Presented pursuant to the Government Resources and Accounts Act 2000 c.20 s.6

Department of Health

Resource Accounts 2005-06

(For the year ended 31 March 2006)

Ordered by the House of Commons to be printed
6 November 2006

LONDON: The Stationery Office
HC 1680

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Contents

Annual Report

Scope

Financial Statements

1. These accounts cover the period 1 April 2005 to 31 March 2006 and have been prepared in accordance with a direction issued by Her Majesty's Treasury (HMT) under Section 7 of the Government Resources and Accounts Act 2000. A copy of the direction may be accessed online on the Treasury website at www.hm-treasury.gov.uk. The financial statements are audited by the Comptroller and Auditor General (C&AG).

2. The financial statements have been prepared in accordance with HMT Financial Reporting Manual (FReM). For 2005-06 FReM introduced a number of modifications to the presentation and format of the financial statements of which the main changes are revised Operating Cost Statement and Cash Flow Statement formats, and additional notes to the accounts.

Departmental accounting boundary

3. These accounts consolidate the financial information within the Departmental Accounting Boundary which includes the parent Department of Health (DH), its on-Vote Executive Agency, and other NHS bodies funded directly by the Department.

4. More information on entities within the departmental family can be found in the annual reports and accounts of the Executive Agency or in the individual and summarised accounts of NHS Trusts, Foundation Trusts, Strategic Health Authorities, Special Health Authorities and Primary Care Trusts which are published separately.

5. NHS Estates, the Medicines and Healthcare products Regulatory Agency, NHS Trusts, Foundation Trusts and all of the Department's Non-Departmental Public Bodies results are included in Resource Budgeting but as they are outside of the Resource Accounting boundary, they are not included in this account. NHS Trusts and those Special Health Authorities that receive their funding from "trading" activities e.g. National Blood Authority and NHS Logistics Authority, produce income and expenditure accounts. Note 37 provides a comprehensive list of the Health bodies, which are inside and outside of the Resource Accounting Boundary.

6. A further 7 NHS trusts moved to NHS foundation trust status. NHS foundation trusts are not subject to direction by the Secretary of State for Health but they are subject to directions from the NHS foundation trust regulator with the approval of Treasury and are accountable to their local community.

Departmental reporting cycle

Departmental Report

7. The Departmental Report is an accountability document which presents the Government's spending plans and achievements to Parliament and the wider public. As such, it is a major statement of Government policy and the primary source of information about public spending programmes and initiatives.

8. It is produced annually around May and contains a wide range of information about our spending programmes.

9. This report provides Parliament and the public with an account of how the Department of Health has spent the resources allocated to it, as well as its future spending plans. It also describes our policies and programmes and gives a breakdown of spending within these programmes.

Autumn Performance Report

10. Following on from the Departmental Report, the Autumn Performance Report is usually published in November/December and provides a further update to the progress against the Public Service Agreement targets that are set out in Section 2 of the main Departmental Report. Publication dates are agreed with HM Treasury.

11. The Departmental and Autumn Performance Reports can be found at www.dh.gov.uk/PublicationsAndStatistics.

Parliamentary Estimates

12. All resources and cash reported in the Resource Account must be approved by Parliament through the Central Government Supply Estimates for the year.

13. Expenditure plans and total cash requirements are presented to Parliament at the start of the financial year in the Main Supply Estimates. Subject to Parliament's agreement, the Estimates may be amended during the year at one of the Supplementary Estimates stages (Summer Supply, Winter Supply and Spring Supply). Typically such amendments result from planned changes in the total resources (e.g. transfers to and from other government Departments or the take up of end year flexibility) or the re-attribution of expenditure within the overall Estimate.

14. Central Government Supply Estimates are published by HM Treasury. They are available from The Stationery Office (TSO).

Management Commentary

15. This section is intended to meet the requirements of the Accounting Standards Board's statement "Operating and financial review", albeit in a public sector context.

Aims and Objectives

16. The Department of Health's overall aim is to improve the health and wellbeing of the population of England. The Departmental Report sets out the following objectives set by Ministers to:

- improve and protect the health of the population, with special attention to the needs of the poorest and those with long term conditions;
- enhance the quality and safety of services for patients and users, giving them faster access to services, and more choice and control;
- deliver a better experience for patients and users;
- improve the capacity, capability and efficiency of the health and social care systems, ensuring that system reform, service modernisation, IT investment and new staff contracts deliver improved value for money and higher quality;
- improve the service we provide as a Department of State to – and on behalf of – Ministers and the public, nationally and internationally; and
- become more capable and efficient as a Department and cement our reputation as an organisation that is both a good place to do business with and a good place to work.

17. These objectives relate specifically to 2005-06. The Consolidated Statement of Operating Costs by Departmental Aim and Objectives uses objectives set within the Spending Review 2004, which covers the period 2005-06 to 2007-08 to allow comparability between financial years.

Principal activities

18. The Department of Health sets overall policy on all health issues, including public health matters and the health consequences of environmental and food issues. It is also responsible for the provision of health services, a function which it discharges through the National Health Service (NHS), The NHS includes independent contractors such as general medical practioners (GPs), dentists, pharmacists and opticians.

19. The Department is also responsible for the overall policy for the delivery of personal social services (PSS) and provides advice and guidance to local authorities. The PSS programme is financed in part by Central Government through grants and credit approvals. Most local authority PSS expenditure depends upon decisions by individual local authorities on how to spend the resources available to them.

Spending Review and Activity

20. NHS funding will increase by an average of 7.1 per cent a year over and above inflation for the three-year period of the 2004 spending review (2005-06 to 2007-08). This will take NHS expenditure from £69,300 million in 2004-05 to £92,000 million in 2007-08. It is not expected the NHS will receive such increased funding in subsequent years.

21. The NHS, including bodies not included in the Resource Accounts, is financed mainly through general taxation with an element coming from National Insurance contributions. In 2005-06, 95.7% of financing for the NHS in England was met from these two sources, 77.9% from the Consolidated Fund, that is, from general taxation and 17.8% from the NHS element of National Insurance Contributions.

Financial Results

22. The overall spending approved by Parliament in 2005-06 and the outturn against provision for all types of expenditure was as follows:

Expenditure type	Provision	Outturn	(Under) spend
	£'000	£'000	£'000
Request for Resources 1	59,554,494	59,142,660	(411,834)
Securing health care for those who need it.			
Request for Resources 2	3,537,170	3,365,716	(171,454)
Securing social care and child protection for those who need it and at national level, protecting, promoting and improving the nation's health.			
Request for Resources 3	17,800	17,543	(257)
Office of the Independent Regulator for NHS Foundation Trusts			
Total Resources	**63,109,464**	**62,525,919**	**(583,545)**

23. The amounts voted in estimates exclude the surplus or deficits of NHS Trusts, the performance of NDPBs outside the resource accounting boundary (listed in note 37) and other expenditure which is not voted.

24. The Statement of Parliamentary Supply shows the net expenditure and income i.e. total resources spent by the Department compared with the net spending authorised by Parliament was £583m less than approved, i.e. that the total resources of the Department was £62,526m compared to the vote estimate of £63,109m.

25. The net total resources of £62,526m for 2005-06 whilst broadly in line with the agreed budget showed an increase of £8,747m over 2004-05 total resources. This increase is almost all attributable to increased net expenditure in Request for Resources 1, whilst both Request for Resources 2 and 3 were almost the same as last year's net expenditure and budget. The increase in Request for Resources 1 is due to increased expenditure incurred by Primary Care Trusts, increases in provisions and a fall in income.

- Primary Care Trusts show an increase in expenditure on primary and secondary healthcare commission of £1,554m and £3,467m respectively.This illustrates the Department's programme of devolved responsibility to the NHS which is now enjoying more autonomy with 83 % of the total NHS budget being controlled by Primary Care Trusts and the Government's continued commitment to deliver better quality care for the whole population.

- The increase in provisions of £2,395m was due to a change in the Treasury discount rate, the rate used to calculate the net present value of payments in future years, from 3.5% to 2.2% on the 1st April 2005, £777m, and the figures for the 2004-05 comparative included a credit of £1,486m due to a recalculation of prior year provisions.

- Government financing from National Insurance contributions is recorded as income. In 2005-06 the NI contributions were £14,256m compared to £15,134m in the previous year, a reduction of £878m.

26. The Balance Sheet shows increased net assets of £218m. This net increase comprises two elements, an increase in fixed assets of £2,042m which is almost offset by an increase in provisions of £1,418m. The increase in provision is mainly due to the change of discount rate refered to above.

27. The increase in fixed assets is due to increased investments in Trusts, £1,421m, further Departmental capital expenditure on the National Programme for IT, £360m, and the implementation of the Credit Guarantee Finance (CGF) scheme, £329m.

28. CGF is a loan, guaranteed by banks, monolines or other acceptable financial institutions, from the sponsoring department to a PFI project Special Purpose Vehicle on 'market' terms. The CGF undertaken by the Department are pilots at two NHS PFI projects – Leeds and Portsmouth. Other than the pilots, the Department will not be undertaking any further CGF loans as Treasury intend to develop the specific powers which will enable them to lend directly to the private sector should the pilots be successful.

29. The Department is subject to an additional control of its overall controllable expenditure Department Expenditure Limit (DEL). This includes all the bodies included in this account plus other Arm's Length Bodies. The Department has not yet received the accounts for all the Arm's Length Bodies but provisionally has overspent its 2005-06 DEL by £51 million, 0.1% of its expenditure.

Resources by Programme Budget Categories for the year ended 31 March 2006

30. The Government Financial Reporting Manual requires a Statement of Operating Costs by Departmental Aim and Objectives.

31. The Department of Health's overall aim is to improve the health and wellbeing of the people of England through the resources available to prevent/treat:

		2005-06		2004-05
	Gross	Income	Net	Net
	£'000	£'000	£'000	£'000
Mental Health Problems (Total) of which	8,538,755	322,834	8,215,921	7,588,127
Mental Health Sub Group: Substance Abuse	756,974	28,640	728,334	609,352
Mental Health Sub Group: Dementia	855,104	27,017	828,087	811,658
Mental Health Sub Group: Other	6,926,677	267,176	6,659,501	6,167,117
Circulation Problems (CHD)	6,361,965	227,900	6,134,065	5,953,869
Cancers & Tumours	4,302,656	130,046	4,172,610	3,670,133
Trauma & Injuries (includes burns)	3,853,415	101,034	3,752,381	3,496,667
Musculo Skeletal System Problems (excludes Trauma)	3,768,838	105,771	3,663,067	3,473,882
Gastro Intestinal System Problems	3,973,450	102,260	3,871,190	3,433,018
Genito Urinary System Disorders (except infertility)	3,507,715	112,215	3,395,500	3,011,712
Respiratory System Problems	3,468,754	104,405	3,364,349	2,978,795
Maternity & Reproductive Health	2,929,764	59,190	2,870,574	2,565,581
Dental Problems	2,759,703	343,735	2,415,968	1,975,957
Learning Disability Problems	2,595,671	116,961	2,478,710	2,257,026
Neurological System Problems	2,120,334	71,504	2,048,830	1,719,629
Infectious Diseases	1,257,698	46,971	1,210,727	1,520,276
Social Care Needs	1,744,998	96,844	1,648,154	1,517,621
Endocrine, Nutritional and Metabolic Problems (Total) of which	1,895,306	79,831	1,815,475	1,527,816
Endocrine Sub-group: Diabetes	866,000	37,020	828,980	655,599
Endocrine Sub-group: Other	1,029,306	42,811	986,495	872,217
Eye/Vision Problems	1,356,043	27,499	1,328,544	1,277,600
Skin Problems	1,334,858	40,951	1,293,907	1,177,037
Healthy Individuals	1,340,573	53,598	1,286,975	1,113,067
Blood Disorders	1,051,290	53,667	997,623	904,702
Neonate Conditions	786,390	36,954	749,436	743,944
Poisoning	707,623	15,882	691,741	586,153
Hearing Problems	321,811	10,432	311,379	308,795
Other Areas of Spend/Conditions:				
• General Medical Services/Personal Medical Services	7,308,435	186,057	7,122,378	6,219,406
• Strategic Health Authorities (inc WDCs)	3,818,412	479,131	3,339,281	3,537,180
• National Insurance Contribution	–	14,255,599	(14,255,599)	(15,133,971)
• Miscellaneous	9,080,784	478,591	8,602,193	6,353,837
Net Operating Cost	**80,185,241**	**17,659,861**	**62,525,380**	**53,777,859**

32. The analysis contained in the Statement of Operating Costs by Departmental Aim and Objectives is a calculation which uses the latest available activity indicative provider costs (reference costs), 2004-05, and prescribing information as the basis for apportioning the totality of NHS/Department spend across various programme budget categories. The analysis was based on a "bottom up" approach. PCTs allocated/ apportioned their spend at the local level and reported the results to the Department. The Statement of Operating Costs by Departmental Aim and Objectives is an aggregate of these returns.

33. The increase in total NHS dental expenditure (22%) reflects a combination of factors:

- a drive to improve access to primary dental care through recruiting the equivalent of over 1400 additional dentists to provide NHS services;
- the recovery of relatively less patient charge income, leading to higher net costs, because the former patient charge system was ill-adapted to the new ways of working observed in PDS pilots; and
- a one-off cost in accounting for the closure of the former General Dental Service arrangements on 31 March 2006 prior to the introduction of a local commissioning framework for all primary dental care services from 1 April 2006.

Management

34. The Department is headed by a team of Ministers, supported by officials, the most senior of whom is the Permanent Secretary who is also the Chief Executive of the NHS. The Permanent Secretary is the Accounting Officer for the Department and for the NHS, and appoints the Chief Executives of the Department's Executive Agency and Special Health Authorities as Accounting Officers for their respective bodies, and Chief Executives of PCTs and Strategic Health Authorities as Accountable Officers.

Ministers

35. The following Ministers were responsible for the Department during 2005-06:

Secretary of State for Health with overall responsibility for the work of the Department:

- The Right Honourable John Reid MP to 6 May 2005
- Rt Hon Patricia Hewitt MP Secretary of State from 6 May 2005

Ministers of State with responsibilities for the NHS, and Social Care, including long term care, disability and mental health:

- Lord Warner Minister of State from 10 May 2005
- Rosie Winterton MP Minister of State continuous
- Rt Hon Jane Kennedy MP Minister of State from 10 May 2005

Parliamentary Under Secretary (Lords) with responsibilities including Departmental management:

- Lord Warner to 10 May 2005

Parliamentary Under Secretaries (Commons) with responsibility for Health and Public Health:

- Melanie Jonson MP to 10 May 2005
- Stephen Ladyman MP to 10 May 2005
- Caroline Flint MP from 10 May 2005
- Liam Byrne MP from 10 May 2005

Officials

The Departmental Management Board

36. During 2005-06 the Department comprised three groups, dealing with various aspects of the organisation's work (Health & Social Care Standards and Quality of Public Health and Care Services, Health & Social Care Delivery and Performance in the NHS, and Business Development). Group Directors report to the Chief Executive/Permanent Secretary.

37. The following senior officials served on the Departmental Management Board in 2005-06:

Sir Nigel Crisp, Permanent Secretary and Chief Executive of the NHS
Professor Sir Liam Donaldson, Chief Medical Officer, and Director of Health & Social Care Standards & Quality Group
John Bacon, Director of Health and Social Care Services Delivery Group
Hugh Taylor, Director of Health and Social Care Strategy and Business Development Group
Stephen O'Brien, Director of Strategy to 12 January 2006.
Sian Jarvis, Director of Communications, to 11 December 2005
Matt Tee, Interim Director General Communications, from 12 December 2005
Richard Douglas, Director of Finance and Investment
Christine Beasley, Chief Nursing Officer, and Director of Patient and Public Involvement
Derek Myers, non-executive director from 8 September 2005
Julie Baddeley, non-executive director from 8 September 2005

38. Following a high level structural review the following additional officials joined the Departmental Management Board in February 2006:

Sir Ian Carruthers, Acting Director of Commissioning
Bill McCarthy, Acting Director of Policy and Strategy
Andrew Foster, Director of Workforce
Duncan Selbie, Director of Performance
Margaret Edwards, Director of Access
Ken Anderson, Commercial Director
Richard Granger, Director General Connecting for Health/NHS IT

Appointment of senior officials

39. Senior Civil Servants, including the Permanent Secretary and the Departmental Management Board members are appointed in accordance with the Department's Procedures, the Civil Service Commissioner's Recruitment Code and the Guidance on Civil Service Commissioner's Recruitment to Senior Posts.

How remuneration of Ministers and senior officials is determined

40. Ministers' remuneration is set by the Ministerial and Other Salaries Act 1975 (as amended by the Ministerial and Other Salaries Order 1996) and the Ministerial and Other Pensions and Salaries Act 1991.

41. The majority of Senior Civil Servants in the Department, including the Permanent Secretary and Departmental Board members, are paid in accordance with the Senior Civil Service pay system, which is determined centrally. A minority of Senior Civil Servants in the Department are on NHS pay terms.

Remuneration of Ministers and senior officials

42. Details of remuneration of Ministers and senior officials are given in the Remuneration Report.

Events since the year end

43. In July 2005 the Department announced Improvements in commissioning, the determination to make progress on working with Local Authorities on Choosing Health, and the commitment to make £250 million of savings in overhead costs, this required NHS organisations to change and develop.

44. Following consultations, legislation has now passed to reduce the number of Strategic Health Authorities from 28 to 10 from 1 July 2006 and the number of PCTs from 303 to 152 from 2006.

Ministerial changes

45. Following a Government reorganisation in May the following new Ministers were appointed:

Ministers of State

– Andy Burnham MP replaced Rt Hon Jane Kennedy MP

– Caroline Flint MP became a Minister of State

Parliamentary Under-Secretaries of State

– Ivan Lewis MP replaced Liam Byrne MP

Management changes

46. On the 31st of March 2006 Sir Nigel Crisp, permanent secretary and chief executive of the NHS, retired. On 1 April 2006 he was replaced as acting chief executive of the NHS by Sir Ian Carruthers and as acting permanent secretary by Hugh Taylor. At 1 September David Nicholson became the chief executive of the NHS.

47. Mike Wheeler, non-executive director, joined the Departmental Management Board on 8 June 2006.

Public Interest and Other

Employment of Disabled Persons policy

48. The Department of Health is committed to the employment and career development of disabled people. Selection to posts is based upon the ability of the individual to do the job using a competence based selection system. The Department operates the Guaranteed Interview Scheme, which guarantees an interview to anyone with a disability whose application meets the minimum criteria for the post. Once in post disabled staff are provided with any reasonable support they might need to carry out their duties.

Equal Opportunities policy

49. The Department of Health 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 no employee or job applicant is discriminated against either directly or indirectly on such grounds as race, colour, ethnic or national origin, sex, marital status, responsibility for children or other dependants, disability, age, work pattern, sexual orientation, gender reassignment, Trade Union membership or activity, religious or political beliefs. Line managers are responsible for promoting equal opportunities within their own work teams and for ensuring business compliance with equal opportunities legislation. Support is provided by the HR units in the Department's Group Business Teams.

Payment of Suppliers

50. The Department complies with the CBI prompt payment code and the British Standard on prompt payment. The Department's policy is to pay bills in accordance with agreed contractual conditions or, where no such conditions exist, within thirty days. In 2005-06 the core Department paid 96 per cent of bills (2004-05 93 per cent), 293,896 invoices (2004-05 267,399), in accordance with the policy. The prompt payment performance of other members of the departmental family can be found in their published annual accounts.

External auditor

51. The resource accounts have been prepared under a direction issued by HM Treasury in accordance with the Government Resources and Accounts Act 2000 and are subject to audit by the Comptroller and Auditor General. As far as the Accounting Officer is aware, there is no relevant audit information of which the Department's auditors are unaware, and the Accounting Officer has taken all the steps that he ought to have taken to make him aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

Provision of Information to, and Consultation with, Employees

52. The Department has a series of communication channels in place to communicate organisational and business developments to staff, and to provide an opportunity for feedback, both at a corporate and local level. The channels used range from timely electronic communications to face-to-face briefings by Departmental Management Board members and the department's Senior Leadership Team to involve all staff. The Department also works in partnership with the Departmental Trade Unions to agree the full range of qualitative and quantitative consultation mechanisms necessary to build engagement in senior decision making.

Details of Company Directorships and other significant interests held by the Board

53. Other than those disclosed in note 34 there are no company directorships or significant interests held by Board members.

Hugh Taylor

Acting Permanent Secretary,

Department of Health 26 October 2006

Statement of Principal Accounting Officer's Responsibilities

54. Under the Government Resources and Accounts Act 2000, the Department of Health is required to prepare resource account for each financial year, in conformity with a Treasury direction, detailing the resources acquired, held or disposed of during the year, and the use of resources by the Department during the year.

55. The resource accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Department, the net resource outturn, resources applied to objectives, recognised gains and losses and cash flows for the financial year.

56. HM Treasury has appointed the Permanent Secretary of the Department as principal Accounting Officer of the Department with overall responsibility for preparing the Department's accounts and for transmitting them to the Comptroller and Auditor General.

In preparing the accounts, the Principal Accounting Officer is required to comply with the Financial Reporting Manual, prepared by HM Treasury, and in particular to:

– observe the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

– make judgements and estimates on a reasonable basis;

– state whether applicable accounting standards, as set out in the 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.

57. In addition, the 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. This appointment does not detract from the Permanent Secretary's overall responsibility as Accounting Officer for the Department's accounts.

58. The responsibilities of an Accounting Officer, including the responsibility for the propriety and regularity of the public finances for which an Accounting Officer is answerable, for keeping proper records and for safeguarding the Department's assets, are set out in the Accounting Officer's Memorandum issued by HM Treasury and published in Government Accounting. Under the terms of the Accounting Officer's Memorandum, the relationship between the Department's principal and additional Accounting Officers, together with their respective responsibilities, is set out in a written statement.

Remuneration Report

Departmental Board Members

1. The Departmental Management Board membership increased following a Top Structure Review at the end of February 2006. The information contained in this report refers to Departmental Management Board members both prior to and after this review.

2. Responsibility for Senior Civil Service pay lies with the Minister for the Civil Service. It has not been delegated to Departments. Departments are required to operate within agreed pay band structures and associated pay ranges and target rates detailed in the Senior Salaries Review Body Annual Report. Departments are given discretion in some areas to adapt the system to local needs under the auspices of a Departmental Senior Pay Strategy Committee and to produce an annual senior pay strategy agreed by the Committee. The strategy document sets out how the system operates in DH.

3. Permanent Secretaries salaries are determined by the Cabinet Office. Increase to salary for other Departmental Board Members is determined by the Pay Committees in accordance with the Departmental SCS Pay Strategy. All pay increases are performance related.

4. The Senior Pay Strategy Committee is responsible for setting the Department's strategic approach to SCS pay and producing the yearly Departmental Pay Strategy – operating within the parameters set by the Cabinet Office for the whole of the Senior Civil Service. Because of the size of the SCS in the Department of Health, it is not possible for the Pay Committee itself to make decisions regarding individual pay for the whole Department. The Senior Pay Strategy Committee therefore delegates responsibility for implementing the pay strategy to sub committees who are responsible for assessing, in the light of the strategy, the relative contribution of individual SCS members and making the final pay decisions. Each of the pay sub committees has an independent member whose role it is to ensure consistent application of standards and provide quality assurance to the process. The independent member had no line management responsibility for any of the staff discussed at the individual Pay Committee meeting. In addition, one Pay Committee reviews the decisions of other Pay Committees to ensure consistency across the whole Department at SCS Pay Bands 1 and 2 level.

5. The membership of the main Pay Committee in 2005 was as follows:

Chair: Sir Nigel Crisp (Permanent Secretary/Chief Executive)
Hugh Taylor (Director, Strategy and Business Development)
John Bacon (Group Director, Health and Social Care Delivery Group)
Sir Liam Donaldson (Chief Medical Officer and Director Health and Social Care Standards and Quality Group)
Anne Rainsberry (Head of Corporate HR)
C Marc Taylor (First Division Association)
Kent Woods (Chief Executive, Medicines and Healthcare Products Regulatory Agency)
Linda Smith (Chair, South East London Health Authority)
Susan Thomas (Director-General Corporate Services and Development, DfES)
Secretariat: John Weeks (Corporate HR – SCS Unit)

6. For 2005 pay round there were six sub committees reflecting the organisational structure at the end of the reporting year.

Committee A made decisions in the case of all members of the SCS pay band 3 Departmental Board members (JESP 19-22)

The Committee was chaired by Sir Nigel Crisp. The other members were Sir Liam Donaldson and Linda Smith (an external member of the main Pay Committee).

Committee B made decisions in the case of all SCS staff in pay band 3 who were not DB members Agency Chief Executives. The Committee also ratified the decisions made on pay bands 1 and 2 staff by the Group Business Pay Committees.

The Committee was chaired by Hugh Taylor and the other members were John Bacon, Sir Liam Donaldson, and, as the 'independent' member, Susan Thomas.

Committee C made decisions in the case of all SCS staff in pay bands 1 and 2 in the Health and Social Care Delivery Group, the Modernisation Agency, the Purchasing and Supplies Agency and NHS Estates (except the Chief Executives of the Agencies – Committee B above).

The Committee was chaired by John Bacon. The other members were Margaret Edwards, Director of Access, Richard Douglas, Director of Finance, Andrew Foster, Director of Workforce, Richard Granger, Director of NHS IT, Duncan Selbie, Director of programmes and Performance, Ken Anderson, Commercial Director, Duncan Eaton, Chief Executive of the NHS Purchasing and Supplies Agency and 'independent' member, Hugh Taylor.

Committee D made decisions in the case of all staff in SCS pay bands 1 and 2 in the Health and Social Care Standards and Quality Group.

The Committee was chaired by Sir Liam Donaldson. The other members were Alan Doran, Group Business Director, Fiona Adshead, Deputy Chief Medical Officer, Bill Kirkup, Acting Deputy Chief Medical Officer, Antony Sheehan, Director Care Services, David Harper, Director of Health Protection, International Health and Scientific Development, Sally Davies, Director of Research and Development, and 'independent' member, Hugh Taylor.

Committee E made decisions in the case of all staff in SCS pay bands 1 and 2 in the Strategy and Business Development Group.

The Committee was chaired by Hugh Taylor. The other members were Sian Jarvis, Director of Communications, Christine Beasley, Chief Nursing Officer, Stephen O'Brien, Director of Strategy, and, as the 'independent' member, John Bacon.

Committee F made decisions on staff in Pay Band 1 in the Medicines and Healthcare Products Regulatory Agency.

The Committee was chaired by MHRA Chief Executive Kent Woods and the members were the MHRA Board, supplemented by Hugh Taylor as the 'independent' member. The awards for the MHRA Board members were decided in a separate meeting by Kent Woods and Hugh Taylor.

7. The performance review system used for members of the SCS in the Department of Health has been developed by the Cabinet Office for use throughout the Civil Service. The record of responsibilities and agreed objectives is completed at the start of the performance review year. SCS members complete mid-year development review with line managers. In the mid-year review, SCS members have the opportunity to discuss progress against objectives for the current year, any changes to duties and objectives as well as discussing long-term development. The outcome of the mid-year review is recorded to inform the end of year discussion between SCS members and line managers.

All managers must ensure that they discuss reporting standards with their colleagues before they complete their reports to ensure that relativities are fair, and to be rigorous in this process.

Medical doctors are required to complete a slightly lengthened version of the performance review form that is also used for revalidation purposes.

8. Thirteen of the Departmental Board Members, covered in this report, hold permanent Senior Civil Service contracts. 1 member holds a fixed term contract and another is seconded to the Department. The following table details the date members took up appointment as Permanent Secretary or Director General appointment:

DMB Member	Job Title	Date of Appointment
Sir Nigel Crisp	Permanent Secretary/NHS Chief Executive	1st November 2000
Sir Liam Donaldson	Permanent Secretary/Chief Medical Officer	21st September 1998
Hugh Taylor	Director of Departmental Management	5th February 2001
John Bacon	Director of Delivery	2nd June 2003
Chris Beasley	Chief Nursing Officer	19th October 2004
Stephen O'Brien	Director of Strategy	1st June 2004
Richard Douglas	Director of Finance	1st May 2001
Sian Jarvis	Director of Communications	17th September 2001
Matt Tee *(from 12 December 2005)*	Interim Director of Communications	See section (9)
Bill McCarthy *(from 14 February 2006)*	Acting Director of Policy	1st October 2005
Andrew Foster *(from 14 February 2006)*	Director of Workforce	3rd May 2001
Duncan Selbie *(from 14 February 2006)*	Director of Programmes and Performance	3rd November 2003
Margaret Edwards *(from 14 February 2006)*	Director of Access	7th July 2003
Ken Anderson *(from 14 February 2006)*	Commercial Director	1st July 2003
Richard Granger *(from 14 February 2006)*	Director General of NHS IT	7th October 2002
Sir Ian Carruthers *(from 1 February 2006)*	Acting Director of Commissioning, on secondment from Dorset and Somerset Strategic Health Authority	

9. One Departmental Board Member, Matt Tee, is seconded to the Department. The secondment began on 12th December 2005 and is due to end on 31st August 2006 but may be extended by mutual agreement. The secondment agreement was signed on 18th January 2006. Termination prior to the expiry of the arrangement will normally be subject to 1 month's notice from either party.

10. Another Departmental Board Member, Ken Anderson, holds a fixed term contract. The current contract is due to end on 31st March 2007.

11. Because of the power of the Crown to dismiss at will, Senior Civil Servants are not entitled to a period of notice terminating employment. However, unless the employment is terminated by agreement, in practice, a Senior Civil Service member, holding either a permanent of fixed term contract, will normally be given the following periods of notice in writing terminating their employment:

(i) if retired on age grounds, if dismissed on grounds of inefficiency, or if dismissal is the result of disciplinary proceedings in circumstances where summary dismissal is not justified:

Continuous Service for:

Up to 4 years – 5 weeks

4 years and over – 1 week plus 1 week for every year of continuous service up to a maximum of 13 weeks.

(ii) if retired on medical grounds, the period of notice in (i) above or, if longer, 9 weeks, unless a shorter period is agreed.

(iii) if employment is terminated compulsorily on any other grounds, unless such grounds justify summary dismissal at common law or summary dismissal is the result of disciplinary proceedings – 6 months.

On the expiration of such notice, employment will terminate.

The SCS Member will receive no notice if s/he agrees to flexible or approved early retirement or voluntary redundancy.

If employment is terminated without the notice, which it is stated in, (a) would in practice normally be given, having regard to the reason for such termination, compensation will be paid in accordance with the relevant provisions of the Civil Service Compensation Scheme.

Unless otherwise agreed, the SCS member is required to give a specified period of written notice to line management and copied to the Senior Civil Service Unit if s/he wishes to terminate the employment. This notice period is usually for 3 months, however a different period can be negotiated with line management.

12. The Department of Health's policy on termination payments are outlined in the Civil Service Compensation Scheme.

13. The following section provides details of remuneration interests of Departmental Board Members.

DMB Member	2004 – 2005		2005 – 2006			
	Salary Band £'000	Benefit in Kind – (to the nearest £100)	Salary Band £'000	Benefit in Kind – (to the nearest £100)	Non Cash Remuneration Element	Compensation for Loss of Office
Sir Nigel Crisp	210 – 215	Nil	225 –230	Nil	Nil	*
Sir Liam Donaldson	170 – 175	1200	180 – 185	Nil	Nil	–
Hugh Taylor	130 – 135	Nil	145 – 150	Nil	Nil	–
John Bacon	170 – 175	Nil	210 – 215	Nil	Nil	*
Chris Beasley	125 – 130	Nil	140 – 145	Nil	Nil	–
Stephen O'Brien (to 12 January 2006)	125 – 130	Nil	120–125 (150–155 full year equivalent)	Nil	Nil	–
Richard Douglas	125 – 130	Nil	135 – 140	Nil	Nil	–
Sian Jarvis	130 – 135	Nil	150 – 155	Nil	Nil	–
Matt Tee (from 12 December 2005)	N/A	N/A	35–40 (120–125 full year equivalent)	Nil	Nil	–
Bill McCarthy (from 14 February 2006)	N/A	N/A	10–15 (115–120 full year equivalent)	Nil	Nil	–
Andrew Foster (from 14 February 2006)	N/A	N/A	15–20 (135–140 full year equivalent)	Nil	Nil	–
Duncan Selbie (from 14 February 2006)	N/A	N/A	15–20 (165–170 full year equivalent)	Nil	Nil	–
Margaret Edwards (from February 2006)	N/A	N/A	15–20 (145–150 full year equivalent)	Nil	Nil	–
Ken Anderson (from 14 February 2006)	N/A	N/A	20–25(220–225 full year equivalent)	Nil	Nil	–
Richard Granger (from 14 February 2006)	N/A	N/A	30–35(270–275 full year equivalent)	Nil	Nil	–
Sir Ian Carruthers** *(from 1 February 2006)*	–	–	–	–	–	–

* Compensation for loss of office was provided under the approved Civil Service Scheme
** Acting Director of Commissioning, on secondment from Dorset and Somerset Strategic Health Authority

14. The following section provides details of pension interests of Departmental Board Members.

DMB Member	Real increase in pension	Real increase in lump sum	Pension at End Date	Lump sum at End Date	CETV at Start Date (31/3/2005)	CETV at End Date (31/3/2006)	Employee contributions and transfers in	Real increase in CETV funded by employer
			To nearest £'000		To nearest £'000		To nearest £100	To nearest £100
Sir Nigel Crisp	2.5 – 5	12.5 – 15	65	190 – 195	1,005	1,351	3,100	97,000
Sir Liam Donaldson	2.5 – 5	7.5 – 10	75	220 – 225	1,312	1,682	7,200	66,200
Hugh Taylor	2.5 – 5	10 – 12.5	56	150 – 175	941	1,242	2,000	85,700
John Bacon	5 – 7.5	20 – 22.5	73	220 – 225	1,157	1,579	2,100	153,300
Chris Beasley	2.5 – 5	10 – 12.5	45	125 – 150	889	1,079	2,000	94,800
Stephen O'Brien *(to 12 January 2006)*	0 – 2.5	–	3	–	18	45	2,900	19,500
Richard Douglas	0 – 2.5	5 – 7.5	43	125 – 150	575	780	1,900	32,900
Sian Jarvis	0 – 2.5	2.5 – 5	11	25–50	100	159	1,600	19,600
Matt Tee*	–	–	–	–	–	–	–	–
Bill McCarthy	0 – 2.5	2.5 – 5	23	50 – 75	249	342	179	20,100
Andrew Foster	0 – 2.5	–	8	–	106	135	465	2,700
Duncan Selbie *(from 14 February 2006)*	0 – 2.5	–	6	–	58	79	685	4,200
Margaret Edwards *(from 14 Feb 2006)*	0 – 2.5	0 – 2.5	40	100 – 125	468	602	265	5,400
Ken Anderson *(from 14 February 2006)*	0–2.5	–	5	–	50	67	465	2400
Richard Granger *(from 14 February 2006)*	0–2.5	–	3	–	18	45	2900	19500
Sir Ian Carruthers** (from 1 February 2006)	–	–	–	–	–	–	–	–

* Matt Tee is seconded to the Department. Employer does not contribute to a pension scheme.
** Acting Director of Commissioning, on secondment from Dorset and Somerset Strategic Health Authority

B. MINISTERS

1. Ministers are political appointment made by the Prime Minister – they do not have contracts of employment. Consequently notice periods and termination periods do not apply. Ministers do receive a flat-rate compensation payment for loss of office of three month's salary.

2.The following Ministers were in post during 2005/06 financial year:

April 05 – May 05:

Minister		**Date Appointed**
Rt Hon Dr John Reid MP	Secretary of State	1-May-01
Rt Hon John Hutton MP	Minister of State	11-Oct-99
Rosie Winterton MP	Minister of State	14-Jun-03
Lord Warner	Parliamentary Under Secretary	14-Jun-03
Melanie Johnson MP	Parliamentary Under Secretary	14-Jun-03
Dr Stephen Ladyman MP	Parliamentary Under Secretary	14-Jun-03

May 05 – March 06:

Rt Hon Patricia Hewitt MP	Secretary of State	6-May-05
Lord Warner	Minister of State	10-May-05
Rosie Winterton MP	Minister of State	Continuous
Rt Hon Jane Kennedy MP	Minister of State	10-May-05
Caroline Flint MP	Parliamentary Under Secretary	10-May-05
Liam Byrne MP	Parliamentary Under Secretary	10-May-05

3. There is no provision for compensation for early termination. Compensation for loss of office is payable to former Ministers at the flat-rate of three month's salary. This is set out in legislation rather than an approved Compensation Scheme. There is no other liability in the event of early termination.

4. The following section provides details of remuneration interests of Ministers.

Minister	Salary 2005-2006	Benefit in Kind – (to the nearest £100)	Salary 2004-2005	Benefit in Kind – (to the nearest £100)	Non Cash Remuneration Element	Compensation for Loss of Office
John Reid Secretary of State *(to 8 May 2005)*	£12,484	Nil	£72,862	Nil	N/A	N/A
John Hutton Minister of State *(to 8 May 2005)*	£6,476	Nil	£37,796	Nil	N/A	N/A
Rosie Winterton Minister of State	£38,854	Nil	£37,796	Nil	N/A	N/A
Lord Warner Minister of State	£79,855	Nil	£68,829	Nil	N/A	N/A
Melanie Johnson Parliamentary Under Secretary *(to 6 May 2005)*	£4,915	Nil	£28,688	Nil	N/A	£9,714
Stephen Ladyman Parliamentary Under Secretary *(to 9 May 2005)*	£4,915	Nil	£28,688	Nil	N/A	N/A
Patricia Hewitt Secretary of State *(to 6 May 2005)*	£67,653*	Nil	N/A	Nil	N/A	N/A
Jane Kennedy Minister of State *(from 10 May 2005)*	£32,378	Nil	N/A	Nil	N/A	N/A
Caroline Flint Parliamentary Under Secretary *(from 10 May 2005)*	£22,118	Nil	N/A	Nil	N/A	N/A
Liam Byrne Parliamentary Under Secretary *(from 10 May 2005)*	£26,320	Nil	N/A	Nil	N/A	N/A

* NB – These costs reflect Patricia Hewitt's salary with the Department of Health with effect from 6th May 2006 even though DTI continued to meet the costs until 30th June 2006.

5. The following section provides details of pension interests of Ministers.

Name	Real increase in pension	Pension at End Date	CETV at Start Date (31/3/2005)	CETV at End Date (31/3/2006)	Minister's contributions and transfers in	Real increase in CETV funded by employer
	£	£ '000	£'000	£'000	£	£
Melanie Johnson *(to 6 May 2005)*	73	2.5 – 5	35	35	293	382
Stephen Ladyman *(to 9 May 2005)*	103	0 – 2.5	13	15	418	652
John Reid *(to 8 May 2005)*	181	10 – 12.5	138	141	725	2,592
John Hutton *(to 8 May 2005)*	115	5 – 7.5	51	54	463	670
Liam Byrne *(from 10 May 2005)*	658	0 – 2.5	–	4	2,632	1,587
Caroline Flint *(from 10 May 2005)*	658	0 – 2.5	11	16	2,632	2,586
Patricia Hewitt *(from 6 May 2005)*	1,054	7.5 - 10	90	105	4,200	7,587
Jane Kennedy *(from 10 May 2005)*	868	5 – 7.5	52	61	3,468	4,240
Lord Norman Warner	1,988	5 – 7.5	36	60	7,938	15,408
Rosie Winterton	974	2.5 - 5	25	35	3,885	4,453

NON EXECUTIVE DIRECTORS

1. The Department of Health appointed two Non-Executive Directors to the Management Board for the first time in 2005. Guidance about the reimbursement for Non-Executive Directors is available from Cabinet Office and reimbursement ranges from simply reimbursing expenses to significant payments for quite substantial roles.

2. Non-Executive Directors are not employees of the Department of Health. Both Non-Executive Directors are appointed for a fixed term of three years with the possibility of extension. They are appointed to attend Departmental Board meetings which involve an estimated time commitment of eleven four hour meetings and two overnight events per year.

3. Either party may terminate the contract for any reason before the expiry of the fixed period by giving one month's notice in writing. There is no provision for compensation for early termination.

4. Derek Myers is not personally reimbursed for his role as a Non-Executive Director. His employer is reimbursed for £500 for every day worked. Julie Baddeley receives a fee of £2,000 per day.

5. Non-Executive Directors fees are not pensionable.

Hugh Taylor
Acting Permanent Secretary,
Department of Health 26 October 2006

RELATIONSHIP BETWEEN ACCOUNTING OFFICERS IN THE DEPARTMENT OF HEALTH, ITS AGENCIES AND THE NHS

1. This note sets out the nature of the relationship between Accounting Officers in the Department of Health, its Agencies and the NHS. It refers to the Accounting Officer Memorandum published by HM Treasury, in which paragraph 18 indicates that responsibilities within a Department may vary according to the needs of the Department.

2. The Permanent Secretary of the Department of Health is accountable for the Department's administration, some central health and miscellaneous health services, those elements of social services expenditure within the Department's responsibilities, Welfare Foods and European Economic Area (EEA) medical costs. These are covered by the Request for Resources 2 in the Department's Estimates and Accounts. As Head of the Department, he takes responsibility for the consolidation of the Department's Accounts and for the voted cash requirement, and has the Department-wide responsibility for the good management of the Department as a whole, including a high standard of financial management. This includes the parts of the Department managing the NHS (as distinct from the NHS itself) and the Department's Agencies, since they are parts of the Department operating in support of the Secretary of State. He is responsible for carrying out the duties set out in paragraphs 6-17 of the Accounting Officer Memorandum in respect of those responsibilities.

3. As Chief Executive of the NHS, the Permanent Secretary is directly responsible to the Secretary of State for the management of the NHS. He is accountable for expenditure on hospital and community health services, family health services, some central health services, the drugs bill and NHS Trusts' external financing. These are covered by the Request for Resources 1 in the Department's Estimates and Accounts. He is responsible for carrying out the duties set out in paragraphs 6-17 of the Accounting Officer Memorandum in respect of those responsibilities. He is also the Accounting Officer for the Summarised Accounts of NHS Trusts, Primary Care Trusts, Strategic Health Authorities, and Special Health Authorities where required.

4. Each year the Permanent Secretary agrees with the Chief Executives of the Executive Agency within the Department of Health (other than the Medicines & Healthcare Products Regulatory Agency and NHS Estates which are trading funds), a budget for the administration costs to cover their responsibilities and delegates to them immediate responsibility for the good management of the Department's Executive Agency.

5. Chief Executives of NHS Trusts, Primary Care Trusts and Strategic Health Authorities are designated as accountable officers and Chief Executives of Special Health Authorities are designated as accounting officers, who are accountable to Parliament through the NHS Chief Executive for the efficient, effective and proper use of all the resources in their charge.

6. The Chief Executive of the NHS Pensions Agency is also the Accounting Officer for the NHS Pension Scheme. He is responsible for carrying out the duties set out in paragraphs 6-17 of the Accounting Officer Memorandum in relation to the operation of the NHS Pension Scheme. In respect of the administrative expenditure of the Agency, the Chief Executive's responsibilities are set out in the Agency's Framework Document and his letter of designation as Agency Accounting Officer.

7. The Chief Executives of the Medicines & Healthcare Products Regulatory Agency and NHS Estates are accountable for the expenditure relating to these Trading Funds. They are responsible for carrying out the duties set out in paragraphs 6-17 of the Accounting Officer Memorandum for the Agency. Their accountability is subject to the Permanent Secretary's overall responsibility for the organisation and management of the Department of Health, as explained in paragraphs 18 and 19 of the Memorandum and in the Agency's Framework Document.

8. The Chief Executives of Special Health Authorities and the Dental Practice Board are accountable for the expenditure relating to those Bodies. They are responsible for carrying out the duties set out in the Accounting Officer Memorandum in respect of those responsibilities. Their accountability is subject to the Permanent Secretary's overall responsibility for the organisation and management of the Department of Health, as explained in the Memorandum and in their Framework Document.

9. The Chief Executive of Purchasing and Supply Agency within the Department of Health is designated as an Agency Accounting Officer. Their responsibilities are set out in the Agencys' Framework Documents and their letters of designation as Agency Accounting Officers.

Statement on Internal Control 2005–2006

SCOPE OF RESPONSIBILITY

1. As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Department of Health's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Government Accounting.

2. This statement is given in respect of the resource account for the Department that incorporates the transactions and net assets of the core Department, its Executive Agency and other bodies falling within the departmental boundary for resource accounting purposes. This includes English NHS bodies with the exception of NHS Trusts and Foundation Trusts and certain Special Health Authorities. As Principal Accounting Officer for the Department, I acknowledge my overall personal responsibility for ensuring that the Department, its Executive Agency and other bodies maintain a sound system of internal control.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

3. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

   - identify and prioritise the risks to the achievement of departmental policies, aims and objectives,
   - to evaluate the likelihood of those risks being realised and the impact should they be realised, and
   - to manage them efficiently, effectively and economically.

   The system of internal control has been in place in the Department of Health for the year ended 31 March 2006 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

CAPACITY TO HANDLE RISK

4. The internal control system is based on a clear risk management framework and accountability process that is embedded via delivery and business planning processes.

5. Leadership to the system of internal control has been shown by senior staff in visibly owning and supporting risk assessment and control activity in particular in support of the delivery programmes. A particular example during 2005-06 was that the Department completed a high level review following which it made changes to the way it is organised, to

   - strengthen our ability to lead and promote commissioning and create integrated policy
   - enhance the role of finance
   - raise the profile of social care within the Department.

   This has meant that internal structures and process have been revised so that our business control arrangements remain fit for purpose, and risk management is better integrated into the Department's business management.

6. Leadership was also provided through a joint DH/NHS Top Team that met monthly to review progress and address risks to delivery. Following changes to the number and structure of SHAs, this was replaced by the NHS Management Board involving Ministers, and senior officials from the Department and NHS.

7. The Departmental risk framework and process guidance is available for all staff on the internal website. The framework sets out that all staff have responsibility for assessing risks to the achievement of objectives in areas of work for which they are responsible. Directors are responsible for ensuring staff are appropriately trained and support is available for this.

THE RISK AND CONTROL FRAMEWORK

8. Within the Department, I operate an accountability process based around five core assurance standards and the requirement for Directors General, and certain other senior managers, to provide me with assurance statements that address the extent to which they are meeting these standards.

9. The Board is responsible for the ownership and management of strategic risks. Throughout the year the Board, supported by its Corporate Management Committee, has maintained an oversight on these high level risks: risks have been removed, and new ones added, there has been continuing challenge of recorded assessments as the year has progressed. The Department's Delivery Board also looked at risks escalated from individual delivery programmes and the Top Team identified issues and risks arising for Strategic Health Authorities and the Department.

10. During March 2006, the Department reviewed it governance structures. As a result membership of the Departmental Board changed, together with the membership, roles and functions of the existing subcommittees to provide an integrated governance structure to support risk management and delivery of the Department's objectives.

11. Risk management will be integrated more closely into the new Board Committee structure. The underlying aim is to ensure that the Board delegates consideration of specific issues so far as possible to the relevant committees. To achieve this, oversight and review of action on specific risks will be delegated to the relevant Board Committee whenever feasible. Each Board Committee will be given responsibility for overseeing the management of the main risks relating to the area of business which they oversee.

12. The Audit Committee advises on the quality of risk management, corporate governance and internal control. The Committee considers the risk management requirements of subordinate bodies and the key governance information flowing to the Chief Executive from these bodies. It has reviewed this statement in draft and its comments on evidence of assurances received have been reflected.

13. Within the Department, Assurance Strategy and Audit acts as adviser on the developing risk strategy and process. They provide me with an assurance as to the robustness of processes put in place.

14. The Department's Risk Improvement Group is responsible for supporting the Departmental Board by reviewing the strategic risk register, approving inclusion of risks escalated to it for inclusion and making recommendations to the Board. It was also responsible for driving forward the department's risk improvement programme and ensuring continuous improvement.

15. In respect of the Department's arm's length bodies (ALBs), including the Special Health Authorities, an Accounting Officer has been appointed who is held responsible for the maintenance and operation of the system of internal control in that body. I rely on the Statements on Internal Control prepared by those Accounting Officers as part of their annual accounts. In addition, I rely on Senior Departmental Sponsors in the Department to ensure that the bodies they sponsor operate sound Governance arrangements and the Sponsors must meet the Department's standard for the governance of our ALBs.

16. For each Strategic Health Authority, NHS Trust and Primary Care Trust I have appointed an Accountable Officer who is held responsible for the maintenance and operation of the system of internal control in that body. My major source of assurance for these bodies is the Statements on Internal Control signed by the Accountable Officers in support of their accounts. Strategic Health Authorities and NHS Internal Auditors are also engaged in the performance management and objective assessment of NHS trusts' and PCTs' ability to comply with SIC requirements.

17. The Delivery programmes form key elements of the Department's programme and these operate with clear governance and risk management arrangements. Specific programme and project risk guidance has been developed using the wider departmental framework. Programme Boards, co-ordinated by the Department's Central Programme Office, take the lead in managing programme risks.

18. Because of its size and importance, the NHS IT programme has established a separate unit "Connecting for Health". This is run as a managed programme, including Gateway reviews, and progress is closely monitored by senior staff. Best practice structures have been established to deliver the programme. In April 2005, stronger management arrangements were introduced with the Department's Group Director for Health and Social Care Delivery being appointed as Senior Responsible Officer for the Programme. In early 2006, this responsibility moved to the Acting NHS Chief Executive.

19. In addition to the Department's internal processes, I gain assurance from:

- assessments by Strategic Health Authorities, as part of their role of performance management of the NHS, to identify local risks to delivery, where necessary coordinate mitigation actions, and feed into the NHS Management Board discussions;
- work by the Healthcare Commission during the year;
- reports from the National Audit Office (Annex B) and Audit Commission resulting from their work in the Department and the NHS, and the Public Accounts Committee (Annex C);
- the Department's Assurance Strategy and Audit Unit report for 2005-06;
- Gateway reviews of large projects; and
- assessments of the Department's work by other external units, including for example the Prime Minister's Delivery Unit.

REVIEW OF EFFECTIVENESS

20. As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by:

- the work of the executive managers within the department, who have responsibility for the development and maintenance of the internal control framework,
- the work of the internal auditors, and
- comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee and plan to address weaknesses and ensure continuous improvement of the systems in place.

21. The Department has continued to assess its progress against the Treasury's Risk Management Assessment Framework, a self-assessment toolkit developed by the Treasury. While this showed continuing progress in risk management activity within the Department for most of the year, the latest (July 2006) assessment was that there had been some backwards movement in three areas from the position reported in 2004/05 leadership, partnership working, and outcomes. The restructuring of the Department's governance arrangements taking place in 2006/07 should correct this reversal and allow for continuing improvement.

22. The Directors General have provided me with assurance statements recording the position in their business groups over the year. I have reviewed these, through a summary report prepared in my Secretariat. This confirmed that there were no control problems identified. Following the Department's restructuring programme, responsibilities for reconciliation of payroll costs were not fully up-to-date until 2006-07. This resulted in some weakness within the system of controls during 2005-06.

23. I noted, for the Connecting for Health programme, that the National Audit Office report "The National Programme for IT in the NHS" – published in June 2006 – concluded that the Department has established management systems and structures to match the scale of the challenge. A review by QinetiQ in 2005 for the National Audit Office confirmed that project control and planning processes were in place.

24. Since the financial year end, the Department has received a letter from the Commission for Racial Equality about the Department's compliance with race relations legislation. A programme of action has been put in place to review and act on issues arising.

25. For the Department's arm's length bodies, I have reviewed a summary of the key points raised in the Statement on Internal Control that the body's Accounting Officer makes as part of their annual accounts, and of the opinions of their external auditors. I have similarly reviewed assurance statements provided by the senior member of staff in the Department responsible for sponsoring each body. In doing so, I have noted that there is still progress to be made to ensure that high quality internal governance, financial management and reporting procedures extend to all the Department's arm's length bodies.

The Department has put in place stronger oversight of the sector through the establishment of a business support unit to performance manage the sector.

26. For bodies in the NHS (other than Special Health Authorities, which are included among the Department's arms' length bodies), Strategic Health Authorities have collated information from the Accountable Officers' own statements on Internal Control and Internal Audit reports in their area. These show at the 31 March 2006, 99% of PCTs provided evidence that a system of internal control was in place while 1% (4) were unable to do so. The numbers represent an improvement on the 2004/05 year end position where 13 PCTs did not have a sufficiently complete system of internal control in place. The ongoing development of Assurance Frameworks, with all 28 Strategic Health Authorities assessed as having had systems of internal control in place, has provided a robust structure and greater consistency across the NHS for public assurances about how organisations are managing their risks. The SHAs were able to demonstrate that they have maintained the significant progress made in 2004/05.

27. PCTs disclosed 89 significant control issues, about 60 percent were concerned with the financial position of the PCT. The Department has established a centrally managed turnaround programme to support a number of PCTs to ensure financial delivery of key targets and financial balance. Strategic Health Authorities will continue to monitor and review the ongoing development and embedding of Assurance Frameworks by the PCTs.

28. NHS Trusts disclosed 76 significant control issues in their SICs, about 60 percent were concerned with the financial position of the trust. The Department has established a centrally managed turnaround programme to support a number of NHS trusts to ensure financial delivery of key targets and financial balance.

29. My review noted that the accounts of a number of NHS bodies, including over 100 PCTs were qualified on the grounds of regularity. The vast majority were in respect of expenditure by PCTs in excess of their resource limits.

30. My review also drew on the Auditors' Local Evaluation assessments coordinated by the Audit Commission. This assesses how well NHS trusts and primary care trusts (PCTs) manage and use their financial resources. The assessment showed that 61% of NHS bodies demonstrated adequate or more than adequate performance in their use of resources, while 39% failed to meet the minimum requirements. The main cause of this was the number of NHS bodies assessed as having inadequate financial standing (a direct consequence of the number of deficits incurred in 2005/06).

31. I noted that the NHS expenditure for the year, while remaining within the sums made available by Parliament, was slightly in excess of the resource departmental expenditure limit set by HM Treasury.

32. I noted also that the management of NHS capital spending resulted in significant underspending below the sums available in 2005-06. This was caused by

- decisions by NHS bodies that the revenue consequences in later years of capital spending would result in pressures on those budgets, and
- management attention being directed to revenue spending.

I concluded that this underspending did not imply any control failings.

SIGNIFICANT INTERNAL CONTROL PROBLEMS

33. My review of effectiveness, described above, did not identify any significant control issues except for the arrangements to manage the NHS financial position and NHS bodies' need to improve underlying financial management processes. Here there was a disappointing number of authorities reporting recurrent deficits, and the relatively high number of NHS bodies reporting internal control issues in this area. The Department is taking vigorous action to address the issues which this has raised.

Hugh Taylor
Acting Permanent Secretary,
Department of Health 26 October 2006

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

I certify that I have audited the financial statements of the Department of Health for the year ended 31 March 2006 under the Government Resources and Accounts Act 2000. These comprise the Statement of Parliamentary Supply, the Operating Cost Statement and Statement of Recognised Gains and Losses, the Balance Sheet, the Cashflow Statement and the Consolidated Statement of Operating Costs by Departmental Aim and Objectives and the related notes. These financial statements have been prepared under the accounting policies set out within them.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer is responsible for preparing the Annual Report and the financial statements in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions made thereunder and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements, and with International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with HM Treasury directions issued under the Government Resources and Accounts Act 2000. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. I also report to you if, in my opinion, the Annual Report is not consistent with the financial statements, if the Department has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by HM Treasury regarding remuneration and other transactions is not disclosed.

I review whether the statement on pages 24 to 27 reflects the Department's compliance with HM Treasury's guidance on the Statement on Internal Control, and I report if it does not. I am not required to consider whether the Accounting Officer's statement on internal control covers all risks and controls, or to form an opinion on the effectiveness of the Department's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises only the Scope and public interest sections within the Annual Report, the unaudited part of the Remuneration Report, and the Management Commentary. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the Accounting Officer in the preparation of the financial statements, and of whether the accounting policies are most appropriate to the Department's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or error and that in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Consolidated Statement of Operating Costs by Departmental Aim and Objectives

The Consolidated Statement of Operating Costs by Departmental Aim and Objectives analyses the Department's resources by objective in accordance with the methodology set out in note 1.24. This information is collected at a local level and subject to departmental review. The extent of judgement required in this process means that significantly different, yet still defensible, allocations of income and expenditure could have been reported to provide indicative spend.

My opinion on the accounts is not qualified in this or any other respect.

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the Government Resources and Accounts Act 2000 and directions made thereunder by HM Treasury, of the state of the Department's affairs as at 31 March 2006 and the net cash requirement, net resource outturn, resources applied to objectives, recognised gains and losses and cashflows for the year then ended;

- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with HM Treasury directions issued under the Government Resources and Accounts Act 2000; and

- in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

I qualified my opinion on the NHS Pensions Agency account for 2005-06 on the grounds that I could not determine that the Agency had maintained proper accounting records for certain bursary payments made to students under the NHS Bursary Scheme in England. This account, together with my certificate and report, was laid before Parliament on 24 July 2006 (HC 1626). Although these accounts are consolidated within the Department of Health's Resource Account, my qualification on these accounts does not affect my opinion on the Department of Health's Resource Account for the year ended 31 March 2006 as the amounts spent on the Scheme are not a significant element of the Department of Health's expenditure.

John Bourn
Comptroller and Auditor General
30 October 2006

National Audit Office
157-197 Buckingham Palace Road
Victoria
London SW1W9SP

Statement of Parliamentary Supply

Summary of Resource Outturn 2005-06

		Estimate			Outturn			2005-06 Net total outturn compared with Estimate (savings)/ excess	2004-05 Outturn NET TOTAL
Request for Resources	Note	Gross Expenditure	Appropriation –in–Aid	NET TOTAL	Gross Expenditure	Appropriation –in–Aid	NET TOTAL		
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	2	77,151,416	17,596,922	59,554,494	76,729,560	17,586,900	59,142,660	(411,834)	50,339,638
2	2	3,619,268	82,098	3,537,170	3,438,138	72,422	3,365,716	(171,454)	3,423,129
3	2	17,800	–	17,800	17,543	–	17,543	(257)	15,856
Total resources	**3**	**80,788,484**	**17,679,020**	**63,109,464**	**80,185,241**	**17,659,322**	**62,525,919**	**(583,545)**	**53,778,623**
Non-operating cost A-in-A				**2,053,011**			**993,671**	**(1,059,340)**	**1,225,000**

				2005-06	2004-05
				£'000	£'000
	Note	Estimate	Outturn	Net total outturn compared with estimate: (Saving)/ excess	Outturn
Net cash requirement	4	62,384,625	61,494,283	(890,342)	54,283,285

Summary of income payable to the Consolidated Fund

In addition to appropriations in aid, the following income relates to the Department and is payable to the Consolidated Fund (cash receipts being shown in italics).

			Forecast 2005-06		Outturn 2005-06
		Income	Receipts	Income	*Receipts*
	Note	£'000	£'000	£'000	*£'000*
Total	5	–	–	539	*237*

Note:
Explanations of variances between Estimate and outturn are given in Note 2 and in the Management Commentary.

The notes on pages 35-70 form part of these accounts.

Operating Cost Statement

for the year ended 31 March 2006

		2005-06							2004-05
		Core Department					Consolidated	Core	
	Notes	Staff Costs £'000	Other Costs £'000	Income £'000	Staff Costs £'000	Other Costs £'000	Income £'000	Department £'000	Consolidated £'000
Administration Costs:									
Staff costs	9	145,892			145,892			117,619	117,619
Other administration costs	10		135,230			135,230		176,979	176,979
Operating income	12			(17,444)			(17,444)	(9,865)	(9,865)
Programme Costs									
Request for Resources 1									
Securing health care for those who need it.									
Staff Costs	9	106,558			7,013,754			48,917	6,001,986
Programme Costs	11		3,955,797			69,715,806		2,845,231	62,351,920
Income	12			(1,460,767)			(17,586,900)	(1,017,586)	(18,015,032)
Request for resources 2									
Securing social care and child protection for those who need it and, at national level, protecting, promoting and improving the nation's health.									
Staff Costs	9	412			17,641			–	–
Programme Costs	11		3,155,214			3,139,375		3,207,795	3,194,774
Income	12			(55,840)			(55,517)	(54,212)	(56,378)
Request for resources 3									
Office of the Independent Regulator for NHS Foundation Trusts									
Staff Costs	9	–			–			–	–
Programme Costs	11		17,543			17,543		15,856	15,856
Income	12			–			–	–	–
Totals		**252,862**	**7,263,784**	**(1,534,051)**	**7,177,287**	**73,007,954**	**(17,659,861)**	**5,330,734**	**53,777,859**
Net Operating Cost	3,13			**5,982,595**			**62,525,380**	**5,330,734**	**53,777,859**

Statement of Recognised Gains and Losses

for the year ended 31 March 2006

	2005-06 £'000		2004-05 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Net gain/(loss) on revaluation of tangible fixed assets	72,050	219,808	484,639	1,545,161
Net gain/(loss) on revaluation of intangible fixed assets	–	(112)	–	–
Net gain/(loss) on revaluation of investments	–	84	–	–
Receipt/revaluation of donated assets	(109)	15,264	559	26,082
Impairment of fixed assets	(3,637)	(33,578)	–	(26,608)
Total recognised gains for the year	**68,304**	**201,466**	**485,198**	**1,544,635**

The activities reported in the Operating Cost Statement are from continuing operations within the Departmental boundary. There were no material acquisitions or disposals.

The notes on pages 35-70 form part of these accounts.

Balance Sheet

as at 31 March 2006

	Note	2006 £'000 Core Department		2006 £'000 Consolidated	2005 £'000 Core Department	2005 £'000 Consolidated
Fixed assets:						
Tangible assets	14	790,886	6,856,232		1,131,847	6,931,732
Intangible assets	15	607,043	619,894		315,825	325,278
Investments	16	21,394,917	21,423,013		19,586,301	19,599,765
			22,792,846	**28,899,139**		
Debtors falling due after more than one year	18		**75,896**	**116,409**	**(949)**	**39,462**
Current assets:						
Stocks	17	274,105	296,714		147,647	167,585
Debtors	18	520,130	1,703,086		419,593	1,523,727
Cash at bank and in hand	19	779,762	901,626		611,946	640,192
		1,573,997	**2,901,426**		**1,179,186**	**2,331,504**
Creditors (amounts falling due within one year)	20	(1,490,150)	(6,986,457)		(1,156,671)	(5,954,169)
Net current assets			**83,847**	**(4,085,031)**	**22,515**	**(3,622,665)**
Total assets less current liabilities			**22,952,589**	**24,930,517**	**21,055,539**	**23,273,572**
Creditors (amounts falling due after more than one year)	20	–	(111,194)		(42,264)	(89,952)
Provisions for liabilities and charges	21	(1,328,201)	(10,268,192)		(1,120,560)	(8,850,125)
			(1,328,201)	(10,379,386)		
Net Assets			**21,624,388**	**14,551,131**	**19,892,715**	**14,333,495**
Taxpayers' equity						
General fund	22		21,112,697	11,920,659	19,195,871	11,621,234
Revaluation reserve	23.1		510,670	2,498,831	694,504	2,603,477
Donated asset reserve	23.2		1,021	131,641	2,340	108,784
			21,624,388	**14,551,131**	**19,892,715**	**14,333,495**

The notes on pages 35-70 form part of these accounts.

Hugh Taylor
Acting Permanent Secretary
Department of Health

26 October 2006

Consolidated Cash Flow Statement

for the year ended 31 March 2006

	Note	2005-06 £'000	2004-05 £'000
Net cash flow from operating activities	24.1	(59,375,698)	(52,747,516)
Capital expenditure and financial investment	24.2, 24.3	(2,117,822)	(1,535,142)
Receipts due to the Consolidated Fund which are outside the scope of the Department's activities		–	137
Payments of amounts due to the Consolidated Fund		(764)	(13,326)
Financing	24.4	61,755,718	54,521,410
Increase in cash in the period	24.5	**261,434**	**225,563**

The notes on pages 35-70 form part of these accounts.

Consolidated Statement of Operating Costs by Departmental Aim and Objectives

for the year ended 31 March 2006

In addition to the Department of Health's Programme Budgeting Analysis of Net operating Costs (see page 7), below is a presentation of Net Operating Costs by key objectives.

Aim: The Department of Health's overall aim is to improve the health and well being of the people of England, through the resources available.

In pursuance of this aim, the department has the following objectives (as set as part of the 2004 Spending Review process):

	2005-06	2004-05
	£m	£m
Aim		
Objective I		
Access to Services	26,749	24,524
Objective II		
Improving the Patient / User Experience	5,807	5,704
Objective III		
Health of the Population	29,111	26,184
Objective IV		
Long Term Conditions	6,672	6,449
Other	11,846	8,998
	80,185	71,859
Total Income	(17,660)	(18,081)
Net Operating Cost	**62,525**	**53,778**

Note

The majority of income comes from National Insurance Contributions and is treated as central funding rather than allocated as a particular objective. Therefore gross operating figures have been disclosed for each objective.

The presentation above provides high level indicative spend against the key departmental objectives applying a method based on outturn data already collected by the NHS. Although departmental and NHS activity can contribute to both objectives at the same time, the adopted method provides a high-level and fair assessment of spend by objective. The NHS response to many conditions contributes to more than one objective, but the model used to derive the schedule outturn assigns individual PSA target expenditure to single objectives. As a result the figure on long term conditions excludes some spend on conditions which are usually considered long term conditions, such as diabetes because these are included in health of the population. These figures should not be taken as absolute, however.

Costs have been allocated to these objectives in accordance with the methodology set out in Note 1.24 using the latest available data and that for reference costs this is the final 2004-05 data. This information is collected at a local level and subjective to departmental review. The extent of judgement required in this process means that significantly different, yet still defensible, allocations of income and expenditure could have been reported.

See note 25 for further analysis of these objectives.

The notes on pages 35-70 form part of these accounts.

Notes to the Accounts

1 Statement of accounting policies

The financial statements have been prepared in accordance with the The Government Financial Reporting Manual (FReM) for 2005-06 issued by HM Treasury. The accounting policies contained in the FReM follow UK generally accepted accounting practice for companies (UK GAAP) to the extent that it is meaningful and appropriate to the public sector. In addition to the primary statements prepared under UK GAAP, the FReM also required the Department to prepare two additional primary statements. The Statement of Parliamentary Supply and supporting notes show outturn against Estimate in terms of the net resource requirement and the net cash requirement. The consolidated Statement of Operating Costs by Departmental Aim and Objectives and supporting notes analyse the Department's income and expenditure by the objectives agreed with Ministers. Where the FReM permits a choice of accounting policy, the accounting policy which has been judged to be most appropriate to the particular circumstances of the department for the purpose of giving a true and fair view has been selected. The Department's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of certain fixed assets at their value to the business by reference to their current cost.

1.2 Basis of consolidation

These accounts consolidate financial information for the Department of Health (core Department), its supply-financed Executive Agency, and other NHS bodies funded directly by the Department that fall within the departmental boundary as defined in the Government Financial Reporting Manual issued by HM Treasury. The Medicines & Healthcare Products Regulatory Agency, NHS Estates, NHS Trusts, Foundation Trusts and all, except NHS Tribunals, of the Department's non-Departmental Public Bodies are excluded from the consolidation. Note 37 contains a full list of bodies consolidated within and excluded from the accounts. More information on entities within the departmental family can be found in the annual reports and accounts of the Executive Agency or in the individual and summarised accounts of NHS Trusts, Strategic Health Authorities, Special Health Authorities, Foundation Trusts and Primary Care Trusts which are published separately.

1.3 Intangible fixed assets

The following intangible fixed assets are capitalised:

– Purchase computer software licences

– Licences and trademarks

– Development expenditure

Expenditure incurred on the National Programme for IT has been split between capital and revenue expenditure using a financial model that analyses contractor costs over the life of the project. As the majority of assets generated by this project are software related, including the purchase of licences, they have been capitalised within intangible fixed assets. These are being amortised over the life of the project.

1.4 Tangible fixed assets

Fixed assets other than purchased computer software and licenses are capitalised as a tangible asset where expenditure of £5,000 or more is incurred on:

(i) a discrete asset;

(ii) a collection of assets which, individually may be valued at less than £5,000 but which together form a single collective asset because the items fulfil all of the following criteria:

  – the items are functionally interdependent;

  – the items are acquired at about the same date and are planned for disposal at about the same date; and

  – the items are under single managerial control.

(iii) a collection of assets which individually may be valued at less than £5,000 but which form part of the initial equipping and setting-up cost of a new building; and

(iv) enhancing an existing asset beyond its previously assessed standard of performance.

Fixed assets are valued as follows:

i) The Civil Estate was valued as at 30 June 2000, and revalued as at 01September 2005 by independent valuers employed by the Department. All valuations have been according to RICS guidelines. Between valuations, IPD indices for Civil Estate assets and NHS indices for all other assets are applied to arrive at current values; and

ii) The Retained Estate was valued as at 31 March 2005 by professional valuers. Specialised operational property is valued at depreciated replacement cost, non-specialised operational property is valued on an existing use value and non-operational and surplus property are valued at open market value.

iii) IT equipment, assets in the course of construction, transport equipment, furniture and fittings and plant and machinery held for operational use are valued at net current replacement cost using an appropriate index. Surplus equipment is valued at the net recoverable amount.

1.5 Depreciation

Depreciation is charged on a straight-line basis on fixed assets as follows:

i) buildings are depreciated on their revalued amount over the assessed remaining life of the asset as advised by a valuer;

ii) The Retained Estate was valued as at 31 March 2005 by the district valuer.

iii) IT, furniture and fittings, plant and machinery and transport equipment is depreciated over the estimated life of the asset as follows:

– long-life medical and other equipment	15
– furniture, medium-life medical equipment and building set-up costs	10
– mainframe information technology installations	8
– soft furnishing	7
– office machinery	5
– IT software and PC-related hardware (except PCs, laptops and monitors)	5-10
– transport equipment	4
– PCs Laptops and Monitors	3

Land, surplus building and assets in the course of construction are not depreciated.

1.6 Amortisation of Intangible Fixed Assets

Licences and trademarks and purchased computer software licences are amortised over a period of 5 years. Development expenditure is amortised over the life of the project.

Expenditure incurred on the National Programme for IT has been split between capital and revenue expenditure using a financial model that analyses contractor costs over the life of the project. As the majority of assets generated by this project are software related, including the purchase of licences, they have been capitalised within intangible fixed assets. These are being amortised over the life of the project.

1.7 Donated assets

Donated tangible fixed assets are capitalised at their valuation on receipt; this value is credited to the donated assets reserve. Subsequent revaluations are also taken to this reserve. Each year, an amount equal

to the depreciation charge on the asset is released from the donated asset reserve to the Operating Cost Statement.

1.8 Leases

Assets held under finance leases and hire purchase contracts are capitalised in the balance sheet and are depreciated over their useful lives. Rentals under operating leases are charged as operating costs on a straight-line basis over the lease term. Leasing rental income, where the Department acts as a lessor in shared buildings, is recognised as it falls due.

1.9 Investments

Public Dividend Capital (PDC), and any loans, issued by the Department to NHS Trusts, Foundation Trusts, NHS Estates and the Medicines & Healthcare Products Regulatory Agency and for Credit Guarantee Finance are valued at historic cost.

1.10 Stocks

Stocks are valued at the lower of purchase cost (calculated on a first-in, first-out basis) and net realisable value.

1.11 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project
- the related expenditure is separately identifiable
- the outcome of the project has been assessed with reasonable certainty as to:
- its technical feasibility
- its resulting in a product or service which will eventually be brought into use
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation charge is calculated on the same basis as for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Primary Care Trusts are unable to disclose the total amount of research and development expenditure charged to the Operating Cost Statement because some research and development activity cannot be separated from patient care activity.

1.12 Operating income

Operating income is income related directly to the operating activities of the Department. It comprises principally, fees and charges for services provided, on a full cost basis, to external customers and public sector repayment work, but also includes other income such as that from investments. It includes Appropriations-in-Aid (A-in-A) and Consolidated Fund Extra Receipts (CFERs) treated as income but excludes A-in-A and CFERs treated as capital. National Insurance Contributions are included in operating income. Operating income is stated net of VAT.

1.13 Administration and programme expenditure

The Operating Cost Statement is analysed between administration and programme costs. Administration costs reflect the costs of running the Department. These include both administrative costs and associated operating income. Income is analysed in the notes between that which, under the administrative cost-control regime, is allowed to be offset against gross administrative costs in determining the outturn against the administration cost limit, and that operating income which is not. Programme costs reflect non-administration costs, including payments of grants and other disbursements by the department, as well as certain staff costs where they relate directly to service delivery. The classification of expenditure and income as administration or as programme follows the definition of administration costs set by HM Treasury.

1.14 Capital charge

A charge, reflecting the cost of capital utilised by the department, is included in operating costs. The charge is calculated at the real rate set by HM Treasury (currently 3.5 per cent) on the average carrying amount of all assets less liabilities, except for:

a) donated assets, and cash balances with the Office of the Paymaster General, where the charge is nil; and

b) investments in NHS Trusts, Foundation Trusts and in Trading Funds where the charge is applied to their underlying assets at a rate agreed with HM Treasury.

1.15 Audit costs

A charge reflecting the cost of audit is included in operating costs. The Department of Health is audited by the Comptroller and Auditor General. No charge is made for this service but a notional charge representing the cost of the audit is included in the accounts. This charge covers all audit costs on the main Department accounts, and the audit of all the summarised accounts prepared under s98 of the NHS Act 1977 (note 10). Other Group bodies are audited by the Comptroller and Auditor General or the Audit Commission-appointed auditor and are charged audit fees (note 11).

1.16 Foreign exchange

The large majority of the Department's foreign currency transactions relate to EEA medical costs. Because of 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 balance sheet at year-end are converted at the exchange rate ruling at the balance sheet date. Exchange rate gains or losses are calculated in accordance with accepted accounting practice.

1.17 Principal Civil Service Pension Scheme

Past and present employees are covered by the provisions of the Civil Services Pension Schemes which are described at Note 9. The defined benefit schemes are unfunded and are non-contributory except in respect of dependents benefits. The department recognises the expected costs of these elements on a systematic and rational basis over the period during which it benefits from the employees' services by payment to the Principal Civil Service Pension Scheme (PCSPS) of amounts calculated on an accruing basis. Liability for payment of future benefits is a charge on the PCSPS. In respect of the defined contribution schemes, the department recognises the contributions payable for the year.

The Cabinet Office publishes a separate scheme statement for PCSPS as a whole.

1.18 NHS Pension Scheme

Present and past employees of NHS bodies funded directly by the Department are covered by the provisions of the NHS Pension Scheme. This is notionally funded. It is a statutory, defined benefit scheme, the provisions of which are contained in the NHS Pension Scheme Regulations (SI 1995 No.300). Under these regulations the Department is required to pay an employer's contribution, a percentage of pensionable pay as determined from time to time by the Government Actuary's Department.

The NHS compensation for premature retirement scheme is funded by special contributions paid by the employer. These contributions can be paid quarterly over the life of the former employee; paid in five annual instalments; or settled in one lump-sum.

Both the NHS Pensions Scheme and the NHS Compensation for Early Retirements Scheme are administered by the NHS Pensions Agency. Further details are given in the annual financial statements for the 'NHS Pension Scheme and NHS Compensation for Premature Retirement Scheme'.

1.19 Clinical negligence costs

Clinical negligence costs are managed through the following different schemes by the NHS Litigation Authority.

The Existing Liability Scheme and Ex-Regional Health Authority schemes are funded by the Department of Health, Clinical Negligence Scheme for Trusts, from Trust contributions, and the accounts for the schemes are

prepared in accordance with FRS 12. A provision for these schemes is calculated in accordance with FRS 12 by discounting the gross value of all claims received; this is disclosed in note 21.

The calculation is made using:

i) probability factors. The probability of each 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

ii) a discount factor calculated using the real discount rate of 2.2%, RPI of 3% and claims inflation (varying between schemes) of between 3% and 6%, 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 31.

Existing Liabilities Scheme (ELS) and Ex-Regional Health Authorities (Ex-RHA) Scheme

Claims are included in the ELS provision on the basis that the incident ocurred on or before 31st March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to the Authority with effect from 1st April 1996.

The NHS (Residual Liabilities) Act 1996 requires the Secretary of State to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This would include the liabilities assumed by the Litigation Authority in respect of these schemes.

Clinical Negligence Scheme for Trusts (CNST)

A provision for this scheme is calculated in accordance with FRS12 by discounting the gross value of all claims received relating to incidents which occurred on or before 31 March 2006 and after 1 April 1995. This is disclosed in note 21.

Claims are included in the provision on the basis that the CNST members have assessed:-

a. the probable cost and time to settlement in accordance with scheme guidelines;

b. that they are qualifying incidents; and

c. that the Trust remains a member of the scheme.

As at 31st March 2002 all outstanding claims for incidents post 1st April 1995 became the direct responsibility of the NHSLA. 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.

The NHS (Residual Liabilities) Act 1996 requires the Secretary of State to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This would include the liabilities assumed by the Authority in respect of this scheme.

Incidents Incurred but not reported (IBNR)

FRS 12 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to the NHS Litigation Authority as at 31 March 2006 where the following can be reasonably forecast:

a) that an adverse incident has occurred; and

b) that a transfer of economic benefit will occur; and

c) that a reasonable estimate of the likely value can be made.

The NHSLA uses its actuaries, Lane, Clark & Peacock, 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 21 and 31 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.

1.20 Derivatives and other financial instruments

The Department of Health mainly relies on Parliamentary voted funding and receipt of a proportion of National Insurance Contributions to finance its operations. Other than items such as trade debtors and creditors that arise from its operations and cash resources it holds no other financial instruments nor enters into derivative transactions or interest rate swaps. The Department enters into forward contracts where a specific amount of foreign currency are required at a particular date in the future in accordance with Government Accounting, chapter 28.7.

Investments held in the group relate mainly to transactions between the Department and its bodies.The Department additionally holds investments in Partnership for Health, Shared Business Services and Plasma Resources UK Limited.

The Department has transactions with other EEA member states for medical costs.

1.21 Contingent Liabilities

In addition to contingent liabilities disclosed in accordance with FRS 12, the Department discloses for parliamentary reporting and accountability purposes certain contingent liabilities where the likelihood of a transfer of economic benefit is remote. These comprise:

– items over £100,000 (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

– all items (whether or not they arise in the normal course of business) over £100,000 (or lower, where required by specific statute or where material in the context of resource accounts) which are required by the Financial Reporting Manual to be noted in the resource accounts.

Where the time value of money is material, contingent liabilities which are required to be disclosed under FRS 12 are stated at discounted amounts and the amount reported to Parliament separately noted. Contingent liabilities that are not required to be disclosed by FRS 12 are stated at the amounts reported to Parliament.

1.22 Value Added Tax

Most of the activities of the department are outside the scope of VAT and, in general output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.23 Funds Held on Trust

Some organisations received donations which are held on trust. These funds are administered by Trustees and accounted for separately from other funds for which the Department retains control.

1.24 Consolidated Statement of Operating Costs by Departmental Aim and Objectives

The Government Financial Reporting Manual (FReM) requires a primary statement analysing net operating cost by departmental aim and objectives (Consolidated Statement of Operating Costs by Departmental Aim and Objectives). The Department of Health's objectives used are those agreed and published in the "Spending Review 2004: Public Service Agreements" White Paper. Each objective is supported by one or more Public Service Agreement (PSA) targets which relate directly to the services delivered by the NHS and Social Care systems.

Departmental expenditure has been allocated to the PSA targets using "programme budget categories", indicative provider costs (reference costs) and prescribing data. Primary Care Trusts have allocated their spend at the local level and reported within defined activity categories. Consolidated Statement of Operating Costs by Departmental Aim and Objectives has been built from this underlying data, assigning expenditure to meeting the PSA targets and using the PSA targets to allocate between the objectives.

This method provides high level indicative spend against the key departmental objectives applying a method based on outturn data already collected by the NHS. Although departmental and NHS activity can contribute to both objectives at the same time, the adopted method provides a high-level and fair assessment of spend by objective. These figures should not be taken as absolute, however.

1.25 Provisions

The department provides for legal or constructive obligations which are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the real rate set by HM Treasury (currently 2.2 per cent).

1.26 Private Finance Initiative (PFI) transactions

The Department of Health follows HM Treasury's 'Technical Note 1 (Revised) How to Account for PFI transactions' which provides practical guidance for the application of the FRS 5 Amendment and the guidance 'Land and Buildings in PFI Schemes (version 2)'. PFI schemes are schemes under which premises and facilities are constructed and run by private sector organisations in return for annual payments from Primary Care Trusts for the services provided at those premises or facilities.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where primary care trusts have contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Operating Cost Statement. Where, at the end of a PFI contract, a property reverts to the primary care trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset. Where the balance of risks and rewards of ownership of the PFI property are borne by the primary care trusts, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.27 Assets belonging to third parties

Assets belonging to third parties (such as money held on behalf of Patients) are not recognised in the accounts since the Department has no beneficial interest in them. The balance of money held within PCT bank accounts at the balance sheet date was £2,886,000 (31 March 2005: £3,621,000).

2 Analysis of net resource outturn by section

This note compares outturn with the figures approved by Parliament.

	Admin	Other Current	Current Grant	Gross	A-in-A	Outturn Net Total	Estimate	2005-06 £'000 Net total Outturn compared with Estimate	2004-05 £'000 Prior year outturn
Request for Resources 1:									
Securing health care for those who need it.									
Spending in Departmental Expenditure Limits(DEL)									
Central government spending									
Strategic health authorities and primary care trusts unified budgets and central allocations	–	70,390,584	508,926	70,899,510	(1,416,323)	69,483,187	69,826,268	(343,081)	62,336,843
	–	**70,390,584**	**508,926**	**70,899,510**	**(1,416,323)**	**69,483,187**	**69,826,268**	**(343,081)**	**62,336,843**
FHS-Pharmaceutical Services	–	1,162,165	–	1,162,165	–	1,162,165	1,099,300	62,865	965,623
FHS-Prescription charges income	–	–	–	–	(426,856)	(426,856)	(451,845)	24,989	(422,393)
FHS-General Dental Services	–	1,447,713	–	1,447,713	(409,827)	1,037,886	1,012,000	25,886	1,245,503
FHS-General Ophthalmic Services	–	357,768	–	357,768	–	357,768	352,000	5,768	340,756
	–	**2,967,646**	**–**	**2,967,646**	**(836,683)**	**2,130,963**	**2,011,455**	**119,508**	**2,129,489**
Support for Local Authorities									
Strategic health authority and primary care trusts grants to local authorities	–	–	304,766	304,766	–	304,766	419,981	(115,215)	340,159
	–	**–**	**304,766**	**304,766**	**–**	**304,766**	**419,981**	**(115,215)**	**340,159**
Spending in Annually Managed Expenditure (AME)									
Central Government spending									
Hospital financing for Credit Guarantee Finance (CGF) pilot projects	–	6,737	–	6,737	(2,449)	4,288	1,800	2,488	2,713
Non-budget (not DEL or AME)									
Grant in aid to Non-departmental Public Bodies, NHS Trusts and Foundation trusts PDC issues and repayments, Foundation trusts loans and repayments and repayment of interest	–	2,315,494	235,407	2,550,901	(1,075,846)	1,475,055	1,550,589	(75,534)	664,405
NHS Contributions	–	–	–	–	(14,255,599)	(14,255,599)	(14,255,599)	–	(15,133,971)
	–	**2,315,494**	**235,407**	**2,550,901**	**(15,331,445)**	**(12,780,544)**	**(12,705,010)**	**(75,534)**	**(14,469,566)**
	–	**75,680,461**	**1,049,099**	**76,729,560**	**(17,586,900)**	**59,142,660**	**59,554,494**	**(411,834)**	**50,339,638**

	Admin	Other Current	Current Grant	Gross	A-in-A	Outturn Net Total	Estimate	2005-06 £'000 Net total Outturn compared with Estimate	2004-05 £'000 Prior year outturn
Request for Resources 2:									
Securing social care and child protection for those who need it and at national level, protecting, promoting and improving the nation's health									
Spending in Departmental Expenditure Limits (DEL)									
Central Government Spending									
Central Department	261,107	19,535	–	280,642	(17,444)	263,198	261,055	2,143	285,560
NHS Purchasing and Supplies Authority	–	27,964	–	27,964	(840)	27,124	26,980	144	21,272
Other Services, including medical, scientific and technical services, grants to voluntary bodies, research and development and information services	–	185,402	40,227	225,629	(5,964)	219,665	269,101	(49,436)	329,048
Welfare Food and European Economic Area Medical costs	–	665,230	–	665,230	(44,465)	620,765	684,547	(63,782)	517,293
Other Personal Social Services	–	6,980	60,019	66,999	(610)	66,389	111,015	(44,626)	94,272
Support for local Authorities									
AIDS support grant	–	–	16,690	16,690	–	16,690	16,500	190	16,835
Services for people with a mental illness	–	–	133,486	133,486	–	133,486	132,950	536	131,248
Carers' grant	–	–	184,797	184,797	–	184,797	185,000	(203)	124,832
Preserved rights grant	–	–	339,877	339,877	–	339,877	348,130	(8,253)	435,257
Residential allowance grant	–	–	216,997	216,997	–	216,997	214,455	2,542	405,981
Improving Information management (capital)	–	–	25,037	25,037	–	25,037	25,000	37	24,984
National training strategy	–	–	91,686	91,686	–	91,686	94,859	(3,173)	28,979
Access and systems capacity grant	–	–	642,784	642,784	–	642,784	642,000	784	484,044
Human resources development strategy	–	–	62,859	62,859	–	62,859	62,750	109	23,900
Children and adolescents mental health grant	–	–	90,557	90,557	–	90,557	90,539	18	64,813
Delayed discharged grant	–	–	100,000	100,000	–	100,000	100,000	–	99,959
Training for social support staff	–	–	–	–	–	–	–	–	54,911
Non-budget									
Grant in Aid funding Non-departmental public bodies and special health authorities	–	107	266,797	266,904	(3,099)	263,805	272,289	(8,484)	279,941
	261,107	**905,218**	**2,271,813**	**3,438,138**	**(72,422)**	**3,365,716**	**3,537,170**	**(171,454)**	**3,423,129**

	Admin	Other Current	Current Grant	Gross	A-in-A	Outturn Net Total	Estimate	2005-06 £'000 Net total Outturn compared with Estimate	2004-05 £'000 Prior year outturn
Request for Resources 3:									
Office of the Independent Regulator for NHS Foundation Trusts									
Non-budget									
Grant in aid funding to the Office of the Independent Regulator for NHS Foundation Trusts	–	–	17,543	17,543	–	17,543	17,800	(257)	15,856
Resource Outturn	**261,107**	**76,585,679**	**3,338,455**	**80,185,241**	**(17,659,322)**	**62,525,919**	**63,109,464**	**(583,545)**	**53,778,623**
Reconciliation to Operating Cost Statement									
Income from Consolidated Fund Extra Receipts	–	–	–	–	(539)	(539)			(764)
Net operating cost	**261,107**	**76,585,679**	**3,338,455**	**80,185,241**	**(17,659,861)**	**62,525,380**			**53,777,859**

Explanation of variations between Estimate and Outturn

RfR1

Hospital financing for Credit Guarantee Finance (CGF) pilot projects

Higher capital charges offset by lower than planned income.

Non budget

Grant in aid to Non-departmental Public Bodies, NHS Trusts and Foundation trusts PDC issues and repayments, Foundation trusts loans and repayments and repayment of interest

Mainly lower than forecast expenditure on changes to non budget expenditure for changes in the discount rate for provisions offset by higher than planned grants to Non-departmental public bodies.

RfR2

Other Services, including medical, scientific and technical services, grants to voluntary bodies, research and development and information services

Because of changes in priorities within the Departmental Expenditure limit, it was necessary to reduce spending in RfR2 subheads E and G to offset the deficits of NHS Trusts.

Training for social support staff

Expenditure moved to Non-Budget line "Grant in Aid funding Non-departmental public bodies and special health authorities".

3 Reconciliation of outturn to net operating cost and against Administration Budget

3.1 Reconciliation of net resource outturn to net operating cost

				2005-06	2004-05
				£'000	£'000
	Note	Outturn	Supply Estimate	Outturn compared with Estimate	Outturn
Net Resource Outturn	2	62,525,919	63,109,464	(583,545)	53,778,623
Non-supply income (CFERS)	5	(539)	–	(539)	(764)
Net Operating Cost		**62,525,380**	**63,109,464**	**(584,084)**	**53,777,859**

3.2 Outturn against final Administration Budget

	2005-06	2004-05
	£'000	£'000
	Budget	Outturn	Outturn
Gross Administration Budget	262,750	261,107	277,700
Income allowable against Administration Budget	(14,637)	(15,569)	(9,865)
Net outturn against final Administration Budget	**248,113**	**245,538**	**267,835**

4 Reconciliation of resources to cash requirement

	Note	Estimate £'000	Outturn £'000	Net Total outturn compared with Estimate saving/(excess) £'000
Resource Outturn	2	63,109,464	62,525,919	(583,545)
Capital				
Acquisition of fixed assets		1,322,774	930,651	(392,123)
Investments		4,024,120	2,118,350	(1,905,770)
Non operating A-in-A				
Proceeds of fixed assets disposals		(553,011)	(561,695)	(8,684)
Disposal of investments		(1,500,000)	(431,976)	1,068,024
Accruals adjustments				
Non-cash items	10	(4,349,527)	(3,705,733)	643,794
Changes in working capital other than cash		(478,870)	(388,270)	90,600
Changes in creditors falling due after more than one year	20	–	(21,242)	(21,242)
Use of provision	21	809,675	1,028,279	218,604
Net cash requirement		**62,384,625**	**61,494,283**	**(890,342)**

Note 4 Explanations of variations

Resource outturn: Mainly the result of underspends by the Department, PCTs and SHAs to offset deficits in trusts and less than anticipated expenditure on provisions following a technical change in the discount rate.

Acquisition of fixed assets: Slippage and delays on SHA/PCT capital programmes and the central connecting for health programme.

Investments: Less PDC issues and loans required by the trusts as a result of slippage and delays on capital programmes, lower than anticipated calls by trusts for temporary borrowing facilities and less transfers of PDC between trusts.

Disposal of investments: Lower than anticipated calls by trusts for temporary borrowing facilities and less transfers of PDC between trusts.

Non cash items: Mainly the result of lower than anticipated expenditure on provisions following a technical change in the discount rate and a change in the budgeting arrangements for EEA medical costs. Part of the later expenditure was incurred and paid in year rather than being treated as a provision.

Creditors falling due after more than one year were not identified separately from changes in working capital other than cash in the Estimate.

Use of provisions: Mainly the result of a change in the handling of EEA medical cost payment of provisions, timing differences on PCT payment of provisions (which are demand led) and some central payments higher than budgeted.

5 Analysis of income payable to the Consolidated Fund

In addition to appropriations in aid, the following income relates to the Department and is payable to the Consolidated Fund (cash receipts being shown in italics)

	Note	Income	Receipts	Forecast 2005-06 £'000 Income	Outturn 2005-06 £'000 Receipts
Operating income and receipts-excess A-in-A		–	–	–	–
Other operating income and receipts not classified as A-in-A		–	–	539	*237*
	22	–	–	539	*237*
Non-operating income and receipts excess A-in-A	7	–	–	–	–
Other non-operating income and receipts not classified as A-in-A	8	–	–	–	–
Other amounts collectable on behalf of the Consolidated Fund		–	–	–	–
Total income payable to the Consolidated Fund		**–**	**–**	**539**	***237***

6 Reconciliation of income recorded within the Operating Cost Statement to operating income payable to the Consolidated Fund

	Note	2005-06 £'000	2004-05 £'000
Operating income	12	17,659,861	18,081,275
Gross income		17,659,861	18,081,275
Income authorised to be appropriated-in-aid		(17,659,322)	(18,080,511)
Operating income payable to the Consolidated Fund	5	**539**	**764**

7 Non-operating income – Excess A-in-A

	2005-06 £'000	2004-05 £'000
Principal repayment of voted loans	–	–
Proceeds on disposal of fixed assets	–	–
Other	–	–
Non-operating income excess A-in-A	**–**	**–**

8 Non-operating income not classified as A-in-A

	2005-06 Income £'000	2004-05 Reciepts £'000
Other	–	–

	2005-06 £'000	2004-05 £'000
Receivable in the year	–	–
Recognised in the year	–	–
Carried forward	–	–

9 Staff numbers and related Costs

9.1 Staff costs consist of:

	Permanently employed staff	Others	Ministers	Special Advisers	2005-06 £'000 Total	2004-05 £'000 Total
Salaries and Wages	5,503,539	534,008	283	101	6,037,931	5,111,722
Social Security costs	420,642	6,530	30	21	427,223	372,639
NHS Pension	669,335	9,347	–	–	678,682	620,259
Other pension costs	33,054	381	–	16	33,451	14,985
Total Net Costs*	**6,626,570**	**550,266**	**313**	**138**	**7,177,287**	**6,119,605**
*Of which Core Department is	206,033	46,378	313	138	252,862	166,536

In previous years only the administrative staff cost of the Department was disclosed in this note. The 2004-05 figures have therefore been restated to show core Department staff cost in that year.

The Principal Civil Service Pension Scheme (PCSPS) to which most of the core Department's employees are members is an unfunded multi-employer defined benefit scheme, but Department of Health is unable to identify its share of the underlying assets and liabilities. A full actuarial valuation was carried out at 31 March 2003 and details can be found in the resource accounts of the Cabinet Office: Civil Superannuation (www.civilservice-pensions.gov.uk).

For 2005-06, normal employer contributions of £18,574,000 were payable to the PCSPS at rates in the range 12 to 18.5 per cent of pensionable pay, based on salary bands. Rates will remain the same next year, subject to revalorisation of the salary bands. Employer contribution rates are to be reviewed every four years following a full scheme valuation by the Government Actuary. The contribution rates reflect benefits as they are accrued, not when the costs are actually incurred; and they reflect past experience of the scheme.

Employees joining after 1 October 2002 could opt to open a partnership account, a stakeholder pension with an employer contribution.

Contributions due to the partnership pension providers at the balance sheet date were Nil. Contributions prepaid at that date were Nil.

Other past and present employees are covered by the provisions of the NHS Pension Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The notional surplus of the scheme is £1.1 billion as per the last scheme valuation by the Government Actuary for the period 1 April 1994 to 31 March 1999. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. Employers' contribution from 2004-05 are 14%.

The Scheme is subject to a full valuation every four years. The last valuation took place as at 31 March 2003. Between valuations, the Government Actuary provides an update of the scheme liabilities. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

Employer contribution rates are reviewed every four years following a scheme valuation carried out by the Government Actuary. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. At the last valuation on which contribution rates were based (31 March 1999) employer contribution rates from 2005-06 were set at 14% of pensionable pay (2004-05 14%). Until 2002-03 HM Treasury paid the Retail Price Indexation costs of the NHS Pension Scheme direct but as part of the Spending Review Settlement these costs were devolved in full. From 2004-05 funding has been devolved in full to NHS Pension Scheme employers and the employers' contribution rate is 14%.

The Scheme is a "final salary" scheme. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and up to five times their annual pension, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of investments made.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the Operating Cost Statement at the time the primary care trust commits itself to the retirement, regardless of the method of payment.

Average number of persons employed

9.2 The average number of whole-time equivalent persons employed during the year was as follows. These figures include those working in the department as well as in agencies and other bodies included within the consolidated departmental resource account.

	Total	Permanent staff	Others	Ministers	2005-06 Number Special Advisers	2004-05 Number
Core Department	2,353	2,278	67	6	2	2,807
Connecting for Health	925	925	–	–	–	258
Primary Care Trusts	203,422	190,725	12,697	–	–	193,934
Strategic Health Authorities	4,596	3,931	665	–	–	4,499
Special Health Authorities	5,014	4,670	344	–	–	6,008
Others	350	316	34	–	–	332
Total whole time equivalent persons	**216,660**	**202,845**	**13,807**	**6**	**2**	**207,838**

Others staff numbers does not include agency staff of the core Department.

10 Other administration costs

	Note	2005-06 £'000 Core Department	2005-06 £'000 Consolidated	2004-05 £'000 Core Department	2004-05 £'000 Consolidated
Rental under operating leases:					
Hire of plant and machinery		417	417	313	313
Other operating leases		17,339	17,339	16,282	16,282
Non cash items (See Note b below):					
Depreciation		12,572	12,572	11,743	11,743
Amortisation		–	–	231	231
Impairment/permanent diminution of asset values		890	890	1,015	1,015
Cost of capital charges		3,132	3,132	3,208	3,208
Auditors' remuneration and expenses	a	490	490	500	500
Provision provided for in year	21	7,463	7,463	8,892	8,892
Unwinding of discount on provisions	21	–	–	874	874
Change in discount rate	21	975	975	–	–
Other expenditure		91,952	91,952	133,921	133,921
Total		**135,230**	**135,230**	**176,979**	**176,979**

Note a – The audit fee represents the cost for the audit of the Department's Consolidated Accounts and the Summarised Accounts of the NHS carried out by the Comptroller and Auditor General. This amount does not include fees in respect of non-audit work.

Note b – the total of non-cash transactions included in the Reconciliation of Operating Costs to Operating Cash flows in the Consolidated Cash Flow Statement and the reconciliation of resources to net cash requirement comprises:

	2005-06 £'000	2004-05 £'000
Other administration costs – non-cash items (Note 10)	25,522	26,463
Programme costs – non-cash items (Note 11)	3,686,661	1,118,344
Less non-cash income – deferred donation income released from the Donated Asset Reserve	(6,450)	(7,786)
Consolidated Fund Creditor/Dividend Write-off	–	(303)
Other	–	4,097
Total non-cash transactions	**3,705,733**	**1,140,815**

11 Programme Costs

	Note	2005-06 £'000 Core Department	2005-06 £'000 Consolidated	2004-05 £'000 Core Department	2004-05 £'000 Consolidated
Current grants and other current expenditure		4,784,381	68,352,791	4,229,902	63,697,833
Rental under operating leases:					
Hire of plant and machinery		–	8,429	–	–
Other operating leases		–	137,743	–	–
Interest Charges		–	4,171	–	–
Research and Development expenditure		682,716	682,929	657,492	746,373
Non cash items (See Note b above):					
Depreciation		11,098	229,421	11,332	231,789
Amortisation		77,465	80,577	28,059	80,307
Profit on disposal of fixed assets		–	(31,679)	–	–
Loss on disposal of fixed assets		43,705	49,927	18,350	14,125
Impairment/permanent diminution of asset values		20,298	39,410	52,617	53,339
Cost of capital charges		1,096,666	881,847	889,816	696,913
Write-(on)/off of Investment		(1,438)	(1,438)	–	–
Provision provided for in year	21	289,570	1,581,736	241,192	(12,631)
Unwinding of discount on provisions	21	32,805	80,992	54,502	54,502
Change in discount rate	21	91,288	775,868	–	–
Total		**7,128,554**	**72,872,724**	**6,183,262**	**65,562,550**

	2005-06 £'000	2004-05 £'000
Auditor's Remuneration – Audit Fees	35,839	36,645
Auditor's Remuneration – Other Fees	2,505	3,251

The audit fee represents the cost of the audit of the financial statements of group bodies consolidated within the Resource Account by the Comptroller and Auditor General and auditors appointed by the Audit Commission.

12 Income

	RfR1	RfR2	RfR3	2005-06 £'000 Total	2004-05 £'000 Total
Operating Income analysed by classification and activity, is as follows:					
Administration Income:					
Allowable within the administration cost limit	–	17,444	–	**17,444**	9,865
	–	17,444	–	**17,444**	9,865
Programme Income:					
Fees and charges to external customers	35,546	–	–	**35,546**	540,432
Fees and charges to other departments	567,482	–	–	**567,482**	6,348
Prescription, dental and ophthalmic charges	838,123	–	–	**838,123**	850,451
National Insurance Contribution	14,255,599	–	–	**14,255,599**	15,133,971
Other	1,890,150	55,517	–	**1,945,667**	1,540,208
	17,586,900	55,517	–	**17,642,417**	18,071,410
Total Income*	**17,586,900**	**72,961**	**–**	**17,659,861**	**18,081,275**
* Of which Core Department is	1,460,767	73,284	–	**1,534,051**	**1,081,663**

13 Analysis of net operating cost by spending body

		2005-06 £'000	2004-05 £'000
	Estimate	Outturn	Outturn
Spending body:			
Core Department	261,055	263,198	285,560
Purchasing and Supplies Agency	26,980	26,585	21,272
Non-departmental public bodies	60,636,957	59,142,660	50,339,638
Local authorities	1,912,183	2,252,507	2,285,048
Other bodies	272,289	840,430	846,341
Net Operating Cost	**63,109,464**	**62,525,380**	**53,777,859**

Note: Non-departmental public bodies include all NHS bodies, i.e. Strategic Health Authorities, Special Health Authorities, NHS Trusts, Foundation Trusts and other bodies listed in note 37.

14 Tangible fixed assets

	Land and Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture and Equipment	Plant & Machinery	Transport Equipment	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation								
At 1 April 2005	6,559,567	37,701	329,380	184,763	85,925	170,314	17,672	7,385,322
Additions-purchased	210,040	300	164,229	135,669	19,473	45,346	745	575,802
Additions-donated	7,879	–	86	3,958	121	529	27	12,600
Impairment	(48,759)	(7)	(67)	(73)	–	–	119	(48,787)
Transfers	29,231	(113)	4,270	(813)	859	(27)	8	33,415
Reclassifications	(84,564)	6,629	39,625	(165,119)	1,569	3,883	440	(197,537)
Revaluation and indexation	220,595	1,917	(2,801)	469	59	3,020	308	223,567
Disposals	(571,993)	(7,192)	(9,101)	(947)	(2,572)	(4,255)	(2,481)	(598,541)
At 31 March 2006	**6,321,996**	**39,235**	**525,621**	**157,907**	**105,434**	**218,810**	**16,838**	**7,385,841**
Depreciation								
At 1 April 2005	170,881	1,083	141,723	–	42,437	85,252	12,214	453,590
Charged in year	154,055	1,093	57,168	–	9,115	19,244	1,531	242,206
Impairment	18,856	72	89	–	–	–	–	19,017
Transfers	(4)	(5)	128		8	–	–	127
Reclassifications	(160,872)	(1,083)	(4,026)	–	(756)	(496)	190	(167,043)
Revaluation and indexation	332	–	(1,024)	–	(238)	1,108	194	372
Disposals	(4,385)	(15)	(6,757)	–	(1,908)	(3,417)	(2,178)	(18,660)
At 31 March 2006	**178,863**	**1,145**	**187,301**	**–**	**48,658**	**101,691**	**11,951**	**529,609**
Net Book Value								
At 31 March 2006	**6,143,133**	**38,090**	**338,320**	**157,907**	**56,776**	**117,119**	**4,887**	**6,856,232**
At 31 March 2005	6,388,686	36,618	187,657	184,763	43,488	85,062	5,458	6,931,732
Asset financing:								
Owned	6,086,206	38,090	338,320	157,875	56,407	110,979	4,887	6,792,764
Finance Lease	56,927	–	–	32	369	6,140	–	63,468
Net book value at 31 March 2006	**6,143,133**	**38,090**	**338,320**	**157,907**	**56,776**	**117,119**	**4,887**	**6,856,232**

Assets under construction includes assets purchased and held by the Department for the use of new bodies prior to the formation of those bodies. The assets are subsequently transferred to the new bodies when the bodies become operational.

Analysis of tangible fixed assets								
The net book value of tangible fixed assets comprises:								
Core Department 2005-06	621,992	3,027	128,882	21,886	6,650	8,434	15	**790,886**
Purchasing and Supply Agency 2005-06	330	995	490	89	–	277	–	**2,181**
Core Department 2004-05	1,019,852	4,975	29,947	68,901	7,870	259	43	**1,131,847**
Purchasing and Supply Agency 2004-05	1,325	–	309	–	241	–	252	**2,127**

15 Intangible Fixed Assets

Intangible fixed assets comprise, Purchased Software Licences, Trade Marks and Artistic Originals, and Development Expenditure, and NPfIT for the Department and entities consolidated within these statements.

Cost or valuation	**£'000**
At 1 April 2005	516,635
Additions-purchased	354,849
Transfers	(89)
Revaluation and indexation	(81)
Reclassification	20,549
Disposals	(156,685)
At 31 March 2006	**735,178**
Amortisation	
At 1 April 2005	191,357
Charged in year	80,577
Transfers	4
Revaluation and indexation	(31)
Disposals	(156,623)
At 31 March 2006	**115,284**
Net Book Value	
At 31 March 2006	**619,894**
At 31 March 2005	325,278
Analysis of intangible fixed assets	
The net book value of intangible fixed assets comprises:	
Core Department 2005-06	**607,043**
Purchasing and Supply Agency 2005-06	**449**
Core Department 2004-05	315,825
Purchasing and Supply Agency 2004-05	274

16 Investments

	In NHS Trusts, Trusts Public Dividend Capital (PDC)	Foundation Trusts (PDC)	Foundation Trusts Loans	In Other Bodies PDC	In Other Bodies Loan	In Other Bodies Share Capital	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2005	16,416,607	3,071,504	9,021	1,530	41,802	59,301	19,599,765
Issued:							
To newly established bodies	206,376	4,213	–	–	403,299	9,500	623,388
To existing bodies	1,486,073	151,383	52,140	–	5,813	7,930	1,703,339
Loans issued in previous years	–	–	–	–	2,212	–	2,212
Repaid:							
By continuing bodies	(383,687)	(23,922)	(3,904)	–	(17,567)	(2,896)	(431,976)
Written off:							
By or on behalf of dissolved bodies	(73,025)	–	–	(380)	(394)	–	(73,799)
Revaluation	–	–	–	–	84	–	84
Balance as at 31 March 2006	**17,652,344**	**3,203,178**	**57,257**	**1,150**	**435,249**	**73,835**	**21,423,013**
Investments held by Core Department	17,652,344	3,203,178	57,257	1,150	421,168	59,820	21,394,917
Investments held by other NHS bodies	–	–	–	–	14,081	14,015	28,096

The Department can analyse its investments in other bodies as follows:				Percentage Shareholding
MHRA (Medicines and Healthcare products Regulatory Agency)	1,150	4,050	500	100%
PFH (Partnership for Health)	–	3,562	6,250	50%
Blood Plasma UK Ltd	–	3,460	53,070	100%
Credit Guarantee Fund	–	357,116	–	
iSOFT	–	52,980	–	

In addition Primary Care Trusts have investments of £18,595,000 in LIFT companies. Details of their investments can be found in their individual accounts. Health and Social Care Information Centre (HSCIC) also has an investment of £9,500,000 in a Joint Venture arrangement known as Dr Foster Intelligence. However, the accounts of the HSCIC have yet to be finalised and audited and this figure may be subject to change. The Department consider that any such change will not be material to these resource accounts.

HSCIC acquired 50% of the ordinary share capital and also provided working capital. The remaining share capital is owned by Dr Foster Ltd.

There were in total 763 PDC advances where the amount exceeded £100,000. (273 were Temporary PDC, 490 were Permanent PDC). The total value was £1,899,878,000 (£639,629,000, Temporary and £1,260,249,000 Permanent).

Included in the other bodies figure is an investment of £53,070,000 made in an American company which deals with plasma collection. This guarantees long-term supplies of plasma for NHS patients. The investment was valued at purchase price.

CGF is a loan, guaranteed by banks, monolines or other acceptable financial institutions, from the sponsoring Department to a PFI project SPV on 'market' terms. The CGF undertaken by the Department are pilots at two NHS PFI projects – Leeds and Portsmouth. Other than the pilots, the department will not be undertaking any further CGF loans as Treasury intend to develop the specific powers which will enable them to lend directly to the private sector should the pilots be successful.

NHS Estates was closed during the year.

The Department's share of the net assets and results of the relevant bodies are summarised below.

	NHS Trusts	Foundation Trusts	Medicines and Healthcare products Regulatory Agency	Blood Plasma UK Limited	Joint Ventures
	£'000	£'000	£'000	£'000	£'000
Net Assets at 31 March 2006	27,581,319	5,295,500	9,844	15,674	16,917
Turnover	32,150,192	5,688,600	53,191	44,903	11,262
Surplus/profit for the year (before financing)	341,370	131,300	(10,945)	(140)	(6,902)

17 Stocks and work in progress

	2005-06 £'000		2004-05 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Stocks	274,105	296,714	147,647	167,585
	274,105	296,714	147,647	167,585

18 Debtors

18.1 Analysis by type

	2005-06 £'000		2004-05 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Amounts falling due within one year:				
Trade debtors	60,535	446,906	144,818	556,987
Deposit and advances	–	117	2,226	2,361
Capital debtors	–	34,789	8,715	30,820
Other debtors	78,699	631,109	91,013	568,217
Pension prepayments	–	–	–	3,181
Other prepayments and accrued income	380,895	589,863	172,612	361,952
Consolidated Fund Extra Receipts Receivable	1	302	209	209
	520,130	**1,703,086**	**419,593**	**1,523,727**
Amounts falling due after more than one year:				
Trade debtors, advances for house purchases and other debtors	1,291	6,144	(1,084)	8,114
Deposits and advances	–	–	133	164
Capital debtors	–	269	–	716
Other Debtors	74,605	91,407	2	16,302
Prepayments and accrued income	–	18,589	–	14,166
	75,896	116,409	(949)	39,462
Total Debtors	**596,026**	**1,819,495**	**418,644**	**1,563,189**

18.2 Intra-government balances

	Amounts falling due within one year		Amounts falling due after more than one year	
	£'000	£'000	£'000	£'000
	2005-06	2004-05	2005-06	2004-05
Balances with other central government bodies	93,068	112,432	6,278	24,444
Balances with local authorities	178,800	127,915	7,610	1,306
Balances with NHS Trusts	322,744	524,776	1,186	4,300
Balances with Public Corporations and Trading Funds	22,438	19,627	37	–
Subtotal: Intra-government balances	617,050	784,750	15,111	30,050
Balances with bodies external to government	1,086,036	738,977	101,298	9,412
Total debtors at 31 March	**1,703,086**	**1,523,727**	**116,409**	**39,462**

19 Cash at bank and in hand

	2005-06		2004-05	
	£'000	£'000	£'000	£'000
	Core Department	Consolidated	Core Department	Consolidated
Balance at 1 April	611,946	640,192	366,675	415,772
Net change in cash balance	167,816	261,434	245,271	224,420
Balance at 31 March	**779,762**	**901,626**	**611,946**	**640,192**
The following balances at 31 March were held at:				
Office of HM Paymaster General	779,758	894,672	611,684	639,873
Commercial banks and cash in hand	4	6,954	262	319
Balance at 31 March	**779,762**	**901,626**	**611,946**	**640,192**

20 Creditors

20.1 Analysis by Type

	2005-06		2004-05	
	£'000	£'000	£'000	£'000
	Core Department	Consolidated	Core Department	Consolidated
Amounts falling due within one year:				
Bank Overdraft	–	11,007	–	3,573
VAT	–	–	6,126	7,453
Other taxation and social security	–	122,127	–	96,796
Trade creditors	9,109	4,000,533	196,561	3,666,755
Capital creditors	23,039	72,653	142,719	195,276
Other creditors	69,845	475,560	20,333	416,347
Early retirement costs payable within one year	–	1,674	–	2,290
Accruals and deferred income	497,815	1,407,982	160,787	932,483
Current part of finance lease	–	4,040	832	3,883
Amount issued from the Consolidated Fund for supply but not spent at year end	890,342	890,342	628,340	628,340
Excess cash receipts due to be paid to the Consolidated Fund	–	539	764	764
CFER Receivable due to be paid to the Consolidated Fund	–	–	209	209
	1,490,150	**6,986,457**	**1,156,671**	**5,954,169**
Amounts falling due after more than one year:				
Finance leases	–	76,487	–	23,634
Trade creditors	–	9,764	42,264	52,149
Other creditors	–	24,943	–	14,169
	–	**111,194**	**42,264**	**89,952**

20.2 Intra-government balances

	Amounts falling due within one year		Amounts falling due after more than one year	
	£'000	£'000	£'000	£'000
	2005-06	2004-05	2005-06	2004-05
Balances with other central government bodies	1,078,255	974,903	3,228	3,877
Balances with local authorities	228,131	161,812	7,488	226
Balances with NHS Trusts	1,358,226	1,332,409	9,694	18,325
Balances with Public Corporations and Trading Funds	58,602	38,017	7,110	484
Sub-total: Intra-government balances	2,723,214	2,507,141	27,520	22,912
Balances with bodies external to government	4,263,243	3,447,028	83,674	67,040
Total creditors at 31 March	**6,986,457**	**5,954,169**	**111,194**	**89,952**

21 Provisions for liabilities and charges

	Core Department					Consolidated					
	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	EEA medical costs	Clinical Negligence	Injury Benefits	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2005	72,939	541,910	400,222	105,489	1,120,560	461,628	400,222	6,888,602	542,567	557,106	8,850,125
Provided in the year	16,615	13,017	296,537	2,873	329,042	45,019	296,537	1,512,234	12,360	130,583	1,996,733
Provisions not required written back	(1,488)	(4,425)	–	(26,095)	(32,008)	(13,230)	–	(288,990)	(4,425)	(101,466)	(408,111)
Provisions utilised in the year	(22,220)	(44,368)	(129,606)	(18,267)	(214,461)	(78,583)	(129,606)	(560,516)	(44,368)	(215,206)	(1,028,279)
Unwinding of discount	2,198	13,732	14,008	2,867	32,805	11,339	14,008	37,255	13,732	4,604	80,938
Change in discount rate	12,296	71,073	7,265	1,629	92,263	49,397	7,265	630,867	71,073	18,184	776,786
Balance as at 31 March 2006	**80,340**	**590,939**	**588,426**	**68,496**	**1,328,201**	**475,570**	**588,426**	**8,219,452**	**590,939**	**393,805**	**10,268,192**

HM Treasury changed the discount rate from 3.5% to 2.2% from 1 April 2005. This resulted in additional provision at April 2005 £776,786,000.

Clinical Negligence

The Department of Health provides for future costs where it is the defendant in a number of actions by claimants for damages arising from the effects of alleged clinical negligence. The clinical negligence provision reflects an actuarially determined assessment of incidents that have occurred, including those not yet reported, where it is more than 50% probable that the claim will be successful and the amount of the claim can be reliably estimated. The amount provided is calculated on a percentage expected probability basis. Expenditure is likely to be incurred over a period of more than twenty years.

Clinical negligence claims which may possibly succeed but are less likely or cannot be reliably estimated are shown as contingent liabilities.

Strategic Health Authorities, Primary Care Trusts, Foundation Trusts and NHS Trusts (which are outside the resource accounting boundary) retain legal liability for all liabilities covered by the clinical negligence schemes, the Ex-Regional Health Authority Scheme (RHA), Existing Liabilities Scheme (ELS) and Clinical Negligence Scheme for Trusts (CNST), but the NHS Litigation Authority (NHSLA) accounts for all liabilities under the ELS, CNST and RHA schemes. The NHSLA's actuaries undertake reviews regularly to identify likely future settlements under these schemes and these are recorded in the accounts of the NHSLA.

Clinical negligence provisions in the accounts of the NHSLA as at 31 March 2006 include £28,707,000 for the RHA scheme, £1,402,137,000 under the ELS and £6,788,608,000 for CNST.

Of the total £8,219,452,000 clinical negligence provisions, £897,609,000 is expected to be payable within 1 year, £2,154,401,000 in 1 to 5 years and £5,167,442,000 after 5 years.

Early Departure

This Account provides 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 payment for termination of employment through redundancy, severance or early retirement. The provision also takes account of arrangements with pension schemes under which employees could 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.

The provision mainly relates to early retirement liabilities in Primary Care Trusts totalling £372,676,000. Of the total, £36,104,000 is expected to be payable within 1 year, £145,041,000 in 1 to 5 years and £191,531,000 after 5 years.

Further amounts of £9,522,000 are included in Strategic Health Authorities, £13,032,000 in Special Health Authorities, and £80,340,000 in the Department of Health, of which £15,009,000 is expected to be payable within 1 year, £37,794,000 in 1 to 5 years and £50,091,000 after 5 years.

Injury Benefits

This Account provides 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 in nature 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 earning capacity of that individual as a result. Total claim provided for is £590,939,000 of which £39,907,000 is expected to be payable within 1 year, £151,220,000 in 1 to 5 years and £399,812,000 after 5 years.

EEA Medical Costs

EEA Medical Costs are medical costs incurred by UK Citizens in other European countries which are liabilities payable by the UK to those European countries.

The total cost provided for is £588,426,000 of which £162,544,000 is expected to be payable within 1 year and £425,882,000 in 1 to 5 years.

Other

This Account provides for future support for patients who contracted HIV from contaminated blood supplies. On the basis of historic data, expenditure is likely to be incurred over a period of up to 30 years. Total claim provided for is £9,856,000 of which £3,280,000 is expected to be payable within 1 year, and £6,576,000 in 1 to 5 years.

Other legal claims against Primary Care Trusts are £44,675,000 of which £14,701,000 is expected to be payable within 1 year, and £14,338,000 in 1 to 5 years and £15,636,000 after 5 years. Further amounts of £1,691,000 are included in Strategic Health Authorities, of which £1,690,000 is expected to be payable within 1 year and £1,000 over 5 years.

Restructuring provisions by Primary Care Trusts are £6,296,000 of which £2,238,000 is expected to be payable within 1 year, £1,052,000 in 1 to 5 years and £3,006,000 after 5 years. Further amounts of £1,365,000 are included in Strategic Health Authorities, of which £648,000 is expected to be payable within 1 year and £717,000 after 5 years.

This Account provides for a scheme for persons infected by Hepatitis C contacted through blood and blood products in the course of treatment by the NHS. The amount provided is £32,877,000 of which £13,000,000 is expected to be payable within 1 year, £15,406,000 in 1 to 5 years and £4,471,000 after 5 years.

Other miscellaneous provisions is £297,045,000 of which £146,626,000 is payable within 1 year, £80,316,000 in 1 to 5 years and £70,103,000 after 5 years.

22 General Fund

The General Fund represents the total assets less liabliities of each of the entities within the accounting boundary, to the extent that the total is not represented by other reserves and financing items.

		2005-06		2004-05	
		£'000	£'000	£'000	£'000
	Note	Core Department	Consolidated	Core Department	Consolidated
Balance at 1 April		19,195,871	11,621,234	17,984,108	10,339,217
Net Parliamentary Funding					
Draw Down	24.5	7,298,484	62,384,625	6,373,963	54,911,625
Year end adjustment					
Supply Creditor/(Debtor) – current year	4	(890,342)	(890,342)	(628,340)	(628,340)
Net Transfer from Operating Activities					
Net Operating Cost	2	(5,982,595)	(62,525,380)	(5,445,114)	(53,777,859)
CFERs repayable to Consolidated Fund		–	(539)	(764)	(764)
Non Cash Charges					
Cost of Capital	10, 11	1,099,798	884,979	893,024	700,121
Auditors' remuneration	10, 11	490	542	500	500
PDC Investment adjustment		137,335	137,335	(13,192)	(13,192)
Transfers from Reserve	23.1	252,247	290,848	27,896	61,432
Other Transfers		1,409	17,357	3,790	28,494
Balance at 31 March		**21,112,697**	**11,920,659**	**19,195,871**	**11,621,234**

23 Reserves

The revaluation reserve reflects the unrealised element of the cumulative balance of indexation and revaluation adjustments (excluding donated assets)

23.1 Revaluation reserve

	2005-06		2004-05	
	£'000	£'000	£'000	£'000
	Core Department	Consolidated	Core Department	Consolidated
Balance at 1 April	694,504	2,603,477	237,587	1,166,433
Arising on revaluation during the year (net)	72,050	219,780	484,639	1,545,161
Impairment	(3,637)	(33,578)	–	(26,608)
Transferred to General Fund in respect of realised element of revaluation reserve	–	(38,319)	(1,799)	(34,930)
Transferred to General Fund on disposal	(252,247)	(252,529)	(25,923)	(25,927)
Other movements	–	–	–	(20,652)
Balance at 31 March	**510,670**	**2,498,831**	**694,504**	**2,603,477**

23.2 Donated assets reserve

The donated asset reserve reflects the net book value of assets donated to the department or other bodies within the resource account boundary.

	2005-06		2004-05	
	£'000	£'000	£'000	£'000
	Core Department	Consolidated	Core Department	Consolidated
Balance at 1 April	2,340	108,784	1,962	91,719
Additions arising in year	–	13,524	–	15,532
Revaluation and indexation	(109)	1,740	559	10,550
Release to the Operating Cost Statement in respect of:				
– Depreciation	–	(5,219)	–	(5,632)
– Impairments	–	–	(7)	(2,154)
– Disposals	(1,210)	(1,231)	(174)	(575)
Other movements	–	14,043	–	(656)
Balance at 31 March	**1,021**	**131,641**	**2,340**	**108,784**

24 Notes to the Consolidated Cash Flow Statement

24.1 Reconciliation of operating cost to operating cash flows

	Notes	2005-06 £'000	2004-05 £'000
Net operating cost	13	62,525,380	53,777,859
Adjustment for non-cash transactions	10	(3,705,733)	(1,140,815)
(Increase)/Decrease in Stock		129,129	2,739
(Increase)/Decrease in Debtors		256,306	83,317
less movements in debtors not relating to items not passing through the OCS		(3,522)	47,864
Increase/(Decrease) in creditors		(1,053,530)	(1,417,737)
less movements in creditors not relating to items not passing through the OCS		199,389	369,355
Use of provisions	21	1,028,279	1,024,934
Net cash outflow from operating activities		**59,375,698**	**52,747,516**

24.2 Analysis of capital expenditure and financial investment

	Notes	2005-06 £'000	2004-05 £'000
Tangible fixed asset additions	14	645,572	517,990
Intangible fixed asset additions	15	354,849	217,123
Proceeds of disposal of fixed assets		(558,173)	(251,310)
Purchase of Investments	16	2,116,138	2,025,029
Proceeds of disposal of Investments	16	(431,976)	(973,690)
Transfer of assets		(8,588)	–
Net cash outflow from investing activities		**2,117,822**	**1,535,142**

24.3 Analysis of capital expenditure and financial investment by Request for Resources

	Capital expenditure	Loans and Investments	A-in-A	Net total
	£'000	£'000	£'000	£'000
Request for resources 1	980,621	2,118,350	(990,149)	2,108,822
Request for resources 2	19,800	–	–	19,800
Net movement in debtors/creditors	(69,770)	–	(3,522)	(73,292)
Total 2005-06	**930,651**	**2,118,350**	**(993,671)**	**2,055,330**
Total 2004-05	**735,113**	**2,025,029**	**(1,225,000)**	**1,535,142**

24.4 Analysis of financing

	Notes	2005-06 £'000	2004-05 £'000
From the Consolidated Fund (Supply)-current year	22	62,384,625	54,911,625
Repayment of supply creditor	22	(628,340)	(390,215)
Advances from the Contingencies fund	22	1,700,000	–
Repayment to the Contingencies fund	22	(1,700,000)	–
Other	22	(567)	–
Net financing		**61,755,718**	**54,521,410**

24.5 Reconciliation of Net Cash Requirement to increase/(decrease) in cash

	Notes	2005-06 £'000	2004-05 £'000
Net cash requirement		61,494,283	54,283,285
From the Consolidated Fund (Supply)-current year	24(4)	(62,384,625)	(54,911,625)
Repayment of supply creditor	24(4)	628,340	390,215
Amount due to the Consolidated Fund received in prior year and paid over		764	13,326
Amount due to the Consolidated Fund -received and not paid over	3(1)	(237)	(764)
Other		41	–
Increase/(decrease) in cash		**(261,434)**	**(225,563)**

25 Notes to the Consolidated Statement of Operating Costs by Departmental Aim and Objectives

Programme grants and other current expenditure have been allocated as follows:

	2004-05 £m	2005-06 £m
Objective 1-Access to Services	24,524	26,749
Objective 2-Improving the Patient/User Experience	5,704	5,807
Objective 3-Health of the Population	26,184	29,111
Objective 4-Long Term Conditions	6,449	6,672
Other	8,720	11,585
	71,581	**79,924**

The Department's two high level objectives (as set as part of the Spending Review 2002) are:

- Improve Service Standards;
- Improve Health and Social Care outcomes for everyone;

These objectives have been broken down further (as in accordance with Spending Review 2004):

- Improve Service Standards:
  - I. Access to Services;
  - II. Improving the Patient/User Experience.
- Improve Health and Social Care Outcomes for Everyone:
  - I. Health of the Population;
  - II. Long-Term Conditions.

The Department has allocated expenditure to these objectives through the PSA target that it most closely contributes to.

Access to Services covers the following PSA targets:

- By 2008 no one waits more than 18 weeks from GP referral to hospital treatment;

Expenditure against this objective has been calculated from data presented in the National Schedule of Reference Costs (after stripping out expenditure on Cancer, CHD and Mental health so as not do double count with the Health of the Population) using data for;

- elective admissions (day case and ordinary elective);
- outpatients;
- non-elective admissions and A&E

We have also included expenditure on GMS from the Programme Budgeting data.

Although the PSA target on 'Increase the participation of problem drug users in drug treatment programmes by 100 percent by 2008' could also be included in this category, we have assumed that such expenditure would be subsumed in GMS expenditure.

Improving the Patient/User Experience covers the following PSA targets:

- Sustained annual national improvements in NHS patient experience by 2008;
- Improve the quality of life and independence of vulnerable older people by: increasing the proportion of older people being supported to live in their own home by one percent annually in 2007 and 2008, and;
- By 2008, increasing the proportion of those supported intensively to live at home to 34 percent of the total of those supported at home or in residential care.

This objective includes all expenditure classified as residual expenditure from the National Schedule of reference costs.

Health of the Population covers the following PSA targets:

- Increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women;
- Substantially reduce mortality rates by 2010 from heart disease and strokes, cancer and suicide and underdetermined injury;

- Reduce health inequalities by 10 percent by 2010 as measured by infant mortality and life expectancy at birth;

- Tackle the underlying determinants of health and health inequalities by reducing adult smoking rates to 21 percent or less, halting growth in child obesity and reducing the under-18 conception rate by 50 percent, by 2010.

This objective includes all expenditure estimated from Programme Budgeting expenditure on the Cancer, Circulation (CHD), Mental Health and Healthy Individuals programmes, plus the residual FHS prescription expenditure not already accounted for by Cancer, CHD and Mental Health.

The Long-Term Conditions objective has its own standalone PSA target:

- To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by five percent by 2008, through improved care in primary care and community settings for people with long-term conditions.

This objective includes all expenditure estimated from the latest available expenditure on adult personal social services plus Critical Care expenditure from the National Schedule of reference costs.

The "Other" category includes all activities that do not contribute directly to achieving the PSA targets, including the Workforce Development Confederation costs and funding for arms-length bodies not delivering front-line services.

In addition to matching expenditure against our high-level objectives, we have also presented in the Operating Financial Review an analysis allocating expenditure in terms of overall spend against specific conditions (programme budget categories). This analysis contains data collected directly from the PCTs and SHAs and provides a rich evidence base regarding where Department resources are utilised.

The most recently available reference costs data at the time of compiling these figures was 04/05 data. Therefore the 05/06 figures use this data. Note that this data was available in time to be used in the 04/05 Resource Account and so was also used in compiling the 04/05 figures. However the figures are not identical because they use (a) a different split of reference costs between cancer, CHD, mental health and other, (b) different programme budgeting data and (c) different adult PSS data.

26 Capital Commitments

	2005-06 £'000		2004-05 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Contracted capital commitments at 31 March 2006 for which no provision has been made	3,967,096	4,024,427	3,569,485	3,679,831
Authorised but not contracted	–	67	–	211

Core Department capital commitments relate to contracts entered into by Connecting for Health for the delivery of the National Programme for IT (see note 29 for further details).

27 Commitments under Leases

27.1 Operating Leases

Commitments under operating leases to pay rentals during the year following the year of these accounts are given in the table below, analysed according to the period in which the lease expires.

	2005-06 £'000		2004-05 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Obligations under operating leases comprise:				
Land and buildings:				
Expiry within 1 year	3,482	13,679	1,465	12,858
Expiry after 1 year but not more than 5 years	2,553	31,930	50	45,629
Expiry thereafter	12,849	97,431	6,849	67,800
	18,884	143,040	8,364	126,287
Other:				
Expiry within one year	–	9,759	–	9,389
Expiry after 1 year but not more than 5 years	–	24,988	–	24,426
Expiry thereafter	–	43	–	582
	–	**34,790**	**–**	**34,397**

27.2 Finance leases

Obligation under finance leases are as follows.

	2005-06 £'000		2004-05 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Obligations under finance leases comprise:				
Rentals due within 1 year	832	4,872	832	3,883
Rentals due after 1 year but within 5 years	3,359	71,022	3,404	21,853
Rentals due thereafter	1,842	40,445	1,842	45,793
	6,033	**116,339**	**6,078**	**71,529**
Less interest element	(2,546)	(32,325)	(2,501)	(55,865)
	3,487	**84,014**	**3,577**	**15,664**

28 Commitments under PFI contracts

PFI Schemes deemed to be off balance sheet

In this financial year, 31 PCTs reported off balance sheet PFI schemes over £1 million (2004-05: 21 PCTs). The estimated capital value of these schemes over £1 million is £348.8 million (2004-05: £195.6 million).

The total amount charged in the Operating Cost Statement in respect of off-balance sheet PFI transactions and the service element of on-balance sheet PFI transactions was £28,000,000 and the payments to which the department is committed during 2005-06, analysed by the period during which the commitment expires, is as follows:

	2005-06 £'000		2004-05 £'000 Restated	
	Core Department	Consolidated	Core Department	Consolidated
Expiry within 2 to 5 years	–	–	–	357
Expiry within 11 to 15 years	–	382	–	357
Expiry within 16 to 20 years	–	2,748	–	2,105
Expiry within 21 to 25 years	–	15,769	–	10,072
Expiry within 26 to 30 years	–	32,773	–	16,189
Expiry within 31 to 35 years	–	2,421	–	2,396
Expiry within 36 and beyond	–	3,877	–	3,774
	–	**57,970**	**–**	**35,250**

PFI schemes deemed to be on balance sheet

Teignbridge PCT has entered into an on-balance sheet PFI contract. The asset is treated as an asset of the PCT. The substance of this contract is the PCT has a finance lease and payments comprise an imputed finance lease charge and a service charge. The value of assets brought on balance sheet in respect of this scheme is £2.0 million (2004-05: £2.1 million)

The total amount charged in the Operating Cost Statement in respect of on-balance sheet PFI transactions and the service element of on-balance sheet PFI transactions was £280,000 and the payments to which the department is committed during 2005-06, analysed by the period during which the commitment expires, is as follows.

	2005-06 £'000		2004-05 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Rentals due within 1 year	–	300	–	300
Rentals due within 2 to 5 years	–	1,259	–	1,219
Rentals due thereafter	–	7,300	–	7,641
	–	8,859	–	9,160
Less interest element	–	(3,938)	–	(4,381)
	–	**4,921**	**–**	**4,779**

29 Other financial commitments

The Department (and its Agency) have entered into non-cancellable contracts for the National Programme for IT. Further details are given in note 26-Capital Commitments.

	2005-06 £'000	
	Core Department	Consolidated
Expiry within 1 year	53,581	66,759
Expiry within 2 to 5 years	1,265,649	1,300,020
Expiry thereafter	978,299	1,028,185
	2,297,529	2,394,964

The total amount for 2004-05 was £2,041,405,000.

At the balance sheet date Connecting for Health had entered into contracts which if delivered according to the terms of those contracts would result in commitments of £2,297,529,000 over the next 9 years. The contracts are for National Programme for IT, which is being delivered by the new Department of Health agency, NHS Connecting for Health, which is bringing modern computing systems into the NHS to improve patient care and service. Over the next ten years, Connecting for Health will connect over 30,000 GPs in England, almost 300 hospitals and give patients access to their personal health and care information, transforming the way NHS works. The contracts are such that the obligation to pay does not arise until the suppliers have implemented the solution to the required locations and it has been accepted after a period of live running.

30 Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the relationship that the Department has with NHS bodies and the way those bodies are financed, the Department as a whole is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The Department has limited powers to borrow or invest surplus funds, financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Department in undertaking its activities. As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from the currency profile.

Liquidity risk

The Department's net operating costs are financed from resources voted annually by Parliament. The Department also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. The Department is not, therefore, exposed to significant liquidity risks.

Currency Risk

Bodies within the Resource Accounting boundary have no or a relatively small amount of foreign currency income or expenditure except for EEA medical costs for which the Department has financial liabilities at 31/3/06 totalling £588,426,000. These liabilities are payable in the local currencies of the EEA member countries, primarily Euros. The Department enters into forward contracts for the purchase of Euros for the purpose of paying EEA medical costs in-line with existing arrangements where a specific amount of Euros are required at a particular date in accordance with Government Accounting, chapter 28.7. As at 31/3/06 the Department had entered into forward contracts to purchase €125m in July 2006 and €100m in December 2006.

Interest-Rate Risk

All of the Department's financial assets and financial liabilities carry nil or fixed rates of interest. The Department is not, therefore, exposed to significant interest-rate risk.

31 Contingent Assets and Liabilities disclosed under FRS 12

31.1 Contingent Assets

Government Departments with responsibility for services to look after children provided grants or loans for the provision or improvement of what were formerly approved schools but in 1973 became controlled or assisted community homes. These payments become repayable on change of use or disposal of part or the whole of the premises or facilities. The amount of the repayment is determined by a valuation by the District Valuer. At 31 March 2006 there were a number of cases where repayments to the Department may arise in the future when the homes close.

Property within the retained estate can be disposed of at an initial value with the final sale price being dependant upon the development of the site. Because this may not be known for some years after the initial disposal the Department has contingent assets relating to the future value. The Department will recognise additional disposal income when the development becomes certain, but currently cannot reliably estimate the value.

31.2 Contingent Liabilities

The Department is the actual or potential defendant in a number of actions regarding alleged clinical negligence. In some cases, costs have been provided for or otherwise charged to the accounts. In other cases, there is large degree of uncertainty as to the Department's liability and to the amounts involved. Possible total expenditure might be estimated at £4.27 billion, although £ 3.656 billion relating to the Clinical Negligence Scheme for Trusts (CNST), Property Expense Scheme (PES) and Liability to Third Parties Scheme (LTPS) would be expected to be met by payments receivable from NHS Trusts.

Within Primary Care Trusts' accounts at 31 March 2006, there were net contingent liabilities of £123,537,000 (2004-05: £83,736,000). These are mainly for continuing care and agenda for change. Primary Care Trusts have provided for these liabilities where they can reasonably estimate the likely value of potential claims received. Where these obligations cannot be reliably estimated a contingent liability has been recorded.

32 Contingent Liabilities not required to be disclosed under FRS 12 but included for parliamentary reporting and accountability

32.1 Quantifiable

The Department of Health has entered into the following quantifiable contingent liabilities by offering guarantees, indemnities or by giving letters of comfort. None of these is a contingent liability within the meaning of FRS12 since the likelihood of a transfer of economic benefit in settlement is too remote.

	1 April 2005	No.	Increase in year	Obligation expired in year	31 March 2006	No.	Amount reported to Parliament by departmental Minute
	£'000		£'000	£'000	£'000		£'000
Guarantees:	8,475	1	–	8,475	–	–	–
Indemnities:	157,000	4	1,250	2,000	156,250	4	156,250
	165,475	**5**	**1,250**	**10,475**	**156,250**	**4**	**156,250**

32.2 Unquantifiable

The Department of Health has entered into a number of unquantifiable or unlimited contingent liabilities with various health bodies and private companies. There were 29 indeminities.

None of these is a contingent liability within the meaning of FRS 12 since the possibility of a transfer of economic benefit in settlement is too remote.

Full details of these can be found in the Statement of Contingent or Nominal Liabilities held at the Department.

33 Losses and Special Payments and other Accounting Notes

33(a) Losses

	Cases	2005-06 Total £'000	Cases	2004-05 Total £'000
Total	186,502	189,419	133,441	62,693
Details of cases over £250,000	1	267	–	–
Cash losses	7	73,026	–	13,192
Claims abandoned	3,535	479	–	–
Administrative write-offs	17	9	–	–
Fruitless payments	56	8	–	–

The Department wrote off PDC to the value of £73,025,000 on the dissolution of three trusts North West Surrey Mental Health, Surrey Hampshire Borders and Surrey Oaklands. However, PDC of £206,376,000 was created in respect of the successor trust Surrey and Borders Partnership NHS Trust, so no overall loss was incurred by the Department.

The loss of £267,000 relates to the costs paid in respects of a long running claim against an appliance contractor which was lost on appeal. Central Liverpool PCT is continuing to pursue this claim through the disciplinary mechanisms.

Store losses

2005–06 £'000	2004–05 £'000
7,424	2,418

Write-off of Stock 2005-06 – NHS Logistics Authority reported write-offs relating to date expired of stock items. NHS Logistics Authority holds stocks of childhood vaccines on behalf of the Department. A quantity of these stocks will be destroyed annually due to damage in stores; failure (or suspected failure) to maintain vaccines at appropriate temperature during distribution and storage; variations in demand resulting in the expiry date of stock being exceeded. Other stock write-offs occur because of the technical obsolescence of vaccines or equipment that may arise from time to time. The value of stocks written-off in the year was £7,501,134.02. Included in the above was £7,424,406.64 of vaccines with a short expiry date. £76,727.38 of vaccines damaged by the distribution company, Healthcare Logistics. These monies have been recouped by the Department.

33 (b) Special Payments

	Cases	2005–06 Total £'000	Cases	2004–05 Total £'000
Total	6	5,762	4	49
Details of cases over £250,000	3	5,675	–	–

During the year 3 ex gratia payments were made amounting to £5,675,000 in relation to bids as part of the Independent Sector Treatment Centres programme.

34 Related Party Transaction

The Department is the parent of the executive agencies and other bodies within the group and sponsor of trading funds, executive non-departmental public bodies disclosed in Note 37. These bodies are regarded as related parties with which the Department has had various material transactions during the year.

In addition the Department has had a small number of transactions with other government departments, and other central government bodies.

Mrs C Beasley is an unpaid Trustee of Marie Curie Cancer Care and is a Governor at Thames Valley University, soon to become one of the University's Pro Vice-Chancellors. There is no conflict of interest.

Ms M Edwards partner is Chief Executive of "SMARTRISK" a charity involved in accident prevention. No payments were made to SMARTRISK in 2005-06. He is also Chair of the Health and Social Care Information Centre (from 1/4/2005). In addition he undertakes management consultancy for both DH and the NHS. Ms Edwards takes no part in the decisions to award these management consultany contracts.

Mr A Foster is a Director of Worldcrest Ltd which is an office rental company. At present there is no current conflict of interest, but there is always a possibility that Worldcrest could have NHS clients in the future.

Matt Tee (interim Director of Communications) is on secondment from Dr Foster, a joint venture of HSCIC.

35 Third Party assets

	31 March 2006 £'000	31 March 2005 £'000
Monetary assets		
Bank balances	2,886	3,621

36 Post Balance Sheet Events

As a result of a reorganisation of the NHS the 28 Strategic Healh Authorities formed 10 new Strategic Health Authorities on 1 July 2006 and the 303 Primary Care Trusts formed 152 Primary Care Trusts on 1 October 2006.

37 Entities within the departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2005/06:

Consolidated in the Department's Resource Accounts

Supply financed agencies

NHS Purchasing and Supply Agency

Other Bodies

Strategic Health Authorities
Primary Care Trusts
Special Health Authorities:
- NHS Business Services Authority (formed on 31/03/2006)
- Mental Health Act Commission
- Health and Social Care Information Centre
- Dental Vocational Training Authority
- Prescription Pricing Authority*****
- National Institute for Health and Clinical Excellence
- NHS Litigation Authority
- National Treatment Agency for substance misuse
- NHS Pensions Agency*****
- National Patient Safety Agency
- NHS Counter Fraud and Security Management Service*****
- Dental Practice Board*****
- NHS Appointment Commission
- NHS Institute for Innovation and Improvement (formed on 01/07/2005)
- UK Transplant*
- NHS U**

Not Consolidated

Trading Funds

NHS Estates (closed during the year)
Medicines & Healthcare Products Regulatory Agency

Executive Non-Departmental Public Bodies

National Biological Standards Board
Human Fertilisation and Embryology Authority
General Social Care Council
Health Protection Agency
Commission for Patient and Public Involvement in Health
Independent Regulator of NHS Foundation Trusts
Council for Healthcare Regulatory Excellence
Commission for Social Care Inspection
Health Care Commission***
Human Tissue Authority ****
Postgraduate Medical Education and Training Board

NHS Trusts
Food Standards Agency
Plasma Resources UK Ltd
NHS Blood and Transplant (formed on 01/10/2005)
NHS Logistics Authority*****
NHS Shared Business Services
NHS Direct
NHS Professionals
Social Care Institute for Excellence
Foundation Trusts
NHS Blood Authority*

* Merged to form NHS Blood and Transplant – 01/10/2005.

** Merged to form NHS Institute for Innovation and Improvement – 01/07/2005.

*** To be merged with Commission for Social Care Inspection.

**** To be merged with Human Fertilisation and Embryology Authority.

***** Part of NHS Business Services Authority from 01/04/2006.

Annex A

GLOSSARY OF GOVERNMENTAL TERMS

Administration costs. Administration costs are those which fall under the administration cost control regime.

Appropriations-in-Aid (A-in-A). Receipts retained by the Department and used to finance related expenditure. A-in-A can be revenue or capital in nature.

Comptroller & Auditor General. Head of the National Audit Office. Responsible for auditing the Department's resource accounts.

Consolidated fund. The Treasury's account at the Bank of England which is used by most government Departments for processing payments or receipts.

Consolidated Fund Extra Receipts (CFERs). Receipts which the Department cannot use to finance expenditure and which are surrendered to the Consolidated Fund. CFERs can be revenue or capital in nature.

Cost of capital. A charge on assets employed representing the cost of their use.

Grants. Payments by the Department to other bodies. Can be revenue or capital in nature.

Executive Agencies. These carry out specific functions on behalf of the parent Department within a framework agreed by Ministers.

Health Authorities. Bodies responsible for identifying the health care needs of their population and for commissioning health care provision.

NHS Trusts. These comprise hospitals, community health services, mental health services or ambulance services and provide services to patients as requested by Health Authorities and GPs.

Foundation Trusts (NHSFT). These are trusts with a system of statutory accountability (elected Board of Governors) through an Independent Regulator (IR). Ministers have no powers to intervene directly in an NHSFT, and have no powers of direction over the IR.

Non-Departmental Public Bodies. A body which has a role in the process of government but operates at arm's length from government Ministers.

Operating Cost Statement. Shows net resources consumed during the year.

Parent Department. The Department of Health, including those parts of the Department formerly known as the NHS Executive.

Programme costs. Programme costs include the running costs of NHS bodies funded directly by the Department but otherwise reflect non-administration costs, including payments of grants and other disbursements by the Department.

Personal Social Services (PSS). The services provided by Local Authority Social Service Departments.

Request for Resources (RfR). A statement identifying what the Department will spend on its voted provision.

Resource accounting. The application of accruals accounting to central government.

Resource budget. Covers planning and controlling Departmental expenditure on a resource (accruals) accounting basis.

Vote. Money voted to Departments by Parliament through the supply procedure.

Annex B

NAO Reports principally for DH

Financial Management in the NHS – NHS (England) Summarised Accounts 2004-05

1. This joint report with the Audit Commission provides a detailed analysis of the state of the NHS financial management and reporting issues and considers significant financial issues facing the NHS.

2. An increasing number of bodies are finding it difficult to manage resources effectively and those which have had deficits in the past have often found it difficult to recover from them. The report identifies some of the reasons for this and highlights where improvements could be made. It also identifies some examples of good practice in recovering deficits from which other organisations could learn.

3. The report's recommendations include the following:

   - NHS bodies should develop a whole organisation approach to managing risks, particularly in delivering financial balance;
   - The financial management of changes by NHS bodies, such as the implementation of Payment by Results, and the identification of skills needed to respond to them, should be made an early, board-level priority;
   - The current NHS financial regime should continue to evolve to ensure that it provides the right incentives and reporting arrangements to support long-term financial sustainability; and
   - In order to ensure the faster closing of local NHS accounts, NHS bodies should review their accounts production processes with their auditors.

Improving the Use of Temporary Nursing staff in NHS acute and Foundation Trusts

4. The National Audit Office has found that while the NHS has successfully reduced its expenditure on agency nursing staff, temporary staff remain a key component of trusts' ability to be flexible and expenditure on temporary nursing staff employed through nursing banks and NHS Professionals has increased. Many NHS trusts do not have robust information to help determine cost-effective staffing levels or to understand their real staffing needs. The National Audit Office's report estimates that between £38 million and £85 million a year can be saved by better procurement of temporary nursing staff and better management of permanent nursing staff.

5. Acute and foundation trusts in England spent £790 million on temporary nursing staff in 2004-05. This has fallen from its peak of seven per cent of the total spent on nurses down to three per cent in 2004-05. However, trusts have paid less attention to addressing the wider issues of controlling and managing demand for all types of temporary nursing staff.

6. NHS trusts have to be able to respond to fluctuations in demand and staff availability through flexible staffing arrangements. The use of temporary staff forms a key part of this flexibility for many trusts. In addition high levels of vacancies and extensive use of temporary staff can worsen patient satisfaction and staff morale.

7. The report finds that work by NHS Professionals and the NHS Purchasing and Supply Agency have improved the cost and quality of temporary nursing staff but more needs to be done to ensure that all temporary staffing suppliers are operating to consistent standards.

The National Programme for IT in the NHS

8. The Programme's scope, vision and complexity are wider and more extensive than any ongoing or planned healthcare IT programme in the world and it represents the largest single IT investment in the UK to date. It is designed to deliver important financial, patient safety and service benefits.

9. The NAO found that the Department and NHS Connecting for Health have made substantial progress with the Programme. Successful implementation of the Programme nevertheless continues to present significant challenges for the Department, NHS Connecting for Health and the NHS, especially in three key areas:

- Ensuring that the IT suppliers continue to deliver systems that meet the needs of the NHS, and to agreed timescales without further slippage;
- Ensuring that NHS organisations can and do fully play their part in implementing the Programme's systems;
- Winning the support of NHS staff and the public in making the best use of the systems to improve services.

The Paddington Health Campus scheme

10. The scheme was a complex and ambitious attempt to build a world-class healthcare facility and ultimately proved to be beyond the capacity of the scheme partners to deliver. There were three main reasons for this.
    - the number and scale of the risks and the lack of a single body in charge of the scheme;
    - the way in which the partners organised and carried through the scheme;
    - the lack of active strategic support for the campus vision.
11. The National Audit Office considered that the North West London Strategic Health Authority should either have required the campus partners to draw up a new Outline Business Case in early 2003 or cancelled the scheme at that stage. In late 2002, external construction consultants confirmed that the estimated capital construction costs had more than doubled and Westminster City Council confirmed that the scheme could not fit on the land available.
12. The report concludes that the failure of the Two NHS Trusts – St Mary's NHS Trust and the Royal Brompton and Harefield NHS Trust – to merge at the start of the process was a key factor in the failure of the scheme. Their diverging clinical and financial interests were exposed as the scheme wore on, exacerbated by developments in NHS policy.
13. The scheme eventually failed in May 2005 for three specific reasons:
    - The Campus partners were unable to secure adequate land for the scheme;
    - The Campus partners, and others, differed over whether the scheme was affordable;
    - Capacity planning in 2005 indicated that the local NHS in North West London needed to reduce capacity by 500 to 600 beds.
14. All three reasons caused the Board of the Royal Brompton and Harefield NHS Trust to decline to recommend the scheme for approval to proceed in May 2005. The scheme was formally cancelled in June 2005.

The Provision of Out-of-Hours Care in England

15. There were shortcomings in the process of setting up new arrangements to provide out-of-hours primary medical care in 2004, although there is no evidence that patient safety was compromised. The Primary Care Trusts (PCTs) who took over responsibility for organising out-of-hours services from GPs lacked knowledge and experience in this area. However, most patients say that they are receiving a good service, with six out of ten rating it as excellent or good.
16. The service is now beginning to reach a satisfactory standard but no providers are meeting all the requirements and few are reaching the requirements for speed of response. Fewer than 10 per cent of PCTs who responded to the NAO's survey are meeting the speed of response targets – that a clinical assessment should be started within 20 minutes of a call for urgent cases and within 60 minutes of a call for non-urgent cases.
17. Some PCTs are still confused over whether the out-of-hours services should be restricted to urgent cases or should respond to any request for medical care outside normal working hours – although there is no evidence patient safety is being compromised.

Tackling Child Obesity – First Steps

18. Without clearer leadership from Departments there is a risk that the Government's target to halt the rise in obesity in children under 11 will not be met. "Tackling Childhood Obesity – First Steps" warns that a lack of timely guidance has meant that the various organisations that will need to work together to deliver the target have been unclear about their roles. Without greater clarity, those further down the delivery chain may be wasting resources on ineffective or inappropriate interventions that fail to target those children most at risk.

19. The target 'to halt the increase in obesity among children under the age of 11 by 2010' was set in 2004 as a Public Service Agreement in response to a jump in the growth of childhood obesity. The target is jointly owned by Department of Health, Department for Culture, Media and Sport, and Department for Education and Skills.

20. The report (which is a joint report by the National Audit Office, the Audit Commission and the Healthcare Commission) recommends:

- greater clarity and direction from central Government: it is essential that the three Departments work closely together to provide strong leadership;
- better definition of regional roles and responsibilities: Government Offices for the Regions could play a greater role in bringing together the various elements of the delivery chain;
- strengthening local partnerships: local structures and mechanisms, such as local strategic partnerships and children's trusts, exist to promote joint working and have the potential to reduce the risk of duplication of activities by bringing together funding around agreed priorities;
- more support for front line staff: better information and training on roles and responsibilities and improved dissemination of advice and guidance.

Reducing Brain Damage: Faster access to better stroke care

21. The NAO concluded that the priority afforded to stroke care by the Department of Health and the wider health service can be increased, given its impact and cost. Sir John's report shows that notable progress has been made from a low starting point. It recommended further improvements in preventing, treating and managing stroke patients, in line with recent evidence. These improvements would reduce the number of deaths, improve recovery rates, increase NHS efficiency and lead to significant financial savings. The report made a number of conclusions and recommendations target areas needing attention and action.

A Safer Place for Patients: learning to improve patient safety

22. A report by the National Audit Office reported that around a half of incidents in which NHS hospital patients are unintentionally harmed could have been avoided, if lessons from previous incidents had been learned. Whilst reporting has improved at the local level, at the national level progress on developing a national reporting and learning system has been slower than envisaged in the Department of Health's 2001 strategy "Building a safer NHS for patients". Overall, there remains a clear need to improve evaluation and sharing of lessons and solutions by the large number of organisations with a stake in patient safety. There is also a need for a clear system for monitoring that lessons are learned.

23. The NAO has made a number of recommendations aimed at enhancing and sustaining the development of an effective safety culture; improving the reliability and completeness of reporting; and encouraging learning and the development of effective solutions. For example: trusts need to evaluate their safety cultures and develop systems in which NHS employees need not fear blame or unequal treatment if they report incidents; and patient safety must become a core part of professional clinical training.

24. The report also recommends that there should be a clearer definition of 'near-misses' and encouragement of staff to report them and that the Department should explore the possibility of a single point to which all staff can report, for example, via the National Programme for Information Technology in the NHS.

The Refinancing of the Norfolk & Norwich PFI Hospital: How the deal can be viewed in the light of the refinancing

25. The report concludes that the Norfolk and Norwich University Hospital NHS Trust has shared in the gains from a refinancing of its early PFI hospital contract, but it continues to pay a premium in respect

of the financing costs compared to current deals. The NAO concluded also that the Trust has received the benefits of a new hospital earlier than many other communities and avoided the high rate of recent construction cost inflation.

26. However, other factors, some of which have yet to be fully analysed by the Department of Health, could also affect comparisons between the prices of early PFI deals and those being entered into today. The NAO recommends that the Department should carry out further analysis to identify how the pricing of all elements of PFI deals has changed over time – taking account of changes to the deals being entered into, general economic factors and other factors specific to the PFI market such as whether the private sector is delivering cost efficiencies from their increasing experience of delivering PFI projects.

27. The NAO also concluded that it might have been possible for the Trust to have improved the original deal with greater competition and better defined requirements in the closing stages but the Trust is not convinced it could have obtained any added benefits in what was then an immature market as it sought to close a pathfinder deal which had already been assessed as value for money.

Innovation in the NHS: Local Improvement Finance Trusts

28. The examination was the Local Improvement Finance Trust (LIFT) initiative, launched in 2001. A LIFTCo is a local joint venture made up of local stakeholders (typically Primary Care Trusts, Local Authorities and GPs), a private sector partner and Partnerships for Health, itself a national joint venture between public and private sectors. The LIFTCo takes ownership of the premises it builds or refurbishes and then leases the space to health and social care providers. Main points:

29. The NAO concluded that LIFT is an effective means of improving primary health and social care. The LIFT model has a number of strengths: it takes a long term strategic approach to local health provision which combines the benefits of national support and local control.

30. LIFT appears to be an effective and flexible procurement mechanism, capable of producing value for money. Although not suitable for all areas, LIFT has advantages over alternatives such as third party development or procurement under the Private Finance Initiative. Developments are more likely to meet local needs while benefiting from standardised documentation and LIFT is better suited to small scale deals than PFI.

31. The Department of Health, on the whole, managed well the setting up of the initiative. The initial deals that the NAO examined are robust. They offer clear long term benefits to both the public and private sector, with value for money safeguards built into the contracts.

The NHS Cancer Plan: A Progress Report

32. The National Audit Office reported that, four years into the 10-year NHS Cancer Plan, substantial progress has been made in meeting the Plan's targets. The thirty-four cancer networks which have been established have achieved important improvements in delivering cancer services across England. However, the networks need to be more effective and to develop partnership working further if the targets in the Plan are to be fully met by 2010.

33. Among the NAO's recommendations to the Department are that it consider what changes are necessary to the cancer strategy and that it should publish progress against the Cancer Plan annually. The Department should also ensure that the roles of cancer network constituent organisations are clearly defined and adhered to. In addition, the NAO recommends that strategic health authorities should ensure that cancer networks have the necessary resources required; and that the networks have appropriate planning arrangements in place to implement the Cancer Plan.

Relevant reports covering several Departments

Achieving Innovations in Cental Government Organisations

34. An examination of central departments and agencies to ascertain what kinds of innovations they have recently made, and analysis of the factors that they see as important in sustaining the innovations:

- The innovation process in central government is top-down and dominated by senior management.
- Contributions from lower-level staff are not so important.

- Innovative changes are often launched because of either political or ministerial pressures or efficiency drives.
- Departments and agencies have a stockpile of possible innovations to hand which they use to sustain change.
- The availability of funding is cited as a key factor sustaining innovations.
- The main barriers to innovation are a reluctance to embrace new ways of working and fragmentation within government, creating 'silos' between agencies.
- The main impacts of applied innovations are improvements in services and responsiveness, but innovations seem to be less successful in cutting costs or improving staff working conditions.
- The behaviours needed for innovation often challenge traditional ways of thinking and need to be recognised and rewarded. Departments and agencies can learn lessons from the private sector in developing more regular and serial innovations.

Evaluation of Regulatory Impact Assessments 2005-06

35. This is the third evaluation of the use of Regulatory Impact Assessments (RIAs) including the extent to which RIA practice was integrated into departments' culture by analysing a sample of RIAs from four government departments – the Department of Trade and Industry, the Home Office, the Department for Transport and the Department for Culture, Media and Sport. Main points, which are lessons for all Departments:

    - RIAs are often not used in the right way,
    - the purpose of RIAs is not always understood,
    - there is a lack of clarity in the presentation of the analysis and persistent weaknesses in the assessments,
    - departments have been slow to improve the quality of RIAs and integrate them into the policy-making process.

36. As a result, in many cases RIAs have not offered a robust challenge to proposals to regulate.

37. The NAO found that the quality of RIAs was mixed, but certain elements within them were generally undertaken well, such as stakeholder consultation. The weakest area was the consideration of the level of compliance with the proposed regulation, where departments too often assume that new regulations will be fully complied with and do not consider the impact of lower levels of compliance. The NAO found weaknesses in how costs and benefits were assessed. The NAO also found insufficient evidence of plans being developed for successful implementation and that little thought is given to evaluating the effect of regulations after they are implemented.

Smarter food procurement in the public sector

38. The NAO looked at a full range of public sector catering but with particular focus on schools, hospitals and armed forces bases. The study found that the public sector could save annually over £220 million in food and catering costs by 2010-11, while raising nutritional standards and increasing sustainability. In particular, there is significant scope for improvement by increasing joined up procurement, implementing good practice, enhancing the roles and improving the development of catering staff in the public sector and increasing the take up of meals.

39. The NAO identified scope for significant efficiency gains. There is considerable variation in the prices paid by public bodies for similar items; for example, the price of a pint of milk varied between 17 and 44 pence and a loaf of wholemeal bread cost between 32 pence and £1.10. The NAO estimates that £40 million can be saved by getting lower prices for the same or better quality food ingredients. In addition, a further £80 million can be saved by more joint purchasing to exploit the buying power of the public sector. The report recommended that PASA should continue to increase take-up of its national framework contacts, promote hospitals with central processing units as potential suppliers and develop the work of one of the Collaborative Procurement Hubs in increasing joint procurement of food between Trusts.

Strengthening the links in public service delivery chains

40. Few national targets for improving public services can be achieved by central government departments alone. Successful delivery of Whitehall's targets, set out in Public Service Agreements (PSAs), relies on a complex chain of organisations involving local authorities and health trusts, as well as private, voluntary and community organisations. Government departments should build stronger partnerships with local bodies and come to a better understanding of the challenges they face.

41. This is the key message of a joint report by the National Audit Office and Audit Commission. It draws on a series of joint publications from the Audit Commission and the National Audit Office which analyse national and local aspects of three major PSA targets: supplying affordable housing, promoting bus use, and halting the rise in child obesity. (The last of these reports was prepared with the Healthcare Commission).

Working with the Third Sector

42. A follow up of the 2002 Treasury Reviews that made numerous recommendations aimed at improving funding practices relating to Third Sector Organisatons (TSOs). TSOs already carry out a wide variety of public services such as hospice care for terminally ill patients, childcare services in disadvantaged areas, and advice and guidance for young people. The Home Office co-ordinates the government's efforts to engage with TSOs, but the quality and timeliness of its data on the level of public funds invested should be improved. A number of recommendations were made for the Home Office to implement.

Public Service Agreements: Managing Data Quality – Compendium Report

43. This was an interim report drawing on the NAO's examination of the data systems used by seven Departments and the cross cutting Sure Start programme. It summarises the findings from those validations and highlights successful practices which have wider applicability and can improve the management of data systems across government.

44. A second report was published in March 2006 which set out the NAO's overall findings following its dry run valiadations of the systems underpinning a number of Departments' 2003-06 PSA targets (including those of the Department of Health).

45. The NAO found that Departments had made variable progress in meeting good practice principles for managing data systems. For some targets, Departments had overcome substantial measurement challenges to develop and operate good systems which addressed the main risks to the reliability of reported data. But for other targets Departments had not, at the time of validations, developed operating systems that managed all the significant risks to data reliability or explained the existence of those weaknesses to readers of their public performance reports.

46. The reports identify a number of steps that Departments can take to improve data systems.

Annex C

RECENT PAC HEARINGS: MAIN ISSUES

Reducing brain damage: faster access to better stoke care

1. Examined whether the NHS is providing effective and high quality stroke care services in England, in terms of acute response, rehabilitation and prevention, and whether the Department of Health is managing and supporting the programme of stroke care. Main points:

    - Stroke care had not been a high priority for DH/NHS – leading to needless deaths.
    - Numbers of WTE stroke care consultants significantly below British Association for Stroke Physicians recommendations.
    - Need to improve the ratios of patients to consultants (i.e. it is almost double that for coronary heart disease).
    - England lags behind in international comparisons on speed of initial treatment (Sweden and Australia)
    - Need for more dedicated stroke units and to increase the proportion of patients' stay on these.

A safer place for patients: learning to improve patient safety

2. Examined whether the NHS has been successful in improving the patient safety culture, encouraging reporting and learning from patient safety incidents. Main points:

    - Wide variation in estimates of patient safety incidents.
    - Delays in the development of the National Reporting and Learning System.
    - Need to rationalise the number of agencies involved in monitoring patient safety incidents.
    - International comparisons – England about average.

The refinancing of the Norfolk and Norwich PFI hospital: how the deal can be viewed in the light of refinancing

3. Examined the benefits which accrued to the private sector shareholders as a result of the refinancing, whether the Trust could have improved the original PFI deal and how the price the Trust is paying following the refinancing compares with current PFI hospital deals. Main points:

    - The opportunity for large refinancing gains not seriously considered as part of the original deal negotiations.
    - Through borrowing more, on the back of an extended contract period, benefits to investors increased on refinancing to unacceptable levels.
    - The Accounting Officer had had to defend "the unacceptable face of capitalism".
    - The Trust now has liabilities that could include all the additional borrowings used to boost investors' returns.

Innovation in the NHS: Local Improvement Finance Trusts

4. Examined whether LIFT will support improved primary and social care services that meet local needs while providing value for money. Main points:

    - Rewards for the private sector seem quite high for "low risk" projects.
    - LIFT may be diverting resources from other parts of the local NHS.
    - Need to establish a framework to evaluate the impact of LIFT.

- Lack of a single point of overall accountability for individual schemes.
- Some resistance from some GPs.

The NHS Cancer Plan: a progress report

5. Examined the NHS Cancer Plan, reviewing its content, implementation across the country and progress against the targets and commitments in the Plan. Main points:

- Progress against the targets and commitments in the Plan had been encouraging.
- Targets relating to waiting times, to be met by the end of 2005 would prove challenging.
- Increased funding for cancer services was getting through to the front line and being spent directly to fund new drugs, staffing and new services.
- Cancer networks had introduced a new way of approaching the delivery of cancer services with significant successes in terms of better local cancer services.
- In some network localities, commissioning of cancer services was not sufficiently joined-up.
- Clear disparities between the affluent and poorer members of society in terms of cancer outcomes.
- Wide geographical variation in the use of NICE approved cancer drugs.

Tackling cancer in England: improving the patient journey

6. Examination of an NAO survey of patients with the cancers that cause the most deaths, to gauge progress made in the four years since the introduction of the Cancer Plan. Main points:

- Overall, patients were broadly positive about their experiences; some progress made in most aspects of the patient experience since 2000, but less so for prostate cancer patients.
- Prostate cancer patients and cancer patients in London reported a worse experience than other cancer patients.
- Need to improve communication of information, symptom relief and options for some patients on where they want to be in their last days.

Reforming NHS Dentistry: ensuring effective management of risks

7. Examined the rationale for the changes the Department is to make to NHS dentistry in England, the strengths and weaknesses of the existing system and the risks that the Department and the NHS will need to manage. Main points:

- The Department had set itself an ambitious programme and had not implemented the reforms in line with the original anticipated timescale.
- Concern about the lack of PCTs' experience of commissioning dental services.
- Need for SHAs and PCTs to improve their understanding of both need and demand for NHS dentistry.
- Further work needed to identify suitable measures of oral health.
- Need for effective accountability arrangements for dental performance under the new remuneration system, a communications programme to explain the new dental recall guidelines to patients, and further work to identify how to incentivise dentists to stay in the NHS.

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