Table 38: Summary of NHS Provider's surplus / (deficit)

	Deficit		Surplus		Net	
	number	£m	number	£m	number	£m
Plan						
Providers with agreed control totals	85	(1,125)	127	703	212	(423)
Others	20	(477)	2	0	22	(477)
Uncommitted STF & Other adjustments						404
Net	**105**	**(1,602)**	**129**	**703**	**234**	**(496)**
Outturn						
Equal to or better than control totals	29	(519)	122	1,297	151	**778**
Worse than control totals	52	(1,213)	9	40	61	**(1,173)**
Others	20	(702)	2	0	22	**(702)**
Adjustments						105
Net	**101**	**(2,433)**	**133**	**1,337**	**234**	**(991)**
Variance	***-4***	***(832)***	***4***	***634***	***0***	***(496)***

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.
2. Totals in the table may not sum due to rounding.

Non NHS Bodies - Financial Performance Revenue DEL Spending

10%
Of total DHSC RDEL

537. Outside of the NHS sector, the Department's non-NHS sector contained revenue expenditure within DEL spending limits, absorbing a material starting over-commitment, primarily as a result of the contributions made as part of the 2015 Spending Review (SR15) to mitigate pressures in the NHS. This was extremely challenging and some hard decisions were taken to reduce the non-NHS risk without compromising the support of the wider system, whilst safeguarding the interests of patients and the wider public.

538. During 2017-18, unmanageable pressures emerged relating to lower than anticipated drugs receipts and higher expenditure relating to reciprocal healthcare arrangements in the European Economic Area. Despite our efforts, this gap could not be closed in totality and HM Treasury awarded additional Reserve Claim funding of c. £0.66 billion for items outside of the Department's direct control. As set out in the table below, this comprised £394 million for the change to the Personal Injury Discount Rate and £267 million for higher expenditure relating to reciprocal healthcare arrangements in the European Economic Area.

539. Overall, the sector operated within DEL spending limits, ensuring financial balance across the non-NHS sector. This has been done without compromising the support of the wider system, whilst safeguarding the interests of patients and the wider public.

540. The summarised DEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 39**.

Table 39: Summarised Financial Position for DHSC's ALBs in 2017-18

	Plan £m	Outturn £m	Variance £m
RDEL Non Ring-fenced Spending -			
Opening over-commitment	(738)		(738)
Public Health England	749	737	12
Public Health Local Authority Grants	3,091	3,091	0
Health Education England	4,825	4,823	2
NHS Litigation Authority	146	(106)	252
NHS Litigation Authority (2017-18 reserve claim for Personal Injury Disco	394	406	(12)
NHS Property Services	(152)	(171)	19
Community Health Partnerships (CHP)	20	18	2
NHS Digital	320	310	10
Other ALBs	410	335	75
European Economic Area (EEA) medical costs	630	919	(289)
European Economic Area (EEA) medical costs (2017-18 reserve claim)	267		267
PPRS	(391)	(409)	18
Other DHSC Central Budgets	1,739	1,284	455
Subtotal DHSC & other ALBs Non Ring-fence	**11,310**	**11,237**	73
Public dividend capital (PDC) payments and loan interest	(1,015)	(940)	(75)
NHS and Independent Charities		15	(15)
Total Non-NHS Non Ring-fence	**10,295**	**10,312**	(17)
RDEL depreciation ring-fence	1,345	472	873
Total RDEL	**11,640**	**10,784**	856

Capital Departmental Expenditure Limit (CDEL)

£5.6bn
CDEL Budget

541. The Department's total 2017-18 CDEL outturn is the consolidated net capital spending of all bodies within the Departmental group.

542. **Table 40** summarises the CDEL outturn against budget since 2010-11; highlighting the £360 million (6.4%) underspend in 2017-18.

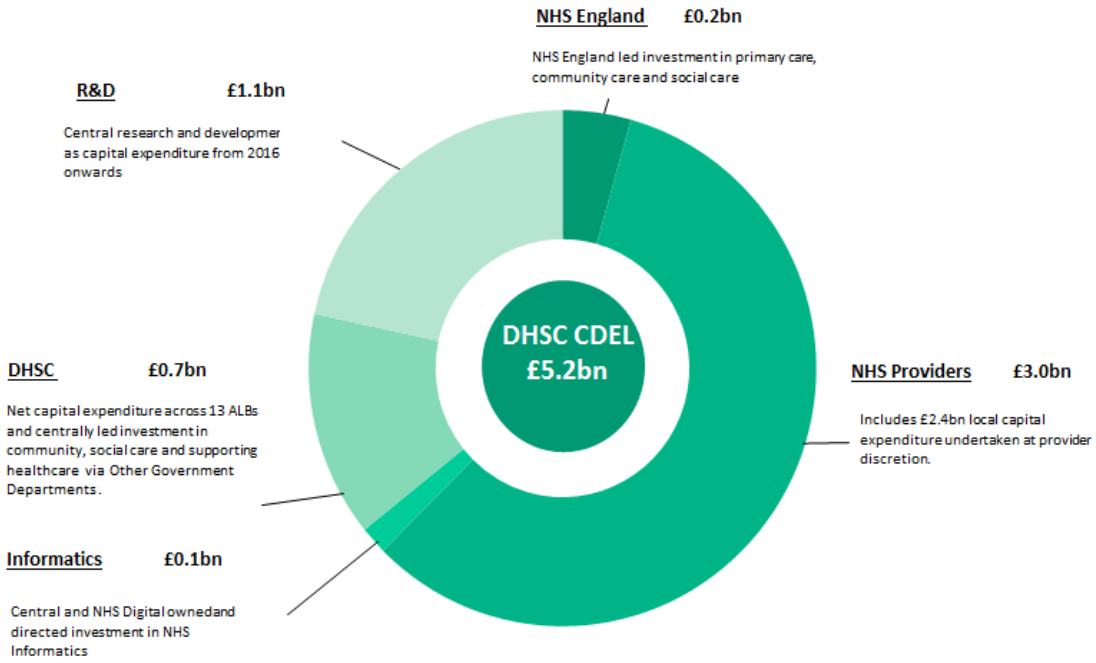
Table 40: Capital DEL Outturn[1]

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m
CDEL Budget	5,783	5,250	5,421	5,462	5,034	4,710	4,616	5,598
CDEL Spending Outturn	**5,045**	**4,669**	**4,708**	**5,367**	**4,971**	**4,652**	**4,604**	**5,238**
CDEL Underspend	*738*	*581*	*713*	*95*	*63*	*58*	*12*	*360*
CDEL Underspend %	*12.76%*	*11.07%*	*13.14%*	*1.75%*	*1.25%*	*1.23%*	*0.25%*	*6.43%*

1. All years have been adjusted to take account of the reclassification of research & development expenditure to capital under ESA 10.
2. Totals in the table may not sum due to rounding.

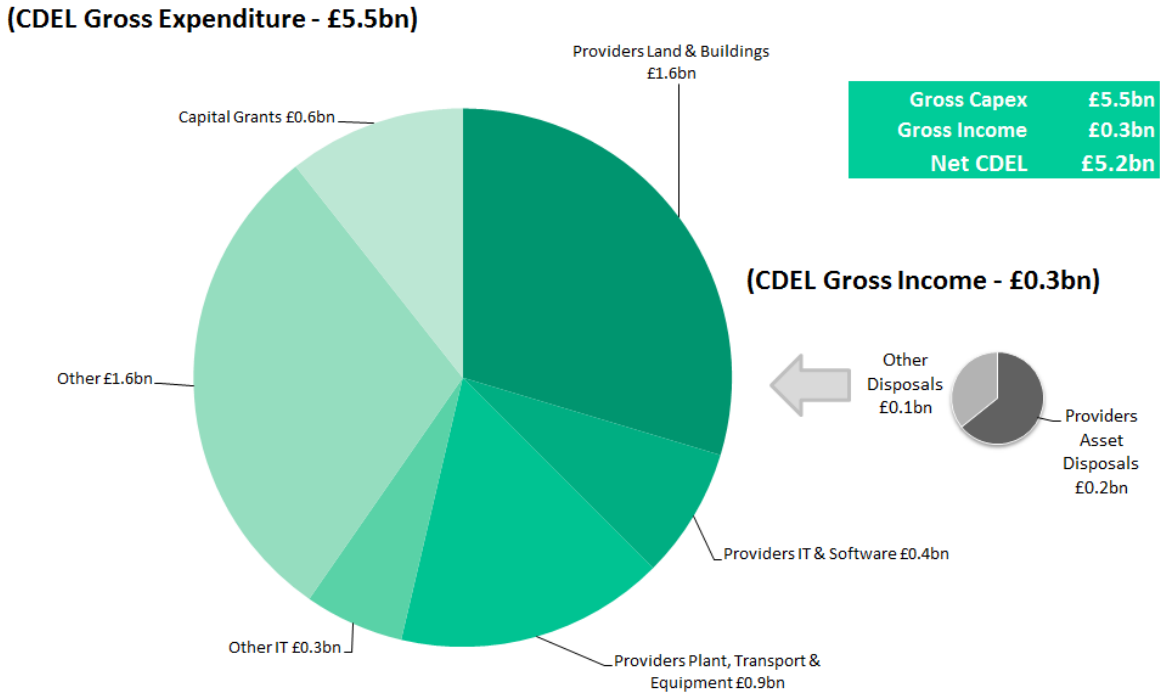
543. **Figure 21** provides a breakdown of 2017-18 capital spend (CDEL) by expenditure type.

Figure 21: Capital DEL - spending breakdown (also see SOPS 1.2)



544. **Figure 22** provides a breakdown of 2017-18 capital spend (CDEL) by sector within the DHSC group.

Figure 22: Capital DEL Spending Breakdown by Sector



NHS Finance - NHS Providers Capital Expenditure

545. As shown in **Figure 22**, NHS provider capital expenditure (CDEL), net of charities contributions, was £3.1 billion in 2017-18.

546. NHS providers finance the majority of capital expenditure themselves (77% during 2017-18) by deploying surplus cash reserves, and any capital loans taken out. This investment is shown as the Local Capital Expenditure line in the following table. The Department, and its ALBs, also inject financing to support specific strategic initiatives.

547. **Table 41** shows how the 2017-18 NHS provider CDEL outturn of £3.1 billion was financed.

Table 41: Financing of Capital DEL

	2017-18 Total £m
Capital DEL Outturn[1]	**3,063**
Of which	
Local Capital Expenditure[2]	2,366
DHSC & ALB led initiatives	551
PFI Residual Interest[3]	147
Capital DEL Allocation set	**3,330**
Variance Under(Over)	***267***

1. NHS CDEL in the table above does not include the net capital investment of NHS Charities
2. Capital Expenditure, financed from internally generated funds; cash from surpluses, depreciation, and monies loaned (from DHSC or externally).
3. HMT's budgeting framework requires PFI residual interest on assets to score to CDEL.

548. The Capital DEL affordable envelope agreed after the 2017 Autumn Budget increases for NHS providers for 2017-18 was £3.3 billion. NHS providers underspent against this Capital DEL target by £267 million.

549. As mentioned previously, the Department and its Arm's Length Bodies have led specific initiatives over the year and issued non-repayable financing in the form of Public Dividend Capital (PDC), directly to NHS providers amounting to £551 million.

550. Further details of these investments can be found in the report 'Financial Assistance under Section 40 of the National Health Service Act 2006'[126], which is published alongside the Annual Report. There have been a several large schemes supporting continued transformation of the delivery of healthcare, through advancing use of information technology and A&E reconfigurations, as recommended in the NHS Five Year Forward View. These allocations are summarised in **Table 42**.

126 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/629929/Financial_assistance_under_section_40_NHS_act_2006_2016-17.pdf

Table 42: Capital PDC Allocations 2017-18

	2017-18 Total £m
Non Programme	
Non Programme PDC	189
DHSC Programme Initiatives PDC	
Accident & Emergency Reconfigurations	98
Anti Microbiotic Research	6
Cancer Transformation Fund	5
Cyber Security	61
Provider Digitalisation	94
Linear Accelerator	46
Wi-Fi Secondary Care	11
Perinatal Mental Health	6
Proton Beam	20
Other Schemes under £5m	14
Total Programme	361
Total PDC	550

Overall DHSC Group Capital Expenditure

551. In summary, the NHS provider's capital expenditure underspend of £267 million combined with underspends in the non-NHS sectors results in an overall underspend of £360 million (6.4%) across the Departmental Group.

RDEL Administration

1/3
Admin Savings since 2011-12

552. 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 of the Department's central government Arm's Length Bodies (ALBs).

553. The Department and our ALBs continue to reduce administration costs compared to prior years building on the one third savings delivered as a result of the Health and Social Care Act 2012 reforms.

554. Over the course of the Spending Review 2015 period, further efficiencies will be delivered across the sector in line with the settlement.

555. **Table 43** shows the administration outturn with spending in 2017-18 reducing by around £53 million (2.3 %) compared to 2016-17, maximising the amount of funding available for frontline services.

Table 43: DHSC Administration

	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m
Administration Outturn	3,307	3,502	3,036	2,781	2,421	2,275	2,222

1. Figures do not include depreciation and as a result will not directly reconcile to Admin outturn as per Statement of Parliamentary Supply (£2,304m).

Annually Managed Expenditure (AME)

556. Details of the Department's total 2017-18 AME budget and expenditure are set out in **Table 44,** which shows the Department underspent by £14.8 billion (52.9%) against its final Revenue AME budget.

£27.9bn
AME Budget

Table 44: Annually Managed Expenditure plans, outturns and under/ (over) spends

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m
Revenue AME Budget	4,844	3,943	5,868	5,502	6,606	31,272	16,150	27,940
RAME Outturn	**3,207**	**3,193**	**5,775**	**4,261**	**3,419**	**29,207**	**9,508**	**13,152**
Underspend/(Overspend) £m	*1,637*	*750*	*93*	*1,241*	*3,187*	*2,065*	*6,642*	*14,788*
Underspend/(Overspend) %	*33.8%*	*19.0%*	*1.6%*	*22.6%*	*48.2%*	*6.6%*	*41.1%*	*52.9%*
Capital AME Budget	4	-	-	120	15	15	15	15
Capital AME Outturn	**8**	-	-	**(70)**	**(5)**	**9**	**13**	**0**
Underspend/(Overspend) £m	*(4)*	-	-	*190*	*20*	*6*	*2*	*15*
Underspend/(Overspend) %	*-122.5%*	-	-	*158.2%*	*132.9%*	*40.0%*	*13.3%*	*100.0%*

557. The Department's AME provision (Revenue and Capital) is set annually outside the Spending Review and the revenue 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.

558. 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.

559. The final AME budget in 2017-18 was set at £27.9 billion. This included an increase of £13.6 billion relating to HM Treasury's changes to the discount rate used to value provisions and a prudent estimate of provisions expenditure. This estimate is provided by NHS Resolution (NHSR), based on an early analysis of the variables that impact clinical negligence costs, and is commissioned by NHSR from their actuarial advisors.

560. As a result of favourable reductions, including the number of clinical negligence claims and claims inflation, the estimated quantum of future clinical negligence expenditure at the end of 2017-18 was significantly lower than had been forecast. DHSC therefore underspent by £14.8 billion on its AME budget of £27.9 billion.

This is the second consecutive year that there have been significant variances between NHSR's forecast and actual provisions expenditure. DHSC will be working with NHSR to explore options to minimise these fluctuations in future years.

Annex C – NHS Operational Performance

NHS Operational Performance against waiting time standards

561. Growth in demand for NHS services can compromise the ability of the health and care system to deliver performance standards. The Department, through its national partners including NHS England and NHS Improvement, worked across the system to support the most challenged providers and to take actions designed to stabilise and recover performance.

562. The 2018-19 Government mandate to NHS England continues the multi-year approach to the mandate established since 2016-17, where we have carried forward the same overarching objectives to 2020, with only one significant change (the role of NHSE to support the Government to make a success of EU Exit in regards to health and care). 2020 goals and annual deliverables from 2017-18 are also being carried forward, with only essential changes. This is to provide continued stability for NHS England and the wider NHS to focus on improving performance on core patient access standards, whilst maintaining progress on key commitments in the NHS's plan, the Five Year Forward View[127].

563. The decision to roll forward the mandate, alongside providing an additional £2.8 billion for the NHS between 2017-18 and 2019-20, reflect the Government's commitment to supporting the NHS to deliver essential improvements in elective care[128] 18-week Referral to Treatment (RTT) and[129] A&E waiting times.

564. Winter is the most challenging time of the year for the NHS – the combination of cold weather, increased levels of flu and other viruses along with higher acuity of patients (a particularly high-acuity patient may need a nurse dedicated solely to their care, while low acuity patients may share their nurses with many other patients. In other words, nurse staffing ratios can change dramatically depending on the level of care each patient needs) and staff sicknesses mean our services come under more pressure than at any other time of year. That is why we undertake rigorous planning each year to ensure the NHS is resilient in the face of the challenges winter brings. As announced in the Autumn Budget, this was supported by an extra £337 million, on top of the previously announced £100 million for Accident and Emergency Departments to support primary care streaming and an additional £1 billion of funding to be spent on meeting adult social care needs, supporting the social care market and reducing pressure on the NHS this year.

565. The National Emergency Pressures Panel (NEPP) was set up ahead of last winter (2017-18) to provide advice on patient safety issues. It consists of clinical leaders and experts from organisations including: the Royal College of Surgeons, the Royal College of Physicians, the Royal College of GPs, the Royal College of Nursing, Public Health England and the CQC. The NEPP met on 20 December 2017[130] and recommended that where it would help with 'winter pressures', trusts should consider reducing elective activity to help provide capacity in urgent care. They made it clear they were not recommending the postponement of cancer, urgent and time critical care. The NEPP initially recommended

[127] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[128] https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
[129] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-time
[130] https://www.england.nhs.uk/publication/national-emergency-pressures-panel-nepp-meeting-notes-20-december-2017/

that this should be in place till mid-January and on review in early January NEPP recommended this period was extended to 31 January 2018.

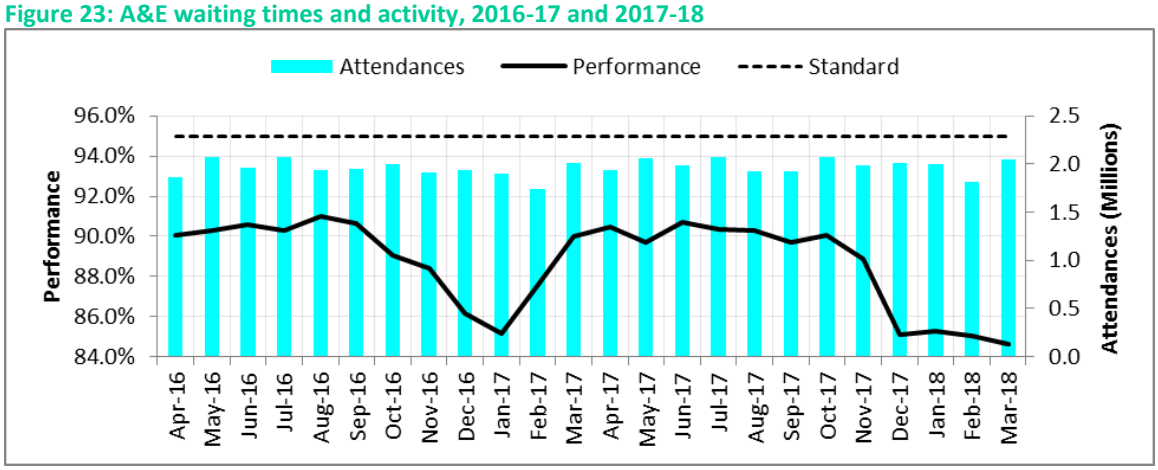
566. The Department will continue to support its partners in delivering the ambition set out in The Five Year Forward View - Next Steps[131] including:
- achieving the 62-day standard[132] - a key objective in the Government's mandate to NHS England for 2017-18 and 2018-19;
- introducing a new cancer waiting times target that, by 2020, NHS cancer patients will be given a definitive diagnosis or the all clear within 28 days of being referred by a GP. This Faster Diagnosis Standard is currently being tested in five local health economies;
- increasing theatre productivity delivered by NHSI's theatre productivity programme;
- delivering growth in elective demand to within sustainable levels; and
- working on pathways, productivity and potential funding opportunities to improve performance.

A&E Waiting Times

567. National performance for A&E waiting times[133] in 2017-18 was 88.4%, not meeting the standard that 95% of patients should be admitted, transferred or discharged within four hours of arrival in an A&E department, slightly lower than 2016-17 when it was 89.1%. The standard has not been met since July 2015.

568. The drop in performance as shown in **Figure 23** should be seen in the context of increasing demand for non-elective services. A&E attendances over the latest twelve months were 2.2% higher than in 2016-17, increasing from 23.4 million in 2016-17 to 23.9 million in 2017-18. Over the same period, the number of emergency admissions from A&E increased by 4.7% from 4.3 million in 2016-17 to 4.5 million in 2017-18.

Figure 23: A&E waiting times and activity, 2016-17 and 2017-18



[131] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
[132] https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

[133] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

Ambulance Response Programme

569. There has been an ongoing review of the way the ambulance service responds to calls through the Ambulance Response Programme (ARP). Following an independent evaluation of extensive trials covering 14 million emergency 999 calls, in July 2017 the Secretary of State approved NHS England's recommendation to implement an improved ambulance performance framework.

570. The previous Red1/Red2/A19 standards have been replaced by six standards over the new call categories of C1 to C4.

571. For C1 (life threatening calls, for time-critical events needing immediate intervention), and C2 (emergency calls, for potentially serious conditions needing rapid assessment) the mean response and 90th centile are measured. The standards[134] for C1 and C2 calls are as follows:
    - C1: 7 minutes mean response time
    - C1: 15 minutes 90th centile response time
    - C2: 18 minutes mean response time
    - C2: 40 minutes 90th centile response time

572. For C3 (For C3 (urgent calls, needs treatment to relieve suffering) and C4 (non-urgent calls, needs face-to-face or telephone assessment), the 90th centile is measured. The standards for C3 and C4 calls are as follows:
    - C3: 120 minutes 90th centile response time
    - C4: 180 minutes 90th centile response time

573. The new framework has been progressively implemented in ambulance trusts from August 2017. From December 2017, all mainland Ambulance Services in England are reporting against the new standards. The ambulance service on the Isle of Wight will report against the new standards from April 2018. This means that data against the new response time categories are incomparable and a year-to-date comparison cannot be made.

574. Performance data against the new standards has revealed a range of performance between ambulance trusts from the first full month of reporting in December 2017 to March 2018. Nationally the C1 90th centile response time standard has been met since January 2018, while other standards have not been met.

575. Monthly mean response times for C1 calls have ranged from 6 minutes 28 seconds to 11 minutes 17 seconds, while 90th centile responses ranged from 10 minutes 55 seconds to 18 minutes 38 seconds.

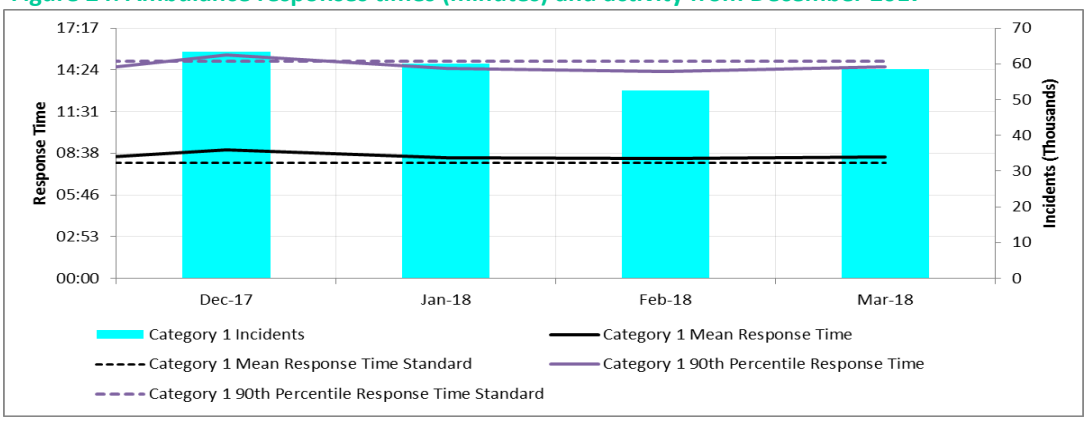
576. Monthly response times for C2, C3, and C4 calls show a wider range. Mean response times for C2 calls ranged from 12 minutes 22 seconds to 45 minutes 6 seconds, while 90th

[134] https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

centile responses ranged from 22 minutes 26 seconds to 1 hour 43 minutes. The 90th centile response time for C3 calls ranged from 1 hour 22 minutes to 5 hours 17 minutes, while 90th centile response times for C4 calls ranged from 2 hour 19 minutes to 5 hours 59 minutes.

577. NHS England is undertaking a spring review of the ARP standards to determine whether any further adjustments should be made.

Figure 24: Ambulance responses times (minutes) and activity from December 2017



*All ten mainland England ambulance services began reporting against the new ARP standards from December 2017; therefore data are only comparable for those months.

Referral to Treatment

578. Elective waiting times are monitored against the **referral to treatment (RTT) incomplete pathway standard**, in that 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. Published performance was 87.2% in March 2018, compared to 90.3% in March 2017. **Figure 26** shows that the standard was not met in any month in 2017-18, and was last met in February 2016. Deteriorating performance against the standard is a result of a mismatch between demand and activity and reduced capacity to treat more complex patients resulting from emergency pressures. Despite a significant reduction in year-on-year growth in GP referrals, below 2017-18 planned levels, the waiting list has still increased.

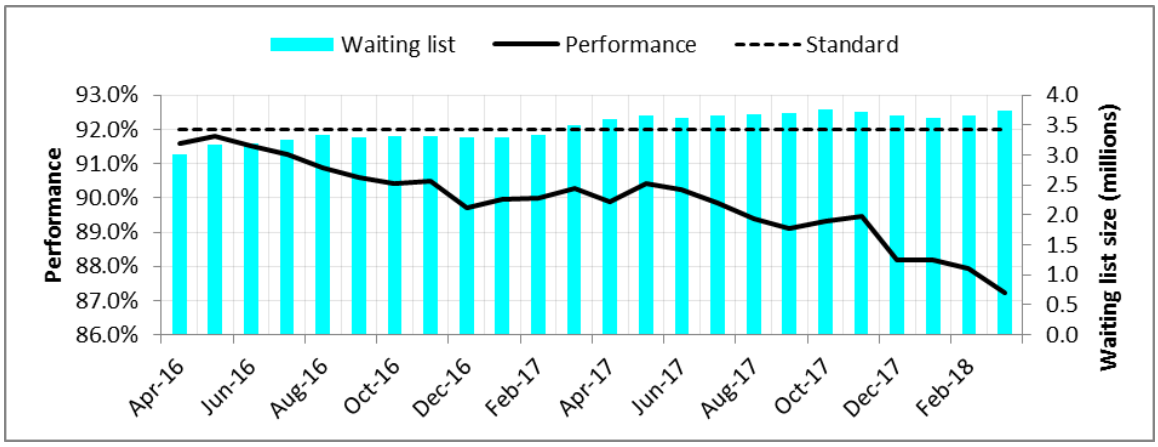
579. As shown in **Figure 25**, NHS England's reported waiting list was 3.84 million in March 2018 compared to 3.73 million in March 2017, an increase of 3%. Once the data for 'non reporters' is added to the waiting list this increases by 5% from 3.90 million in March 2017 to 4.02 million in March 2018. In February 2018 NHS England issued 'Refreshing NHS Plans for 2018-19', outlining that the RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018 and, where possible, they should aim for it to be reduced. Furthermore, the numbers nationally of patients waiting more than 52 weeks for treatment should be halved by March 2019, and locally eliminated wherever possible.

580. NHS England's Elective Care Transformation Programme continues with gastroenterology and Orthopaedics (wave 1) handbooks[135] published. Complete rollout has been extended

[135] https://www.england.nhs.uk/elective-care-transformation/handbooks-and-case-studies/

and indicative testing is not due for completion until February 2019, with final handbooks published in April 2019.

Figure 25: Percentage of patients on RTT incomplete pathways waiting within 18 weeks from referral, 2016-17 to 2017-18



Cancer Waiting Times

581. Early diagnosis and treatment are crucial to improving survival rates for cancer, and eight **cancer waiting time standards**[136] cover different elements of the pathway, to ensure patients benefit from better access to cancer services.

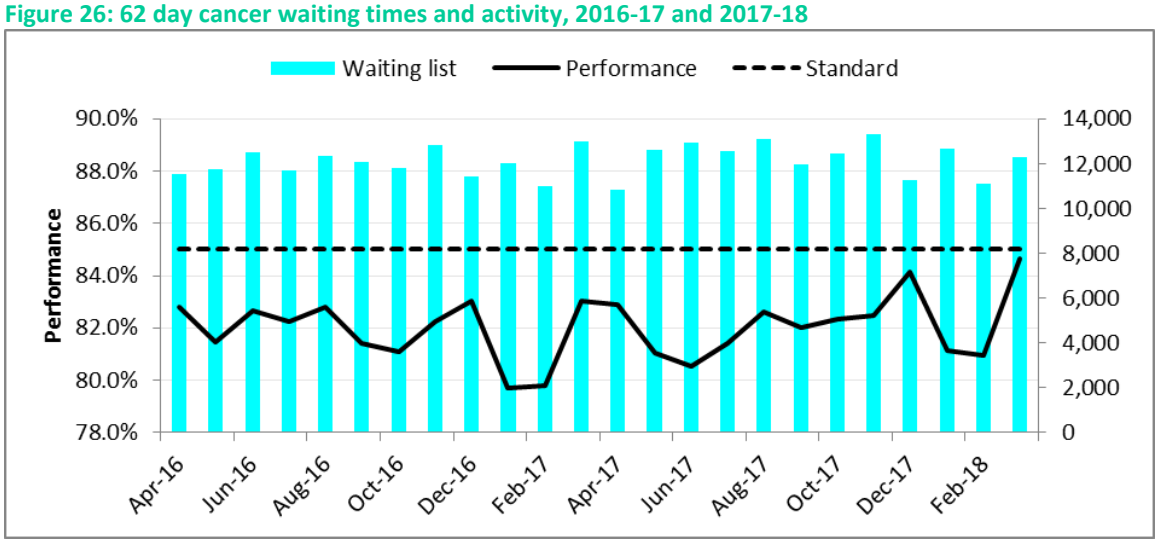
582. As shown in **Figure 26**, the standard that 85% of patients begin first treatment within 62 days of an urgent GP referral for suspected cancer was not met in any month of 2017-18 and was last met in December 2015. Demand continued to rise, with urgent GP referrals for suspected cancer increasing by 3.8% from 1.88 million in 2016-17 to 1.95 million in 2017-18.

583. A joint NHS England and NHS Improvement plan was put in place to recover the 62 day standard in 2017-18, focusing on specific pathway improvements in the tumour type pathways with highest number of breaches and with the aim of sharing best practice through Cancer Alliances and applying where relevant to other cancer pathways. The objective to recover the standard had been rolled over into the Mandate for 2018-19.

584. NHS England plans to start performance managing trusts against the new 28-day faster diagnosis standard from April 2020. The standard is that patients should receive a cancer diagnosis or all clear within 28 days of their first GP appointment. The new Cancer Waiting Times system will be able to measure the new standard (in piloted trusts) from April 2018 with a view to collecting data from all trusts from April 2019. The new faster diagnosis standard will assist the recovery of the 62 day from GP urgent referral to a first treatment for cancer (85%) standard.

[136] 93% of patients to see a specialist for suspected cancer within two week wait of an urgent GP referral;96% of patients to begin first treatment within 31 days of decision to treat for cancer;

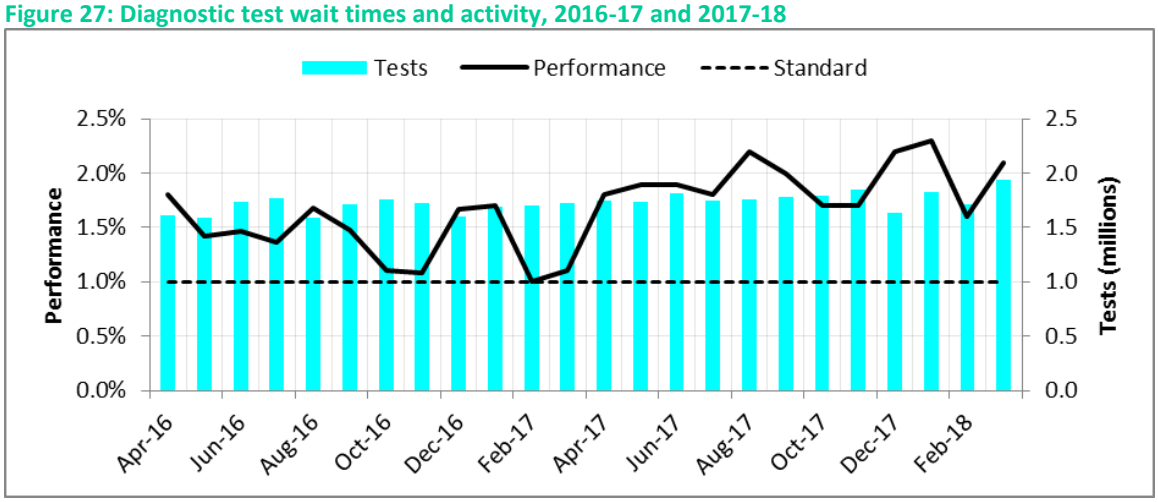
Figure 26: 62 day cancer waiting times and activity, 2016-17 and 2017-18



Diagnostic Tests

585. Waiting times for diagnostic tests[137] are an important contributor to all elective (including cancer) waiting times, because the vast majority of patients require a diagnostic test to determine whether and what treatment is necessary. As shown in **Figure 27**, 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 for the 15 diagnostic tests measured, although the average (median) waiting time remained stable at around two weeks. Furthermore, nearly 98% of patients were waiting less than six weeks for their diagnostic test in every month of 2017-18. This remains strong performance in the context of significant increases in demand for diagnostics tests - with the number of tests carried out increasing by 2.5% from 21.4 million in 2016-17 to 21.9 million in 2017-18.

Figure 27: Diagnostic test wait times and activity, 2016-17 and 2017-18



Delayed Transfers of Care

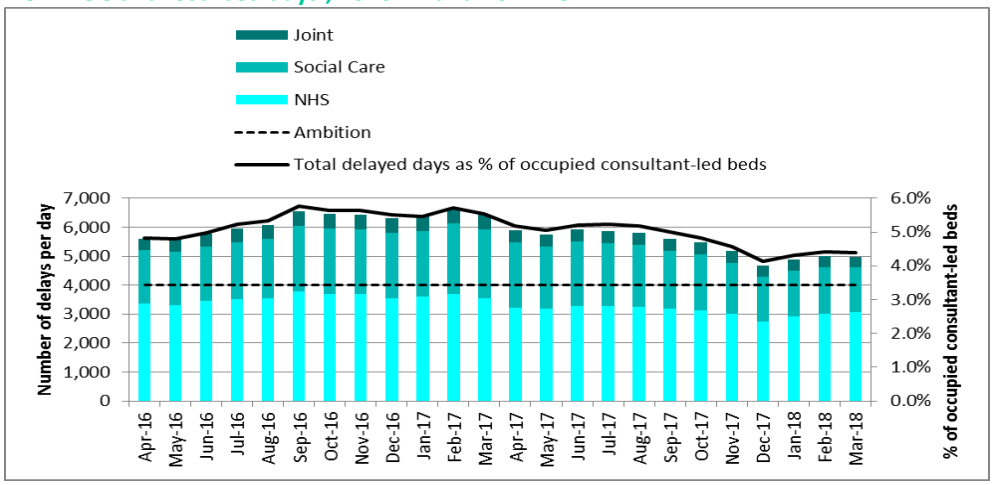
586. A delayed transfer of care (DTOC) is defined as when a patient is ready to depart from hospital care, but is still occupying a bed. This Government is clear that no-one should stay in a hospital bed longer than necessary. The number of bed days lost because of

[137] https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/

delayed transfers of care decreased by 12.3% in 2016-17 from 2.3 million in 2016-17 to just less than 2 million in 2017-18.

587. As shown in **Figure 28**, in March 2018, delayed transfers of care accounted for 4,987 occupied beds per day compared with 6,440 in March 2017 – a decrease of 1,453. All local systems are continuing to implement the High Impact Change Actions to reduce DTOC (as referenced in the Five Year Forward View Next Steps Document and the Better Care Fund Policy Framework[138]).

Figure 28: DTOC and lost 'bed days', 2016-17 and 2017-18



138 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

Annex D – Other Departmental Information

Sustainability Data

588. **Tables 45-47** outline the progress on greenhouse gas emissions, waste and water consumption for the bodies within the Departmental Group that are in scope. ALBs not included in these tables are HTA, HFEA, NHSLA & HRA due to de minimis exclusion.

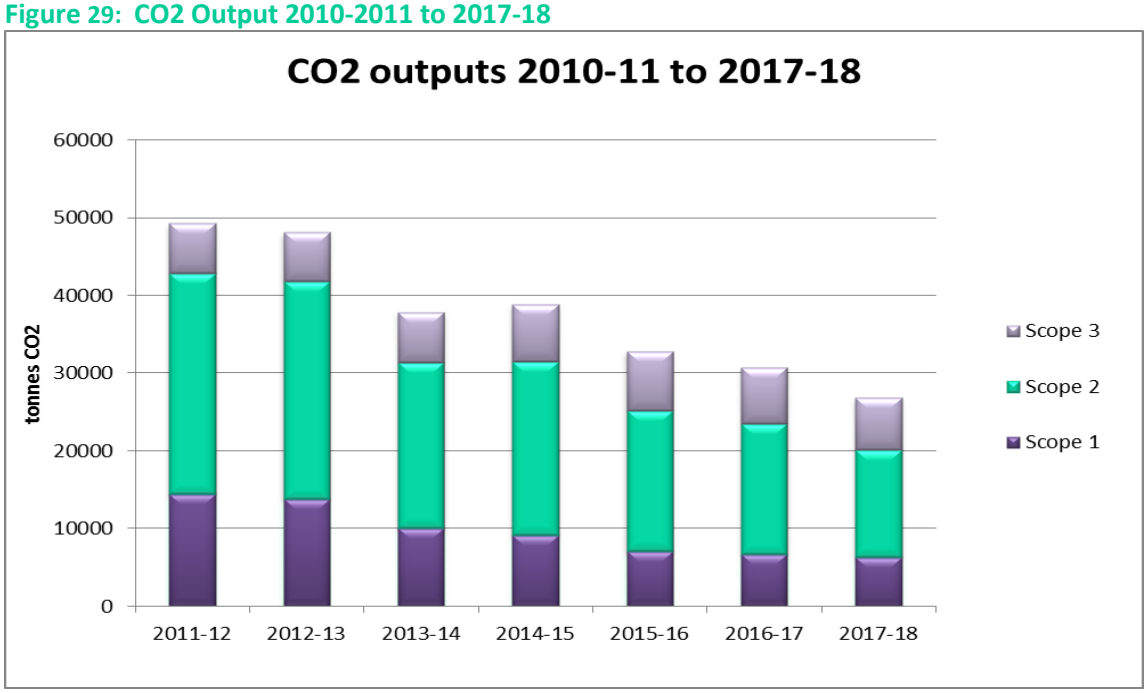
Greenhouse Gas Emissions Performance Commentary

Table 45: Greenhouse Gas Emissions Baseline 2010-11 to 2017-18

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Non Financial Indicators (CO2 tonnes)								
Total Gross Emissions for Scope 1	16,500	14,387	13,802	9,997	9,146	7,076	6,741	6,361
Total Gross Emissions for Scope 2	32,919	28,500	27,981	21,342	22,283	18,089	16,788	13,720
Total Gross Emissions for Scope 3	7,662	6,400	6,317	6,514	7,377	7,637	7,214	6,738
Total Gross Emissions	**57,081**	**49,287**	**48,100**	**37,853**	**38,806**	**32,802**	**30,743**	**26,819**
Related Energy Consumption (mWh)								
Electricity renewable	14,164	15,219	10,606	32,503	31,873	26,798	9,294	71
Electricity non-renewable	55,527	48,924	50,219	15,404	13,211	12,342	31,171	38,954
Gas	75,343	56,872	64,645	43,804	39,620	33,969	34,332	31,080
Gas Oil	3,400	3,853	4,594	4,748	5,489	1,315	510	1,279
Total inc other	**149,018**	**126,283**	**131,328**	**97,370**	**90,985**	**75,266**	**76,818**	**72,039**
Financial Indicators (£k)								
Expenditure on energy	8,433	7,592	7,993	7,014	7,272	5,944	5,437	5,618
Carbon ofsetting costs	352	440	458	147	227	92	112	168
Expenditure on offical business travel	21,593	17,996	18,040	18,618	19,876	20,003	19,620	19,584

1. For sustainability reports for individual organisations, please see organisations' annual report and accounts.
2. The core Department does not report on Quarry House for energy, waste and water. This is included in sustainability reporting for the Department for Work and Pensions.

Figure 29: CO2 Output 2010-2011 to 2017-18



Scope 1 – Direct emissions, Scope 2 – Energy indirect emissions, Scope 3 – Other indirect emissions

589. The results shown in **Figure 29** show the Department has continued to reduce its carbon emissions in 2017-18. We continue to implement initiatives to reduce our carbon footprint, which have included the deployment of energy efficient IT, consolidation of estate, tighter building environment controls and improved Video Conference facilities.

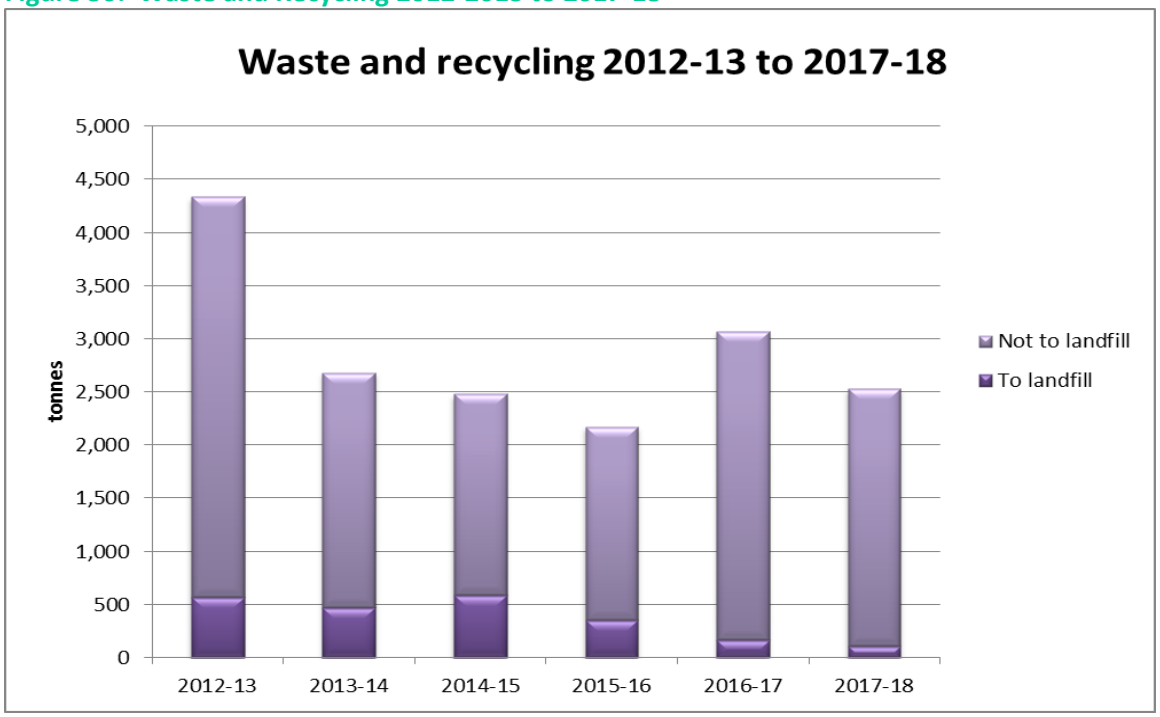
Waste

Table 46: Waste – Financial and Non-Financial Indicators 2010-2011 to 2017-18

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Non Financial Indicators (tonnes)								
Total waste -	**4,022**	**2,841**	**4,337**	**2,679**	**2,484**	**2,172**	**3,074**	**2,532**
Landfill			573	473	585	355	165	111
Not to landfill			3,764	2,207	1,899	1,817	2,909	2,421
Incinerated/energy from waste			259	328	316	259	325	312
Incinerated/energy not recovered			378	334	323	294	244	163
Financial Indicators (£k)								
Total disposal cost (minimum requirement)	**927**	**672**	**805**	**868**	**718**	**978**	**730**	**582**
Hazardous waste - total disposal cost	349	227	244	499	405	621	457	311
Non-hazardous waste - total disposal cost	578	445	561	369	313	357	273	271

1. Breakdown of waste data between landfill and non-landfill not collected for 2010-11 and 2011-12.

Figure 30: Waste and Recycling 2012-2013 to 2017-18



590. As **Figure 30** shows, waste figures for the Department have decreased in 2017-18. The spike in 2012-13 was due to extensive refurbishment programmes taking place, as part of the transition to the new Health and Social Care system. The proportion of waste recycled across the DHSC/ALB estate has improved further, with 96% of waste not to landfill, and 4% to landfill.

Water

591. As **Table 47** indicates, the Department's water consumption (office estate) has increased during the year due to more intensive use of our estate. The benchmark for water consumption is measured per person on a Whole Time Equivalent (WTE) basis. Our performance has improved from the baseline of 7.9m³ per WTE in 2009-10, to 6.0m³ per WTE in 2017-18. This means the Department is in the good practice category. The Department is working with its facilities suppliers and other organisations on how to continue to reduce its water consumption to meet the best practice target of less than 4m³ per WTE.

Table 47: Water Consumption – Financial and Non-Financial Indicators 2010-2011 to 2017-18

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-8
Non Financial Indicators (m3)								
Water Consumption -								
Office	69,051	68,077	73,132	63,067	59,826	65,733	64,936	67,559
Whole estate	254,719	239,426	297,384	235,336	236,742	179,218	188,793	237,757
m3 per FTE/office estate	7.6	7.5	7.6	6.8	5.5	6.0	6.0	6.0
Financial Indicators (£k)								
Water supply costs	338	302	347	364	345	277	335	410

Health Inequalities

Table 48: Health Inequalities Indicators Summary

Indicator	England average (latest)	Inequality by area deprivation* (measured by the slope index of inequality)		
		Baseline	Previous	Latest
Public Health Outcomes Framework (PHOF) Headline Inequality Indicators				
Life expectancy at birth - males *Years of life*	79.5 *(2014-16)*	9.1 *(2010-12)*	9.2 *(2013-15)*	9.3 (2014-16)
Life expectancy at birth - females *Years of life*	83.1 *(2014-16)*	6.8 *(2010-12)*	7.1 *(2013-15)*	7.3 (2014-16)
Healthy life expectancy at birth - males *Years of life*	63.3 *(2014-16)*	18.6 *(2011-13)*	18.9 *(2013-15)*	*19.1* *(2014-16)*
Healthy life expectancy at birth - females *Years of life*	63.9 *(2014-16)*	19.1 *(2011-13)*	19.6 *(2013-15)*	*19.1* *(2014-16)*
NHS Outcomes Framework (NHSOF) Indicators for Health Inequalities Assessment				
Potential years of life lost (PYLL) from causes considered amenable to healthcare - adults *Rate per 100,000 population***		3,165 *(2013)*	3,194 *(2014)*	
Life expectancy at 75 - males *Years of life*	11.5 *(2014-16)*	2.7 *(2011-13)*	2.9 *(2013-15)*	2.9 (2014-16)
Life expectancy at 75 - females *Years of life*	13.2 *(2014-16)*	2.6 *(2011-13)*	2.8 *(2013-15)*	2.9 (2014-16)
Under 75 mortality rate from cardiovascular disease *Rate per 100,000 population*	72.7 *(2016)*	106.5 *(2013)*	109.0 *(2015)*	106.9 (2016)
Under 75 mortality rate from cancer *Rate per 100,000 population*	135.6 *(2016)*	103.9 *(2013)*	105.5 *(2015)*	103.4 (2016)
Infant mortality *Rate per 1,000 live births*	3.8 *(2016)*	3.0 *(2013)*	3.1 *(2015)*	*3.2* *(2016)*
Health-related quality of life for people with long-term conditions *Health status score****	0.737 *(2016-17)*	0.149 *(2013-14)* *(IMD2010)*	0.155 *(2015-16)*	*0.153* *(2016-17)*
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	813 *(2016-17)*	978 *(2013-14)*	1,007 *(2015-16)*	*971* *(2016-17)*

Indicator	England average (latest)	Inequality by area deprivation* (measured by the slope index of inequality)		
		Baseline	Previous	Latest
Rate per 100,000 population				
Emergency admissions for acute conditions that should not usually require hospital admission *Rate per 100,000 population*	1,359 *(2016-17)*	932 *(2013-14)*	965 *(2015-16)*	*925* *(2016-17)*
Patient experience of GP services *% reporting good experience****	84.8 *(2016-17)*	5.1 *(2013-14)* *(IMD2010)*	7.3 *(2015-16)*	*7.2* *(2016-17)*
Access to GP services *% reporting good experience of making appointments****	72.7 *(2016-17)*	5.2 *(2013-14)* *(IMD2010)*	8.0 *(2015-16)*	*8.8* *(2016-17)*

* Area deprivation is based on IMD 2015 unless otherwise stated.
** These have not been significance tested as no new data has been released.
*** For these indicators it has not been possible to update baseline data to reflect changes introduced with the 2015 updating of the Index of Multiple Deprivation. Data for 2015-16 do not match that published in the 2016-17 Annual Report as these are now updated to be based on IMD2015.

Annex E – Department of Health and Social Care Official Development Assistance

592. 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.

593. 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).

594. **Table 49** shows how the Department spent ODA funding in the 2017 calendar year.

Table 49: Official Development Assistance

The Department of Health and Social Care provided £100,990,563 of Official Development Assistance (ODA) in 2017.[139]
The Department of Health and Social Care did not spend any cross-government ODA funds in 2017.
Global Health Research assistance is delivered through the National Institute for Health Research (NIHR) and was focussed on: **NIHR Global Health Research Units and Groups** – this programme supports the production of outstanding global health research focussing on health issues that affect the poorest and most vulnerable people in low- and middle-income countries (LMIC), through equitable partnerships of UK and LMIC researchers who are either established in the global health field (Units) or expanding into it (Groups). 13 Units and 20 Groups were funded through the first call and began work in 2017. **NIHR global health research partnerships** – these programmes are multi-year partnerships where the NIHR has joined with other funders to support existing programmes and develop new ones, contributing to the wide range of high-quality research programmes addressing global health issues for the primary benefit of patients and the public in LMICs. The NIHR supported four partnerships in 2017, including the Joint Global Health Clinical Trials Initiative and Antimicrobial Resistance (AMR) Cross-Council Initiatives. **NIHR support to global health research priority initiatives** – the NIHR has supported five existing programmes looking at specific global health research priority areas that directly affect at-risk populations in LMICs, such as treatments for malaria and tuberculosis (TB) with the Medicines for Malaria Venture (MMV) and Global Alliance for TB Drug Development, and clinical research for poverty-related disease (PRD) epidemics with the European and Developing Country Clinical Trials Partnership (EDCTP). **Global Health Security** assistance was focussed on:

[139] Figures are provisional, taken from Statistics on International Development: Provisional UK Aid Spend 2017 - GOV.UK

The Fleming Fund - This project is focused on improving data and surveillance of Antimicrobial Resistance (AMR) in LMIC's where drug resistant infections have a disproportionate effect. The Fund will improve laboratory capacity and diagnosis in these countries so that the sharing of data on drug resistant infections can be implemented locally, regionally and internationally. In 2017, the most significant areas of ODA spend were:

- grants to multilateral organisations (WHO, OIE, FAO and South Centre);
- launch of the Global Burden of Disease project – a new collaboration with the Institute for Health Metrics and Evaluation to collect and share data on the burden of morbidity and mortality caused by AMR;
- management agent and evaluation supplier costs; and
- project activities, including secondments, technical advice and events.

Vaccines Network - This project is focused on targeted investments in the most promising vaccines and vaccine technologies that will help combat the world's deadliest diseases. In 2017, the most significant areas of spend were:

- 38 pre-clinical and 12 clinical stage vaccine development projects, funded through three Small Business Research Initiative (SBRI) competitions managed by Innovate UK; and
- 6 clinical-stage vaccine development projects, funded through a BBSRC/MRC Intramural Centre competition and managed by NIHR (NETSCC).

UK Public Health Rapid Support Team (UKPHRST) - This project is a DHSC funded partnership between Public Health England (PHE) and the London School of Hygiene and Tropical Medicine (LSHTM). It consists of a rapidly deployable team of public health specialists who investigate significant disease outbreaks in LMICs at the request of the country. The deployment includes capacity building in the LMICs and a research element. In 2017 the UKPHRST deployed to Ethiopia for an outbreak of watery diarrhoea, Nigeria to tackle meningitis, Madagascar with an outbreak of pneumonic plague, Sierra Leone to tackle water borne disease and Bangladesh with diphtheria outbreak in a population of displaced people.

International Health Regulations (IHR) - This project, funded by DHSC and run by PHE, aims to improve IHR compliance in LMICs through specific work in five countries – Sierra Leone, Pakistan, Bangladesh, Myanmar and Ethiopia - through wider local regional structures. In 2017 payments were made to PHE to complete the design phase and to commence delivery of the implementation phase of this project.

Global AMR Innovation Fund (GAMRIF) – this project is focused on developing new international research and development partnerships to develop new One Health solutions to AMR, for the benefit of people in LMICs. In 2017, expenditure related to Innovate UK and the British Embassy Beijing for the cost of establishing and launching the UK-China AMR Innovation Collaboration.

ODA admin – Programme team and legal costs.

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 low and middle income countries (LMICs).

Funding through ODA spend, the FCTC 2030 five year project is now in its second year, and is directly supporting the implementation of the WHO Framework Convention on Tobacco Control

in 15 LMICs. This support will help 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 has received praise from the countries participating, the global public health and development communities, and helped raise the UK's profile as global leaders in tobacco control and strengthens its global reach. In 2017 (year two of the project), the most significant areas of ODA spend were related to:

- Delivering key objectives in accordance with the agreed FCTC 2030 year 2 work programme.
- Supporting the selected 15 countries in developing and approving their tobacco control plans to commence in year three of the project.

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 Foreign and Commonwealth Office in accordance with the UN Charter and UK membership obligations. The Department of Health and Social Care has funded the first twelve months of refugee healthcare costs following their arrival in the UK. These are the estimated healthcare costs of refugees classified as 'Section 95' by the Home Office.

In support of the UK Aid Strategy, **Global Health Research** assistance has delivered the development of new knowledge that promises to improve health by addressing the major causes of mortality or morbidity in LMICs.

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.

Annex F – Our Arm's Length Bodies and Delivery Partners

Our Executive Agencies

Public Health England (PHE) provides national leadership and expert services to support locally-led public health initiatives and to respond to health protection emergencies. PHE works alongside local government, the NHS and other key partners, supporting the development of the public health workforce, jointly appointing local authority directors of public health, supporting excellence in public health practice and providing a national voice for the profession.

The **Medicines and Healthcare products Regulatory Agency (MHRA)** operates as a trading fund, whose mission is to enhance and safeguard the health of the public by ensuring that medicines and medical devices work and are acceptably safe. It does this by protecting public health through regulation, promotion of public health and improving public health by encouraging and facilitating developments in products.

Our Executive non-Departmental Public Bodies

NHS Commissioning Board (known as NHS England (NHSE))

NHS England sets the framework for commissioning of healthcare services in England. It funds Clinical Commissioning Groups (CCGs), which are responsible for commissioning services for their communities and ensures that CCGs do this effectively. NHSE also commissions some services nationally. Working with leading health specialists, NHSE brings together expertise to ensure national standards are consistently in place across the country.

Monitor

Monitor remains a legal entity, however from 1 April 2016 Monitor, along with the NHS Trust Development Authority has operated as a single organisation, **NHS Improvement (NHSI)** under a shared executive leadership and Board membership.

Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care providers in England. It ensures that only those providers who have made a legal declaration to meet the 'fundamental standards of quality and safety' and satisfy the registration process may provide care. Once services are registered, CQC monitors and inspects them against the fundamental standards.

National Institute for Health and Care Excellence (NICE)

NICE provides guidance, standards and information to help health, public health and social care professionals deliver the best possible care based on the best available evidence.

NHS Digital (NHSD)

NHSD (formerly known as the NHS Health and Social Care Information Centre), collects, analyses and publishes national data and statistical information. It also delivers the national IT systems and services to support the health and care system.

Human Fertilisation and Embryology Authority (HFEA)

The HFEA is the UK's independent regulator of treatment using gametes embryos and embryo research. It sets standards for, and issues licences to, UK fertility clinics and all UK research involving human embryos. It also determines the policy framework for fertility issues.

Human Tissue Authority (HTA)

HTA regulates and ensures that human tissue is used safely and ethically with proper consent. It regulates organisations that remove, store and use tissue for a variety of purposes.

Health Research Authority (HRA)

The HRA promotes and protects the interests of patients and the public in health and social care research. It protects patients and the public from unethical research, while enabling them to benefit from participating in research by simplifying the processes for ethical research.

Health Education England (HEE)

HEE is the national leadership organisation for ensuring that the education, training and development of the healthcare workforce support the highest quality public health and patient outcomes.

NHS Improvement (NHSI)[140]

NHSI is the operational name for the organisation that brings together Monitor and NHS Trust Development Authority, with a shared executive leadership and is responsible for overseeing NHS Foundation Trusts, NHS Trusts and independent providers. NHSI supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, helping the NHS to meet its short-term challenges and secure its future.

Our Special Health Authorities

NHS Counter Fraud Authority (NHSCFA)

From 1 November 2017, the NHSCFA became a new special health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group. As a special health authority focused entirely on counter fraud work, the NHSCFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care.

NHS Trust Development Authority (NHSTDA)

The NHS TDA remains a legal entity, however from 1 April 2016, along with Monitor has operated as a single organisation, **NHS Improvement (NHSI)** under a shared executive leadership and Board membership.

NHS Business Services Authority (NHSBSA)

The NHSBSA provides a range of critical business support services to NHS organisations, NHS contractors, patients and the public. Its services include payments to community pharmacists and dentists for their NHS work, the administration of the NHS pension scheme, administration of European Health Insurance Card scheme, the administration of the England Infected Blood Support scheme, managing the social work bursaries scheme in England and the management of NHS Supply Chain.

NHS Resolution (NHSR)

NHSR provides indemnity cover for negligence claims against the NHS in England on behalf of member organisations and helps the NHS learn lessons from claims to improve patient and staff

[140] NHSI is the operational name for Monitor and NHS TDA, it does not have formal entity status.

safety. It also helps to resolve concerns about the professional practice of doctors, dentists and pharmacists and is responsible for the resolution of appeals and disputes between primary care contractors and NHS England. NHS Resolution was previously known as the **NHS Litigation Authority (NHSLA)**. On 1 April 2017 it became known as NHSR with a stronger focus on prevention, learning and early intervention in incidents.

Other bodies included within the Departmental Group

NHS Property Services Ltd (NHSPS)

NHSPS is a limited company, wholly owned by the Secretary of State for Health and Social Care. NHSPS provides strategic and operational management of NHS estates, property and facilities.

Community Health Partnerships Ltd (CHP)

CHP is a limited company wholly owned by the Secretary of State for Health and Social Care. It was established in 2001 to implement the NHS Local Improvement Finance Trusts (LIFT) programme. It inherited the LIFT shareholdings and property interests previously held by PCTs. From 1 April 2013 the company is included within the DHSC accounting boundary (having previously been held as an investment by DHSC). CHP facilitates public-private partnerships to deliver a wide range of health planning and estate services, to support health providers and local authorities achieve improvements in the estate.

Genomics England Ltd

Genomics England is a limited company, wholly owned by the Secretary of State for Health and Social Care, set up to deliver the 100,000 Genomes Project. Genomics England will manage contracts for specialist UK based companies, universities and hospitals to supply services on sequencing, data linkage and analysis. It will also strictly manage secure storage of personal data in accordance with existing NHS rules, designed to securely protect patient information. Genomics England is funded by the Department of Health and Social Care in the medium term.

Skipton Fund Ltd

The Skipton Fund was established by the Department of Health and Social Care on behalf of the Secretary of State for Health and Social Care to administer an ex gratia payment scheme and make payments to relevant claimants on behalf of UK health administrations, to people who were infected with hepatitis C through treatment with NHS blood or blood products prior to September 1991 and other eligible persons.

Nursing & Midwifery Council (NMC)

The NMC is the independent nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland and accountable to Parliament through the Privy Council. The NMC works to (1) protect, promote and maintain the health, safety and well-being of the public, (2) promote and maintain public confidence in the nursing and midwifery professions and (3) promote and maintain proper professional standards and conduct for members of the nursing and midwifery professions. The NMC regulatory responsibilities are to (1) keep a register of all nurses and midwives who meet the requirements for registration, (2) set standards of education, training, conduct and performance so that nurses and midwives are able to deliver high-quality healthcare consistently throughout their careers and (3) take action to deal with individuals whose integrity or ability to provide safe care is questioned, so that the public can have confidence in the quality and standards of care provided by nurses and midwives.

Health & Care Professions Council (HCPC)

The HCPC is the independent regulator of 15 health and care professions in the UK, and for social workers in England. The HCPC is accountable to Parliament through the Privy Council. The HCPC works to safeguard the health and well-being of persons using or needing the services of its registrants. To fulfil this public protection role, the HCPC (1) sets standards for the education and training, professional skills, conduct, performance and ethics of registrants, (2) keeps a register of professionals who meet those standards, (3) approves programmes which professionals must complete before they can register and (4) takes action when professionals on its register do not meet its standards.

Professional Standards Authority (PSA)

PSA is accountable to Parliament and carries out a range of activities to promote the health and well-being of patients, service users and the public in relation to the regulation of health and social care professionals. The PSA has duties and powers in relation to (1) oversight of nine statutory bodies that regulate health and social care professionals in the UK, (2) provision of advice to, and undertaking investigations for, government, (3) accreditation of the voluntary registers held by non-statutory regulators of health and care professionals and (4) provision of advice to other similar organisations in the UK and overseas.

Other bodies not included in this Annual Report and Accounts

NHS Blood and Transplant (NHSBT)

NHSBT is responsible for the supply of blood, organs, tissues and stem cells. It manages the voluntary donation and processing of around two million units of blood per year, as well as organ and tissue donations.

Medicines and Healthcare products Regulatory Agency (MHRA)

The role of the MHRA is described at the start of Annex F.

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