Department of Health

Annual Report and Accounts

2011-12

(For the period ended 31 March 2012)

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

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

Annual Report and Accounts presented to the House of Lords by Command of Her Majesty

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ANNUAL REPORT AND MANAGEMENT COMMENTARY

1 SUMMARY OF THE YEAR

1.1 Transformation and reform have been the defining themes for both the Department and the health and care system during 2011-12. A year of unprecedented change has seen royal assent for the Health & Social Care Act 2012. This modernising legislation will open up the pace of reform and put patients and their communities at the heart of service delivery – with change driven by local service providers and clinicians. It will also transform the way in which healthcare is commissioned, and will redefine the relationship between commissioners and providers.

1.2 The Health & Social Care Act 2012 responds to the clear imperative for action driven by the rising incidence of chronic, long-term and lifestyle-related health conditions and by the increasing pressure that a rapidly ageing population puts on the health and care systems. With this in mind, the empowerment of both patients and the users of care, in the context of local priorities and decision-making, rests at the heart of these reforms.

1.3 The Government has set out a number of aspirations for the health and care systems:

- A focus on ensuring that the people they serve have the best possible health, with outcomes that are as good as those in the healthiest nations in the World;
- A focus on prevention – ensuring that the services provided are as effective at keeping people in good health as they are at treating ill-health;
- A focus on people and patients, responding to their needs according to local priorities, and led by clinicians and health care professionals; and
- A focus on improving health outcomes, increasing productivity and ensuring that quality lies at the heart of every service provided.

1.4 Progress has been made in terms of creating the new structural architecture that will support system transformation. For example, the NHS Commissioning Board Authority was established in October 2011, and has laid solid foundations for the authorisation of the 212 Clinical Commissioning Groups. The NHS Trust Development Authority (NTDA) was established in June 2012, with a principal aim of supporting the transition of the remaining NHS Trusts to achieving NHS Foundation Trust status.

1.5 Throughout 2011-12, the Department has also begun a period of significant change as it develops its new role in response to the substantial changes in the wider health and care system. Crucially, DH will no longer have a direct relationship with NHS organisations, but will instead operate via its Arms Length Bodies – in particular, through the NHS Commissioning Board, Monitor and the NTDA. By means of a thorough planning exercise, the Department has already begun to establish the scope and size of its own future workforce, so that by April 2013, there will be significantly fewer permanent and non-permanent staff employed by DH across five rather than the current 10 Directorates.

1.6 As part of this process of self-examination, and to support the Coalition Government's principles of reducing the costs of Non-Departmental Public Bodies, the Department has undertaken a detailed review of the purpose and functions of its own Arms Length Bodies (ALBs). As a result, seven of these organisations will either leave the sector (to become self-funding) or will be abolished. Continuing ALBs will be required to operate more efficiently, making the best use of commercial opportunities. Their relationship with the Department, especially in terms of relative roles and responsibilities, will be clearly defined in formal framework agreements.

1.7 In a further very significant change, from 2011-12, overall DH administration costs have been extended to cover the costs of running both the Department itself and all other non-provider NHS organisations (including Primary Care Trusts, Strategic Health Authorities and all Arms Length Bodies). In this context, the Department has continued to work towards the challenge set in the 2010 Spending Review of reducing total administration expenditure by one third by 2014-15. The key results are set out below.

1.8 In terms of the Department's Annual Report & Accounts, the Treasury's Clear Line of Sight legislation (designed to bring consistency between budgets, estimates and accounts) has led to a very substantial increase in the Department's Resource Accounting Boundary in 2011-12. Essentially, the number of individual organisations' accounts consolidated into the DH group account has increased to 437, compared to 169 in 2010-11. This is mainly because the financial results of the entire provider sector are now included for the first time. To allow proper comparison between the years, the Department has

restated its 2010-11 accounts, and the new comparators (with appropriate explanatory notes) are presented in the 2011-12 financial statements.

1.9 In summary, key results for the year have included:

- The Department met all of its financial duties for the year, managing its resources within the budgets set by Treasury or the amounts voted by Parliament. Overall revenue expenditure for the Department of Health increased by 2.9% to £101.6 billion in 2011-12 (compared to £100.3 billion in 2010-11). The Department recorded a £829 million (or 0.8%) underspend against this revenue resource limit.

- Total capital expenditure in 2011-12 was £372 million lower (9%) in cash terms when compared to 2010-11. At the end of the year, there was an underspend of £566 million, which mainly resulted from lower than expected expenditure by both NHS Connecting for Health and the NHS Foundation Trust sector.

- Spending on front line services for patients increased in real terms by 1% in 2011-12. Primary Care Trusts reported a 4% increase in expenditure on secondary healthcare (driven by an increase in activity, a change in case mix and a degree of price inflation) and a 1% increase in the purchase of primary health care.

- In contrast by the end of the year, the Department's administration spend was some £662 million lower in real terms than had been forecast in the revised impact assessment for 2010-11. This significant reduction reflected a faster pace of decrease than anticipated, and resulted both from the downsizing of the Department and the NHS commissioning sector, a targeted reduction in certain categories of administration spend and a reduction in staffing and other costs. This means that, over the life of the current Parliament, the expected savings associated with this programme of reform have increased from £4.5 billion to £5.6 billion.

- Total DH expenditure (revenue expenditure plus capital expenditure less depreciation) in 2011-12, including expenditure on both administration and front- line services was 0.1% higher in real terms than in 2010-11.

- Compared to 2010-11, the Core Department (including NHS Connecting for Health) and its Arms Length Bodies reduced expenditure on consultancy by £2.9 million (13%) and on temporary and agency staff by £79 million (43%).

- The average number of whole time equivalent staff employed by the core Department fell by 605 (18%) compared to 2010-11. The total number of whole-time-equivalent staff employed by NHS organisations decreased by 28,697 (2.6%) over the same period.

- Despite the focus on reform, the NHS, acting through its 1.1 million staff, continued to ensure that health services were provided to 1.5 million patients every day, and that waiting times remained low and stable. In this context, the NHS as a whole delivered a surplus of £2.0 billion (comprising £1.58 billion in the Commissioning sector and £497 million from NHS providers, before impairments).

- The Department continued to set the overall strategic framework for adult social care during the year, with 1.6 million social care workers providing services to 1.6 million care users through 25,000 registered providers.

- The NHS has delivered against five key ambitions for the year:

    - All performance measures relating to A&E attendance, cancer treatment, access to dentistry and waiting times were met;
    - MRSA and C. Difficile infection rates are at their lowest level since mandatory monitoring and reporting were introduced;
    - For the first time, all ambulance trusts exceeded the performance measure to respond to immediately life-threatening calls within eight minutes;

- The lowest ever level of patients waited more than 18 weeks for treatment, with both the 90% target for admitted patients and the 95% target for non-admitted patients met in each month; and
- In terms of the Quality, Innovation, Productivity and Prevention (QIPP) challenge, the NHS delivered its target savings for 2011-12 of £5.8 billion.

2 ACCOUNTING & LEGISLATIVE FRAMEWORK

2.1 The Department's Annual Report and Accounts are published each year by HM Treasury, and form an essential part of the Department's accountability to both Parliament and the public for financial performance and the use of resources. These accounts also provide details of the high-level management and governance of the Department, and summarise performance, policy and financial achievements for the year just ended. There are a number of significant differences in this year's accounts compared to previous years. Most notably, the impact of the Treasury's Clear Line of Sight legislation (Constitutional Reform & Governance Act 2010) means that from 2011-12, the Department's accounts now cover a much wider group, because the individual accounts of all 256 NHS provider organisations, and all Arms Length Bodies, are consolidated for the first time. In turn, the Annual Report now focuses to a much greater extent on financial results across the whole group, and brings together the key financial and performance material which used to be published in the annual report to the NHS Summarised Accounts, and which Monitor has published in respect of NHS Foundation Trusts in the NHS Foundation Trusts: Consolidated Accounts 2011-12.

2.2 In July, the Secretary of State published his Annual Report: *2011-12 National Health Service and Public Health Service in England*. This described the developments in the comprehensive health system in 2011-12 and reported on performance across the health service. The Secretary of State's Report complements the material in this Annual Report to the accounts, and, as it develops in future years, it will focus on demonstrating the Secretary of State's accountability for the National Health Service, and in assessing the performance of NHS organisations in exercising their functions. Further, more detailed information in respect of NHS financial and operational performance can also be found in *The Year* – Sir David Nicholson's annual report on the NHS which was published in June.

2.3 In addition to the Annual Report and Accounts, the other key elements of financial accountability published during the year are as follows:

- **Parliamentary Estimates** – Estimates are the Government's requests for resources from Parliament, presented annually in a cycle prescribed by the Treasury. Details of each Department's Estimate can be found on the Treasury website: www.hm-treasury.gov.uk:
  - Main Supply Estimates start the supply procedure and are presented at the beginning of the financial year to which they relate;
  - In 2011-12, as a consequence of the changes introduced by the Treasury's Clear Line of Sight (alignment) legislation, only one Supplementary Estimate was permitted, and this was voted in February 2012. This further Estimate represented the final changes to supply and funding required by the Department for the year. In previous years, Supplementary Estimates were presented, as necessary, in June (Summer Supplementary), November (Winter Supplementary) and February (Spring Supplementary).
- **Public Expenditure Statistical Analyses –** The Government regularly publishes information on departmental and other government spending in the Public Expenditure Statistical Analyses (PESA). This analysis covers both spending plans and outturn expressed in terms of budgeting aggregates, and functional spending based on the Total Expenditure on Services framework (TES), which broadly represents the total revenue and capital spending of the public sector. Treasury published these outturn forecasts for 2011-12 in April and July 2012 showing provisional expenditure against the Departmental Expenditure Limits and the Administration Cost Limit (which covers the Department's running costs).

2.4 For the first time, the Annual Report includes a discrete annex to report performance on sustainability by all health organisations within the accounting boundary. This new reporting requirement includes a comparison of financial and non-financial information in respect of organisations' emissions, waste and finite resource consumption, and is consistent with the Greening Government commitments.

Accounting framework

2.5 These Accounts relate to the financial year 1 April 2011 to 31 March 2012. They have been prepared in accordance with a direction issued by HM Treasury under section 7 of the Government Resources and Accounts Act 2000. A copy of this direction is available online, by accessing the HM Treasury website at www.hm-treasury.gov.uk.

2.6 The Department's Annual Report & Accounts consolidates the financial information of organisations within the Department's Resource Accounting Boundary. As such, this consolidation includes the Department itself, those Special Health Authorities that are not funded by trading activities, all Strategic Health Authorities and Primary Care Trusts, and for the first time in 2011-12, the accounts of 8 Executive Non-Departmental Public Bodies, 9 Arms Length Bodies, 113 NHS Trusts (including 6 which became NHS Foundation Trusts in year), 143 NHS Foundation Trusts (FTs) and one other body (the Skipton Fund) classed by the Office for National Statistics (ONS) as central to government and sponsored by the Department of Health. This change is a result of HM Treasury's alignment legislation, the main consequences of which are set out in paragraph 2.17 below. Note 32 to the accounts provides a complete list of the organisations included within the Departmental boundary. In a very significant change, therefore, the individual accounts of 437 organisations are now consolidated into the Department's group account, a 268 increase from the 169 organisations in 2010-11.

2.7 The relationship between organisations within this Resource Accounting Boundary is substantially different from the concept of a group in the commercial sector, as it is based on in-year budgetary controls, rather than strategic controls or profit motive. In general terms, the primary focus of the Government-funded organisations within the Resource Accounting Boundary lies with the commissioning of healthcare from the provider sector. The group is essentially characterised by the relatively complex trading relationship that exists between NHS commissioners and the NHS Trusts and NHS Foundation Trusts that comprise the provider sector.

2.8 The primary statements and related disclosures contained within these accounts show the total financial effects of all the activities in the year for all bodies within the Resource Accounting Boundary. The Comptroller and Auditor General audits these financial statements, and gives an opinion as to whether they provide a true and fair view. His opinion is provided with these accounts.

2.9 The rules for completing the accounts in each financial year are provided in HM Treasury's Government Financial Reporting Manual (FReM) which is available at www.financial-reporting.gov.uk. The Manual is given the force of law by an accounts direction issued by HM Treasury under section 5(2) of the Government Resources and Accounts Act 2000.

2.10 NHS organisations are statutorily obliged to comply with both the determination and directions given by the Secretary of State for Health in the preparation of their annual report and individual accounts. These directions require NHS organisations to prepare their accounts in accordance with guidance contained in the NHS Manual for Accounts, as agreed with HM Treasury and the Financial Reporting Advisory Board (FRAB). The NHS Manual for Accounts, which is prepared by the Department, provides an NHS context to the accounting rules provided in the FReM. Similarly, NHS Foundation Trusts are required to prepare their accounts in accordance with the Annual Reporting Manual (FT ARM), in accordance with an accounts direction issued by Monitor and agreed with HM Treasury and FRAB. The Department will continue to define the accounting framework for the DH group as the structural reforms of the NHS continue to take effect, and this will ensure that consistency can be maintained across all organisations for both accounting and audit purposes.

2.11 These various Manuals for Accounts reflect the rules in professional accounting standards to the extent that they are appropriate to both the public sector and Government accounting requirements. From 2009-10, HM Treasury has required Government Departments to prepare their annual accounts on the basis of International Financial Reporting Standards (IFRS). A number of older international standards, many of which remain in use, are described as International Accounting Standards (IAS). However, other than where referring to a specific standard, these terms can be used interchangeably.

2.12 NHS bodies and NHS Foundation Trusts are required to follow the FReM guidance referred to above, except where a divergence has been formally agreed between the Department or Monitor and HM Treasury. Treasury agreed that charitable funds should once again not be consolidated into local NHS accounts in 2011-12. For NHS Foundation Trusts the only further departure relates to the discounting of future cash flows to measure fair value, where it was agreed that organisations should use a market rate to measure value, rather than the higher of either the rate intrinsic to the financial instrument or the real

discount rate set by Treasury. The statement of accounting policies (Note 1 to these accounts) provides further details of the accounting framework.

2.13 The financial statements consist of five primary statements (which provide summary information) and accompanying notes. The five primary statements are:

- **Statement of Parliamentary Supply:** This is the prime Parliamentary accountability statement. It provides a comparison of outturn against the Supply Estimate voted by Parliament and a summary of the cash required to finance expenditure.
- **Consolidated Statement of Comprehensive Net Expenditure (CSCNE):** This reports net resources (administration costs, programme costs and income) consumed by organisations within the Resource Accounting Boundary in the year.
- **Consolidated Statement of Financial Position:** This shows the current and non-current assets, liabilities and taxpayers' equity of organisations within the Resource Accounting Boundary at the beginning and end of the financial year.
- **Consolidated Cash Flows Statement:** This shows how cash has been used during the year on operating, investing and financing activities.
- **Consolidated Statement of Changes in Taxpayer's Equity:** This shows the changes in the General Fund and reserves in the year.

2.14 Note 6 to these Accounts provides a Statement of Operating Costs by Operating Segment. This very comprehensive note reflects the significantly expanded parameters of the Departmental Group, and provides a detailed analysis of income and expenditure (categorised into either administration or programme elements as appropriate) for each sector within the DH group. These sectors, or operating segments, cover the core Department of Health, NHS Commissioners (Primary Care Trusts and Strategic Health Authorities), NHS Providers (NHS Trusts and NHS Foundation Trusts) and all Arms Length Bodies. Financial information relating to each of these segments is regularly reported to the Departmental Board for financial management purposes. There is considerable trading activity between all organisations in the DH group – principally between NHS Commissioners and NHS Providers. Such inter-company transactions are eliminated during preparation of the consolidated group account, and the value of this elimination is shown in Note 6 so that the flow of funds through the system is more transparent.

2.15 The expansion of Note 6 to include financial information relating to each NHS sector reflects the fact that, as a direct consequence of the Treasury's alignment legislation, the Department (subject to agreement from Treasury) has opted to no longer prepare separate NHS Summarised Accounts as it has done in previous years. With the expansion of the Resource Accounting Boundary under alignment, all key financial information relating to each NHS sector is now presented on a fully consolidated (and therefore more meaningful) basis within the Department's group account. In effect, the accounting boundary for each of the NHS Summarised Accounts is now completely contained within the Department's overall group account boundary. Appropriate commentary relating to NHS financial performance (including the performance of NHS Foundation Trusts) is now included within this Annual Report (Section 3 below). It should be noted, however, that Monitor (the independent regulator of NHS Foundation Trusts) continues to prepare and publish a consolidated account for the NHS Foundation Trust sector: *NHS Foundation Trusts: Consolidated Accounts 2011-12*.

2.16 When reading the Department's Annual Report and Accounts, a number of accounting issues should be considered:

Resource Account Boundary – Alignment

2.17 The 2010-11 Annual Report & Accounts began the process of implementing HM Treasury's changes to the budgetary framework as set out in the Constitutional Reform and Governance Act 2010. The aim of this legislation has been to align budgets, estimates and accounts, bringing the HM Treasury budgeting framework into line with International Financial Reporting Standards (IFRS). In summary:

- From 2010-11, HM Treasury introduced changes to the budgetary framework; consequently, all budgetary information disclosed in the 2010-11 Annual Report was presented on an aligned basis, with comparators restated wherever possible;
- From 2011-12, the Department of Health's Resource Accounting Boundary has been substantially increased. Consequently, in addition to the Core Department, Primary Care Trusts and Strategic Health Authorities, the group account also consolidates the individual accounts of NHS Trusts, NHS Foundation Trusts, and all Arms Length Bodies and Executive Non-Departmental Bodies

(except those with public corporation status). This is a fundamental change, and more than doubles the size and scope of the Department's Annual Report & Accounts (i.e. from 169 organisations to 437). Whilst 2011-12 has seen the abolition of a number of the Department's Arms Length Bodies, a handful of new, and very significant organisations have also been created – most notably the NHS Commissioning Board Special Health Authority in October 2011. The Board has become a full Executive Non-Departmental Body from October 2012 as it takes up its full powers in respect of NHS commissioning;

- Two bodies remain outside the Department's Resource Accounting Boundary – NHS Blood & Transplant and the Medicines & Healthcare Products Regulatory Agency – as these both have public corporation status;
- The magnitude of change is demonstrated by the difference in the Net Book Value at 1 April 2011 in Property Plant and Equipment from £8.7 billion as reported as the closing balance in the 2010-11 Resource Account to £47.4 billion as shown in the Statement of Financial Position for the revised group. However, the net operating costs for 2010-11 in the account has only changed by £19 billion (from £85 billion in the 2010-11 Resource Account to £104 billion as restated in this account) as NHS Trusts and NHS Foundation Trusts receive their main income through trading activity with healthcare commissioners, so by far the majority of their transactions are with organisations within the boundary and, as such, are eliminated on consolidation;
- A Treasury-led change in the treatment of Government Grant and Donated Asset Reserves has been implemented across the group, and is reflected in these financial statements;
- A change in the treatment of National Insurance Contributions has been implemented, such that, in the DH group account, these contributions are now recorded as funding rather than income as was the case in previous years;
- The Department has also implemented the new Treasury control in respect of reporting expenditure between its administration and programme components. This control has been applied to the Core Department, NHS Commissioners, and most Arms Length Bodies. With the agreement of the Treasury, all income and expenditure within the accounts of NHS Providers has been classified to programme to reflect the fact that these organisations are primarily concerned with the delivery of front line health services; and
- The Parliamentary Estimate for 2011-12 is now prepared on a net basis. This means that the Department is able to retain and spend all the income generated in the categories that Parliament has approved through the estimate.

Restatement of the 2010-11 accounts and application of the IAS8 exemption

2.18 One significant consequence of the issues listed above, has been the requirement to restate both the DH group account and the accounts of individual consolidating organisations for 2010-11. More detail relating to the rationale and mechanics of this restatement is provided in Note 1b to these accounts. In preparing the prior year comparators for this account, the main principles applied by the Department can be summarised as follows:

- Prior period comparative figures disclosed in the 2011-12 accounts are as comparable, accurate and meaningful as possible to the users of the accounts within the meaning of IAS1; and
- The methods and accounting principles used to create prior period comparators have been clearly disclosed either in this Annual Report or as appropriate narrative disclosure in the Primary Statements or Notes to the accounts.

2.19 In terms of the restatement of the 2010-11 accounts, the accurate elimination of trading (e.g. income & expenditure and/or payables & receivables) and other balances between organisations within the group has proved particularly challenging. The Department undertook a number of exercises to attempt to bring the overall level of mismatch to within a materially acceptable level. However, for a number of very valid reasons, this has proved impossible to achieve without undertaking further resource intensive exercises in respect of all affected organisations. The main cause of the material imbalance is the fact that over half the organisations (i.e. NHS Trusts and NHS Foundation Trusts) now within the DH Resource Accounting Boundary were not included in 2010-11, which means that those organisations were not required to agree balances at the time their 2010-11 accounts were being prepared and audited.

2.20 Having made every reasonable effort to reduce the level of material imbalance in the 2010-11 (and relevant 2009-10) comparators, the Department has concluded that it is impracticable to do so within the meaning of IAS8. The standard allows, for example, that *"applying a requirement is impracticable when the entity* [in this case the Department of Health] *cannot apply it after making every reasonable effort to do so".* The most important principles of the 2010-11 restatement are described below.

2.21 In the interests of presenting comparative information that will be of value to the readers of these accounts, and with the support of both the Treasury and the National Audit Office, the Department has restated its 2010-11 (and where relevant 2009-10) comparatives to the greatest extent possible (although it has not been possible to achieve full comparability). This means that all practicable restatements, required either as a result of Clear Line of Sight or other accounting changes (as detailed in Note 1b) have been applied. In effect, the Department has adopted a "best endeavours" approach in relation to the elimination of trading and other balances in prior periods, with the Department replicating, as far as possible, the elimination techniques applied in relation to 2011-12 balances.

2.22 The Department recognises, however, that the material level of residual mismatch (as described above) will cast doubt over the accuracy of these eliminations, such that the income, expenditure, payables and receivables figures presented in the consolidated prior period columns in this account may not represent a true and fair view of the Department's activities. For this reason, therefore, the Department has applied the IAS8 impracticability exemption. As such, these consolidated comparative figures have not been subject to audit. Nevertheless, whilst the NAO has not provided an audit opinion in respect of these comparatives, they have included an Emphasis of Matter report within their overall opinion on the 2011-12 account. Both the Department and the NAO agree that the unique set of circumstances arising from the Clear Line of Sight legislation have made it necessary to apply the IAS8 impracticability exemption to the 2011-12 accounts. The Department does not expect the same set of conditions to apply in future years, so the application of the IAS8 exemption is confined to the 2011-12 accounts. It should also be noted that, notwithstanding the level of residual imbalance described above, the closing balances of the 2010-11 primary statements, and therefore the opening balances for 2011-12, are not misstated, because, for example, an expenditure imbalance in one direction, would be exactly off-set by an income imbalance in the opposite direction .

2.23 Clear disclosure in respect of this issue has been provided throughout these financial statements. In particular, Note 1b *Restatement* explains the extent to which the Department has been able to produce comparable prior period consolidated restated figures and the methodology used to derive those comparatives. Where either primary statements or disclosure notes have been directly affected, detailed explanatory footnotes have been included, and these have been cross-referenced to Note 1b as appropriate. The statement of accounting policies (Note 1) also refers to the non-comparable nature of a limited number of consolidated prior period figures. The Governance Statement refers to both the IAS8 exemption and the difficulties experienced with the agreement of balances exercises, which have ultimately made it impracticable to accurately eliminate trading and other balances in prior years.

Transfer of Community Health Services from PCTs

2.24 As was the case last year, during 2011-12 certain provider functions continued to be transferred between organisations consolidated into the Department's Annual Report & Accounts. The majority of such transactions relate to the "Transforming Community Services" initiative, whereby elements of PCT provider functions have transferred to NHS Trusts, NHS Foundation Trusts or social enterprises. HM Treasury require that merger accounting principles are applied in full in these circumstances. However, for TCS transactions specifically, as was the case in 2010-11, both HM Treasury and the Financial Reporting Advisory Board have agreed that it is impracticable to adjust prior period comparators as would normally be required. Prior period restatement is therefore effected by an adjustment to 1 April 2011 opening balances rather than by a full restatement of prior year comparators.

Disclosures in the Underlying Accounts

2.25 Given the range and number of individual accounts consolidated into the Group Accounts, it is not practical for the following local disclosures to be summarised in this report. However they are disclosed, and therefore publicly available, in the Annual Reports of the individual underlying organisations:

- Management commentary;
- The legislative, regulatory, operational and external environment in which the individual organisation operates;
- Remuneration and pension entitlements in respect of senior managers;

- The organisation's policies for managing risk;
- Significant differences in asset values compared to market values;
- Interests of board members;
- Data loss incidents;
- Environmental, social and community issues;
- Key performance indicators relating to employee matters and environment; and
- Auditors' remuneration in respect of non-audit services.

3 SUMMARY OF FINANCIAL RESULTS

3.1 These financial statements show how the Department's activities have been funded, and its resources deployed, during the 2011-12 financial year. For the third year, the Department's accounts and supporting notes have been prepared in accordance with the requirements of International Financial Reporting Standards (IFRS).

3.2 The Department has two primary sources of funding: Parliamentary (Supply) funding and National Insurance Contributions. In 2011-12, National Insurance Contributions amounted to around £16.9 billion (a decrease from the £17.9 billion in 2010-11). HM Treasury (HMT) sets the Department's budgets independently from the level of National Insurance Contributions and, as such, they have no impact on the resources available to cover expenditure on healthcare. As noted in paragraph 2.17 above, National Insurance Contributions are now treated as funding within these accounts and not as income as was the case in previous years.

3.3 The Department is required to contain expenditure within a series of controls operated by both HMT and Parliament:

- Revenue expenditure must be contained within either the Revenue Departmental Expenditure Limit (RDEL) or Annually Managed Expenditure (AME). Details of 2011-12 revenue expenditure are set out below in Table one for RDEL and Table two for AME;
- Administration revenue expenditure must be contained within the Department's Administration limit, which is a subset of the overall revenue DEL. Details of 2011-12 administration expenditure are set out in Tables six and seven; and
- Capital expenditure must be contained within the Capital Departmental Expenditure Limit (CDEL). Details of 2011-12 capital expenditure are set out in Table four.

3.4 In 2011-12, the Department met all its financial duties, by managing resources within the budgets set by HM Treasury and the amounts voted by Parliament.

Revenue expenditure

3.5 Table one details the 2011-12 RDEL outturn compared to budget and 2010-11.

Table One: Revenue Departmental Expenditure Limit (RDEL) 2011-12

	2011-12 £m	2010-11 £m	2010-11 (exc PSS)[1] £m	Growth £m	Growth %
Revenue DEL budget	102,418	101,384	99,819	2,599	2.6%
Revenue DEL expenditure	101,589	100,286	98,765	2,824	2.9%
Under/(over) spend £m	829	1,098	1,054		
Under/(over) spend %	0.8%	1.1%	1.1%		

Breakdown of 2011-12 Revenue DEL underspend (Note 2):	
NHS Surpluses (Primary Care Trusts, Strategic Health Authorities, NHS Trusts and Foundation Trusts)	*2,046*
SHA & PCT End Year Flexibilty Allocation	*(1,372)*
NHS	***674***
DH Central & ALBs	***154***

Notes

1. In order to calculate growth on a consistent basis, 2010-11 figures have been restated to exclude PSS as this was transferred to DCLG as part of the 2010 Spending Review
2. The breakdown is before the elimination of intra-group transactions so the figures do not match those in table 3.
3. Figures may not sum due to roundings

3.6 The Department underspent by £829 million (0.8%) against its final RDEL budget in 2011-12. (This compares to a £1,054 million (1.1%) restated underspend in 2010-11).

3.7 The 2011-12 underspend has been broken down by spending sectors. The overall NHS underspend of £674 million comprises an underspend of £2,046 million offset by an allocation of £1,372 million to PCTs and SHAs. This allocation relates to the underspend that PCTs and SHAs delivered in 2010-11 and was returned to them in 2011-12 (known as End of Year Flexibility).

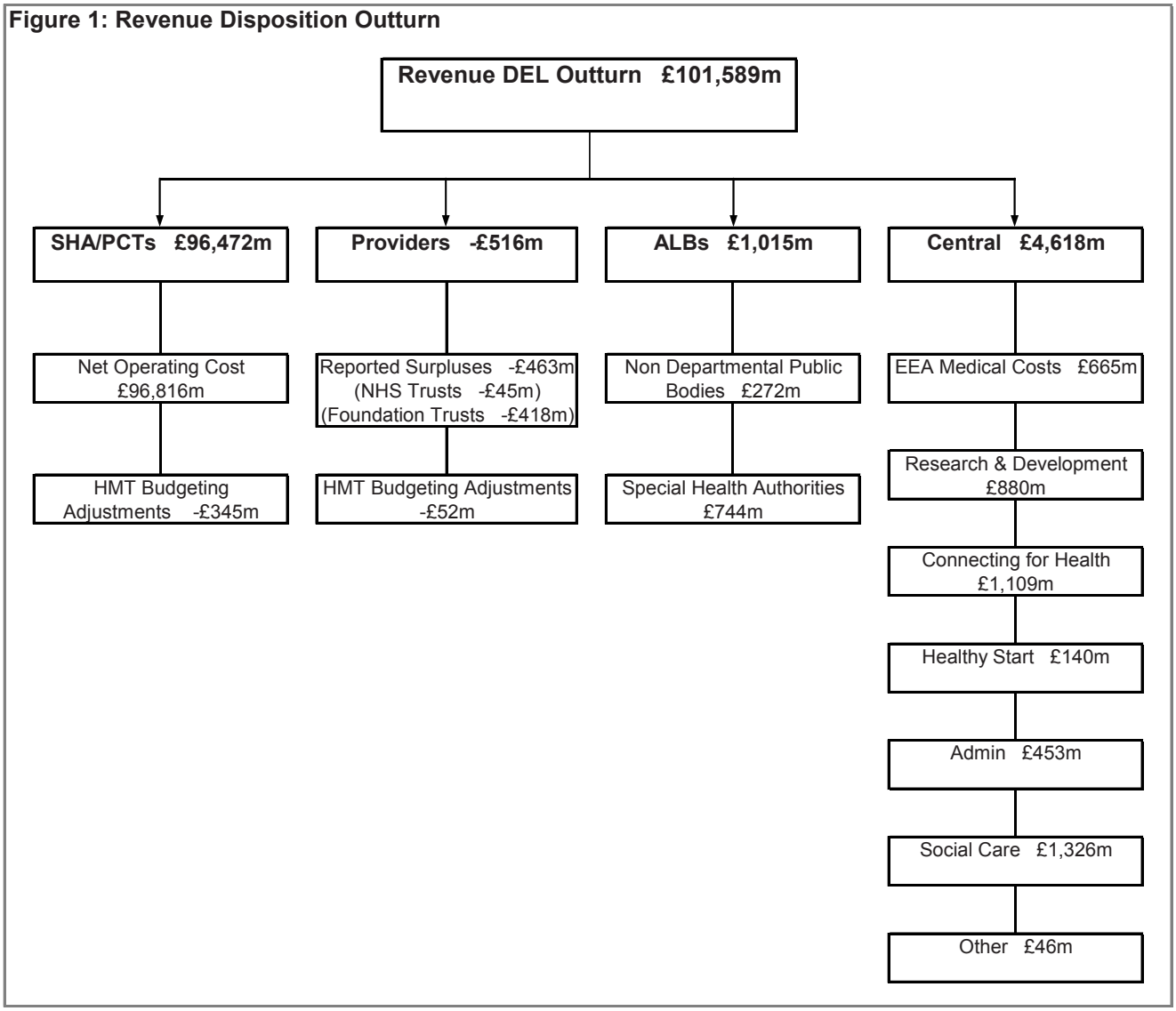
3.8 In 2011-12, as announced in the 2010 Spending Review, HMT introduced the Budget Exchange Scheme. This scheme allows departments to surrender an underspend in advance of the end of the financial year in return for a corresponding increase in their budget in the following year, subject to a prudent limit. DH took advantage of this scheme and transferred £250 million of the 2011-12 RDEL into 2012-13. This transfer was based on a prudent estimate of the forecast underspend in December 2011.

3.9 In cash terms, RDEL expenditure increased in 2011-12 by £2,824 million (or 2.9%).

Disposition of the Department's 2011-12 Departmental Expenditure Limit (DEL) expenditure (Revenue)

3.10 Figure 1 below illustrates the high-level disposition, by spending sector, of the expenditure that scores against the Departmental Revenue Expenditure Limit (RDEL). The distribution does not represent an allocation of resources, rather it relates to the outturn position by sector. The figure for the provider sector represents the actual surplus, before PDC dividend, of both NHS Trusts and NHS Foundation Trusts.

Figure 1: Revenue Disposition Outturn



Notes
1. Negative numbers indicate benefit to the DEL - eg Providers reported a DEL surplus of £516m
2. Further explanation of the provider surplus is in the NHS Finance and Performance paragraphs below.
3. RDEL outturn is before impairments and adjustments for service concession IFRIC 12 arrangements and donated assets / government grant reserves.
4 Figures may not sum due to roundings

Revenue – Annually Managed Expenditure (AME)

3.11 Expenditure that HM Treasury has deemed to be demand-led or exceptionally volatile scores against the Annually Managed Expenditure (AME) budget. For DH, this includes expenditure on provisions, certain impairments relating to assets and Credit Guarantee Finance. Details of the AME budget and expenditure are set out in Table two below:

Table Two: Annually Managed Expenditure (AME) 2011-12

	2011-12 £m	2010-11 £m	Growth £m	Growth %
AME budget	3,943	4,844	(901)	-18.6%
AME expenditure	3,193	3,207	(14)	-0.4%
Under/(over) spend £m	750	1,637		
Under/(over) spend %	19.0%	33.8%		

3.12 The Department underspent by £750 million (or 19.0%) against its final AME budget in 2011-12. This underspend is mainly because actual spend was lower than the estimated redundancy provisions relating to the NHS reforms. See paragraph 3.31 for more details.

3.13 AME expenditure in 2011-12 reduced in cash terms by £14 million or 0.4% compared to 2010-11.

3.14 Table three provides an explanation of the differences between provision and outturn in the Parliamentary Estimates for both DEL and AME expenditure, relating to the figures in Note 2.1 of the accounts.

Table Three: Explanation of Differences between Provision and Outturn

	Provision £m	Outturn £m	Difference £m	Difference %	Explanation of difference
Revenue DEL					
PCT & SHA expenditure	19,248	18,371	877	5%	The underspend on this line of £877 million or 5% results from: 1. An under forecast of the level of intra group eliminations of £694 million; and 2. the remaining difference is because PCT/SHA expenditure was £183 million lower than forecast in the Supplementary Parliamentary Estimate.
DH Programme expenditure (NHS)	1,886	1,842	44	2%	
Special Health Authorities expenditure	1,630	2,270	(640)	-39%	The overspend on this line of £642 million or 39% results from: 1. An under forecast of the level of intra group eliminations expenditure of £615 million; and 2. the remaining difference of £28 million or 1.7% is because Special Health Authority expenditure was higher than forecast in the Supplementary Parliamentary Estimate.
DH Programme & Administration expenditure	2,162	1,769	392	18%	The underspend on this line is because the Department underspent overall on its Revenue DEL by £825 million.
Social Care Expenditure	1,326	1,326	0	0%	
NHS Trust net expenditure	28,241	27,530	712	3%	The underspend on this line of £712 million or 3% results from: 1. An under forecast of the level of intra group eliminations of £604 million; and 2. the remaining difference is because Trust expenditure was £107 million lower than forecast in the Supplementary Parliamentary Estimate.
NHS Foundation Trusts net expenditure	30,815	31,329	(514)	-2%	The overspend on this line of £517 million or 2% results from: 1. An under forecast of the level of intra group eliminations of £713 million; and 2. the remaining difference is because Foundation Trust expenditure was £196 million lower than forecast in the Supplementary Parliamentary Estimate.
Non Departmental Bodies net expenditure	281	289	(8)	-3%	
PCT & SHA expenditure financed by NI contributions	16,829	16,864	(35)	0%	
Total RDEL	**102,418**	**101,589**	**829**		
Annually Managed Expenditure (AME)					
PCT & SHA expenditure	966	218	748	77%	The underspend of £748 million or 77% on this line is because actual spend was lower than the estimated redundancy provisions relating to the NHS reforms. See paragraph 3.31 of the Annual Report for more details.
DH Programme expenditure (NHS)	1	45	(45)	-8924%	A review of provisions undertaken prior to the Supplementary Supply Estimate, identified the need to increase AME cover for blood borne disease provisions. This increase was recorded in error against the AME estimate line "DH Programme expenditure".
Special Health Authorities expenditure	2,084	2,018	67	3%	
DH Programme & Administration expenditure	166	90	75	45%	Please see the explanation for the "DH Programme expenditure (NHS)" line above.
NHS Trust net expenditure	429	418	11	2%	
NHS Foundation Trusts net expenditure	302	399	(97)	-32%	The overspend of £97 million or 32% on this line is because expenditure on impairments and provisions in this sector was higher than forecast in the Supplementary Supply Estimate.
Non Departmental Bodies net expenditure	(3)	5	(8)	249%	
Total AME	**3,943**	**3,193**	**750**	19%	

Capital Departmental Expenditure Limit

3.15 Table four below provides details of the CDEL outturn for 2011-12 compared to both the budget and the 2010-11 position.

Table Four: Capital Department Expenditure Limit (CDEL) 2011-12

	2011-12 £m	2010-11 £m	Growth £m	Growth %
Capital DEL budget	4,353	4,897	(544)	-11.1%
Capital DEL expenditure	3,786	4,159	(372)	-9.0%
Under/(over) spend £m	566	738		
Under/(over) spend %	13.0%	15.1%		

Breakdown of 2011-12 Capital DEL underspend (note 1):

NHS Bodies (Primary Care Trusts, Strategic Health Authorities, NHS Trusts and Foundation Trusts)	*363*
DH Central & ALBs	*204*

Notes

1. Breakdown of the underspend is based on the original planning assumptions for each sector so figures do not match those in Note 2.2 in the accounts
2. Figures may not sum due to roundings

3.16 CDEL expenditure in 2011-12 reduced in cash terms by £372 million (or 9.0%) compared to 2010-11. The 2011-12 CDEL underspend of £566 million (or 13.0%) has been broken down by spending sectors. The main reasons for the CDEL underspend relates to the fact that:

- expenditure in Connecting for Health was around £400 million lower than originally planned;
- NHS expenditure, mainly in NHS Trusts, was around £363 million lower than originally planned; offset by
- increased capital expenditure of £300 million by the NHS Supply Chain within the NHS Business Services Authority's accounts.

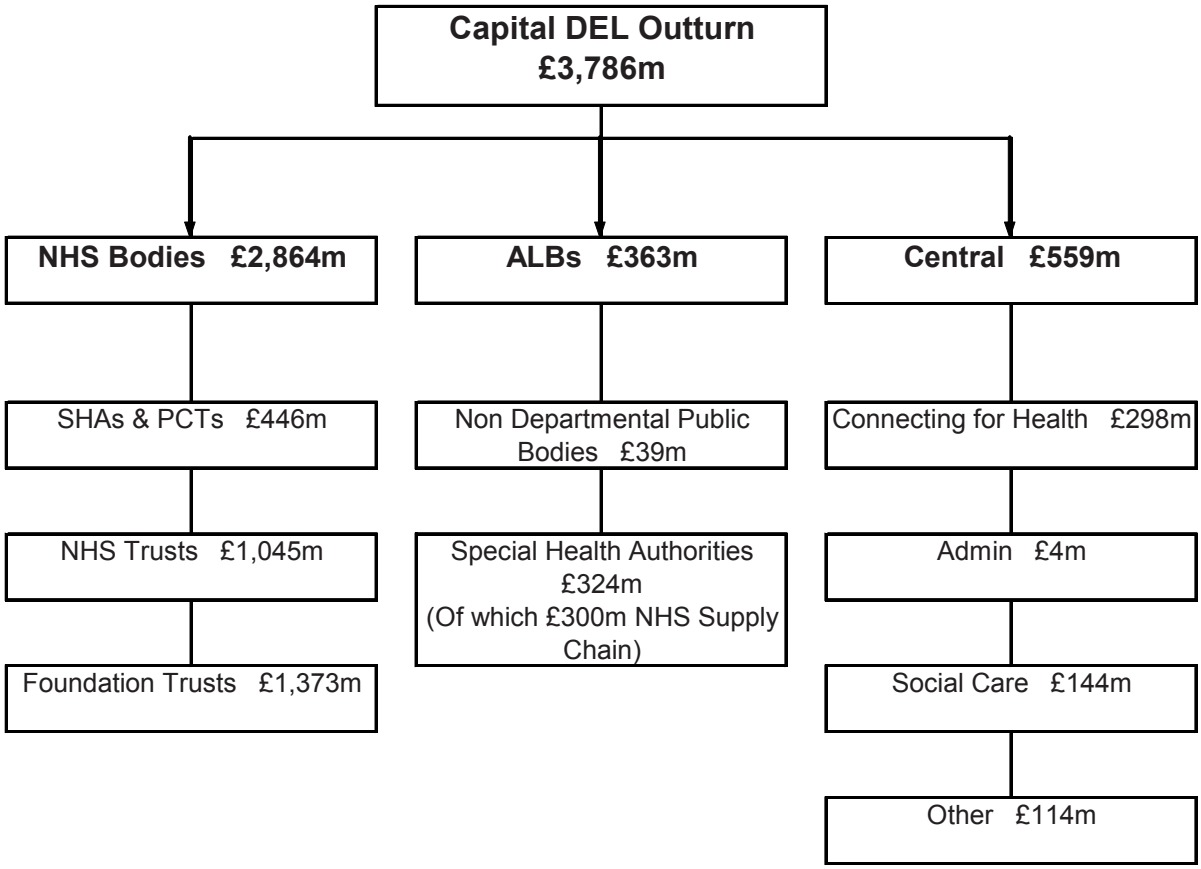
3.17 The impact of the tighter financial position has contributed to the reduction in spend between years, as organisations make decisions about the prioritisation of spending locally. A contributory factor has been that spending has had to be contained within a lower budget as set by HM Treasury in the 2010 Spending Review.

3.18 The Department took advantage of HMT's Budget Exchange Scheme and transferred £66 million of the CDEL into 2012-13, this was the maximum permitted for capital within the scheme.

Disposition of the Department's 2011-12 Departmental Expenditure Limit (DEL) expenditure (Capital)

3.19 Figure 2 below illustrates the high-level disposition, by spending sector, of the expenditure that scores against the Department's Capital DEL. The distribution does not represent an allocation of resources, rather it relates to the outturn position by sector.

Figure 2: Capital Disposition Outturn



Note
1) Figures may not sum due to rounding

Total Departmental Expenditure Limit (TDEL)

3.20 The Treasury's presentation of departmental expenditure in its publications (e.g. Spending Review and Budget reports) is on a Total DEL basis, calculated as the total of RDEL expenditure plus CDEL expenditure less depreciation. Table five below sets out TDEL expenditure for 2010-11 and 2011-12.

Table Five: Total Departmental Expenditure Limit (TDEL) and Real Terms Growth 2011-12

	2011-12 £m	2010-11 £m	Growth in cash terms £m	Growth in real terms £m [2]	Real terms growth %
RDEL	101,589	100,286	1,304	(1,043)	-1.0%
CDEL	3,786	4,159	(372)	(470)	-11.3%
Less PSS [1]		(1,520)	1,520	1,556	-102.3%
Less depreciation[3]	(1,193)	(1,210)	16	45	-3.7%
TDEL	**104,182**	**101,714**	**2,468**	**88**	**0.1%**

Notes

1. In order to calculate growth on a consistent basis, 2010-11 figures have been restated to exclude PSS as this was transferred to DCLG from 2011-12 as part of the 2010 Spending Review
2. Real terms are the cash figures for 2010-11adjusted to 2011-12 prices using GDP deflators
3. Category also includes some types of impairment
4. Figures may not sum due to roundings

3.21 Total DH expenditure in 2011-12 was 0.1% higher in real terms than in 2010-11 – this includes expenditure on both administration and front- line services. Expenditure on front-line services increased in cash terms by £3.4 billion or 3.5% in 2011-12 and in real terms by £1.1 billion or 1.1%.

DEPARTMENT OF HEALTH ADMINISTRATION

3.22 As part of the 2010 Spending Review, the Department's administration cost limit, which had previously applied only to the core department, was extended to include the administration costs of Primary Care Trusts, Strategic Health Authorities, Special Health Authorities and Non-Departmental Public Bodies. This extended administration limit took effect from 2011-12.

3.23 The revised impact assessment for the Health and Social Care Bill (now the Health and Social Care Act 2012) published in September 2011, set out a revised trajectory of how the Department planned to implement the required one-third reduction in administration costs by 2014-15 as set out in the 2010 Spending Review. The one-third reduction is measured against the 2010-11 baseline in real terms, ie the baseline in subsequent years is uplifted for inflation.

3.24 From 2011-12, therefore, administration costs reflect the costs of running the Department and other non-provider NHS organisations, and do not directly relate to the provision of front-line services. 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, or support, front-line service delivery. Expenditure on the direct provision of healthcare by NHS provider organisations (including the running costs of those bodies) is also classified as programme.

3.25 In 2011-12, HM Treasury recategorised a number of expenditure types between administration and programme with the movement predominantly being from programme to administration. Reclassified items include certain grant-in-aid expenditure and policy payments. The Department estimates the net impact of this recategorisation to be in the region of a £250 million increase in administration costs, with a corresponding decrease in programme costs. The analysis of 2010-11 Core Department expenditure has not been adjusted and continues with the categorisation in place at the time. This ensures a consistent date of application of the revised administration costs regime across the Departmental Group, and the impact of the recategorisation is not material.

3.26 The analysis of 2010-11 income and expenditure between administration and programme categories has not been restated to reflect the wider interpretation of administration costs adopted in 2011-12, rather it continues to reflect the administration costs regime in place at the time. As agreed with HM Treasury and the Financial Reporting Advisory Board, the Department deems it to be impracticable, per the IAS 8 definition, for NHS bodies to restate prior period income and expenditure figures based on an administration costs regime that was not in place at the time.

3.27 Table six provides a comparison of the Department's 2011-12 administration expenditure against the 2011-12 administration limit.

Table Six: Administration Limit 2011-12

	2011-12 Admin Limit £m	2011-12 Admin Outturn £m	Underspend £m	Underspend %
Administration - excluding depreciation	4,073	3,307	767	18.8%
Administration depreciation	359	234	125	34.8%
Administration total	**4,432**	**3,541**	**892**	**20.1%**

Notes

1. Figures may not sum due to roundings

3.28 The Department underspent by £892 million (or 20.1%) against the 2011-12 administration limit. This resulted from a combination of a faster pace of administration reductions than were expected at the time of setting the administration limit particularly in PCTs and SHAs and the fact that contingencies to account for the uncertainty in the split of expenditure between administration and programme were not required.

3.29 Table seven below provides a comparison of the 2011-12 administration outturn against the revised impact assessment for the Health and Social Care Bill (now the Health and Social Care Act 2012).

Table Seven: Administration Costs Forecast 2011-12 to 2014-15

	Baseline 2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m
Administration costs forecast [1, 2]	4,500	3,969	3,811	3,553	3,337
2011-12 outturn [3]		3,307			
Under/(over) spend		662			

Notes

1. The administration costs forecast is as published in the revised impact assessment for the Health and Social Care Bill. Note, the actual published figures were in 2010-11 prices

2. Administration figures do not include depreciation

3. The 2011-12 outturn includes PCT redundancy costs of £70 million - as per HMT's budgeting guidance, these costs score to administration rather than programme

4. Figures may not sum due to roundings

3.30 The Impact Assessment forecasted administration costs (excluding depreciation) in 2011-12 to be £3,969 million (below the £4,073 million administration limit in Table six). The administration costs outturn in 2011-12 is £662 million lower than forecast in the published Impact Assessment. This is because the Health and Social Care Act 2012 reforms have delivered faster administration reductions than were

expected at the time of the Impact Assessment. These faster reductions mean the savings over the course of this Parliament associated with the reforms have increased from £4.5 billion to £5.6 billion. This allows more spending on frontline services.

3.31 In 2011-12 lower redundancy costs were incurred than forecast in the Impact Assessment. This is likely to be the result of a number of factors: more natural wastage than expected, lower payouts per person than expected, greater reductions in non-staff costs and the redundancies required to deliver the skill mix for the future organisations are happening later than expected.

NHS Administration

3.32 By 2014-15 the overall administration costs of the new NHS superstructure, compared to the administration costs of the current NHS group, will decrease by one third. The NHS baseline for the reduction was set at £3,205 million in the Impact Assessment published in September 2011, which also recorded that £240 million was achieved in 2010-11 year. SHA and PCT administration costs in 2011-12 excluding depreciation totalled £2,423 million a further reduction of £542 million. The total reduction of £782 million against the baseline shows good progress towards the one-third real reduction.

Arm's Length Bodies' Administration and Programme Costs

3.33 Arm's Length Bodies (ALBs) are stand-alone national organisations sponsored by the Department of Health, created to help support and manage the health and social care system. They are accountable to the Department of Health and sometimes directly to Parliament, and typically provide the following type of functions:

- regulating the health and social care system and workforce;
- establishing national standards and protecting patients and the public; and
- providing central services to the NHS.

3.34 The White Paper *Equity and Excellence: Liberating the NHS* and the subsequent Command Paper, *Liberating the NHS: Report of the arm's-length bodies review* ('the ALB review' published July 2010), set out the Government's commitment to reduce and streamline the NHS, including the Department's ALBs.

3.35 The ALB review provided the opportunity to undertake a detailed look at the functions of each body to determine whether in the future health and social care system their functions were essential and whether they:

- are sufficiently technical that there is a scarcity of capability and expertise for the function to be provided by other means;
- need to be performed independently of Ministers to ensure political impartiality;
- provide accountability and assurance to patients, service users and taxpayers by independently establishing facts.

3.36 The review found that some seven ALBs currently within the Resource Accounting Boundary would leave the sector, to become self-funding, or to be abolished and have their continuing functions transferred to other bodies. Continuing ALBs will operate more efficiently, streamlining support services wherever possible and making use of commercial opportunities where this is appropriate. The Department will also clarify and strengthen the system of governance that supports them. Formal Framework Agreements will set out roles and responsibilities with the Department, and how they will deliver their objectives within their resource limit.

3.37 The Department's current Arms Length Bodies (ALBs) are listed in Note 32 to the accounts. Nine of these organisations have Special Health Authority status and eight are Executive Non-Departmental Public Bodies (ENDPB). The Skipton Fund is included as an ENDPB. This organisation was set up to make payments to people infected with hepatitis C through NHS blood or blood products.

3.38 The establishment of four new ALBs was highlighted in *Equity and excellence - Liberating the NHS.* Two new special health authorities commenced in 2011-12, the NHS Commissioning Board Authority in October 2011 and the Health Research Authority in December 2011. Health Education England and NHS Trust Development Authority were established in June 2012.

3.39 The seven ALBs that are leaving the sector in 2012-13 are listed below. In 2011-12 these bodies have prepared for the transfer of their continuing functions.

- The Appointments Commission will close in October 2012, and the senior NHS appointment functions will transfer to NHS Trust Development Authority;
- The National Patient Safety Agency (NPSA) residual functions will move to the NHS Commissioning Board, and it closed in July;
- The General Social Care Council closed in July 2012 and its residual functions transfer to the Health and Care Professions Council;
- The Health Protection Agency's main functions will transfer to Public Health England at the end of the year;
- The National Treatment Agency for Substance Misuse (NTA) will close by April 2013, and its residual functions will move to Public Health England;
- The functions of the NHS Institute relating to quality improvements will transfer to the NHS Commissioning Board and alternative delivery models are being explored for their other functions; and
- The Council for Healthcare Regulatory Excellence will be made into a self funding body and it will be renamed Professional Standards Authority.

3.40 As part of the requirement to achieve the overall efficiency savings set out in the Spending Review, and following the review of their functions, many ALBs received lower parliamentary funding in 2011-12 compared to 2010-11. Table 8 summarises the changes for each organisation, together with their net operating cost position derived from Note 6 to the accounts.

3.41 The movements on NHSLA and NHSBSA are explained below. Excluding these two organisations, the table shows that total parliamentary funding reduced from £510 million in 2010-11 to £422 million in 2011-12 (17%). Parliamentary funding includes administration, programme and capital funding. Some funding within the categories are non-recurrent.

Table Eight: Summarised Financial Performance for DH's Arm's Length Bodies in 2011-12 and prior year

Arms Length Bodies	Operating Costs	Operating Income	Net Operating Costs/ (Income)	Net Operating Costs/ (Income)	Grant in Aid/ Parliamentary Funding	Grant in Aid/ Parliamentary Funding	% Change in Parl. Funding
	2011-12	2011-12	2011-12	2010-11	2011-12	2010-11	
Special Health Authorities	£millions	£millions	£millions	£millions	£millions	£millions	
Health Research Authority (HRA)	3.6	3.0	0.6	0.0	4.2	0.0	n/a
Health and Social Care Information Centre (IC)	46.3	11.1	35.2	39.8	40.1	35.5	13.0%
National Patient Safety Agency (NPSA)	22.4	2.8	19.6	30.5	17.0	31.9	-46.6%
NHS Business Services Authority (BSA)	761.2	606.4	154.8	140.0	428.2	140.8	204.1%
NHS Institute for Innovation and Improvement	56.4	6.8	49.6	60.2	44.8	57.4	-21.9%
NHS Commissioning Board Authority	4.4	0.0	4.4	0.0	5.0	0.0	n/a
NHS Litigation Authority (NHSLA)	3,362.5	934.4	2,428.1	1,864.8	408.2	85.6	376.6%
National Institute for Health and Clinical Excellence (NICE)	64.9	5.8	59.2	61.5	59.0	62.8	-6.0%
National Treatment Agency (NTA)	15.2	5.5	9.7	10.2	10.1	10.7	-5.3%
Total	**4,336.8**	**1,575.7**	**2,761.1**	**2,207.0**	**1,016.7**	**424.7**	**139.4%**
Executive Non-Departmental Public Bodies							
Appointments Commission	3.5	1.4	2.1	4.6	2.3	2.8	-19.0%
Care Quality Commission (CQC)	149.4	88.5	60.9	59.0	45.3	92.3	-50.9%
Council for Healthcare Regulatory Excellence (CHRE)	2.7	0.3	2.5	2.4	1.5	2.1	-26.5%
General Social Care Council	57.8	38.5	19.3	8.0	6.0	7.4	-19.0%
Human Fertilisation and Embryology Authority (HFEA)	5.3	5.7	-0.4	2.1	0.4	2.3	-80.7%
Health Protection Agency (HPA)	317.5	156.7	160.8	176.5	169.8	190.0	-10.6%
Human Tissue Authority (HTA)	4.4	3.3	1.1	1.2	1.1	1.2	n/a
Monitor	23.7	8.2	15.5	14.8	15.7	14.2	10.8%
Skipton Fund	52.5	37.3	15.1	-15.0	0.0	0.0	n/a
Total	**616.9**	**339.9**	**277.0**	**253.7**	**242.1**	**312.1**	**-22.4%**
Combined Total	**4,953.7**	**1,915.6**	**3,038.1**	**2,460.7**	**1,258.8**	**736.8**	**70.8%**
Total excluding BSA and NHSLA	**830.0**	**374.8**	**455.2**	**456.0**	**422.4**	**510.4**	**-17.2%**

Note
1. Figures are from the individual accounts and inter-group transactions have not be eliminated. So the totals do not represent the consolidated position.
2. Operating income is income which relates directly to the operating activities of the authority. It principally comprises fees and charges for services provided on a full-cost basis to external customers, as well as public repayment work, but it also includes other income such as that from Devolved Administrations and from other NHS organisations. It includes both income appropriated-in-aid and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income.
3. CQC received non-recurrent transition funding from the Department in 2010-11.

3.42 The majority of Special Health Authority spending relates to claims made to the NHS Litigation Authority (NHSLA) in respect of clinical negligence (net £2.4 billion of £2.7 billion total spending). This figure comprises claims settled (net of contributions from the NHS) and new claims recognised. Parliamentary funding is provided to meet the claims outside the NHS contribution scheme paid in the year rather than the estimated costs of those future claims.

3.43 Claims can take a significant length of time to be reported to the NHSLA, and the settlement of claims can take a long time depending on the circumstances of the claim. Claims can take over 30 years to be reported, over 10 years to be settled and, if the claim is settled as a periodic payment order, the claim payments can potentially span a further period of 50 years.

3.44 IAS 37 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported (IBNRs) to the NHS Litigation Authority as at 31st March 2012. Given the long-term nature of the liabilities, these incidents form the most significant and uncertain part of the NHSLA's total £18.8 billion provisions. The numbers of clinical claims reported to the NHSLA have increased in recent years. This is believed to be the result of more incidents converting to claims as well as claims being reported to the NHSLA more quickly. It is uncertain to what extent each of these factors is driving the change in the total number of claims.

3.45 NHS Business Services Authority received a non-recurrent capital funding of £300 million in 2011-12. This followed the Public Accounts Committee recommendations regarding the aggregation of NHS spend for capital equipment purchases to deliver savings across the wider NHS via the NHS Supply Chain. This arrangement was made as a supplemental agreement to the existing master services agreement governing the relationship between NHS Business Services Authority and the NHS Supply Chain.

Government Core Tables

3.46 The following set of tables known as "Core Tables" are a common set of tables included in Annual Reports by all Government departments, showing total departmental spending, plan and outturn on the Department's public spending totals, total capital employed, and total administration budget. The figures in core tables 1 and 2 are from HM Treasury's public expenditure database OSCAR and the 2011-12 figures were submitted before the accounts so they do not match the Resource Account.

Core Table 1 Public Spending

Total departmental spending

£'000

	2007-08 Outturn [4, 5]	2008-09 Outturn [4, 5]	2009-10 Outturn [4, 5]	2010-11 Outturn [4, 5]	2011-12 Outturn [4, 5]	2012-13 Plans [2]	2013-14 Plans	2014-15 Plans
Resource DEL	84,207,717	90,156,640	97,075,200	100,285,509	101,589,191	105,474,995	108,155,452	111,056,302
of which depreciation [3]	*733,404*	*971,188*	*1,187,318*	*1,209,739*	*1,193,265*	*1,181,699*	*1,224,240*	*1,268,313*
Resource AME	3,679,949	1,588,034	3,699,212	3,206,683	3,193,101	3,948,792	2,325,973	2,555,453
of which depreciation [3]	*548,759*	*386,765*	*2,499,236*	*1,000,777*	*716,384*	*900,000*	*700,000*	*700,000*
Total Resource Budget	**87,887,666**	**91,744,674**	**100,774,412**	**103,492,192**	**104,782,292**	**109,423,787**	**110,481,425**	**113,611,755**
Capital DEL	3,966,103	4,368,533	5,182,275	4,158,605	3,786,270	4,495,435	4,437,000	4,648,000
Capital AME	37,142	13,831	6,441	7,876	-	-	-	-
Total Capital Budget	**4,003,245**	**4,382,364**	**5,188,716**	**4,166,481**	**3,786,270**	**4,495,435**	**4,437,000**	**4,648,000**
Total departmental	**90,608,748**	**94,769,085**	**102,276,574**	**105,448,157**	**106,658,913**	**111,837,523**	**112,994,185**	**116,291,442**
of which:								
Total DEL	87,440,416	93,553,985	101,070,157	103,234,375	104,182,196	108,788,731	111,368,212	114,435,989
Total AME	3,168,332	1,215,100	1,206,417	2,213,782	2,476,717	3,048,792	1,625,973	1,855,453

Notes

1. Total departmental spending is the sum of the resource budget and the capital budget less depreciation. Similarly, total DEL is the sum of the resource budget DEL and capital budget DEL less depreciation in DEL, and total AME is the sum of resource budget AME plus capital budget AME less depreciation in AME.
2. A breakdown of the 2012-13 plan data is set out in the 2012-13 Main Estimate(http://www.hm-treasury.gov.uk/d/doh_mainsupplyestimates_201213.pdf)
3. Includes impairments
4. The outturn figures for 2007-08 to 2010-11 include Resource DEL PSS of 1,782 / 1,295 / 1,395 / 1,522 and Capital DEL 213 / 141 / 134 / 118
5. For presentational purposes, the outturn for 2007-08 to 2009-10 includes the Machinery of Government transfer from the Food Standards Agency. This transfer actually took effect funding 2010-11.
6. All the figures in the core tables are taken from HM Treasury's (HMT) public expenditure database "OSCAR".
7. Figures may not sum due to rounding.

Spending by local authorities on functions relevant to

£'000

	2007-08 Outturn	2008-09 Outturn	2009-10 Outturn	2010-11 Outturn	2011-12 Outturn	2012-13 Plans	2013-14 Plans	2014-15 Plans
Current spending	**-**	**-**	**-**	**-**		**-**	**-**	**-**
of which:								
financed by grants from budgets above	1,609,038	1,073,844	1,228,087	1,320,179	1,325,914	1,357,000	-	-
Capital spending	**-**	**-**	**-**	**-**		**-**	**-**	**-**
of which:								
financed by grants from budgets above	116,389	108,392	120,420	118,416	123,790	126,590	-	-

Core Table 2 Public Spending Control

	2011-12 Original plan £'000	2011-12 Final plan £'000	2011-12 Outturn £'000
Resource DEL	102,652,756	102,417,984	101,589,191
Capital DEL	4,429,000	4,352,565	3,786,270
Resource AME	2,964,845	3,942,954	3,193,101
Capital AME	-	-	-

Note

1. All figures in the core table are taken from HM Treasury's (HMT) public expenditure database "OSCAR".

Core Table 3 Capital Employed

	2007-08 [1] Pre-alignment outturn £'000	2008-09 [1] Pre-alignment outturn £'000	2009-10 [1] Pre-alignment outturn £'000	2009-10 IAS8 Aligned outturn £'000	2010-11 IAS8 Aligned outturn £'000	2011-12 IAS8 Aligned outturn £'000	2012-13 [4] IAS8 Aligned plan £'000	2013-14[4] IAS8 Aligned plan £'000	2014-15[4] IAS8 Aligned plan £'000
Assets and Liabilities on the statement of financial position at end of year									
Fixed assets									
Property plant and equipment	8,646,071	8,720,252	8,415,077	45,272,535	47,436,935	48,332,773	49,477,327	50,825,418	52,225,535
Intangible assets	1,446,397	1,500,766	1,618,071	1,895,626	1,904,883	2,024,457	2,072,398	2,128,864	2,187,509
Financial Assets [1]	23,900,035	23,980,987	24,580,024	872,410	1,050,923	1,304,438	1,335,328	1,371,712	1,409,499
Other non-current assets	187,156	204,814	227,249	670,349	643,702	613,145	627,664	644,766	662,528
	34,179,659	34,406,819	34,840,421	48,710,920	51,036,443	52,274,813	53,512,718	54,970,760	56,485,071
Current assets									
Assets classified as held for sale	100,558	88,407	101,233	197,295	215,662	246,000	251,825	258,687	265,813
Inventories	240,405	194,051	302,738	1,009,073	905,761	931,887	953,954	979,947	1,006,942
Trade and other receivables	1,239,076	962,580	1,050,361	2,357,901	1,016,447	786,159	804,775	826,703	849,477
Other current assets	928,688	710,717	551,982	742,479	1,233,241	1,567,210	1,604,323	1,648,035	1,693,435
Financial assets	155,492	154,987	169,990	9,269	47,561	64,749	66,283	68,089	69,964
Cash and cash equivalents	2,452,244	1,745,219	1,336,302	4,980,408	5,890,739	5,805,198	5,942,669	6,104,587	6,272,754
	5,116,463	3,855,961	3,512,606	9,296,425	9,309,411	9,401,203	9,623,830	9,886,047	10,158,384
Current liabilities									
Trade and other payables	(4,550,590)	(4,787,953)	(4,918,629)	(8,216,273)	(5,274,878)	(4,978,137)	(5,096,023)	(5,234,872)	(5,379,080)
Other liabilities	(4,601,903)	(3,932,068)	(3,905,593)	(5,291,630)	(8,147,676)	(7,759,509)	(7,943,260)	(8,159,687)	(8,384,467)
Provisions	(2,049,898)	(2,071,330)	(2,311,428)	(2,579,982)	(3,064,967)	(3,289,631)	(3,367,532)	(3,459,286)	(3,554,581)
	(11,202,391)	(10,791,351)	(11,135,650)	(16,087,886)	(16,487,522)	(16,027,277)	(16,406,815)	(16,853,845)	(17,318,128)
Non-Current liabilities									
Other payables	(244,353)	(297,303)	(267,840)	(36,254)	(667,379)	(611,855)	(626,344)	(643,410)	(661,134)
Provisions	(12,325,793)	(13,611,191)	(14,621,516)	(15,113,916)	(16,706,127)	(18,899,535)	(19,347,089)	(19,874,233)	(20,421,720)
Financial Liabilities	(1,446,889)	(1,761,084)	(2,030,926)	(9,237,690)	(10,514,246)	(11,902,820)	(12,184,687)	(12,516,679)	(12,861,483)
	(14,017,035)	(15,669,578)	(16,920,282)	(24,387,859)	(27,887,752)	(31,414,210)	(32,158,121)	(33,034,322)	(33,944,337)
Capital employed within main department	**14,076,696**	**11,801,851**	**10,297,095**						
Total Capital employed Trusts	23,366,800	17,890,600	13,992,300						
Total Capital employed Foundation Trusts	13,469,600	16,537,800	15,786,200				-	-	-
Others [2]	274,141	229,838	200,534				-	-	-
							-	-	-
Non Department Public Bodies Net Assets	**36,836,400**	**34,428,400**	**29,778,500**	**-**	**-**	**-**	**-**	**-**	**-**
Total Capital Employed in Departmental Group [3,5]	**27,785,312**	**23,046,668**	**16,299,189**	**17,531,600**	**15,970,581**	**14,234,529**	**14,571,612**	**14,968,640**	**15,380,990**

Notes:

1. 2007-08 to 2009-10 are shown in the previous group structure before IAS8 restatement, and 2009-10 is restated following alignment. The changes due to restatement are described in Note 1b to the Accounts. Main impact is the reduction in group financial assets, as pre-alignment loans and pdc to Trusts and FT are included in the figure
2. Other organisations in 2009-10 comprise: Monitor, Appointments Commission, Commission for Healthcare Regulatory Excellence, Care Quality Commission, General Social Care Council, Health Protection Agency, Health Treatment Agency, Human Fertilisation and Embryology Authority; the composition of these organisations has changed in prior years; so an overall figure for others has been interpolated based on the growth in capital employed within the main department

Others: Detail	**£'000**
Total Capital Employed Monitor	2,222
Total Capital Employed Appointments Commission	835
Total Capital Employed CHRE	291
Total Capital Employed Care Quality Commission	22,900
Total Capital Employed GSCC	28
Total Capital Employed Health Protection Agency	171,200
Total Capital Employed Health Treatment Agency	597
Total Capital Employed HFEA	2,461
	200,534

3. This is calculated as the sum of capital employed within the main department and non-department public body net assets minus financial assets reported within the main department's "Consolidated Statement of Financial Position", that are with Trusts and FTs

Actual Investment not with Trusts/FTs	772,251	797,404	803,618

4. Forecast growths are consistent with expenditure growth assumptions in Spending Review 2010 Settlement below

Spending Review Settlement Total Expenditure:	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	99,450	102,985	105,909	108,417	111,371	114,439

5. The decline in total capital employed in departmental group in 2008-09 and 2009-10 is linked to the Modern Equivalent Asset Revaluation (IFRS)
6. Figures may not sum due to rounding.

Core Table 4 Administration Budgets

	2007-08 Outturn [1] £'000	2008-09 Outturn [1] £'000	2009-10 Outturn [1] £'000	2010-11 Outturn [2] £'000	2011-12 Outturn £'000	2012-13 Plans £'000	2013-14 Plans £'000	2014-15 Plans £'000
Total administration budget				**5,425,184**	**3,540,726**	**4,420,662**	**4,114,103**	**4,129,940**

Note
1. The extended administration control did not exist in the outturn years.

2. The 2010-11 administration figure is as per the baseline used for the Spending Review

NHS Finance and Performance

3.47 As described in the first section of this Annual Report, the scope of the Department's annual accounts has significantly increased this year through the inclusion of the individual accounts of NHS Providers (both NHS Trusts and NHS Foundation Trusts) and all Arms Length Bodies. The financial performance of this expanded group is now reported in detail for the first time within Note 6 to these accounts (Statement of Operating Costs by Operating Segment). This note also reflects the outcome of the trading activity between the commissioners and providers of healthcare that are eliminated on consolidation.

NHS Financial Duties

3.48 Each NHS organisation is subject to a series of either statutory or departmental financial duties. These differ slightly depending on the type of organisation, and in particular, on whether an organisation's income is received as a result of direct Government funding allocations (i.e. the commissioners of healthcare), or whether it is derived through trading activity (i.e. NHS providers). A summary of these various duties is set out in the following paragraphs.

Primary Care Trust (PCT) Financial Duties

3.49 PCTs first came into existence in April 2000, and are responsible for the commissioning of health care on behalf of their resident populations. They also ensure that the health and social care systems work together for the benefit of patients, and that other health services are provided as required, including services from dentists, opticians, mental health professionals, NHS walk-in centres, NHS Direct, patient transport, screening and pharmacies. In addition, many PCTs have, in past years, also provided healthcare and community services direct to the people in their area. However, as part of the ongoing Transforming Community Services (TCS) programme, PCTs are transferring these services and other provider functions to NHS Trusts, NHS Foundation Trusts or social enterprises. The majority of these services transferred during 2010-11 and 2011-12, and both local and national accounts have been restated to reflect this change.

3.50 Early in 2011-12, as an integral part of transition arrangements and to ensure resilience in the system prior to close down on 31 March 2013, all 151 PCTs were clustered into 51 separate groups. This was to ensure that managerial capacity and financial performance management could be maintained across the NHS during this transition period. This clustering led to a degree of change in terms of both geographical areas and to the executive and non-executive membership of each organisation. Clustering has not changed the status of any individual PCT as a statutory accounting entity. The senior leadership of the NHS took steps to ensure that the focus on data quality was not lost during the movement of staff under clustering arrangements, and that individual statutory organisations produced sufficiently detailed hand-over documents.

3.51 PCTs have four main financial duties:

- To keep revenue expenditure (on an accruals basis) within approved revenue resource limits;
- To keep cash expenditure within approved limits;
- To keep capital expenditure (on an accruals basis), within approved capital resource limits; and
- For the reducing number of PCTs that retain a provider function, that the full cost of those functions is recovered.

Strategic Health Authority (SHA) Financial Duties

3.52 SHAs are responsible for the performance management of NHS Trusts and PCTs in their particular geographical area and for elements of specialist commissioning. They effectively act as local headquarters on behalf of the Department of Health. In a similar way to the PCTs, by October 2011 all 10 SHAs had been organised into four clusters. This is to ensure that managerial capacity and focus will be maintained during transition, and that system-wide resilience will not be lost as these organisations continue to prepare for closure on 31 March 2013. This clustering did not affect any individual organisation's status as a distinct accounting entity.

3.53 SHAs have three main financial duties:

- To contain resource expenditure, measured on an accruals basis, within approved revenue resource limits (a statutory duty);
- To contain cash expenditure within approved limits (a statutory duty); and

- To contain capital expenditure, measured on an accruals basis, within approved capital resource limits (a statutory duty).

NHS Trust Financial Duties:

3.54 Until 2011-12, all healthcare providers (i.e. NHS Trusts and NHS Foundation Trusts) were outside the Department's Resource Accounting Boundary. Consequently, this is the first year that the financial results of individual provider organisations have been consolidated into the Department's Annual Report & Accounts. These organisations receive the vast majority of their income through trading activity with healthcare commissioners, and not through direct funding from the Government.

3.55 In relation to the provider sector, there were a number of organisational changes during the year. An additional seven NHS Foundation Trusts were established, with the corresponding NHS Trust being dissolved. Six of these new trusts were established part way through the year, and one was created from 1 April 2011. Two NHS Trusts merged during the year, and a further two NHS Trusts merged with Foundation Trusts. In accordance with merger accounting rules, the income and expenditure of these NHS Trusts, together with the opening and closing balances on their respective Statements of Financial Position, are now included within the NHS Foundation Trusts figures.

3.56 Moreover, as part of the Transforming Community Services initiative, six new Community Service NHS Trusts were established on 1 April 2011, a further two on 1 July 2011 and one more on 1 September 2011. These new trusts assumed responsibility for the community services previously provided by PCTs in their area.

3.57 NHS Trusts have the following five financial duties:

- A statutory break-even duty, by which the organisation must ensure that revenue is sufficient, taking one year with another, to meet expenditure. NHS Trusts normally plan to meet this duty by achieving a balanced position on their Statement of Comprehensive Income each and every year. However, the duty is to break-even "taking one financial year with another", which provides a degree of flexibility about the time-scale for matching income with costs where timing is uneven (such as early retirement and clinical negligence, and when managing a financial recovery). Exceptionally, and with the express agreement of the relevant SHA, a recovery period can be extended to five years;
- A departmental/regulatory duty to break-even each and every year;
- A duty to absorb cost of capital at a rate of 3.5% on average relevant net assets, through the public dividend payment to the Department of Health;
- To manage within the External Financing Limit (EFL) set for each NHS Trust by the Department, which is calculated by reference to the difference between internal cash generated from operations and cash needed for fixed assets and working capital; and
- To remain within the Capital Resource Limit (CRL) set for each NHS Trust by the Department of Health.

NHS Activity

3.58 Overall, in seeking to meet the efficiency challenge, the aim of the NHS has been to redesign care pathways to ensure that patients are treated in the most appropriate way in the most appropriate setting. This focus is expected to reduce the need for unplanned emergency admissions. A modest overall reduction in activity in 2011-12 compared to 2010-11 suggests that this ambition is being delivered. In particular, (as indicated in the Deputy NHS Chief Executive's report *The Quarter* for the final three-month period of 2011-12, published in June 2012) the position at the end of the financial year indicates a slow down in GP referrals for first outpatient appointments. Despite an increase in other referrals, elective growth in 2011-12 remained the same as for 2010-11. This suggests that the NHS is starting to treat more people in the most appropriate setting whilst reducing the level of unnecessary admissions. In addition, taken as a whole, the levels of non-elective activity have remained stable, or were lower, when compared to 2010-11. This indicates that, despite a continuing increase in the demand for acute services, emergency admissions are being avoided or patients are being treated in more appropriate settings.

NHS Financial Performance

3.59 The following table provides a summary of NHS financial performance by sector and SHA area in 2011-12, showing the surpluses (or deficits) by the NHS organisations in each geographical area. Comparable figures are provided for 2010-11 below. In relation to both PCTs and NHS Trusts, Table ten shows the number of organisations in each sector reporting a gross surplus or deficit in 2011-12 and provides comparable figures for 2010-11. The financial results for NHS Foundation Trusts are shown separately in Table fourteen.

Table Nine: Summary of NHS financial performance by sector and SHA geographical area.

Organisation	2011-12				2010-11				Movement between 2011-12 and 2010-11			
	SHA £m	PCT £m	NHS Trust £m	Total £m	SHA £m	PCT £m	NHS Trust £m	Total £m	SHA £m	PCT £m	NHS Trust £m	Total £m
North East SHA	59	5	2	67	65	6	3	73	(5)	(0)	(1)	(7)
North West SHA	215	52	31	298	175	40	20	235	40	12	11	63
Yorkshire and the Humber SHA	118	70	(6)	182	121	66	9	196	(3)	5	(15)	(14)
East Midlands SHA	45	45	25	115	23	67	3	93	22	(22)	22	22
West Midlands SHA	38	54	33	125	23	50	25	98	14	4	9	27
East of England SHA	95	13	12	120	84	17	22	124	11	(4)	(11)	(4)
London SHA	256	187	(72)	370	257	135	(35)	357	(2)	52	(37)	13
South East Coast SHA	62	24	(3)	83	46	20	14	79	16	4	(16)	4
South Central SHA	55	17	8	80	55	12	7	74	(0)	5	1	6
South West SHA	118	59	29	206	51	64	28	143	67	(5)	1	63
Total - England	1061	527	59	1646	900	476	95	1,471	160	50	(36)	175
NHS Direct			1				3				(2)	
NHS Trust Impairments			(777)				(465)				(312)	
NHS Trust including Impairments			**(718)**				**(367)**				**(350)**	

Notes
1. 2010-11 figures are not restated
2. Paragraph 3.75 below explains the difference to the NHS Trusts reported surplus of £45m in Figure 1 and The Year.
3. Figures may not sum due to rounding

Table Ten: Number of Primary Care Trusts and NHS Trusts reporting a gross surplus or deficit

	2011-12		2010-11	
	PCT	NHS Trust	PCT	NHS Trust
Gross Deficit (£m)	(49)	(920)	(18)	(516)
Gross Deficit (number of orgs)	3	41	2	48
Gross Surplus (£m)	575	202	494	149
Gross Surplus (number of orgs)	148	72	149	68
Net Surplus / (deficit)	527	(718)	476	(367)

Note
1. 2010-11 figures are not restated
2. Figures may not sum due to rounding

Primary Care Trust Financial Performance

3.60 In 2011-12, PCTs reported a revenue resource limit under-spend of £527 million, an increase of £51 million when compared to 2010-11.

3.61 As Table ten indicates, the overall PCT underspend for 2011-12 derives from:

- 148 PCTs reporting an aggregate under-spend of £575 million; and
- 3 PCTs reporting an aggregate over-spend of £49 million.
- As in 2010-11, no PCT reported an exactly balanced position in 2011-12.

3.62 The PCT sector also reported an aggregate under-spend of £69 million against the overall capital resource limit, an increase of £5 million compared to 2010-11.

- 127 PCTs reported an aggregate capital under-spend of £70.8 million. In 2010-11, 126 PCTs reported an under spend of £61 million;

- 2 PCTs reported an over-spend of £1.4 million. In 2010-11, just one PCT reported an over spend of £3 million; and
- A total of 22 PCTs reported a balanced position (24 in 2010-11).

3.63 In 2011-12, a total of 24 PCTs retained their provider functions. Of this total, one PCT had not fully recovered its provider function costs from income provided by commissioners by the end of the year (2010-11: 6 PCTs).

3.64 The transfer of provider functions from PCTs under the "Transforming Community Services" initiative is reflected in the reduction of PCT staff costs from £7.4 billion in 2010-11 to £2.4 billion in 2011-12. The Consolidated Statement of Financial Position also indicates that £67 million of net assets transferred outside the Resource Account Boundary as a result of TCS transfers.

3.65 Table eleven analyses PCT operational expenditure, and shows how this relates to the purchase of healthcare on behalf of PCT resident populations.

Table Eleven: PCT Operating Expenditure relating to primary and secondary healthcare purchased

	2011-12	2010-11	Change from
	£000	£000	2010-11
Purchase of Primary Healthcare			%
GP Services	**7,761,467**	7,685,150	1.0
Prescribing Costs	**8,248,643**	8,279,046	(0.4)
Dental Services	**2,859,325**	2,818,288	1.5
General Ophthalmic Services	**490,712**	478,163	2.6
Pharmaceutical Services	**2,135,655**	2,008,408	6.3
Other	**140,756**	115,512	21.9
Total Primary Healthcare purchased	**21,636,558**	21,384,567	**1.2**
Purchase of Secondary Healthcare			
Learning Difficulties[1]	**2,710,359**	2,584,461	4.9
Mental Illness	**8,608,022**	8,377,303	2.8
Maternity	**2,620,977**	2,532,350	3.5
General and Acute	**40,203,872**	38,927,492	3.3
Accident and Emergency	**2,326,344**	2,224,765	4.6
Community Health Services	**9,118,775**	8,413,929	8.4
Other Contractual	**3,170,415**	3,067,336	3.4
Total Secondary Healthcare Purchased	**68,758,764**	66,127,636	**4.0**
Capital Grants	**59,439**	129,197	
Revenue Grants	**152,917**	0	
Total Healthcare Purchased by PCT	**90,607,678**	87,635,649	**3.4**

Note
1. £1,294m to Local Authorities for Learning Difficulties was provided centrally by the Department in 2011-12 rather than included in PCT allocations.

3.66 Expenditure on secondary healthcare has increased by 4% (after adjusting for the central funding for Learning Difficulties), with 1.3% of this increase relating to increased activity and the 2.7% balance relating to change of case mix and price increases in non-tariff activity.

3.67 Overall, the cost of primary healthcare rose by 1.2%, with some of the volume growth offset by lower prices; for instance, dental volumes increased by 1.6% and prescribing volumes by 3.9%. PCT expenditure on pharmaceutical services increases each year as a result of the continuous increase in prescription volumes and new services that pharmacy contractors can choose to provide.

3.68 The Government is committed to ensuring the best value for money for the taxpayer from NHS expenditure on drugs. It has two principal ways of achieving this:

- Through the Pharmaceutical Price Regulation Scheme (PPRS) – which controls the price of branded prescription medicines supplied to the NHS by the regulation of manufacturer profits; and

- Through the community pharmacy contractual framework – which uses the prices of a group of generic medicines to adjust the reimbursement prices of around 500 drugs. This allows profit margins to be monitored, and any excess profit, above that agreed in the framework, to be removed.

3.69 These actions have driven substantial savings in the cost of medicines in recent years, and is partly shown by the decrease in prescribing expenditure indicated in the table above, as the figure also reflects an increase in the volume of drugs prescribed.

Strategic Health Authority Financial Performance

3.70 As with last year, all ten SHAs met their statutory financial duties in 2011-12, reporting a £1,061 million under-spend against the overall revenue resource limit. This compares to a £900 million under spend in 2010-11. SHAs also reported a £4 million under-spend against the capital resource limit, compared to an £11 million under-spend in 2010-11.

3.71 This level of financial performance continues to be important as the NHS works towards delivering its efficiency savings target.

NHS Trust Financial Performance

3.72 A summary of the key financial figures for 2011-12 and the restated 2010-11 year is shown in Table twelve below. This shows that the 113 NHS Trusts generated total revenues of £30.9 billion, an increase of £1.4 billion (4.9%) compared with the prior year. Part of this increase related to revenues arising from the transfer of functions from PCTs. The total revenue increase was off-set by a reduction caused by the conversion of a number of NHS trusts to NHS Foundation Trusts during the year.

Table Twelve: Summary of NHS Trust financial performance

	2011-12			2010-11 (restated)		
	Before Impairments	Impairments	After Impairments	Before Impairments	Impairments	After Impairments
	£ millions	£ millions	£ millions	£ millions	£ millions	£ millions
Revenue	30,911		30,911	29,463		29,463
Expenditure	(30,453)	(778)	(31,231)	(28,902)	(462)	(29,364)
PDC dividends	(398)		(398)	(428)		(428)
Retained Surplus / (Deficit) for the financial year	**60**	**(778)**	**(718)**	133	(462)	(329)
Total Net Assets			12,115			13,283

Note
1. Figures may not sum due to rounding.
2. Impairments exclude inventory write-offs which is the difference to the figure in Note 6.2

3.73 Overall, NHS Trusts reported an operating surplus of £60 million (i.e. before the impact of non-current asset impairments). However, when impairments are taken into account, NHS Trusts reported a deficit of £718 million in 2011-12. It is this accounting deficit which is reported in individual statutory accounts.

3.74 Some 92 out of a total of 113 NHS Trusts generated an operating surplus for the year before impairments. A further 21 reported deficits before these impairments were taken into account, and for 12 of these organisations, this deficit is considered material (i.e. it is greater than 0.5% of revenue). Finally, as Table Ten above indicates, 72 of the 113 Trusts generated an operating surplus of £202 million after the impact of impairments was taken into account.

3.75 Please note that, in the quarterly financial and service performance report on the NHS: *The Year (incorporating The Quarter) 2011-12,* published by Sir David Nicholson in June 2012, a surplus of £45 million was reported in relation to the NHS Trust sector. This value is calculated by adjusting for impairments, service concession arrangements under IFRIC 12 and the elimination of donated asset and government grant reserves. The operating surplus of £60 million reported in paragraph 3.73 above is an aggregate value from the NHS Trust accounts, which is adjusted for impairments only.

Cash balances and borrowing

3.76 Total cash balances amounted to £1,161 million at 31 March 2012 (2010-11: £826 million), an increase of £335 million. The two main components of this increase related to lower spending on capital and the net receipt of additional Public Dividend Capital. Of the total cash balance, £1,153 million was held with the Government Banking Service at the year end.

3.77 Total long-term and working capital borrowing at 31 March 2012 was £5.6 billion (2010-11: £4.6 billion). Of this total, £5.1 billion relates to PFI schemes and finance leases (2010-11: £4.1 billion) and £524 million relates to loans from the Department of Health (2010-11: £515 million). The principal driver for the

increase in borrowing is 3 PFI schemes which have become operational during the year. This increase in long-term borrowing is reflected in the reduction in NHS Trust net total assets at 31 March 2012 to £12.1 billion (from £13.3 billion at 31 March 2011).

3.78 A summary of NHS Trust performance against duties relating to the capital absorption rate, External Financing Limit and Capital Resource Limit, is set out in Table 13 below:

Table Thirteen: Performance against Financial Duties

NHS Trusts achieving Targets	2011-12 Number	2011-12 Percentage	2010-11 Number	2010-11 Percentage
Total number of NHS Trusts	113	100%	116	100%
Capital Absorption Rate				
Total achieving 3.5% or more	38	36%	54	50%
After adjusting for immaterial results	92	87%	104	95%
External Financing Limit (EFL)				
Total achieving target	109	96%	114	98%
After adjusting for immaterial results	110	97%	115	99%
Capital Resource Limit (CRL)				
Total achieving target	113	100%	113	97%
After adjusting for immaterial results	113	100%	113	97%

Note
1. Source: 2011-12 and 2010-11 audited summarisation schedules individual NHS Trusts.
2. A shortfall on the rate of return duty of less than 0.5% is treated as immaterial.
3. An EFL overshoot of less than £10,000 is treated as being within immaterial limits.
4. A CRL overshoot of less than £50,000 is treated as being within immaterial limits.

3.79 The six NHS Trusts which achieved NHS Foundation Trust status part-way through the year had an opportunity to set their EFL and CRL control totals to match the charge against the EFL and CRL incurred during the part of the year that they were NHS Trusts so they could report a balanced position. In addition those Trusts are shown as achieving the capital charge absorption duty, which is an annual measure.

NHS Foundation Trusts Financial Performance

3.80 A summary of the key financial results for NHS Foundation Trusts for 2011-12 and the restated 2010-11 year is shown in the table below. This shows that in the year to 31 March 2012, 143 NHS Foundation Trusts generated total revenues of £35.8 billion, an increase of £5.15 billion (17%) compared with the prior year. Over 50% of this increase related to revenues arising from the transfer of functions to NHS Foundation Trusts from PCTs under the TCS initiative. A further 29% of the increase is due to the impact of the new NHS Foundation Trusts authorised during the year (£0.7 billion) together with the full year impact of the new NHS Foundation Trusts authorised during 2010-11 (£0.8 billion), with the balance being driven by increased activity across the rest of the sector (£1.1 billion).

Table Fourteen: NHS Summary of Foundation Trust Accounts 2011-12 and prior year

	2011-12			2010-11 (restated)		
	Before Impairments £ millions	Impairments £ millions	After Impairments £ millions	Before Impairments £ millions	Impairments £ millions	After Impairments £ millions
Revenue	35,856		35,856	30,705		30,705
Expenditure	(35,418)	(361)	(35,779)	(30,312)	(788)	(31,100)
Retained Surplus / (Deficit) for the financial year	**437**	**(361)**	**76**	393	(788)	(395)

Notes
1. Figures may not sum due to rounding
2. Impairments is a net figure and excludes inventory write-offs

3.81 Overall, NHS Foundation Trusts reported an operating surplus of £437 million in 2011-12 (i.e. before the impact of non-current asset impairments). However, when these impairments were taken into account, this surplus reduced to £76 million.

3.82 NHS Foundation Trusts at 31 March 2012 had net assets of just under £17.5 billion, compared with £16.3 billion at 31 March 2011(restated). The main increase related to property, plant and equipment where the net asset value increased by £1.2 billion, with about £0.2 billion of the increase arising from PFI schemes coming into operation.

Cash balances and borrowing

3.83 Total cash balances amounted to £3.95 billion as at 31 March 2012 (2010-11: £3.26 billion), an increase of £690 million. This was caused by an increase in cash flow from operations, together with lower spending on capital. Of the total cash balance, £3.79 billion was held with the Government Banking Service at the year end.

3.84 Total long-term and working capital borrowing at 31 March 2012 was £5.5 billion (2010-11: £5.2 billion), which compares with the aggregate prudential borrowing limit for all NHS Foundation Trusts of £11.8 billion (2010-11: £10.8 billion). Of the £5.5 billion long-term and working capital borrowing, £4.4 billion relates to PFI and finance leases (2010-11: £4.3 billion) and £1 billion relates to loans (2010-11: £0.8 billion). The principal driver for the increase in borrowing relates to three PFI schemes which have become operational during the year. The prudential borrowing limit is set at the beginning of the year by Monitor for each NHS Foundation Trust in accordance with the Prudential Borrowing Code, and represents the maximum that each trust may borrow.

3.85 The consolidated accounts of NHS Foundation Trusts are published on Monitor's website: NHS *Foundation Trusts: Consolidated Accounts 2011-12.*

NHS Workforce position

3.86 On the basis of financial year average whole time equivalent numbers reported in the accounts of NHS organisations, the total number of staff employed by the NHS reduced during 2011-12 by 28,697, or 2.55% (from 1,125,877 in 2010-11 to 1,097,180 in 2011-12).

3.87 Workforce statistics published by the Health and Social Care Information Centre indicate that the overall number of managers and senior managers within the NHS has reduced by 3.3%, whilst the total number of doctors, including locums, has increased by 2% and the number of professionally qualified clinical staff has increased by 0.4%.

3.88 The overall number of qualified nursing, midwifery and health visiting staff has decreased by 0.3%. Although the number of nurses has reduced in the year, the nurse to bed ratio has increased from an annual average of 1.7 in 2010-11 to an average of 1.8 in 2011-12. This gives an extra two to three hours of nursing time per week per occupied bed. In 2011-12 the number of health visitors has increased by 4%, and the NHS is on track to meet the Government's commitment to increase the number of health visitors by an extra 4,200 by April 2015.

3.89 Nurses and other frontline staff are central to plans for the future of the health service and nurses in hospitals are being given more time for caring responsibilities. The Department wants to remove excessive paperwork and bureaucracy and has asked the Nursing and Care Quality Forum to find ways to free up nurses to spend as much time as possible with patients.

3.90 Improvements in the NHS will mean changing patterns of care and services being provided in different settings and with a different skill-mix of staff. This local reconfiguration of services may mean that some clinical posts are no longer required and that is why it is important that decisions on the appropriate workforce needed to deliver high quality care need to be taken locally.

3.91 The Department recognises that local organisations will, in some cases, have to make difficult choices about staffing changes in the coming years, and has advised that organisations must ensure that, where changes are made, the safety and quality of care is maintained or improved and the changes have been signed off by the relevant clinical directors.

3.92 Where there does need to be change to the workforce locally, the Department expects organisations to put in place comprehensive programmes of support and retraining to enable frontline staff to make the transition to other roles. The Department has developed a HR Transition Framework and series of associated guidance to support staff who are affected by the proposed Healthcare reforms. Staff who are displaced are given preferential access to vacancies and support with retraining and redeployment.

3.93 The average number of staff employed by NHS Trusts in 2011-12 increased by 25,207 or 5.6%, (from 449,852 in 2010-11 to 475,059 in 2011-12). The main reason for this increase has been the transfer of provider functions from Primary Care Trusts to NHS Trusts under the Transforming Community Services (TCS) initiative.

3.94 Similarly, the average number of staff employed by NHS Foundation Trusts in 2011-12 increased by 80,586, or 16.6%, (from 486,116 in 2010-11 to 566,702 in 2011-12). Once again, one of the principal reasons for this increase has been the transfer of provider functions from Primary Care Trusts under TCS.

3.95 The average number of staff employed by PCTs reduced by 134,124, or 72.2% in 2011-12 to 51,528. This very significant reduction is a direct result of the transfer of functions under TCS. As a result of the separation of PCT provider and commissioner functions, large numbers of staff moved into NHS Foundation Trusts, NHS Trusts and a small number of community interest companies and social enterprises.

3.96 In addition, workforce statistics published by the Health and Social Care Information Centre, indicate that the number of PCT managers and senior managers reduced significantly (30% in FTEs) in 2011-12 reflecting the commitment to reduce administration costs, the TCS transfer and the clustering of PCTs in advance of their abolition in March 2013.

3.97 Strategic Health Authorities will remain statutory bodies until the end of 2012-13 and will oversee the handover of duties to Health Education England, local education and training boards, the NHS Commissioning Board and Clinical Commissioning Groups by the end of March 2013. The average number of staff employed in the SHA sector reduced by 366 or 8.6% in 2011-12 compared to 2010-11. This modest decrease reflects the fact that SHA staffing levels have been maintained to manage close down across SHA areas, and to ensure the proper transfer of commissioning functions to successor bodies – most notably the NHS Commissioning Board and Health Education England.

4 MANAGEMENT & GOVERNANCE OF THE DEPARTMENT

Accountabilities within the Department of Health Group

4.1 The Department is led by a team of Ministers supported by officials, the most senior of whom are: the Permanent Secretary, the NHS Chief Executive and the Chief Medical Officer.

4.2 The **Permanent Secretary**, Una O'Brien, is also the Principal Accounting Officer for the Department. As such, she has personal responsibility for the proper presentation of the Department's Annual Report & Accounts and its transmission to the Comptroller & Auditor General for audit. She is also responsible for the use of public money and the stewardship of assets. In particular, in the context of Treasury's guidance: *Managing Public Money,* the Accounting Officer's responsibilities can be summarised as follows:

- To ensure that the expenditure of the Department, its Arm's Length Bodies and the NHS (including NHS Trusts and NHS Foundation Trusts) is contained within the overall budget for the Department – the Departmental Expenditure Limit (DEL);
- To be assured that the individual organisations within the group are performing their functions and duties effectively, and have the necessary governance and controls in place to ensure regularity, propriety and value for money; and
- To ensure that Ministers are appropriately advised on all matters of financial propriety, regularity and value for money across the system for which the Department is responsible.

4.3 Therefore, as well as leading the Department – the Permanent Secretary must also ensure that it operates effectively, that Ministers receive the advice and support they need, and that there is effective working with all Department of Health partners across local and national government, the NHS and in the private, public and third sectors.

4.4 The **NHS Chief Executive**, Sir David Nicholson, is appointed by the Treasury as an Additional Accounting Officer for NHS expenditure. He is directly accountable for the Department's own programme expenditure relating to the NHS, and for managing the expenditure of all NHS organisations that are subject to direction by the Department (namely Primary Care Trusts, Strategic

Health Authorities, NHS-facing Special Health Authorities and NHS Trusts). [The Permanent Secretary is therefore responsible for the remainder of the Department's budget, including expenditure of non-Departmental public bodies, and for ensuring that the net expenditure of NHS Foundation Trusts (which are not subject to direction by the Department) is contained within the overall DH budget]. In addition to his financial accountabilities, Sir David Nicholson is responsible for leading the NHS, and is chief advisor to the Secretary of State in respect of all aspects of NHS delivery and management, and he also took up an additional role as Chief Executive of the NHS Commissioning Board Authority in October 2011.

4.5 The **Chief Medical Officer**, Professor Dame Sally Davies is the most senior professional advisor to both the Department of Health and Government Ministers in respect of medical and public health issues.

4.6 The accountabilities described above will continue until the end of March 2013, after which the Accounting Officer roles will change significantly. From 1 April 2013, the Department will have a single Permanent Secretary, accountable for the Parliamentary Estimate as a whole. DH will allocate NHS funding to the NHS Commissioning Board, with the Chief Executive of the NHS Commissioning Board becoming directly accountable to Parliament for the regularity, propriety and value for money in respect of this funding. Within the new system, the Department and its Ministers will remain ultimately accountable for the overall health and care legislative framework. By contrast, day-to-day operational management for the NHS will take place at arms length from DH, as front-line professionals are empowered to deliver services according to local priorities. A robust governance and assurance structure will remain in place across the group, however, to allow the Permanent Secretary to continue to discharge her responsibilities as Accounting Officer for the Department of Health.

4.7 Further information on the role of the Accounting Officer in relation to the NHS, public health and adult social care and arrangements after April 2013 is available in the Accounting Officer system statement on the Department's website: http://www.dh.gov.uk/health/2012/01/accounting-officer-statement/ .

Ministers

4.8 The following Ministers were responsible for the Department in 2011-12:

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

Rt. Hon Andrew Lansley CBE MP

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

Rt. Hon Simon Burns MP, Minister of State for Health

Paul Burstow MP, Minister of State for Care Services

- **Parliamentary Under Secretaries** with responsibility for Health and Public Health:

Anne Milton MP, Parliamentary Under Secretary of State Public Health

Earl Howe, Parliamentary Under Secretary of State for Quality (Lords)

Board Structure and Membership

4.9 The Departmental Board (DB) and its supporting governance structures were revised in January 2011 to reflect both the Department's priorities and the Cabinet Office Protocol on Enhanced Departmental Boards. The DB is chaired by the Secretary of State and brings together ministerial and civil service leaders with a strengthened team of non-executive directors. The Board provides the collective strategic and operational leadership for the Department. It advises on strategic and operational issues affecting the Department's performance, as well as scrutinising and challenging Departmental policies and performance, and this includes appropriate oversight of sponsored bodies.

4.10 Membership of the Departmental Board during 2011-12 was as follows:

Rt. Hon Andrew Lansley CBE MP	Secretary of State (Chair)
Rt. Hon Simon Burns MP	Minister of State for Health
Paul Burstow MP	Minister of State for Care Services
Anne Milton MP	Parliamentary Under Secretary of State for Public Health

Earl Howe	Parliamentary Under Secretary of State for Quality (Lords)
Una O'Brien CB	Permanent Secretary
Sir David Nicholson KCB CBE	NHS Chief Executive and Chief Executive of NHS Commissioning Board Authority
Professor Dame Sally Davies DBE	Chief Medical Officer
David Behan CBE	Director General of Social Care, Local Government and Care Partnerships
Richard Douglas CB	Director General for Strategy, Finance and the NHS
Peter Sands	Lead non-executive member (1 May 2011)
Dr Catherine Bell	Non-Executive member
Professor David Heymann	Non-Executive member
Mike Wheeler	Non-Executive member
Chris Pilling	Non-Executive member (1 April 2011)

4.11 The Departmental Board is responsible for:

- Supporting Ministers to manage and shape strategic issues relating to the development and implementation of Government objectives for the health and social care systems;
- Ensuring that there is strategic alignment across all those organisations which are accountable to the Department for the health and care system;
- Agreeing the Department's three-year rolling business plan, and providing appropriate oversight of progress against all milestones within it, including performance against efficiency metrics;
- Ensuring sound financial management in the Department, especially in the context of the business plan;
- Gaining assurance on performance by the Department's sponsored bodies; and
- Ensuring, with the advice of the Executive Board, the effective management of risks within the Department and its sponsored bodies.

The lead non-executive member's report follows in Section 5.

4.12 The Departmental Board is supported by:

- The **Executive Board**, which is chaired by the Permanent Secretary, and includes the NHS Chief Executive, the Chief Medical Officer, the Director General for Strategy, Finance and the NHS, and the Director General of Social Care, Local Government and Care Partnerships. This Board supports the Permanent Secretary in the discharge of her responsibilities as Principal Accounting Officer, and is responsible for escalating key risks to the Departmental Board where that becomes necessary;
- The **DH Management Committee**, which is chaired by the Permanent Secretary, and includes all Directors General and Managing Directors. The Committee provides corporate leadership for the Department of Health and supports the Executive Board in supporting the Permanent Secretary in the discharge of her responsibilities as Accounting Officer for the Department;
- The **Audit and Risk Committee**, which is chaired by Mike Wheeler, one of the Department's Non-Executive Board Members, comprises other non-executive members. The Audit and Risk Committee advises the Department of Health's Principal Accounting Officer and the Departmental Board on risk management, corporate governance and assurance arrangements in the Department of Health and its subordinate bodies. This Committee also reviews the Department's Annual Report & Accounts, and recommends these for signing to the Permanent Secretary;
- The **Nominations and Governance Committee** (from October 2011), which is chaired by Peter Sands, the Department's lead Non-Executive Board Member, with Una O'Brien, the Permanent Secretary, and Dr Catherine Bell, a Non-Executive Board Member, as the other members. This Committee advises the Departmental Board on matters relating to leadership and succession

planning for the Department and the Board, and scrutinises governance arrangements in the Department. It also considers matters relating to leadership and succession planning for non-executive board members amongst the Department's arms-length bodies.

- **Transition Boards** were created to oversee and manage the design and implementation of the changes to the new health and social care system. The Programme Transition Board operated until September 2011, and was chaired by the Director General for Strategy, Finance and the NHS, and comprised of the directors leading each of the transition work streams. The format of subsequent transition boards from October 2011 are set out below.

4.13 Until October 2011, the **NHS Management Board** supported the NHS Chief Executive in his responsibility as Accounting Officer for NHS expenditure and provided leadership for the NHS, ensuring effective two-way communication, managing NHS performance and shaping policy and strategy for the NHS. The role of this Board has largely been assumed by the Board of the NHS Commissioning Board Authority following its establishment in October 2011, along with the NHS Transition Executive Forum which provides oversight of NHS operational delivery and the development of NHS future systems within the Department.

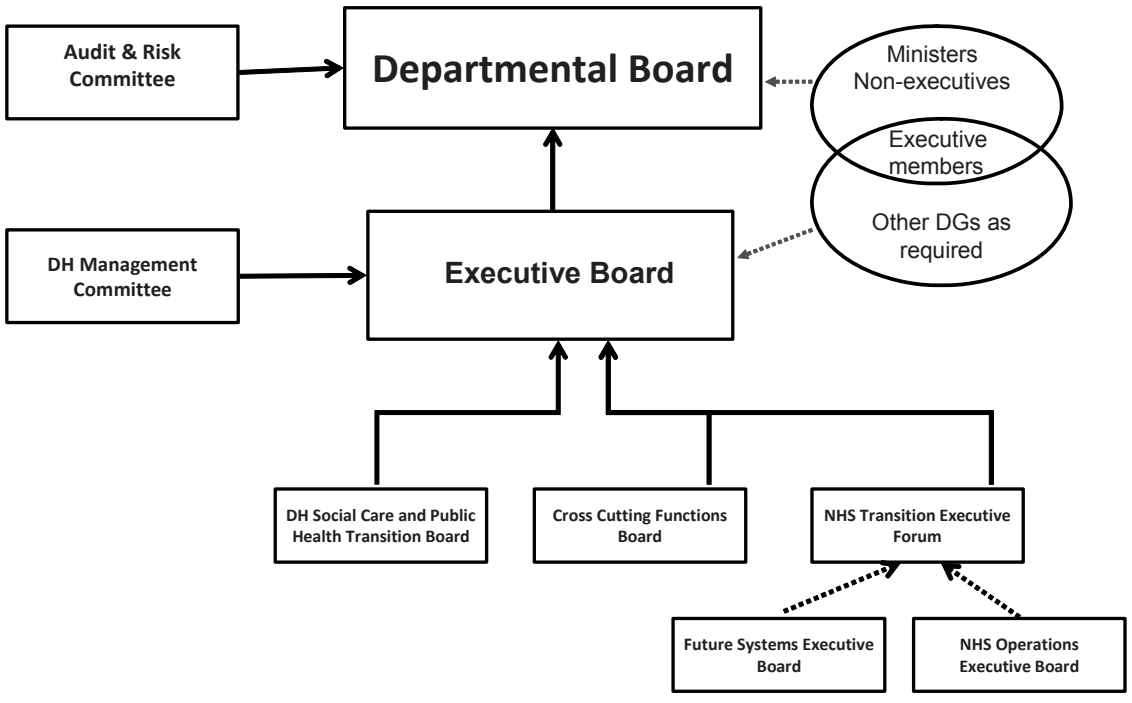
4.14 With the above change, the transition management was further split between the Cross Cutting Functions Board and the Department, Social Care and Public Health Transition Board as shown in the diagram below.

4.15 The Department's performance in meeting its equality and human rights aspirations and legal obligations, including the Public Sector Equality Duty, is overseen by the **Equality and Human Rights Assurance Group (EHRAG).** The committee is chaired by the Director General for Social Care, Local Government and Care Partnerships and comprises other Directors General with responsibilities for the major policy and operational activity relating to equality and human rights.

4.16 The Department puts equality and diversity at the heart of all its business, not least by following a systematic approach to considering equality as a matter of course in policy development and service design. The public sector equality duty, implemented in April 2011, provides a simpler, more focused and less process-based mechanism for ensuring that all public bodies act specifically to eliminate discrimination, harassment and victimisation; advance equality of opportunity; and promote good relations.

4.17 The relationship between the principal Departmental Boards and Committees and the overall governance structure for the Department, is illustrated in the following diagram:

Board Structure From October 2011



Remuneration of Ministers and senior officials

4.18 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. Further details are included in the Remuneration Report.

Appointment of senior officials

4.19 Senior Civil Servants, including the Permanent Secretary, are appointed in accordance with the Department's procedures, the Civil Service Commission's Recruitment Principles, and Guidance on the Civil Service Commission's Recruitment to Senior Posts. Non-Executive members are appointed to the Departmental Board by the Secretary of State for Health following consultation with the Government Lead Non-Executive and consideration by a Departmental panel. The appointments follow the principles of selection based on merit, with an open and transparent process, and information is placed in the public domain about vacancies.

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

4.20 Other than those interests disclosed in Note 28 (Related Party Transactions), Board Members hold no company directorships or other significant interests.

Department of Health Workforce

4.21 From the end of the 2009-10 financial year, the Department has been following a plan to reduce staffing costs and numbers on a permanent basis to reflect year-on-year reductions in departmental budgets. The strategies initially adopted to achieve this goal were:

- To significantly reduce the number of programme-funded non-permanent workers, with a target date of 31 March 2011;
- The operation of central recruitment controls (including those prescribed by the Cabinet Office); and
- A reduction in the Senior Civil Service (SCS) pay bill.

4.22 The first two strategies operated throughout 2010-11 and 2011-12. The SCS target reductions have subsequently been subsumed in a more comprehensive target to reduce the overall pay bill by one third over the Spending Review period.

4.23 Following the general election in May 2010, further strict controls on staffing levels were introduced by the Cabinet Office and applied across the whole of central Government including ALBs. These controls have included a restriction on external recruitment into the Civil Service in respect of all non-front line posts, a continuing freeze on SCS pay, followed by a freeze on non-SCS pay from 1 August 2011. These will continue until 2013-14, when both groups emerge from the pay freeze. These measures are intended to contribute to the Government's overall programme of control over public spending and deficit reduction.

4.24 In December 2011, the Department completed a large-scale bottom-up planning exercise to prepare for its new role in the Health and Social Care system and establish the shape and size of its workforce from April 2013. This included transferring a significant range of functions in NHS-facing areas to other bodies in the new system. This exercise followed an earlier voluntary exit scheme which had been run in February with the specific objective of reducing the number of senior staff in DH, as well as reducing overall paybill costs significantly. The aim of both of these exercises was to:

- Develop an affordable workforce which was focussed on delivering DH business objectives;
- Ensure safe delivery of the transition agenda; and
- Minimise the need for compulsory redundancies.

4.25 These exercises resulted in the design of a new Department with five Directorates (instead of 10). These changes will take full effect from April 2013, and will lead to a significantly smaller number of permanent and non-permanent staff. The size of the Department will reduce further through 2013-14 and 2014-15 through further productivity and efficiency gains.

4.26 The average number of whole-time equivalent staff employed by the Core Department, (excluding Connecting for Health), during the 2011-12 financial year fell by a total of 605 (18%) compared to 2010-

11. This is reported in Note 7 to these accounts. Including Connecting for Health staff, the average number fell by 727 between the two years. A breakdown of the Core Department figures is set out in table fifteen below, and this also shows the £96 million reduction in costs associated with the decrease in numbers.

Table Fifteen: Average number of persons employed by the Core Department

	Average number of Staff Employed (WTE basis)			Total Staff Cost
	Permanently employed staff	Other	Total	£m
2010-11	2,551	800	3,351	377
2011-12	2,350	396	2,746	281
Reduction	201	404	605	96

4.27 Most of this decrease in the number of average staff employed in the Core Department arose through a reduction in the non-permanent workforce (down by 50.5%), accompanied by a reduction of 7.9% in the permanent workforce. The latter was largely the result of departures under the voluntary exit scheme (which occurred mainly between 31 March and 30 June 2011) and the application of recruitment controls. The scheme resulted in 276 departures during 2011-12, significantly reducing the number of permanently employed staff funded by administration expenditure. Most of the associated costs accrued in 2010-11 when departure dates and exit terms were agreed.

4.28 The table below provides a snapshot of the actual number of permanent DH core staff in post at year end for the last three years, and is therefore presented on a different basis to the average numbers shown in Table 15 above. These actual figures indicate that reductions in staff have continued through the year, with the March 2012 actual year end figure being below the 2011-12 average.

Core Table 5: Core Department Permanent Staff in Post at 31 March

	March 2009 number	March 2010 number	March 2011 number	March 2012 number
Core Department	2,256.50	2,627.2	2,555.9	2,284.5

Note

1. Figures represent the position at the end of each financial year, and are following Cabinet Office guidelines

4.29 The initiative to reduce the number of non-permanent workers in the Department has made substantial progress, with many of these workers leaving DH between the last quarter of 2010-11 and the first quarter of 2011-12. Consequently, by the end of the first quarter of 2011-12, there had been in excess of an 80% reduction in the number of programme-funded non-permanent staff. Some of this reduction has been off-set by the reclassification of a number of programme-funded workers into the administration-funded category following the changes in the funding categories set out in section 2. However, overall in net terms over 200 non-permanent programme staff left the Department.

4.30 The average number of staff employed by NHS Connecting for Health (CfH) in 2011-12 was 1,311, a reduction of 122 (18%) compared to the previous year. The employment contracts or secondment agreements of almost all of its staff are held for the Department on a “hosted” basis by the NHS Business Services Authority. The numbers and costs associated with these staff as in 2010-11 are reported in the “Others” column as they do not have a permanent employment contract with the Department.

Pension Liabilities

4.31 The transactions and balances of the NHS Pension Scheme are not consolidated in the Department of Health accounts. The report and accounts of the NHS Pension Scheme are prepared separately by the Chief Executive of the NHS Business Services Authority (BSA) who is the Accounting Officer for the scheme. Further information is available at: http://www.nhsbsa.nhs.uk/Pensions.

4.32 The Department's share of the transactions and balances of the Principal Civil Service Pension Scheme (PCSPS), to which its employees belong, are also not consolidated into the Department of Health's accounts: separate accounts are prepared, and details can be found at: http://www.civilservice.gov.uk/pensions.

4.33 Some NHS Foundation Trusts and Arm's Length Bodies have employees who are members of defined benefit schemes other than the NHS Pension Scheme, including the Local Government Pension scheme. Where the individual body is able to identify its share of the underlying assets and liabilities these are recognised in the accounts and are consolidated.

Equal Opportunities Policy

4.34 The Department of Health set out its strategic commitments to equal opportunities and diversity in its Single Equality Scheme, published in 2009. These commitments incorporate an extensive range of activities, and include targets to increase the representation of women, ethnic minority and disabled staff in the Senior Civil Service (SCS); a comprehensive suite of equality polices; work-life balance and mental health initiatives; workforce monitoring by diversity characteristics; staff awareness programmes; and targeted action such as career progression support for ethnic minority staff. The Department intends to refresh its diversity strategy in line with the requirements of the Equality Act 2010.

4.35 At an operational level, the Department's Equal Opportunities Policy underpins the development and implementation of all policies, guidance and activities:

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 on the grounds of their race, colour, ethnic or national origin, sex, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy or maternity status, marital or civil partnership status, responsibility for children or other dependants, work pattern, Trade Union membership or activity.

4.36 The Department uses a range of measures to track progress – including specific SCS targets, trends in staff survey data, and participation in external benchmarking exercises such as the cross-sector Stonewall Workplace Equality Index. During the course of 2011-12, the Department achieved its targets for the proportions of women, ethnic minority and disabled staff in senior grades. It also increased its position by 19 places to a ranking of 53 in the Stonewall 'Top 100 Employers' Workplace Equality Index.

Recruitment and Retention of Disabled Persons

4.37 The Department has put in place a number of policies and activities to aid the recruitment and retention of disabled staff. These include: involving the disabled staff network in the assessment (by equality) of all workforce policies and guidance; a comprehensive suite of flexible working policies; development of specific guidance for managers and staff, (covering such issues as 'Making reasonable adjustments', 'Mental health', 'Support for carers', 'Anti-bullying and harassment' and the 'Guaranteed Interview Scheme'); occupational health support; and accessible IT systems, information, accommodation and facilities.

Sickness absence data

4.38 Sickness absence data is provided in the table below for the Core Department, NHS Connecting for Health, Primary Care Trusts, Strategic Health Authorities, NHS Trusts and NHS Foundation Trusts. Sickness absence data for Special Health Authorities, and other Arms Length Bodies consolidated into these accounts is available in the underlying accounts of each organisation.

Table Sixteen: Sickness Absence

	2011-12							
	Days Lost (short Term) Headcount Days	Days Lost (Long Term) Headcount Days	Total Days Lost (12 month Period)	Total Staff Years	Average Working Days Lost	Total Staff Employed in Period (Headcount)	Total Staff Employed in Period with no sickness absence (Headcount)	% Staff with no sickness absence Headcount
Core Department	4,556	4,975	9,531	2,364	4.0	2,777	1,587	57
Connecting for Health (3)	2,120	3,920	6,040	1,168	5.2	1,233	728	59
Strategic Health Authorities			13,971	2,916	4.8			
Primary Care Trusts (4)			1,004,737	113,498	8.9			
NHS Trusts and FTs (5)			8,484,392	907,097	9.4			

Note
1. Sickness absence data is collected by the Health and Social Care Information Centre
2. Sickness absence is based on available staff days on a headcount basis
3. NHS Connecting for Health is managed by the Department's Director General for Informatics and Chief Information Officer. Information relating to staff is disclosed separately from the core Department.
4. PCT figures include some staff relating to provider functions which transferred to NHS Trusts and Foundation Trusts in 2011-12.
5. Data relating to NHS Trusts and NHS Foundation Trusts staff cannot be disaggregated in the information available from the Health and Social Care Information Centre. Two NHS Foundation Trusts have opted out of the information returns and DH has estimated the numbers of extra days applicable on an average basis.

Provision of information to, and consultation with, employees

4.39 The Department has a series of communication channels in place to deliver information about organisational and business developments to staff, and to provide an opportunity for feedback, both at a corporate and local level. Methods of communication range from regular electronic messages to all staff via e-mail or the Department's intranet site (including the Permanent Secretary's updates) to face-to-face briefings by DH Management Committee members and the Department's senior managers. The Department also works in partnership with the Departmental Trade Unions through consultation and negotiation to encourage involvement and build engagement in decision-making processes. There are a number of sites on the DH intranet which are dedicated specifically to informing staff about progress with transition in both the Department and the wider health and care system. The "Permanent Secretary's corner" also allows staff to communicate their ideas and concerns directly to the Permanent Secretary and her senior team.

Well-being of DH staff

4.40 The Department's Health & Well-being (H&WB) Board has been active throughout the year. It has developed the concept of H&WB partners in conjunction with the Civil Service Benevolent Fund (CSBF), HASSRA Sports and Social Club, Medigold Occupational Health Services and NHS Choices joining DH directors on the board to '*promote, support, encourage and inspire health and wellbeing of DH staff through transition and beyond'.*

4.41 The Health and Well-being Board is committed to ensuring that the Department of Health is (and continues to be) a good place to work, where:

- The health and well-being of all staff is given the attention it deserves;
- Any barriers to returning to, or remaining at, work or to being productive whilst at work, are removed or minimised;
- The health of staff is not adversely affected by work, and good quality advice and support is available and accessible;
- Staff have opportunities to improve their individual health and well-being – both physically and emotionally, and staff with health conditions or disabilities can make the most of their work opportunities with the active support of their employer; and
- The Department's culture promotes, supports, encourages and inspires positive life-style choices.

4.42 In the context of unprecedented structural and organisational change in the Department, the Health & Well-being Board has implemented a coordinated programme of activities and events under three core work streams covering emotional, physical, and workplace well-being. This year, over 500 staff members took part in 'Impact of Change' workshops; over 1,000 colleagues participated in the NHS

Choices 'health check' and other physical follow-up activities, and a similar number engaged in surveys and focus groups to look at flexible working initiatives in DH.

4.43 In addition, DH buildings now include designated health and well-being spaces, such as 'Quiet rooms' and private facilities specifically for new mothers. Together with special projects designed to enhance existing support in dealing with long-term health conditions or caring responsibilities, the Health and Well-being Board has promoted other health-related activities and awareness sessions.

4.44 Through these and other initiatives, the Department has been able to sign up to all of the Responsibility Deal pledges on work and health issues. It has started work with key cross-Whitehall stakeholders, including Dame Carol Black, to promote DH as an exemplar across government, share best practice and extend the reach of Responsibility Deal pledges. The October 2011 Civil Service People Survey showed a 60% positive response from staff on health and well-being, up from 50% in May 2011.

Health and Safety at Work

4.45 The Department of Health recognises its responsibilities, under the Health and Safety at Work etc. Act 1974, for ensuring, so far as is reasonably practicable, the health, safety and welfare of its employees, temporary staff, and visitors to its premises and to others who may be affected by its operations and/or activities. Health and safety is regarded as a key component of the organisation's strategy and its operational considerations and a prime responsibility of the management team. In 2011-12, there were 41 reported accidents; 1 of which resulted in absence and 4 near misses.

Social and Community Policies

4.46 The Department encourages staff working within the Department and its ALBs to take part in community activities, through volunteering in the local area and offering work experience opportunities to people from disadvantaged backgrounds.

4.47 The Department's volunteering policy encourages staff to work with people from all strands of the local community, particularly those from under-privileged backgrounds. As part of its implementation plan for employer supported volunteering, the Department has set up partnership arrangements with Southwark Volunteering Centre, Time and Talents (Westminster), and Leeds Ahead (Yorkshire) - to help put people and teams in touch with local community groups for volunteering opportunities.

4.48 The Department also offers work experience opportunities as part of its commitment to the social mobility agenda. This includes the cross-government Whitehall Summer Internship scheme, which provides school-age students from under-represented socio-economic backgrounds with an opportunity to experience life in Whitehall and undertake interesting work placements in high-profile policy teams. The Department supported three interns in 2011-12, and will continue to run this scheme on an annual basis. For graduates and under-graduates, there is the cross-government Summer Internship programme – targeting students from ethnic minority backgrounds or who have a disability. Each year, the Department takes four to five candidates.

4.49 In addition, the Department embarked on a local work experience initiative in 2010. This programme – 'Building Bridges' – is aimed at high-achieving pupils from local schools in Southwark and Westminster, focusing in particular on schools in disadvantaged areas. Participants are given the opportunity to see policy-making in action, through two-week placements in the Department. The programme offers four placements a year, and will increase to seven in 2012-13, due to increasing demand. Last year, we adapted the programme to provide a placement for a young person with a learning disability.

5. LEAD NON-EXECUTIVE BOARD MEMBER'S REPORT

Performance and priorities

5.1 The Department of Health has demonstrated commendable resilience and flexibility over the last year, simultaneously confronting a vast range of issues from ensuring ongoing delivery of quality health services, to driving the productivity programme and managing the transformation of the overall health system.

5.2 The care system faces considerable challenges, given demographic changes, rising expectations and the pressures on public finances. The policy response to these challenges, set out primarily in the

Health and Social Care Act 2012, bring with them significant structural change, as well as the need to develop common purpose around continuous quality improvement. The Department's staff have responded to the challenge impressively, recognising the scale of the task ahead, and the imperative for change.

5.3 The Board plays a vital role in the governance of the Department, helping it navigate the multiple and complex challenges it faces as it embarks on this transformation without compromising current performance, either in terms of quality of services or financial discipline. Given members' wealth of experience across the public, charitable and private sectors, the Board can offer constructive challenge as well as support. For example, the non executive members have led the Board's work, in partnership across Whitehall, on supporting economic growth.

5.4 The Board met formally four times in 2011-12, and informally on five occasions. The Board took care to plan its agendas around the Department's key responsibilities, overseeing current performance and ensuring a detailed understanding of the important issues facing the Department and the wider system, including risks and strategic priorities. Of particular importance was the Board's developing a comprehensive understanding of the Department's - and thus the system's - finances. This has enabled the Board to help the Department live within its limits as well as to underpin more informed planning for the future.

5.5 Topics the Board devoted particular attention to include:

- **Ensuring the development of effective relationships between the Department and the key arms-length bodies (ALBs) in the transformed health system.** To deliver better outcomes, the Department and its partner agencies must work together seamlessly. This requires clearly defined mechanisms for communication, consultation and decision-making. Board members have discussed these topics on several occasions, including with members of the ALBs' own Boards. Building common purpose across the system is a key priority for the year ahead.

- **Overseeing the transition programme and its associated risks.** As the Department has been leading the transformation of the health and social care system, the Board has kept a close eye on the transition programme. The Board has kept the Department's strategic risk register under continuous review, and offered considered advice in both the main Board and in its Audit and Risk sub-committee.

- **Overseeing the Department's Capability Review.** The Department's role is undergoing significant change, becoming less about controlling and directing the system, and more about being the architect and ongoing guardian of the care system as a whole – developing its structure and ensuring that it works. This change in role required the Department to strengthen its capabilities in key areas. For this reason, the Board, and particularly the Non-Executive Members, took as a priority to engage in depth with the Department's Capability Review, significantly influencing the Department's final scores and the substance of the resulting Action Plan. Board members are keen to ensure the Department maintains its understanding of its strengths and weaknesses as it grows into this role; and that the comprehensive Action Plan continues to address the gaps, and develop the Department's capabilities. Thanks to solid progress against the Action Plan, the Board are more confident in Summer 2012 that the Department is on track than they were able to be in Autumn 2011.

- **Enhancing communication across the Department and the ALBs to ensure common purpose and understanding across the system as a whole.** The Capability Review reinforced the importance of effective communication to build trust, confidence and effective collaboration. Given the scale of change within the Department and across the system as a whole, it is vital that the overarching purpose of the changes, the mechanics of how they will work and the roles of the new bodies are well understood by all staff within the system. The Board sees this as an ongoing priority for the Department.

- **Reinforcing performance management.** The Board has been impressed by the wide range of performance and management information it has received over the past year. However, Board members have on occasion found it difficult to engage fully with this information due to the amount and format of information supplied. The Board discussed this issue, and as a result, the Department is developing a performance scorecard to summarise this information, whilst at the

same time allowing members to drill down in greater depth where required. The Board will continue to encourage the Department to refine the quality and clarity of performance metrics.

Actions from the Board effectiveness review

5.6 In early 2012, the Board undertook its first effectiveness evaluation, through a survey and interviews with individual Board members. This was a useful exercise which demonstrated that the Board is making good progress in its core objective of improving the governance of the Department of Health. As expected, the evaluation process also identified some areas for improvement. Some changes the Board needs to consider stem from the Department's changing role within the wider healthcare system. Others relate more to the practical details of how we make best use of the Board's time, ensuring we are focused on the most critical issues. As a result of the effectiveness review, the Board has identified a number of key actions, summarised below:

- **Determine the Board's role in ensuring effective governance of the health care system as a whole**. The Board needs to work out how to fulfill its role in ensuring effective governance across all aspects of the health and care system, without compromising the independence of the Boards of the individual ALBs.

- **Reinforce focus on outcomes in monitoring performance of the Department and the system as a whole.** Current performance metrics focus mainly on inputs. The Board would like to see these complemented by metrics from the Outcome Framework, which highlight performance against critical health and patient care indicators.

- **Ensure the Board spends sufficient time on the big strategic issues affecting the longer term shape and performance of the health and care system.** The Board is determined to ensure that the requirement to monitor current performance and deal with more tactical issues does not detract from the Board's ability to debate more strategic issues that will shape the performance of the system over many years.

- **Enhance the Board's ability to identify and discuss the most critical risks.** Whilst the Board has regularly discussed the risks facing the Department and its objectives, it seems appropriate to devote more time to such issues as we embark on the transformation of the system.

- **Continue to build the Board's effectiveness through refining formats, scheduling and prioritization.**

- **Refine the composition of the Board to reflect it's changing role in the governance of the system.**

6 DEPARTMENTAL PERFORMANCE REPORTING

6.1 The overall purpose of the Department of Health is to improve the health and well-being of the people of England. Consequently, the principal focus of the Department's work, for which it is accountable to both Parliament and the public, includes setting appropriate national policies and standards to shape the direction of the NHS and adult social care systems, and to promote healthier living in the population. In working with its partners to achieve these goals, the Department is responsible for around £105 billion of public funds. It advises Ministers on how best to use this funding in order to inform and achieve their decisions and to carry out their objectives. DH staff are responsible for leading and driving forward change in both the NHS and social care, as well as setting the direction on promoting and protecting the public's health. This includes taking the lead on issues such as environmental hazards to health, infectious diseases, health promotion and education, the safety of medicines, and ethical issues.

6.2 The Department of Health in its current form was formally created in 1988, through The Transfer of Functions (Health and Social Security) Order 1988. This Order split the Department of Health and Social Security (DHSS) into two government departments, one being Health, and the other being what is now the Department for Work & Pensions. The very first department responsible for the nation's

health, was the appropriately named Ministry of Health, which was created in 1919 by the Ministry of Health Act. This new Department consolidated under a single authority the medical and public health functions of central government.

6.3 The Department of Health continues to be one of the busiest departments of state in Whitehall. Working through and with the 1.1 million NHS staff operating in more than 400 organisations and approximately 8,200 GP practices, the Department is responsible for the provision of health services to around 1.5 million patients and their families every day.

6.4 The Department also sets the strategic framework for adult social care. It gives advice and guidance to local authorities, which are responsible for managing social care funding according to local priorities and the principles of local accountability. Over 1.6 million staff work in the social care sector. Local authorities provide or arrange services for 1.6 million users through the year through almost 25,000 social care providers registered with Care Quality Commission, of which the great majority are smaller, independent sector organisations.

Structural Reform Plan priorities

6.5 Following the 2010 general election, the Department published its five principal strategic priorities in its Structural Reform Plan. These Plans are intended to replace targets and onerous top-down management, and for the Department of Health will:

- **Create a patient-led NHS** - strengthen the ability of patients to exercise extended choice, have a greater say in managing their own care, and have their voice heard in the NHS;
- **Promote better healthcare outcomes** – shift focus and resources away from top-down process targets towards better healthcare outcomes, including national health outcome measures, patient reported outcome measures and patient experience measures;
- **Revolutionise NHS accountability –** create a long term, sustainable framework of institutions, with greater autonomy for doctors and nurses, greater accountability to patients and the public, and increased democratic participation in the NHS;
- **Promote public health –** create a public health service which rebalances the Department's approach to health, drawing together national leadership with local delivery and fostering a new sense of community and social responsibility; and
- **Reform social care –** enable the users of care to be treated with dignity and respect, and work to reform the social care system to give more control to individuals and those who care for them, thereby easing their cost burden.

6.6 These priorities and ambitions for the health and social care system form the key principles of the Health and Social Care Act 2012, and will also inform the shape of future Social Care reform and legislation.

6.7 These Structural Reform Priorities are set out in the Department's Business Plan 2011-15. This plan was developed following public consultation during the Summer of 2010, and was published in November 2010. At the start of the 2011-12 financial year, passage of the Health & Social Care Bill through Parliament was paused to allow the NHS Future Forum to conduct a wide-ranging "listening exercise" with all key stakeholders. This pause resulted in a delay to the publication of the Department's 2011 Business Plan and, on the recommendation of the NHS Future Forum, led to a revised timetable for the delivery of some SRP commitments. The refreshed Plan was published in July, took account of the outcomes of the listening exercise, and included four additional major responsibilities:

- **Maintain Performance on Waiting Times** - including the maximum 18-weeks referral to treatment, 4 hour A&E standard and cancer waiting times;
- **Run an efficient and effective Department of State –** provide an efficient and effective service to the public, Parliament and Ministers through advice and timely responses to queries on health and adult social care policy;
- **Help prepare for emergencies –** work with other Government departments and public services to ensure that both the Department of Health and the NHS are prepared for emergencies and other critical events;
- **Devolve leadership of Information Technology (IT) development –** devolve the leadership of IT

development to NHS organisations, taking implementation closer to the front line.

6.8 Except where set out in either the Structural Reform Priorities or these additional responsibilities, the Department made a clear commitment in its 2011-15 Business Plan that it will *no longer*:

- manage the NHS through central process targets. Instead, the Department will ensure that patients have access to the data they need to make meaningful choices about their care;
- require the publication of data which does not help inform patient choice, or the holding of public servants to account; and
- support the existence of Arm's Length Bodies that are no longer needed or which duplicate functions. The Department will streamline those that should continue.

6.9 The Department delivers its objectives by working with Ministers, the NHS, social care providers and other partners through five distinct but inter-related roles:

- Setting direction for the NHS, adult social care and public health, including the integration of public health, health care commissioning and social care at a national level;
- Supporting delivery, which includes securing the financial resources within which health and social care providers can successfully deliver appropriate services;
- Leading health and well-being for Government;
- Ensuring appropriate accountability to both Parliament and the public in respect of both the services and resources for which the Department is responsible;
- Supporting staff to succeed.

6.10 Key performance indicators in the wider health and social care system are measured and challenged by the relevant management or programme board. At each of its formal meetings, for example, the Departmental Board receives a key information pack which includes performance data relating to both the Department and the wider health and care system. A discussion about performance is a standing item on the agenda of each Departmental Board meeting, with non-executive board members providing rigorous challenge.

6.11 From July 2011, the Department has published Quarterly Data Summaries (QDS) on its website. These provide a quarterly snapshot in relation to the indicators included in the Departmental Business Plan, as well as other published data and management information. This includes details of how the Department spends its budget, the results achieved and how its workforce is deployed. The QDS includes the latest indicative information about the number and structure of people working in DH and its agencies.

Progress against the Structural Reform Plan

6.12 Key SRP achievements for the Department of Health during 2011-12 were as follows:

- Royal Assent in March 2012 for the Health and Social Care Act 2012. This legislation fundamentally changes the infrastructure for commissioning health care services through the establishment of the NHS Commissioning Board and Clinical Commissioning Groups (CCGs). It gives more power to clinicians, more choice and control to patients, and provides a clear framework for the Government's modernisation of the NHS;
- Publication of a number of key documents to communicate details of the next stages of health and care system reform:
  - *Building the National Trust Development Authority;*
  - *Building a Public Health England – People Transition Policy ; and*
  - *the Quality, Innovation, Productivity and Prevention (QIPP) national update;*
- Establishment of the NHS Commissioning Board as a Special Health Authority;
- Consultation on proposals to establish Clinical Commissioning Groups;
- Conclusion of Tripartite Formal Agreements between Strategic Health Authorities and NHS Trusts that set out the commitments required from each party to enable achievement of NHS Foundation Trust status;

- Establishment of the Health Research Authority as a Special Health Authority;
- Launch of the Public Health Responsibility Deal and issue of the first NHS Outcomes Framework;
- Launch of the first two research partnerships between academics and the NHS to work with industry and help turn scientific discoveries into treatments;
- Review of the rules on charging non-residents for NHS healthcare; and
- Publication of plans for a secure e-health record data service that is viable and affordable.

6.13 Each month, the Department reports on progress made against the commitments in its SRP. DH met 66% of its current commitments on time. Reasons for delay, other than the pause in the passage of the Health & Social Care Bill, included slippage in the parliamentary timetable, (e.g. in relation to the Care and Support White Paper), or were the result of policy decisions, (e.g. some commitments shared with the Ministry of Justice and overseen by the Health and Criminal Justice Programme Board).

Supporting Departmental Staff to Succeed

6.14 The Department can only meet its objectives or discharge its responsibilities by having a highly-skilled, professional and motivated workforce, with staff being supported by the right tools and infrastructure to help them succeed. Such support includes:

- access to appropriate training and development opportunities; and
- provision of effective and efficient support services, especially relating to information technology, human resources, accommodation and finance.

6.15 The Department's relationship with its workforce is supported by a series of core values relating to people, overall purpose, the principle of working together, and accountability.

6.16 The Department's Learning and Development (L&D) activity during the year focused particularly on building organisational capability in respect of managing and leading change. In addition, there was a strong emphasis on developing wider management and leadership skills, enhancing the quality of support for ministers and Parliament and strengthening the skills associated with partnership building and sector leadership capabilities. For example, in 2011-12, over 750 members of staff attended bespoke workshops on various aspects of managing and leading change.

6.17 In each month since April 2011, the corporate L&D team has, on average, provided 40 hours of bespoke L&D consultancy support across all directorates. Topics included in this support covered a range of development needs: managing local change and transition, Professional Skills for Government, teambuilding, providing emotional support, and workshops on the development of new working systems and understanding different working styles.

Dealing with Risks and Uncertainties

6.18 The Department's strategic risk register provides the focal point for overall risk management within the Department of Health. This register is updated on a regular basis, and the contents are considered by the Departmental Board and the Audit & Risk Committee at each of their meetings. Supporting Committees and groups manage those risks which fall within their specific areas of responsibility, and, as appropriate, will escalate those risks for inclusion in the strategic risk register. During 2011-12, the Department revised the format of its strategic risk register, with risks now categorised into one of three areas: (i) business as usual risks; (ii) transition specific risks; and (iii) risks inherent in the new system.

6.19 Further commentary on this risk and control framework is included in the Governance Statement.

6.20 In March 2011, in circumstances which attracted significant media attention, Southern Cross, the biggest provider of care homes in the UK, announced it was in financial difficulties. Some 31,000 residents in 750 different care homes were potentially affected. The Government's primary concern was the welfare of those residents. Ministers gave a commitment that, whatever the outcome, no-one would find themselves homeless or without care. The Department, working with the Association of Directors of Adult Social Services, the Local Government Association and the Care Quality Commission, ensured that robust local arrangements were put in place to address the consequences of this financial failure. The Department oversaw the negotiations that led to the Southern Cross company being wound up and its business taken on by alternative providers during 2011-12. The risks to the health and well-being of residents were therefore successfully mitigated.

Transparency and Efficiency Controls

6.21 An emphasis on greater transparency lies at the heart of the Coalition Government's commitment to provide a means for the public to hold politicians and public bodies to account. The Department is fully committed to this transparency agenda and has made available a number of key documents on the DH website via a link to data.gov.uk. During 2011-12, key DH documents were made available in respect of:

- DH staff salaries above £150,000;
- senior DH civil servants' pay and details;
- senior staff pay details in relation to the Department's Arms Length Bodies (ALBs), Executive Agency, Executive Non-Departmental Bodies and Special Health Authorities;
- all new DH ICT contracts and central DH contracts;
- all new DH tender documents for contracts over £10,000;
- the Department's organisation chart and related staff data;
- new items of central DH spending over £25,000;
- publication of expenses information for senior officials in the Department;
- management information relating to the DH workforce (April to August 2011); and
- details of Government Procurement Card (GPC) transactions over £500.

6.22 The DH Business Plan 2011-15 sets out the priorities for the Department. As described above, the Structural Reform section of the Plan sets out the key commitments involved in delivering the Department's reform programme. Each month, DH reports on the progress made in meeting its SRP commitments. These reports are available on both the Department's and the Number 10 websites. The transparency section of the Business Plan sets out the key indicators that the Department believes will be most useful to the public in terms of understanding the costs and outcomes of health and social care services.

6.23 In May 2010, the Coalition Government introduced a range of efficiency controls relating to both the Civil Service and the work of Departments and Arms Length Bodies, with the purpose of securing billions of pounds in efficiency savings. These controls introduced an immediate freeze on a number of expenditure areas, including: external recruitment, new consultancy spend, new ICT projects over £1 million and paid for communications, advertising and marketing activity. In addition, the Cabinet Office introduced tighter controls over procurement, property, pay and business travel, and, in March 2011, announced that all these controls would remain in place until March 2015.

6.24 The Department of Health implemented these controls (with appropriate guidance) both for itself and its ALBs in May 2010 and has, in some cases (for example, professional services), extended the scope of the controls beyond that imposed by the Cabinet Office.

Spend on Consultancy, Agency and Temporary Workers

6.25 The following table provides details of expenditure by the Department and other bodies within the Resource Accounting Boundary in respect of consultancy and temporary agency workers.

6.26 The table shows that the Core Department, Connecting for Health (CfH) and its ALBs reduced its expenditure on consultancy by £2.9 million (13%) and on temporary and agency staff by £79 million (43%) compared to 2010-11.

6.27 Although there has been a total reduction in spend across these organisations, reflective of the Efficiency Reform Group (ERG) controls in place, there are some increases, predominantly within CfH for consultancy because of increased legal consultancy requirements; and within Monitor for transitional work related to the new economic regulator (both consultancy and temporary agency).

6.28 Across the total group accounting boundary, total consultancy expenditure increased by 1% (£6 million) from £470 million to £476 million. The overall increase is explained by NHS Trusts and Foundation Trusts (FTs) reporting a total increase of £49m, offset by a reduction across SHAs and PCTs of £40 million (23%) and the DH Core, Connecting for Health and ALBs of £2.9 million (13%).

6.29 Total temporary and agency staff expenditure in 2011-12 reduced by 10% (£353 million) from £3,619 million to £3,266 million. DH Core and ALBs reduced their expenditure by £63 million (47%), NHS Connecting for Health by £17 million (33%) and PCTs by £371 million (64%). NHS Trusts and FTs combined recorded a marginal increase of £88 million (3%), and SHAs increased their expenditure by £9 million (18%)

Table Seventeen: Department and Other Bodies Expenditure on Consultancy, and Temporary/ Agency Workers

	2011-12		2010-11	
	Consultancy[1]	Temporary Agency[2]	Consultancy[1]	Temporary Agency[2, 3]
	£ 000	£ 000	£ 000	£ 000
Core Department	2,920	36,886	9,797	87,516
Connecting for Health	11,997	34,078	4,975	50,734
Sub Total DH Core	**14,917**	**70,964**	**14,772**	**138,250**
% Change on prior year	**1%**	**-49%**		
RAB Special Health Authorities:				
NHS Institute for Innovation and Improvement	-	1,498	1,548	9,196
National Patient Safety Agency	212	782	243	2,614
NHS Business Services Authority	-	1,206	95	1,578
The Information Centre	461	4,261	197	5,664
National Institute for Health and Clinical Excellence	20	5,970	-	4,813
NHS Litigation Authority	-	428	-	428
National Treatment Agency for Substance Misuse	-	4	35	833
NHS Commissioning Board Authority	101	-	n/a	n/a
Health Research Authority		86	n/a	n/a
Sub Total - RAB SpHAs	**794**	**14,235**	**2,118**	**25,126**
RAB NDPBs:				
Care Quality Commission	59	8,063	1,559	8,654
Appointments Commission	-	-	-	2
Council for the Regulation of Healthcare Professionals	40	2	45	7
General Social Care Council	-	1,390	129	2,418
Health Protection Agency	223	6,619	2,782	7,323
Human Fertilisation and Embryology Authority	170	-	206	574
Human Tissue Authority	261	214	320	439
Monitor – Independent Regulator of NHS Foundation Trusts[4]	3,650	3,712	1,056	1,645
Sub Total - RAB NDPBs	**4,403**	**20,000**	**6,097**	**21,062**
Sub Total - DH and ALBs	**20,113**	**105,199**	**22,987**	**184,438**
% Change on prior year	**-13%**	**-43%**		
Strategic Health Authorities	23,525	58,733	35,482	49,663
Primary Care Trusts	109,750	210,778	137,960	581,470
NHS Trusts	146,759	1,573,918	117,605	1,625,556
NHS Foundation Trusts	176,292	1,317,203	156,100	1,177,495
Sub Total - Trusts and SHAs	**456,326**	**3,160,632**	**447,147**	**3,434,184**
	2%	**-8%**		
RAB Total	**476,439**	**3,265,832**	**470,134**	**3,618,622**
% Change on prior year	**1%**	**-10%**		

Notes

1. Consultancy values for Core Department reported receipted amounts against purchase orders in line with Office of Government Commerce (OGC) definitions. This source was used in 2010-11. This differs to the source of data used in the main body of the resource accounts (for example, notes 8 and 9), which is taken from the Department's General Ledger. There are definitional and timing differences between these sources. For example, see footnote 4.

2. Temporary Agency values are on an accrual basis from the accounting systems

3. The 2010-11 figures have been restated both to exclude some pensions costs that were incorrectly included last year and to correct some classification errors. The main figures affected are those for Connecting for Health, the NHS Institute and the Care Quality Commission.

4. Monitor consultancy expenditure includes transition activity (Circa £3m) which has since been recharged to the Core Department and is reflected in the DH Core resource accounts within notes 8 and 9.

Other Department Efficiencies and Cost Reductions

6.30 In 2011-12, the Department reduced the space within its London estate by 15%, thereby saving around £4 million per year. It will continue to exercise tight control over its core and ALB estate and will seek to futher reduce the future size and cost of the estate in line with operational requirements. The Department also negotiated a new shared ICT service for the Department and its ALBs, which will help deliver future savings of over one third against the cost of current contracts. In addition, the Department made savings of £4.2 million through its procurement function, achieving better value for money on a range of contracts.

6.31 The Department has successfully completed the Public Sector Carbon Management programme, leading to a reduction in energy consumption by 25% compared to 1999-2000 baseline figures.

7 REVIEW OF THE YEAR

7.1 Without doubt, 2011-12 has been a year of almost unprecedented change for both the Department and the wider health and social care system. Successful delivery of the Health & Social Care Act, which received the Royal Assent in March 2012, marks a fundamental shift in the way in which health care is commissioned and delivered. There is a significantly greater emphasis on local engagement – not least through the creation of Health and Well-being Boards and Public Health England – with the empowerment of patients and local communities lying at the heart of the Coalition's reforms.

7.2 The Government's aspirations for the health and care system can be summarised as being:

- To ensure that people have the best possible health, with outcomes as good as the healthiest nations in the World;
- To be as effective at keeping the nation in good health, as it is at treating ill health;
- To have a health and care system that is built around people and patients (and which responds to their needs according to locally determined priorities) and which is not focused on process. Patients will be empowered to take more control of their own care;
- To have a health system that is led by clinicians and health care professionals;
- To drive substantial improvements in health outcomes, productivity and the quality of care; and
- To develop innovative improvements in terms of delivering patient care, especially in respect of patients with long-term conditions and for older people.

7.3 As well as defining the future direction of the health and care systems in its new legislation during 2011-12, the Department has also:

- Maintained financial performance (as set out in Section 2 above) whilst making good progress in terms of reducing administration costs and, for the NHS, in working to achieve QIPP efficiency saving targets;
- Maintained successful performance across the health and care sectors, including in respect of waiting times and healthcare associated infections;
- Promoted further integration of care services, whilst taking steps to improve the future of social care in the face of an ageing population and rising demand; and
- Improved the efficiency of its own operations, whilst continuing to reduce costs.

Progress on the Transition to Modernise the Health and Care system

7.4 The Health and Social Care Act 2012 provides a series of powers and structural changes which are designed to modernise and improve the health and care system. The Act reflects the proposals set out in the Government's White Paper: Equality and Excellence: Liberating the NHS, (published in July 2010). This reforming legislation will:

- **Hand power to doctors and nurses:** Health professionals will have the power to design the best local health services for their patients according to local priorities – this more autonomous and accountable system will be achieved through 212 Clinical Commissioning Groups;

- **Drive up quality:** healthcare commissioners will be under a duty to continuously improve the quality of services on behalf of the people they serve. The Act places specific duties on the Secretary of State, the NHS Commissioning Board and Clinical Commissioning Groups in this regard;
- **Ensure a focus on integration:** Commissioners will be under a duty to promote the integration of services with both providers and local authority partners. Monitor will have stronger regulatory powers in relation to providers and will act more explicitly in the interests of patients;
- **Tackle health inequalities:** For the first time, Clinical Commissioning Groups, the NHS Commissioning Board and the Secretary of State will be placed under a duty to tackle health inequalities;
- **Develop a stronger patient voice:** The Act establishes Health Watch England and local Health Watch organisations; these will have a responsibility to represent patients' interests both locally and nationally;
- **Strengthen local democratic involvement:** The Act also establishes Health and Well-being Boards. Each Board must have at least one locally elected councillor and a representative of Health Watch as members. It will also bring together NHS, social care and public health commissioners and patient representatives. The particular role of these Boards will be to influence and challenge commissioning decisions on behalf of patients. Local Authorities will also have a much greater leadership role in respect of local health services;
- **Strengthen public health:** The Act transfers responsibilities for local public health services to local authorities, who will then be able to co-ordinate the work done by the NHS, social care, housing, environmental health, leisure and transport services in the interests of public health. Public Health England will co-ordinate public health activities at a national level;
- **Give patients more information and choice:** The Act strengthens the role of the Health and Social Care Information Centre to ensure that commissioners, patients and the public will have improved access to information about how the NHS is performing;
- **Improved provider landscape:** Under the Act, patients will be able to choose, and health service providers will compete, on the basis of clinical quality and outcomes;
- **Strengthened regulation:** The Care Quality Commission will continue to ensure that providers meet safety and quality standards. The powers of Monitor, the current independent regulator for NHS Foundation Trusts, will be significantly extended to include all NHS providers. Monitor will be required to promote and protect patients' interests through its key activities: the licensing of providers, setting the NHS tariff, and ensuring the continuity of essential services; and
- **Reduced bureaucracy:** Two layers of administration and management, namely Primary Care Trusts and Strategic Health Authorities, will be abolished from the end of March 2013.

7.5 The Department of Health Transition Programme is driving implementation of these reforms. The legislative programme was 'paused' during April and May 2011 whilst the independent NHS Future Forum carried out its "listening exercise". Following this review, a number of recommendations were made to broaden the range of expertise involved in commissioning groups, create stronger safeguards for patients, break down barriers between health and social care and adopt a more phased approach to reform. Appropriate amendments were made to the Health and Social Care Act to properly reflect the recommendations made.

7.6 The reformed health and care system will become fully operational in April 2013. During 2011-12, however, a substantial amount of preparatory work has taken place to design and build the infrastructure for the new system. In this way, significant progress could be made prior to the legislation receiving Royal Assent at the end of March 2012. This preparatory work will continue during 2012-13.

7.7 Towards the end of 2011, PCTs and SHAs were organised into clusters, both to provide resilience and to maintain NHS performance during the transition period, especially in terms of maintaining financial control and ensuring the accuracy of local accounts. These clusters also ensured continued performance across a range of qualitative indicators including waiting times and key measures of quality and safety.

7.8 In October 2011, the Department set up the NHS Commissioning Board Authority with the remit of preparing for the establishment of the NHS Commissioning Board as an Executive Non-Departmental Public Body in October 2012. In the few months since its inception, this Authority has managed the

development of the new commissioning system, not least by supporting the foundation of 212 Clinical Commissioning Groups (CCGs). Commissioning Support Services will support CCGs in the delivery of areas such as contract management, service redesign, analytical support and other professional services, including finance and accountancy.

7.9 Significant progress has been made in terms of developing a robust and diverse provider sector. NHS Trusts which have not yet achieved NHS Foundation Trust status are being actively supported to do so, and this process will be reinforced by the NHS Trusts Development Authority (NTDA) (established as a Special Health Authority in June 2012). Preparatory work is underway to facilitate the extension of patient choice to any qualified provider in at least three community and mental health services by September 2012. A new regulation regime for the provider sector is being developed and a guide for providers of NHS-funded services has also been published.

7.10 The development of local Health & Well-being boards will bring together leaders of the health and care system with local commissioning groups, elected representatives, public health providers, and the local Health Watch.

7.11 The Health Research Authority was established as a Special Health Authority in December 2011 and has begun its work to promote proportionate standards for research regulation and governance. Health Education England was established as a Special Health Authority in June 2012 and Public Health England will be in place by April 2013.

7.12 In all these activities, a people transition process has been put in place to ensure a co-ordinated approach to staff movement. Staff transfers are planned in line with the Cabinet Office Statement of Practice (COSOP) with the aim of minimising redundancies and retaining essential skills.

7.13 In the midst of all the changes brought into effect by the Health and Social Care Act 2012, it should be remembered that the Secretary of State for Health will remain fully accountable for the NHS. The Act does not change the Secretary of State's duty to promote a comprehensive health service. In particular, Ministers will set transparent objectives for the NHS through a mandate given to the NHS Commissioning Board. Ministers will hold all national bodies to account, with powers to intervene in the event of a significant failure, or in the case of an emergency.

Cost of Transition

7.14 The Impact Assessment for the Health and Social Care Bill, published in September 2011, included an estimate of the costs of implementing the changes. The most likely overall cost was estimated at between £1.2 and £1.3 billion (in 2010-11 prices), to be incurred predominantly by April 2013. Of this, £810 million was attributable to redundancy costs (£852 million in nominal terms). The remainder was mainly attributable to the costs of setting up and closing down organisations, including expenditure on estates and IT.

7.15 Overall, the current cost forecasts relating to transition are broadly consistent with the Impact Assessment. Note 7.3 sets out the number and cost range of all exit packages in PCTs, SHAs, the Department and its Arms Length Bodies in 2011-12. These figures include exits attributable to Transition. Non-redundancy transition costs relate to a number of account headings in different organisations and so have not been disaggregated in these accounts.

Progress on Spending Review Commitments and the 'Quality, Innovation, Productivity and Prevention' challenge

7.16 The Department holds the NHS in England to account through the NHS Operating Framework. The 2011-12 Operating Framework was published in December 2010 and this set out key priorities and accountability arrangements for the NHS for the year, particularly in the context of transition. It also described the requirement to reduce administration costs across the health system by one third in real terms by 2014-15.

7.17 As noted in Section 3 of this Report, the NHS ended the year with a very strong financial performance, achieving an overall surplus, before impairments, of £2 billion, in line with the target set out in the 2011-12 NHS Operating Framework. Achieving this surplus will help the NHS to ensure funds are available for meeting the challenges and demands throughout the transition period, as well as continuing to improve quality and services for patients.

7.18 NHS funding was provided in line with the Autumn 2010 Spending Review settlement. This protected healthcare funding in real terms, with growth in cash funding set to increase by £12.6 billion by 2014–15. However, over the four-year Spending Review period, the NHS will face an additional demand for

services from an aging population, an increase in the number of people living with multiple long-term conditions, and the continuing need to fund new technologies and drugs. The Department believes that to achieve these demands the NHS will have to deliver and re-invest up to £20 billion in efficiency savings, whilst continuing to drive up the quality of the services it provides.

7.19 Since 2010-11 the NHS has been planning to meet the 'Quality, Innovation, Productivity and Prevention' (QIPP) challenge, with every local NHS economy required to identify opportunities for financial efficiencies to be re-invested in meeting future demand and improving the quality of services provided. The measures were set out in Integrated Strategic Operating Plans, which were approved by the Department in 2011. The total efficiency savings identified across the health system were £18.9 billion, with the Department contributing £1.5 billion of these savings from central Department and Arms Length Body budgets. This total is based on assumptions for variables such as future demand for healthcare and likely cost pressures, and will continue to be refined and updated throughout the QIPP period.

7.20 In 2011–12, the first year of the QIPP delivery period, the NHS delivered its forecast efficiency savings, with PCTs reporting the delivery of £5.8 billion savings whilst maintaining or improving the quality of services provided (as set out in The Year: NHS Chief Executives Annual report 2011-12). While these savings are encouraging, the NHS will need to maintain its focus on quality and productivity, in particular delivering transformational change, in order to sustain delivery of savings in future years.

7.21 The Department also established QIPP national work streams to support the NHS. To date, these work streams have delivered a number of valuable products, namely:

- **Right Care Atlases of Variation series:** first published in November 2010, and extended in November 2011. These Atlases support local commissioners to identify unwarranted variations in services and to take steps to reduce them. A series of themed atlases, including one on child health, will be published in 2012.
- **The NHS Safety Thermometer:** measures patient safety by collecting information on four high-volume health issues (i.e. pressure ulcers, falls, catheters & urine infection and venous thromboembolism (VTE)) on one day per month in respect of every patient receiving NHS funded care on that day. From April 2012, the Department of Health will be working towards national rollout of the NHS Safety Thermometer, with implementation due for completion by March 2013.
- **Back Office Efficiency and Management Optimisation report:** This report, published in November 2010, and jointly commissioned by the Foundation Trust Network (FTN) and the Department of Health, outlines ways to simplify core functions, drive out unnecessary work and activities, standardise processes and maximize opportunities for shared services in order to improve quality and drive out efficiencies.
- **Urgent Care Clinical Dashboard:** Developed by NHS Bolton, this tool gives GPs better, and more immediate information, about their patients' use of urgent and emergency services. This enables GPs to better meet their patients' needs and improve commissioning capability.

Delivery of Key Performance Outcomes in the NHS

7.22 The NHS continued to maintain the core performance standards set out in the 2011-12 NHS Operating Framework. Access to services was maintained, with the NHS delivering above the NHS Constitution commitment to provide treatment within 18 weeks of referral for 90% of admitted patients and 95% of non-admitted services.

7.23 The Secretary of State's Annual Report on the NHS provides details of performance against the five key areas of the Outcomes Framework. In summary:

- Standards were maintained for A&E attendance and cancer treatment;
- Nationally, the ambulance service achieved 76.1% against the 75% target to respond to immediately life threatening calls within eight minutes. This was the first time that this target has been achieved nationally, and by all ambulance trusts, since the current system of measuring response times was introduced;
- The number of diagnostic tests carried out in 2011-12 increased by 5.5% compared to 2010-11. The percentage of total waiting times of six weeks or longer for the 15 key diagnostic tests had

decreased to 0.7% by the end of March 2012 compared to 1.9% at the end of March 2011;

- Infection rates are at their lowest level since mandatory surveillance was introduced. MRSA infections fell by 24.7% from the previous year, whilst C. Difficile infections decreased by 17% in 2011-12 compared to 2010-11; and
- In March 2012, providers of NHS-funded healthcare reported 466 breaches of the MSA guidance compared to 5,466 in the same period in 2011. This represents a decrease of 90% and a significant improvement from the 11,802 breaches identified back in December 2010 when monitoring started.

Integration of Care Services and Improving the Future of Social Care

7.24 2011-12 was an important year for social care for two reasons:

- There has been a significant improvement in the degree of integration between health and care. The vast majority of Local Authorities opted to be early implementers of Health & Well-being boards and this has laid the foundations for strong local relationships. Improved integration has been further enhanced through NHS financial support for social care during the year.
- There has been a significant level of development activity with the social care sector in terms of the priorities for social care reform. This collaborative work will inform the content of the forthcoming White Paper on care and support, and will lay the foundation for subsequent implementation.

7.25 During 2011-12, the Department has promoted the further integration of care services through its publication of the first ever outcomes frameworks for the NHS, social care and public health. At a local level, Health and Well-being boards will provide an important step towards securing this improved integration. The Department invited local authority areas to participate in the National Learning Network, which was designed to support early implementer Health and Well-being boards in developing their understanding of how to be most effective in improving outcomes and accountability. Health and Well-being boards have now significantly moved on from the early implementation phase, and out of 152 top-tier Local Authorities, almost every area has already established a shadow board. This demonstrates a clear appetite in local government for a strengthened local leadership role, and this lies at the heart of the Government's vision for greater integration in the health and care system.

7.26 This year, the Department allocated £648 million to Primary Care Trusts (PCTs) for onward transfer to Local Authorities for spending on social care services. Feedback from both PCTs and Local Authorities has been positive, with many areas stating that these funds have been used to stimulate greater co-operation and joint planning.

7.27 In particular, PCTs and Local Authorities have used the allocation to prioritise upstream investment, that is, to help delay or prevent future costs in the health and care systems. Feedback also suggests that approximately 18% of the funding was used to 'maintain eligibility criteria' – which suggests that the funding was used to support general social care capacity, thereby ensuring that demand would continue to be met. There is also clear evidence that the funding has been used to maintain specific prevention and rehabilitation capacity in councils. 'Re-ablement services' account for a further 18% of the transfer, intermediate care accounts for 10%, early supported hospital discharge schemes 8% and integrated crisis response a further 8%.

7.28 The social care sector has continued to deliver the Government's reform agenda. For example, an Association of Directors of Adult Social Services (ADASS) personalisation survey in March 2012 indicated that 432,349 users of care services received a personal budget. This was a significant increase from the 338,000 recipients in April 2011. The 2012 survey data illustrates this further growth during the last year, with provision of personal budgets now standing at around 52% (an increase from 35% last year).There are still challenges in some areas in terms of achieving the aim of all eligible users being in receipt of personal budgets by April 2013.

7.29 During 2011-12, there were two independent reports on the reform of care and support:

- The Law Commission's proposals to modernise the social care legislative framework; and
- The Commission on Funding Care and Support.

7.30 In response to these reports, the Department initiated a period of engagement with the social care sector - Caring for our Future – in order to better shape its understanding of the key priorities for

reform. This engagement focused on issues relating to quality and workforce, integration, prevention and early intervention, markets, personalisation and financial services. Feedback from this exercise has supported development of the draft Care and Support Bill.

7.31 In March 2012, the Prime Minister launched his Challenge on Dementia. This sets out a renewed ambition to build on progress made through the National Dementia Strategy, and go further and faster towards securing greater improvements in dementia care and research.

Investing in Research and Development

7.32 The Department spent £952 million on Research and Development in 2011-12. Of this, £920 million was provided to the National Institute of Health Research (NIHR). This funding was utilised in four key areas:

- £610 million – Infrastructure to provide the support and facilities the NHS needs to deliver first class research;
- £202 million – Research Programmes to provide evidence to support decision making by professionals, policy makers and patients;
- £91 million – Development of a research capability and talent in clinical and applied health and social care research; and
- £17 million – Systems to simplify and streamline the approvals and procedures underpinning research.

7.33 The Clinical Practice Research Datalink, funded by the Department of Health through NIHR and MHRA, was launched at the end of March 2012. This world-class service will enable life science researchers to draw on the power of large, linked, anonymised clinical data sets to produce evidence that will improve the quality of care and safeguard health.

7.34 As mentioned in paragraph 7.11 above, the Health Research Authority (HRA) was also established on 1 December 2011, and has started its work to protect and promote the interests of patients and the public in health research.

Leading Health and Well-being for Government

7.35 The Department leads on the integration of health and well-being issues into cross-Government policies, and, conversely, on the incorporation of wider public policy considerations into the delivery of health and social care services. The Department's work cuts across both the public and private sectors, and Government at local, national and international level, and includes:

- Working with the wider public, third and private sectors on issues such as health protection or lifestyle choices, including the integration of health and well-being issues into other Government priorities at the local level through the work of regional teams; and
- Working with international partners, including the European Union (EU), World Health Organisation (WHO) and the Organisation for Economic Co-operation and Development (OECD).

7.36 In providing leadership across Government on health and well-being issues, DH has:

- Continued its Act F.A.S.T stroke initiative with a further TV advertising campaign to publicise the early warning signs of stroke, and to demonstrate the importance of a rapid response. This campaign was supported by both public sector and industry partners;
- In this year of the 2012 London Olympics, expanded the Change4Life programme, a national movement designed to help people eat more healthily and be more active. The campaign also now focuses on the harmful effects of alcohol. Since its inception, more than half a million adults and their families have registered to join Change4Life;
- Building on the success of the Smokefree campaign – over 500,000 people ordered a Quit Kit in 2011-12. The updated kit was developed and distributed in conjunction with commercial, retail and independent pharmacy partners; and

- Launched a new campaign, supported by leading charities, to raise awareness about the signs and symptoms of the three most common cancers – bowel, breast and lung – and to encourage people to seek treatment early.

Forward Look

Developing the Department

7.37 The Department will continue to lead the way in terms of protecting and improving the health of the nation, and will maintain its strategic role in shaping and designing the overall health and care system, and in acquiring and accounting for resources at a national level. It will be the 'architect' of the new system and will set a clear vision for the system's delivery of health care outcomes and the proper use of resources.

7.38 The Department's enduring purpose is to achieve better health, better care and better value: working to help people live better for longer. The 2012-13 Corporate Plan, which was launched in May 2012, sets out the Department's priorities for the year ahead. This Plan is available on the Department's website. DH activities are grouped into six priority areas:

- **Better health –** helping people live healthier lives by:
  - improving the nation's public health system,
  - ensuring the Department has the capabilities and policies in place to address threats to public health, and
  - promoting health and well-being to deliver better health outcomes and tackle health inequalities across all age groups.
- **Better care -** helping people get better, and ensuring people are treated with dignity and respect; supporting a patient-led health and care system by:
  - reforming social care,
  - working with the NHS to strengthen people's ability to make meaningful choices about their care; supporting the integration of services around the individual; getting the basics right on safety in health and care, and
  - having a greater focus on health outcomes.
- **Better Value** – providing better quality care by improving productivity and ensuring value for money for the taxpayer by:
  - reducing bureaucracy;
  - supporting the NHS to save up to £20 billion to reinvest in frontline services; and
  - simplifying regulation of the development and adoption of new medicines and treatments.
- **Successful Change** – delivering the transition to a more autonomous and accountable system by:
  - making sure the new partnership organisations, Clinical Commissioning Groups and Health & Well-being Boards are ready to take on their new responsibilities by April 2013, and
  - continuing the Department's transformation into a smaller, more purposeful organisation, with a clear sense of its role in relation to the health and care systems.
- **Working With Partners** – achieving strategic clarity, building a common sense of purpose by developing strong relationships with our external stakeholders, and:
  - establishing effective ways of working with the new organisations in the health and care system, and
  - playing a full role in delivering the government's priorities when these are led by other departments.
- **Transforming the Department itself** – improving capability and becoming a better department by:
  - developing new ways of working to reflect the leadership role the Department will play in the new system
  - engaging with our partners; and building understanding of the Department's work within the health and care system and the wider public, and

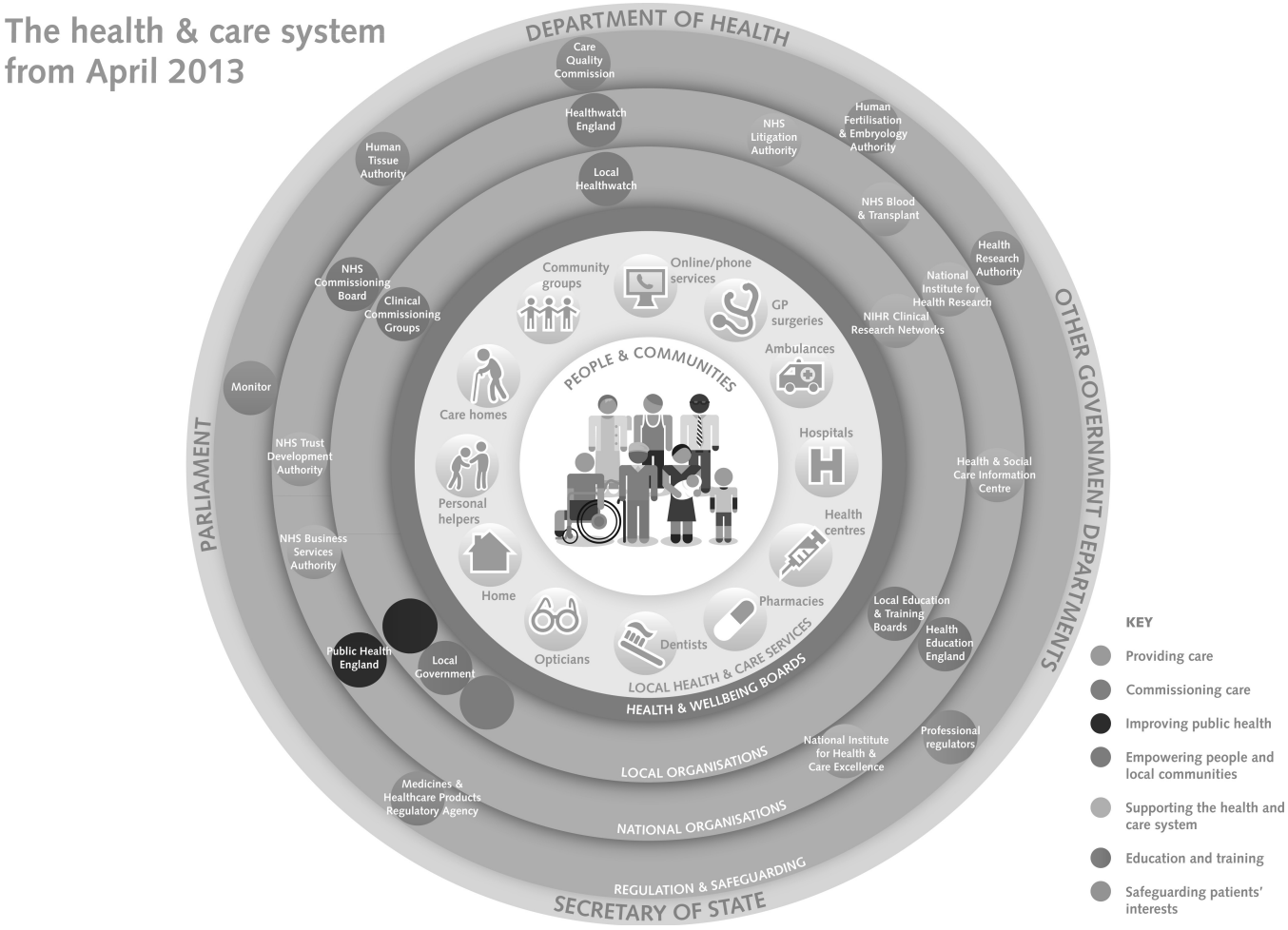
- putting equality and diversity at the heart of the Department's work.

7.39 By April 2013, the Department and the wider health and care system will look and feel very different. Within the Department there will be a new way of working and structural changes will be brought into place progressively by spring 2013.

7.40 From April 2013, the Department will have a single Permanent Secretary (and single Accounting Officer) who will oversee five directorates. The Chief Medical Officer will continue to work alongside the Permanent Secretary and will oversee a research and development function. Of the five new directorates, three will focus on the key delivery chains in the system: NHS, Social Care and Public Health. One directorate will explore the means by which the Department will become better connected to the people it works with and for, and the fifth directorate will focus on the Department's corporate responsibilities across DH itself and the ALBs.

Implementation of the Future Health and Care System

Health and Social Care Structure following Health & Social Care Act 2012



7.41 The reforms contained in the Health and Social Care Act are being developed over the course of 2012-13, with some parts of the new system running in parallel to ensure no disruption or drop in standards during transition. The new health and care system will be operational by April 2013.

7.42 In June 2012, the **NHS Trust Development Authority (NTDA)** and **Health Education England (HEE)** were legally established as Special Health Authorities. Medical Education England (MEE) ceased operating.

7.43 In July 2012, The National Patient Safety Agency (NPSA) closed, with its functions transferring to the NHS Commissioning Board. Operational closure of the **General Social Care Council (GSCC)** also took place and the **Alcohol Education Research Council (AERC)** was abolished.

7.44 In October 2012, the **NHS Commissioning Board (NHSCB)** will be established as a Non-Departmental Public Body and will carry out limited functions including the authorisation of **Clinical Commissioning Groups (CCGs)**. **Health Watch England** will also be established as a statutory committee of the Care Quality Commission. The **Appointments Commission (AC)** will be abolished and its functions transferred to the NTDA. NPSA will be legally abolished, along with full closure and abolition of GSCC.

7.45 By the end of 2012, the **Council for Healthcare Regulatory Excellence's (CHRE)** role will be extended to set standards for, and quality assure, voluntary registers held by existing statutory health and care professions regulators, and others such as professional bodies. Then over time it is intended to become an independent, self-funding body by charging a levy on regulators, and it will be renamed the Professional Standards Authority.

7.46 In April 2013, the NHS Commissioning Board will take on its full functions and **Clinical Commissioning Groups** will take on their full statutory powers. At this point Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) will be abolished. From 2013-14, the Secretary of State will hold the NHS Commissioning Board to account on the basis of its Mandate. The latter will be developed during 2012-13. CCGs will be accountable to the NHSCB for their performance.

7.47 Those parts of the NHS estate that will not transfer to NHS community health providers will transfer instead to a new government owned limited company, NHS Property Services Ltd. This company will deliver property services, including to CCGs and social enterprises, and will dispose of estate that is surplus to NHS requirements.

7.48 Health & Well-being Boards will be operational by April 2013, working together with community groups, elected representatives, health and care providers and other agencies, and local **Health Watch** organisations.

7.49 As local authorities take on their new public health responsibilities, **Public Health England** (PHE) will be established and the **Health Protection Agency** (HPA) will be abolished, with its functions transferring to PHE. The functions of **The National Treatment Agency** will be transferred to PHE upon its abolition.

7.50 NTDA will take on its full responsibilities, and **Monitor** will take on its new role as the provider sector regulator for health, working with the NHS Commissioning Board to regulate prices for NHS-funded services and license providers. **The National Institute for Health and Clinical Excellence (NICE)** will become a Non-Departmental Public Body to be known as the **National Institute for Health and Care Excellence** to reflect its wider role.

7.51 **Health Education England (HEE)** will take on responsibility for education and training from SHAs and **Local Education and Training Boards (LETBs)** will come into operation.

7.52 **The Health and Social Care Information Centre** will become a Non-Departmental Public Body. Some functions of **NHS Connecting for Health** will transfer to the Information Centre as it is closed. The **NHS Institute** will also close down.

7.53 2012-13 will also see publication of the Care and Support White Paper, the progress report on funding reform, and the draft Care and Support Bill published for Pre-Legislative Scrutiny.

Information Strategy and NHS Informatics

7.54 The Government's information strategy "The Power of Information: putting all of us in control of the health and care information we need" was published on 21 May 2012. It set the vision, ambition and next steps in terms of harnessing information and new technologies to achieve high quality care and to improve outcomes for patients and service users. The strategy signals the move towards a more local approach, encouraging diversity and innovation at a local level. The balance of funding and responsibility for IT will increasingly become local; particularly from 2016, when nationally held contracts wind down.

7.55 The strategy sets out a continuing role for a national IT infrastructure to ensure effective and secure information flows across the health and social care system. Central organisations such as the Department of Health and the NHS Commissioning Board will continue to secure national infrastructure

(such as the 'spine' allowing secure connections between organisations), but doing only what needs to be done centrally.

7.56 Following the conclusions of a series of reviews carried out by the National Audit Office and the Major Projects Authority (MPA), the Government announced in September 2011 an acceleration in the plan to dismantle the National Programme for IT. The Department committed to moving away from a top down approach and will instead provide information systems driven by local decision-making. The dismantling process is now complete, with changes to the governance of the programme. The component programmes continue and the new governance arrangements place accountability on an individual Senior Responsible Owner (SRO) for each programme within NHS Informatics Directorate.

7.57 The MPA found that there have been substantial achievements in the national programme which are now firmly established, such as the Spine, N3 Network, NHS mail, Choose and Book, Secondary Uses Service and Picture Archiving and Communications Service. These IT solutions and systems will continue to provide vital support to the NHS. The component programmes' major successes include:

- The number of patients with a Summary Care Record has increased from 5.8 million in March 2011 to over 13 million in March 2012;
- Over 35 million patient referrals have now been booked via Choose and Book and various upgrades to the service have been completed, on time and to budget;
- The deployment of the Electronic Prescription Service Release 2 is increasing, with over 100 general practices and 4,000 community pharmacy sites being ready to start using the system;
- The NHS Network, N3, Managed Video Conferencing is now routinely saving the NHS in excess of £400,000 per month and the N3 Voice has exceeded its target for 2011-12, achieving savings for the NHS of £1.2 million during the year. The benefits are not only financial, as the use of technologies, such as video conferencing, reduces the requirement for travel with resulting reductions in carbon emissions estimated to be 600 tonnes of Green House Gas (equivalents) in 2011-12; and
- Local Service Provider contracts have delivered a number of systems to support the NHS, for example the acute sector in the South saw the completed deployment of significant additional clinical functionality to the final three (of the eight) live Cerner Millennium sites: Nuffield Orthopaedic Centre NHS Trust, Buckinghamshire Hospitals NHS Trust and Milton Keynes NHS Foundation Trust.

7.58 Additional structure changes are expected going forward as the Health and Social Care Act reforms take effect and plans are put into place to implement the information strategy.

Future of the CSC contract

7.59 As a result of the continuing delays to the Computer Sciences Corporation's (CSC) Lorenzo Product – part of the NHS care record system – the Department for Health, in collaboration with the Cabinet Office, formed a Negotiation Team to enter into discussions with CSC in October 2011. NHS Informatics and CSC reached agreement about a non-legally binding "Letter of Intent" which was jointly signed by both NHS Informatics, following approval by the Secretary of State and HM Treasury, and the IT supplier on 2 March 2012.

7.60 Following negotiations with CSC, an Interim Agreement was signed in September 2012 that enacts legally binding changes to the underlying contract for the Lorenzo product. This will now be consolidated over the next few months into a revised contract.

7.61 Under the previous contract, the majority of trusts in the North, Midlands and East were obliged to take the Lorenzo product. The new agreement supersedes that obligation and removes CSC's exclusive rights as the only provider of electronic patient record systems in those areas. Local NHS organisations now have the power to make their own decisions about which IT systems they use. This has enabled the Department to reduce its contractual commitment to CSC. CSC retains their responsibility to roll out the core Electronic Patient Record to current users and depending on their local needs, the NHS can choose to roll out other parts of Lorenzo.

8 PUBLIC INTEREST AND OTHER ISSUES

Accounting to Parliament and the Public

8.1 As a Department of State, the Department of Health supports Ministers in discharging their accountabilities to Parliament and the public, and remains one of the busiest in Whitehall. In 2011-12, DH:

- Laid an unqualified, IFRS-compliant Annual Report and Accounts for 2010-11 in early September 2011;
- Published a total of 20 impact assessments. Four of these accompanied regulations which came into force during 2011-12, and 16 were part of the policy-development process;
- Completed a total of 27 Equality Impact Assessments;
- Answered 1,945 Freedom of Information (FOI) requests, responding to 100% of these within the deadline, (including permitted extensions); and
- Answered 5,945 Parliamentary Questions, supported 11 Health Select Committee inquiries and 8 Public Accounts Committee hearings; and 4 other section committee enquiries on cross government issues.

8.2 In respect of the Department, the Parliamentary Ombudsman has confirmed there were no complaints accepted for investigation in 2011-12.

Public Dividend Capital

8.3 Public Dividend Capital (PDC) represents the Government's investment in NHS Trusts and NHS Foundation Trusts. PDC is recorded on the Statement of Financial Position of NHS Trusts and NHS Foundation Trusts, and is an asset of the Consolidated Fund.

8.4 The rules governing PDC for NHS Trusts and NHS Foundation Trusts are provided in the NHS Act 2006. This allows for the use of PDC as originating capital for NHS Trusts, and initial PDC for NHS Foundation Trusts. The Act also sets out the Secretary of State's powers in determining the conditions under which PDC can be issued. Consequently, with the consent of the Treasury, the Secretary of State may determine, in respect of an NHS Trust:

- The dividend which is payable at any time on any PDC issued, or treated as issued, to an NHS Trust or NHS Foundation Trust under the 2006 Act;
- The amount of any such PDC which must be repaid at any time; and
- Any other terms on which any PDC is issued, or treated as issued.

8.5 The NHS Act 2006 also sets out how initial PDC is determined for NHS Foundation Trusts, and details the powers that the Secretary of State may exercise in setting the terms under which PDC is treated as having been issued and the dividend payable. Under the financial regime currently operating in the provider sector, both NHS Trusts and NHS Foundation Trusts are required to pay a PDC dividend to the Department. This is currently set at 3.5% of the average net relevant assets of each NHS Trust and NHS Foundation Trust.

8.6 As Note 13 to these accounts reports, a total of £32.9 million of PDC was cancelled in 2011-12. This represents the outstanding PDC of Worcestershire Mental Health Partnership NHS Trust which was dissolved on 1 July 2011. This NHS Trust was dissolved as a result of a merger with a Primary Care Trust provider function under the Transforming Community Services initiative, to form a new organisation – the Worcestershire Health and Care NHS Trust. The new Trust was issued with £32.4 million of PDC in the form of Originating Capital. The difference between this newly issued PDC, and the amount cancelled, reflects movements in the composition and valuation of the assets of the dissolved NHS Trust in the years since it was established.

Payment to Suppliers

8.7 The Department complies with both the CBI prompt payment code and the British Standard on prompt payment. The Department is a signatory to the Government's Prompt Payment Code, and has a policy to pay all bills as soon as possible.

8.8 The standard terms of payment for all supplier contracts is 30 days from receipt and agreement of a valid invoice. This is embedded in all contracts with suppliers, with any exceptions agreed as part of contractual negotiations. Exceptions have to be fully justified and agreed by the appropriate senior management and finance colleagues. Payment terms for most other types of valid payments for grants, funding and to other bodies are immediate.

8.9 In 2011-12, the core Department paid 99.31% (171,866) of its invoices in accordance with the 30-day policy. The comparable figures for 2010-11 were 99.48% (192,668). In the same period, the core Department paid 97.86% (169,344) of its bills within 10 days, compared to 97.68% (189,195) in 2010-11, and 95.46% (165,202) compared to 91.18% (176,609) invoices in accordance with the new 5-day target. The Department's prompt payment performance is published on the DH website.

8.10 The Department is required to report its payment to suppliers on a payable days basis. This is calculated as a proportion of the amount owed to trade payables at the year end compared with the aggregate amount invoiced by suppliers during the year, expressed as a number of days in the same proportion to the total number of days in the financial year. Under this measure, the core Department paid suppliers within an average of 4 payable days in 2011-12 (2010-11 9 payable days).

Better Payment Practice Code – NHS Organisations

8.11 The percentage of bills paid in compliance with the better payment practice code in 2011-12 by NHS Trusts, PCTs and SHAs is shown in the following tables. Currently, all NHS Trusts, PCTs and SHAs must meet a Better Payment Practice Code target of paying 95% of bills within contract terms, or 30 days where no terms have been agreed. Monitor does not collect comparable supplier payment performance from NHS Foundation Trusts.

Table Eighteen: NHS Trusts Supplier Payments

	Number of NHS Trusts			
	By number of bills		By value of bills	
	Non-NHS	NHS	Non-NHS	NHS
Between 95% and 100%	27	20	34	34
Between 85% and 94.9%	56	32	44	29
Between 75% and 84.9%	10	22	17	15
Less than 75%	20	39	18	35
Total	113	113	113	113
Overall Performance 2011-12 (%)	83.8	78.8	85.7	79.3

8.12 In 2011-12, NHS Trusts paid 83.8% (81.0% in 2010-11) of their non-NHS bills and 78.8% (71.1%) of their NHS bills by number, and 85.7% (83.2%) of non-NHS bills and 79.3% (75.2%) of NHS bills when measured by value within 30 days or contracted terms. The performance in 2011-12 is in the context of NHS Trusts processing and paying over 6 million invoices during the year.

Table Nineteen: PCTs Supplier Payments

	Number of Primary Care Trusts			
	By number of bills		By value of bills	
	Non-NHS	NHS	Non-NHS	NHS
Between 95% and 100%	66	58	72	130
Between 85% and 94.9%	63	44	57	20
Between 75% and 84.9%	13	31	13	1
Less than 75%	9	18	9	0
Total	151	151	151	151
Overall Performance 2011-12 (%)	91.6	87.4	93.1	98.0

8.13 In 2010-11, PCTs paid 91.6% (93.2%) of their non-NHS bills and 87.4% (87.8%) of their NHS bills by number, and 93.1% (93.6%) of non-NHS bills and 98.0% (97.8%) of NHS bills when measured by value within 30 days or contracted terms. The 2011-12 performance is in the context of PCTs processing and paying over 2.6 million invoices during the year.

Table Twenty: Strategic Health Authorities Supplier Payments

	Number of Strategic Health Authorities			
	By number of bills		By value of bills	
	Non-NHS	NHS	Non-NHS	NHS
Between 95% and 100%	9	6	10	10
Between 85% and 94.9%	1	4	0	0
Between 75% and 84.9%	0	0	0	0
Less than 75%	0	0	0	0
Total	10	10	10	10
Overall Performance 2011-12 (%)	97.2	95.5	98.0	97.9

8.14 In 2011-12, SHAs paid 97.2% (96.2%) of their non-NHS bills and 95.5% (95.2%) of their NHS bills by number, and 98.0% (97.5%) of non-NHS bills and 97.9% (98.6%) of NHS bills by value within 30 days or contracted terms. The performance in 2011-12 is in the context of SHAs processing and paying over 107,000 invoices during the year.

8.15 Strategic Health Authorities monitor the performance of individual NHS Trusts and Primary Care Trusts, and work with poor performing organisations to achieve and maintain a level of payment performance consistent with Managing Public Money regulations and the Better Payment Practice Code. Performance management takes the form of meetings and discussions with organisations to understand incidences of poor performance and what corrective actions should be taken to ensure that performance improves. The Department of Health has a similar role with poor performing SHAs.

8.16 Further details on the Better Payment Practice Code can be found at www.payontime.co.uk.

Political Donations and Expenditure and Charitable Donations

8.17 The Department maintains a register for such items and no entries were recorded in 2011-12.

Contingent Liabilities

8.18 The Department discloses possible obligations that may arise but are dependent upon uncertain future events or decisions partly or wholly outside the control of the Department in the Contingent Liabilities note to the accounts. Note 26.1 therefore reports that the Department had £96.5 million in quantifiable contingent liabilities in 2011-12. These are disclosed under parliamentary reporting requirements but are not disclosed under IAS37, as the likelihood of payment is remote.

8.19 In addition to these quantifiable contingent liabilities, a further 31 unquantified contingent liabilities (indemnities) were recorded in 2011-12. These indemnities mainly relate to potential legal action against organisations or individuals, and the Department continues to monitor the potential risks relating to these remote contingencies.

8.20 In addition, in Note 26, the Department has reported a number of operational contingent liabilities which are required to be disclosed under IAS37.

Reporting on Better Regulations

8.21 In line with the Coalition Government's commitment to reducing the regulatory burden which affects business, since April 2011 the Department has participated in the Cabinet Office-led Red Tape Challenge (RTC) initiative. In preparation for the public review of regulations linked to medicines, which took place in April 2012, the Department's internal review process revealed a high number of regulations which may potentially be amended or scrapped altogether. Preparations for the internal challenge phase of the DH Healthy Living and Social Care theme RTC have been underway since January 2012. This process will review non-medicine related regulations that have an impact on business. The internal challenge will take place in July 2012, and the public review of the relevant regulations will take place in October 2012.

8.22 Between April 2011 and March 2012, the Department introduced five new regulations, leading to an increase in the One-In, One-Out (OIOO) deficit. The principle of OIOO is such that, for any direct net cost imposed on business by the introduction of a regulation, departments are required to identify and remove existing regulations with an equivalent value. The outcome of the Red Tape Challenges will

mean that a number of DH regulations will be amended or scrapped, and this decrease will lead to a reduction in the Department's OIOO deficit.

Sustainable development and climate change

8.23 Details of the Department's actions in respect of sustainable development and climate change are now included in a separate report in these accounts (page 69).

Spending By Country, Region and Function

8.24 Core Tables 6, 7 and 8 below show analyses of the Department's spending by country and region, and by function for 2006-07 to 2010-11. The data presented in these tables are consistent with the country and regional analyses (CRA) published by HM Treasury as part of the October 2011 Public Expenditure Statistical Analyses (PESA) National Statistics release. The figures were taken from the HM Treasury public spending database in summer 2011 and the regional distributions were completed by autumn 2011. Therefore the tables may not show the latest position and are not consistent with other tables in the Departmental Report. Totals may not sum due to rounding. The 2011-12 outturn is expected to be published later this year.

8.25 The analyses are set within the overall framework of Total Expenditure on Services (TES). TES broadly represents the current and capital expenditure of the public sector, with some differences from the national accounts measure Total Managed Expenditure. The tables show the central government and public corporation elements of TES. They include current and capital spending by the Department and its NDPBs, and public corporations' capital expenditure, but do not include capital finance to public corporations. They do not include payments to local authorities or local authorities' own expenditure.

8.26 TES is a cash equivalent measure of public spending. The tables do not include depreciation, cost of capital charges, or movements in provisions that are in departmental budgets. They do include pay, procurement, capital expenditure, and grants and subsidies to individuals and private sector enterprises. Further information on TES can be found in Appendix E of PESA 2011 available on the HM Treasury website.

8.27 The data are based on a subset of spending – identifiable expenditure on services – which is capable of being analysed as being for the benefit of individual countries and regions. Expenditure that is incurred for the benefit of the UK as a whole is excluded. Regional attribution of expenditure for the years 2006-07 to 2010-11 is based on NHS annual accounts; central expenditure is attributed pro rata to NHS expenditure for all years.

8.28 The regional spending is largely driven by the recurrent revenue allocations (over 80% of total resources) the Department currently makes directly to local PCTs, on the basis of the relative needs of their populations and in line with pace of change policy. A weighted capitation formula determines each PCT's target share of available resources, to enable them to commission similar levels of health services for populations in similar need, and to reduce avoidable health inequalities. The formula calculates PCTs' target shares of available resources based on PCT populations adjusted for their age distribution, additional need above that accounted for by age, and unavoidable geographical variations in the cost of providing services.

8.29 The functional analyses of spending in Core Table 8 are based on the United Nations Classification of the Functions of Government (COFOG), which is the international standard. The presentations of spending by function are consistent with those used in Chapter A of the CRA October 2011 release. These are not the same as the strategic priorities shown elsewhere in the report.

Core Table 6 Total Identifiable Expenditure on Services by Country and Region

£ million

Department of Health	National Statistics 2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 outturn	2010-11 outturn
North East	4,139	4,482	4,899	5,186	5,344
North West	10,923	11,959	12,774	13,759	13,999
Yorkshire and the Humber	7,604	8,230	9,010	9,626	9,963
East Midlands	5,800	6,443	7,008	7,401	7,682
West Midlands	7,923	8,605	9,257	9,985	10,211
East	7,353	7,849	8,640	9,474	9,821
London	12,219	13,766	14,796	16,574	16,926
South East	11,016	11,867	12,851	13,980	14,173
South West	6,925	7,643	8,292	8,822	9,020
Total England	**73,900**	**80,845**	**87,527**	**94,808**	**97,138**
Scotland	34	38	42	47	51
Wales	-191	-162	-164	-162	-139
Northern Ireland	4	5	5	6	6
UK identifiable expenditure	**73,747**	**80,726**	**87,410**	**94,699**	**97,056**
Outside UK	666	907	816	984	1,140
Total identifiable expenditure	**74,414**	**81,633**	**88,226**	**95,683**	**98,196**
Non-identifiable expenditure	-	-	-	-	-
Total expenditure on services	**74,414**	**81,633**	**88,226**	**95,683**	**98,196**

Note

1. Figures may not sum due to rounding.

Core Table 7 Total Identifiable Expenditure on Services per Head, by Country and Region

£ per head

Department of Health	National Statistics 2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 outturn	2010-11 outturn
North East	1,621	1,751	1,906	2,007	2,050
North West	1,594	1,742	1,858	1,995	2,018
Yorkshire and the Humber	1,477	1,588	1,727	1,831	1,879
East Midlands	1,329	1,465	1,582	1,663	1,714
West Midlands	1,478	1,600	1,712	1,839	1,872
East	1,315	1,390	1,511	1,643	1,684
London	1,619	1,811	1,929	2,138	2,163
South East	1,339	1,431	1,536	1,657	1,663
South West	1,351	1,476	1,591	1,686	1,710
England	**1,456**	**1,582**	**1,701**	**1,830**	**1,860**
Scotland	7	7	8	9	10
Wales	-64	-55	-55	-54	-46
Northern Ireland	2	3	3	3	3
UK identifiable expenditure	**1,217**	**1,324**	**1,424**	**1,533**	**1,559**

Note

1. Figures may not sum due to rounding.

Core Table 8 Total identifiable expenditure on services by function, country and region, for 2010-11

Data in this table are National Statistics £ million

Department of Health	North East	North West	Yorkshire and The Humber	East Midlands	West Midlands	East	London	South East	South West	England	Scotland	Wales	Northern Ireland	UK Identifiable expenditure	Outside UK	Total identifiable expenditure	Not Identifiable	Totals
Health																		
Central and other health services	30	78	55	43	57	55	94	79	51	541	-	-	-	541	930	1,471	-	1,471
Medical services	5,398	14,146	10,068	7,764	10,307	9,932	17,024	14,380	9,163	98,182	-	-	-	98,182	19	98,201	-	98,201
Health n.e.c	5	13	9	7	9	9	15	13	8	87	-	-	-	87	-	87	-	87
Total health	**5,432**	**14,237**	**10,132**	**7,814**	**10,373**	**9,995**	**17,133**	**14,472**	**9,222**	**98,810**	**-**	**-**	**-**	**98,810**	**949**	**99,759**	**-**	**99,759**
Social protection																		
Sickness and disability	11	29	20	16	21	20	35	30	19	202	-	-	-	202	-	202	-	202
of which: incapacity, disability and injury benefits	*11*	*29*	*20*	*16*	*21*	*20*	*35*	*30*	*19*	*202*	-	-	-	*202*	-	*202*	-	*202*
Old age	-99	-267	-189	-148	-182	-195	-242	-329	-221	-1,874	51	-139	6	-1,956	191	-1,765	-	-1,765
of which: pensions	*-99*	*-267*	*-189*	*-148*	*-182*	*-195*	*-242*	*-329*	*-221*	*-1,874*	*51*	*-139*	*6*	*-1,956*	*191*	*-1,765*	-	*-1,765*
Total social protection	**-88**	**-238**	**-169**	**-132**	**-161**	**-175**	**-207**	**-300**	**-202**	**-1,672**	**51**	**-139**	**6**	**-1,754**	**191**	**-1,563**	**-**	**-1,563**
TOTAL DEPARTMENT OF HEALTH	**5,344**	**13,999**	**9,963**	**7,682**	**10,211**	**9,821**	**16,926**	**14,173**	**9,020**	**97,138**	**51**	**-139**	**6**	**97,056**	**1,140**	**98,196**	**-**	**98,196**

External Auditors

8.30 Finally, the Department's 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. Note 8 and 9 to the accounts disclose the audit, and where applicable the non-audit fees for the Department and the consolidated group bodies. The Department's audit fee is notional and is shown as a non-cash item in Note 8.

8.31 As far as the Principal and Additional Accounting Officers are aware, there is no relevant audit information of which the Department's auditors are unaware, and the Accounting Officers have taken all the steps necessary to make themselves aware of any relevant audit information and to establish that the Department's auditors are aware of that information.

Una O'Brien

9 October 2012

Permanent Secretary & Principal Accounting Officer
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Publications List

HMT Direction for Accounts
http://www.hm-treasury.gov.uk/d/accounts_direction_guidance.pdf

HMT Supply Estimates
http://www.hm-treasury.gov.uk/psr_estimates_mainindex.htm

HMT Public Expenditure White Paper
http://www.hm-treasury.gov.uk/pespub_index.htm

Finance Directors report to the Secretary of State on NHS financial Performance Quarter 4
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_087335

Annual Report of the Chief Medical Officer: On the state of Public Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/index.htm#jumpTo2

The NHS Operating Framework 2011-12
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

The Revised NHS Operating Framework 2010-11
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

Liberating the NHS White Paper
http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

Health and Social Care Bill
http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm

NHS Future Forum Recommendations to Government
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

Government response to the NHS Future Forum Recommendations
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_127868

SUSTAINABLE DEVELOPMENT REPORT

Introduction

1. The Department of Health (DH) is committed to long-term sustainable development, and must ensure that, by delivering better care and well-being for the nation, it is also contributing to a strong, healthy and sustainable society for the generations of the future. This fundamental principle underpins the Department's health and social care vision, such that sustainability resonates with both staff and stakeholders.

2. The Government believes that it should set a good example to the country, by managing its own estate and activities in a way that is compatible with the principles and objectives of sustainability. All central Government Departments are required to report their progress in terms of reducing the environmental impacts of their operations. This is achieved through the Greening Government Commitments (GGC), (which have replaced the Sustainable Operations on the Government Estate (SOGE) targets). Details of these Commitments can be found at:

   http://sd.defra.gov.uk/gov/green-government/commitments/

Greenhouse Gas Emissions Performance Commentary

Table 1: Greenhouse Gas Emissions 2009-10 to 2011-12

GREENHOUSE GAS EMISSIONS		2009-10	2010-11	2011-12
Emissions (tonnes CO^2)	Total Gross Emissions	57,927	57,609	49,991
	Gross emissions Gas	13,627	13,833	10,460
	Gross emissions Electricity	35,334	36,561	33,703
	Gross emissions Travel	8,966	7,215	5,828
Related Energy Consumption ('000 KWh)	Electricity: Non renewable	62,439	55,527	49,024
	Electricity: renewable	4,912	14,164	15,219
	Gas	74,222	75,343	56,972
	Gas Oil	5,470	3,400	3,853
Financial Indicators (£k)	Expenditure on energy	9,144	8,713	7,801
	CRC licence expenditure	322	347	348
	Expenditure on business travel	22,548	17,332	14,821

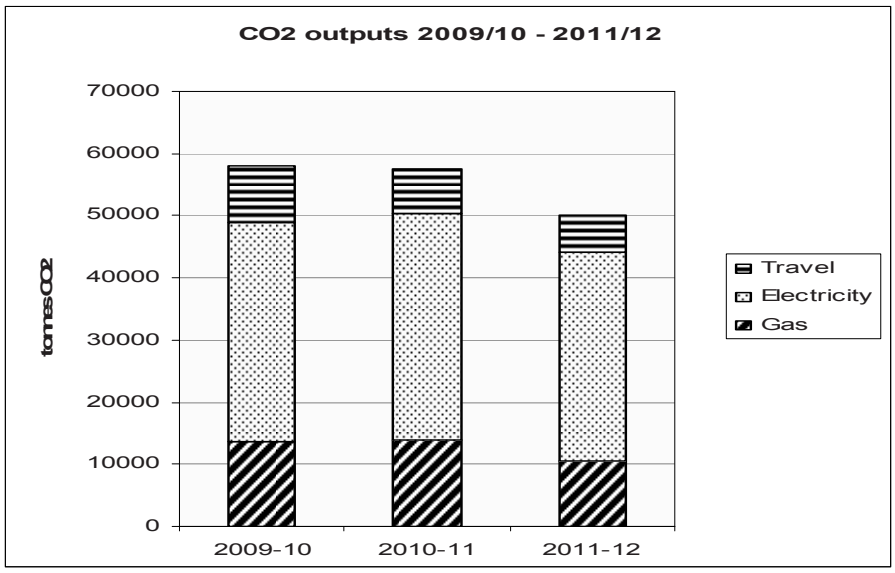
Notes: 1.The gross emissions indicators cover core Department of Health, NHS Business Services Authority, Care Quality Commission, Monitor, Health and Social Care Information Centre, Health Protection Agency, National Institute for Clinical Excellence and NHS Connecting for Health. For sustainability reports for individual organisations, please see their own Annual Report and Accounts.

2. The core Department does not report on Quarry House for energy, waste and water. This is included in the sustainability reporting for Department of Work and Pensions.

3. The increase in energy consumption for 2010-11 is due to improved data quality reporting on buildings where data was not previously available.

4. Travel data includes international travel.

Figure 1. CO2 Output 2009-2011-12



3. Based on current initiatives, the results presented in Table 1 indicate that DH is on track to meet the target to reduce carbon emissions by 25% by 2015 (13% reduction between 2009-10 and 2011-12). This has been achieved by introducing a number of initiatives, which have included the deployment of energy efficient IT, consolidation of estate, tighter controls, improved IT file storage facilities and the rationalisation of local IT servers.

4. Having engaged with the Carbon Trust, the Department has produced a Carbon Management Plan. This covers a number of ongoing projects, including an upgrade to DH Building Management Systems, implementation of LED lighting and boiler optimisation.

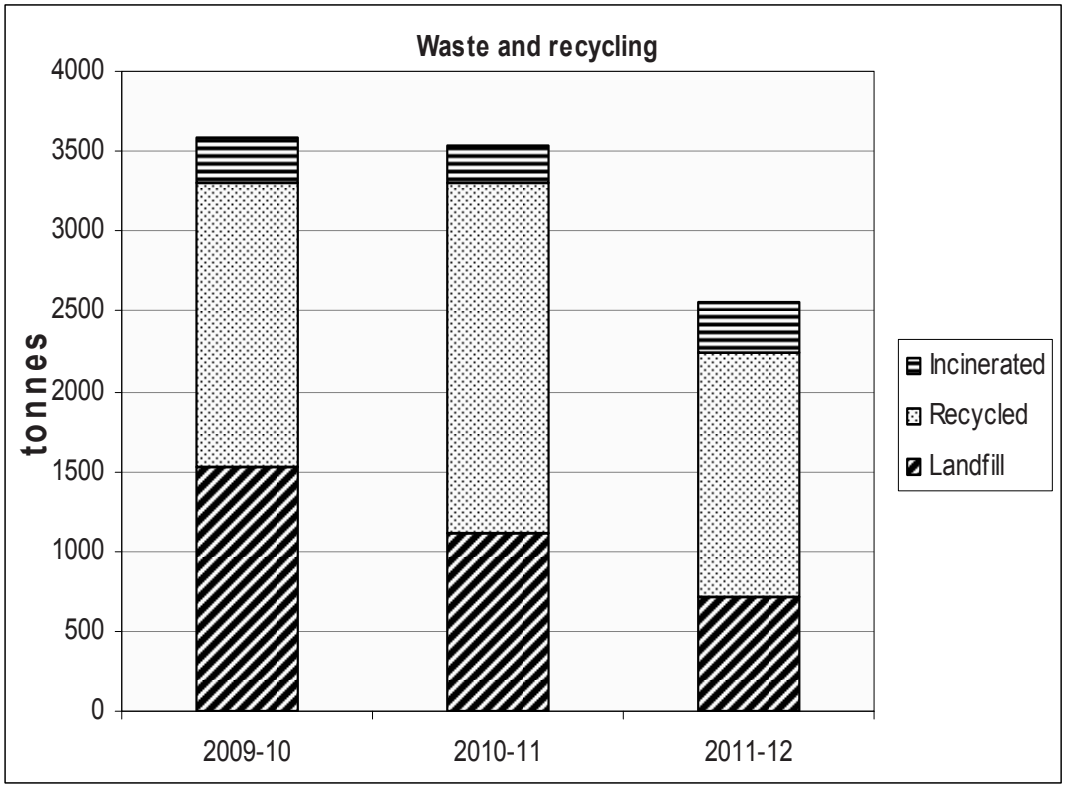
5. DH continues to work towards ensuring a consistent decrease in recorded emissions from business travel, which have decreased by 35% from 2009-10 to 2011-12. The Department has implemented a number of additional travel initiatives, such as the increased use of cycles on official business, and the provision of additional video conferencing facilities across the estate. For the core Department, there has been a significant reduction during 2011-12 in the number of domestic flights, currently 1,861 less than in 2009-10.

Waste

Table 2 Waste Financial and Non-Financial Indicators

WASTE			2009-10	2010-11	2011-12
Non-financial indicators (tonnes)	Total Waste		3763.8	3982.3	2855.4
	Hazardous Waste	Total	182.0	445.0	299.0
	Non-Hazardous Waste	Landfill	1524.4	1111.6	720.8
		Reused/recycled (non-prescription waste)	1574.0	1612.9	1401.9
		Reused/recycled (prescription waste)	200.0	585.0	114.0
		Incinerated energy recovered	276.6	221.2	313.1
		Incinerated energy not recovered	6.8	6.7	6.6
Financial Indictors (£k)	Total disposal cost (k)		873.0	926.2	671.6
	Hazardous Waste - Total Disposal Cost		311.0	348.0	228.0
	Non-Hazardous Waste - Total Disposal costs		562.0	578.2	443.6
Notes: 1. Increase in 2010/11 mainly due to an increase in prescription waste and better data reporting.					

Figure 2: Waste and Recycling



6. The Department has worked to significantly reduce its overall levels of waste. The results presented in Table 2 above indicate a 24% reduction between 2009-10 and 2011-12. The core DH has a current recycling rate of about 80%, with the greatest proportion of recycling activity relating to paper. In addition, the introduction of a managed print service has significantly reduced the volume of paper used by the Department. DH has also reduced the number of printers and photocopiers in use across the estate by about 75%.

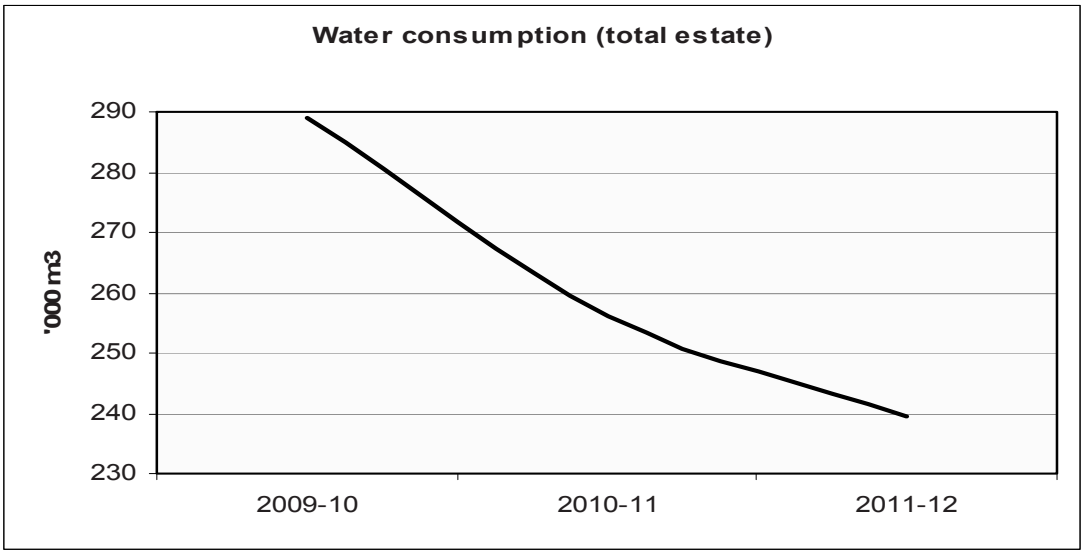
7. The Department is fully engaged with the Closed Loop Recycling initiative, launched by the Cabinet Office to provide for the recycling, production, delivery and collection of paper, and is developing an implementation strategy with HMRC, Arms Length Bodies and a new paper supplier.

Water

Table 3 Water Consumption Financial and Non-Financial Indicators

WATER CONSUMPTION (m^3)			2009-10	2010-11	2011-12
Non-financial indicators (m^3)	Water Consumption (office estate)	Supplied	73,915	68,391	68,077
		Per FTE	7.93	7.52	8.31
	Water Consumption (total estate)	Supplied	288,880	256,058	239,426
Financial Indictors (£k)	Water Supply Costs (total estate)		370.8	332.6	297.1

Figure 3 Water Consumption Total Estate



8. As Table 3 indicates, the Department and its Arms Length Bodies have reduced their water consumption by 49,454m^3 or 17% since 2009-10. The benchmark for water consumption has changed this year to consumption (of water) per person on a Full Time Equivalent basis. At 8.31m^3 per FTE, the Department will be consulting with its facilities suppliers on how to reduce its water consumption to meet the best practice target of less than 4 m^3 per FTE. The increase is due to the 12% reduction in staff numbers and ongoing building rationalisation.

Sustainable Procurement

9. The Department has maintained a good level of compliance with Government Buying Standards and strengthened arrangements with the letting of new contracts in key areas of ICT, Printing and Stationery. Work continues under the facilities management contract to support energy efficiency and carbon reduction.

10. The Department recently published 'Standards of Procurement'. This sets out a range of key standards for DH and NHS organisations, including one for Sustainable Procurement. The Department will work over the coming year to develop further guidance to support the NHS.

11. The Department has also engaged with Defra in the development and testing of the Food and Catering Government Buying Standards and has worked closely with the NHS Sustainable Development Unit to develop tools and training to support the NHS Procuring for Carbon Reduction project.

Climate Change Adaptation

12. In March 2010, the Department published its Climate Change Plan. This sets out the detail of how DH will ensure that climate change issues are addressed as an integral part of both policies and operations. This plan is available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114929

13. The Department has a Departmental Adaptation plan (published in March 2010 and updated in May 2011). This plan can be found by following the attached link:

http://archive.defra.gov.uk/environment/climate/documents/dept-adapt-plans/dap-dept-health-110519.pdf

14. The Department of Health annual 'Heatwave Plan' was published in May 2012. The plan can be viewed at

http://www.dh.gov.uk/health/2012/05/heatwave-plan/

15. It is a key part of the Department's national adaptation planning to reduce the health impacts of climate change as highlighted in the first Climate Change Risk Assessment which was laid before Parliament in January 2012.

    http://www.defra.gov.uk/environment/climate/government/risk-assessment/

Biodiversity and Natural environment

16. The Department is not required to have a biodiversity action plan as the majority of sites are based in city centres or street faced buildings.

Procurement of Food and Catering Services

17. Defra are actively encouraging central Government Departments and the wider public sector to support Hospitality and Food Sector Voluntary Agreements. The Department is about to go out to tender for a new contract and this will be a requirement.

18. The Department's current catering suppliers are already committed to sustainable sourcing, which includes providing full traceability of products and suppliers within their supply chain to ensure that sustainability, ethical and safety standards are built in. DH is also committed to working with clients, suppliers and distributors to reduce the impact of their business on the environment.

People

19. Improving the health and well-being of the nation is one of the Department's key responsibilities, and this core objective is extended to the Department's own workforce. For example, DH has implemented a Health & Well-being Board, with the key objective of "inspiring, promoting and encouraging the health and well-being of all staff, in line with the aspiration to become a Top 100 employer." The Department issues regular communications to its staff to reinforce the role that they can take, both within the workplace and outside, to reduce carbon emissions and change behaviour.

Governance

20. The Department has a dedicated team in place to deal with all Greening Government Commitments. This team reports to the Department's Property Asset Management Board, chaired by the DH Senior Responsible Officer for Sustainable Development. These financial statements contain core Department, Arms Length Body and Special Health Authority data in respect of progress against Greening Government commitments. All other health bodies fall outside the scope of the Greening Government requirements, and, therefore sustainability reporting, unless they wish to report on a voluntary basis.

NHS Sustainable Development

21. The Department of Health works closely across Government (i.e. Defra, DECC) and, at NHS level, supports the NHS Sustainable Development Unit. The Unit assists the NHS in developing Sustainable Development Management Plans and making the links between sustainability and health care improvement.

Bodies consolidated in the Department's Sustainability Report

22. The ALBs included in these annual accounts are NHS Business Services Authority, Care Quality Commission, Monitor, Health and Social Care Information Centre, Health Protection Agency, National Institute for Clinical Excellence and NHS Connecting for Health. MHRA and NHS Blood and Transplant are excluded as they are catergorised as Public Corporations. The following ALBs are excluded on grounds of immateriality: Appointments Commisssion, Council for Health Regulatory Excellence, Human Tissue Authority, NHS Litigation Authority, and the NHS Institute for Innovation and Improvement.

STATEMENT OF PRINCIPAL ACCOUNTING OFFICER'S RESPONSIBILITIES

1. Under the Government Resources and Accounts Act 2000, the Department of Health is required to prepare Resource Accounts for each financial year, in conformity with a HM Treasury direction, which details the resources acquired, held or disposed of, and the use of resources by the Department, during the year.

2. 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, changes in taxpayer's equity and cash flows for the financial year.

3. 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.

4. In addition, HM Treasury has appointed:
    - the Chief Executive of the NHS as an Additional Accounting Officer to be accountable for the Department's own programme expenditure on the NHS and for overseeing the spending of all NHS bodies that are subject to direction by DH (that is, Primary Care Trusts, Strategic Health Authorities, Special Health Authorities and NHS Trusts); and
    - 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.

5. The NHS Act 2006, designated Chief Executives of NHS Foundation Trusts as their Accounting Officers for each of their organisations. They produce and publish separate annual accounts and Monitor (the independent regulator of NHS Foundation Trusts) prepares and publishes a consolidated account.

6. These appointments do not detract from the Permanent Secretary's overall responsibility as Principal Accounting Officer for the Department's accounts, and the group Resource Accounts. The Principal Accounting Officer draws assurance from the audits of the NHS Foundation Trusts accounts, in preparing the Department's group Resource Account.

7. The responsibilities of an Accounting Officer, including responsibility for regularity and accounting accurately for their organisation's financial position and transactions are set out by HM Treasury in Managing Public Money.

REMUNERATION REPORT

Remuneration Policy

1. The remuneration of senior civil servants (SCS) is set by the Prime Minister following independent advice from the Senior Salaries Review Body (SSRB).

2. The Review Body also advises the Prime Minister from time to time on the pay and pensions of Members of Parliament and their allowances; on Peers' allowances; and on the pay, pensions and allowances of Ministers and others whose pay is determined by the Ministerial and Other Salaries Act 1975.

3. In reaching its recommendations, the Review Body has regard to the following considerations:
   - the need to recruit, retain and motivate suitably able and qualified people to exercise their different responsibilities;
   - regional/local variations in labour markets and their effects on the recruitment and retention of staff;
   - Government policies for improving the public services including the requirement on Departments to meet the output targets for delivery of Departmental services;
   - the funds available to Departments as set out in the Government's Departmental expenditure limits; and
   - the Government's inflation target.

4. The Review Body takes account of the evidence it receives about wider economic considerations and the affordability of its recommendations. Further information about the work of the Review Body can be found at www.ome.uk.com.

Remuneration of Board Members and Directors General

5. The remuneration of the Permanent Secretary, the Chief Executive of the NHS and the Chief Medical Officer is set by the Prime Minister on the recommendation of the Permanent Secretaries' Remuneration Committee. Departments are given discretion in some areas to adapt the pay 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 the Department. In 2011, the Senior Pay Strategy Committee was chaired by Una O'Brien (Permanent Secretary). The other members were Sir David Nicholson (NHS Chief Executive), Dame Sally Davies (Chief Medical Officer), Mike Wheeler (Non Executive Director), Harbhajan Brar (Director of Human Resources), Simon Reeve (FDA) and Kent Woods (Chief Executive, Medicines and Healthcare Products Regulatory Agency - MHRA). In 2012 it was chaired by Una O'Brien (Permanent Secretary). The other members were Sir David Nicholson (NHS Chief Executive), Dame Sally Davies (Chief Medical Officer), Mike Wheeler (Non Executive Director), Karen Wheeler (Director General of Group Operation and Assurance Directorate), Flora Goldhill (Interim Director of People), Simon Reeve (FDA) and Kent Woods (Chief Executive, MHRA)

6. From 1st April 2011, there was no change in base pay levels for the SCS.

7. The remuneration of Directors General is determined by a pay committee in accordance with the rules set out in the Civil Service Management Code (Chapter 7.1, Annex A). In 2011 the relevant Committee was chaired by Una O'Brien (Permanent Secretary). The other members were Sir David Nicholson (NHS Chief Executive), Dame Sally Davies (Chief Medical Officer) and Mike Wheeler (Non-Executive Director). In 2012 the relevant Committee was chaired by Una O'Brien (Permanent Secretary). The other members were Sir David Nicholson (NHS Chief Executive), Dame Sally Davies (Chief Medical Officer) and Mike Wheeler (non-Executive Director).

8. In the case of the three inward secondees who served as Directors General, various remuneration arrangements apply. One of the secondees (Sir Bruce Keogh) is subject to SCS terms and conditions,

which means that his pay is determined in the same way as the civil servants who are permanent employees of the Department. Sir Bruce Keogh remains a member of the NHS Pension Scheme. The pay of David Flory is determined in accordance with the Pay Framework for Very Senior Managers (VSMs) in the NHS which falls under the remit of the Senior Salaries Review Body. Any non-consolidated performance pay payable is subject to recommendation from the Department's Pay Committees. Professor Dame Sally Davies became an employee from 1 June 2011 and her pay is determined in the same way as civil servants in the Department..

Service Contracts

9. Civil Service appointments are made in accordance with the Civil Service Commissioners' Recruitment Code, which requires appointment to be on merit on the basis of fair and open competition but also includes the circumstances when appointments may otherwise be made. Further information about the work of the Civil Service Commissioners can be found at http://www.civilservicecommissioners.gov.uk.

10. Unless otherwise stated below, the officials covered by this report hold appointments which are open-ended. Early termination, other than for misconduct, would result in the individual receiving compensation as set out in the Civil Service Compensation Scheme available on the civil service website, www.civilservice.gov.uk.

A – MEMBERS OF THE DEPARTMENTAL BOARD AND DIRECTORS GENERAL

11. This Remuneration Report covers Ministers, Non-Executive Directors, all officials sitting on the Departmental Board (DB) and Director Generals (DGs) in the Department of Health. The following elements of the Remuneration Report are subject to audit:
    - Salaries (including non-consolidated performance pay) and allowances;
    - Compensation for loss of office;
    - Non-cash benefits;
    - Pension increases and values;
    - Cash Equivalent Transfer Values (CETV) and increases;
    - Amounts payable to third parties for the services of senior managers.

12. The following table details the dates of appointment, and where appropriate, departure, of the five officials sitting on the DB and the additional ten DGs. Twelve held permanent Senior Civil Service contracts during this period and three were seconded. One of the secondees became a permanent Senior Civil Servant during the year.

Individual	Job Title	Date of Appointment to Grade/Departure	Employing Authority (if Seconded)
SCS Contract			
Dame Christine Beasley	Chief Nursing Officer	19 October 2004	
David Behan	Director General of Social Care, Local Government and Care Partnerships	29 August 2006	
Clare Chapman	Director General of Workforce	3 January 2007 – 6 July 2011	
Christine Connelly	Director General – Chief Information Officer	22 September 2008 – 30 June 2011	
Richard Douglas	Director General Policy, Strategy & Finance	1 May 2001	
David Harper	Director General of Health Improvement and Protection	14 October 2003 – 29 February 2012	
Sian Jarvis	Director General of Communications	1 April 2004 – 30 September 2011	
Sir David Nicholson	NHS Chief Executive	1 September 2006	
Una O'Brien	Permanent Secretary	1 November 2010	
Flora Goldhill	Acting Director General - Transition for the Department of Health	6 September 2010	
Kate Davies	Managing Director NHS Informatics	1 July 2011 (on loan)	
Secondments			
Dame Sally Davies	Chief Medical Officer from 3 March 2011; Director General of Research and Development and interim Chief Medical Officer from 1 June 2010.	1 May 2005 – 31 May 2011	North West London Hospitals Trust
David Flory	Director General of NHS Finance, Performance and Operations	1 June 2007	NHS North East
Sir Bruce Keogh	NHS Medical Director	12 November 2007	UCL Hospitals NHS Foundation Trust
Fixed Term Appointments			
Dame Sally Davies	Chief Medical Officer	1 June 2011	

13. Table 1 provides details of remuneration interests of the officials on the DB and DGs (provided on page 73).

Table 1

	Salary (excl non-consol perf pay)	Full Year Equivalent Salary (excl non-consol perf pay)	Non-consolidated performance payments[2]	Benefit in Kind (gross)	2010-11 Benefit in Kind (net)		Salary (excl non-consol perf pay)[13]	Full Year Equivalent Salary (excl non-consol perf pay)	Non-consolidated performance payments[4]	Benefit in Kind (gross)	2011-12 Benefit in Kind (net)
	£ '000	£ '000	£'000	nearest £100	nearest £100		£ '000	£ '000	£'000	nearest £100	nearest £100
Dame Christine Beasley	140-145	140-145	Nil	Nil	Nil	Dame Christine Beasley[9]	65-70	140-145	Nil	Nil	Nil
David Behan	180-185	180-185	5-10	Nil	Nil	David Behan	180-185	180-185	5-10	Nil	Nil
Clare Chapman[5]	220-225	220-225	35-40	Nil	Nil	Clare Chapman[7]	60-65	220-225	Nil	Nil	Nil
Christine Connelly	200-205	200-205	Nil	Nil	Nil	Christine Connelly[7]	60-65	200-205	Nil	Nil	Nil
Dame Sally Davies[1,]	225-230	225-230	Nil	Nil	Nil	Dame Sally Davies[1,]	35-40	225-230	Nil	Nil	Nil
						Dame Sally Davies	165-170	200-205	Nil	5600	4,900
Richard Douglas	140-145	140-145	5-10	Nil	Nil	Richard Douglas	140-145	140-145	5-10	Nil	Nil
David Flory[,]	205-210	205-210	10-15	37,700[13]	37,700	David Flory[1,]	205-210	205-210	10-15	42,800	37,700
David Harper	130-135	130-135	Nil	Nil	Nil	David Harper	120-125	130-135	Nil	Nil	Nil
Sian Jarvis	135-140	135-140	Nil	Nil	Nil	Sian Jarvis[8]	145-150	135-140	Nil	Nil	Nil
Bruce Keogh[1]	190-195	190-195	Nil	3,300	3,000	Bruce Keogh[1,11]	190-195	190-195	Nil	2,400	2,100
Sir David Nicholson	210-215	210-215	15-20	72,300	41,100	Sir David Nicholson[6,10]	210-215	210-215	15-20	56,400	45,700
Una O'Brien	140-145	140-145	0-5	Nil	Nil	Una O'Brien	160-165	160-165	Nil	Nil	Nil
Flora Goldhill	75-80	130-135	Nil	Nil	Nil	Flora Goldhill	130-135	130-135	Nil	Nil	Nil
Kate Davies	N/A	N/A	N/A	N/A	N/A	Kate Davies	80-85	140-145	Nil	Nil	Nil
Sir Liam Donaldson	60-65	205-210	Nil	300	300	Sir Liam Donaldson	N/A	N/A	N/A	N/A	N/A
Sir Hugh Taylor	60-65	155-160	Nil	300	300	Sir Hugh Taylor	N/A	N/A	N/A	N/A	N/A
Gary Belfield	35-40[12]	135	Nil	Nil	Nil	Gary Belfield	N/A	N/A	N/A	N/A	N/A
Highest Earner's Total Remuneration (£'000)	280-285					**Highest Earner's Total Remuneration (£'000)**	285-290				
Median Total Remuneration (£)	41,997					**Median Total Remuneration (£)**	40,410				
Ratio	6.73					**Ratio**	7.11				

(1)Each of these individuals was seconded into the Department from NHS oganisations and were paid by their employing authority. Details of their individual terms and conditions can be found in paragraph 8. The Department re-imburses the employing authority for salary and associated expenses. The table above shows the amount paid in salary by the employing authority not the amount invoiced to the Department.

(2) Performance pay is awarded in arrears and disclosed on an accruals basis. Therefore, the non-consolidated performance pay included in the 2010-11 column relates to 2010-11 performance year. Actual payments in respect of this performance year were made to individuals during 2011-12.

(3) Details of start and end dated for those not serving the full term can be found in paragraph 12.

(4) Performance pay is awarded in arrears and disclosed on an accruals basis. Therefore, the non-consolidated performance pay included in the 2011-12 column relates to the 2011-12 performance year. Actual payments in respect of this performance year were made to individuals during 2012-13.

(5) Clare Chapman receives non-consolidated performance pay of £25-30k per annum subject to satisfactory performance. This is paid in the year to which it is related and is in addition to any non-consolidated performance pay awarded under the Senior Civil Service Performance Management and Reward policy.

(6) David Nicholson gave up his rented accommodation in London in May 2011, the last payment for rent and related expenses was also in May 2011.

(7)Salary for 2011-12 includes payment in lieu of untaken annual leave

(8) Salary for 2011-12 includes compensation in lieu of notice which was provided under approved Civil Service compensation arrangements.

(9) Dame Christine Beasley took partial retirement from 1 April 2011

(10) David Nicholson was seconded to the NHS Commissioning Board for 2 days per week from 1 November 2011 and the Department has been reimbursed £35 - £40K in respect of his salary.

(11) Sir Bruce Keogh worked for the NHS Commissioning Board for 2 days per week (40%) from 10 December 2011 and the Department has re-charged £25 - £30k in respect of his salary

(12) Includes compensation payment of £11,321 paid in lieu of notice to avoid a conflict of interest

(13) Gross figure not available for 2010-11 Remuneration Report, this reflects the figures reported.

14. Table 2 provides details of pension interests of officials on the DB and DGs (provided on page 73).

		Accrued pension at pension age as at 31/3/12 and related lump sum £'000	Real increase in pension and related lump sum at pension age £ '000	CETV at 31/3/12 £ '000	CETV at 31/3/11 [1] £ '000	Real increase in CETV £'000	Employer contribution to partnership pension account Nearest £100
Dame Christine Beasley[5]	Chief Nursing Officer	45-50 plus lump sum of 315-320	- 0 to -2.5' plus lump sum of '-10 to -15	1,144	1,148	-43	N/A
David Behan	Director General of Social Care, Local Government and Care Partnerships	10-15	0-5	212	161	33	N/A
Clare Chapman[6]	Director General of Workforce	15-20	0-2.5	257	241	10	N/A
Christine Connelly [9]	Director General, Chief Information Officer	10-15	0-2.5	123	109	9	N/A
Dame Sally Davies[3]	Chief Medical Officer	70-75 plus lump sum of 220-225[2]	0-2.5 plus lump sum of 0-2.5	Nil[2]	Nil [2]	Nil [2]	N/A
Dame Sally Davies	Chief Medical Officer	2.5-5	0	53	0	47	N/A
Richard Douglas	Director General Policy, Strategy & Finance	60-65 plus lump sum of 180-185	- 0 to -2.5 plus lump sum of -2.5 to -5	1,214	1,143	-27	N/A
David Flory	Director General of NHS Finance, Performance and Operations	20-25 plus lump sum of 70-75	2.5-5 plus lump sum of 7.5-10	466	334	77	N/A
David Harper [8]	Director General of Health Improvement and Protection	50-55 plus lump sum of 155-160	- 0 to -2.5 plus lump sum of '-2.5 to -5'	1,074	1,012	-20	N/A
Sian Jarvis[4,7]	Director General of Communications	20-25 plus lump sum of 60-65	2.5-5 plus lump sum of 10-15	338	274	47	N/A
Bruce Keogh	NHS Medical Director	75-80 plus lump sum of 225-230	0-2.5 plus lump sum of 0-2.5	1,645	1,524	74	N/A
Sir David Nicholson	NHS Chief Executive	105-110	0 to -2.5	1,875	1,761	-40	N/A
Una O'Brien	Permanent Secretary	40-45 plus lump sum of 120-125	0-2.5 plus lump sum of 2.5-5	775	689	27	N/A
Flora Goldhill	Acting Director General - Transition for Department of Health	60-65 plus lump sum of 190-195	0-2.5 plus lump sum of 2.5-5	1426	1285	23	N/A
Kate Davies	Managing Director NHS Informatics	10-15	0-2.5	197	170	13	N/A

(1) The actuarial factors used to calculate CETVs were changed in 2011/12. The CETVs at 31/3/11 and 31/3/12 have both been calculated using the new factors, for consistency. The CETV at 31/3/11 therefore differs from the corresponding figure in last year's report which was calculated using the previous factors.

(2) Under the NHS Pension Scheme rules, the pension cannot be transferred for those over pension age so CETV value is nil.

(3) Line refers to secondment from North West London Hospitals NHS Trust which ceased 31 May 2011. Line below refers to employment with Department of Health which commenced 1 June 2011

(4) Purchased additional added pension

(5) Christine Beasley took partial retirment from 1 April 2011, this figure reflects pension and lump sum paid plus pension and lump sum accrued from April 2011.

(6) Until 6 July 2011
(7) Until 30 September 2011.

(8) Until 29 February 2012

(9) Until 30 June 2011

Median Earnings

15. Reporting bodies are required to disclose the relationship between the salary of the most highly-paid individual in their organisation and the median earnings of the organisation's workforce. The total remuneration of the most-highly paid individual in Department of Health in the financial year 2010-11 was £280-285k. This was 6.71 times the median salary of the workforce, which was £42,085. The total remuneration of the most-highly paid individual in Department of Health in the financial year 2011-12 was £285-£290k. This was 7.1 times the median salary of the workforce, which was £40,484.

16. Total remuneration includes salary, non-consolidated performance related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. There was no change in the most-highly paid individual in Department of Health from 2010-11 to 2011-12. The median salary reduced between the two years, largely as a result of the Department running a voluntary exit scheme in 2011-12 which had the effect of modifying the grade mix, resulting in a less senior workforce overall.

17. Staff from the Department's executive agency, the Medicines and Healthcare products Regulatory Agency (MHRA) are not included in the calculation because no MHRA staff costs are included in the core Departmental account. The calculation of the median does not include agency workers, secondees in or staff who are 'hosted' by other bodies as central records on the remuneration of these workers are not currently held.

Salary

18. 'Salary' includes gross salary; performance pay or non consolidated performance pay; overtime; reserved rights to London Weighting or London allowances; and any other allowance to the extent that it is subject to UK taxation.

Non-Consolidated performance pay

19. The performance management and reward policy for members of the Senior Civil Service, including board members, is managed within a central framework set by the Cabinet Office. The framework allows for non-consolidated performance-related awards following SSRB recommendations. The Senior Civil Service Performance Management and Reward principles, which include explanations of how non-consolidated performance awards are determined, can be found at: www.civilservice.gov.uk. SCS non-consolidated performance pay is allocated from a central 'pot', which is agreed each year following SSRB recommendations, and is expressed as a percentage of the Department's total base pay for the SCS. Pay Committees are responsible for assessing, in the light of the SCS Pay Strategy, the relative contribution of individual SCS members and making the final pay decisions. Non-consolidated performance pay is awarded in arrears. The non-consolidated performance pay included in the 2010-11 figures in Table 1 relates to awards made in respect of the 2010-11 performance year but paid in 2011-12. Similarly, the non-consolidated performance pay included in the 2011-12 figures in Table 1 relate to awards made in relation to the 2011-12 performance year, but which will be paid in 2012-13. Following Cabinet Office recommendations, non-consolidated performance awards could be awarded to no more than 25% of the SCS. A flat rate of £8,500 was paid to these 25% in 2011 and 2012.

Benefits in Kind

20. The monetary value of benefits in kind covers any payments or other benefits provided by the Department which are treated by HM Revenue & Customs as a taxable emolument. For its direct employees, the Department pays the individual a net sum and pays tax directly to HMRC.

21. Four members received payments deemed by the HMRC to be benefits in kind. In line with Departmental policy, Sir David Nicholson received an allowance for the extra costs of living away from his home base. Sir David was based in Leeds, and the payment covered the cost of rent and related expenses for staying in London where he has an office and is required to spend several days each week. In 2011-12 Sir David received £9,833 (gross). Sir David gave up his rented accommodation in London in May 2011. The last payment for rent and related expenses was also in May 2011. He was also entitled to one return journey per week from his home base to London. During 2011-12, Sir David's working pattern effectively meant that he had a permanent base in London until the end of October 2011 and a split base between London and Leeds from November 2011. The associated travel and accommodation costs in addition to the cost of rented accommodation resulted in a gross benefit in kind of £46,540 (£40,897 net) during 2011-12.

22. David Flory has been on secondment from NHS North East (previously known as North East Strategic Health Authority) since 1st June 2007. He is entitled to accommodation and travel expenses for living away from home. As the secondment has gone beyond two years, these expenses are accounted for as a benefit in kind, which in 2011-12 amounted to £40,865 (gross). He also has the benefit of a lease car under the North East SHA's family lease car salary sacrifice scheme. Even though the car is not for work use, there is a benefit in kind of £1,984 (gross) in 2011-12.

23. Sir Bruce Keogh is entitled to claim one return journey per week from his home base to London. This amounted to £2,368 (gross) in 2011-12.

24. Dame Sally Davies has occasional use of an official car for the journey between her home and office. The benefit in kind amounted to £5,629 (gross) in 2011-12

Civil Service Pensions

25. Pension benefits are provided through the Civil Service pension arrangements. From 30th July 2007, civil servants may be in one of four defined benefit schemes; either a "final salary" scheme (Classic, Premium or Classic Plus); or a "whole career" scheme (Nuvos). These statutory arrangements are unfunded with the

cost of benefits met by monies voted by Parliament each year. Pensions payable under Classic, Premium, Classic Plus and Nuvos are increased annually in line with Pensions Increase legislation. Members joining from October 2002 may opt for either the appropriate defined benefit arrangement or a 'money purchase' stakeholder pension with an employer contribution (partnership pension account).

26. Employee contributions are set at the rate of 1.5% of pensionable earnings for Classic and 3.5% for Premium, Classic Plus and Nuvos. Increases to employee contributions will apply from 1 April 2012. Benefits in Classic accrue at the rate of 1/80th of final pensionable earnings for each year of service. In addition, a lump sum equivalent to three years' initial pension is payable on retirement. For Premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike Classic, there is no automatic lump sum. Classic Plus is essentially a hybrid with benefits in respect of service before 1 October 2002 calculated broadly as per Classic and benefits for service from October 2002 calculated as in Premium. In Nuvos a member builds up a pension based on his/her pensionable earnings during their period of scheme membership. At the end of the scheme year (31st March) the member's earned pension account is credited with 2.3% of their pensionable earnings in that scheme year and the accrued pension is updated in line with Pensions Increase legislation. In all cases, members may opt to give up (commute) pension for lump sum up to the limits set by the Finance Act 2004.

27. The Partnership pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 3% and 12.5% (depending on the age of the member) into a stakeholder pension product chosen by the employee from a panel of three providers. The employee does not have to contribute, but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.8% of pensionable salary to cover the cost of centrally-provided risk benefit cover (death in service and ill health retirement).

28. The accrued pension quoted is the pension the member is entitled to receive when they reach pension age or immediately on ceasing to be an active member of the scheme if they are already at or over pension age. Pension age is currently 60 for members of Classic, Premium and Classic Plus and 65 for members of Nuvos.

29. Further details about the Civil Service pension arrangements can be found at the website www.civilservice-pensions.gov.uk.

Cash Equivalent Transfer Values

30. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The figures include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the Civil Service pension arrangements. They also include any additional pension benefit accrued to the member as a result of their purchasing additional pension benefits at their own cost. CETVs are worked out in accordance with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulation 2008 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are drawn.

Real Increase in CETV

31. This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement). It does rely on common market valuation factors for the start and end of the period.

Table 1 - Remuneration interests of officials who are members of the DB and DGs.

Table 2 – Pension interests of officials who are members of the DB and DGS.

Compensation for Loss of Office

32. Following restructuring in the Department, the number of Director General roles in the Department decreased. Sian Jarvis agreed to leave the Department on a voluntary basis under Compulsory Redundancy terms on 30 September 2011. She received a compensation payment of £134,639.

B - MINISTERS

33. Ministers are political appointments made by the Prime Minister; they do not have contracts of employment. Consequently notice periods and termination periods do not apply.

34. The following Ministers were in post during the 2011-12 financial year:

Minister		**Date Appointed**
Rt Hon Andrew Lansley CBE, MP	Secretary of State	12 May 2010
Paul Burstow MP	Minister of State	13 May 2010
Rt Hon Simon Burns MP	Minister of State	13 May 2010
Anne Milton MP	Parliamentary Under Secretary	14 May 2010
Earl Howe	Parliamentary Under Secretary	14 May 2010

Table 3 provides details of remuneration interests of Ministers:

Table 3

	2010-11					2011-12			
	Salary	Full Year Equivalent Salary	Lords Ministers Night Subsistence	FYE Lords Ministers Night Subsistence		Salary	Full year Equivalent Salary	Lords Office Holders' Allowance	FYE Lords Office Holders' Allowance
	£	£	£	£					
Andrew Lansley [1]	61,056	68,827				68,827	68,827		
Paul Burstow [1]	29,187	33,002				33,002	33,002		
Simon Burns [1]	29,187	33,002				33,002	33,002		
Anne Milton [1]	20,894	23,697				23,697	23,697		
Earl Howe [1,2]	60,583	68,710	16,032	18,183		68,710	68,710	18,183	18,183

[1] Ministers did not draw ministerial pay rise accruing for 2009-10; there is no increase for 2010-11and 2011-12 with salaries remain at the entitled rate as at 31 March 2008.

[2] Earl Howe is entitled to the full amount of Lords Ministers Night Subsistence however, he only claims 50% of his entitlement which amounts to £18,183.

Table 4 provides details of pension interests of Ministers.

Table 4

	Real increase in pension	Pension at End Date	CETV at Start Date (31/3/11)	CETV at End Date (31/03/12	Employee contributions and transfers in	Real increase in CETV as funded by employer
	(£ '000)	(£ '000)	(£ '000)	(£ '000)	To nearest £1,000	To nearest £1,000
Andrew Lansley	0-2.5	0-5	15	34	5	13
Paul Burstow	0-2.5	0-5	11	23	4	6
Simon Burns	0-2.5	0-5	36	52	4	9
Anne Milton	0-2.5	0-5	10	20	3	6
Earl Howe	0-2.5	10-15	160	192	8	10

Salary

35. In respect of Ministers in the House of Commons, Departments bear only the cost of the additional ministerial remuneration; the salary for their services as an MP (£65,738 from 1st April 2010) and various allowances to which they are entitled are borne centrally. The Department does pay legitimate expenses for Ministers which are not a part of the salary or a benefit in kind.

36. However, the arrangement for Ministers in the House of Lords is different, in that they do not receive a salary but rather an additional remuneration which cannot be quantified separately from their Ministerial salaries. This total remuneration, as well as the allowances to which they are entitled, is paid by the Department and is therefore shown in full in Table 3.

Ministerial pensions

37. Pension benefits for Ministers are provided by the Parliamentary Contributory Pension Fund (PCPF). The scheme is statutorily based (made under Statutory Instrument SI 1993 No 3253, as amended).

38. Those Ministers who are Members of Parliament may also accrue an MP's pension under the PCPF (details of which are not included in this report). The arrangements for Ministers provide benefits on an 'average salary' basis, taking account of all service as a Minister. The accrual rate has been 1/40th since 15 July 2002 (or 5 July 2001 for those that chose to backdate the change) but Ministers, in common with all other members of the PCPF, can opt for a 1/50th accrual rate and the lower rate of employee contribution. An additional 1/60th accrual rate option (backdated to 1 April 2008) was introduced from 1 January 2010.

39. Benefits for Ministers are payable at the same time that MPs' benefits become payable under the PCPF or, in the case of those who are not MPs, on retirement from Ministerial office, from age 65. Pensions are re-valued annually in line with changed Pension Increase legislation. From 1 April 2009, members pay contributions of 5.9% of their ministerial salary if they have opted for the 1/60th accrual rate, 7.9% of salary if they have opted for the 1/50th accrual rate or 11.9% of salary if they have opted for the 1/40th accrual rate. There is also an employer contribution paid by the Exchequer representing the balance of cost as advised by the Government Actuary. This is currently 28.7% of the Ministerial salary. Increase to member and Exchequer contributions will apply from 1 April 2012.

40. The accrued pension quoted is the pension the Minister is entitled to receive upon reaching 65, or immediately on ceasing to be an active member of the scheme if they are already 65.

Cash Equivalent Transfer Values

41. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total Ministerial service, not just their current appointment as a Minister. CETVs are calculated in accordance with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

Real Increase in CETV

42. This reflects the increase in accrued pension funded by the Exchequer. It does not include the increase in accrued pension due to inflation or contributions paid by the Minister. It uses common market valuation factors for the start and end of the period.

C – NON-EXECUTIVE DIRECTORS

43. The Department appointed two Non-Executive Directors (now known as Non-Executive Board Members) to the Departmental Board for the first time in 2005. A third Non-Executive Member joined the Departmental Board in June 2006. With the introduction of enhanced Departmental Boards in 2010, the Department appointed two additional Non-Executive Members in spring 2011 to bring the total number of Non-Executive Board Members to five. Guidance about the reimbursement for Non-Executive Members is available from Cabinet Office and reimbursement ranges from simply reimbursing expenses to significant payments for discharging substantial roles.

44. Non-Executive Board Members are not employees of the Department. They are appointed for a fixed term of three years initially, with the possibility of extension. They are appointed primarily to attend and contribute to DB meetings, which involve an estimated time commitment of eleven three-hour meetings, and occasional overnight events per year. One of the Non-Executive Members chairs the Department's Audit Committee (4-5 meetings per year). The lead Non-Executive Board Member chairs the Department's Nominations and Governance Committee, which has an additional Non-Executive Member. The Non-Executive Members also make a significant contribution to Departmental business by working through Committees and with senior officials..

45. 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.

46. Mike Wheeler was entitled to charge a fee of £2,000 per day, with payments of £7,000 made in 2011-12 for the period to 30 June 2011. This amount excludes VAT. Mike was appointed on a 3 year fixed term contract from 1 July 2011 on an annual fee of £20,000 (£15,000 as a Board member and £5,000 as Chair of the Audit and Risk Committee) which is paid monthly in arrears. Catherine Bell was appointed on a 3 year fixed-term contract from 1st January 2011 on an annual fee of £15,000 which is paid monthly in arrears. David Heymann was appointed on a fixed-term contract for the period January 2011 to April 2012 and was reimbursed for his expenses only. No claims have been made for 2011-12. Peter Sands and Chris Pilling were both appointed on 3 year contract; Peter Sands from 1 May 2011 and Chris Pilling from 1 April 2011. Both waived their fees and are reimbursed for their expenses only. No claims have been made for 2011-12.

47. Non Executive Directors fees are not pensionable.

Una O'Brien

9 October 2012
Permanent Secretary
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

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 Arms Length Bodies, the NHS and Foundation Trusts. It refers to Managing Public Money published by HM Treasury.

2. As Principal Accounting Officer, 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, European Economic Area (EEA) medical costs and resources voted for the Office of the Independent Regulator for NHS Foundation Trusts. As Head of the Department, she 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. The Principal Accounting Officer is responsible for carrying out the duties set out in Chapter 3 of Managing Public Money.

3. As an Additional Accounting Officer the Chief Executive of the NHS is directly responsible to the Secretary of State for the management of the NHS. He is accountable for the Department's own programme expenditure on the NHS and for overseeing the spending of all NHS bodies that are subject to direction by DH (that is, Primary Care Trusts, Strategic Health Authorities, Special Health Authorities and NHS Trusts) He is responsible for carrying out the duties set out in Chapter 3 of Managing Public Money.

4. Chief Executives of NHS Foundation Trusts are designated by legislation as Accounting Officers, and are accountable for the expenditure relating to those bodies and for safeguarding public funds and the organisations' assets. Their responsibilities are set out in the NHS Foundation Trusts Accounting Officer Memorandum, based on Managing Public Money. NHS Foundation Trusts are financially independent organisations and are not directly accountable to the Department. NHS Foundation Trusts are held to account by their governors, who represent their membership and communities they service, and they apply the national standards and legal framework for the NHS. Each NHS Foundation Trust lays their annual report and accounts before Parliament.

5. The Chief Executive of the Medicines & Healthcare Products Regulatory Agency and NHS Blood & Transplant are accountable for the expenditure relating to these Trading Funds. They are responsible for carrying out the duties set out in Chapter 3 of Managing Public Money in respect of the Agency. Their accountability are subject to the Permanent Secretary's overall responsibility for the organisation and management of the Department of Health.

6. 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. The Chief Executives of Special Health Authorities are accountable for the expenditure relating to those bodies. They are responsible for carrying out the duties set out in Managing Public Money in respect of those Authorities. Their accountability is subject to the Permanent Secretary's overall responsibility for the organisation and management of the Department of Health.

7. The Chief Executive of the NHS Business Services Authority is also the Accounting Officer for the NHS Pension Scheme. He is responsible for carrying out the duties set out in Chapter 3 of Managing Public Money in relation to the operation of the NHS Pension Scheme. In respect of the administrative expenditure of the Authority, the Chief Executive's responsibilities are set out in the Authority's Framework Document and his letter of designation as Authority Accounting Officer.

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

8. The Chief Executives of Non Departmental Public Bodies are designated as Accounting Officers and are accountable to Parliament through either the Permanent Secretary or the NHS Chief Executive, depending upon their designation, for the efficient, effective and proper use of all the resources in their charge. They are responsible for carrying out the duties set out in Managing Public Money in respect of their organisations.

GOVERNANCE STATEMENT

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, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money.* I am supported in exercising this responsibility by the Chief Executive of the NHS in his capacity as Additional Accounting Officer for the resources voted by Parliament for the NHS.

2. This Statement is given in respect of the Resource Account for the Department of Health, which consolidates the financial information of organisations within the Department's Resource Accounting Boundary, as set out in paragraphs 2.1 and 2.6 of this End of Year Report. As paragraph 2.6 states, the formal relationships between organisations within the Resource Accounting Boundary and the Department are varied, encompassing Executive Non Departmental Public Bodies, an Executive Agency, Strategic Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts. The nature of control in the Department of Health group is consequently substantially different from the concept of a group in the commercial sector. Further detail on these relationships is set out in the statement of the principal Accounting Officer's responsibilities in this Report**.**

3. The following sections cover the core Department, its Arms Length Bodies (ALBs), and the NHS (Strategic Health Authorities, Primary Care Trusts and NHS Trusts). The Accounting and Accountable Officers for all of these organisations are appointed by either myself or Sir David Nicholson as Accounting Officer for the NHS. This Statement also has a section covering NHS Foundation Trusts, whose Accounting Officers are directly accountable to Parliament.

4. I am responsible for ensuring that there is a high standard of financial management in the Department as a whole. Therefore, I have a duty to be satisfied that ALBs sponsored by DH and those NHS organisations for which I am accountable, have in place adequate financial systems and procedures to promote the efficient and economical conduct of their business and to safeguard financial propriety and regularity. I am also accountable for ensuring that administration revenue expenditure is contained within the Department's administration limit and across the core Department, NHS commissioners and ALBs.

Compliance with the Corporate Governance Code

5. The detailed provisions of the *Corporate Governance Code* published by HM Treasury and the Cabinet Office relate to Ministerial departments, of which the Department of Health is one. This Governance Statement demonstrates DH's compliance with the principles set out in the Code.

Local accountability frameworks

6. The report from Sir Bob Kerslake to the Cabinet Secretary on Accountability: Adapting to decentralisation, published in September 2011, proposed that in future departmental accounting officers should publish accountability system statements explaining how they achieve accountability for the grants they distribute to local bodies. This allows Accounting Officers to demonstrate that, as departmental responsibilities are devolved, the appropriate accountability mechanisms are still in place. HM Treasury included this requirement in guidance to accounting officers on Governance Statements on 17 February 2012 (DAO(GEN)02/12).

7. The Department of Health published on its website an Accounting Officer (AO) System Statement in January 2012, setting out my responsibilities for the three devolved service sectors that DH oversees in England: the NHS, public health and adult social care. These sectors are funded and structured differently, and have different mechanisms for accountability. The Government's reforms to the NHS and public health will significantly affect the way accountability works, and the Statement was updated and republished on the DH website in August 2012 in the light of amendments to the Health and Social Care Bill before it was enacted as the Health and Social Care Act 2012. The AO System Statement sets out the accountability arrangements in place in 2011-12 and 2012-13, but it focuses particularly on the changes to arrangements after April 2013, when the majority of the Government's reforms are expected to be in place.

8. In terms of the allocation of funds, the Department of Health used a national weighted capitation formula to determine the recurrent allocation of resources to PCTs in 2011-12. The objectives of the formula were to support equal access for equal need and to contribute to the reduction in avoidable health inequalities. An independent committee, the Advisory Committee on Resource Allocation (ACRA) oversaw the development of the formula used to determine the allocation of resources to PCTs to ensure equity in resource allocation. ACRA's current membership comprises individuals with a wide range of relevant experience and expertise from within and outside the NHS including NHS managers, academics, GPs and representatives from other Government departments.

9. For the recurrent revenue allocations for 2011-12, the Department was clear about the priorities for the NHS through the Operating Framework. It was then for individual PCTs to decide how their resources were invested, to meet the healthcare needs of their local populations, taking account of local and national priorities.

10. NHS trusts, Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) are required to submit an audited annual Governance Statement to the Department which gives a sense of how successfully the NHS organisation has coped with the challenges it has faced and is facing and of how vulnerable the organisation's performance is or might be. The Governance Statement constitutes a position statement and provides evidence on governance, risk management and control in order to provide a coherent and consistent reporting mechanism. It is a national exercise in the NHS in which SHA, PCT and NHS trust accountable officers give assurance to the NHS Chief Executive about the stewardship of their organisations.

11. A quarterly report, *The Quarter*, is also published which includes a summary of the overall NHS financial forecast for each NHS trust, PCT and SHA.

12. The DH sets out its expectations for the NHS in the annual NHS Operating Framework. The NHS submits plans to deliver the commitments in the Operating Framework and then data is collected in order to monitor the delivery of these plans.

13. Strategic Health Authorities (SHAs) hold NHS Trusts to account for delivering Operating Framework requirements through regular performance monitoring. The DH in turn oversees SHAs; formal performance management discussions are undertaken at regular intervals supported by data monitoring and intelligence from engagement with professional bodies and regulators, which feed into six monthly and annual reviews with SHA Chief Executives.

14. In order to provide the Permanent Secretary and the Chief Executive of the NHS with the necessary level of assurance on the use of money by these NHS organisations, regular monitoring by the Department and reporting takes place.

15. The Department performs a monthly monitoring exercise which includes the collection of financial monitoring returns through SHAs at organisational level, showing actual expenditure against plan. In addition to performance monitoring, financial reporting and management, the financial returns are also used for policy decision-making purposes.

16. An overall NHS finance report is presented to the NHS Operations Executive as part of the overall performance reporting which includes activity reports and updates on Quality, Improvement, Productivity and Prevention. In addition, on a monthly basis, reports received by the Departmental Board include reports on the in-year performance of the NHS, spanning the areas of finance, quality, access, workforce and efficiency. These reports also include progress on the reform agenda.

17. Where individual organisations are failing to meet key performance standards, DH expects SHAs (through Primary Care Trust clusters) to remain accountable by holding the failing organisation to account– producing plans for improvement and recovery.

18. In relation to grant funding, the Department has a variety of measures in place to ensure that all grants awarded constitute value for money. Each type of grant has its own measures available. For example, the system covering grants issued to voluntary organisations under Section 64 of the Health Services and Public Health Act 1968, requires that prior to their award they are reviewed to ensure they offer value for money, and fit with the Departments' Strategic Objectives and expectations that are set out clearly when

the grant is awarded. An "end of grant" monitoring report is compiled and reviewed, in order to ensure the outcomes are satisfactory. Like all financial management systems, its operation and application are regularly reviewed and the system has been tightened where necessary to ensure coverage of these high standards.

19. The adult social care outcomes framework, together with related local authority data collections, is the key mechanism for measuring the outcomes and experience of people who use services as well as carers, and demonstrating what local authorities have achieved. The publication of this information allows for assessments of the performance of individual local authorities, encourages sector-led improvement initiatives, and supports greater local accountability.

20. The Department is working in partnership with a range of sector-led initiatives to improve performance. These include the *Think Local, Act Personal* partnership (focussing on the development of personalised and community-based care and support), the *Towards Excellence in Adult Social Care* programme (focussing on the performance of local authorities) and the Local Government Association's *Adult Social Care Efficiency Programme* (focussing on achieving value for money in care and support).

21. In terms of specific grants to local authorities, the amount allocated is relatively small. The main specific grant is the Learning Disability and Health Reform Grant, of around £1.3 billion in 2011-12. This is not ring-fenced, though specific guidance is attached on the intended focus of the funds. The Department accounts for the outcomes achieved through this grant as part of its overall approach to monitoring performance in adult social care.

The Department's system of internal control

22. The system of internal control is the set of processes and procedures in place in the Department of Health and the wider DH Group to ensure that the Group delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

23. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control has been in place in the Department for the year ended 31 March 2012 and up to the date of approval of the annual report and consolidated accounts, and accords with Treasury guidance.

24. As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control in the Department. Directors-General have responsibility for ensuring that their directorates are managed on the basis of demonstrable and evidenced compliance with an internal control framework, which contains five core assurance standards covering: planning and delivery, resource management, policy development, risk management and governance of arms length bodies.

25. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the comments made by the external auditors (the National Audit Office) in their management letter and other reports, including Value for Money reviews. Recommendations are implemented on a timely basis.

26. I have been advised, in my review of the effectiveness of the system of internal control, by the Department's Audit and Risk Committee. The priorities for 2012-13, in terms of risk management, will continue to be the delivery of the Departmental Business Plan, particularly the commitments in the Structural Reform Plan and the transition.

The DH Group governance framework

27. In line with central guidance on corporate governance, the Department has constituted an enhanced Departmental Board chaired by the Secretary of State including non-executives from outside government. This brings together Ministerial and civil service leadership. In compliance with the Code of Practice on Corporate Governance, the Board's terms of reference will be used as the basis for development of a board operating framework in 2012-13. The arrangements for management and governance of the Department, including the board and committee structure which underpins the Departmental Board, are set out in detail in section 4 of this Annual Report and Accounts.

28. The Secretary of State chaired four meetings of the main Board in 2011-12, and members met on a further five occasions during the year to discuss issues of strategic importance. The following Board members attended main Board meetings: Rt Hon Andrew Lansley CBE MP (Secretary of State for Health), myself (Una O'Brien CB (Permanent Secretary)), Richard Douglas CB (Director General for Policy, Strategy and Finance), David Behan CBE (Director General for Social Care, Local Government and Care Partnerships), Peter Sands (Lead Non-Executive Member), Dr Catherine Bell (Non-Executive Member), Mike Wheeler (Non-Executive Member) and Professor David Heymann (Non-Executive Member).

29. The remaining Board members attended three out of the four main Board meetings: Rt Hon Simon Burns MP (Minister of State for Health), Paul Burstow MP (Minister of State for Care Services), Anne Milton MP (Parliamentary Under Secretary of State for Public Health), Earl Howe (Parliamentary Under Secretary of State for Quality (Lords)), Sir David Nicholson KCB CBE (NHS Chief Executive), Dame Sally Davies DBE (Chief Medical Officer) and Chris Pilling (Non-Executive Member).

30. Elsewhere in this Annual Report, the lead Non-Executive Director of the Departmental Board, Peter Sands, details the areas to which the Board devoted particular attention; these included:

    - Ensuring the development of effective relationships between the Department and the key ALBs in the transformed health system;
    - Overseeing the transition programme and its associated risks;
    - Overseeing the Department's Capability Review, including challenging and influencing the Department's scores and action plan;
    - Enhancing communication across the Department and the ALBs to ensure common purpose and understanding across the system as a whole; and
    - Reinforcing financial management and performance management, particularly developing a new and clearer format for the monthly performance report.

31. The Board was impressed by the wide range of performance and management information it received over the year. However, Board members on occasion found it difficult to engage fully with the information due to the amount and format of information supplied. As a result, the Department is developing a performance scorecard to summarise this information, whilst at the same time allowing members to drill down in greater depth where required. The Board will continue to encourage the Department to refine the quality and clarity of performance metrics.

32. Peter Sands conducted a Board Effectiveness Evaluation in accordance with Cabinet Office requirements. He found that the Department had demonstrated commendable resilience and flexibility over the year, simultaneously confronting a vast range of issues from ensuring ongoing delivery of quality health services, to driving the productivity programme and managing the transformation of the overall health system. The evaluation exercise found that the Board was making good progress in its core objective of improving the governance of the Department, and identified some areas for improvement. Some of these concerned the Board's need to consider the Department's changing role within the wider healthcare system.

33. Others related to ensuring that the Board spends sufficient time on the big strategic issues affecting the longer term shape and performance of the health and social care system, and enhancing the Board's ability to identify and focus on the most critical risks.

Risk management

34. Within the Department, I operate an accountability process based around compliance with five core assurance standards, including one covering risk management. The risk management standard, communicated to Director-Generals (DGs) in their budget accountability letters in April 2011, sets out the DGs' accountabilities for identifying, assessing, communicating, escalating and managing risk in their directorates. DGs are required to set out in directorate risk registers the key risks to successful delivery of their business plans. Senior Responsible Owners are accountable for the effective management and escalation of risks within their programmes.

35. The most significant risks are escalated by DGs and SROs to the strategic risk register, which is used by the Departmental Board to maintain an overview of high-level strategic risks. Each risk on the strategic register has a Board level owner. During 2011-12, the Board has challenged risk ratings, suggested new risks and commissioned additional mitigation activity where appropriate.

36. The Audit and Risk Committee has been involved in the way in which the Department has managed risk. During the year, the Committee considered and challenged the Department's strategic risk register at each of its regular meetings. It also supported the Board in ensuring there is an effective system in place for control, governance and risk management.

37. Risk management is a key component of the governance framework across the Department's ALBs and NHS organisations. The systems in place are covered at paragraphs 61-62 and 13-16 of this Statement.

38. Mike Wheeler, as Chair of the Department's Audit and Risk Committee, during the year took steps to strengthen the relationship with the Chairs of the Audit and Risk Committees of the Department's ALBs.

Transition – planning and implementations of reforms across the NHS

39. Since 2010, the Department has been taking forward a major programme of change, involving the planning and implementation of reforms across the NHS, the Department of Health and the public health sector more generally. As noted last year, the reforms represent one of the biggest change programmes the Department has undertaken and, as with any such change programme, the delivery and transition will involve significant risk. The risks range across a variety of areas such as system design, finance, staffing and accountability, in addition to the inherent risks around ensuring that business as usual and levels of performance are maintained during the period of transition.

40. The programme of change is being run as an integrated programme between the Department and the NHS. Sir David Nicholson and I are the Board sponsors, and Karen Wheeler, Director-General of Group Operations and Assurance, is the programme's Senior Responsible Owner. The programme is managed through the Department's Executive Board (EB), which provides oversight of the design, strategic approach, planning and implementation of the new direction of the health and care system. The EB also serves to ensure that the transition is co-ordinated between NHS, DH, ALBs and local government, and provides a single point for joint decision making for all aspects of transition which require senior level decisions.

41. Below the Executive Board, the programme is governed primarily via three programme-wide boards:

    - The DH, Social Care and Public Health Transition Board;
    - The NHS Future Systems Executive; and
    - The Cross Cutting Functions Board

42. From October 2012, this governance structure will be adapted to take account of the reality that a number of the new bodies will be able to start activity on aspects of their responsibilities.

43. There are a number of individual workstreams, and each reports into one of the three Boards. Each workstream's Senior Responsible Owner is responsible for determining, establishing, recording and managing risks and issues within that workstream, and for providing regular risk updates to the central Transition Integrated Programme Office (IPO), as part of an established reporting process. The information from these reports, including that on risks, is collated and submitted to the relevant Board or Committee.

44. To support the senior Boards in their responsibility for co-ordinating risks and issues, the Integrated Programme Office has established and maintains a programme-wide transition risk register. This incorporates key risks from across the programme and is also reviewed and updated regularly. Key risks are included in the separate Strategic Risk Register.

45. As reported last year, the Transition Programme has been subject to a series of reviews by the Cabinet Office's Major Projects Authority. These include reviews of the key workstreams within the programme, and a wider Major Projects Review Group (MPRG) review of the programme as a whole. The initial MPRG review was undertaken in early 2012 and the Department accepted its recommendations.

46. The Department has accepted all of the recommendations arising from the review and has put actions in place to address these. It is providing regular updates to the Major Projects Authority on progress against the recommendations and a follow up review has been arranged for early September. The DH Board is also kept fully informed.

Risk register

47. The Transition Programme's Risk Register was subject to a request made under the Freedom of Information (FOI) Act in November 2010 from the then Shadow Health Secretary, John Healey MP. The Department's Strategic Risk Register was then subject to an FOI request in February 2011, from Nicholas Cecil, a journalist.

48. The Department withheld both risk registers under Section 35 of the FOI Act, on the grounds that they were part of ongoing policy development and their release would undermine the health reform programme's progress. Both cases were referred to the Information Commissioner, who ruled that the registers should be released, after which the Department appealed to the Information Tribunal, with the hearing held in March 2012. Lord O'Donnell, the former Cabinet Secretary, and I gave evidence.

49. The Tribunal upheld the decision by the Department to withhold the Strategic Risk Register but ordered the release of the Transition Risk Register, ruling that the public interest in the health reforms outweighed the arguments for exemption. Having referred the matter to Cabinet for their view, the Secretary of State for Health on 8 May announced the Cabinet's support for his decision to veto the release of the Transition Risk Register. In doing so, however, the Department acknowledged the importance of being more open about transition programme risks and their management and published a document that described and explained the areas of risk in the withheld risk register, and the mitigating actions in respect of those areas.

50. It also published a "Scheme for Publication", setting out key dates by which transition programme material would be reviewed in order to identify what material could then be released. Both these documents, along with the Secretary of State's Statement of Reasons for exercising the veto, and the Tribunal witness statements from both Lord O'Donnell and I are available on the DH website.

Information Risk

51. Regarding information risk, the Department ensured that appropriate policies and guidance were in place to assure compliance with Cabinet Office mandates on electronic and physical data security. DH has continued work to raise the level of compliance with the Cabinet Office Information Assurance Maturity Model, and is on course to achieve 100% compliance in 2012. In procuring a new ICT services contract the Department has taken the opportunity to update its requirements for information security, specifying ICT controls that will provide improved security, proportionate to the information risks we face while supporting our ability to conduct our business efficiently.

52. Within the core Department, there were five recorded instances of personal data loss or mis-management during 2011-12. Two of these incidents were reported to the Information Commissioner: one put patient data at risk as it involved 1010 patient experience survey forms being sent to incorrect addresses, with the risk of exposing the patients' diagnoses to a third party; the other compromised NHS employee data, as it involved data on 1822 specialist staff being inadvertently included in a report sent to a reference group. Appropriate corrective action was undertaken in all five instances, with working processes being reviewed and updated where necessary.

53. Information security and data loss issues in the Department's ALBs, and in NHS bodies and NHS Foundation Trusts, are disclosed in the governance statements in their accounts.

Role of Internal Audit

54. The Department's Internal Audit Service (IAS) plays a crucial role in the review of the effectiveness of risk management, controls and governance by:

- focusing audit activity on the key business risks;
- being available to guide managers and staff through improvements in internal controls;
- auditing the application of risk management and control as part of Internal Audit reviews of key systems and processes; and
- providing advice to management on internal control implications of proposed and emerging changes.

55. The Department's Internal Auditors operate in accordance with Government Internal Audit Standards and to an Internal Audit Plan approved by the Audit and Risk Committee. Internal Audit updates the plan to reflect changes in risk profile and the revised plan is reviewed and approved by the Audit and Risk Committee. The Internal Audit Service submits regular reports on the adequacy and effectiveness of the Department's systems of internal control and the management of key business risks, together with recommendations for improvement. These recommendations have been accepted by management including an agreed timetable for implementation. The status of Internal Audit recommendations, and the collection of evidence to verify their implementation, are reported to the Audit and Risk Committee.

Internal Audit Opinion

56. Following completion of the planned audit work for 2011-12 for the Department, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Department's system of risk management, governance and internal control. She concluded that:

    'I can give reasonable assurance to the Accounting Officer that the Department of Health has had adequate and effective systems of control, governance and risk management in place for the reporting year 2011-12'.

57. In addition, I also asked the Head of Internal Audit to conduct a review of the governance, risk management and financial management of each Directorate. In compiling this statement, I have considered the outcomes of these formal internal audit reports and the overarching management note drawing together the results.

Governance and Control in the Core Department of Health

58. A summary report of the governance and control system in the core Department of Health has been drawn up by my Governance Team. The report covered key issues for each Directorate, and was supported by financial information and material supplied by the Internal Audit Service.

59. On the basis of the summary report, I have reviewed the end of year assurance statements provided to me by all Director Generals and Managing Directors, which recorded the position in their business groups over the year. These confirmed that the Department has adequate and effective systems of control in place, and that where issues have arisen during the year assurance arrangements have been in place to pick up and address any weaknesses.

Compliance with Equality & Human rights legislation

60. As part of consolidated action to strengthen compliance, the Department entered into a voluntary Framework Agreement with the Equality and Human Rights Commission (EHRC) for the period September 2010 to March 2012. We have provided EHRC with quarterly progress reports and published these, alongside other equality information, on 31 January 2012. All DGs were committed to action to ensure equality was integral to key planning and reform activities and this was overseen by a DG level Equality and Human Rights Assurance Group. Following delivery of the EHRC Framework Agreement, we have set new Departmental Equality Objectives, aligned to the DH business plan, and will report progress annually.

Governance and Control in the DH's Arms Length Bodies

61. The Department sponsored twenty Arms Length Bodies in 2011-12. Through its sponsorship teams, the Department engages directly with each body proportionate to the level of risk the body poses to the Department. ALB risks can either be escalated to the Department, through the quarterly ALB accountability review meetings undertaken by the sponsors, or highlighted to the Department through the other formal and informal interactions that the sponsors maintain with ALBs.

62. Going forward, the Department is strengthening its sponsorship responsibilities and putting in place more systematic processes to assure the Department that ALBs are delivering against strategic objectives and

outcomes and that risks to the DH and ALBs are understood, managed effectively and escalated as appropriate. To achieve this, a Sponsorship Support Unit has been established in the new Group Operations and Assurance Directorate under the new Director of Assurance.

63. Each body compiled a Governance Statement for its Accounts, and these have been reviewed on my behalf. There were no significant control issues in ALBs which warranted escalation for disclosure in this Statement.

64. With regard to the Care Quality Commission (CQC), on the 31st May 2011, BBC's Panorama programme presented footage of abuse at the Winterbourne View private hospital. Whistleblowers had previously alerted the CQC to abuse at the home, but the Commission had not taken appropriate regulatory action. The CQC has subsequently strengthened its arrangements for dealing with whistleblowing. During the remainder of the year, the Care Quality Commission was subject to significant external scrutiny, and reports on the CQC's operations have been published by the Health Select Committee, the National Audit Office, the Public Accounts Committee and the Department of Health.

65. The Department stepped in and undertook a Performance and Capability Review of the CQC, which concluded in February 2012. The review noted that the CQC had made significant improvements in the previous nine months, increasing staffing and focussing more on its core duties to register and inspect healthcare and social care providers. However, it identified that a number of improvements were still needed. The recommendations from the Capability Review cover a range of areas including strategy, finance, accountability and governance, communications and operational development. Based on these recommendations, and the lessons from other external scrutiny, the Department and the CQC now have firm action plans to drive improvements and progress is subject to monitoring by Ministers.

66. After almost four years as Chief Executive, Cynthia Bower decided to step down in February 2012. She led the organisation from the merging of three existing regulators, and worked to establish a single system of regulation for over 40,000 provider locations across health and social care. David Behan was appointed as new Chief Executive in June 2012.He will continue to implement improvements including, with the Chair, the development of the CQC's Board to enable more robust oversight, a clearer focus on strategic priorities and better co-ordinated accountability to the Senior Departmental Sponsor at the Department and to Parliament.

Prescription Charge Fraud

67. For several years, the Department's annual statement has noted the position on prescription fraud. The former account in which these charges were recorded was qualified for a number of years on the grounds of regularity, because of estimated loss of revenue due to patients fraudulently claiming entitlement to free prescriptions. The Audit & Risk Committee has dedicated time to examining the position for the year 2011-12. There has been no estimation exercise made; however, we believe two factors will have reduced the fraud rate. Firstly, exemption from prescription charges was widened in 2009 to include cancer patients. Secondly, the underlying unemployment rate (and associated claimant count) has risen significantly since 2007/8, which means that more people would qualify for exemption from health charges through the benefits system.

68. From April 2013, the NHS Commissioning Board will be responsible for commissioning of primary care services and will be accountable for the payments made to community pharmacists and dispensing doctors, including the amounts netted off for prescription charges. The NHS Commissioning Board will be responsible for deciding in operational terms the discharge of these functions, and will consider options for how best to build on the current systems used by PCTs to detect and deter prescription charge fraud. The Board will also be responsible for terms and conditions of service for pharmacists, including the continuing requirements for point of dispensing checks.

Governance and Control in the NHS

69. The Boards and Accountable Officers of the individual NHS Bodies covered by the Report and Accounts are responsible for their own systems of internal control and governance.

70. For NHS Trusts, PCTs and SHAs I gain assurance through the performance management line through the NHS Chief Executive. The SHAs have reviewed the Governance Statements of all NHS Trusts and PCTs prepared by their Accountable Officers together with relevant internal audit reports. Similarly, the Department has reviewed the Governance Statements prepared by the SHAs. These show that an

adequate system of internal control was in place and there were no significant control issues that would be material to this set of Report and Accounts.

71. Overall, the NHS operated within the expenditure controls set by HMT and voted by Parliament. SHAs, PCTs and NHS Trusts delivered a combined surplus of £1,632m and Foundation Trusts a surplus of £437m. The aggregate surplus delivered in 2011-12 by SHAs and PCTs of £1.587 billion will be carried forward to 2012-13.

72. Since the end of the financial year ,one NHS Trust (South London Healthcare) has been placed into the unsustainable provider regime with the appointment on 12th July 2012 by the Secretary of State of a Trust Special Administrator. The aim of the unsustainable provider regime is to establish how best to deliver high quality services for patients, within an affordable financial envelope for taxpayers. Despite some recent improvements in the quality of services, there had been a long-standing history of underperformance at the Trust both in service quality and financial management. The Trust Special Administrator is working to develop a solution that will bring about the transformational level of change needed to ensure clinically and financially viable services are secured for the people of south east London.

73. The Board of an NHS organisation must be assured of the management of current risks, supported by a strong risk management culture embedded throughout the organisation. The Department operates a "grandparent" system for the NHS Trusts and PCTs. Any major risks are initially reported to their respective Strategic Health Authorities (SHAs). Where the risk is likely to be of significant impact, the risk would then be reported to the Department by the SHA.

Governance and Control in NHS Foundation Trusts

74. A different system operates for Foundation Trusts under primary legislation. Monitor, the Independent Regulator of NHS Foundation Trusts (FTs), is responsible for authorising, monitoring and regulating NHS Foundation Trusts. The National Health Service Act 2006 requires Monitor to prepare an overall summary of the accounts of FTs and lay this before Parliament. The NHS Foundation Trust Consolidated Accounts 2011-12 were laid before Parliament by Monitor on 12th July 2012, and contain an Annual Governance Statement for the FT sector.

75. Neither the Department of Health nor Monitor is accountable for the internal control and systems of FTs, this is the responsibility of each FT's board. The Governance Statement in the FT Consolidated Accounts summarises the internal control issues in the FT sector, and provides details of internal control weaknesses disclosed by FTs in their individual governance statements, together with the actions being taken to address them. There were no significant control issues that would be material to this set of Annual Report.

76. There are no significant internal control issues set out in Monitor's Annual Governance Statement for the FT sector. I am therefore satisfied that I have fulfilled my duty as Accounting Officer to ensure that all expenditure by DH and NHS bodies (including FTs) is contained within the Department's expenditure limits.

Mid-Staffordshire Foundation NHS Trust

77. On 9th June 2010, the Secretary of State announced a full public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust from 2005 to 2009. The Inquiry, led by Robert Francis QC, builds on the work of his previous independent Inquiry, which considered individual cases of patient care and reported in February 2010.

78. Robert Francis QC has indicated publically that he plans to deliver his final report to the Secretary of State in early January 2013. The report will be laid before Parliament in due course and, once the recommendations have been considered with care, a full Government response will be produced.

Delayed Publication of these Accounts

79. Alongside a small number of other Departments, the Department did not meet the timetable set by HM Treasury to publish its Annual Report and Accounts before Parliament rose for the summer recess. This is the second year that the Department has not met the timetable. Although the Department faces the most complex consolidation in government, it is committed to meeting the pre-recess timetable.

80. Following the delay in 2010-11, the Department completed a lessons learnt review with the NAO overseen by the Chair of its Audit and Risk Committee. As a result of this, the Department increased the resources committed and made a number of process changes. For 2011-12, the Department and the NAO recognised from the outset that the timetable was very challenging and allowed little room for slippage. The task was significant this year, because for the first time, the Department had to achieve reconciliation between all provider and commissioner accounts. This was consequent upon the Constitutional Reform and Governance Act 2010. In the event, the Department encountered delays in two areas. First, there were issues with the configuration of the IT system used for consolidation. Secondly, following the extension of the boundary to include Foundation Trusts more difficulties than anticipated were encountered in agreeing debtors and creditors between organisations within the Group. The Department acknowledges that it under-estimated the scale of the changes that were needed to guarantee delivery by the summer recess 2012.

81. Planning for the financial year 2012-13 has already started. The Department is working with the NAO on the action needed to deliver the Report and Accounts, recognising that the structural changes being made to the NHS (the abolition of SHAs and PCTs) will further add to the complexity of the task.

Conclusion

82. Prior to signing this Governance Statement, the Department's Audit and Risk Committee has recommended that I submit this Governance Statement.

Una O'Brien
Permanent Secretary and Principal Accounting Officer
9 October 2012

THE CERTIFICATE 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 and of its Departmental Group for the year ended 31 March 2012 under the Government Resources and Accounts Act 2000. The Department consists of the core Department and its agencies. The Departmental Group consists of the Department and the bodies designated for inclusion under the Government Resources and Accounts Act 2000 (Estimates and Accounts) Order 2011. The financial statements comprise: the Department's and Departmental Group's Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. I have also audited the Statement of Parliamentary Supply and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Government Resources and Accounts Act 2000. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Department's and the Departmental Group's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the Statement of Parliamentary Supply properly presents the outturn against voted Parliamentary control totals and that those totals have not

been exceeded. The voted Parliamentary control totals are Departmental Expenditure Limits (Resource and Capital), Annually Managed Expenditure (Resource and Capital), Non-Budget (Resource) and Net Cash Requirement. I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects:

- the Statement of Parliamentary Supply properly presents the outturn against voted Parliamentary control totals for the year ended 31 March 2012 and shows that those totals have not been exceeded; and

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the Department's and the Departmental Group's affairs as at 31 March 2012 and of the Department's net operating cost and Departmental Group's net operating cost for the year then ended; and

- the financial statements have been properly prepared in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions issued thereunder.

Emphasis of matter: IAS 8 and Comparative Restatement under the Clear Line Of Sight Initiative

- Without qualifying my opinion, I draw attention to the disclosures in note 1 to the financial statements regarding the Department's decision when presenting comparative information for the consolidation of additional entities required by the Clear Line of Sight project (CLOS). The Department applied the exemption from restatement permitted under International Accounting Standards 8. I have obtained sufficient and appropriate evidence that the 2011-2012 financial statements are not materially misstated as a result of this decision. Further detail is provided within my report.

Opinion on other matters

In my opinion:

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

- the information given in the Annual Report and Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

REPORT

Treasury initiated a Clear Line of Sight project which sought to align the annual financial statements to the budgets set by Treasury and the revised Parliamentary Supply process. As a result of these changes the number of bodies which are consolidated into a Department's accounts has increased. These changes were applicable for the 2011-2012 financial statements.

The Department of Health group financial statements in 2011-2012 consolidates 437 entities. The 2010-2011 group financial statements consolidated 169 entities. This significant change is due to the inclusion of NHS Trusts and Foundation Trusts. In order to ensure that the prior year figures were comparable the Department of Health was required to restate the prior year comparative information to include these additional entities. Treasury guidance stipulated that Department should apply the principles outlined in International Accounting Standard 8 'Accounting Policies, Changes in Accounting Estimates and Errors' to the restatement exercise.

The Department of Health has made a significant effort but has been unable to restate the comparative information and therefore has utilised the exemption included in International Accounting Standard 8, which can be applied when a robust restatement exercise is considered impracticable. This assessment was based on an absence of data to support the intra group trading figures for the expanded group in the prior year. I have considered the use of the exemption and I agree that it would be impractical to produce robust comparative information because the detailed data required is not available and the time and cost to reproduce this data would be prohibitive.

As outlined in Note 1 to the financial statements, the Department of Health has opted to include group comparative information which is presented on a 'best endeavours' basis as opposed to including the 2010-2011 audited figures. This was on the basis that the impact of the Clear Line of Sight Initiative had a fundamental impact on the size and scale of the Department and that the previously audited information was therefore of no use to the user of the accounts in the context of the current year.
Whilst the comparative information is not robust I have been able to audit it to the extent required to provide an unqualified audit opinion on the current year financial statements. My audit opinion does not extend to the comparative information as this is not required to be presented since the Department has applied the International Accounting Standard 8 exemption. My audit opinion on the Department's 2010-2011 group financial statements, which did not include NHS Trusts and Foundation Trusts, was unqualified.

Amyas CE Morse
Comptroller and Auditor General

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

15 October 2012

Statement of Parliamentary Supply

for the year ended 31 March 2012

Summary of Resource and Capital Outturn 2011-12

	Note	Estimate Voted £'000	Estimate Non-Voted £'000	Estimate Total £'000	Outturn Voted £'000	Outturn Non-Voted £'000	Outturn Total £'000	2011-12 Voted outturn compared with Estimate: saving/ (excess) £'000	Unaudited Restated 2010-11 Outturn Total £'000
Departmental Expenditure Limit									
- Resource	3.1	85,588,847	16,829,137	102,417,984	84,725,341	16,863,807	101,589,148	863,506	100,285,508
- Capital		4,352,565	-	4,352,565	3,786,270	-	3,786,270	566,295	4,158,605
Annually Managed Expenditure									
- Resource	3.1	3,942,954	-	3,942,954	3,193,101	-	3,193,101	749,853	3,206,683
- Capital		-	-	-	-	-	-	-	7,876
Total Budget		93,884,366	16,829,137	110,713,503	91,704,712	16,863,807	108,568,519	2,179,654	107,658,672
Non-Budget									
- Resource	3.1	-	-	-	-	-	-	-	-
Total		**93,884,366**	**16,829,137**	**110,713,503**	**91,704,712**	**16,863,807**	**108,568,519**	**2,179,654**	**107,658,672**
Total Resource		89,531,801	16,829,137	106,360,938	87,918,442	16,863,807	104,782,249	1,613,359	103,492,191
Total Capital		4,352,565	-	4,352,565	3,786,270	-	3,786,270	566,295	4,166,481
Total		**93,884,366**	**16,829,137**	**110,713,503**	**91,704,712**	**16,863,807**	**108,568,519**	**2,179,654**	**107,658,672**

Net cash requirement 2011-12

	Note	2011-12 Estimate £'000	2011-12 Outturn £'000	2011-12 Outturn compared with Estimate: saving/ (excess) £'000	2010-11 Outturn £'000
Net cash requirement	4	87,686,602	86,263,864	1,422,738	84,745,496

Administration Costs 2011-12

	2011-12 Estimate £'000	2011-12 Outturn £'000	2010-11 Outturn £'000
Administration Costs	4,312,858	3,540,726	239,708

Footnotes

1) From 2011-12, the Department implemented the new HM Treasury control in respect of reporting its expenditure between administration and programme components. This control has been applied to the Core Department, NHS Commissioners (Strategic Health Authorities and Primary Care Trusts) and most Arms Length Bodies. With the agreement of HM Treasury, all income and expenditure within the accounts of NHS Providers (NHS Trusts and NHS Foundation Trusts) has been classified to programme. The 2010-11 Administration Costs outturn figure has not been restated to reflect this wider interpretation of Administration costs adopted in 2011-12, rather it continues to reflect the Administration costs regime in place at the time. As agreed with HM Treasury and the Financial Reporting Advisory Board, it is impracticable, as per the IAS 8 definition, for NHS bodies to restate prior period income and expenditure figures based on an Administration costs regime that was not in place at the time. HM Treasury guidance relating to the Department's own classification of income and expenditure between administration and programme has also been amended. As detailed in Note 1.6, this revised guidance re-categorised a number of Core Department administration and programme expenditure types, with the movement predominantly being from programme to administration. The Department has applied this revised methodology from 1 April 2011, thus ensuring a consistent date of application for the revised Administration costs regime across the Departmental Group.

2) The 2010-11 comparators within the Summary of Resource and Capital Outturn have been restated to reflect the new format of the Estimate. Further information regarding the nature and extent of the restatement can be found in Note 1b *Restatement*.

3) The 2010-11 net cash requirement has been restated (reduced by £735,792,000) as the 2010-11 published account included £735,792,000 of excess appropriations-in-aid in respect of National Insurance Contribution income. From 2011-12, Estimate control totals are voted net of income, which means that the concept of excess appropriations-in-aid no longer exists, and the Department is

able to retain all income generated, with the exception of any income that falls outside the ambit of the resources voted by Parliament. Additionally, National Insurance Contributions have been re-categorised as funding rather than income. Further information regarding these accounting policy changes can be found in Note 1b *Restatement*.

4) Figures in the areas outlined in bold are voted totals or other totals subject to Parliamentary control.

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

The notes on pages 111-207 form part of these accounts.

Consolidated Statement of Comprehensive Net Expenditure

for the year ended 31 March 2012

		2011-12		Unaudited Restated 2010-11	
	Notes	Core Department £'000	Departmental Group £'000	Core Department £'000	Departmental Group £'000
Administration Costs:					
Staff costs	7	264,855	1,887,700	167,572	167,572
Other administration costs	8	195,642	1,872,126	76,490	76,490
Operating income	10.1	(12,513)	(276,495)	(4,406)	(4,406)
Grant in Aid to NDPBs	8	143,689	-	-	-
Funding to Group Bodies	8	2,828,338	-	-	-
Programme Costs					
Staff Costs	7	1,492	44,402,129	182,108	46,699,102
Programme Costs	9	5,669,901	63,661,762	6,155,691	62,876,434
Income	10.2	(1,113,936)	(6,046,266)	(1,200,650)	(5,608,017)
Grant in Aid to NDPBs	9	98,460	-	313,447	-
Funding to Group Bodies	9	94,820,215	-	96,200,492	-
Net Operating Costs for the year ended 31 March 2012		**102,896,143**	**105,500,956**	**101,890,744**	**104,207,175**
Total expenditure		104,022,592	111,823,717	103,095,800	109,819,598
Total income		(1,126,449)	(6,322,761)	(1,205,056)	(5,612,423)
Net Operating Costs for the year ended 31 March 2012		**102,896,143**	**105,500,956**	**101,890,744**	**104,207,175**
Other Comprehensive Net Expenditure					
Net (gain)/loss on:					
- revaluation of property, plant and equipment		(6,615)	(851,133)	(73,858)	(860,110)
- revaluation of assets held for sale		-	(1,698)	-	-
- revaluation of intangibles		(533,888)	(533,733)	(137,726)	(138,018)
- revaluation of investments		15,901	15,539	(115,724)	(115,997)
- impairments and reversals transferred to revaluation reserve		42	607,115	28,634	493,377
- disposal of available for sale financial assets		-	280	-	-
- other reserves		-	1,097	-	(135)
- Actuarial gains/(losses) on defined benefit pension schemes		-	66,734	-	(32,216)
- other gains and (losses)		-	(3,512)	-	(4,046)
Release of reserves to the CSCNE		-	1,224	-	965
Total Other Comprehensive Net Expenditure		**(524,560)**	**(698,087)**	**(298,674)**	**(656,180)**
Total Comprehensive Expenditure for the year ended 31 March 2012		**102,371,583**	**104,802,869**	**101,592,070**	**103,550,995**

Footnotes

1) Consolidated Statement of Comprehensive Net Expenditure (CSCNE) information should be disclosed in separate columns which relate to the Core Department, the Core Department and its Executive Agencies, and the Departmental Group as a whole. As the Department of Health has no Executive Agencies, all information presented in relation to the Core Department and its Agencies would be identical to information presented for the Core Department only. Consequently, the CSCNE includes two columns only, one relating to the Core Department, and the other relating to the Departmental Group.

2) The Core Department columns have been restated to include “Funding to Group Bodies” as an expenditure item rather than as a reserves movement. This significant change follows confirmation from HM Treasury that, as a consequence of alignment, both funding to Group Bodies and Grant-in-Aid to Non-Departmental Public Bodies (NDPBs) should be treated consistently.

3) The 2010-11 comparatives have been restated to reflect a number of accounting policy changes which have primarily arisen because of amendments to the FReM driven by the Clear Line of Sight (alignment) legislation [Constitutional Reform and Governance Act 2010]. Further information on the nature and extent of each element of the restatement is given in Note 1b *Restatement*.

4) The Department has applied the IAS 8 impracticability exemption to the elimination of restated prior period trading transactions and balances, with all prior period consolidated figures being unaudited as a result. Whilst the Department has made every reasonable effort to produce accurate, fully comparable prior period information, this may not be the case in respect of consolidated comparative income, expenditure, payable and receivable figures. Notwithstanding this residual level of imbalance, the closing balances of the 2010-11 primary statements, and therefore the opening balances for 2011-12 are not misstated, because, for example, an expenditure imbalance in one direction would be exactly off-set by an income imbalance in the opposite direction. The reasons for applying this exemption, along with the methodology used to produce the prior period comparatives, are disclosed in Note 1b below.

5) Included within the Grant in Aid total is Revenue of £204,709k and Capital of £37,440k.

The notes on pages 111-207 form part of these accounts.

Consolidated Statement of Financial Position

as at 31 March 2012

	Note	2012 £'000 Core Department	2012 £'000 Departmental Group	Restated[1,2,3,4] For Alignment and TCS 1 April 2011 £'000 Core Department	Restated[1,2,3,4] For Alignment and TCS 1 April 2011 £'000 Departmental Group	Impact of Transfer of Functions (TCS[4]) and other Opening Balance Adjustments[5]	Unaudited Restated[1,2,3] For Alignment 2011 £'000 Departmental Group	Unaudited Restated[1,2,3,4] For Alignment and TCS 1 April 2010 £'000 Core Department	Unaudited Restated[1,2,3,4] For Alignment and TCS 1 April 2010 £'000 Departmental Group
Non-current assets									
Property plant and equipment	11	1,197,004	48,266,225	1,297,571	47,366,059	(6,068)	47,372,127	1,176,845	45,214,447
Investment Property	11.1	263	66,549	338	64,807	-	64,807	313	58,088
Intangible assets	12	1,589,475	2,024,457	1,495,695	1,904,462	(422)	1,904,884	1,542,567	1,895,626
Financial assets- Investments	13	25,924,137	1,304,438	25,323,617	1,050,923	-	1,050,923	24,529,424	872,410
Other non-current assets	16	122,726	613,145	129,975	643,729	27	643,702	153,540	670,349
Total non-current assets		**28,833,605**	**52,274,814**	**28,247,196**	**51,029,980**	**(6,463)**	**51,036,443**	**27,402,689**	**48,710,920**
Current assets									
Assets classified as held for sale	18	8,656	246,000	6,084	215,662	-	215,662	12,852	197,295
Inventories	14	107,960	931,886	89,428	903,342	(2,419)	905,761	215,634	1,009,073
Trade and other receivables	16	118,141	786,159	100,689	1,007,057	(9,390)	1,016,447	164,294	2,357,901
Other current assets	16	233,175	1,567,210	184,458	1,233,176	(65)	1,233,241	224,967	742,479
Other financial assets	16	231,953	64,749	189,138	47,561	-	47,561	167,342	9,269
Cash and cash equivalents	17	520,148	5,805,198	1,624,356	5,891,667	928	5,890,739	1,237,866	4,980,408
Total current assets		**1,220,033**	**9,401,202**	**2,194,153**	**9,298,465**	**(10,946)**	**9,309,411**	**2,022,955**	**9,296,425**
Total assets		**30,053,638**	**61,676,016**	**30,441,349**	**60,328,445**	**(17,409)**	**60,345,854**	**29,425,644**	**58,007,345**
Current liabilities									
Trade and other payables	19	(146,521)	(4,978,137)	(196,597)	(5,184,061)	90,817	(5,274,878)	(409,854)	(8,216,273)
Other liabilities	19	(1,578,597)	(7,759,509)	(2,709,129)	(8,143,934)	3,743	(8,147,677)	(2,160,468)	(5,291,630)
Provisions	20	(236,316)	(3,289,631)	(270,996)	(3,066,331)	(1,365)	(3,064,966)	(406,243)	(2,579,982)
Total current liabilities		**(1,961,434)**	**(16,027,277)**	**(3,176,722)**	**(16,394,326)**	**93,195**	**(16,487,521)**	**(2,976,565)**	**(16,087,885)**
Non-current assets plus/less net current assets/liabilities		**28,092,204**	**45,648,739**	**27,264,627**	**43,934,119**	**75,786**	**43,858,333**	**26,449,079**	**41,919,460**
Non-current liabilities									
Other payables	19	(283,472)	(611,855)	(352,719)	(677,335)	(9,956)	(667,379)	(198,331)	(36,254)
Provisions	20	(1,419,220)	(18,899,535)	(1,216,010)	(16,704,698)	1,429	(16,706,127)	(968,684)	(15,113,916)
Net pension asset/(liability)	30.1	-	(87,584)	-	(21,668)	-	(21,668)	-	(72,105)
Financial liabilities	19	(55,816)	(11,815,236)	(72,965)	(10,492,578)	-	(10,492,578)	(63,057)	(9,165,585)
Total non-current liabilities		**(1,758,508)**	**(31,414,210)**	**(1,641,694)**	**(27,896,279)**	**(8,527)**	**(27,887,752)**	**(1,230,072)**	**(24,387,860)**
Assets less liabilities		**26,333,696**	**14,234,529**	**25,622,933**	**16,037,840**	**67,259**	**15,970,581**	**25,219,007**	**17,531,600**
Taxpayers' equity and other reserves									
General fund		25,381,019	3,846,803	25,158,922	6,073,216	65,360	6,007,856	24,949,378	7,822,726
Revaluation reserve		952,677	10,223,592	464,011	9,796,520	(3,829)	9,800,349	269,629	9,548,979
Other Reserves		-	164,134	-	168,104	5,728	162,376	-	159,895
Total Taxpayers' Equity		**26,333,696**	**14,234,529**	**25,622,933**	**16,037,840**	**67,259**	**15,970,581**	**25,219,007**	**17,531,600**

Footnotes

i) The Consolidated Statement of Financial Position for both 2010 and 2011 has been restated in respect of the following:

1) To reflect the increase in the Department's Resource Accounting Boundary to include NHS Trusts, NHS Foundation Trusts and all Arms Length Bodies.

2) To reflect the change in accounting policy relating to the donated asset and government grant reserves.

3) To reflect the fact that investment properties are now disclosed as a separate category of non-current assets. This category was previously included within Property, Plant and Equipment due to its immaterial value. However, this is no longer appropriate, as the value of investment property has become much more significant following the extension of the accounting boundary.

4) The Consolidated Statement of Financial Position for 2011 has also been restated to include the impact of the transfer of provider functions from Primary Care Trusts (PCTs) to NHS Trusts, NHS Foundation Trusts or Social Enterprises under the "Transforming Community Services" initiative. The impact of these transfers is shown in the column labelled "Impact of Transfer of Functions (TCS)". The impact will be minimal, however, as the majority of transfers have occurred between bodies within the accounting boundary which means that the result is eliminated on consolidation.

5) Other opening balances adjustments, relate to prior period adjustments made to financial statements at a local level. Further information is available within local financial statements.

Further information on the nature and extent of each of these restatement items is provided in Note 1b *Restatement*.

ii) The 2010-11 Core Department Statement of Financial Position has been restated to incorporate the working capital "float" provided to the NHS Business Services Authority in support of their role as single payment agent for all injury benefit payments. The float was omitted from the Department's 2010-11 Annual Report and Accounts in error.

iii) In order to better reflect the true commercial nature of the outsourced Supply Chain arrangement, the NHS Business Services Authority (NHS BSA) has revised its accounting treatment in this area, with prior period figures having been restated to reflect this change. Previously, the individual components of Supply Chain working capital, totalling £65.5 million, were reported separately in the Statement of Financial Position and its associated notes. This total, which reflects the amount which will be due to the NHS BSA at the end of the arrangement on 30 September 2016, is now shown as a Financial Asset in the Departmental Group account.

iv) £4 million of hosted cash used to make payments to pharmaceutical companies has been added to the Core Department Statement of Financial Position via a prior period adjustment. This cash is held and administered by the NHS Business Services Authority on behalf of the Department and was previously omitted from the Department's accounts in error.

v) The Department has applied the IAS 8 impracticability exemption to the elimination of restated prior period trading transactions and balances, with all prior period consolidated figures being unaudited as a result. Whilst the Department has made every reasonable effort to produce accurate, fully comparable prior period information, this may not be the case in respect of consolidated comparative income, expenditure, payable and receivable figures. Notwithstanding this residual level of imbalance, the closing balance of the 2010-11 primary statements, and therefore the opening balances for 2011-12 are not misstated, because, for example, a payables imbalance in one direction would be exactly off-set by a receivables imbalance in the opposite direction. The reasons for applying this exemption, along with the methodology used to produce the prior period comparatives, are disclosed in Note 1b below.

Una O'Brien

Permanent Secretary and Principal Accounting Officer

9 October 2012

The notes on pages 111-207 form part of these accounts.

Consolidated Statement of Cash Flows

for the year ended 31 March 2012

	Note	2011-12 £'000	Unaudited Restated 2010-11 £'000
Net cashflow from operating activities			
Net Operating Cost [1]	CSCNE	(105,500,956)	(104,207,175)
Adjustments for non-cash transactions	8b	9,221,700	8,532,240
(Increase)/decrease in trade and other receivables [1]	16	(90,312)	839,047
less movements in receivables relating to items not passing through the CSCNE	16	55,970	165,130
(Increase)/decrease in inventories	14	(26,124)	103,319
Increase/(decrease) in trade and other payables [1]	19	582,225	1,872,769
less movements in payables relating to items not passing through the CSCNE	19	(128,323)	(2,089,452)
Use of provisions	20	(1,833,785)	(1,425,786)
Consumption of stockpiled goods	11,14	39,483	7,744
Transfer of provisions to payables	20	(520,344)	(642,365)
Increase/(decrease) in pension deficit provision			
Other cash flow from operating activities			
Net cash outflow from operating activities		**(98,200,466)**	**(96,844,529)**
Cash flows from investing activities			
Purchase of property, plant and equipment	11,19	(3,370,232)	(4,127,390)
Purchase of intangible assets	12,19	(483,225)	(441,642)
Proceeds of disposal of property, plant and equipment		309,568	153,505
Proceeds of disposal of intangibles		2,779	10,086
Purchase of investments	13	(351,578)	(87,733)
Disposal of investments	13,16	8,204	(37,493)
Loans to other bodies			
Other investing cashflows			
Net cash outflow from investing activities		**(3,884,484)**	**(4,530,667)**
Cash flows from financing activities			
From the Consolidated Fund (Supply) - current year		85,885,270	84,400,000
Advances from the Contingencies Fund			
Repayments to the Contingencies Fund			
Capital element of payments in respect of finance leases and on-SOFP PFI contracts		(363,663)	(309,527)
Financing from the National Insurance Fund		16,863,807	17,907,815
Other capital receipts			
Other		364,476	309,863
Net financing		**102,749,890**	**102,308,151**
Net increase/(decrease) in cash and cash equivalents in the period before receipts and payments to the Consolidated Fund		**664,940**	**932,955**
Receipts due to the Consolidated Fund which are outside the scope of the Department's activities			
Cash transferred			
Payment of amounts due to the Consolidated Fund		(735,845)	(176)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipt and payment to the Consolidated Fund		**(70,905)**	**932,779**
Cash and cash equivalents at the beginning of the period		5,854,426	4,929,449
Adjustment for mergers		928	(7,802)
Restated cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**5,855,354**	**4,921,647**
Cash and cash equivalents at the end of the period	17	**5,784,449**	**5,854,426**

Footnote

1) The Department has applied the IAS 8 impracticability exemption to the elimination of restated prior period trading transactions and balances, with all prior period consolidated figures being unaudited as a result. Whilst the Department has made every reasonable effort to produce accurate, fully comparable prior period information, this may not be the case in respect of consolidated comparative income, expenditure, payable and receivable figures. As the 2011-12 Consolidated Statement of Cash Flows discloses movements between the opening and closing payables and receivables balances, any inaccuracies in those

opening balances will create similar inaccuracies in the reported in-year movements. As any inaccuracy in receivables will be offset by an equal and opposite inaccuracy in payables there is no impact on the bottom line of the 2011-12 Consolidated Statement of Cash Flows. The reasons for applying this exemption, along with an explanation of the methodology used to produce the prior period comparatives, are disclosed in Note 1b below.

2) The in-year movements reported in the restated 2010-11 Consolidated Statement of Cash Flows (for example the "(Increase)/decrease in trade and other receivables") may not correspond to the apparent movements in the Statement of Financial Position (SoFP). In cases of restatement, IAS 1 requires disclosure of a third SoFP. This third SoFP relates to the year starting 1 April 2010. The Consolidated Statement of Cash Flows compares balances at 31 March 2010 against balances reported at 31 March 2011. The 31 March 2010 balances differ from those at 1 April 2010 due to opening balance adjustments including transforming Community Services transfer adjustments.

3) The "Other" line within the "Cash flows from financing activities" section of the Consolidated Statement of Cash Flows includes cash flow items recorded by underlying NHS bodies not separately identified within the Resource Account format. This includes an immaterial adjustment to ensure the internal consistency of the Resource Account Consolidated Statement of Cash Flows.

The notes on pages 111-207 form part of these accounts.

Consolidated Statement of Changes in Taxpayer's Equity

Statement of Changes in Taxpayers' Equity
for the year end 31 March 2012

		Core Department			Departmental Group			
		General Fund	Revaluation Reserve	**Taxpayers' Equity**	General Fund	Revaluation Reserve	Other Reserves	**Taxpayers' Equity**
	Note	£'000	£'000	**£'000**	£'000	£'000	£'000	**£'000**
Balance at 31 March 2011								
Changes in accounting policy								
Restated balance at 1 April 2011		25,158,923	464,011	25,622,934	6,007,856	9,800,349	162,376	15,970,581
Opening balance adjustment		-	-	-	75,660	(3,693)	5,211	77,178
Adjustment for transfer of functions		-	-	-	(10,300)	(136)	517	(9,919)
Restated balance at 1 April 2011		25,158,923	464,011	25,622,934	6,073,216	9,796,520	168,104	16,037,840
Net parliamentary funding - drawn down		85,885,270		85,885,270	85,885,270		-	85,885,270
Net parliamentary funding - deemed		982,689		982,689	982,689		-	982,689
Consolidated fund standing services		-		-	-		-	-
Net finances from the contingencies fund		-		-	-		-	-
National Insurance contributions		16,863,807		16,863,807	16,863,807		-	16,863,807
Supply (payable)/receivable adjustment		(604,095)		(604,095)	(604,095)		-	(604,095)
CFERs and other amounts payable to the Consolidated Fund		(4,029)		(4,029)	(4,029)		-	(4,029)
PDC investment adjustment		-		-	-		-	-
Comprehensive Net Expenditure for the Year		(102,896,143)		(102,896,143)	(105,500,956)		-	(105,500,956)
Non-cash adjustments:								
Non cash charges - auditor's remuneration	8,9	848		848	933		-	933
Movements in Reserves								
Release of reserves to the CSCNE		-	-	-	-	(1,224)	-	(1,224)
Recognised in Statement of Comprehensive Expenditure								
Net gain/(loss) on revaluation of property, plant and equipment			6,615	6,615		851,133	-	851,133
Net gain/(loss) on revaluation of Assets held for Sale			-	-		1,698	-	1,698
Net gain/(loss) on revaluation of intangible assets			533,888	533,888		533,733	-	533,733
Net gain/(loss) on revaluation of investments			(15,901)	(15,901)		(15,539)	-	(15,539)
Net gain/(loss) on disposal of available for sale financial assets		-	-	-	(197)	(83)	-	(280)
Impairments and reversals			(42)	(42)		(607,115)	-	(607,115)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme		-		-	(61,151)		(5,583)	(66,734)
Other gains and losses		-		-	52,001	(50,519)	2,030	3,512
Reserves eliminated on dissolution					8,852	(8,395)	-	457
Transfer of impairments from revaluation reserve to general fund		-	-	-	-	-	-	-
Transfers between reserves		35,894	(35,894)	-	272,617	(276,210)	(105)	(3,698)
Other Transfers		(42,146)	-	(42,146)	(122,154)	(407)	(313)	(122,874)
Balance at 31 March 2012		**25,381,019**	**952,677**	**26,333,696**	**3,846,803**	**10,223,592**	**164,134**	**14,234,529**

Footnotes

1) The General Fund is used in public sector accounting to reflect the total assets less liabilities of an entity, which are not assigned to another special purpose fund.
2) The Revaluation Reserve is a capital reserve used when an asset has been revalued but for which no cash benefit is received. Revaluations are completed periodically to reflect the fair market value of an asset owned by an organisation.
3) Other Reserves are used in NHS bodies to account for a difference between the value of non-current assets taken over by them at establishment and the corresponding figure in the opening capital debt. This could arise where opening capital debt is set on estimated values, or where there has been an error. Additionally, they may arise to reflect pension assets/liabilities in respect of staff in non-NHS defined benefit pension schemes.

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

Unaudited Prior year: for the year end 31 March 2011

		Core Department			Departmental Group			
		General Fund	Revaluation Reserve	**Taxpayers' Equity**	General Fund	Revaluation Reserve	Other Reserves	**Taxpayers' Equity**
	Note	£'000	£'000	**£'000**	£'000	£'000	£'000	**£'000**
Balance at 31 March 2010		24,949,378	269,629	25,219,007	7,185,709	9,466,437	897,654	17,549,800
Opening balance adjustment		-	-	-	26,590	(32,976)	2,636	(3,750)
Adjustment for transfer of functions		-	-	-	610,427	115,518	(740,395)	(14,450)
Restated balance at 1 April 2010		24,949,378	269,629	25,219,007	7,822,726	9,548,979	159,895	17,531,600
Net parliamentary funding - drawn down		84,400,000		84,400,000	84,400,000		-	84,400,000
Net parliamentary funding - deemed		1,328,185		1,328,185	1,328,185		-	1,328,185
Consolidated fund standing services		-		-	-		-	-
Net finances from the contingencies fund		-		-	-		-	-
National Insurance contributions		17,907,815		17,907,815	17,907,815		-	17,907,815
Supply (payable)/receivable adjustment	21.1	(982,689)		(982,689)	(982,689)		-	(982,689)
CFERs and other amounts payable to the Consolidated Fund	21.1	(750,286)		(750,286)	(750,286)		-	(750,286)
PDC investment adjustment		-		-	-		-	-
Comprehensive Net Expenditure for the Year		(101,890,744)		(101,890,744)	(104,207,176)		-	(104,207,176)
Non-cash adjustments:								
Non cash charges - auditor's remuneration	7,8	665		665	750		-	750
Movements in Reserves								
Release of reserves to the CSCNE		-	-	-	19	(500)	(484)	(965)
Recognised in Statement of Comprehensive Expenditure								
Net gain/(loss) on revaluation of property, plant and equipment			73,858	73,858		858,886	1,224	860,110
Net gain/(loss) on revaluation of Assets held for Sale			-	-		-	-	-
Net gain/(loss) on revaluation of intangible assets			137,726	137,726		138,018	-	138,018
Net gain/(loss) on revaluation of investments			115,724	115,724		115,997	-	115,997
Net gain/(loss) on disposal of available for sale financial assets		-	-	-	158	(158)	-	-
Impairments and reversals			(28,634)	(28,634)		(491,861)	(1,516)	(493,377)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme		-		-	27,759		4,457	32,216
Other gains and losses		-		-	118,778	(115,186)	454	4,046
Reserves eliminated on dissolution					318	-	(326)	(8)
Transfer of impairments from revaluation reserve to general fund								
Transfers between reserves		104,292	(104,292)	-	256,948	(253,867)	(4,855)	(1,774)
Other Transfers		92,306	-	92,306	84,551	41	3,527	88,119
Balance at 31 March 2011		**25,158,922**	**464,011**	**25,622,933**	**6,007,856**	**9,800,349**	**162,376**	**15,970,581**

Footnotes

The Consolidated Statement of Changes in Taxpayer's Equity has been restated in respect of the following:

1) The expansion of the accounting boundary to include NHS Trusts, NHS Foundation Trusts and all Arms Length Bodies.
2) The change in accounting policy in respect of the donated asset reserve and government grant reserve.
3) The reclassification of National Insurance Contributions from income to funding, with such contributions now being credited to the general fund upon receipt.
4) The reclassification of £735,792,000 of 2010-11 excess appropriations-in-aid from "CFERs payable to the Consolidated Fund" to "Other amounts payable to the Consolidated Fund". Under the Clear Line of Sight (alignment) legislation, Estimate control totals are voted net of income and thus excess appropriations-in-aid can no longer exist. Following HM Treasury guidance, however, all prior period CFERs, including excess appropriations-in-aid, remain payable to the Consolidated Fund, and this requires the amount to be reclassified to "Other amounts payable to the Consolidated Fund".
5) The 2010-11 Core Department general fund balance has been increased by £2,201,062 to recognise a working capital float provided to the NHS Business Services Authority, but owned by the Department, which was excluded from the Department's 2010-11 Annual Report and Accounts in error. Further details of this prior period adjustment can be found in Note 1b *Restatement*.
6) In previous years, Core Department "Net Parliamentary Funding – Drawn Down" represented in-year cash drawn down from the Consolidated Fund less funding payments made to bodies within the Departmental Group. Following HM Treasury confirmation that, under alignment, Funding to Group Bodies and Grant in Aid should be treated consistently, the Core Department columns of this account have been restated to show Funding to Group bodies as an expenditure item, rather than a debit to "Net Parliamentary Funding – Drawn Down". The "Net Parliamentary Funding – Drawn Down" figures above therefore represent the in-year cash drawn down from the Consolidated Fund only, and, when added to deemed supply and National Insurance Contribution receipts, represent the total funding made available to the Department. The Departmental Group figures are unaffected by this restatement as Funding to Group Bodies is eliminated in full upon consolidation.

NOTES TO THE DEPARTMENT'S ANNUAL REPORT AND ACCOUNTS

1 Statement of accounting policies

HM Treasury have directed that the financial statements of the Department of Health shall meet the accounting requirements of the Government Financial Reporting Manual (FReM). Consequently, the financial statements within this Annual Report and Accounts have been prepared in accordance with the 2011-12 FReM issued by HM Treasury. The Department of Health's Annual Report and Accounts are prepared on a going concern basis and provide a true and fair view of the state of affairs of the Department at the end of the financial year, and of the results for the year. The functional and presentational currency is pounds sterling and figures are expressed in thousands of pounds unless expressly stated otherwise.

HM Treasury has required Government bodies to follow International Financial Reporting Standards (IFRS), in place of UK Generally Accepted Accounting Practice (UKGAAP), since 2009-10. The accounting policies contained in the FReM follow IFRS to the extent that they are meaningful and appropriate to Government bodies. Whether the standards are meaningful and appropriate is determined by HM Treasury acting on the advice of the Financial Reporting Advisory Board (FRAB). Where the FReM permits a choice of accounting policy, the policy that is judged to be most appropriate by the Department to its particular circumstances, especially for the purposes of giving a true and fair view, has been selected. The particular policies adopted by the Department are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

In recent years, new international accounting standards have been issued in the form of International Financial Reporting Standards (IFRS) whereas older standards, many of which remain in use, are described as International Accounting Standards (IAS). Other than when referring to a specific standard, the two terms are used interchangeably in these accounts.

The FReM requires the Department to prepare the following primary statement in addition to those required under IFRS:

- **The Statement of Parliamentary Supply**: This statement and its supporting notes show outturn against Estimate for the net resource requirement and net cash requirement.

A significant number of accounting policy changes have arisen in-year as a result of changes to FReM requirements that have been driven by HM Treasury's Clear Line of Sight (alignment) legislation [Constitutional Reform and Governance Act 2010]. The primary aim of this legislation has been to align budgets, Estimates and accounts in a way that enhances accountability to Parliament and the public, underpins the Government's fiscal framework and incentivises good value for money. The most profound impact of the legislation on the Department's 2011-12 accounts relates to the expansion of the Resource Accounting Boundary to include all Arms Length Bodies, NHS Foundation Trusts and NHS Trusts. This, along with all other in year accounting policy changes, is described within this note.

The 2011-12 Annual Report and Accounts includes five departures from the FReM which have been agreed with HM Treasury:

- Public Dividend Capital issued by the Department on the creation of new NHS Trusts, or written-off on the dissolution of NHS Trusts, is debited or credited, as appropriate, to the General Fund rather than to the Consolidated Statement of Comprehensive Net Expenditure.
- National Insurance Contributions are recognised on a cash basis.
- Some NHS organisations whose accounts are consolidated into the Department's Annual Report and Accounts receive donations that are held on trust. For 2010-11 and 2011-12, HM Treasury has agreed that NHS bodies should not consolidate the NHS charitable funds for which they are trustees. Consequently, any such charitable funds are not consolidated into the Annual Report and Accounts.
- The 2010 Spending Review Settlement Letter expanded the boundary of the Department's Administration Budget to include Arms Length Bodies, Strategic Health Authorities and the commissioning functions of Primary Care Trusts. Expenditure on the direct provision of healthcare by NHS provider organisations (including NHS Trusts and NHS Foundation Trusts) remains classified as programme. The 2010-11 comparators have not been restated to reflect the revised administration/programme split of income and expenditure (and will thus

reflect the administration/programme regime in place at the time), as HM Treasury and the FRAB have agreed that it is impracticable to restate in respect of this change. HM Treasury guidance in respect of the Department's own classification of income and expenditure as between administration and programme categories has also been amended. The revised guidance re-categorises a number of Core Department administration and programme expenditure types, with the movement being predominantly from programme to administration. The Department has applied this revised methodology from 1 April 2011, thus ensuring a consistent date of application for the revised Administration costs regime across the Departmental Group.

- Under the Transforming Community Services (TCS) initiative, services historically provided by Primary Care Trusts have transferred to other providers; notably NHS Trusts and NHS Foundation Trusts. The FReM requires that such transactions be accounted for by use of merger accounting. Merger accounting principles will be applied in full in 2011-12. However, for TCS transactions specifically, as was the case in 2010-11, HM Treasury and the FRAB have agreed that it is impracticable to adjust prior period comparators. Restatement is therefore effected by an adjustment to 1 April 2011 opening balances rather than by full restatement of 2010-11 comparators.

The in-year accounting policy changes detailed within this note have necessitated retrospective restatement of financial statement items. In line with IAS 1 requirements, three Consolidated Statements of Financial Position have been presented. As in 2010-11 the restated 1 April 2010 balances are presented at primary statement level detail only.

Whilst not a FReM departure, the Department has applied the impracticability exemption allowed under IAS 8 *Accounting policies, accounting estimates and errors* in respect of the requirement to produce full restated financial statements for 2010-11, and a 2009-10 Consolidated Statement of Financial Position which contain eliminations of inter-company trading transactions and balances that can be demonstrated as being materially accurate. All consolidated prior period figures are unaudited as a result. Due to the Alignment legislation, the accounting boundary of the Department has grown significantly from 169 entities in 2010-11 to 437 in 2011-12. In 2010-11, when completing the agreement of balances exercises, the majority of entities that are now included within the group did not take part. Therefore, in 2011-12, despite the Department having carried out three Agreement of Balances exercises to try to obtain the information required to restate its 2010-11 and 2009-10 financial statements, a material mismatch has remained. As the Department has made every reasonable effort to produce the data required for accurate elimination of intra-group transactions, balances and transfers, and a material mismatch still exists, it has chosen to apply the IAS 8 impracticability exemption for 2010-11 and 2009-10. HM Treasury and the National Audit Office (NAO) agree that the non-recurrent application of this exemption is appropriate, given the unique set of circumstances affecting the DH Group account in 2011-12 because of Alignment.

Under the IAS 8 exemption, the Department has adopted a "best endeavours" approach to restating its comparators, under which prior year figures have been restated to the greatest extent possible, whilst recognising that they cannot be restated to a fully comparable level due to the remaining material mismatch. As detailed in Note 1b below, all practicable restatements, including those relating to the expansion of the accounting boundary and the elimination of all non-trading inter-company transactions and balances, have been made, with the "best endeavours" approach being applied to the elimination of trading inter-company transactions and balances. Under this approach, the Department has replicated, as far as possible, the elimination techniques applied in the current accounting period, therefore producing prior period comparative figures that are as comparable, accurate and meaningful to the users of the accounts as possible.

The 2010-11 Annual Report and Accounts included the following two additional departures from the FReM which are no longer relevant:

- *Income from NHS bodies received by the Department or bodies within the accounting boundary is excluded and netted off the relevant expenditure.* This departure is not required in the 2011-12 Annual Report and Accounts as all NHS bodies now fall within the expanded Resource Accounting Boundary, with income and expenditure between all Group bodies being subject to elimination upon consolidation.
- *In the Analysis of net operating cost by spending body, formerly Note 13, the Department has grouped the spending bodies, rather than listing them individually.* This departure is not required in the 2011-12 Annual Report and Accounts as the FReM requirement to analyse net operating cost by spending body was withdrawn in 2011-12.

1.1 Operating segments

Income, expenditure, depreciation and other material items are analysed in the Statement of Operating Costs by Operating Segment (Note 6) across the headings of: DH Core, PCT, SHA, NHS Trusts, NHS Foundation Trusts, ALBs (Special Health Authorities) and ALBs (Executive Non Departmental Public Bodies), as reported to, and used by, the chief operating decision makers of the Department.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation to fair value of property, plant and equipment, intangible assets, certain financial assets and financial liabilities and current cost for inventories.

1.3 Basis of consolidation

The basis of consolidation in the Department's Annual Report and Accounts differs from that of a group consolidation in a private sector entity. HM Treasury requires that Government departments consolidate the accounts of those bodies that meet the appropriate requirements for consolidation under IFRS, provided that they are both inside the departmental accounting boundary, as defined in the Government Financial Reporting Manual, and are the subject of in-year budgetary and spending control by the parent department. Note 32 provides a list of the entities within the Department of Health's accounting boundary whose accounts are consolidated into these financial statements, and those which are not. Transactions between entities included in the Resource Accounting Boundary are eliminated on consolidation.

The Department's Resource Accounting Boundary, as defined in the FReM, has expanded significantly in 2011-12 as a result of the changes to FReM requirements which have been driven by HM Treasury's Clear Line of Sight (alignment) legislation. In contrast to prior years, the Department now also consolidates the individual accounts of all Arms Length Bodies, NHS Trusts and NHS Foundation Trusts (in addition to the accounts of Strategic Health Authorities, Primary Care Trusts and the Core Department itself). This accounting policy change has been applied retrospectively which means that all prior period results have been restated to reflect the enlarged Departmental Group. As mentioned above, the Department has applied the IAS 8 exemption to the restatement of prior period data where inter-company elimination of trading transactions and balances is required. Whilst the Department has restated its comparators to the greatest extent possible it is recognised that these figures cannot be restated to a fully comparable level.

More information on the individual entities within the Departmental family can be found in the annual reports and accounts of those organisations, and in the NHS Foundation Trusts Consolidated Accounts prepared by Monitor.

1.4 Going Concern

The Department of Health's Annual Report and Accounts are produced on a going concern basis. Under the Health and Social Care Act 2012 all Strategic Health Authorities and Primary Care Trusts (whose accounts we consolidated into these accounts) will be abolished by April 2013. However, the majority of functions of these bodies will be transferred to, or subsumed by, new or existing bodies within the Resource Accounting Boundary. The Department is supply financed and thus draws the majority of its funding from the Consolidated Fund. Parliament has demonstrated its commitment to fund the Department for the forseeable future via the latest Spending Review and it is therefore considered appropriate to adopt the going concern basis for the preparation of these accounts.

As detailed in Note 32, the General Social Care Council is not preparing its underlying statutory accounts on a going concern basis due to the provisions relating to its future, as set out in the Health and Social Care Act 2012. The going concern basis remains appropriate for the Department's Annual Report and Accounts, however, as the transactions and balances associated with the General Social Care Council are not significant in the context of the Departmental Group.

1.5 Staff costs

Short-term employee benefits

In relation to the Core Department, salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for non-consolidated performance pay, which is recognised when paid on the grounds of immateriality. Annual leave that has been earned but not taken at the year end is not accrued by the Core Department, as it is not material.

In relation to Strategic Health Authorities, Primary Care Trusts, NHS Trusts, NHS Foundation Trusts and Arms Length Bodies, salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Where material, annual leave that has been earned but not taken at the year end, and non-consolidated performance pay, are recognised in the financial statements of the underlying organisations.

Retirement benefit costs:

Principal Civil Service Pension Scheme

Past and present employees of the Department are covered by the provisions of the Principal Civil Service Pension Scheme (PCSPS) which is described at Note 7.3. 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 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 Department recognises the full cost of benefits paid under the Civil Service Compensation Scheme, including the early payment of pensions.

NHS Pension Scheme

Past and present employees of the NHS are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions

This scheme is an unfunded, defined benefit scheme which covers NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as being equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the organisation commits itself to the retirement, regardless of the method of payment.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. More details can be found in Note 7.3.

Local Government Superannuation Scheme

Some NHS and Arms Length Body employees are members of the Local Government Superannuation Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributed to these employees can be identified and are recognised in the organisation's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised

within expenditure. Actuarial gains and losses during the year are recognised in the General Fund and reported on the Statement of Changes in Taxpayers' Equity.

Other Pension Schemes

Some NHS Foundation Trusts, NHS Trusts, the Care Quality Commission and the General Social Care Council have employees who are members of defined benefit pension schemes other than the NHS Pension Scheme or the Local Government Superannuation Scheme. Where the NHS organisation is able to identify its share of the underlying scheme liabilities these are accounted for as a defined benefit pension scheme ('on Statement of Financial Position'). Otherwise, these are accounted for as defined contribution pension schemes ('off Statement of Financial Position').

For further details, including a list of all these defined benefit pension schemes, please refer to the 2011-12 NHS Foundation Trusts Consolidated Accounts or the underlying statutory accounts of the relevant NHS organisation.

1.6 Administration and programme costs

The Consolidated Statement of Comprehensive Net Expenditure (hereafter referred to as the CSCNE) is analysed between administration and programme costs, as defined by HM Treasury. Prior to 2011-12, administration costs reflected the costs of running the Core Department only. However the 2010 Spending Review Settlement Letter expanded the boundary of the Department's administration costs regime to include Arms Length Bodies, Strategic Health Authorities and the commissioning functions of Primary Care Trusts. Expenditure on the direct provision of healthcare or healthcare related services by NHS provider organisations (including NHS Trusts and NHS Foundation Trusts) remains classified as programme. From 2011-12, administration costs reflect the costs of running the Department and other non-provider NHS organisations, and do not directly relate to the provision of front-line services. 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, or support, front-line service delivery. Expenditure on the direct provision of healthcare by NHS provider organisations (including the running costs of those bodies) is also classified as programme.

The analysis of 2010-11 income and expenditure between administration and programme categories has not been restated to reflect the wider interpretation of administration costs adopted in 2011-12, rather it continues to reflect the administration costs regime in place at the time. As agreed with HM Treasury and the Financial Reporting Advisory Board (FRAB), the Department deems it to be impracticable, within the definition set out in IAS 8, for NHS bodies to restate prior period income and expenditure figures based on an administration costs regime that was not in place at the time.

In 2011-12, HM Treasury recategorised a number of administration and programme expenditure types in the core Department, with the movement predominantly being from programme to administration. Reclassified items include certain items of grant-in-aid expenditure and policy payments. The Department estimates the net impact of this recategorisation to be in the region of a £250 million increase in core Department administration costs with a corresponding decrease in programme costs. The analysis of 2010-11 Core Department expenditure continues to reflect the categorisation in place at the time, as the impact of the recategorisation is not material, and it ensures a consistent date of application for the revised administration costs regime across the Departmental Group.

The format of the expenditure notes (Notes 8 and 9) has been revised in 2011-12 to give more detail in respect of the types of expenditure incurred across the Departmental Group, and to ensure that all significant items are listed individually. Whilst there is no impact on the overall value of expenditure, the 2010-11 expenditure figures have been restated to ensure comparable categorisation.

1.7 Departmental Expenditure Limit (DEL) and Annually Managed Expenditure (AME)

The Statement of Parliamentary Supply is analysed between DEL and AME, as defined by HM Treasury. DELs are agreed with HM Treasury as part of four year spending plans set during Spending Reviews, with the associated income and expenditure deemed to be within the Department's direct control. All income and expenditure is classified as DEL unless the Chief Secretary to the Treasury has determined that the

programme to which it relates should be classified as AME. AME income and expenditure is generally demand-led or exceptionally volatile in a way that could not be controlled by the Department. Alternatively, a programme may be classified as AME if it is so large that the Department could not be expected to absorb the effects of any related volatilities within its DEL, or for other reasons the programmes are not suitable for inclusion in firm four year spending plans set during Spending Reviews.

1.8 Estimate structure

The format of the 2011-12 Statement of Parliamentary Supply, and its supporting note: Analysis of net resource outturn by section (Note 2), have changed significantly in comparison to prior years as a result of the Clear Line of Sight (alignment) legislation. Estimates are now prepared on a budgeting basis with a reconciliation provided between net resource outturn and net operating cost. Requests for Resources no longer exist, with net outturn against Estimate instead being analysed between Resource DEL, Capital DEL, Resource AME and Capital AME, as well as between Voted and Non-Voted net expenditure. The 2010-11 Statement of Parliamentary Supply and supporting note have been restated to reflect the new Estimate structure, and thereby ensure comparability with the current year.

As the Statement of Parliamentary Supply is now produced on a budgeting basis, the reconciliation between net resource outturn and net operating cost highlights items which are treated differently under accounting and budgeting guidelines. The main reconciling items in the Department's Annual Report and Accounts are:

- IFRIC12 adjustments: within the accounts, PFI/LIFT schemes follow IFRS accounting requirements, under which the majority of schemes are accounted for on the Statement of Financial Position. Budgets follow ESA95 (European System of National and Regional Accounts), a regime more closely aligned to accounting under UK GAAP, by which the majority of schemes are classified as off-Statement of Financial Position.
- Capital grants: these are included in the Consolidated Statement of Comprehensive Net Expenditure but for budgeting purposes are classified as capital DEL.
- Utilisation of provisions: under budgeting rules the creation of a provision scores to AME, but on utilisation, the amount used is reversed out of AME and reclassified to DEL. Although the utilisation of provisions has no impact on the Consolidated Statement of Comprehensive Net Expenditure, the movement between budget categories must nevertheless be recorded in the Statement of Parliamentary Supply.
- Consolidated Fund Extra Receipts: these are recorded as income in the Consolidated Statement of Comprehensive Net Expenditure but are excluded from the Statement of Parliamentary Supply as they fall outside the Ambit of the Vote and are thus excluded from the Estimate.

1.9 Grants payable

Grants made by the Department are recognised as expenditure in the period in which they are paid, as grant funding is not intended to be directly related to activity in a specific period.

1.10 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 cash charge is made for this service but a notional charge representing the cost of the audit is included in the accounts. This charge covers the audit costs in respect of the Department's Annual Report and Accounts. With the exception of NHS Foundation Trusts, other Group bodies are audited by the Comptroller and Auditor General or an Audit Commission appointed auditor and include expenditure in respect of audit fees in their individual accounts. The accounts of NHS Foundation Trusts are audited by auditors appointed by their board of governors and also include expenditure in respect of audit fees. (Note 9 to the accounts refers).

1.11 Value added tax

Most of the activities of the Department are outside the scope of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.12 Corporation tax

With the exception of some NHS Foundation Trusts, bodies within the Departmental Group are not liable to pay corporation tax.

The Finance Act 2004 amended s.519A Income and Corporation Taxes Act 1998 in order to give power to the Treasury to make certain non-core activities of NHS Foundation Trusts potentially subject to corporation tax. Subsequently, HM Revenue and Customs decided that Corporation tax would not be payable by NHS Foundation Trusts until the 2010-11 financial year.

The Corporation Tax expense recognised in these financial statements represents the sum of the tax currently payable and deferred tax. Current tax is the expected tax payable on the taxable surpluses generated during the year, using tax rates enacted or substantively enacted at the Statement of Financial Position (SoFP) date, and any adjustments to tax payable in respect of previous years.

Using the liability method, deferred tax is provided on all temporary differences at the SoFP date between the tax bases of assets and liabilities and their carrying amounts for financial reporting purposes. Deferred tax assets are recognised to the extent that it is probable that taxable profits will be available against which deductible temporary differences can be utilised. The carrying amount of deferred tax assets is reviewed at each SoFP date and reduced to the extent that it is no longer probable that sufficient taxable profits will be available to allow all or part of the asset to be recovered. Deferred tax assets and liabilities are not discounted.

1.13 Income

Income principally comprises fees and charges for services provided on a full cost basis, investment income and public repayment work. It includes income Voted during the Estimates process and Consolidated Fund Extra Receipts (CFERs) which fall outside the Ambit of the Vote and must therefore be returned to HM Treasury. Income in respect of services provided is recognised when the service is rendered and the stage of completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that economic benefit associated with the transaction will flow to the Department. Income is measured at fair value of the consideration receivable.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

In prior years, National Insurance Contributions were recognised as income within consolidated entries rather than within entries for the core Department. From 2011-12, as a consequence of the Clear Line of Sight (alignment) legislation, National Insurance Contributions are classified as funding rather than income, and are therefore credited to the general fund upon receipt. Comparator figures for 2010-11 have been restated as appropriate to reflect this change and to ensure comparability with the current year.

Another consequence of the Clear Line of Sight (alignment) legislation is that from 2011-12 Estimates are Voted by Parliament on a net basis. As a result, the concept of excess appropriations-in-aid (A-in-A) no longer exists, and the Department retains all income generated with the exception of that falling outside the Ambit of the Vote. In 2010-11 the Department classified £735,792,000 of income as excess A-in-A. In line with HM Treasury guidance the Statement of Parliamentary Supply and all supporting notes have been restated to reflect this change, with the effect that the value of the 2010-11 net cash requirement has been reduced by this £735,792,000.

The format of the income note (Note 10) has been revised in 2011-12 to give more detail about the types of income earned and to ensure that all significant items are listed individually. Whilst there is no impact on the overall value of income, the 2010-11 income figures have been restated to ensure comparable categorisation.

1.14 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Department;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where an asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Expenditure incurred on NHS Connecting for Health programmes has been split between capital and revenue using a financial model that analyses contractor costs over the life of the project.

Valuation of property, plant and equipment (excluding assets relating to NHS Connecting for Health programmes)

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost as a proxy for fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is only recognised as an impairment charged to the revaluation reserve when it does not result from a loss in the economic value or service potential to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported in the Statement of Changes in Taxpayers' Equity.

Valuation of property, plant and equipment assets relating to NHS Connecting for Health programmes

The plant and equipment relating to the NHS Connecting for Health programmes is held at depreciated replacement cost. The Department revalues these non-current assets at the end of each financial year, by indexing their original cost using the modified historic cost accounting (MHCA) approach. Given the very significant value of these assets, the Department applies as an uplift the difference between the Retail Price Index (RPI) operating in the month of purchase and the RPI as at 31 March. RPI is considered by the Department to be the most appropriate measure of indexation to use with this group of assets, as no other

indexation factor is available that (i) more accurately reflects the commercial environment in the computer services sector or (ii) would not be compromised by the very high value of this group of assets. This valuation method is reviewed each year by the Department to determine whether it remains the most appropriate index to use.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Specific NHS Accounting Treatment of Land, Buildings, Dwellings and Assets under Construction

Until 2009-10, the PCT, SHA and NHS Trust accounts followed a FReM departure which had been agreed with HM Treasury, whereby the accumulated depreciation at the end of the previous financial year was netted off against the cost of the asset brought forward at the beginning of the current financial year. This applied to the following classes of assets:

- Land
- Buildings
- Dwellings
- Assets under construction

From 2010-11 onwards, all consolidated bodies are required to show gross values in respect of these classes of assets, unless assets have been revalued in the year. This change ensures consistency of presentation across the Departmental Group. Where an asset has been revalued, the accumulated depreciation at the date of revaluation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount of the asset.

1.15 Intangible non current assets

Intangible non-current assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Department's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Department; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible non-recurrent assets acquired separately are initially recognised at fair value. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at replacement cost if the asset is not yet available for use or amortised replacement cost if it is, as a proxy for fair value.

Recognition and Valuation of intangible assets relating to NHS Connecting for Health programmes

The Department commissioned KPMG LLP to carry out a review of accounting principles in respect of NHS Connecting for Health programme transactions. A product of this review was the development in 2006 of financial models designed to apportion expenditure between revenue and capital for the Local Service Provider contracts pertaining to the South and London. The model is reviewed regularly, with the latest such review being carried out in March 2012. Applying the financial models, NHS Connecting for Health programme assets are capitalised by reference to the two contracts and not individual assets. In terms of valuing these Local Service Provider assets, the financial model output alone is used.

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

The intangible assets relating to NHS Connecting for Health programmes, are held at depreciated replacement cost which is calculated by indexing the historic cost of the assets by the movement in the Retail Price Index between the month of purchase and the Statement of Financial Position date. The modified historic cost accounting methodology is used to apply these indexation adjustments.

1.16 Research and development

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to reliably measure the expenditure attributable to the intangible asset during its development.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.17 Depreciation, amortisation and impairments

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

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight-line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which the Department expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each financial year-end, the Department determines whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is an indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year-end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with HM Treasury's budgeting guidance. DEL limits are set in each Spending Review, and Departments may not exceed the limits that they have been set. AME budgets are set by HM Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform HM Treasury if they expect AME spending to rise above the level forecast. Whilst HM Treasury accepts that in some areas of AME inherent volatility may mean

departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME still require HM Treasury approval.

1.18 Donated assets

Following the accounting policy change outlined in the 2011-12 FReM, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively with the result that the 2010-11 results have been restated.

1.19 Government grants

Following the accounting policy change outlined in the 2011-12 FReM, a government grant reserve is no longer maintained by Group bodies in receipt of government grants. Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.20 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is satisfied once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.:

  (i) management are committed to a plan to sell the asset

  (ii) an active programme has begun to find a buyer and complete the sale

  (iii) the asset is being actively marketed at a reasonable price

  (iv) the sale is expected to be completed within 12 months of the date of classification as “Held for Sale”; and

  (v) the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset in the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.21 Investment property

Investment properties are measured at fair value. Changes in fair value are recognised as revenue gains or losses.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not investment properties.

1.22 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the CSCNE.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.23 Private Finance Initiative (PFI) and NHS Local Improvement Finance Trust (LIFT) transactions

HM Treasury has determined that Government bodies shall account for infrastructure PFI and NHS LIFT schemes, where the Government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement, as service concession arrangements, following the principles set out in IFRIC 12. Consolidated bodies therefore recognise the PFI/LIFT asset as an item of property, plant and equipment together with a liability to pay for it, on their Statement of Financial Position.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

a) Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

b) PFI and LIFT assets, liabilities, and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. They are measured initially at fair value in accordance with the principles of IAS 17. Subsequent measurement is carried at fair value in accordance with IAS 16. A PFI/LIFT liability is recognised at the same time as the assets are recognised. It is measured initially at the same amount as the fair value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to the CSCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

c) Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the consolidated bodies' criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by consolidated bodies to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment.

Other assets contributed by consolidated bodies to the operator

Other assets contributed (e.g. cash payments, surplus property) by the consolidated bodies to the operator before the asset is brought into use, where these are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the consolidated body, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.24 Inventories

Inventories and stockpiled goods are held at fair value.

Inventories held by the Core Department are held at last price paid as a proxy for fair value. The Department undertakes an annual review of the difference between the last price paid for inventory and fair value. Where the difference is found to be material, the inventory is revalued to fair value. In 2011-12, the adult and childhood vaccines and emergency preparedness inventories were both revalued to fair value. Inventories held by NHS Trusts, NHS Foundation Trusts and Primary Care Trusts are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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

1.25 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and which are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Consolidated Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management.

Cash, bank and overdraft balances are recorded at current values. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, 'Interest receivable' and ' Interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.26 Provisions

Provisions are recognised when the Department has a present legal or constructive obligation as a result of a past event, it is probable that the Department will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% (2010-11: 2.9%) in real terms.

1.27 Clinical and non-clinical negligence costs

Clinical and non-clinical negligence costs are managed through schemes run by the NHS Litigation Authority (NHSLA). The Existing Liability and Ex-Regional Health Authority schemes are funded by the Department of Health, whilst the Clinical Negligence Scheme for Trusts, Liability to Third Parties and Property Expenses Schemes are funded from Trust contributions. The accounts for the schemes are prepared by the NHSLA in accordance with IAS 37. A provision for these schemes, disclosed in Note 20, is calculated in accordance with IAS 37 by discounting the gross value of all claims received.

Calculation of the provision for each scheme is made using:

- probability factors. The probability of a claim having to be settled is assessed between 10% and 94%. This probability is applied to the gross value to give the probable cost of each claim; and
- a discount factor calculated using HM Treasury's real discount rate of 2.2%, RPI of 3% and claims inflation (varying between schemes) of between 5% and 10%, 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 26.

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 those which were brought against the former Regional Health Authorities whose clinical negligence liabilities passed to the NHS Litigation Authority with effect from 1st April 1996.

The NHS (Residual Liabilities) Act 1996 requires the Secretary of State to exercise his/her 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 NHS Litigation Authority in respect of these schemes.

Clinical Negligence Scheme for Trusts (CNST)

A provision for this scheme is calculated in accordance with IAS 37 by discounting the gross value of all claims received relating to incidents that occurred on or before 31 March 2012 and after 1 April 1995.

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

- the probable cost and time to settlement in accordance with scheme guidelines;
- that they are qualifying incidents; and

- 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/her 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 NHSLA in respect of this scheme.

Property Expenses Scheme and Liability to Third Parties Scheme

These schemes are managed and funded via the same mechanisms as CNST except that specific excesses exist for some types of claims. The provisions for these schemes are calculated in accordance with IAS 37 but relate only to the organisation's proportion of each claim.

Incidents Incurred but not reported (IBNR)

IAS 37 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to the NHS Litigation Authority as at 31 March 2012 where the following can be reasonably forecast:

- that an adverse incident has occurred;
- that a transfer of economic benefit will occur; and
- 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 20 and 26 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.

1.28 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Department, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Department. A contingent asset is disclosed where an inflow of economic benefits is probable.

In addition to contingent liabilities disclosed in accordance with IAS 37, the Department discloses for Parliamentary reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to Parliament in accordance with the requirements of Managing Public Money. These comprise:

- items over £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 the Annual Report and Accounts) which are required by the Financial Reporting Manual to be noted in the Annual Report and Accounts.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to Parliament is separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to Parliament.

1.29 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. The Department holds investments in private limited companies and other items such as trade receivables and payables that arise from its operations and cash resources. It does not enter into speculative transactions such as interest rate swaps. The Department enters into forward contracts where a specific amount of foreign currency is required at a particular date in the future.

The Department's investment in NHS Trusts, NHS Foundation Trusts and the Medicines & Healthcare Products Regulatory Agency is represented by Public Dividend Capital (PDC) which, being issued under statutory authority, is not classed as being a financial instrument.

Foreign currency forward purchase contracts are measured at fair value with movements in fair value being charged or credited to the Statement of Comprehensive Net Expenditure. The fair value is measured as the difference between the currency's closing mid-market rate at the date of valuation (representing the spot rate) and the rate stipulated in the contract, multiplied by the number of contracted units of currency. The Department obtains the closing mid-market rate from the Bank of England. The forward contracts will only have a fair value up to their date of settlement. Once each contract has been settled, it is removed from the Department's Statement of Financial Position. Any forward contracts are purchased from the Bank of England. As at 31 March 2012 the Department had no foreign currency forward purchase contracts in place.

1.30 Financial assets

Financial assets are recognised on the Consolidated Statement of Financial Position when the Department becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

As available for sale financial assets, the Department's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the CSCNE on de-recognition.

Where the Department has a formal investment in another public sector entity that does not meet the criteria for consolidation (for example its investment in the Medicines and Healthcare products Regulatory Agency) the investment is measured at historic cost, less any impairment, as required by the FReM.

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

Derivatives are measured at fair value with changes in value recognised in the CSCNE.

At the Statement of Financial Position date, the Department assesses whether any financial assets are impaired. Financial assets are impaired, and impairment losses recognised, if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which have an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the

present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the CSCNE.

1.31 Financial liabilities

Financial liabilities are recognised in the Consolidated Statement of Financial Position when the Department becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Note that the Core Department sets the following de minimis threshold levels for the raising of manual accruals: £2,499 for accruals relating to administration budgets and £9,999 for accruals relating to central programme budgets. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Derivatives are measured at fair value with changes in value recognised in the CSCNE.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.32 Foreign exchange

The functional and presentational currencies of all consolidated bodies are pounds sterling.

The large majority of the Department's foreign currency transactions relate to European Economic Area (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 and the Department enters into forward contracts for the purchase of Euros for this purpose. Amounts in the Statement of Financial Position at year-end are converted at the exchange rate ruling at the Statement of Financial Position date. Exchange rate gains or losses are calculated in accordance with accepted accounting practice.

1.33 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. These amounts are disclosed in Note 30.

1.34 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Department or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled. Futher information can be found on the HM Treasury website: www.hm-treasury.gov.uk. Losses and special payments are disclosed in Note 27.

Losses and special payments are charged to the relevant functional headings, including losses which would have been made good through insurance cover had the Department not been bearing its own risks.

1.35 Transfer of Functions

In the course of 2011-12, certain functions were transferred to or from entities consolidated in this account, the counter parties being other public sector entities. The majority of the transactions were in connection with the "Transforming Community Services" (TCS) initiative, whereby elements of PCTs' provider functions transferred to NHS Trusts, NHS Foundation Trusts or Social Enterprises.

Such transactions are outside the scope of IFRS 3 Business Combinations. HM Treasury requires that merger accounting is to be applied when functions transfer between two public sector bodies.

Merger accounting involves the presentation of the current year's results as if the recipient of the functions had exercised those functions from the commencement of the year, whatever the actual date of the transfer. Similarly, the entity relinquishing the functions presents results that exclude any transactions relating to those functions for the full 12 month period. The Consolidated Statement of Comprehensive Net Expenditure follows this presentation and so excludes certain transactions carried out by PCTs, for example, where these are now accounted for as 2011-12 NHS Trust or Foundation Trust transactions.

For TCS transactions specifically, HM Treasury and the FRAB have agreed that it is impracticable for NHS bodies to re-state prior-period comparator figures in view of the degree of estimation and risk of mis-statement that would have attended re-statements of financial data by individual NHS bodies. Had such information been available, 2010-11 comparator figures in respect of, mainly, the provision of healthcare by PCTs would have been reduced. The corresponding adjustments would have been found in NHS Trusts' and Foundation Trusts' accounts which also consolidate into these accounts, meaning that the vast majority of TCS transfers have nil impact at the consolidated account level as they are internal transfers between two Group bodies. As it is impracticable for Group bodies to restate their prior periods, restatement is effected by an adjustment to 1 April 2011 opening balances rather than by full restatement of comparators.

1.36 Accounting for the costs of the Carbon Reduction Commitment Energy Efficiency Scheme

The Department participates in the Carbon Reduction Commitment Energy Efficiency Scheme, which is in its introductory phase until April 2014. The Department is required to purchase and surrender allowances, currently retrospectively, on the basis of emissions, i.e. for carbon dioxide produced as energy is used. A liability and an expense are recognised, measured at the best estimate of the allowances for the energy usage in 2011-12.

1.37 Accounting standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts in 2011-12, were they applied in that year:

- IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
- IAS 12 - Income Taxes (amendment) - subject to consultation
- IAS 19 Post-employment benefits (pensions) - subject to consultation
- IAS 27 Separate Financial Statements - subject to consultation
- IAS 28 Investments in Associates and Joint Ventures - subject to consultation
- IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13
- IFRS 9 Financial Instruments - subject to consultation
- IFRS 10 Consolidated Financial Statements - subject to consultation
- IFRS 11 Joint Arrangements - subject to consultation
- IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
- IFRS 13 Fair Value Measurement - subject to consultation
- IPSAS 32 - Service Concession Arrangement - subject to consultation

1.38 Significant Accounting Policies and material judgements

Estimates and the underlying assumptions are reviewed on a regular basis by management. Areas of significant judgement made by management are:-

IFRS 5 Assets Held For Sale - impose conditions to be met for assets to be classified as Non Current Assets Held for Sale. In meeting these conditions the Department has made a judgment that the asset sale will be highly probable and the assets carrying amount will be recovered through a sale of the asset.

IAS37 Provisions - judgement is made on the best estimate that can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

IAS38 Intangible Assets - Accounting note 12 shows the Department's consolidated position of Intangible Assets. Recognition and measurement of Intangible Assets is in line with IAS38. Management have made judgement to use the Retail Price Index as the most appropriate index for use in valuing the National Programme for IT. The RPI has been used as it is the Department's consideration that, given the size of the National Programme for IT, any IT specific index would be skewed by the programme itself.

IAS36 Impairments - Management make judgement on whether there are any indications of impairments to the carrying amounts of the Departments Assets. The Department recognised impairments in respect of the Emergency Preparedness Stockpile goods of £6 million in 2011-12, and in respect of the Pandemic Flu Countermeasures Stockpile goods of £21 million. Both Impairments resulted from the stockpiled goods reaching their shelf life. There was a marked reduction in UK demand for a number of stockpiled medicines and as a result, it was not possible to sell all the stocks back to the market. An impairment of Essential Medicines stockpile goods of £1 million has been recognised as a result. As a result of contract negotiations with CSC NHS Connecting for Health undertook a review of the assets held on the non-current asset register. As a result an impairment of £44 million has been recognised.

1b Restatement

A significant number of accounting policy changes have arisen in-year, primarily as a result of changes to FReM requirements driven by HM Treasury Clear Line of Sight (alignment) legislation. Except where explicitly agreed with the Financial Reporting Advisory Board and HM Treasury, in line with IAS 8 requirements, these accounting policy changes have been applied retrospectively and prior period comparators restated to ensure comparability. Additionally, three Core Department prior period errors have been amended via prior period adjustments, all of which affect the Consolidated Statement of Financial Position only. The overall impact of the restatement on the 2010-11 Consolidated Statement of Comprehensive Net Expenditure and Consolidated Statement of Financial Position as at 31 March 2011 is shown below. An explanation of the nature and value of the various items contributing to the restatement is also provided.

Restatement: Consolidated Statement of Comprehensive Net Expenditure
For the year ended 31 March 2011

	2010-11 restated account as reported in 2011-12 (A) For the year ended 31 March 2011		Per 2010-11 published account (B) For the year ended 31 March 2011		Variance (A-B)	
	Core Department £'000	Departmental Group £'000	Core Department £'000	Departmental Group £'000	Core Department £'000	Departmental Group £'000
Administration Costs:						
Staff costs	167,572	167,572	167,572	167,572	-	-
Other administration costs	76,490	76,490	76,490	76,490	-	-
Operating income	(4,405)	(4,406)	(4,405)	(4,405)	-	(1)
Grant in Aid to NDPBs	-	-	-	-	-	-
Funding to Group Bodies	-	-	-	-	-	-
Programme Costs:						
Staff Costs	182,108	46,699,102	182,108	7,983,207	-	38,715,895
Programme Costs	6,155,692	62,876,434	6,473,140	98,775,992	(317,448)	(35,899,558)
Income	(1,200,649)	(5,608,017)	(1,200,649)	(21,362,114)	-	15,754,097
Grant in Aid to NDPBs	313,447	-	-	-	313,447	-
Funding to Group Bodies	96,200,492	-	-	-	96,200,492	-
Net Operating Costs for the year ended 31 March 2011	101,890,747	104,207,175	5,694,256	85,636,742	96,196,491	18,570,433
Total expenditure	103,095,801	109,819,598	6,899,310	107,003,261	96,196,491	2,816,337
Total income	(1,205,054)	(5,612,423)	(1,205,054)	(21,366,519)	-	15,754,097
Net Operating Costs for the year ended 31 March 2011	101,890,747	104,207,175	5,694,256	85,636,742	96,196,491	18,570,433
Other Comprehensive Expenditure						
Net (gain)/loss on:						
revaluation of property, plant and equipment	(73,858)	(860,110)	(73,858)	(234,451)	-	(625,659)
revaluation of Assets held for Sale	-	-	-	-	-	-
revaluation of intangibles	(137,726)	(138,018)	(137,726)	(137,726)	-	(292)
revaluation of investments	(115,724)	(115,997)	(115,724)	(115,764)	-	(233)
Impairment and reversals	28,634	493,377	28,634	131,905	-	361,472
transferred to revaluation reserve						
- disposal of available for sale financial assets	-	-	-	-	-	-
- other reserves	-	(135)	-	-	-	(135)
- Actuarial gains/(losses) on defined benefit pension schemes	-	(32,216)	-	-	-	(32,216)
- other gains and (losses)	-	(4,046)	-			(4,046)
Release of reserves to the CSCNE	-	965	-	-	-	965
Total Comprehensive Expenditure for the year ended 31 March 2011	101,592,073	103,550,995	5,395,582	85,280,706	96,196,491	18,270,289

Restatement: Consolidated Statement of financial position

as at 31 March 2011

	2010-11 restated account as reported in 2011-12 (A) 2011 £'000		Per 2010-11 published account (B) 2011 £'000		Variance (A-B) £'000	
	Core Department	Departmental Group	Core Department	Departmental Group	Core Department	Departmental Group
Non-current assets						
Property plant and equipment	1,297,571	47,366,059	1,297,908	8,721,063	(337)	38,644,996
Investment property	338	64,807	-	-	338	64,807
Intangible assets	1,495,695	1,904,462	1,495,696	1,573,344	(1)	331,118
Financial assets	25,323,617	1,050,923	25,323,617	25,363,912	-	(24,312,989)
Other non-current assets	129,975	643,729	129,975	203,494	-	440,235
Total non-current assets	**28,247,196**	**51,029,980**	**28,247,196**	**35,861,813**	**-**	**15,168,167**
Current assets						
Assets classified as held for sale	6,084	215,662	6,084	77,235	-	138,427
Inventories	89,428	903,342	89,428	169,797	-	733,545
Trade and other receivables	100,689	1,007,057	94,825	896,434	5,864	110,623
Other current assets	184,458	1,233,176	184,458	549,020	-	684,156
Financial assets	189,138	47,561	189,138	195,765	-	(148,204)
Cash and cash equivalents	1,624,356	5,891,667	1,619,343	1,724,498	5,013	4,167,169
Total current assets	**2,194,153**	**9,298,465**	**2,183,276**	**3,612,749**	**10,877**	**5,685,716**
Total assets	**30,441,349**	**60,328,445**	**30,430,472**	**39,474,562**	**10,877**	**20,853,883**
Current liabilities						
Trade and other payables	(196,597)	(5,184,061)	(194,029)	(4,420,320)	(2,568)	(763,741)
Other liabilities	(2,709,129)	(8,143,934)	(2,904,033)	(4,709,523)	194,904	(3,434,411)
Provisions	(270,996)	(3,066,331)	(270,996)	(2,707,147)	-	(359,184)
Total current liabilities	**(3,176,722)**	**(16,394,326)**	**(3,369,058)**	**(11,836,990)**	**192,336**	**(4,557,336)**
Non-current assets plus/less net current assets/liabilities	**27,264,627**	**43,934,119**	**27,061,414**	**27,637,572**	**203,213**	**16,296,547**
Non-current liabilities						
Other payables	(352,719)	(677,335)	(157,439)	(211,701)	(195,280)	(465,634)
Provisions	(1,216,010)	(16,704,698)	(1,216,010)	(16,215,774)	-	(488,924)
Net pension asset/(liability)	-	(21,668)	-	-	-	(21,668)
Financial liabilities	(72,965)	(10,492,578)	(72,965)	(2,100,143)	-	(8,392,435)
Total non-current liabilities	**(1,641,694)**	**(27,896,279)**	**(1,446,414)**	**(18,527,618)**	**(195,280)**	**(9,368,661)**
Total Assets less liabilities	**25,622,933**	**16,037,840**	**25,615,000**	**9,109,954**	**7,933**	**6,927,886**
Taxpayers' equity						
General fund	25,158,922	6,073,216	25,150,989	7,043,047	7,933	(969,831)
Revaluation reserve	464,011	9,796,520	464,011	1,944,872	-	7,851,648
Donated asset reserve		-	-	122,035	-	(122,035)
Other reserves	-	168,104	-	-	-	168,104
Total Taxpayers' Equity	**25,622,933**	**16,037,840**	**25,615,000**	**9,109,954**	**7,933**	**6,927,886**

The Department's Annual Report and Accounts have been restated in respect of the following:

- Under HM Treasury's Clear Line of Sight (alignment) legislation the Departmental Group has expanded to include NHS Trusts, NHS Foundation Trusts and all Arms Length Bodies. The number of individual organisations' accounts consolidated into the Departmental Group account has therefore increased from 169 in 2010-11 to 437 in 2011-12.

- As mentioned in Note 1 *Statement of accounting policies* the Department has applied the impraticability exemption allowed under IAS 8 *Accounting policies, changes in estimates and errors*. By this: "*Applying a requirement is impracticable when the entity cannot apply it after making every reasonable effort to do so*." The element of restatement considered impracticable is the elimination of trading inter-company transactions and balances for the expanded DH Group. In 2010-11, when completing the Agreement of Balances exercises, the majority of entities that are now new to the group were not required to participate. Therefore, despite the Department having carried out three Agreement of Balances exercises in an attempt to obtain the information required to restate its 2010-11 financial statements and the 2009-10 Consolidated Statement of Financial Position, a material mismatch has remained. This mismatch creates uncertainty with regards to the accuracy of the elimination of inter-company transactions and balances upon consolidation, and, given that the Department has made every reasonable effort to recreate the data required for accurate elimination, and a material mismatch still exists, it has chosen to apply the IAS 8 impracticablity exemption for 2010-11 and 2009-10. HM Treasury and the NAO agree that the non-recurrent application of this

exemption is appropriate, given the unique set of circumstances affecting the Departmental Group account in 2011-12 because of Alignment.

- In applying the IAS 8 impracticability exemption, the Department recognises that its consolidated prior period income, expenditure, payable and receivable figures cannot be restated to a fully comparable level. Given these figures may not represent a true and fair view of the activities of the Departmental Group the consolidated prior period figures have not been audited, with each consolidated comparative column headed "unaudited" to highlight this. The Department has nevertheless adopted a "best endeavours" approach to producing prior period comparators for its 2011-12 accounts. Under this approach, whilst recognising and disclosing the limitations resulting from the residual Agreement of Balances mismatch, the Department has produced prior period figures that are as comparable, accurate and meaningful to the users of the accounts as possible, as required by IAS 1. The key features of the Department's approach to producing prior period comparatives are as follows:
    - The Department's Annual Report and Account continues to include prior period comparatives, including three consolidated Statements of Financial Position as required by IAS 1;
    - All practicable restatements, whether required as a result of Alignment or other accounting changes and as detailed in this restatement Note, have been made, including those relating to the expansion of the accounting boundary and the elimination of all non-trading inter-company transactions and balances (e.g. public dividend capital, funding transactions and loans);
    - A "best endeavours" approach has been used in relation to the elimination of trading inter-company transactions and balances in prior periods. As far as possible, the Department has replicated the elimination techniques appied in the current accounting period; and
    - The Department's Annual Report and Accounts contains narrative disclosures to explain the application of the IAS 8 impracticability exemption, and to highlight where figures cannot be restated to a fully comparable level. This includes a footnote to each primary statement affected by the exemption.
- The prior period agreement of balances discrepancies create uncertainty over the level of inter-company transactions and balances to eliminate. If, for example, too much income was eliminated (resulting in an understatement of consolidated income) too much expenditure would also be eliminated meaning there is a classification error in the prior period accounts but no bottom line impact on either net operating cost or net assets. The 2011-12 opening balances are similarly unaffected. The NAO have included an emphasis of matter report in their opinion, which cross refers to the Department's own disclosures on this matter and highlights the fact that they are not providing an audit opinion on the comparatives and explains why this was not possible.
- Following a change in the interpretation of IAS 20 for the public sector context, the 2011-12 FReM changes the accounting treatment in respect of government grants, donations and lottery grants. From 2011-12, Group bodies will no longer hold Government Grant or Donated Asset Reserves. The balances on such reserves have been transferred to the General Fund and Revaluation Reserve as appropriate. Where assets are funded by government grant or donation the financing element of the transaction is now recognised as income and taken through the CSCNE. The closure of these reserves means that there will no longer be any release from the reserves to current year income to, for example, offset depreciation and loss on disposal transactions. The restatement of prior period comparators, so as to present these figures as if the new accounting policy had always applied, relates solely to certain Departmental Group bodies as the Core Department does not hold donated or government granted assets. As reported in the published 2010-11 Department of Health Annual Report and Account, the 2010-11 NHS Trust Summarised Account, the 2010-11 Consolidated Foundation Trust Account and the published 2010-11 annual accounts of the Department of Health's Non Departmental Public Bodies, the collective balance on the donated asset and government grant reserves held by bodies within the Departmental Group was £1,540m at the 31 March 2011.
- In prior years, National Insurance Contributions were recognised as income in the Departmental Group Consolidation rather than within the Core Department. From 2011-12, as a consequence of the Clear Line of Sight (alignment) legislation, National Insurance Contributions are classified as funding rather than income, and are thus credited to the general fund upon receipt. 2010-11 income associated with the Departmental Group has been reduced by £17,172,023,000 to reflect this change and so ensure comparability with the current year.

- From 2011-12, as a consequence of HM Treasury's Clear Line of Sight (alignment) legislation, Estimates are Voted on a net basis. As a result, the concept of excess appropriations in aid (A-in-A) no longer exists, and the Department retains all income generated with the exception of that falling outside the Ambit of the Vote. In 2010-11 the Department classified £735,792,000 of income as excess A-in-A. In line with HM Treasury guidance, the Statement of Parliamentary Supply and all supporting notes have been restated to reflect this change. As the £735,792,000 remains payable to HM Treasury, it remains within the 2010-11 payables note (Note 19) but has been recategorised as an "Other amount payable to the Consolidated Fund" as it is no longer a Consolidated Fund Extra Receipt.
- The format of the 2011-12 Statement of Parliamentary Supply, and its supporting note: Analysis of net resource outturn by section (Note 2), have changed significantly in comparison to prior years as a result of the Clear Line of Sight (alignment) legislation. Estimates are now prepared on a budgeting basis with a reconciliation provided between net resource outturn and net operating cost. Requests for Resources no longer exist, with net outturn against Estimate instead being analysed between Resource DEL, Capital DEL, Resource AME and Capital AME as well as between Voted and Non-Voted net expenditure. The 2010-11 Statement of Parliamentary Supply and supporting note have been restated to reflect the new Estimate structure and so ensure comparability with the current year. This is a categorisation change only and does not result in a change to overall net resource outturn.
- In the course of 2011-12, certain functions were transferred to or from entities consolidated in this account, the counter parties being other public sector entities. The majority of the transactions were in connection with the "Transforming Community Services" (TCS) initiative, whereby elements of PCTs' provider functions transferred to NHS Trusts, NHS Foundation Trusts or Social Enterprises. Such transactions are outside the scope of IFRS 3 Business Combinations. HM Treasury requires that merger accounting is to be applied when functions transfer between two public sector bodies. Merger accounting involves the presentation of the current year's results as if the recipient of the functions had exercised those functions from the commencement of the year, whatever the actual date of the transfer. Similarly, the entity relinquishing the functions presents results that exclude any transactions relating to those functions for the full 12 month period. For TCS transactions specifically, HM Treasury and the FRAB have agreed that it is impracticable for NHS bodies to re-state prior-period comparator figures in view of the degree of estimation and risk of mis-statement that would have attended re-statements of financial data by individual NHS bodies. As it is impracticable for Group bodies to restate their prior periods, restatement is effected by an adjustment to 1 April 2011 opening balances rather than by full restatement of comparators.
- Investment property is defined as property (land, buildings or part of a building) held by the owner or by the lessee under a finance lease to earn rentals, or for capital appreciation, or both, rather than for a) use in the production or supply of goods or services or for administrative purposes; or b) sale in the ordinary course of business. In previous years investment property has not been separately disclosed due to the immaterial value of investment property held by bodies within the Departmental Group. Rather it was included within land and buildings in the Property Plant and Equipment note. The expansion of the accounting boundary to include NHS Foundation Trusts has significantly increased the value of investment property held by consolidated bodies and thus, per IAS 40 *Investment Property* requirements, investment property is now separately disclosed. Prior period Statement of Financial Position figures have been restated to ensure comparability, with £0.3m and £66.5m of investment property now separately disclosed in respect of the Core Department and Departmental Group respectively as at 31 March 2011.
- The analysis of Other administration costs (Note 8), Programme costs (Note 9) and Administration and programme income (Note 10) has been revisited in 2011-12 to ensure that all items of significance to the Departmental Group are individually listed. As a result, a number of income and expenditure categories are now separately disclosed which were previously incorporated within larger aggregate figures, or which were reported in more detail in the NHS Summarised Accounts. Whilst the 2010-11 figures have been restated to ensure comparability, this is a recategorisation change only, with nil impact on the overall income and expenditure totals.
- The CSCNE has been restated to separately disclose the £313 million of grant in aid provided to NDPBs in 2010-11. In previous years these amounts were included within other costs.
- The Core Department columns of the account have been restated to show Funding to Group Bodies as an expenditure item rather than a reserves movement. This follows Treasury confirmation that under Alignment Funding to Group Bodies and Grant in Aid to NDPBs should be treated consistently. The 2010-11 Core Department "Net Parliamentary Funding – Drawn down" figure, which previously showed in-year cash drawn down from the Consolidated Fund net of funding paid to Departmental Group bodies, has increased by £96,200,492k as a result, with Core Department expenditure having increased by the same

amount. The Departmental Group figures are unaffected by this restatement as Funding to Group Bodies is eliminated in full upon consolidation.

- The losses and special payments note (Note 27) has been restated to separately disclose losses and special payments incurred by the Core Department and the Departmental Group. The value of losses and special payments incurred is unaffected by this restatement.
- The Statement of Operating Costs by Operating Segment (Note 6) has been restated to ensure that the reported operating segments mirror the information reported to the Departmental Board (the Department's chief operating decision maker) as required by IFRS 8 *Operating Segments*. In 2010-11, the operating segments were NHS, DH Programme and DH Admin, whereas from 2011-12 onwards the operating costs are further broken down between DH Core, PCT, SHA, NHS Trusts, NHS Foundation Trusts, ALBs (Special Health Authorities) and ALBs (Executive Non-Departmental Public Bodies) as well as by administration and programme income. The significant items of income and expenditure that are separately disclosed by segment have also been restated to reflect the enhanced level of breakdown included within the income and expenditure notes. The note also provides additional breakdowns of NHS information that has historically been reported in the NHS Summarised Accounts.
- The Software Licences category of Intangible Non-Current Assets (Note 12) has been renamed "Software Licences and Internally Developed Software" so it is clear that both types of intangible asset are included within the category. This terminology change has nil impact on the current or prior year figures because internally developed software has always been incorporated within this category.
- The provisions for liabilities and charges note (Note 20) has been restated to separately disclose pension, restructuring and redundancy provisions. These provision types were previously included in the Other category but are now considered sufficiently significant to warrant separate disclosure given the expansion of the accounting boundary and the extent of restructuring arising from the Health and Social Care Act 2012.
- The NHS Business Services Authority acts as a payment agent for all injury benefit payments. The expenditure in respect of pre-1997 injury benefits, for which the Department is responsible, is included within the Department's accounts upon providing for such costs. The NHS Business Services Authority then invoice the Department for the in-year amount paid against the provision. The expenditure in respect of post-1997 injury benefits, for which NHS organisations (the employing authorities) are responsible, is included by means of provisions within the accounts of those employing authorities, with the NHS Business Services Authority again acting as a payment agent and recovering the amounts paid from each employing authority. The Department has provided a working capital "float" to allow the NHS Business Services Authority to undertake its role as a single payment agent for all injury benefit payments. This float provides the working capital required to fund the gap between cash payment of injury benefit claims and the subsequent recovery of funds from the Department, employing authorities or other organisations. The Department retains ownership of the working capital float. However, in previous years the working capital items constituting the float were excluded from the Department's accounts in error. Whilst this omission is not considered material by value in the context of the Department's accounts, the 2010-11 figures have nevertheless been restated to ensure the accuracy of the 2010-11 year-end cash balance which would otherwise adversely impact the in-year cash movement disclosed in the Department's Consolidated Statement of Cash Flows. Note that the 2009-10 Statement of Financial Position has not been adjusted to include the working capital float as insufficient data is held to make the adjustment. The impact of the 2010-11 restatement is to increase receivables by £5,864k, increase cash by £1,011k, increase payables by £4,674k and increase the closing general fund balance by £2,201k.
- £4 million of hosted cash used to make pharmaceutical payments has been added to the Core Department Statement of Financial Position via a prior period adjustment. This cash is held and administered by the NHS Business Services Authority on behalf of the Department and was previously omitted from the Department's accounts in error.
- In order to better reflect the true commercial substance of the outsourced Supply Chain arrangement, NHS Business Services Authority (NHS BSA) have revised their accounting treatment in this area, with prior period figures having been restated to reflect the revised accounting treatment. Previously, the individual components of Supply Chain working capital totalling £65.5 million were reported separately in the Statement of Financial Position and its associated notes. This total, which reflects the amount due to the NHS BSA at the end of the arrangement on 30 September 2016, is now shown as a Financial Asset.

- In 2010-11 the accruals associated with European Economic Area (EEA) medical costs were incorrectly categorised within the payables note. In particular, all long term accruals were incorrectly categorised as amounts falling due within 1 year and some accruals were incorrectly recorded as Other accruals rather than EEA Medical Costs Accruals. Whilst this classification error does not affect the bottom line and is not considered a fundamental error, the 2010-11 figures have nevertheless been restated to ensure comparability with the current year. The impact on the individual items in the 2010-11 payables note is as follows: EEA Medical Costs Accrual (amounts falling due after one year) increased by £195,280k, EEA Medical Costs Accrual (amounts falling due within one year) decreased by £82,558k and Other Accruals (amounts falling due within one year) decreased by £112,722k.

2 Net outturn

2.1 Analysis of net resource outturn by section

	Administration			Programme			Outturn Total	Estimate Net Total	2011-12 £'000 Net outturn compared to Estimate savings /(excess)	Unaudited Restated 2010-11 £'000 Outturn Total
	Gross	Income	Net	Gross	Income	Net				
Spending in Departmental Expenditure Limits (DEL)										
Voted:										
PCT & SHA expenditure	2,697,981	(145,112)	2,552,869	17,544,261	(1,726,325)	15,817,936	18,370,804	19,248,281	877,477	22,346,824
DH Programme expenditure (NHS)	11,581	-	11,580	1,833,710	(3,532)	1,830,178	1,841,758	1,885,722	43,964	2,192,842
Special Health Authorities expenditure	351,587	(21,478)	330,109	1,968,132	(28,078)	1,940,054	2,270,163	1,630,003	(640,160)	3,036,700
DH Programme and Administration expenditure	506,084	(21,953)	484,131	1,291,262	(5,947)	1,285,315	1,769,447	2,161,856	392,409	852,968
Social Care expenditure	-	-	-	1,325,914	-	1,325,914	1,325,914	1,326,000	86	1,312,951
NHS Trusts net expenditure	-	-	-	27,529,577	-	27,529,577	27,529,577	28,241,251	711,674	26,425,142
NHS Foundation Trusts net expenditure	-	-	-	31,332,318	-	31,332,318	31,332,318	30,814,792	(517,526)	25,952,879
Non Departmental Public Bodies net expenditure	162,037	-	162,037	123,366	-	123,366	285,403	280,942	(4,461)	257,387
Non-voted:										
PCT and SHA expenditure financed by NI Contributions	-	-	-	16,863,807	-	16,863,807	16,863,807	16,829,137	(34,670)	17,907,815
	3,729,270	**(188,544)**	**3,540,726**	**99,812,347**	**(1,763,882)**	**98,048,466**	**101,589,191**	**102,417,984**	**828,793**	**100,285,508**
Annually Managed Expenditure (AME)										
Voted:										
PCT & SHA expenditure	-	-	-	217,568	-	217,568	217,568	965,632	748,064	256,896
DH Programme expenditure (NHS)	-	-	-	45,118	-	45,118	45,118	500	(44,618)	114,345
Special Health Authorities expenditure	-	-	-	2,017,572	-	2,017,572	2,017,572	2,084,385	66,813	1,788,619
DH Programme and Administration expenditure	-	-	-	113,467	(23,198)	90,269	90,269	165,514	75,245	(9,744)
Social Care expenditure	-	-	-	-	-	-	-	-	-	1,103
NHS Trusts net expenditure	-	-	-	417,923	-	417,923	417,923	428,554	10,631	379,679
NHS Foundation Trusts net expenditure	-	-	-	399,321	-	399,321	399,321	301,732	(97,589)	639,043
Non Departmental Public Bodies net expenditure	-	-	-	5,330	-	5,330	5,330	(3,363)	(8,693)	36,742
	-	**-**	**-**	**3,216,299**	**(23,198)**	**3,193,101**	**3,193,101**	**3,942,954**	**749,853**	**3,206,683**
Total	**3,729,270**	**(188,544)**	**3,540,726**	**103,028,647**	**(1,787,080)**	**101,241,567**	**104,782,292**	**106,360,938**	**1,578,646**	**103,492,191**
Reconciliation to Statement of Comprehensive Net Expenditure										
Capital Grants	1,203	-	1,203	295,745	-	295,745	296,948	329,683	32,735	260,163
Income from Consolidated Fund Extra Receipts	-	-	-	-	(4,072)	(4,072)	(4,072)	-	4,072	(14,494)
Utilisation of provisions	(73,255)	-	(73,255)	73,255	-	73,255	-	-	-	-
IFRIC 12 adjustments	14,657	-	14,657	568,283	-	568,283	582,940	-	(582,940)	595,562
Prior period adjustments	-	-	-	-	-	-	-	-	-	-
Donated asset/government granted income	-	-	-	-	(157,151)	(157,151)	(157,151)	-	157,151	(126,246)
Expenditure presented on net basis[1]	87,950	(87,950)	-	4,097,963	(4,097,963)	-	-	-	-	-
Other adjustments								-	-	
Net operating cost	**3,759,825**	**(276,494)**	**3,483,331**	**108,063,893**	**(6,046,266)**	**102,017,626**	**105,500,957**	**106,690,621**	**1,189,664**	**104,207,176**

Footnote
1) Under Parliamentary reporting requirements, expenditure for NDPBs, NHS Trusts and Foundation Trusts is shown net of income. This differs from the treatment in the Consolidated Statement of Comprehensive Net Expenditure, where income and expenditure are reported separately on a gross basis.

2.2 Analysis of net capital outturn by section

This note compares outturn with the figures approved by Parliament.

	2011-12 £'000					Unaudited Restated 2010-11 £'000
	Outturn			Estimate		Outturn
	Gross	Income	Net Total	Net Total	Net total compared to Estimate savings /(excess)	Net Total
Spending in Departmental Expenditure Limits (DEL)						
Voted:						
PCT & SHA expenditure	543,974	(98,454)	445,520	444,000	(1,520)	511,210
DH Programme expenditure (NHS)	400,201	(42,311)	357,890	649,630	291,740	486,438
Special Health Authorities expenditure	325,822	(1,920)	323,902	30,378	(293,524)	20,681
DH Programme and Administration expenditure	57,451	-	57,451	76,808	19,357	16,039
Social Care expenditure	143,790	-	143,790	123,790	(20,000)	165,292
NHS Trusts net expenditure	1,044,998	-	1,044,998	1,347,417	302,419	1,206,837
NHS Foundation Trusts net expenditure	1,373,259	-	1,373,259	1,641,582	268,323	1,707,475
Non Departmental Public Bodies net expenditure	39,461	-	39,461	38,960	(501)	44,633
Non-voted:						
PCT and SHA expenditure financed by NI Contributions	-	-	-	-	-	-
	3,928,956	**(142,685)**	**3,786,270**	**4,352,565**	**566,295**	**4,158,605**
Annually Managed Expenditure (AME)						
Voted:						
PCT & SHA expenditure	-	-	-	-	-	-
DH Programme expenditure (NHS)	-	-	-	-	-	7,876
Special Health Authorities expenditure	-	-	-	-	-	-
DH Programme and Administration expenditure	-	-	-	-	-	-
NHS Trusts net expenditure	-	-	-	-	-	-
NHS Foundation Trusts net expenditure	-	-	-	-	-	-
Non Departmental Public Bodies net expenditure	-	-	-	-	-	-
	-	**-**	**-**	**-**	**-**	**7,876**
Total	**3,928,956**	**(142,685)**	**3,786,270**	**4,352,565**	**566,295**	**4,166,481**

Explanations of variances between Estimate and outturn are given in the Annual Report & Management Commentary.

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

3.1 Reconciliation of net resource outturn to net operating cost

			2011-12 £'000	Unaudited Restated 2010-11 £'000
		Note	Outturn	Outturn
Total resource outturn in Statement of Parliamentary Supply				
	Budget	2.1	104,782,249	103,492,191
	Non-Budget	2.1	-	-
			104,782,249	103,492,191
Add:	Capital Grants		296,948	260,163
	PFI/LIFT expenditure under IFRS		2,032,628	1,712,526
			2,329,576	1,972,689
Less:	Income payable to the Consolidated Fund	5.1	(4,029)	(14,494)
	Donated asset/government granted income		(157,151)	(126,246)
	PFI/LIFT expenditure under UK GAAP		(1,449,688)	(1,116,964)
	Prior period adjustments		-	-
			(1,610,868)	(1,257,704)
Net Operating Cost in Consolidated Statement of Comprehensive Net Expenditure			**105,500,956**	**104,207,176**

3.2 Outturn against final Administration Budget and Administration net operating cost

	2011-12 £'000	Unaudited Restated 2010-11 £'000
	Outturn	Outturn
Estimate - Administration limit	4,432,478	215,280
Outturn - Gross Administration Costs	3,817,220	244,061
Outturn - Gross income relating to administration costs	(276,495)	(4,354)
Outturn - Net administration costs	**3,540,725**	**239,707**
Reconciliation to operating costs:		
Add: Capital Grants	1,203	-
Add: PFI/LIFT expenditure under IFRS	34,264	-
Less: provisions utilised (transfer from Programme)	(73,255)	-
Less: PFI/LIFT expenditure under UK GAAP	(19,607)	-
Less: Income payable to the Consolidated Fund	-	(52)
Administration Net Operating Costs	**3,483,330**	**239,655**

4 Reconciliation of net cash requirement to increase/(decrease) in cash

	Note	2011-12 £'000	Unaudited Restated 2010-11 £'000
Net cash requirement		(86,263,864)	(84,745,496)
From the Consolidated Fund (Supply) - current year		85,885,270	84,400,000
Amounts due to the Consolidated Fund received in prior year and paid over		(735,845)	(176)
Amounts due to the Consolidated Fund received and not paid over		95	53
Other amount repayable to the Consolidated Fund		-	735,792
Movement in overdraft		415	(2,368)
Other		5,161	(98)
Increase/(decrease) in cash held by Department (excluding NHS Trusts, Foundation Trusts and NDPBs)		(1,108,768)	387,707
Add - Increase/(decrease) in cash held by all other consolidated bodies		1,022,299	522,624
Net increase/(decrease) in cash held by departmental group		(86,469)	910,331

5 Income payable to the Consolidated Fund

5.1 Analysis of income payable to the Consolidated Fund

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

	Outturn 2011-12 £'000		Unaudited Restated Outturn 2010-11 £'000	
	Income	*Receipts*	Income	*Receipts*
Operating income outside the ambit of the Estimate	4,029	*95*	14,494	*53*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total income payable to the Consolidated Fund	**4,029**	***95***	**14,494**	***53***

5.2 Consolidated Fund Income

There were no amounts collected by the Department in cases where it was acting as an agent of the Consolidated Fund.

6 Statement of Operating Costs by Operating Segment

The reportable segments disclosed within this note reflect the current structure of the Departmental Group as defined in legislation, with the activities of each reportable segment thus reflecting the statutory remit of those bodies. These operating segments are reported to the Department of Health Departmental Board (the DH Chief Operating Decision Maker) for financial management purposes. They cover the Core Department of Health (which includes Connecting for Health and Social Care Grants), the NHS (both SHAs and PCTs as commissioners and NHS Trusts and NHS Foundation Trusts as providers of healthcare), and all Arms Length Bodies (both Special Health Authorities and Executive non-Departmental Public Bodies). Where appropriate, total net expenditure has been categorised into either administration or programme types. Net expenditure by operating segment is regularly reported on this basis to the Departmental Board. The information provided to the Departmental Board is presented on a budgeting basis and therefore mirrors the Statement of Parliamentary Supply but can be reconciled to the Consolidated Statement of Comprehensive Net Expenditure as shown in the table below. Multiple transactions take place between reportable segments; primarily between commissioning and provider bodies within the NHS. All inter company transactions are eliminated upon consolidation as shown in the "Inter company Eliminations" column of the table below. The 2010-11 operating segments note has been restated to ensure that the reported operating segments mirror the information reported to the Chief Operating Decision Maker as required by IFRS8. Further information about this restatement is provided in Note 1b *Restatement*. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure. Further breakdowns of certain NHS information have also been provided within this note. Whilst this is not an IFRS 8 requirement this information was previously disclosed in the NHS (England) Summarised Accounts.

6.1 Departmental Group Summary

										2011-12
		DH Core £000	PCT £000	SHA £000	NHS Trusts £000	NHS Foundation Trusts £000	ALBs (SpHA) £000	ALBs (ENDPB) £000	Inter company Eliminations £000	Departmental Group £000
Administration gross expenditure		3,432,524	2,301,476	374,617	-	-	338,051	302,333	(2,989,176)	3,759,826
Administration income		(12,513)	(148,199)	(23,867)	-	-	(23,861)	(85,099)	17,045	(276,495)
Administration net expenditure		**3,420,011**	**2,153,277**	**350,750**	**-**	**-**	**314,190**	**217,234**	**(2,972,131)**	**3,483,331**
Programme gross expenditure		100,590,068	91,610,826	5,475,366	31,628,818	35,779,357	3,998,306	314,534	(161,333,384)	108,063,891
Programme income		(1,113,936)	(2,739,586)	(34,604)	(30,911,248)	(35,855,513)	(1,551,403)	(254,788)	66,414,812	(6,046,266)
Programme net expenditure		**99,476,132**	**88,871,240**	**5,440,762**	**717,570**	**(76,156)**	**2,446,903**	**59,746**	**(94,918,572)**	**102,017,625**
Total net expenditure (per CSCNE)		**102,896,143**	**91,024,517**	**5,791,512**	**717,570**	**(76,156)**	**2,761,093**	**276,980**	**(97,890,703)**	**105,500,956**
Budgeting adjustments per Note 3										
Capital Grants		237,484	59,464	-	-	-	-	-	-	296,948
Prior period adjustments		-	-	-	-	-	-	-	-	-
Other		14,585	67,479	-	349,015	(9,319)	-	-	-	421,760
Total adjustments		**252,069**	**126,943**	**-**	**349,015**	**(9,319)**	**-**	**-**	**-**	**718,708**
Budget outturn per note 2, of which:		**102,644,074**	**90,897,574**	**5,791,512**	**368,555**	**(66,837)**	**2,761,093**	**276,980**	**(97,890,703)**	**104,782,249**
	RDEL	102,508,687	90,684,336	5,787,181	(49,367)	(466,158)	743,521	271,650	(97,890,703)	101,589,148
	AME	135,386	213,237	4,331	417,923	399,321	2,017,572	5,330	-	3,193,101

		DH Core £000	PCT £000	SHA £000	NHS Trusts £000	NHS Foundation Trusts £000	ALBs (SpHA) £000	ALBs (ENDPB) £000	Inter company Eliminations £000	Unaudited Restated 2010-11 Departmental Group £000
Administration gross expenditure		244,062	-	-	-	-	-	-	-	244,061
Administration income		(4,406)	-	-	-	-	-	-	-	(4,406)
Administration net expenditure		**239,656**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**239,655**
Programme gross expenditure		102,851,738	93,040,493	5,867,682	29,792,096	31,100,289	3,700,967	554,300	(157,332,028)	109,575,537
Programme income		(1,200,650)	(3,192,052)	(67,936)	(29,462,879)	(30,704,617)	(1,493,921)	(300,637)	60,814,675	(5,608,017)
Programme net expenditure		**101,651,088**	**89,848,441**	**5,799,746**	**329,216**	**395,672**	**2,207,046**	**253,663**	**(96,517,353)**	**103,967,520**
Total net expenditure (per CSCNE)		**101,890,744**	**89,848,441**	**5,799,746**	**329,216**	**395,672**	**2,207,046**	**253,663**	**(96,517,353)**	**104,207,175**
Budgeting adjustments per Note 3										
Capital Grants		196,625	63,538	-	-	-	-	-	-	260,163
Prior period adjustments		-	-	-	-	-	-	-	-	-
Other		(10,227)	41,515	-	109,738	313,796	-	-	-	454,822
Total adjustments		**186,398**	**105,053**	**-**	**109,738**	**313,796**	**-**	**-**	**-**	**714,985**
Budget outturn per note 2, of which:		**101,704,346**	**89,743,388**	**5,799,746**	**219,478**	**81,876**	**2,207,046**	**253,663**	**(96,517,353)**	**103,492,190**
	RDEL	101,598,642	89,488,021	5,798,217	(160,201)	(557,167)	418,427	216,921	(96,517,353)	100,285,507
	AME	105,704	255,367	1,529	379,679	639,043	1,788,619	36,742	-	3,206,683

6.2 Departmental Group Detail – Expenditure

	DH Core £000	PCT £000	SHA £000	NHS Trusts £000	NHS Foundation Trusts £000	ALBs (SpHA) £000	ALBs (ENDPB) £000	Inter company Eliminations £000	2011-12 Departmental Group £000
Total net expenditure (per CSCNE)	**102,896,143**	**91,024,517**	**5,791,512**	**717,570**	**(76,156)**	**2,761,093**	**276,980**	**(97,890,703)**	**105,500,956**
Material Expenditure Items									
Staff costs	266,348	2,358,373	259,805	19,821,928	23,140,959	162,793	318,916	(39,293)	46,289,829
Purchase of Healthcare from Non-NHS bodies	-	8,457,864	-	222,749	-	-	-	(5,727)	8,674,886
Social Care from Independent Providers	-	190,565	-	-	-	-	-	-	190,565
Expenditure on Drugs Action Teams	-	420,793	-	-	-	-	-	(47,768)	373,025
Non-GMS Services from GPs	-	182,974	-	-	-	-	-	-	182,974
General Dental Services (GDS) and Personal Dental Services (PDS	-	2,857,627	-	-	-	-	-	(44,946)	2,812,681
Consultancy Services	18,199	109,750	23,525	144,738	176,292	2,317	5,967	(7,557)	473,231
Establishment	137,973	217,335	30,979	440,508	533,554	21,670	1,754	(63,839)	1,319,934
Transport	186	19,538	295	347,942	157,178	4,976	11,048	(12,295)	528,868
Premises	19,102	686,690	28,195	1,539,620	1,734,364	22,657	32,280	(493,979)	3,568,927
NHS CIO major contract costs	453,548	-	-	-	-	-	-	-	453,548
Clinical Negligence Costs	-	8,889	-	445,845	445,861	-	-	(862,930)	37,665
Education, Training & Conferences	2,459	145,802	-	175,373	109,083	652	31,855	(79,664)	385,560
MPET	-	-	4,686,277	-	-	-	-	(3,564,473)	1,121,804
Prescribing Costs	-	8,251,173	-	-	-	-	-	(7,704)	8,243,469
G/PMS	-	7,580,499	-	-	-	-	-	(110,194)	7,470,305
Pharmaceutical Services	-	2,139,334	-	-	-	-	-	-	2,139,334
General Ophthalmic Services	-	490,440	-	-	-	-	-	-	490,440
Supplies and Services - Clinical	-	256,188	-	1,741,231	2,788,262	29	-	(341,452)	4,444,258
Supplies and Services - General	-	99,305	-	677,648	653,231	16,856	81,309	(83,031)	1,445,318
Current Grants to Other Bodies	234,874	152,917	-	-	-	16,856	-	-	404,647
Current Grants to Local Authorities	1,346,195	-	-	-	-	-	-	-	1,346,195
Capital Grants	237,484	59,464	-	-	-	-	-	-	296,948
Impairment of Receivables	(1,208)	17,850	6	44,933	53,637	-	-	(986)	114,232
Inventories consumed	205,576	16,450	-	2,692,391	2,793,230	-	-	-	5,707,647
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	398,350	445,032	-	-	(843,382)	-
Rentals under operating leases	22,214	268,077	12,174	351,205	288,676	9,112	12,937	(133,807)	830,589
Interest charges	2,506	173,684	-	347,494	-	-	-	(27,199)	496,485
Research and Development Expenditure	914,658	17,586	-	81,930	86,562	1,764	-	(37,198)	1,065,302
Depreciation	106,005	335,841	1,613	943,846	977,531	5,994	25,908	-	2,396,738
Amortisation	557,908	8,511	110	32,450	42,038	17,218	13,508	-	671,743
Impairments and reversals	83,772	187,491	-	780,810	366,240	30,516	7,627	-	1,456,456
Provisions provided for in year	777,643	228,221	11,174	178,991	165,282	3,356,610	1,304	-	4,719,225
Grant in Aid	242,149	-	-	-	-	-	-	(242,149)	-
Funding to Group Bodies	97,648,553	-	-	-	-	-	-	(97,648,553)	-
Other	719,556	13,668	792,942	(101,155)	708,386	667,926	67,618	(1,464,605)	1,404,336
Non material expenditure items	26,892	57,959,403	2,888	319,991	113,959	(1,589)	4,836	(58,159,827)	266,553
Total Expenditure	**104,022,592**	**93,912,302**	**5,849,983**	**31,628,818**	**35,779,357**	**4,336,357**	**616,867**	**(164,322,559)**	**111,823,717**

	DH Core £000	PCT £000	SHA £000	NHS Trusts £000	NHS Foundation Trusts £000	ALBs (SpHA) £000	ALBs (ENDPB) £000	Inter company Eliminations £000	Unaudited Restated 2010-11 Departmental Group £000
Total net expenditure (per CSCNE)	**101,890,744**	**89,848,441**	**5,799,746**	**329,216**	**395,672**	**2,207,046**	**253,663**	**(96,517,353)**	**104,207,175**
Material Expenditure Items									
Staff costs	349,680	7,362,709	263,983	18,774,442	19,654,469	178,035	290,353	(6,997)	46,866,674
Purchase of Healthcare from Non-NHS bodies	-	8,346,855	-	215,625	-	-	-	-	8,562,480
Social Care from Independent Providers	-	385,424	-	-	-	-	-	-	385,424
Expenditure on Drugs Action Teams	-	392,019	-	-	-	-	-	(35,164)	356,855
Non-GMS Services from GPs	-	149,893	-	-	-	-	-	(316)	149,577
General Dental Services (GDS) and Personal Dental Services (PDS)	-	2,724,803	-	-	-	-	-	(31,824)	2,692,979
Consultancy Services	22,218	137,815	36,476	114,884	156,569	1,672	3,953	(7,157)	466,430
Establishment	142,928	452,095	40,291	374,957	424,035	29,135	1,628	(80,447)	1,384,622
Transport	466	47,005	566	350,125	121,292	3,460	10,527	(18,162)	515,279
Premises	18,007	793,410	32,425	1,250,568	1,413,419	22,870	32,573	(203,312)	3,359,960
NHS CIO major contract costs	423,680	-	-	-	-	-	-	-	423,680
Clinical Negligence Costs	-	18,619	-	410,294	375,947	-	-	(733,611)	71,249
Education, Training & Conferences	8,837	155,800	-	166,047	100,516	422	31,477	(71,224)	391,875
MPET	-	-	4,669,462	-	-	-	-	(3,512,782)	1,156,680
Prescribing Costs	-	8,280,308	-	-	-	-	-	-	8,280,308
G/PMS	-	7,441,646	-	-	-	-	-	(46,806)	7,394,840
Pharmaceutical Services	-	2,039,563	-	-	-	-	-	-	2,039,563
General Ophthalmic Services	-	478,676	-	-	-	-	-	-	478,676
Supplies and Services - Clinical	-	573,200	-	1,826,485	2,363,582	-	-	(1,275,358)	3,487,909
Supplies and Services - General	-	162,903	-	642,491	558,649	18,527	104,283	(179,537)	1,307,316
Current Grants to Other Bodies	321,879	41,168	-	-	-	9,178	-	-	372,225
Current Grants to Local Authorities	1,325,445	-	-	-	-	-	-	-	1,325,445
Capital Grants	196,625	63,538	-	-	-	-	-	-	260,163
Impairment of Receivables	89	21,655	(3)	20,127	61,064	-	-	-	102,932
Inventories consumed	169,530	49,942	-	2,331,781	2,509,026	-	2,163	-	5,062,442
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	428,026	437,153	-	-	(865,179)	-
Rentals under operating leases	23,526	288,590	12,525	217,739	191,861	9,812	6,716	(57,822)	692,946
Interest charges	4,051	158,072	-	295,208	315,234	-	-	(75,651)	696,915
Research and Development Expenditure	920,581	22,702	-	78,786	69,884	-	-	(28,158)	1,063,795
Depreciation	99,544	339,399	1,566	956,083	902,854	7,853	28,063	(1)	2,335,361
Amortisation	595,048	8,764	146	30,265	32,822	16,512	11,493	-	695,050
Impairments and reversals	105,503	187,680	558	462,473	789,969	3,072	1,848	-	1,551,103
Provisions provided for in year	968,807	186,663	12,321	87,948	149,040	2,724,437	5,524	-	4,134,740
Grant in Aid	313,447	-	-	-	-	-	-	(313,447)	-
Funding to Group Bodies	96,200,492	-	-	-	-	-	-	(96,200,492)	-
Other	845,741	67,655	793,982	430,095	371,750	696,528	18,088	(1,741,406)	1,482,433
Non material expenditure items	39,675	51,661,923	3,384	327,647	101,154	(20,546)	5,611	(51,847,176)	271,672
Total Expenditure	**103,095,800**	**93,040,493**	**5,867,682**	**29,792,096**	**31,100,289**	**3,700,967**	**554,300**	**(157,332,028)**	**109,819,598**

6.3 Departmental Group Detail – Income

	DH Core £000	PCT £000	SHA £000	NHS Trusts £000	NHS Foundation Trusts £000	ALBs (SpHA) £000	ALBs (ENDPB) £000	Inter company Eliminations £000	Departmental Group Group £000
2011-12									
Material Income Items									
Income from Local authorities	-	(354,230)	-	(211,077)	-	-	-	-	(565,307)
Income from Private patients	-	(1,571)	-	(177,312)	(275,179)	-	-	-	(454,062)
Interest revenue	(89,161)	(7,518)	-	(8,169)	(29,271)	-	(15)	59,208	(74,926)
Prescription Pricing Regulation Scheme	(65,316)	-	-	-	-	-	-	-	(65,316)
Prescription Fees and Charges	-	(426,095)	-	-	-	-	-	-	(426,095)
Dental Fees and Charges	-	(637,121)	-	-	-	-	-	-	(637,121)
Other Fees and Charges	-	(10,176)	(20,157)	(212,431)	-	(5,873)	(98,787)	81,317	(266,107)
PDC Dividend Received	(846,102)	-	-	-	-	-	-	846,102	-
Patient transport services	-	(159)	-	(3,370)	(22,955)	-	-	24,748	(1,736)
Education, training and research	-	(184,566)	-	(1,738,521)	(1,396,047)	(30)	-	3,152,633	(166,531)
Sale of Goods and Services	(42,462)	-	-	-	(31,568,389)	(945,600)	(156,668)	31,760,923	(952,196)
Income from Injury costs recovery	-	(1,255)	-	(110,894)	(109,570)	-	-	-	(221,719)
Charitable and other contributions to expenditure	-	(2,806)	-	(28,255)	(69,293)	-	-	-	(100,354)
Other income	(38,217)	(178,904)	(28,780)	(535,376)	(1,607,477)	(620,731)	(84,058)	1,707,023	(1,386,520)
Non-material income categories	(45,192)	(1,083,383)	(9,534)	(27,885,843)	(777,332)	(3,030)	(359)	28,799,903	(1,004,771)
Total Income	**(1,126,450)**	**(2,887,785)**	**(58,471)**	**(30,911,248)**	**(35,855,513)**	**(1,575,264)**	**(339,887)**	**66,431,857**	**(6,322,761)**
Total net expenditure (per CSCNE)	**102,896,143**	**91,024,517**	**5,791,512**	**717,571**	**(76,156)**	**2,761,093**	**276,980**	**(97,890,703)**	**105,500,956**

	DH Core £000	PCT £000	SHA £000	NHS Trusts £000	NHS Foundation Trusts £000	ALBs (SpHA) £000	ALBs (ENDPB) £000	Inter company Eliminations £000	Departmental Group £000
Unaudited Restated 2010-11									
Material Income Items									
Income from Local authorities	-	(781,070)	-	(187,294)	-	-	-	-	(968,364)
Income from Private patients	-	(2,085)	-	(175,399)	(253,076)	-	-	-	(430,560)
Interest revenue	(90,832)	(8,654)	-	(9,387)	(26,201)	-	(927)	49,547	(86,454)
Prescription Pricing Regulation Scheme	(70,456)	-	-	-	-	-	-	-	(70,456)
Prescription Fees and Charges	-	(455,956)	-	-	-	-	-	-	(455,956)
Dental Fees and Charges	-	(617,014)	-	-	-	-	-	-	(617,014)
Other Fees and Charges	-	(17,195)	(23,401)	(221,185)	-	(29,664)	(95,781)	98,372	(288,854)
PDC Dividend Received	(866,025)	-	-	-	-	-	-	866,025	-
Patient transport services	-	(1,973)	-	(6,739)	(1,192)	-	-	4,142	(5,762)
Education, training and research	-	(203,830)	-	(1,736,571)	(1,315,172)	-	-	3,021,074	(234,499)
Sale of Goods and Services	(80,830)	-	-	-	(26,737,156)	(839,576)	(146,298)	26,927,676	(876,184)
Income from Injury costs recovery	-	(5,193)	-	(109,875)	(95,381)	-	-	-	(210,449)
Charitable and other contributions to expenditure	-	(17,231)	-	(36,512)	(100,764)	-	-	-	(154,507)
Other income	(17,554)	(221,515)	(37,579)	(704,938)	(1,451,569)	(618,377)	(56,791)	2,857,260	(251,063)
Non-material income categories	(79,358)	(860,336)	(6,956)	(26,274,979)	(724,106)	(6,304)	(840)	26,990,579	(962,300)
Total Income	**(1,205,055)**	**(3,192,052)**	**(67,936)**	**(29,462,879)**	**(30,704,617)**	**(1,493,921)**	**(300,637)**	**60,814,675**	**(5,612,422)**
Total net expenditure (per CSCNE)	**101,890,744**	**89,848,441**	**5,799,746**	**329,216**	**395,672**	**2,207,046**	**253,663**	**(96,517,353)**	**104,207,175**

6.4 NHS Regional Analysis

NHS Trusts	North East SHA	North West SHA	Yorkshire & Humber SHA	East Midlands SHA	West Midlands SHA	East of England SHA	London SHA	South East Coast SHA	South Central SHA	South West SHA	Total operating segments	NHS Direct	Inter-Trust Consolidation Elimination	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Revenue	(61,433)	(3,271,129)	(2,555,211)	(3,331,717)	(4,156,025)	(2,361,427)	(8,377,458)	(2,625,187)	(2,189,829)	(2,177,483)	(31,106,899)	(143,802)	347,622	(30,903,079)
Interest revenue	(29)	(724)	(391)	(720)	(1,490)	(1,246)	(2,689)	(283)	(290)	(253)	(8,115)	(54)	-	(8,169)
Interest expenses	202	33,016	30,316	5,619	57,141	17,882	112,663	32,399	47,828	10,428	347,494	-	-	347,494
Depreciation and amortisation	4,277	91,028	81,204	95,842	118,883	64,342	274,678	81,828	77,516	81,816	971,414	4,882	-	976,296
Retained surplus/(deficit) for the year before impairments	**2,312**	**30,991**	**(6,085)**	**24,977**	**33,498**	**11,720**	**(71,791)**	**(2,799)**	**7,563**	**28,816**	**59,202**	**697**	**-**	**59,899**
Impairments and reversals charged to operating expenses	92	36,913	(23,506)	103,668	153,792	963	375,355	35,947	(9,714)	103,751	777,261	209	-	777,470
Retained surplus/(deficit) for the year	**2,220**	**(5,922)**	**17,421**	**(78,691)**	**(120,294)**	**10,757**	**(447,146)**	**(38,746)**	**17,277**	**(74,935)**	**(718,059)**	**488**	**-**	**(717,571)**
Additions to non current assets	4,205	117,708	86,445	146,627	382,780	85,706	1,103,810	250,228	58,748	93,118	2,329,375	2,917	-	2,332,292
Total assets	-	2,096,316	1,793,653	1,966,738	2,651,656	1,369,495	6,730,785	1,837,580	1,489,865	1,373,136	21,309,224	59,780	(92,207)	21,276,797
Total liabilities	-	(915,479)	(925,456)	(423,512)	(1,418,195)	(552,223)	(3,036,021)	(705,850)	(875,857)	(376,665)	(9,229,258)	(24,818)	92,207	(9,161,869)

NHS Trusts	North East SHA	North West SHA	Yorkshire & Humber SHA	East Midlands SHA	West Midlands SHA	East of England SHA	London SHA	South East Coast SHA	South Central SHA	South West SHA	Total operating segments	NHS Direct	Inter-Trust Consolidation Elimination	Unaudited Restated 2010-11 Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Revenue	(105,991)	(2,999,360)	(2,300,191)	(2,775,850)	(3,505,164)	(2,398,919)	(8,164,252)	(2,688,550)	(2,224,695)	(2,171,811)	(29,334,783)	(149,607)	30,897	(29,453,493)
Interest revenue	(20)	(522)	(1,021)	(789)	(1,088)	(1,178)	(3,835)	(290)	(363)	(231)	(9,337)	(50)	-	(9,387)
Interest expenses	449	27,424	22,125	6,135	51,901	14,424	96,649	22,017	48,748	11,203	301,075	-	(5,867)	295,208
Depreciation and amortisation	7,060	94,541	82,633	93,760	111,838	66,642	272,390	80,054	89,034	84,091	982,043	4,305	-	986,348
Retained surplus/(deficit) for the year before impairments	**3,120**	**18,902**	**10,532**	**563**	**27,449**	**21,837**	**(1,109)**	**11,639**	**5,050**	**32,542**	**130,525**	**2,733**	**-**	**133,259**
Impairments and reversals charged to operating expenses	1,768	49,741	69,781	54,796	105,706	52,971	81,204	41,624	(12,226)	17,108	462,473	-	-	462,473
Retained surplus/(deficit) for the year	**1,352**	**(30,839)**	**(59,249)**	**(54,233)**	**(78,257)**	**(31,134)**	**(82,313)**	**(29,985)**	**17,276**	**15,434**	**(331,948)**	**2,733**	**-**	**(329,215)**
Additions to non current assets	8,612	170,917	368,858	134,171	277,059	265,571	553,367	239,306	64,929	115,941	2,198,731	22,835	-	2,221,566
Total assets	55,216	1,986,825	1,723,258	1,941,110	2,467,167	1,375,346	6,762,316	1,661,745	1,838,796	1,425,380	21,237,159	59,621	(62,789)	21,233,991
Total liabilities	(14,448)	(843,460)	(902,715)	(360,285)	(1,077,422)	(528,594)	(2,410,926)	(548,335)	(958,381)	(343,829)	(7,988,395)	(25,147)	62,789	(7,950,753)

PCTs	North East SHA	North West SHA	Yorkshire & Humber SHA	East Midlands SHA	West Midlands SHA	East of England SHA	London SHA	South East Coast SHA	South Central SHA	South West SHA	Inter-PCT Consolidation Elimination	Pharmaceutical Services	2011-12 Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
Net operating costs	**5,063,510**	**13,283,929**	**9,526,831**	**7,486,305**	**9,618,178**	**9,194,587**	**15,029,614**	**7,246,143**	**5,893,426**	**8,681,993**	**-**	**-**	**91,024,516**
Revenue resource limit RRL	5,068,650	13,335,905	9,597,169	7,531,122	9,672,156	9,207,966	15,216,326	7,269,989	5,910,769	8,741,010	-	-	91,551,062
Under/(over) spend against RRL	**5,140**	**51,976**	**70,338**	**44,817**	**53,978**	**13,379**	**186,712**	**23,846**	**17,343**	**59,017**	-	-	**526,546**
Depreciation and amortisation	14,637	44,290	29,032	28,412	33,712	26,558	76,516	23,783	31,126	36,286	-	-	344,352
Impairments and reversals	11,828	21,831	22,779	9,134	9,358	7,258	33,522	13,000	22,252	36,193	-	-	187,155
Interest expense	7,188	36,168	18,352	20,975	15,531	14,319	32,997	5,554	11,609	10,994	-	-	173,687
Interest revenue	(146)	(1,466)	(656)	(1,307)	(572)	(163)	(2,499)	(90)	(357)	(262)	-	-	(7,518)
Additions to non current assets	24,652	103,959	73,534	52,348	111,288	81,949	62,582	55,747	48,488	97,165	-	-	711,712
Total assets	404,672	1,168,929	662,644	778,007	915,459	802,533	1,918,394	674,724	834,032	945,395	(267,613)	-	8,837,176
Total liabilities	406,800	1,378,636	871,308	790,201	1,013,552	820,426	1,715,532	605,938	567,433	750,047	(267,613)	-	8,652,259

PCTs	North East SHA	North West SHA	Yorkshire & Humber SHA	East Midlands SHA	West Midlands SHA	East of England SHA	London SHA	South East Coast SHA	South Central SHA	South West SHA	Inter-PCT Consolidation Elimination	Pharmaceutical Services	Unaudited Restated 2010-11 Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
Net operating costs	**4,996,752**	**13,146,200**	**9,328,619**	**7,325,750**	**9,512,943**	**9,079,038**	**14,883,108**	**7,179,550**	**5,868,900**	**8,529,689**	**-**	**(2,108)**	**89,848,441**
Revenue resource limit RRL	5,004,303	13,188,230	9,396,781	7,392,659	9,563,301	9,100,431	15,016,414	7,198,589	5,879,759	8,595,116	-	(2,108)	90,333,475
Depreciation and amortisation	18,094	44,420	29,810	28,391	34,812	27,408	75,337	21,890	31,987	36,014	-	-	348,163
Impairments and reversals	3,567	20,570	6,509	18,386	35,005	4,063	36,269	7,839	36,565	18,907	-	-	187,680
Interest expense	6,876	33,574	15,920	18,789	13,021	11,819	30,176	5,747	11,801	10,509	-	-	158,232
Interest revenue	(146)	(1,274)	(622)	(1,302)	(1,643)	(225)	(2,428)	(117)	(340)	(557)	-	-	(8,654)
Additions to non current assets	67,943	122,129	82,389	61,131	64,183	47,395	92,859	42,625	59,576	103,439	-	-	743,669
Total assets	431,025	1,107,647	672,140	741,429	829,386	767,929	1,971,182	663,139	849,121	921,575	(316,713)	-	8,637,860
Total liabilities	423,008	1,337,790	828,512	775,220	936,682	757,323	1,689,630	613,365	554,710	693,478	(316,713)	-	8,293,005

Primary Care Trusts have a statutory duty to contain revenue expenditure within approved revenue resource limits. As such, performance against this duty for 2010-11 has not been restated.

SHAs	North East SHA	North West SHA	Yorkshire & Humber SHA	East Midlands SHA	West Midlands SHA	East of England SHA	London SHA	South East Coast SHA	South Central SHA	South West SHA	Inter-SHA Consolidation Elimination	2011-12 Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net operating costs	**287,496**	**717,646**	**565,770**	**394,408**	**526,404**	**564,425**	**1,724,383**	**288,382**	**331,807**	**390,791**	**-**	**5,791,512**
Revenue resource limit RRL	346,815	932,770	683,947	439,556	563,938	659,254	1,980,055	350,472	386,592	508,623	-	6,852,022
Under/(over) spend against RRL	**59,319**	**215,124**	**118,177**	**45,148**	**37,534**	**94,829**	**255,672**	**62,090**	**54,785**	**117,832**	-	**1,060,510**
Depreciation and amortisation	4	-	380	113	-	311	532	293	65	25	-	1,723
Impairments and reversals	-	-	-	-	-	-	-	-	-	-	-	-
Interest expense	-	-	-	-	-	-	-	-	-	-	-	-
Interest revenue	-	-	-	-	-	-	-	-	-	-	-	-
Additions to non current assets	-	-	51	-	-	200	400	-	9	-	-	660
Total assets	2,424	3,338	3,980	2,663	2,258	6,997	12,469	14,453	3,410	2,499	(2,404)	52,087
Total liabilities	6,084	16,600	26,661	18,694	18,718	24,347	64,322	7,222	8,966	3,899	(2,404)	193,109

SHAs	North East SHA	North West SHA	Yorkshire & Humber SHA	East Midlands SHA	West Midlands SHA	East of England SHA	London SHA	South East Coast SHA	South Central SHA	South West SHA	Inter-SHA Consolidation Elimination	Unaudited Restated 2010-11 Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net operating costs	**286,354**	**697,882**	**567,023**	**413,539**	**526,220**	**601,567**	**1,682,779**	**288,619**	**331,353**	**404,410**	**-**	**5,799,746**
Revenue resource limit RRL	351,108	873,300	688,075	436,444	549,424	685,527	1,939,966	334,387	386,141	455,464	-	6,699,836
Under/(over) spend against RRL	**64,754**	**175,418**	**121,052**	**22,905**	**23,204**	**83,960**	**257,187**	**45,768**	**54,788**	**51,054**	-	**900,090**
Depreciation and amortisation	15	-	179	195	-	304	577	332	71	39	-	1,712
Impairments and reversals	-	-	-	-	-	259	-	299	-	-	-	558
Interest expense	-	-	-	-	-	-	-	-	-	-	-	-
Interest revenue	-	-	-	-	-	-	-	-	-	-	-	-
Additions to non current assets	-	-	50	-	-	437	174	-	67	-	-	728
Total assets	2,282	1,977	4,982	4,458	3,352	5,873	29,254	14,443	2,489	3,718	(744)	72,084
Total liabilities	6,506	10,655	26,535	15,696	16,173	46,509	52,523	11,153	14,560	4,727	(744)	204,293

Strategic Health Authorities have a statutory duty to contain revenue expenditure within approved revenue resource limits. As such, performance against this duty for 2010-11 has not been restated.

7 Staff numbers and related costs

7.1 Staff costs comprise:

	2011-12 £'000					Unaudited Restated 2010-11 £'000
	Total	Permanently employed staff	Others	Ministers	Special Advisors	Total
Salaries and Wages	38,836,158	35,852,112	2,983,663	227	156	39,498,490
Social Security costs	2,890,775	2,859,718	31,013	24	20	2,816,404
NHS Pension	4,103,697	4,093,035	10,662	-	-	4,148,447
Other pension costs	90,996	81,094	9,859	1	42	25,230
Termination benefits	467,384	459,661	7,694	-	29	480,212
Sub-total	**46,389,010**	**43,345,620**	**3,042,891**	**252**	**247**	**46,968,783**
Less recoveries in respect of Outward Secondments	(5,269)	(5,269)	-	-	-	(6,824)
Total Net Costs	**46,383,741**	**43,340,351**	**3,042,891**	**252**	**247**	**46,961,959**
Of which Core Department Revenue Expenditure is	266,347	139,854	125,994	252	247	349,680
Of which Core Department Capital Expenditure is	15,641	37	15,604	-	-	27,804
Of which other Departmental Group bodies Revenue Expenditure is	46,023,482	43,137,376	2,886,106	-	-	46,516,994
Of which other Departmental Group bodies Capital Expenditure is	78,271	63,084	15,187	-	-	67,481

Footnote

1) NHS Connecting for Heath (responsible for implementing major IT programmes in the NHS) is a major component of the Department's Informatics Directorate. The employment contracts or secondment agreements of almost all of its staff are held for the Department on a "hosted" basis by the NHS Business Services Authority. The staff costs associated with these employees are reported in the "Others" column as they do not have a permanent employment contract with the Department.

7.2 Average number of persons employed

The average number of whole-time equivalent persons employed during the year is shown in the table below. These figures include those individuals working in the Department as well as in other bodies included within the consolidated Departmental Annual Report and Accounts.

Average number of whole-time equivalent employees

	2011-12 Number					Unaudited Restated 2010-11 Number
	Total	Permanent staff	Others	Ministers	Special Advisors	Total
Core Department (excluding NHS Connecting for Health)	2,753	2,350	396	5	2	3,358
NHS Connecting for Health	1,311	25	1,286	-	-	1,433
Primary Care Trusts	51,528	47,610	3,919	-	-	185,652
Strategic Health Authorities	3,890	2,977	913	-	-	4,256
NHS Trusts	475,060	442,608	32,451	-	-	449,853
NHS Foundation Trusts	566,702	527,665	39,037	-	-	486,116
Special Health Authorities	4,246	3,829	417	-	-	4,456
Non Departmental Public Bodies	6,080	5,693	387	-	-	6,467
Others	-	-	-	-	-	-
Total	**1,111,570**	**1,032,757**	**78,806**	**5**	**2**	**1,141,591**

Of the above, the following staff were engaged on capital projects:

Core Department (including NHS Connecting for Health)	137	1	136	-	-	214
Other Departmental Group bodies	666	577	89	-	-	289

The average number of whole time equivalent persons employed during the year by NHS Foundation Trusts, NHS Trusts and Primary Care Trusts (as set out in the table above) is analysed by employee type below.

	2011-12 Number			Unaudited Restated 2010-11 Number		
	NHS Foundation Trusts	NHS Trusts	Primary Care Trusts	NHS Foundation Trusts	NHS Trusts	Primary Care Trusts
Medical and dental	55,916	49,577	1,299	50,770	49,799	4,688
Ambulance staff	6,862	22,802	75	3,501	26,513	116
Administration and estates	119,718	100,030	31,977	104,122	97,729	66,725
Healthcare assistants and other support staff	76,777	76,554	4,558	65,321	67,354	25,854
Nursing, midwifery and health visiting staff	197,153	154,491	8,119	166,973	143,967	57,371
Nursing, midwifery and health visiting learners	2,569	1,618	30	1,895	1,561	619
Scientific, therapeutic and technical staff	80,467	66,181	4,058	66,614	59,332	26,401
Social Care staff	2,554	307	231	2,429	238	1,352
Other	24,686	3,500	1,181	24,491	3,358	2,525
Total	566,702	475,060	51,528	486,116	449,852	185,652

Staff numbers in the accounts are calculated using a financial year average.

Core Department

The £83.33 million decrease in staff costs attributable to Core Department Revenue Expenditure (£266.35 million compared to £349.68 million in 2010-11) results from the interaction of two main elements: (i) the costs of the recent voluntary exit scheme were predominantly reported in the prior year (with a value of £20.73 million). The costs of exit in 2011-12 reduced to £2.26 million (a £18.47 million decrease); (ii) a departmental objective to reduce the number of non-permanent workers predominantly accounts for a £52.84 million reduction in “Other” staff costs (£125.99 million compared to £178.83 million in 2010-11).

NHS Workforce

On the basis of financial year average whole time equivalent numbers as reported in the accounts of NHS organisations, the total number of staff employed within the NHS reduced during 2011-12 by 2.55%, from 1,125,877 to 1,097,180.

Strategic Health Authorities

Strategic Health Authorities will remain statutory bodies until the end of the 2012-13 financial year. The average number of staff employed in the SHA sector reduced by 366 or 8.60% (from 4,256 to 3,890) compared to 2010-11. This modest decrease is principally because SHA staffing levels have been maintained throughout the year to manage close down activities across SHA areas, and to ensure the proper transfer of functions to successor organisations, most notably the NHS Commissioning Board and Health Education England. However, there has been a clear movement from permanent to non-permanent staff categories.

Primary Care Trusts

The average number of staff employed by PCTs decreased by 134,124 (or 72.2%) in 2011-12 to 51,528. This very significant reduction is a direct result of the transfer of functions under the “Transforming Community Services” initiative, under which large numbers of staff moved into NHS Foundation Trusts, NHS Trusts and a small number of community interest companies and social enterprises. The number of PCT managers and senior managers has also reduced significantly (30% reduction in full-time equivalents), which, apart from the impact of TCS, reflects the commitment to reduce administration costs and the clustering of PCTs in advance of their abolition at the end of March 2013.

NHS Trusts

The average number of staff employed by NHS Trusts in 2011-12 increased by 25,207 or 5.6%, (from 449,852 to 475,059). A principal reason for this increase has been the transfer of provider functions from Primary Care Trusts under the Transforming Community Services initiative.

NHS Foundation Trusts

The average number of staff employed by NHS Foundation Trusts in 2011-12 increased by 80,586, or 16.6%, (from 486,116 in 2010-11 to 566,702 in 2011-12). In a similar way to NHS Trusts, one principal reason for this increase has been the transfer of provider functions from Primary Care Trusts.

Arms Length Bodies

The average number of full time equivalent staff employed in the Department's Arms Length Bodies (Special Health Authorities and Non-Departmental Public Bodies) decreased by 597, or 5.5% (i.e. from 10,923 in 2010-11 to 10,326 in 2011-12). This decrease is the net result of a total reduction of 868 full time equivalent staff in existing ALBs, offset by an increase of 181 to reflect the appointment of staff to two new organisations (The NHS Commissioning Board Special Health Authority and the Health Research Authority) and of 90 in NICE and Monitor to reflect the extended roles for those organisations as set out in the Health & Social Care Act 2012.

7.3 Reporting of Civil Service and other compensation schemes - exit packages

Reporting of other compensation schemes

2011-12

	Core Department					Departmental Group				
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages**	**Number of departures where special payments have been made**	**Cost of special payment element included in exit packages**	***Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages**	**Number of departures where special payments have been made**	**Cost of special payment element included in exit packages**
	Number	Number	Number	Number	£000s	Number	Number	Number	Number	£000s
<£10,000	-	-	-	-	-	1,098	1,831	2,929	32	161
£10,001 - £25,000	-	1	1	-	-	1,002	1,774	2,775	43	551
£25,001 - 50,000	-	1	1	-	-	881	1,265	2,146	7	192
£50,001 - £100,000	1	1	2	-	-	670	683	1,353	10	566
£100,001 - £150,000	2	5	7	-	-	220	194	414	2	75
£150,001 - £200,001	-	2	2	-	-	79	44	123	-	-
>£200,000	-	3	3	-	-	51	40	91	4	1,130
Total Number	**3**	**13**	**16**	**-**	**-**	**4,001**	**5,831**	**9,831**	**98**	**2,675**
Total Cost (£)	**355,626**	**1,909,295**	**2,264,921**			**154,484,051**	**271,884,707**	**426,368,758**		

Unaudited 2010-11

	Core Department					Departmental Group				
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages**	**Number of departures where special payments have been made**	**Cost of special payment element included in exit packages**	***Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages**	**Number of departures where special payments have been made**	**Cost of special payment element included in exit packages**
	Number	Number	Number	Number	£000s	Number	Number	Number	Number	£000s
<£10,000	-	5	5	-	-	1,018	2,113	3,131	21	104
£10,001 - £25,000	-	33	33	-	-	898	1,860	2,758	16	10,422
£25,001 - 50,000	-	69	69	-	-	693	1,511	2,204	11	47,324
£50,001 - £100,000	-	76	76	-	-	502	778	1,281	8	404
£100,001 - £150,000	-	48	48	-	-	228	261	489	4	349
£150,001 - £200,001	-	14	14	-	-	78	64	142	1	161
>£200,000	-	9	9	-	-	42	40	82	-	-
Total Number	**-**	**254**	**254**	**-**	**-**	**3,459**	**6,627**	**10,087**	**61**	**58,764**
Total Cost (£)	**-**	**20,726,091**	**20,726,091**			**200,335,261**	**319,631,098**	**519,966,359**		

Redundancy and other departure costs have been paid in accordance with the provisions of the Civil Service Compensation Scheme, a statutory scheme made under the Superannuation Act 1972. Exit costs are accounted for in full in the year of departure. Where the department has agreed early retirements, the additional costs are met by the department and not by the Civil Service pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. The expense associated with these departures may have been recognised in part or in full in a previous period. Where early retirements have been agreed, the additional costs are met by the organisation and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in the table.

Principal Civil Service Pension Scheme (PCSPS)

The Principal Civil Service Pension Scheme (PCSPS) is an unfunded multi-employer defined benefit scheme. As such, the Department of Health is unable to identify its share of the underlying assets and liabilities. The scheme actuary valued the scheme as at 31 March 2007. Details can be found in the Annual Report and Accounts of the Cabinet Office: Civil Superannuation www.civilservice.gov.uk/pensions.

For 2011-12, employers' contributions of £22,237,894 were payable to the PCSPS (2010-11 restated: £24,447,529) at one of four rates in the range 16.7% to 24.3% (2010-11: 16.7% to 24.3%) of pensionable pay, based on salary bands. The Scheme Actuary reviews employer contributions usually every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2011-12 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employers' contributions of £92,249 were paid to one or more of the panel of three appointed stakeholder pension providers. Employer contributions are age-related and range from 3% to 12%.

Employers also match employee contributions up to 3% of pensionable pay. In addition, employer contributions of £7,298, 0.8% of pensionable pay, were payable to the PCSPS to cover the cost of the future provision of lump sum benefits on death in service and ill health retirement of these employees.

Contributions to the Partnership pension providers at the Statement of Financial Position date were £8,181. Contributions prepaid at that date were £Nil.

One individual retired early on ill-health grounds; the total additional accrued pension liabilities in the year amounted to £4,140.

From 1 April 2012, most members of the various PCSPS arrangements will pay extra contributions towards their pensions. In its 2011 Budget, the Government accepted the recommendations put forward by Lord Hutton in his independent review of public service pension schemes. In completing this review, Lord Hutton recognised that people are generally living longer whilst also noting that, in the past, improvements to the life expectancy of PCSPS members had been mostly paid for by taxpayers as a whole, rather than those scheme members themselves. This had given rise to a relatively urgent need to rebalance contributions. The new contribution rate will be assessed on the value of pensionable earnings at 31 March 2012. However, members of the scheme who earn a full-time equivalent of less than £15,000 per year will not see an increase in their contributions. There are no plans to change the four rates of employer contribution as set out above. Neither will there be any change to partnership pension arrangements.

NHS Pension Scheme

The NHS Pension scheme is an unfunded, multi-employer defined benefit scheme. Individual NHS bodies are therefore unable to identify their shares of the underlying scheme assets and liabilities. The scheme actuary valued the scheme as at 31 March 2004. Details can be found on the pension scheme website at www.nhsbsa.nhs.uk/pensions.

For 2011-12, employers' contributions were payable to the NHS Pension Scheme at the rate of 14% of pensionable pay. The scheme's actuary reviews employer contributions every four years following a full scheme valuation. The last review took effect from April 2008 with the employer contribution rate maintained at 14%. These costs are included in the NHS pension line of note 7.1.

Of the £4,104 million (2010-11 restated: £4,147 million) against NHS pension costs in note 7.1, £220 million (2010-11 £709 million) is attributable to PCTs, £20 million (2010-11 £22 million) to SHAs, £1,782 million (2010-11 £1,662 million) to NHS Trusts and £2,074 million (2010-11 £1,780 million) to NHS Foundation Trusts.

Other Pension schemes

Within the Departmental Group, the Care Quality Commission and a number of Foundation Trusts account for defined benefit pension scheme assets and liabilities primarily in respect of local government superannuation schemes. These schemes are immaterial to the group account and therefore have not been disclosed separately within these financial statements. Full disclosures are available in the underlying bodies own published accounts.

8 Other administration costs

		2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Note	Core Department	Departmental Group	Core Department	Departmental Group
Rental Under Operating Leases		21,717	40,223	11,417	11,417
Interest Charges		(113)	35,522	16	16
Chair and non-executive Directors' costs		37	15,192	-	-
PCT Executive Committee member costs		-	16,846	-	-
Supplies and services - clinical (excluding Drugs)		-	10,624	-	-
Supplies and services - general		-	89,595	-	-
Goods and services from other NHS bodies		-	6,588	-	-
Multi Professional Education and Training (MPET)		-	-	-	-
G/PMS, APMS and PCTMS		-	14,343	-	-
Non GMS Services from GPs		-	16,130	-	-
Consultancy services		17,831	111,228	(264)	(264)
Establishment		39,163	217,434	10,097	10,097
Transport (Business Travel)		186	16,498	338	338
Premises		17,144	390,341	12,027	12,027
Non cash items					
Movement in provision for impairment of receivables		-	8,999	(126)	(126)
Depreciation on property, plant and equipment		12,815	172,119	5,222	5,222
Amortisation on intangible assets		10,897	39,859	8,336	8,336
Profit on disposal of property plant and equipment		-	-	-	-
Loss on disposal of property plant and equipment		4	8,686	-	-
Profit on disposal of intangible non current assets		-	-	-	-
Loss on disposal of intangible non current assets		-	931	-	-
Profit on disposal of Assets held for sale		-	-	-	-
Loss on disposal of Assets held for sale		-	-	-	-
Profit on disposal of financial asset investments		-	-	-	-
Loss on disposal of financial asset investments		-	-	-	-
Impairments and reversals of property, plant and equipment		252	413	18	18
Impairments and reversals of investment properties		-	-	-	-
Impairments and reversals of intangible assets		-	1,600	696	696
Impairments and reversals of financial assets		-	27,985	-	-
Impairments and reversals of non-current assets held for sale		-	-	-	-
Audit fees - non cash	a	848	933	665	665
Other non-cash		-	(1,339)	-	-
Inventories impairment and write off		-	-	-	-
Inventories revaluation		-	-	-	-
Inventories consumed		-	-	-	-
Legal fees		-	2,893	-	-

Audit fees - statutory audit	-	31,429	-	-
Other auditor's remuneration	-	5,581	-	-
Clinical negligence	-	3,377	-	-
Research and development	10,640	13,496	51	51
Education and training	1,601	62,658	1,346	1,346
Insurance	1	10	37	37
Grants to Local Authorities	-	-	-	-
Grants to Other bodies	-	10,642	-	-
Capital Grants	-	1,203	-	-
NHS Informatics Major Contracts Cost	7,991	7,991	-	-
Other	54,628	492,096	26,614	26,614
Sub total	**195,642**	**1,872,126**	**76,490**	**76,490**
Grant in Aid	143,689	-	-	-
Funding to Group Bodies	2,828,338	-	-	-
Total	**3,167,668**	**1,872,126**	**76,490**	**76,490**

Note a - The Core Department audit fee represents the cost of the audit of the Department's Annual Report and Accounts carried out by the Comptroller and Auditor General.

Note b - The total of non-cash transactions included in the Reconciliation of Operating Costs to Operating Cash flows in the Consolidated Statement of Cash Flows comprises:

	2011-12 £'000 Departmental Group	Unaudited Restated 2010-11 £'000 Departmental Group
Other administration costs - non-cash items (Note 8)	260,187	14,811
Programme costs - non-cash items (Note 9)	14,834,731	13,905,091
Other non-cash amounts charged to operating expenditure	-	-
Less non-cash income: - income recognised in respect of Donated Assets	(128,610)	(130,036)
Total non-cash transactions	**14,966,308**	**13,789,866**
Movement in provision for impairment of receivables	(114,232)	(102,933)
Inventories revaluation	15,010	-
Inventories consumed	(5,707,647)	(5,062,442)
Inventories impairment and write off	(6,703)	(92,251)
Less non cash movements on SoFP balances analysed separately in the Cash Flow statement	**(5,813,572)**	**(5,257,626)**
Total non cash transactions as per Consolidated Statement of Cash flow	**9,152,736**	**8,532,240**

Footnotes

1) As detailed in Note 1.6, the 2010 Spending Review Settlement Letter expanded the boundary of the Department's administration costs regime to include Arms Length Bodies, Strategic Health Authorities and the commissioning functions of Primary Care Trusts. Expenditure on the direct provision of healthcare or healthcare related services by NHS provider organisations (including NHS Trusts and NHS Foundation Trusts) remains classified as programme. The 2010-11 Administration costs figures have not been restated to reflect the wider interpretation of Administration costs adopted in 2011-12, rather the 2010-11 administration and programme cost figures within this account continue to reflect the Administration costs regime in place at the time. As agreed with HM Treasury and the Financial Reporting Advisory Board, it is impracticable, as defined by IAS8, for NHS bodies to restate prior period income and expenditure figures based on an Administration costs regime that was not in place at the time. Consolidated administration costs have therefore increased significantly in comparison to the prior year due to the reclassification of costs which were previously recorded as programme. Additionally, in 2011-12 HM Treasury re-categorised a number of core Department administration and programme expenditure types, with the movement being predominantly from programme to administration. Reclassified items include certain grant-in-aid expenditure and policy payments. The Department has applied this revised methodology from 1 April 2011, thus ensuring a consistent date of application for the revised Administration costs regime across the Departmental Group. The Department estimates the net impact of this re-categorisation to be in the region of a £250 million increase to administration costs.
2) Due to the major re-categorisation of costs between administration and programme from 2011-12, year-on-year cost comparisons are best undertaken at the aggregate level (i.e. administration and programme costs collectively). Overall Core Department expenditure on grant in aid reduced from £313.45 million in 2010-11 to £242.15 million in 2011-12 (a £71.30 million reduction).
3) General Medical Services,/Personal Medical Services (G/PMS), Alternative Provider Medical Services (APMS) and Primary Care Trust Medical Services (PCTMS) are differing models for providing primary care services.
4) In 2011-12 the Non cash transaction balance taken to the Cashflow, is £68.9m greater than the total balance above. This is due to the reclassification of Computer Sciences Corporation's (CSC) assets.

9 Programme Costs

	Note	2011-12 [1] £'000 Core Department	2011-12 [1] £'000 Departmental Group	Unaudited Restated 2010-11 [1] £'000 Core Department	Unaudited Restated 2010-11 [1] £'000 Departmental Group
Rental Under Operating Leases					
Rentals Under Operating Leases		498	790,366	12,108	681,529
Interest charges		2,618	460,962	4,035	696,898
Chair and non-executive Directors' costs		-	24,872	-	43,579
PCT Executive Committee member costs		-	315	-	19,330
Supplies and services - clinical (excluding Drugs)		-	4,433,634	-	3,487,909
Supplies and services - general		-	1,355,723	-	1,307,316
Goods and services from other NHS bodies		-	22,728	-	25,658
Purchase of healthcare from non NHS bodies		-	8,674,886	-	8,562,480
Purchase of Social Care from Independent Providers		-	190,565	-	385,424
Expenditure on Drug Action Teams		-	373,025	-	356,855
General Dental Services (GDS) and Personal Dental Services (PDS)[2]		-	2,812,681	-	2,692,979
Multi Professional Education and Training (MPET)		-	1,121,804	-	1,156,680
Prescribing Costs		-	8,243,469	-	8,280,308
Pharmaceutical Services[3]		-	2,139,334	-	2,039,563
General Ophthalmic Services		-	490,440	-	478,676
G/PMS, APMS and PCTMS[4]		-	7,455,962	-	7,394,840
Non GMS Services from GPs		-	166,844	-	149,577
Consultancy services		368	362,003	22,482	466,694
Establishment		98,810	1,102,500	132,831	1,374,525
Transport (Business Travel)		-	512,371	128	514,941
Premises		1,958	3,178,586	5,980	3,347,933
Legal fees		-	45,074	-	42,331
Non cash items					
Movement in provision for impairment of receivables		(1,208)	105,233	215	103,058
Depreciation on property, plant and equipment		93,189	2,224,618	94,322	2,330,139
Amortisation on intangible assets		547,011	631,884	586,712	686,714
Profit on disposal of property plant and equipment		(1,224)	(27,017)	(1,405)	(28,043)
Loss on disposal of property plant and equipment		9,502	17,741	5,622	26,620
Profit on disposal of intangible non current assets		-	-	-	(1,516)
Loss on disposal of intangible non current assets		20	841	-	1,391
Profit on disposal of Assets held for sale		-	(2,793)	-	(603)
Loss on disposal of Assets held for sale		-	404	-	224
Profit on disposal of financial asset investments		-	(2,346)	-	(2)
Loss on disposal of financial asset investments		-	-	-	1
Impairments and reversals of property, plant and equipment		36,635	1,333,143	11,093	1,438,994
Impairments and reversals of investment properties		-	175	-	-
Impairments and reversals of intangible assets		43,590	54,160	6,153	15,220
Impairments and reversals of financial assets investments		2,247	3,168	5,485	3,956
Impairments and reversals of non-current assets held for sale		-	29,109	-	9,308
Audit fees - non cash[5]		-	-	-	85
Provision provided for in year - EEA[6]		613,751	613,751	788,298	788,298
Provision provided for in year - Clinical Negligence		-	3,261,763	-	2,625,896
Provision provided for in year - Injury Benefit		31,674	31,674	11,560	11,560
Provision provided for in year - Other		132,218	812,037	168,949	708,986
Unwinding of discount on provisions		32,713	47,930	29,567	24,937
Other non-cash Expenditure		(84)	(84)	5,176	5,176
Inventories impairment and write off		1,048	6,703	82,059	92,251
Inventories revaluation		(15,010)	(15,010)	-	-

Programme Costs Note continued	Note	2011-12 £'000 Core Department	2011-12 £'000 Departmental Group	Unaudited Restated 2010-11 £'000 Core Department	Unaudited Restated 2010-11 £'000 Departmental Group
Inventories consumed		205,576	5,707,647	169,530	5,062,442
Audit fees - statutory audit (cash)		-	31,192	-	67,629
Other auditor's remuneration		-	11,372	-	17,803
Clinical negligence		-	34,288	-	71,249
Research and development		904,018	1,051,806	920,530	1,063,744
Education and training		858	322,902	7,491	390,529
Early retirements		-	5,927	-	757
Insurance		85	17,656	13	16,274
Grants to Local Authorities		1,346,195	1,346,195	1,325,445	1,325,445
Grants to Other bodies		234,874	394,005	321,879	372,225
Capital Grants		237,484	295,745	196,625	260,163
NHS Informatics Major Contracts Cost		445,556	445,556	423,680	423,680
PDC Dividend Payable		-	-	-	-
Other		664,931	912,243	819,128	1,455,821
Sub total		**5,669,901**	**63,661,762**	**6,155,691**	**62,876,434**
Grant in Aid		98,460	-	313,447	-
Funding to Group Bodies		94,820,215	-	96,200,492	-
Total		**100,588,576**	**63,661,762**	**102,669,630**	**62,876,434**

	2011-12 £'000	Unaudited Restated 2010-11 £'000
Auditors' remuneration		
Auditors' Remuneration - Audit Fees	31,192	67,629
Auditors' Remuneration - Other Fees	11,372	17,803

The audit fee represents the cost of the audit of the financial statements of group bodies consolidated within the Departmental Group account. The Comptroller and Auditor General and auditors appointed by the Audit Commission undertake these audits.

Footnotes

1) Please see the footnote to Note 8 Administration costs which explains differences in the classification of costs between administration and programme between 2010-11 and 2011-12.

2) General Dental Services (GDS) and Personal Dental Services (PDS) are alternative models for dental care.

3) Pharmaceutical Services includes Local Pharmaceutical Services Pilots and the New Pharmacy Contract.

4) General/Personal Medical Services (G/PMS), Alternative Provider Medical Services (APMS) and Primary Care Trust Medical Services (PCTMS) are differing models for providing primary care services.

5) The audit fee represents the programme cost for the audit of the underlying financial statements of consolidated bodies. With the exception of NHS Foundation Trusts, consolidated bodies are audited by the Comptroller and Auditor General (Arms Length Bodies and Special Health Authorities) or an Audit Commission appointed auditor (NHS Trusts, Primary Care Trusts and Strategic Health Authorities) and include expenditure in respect of audit fees in their individual accounts. The accounts of NHS Foundation Trusts are audited by auditors appointed by their board of governors and also include expenditure in respect of audit fees.

6) Provisions provided for in year in respect of European Economic Area (EEA) medical costs decreased from £788.30 million in 2010-11 to £613.75 million in 2011-12 (a reduction of £174.55 million). The main reasons for this decrease are as follows: i) A favourable move in the euro exchange rate; ii) The actual claims activity of France being lower than expected in 2010 leading to revised claims estimates for 2011-12, and iii) a bilateral agreement with Ireland made in 2011 lowering the original activity assumptions.

10 Income

10.1 Administration Income

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Administration Income:				
Income from Local Authorities	-	14,976	-	-
Sale of Goods and Services	8,241	8,815	614	614
Income in respect of EEA claims	-	-	-	-
Other Non Trading Income				
Other Fees and Charges	-	9,048	-	-
Education, training and research	-	1,924	-	-
Other non-NHS patient care services	-	659	-	-
Charitable and other contributions to expenditure	-	883	-	-
Non-patient care services to other bodies	-	1,656	-	-
Rental revenue from finance leases	-	-	-	-
Rental revenue from operating leases	3,115	17,519	3,067	3,067
Interest from Overseas	-	-	-	-
Interest and investment income	-	2,176	-	-
Dividends	-	-	-	-
Unwinding of discount on receivables	-	-	-	-
Income in respect of Staff Costs	-	15,296	-	-
Other	1,157	203,543	725	725
Non cash income	-	-	-	-
Total Administration Income	**12,513**	**276,495**	**4,406**	**4,406**

10.2 Programme Income

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Revenue from Patient Care activities				
Income from Local authorities	-	550,331	-	968,364
Income from Private patients	-	454,062	-	430,560
Income from Overseas patients (non-reciprocal)	-	32,714	-	35,405
Income from Injury costs recovery	-	221,719	-	210,449
Income in respect of EEA claims	36,216	36,216	71,639	71,639
Sale of Goods and Services	34,221	943,381	80,216	875,570
Other Non Trading Income				
Prescription Pricing Regulation Scheme	65,316	65,316	70,456	70,456
Prescription Fees and Charges	-	426,095	-	455,956
Dental Fees and Charges	-	637,121	-	617,014
Other Fees and Charges	-	257,059	-	288,854
PDC Dividend Received	846,102	-	866,025	-
Patient transport services	-	1,736	-	5,762
Education, training and research	-	164,607	-	234,499
Other non-NHS patient care services	-	226,918	-	257,145
Charitable and other contributions to expenditure	-	99,471	-	154,507
Receipt of donations for capital acquisitions	-	125,199	-	121,579
Receipt of grants for capital acquisitions	-	3,411	-	8,457
Non-patient care services to other bodies	-	296,874	-	244,875
Rental revenue from finance leases	-	2,877	-	3,089
Rental revenue from operating leases	432	148,288	-	129,508
Interest from Overseas	1,931	1,931	2,610	2,610
Interest and investment income	28,036	70,819	38,690	83,844
Interest Receivable on NHS Trust Loans	10,428	-	15,201	-
Interest Receivable NHS Capital Loans (LT)	16,771	-	12,969	-
Interest Receivable FT Financing Facility Loans	31,995	-	21,362	-
Dividends	2,271	2,271	1,583	1,583
Amortisation of PFI deferred credits				
- Main scheme	-	828	-	656
- Additional lifecycle assets received	-	-	-	29
Unwinding of discount on receivables	3,158	3,158	3,070	3,070
Income in respect of Staff Costs	-	90,887	-	82,199
Other	37,059	1,182,977	16,829	250,338
Non cash income	-	-	-	-
Total Programme Income	**1,113,936**	**6,046,266**	**1,200,650**	**5,608,017**
Total Income	1,126,449	6,322,761	1,205,056	5,612,423

Footnote

1) Income in respect of European Economic Area (EEA) medical costs has decreased from £71.64 million in 2010-11 to £36.22 million in 2011-12 (£35.42 million reduction). This is predominantly due to an income reduction resulting from a bilateral agreement with Ireland. There has also been a reduction in the number of EU member states' visitors to the UK in the last twelve months, which has also reduced the accrued income for 2011-12.

10.3 Fees and Charges

			2011-12 Departmental Group
	Fees and Charges Income £'000	Full Cost of Service £'000	Suplus/(Deficit) £'000
Dental	637,121	2,812,681	(2,175,560)
Prescription	426,095	8,243,469	(7,817,374)
Other Fees and Charges for which the cost of providing the service is over £1million	96,023	137,219	(41,196)
Total	1,159,239	11,193,369	(10,034,130)

			Unaudited 2010-11 Departmental Group
	Fees and Charges Income £'000	Full Cost of Service £'000	Suplus/(Deficit) £'000
Dental	617,014	2,692,979	(2,075,965)
Prescription	455,956	8,280,308	(7,824,352)
Other Fees and Charges for which the cost of providing the service is over £1million	91,489	91,200	289
Total	1,164,459	11,064,487	(9,900,028)

The fees and charges information in this note is provided in accordance with section 5.4.28 of the HM Treasury FReM. It is provided for fees and charges purposes and not for IFRS 8 purposes. The Core Department does not provide services for which a fee is charged, therefore all disclosures relate to consolidated bodies. Primary Care Trusts receive income in respect of Prescription and Dental charges to patients. The financial objective of Prescription and Dental charges is to collect charges only from those patients that are eligible to pay. Other fees and charges for which the cost of providing the service is over £1 million, relate to services provided by Arms Length Bodies and Special Health Authorities. A significant proportion of this, (income £85.99 million (2010-11: £80.06 million) and Expenditure £128.09 million (2010-11: £80.06 million)) relates to Regulatory income at the Care Quality Commission.

Further information relating to fees and charges, can be obtained from the financial statements of underlying bodies.

11 Property, plant and equipment

2011-12

	Land	Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture and Fittings	Plant & Machinery	Transport Equipment	Stockpiled Goods	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation										
At 1 April 2011	**8,070,212**	**35,872,096**	**488,817**	**3,354,399**	**1,551,107**	**804,871**	**7,934,094**	**432,827**	**830,229**	**59,338,652**
Opening balance adjustment	(27,730)	(576,972)	1,320	2,570	1	1,122	(1,151)	173	-	(600,667)
Adjustment for transfer of functions	1	-	-	(10,143)	-	(3,388)	(7,466)	303	-	(20,693)
Restated Balance as at 1 April 2011	**8,042,483**	**35,295,124**	**490,137**	**3,346,826**	**1,551,108**	**802,605**	**7,925,477**	**433,303**	**830,229**	**58,717,292**
Additions-purchased	51,622	2,428,203	3,090	269,218	1,336,608	39,264	440,091	21,315	84,274	4,673,685
Additions-donated	-	16,850	-	1,606	83,535	948	51,902	282	-	155,123
Impairment transferred to Revaluation Reserve	(141,769)	(505,549)	(19,592)	(511)	(1,945)	(413)	(1,260)	-	-	(671,039)
Impairment transferred to the CSCNE	(195)	(184)	-	-	(56,981)	(19)	(9,658)	-	(28,072)	(95,109)
Impairment reversals	(58,453)	124,993	380	63	58	410	607	(2)	-	68,056
Transfers	(7,950)	(18,462)	-	901	(19,715)	(26,159)	8,010	26	(56,564)	(119,913)
Reclassifications to assets held for sale	(135,993)	(125,266)	(16,416)	(19,633)	(438)	(9,811)	(48,189)	(11,347)	-	(367,093)
Other Reclassifications	7,037	1,210,645	(6,099)	318,661	(1,487,568)	6,446	117,193	39,320	-	205,635
Revaluation and indexation	101,191	209,401	6,534	(3,903)	(762)	135	(11,579)	129	4,519	305,665
Cumulative depreciation netted off cost on revaluation	(26,657)	(805,435)	(10,878)	(7,241)	-	(2,619)	(1,835)	-	-	(854,665)
Disposals	(36,603)	(176,814)	(16,456)	(166,330)	(1,534)	(33,052)	(442,014)	(42,562)	(11,623)	(926,988)
At 31 March 2012	**7,794,713**	**37,653,506**	**430,700**	**3,739,657**	**1,402,366**	**777,735**	**8,028,745**	**440,464**	**822,763**	**61,090,649**
Depreciation										
At 1 April 2011	**150,346**	**4,046,692**	**49,192**	**2,125,830**	**-**	**443,419**	**4,898,127**	**252,919**	**-**	**11,966,525**
Opening balance adjustment	(26,706)	(580,214)	1,826	2,986	-	1,127	(1,773)	180	-	(602,574)
Adjustment for transfer of functions	-	-	-	(5,447)	-	(2,065)	(5,453)	247	-	(12,718)
Restated Balance as at 1 April 2011	**123,640**	**3,466,478**	**51,018**	**2,123,369**	**-**	**442,481**	**4,890,901**	**253,346**	**-**	**11,351,233**
Charged in year	545	1,162,531	16,154	459,693	-	63,083	645,616	49,115	-	2,396,737
Impairment transferred to Revaluation Reserve	-	-	-	-	-	-	-	-	-	-
Impairment transferred to the CSCNE	127,525	1,425,446	8,417	5,780	-	6,893	18,116	3	-	1,592,180
Impairment reversals	(76,184)	(273,671)	(3,498)	-	-	(3)	(378)	-	-	(353,734)
Transfers	-	(446)	-	165	-	(1,678)	(3)	-	-	(1,962)
Reclassifications to assets held for sale	(639)	(22,810)	(1,236)	(17,262)	-	(9,847)	(45,536)	(11,369)	-	(108,699)
Other Reclassifications	(912)	(8,645)	(365)	163,499	-	(91)	(12,965)	7,785	-	148,306
Revaluation and indexation	(32,070)	(476,735)	(7,951)	(4,290)	-	(2,174)	(22,451)	75	-	(545,596)
Less cumulative depreciation written down on revaluation	(26,657)	(805,435)	(10,878)	(7,241)	-	(2,619)	(1,835)	-	-	(854,665)
Disposals	(435)	(139,251)	(7,606)	(159,710)	-	(31,137)	(428,469)	(32,768)	-	(799,376)
At 31 March 2012	**114,813**	**4,327,462**	**44,055**	**2,564,003**	**-**	**464,908**	**5,042,996**	**266,187**	**-**	**12,824,424**
At 31 March 2012	**7,679,900**	**33,326,044**	**386,645**	**1,175,654**	**1,402,366**	**312,827**	**2,985,749**	**174,277**	**822,763**	**48,266,225**
At 31 March 2011	7,919,866	31,825,404	439,625	1,228,569	1,551,107	361,452	3,035,967	179,908	830,229	47,372,127
Asset financing:										
Owned - purchased	7,404,477	22,762,023	317,363	1,156,348	1,335,085	300,231	2,516,260	165,108	822,763	36,779,658
Owned - donated	90,581	657,584	1,389	8,646	38,469	7,242	168,653	662	-	973,226
Finance Lease	64,326	267,029	43,880	7,735	1,296	2,207	165,376	8,507	-	560,356
On-Statement of Financial Position PFI contracts	117,516	9,606,946	19,448	2,925	27,516	3,147	135,460	-	-	9,912,958
PFI residual interests	3,000	32,462	4,565	-	-	-	-	-	-	40,027
Net book value at 31 March 2012	**7,679,900**	**33,326,044**	**386,645**	**1,175,654**	**1,402,366**	**312,827**	**2,985,749**	**174,277**	**822,763**	**48,266,225**

Analysis of property, plant and equipment

	Land	Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture and Fittings	Plant & Machinery	Transport Equipment	Stockpiled Goods	Total
Of the total:	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Core Department (excluding NHS Connecting for Health)	101,903	88,506	-	17,527	-	8,035	43,397	-	822,763	1,082,131
NHS Connecting for Health	435	1,357	-	112,803	-	278	-	-	-	114,873
Primary Care Trusts	1,701,833	5,161,636	18,632	245,060	142,214	77,033	130,764	4,278	-	7,481,450
Strategic Health Authorities	8,723	5,172	-	1,049	-	1,234	13	-	-	16,191
NHS Trusts	2,748,542	12,589,324	165,301	395,655	508,883	107,811	1,339,123	92,507	-	17,947,146
NHS Foundation Trusts	3,085,155	15,287,107	202,712	387,899	726,910	107,446	1,433,023	77,470	-	21,307,722
Special Health Authorities	5,084	13,568	-	8,277	-	4,509	627	22	-	32,087
Non Departmental Public Bodies	28,225	179,374	-	7,384	24,359	6,481	38,788	-	-	284,611
Other	-	-	-	-	-	-	14	-	-	14
Net book value at 31 March 2012	**7,679,900**	**33,326,044**	**386,645**	**1,175,654**	**1,402,366**	**312,827**	**2,985,749**	**174,277**	**822,763**	**48,266,225**

Footnotes
1) Stockpiled goods are not depreciated, as agreed with HM Treasury.
2) NHS Connecting for Health (responsible for implementing major IT programmes in the NHS) is part of the Department's Informatics Directorate. Whilst it is not a separate entity, its figures are separately disclosed due to their significance in relation to the Department as a whole.
3) As detailed in Note 1b *Restatement*, the value of investment property held by the Departmental Group became significant as a result of the expansion of the Resource Accounting Boundary. Investment property is now separately disclosed (see Note 11.1) and is no longer included within the Core Department Property Plant and Equipment (land) figures. Consequently, the land balance as at 31 March 2011 has reduced by £338k.
4) Plant and machinery depreciation charged in year in respect of the Core Department is negative due to the in-year correction of an immaterial prior period over depreciation error.
5) Included within the Transfers lines are the following transfers out of assets to Bio Products Laboratory (BPL): i) £7.95 million transfer of land; ii) £27.46 million transfer of buildings and a £0.45 million transfer of the associated depreciation; iii) £27.32 million transfer of furniture and fittings within the DH Core account, and a £1.68 million transfer of the associated depreciation. These assets are owned by BPL but were recognised by the Department in error in 2010-11. These transfers have resulted in the in-year de-recognition of the assets, thus correcting the immaterial prior period error.
6) Of the £56.6 million stockpiled goods transferred from Property, Plant and Equipment, £39.5 million is transferred to Inventory. A further £17.1 million transfer incorporates write downs associated with stocks that have been replaced and the reversal of temporary recategorisations from prepayments.
7) The reclassifications within this Note do not net to zero within PPE primarily because of the transfer of a £30.963 million PFI scheme at University Hospitals Birmingham NHS Foundation Trust. The asset was previously recorded as a financial asset whilst it was under construction. On completion the asset has been reclassified to PPE.

Prior Year

	Land	Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture and Fittings	Plant & Machinery	Transport Equipment	Stockpiled Goods	Unaudited Restated 2010-11 Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation										
At 1 April 2010	**8,102,497**	**31,820,718**	**485,336**	**3,391,015**	**1,766,153**	**756,757**	**7,841,380**	**419,230**	**597,900**	**55,180,986**
Additions-purchased	61,109	2,985,589	9,144	297,996	1,649,323	45,151	516,925	26,500	260,491	5,852,228
Additions-donated	16	21,801	-	1,131	55,689	1,023	42,593	208	-	122,461
Impairment transferred to Revaluation Reserve	(137,783)	(367,059)	(7,000)	(202)	(2,647)	(167)	(2,121)	(29)	(15,139)	(532,147)
Impairment transferred to the CSCNE	-	-	-	(1,431)	(46,977)	(1,741)	-	-	(113,389)	(163,538)
Impairment reversals	5,313	26,309	459	-	129	-	(131)	1	13,662	45,742
Transfers	7,697	45,998	-	2,197	(32,598)	30,778	10,127	(294)	67,439	131,344
Reclassifications to assets held for sale	(105,800)	(79,111)	(5,347)	(4,005)	(2,177)	(1,151)	(25,667)	(15,408)	-	(238,666)
Reclassifications	19,439	1,564,873	(213)	(132,385)	(1,830,844)	157	92,367	49,984	-	(236,622)
Revaluation and indexation	144,687	(71,770)	8,277	(271)	(282)	380	9,560	70	27,559	118,210
Disposals	(26,963)	(75,252)	(1,839)	(199,646)	(4,662)	(26,316)	(550,939)	(47,435)	(8,294)	(941,346)
At 31 March 2011	**8,070,212**	**35,872,096**	**488,817**	**3,354,399**	**1,551,107**	**804,871**	**7,934,094**	**432,827**	**830,229**	**59,338,652**
Depreciation										
At 1 April 2010	**104,205**	**2,410,399**	**33,383**	**1,972,742**	**-**	**411,605**	**4,770,655**	**263,550**	**-**	**9,966,539**
Charged in year	997	1,119,189	16,197	428,661	-	63,634	662,227	44,431	-	2,335,336
Impairment transferred to Revaluation Reserve	-	(7,085)	-	-	-	-	-	-	-	(7,085)
Impairment transferred to the CSCNE	97,499	1,495,716	9,049	3,493	-	1,501	18,830	44	-	1,626,132
Impairment reversals	(44,398)	(203,979)	(985)	-	-	-	(169)	-	-	(249,531)
Transfers	-	445	-	(98)	-	1,679	(606)	(250)	-	1,170
Reclassifications to assets held for sale	(6,006)	(11,189)	(138)	(3,064)	-	(401)	(20,984)	(14,904)	-	(56,686)
Reclassifications	-	5,474	(337)	(81,915)	-	(10,379)	(8,474)	1,124	-	(94,507)
Revaluation and indexation	(1,887)	(735,439)	(7,894)	419	-	186	3,307	29	-	(741,279)
Disposals	(64)	(26,839)	(83)	(194,408)	-	(24,406)	(526,659)	(41,105)	-	(813,564)
At 31 March 2011	**150,346**	**4,046,692**	**49,192**	**2,125,830**	**-**	**443,419**	**4,898,127**	**252,919**	**-**	**11,966,525**
Net Book Value										
At 31 March 2011	**7,919,866**	**31,825,404**	**439,625**	**1,228,569**	**1,551,107**	**361,452**	**3,035,967**	**179,908**	**830,229**	**47,372,127**
At 31 March 2010	7,998,292	29,410,319	451,953	1,418,273	1,766,153	345,152	3,070,725	155,680	597,900	45,214,447
Asset financing:										
Owned	7,637,938	22,480,780	372,027	1,211,139	1,486,911	345,214	2,587,808	163,747	830,229	37,115,793
Donated	91,748	562,228	1,211	7,599	40,412	6,062	146,568	775	-	856,603
Finance Lease	67,530	275,027	41,965	6,726	-	6,393	180,388	15,386	-	593,415
On-Statement of Financial Position PFI contracts	119,650	8,498,801	19,664	3,105	23,784	3,783	121,203	-	-	8,789,990
PFI residual interests	3,000	8,568	4,758	-	-	-	-	-	-	16,326
Net book value at 31 March 2011	**7,919,866**	**31,825,404**	**439,625**	**1,228,569**	**1,551,107**	**361,452**	**3,035,967**	**179,908**	**830,229**	**47,372,127**

Analysis of property, plant and equipment

Of the total:	Land	Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture and Fittings	Plant & Machinery	Transport Equipment	Stockpiled Goods	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Core Department (excluding NHS Connecting for Health)	113,193	122,237	-	25,606	815	34,143	48,477	-	830,229	1,174,700
NHS Connecting for Health	435	1,415		120,634		387				122,871
Primary Care Trusts	1,745,794	4,855,632	26,492	277,821	202,300	95,421	158,498	5,873	-	7,367,831
Strategic Health Authorities	8,723	5,592	-	1,435	-	1,606	29	-	-	17,385
NHS Trusts	2,932,215	12,503,070	199,623	422,305	550,421	105,944	1,423,888	129,745	-	18,267,211
NHS Foundation Trusts	3,087,696	14,147,352	213,510	359,567	774,605	110,118	1,361,870	44,242	-	20,098,960
Special Health Authorities	3,584	9,432	-	10,175	1,765	5,711	1,160	48	-	31,875
Non Departmental Public Bodies	28,226	180,674	-	11,026	21,201	8,122	42,038	-	-	291,287
Other	-	-	-	-	-	-	7	-	-	7
Net book value at 31 March 2011	**7,919,866**	**31,825,404**	**439,625**	**1,228,569**	**1,551,107**	**361,452**	**3,035,967**	**179,908**	**830,229**	**47,372,127**

Revaluation Reserve surplus in respect of Core Department PPE assets

	£'000
As at 1 April 2011	116,684
Movement in year	849
As at 31 March 2012	**117,533**

Property has been valued as follows:

- The Civil Estate (land and buildings held for use by the core Department) was valued on 1 September 2010 by independent valuers employed by the Department. Since then, Investment Property Databank indices have been applied, as appropriate, to uplift values as at the year end using the IAS 16 revaluation model methodology.
- Land and buildings held by NHS bodies were valued, by independent valuers, to a modern equivalent basis as required by HM Treasury, during either 2008-09 or 2009-10.
- All valuations have been undertaken according to Royal Institute of Chartered Surveyors (RICS) guidelines.
- The Retained Estate comprises land and buildings which were primarily intended for use by NHS bodies but which are now surplus to requirements and are therefore held by the Department. The Retained Estate was revalued by professional valuers as at 31 March 2010. Additional valuations were carried out as necessary in circumstances where there were indications that values had substantially changed.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 - 188 years
- Transport equipment: 1 - 21 years
- Information technology: 1 - 40 years
- Plant and machinery: 1 - 80 years
- Furniture and fittings: 1 - 99 years

Explanation of Opening Balance Adjustments

- **PCT mergers**
  A number of PCTs divested provider functions to NHS Trusts, NHS Foundation Trusts and Social Enterprises during 2011-12 as part of the "Transforming Community Services" initiative. HM Treasury require that merger accounting principles are applied in these circumstances. This has resulted in a restatement of prior year balances. Paragraph 1.35 of Note 1 refers.

Explanation of material impairments in the Core Department

The Core Department recognised impairments in 2011-12 of £36 million. These include impairments of £28 million relating to stockpiled goods where these have reached the end of their shelf life, become damaged or where there is a difference between the contract price and the external market price of the goods.

An impairment of £8 million of leased plant and machinery was also identified to recognise the incorrect capitalisation in prior years of pass through costs in respect of equipment purchased as part of the Ambulance Radio Programme for use by Trusts.

11.1 Investment Property

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Carrying Value at 1 April 2011	**338**	**64,807**	**313**	**55,238**
Opening balance adjustment	-	-	-	2,850
Adjustment for transfer of functions	-	-	-	-
Restated Carrying Value as at 1 April 2011	**338**	**64,807**	**313**	**58,088**
At start of period for new NHS Foundation Trusts	-	-	-	-
Additions	-	990	-	-
Reclassifications from PPE	-	-	75	75
Revaluations	-	579	-	5,463
Impairment	(3)	172	-	-
Impairment reversals	-	-	-	-
Transfers to assets held for sale	(72)	(2,916)	(50)	645
Other changes	-	2,917	-	536
Carrying Value at 31 March 2012	263	66,549	338	64,807

11.2 Investment property income and expenditure

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Investment Property income	-	3,281	-	1,688
Direct operating expenses arising from investment property that:				
a) generated rental income during the period	-	-	-	-
b) did not generate rental income during the period	-	-	-	-

Investment property within the Departmental Group is measured at fair value. Core Department investment property assets are valued on the same basis as property, plant and equipment assets: i.e. they are initially measured at cost and subsequently measured at fair value (see Note 1.14 for further details).

The majority of investment properties within the Departmental Group (£58.9 million as at 31 March 2012 (2010-11; £46.8m)) are held by NHS Foundation Trusts. Where relevant/significant the following information is disclosed in the underlying accounts of the consolidated bodies holding investment properties:

- The methods and significant assumptions applied in determining the fair value of investment property, including information on whether the determination of fair value was supported by market evidence or was more heavily based on other factors because of the nature of the property and lack of comparable data.
- The extent to which the fair value of investment property is based on a valuation by an independent valuer who holds a recognised and relevant professional qualification and has recent experience in the location and category of the investment property being valued. If there has been no such valuation, that fact will be disclosed.

- The existence and number of restrictions on the realisability of investment property or the remittance of income and proceeds of disposal. No such restrictions exist in respect of Core Department investment property.
- Contractual obligations to purchase, conduct or develop investment property, or in relation to repairs, maintenance or enhancements to that property. The Core Department has no such contractual obligations.

In respect of the Core Department, the amounts recognised in the CSCNE for: a) rental income from investment property; and b) direct operating expenses (including repairs and maintenance) arising from investment property, are insignificant and are not therefore separately disclosed in the income and expenditure notes.

12 Intangible Non-Current Assets

Intangible non-current assets comprise: Purchased Software Licences and Internally Developed Software, Trade Marks and Development Expenditure relating to both the Department and the entities consolidated within these financial statements.

				2011-12
	Software Licences and Internally Developed Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2011	**3,793,753**	**154,712**	**57,755**	**4,006,220**
Opening balance adjustment	(739)	(1)	(1)	(741)
Adjustment for transfer of functions	(640)	-	-	(640)
Restated Balance as at 1 April 2011	**3,792,374**	**154,711**	**57,754**	**4,004,839**
Additions-purchased	365,604	28,173	36,151	429,928
Additions-donated	342	328	1,358	2,028
Impairment transferred to Revaluation Reserve	(718)	(161)	-	(879)
Impairment transferred to the CSCNE	(97,265)	(14,066)	-	(111,331)
Impairment reversals	-	-	-	-
Transfers	1,618	413	609	2,640
Reclassification to assets held for sale	(576)	-	(773)	(1,349)
Other Reclassifications	(365,712)	19,067	(17,871)	(364,516)
Revaluation and indexation	415,095	(39)	-	415,056
Disposals	(688,112)	(8,646)	(779)	(697,537)
At 31 March 2012	**3,422,650**	**179,780**	**76,449**	**3,678,879**
Amortisation				
At 1 April 2011	**2,026,698**	**69,350**	**5,288**	**2,101,336**
Opening balance adjustment	(741)	-	-	(741)
Adjustment for transfer of functions	(218)	-	-	(218)
Restated Balance as at 1 April 2011	**2,025,739**	**69,350**	**5,288**	**2,100,377**
Charged in year	644,224	24,999	2,520	671,743
Impairment transferred to Revaluation Reserve	-	-	-	-
Impairment transferred to the CSCNE	(52,234)	(5,893)	2,559	(55,568)
Impairment reversals	(2)	-	-	(2)
Transfers	(1,061)	(843)	-	(1,904)
Reclassification to assets held for sale	(342)	-	(460)	(802)
Other Reclassifications	(248,367)	134	153	(248,080)
Revaluation and indexation	(118,597)	(53)	-	(118,650)
Disposals	(686,234)	(6,282)	(177)	(692,693)
At 31 March 2012	**1,563,126**	**81,412**	**9,883**	**1,654,421**
Net book value at 31 March 2012	**1,859,523**	**98,368**	**66,566**	**2,024,457**
Net book value at 31 March 2011	1,767,055	85,362	52,467	1,904,884

	Software Licences and Internally Developed Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Of the total:				
Core Department (excluding NHS Informatics)	388,432	-	-	388,432
NHS Informatics[1]	1,201,043	-	-	1,201,043
Primary Care Trusts	22,849	1,397	867	25,113
Strategic Health Authorities	423	-	-	423
NHS Trusts	95,739	23,173	19,370	138,282
NHS Foundation Trusts	113,558	42,973	41,533	198,064
Special Health Authorities	28,559	15,503	4,796	48,858
Non Departmental Public Bodies	8,920	15,322	-	24,242
Other	-	-	-	-
Net book value at 31 March 2012	**1,859,523**	**98,368**	**66,566**	**2,024,457**

	Software Licences and Internally Developed Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2010	3,439,294	159,600	33,844	3,632,738
Opening balance adjustment	(827)	(487)	-	(1,314)
Adjustment for transfer of functions	(17)	676	-	659
At 1 April 2010	**3,438,450**	**159,789**	**33,844**	**3,632,083**
Additions - purchased	340,383	28,294	45,011	413,688
Additions - donated	1,088	(14)	397	1,471
Additions - Government granted	-	465	906	1,371
Impairment transferred to Revaluation Reserve	41	0	(125)	(84)
Impairment transferred to the CSCNE	(1,441)	(421)	-	(1,862)
Impairment reversal	-	-	-	-
Transfers	(635)	389	(283)	(529)
Reclassification to assets held for sale	(202)	-	-	(202)
Other Reclassifications	287,825	(12,853)	(21,320)	253,652
Revaluation and indexation	154,116	(1,661)	-	152,455
Disposals	(425,872)	(19,276)	(675)	(445,823)
At 31 March 2011	**3,793,753**	**154,712**	**57,755**	**4,006,220**
Amortisation				
At 1 April 2010	1,673,467	59,868	3,581	1,736,916
Opening balance adjustment	(581)	-	-	(581)
Adjustment for transfer of functions	(67)	189	-	122
At 1 April 2010	**1,672,819**	**60,057**	**3,581**	**1,736,457**
Charged in year	673,360	19,827	1,863	695,050
Impairment transferred to Revaluation Reserve	-	-	-	-
Impairment transferred to the CSCNE	6,302	-	-	6,302
Impairment reversal	-	-	-	-
Transfers	2	98	(17)	83
Reclassification to assets held for sale	(120)	-	-	(120)
Other Reclassification	83,526	1,134	28	84,688
Revaluation and indexation	15,768	(173)	-	15,595
Disposals	(424,959)	(11,593)	(167)	(436,719)
At 31 March 2011	**2,026,698**	**69,350**	**5,288**	**2,101,336**
Net book value at 31 March 2011	**1,767,055**	**85,362**	**52,467**	**1,904,884**
Net book value at 31 March 2010	1,765,827	99,732	30,263	1,895,822

Unaudited Restated 2010-11

	Software Licences and Internally Developed Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Of the total:				
Core Department (excluding NHS Informatics)	123,454	1,459	-	124,913
NHS Informatics[1]	1,370,782	-	-	1,370,782
Primary Care Trusts	23,472	2,027	1,025	26,524
Strategic Health Authorities	292	-	-	292
NHS Trusts	96,334	24,759	19,981	141,074
NHS Foundation Trusts	104,847	28,176	31,356	164,379
Special Health Authorities	41,669	9,059	105	50,833
Non Departmental Public Bodies	6,205	19,882	-	26,087
Other	-	-	-	-
Net book value at 31 March 2011	**1,767,055**	**85,362**	**52,467**	**1,904,884**

Footnote
1) NHS Connecting for Health (responsible for implementing major IT programmes in the NHS) is part of the Department's Informatics Directorate. Whilst it is not a separate entity, its figures are separately disclosed due to their significance in relation to the Department as a whole.

2) Included within the total value for Software Licences and Internally Developed Software, £28.0 million (net book value) relates to internally developed software for the Core Department.

Net book value of intangible assets in the Revaluation Reserve

	£'000
As at 1 April 2011	123,142
Movement in year	457,944
As at 31 March 2012	581,086

The ranges of estimated useful lives are currently:
- Software licences: 1 – 20 years
- Internally Developed Software: 1 – 15 years
- Development expenditure: 1 - 99 years

The Department revalues intangible non-current assets associated with NHS Connecting for Health programmes at the end of each financial year, by indexing their original cost. Given the very significant value of these assets, the Department applies the difference between the Retail Price Index (RPI) operating in the month of purchase and the RPI at the end of the year. RPI is considered the most appropriate measure of indexation to use with this group of assets, as no other indexation factor is available that more accurately reflects the commercial environment in the computer services sector, or would not be compromised by the high value of the assets. This valuation method is reviewed annually to ascertain whether RPI remains the most appropriate index to use.

The effective date of revaluation for NHS Connecting for Health non-current assets is 31 March 2012.

NHS Connecting for Health non-current assets (whether classified as property, plant and equipment or intangible assets) are not added to the Department's Non-Current Asset Register until confirmation has been received from the appropriate NHS organisation that the relevant system has been deployed successfully.

13 Financial Assets – Investments

	2011-12 Core Department								2011-12 Departmental Group			
	NHS Trusts PDC	NHS Trusts Loans	NHS Foundation Trusts PDC	NHS Foundation Trusts Loans	Other Bodies PDC	Other Bodies Loans	Other Bodies Share Capital	Total	Other Bodies PDC	Other Bodies Loans	Other Bodies Share Capital	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2011	11,534,498	546,097	11,586,858	713,466	1,328	572,068	369,302	25,323,617	1,328	666,442	383,153	1,050,923
Opening balance adjustment	-	-	-	-	-	-	-	-	-	-	-	-
Adjustment for transfer of functions	-	-	-	-	-	-	-	-	-	-	-	-
Restated Balance as at 1 April 2011	**11,534,498**	**546,097**	**11,586,858**	**713,466**	**1,328**	**572,068**	**369,302**	**25,323,617**	**1,328**	**666,442**	**383,153**	**1,050,923**
Issued:												
To newly established bodies	32,802	-	800	-	-	-	-	33,602	-	-	-	-
To existing bodies	372,713	159,076	102,832	249,987	-	3,548	-	888,156	-	304,524	47,054	351,578
Repaid:												
By continuing bodies	(43,200)	(14,892)	(1,067)	(1,000)	-	(820)	-	(60,979)	-	(820)	-	(820)
Written off:												
By or on behalf of dissolved bodies	(32,869)	-	-	-	-	(299)	-	(33,168)	-	(299)	-	(299)
Other:												
Revaluation	-	-	-	-	-	101	84,304	84,405	-	101	84,666	84,767
Disposals	-	-	-	-	-	-	-	-	-	-	(38,181)	(38,181)
Current element of loans issued in year transferred to receivables	-	(11,153)	-	(2,270)	-	-	-	(13,423)	-	-	-	-
Other movements to and from receivables	-	(106,804)	-	(79,543)	-	(9,256)	-	(195,603)	-	(9,256)	(6,698)	(15,954)
Impairment	-	-	-	-	-	(647)	(101,906)	(102,553)	-	(28,632)	(101,906)	(130,538)
Impairment reversal	-	-	-	-	-	-	-	-	-	-	-	-
Reclassification	(549,857)	(44,148)	549,857	44,148	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	83	-	83	-	83	2,879	2,962
Balance as at 31 March 2012	**11,314,087**	**528,176**	**12,239,280**	**924,788**	**1,328**	**564,778**	**351,700**	**25,924,137**	**1,328**	**932,143**	**370,967**	**1,304,438**
Investments held by Core Department	11,314,087	528,176	12,239,280	924,788	1,328	564,778	351,700	25,924,137	1,328	564,778	351,700	25,924,137
Investments held by other NHS bodies	-	-	-	-	-	-	-	-	-	367,365	19,267	386,632

Total "Investments held by the Core Department" plus "Investments held by other NHS bodies" do not equal the total investment balance for the Departmental Group as at 31 March 2012. This is because the Core Department figure excludes inter-company eliminations of NHS Trust and NHS Foundation Trust PDC and loans totalling £25,006,331k.

The Department can analyse its investments in other bodies as follows:	Other Bodies PDC	Other Bodies Loans	Other Bodies Share Capital	Percentage Shareholding
	£'000	£'000	£'000	%
MHRA (Medicines and Healthcare products Regulatory Agency)	1,328	1,328	500	100%
Community Health Partnerships	-	10,000	103,000	100%
Credit Guarantee Fund (CGF)	-	493,998	-	0%
SBS	-	16,850	20,500	50%
LIFT companies	-	-	-	0%
Social Enterprise Loans	-	11,315	-	0%
NHS Property Services Ltd	-	-	-	100%
Other	-	31,287	227,700	0%
Total	**1,328**	**564,778**	**351,700**	

Footnote

1) The Core Department's PDC investment in, and loans to, NHS Trusts and NHS Foundation Trusts eliminate on consolidation, and so are not shown as consolidated Departmental Group investments as they are not with bodies external to the Group. With the exception of MHRA, PDC is only issued to bodies within the Departmental Group.
2) The consolidated "Other bodies loans" figure has increased significantly between 2010-11 and 2011-12, primarily due to the NHS Business Services Authority making £300 million of working capital available to the outsourced Supply Chain arrangement to facilitate aggregated capital purchases for the NHS.
3) The "Repaid" line records repayments of non-current amounts: i.e. repayments of amounts in advance of the dates specified in the relevant loan agreements/schedules. The repayment of the current element of financial assets is accounted for in the receivables note.
4) The "Issued" line records the full value of all new loans let in-year. These loans will comprise a current and non-current element, with the current element being immediately transferred to receivables via the "Current element of loans issued in-year transferred to receivables" line.

Investments categorised as "Other" include Dr Foster Intelligence Ltd, Plasma Resources UK and NHS Professionals. These investments are for sale, but do not currently meet the IFRS 5 criteria for assets held for sale, and are shown in aggregate in these accounts on the grounds of commercial sensitivity.

	2010-11 Core Department								Unaudited Restated 2010-11 Departmental Group			
	NHS Trusts PDC	NHS Trusts Loans	NHS Foundation Trusts PDC	NHS Foundation Trusts Loans	Other Bodies PDC	Other Bodies Loans	Other Bodies Share Capital	Total	Other Bodies PDC	Other Bodies Loans	Other Bodies Share Capital	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2010	**11,747,217**	**474,317**	**11,098,981**	**455,891**	**1,328**	**561,310**	**190,380**	**24,529,424**	**1,328**	**653,864**	**217,218**	**872,410**
Issued:												
To newly established bodies	3,605	-	-	-	-	16,112	58,300	78,017	-	16,112	58,300	74,412
To existing bodies	301,087	242,042	69,178	310,393	-	-	-	922,700	-	5,401	7,920	13,321
Repaid:												
By continuing bodies	(93,153)	(39,369)	(5,559)	(10,199)	-	(338)	-	(148,618)	-	(338)	(6,949)	(7,287)
Written off:												
By or on behalf of dissolved bodies	-	-	-	-	-	-	-	-	-	-	-	-
Other:												
Revaluation	-	-	-	-	-	-	115,724	115,724	-	273	110,734	111,007
Loan repayable within 12 months transferred to receivables	-	(121,040)	-	(52,473)	-	(2,634)	-	(176,147)	-	(6,488)	-	(6,488)
Impairment	-	1	-	-	-	(2,384)	(3,100)	(5,483)	-	(2,384)	(3,100)	(5,484)
Impairment reversal	-	-	-	-	-	-	-	-	-	-	-	-
Reclassification	(424,258)	(9,854)	424,258	9,854	-	2	7,998	8,000	-	2	(2)	-
Other Movements	-	-	-	-	-	-	-	-	-	-	(968)	(968)
Balance as at 31 March 2011	**11,534,498**	**546,097**	**11,586,858**	**713,466**	**1,328**	**572,068**	**369,302**	**25,323,617**	**1,328**	**666,442**	**383,153**	**1,050,923**
Investments held by Core Department	11,534,498	546,097	11,586,858	713,466	1,328	572,068	369,302	25,323,617	1,328	572,068	369,302	25,323,617
Investments held by other NHS bodies	-	-	-	-	-	-	-	-	-	94,374	13,851	108,225

The Department can analyse its investments in other bodies as follows:

	Other Bodies PDC	Other Bodies Loans	Other Bodies Share Capital	Percentage Shareholding
	£'000	£'000	£'000	%
MHRA (Medicines and Healthcare products Regulatory Agency)	1,328	1,328	500	100%
Community Health Partnerships	-	10,000	93,700	100%
Plasma Resources UK Ltd	-	31,186	220,602	100%
Credit Guarantee Fund (CGF)	-	497,083	-	0%
SBS	-	21,766	20,000	50%
LIFT companies	-	-	-	
Dr Foster Intelligence Ltd	-	-	8,000	48.75%
NHS Professionals	-	-	26,500	100%
Social Enterprise Loans	-	10,405	-	
Other	-	300	-	
Total	**1,328**	**572,068**	**369,302**	

Where the Department has a formal investment in another public sector entity that does not meet the criteria for consolidation (for example its investment in the Medicines and Healthcare products Regulatory Agency) the investment is measured at historic cost, less any impairment, as required by the FReM.

The Department values its other financial investments internally each year with reference to quoted market prices. Independent valuations are carried out at intervals of no more than three years. The Department's investments in Community Health Partnerships, Plasma Resources UK Ltd, SBS, NHS Professionals and Dr Foster Intelligence Ltd were all subject to independent valuation in 2011-12.

One of the main considerations, in both the internal and independent valuation techniques employed by the Department, is an assessment of the value of future liabilities of the entities, including future pension liabilities.

The Government began a consultation on the Fair Deal for Pensions policy in 2011, in response to a recommendation made in an interim report by the Independent Public Service Pensions Commission. This consultation covers the options on pension provision in the public sector, and potentially creates significant uncertainity with regard to the future value of public sector pension liabilities.

The Department's investments predominately relate to organisations that have a substantial number of employees with public sector pensions. These could potentially be affected by the outcome of the Fair Deal consultation. When the Department's investments were subject to independent valuation for these accounts, the Government's application of the Fair Deal reforms were, and still are, subject to significant uncertainty. It is not yet clear to what extent, if at all, the proposed changes will affect the staff employed in the organisations, so there was no impact on the value of the Department's investments in 2011-12.

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	Plasma Resources UK Limited	Community Health Partnerships	Joint Ventures SBS	Dr Foster Intelligence Ltd	NHS Professionals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Net Assets at 31 March 2012	12,115,648	17,497,184	95,411	94,267	56,419	5,872	6,676	35,937
Turnover	30,911,248	35,855,513	117,247	123,069	629	62,447	14,863	311,024
Surplus/profit for the year (before financing)	(717,571)	76,156	17,215	(18,238)	2,915	4,168	(9,438)	3,423
Net Assets at 31 March 2011	13,414,037	16,338,866	79,383	53,850	53,514	1,704	16,213	32,514
Turnover	29,462,879	30,704,617	122,931	80,497	411	53,265	20,320	297,600
Surplus/profit for the year (before financing)	(329,216)	(395,672)	30,946	3,567	3,056	2,481	(1,469)	309

Investments held by the Department of Health in 2011-12

The figures for Plasma Resources UK, SBS and Dr Foster Intelligence Ltd are for the financial year ending 31st December 2011.

Credit Guarantee Finance (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 loans undertaken by the Department are pilots at two NHS PFI projects – Leeds and Portsmouth. Other than these pilots, the Department will not be undertaking any further CGF loans.

New Social Enterprise loans of £3.5 million have been issued in 2011-12. Additionally, £299,000 of loans made in prior periods have been written off over a number of years and reported as losses in Note 27: Losses and Special Payments.

NHS Property Services Ltd is a company wholly owned by the Department of Health. It was established on 20 December 2011 and registered at Companies House. The Department owns a single ordinary £1 share and has made no further investment in the company to date. The company will become active in the latter half of the 2012-13 financial year as the Department plans for the transfer of PCT estate assets with associated liabilities and staff to the company following PCT abolition. From that point, the company will own and run the ex-PCT estate and will take over the PCT role in relevant arrangements (for example landlord responsibilities and strategic management).

Investments held by other NHS bodies in 2011-12

In order to better reflect the commercial substance of the outsourced Supply Chain arrangement, the NHS Business Services Authority (NHS BSA) has revised the accounting treatment in this area. Previously, the individual components of Supply Chain working capital totalling £65.6 million were reported separately in the Statement of Financial Position (SoFP) and its associated notes. This total, which reflects the amount due to the NHS BSA at the end of the arrangement on 30 September 2016, is now recorded as a financial asset. As

detailed in Note 1b Restatement, prior year figures have been restated to reflect this revised accounting treatment. In 2011-12 a further £300 million of working capital has been made available to facilitate aggregated capital purchases for the NHS.

Further details relating to investments can be found in the accounts of underlying bodies.

Financing of NHS Trusts and NHS Foundation Trusts

The Department has two means of financing NHS Trusts and NHS Foundation Trusts:

(1) **Public Dividend Capital (PDC)** - issued as either structural capital when NHS Trusts are established, or when the Department needs to provide additional financing to NHS Trusts or NHS Foundation Trusts after establishment.

(2) **Loans** – normally made under standard Government loan terms, i.e. 6 monthly equal instalments of principal and interest charged on outstanding balances. National Loan Fund rates of interest (as published by the UK Debt Management Office) are applied.

Both PDC and Loans are held at historic value.

In 2011-12, three NHS Trusts defaulted on loan principal repayments with a value of £26.4 million. The Department has rescheduled two of the principal repayments and the third is in negotiation (£14.3 million). All the loans remain repayable in full. There was no default of interest payments in the year.

The Department judges that there is no material credit risk associated with either form of investment. The financial performance of NHS Trusts and NHS Foundation Trusts is rigorously managed by Strategic Health Authorities and the independent regulator Monitor, not least through their respective powers of intervention. No loan to NHS Trusts or NHS Foundation Trusts has been written off since the re-introduction of loan-financing for NHS providers in 2004.

14 Inventories and work in progress

Core Department	Emergency preparedness	Adult and Childhood Vaccines	Work in progress	Essential Medicines	Pandemic Flu Counter-measures	Pre Pandemic Flu	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2011	**-**	**89,421**	**-**	**-**	**-**	**-**	**7**	**89,428**
Opening balance adjustment	-	-	-	-	-	-	-	-
Adjustment for transfer of functions	-	-	-	-	-	-	-	-
Restated Balance as at 1 April 2011	**-**	**89,421**	**-**	**-**	**-**	**-**	**7**	**89,428**
Additions	-	203,474	-	-	-	-	-	203,474
Consumed/Disposed of	(164)	(198,897)	-	(8,856)	(30,462)	-	(7)	(238,386)
Written down charged to CSCNE	-	(710)	-	-	-	-	-	(710)
Revaluation	-	14,672	-	-	-	-	-	14,672
Transfer (to) / from non-current assets	164	-	-	8,856	30,462	-	-	39,482
Other	-	-	-	-	-	-	-	-
Balance as at 31 March 2012	**-**	**107,960**	**-**	**-**	**-**	**-**	**-**	**107,960**

2011-12

Departmental Group	Emergency preparedness	Adult and Childhood Vaccines	Work in progress	Essential Medicines	Pandemic Flu Counter-measures	Pre Pandemic Flu	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2011	**155**	**89,468**	**4,727**	**-**	**219**	**477**	**810,715**	**905,761**
Opening balance adjustment	-	-	-	-	-	-	48	48
Adjustment for transfer of functions	-	-	-	-	-	-	(2,467)	(2,467)
Restated Balance as at 1 April 2011	**155**	**89,468**	**4,727**	**-**	**219**	**477**	**808,296**	**903,342**
Additions	165	203,702	6,202	-	30	25	5,674,673	5,884,797
Consumed/Disposed of	(339)	(199,115)	(5,185)	(8,856)	(30,727)	(96)	(5,499,701)	(5,744,019)
Written down charged to CSCNE	-	(710)	-	-	-	-	(5,729)	(6,439)
Revaluation	-	14,672	-	-	-	-	(22)	14,650
Transfer (to) / from non-current assets	269	2	-	8,856	30,462	-	(18,346)	21,243
Consumables and Raw Materials	-	-	-	-	-	-	(131,766)	(131,766)
Other	-	-	34	-	150	31	(10,137)	(9,922)
Balance as at 31 March 2012	**250**	**108,019**	**5,778**	**-**	**134**	**437**	**817,268**	**931,886**

2010-11

Core Department	Emergency preparedness	Adult and Childhood Vaccines	Work in progress	Essential Medicines	Pandemic Flu Counter-measures	Pre Pandemic Flu	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2010	12,139	146,992	-	56,503	-	-	-	215,634
Opening balance adjustment	-	-	-	-	-	-	-	-
Adjustment for transfer of functions	-	-	-	-	-	-	-	-
Restated Balance as at 1 April 2010	**12,139**	**146,992**	**-**	**56,503**	**-**	**-**	**-**	**215,634**
Additions	-	128,801	-	-	-	-	-	128,801
Consumed/Disposed of	-	(204,223)	-	(7,744)	-	-	-	(211,967)
Written down charged to CSCNE	-	(2,261)	-	-	-	-	-	(2,261)
Revaluation	-	-	-	-	-	-	-	-
Transfer (to) / from non-current assets	(12,139)	-	-	(48,759)	(9,318)	-	-	(70,216)
Consumables and Raw Materials	-	20,112	-	-	9,318	-	7	29,437
Other	-	-	-	-	-	-	-	-
Balance as at 31 March 2011	**-**	**89,421**	**-**	**-**	**-**	**-**	**7**	**89,428**

Unaudited Restated 2010 11

Departmental Group	Emergency preparedness	Adult and Childhood Vaccines	Work in progress	Essential Medicines	Pandemic Flu Counter-measures	Pre Pandemic Flu	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2010	12,557	147,036	5,452	56,503	922	561	786,050	1,009,081
Opening balance adjustment	-	-	-	-	-	-	-	-
Adjustment for transfer of functions	-	-	-	-	-	-	(8)	(8)
Restated Balance as at 1 April 2010	**12,557**	**147,036**	**5,452**	**56,503**	**922**	**561**	**786,042**	**1,009,073**
Additions	442	128,906	4,943	-	539	31	5,060,110	5,194,971
Consumed/Disposed of	(700)	(204,319)	(5,598)	(7,744)	(1,242)	(115)	(4,886,462)	(5,106,180)
Written down charged to CSCNE	(5)	(2,261)	-	-	-	-	(10,289)	(12,555)
Revaluation	-	-	-	-	-	-	17	17
Transfer (to) / from non-current assets	(12,139)	-	-	(48,759)	(9,318)	-	(15,485)	(85,701)
Consumables and Raw Materials	-	20,112	-	-	9,318	-	(124,411)	(94,981)
Other	-	(6)	(70)	-	-	-	1,193	1,117
Balance as at 31 March 2011	**155**	**89,468**	**4,727**	**-**	**219**	**477**	**810,715**	**905,761**

15 Impairments

	2011-12 Core Department	2011-12 Departmental Group	2010-11 Core Department	Unaudited Restated 2010-11 Departmental Group
	£'000	£'000	£'000	£'000
Impairments charged to Consolidated Statement of Comprehensive Net Expenditure				
Property Plant and Equipment impairments	36,887	1,333,556	11,110	1,439,011
Intangible asset impairments	43,590	55,760	6,849	15,916
Financial asset impairments	2,247	31,153	5,485	3,956
Non Current Assets Held for Sale impairments	-	29,109	-	9,308
Investment Property impairments	-	175	-	-
Total impairments charged to Consolidated Statement of Comprehensive Net Expenditure	**82,724**	**1,449,753**	**23,444**	**1,468,191**
Impairments charged to Revaluation Reserve				
Property Plant and Equipment impairments	42	602,983	42,804	507,262
Intangible asset impairments	-	879	-	84
Financial asset impairments	100,306	100,306	-	-
Total impairments charged to Revaluation Reserve	**100,348**	**704,168**	**42,804**	**507,346**
Total impairments charged in year	**183,072**	**2,153,921**	**66,248**	**1,975,537**

16 Trade Receivables and other current assets

16.1 Analysis by type

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Amounts falling due within one year:				
Trade receivables	43,750	246,288	45,652	232,458
Deposits and advances	-	2,198	-	120
Capital receivables - property plant and equipment	-	55,085	-	54,660
Capital receivables - intangible non current assets	-	1,103	-	919
Interest receivable	210	1,920	30	1,251
Other receivables	74,181	479,564	55,007	727,039
Pension prepayments maturing in one year	-	-	-	-
Consolidated Fund Extra Receipts receivable	27,279	27,279	23,345	23,345
Other prepayments and accrued income	205,896	1,505,001	161,113	1,184,704
Current part of loans repayable transferred from investments	231,953	64,749	189,138	47,561
Current part of PFI and other service concession arrangements prepayments	-	34,931	-	25,192
	583,269	**2,418,118**	**474,285**	**2,297,249**
Amounts falling due after more than one year:				
Trade receivables	-	71,327	-	86,949
Deposits and advances	-	-	-	22
Capital receivables - property plant and equipment	-	15,757	-	15,679
Capital receivables - intangible non current assets	-	395	-	285
Other receivables	110,974	301,591	117,913	327,496
Pension prepayments maturing after one year	-	-	-	261
Other Prepayments and accrued income	11,752	160,906	12,062	161,004
Non-current part of PFI and other service concession arrangements prepayments	-	63,169	-	52,006
	122,726	**613,145**	**129,975**	**643,702**
Total receivables at 31 March 2012	**705,995**	**3,031,263**	**604,260**	**2,940,951**

16.2 Intra-Government balances

16.2 Intra-government balances

	Departmental Group			
	Amounts falling due within one year	Amounts falling due after one year	Amounts falling due within one year	Amounts falling due after one year
	£'000	£'000	£'000	£'000
	2011-12	2011-12	Unaudited Restated 2010-11	Unaudited Restated 2010-11
Balances with other central government bodies	638,900	19,248	710,838	38,915
Balances with local authorities	91,678	400	234,160	2,144
Balances with NHS bodies outside the Departmental Group	-	-	-	-
Balances with Public Corporations and Trading Funds	307	-	6,584	-
Subtotal: Intra-government balances	**730,885**	**19,648**	**951,582**	**41,059**
Balances with bodies external to government	1,687,233	593,497	1,345,667	602,642
Total receivables	**2,418,118**	**613,145**	**2,297,249**	**643,701**

	Core Department			
	Amounts falling due within one year	Amounts falling due after one year	Amounts falling due within one year	Amounts falling due after one year
	£'000	£'000	£'000	£'000
	2011-12	2011-12	2010-11	2010-11
Balances with other central government bodies	52,187	-	9,555	-
Balances with local authorities	9	-	-	-
Balances with NHS bodies outside the Departmental Group	-	-	-	-
Balances with NHS bodies inside the Departmental Group	260,250	-	-	-
Balances with Public Corporations and Trading Funds	-	-	-	-
Subtotal: Intra-government balances	**312,446**	**-**	**9,555**	**-**
Balances with bodies external to government	270,823	122,726	464,730	129,975
Total receivables	**583,269**	**122,726**	**474,285**	**129,975**

17 Cash and cash equivalents

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	**Departmental Group**	**Core Department**	**Departmental Group**
Balance as at 1 April 2011	**1,624,356**	**5,890,739**	**1,237,866**	**4,988,210**
Adjustment for transfer of functions	-	(5,464)	-	(3,081)
Opening balance adjustment	-	6,392	-	(4,721)
Restated Balance as at 1 April 2011	**1,624,356**	**5,891,667**	**1,237,866**	**4,980,408**
Net change in cash	(1,104,208)	(86,469)	386,490	910,331
Balance at 31 March 2012	**520,148**	**5,805,198**	**1,624,356**	**5,890,739**
The following balances at 31 March were held at:				
Office of HM Paymaster General	-	-	-	861,624
Commercial banks and cash in hand	520,148	5,763,719	1,624,356	4,987,817
Short term investments	-	41,479	-	41,298
Balance at 31 March 2012	**520,148**	**5,805,198**	**1,624,356**	**5,890,739**

Following the introduction of the Government Banking Service (GBS) in 2009-10, cash balances held in bank accounts operated by the Office of HM Paymaster General have reduced to zero during the year. Cash held in GBS accounts are included within the Commercial banks and cash in hand line of the above note.

As a result of tighter cash management across the Group during the financial year the Department was able to plan for a significantly reduced level of cash than was anticipated when the Supplementary Estimate was completed.

18 Assets classified as held for sale

	Land £'000	Buildings £'000	Plant and Machinery £'000	Stockpiled goods £'000	Intangible Assets £'000	Total £'000
						Departmental Group 2011-12
As at 1 April 2011	**153,758**	**58,363**	**3,548**	**-**	**(7)**	**215,662**
Opening balance adjustment	9	(10)	(4)	-	4	(1)
Adjustment for transfer of functions	1	-	-	-	-	1
Restated Balance as at 1 April 2011	**153,768**	**58,353**	**3,544**	**-**	**(3)**	**215,662**
Assets held for sale in year	137,482	132,606	6,006	-	547	276,641
Assets sold in year	(126,060)	(69,250)	(4,841)	-	(230)	(200,381)
Impairment of assets held for sale	(19,956)	(15,448)	(561)	-	-	(35,965)
Reversal of impairments of assets held for sale	4,195	941	-	-	-	5,136
Assets no longer held for sale (for reasons other than sale)	(2,276)	(12,172)	(645)	-	-	(15,093)
Gain/(loss) on transfer to assets held for sale	-	-	-	-	-	-
Transfer to NHS Foundation Trusts	-	-	-	-	-	-
As at 31 March 2012	**147,153**	**95,030**	**3,503**	**-**	**314**	**246,000**
Liabilities associated with assets held for sale at 31 March 2012	(88)	(171)	-	-	-	(259)

Amount attributable to Core Department:

	Land £'000	Buildings £'000	Plant and Machinery £'000	Stockpiled goods £'000	Intangibles £'000	Total £'000
Core Department as at 31 March 2012	7,847	809	-	-	-	8,656

	Land £'000	Buildings £'000	Plant and Machinery £'000	Stockpiled goods £'000	Intangible Assets £'000	Total £'000
						Departmental Group Unaudited Restated 2010-11
As at 1 April 2010	**129,969**	**67,010**	**316**	**-**	**-**	**197,295**
Assets designated as held for sale in year	129,754	82,694	9,162	-	82	221,692
Assets sold in year	(72,290)	(74,489)	(5,810)	-	(89)	(152,678)
Impairment of assets held for sale	(4,541)	(8,736)	(11)	-	-	(13,288)
Reversal of impairments of assets held for sale	1,398	1,705	-	-	-	3,103
Assets no longer held for sale (for reasons other than sale)	(30,532)	(9,821)	(109)	-	-	(40,462)
Transfer to NHS Foundation Trusts	-	-	-	-	-	-
As at 31 March 2011	**153,758**	**58,363**	**3,548**	**-**	**(7)**	**215,662**
Liabilities associated with assets held for sale at 31 March 2011	-	-	-	-	-	-

Amount attributable to Core Department:

	Land £'000	Buildings £'000	Plant and Machinery £'000	Stockpiled goods £'000	Intangibles £'000	Total £'000
Core Department as at 31 March 2011	5,854	230	-	-	-	6,084

The Department holds Retained Estates that are property not transferred to the ownership of the NHS with a total book value of £55.6m. Of this total, the department proposes to sell property with a book value of £45.9m to third parties. Only £8.7 million of these planned asset sales meet the IFRS 5 “held for sale” recognition criteria and are therefore included within this note.

19 Trade Payables and other current liabilities

19.1 Analysis by type

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Amounts falling due within one year:				
Bank Overdraft	-	20,749	44	36,313
VAT	-	4,987	21,384	28,040
Other taxation and social security	3,270	732,960	3,882	760,789
Trade payables	47,300	3,511,260	58,847	3,717,576
Capital payables - property plant and equipment	4	536,224	-	492,555
Capital payables - intangible non current assets	95,189	106,970	122,362	130,955
Other payables	4,028	823,683	15,388	933,792
Early retirement costs payable within one year	-	252	-	38
EEA Medical Costs Accrual	541,593	541,593	557,106	557,106
Other Accruals	325,403	4,779,357	310,674	3,948,469
Deferred grants income (including transfer from reserves to match depreciation)	-	20,179	-	15,303
Deferred income - goods and services	68,609	497,598	60,823	518,070
Deferred income - rent of land	-	7	-	319
Other deferred income	-	203,814	-	158,669
Current part of finance lease	8,253	62,085	13,337	149,973
Current part of imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	260,547	-	231,804
Amount issued from the Consolidated Fund for supply but not spent at year end	604,095	604,095	982,689	982,689
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received	95	95	53	53
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Receivable	27,279	27,279	23,345	23,345
Other amount payable to the Consolidated Fund	-	-	735,792	735,792
Current loans payable by NHS Trusts to entities outside the accounting boundary	-	3,230	-	226
Investment payables	-	-	-	-
Pension Liabilities	-	682	-	679
	1,725,118	**12,737,646**	**2,905,726**	**13,422,555**
Amounts falling due after more than one year:				
Finance leases	55,816	354,486	72,965	396,690
Imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	11,454,095	-	10,091,509
Trade payables	-	21,521	-	23,417
EEA Medical Costs Accrual	160,831	160,831	195,280	195,280
Capital payables - property plant and equipment	-	5,848	-	8,055
Capital payables - intangible non current assets	104,313	104,387	133,510	133,699
Other payables	-	144,714	-	135,647
Deferred grants income (including transfer from reserves to match depreciation)	-	480	-	19,081
Deferred income - goods and services	18,328	72,418	23,929	57,800
Deferred income - rent of land	-	1,228	-	1,503
Other deferred income	-	94,443	-	86,523
Non-current loans payable by NHS Trusts to entities outside the accounting boundary	-	5,985	-	6,374
Pension Liabilities	-	6,655	-	4,379
	339,288	**12,427,091**	**425,684**	**11,159,957**
Total payables	**2,064,406**	**25,164,737**	**3,331,410**	**24,582,512**

Footnote

1) As detailed in Note 1b Restatement, in 2010-11 the accruals associated with European Economic Area (EEA) medical costs were incorrectly categorised within the payables note. In particular, all long term accruals were incorrectly categorised as amounts falling due within 1 year and some accruals were incorrectly recorded as Other accruals rather than EEA Medical Costs Accruals. Whilst this classification error does not affect the bottom line and is not considered a fundamental error, the 2010-11 figures have nevertheless been restated to ensure comparability with the current year. The impact on the individual items in the 2010-11 payables note is as follows: EEA Medical Costs Accrual (amounts falling due after one year) increased by £195.28 million, EEA Medical Costs Accrual (amounts falling due within one year) decreased by £82.56 million and Other Accruals (amounts falling due within one year) decreased by £111.02 million.
2) From 2011-12, as a consequence of HM Treasury's Clear Line of Sight (alignment) legislation, Estimates are Voted on a net basis. As a result, the concept of excess appropriations in aid (A-in-A) no longer exists, and the Department retains all income generated with the exception of that falling outside the Ambit of the Vote. In 2010-11 the Department classified £735,792,000 of income as excess A-in-A. In line with HM Treasury guidance, the Statement of Parliamentary Supply and all supporting notes have been restated to reflect this change. As the £735,792,000 remains payable to HM Treasury, it remains within the 2010-11 payables note but has been recategorised as an "Other amount payable to the Consolidated Fund" as it is no longer a Consolidated Fund Extra Receipt. The equivalent 2011-12 figure is zero as excess A-in-A no longer exists.

19.2 Intra-Government balances

				Departmental Group
	Amounts falling due within one year	Amounts falling due after more than one year	Amounts falling due within one year	Amounts falling due after more than one year
	£'000	£'000	£'000	£'000
	2011-12	2011-12	Unaudited Restated 2010-11	Unaudited Restated 2010-11
Balances with other central government bodies	1,106,897	-	2,779,291	8,665
Balances with local authorities	248,328	4,398	284,424	-
Balances with NHS bodies outside the Departmental Group	-	-	-	-
Balances with Public Corporations and Trading Funds	5,448	-	24,692	-
Subtotal: Intra-government balances	**1,360,673**	**4,398**	**3,088,407**	**8,665**
Balances with bodies external to government	11,376,973	12,422,693	10,334,148	11,151,292
Total payables	**12,737,646**	**12,427,091**	**13,422,555**	**11,159,957**

				Core Department
	Amounts falling due within one year	Amounts falling due after more than one year	Amounts falling due within one year	Amounts falling due after more than one year
	£'000	£'000	£'000	£'000
	2011-12	2011-12	2010-11	2010-11
Balances with other central government bodies	650,894	-	1,739,609	-
Balances with local authorities	588	-	-	-
Balances with NHS bodies outside the Departmental Group	-	-	-	-
Balances with NHS bodies inside the Departmental Group	73,088	-	-	-
Balances with Public Corporations and Trading Funds	805	-	-	-
Subtotal: Intra-government balances	**725,375**	**-**	**1,739,609**	**-**
Balances with bodies external to government	999,743	339,288	1,166,117	425,684
Total payables	**1,725,118**	**339,288**	**2,905,726**	**425,684**

20 Provisions for liabilities and charges

	2011-12										
	Core Department					Departmental Group					
	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance At 1 April 2011	**13,193**	**655,923**	**551,769**	**266,121**	**1,487,006**	**591,640**	**655,923**	**551,769**	**16,639,494**	**1,332,267**	**19,771,093**
Opening balance adjustment	-	-	-	-	-	2,236	-	-	-	(2,863)	(627)
Adjustment for transfer of functions	-	-	-	-	-	287	-	-	-	276	563
Restated Balance At 1 April 2011	**13,193**	**655,923**	**551,769**	**266,121**	**1,487,006**	**594,163**	**655,923**	**551,769**	**16,639,494**	**1,329,680**	**19,771,029**
Provided in the year	432	43,109	613,751	141,277	798,569	44,655	43,109	613,751	4,616,234	1,016,653	6,334,402
Transfers in Year	-	-	-	-	-	-	-	-	-	2,882	2,882
Provisions utilised in the year	(4,711)	(49,026)	(41,585)	(28,292)	(123,614)	(92,147)	(49,026)	(41,585)	(1,277,371)	(373,656)	(1,833,785)
Provisions not required written back	-	(11,435)	-	(9,490)	(20,925)	(19,972)	(11,435)	-	(1,354,471)	(229,299)	(1,615,177)
Unwinding of discount	369	14,430	12,140	5,773	32,712	14,655	14,430	12,140	(3,887)	10,593	47,931
Change in discount rate	-	-	-	-	-	1,660	-	-	-	568	2,228
Transfer to accruals	-	-	(518,212)	-	(518,212)	(1,989)	-	(518,212)	-	(143)	(520,344)
Balance as at 31 March 2012	**9,283**	**653,001**	**617,863**	**375,389**	**1,655,536**	**541,025**	**653,001**	**617,863**	**18,619,999**	**1,757,278**	**22,189,166**

	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
2011-12											
Current	3,503	47,496	161,138	24,179	236,316	58,696	47,496	161,138	2,062,595	959,706	3,289,631
Non Current	5,780	605,505	456,725	351,210	1,419,220	482,329	605,505	456,725	16,557,404	797,572	18,899,535
Expected timing of cash flow											
Not later than 1 year	3,503	47,496	161,138	24,179	236,316	58,696	47,496	161,138	2,062,595	959,706	3,289,631
Later than 1 year, not later than 5 years	5,141	179,821	456,725	81,588	723,275	208,374	179,821	456,725	4,754,160	377,705	5,976,785
Later than 5 Years	639	425,684	-	269,622	695,945	273,955	425,684	-	11,803,244	419,867	12,922,750
Total	**9,283**	**653,001**	**617,863**	**375,389**	**1,655,536**	**541,025**	**653,001**	**617,863**	**18,619,999**	**1,757,278**	**22,189,166**

Prior year	Core Department					Departmental Group					Unaudited Restated 2010-11
	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance At 1 April 2010	**14,778**	**678,194**	**483,385**	**198,569**	**1,374,926**	**634,682**	**678,194**	**483,385**	**14,899,455**	**998,181**	**17,693,897**
Provided in the year	6,946	24,535	788,297	197,391	1,017,169	68,681	24,535	788,297	3,319,335	846,852	5,047,700
Provisions utilised in the year	(7,550)	(48,751)	(90,883)	(99,446)	(246,630)	(98,771)	(48,751)	(90,883)	(863,398)	(323,983)	(1,425,786)
Provisions not required written back	(1,369)	(12,975)	-	(34,018)	(48,362)	(15,804)	(12,975)	-	(693,439)	(190,742)	(912,960)
Unwinding of discount	388	14,920	10,634	3,625	29,567	14,555	14,920	10,634	(22,459)	7,287	24,937
Change in discount rate	-	-	-	-	-	(9,694)	-	-	-	(4,636)	(14,330)
Transfer to accruals	-	-	(639,664)	-	(639,664)	(2,009)	-	(639,664)	-	(692)	(642,365)
Balance as at 31 March 2011	**13,193**	**655,923**	**551,769**	**266,121**	**1,487,006**	**591,640**	**655,923**	**551,769**	**16,639,494**	**1,332,267**	**19,771,093**

	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
2010-11											
Current	4,294	46,714	184,594	35,394	270,996	64,773	46,654	184,594	2,055,896	713,049	3,064,966
Non Current	8,899	609,209	367,175	230,727	1,216,010	526,867	609,269	367,175	14,583,598	619,218	16,706,127
Prior year: expected timing of cash flow											
Not later than 1 year	4,294	46,714	184,594	35,394	270,996	64,773	46,654	184,594	2,055,896	713,049	3,064,966
Later than 1 year, not later than 5 years	7,887	177,416	367,175	91,080	643,558	226,692	177,352	367,175	4,335,308	348,145	5,454,672
Later than 5 Years	1,012	431,793	-	139,647	572,452	300,175	431,917	-	10,248,290	271,073	11,251,455
Total	**13,193**	**655,923**	**551,769**	**266,121**	**1,487,006**	**591,640**	**655,923**	**551,769**	**16,639,494**	**1,332,267**	**19,771,093**

Clinical Negligence

The Department of Health provides for future costs in a number of cases where it is the defendant in legal proceedings brought by claimants seeking damages for the effects of alleged clinical negligence.

Strategic Health Authorities, Primary Care Trusts, NHS Foundation Trusts and NHS Trusts retain legal responsibility for all liabilities covered by the clinical negligence schemes: the Ex-Regional Health Authority Scheme (ex RHA), Existing Liabilities Scheme (ELS) and Clinical Negligence Scheme for Trusts (CNST), but the NHS Litigation Authority (NHSLA) accounts for all the liabilities under these separate schemes. Actuaries appointed by the NHSLA undertake regular reviews to identify movements in the value of likely future settlements under these schemes, and these are recorded in the NHSLA's annual accounts.

The movements in provisions recorded in the Statement of Financial Position of the NHSLA are made up of several elements namely: changes to the value of existing claims brought forward at the start of the financial year, the outstanding value of new claims received in year which remain open at the end of the financial year, and an allowance for claims incurred during 2011-12 which are yet to be reported.

Known reported claims are individually valued using likely costs to resolve the claim and probability factors to take account of the potential of a successful defence, whilst incurred but not reported (IBNR) claims are valued using actuarial models to predict likely values. The NHSLA reviews its actuarial models twice each year as it seeks to compare previous forecasts to actual activity in year. In 2011-12 an independent review of actuarial projections was undertaken to provide additional assurance to the NHSLA. During 2011-12, the value of known provisions charged was higher than in 2010-11 mainly as a result of an increase in the volume of claims reported. In 2011-12, the reported number of new clinical negligence claims increased by approximately 6% compared to 2010-11, a significant increase but a substantially lower one than in 2010-11 (31% increase compared to 2009-10) and lower than each of the previous three years. Other types of claims also increased by approximately 6%. Following a review of these new claims, it appears that this growth can be principally attributed to faster reporting patterns i.e. claims being made faster than predicted, and not to a systemic increase in the incidence of clinical negligence.

Clinical negligence claims which may succeed, but are less likely or cannot be reliably estimated, are accounted for as contingent liabilities.

Clinical negligence provisions in the accounts of the NHSLA as at 31 March 2012 include £32,419,000 for the RHA scheme, £2,273,076,000 under the ELS and £16,314,504,000 for CNST.

Of the total £18,619,999,000 clinical negligence provisions, £2,062,595,000 is expected to be payable within 1 year, £4,754,160,000 in 1 to 5 years and £11,803,244,000 after 5 years. These estimates are based on the anticipated timing and progress of claims through the legal process.

Early Departure

These financial statements provide for the additional future costs, beyond the normal benefit awards for which employees are eligible under the terms of their pension scheme, arising from compensation payments for termination of employment through redundancy, severance or early retirement. The provision also takes account of arrangements with pension schemes under which employees can make prepayments to meet future liabilities. On the basis of the age of retirees, expenditure is likely to be incurred over a period of up to nine years.

The provision mainly relates to early retirement liabilities in Primary Care Trusts, NHS Trusts and NHS Foundation Trusts.

Primary Care Trust liabilities total £196,274,000. Of the total, £23,865,000 is expected to be payable within 1 year, £85,191,000 in 1 to 5 years and £87,218,000 after 5 years. NHS Trust liabilities total £154,784,000, of which £13,248,000 is expected to be payable within 1 year, £55,658,000 in 1 to 5 years, and £85,878,000 after 5 years. NHS Foundation Trust liabilities total £172,617,000, of which £15,254,000 is expected to be payable within 1 year, £58,704,000 in 1 to 5 years, and £98,659,000 after 5 years.

Further amounts of £3,614,000 are included in Strategic Health Authorities, of which £245,000 is expected to be payable within 1 year, £2,433,000 in 1 to 5 years, and £936,000 after 5 years; £4,453,000 in Special Health Authorities and Arms Length Bodies of which £2,581,000 is expected to be payable within 1 year, £1,247,000 in 1 to 5 years and £625,000 after 5 years; and £9,283,000 in the Department of Health, of which £3,503,000 is expected to be payable within 1 year, £5,141,000 in 1 to 5 years and £639,000 after 5 years.

Injury Benefits

The Department's Annual Report and Accounts provide for the future costs of permanent Injury Benefits awarded up to April 1997 to NHS staff injured in the course of their duties. From this date, the respective NHS body which employed the injured person has been liable for the costs. The Injury Benefit awards are guaranteed minimum income levels, and are granted for the life of the individual. The award is based on an assessment of the nature of the injury and the effect on the individual's earning capacity which results. The total claim provided for is £653,001,000 of which £47,496,000 is expected to be payable within 1 year, £179,821,000 in 1 to 5 years and £425,684,000 after 5 years.

EEA Medical Costs

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

The total cost provided for is £617,863,000 of which £161,138,000 is expected to be payable within 1 year and £456,725,000 in 1 to 5 years.

Other

These financial statements disclose other provisions of £1,757,278,000, which relate to the following:

- The future support of patients who contracted HIV from contaminated blood supplies. The total provision is £108,185,000 of which £5,071,000 is expected to be paid within 1 year, £24,081,000 in 1 to 5 years and £79,033,000 after 5 years.
- Legal claims against Primary Care Trusts amounting to £34,139,000, of which £18,757,000 is expected to be paid within 1 year, £6,117,000 in 1 to 5 years and £9,265,000 after 5 years.
- Legal claims against Strategic Health Authorities amounting to £5,887,000, of which £3,650,000 is expected to be paid within 1 year and £2,237,000 in 1 to 5 years.
- Legal claims against NHS Trusts amounting to £38,839,000, of which £25,012,000 is expected to be paid within 1 year, £8,677,000 in 1 to 5 years and £5,150,000 after 5 years.
- Legal claims against NHS Foundation Trusts amounting to £41,203,000, of which £28,877,000 is expected to be paid within 1 year, £4,616,000 in 1 to 5 years and £7,710,000 after 5 years.
- Restructuring provisions recorded by Primary Care Trusts amounting to £16,990,000, of which £14,934,000 is expected to be paid within 1 year, £1,839,000 in 1 to 5 years and £217,000 after 5 years.
- Restructuring provisions recorded by Strategic Health Authorities, with a total value of £1,907,000, of which £1,692,000 is payable within 1 year and £215,000 payable within 1 to 5 years.
- Restructuring provisions recorded by NHS Trusts amounting to £75,888,000, of which £71,260,000 is expected to be paid within 1 year, £4,269,000 in 1 to 5 years and £359,000 after 5 years.
- Restructuring provisions recorded by NHS Foundation Trusts amounting to £40,794,000, of which £38,762,000 is expected to be paid within 1 year, £671,000 in 1 to 5 years and £1,361,000 after 5 years.
- Redundancy provisions recorded by Primary Care Trusts amounting to £73,810,000, of which £62,163,000 is expected to be paid within 1 year, £11,536,000 in 1 to 5 years and £111,000 after 5 years.
- Redundancy provisions recorded by Strategic Health Authorities, with a total value of £12,593,000, of which £10,820,000 is payable within 1 year and £1,773,000 payable within 1 to 5 years.
- Redundancy provisions recorded by NHS Trusts amounting to £55,365,000, of which £52,179,000 is expected to be paid within 1 year and £3,186,000 in 1 to 5 years.

- Redundancy provisions recorded by NHS Foundation Trusts amounting to £52,482,000, of which £49,110,000 is expected to be paid within 1 year, £2,371,000 in 1 to 5 years and £1,001,000 after 5 years.
- Continuing Care provisions recorded by Primary Care Trusts amounting to £133,819,000, of which £107,291,000 is expected to be paid within 1 year, £23,507,000 in 1 to 5 years and £3,021,000 after 5 years.
- A scheme in respect of persons who have contracted Hepatitis C through blood and blood products in the course of treatment by the NHS. The total amount provided is £218,323,000 of which £15,624,000 is expected to be paid within 1 year, £0 in 1 to 5 years and £202,699,000 after 5 years.
- Non-clinical claims administered by NHSLA under the Liabilities to Third Parties Scheme (LTPS) and the Property Expenses Scheme (PES), with a total value of £246,937,000, of which £130,937,000 is expected to be paid within 1 year, £100,000,000 in 1 to 5 years and £16,000,000 after 5 years.
- Of the remaining £600,117,000 balance in Other provisions (of which £323,567,000 is payable within 1 year, £182,610,000 in 1 to 5 years and £93,940,000 after 5 years) £527,254,000 relates to miscellaneous provisions recorded by SHAs, PCTs, NHS Trusts and NHS Foundation Trusts. These relate to a range of issues, including: equal pay, onerous contracts, lease dilapidations, Independent Sector Treatment Centres, and partially completed treatments.

21 Capital Commitments

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Property, plant and equipment	513,295	1,527,242	1,098	1,383,719
Intangible non-current assets	667,288	699,825	1,891,505	1,915,061
Total contracted capital commitments at 31 March not otherwise included in these financial statements	**1,180,583**	**2,227,067**	**1,892,603**	**3,298,780**

This note discloses commitments to future capital expenditure, not otherwise disclosed elsewhere in the financial statements. Included within capital commitments are non cancellable contracts and purchase orders which commit the Department to capital expenditure in a future period. Commitment to expenditure under other forms of agreement such as Memorandums of Understanding may be considered as capital commitments if they, in exceptional circumstances, effectively commit the Department to the expenditure as it would be reputationally or politically damaging for the Department to withdraw from the agreement. Any future capital funding within the Department's accounting boundary does not represent a capital commitment. The above methodology has been applied prospectively from 2011-12.

A large proportion of Core Department capital commitments relate to contracts entered into by NHS Connecting for Health for the delivery of the National Programme for IT (see note 23 for further details). In 2011-12 NHS Connecting for Health had capital commitments amounting to £534m (2010-11: £1,866m). The principle reason for the reduction from 2010-11 relates to the renegotiation of the CSC contract, where the commitment has reduced by £969m.

The Department has additional Capital Commitments of £188 million in respect of the construction of the Frances Crick Institute for Bio Medical Research, £126 million for the confirmed Capital Grant Allocations in respect of the Community Capacity Grant for Adult Personal Social Services, £113 million for the Midland Medical Accommodation Project which establishes the West Midlands as the central focus for the Defence Medical Services. There is a further £94 million for the purchase of residual interests in Independent Sector Treatment Centre (ISTC) schemes at three NHS syndicates, and £30 million relating to the Olympics to fund three National Centres for Sports and Exercise Medicine. The establishment of these National Centres will fulfill one of the Government's key 2012 Olympic Games bid commitments and will be a lasting legacy of the Games.

Of the Departmental Group's capital commitments, £572 million and £380 million are within the accounts of NHS Foundation Trusts and NHS Trusts, respectively.

Commitments under leases

21.1 Operating leases

£85 million of the Core Department's minimum payments relate to the rental of office accommodation. The Department rents accommodation in 12 buildings and the term of the leases will expire in the period 2012-2018.

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Payments recognised as an expense				
Minimum lease payments	22,215	809,820	23,526	675,102
Contingent rents	-	8,393	-	6,825
Sub-lease payments	-	12,376	-	11,019
Total	**22,215**	**830,589**	**23,526**	**692,946**

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Total future minimum lease payments under non-cancellable operating leases				
Land:				
Not later than 1 year	-	10,019	-	12,894
Later than 1 year, not later than 5 years	-	21,835	-	29,260
Later than 5 Years	-	78,260	-	96,101
	-	**110,114**	**-**	**138,255**
Buildings:				
Not later than 1 year	20,986	548,582	24,613	366,532
Later than 1 year, not later than 5 years	66,092	1,151,864	81,550	1,055,947
Later than 5 Years	7,851	1,777,838	17,191	1,729,001
	94,929	**3,478,284**	**123,354**	**3,151,480**
Other:				
Not later than 1 year	76	184,951	127	190,533
Later than 1 year, not later than 5 years	41	325,684	64	320,820
Later than 5 Years	-	64,021	16	59,154
	117	**574,656**	**207**	**570,507**

Operating Lease receipts

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Receipts recognised as revenue				
Minimum lease receipts	3,547	152,104	-	127,003
Contingent rents	-	13,464	-	11,578
Sub-lease receipts	-	-	-	-
Total	**3,547**	**165,568**	**-**	**138,581**

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Total future minimum lease receipts under non-cancellable operating leases				
Land:				
Not later than 1 year	-	2,354	-	1,467
Later than 1 year, not later than 5 years	-	5,318	-	2,579
Later than 5 Years	-	78,057	-	29,008
	-	**85,729**	**-**	**33,054**
Buildings:				
Not later than 1 year	1,686	23,040	1,814	20,328
Later than 1 year, not later than 5 years	3,282	65,052	4,535	60,641
Later than 5 Years	1,494	98,291	226	115,161
	6,462	**186,383**	**6,575**	**196,130**
Other:				
Not later than 1 year	-	310,916	-	142,196
Later than 1 year, not later than 5 years	-	574,302	-	361,505
Later than 5 Years	-	1,105,833	-	909,779
	-	**1,991,051**	**-**	**1,413,480**

21.2 Finance leases

The Department's significant finance leases relate to the Ambulance Radio Programme, where leased assets include terminal equipment for radio dispatchers and associated voice systems, and to the Renal Programme, where leased assets are used in the delivery of services, and which comprise land, buildings (wards and theatres) and equipment. Different types of equipment are contained in the facilities and the major items include water treatment plants, the Commissioning Data Set (CDS) and dialysis machines.

The minimum payments of the Ambulance Radio Programme are £41,582,000 and the lease expires in 2020-21. The minimum payments of the Renal Programme are £20,896,000 and the lease expires in 2016-17. Commitments under finance leases are as follows:

Minimum lease payments:	**2011-12 £'000**		**Unaudited Restated 2010-11 £'000**	
	Core Department	**Departmental Group**	**Core Department**	**Departmental Group**
Buildings:				
Not later than 1 year	1,373	25,732	1,373	102,284
Later than 1 year, not later than 5 years	17,055	133,220	8,767	143,324
Later than 5 Years	-	302,761	9,661	316,696
	18,428	**461,713**	**19,801**	**562,304**
Less interest element	(2,403)	(234,609)	(2,992)	(251,743)
	16,025	**227,104**	**16,809**	**310,561**
Other:				
Not later than 1 year	9,874	56,381	17,975	72,292
Later than 1 year, not later than 5 years	39,828	130,193	48,991	153,255
Later than 5 Years	7,175	29,636	15,462	40,536
	56,877	**216,210**	**82,428**	**266,083**
Less interest element	(8,833)	(31,044)	(12,935)	(38,929)
	48,044	**185,166**	**69,493**	**227,154**
Land:				
Not later than 1 year	-	879	-	1,861
Later than 1 year, not later than 5 years	-	2,377	-	4,736
Later than 5 Years	-	11,138	-	15,914
	-	**14,394**	**-**	**22,511**
Less interest element	-	(10,094)	-	(13,563)
	-	**4,300**	**-**	**8,948**

Present value of minimum lease payments:	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Buildings:				
Not later than 1 year	812	12,789	784	87,826
Later than 1 year, not later than 5 years	15,213	94,433	6,696	98,962
Later than 5 Years	-	117,955	9,329	122,330
	16,025	**225,177**	**16,809**	**309,118**
Other:				
Not later than 1 year	7,441	47,109	12,553	60,560
Later than 1 year, not later than 5 years	34,031	108,724	39,280	128,592
Later than 5 Years	6,572	25,928	17,660	39,444
	48,044	**181,761**	**69,493**	**228,596**
Land:				
Not later than 1 year	-	2,187	-	1,587
Later than 1 year, not later than 5 years	-	2,891	-	2,557
Later than 5 Years	-	4,555	-	4,805
	-	**9,633**	**-**	**8,949**

21.3 Finance lease receivables

Amounts receivable under finance leases

Gross investments in leases

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	**Departmental Group**	**Core Department**	**Departmental Group**
Not later than 1 year	-	1,439	-	926
Later than 1 year, not later than 5 years	-	6,542	-	6,532
Later than 5 Years	-	40,923	-	43,189
Less future finance income	-	(19,940)	-	(21,658)
Present value of minimum lease payments	**-**	**28,964**	**-**	**28,989**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**-**	**28,964**	**-**	**28,989**

Of minimum lease payments

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	**Departmental Group**	**Core Department**	**Departmental Group**
Within 1 year	-	476	-	227
Between 1 and 5 years	-	2,273	-	2,153
After 5 years	-	26,215	-	26,609
Less future finance income	-	-	-	-
Present value of minimum lease payments	**-**	**28,964**	**-**	**28,989**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**-**	**28,964**	**-**	**28,989**
included in:				
Current finance lease receivables	-	466	-	217
Non-current finance lease receivables	-	28,498	-	28,772
Sub total	**-**	**28,964**	**-**	**28,989**

Rental revenue

Contingent rent	-	2,430	-	1,570
Other	-	4	-	2,049
Total rental revenue	**-**	**2,434**	**-**	**3,619**

22 Commitments under PFI and LIFT contracts

Details of PFI and LIFT contracts in respect of each of the following categories are recorded in the individual accounts of relevant PCTs, NHS Trusts and NHS Foundation Trusts.

22.1 NHS LIFT schemes deemed to be off Statement of Financial Position

In this financial year, four PCTs reported off-Statement of Financial Position LIFT schemes (2010-11: four PCTs). The estimated capital value of these schemes is £6,770,000 (2010-2011: £6,709,000). The assets which make up this capital value are not assets of the PCTs. The amount included within operating expenses for these schemes is £1,123,000 (2010-11; £864,000).

22.2 NHS LIFT schemes deemed to be on Statement of Financial Position

PCTs

In this financial year, 80 PCTs reported on-Statement of Financial Position LIFT schemes (2010-11; 80 PCTs). The assets of these schemes are treated as assets of the PCTs. The substance of each contract is that the PCT has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The amount included within operating expenses for the service element of these schemes is £48,876,000 (2010-11; £43,748,000).

NHS Trusts

In this financial year, two NHS Trusts (2010-11 three) reported on-Statement of Financial Position LIFT schemes. The assets of these schemes are treated as assets of the trusts. The substance of each contract is that the NHS Trust has a finance lease and payments comprise an imputed finance lease charge and a service charge.

Details of the individual LIFT schemes are included in the accounts of each NHS Trust.

Total obligations for the on-Statement of Financial Position NHS LIFT Schemes due:

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Not later than 1 year	-	148,412	-	126,776
Later than 1 year, not later than 5 years	-	586,005	-	513,998
Later than 5 years	-	2,992,966	-	2,652,976
Sub total	**-**	**3,727,383**	**-**	**3,293,750**
Less: interest element	-	(2,099,642)	-	(1,858,049)
Total	**-**	**1,627,741**	**-**	**1,435,701**

22.3 Charges to the Consolidated Statement of Comprehensive Net Expenditure in respect of NHS LIFT Contracts

The total charged in the year to expenditure in respect of off-Statement of Financial Position NHS LIFT contracts and the service element of on-Statement of Financial Position NHS LIFT contracts was £50,296,000 (2010-11; £44,276,000).

The PCTs and NHS Trusts with NHS LIFT contracts are committed to the following total charges:

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
NHS LIFT Scheme Expiry				
Not later than 1 year	-	56,716	-	50,107
Later than 1 year, not later than 5 years	-	251,399	-	221,627
Later than 5 years	-	1,387,958	-	1,237,056
Total	**-**	**1,696,073**	**-**	**1,508,790**

22.4 PFI Schemes deemed to be off Statement of Financial Position

PCTs

In this financial year, no PCTs reported off-Statement of Financial Position PFI schemes (2010-11: Nil).

NHS Trusts

In this financial year, four NHS Trusts reported off-Statement of Financial Position PFI schemes (2010-11: four trusts). The estimated capital value of these schemes is £16,001,000 (2010-11 Restated: £16,951,000). The assets which make up this capital value are not assets of the individual organisations. The amount included within operating expenses for these schemes is £12,659,000 (2010-11 Restated: £11,983,000).

Details of the individual PFI schemes are included in the accounts of each NHS Trust.

NHS Foundation Trusts

The assets used to provide the services under the PFI schemes are not assets of the Foundation Trust. The gross amount included within operating expenses for these schemes is £7,971,000 (2010-11: £10,459,000). Details of the individual PFI schemes are included in the accounts of each Foundation Trust.

22.5 NHS PFI schemes deemed to be on Statement of Financial Position

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Not later than 1 year	-	767,528	-	685,389
Later than 1 year, not later than 5 years	-	3,056,189	-	2,751,083
Later than 5 years	-	16,535,358	-	15,285,596
Sub total	**-**	**20,359,075**	**-**	**18,722,068**
Less: interest element	-	(10,272,371)	-	(9,825,595)
Total	**-**	**10,086,704**	**-**	**8,896,473**

PCTs and NHS Trusts

In this financial year, 28 PCTs and 46 NHS Trusts reported on-Statement of Financial Position PFI schemes (2010-11; 28 PCTs and 48 trusts). The assets of these schemes are treated as assets of the PCT/NHS Trust. The substance of each contract is that the PCT/Trust has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The amount included within operating expenses for the service element of these schemes is £463,547,000 (2010-11; £433,568,000).

Details of the individual PFI schemes are included in the accounts of each PCT and NHS Trust.

NHS Foundation Trusts

The assets of these schemes are treated as assets of the NHS Foundation Trust. The substance of each contract is that the organisation has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The amount included within operating expenses for the service element of these schemes is £390,617,000 (2010-11; £347,872,000).

Details of the individual PFI schemes are included in the accounts of each NHS Foundation Trust.

22.6 Charges to the Consolidated Statement of Comprehensive Net Expenditure in respect of NHS PFI contracts

The total charged in the year to expenditure in respect of off-Statement of Financial Position PFI contracts and the service element of on-Statement of Financial Position PFI contracts was £874,794,000 (2010-11; £803,882,000).

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
PFI Scheme Expiry				
Not later than 1 year	-	829,755	-	786,961
Later than 1 year, not later than 5 years	-	3,477,159	-	3,239,471
Later than 5 years	-	25,328,802	-	23,972,404
Total	**-**	**29,635,716**	**-**	**27,998,836**

23 Other Financial Commitments

	2011-12 £'000		Unaudited Restated 2010-11 £'000	
	Core Department	Departmental Group	Core Department	Departmental Group
Not later than 1 year	3,089,420	3,282,990	1,106,602	1,200,727
Later than 1 year, not later than 5 years	1,487,578	1,731,975	3,283,289	3,433,451
Later than 5 Years	84,226	150,851	146,007	273,699
	4,661,224	**5,165,816**	**4,535,898**	**4,907,877**

This note discloses commitments to future expenditure, not otherwise disclosed elsewhere in the financial statements. Included within other financial commitments are non cancellable contracts and purchase orders which commit the Department to revenue expenditure in a future period. Commitments to expenditure under other forms of agreement such as Memorandums of Understanding may be considered as commitments if they, in exceptional circumstances, effectively commit the Department to the expenditure as it would be reputationally or politically damaging for the Department to withdraw from the agreement. Any future funding within the Department's accounting boundary does not represent a financial commitment. The above methodology has been applied prospectively from 2011-12.

At the end of the reporting period, NHS Informatics had entered into various contracts which, if delivered according to the terms of those contracts, would result in financial commitments of £1,042,043,000 (2010-11: £2,703,947,000) over the next 5 years. The main reasons for this reduction are due to the change in methodology noted above, and the renegotiation of the CSC contract, which resulted in reducing the commitment by £510m.

The contracts relate to Programmes managed under the National Programme for IT, which will in the future continue to be delivered by NHS Informatics, a Directorate of the Department of Health, for the purpose of bringing modern computing systems into the NHS to improve patient care and services. Over the life of the programmes, they will connect over 30,000 GPs in England and almost 300 hospitals, and will give patients access to their personal health and care information, transforming the way the NHS works. The contracts are such that the obligation to pay does not arise until the suppliers have successfully implemented solutions in the required locations, and it has been accepted after a period of live running.
The largest element of the commitment for NHS Informatics relates to Local Service Provider contracts which are contracts over a fixed term and therefore there is a reduction in the total committed amount year on year. In addition, contract renegotiations for the North Midlands and East Local Service Provider contract has reduced the level of commitment over the remaining term of the contract.

Additionally, the Department has entered into commitments for a £1,374 million grant for Adult Personal Social Services delivered through Local Authorities, £393 million for the purchase of Childhood and Adult Vaccines and Pan Flu, £331 million for Independent Sector Treatment Centres, and research and development of £539 million with a number of NHS organisations, universities and private research organisations. The purpose of research and development arrangements varies from the development of the health research workforce and research infrastructure in the NHS and the provision of research support by the NHS to specific research programmes or projects. The overall purpose of the work is to develop an evidence base for improved health care.

Of the Departmental Group's other financial commitments, £231 million, £124 million and £88 million are within the accounts of NHS Foundation Trusts, Primary Care Trusts and NHS Trusts, respectively.

The Department has publically communicated its intention to provide national support to a small number of NHS Trusts with significant PFI debts. Whilst up to £1.5 billion will be made available to these organisations over a 25 year period, the support is not in the nature of a contractual commitment and does not therefore form part of the Other Financial Commitments figure disclosed in these accounts.

24 Financial Instruments

As the cash requirements of the Department are met through the Estimates process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body of a similar size.

Currency Risk

The Department undertakes certain transactions denominated in foreign currencies, the vast majority of which are transactions relating to European Economic Area (EEA) medical costs.

Due to delays in the submission of medical cost claims by member states (as per current EU regulations), the Department estimates annual medical costs and adjusts future years' expenditure when actual costs arise (are claimed). Estimated costs are converted into sterling at average rates calculated using EU published rates. Payments made are valued at prevailing exchange rates and the Department enters into forward contracts for the purchase of Euros for this purpose i.e. to mitigate risk of exposure to 'Sterling'/'Euro' exchange rate fluctuations. Amounts in the Statement of Financial Position at year-end are converted at the exchange rate ruling at the Statement of Financial Position date, with any exchange rate gains or losses calculated in accordance with accepted accounting practice.

Foreign currency forward purchase contracts are measured at 'fair value', with movements in fair value being charged or credited to the Consolidated Statement of Comprehensive Net Expenditure.

The Department's investments in NHS Trusts, NHS Foundation Trusts and the Medicines & Healthcare Products Regulatory Agency are represented by Public Dividend Capital (PDC) which, being issued under statutory authority, is not classed as being a financial instrument.

The Department did not have any forward currency contracts outstanding as at 31st March 2012, and so no financial asset existed at the Statement of Financial Position date. However, a new Forward currency contract was entered into on 2nd April 2012. The Exchange rate exposure on this covers approximately 66% of 2011-12 in year EEA revenue DEL expenditure.

The NHS sector is made up principally of domestic organisations with the great majority of transactions, assets and liabilities being in the UK and sterling based. Exposure to currency rate fluctuations is therefore low.

Liquidity risk

The income within the Department of Health Group mostly originates from Central Government and remains within the group. Due to the continuing service provider relationship that health bodies have with each other, they are not exposed to the degree of financial risk faced by business entities. NHS Trusts and Foundation Trusts, for example, generate their income from contractual arrangements with their commissioning NHS Primary Care Trusts based either on a tariff for services performed or on assumptions for the amount of work to be carried out.

Interest rate risk

The Departmental Group has limited exposure to Interest Rate Risk:

NHS Trusts borrow from government for capital expenditure, subject to affordability. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans rate, fixed for the life of the loan. NHS trusts therefore have low exposure to interest rate fluctuations.

NHS Foundation trusts have the power to enter into loans and working capital facilities with commercial lenders. They are also able to borrow from the Foundation Trust Financing Facility (FTFF), managed by the Department of Health. The term of FTFF loans can range up to 25 years with the interest rate fixed at the National Loan Fund fixed rate for the period of the loan prevailing on the date of signing of the loan agreement. NHS foundation trusts are required to maintain their borrowing within a limit determined by a code devised by Monitor.

Credit risk

The vast majority of the NHS sector's income is generated from public sector bodies and as such is exposed to low credit risk.

25 Contingent Assets and Liabilities disclosed under IAS 37

25.1 Contingent Assets

It is probable the Department will receive "overage" payments following a portfolio transfer of almost 100 properties to the Homes and Communities Agency (HCA) between 2005 and 2007. A base payment of £320 million was received with further possible payments when the cash received from the subsequent sales of the properties by the HCA, less their costs of holding and disposal, exceeds the base payment. The HCA estimates that future overage payments in the region of £92 million may become payable to the Department, with £23 million of this overall figure being considered a highly probable future inflow of economic benefit.

Primary Care Trusts have £54,071,000 of contingent assets (2010-11: £48,936,000), mainly in respect of legal charges held on properties which have been purchased using grants from PCTs. Strategic Health Authorities have no contingent assets (2010-11: £0). NHS Trusts have £1,813,000 contingent assets (2010-11: £817,000). Foundation Trusts have £2,000,000 contingent assets (2010-11: £2,000,000).

25.2 Contingent Liabilities

The contingent liabilities considered most important to the users of the accounts are detailed below. Further information for all contingent liabilities can be found in the underlying accounts of individual bodies

Clinical Negligence
The Department is the actual or potential defendant in a number of actions regarding alleged clinical negligence, or liabilities relating to the NHS property or third parties. In some cases, costs have been provided for or otherwise charged to the accounts. In other cases, there is a large degree of uncertainty as to the Department's liability and the amounts involved. Possible total expenditure might be estimated at £8.46 billion (2010-11: £7.75 billion), although £7.83 billion (2010-11: £7.14 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 from NHS Trusts.

NHS Contingent Liabilities
Within Primary Care Trusts' accounts at 31 March 2012, there were net contingent liabilities of £55,637,000 (2010-11: £48,796,000). These are mainly in respect of continuing care liabilities.

Within NHS Trusts' accounts at 31 March 2012, there were net contingent liabilities of £47,927,000 (2010-11: £52,482,000). These are mainly in respect of legal and litigation claims.

Dr Foster
The joint venture contract between the Department and Dr Foster LLP includes a put option whereby if, anytime from 1 January 2009 to 31 December 2013, Dr Foster LLP shareholders wish to sell their share in the investment, the Department would be obliged to buy out their share of the business, at market value, if no other buyer can be found.

Social Enterprise Investment Fund (SEIF)
The Social Enterprise Investment Fund supports social enterprises involved in the delivery of health and social care services. Investment is available for new social enterprises to start up and existing social enterprises to grow and improve their service. By its nature the fund invests in organisations for which commercial bank support might not be readily available in order to bridge the gap between business and service need and commercial risk. Therefore, it is prudent to acknowledge that although there is a strict due diligence process in place to mitigate risk of default, there may be some level of default on SEIF loan assets. At 31 March 2012 there is no indication that any defaults will occur other than that specifically provided for in the accounts.

Nursing and Midwifery Council
The Department has recorded a contingent liability in relation to the Nursing and Midwifery Council pension scheme. As an employer in the NMC Scheme, the Department is liable to pay a proportion of any funding shortfall that arises following the Scheme's Actuarial valuation. It is unlikely that the next valuation will be published until 2014, which will take into account the Scheme's liabilities as at 31 March 2013 and therefore it is unlikely that any liabilities will crystallise before 2015. Due to recent market trends, the estimated DH funding position in relation to its portion of the Scheme liabilities has fallen from a small surplus as at 31 March 2011 to a small shortfall as at 31 March 2012 and so immaterial additional contributions may be required. However as the position is quite volatile, this could change significantly by the date of the next valuation.

Injury Benefit Scheme
An investigation into the administration of the injury benefits scheme began in 2006 following a decision by the Pensions Ombudsman. As a result of the review, monies were due to be paid to some 10,000 people who had not received the correct payments due to irregularities in the administration of the injury benefits scheme between 1972 and 2006. Due to difficulties in contacting beneficiaries, it has not been possible to make full payment to all the affected individuals in this financial year. There are still people for whom the Department retains a financial liability but who currently cannot be traced. This financial liability currently stands at £2,574,619. Although at this stage the Department cannot estimate how many of these claims will be successful nor how much benefit will eventually be owed.

Other
There are a number of recorded contingent liabilities relating to changes in funding arrangements between the Department and other bodies. These cases relate to potential costs for terminating contracts early but as these contracts may transfer to new organisations, a reliable estimate of costs or timings cannot be made.

26 Contingent Liabilities not required to be disclosed under IAS 37 but included for Parliamentary reporting and accountability purposes

26.1 Quantifiable

The Department of Health has entered into the following quantifiable contingent liabilities by offering indemnities or by giving letters of comfort. None of these is a contingent liability within the meaning of IAS 37 since the likelihood of a transfer of economic benefit in settlement is too remote. They therefore fall to be measured following the requirements of IAS 39. HM Treasury's guidance *Managing Public Money* requires that the full potential costs of such contracts be reported to Parliament. These costs are reproduced in the table below.

	1 April 2011		Increase in year	Liabilities crystallised in year	Obligation expired in year	31 March 2012 Cost	31 March 2012 Number	Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	£'000	No.	£'000
Guarantees:	-	-	1,500	-	-	1,500	1	1,500
Indemnities:	93,750	3	1,250	-	-	95,000	3	95,000
Letters of comfort	-	-	-	-	-	-	-	-
	93,750	**3**	**2,750**	**-**	**-**	**96,500**	**4**	**96,500**

26.2 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 31 indemnities. None of these is a contingent liability within the meaning of IAS 37 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.

27 Losses and Special Payments and other Accounting Notes

27.1 Losses Statement

	2011-12 Total		Unaudited Restated 2010-11 £'000	
	Cases	£'000	Cases	£'000
Total	89,434	292,849	92,723	322,490
Cases over £250,000				
Cash losses	3	2,058	-	-
Claims abandoned	2	1,830	4	2,054
Cancellation of Public Dividend Capital (PDC)	1	32,869	-	-
Administrative write-offs	-	-	-	-
Fruitless payments	7	27,178	3	38,697
Constructive Loss	8	67,229	1	6,153
Store losses	-	-	6	89,946
Of the total the following relates to the Core Department	118	235,132	136	273,758

In 2011-12, HM Treasury clarified that loss of accountable stores should only be recorded as a stores loss where there is an element of blame: e.g. from theft, arson or other culpable causes. Where a loss arises through the normal course of business this should be recorded as a constructive loss. Losses resulting from date expired stocks which had been correctly ordered and stored have therefore been categorised as constructive losses in 2011-12. Equivalent losses in 2010-11 were categorised as stores losses which explains the significant year-on-year increase in constructive losses and corresponding decrease in stores losses.

Department of Health Share of National Insurance Contribution Losses
Included within its total losses, the Department has recorded a technical loss of £115,593,623, which is its share of the overall, cross-Government loss relating to National Insurance Contributions (NICs). Such losses occur when contributions cannot be collected because companies have ceased to exist during the year. Her Majesty's Revenue & Customs (HMRC) allocates this category of loss to those Departments which are partially funded from NICs, on a proportional basis. It should be noted that the disclosure of this category of loss is a technical requirement which is completely outside the Department's control.

Cancellation of Public Dividend Capital (PDC)
By means of an HM Treasury Minute laid before Parliament, the Department has recorded a loss of £32,869,000 relating to PDC cancelled in 2011-12. This was in respect of the outstanding PDC of Worcestershire Mental Health Partnership NHS Trust which was dissolved on 1 July 2011. £32,412,000 was issued to the successor body, Worcestershire Health & Care NHS Trust, in the form of Originating Capital by means of a statutory instrument. The £457,000 difference between the value of PDC cancelled and the newly issued PDC reflects movements in both the composition and valuation of the assets of the dissolved NHS Trusts in the years since their initial establishment. There is consequently no overall loss of PDC.

Claims abandoned

The Social Enterprise Investment Fund
The Department has recognised a loss of £304,290 relating to an investment made by The Social Enterprise Fund (SEIF). The SEIF supports social enterprises involved in the delivery of health and social care services. Investment is available for the start up of new projects or the development of existing social enterprise schemes, particularly where it might have been difficult to obtain commercial finance. A loan was provided through SEIF in 2008 to promote and develop products and services which enabled independence for disabled and older people. However, the organisation to which the loan was issued experienced cashflow problems in 2011 and proved non-financially viable, at which point it was deemed necessary to write off both the loan principal and interest.

Constructive losses

Emergency Preparedness Stockpile
The Department authorised write-offs relating to date expired inventory items in line with existing accounting standards. The Department holds countermeasures inventory for use in the event of an accidental or malicious release of chemical, biological, radiological or nuclear agents. If no such incidents occur the inventory inevitably reaches the end of its useable life and needs to be disposed of and replaced in order to maintain a measure of protection for the UK's population. The value of inventory written-off in the period April 2011 to March 2012 due to expiration of their shelf life was £14,088,609.

Pandemic Flu Countermeasures Stockpile
The Department wrote-off £51,162,113 in relation to countermeasures held for pandemic flu preparedness that have now passed their shelf life. These write offs are a planned consequence of our preparedness strategy that involves central stockpiling.

Essential Medicines Stockpile
The Department wrote-off £1,103,546 in relation to the essential medicines stockpile. This write-off is in respect of stockpile goods items that have now passed their shelf life.

CSC missed deployment payments
Through negotiations with CSC in 2008, agreement was reached to include a £19.9 million payment relating to the fixed element of previously missed deployments as part of the renegotiation of the CSC Contract for the NME region as per contractual terms. This payment was incorrectly capitalised and added to the non-current asset register at that time and has been removed during 2011-12. This has resulted in the net book value of £8.8 million being written off in 2011-12.

NHS Losses
Losses within the NHS are predominantly within Foundation Trusts (48,850 cases totalling £23,115,000), NHS Trusts (34,655 cases totalling £20,158,000) and Primary Care Trusts (2,728 cases totalling £9,730,000).

27.2 Special Payments

	2011-12 Total		Unaudited Restated 2010-11 £'000	
	Cases	£'000	Cases	£'000
Total	10,706	139,300	10,642	37,122
Details Of Cases Over £250,000	4	105,394	9	6,654
Of the total the following relates to the Core Department	17	100,177	19	4,400

CSC de-commitment payment
During negotiations with CSC, agreement has been reached to include a £100 million de-commitment payment as part of the renegotiation of the CSC Contract for the North, Midlands and East (NME) region. Under the new terms of the contract, the NHS is no longer obligated to put forward 222 NHS Trusts to procure the CSC product; in addition CSC's exclusivity in the NME territories will be removed. By making these changes, the Coalition government's localisation agenda will be promoted, as NHS Trusts will be able to procure either the CSC product or other available solutions which meet their specific requirements.

NHS Special Payments
Special Payments within the NHS are predominantly within Foundation Trusts (5,410 cases totalling £18,555,000), NHS Trusts (4,825 cases totalling £15,007,000) and Primary Care Trusts (363 cases totalling £4,090,000).

28 Related Party Transactions

Related party transactions associated with the Core Department are disclosed within this note. Details of related party transactions associated with other bodies within the Departmental Group are disclosed in their underlying statutory accounts. As disclosed in Note 32, the Department acts as the parent of the group of organisations (Strategic Health Authorities, Primary Care Trusts, NHS Trusts, NHS Foundation Trusts, Executive Non-Departmental Public Bodies and Special Health Authorities) whose accounts are consolidated within this Annual Report and Account. It also acts as the sponsor for the trading funds which are not consolidated. These bodies are regarded as related parties with which the Department has had various material transactions during the year.

In addition, the Department had a small number of transactions with other Government Departments and other central Government bodies in 2011-12.

A number of Ministers, Non-Executive Directors and members of either the Departmental Board or Department of Health Management Committee have connections with a wide range of outside organisations for reasons unrelated to their work in the Department. In the normal course of its business during the year, the Department may enter into business transactions with such outside organisations or related parties. In cases where an individual within DH has an outside connection with one of these related parties, the Department is obliged to disclose the extent of its own transactions with those organisations, as set out in the table below:

	Sub Note	Payables with related party 2011-12 £'000	Purchases from related party 2011-12 £'000	Receivables with related party 2011-12 £'000	Sales to related party 2011-12 £'000
Royal College of Physicians	1	107	306	-	-
Marie Curie	2	-	3,056	-	-
Thames Valley University	3	-	223	-	-
Queen's Nursing Institute	4	-	10	-	-
Medical Research Council	5	-	6,885	3,621	16,817
Medway Hospital NHS Trust	6	-	-	-	229
The Royal College of General Practitioners	7	1	792	-	-
University of Birmingham	8	-	14,808	11	11
Birmingham Children's Hospital	9	-	1,780	-	-
Unitied Utilities Plc	10	-	7	-	-
Civil Service Benevolent Fund	11	-	40	-	-
London School of Economics	12	-	4,116	5	20

Sub Note
1) Fiona Adshead holds a position at Royal College of Physicians
2) Dame Christine Beasley is a Trustee of Marie Curie Cancer Care (a registered charity)
3) Dame Christine Beasley is Pro-Vice Chancellor at Thames Valley University
4) Dame Christine Beasley is a fellow at Queen's Nursing Institute
5) Dame Sally Davies is a Council Member of Medical Research Council
6) Richard Douglas' wife is employed by Medway Hospital NHS Trust
7) Sir David Nicholson is an Honorary Fellow at the Royal College of General Practitioners
8) Sir David Nicholson is an Honorary Fellow at the University of Birmingham Health Service Management Centre
9) Sir David Nicholson's wife is the Chief Executive of Birmingham Children's Hospital NHS Foundation Trust
10) Catherine Bell is a Non Executive Director for United Utilities
11) Catherine Bell is a trustee (pro bono) of the Civil Service Benevolent Fund
12) Catherine Bell is a Governor of the London School of Economics

The sub-note above identifies those individuals with outside connections to the organisations listed in the Table. It is important to note that the financial transactions disclosed were between the Department itself and the named organisation. The individuals named in the sub-note have not benefited from those transactions.

Apart from where disclosed in this note, no other Minister, Board member, key manager or other related party has undertaken any material transactions with the Department during the year.

29 Third Party Assets

	1 April 2011 £'000	Net in-year movement £'000	31 March 2012 £'000
Monetary assets			
Bank balances	93,706	9,064	102,770
Monies on deposits	10,986	(1,408)	9,578
Total	**104,692**	**7,656**	**112,348**

Third party assets are those which do not belong to the Department and are therefore not included in the financial statements. The above third party monetary assets, at 31 March 2012, were held by the Department of Health (but are not included in the financial statements) and include £85,931,000 held by NHS Foundation Trusts (2010-11: £77,188,000), £8,404,000 held by NHS Trusts (2010-11 £8,307,000) and £1,358,000 held by NHS Primary Care Trusts (2010-11 restated: £2,538,000) in banks and in hand in respect of monies held on behalf of patients. They also include £16,654,358 (2010-11: £16,658,512) held by the Department of Health in Escrow accounts relating to NHS Connecting for Health. These amounts are in relation to service and delay deductions and are calculated in line with the contractual clauses in respect of Service Level Agreements and Key Milestone dates.

30 Pensions

30.1 Movements in defined benefit obligation and fair value of plan assets

Reconciliation of movements in the defined obligation and the fair value of plan assets during the year for the amounts recognised in the Statement of Financial Position

	2011-12 £'000	Unaudited Restated 2010-11 £'000
Present value of the defined benefit obligation 1 April 2011	(328,648)	(366,922)
Current service cost	(7,660)	(10,242)
Interest Cost	(18,220)	(20,825)
Contributions from members	(2,877)	(3,138)
Actuarial gains and (losses)	(39,153)	26,511
Benefits paid	8,118	11,591
Business combinations	(905)	-
Past service cost	-	32,783
Settlements and curtailments	(7,329)	(219)
Other		1,813
At 31 March 2012	**(396,674)**	**(328,648)**
Plan assets at fair value at 1 April 2011	306,980	294,817
Expected return on assets	20,820	19,469
Actuarial gain/(losses)	(21,150)	(6,400)
Contributions by the employer	6,889	7,547
Contributions by the plan participants	2,877	3,138
Benefits paid	(8,118)	(11,591)
Business combinations	792	-
Settlements	-	-
At 31 March 2012	**309,090**	**306,980**
Plan surplus/(deficit) at 31 March 2012	**(87,584)**	**(21,668)**

30.2 Amounts recognised in the Consolidated Statement of Net Expenditure

	2011-12 £'000	Unaudited Restated 2010-11 £'000
Current service cost	(7,660)	(10,242)
Interest cost	(18,220)	(20,825)
Expected return on assets	20,820	19,469
Past service costs	-	(32,783)
Settlement or curtailment	(7,329)	(219)
Total	**(12,389)**	**(44,600)**

Included within the above pensions note are the pension obligations held by NHS Foundation Trusts, Care Quality Commission and General Social Care Council. The planned Surplus/ (Deficit) can be broken down as follows:

	2011-12 (£'000)	**2010-11 (£'000)**
NHS Foundation Trusts	(5,633)	(2,923)
Care Quality Commission	(67,768)	(13,957)
General Social Care Council	(14,183)	(4,788)
Total	**(87,854)**	**(21,668)**

Further information regarding these pension obligations can be found in the underlying financial statements of these bodies.

31 Events after the Reporting Period

The Accounts were authorised for issue by the Accounting Officer on the 15 October 2012.

32 Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2011-12:

Consolidated in the Department's Annual Report and Accounts

Supply financed agencies

Other Bodies

- Strategic Health Authorities[1]
- Primary Care Trusts[2]
- NHS Trusts
- NHS Foundation Trusts
- NHS Direct
- Skipton Fund Limited

Special Health Authorities:

- NHS Business Services Authority
- The Information Centre
- National Institute for Health and Clinical Excellence
- NHS Litigation Authority
- National Treatment Agency for substance misuse[3]
- National Patient Safety Agency[4]
- NHS Institute for Innovation and Improvement[5]
- NHS Commissioning Board[8]
- Health Research Authority[11]

Executive Non-Departmental Public Bodies

- Appointments Commission[6]
- Human Fertilisation and Embryology Authority
- General Social Care Council[7]
- Health Protection Agency[9]
- Care Quality Commission
- Independent Regulator of NHS Foundation Trusts
- Council for Healthcare Regulatory Excellence[10]
- Human Tissue Authority

DH advisory committees/advisory NDPBs

These advisory bodies/advisory NDPBs are not separate legal entities, rather they are part of the Core Department with their associated costs being included within the Core Department account. As such, they are not separately consolidated into these financial statements.

- Administration of Radioactive Substances Advisory Committee
- Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection
- Advisory Committee on Dangerous Pathogens (DH)
- Advisory Group on Hepatitis
- Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment
- Committee on the Medical Aspects of Radiation in the Environment
- Committee on the Mutagenicity of Chemicals in Food, Consumer Products and the Environment
- Committee on the Medical Effects of Air Pollutants (DH)
- Expert Advisory Group on AIDS
- Expert Group on Vitamins and Minerals
- Gene Therapy Advisory Committee
- Genetics and Insurance Committee
- Health Research Authority
- Human Genetics Commission
- Joint Committee on Vaccination and Immunisation
- NHS Commissioning Board
- The NHS Pay Review Body
- Review Body on Doctors' and Dentists' Remuneration
- Scientific Advisory Committee on Nutrition

Not Consolidated

Trading Funds

- Medicines & Healthcare Products Regulatory Agency
- NHS Blood and Transplant

DH Controlling Equity Investments[12]

- Plasma Resources UK
- Credit Guarantee Fund
- Dr Foster Intelligence Ltd
- NHS Professionals Ltd
- SBS
- Community Health Partnerships
- NHS Property Services Limited

1) Strategic Health Authorities will be abolished on 1 April 2013.

2) Primary Care Trusts will be abolished on 1 April 2013.

3) The National Treatment Agency for substance misuse is to be abolished by 1st April 2013 subject to the passage of legislation, and most of its functions transferred to Public Health England.

4) The National Patient Safety Agency is to be abolished during 2012 and most of its functions transferred to the NHS Commissioning Board.

5) The NHS Institute for Innovation and Improvement is to be abolished during 2012 and may become an independent organisation with some of its functions transferred to the NHS Commissioning Board.

6) The Appointments Commission is due to be abolished with its residue functions transferred within Government.

7) The General Social Care Council will transfer functions for regulation to the Health Professions Council.

8) The NHS Commissioning Board Special Health Authority was established on 31 October 2011 and is a preparatory body responsible for designing the proposed commissioning landscape and developing its business functions. The NHS Commissioning Board will be established as an Executive Non-Departmental Public Body by October 2012.

9) The Health Protection Agency will be dissolved and its functions transferred within Government by 1st April 2013.

10) The Council for Healthcare Regulatory Excellence will become an independent body during 2012.

11) The Health Research Authority was established as a Special Health Authority on 1 December 2011. It will subsequently be established as a Non-Departmental Public Body.

12) The Department holds a 50% or more controlling equity investment in the bodies listed, the detail of which can be found in Note 16 - Financial Assets.

The Annual Reports and Accounts of the bodies listed can be obtained from the following places:

Strategic Health Authorities	Available on the website of the relevant organisation.
Primary Care Trusts	Available on the website of the relevant organisation.
NHS Trusts	Available on the website of the relevant organisation.
NHS Foundation Trusts	Available on the website of the relevant organisation. Additionally the Consolidated Account of Foundation Trusts is available at: http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-review-and-consolidated-
NHS Direct	http://www.nhsdirect.nhs.uk/en/About/OperatingStatistics
Skipton Fund Limited	http://www.skiptonfund.org/resources.php
NHS Business Services Authority	http://www.nhsbsa.nhs.uk/annual_report.aspx
The Information Centre	http://www.ic.nhs.uk/about-us/more-about-us/corporate-documents
National Institute for Health and Clinical Excellence	http://www.nice.org.uk/aboutnice/whatwedo/corporatepublications/annualreports/annualreports.jsp
NHS Litigation Authority	http://www.nhsla.com/NHSLA_PW/Templates/Publications.aspx?NRMODE=Published&NRORIGINALURL=%2fPublications%2f&NRNODEGUID={60FC2B06-1B64-4466-B251-7DE5BA084717}&NRCACHEHINT=Guest
National Treatment Agency for substance misuse	http://www.nta.nhs.uk/publications.aspx?category=Corporate
National Patient Safety Agency	http://www.ncas.npsa.nhs.uk/publications/
NHS Institute for Innovation and Improvement	http://www.institute.nhs.uk/organisation/about_nhsi/about_the_nhs_institute.html
NHS Commissioning Board	http://www.commissioningboard.nhs.uk/category/news/
Health Research Authority	http://www.nres.nhs.uk/hra/hra-publications/
Appointments Commission	https://www.appointments.org.uk/Home/AboutUs/Overview
Human Fertilisation and Embryology Authority	http://www.hfea.gov.uk/146.html
General Social Care Council	http://www.gscc.org.uk/page/113/Annual+reports+and+plans.html
Health Protection Agency	http://www.hpa.org.uk/Publications/CorporateReports/
Care Quality Commission	http://www.cqc.org.uk/publications
Independent Regulator of NHS Foundation Trusts	http://www.monitor-nhsft.gov.uk/home/our-publications/reports-about-foundation-trusts/nhs-foundation-trusts-review-and-consolidated-
Council for Healthcare Regulatory Excellence	http://www.chre.org.uk/publications/#folder8
Human Tissue Authority	http://www.hta.gov.uk/publications/annualreviewsandreports.cfm
Medicines & Healthcare Products Regulatory Agency	http://www.mhra.gov.uk/Publications/Corporate/index.htm

Annex A

GLOSSARY OF IFRS TERMS

The adoption of International Financial Reporting Standards (IFRS) from 2009-10 has brought with it some changes in terminology. The following is a list of new IFRS terms and the names by which they were previously known under UK Generally Accepted Accounting Practice (UK GAAP):

IFRS name	**UK GAAP name**
Consolidated Statement of Comprehensive Net Expenditure	Operating Cost Statement
Statement of Financial Position	Balance sheet
Non-current assets	Fixed Assets
Inventories	Stocks
Receivables	Debtors
Payables	Creditors
Property, plant and equipment	Tangible assets

GLOSSARY OF GOVERNMENTAL TERMS

Administration Limit An overall limit applied to administration costs within the Department which should not be exceeded by the administration expenditure for the year.

Annually Managed Expenditure (AME) A Treasury budgetary control for spending that is generally difficult to control, large as a proportion of the Department's budget, and volatile in nature.

Comptroller & Auditor General Head of the National Audit Office. Responsible for auditing the Department's Resource Accounts and NHS Summarised 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.

Core Department The Department of Health only. It does not include any of the bodies listed in Note 32.

Departmental Expenditure Limit (DEL) A Treasury budgetary control for spending that is within the department's direct control and which can therefore be planned over an extended (Spending Review) period (such as the costs of its own administration, payments to third parties, etc).

Estimate A summary of the resources and cash voted by Parliament to the Department for a particular year and against which expenditure is monitored. It is analysed by Requests for Resources, each being monitored separately.

General Fund The General Fund represents the historic cost of the total assets less liabilities of the Department, to the extent that it is not represented by other reserves and financing items. It is included in Taxpayer's Equity on the Statement of Financial Position.

Net Cash Requirement The amount of cash required and authorised from the Consolidated Fund for the Department to carry out the functions specified in the Estimate. Actual cash used during the year is described as the outturn of the net cash requirement.

Net Resource Outturn This is the net total of income and expenditure consumed by the Department during the financial year.

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.

Arms Length Bodies

Arms Length Bodies are organisations set up by the Department to complete specific and specialised functions on behalf of the Department.

The Department of Health has two types of Arms Length Bodies:

1) Special Health Authority – these organisations are funded by the Department through Parliamentary Funding
2) Non Departmental Public Body – theses organisations are funded by the Department through Grant in Aid.

Annex B

NAO REPORTS PRINCIPALLY FOR DEPARTMENT OF HEALTH

NHS National Programme for I.T. in the NHS: an update on delivery of detailed care records systems. (May 2011)

The National Audit Office (NAO) reported that central to achieving the Programme's aim of improving services and the quality of patient care, was the successful delivery of an electronic patient record for each NHS patient. Although some care records systems are in place, progress against plans has fallen far below expectations and the Department has not delivered care records systems across the NHS, or with anywhere near the completeness of functionality that will enable it to achieve the original aspirations of the Programme. The Department has also significantly reduced the scope of the Programme without a proportionate reduction in costs, and is in negotiations to reduce it further still. The NAO found a steady reduction in value delivered not matched by a reduction in costs. On this basis the NAO concluded that the £2.7 billion spent on care records systems so far does not represent value for money, and could not find grounds for confidence that the remaining planned spend of £4.3 billion will be different

The Department did not agree with the NAO's conclusion and considers that the money spent to date has not been wasted and will potentially deliver value for money. This is based on the fact that more than half of the Trusts in England have received systems under the programme and no supplier is paid for a system until that system has been verified by the Trust to have been deployed successfully. The Department believes that the flexibility provided by the future delivery model for the programme will deliver functionality that best fits the needs of the clinical and managerial community. The future architecture of the programme allows many sources of information to be connected together as opposed to assuming that all relevant information will be stored in a single system. This approach has been proven in other sectors and is fully consistent with the Government's recently published ICT strategy

Establishing social enterprises under the Right to Request Programme (June 2011)

The NAO found that it is too early to assess the costs and benefits from the Right to Request Programme as only 20 social enterprises are operational, and have not yet established a track record. The majority have only recently launched in April 2011. Nevertheless, there are a number of risks to be managed if value for money is to be achieved for the sums expended on the programme and for the £900 million contracts awarded to the enterprises non-competitively. Not setting separate objectives for the programme makes it difficult to judge whether success and value for money is achieved. PCTs have not contracted for any benefits that social enterprises could deliver over and above what they would have required of alternatives, reducing the likelihood that such benefits will be delivered. Many risks and liabilities still reside with PCTs and will need to be managed if value for money is to be achieved. The sustainability of social enterprises is, currently, heavily dependent upon funding and cash flow from the NHS.

The Department disagreed with the NAO's report for the following reasons:

It would be against the principles of NHS competition to offer Right to Request providers different contracts to any other provider. PCTs as commissioners must treat all provider organisations equally when contracting for the provision of services. Social enterprises as a class cannot and should not be contracted with by NHS commissioners on different terms from other providers and should not be expected to deliver more or less through their contracts than other provider forms. Commissioners stipulate through contracts the service to be delivered, and in delivering these contracts social enterprises are also able to provide additional benefits to local communities through their social mission.

It is not accurate to claim that there were not clear objectives for the Right to Request programme. R2R was not a stand-alone programme, but as a sub-set of the wider Transforming Community Services (TCS), contributed to delivery of the objectives of this programme - objectives were clearly articulated in the NHS Next Stage Review Final Report (June 2008). R2R schemes also had to demonstrate significant service improvements.

Transforming NHS Ambulance Services. (June 2011)

The NAO reported in England, urgent and emergency healthcare and patient transport services are provided by 11 regionally-based ambulance services, with separate arrangements for the Isle of Wight. In 2009-10, the cost of ambulance services was £1.9 billion, of which around £1.5 billion was for urgent and emergency services. In 2009-10, 7.9 million emergency '999' calls were received by the ambulance service, which resulted in 6.4 million ambulance incidents and 4.7 million emergency or urgent patient journeys. The number of emergency or urgent calls that the ambulance service receives has increased by about 4 per cent each year since 2007-08. Until 1 April 2011, ambulance responses were split into three categories: A - immediately life-threatening; B - serious but not immediately life-threatening; or C – not immediately serious or life-threatening (Figure 1). For category A incidents, the service has a target of an emergency response arriving at the scene within eight minutes in 75per cent of cases, and a vehicle able to transport the patient in a clinically safe manner, if required, to attend within 19 minutes in 95 per cent of cases. There was a similar 19-minute target for category B incidents. Category B responses and the associated target were abolished by the Department of Health (the Department) from1 April 2011, and a set of clinical quality indicators were introduced to complement the response time target for category A incidents.

The report concluded the ambulance service provides life-saving assistance to patients, is highly regarded by the public, and rightly remains committed to providing a rapid response to urgent and emergency calls at a time of steadily growing call volumes. But, until April 2011, the Department's emphasis on response time as a measure of performance rather than on a more rounded view of clinical outcomes meant that the incentive structure did not encourage resource optimisation .In addition, limitations in management information and benchmarking prevent the Department, commissioners and the ambulance service driving improvement - as Transforming NHS ambulance services demonstrated by the wide variations in the efficiency of resource use across the ambulance services, even after allowing for external factors such as geographic variations. These differences indicate that value for money is not being achieved across the entire network. The introduction of a new outcome measurement regime, together with the NAO recommendations, may begin to address these problems and help deliver better value for money in the future.

Formula Funding of local public services (July 2011)

The NAO reported that the Department of Health has had long-standing objectives for its formula. The terms of reference for a working party established in 1975 to consider formula funding set the first objective of the weighted capitation approach: "to ensure equal opportunity of access to health care for people at equal risk". A second objective was added in 1999: "to contribute to the reduction in avoidable health inequalities". These continue to be the objectives of the independent Advisory Committee on Resource Allocation, which advises the Department on the funding formula. An independent report commissioned by the Department of Health on behalf of the Advisory Committee on Resource Allocation2 criticised the inequalities objective as being too broad to enable the design of the formula to target accurately.

The report concluded that while the Department of Health is to be credited with setting transparent objectives, the objectives may benefit from further refinement to provide clearer direction and public accountability

Over sight of user Choice and provider competition in care markets. (September 2011)

The NAO reported that the Department has recognised that delivering care through user choice and provider competition brings different risks to those associated with delivering or commissioning care directly**.** The Department provided £520 million to help local authorities manage the changes required by increasing personalisation. The 'Putting People First' Consortium (the Association of Directors of Adult Social Services, the Local Government Association and the Department of Health) created milestones to track the progress of local authorities introducing user choice and competition. Most local authorities reported that they had met the five milestones by April 2011, and 83 per cent reported they had achieved the April 2011 milestone that at least 30 per cent of eligible users should have a personal budget, though 25 (17 per cent) did not. The Department has few formal levers over and above legislation, policy advice and the outcomes framework to influence those authorities that are struggling to implement the Department's preferred delivery method although it is working closely with the sector's 'Think Local Act Personal' partnership and with the sector-led improvement agencies.

The report concluded evaluations suggest that, to date, most social care users have gained improved

well-being and control from using personal budgets, and some local authorities report they have led to efficiency improvements. The Government intends to extend personal budgets to all eligible users of social care by 2013. For this to deliver value for money, sufficient oversight arrangements must be in place to ensure that care markets operate effectively. Currently, however, there are wide variations between local authorities in the amount of engagement and support offered to personal budget users. In addition, some self-funders do not feel well informed. Market oversight at the local level is very varied, and there are no formal arrangements to monitor markets at the national and regional levels. These shortcomings must be addressed if value for money is to be secured in the future.

Achievement of Foundation Trust status by NHS hospital trusts. (October 2011)

The Department required all remaining NHS Trust to complete a 'tripartite formal agreement' (TFA) to summarise the main challenges they faced, and the resulting actions to be taken by the trust, Strategic Health Authority (SHA), and the Department. The NAO reported that the process of developing and committing to TFAs has made much more transparent the challenges trusts face to demonstrate their long-term viability, and has forced the signatories publicly to accept accountability for addressing them. Some of these issues, though well-known within the local health economy, have lain unresolved for a number of years.

It has taken six months to finalise TFAs. The time taken reflects the extent and complexity of the issues faced by some trusts and the degree of effort being taken to ensure they are an accurate assessment of both the challenges faced and the actions required. Different SHAs have been involved to differing extents in drafting the documents. The Department asked for all draft TFA documents to be submitted by trusts in March 2011. There were questions about the quality of some original submissions, and the Department identified a need to develop national responses for trusts with common financial problems. The Department signed the TFAs for the final 46 of the 113 trusts on 30 September 2011 committing trusts to agreed actions, although for some of the most challenged trusts the process of agreeing the set of actions they, their SHAs, and the Department will need to take is not complete.

The Department has put in place a national framework to monitor progress against milestones and track risks. Now that TFAs are agreed, progress against timelines will be monitored by SHAs. The Department has asked each SHA to report monthly on progress against milestones and, following discussion with the Department, to agree the level of risk in each case. Ultimately, this information will flow to the NHS Operations Board. If there are concerns about trusts' progress, the SHA will address these through its existing performance management arrangements.

The level of resources being devoted to ensuring that TFAs are robust varies considerably between SHAs. The progress of trusts through the pipeline will also require continued investment of staff time and monitoring by SHAs. Those that are most challenged will require the closest scrutiny and support. A number of SHAs have developed robust local performance management systems, for example in the North West and East of England, but these are not universal and there is scope to learn from exemplars. As part of the Government's wider health reforms, the ten existing SHAs were grouped into four clusters on 1 October 2011. The Department and the new clusters are developing a single operating model to manage trusts' performance through the pipeline ahead of the introduction of the NHS Trust Development Authority in 2013.

The report concluded, based on statements in the TFA documents, the processes the Department has put in place have introduced a new sense of purpose among NHS trusts in the pipeline for foundation trust status. The Department has made it clear that it is not in the business of maintaining back-door subsidies to financially weak trusts with a record of poor care. Even where foundation trust status is a realistic possibility, many trusts will need to substantially improve their performance. This will involve a step change in the quality of local management, together with close performance monitoring, and timely intervention by SHAs, the Department and, in due course, by the NHS Trust Development Authority, if trusts start to miss milestones. There are, however, at least 20 trusts that face such substantial and long-standing problems that they are not viable in their current form. The Department is now in the process of determining, with the NHS, how it will deal with these trusts.

Care Quality Commission: regulating the quality and safety of health and social care. (November2011.)

The NAO reported the regulators for health and social care have been subject to considerable change in the last 10 years. The Commission is the third regulator for each sector, although it is the first to cover both health and social care providers. The changes have created disruption for providers and confusion for the public. The proposal to extend the Commission's role into new areas risks distracting the Commission from its core work of regulating health and social care. The Department proposes that the Commission should take on a variety of

additional responsibilities, such as overseeing fertility clinics and responsibility for HealthWatch England, the national consumer body for health and social care. There is a gap between what the public and providers expect of the Commission and what it can achieve as a regulator**.** Although the Commission's role is clearly defined, it has not been communicated effectively and the Commission has not made clear what success in delivering its priorities would look like.

The report concluded the Commission had a challenging task in merging three former regulators to establish a new organisation and implementing a new regulatory approach, which integrates health and social care, at a time of diminishing resources. It was inevitable that there would be some transitional difficulties and that it would take time for the Commission to settle down into a steady state. In the event the difficulties were considerable.

The ultimate measure of the Commission's value for money is the impact of regulation on the quality and safety of care, relative to the cost. In the absence of measures of impact, we assessed value for money in terms of whether the Commission delivered what it set out to deliver. With the exception of NHS trusts, the Commission did not meet the deadlines set for registering providers; at the same time, levels of compliance and inspection activity fell significantly, although the Commission was hampered by government-wide recruitment constraints which made it difficult to fill vacancies quickly. We therefore conclude that, although regulation is being delivered more cheaply, the Commission has not so far achieved value for money in regulating the quality and safety of health and social care. The NAO stated it is not clear exactly where the balance of responsibility lies between the Commission and the Department for failing to achieve value for money; but it is clear that responsibility is shared.

Services for people with neurological conditions. (December 2011.)

The NAO reported that this was a 'new style' Framework, developed to reflect changes in the way that the NHS was managed, significantly devolving decision making. By design, it did not have the traditional levers to support implementation including national monitoring, targets and ring-fenced funding for specific initiatives. Health spending on neurological services has increased significantly since the introduction of the Framework in 2005. Between 2006-07 and 2009-10 health spending increased by 38 per cent in real terms, from £2.1 billion in 2006-07 to £2.9 billion in 2009-10. This was part of local commissioners' general budget and was not ring-fenced by the Department. Social services' spending on adults with a physical disability, of which a significant proportion will have a neurological condition, has remained flat in real terms since 2005-06. The Department put in place no specific arrangements for monitoring how commissioners implemented the Framework. As a result, the Department was unable to hold local commissioners to account for implementation. There was no national baseline assessment of the cost, access to and quality of neurological services, when the Framework was introduced, and no national monitoring of its impact. The Framework indicated that local delivery organisations should establish a baseline of services. However, the Department does not know how local organisations have gone about this, if at all. Therefore, the Department has no way to measure the effect of the additional spending on services or patient outcomes. With the Department cancelling its mid-point review of the Framework, agreed by the previous Government, it is not clear how lessons will be learnt and integrated into the design of the Department's new long-term conditions strategy. Data limitations mean that it is difficult to assess progress in implementing the Framework.

Overall, the achievement of the quality requirements within the Framework has been poor. For example, a North East Public Health Observatory report of an audit undertaken in 2008, rated performance against the Quality Requirements for all Primary Care Trusts in its region as below 'the good-doing well' standard. A report by Neurological Commissioning Support of its audit of 11 sites across England found that not one had fully met a single quality requirement. However, a minority had met some of the Quality Requirement's individual evidence-based markers. Further, the 2011 Royal College of Physicians and the Multiple Sclerosis Trust audit concluded that there had been no major improvements in many aspects of service provision for people with multiple sclerosis since 2006.

The report concluded the Department has clearly improved access by delivering against the 18 week waiting time target and reduced occupied bed days. However, although the Framework specified increased devolved decision making, it had none of the levers or incentives necessary to motivate local organisations to implement its 11 quality requirements. In addition, the Department did not put in place empirical baselines or arrangements to monitor implementation. The evidence presented in our key findings, therefore, leads us to conclude that current spending on neurological health and social services is not value for money as the

Department cannot demonstrate any significant quantifiable improvements against the Frameworks quality requirements.

It is the Department's view that there is insufficient evidence to support a conclusion that current spending on neurological health and social services is not value for money.

Annex C

PUBLIC ACCOUNTS COMMITTEE REPORTS PRINCIPALLY FOR THE DEPARTMENT

National Health Service health landscape review (April 2011)

The report provides an overview of aspects of the reforms where Parliament requires clarification and draws out a number of risks associated with the transition to the new model that need to be managed.

The report focus is in respect of the health reform programme is on accountability for taxpayers' money. With the health reforms still at an early stage, there are some aspects of the accountability arrangements which have yet to be resolved. There are also a number of risks during the three-year transition period which need to be managed

NHS National Programme for I.T. in the NHS: an update on delivery of detailed care records systems (August 2011)

The Committee reported that the National Programme for IT in the NHS (the Programme) was an ambitious £11.4billion programme of investment designed to reform how the NHS in England uses information to improve services and patient care.

The Programme was launched in 2002,and the Department of Health (the Department) has spent some £6.4 billion on the Programme so far. This report is concerned with a central part of the Programme, where the aim was to create a fully integrated electronic care records system, which is expected to cost around £7 billion in total. The original objective was to ensure every NHS patient had an individual electronic care record which could be rapidly transmitted between different parts of the NHS, in order to make accurate patient records available to NHS staff at all times. This intention has proved beyond the capacity of the Department to deliver and the department is no longer delivering a universal system

Transforming NHS Ambulance Services. (September 2011)

The Committee reported that there is wide variation in the cost of responding to an incident across ambulance services, which is underpinned by variation in a number of other factors, such as sickness absence, overtime and back office costs.

Ambulance services need to produce more consistent performance data in order to benchmark and share best practice so that efficiency can be improved and variations reduced across the country. For example, they do not currently collect and share comparable data on the extent to which ambulance crews are utilised when on duty. Although we note the Department's and ambulance services' commitment to provide more reliable benchmarking data and reduce variation.

Under the NHS reforms, the Committee believes there is still a great deal of vagueness around who will be responsible for what in the new system. It is not clear who will be responsible for commissioning ambulance services, who will be responsible for improving efficiency across ambulance services, or who will intervene if a service runs into financial trouble or seriously underperforms. In the future, ambulance services will become foundation trusts and be directly accountable to Parliament, but it is not realistic for each ambulance service to be individually accountable to us for value for money. The report states there should be greater clarity on the roles and responsibilities of the Department, commissioners and ambulance trusts, with appropriate structures for accountability to Parliament on value for money. Other parts of the health system affect ambulance services' performance.

The committee stated a more integrated emergency care system is required to ensure that ambulances are not kept waiting outside accident and emergency, can hand over patients faster and get back out to help others. The Department has plans to align the objectives of those involved in the provision of urgent and emergency care providers. There are also varying levels of collaboration between ambulance, fire and police services which should be strengthened and the Committee will look to government to investigate the scope for further co-operation to identify savings in areas such as procurement and back-office services.

Use of high value equipment in the NHS (October 2011)

The committee reported that the NHS currently has inadequate information to assess cost, performance and capacity across the system as a whole. Commissioners and trusts have no mechanism to understand the reasons for large variations that persist in the use of MRI and CT machines, as they are unable to compare their performance with other trusts. The NHS needs to make high quality, comparable data available on machine use and cost. We welcome the Department's plan to require all trusts to produce data on MRI and CT scan use. A standardised, national dataset would help trusts to compare unit costs and benchmark their performance. It would also enable commissioners to identify the large variations in utilisation across trusts and take appropriate action.

The committee stated the procurement and management of high value equipment is fragmented and uncoordinated, leading to wasted resources and variable standards of services. Trusts have three main ways to purchase high value equipment: by dealing directly with suppliers; through framework agreements, managed by NHS Supply Chain; or by joining up with other trusts in collaborative purchasing arrangements.

Formula funding of local public services (November 2011)

The Committee reported that the priorities accorded to different elements of the formulae are judgements which have a direct impact on the distribution of funds. In some cases the basis for the judgement is guided by authoritative, published independent advice. One example of this is the weighting the Department of Health applies to the health inequalities element of Primary Care Trust Allocations

Oversight of user choice and provider competition in care markets (December 2011)

The Committee reported that there are risks to the future functioning of the social care market from local authority budget reductions. Social care homes face inevitable increases in costs at the same time as local authorities inevitably reduce what they will pay to fund places. At present, 63% of funding of care comes from the public purse. Reducing this funding could create some degree of pressure in the market.

Most users hold personal budgets in high regard, and the early research shows that they like having choice and control. However, users need more support to obtain optimum value from their budgets. Some users are confused about what they can spend their budget on, and there are wide disparities in the level of information and support they receive across different authorities. Only around half of users find it easy to change their support, or get relevant information and advice, and around a third of users find the experience of employing personal assistants to provide their care daunting. The committee found the procedures for users to complain or get redress when things go wrong to be inadequate. These issues must be addressed if personal budgets are to be successfully sustained.

The Department has to rely on local authorities to implement its policy of universal provision of personal budgets to eligible users by April 2013 but it cannot compel local authorities to act. In consequence there are a small number of local authorities which are dragging their feet in offering personal budgets to users. There should be a clear line of accountability on policies that are generally agreed. A more radical option might be to enshrine in law people's rights to a budget.

Care Quality Commission: regulating the quality and safety of health and social care (March 2012)

The Committee reported that the Commission has more responsibilities but less money than its predecessors. Despite this it has consistently failed to spend its budget because of delays in filling staff vacancies. It is overseen by the Department of Health (the Department), which underestimated the scale of the task it had set in requiring the Commission to merge three bodies at the same time as taking on an expanded role. The Commission did not act quickly on vital issues such as information from whistleblowers. Neither did it deal with problems effectively, and the Department is only now taking action.

The Committee has serious concerns about the Commission's governance, leadership and culture. A Board member, Commission staff, and representatives of the health and adult social care sectors have all been critical of how the Commission is run.

Neither the Commission nor the Department have defined what success would look like in regulating health and adult social care. This makes it hard for the Committee to know whether the Commission has the resources it

needs to operate effectively. In addition, while the Commission reports what it does, it does not measure the quality or impact of its work. Where information is available, it is not presented in a way that allows the public to make meaningful comparisons between care providers. As a result, the public are unclear what the Commission's role is and lack confidence that it is an effective regulator.

The Commission faces a major challenge later in 2012 with the registration of 10,000 GP practices. In the past, the Commission's inspection work has suffered when it has had to register large groups of providers. It shifted its focus to registration and carried out far fewer inspections than planned. In the light of these problems, the Commission has changed the registration process. Registration will now be decided primarily on the information provided by the GPs themselves. GP practices will be required to declare whether or not they are meeting the essential standards. This process carries risks and the Commission must make sure the registration process is robust and provides meaningful assurance about the quality of GP practices.

Achievement of Foundation Trust status by NHS hospital trusts (December 2011)

The committee reported that a vital component of a successful health service is that everybody wherever they live should have ready access to a high standard of care through a network of acute hospitals that are subject to strong clinical and financial governance. The Department of Health (the Department) sees self-governing foundation status as necessary if hospitals are to succeed in a financially demanding environment. Becoming a foundation trust requires strong governance, long-term financial viability, and a framework to secure delivery of quality services. NHS foundation trusts were first created in 2004 and, between then and the end of September 2011, 139 NHS trusts attained foundation status. The Government intends that the majority of the remaining 113 NHS trusts will become foundation trusts by April 2014.It is already clear that this will be extremely difficult to achieve.

The challenges facing those hospitals which have still to attain foundation status are more severe than previously thought. Four out of five now face financial difficulties; 78% say they have to tackle strategic issues; two thirds acknowledge they have performance and quality challenges and nearly 40% say they need to strengthen their governance and their leadership.

Creating a national network of hospital trusts which are autonomous and financially viable presents hugely difficult challenges. It remains unclear whether all the problems trusts have highlighted can be resolved. Making all trusts viable will involve reconfiguration of some services, including through mergers. It is critical that local communities are consulted on these decisions and benefit from them. Where changes are proposed, trusts will need to demonstrate how merging organisations will create healthcare benefits to local communities while addressing the root causes of the financial problems that exist. Many of these trusts are in deprived areas and solutions should not reduce access to services for vulnerable people, thereby exacerbating health inequalities. The Committee are particularly alarmed that the healthcare system in London has been allowed to deteriorate despite its problems having been known about for many years. At least half of the acute trusts in London are not viable in their current form. The Department reassured the Committee that none of trusts' current plans involve closing hospitals, but some trusts are in such a poor financial state it is difficult to see why other organisations would want to take them on.

Strong leadership is urgently needed if those trusts facing clinical and financial difficulties are to meet the challenge of achieving foundation status. The flow of trusts through the 'pipeline' towards foundation trust status is already behind schedule. Decisions about changes to services, need to be taken promptly but wisely, and some trusts are still putting off difficult decisions. A particular problem is the quality of leadership, but prolonged uncertainty makes it harder to recruit good board members and clinical staff.

The Department has made an explicit commitment to intervene if trusts fail to tackle problems.

Services for people with neurological conditions (March 2012)

The Committee reported that people with neurological conditions need a wide range of services that can cross boundaries between health and social care, employment and benefit services, transport, housing and education. Despite these complex needs, coordination of care for individuals is poor, and there is a lack of integration between health and social services. There is still a lack of neurological expertise, both in hospitals and in the community, and access to services varies widely.

Implementation of the Framework lags behind those for cancer and stroke care, even though many neurological conditions severely affect quality of life and cause lifelong disability. Of particular concern is the 32% increase in emergency admissions, and the increased rate of readmissions to hospital within 28 days from 11.2% to 14%, since the introduction of the Framework. Rates are well above those for the NHS as a whole, and represent poor outcomes for people with neurological conditions and poor value for money for the NHS.

Unlike the Cancer and Stroke strategies the model used to implement the Framework has not worked. Implementation was left to local commissioners without the national leadership necessary to drive improvements. No baseline for services or outcomes was established when the Framework was introduced. There was no monitoring of progress, and local commissioners were not held to account for implementation.

There are key lessons to be learnt as the Department develops its proposed new health and social care landscape. The Department intends to decentralise and localise decision making, with central monitoring, and it will be vital that it sets clear objectives for the outcomes and services for people with neurological conditions. The delivery model needs to work better and put patient needs at its heart if services and outcomes are to improve.

Annex D

OUTSTANDING PUBLIC ACCOUNTS COMMITTEE RECOMMENDATIONS

Managing High Value Equipment in the NHS in England.	
Recommendation	Government Response
Recommendation 2 The Department has pledged to produce a dataset by April 2012 covering the use of MRI and CT machines by trusts, and the Committee welcomes this. From 2012-13 onwards, the NHS Commissioning Board should ensure that this dataset enables local clinical commissioning groups to hold trusts to account for their performance, and to drive improvements in efficiency.	Subject to finalising the necessary approvals, it is expected that both NHS trusts and NHS foundation trusts will be mandated to implement the Diagnostic Imaging Dataset from April 2012 with the first data available in summer 2012.
Recommendation 4 Commissioners should require trusts to share their plans for the replacement of high value equipment with NHS Supply Chain and / or other collaborative procurement bodies. This would enable NHS Supply Chain and others to aggregate orders across trusts to secure better prices.	The NHS Commissioning Board is considering what guidance is needed to support effective commissioning, for example to support CCGs to contract better for patient care whilst achieving value for money. The Board will take the Committee's recommendation into account in these considerations. A new service is being developed by NHS Supply Chain (NHS SC), with the support of the Department, based around a combined capital planning, procurement, maintenance and finance offering for the NHS. This will involve NHS SC taking a more proactive approach. Rather than waiting for NHS trusts and NHS foundation trusts to send them their plans, NHS SC propose to visit potential customers to discuss their needs and then help them to develop and shape their plans for a ten year period. This should result in a higher quality of capital planning across the NHS. Participation by all trusts will be voluntary, but the greater the number of NHS trusts and foundation trusts making use of this service, the greater understanding of NHS-wide capital requirements that NHS SC will develop and the greater the opportunity for NHS SC to aggregate demand to achieve savings. NHS SC is also actively considering the opportunities for bulk purchasing, at risk, certain types of medical equipment in order to maximise the competitiveness of their offering in response to anticipated future demand for replacement equipment. Details should be available later in the year.
Achievement of Foundation Trust status by NHS hospital trusts.	
Recommendation 5 *PFI is an additional challenge facing a few hospitals and PFI service charges are contributing significantly to some trusts'*	A number of potential solutions to this issue are being considered by the Government and the Department will work to complete this before Summer 2012.

financial problems. Analysis commissioned by the Department has identified six trusts where their PFI contract is a major obstacle to them becoming financially viable. *The Department recognises that those financial commitments need to be met, but has not yet explained how it will support these trusts without disadvantaging others. The Department will need to ensure the long term sustainability of these hospitals whilst at the same time minimising any extra financial support it offers.*	
Services for people with neurological conditions.	
Recommendation 2. The Department lacks the data to measure the effectiveness of services for people with neurological conditions. The Framework lacked an empirical baseline from which progress could be measured nationally or locally for health and social care, and the Department has no way of assessing what resources and activities result in the best outcomes. *The Department should develop a neurological data set covering resources, services and outcomes, which should include linking existing health and social care data using the patient's NHS number. Key indicators from the data set, including emergency admissions and readmissions for neurological conditions, should be included in the NHS and Adult Social Care Outcomes Frameworks with appropriate targets for reduction.*	Target implementation date**:** April 2014. The Department acknowledges that there was not an established baseline to support measurement of progress against the National Service Framework (NSF) for long term neurological conditions. However, there is currently data available including: • the Long term neurological conditions reference dataset (70 data items) available via the NHS Information Centre; • neurological data is included in NHS Comparators; • Quality Neurology – an audit tool that can be used by Primary Care Trusts and CCGs to scope progress against the Quality requirements; and • Neurological Commissioning Support has developed *Neuro Navigator*, a tool to support commissioners to assess the budget required to provide services across the whole care pathway for Parkinson's Disease, Multiple sclerosis and Motor neurone disease based on population size.
Recommendation 3 The quality of services for people with neurological conditions varies around the country, with some areas having insufficient expertise both in hospitals and in the community. The compliance of individual Primary Care Trusts with the Framework's quality requirements has been poor and so the support and treatment available to people continue to depend on where they live. *The Department should set out in its reply to the Committee how it will ensure all people with neurological conditions have* appropriate access to services. The Committee would expect this to include how the Department will drive improvements through the quality section of the NHS Standard Contract, the Commissioning Outcomes	Target implementation date: April 2013. A number of developments to the health and care system provided by the Health and Social Care Act 2012 will ensure improved access and more local accountability for services to the needs of individuals, including people with long term neurological conditions.

Framework, the Joint Strategic Needs Assessments and the Health and Wellbeing Boards.	
Care Quality Commission: regulating the quality and safety of adult social care.	
Recommendation 3 The Commission's role is unclear and it does not measure the quality or impact of its own work. The Commission's objective, as set out in legislation, is to 'protect and promote the health, safety and welfare of people who use health and social care services' but it has not defined what success in delivering this objective would look like. It is unclear to what extent the Commission's role involves improvement beyond the essential basic standards of quality and safety. Although the Commission is a Quality Commission it only measures itself against quantitative, activity-based performance measures, with no measures of quality or impact. *The Commission, working with the Department, should set out clearly what it is seeking to achieve and develop measures of quality and impact which can be used to assess its effectiveness.*	While CQC need to be clear on how it carries out its functions within the system, the Department has ultimate responsibility for overall system design. To help address the uncertainty on CQC's role, the Department, through the National Quality Board, intends to build on work already underway with CQC and others to develop explicit statements as to the distinctive roles of national bodies in assuring quality and providing incentives for quality improvement by autumn 2012. CQC will publish, in December 2012, a new strategy, which will set out more clearly CQC's role, its aims and the measures of success. The strategy will be tested extensively with the public and stakeholders, as part of a full consultation during summer 2012. In April 2012, CQC published a scorecard based on success measures in its business plan such as progress towards an inspection target and achievement of target time limits for registering new applications. These success measures will be developed alongside the strategy. Some of these measures are proxy measures and whilst they may reflect improved efficiency, they may not address the issue of impact. Therefore, CQC is also undertaking a review of the processes and supporting IT systems used to define, collect and confirm organisational performance data. The output from this review will set out the system and processes required to support future operational and organisational needs. CQC is implementing information system improvements that will allow CQC, at individual inspector level, to capture and analyse decisions that led to inspection activity and resulting judgements about compliance. This and other information, such as the amount of time taken to deliver an inspection, and feedback from providers, will allow the Department and CQC to monitor and review its effectiveness as a regulator. These changes will be completed by September 2012, which will allow CQC to gather the first set of data on effectiveness by December 2012. A further review will be undertaken by April 2013.
Recommendation 5 The registration of GP practices must involve a meaningful assessment of compliance with the essential standards of quality and safety. The proposed process will involve GP practices declaring areas where they are not compliant, and the Commission told us that it will seek to draw on other sources of information to indicate which practices give rise for concern. The Committee is not convinced that this approach will work in practice, particularly given the number of GP practices to be registered, and the	Target implementation date: Completion of GP registration by April 2013. The registration of GP practices by the Commission will provide assurance that these providers are meeting and will continue to meet essential levels of safety and quality. The Department accepts that the process of registering GP practice should be meaningful. The Commission will carry out a compliance pilot with GP practices in two regions in 2012 and this pilot will inform CQC's approach to registration. CQC's engagement with GPs ahead of registration has been extensive. CQC has a sectoral advisory group and an online community which has commented on and helped it improve its documentation for GPs registering.

Commission risks becoming simply a post box. *The Commission should review and set out how it will make sure that the assessment of GP practices is meaningful. It should develop clear criteria to use to judge when it needs to undertake further investigations before a practice can be registered.*	The Commission also has groups helping design the streamlined online registration system which is significantly simpler and more tailored than previous tranches of registration. Over 450 people have been involved in web chats to explore what registration means for them. Additionally, CQC co-produced its engagement plan with key stakeholders and issued its guidance documents far earlier to GPs as a result. Registration is not automatic. The CQC has to make a judgment as to whether applicant providers have made credible legal declarations that they will meet the essential standards and that they are fit to provide care services. CQC intends to review every registration application in conjunction with information from other sources including the General Medical Council (GMC), the Criminal Records Bureau (CRB) and from whistleblowers. Assessing applications is only the start of the process. CQC has criteria which will prompt its GP registration assessors to look more closely at certain applications. These include issues with GMC registration, information of concern from the Primary Care Trust cluster and whistleblowing correspondence. CQC will follow up in each case and where it has concerns, will visit the practice and conduct an interview. Once registered, GP practices are required to continue to meet the essential standards of care quality and safety and the Commission has a range of enforcement powers that it can use to address non-compliance. Providers of primary medical services will be inspected by the Commission at least 19 20 once every two years, and it is through this regular inspection process, as much as through initial registration, that the Commission will identify and address non-compliance by GP practices.
Recommendation 6 There are inconsistencies in the judgements of individual inspectors and in the Commission's approach to enforcement. The Commission's own internal auditors found variations in how inspectors assess risk and the Committee received evidence that there is insufficient focus on both the quality and consistency of inspectors' work. In addition, the approach to enforcement is variable, with action more likely to be taken against care homes than hospitals. *The Commission should provide training and guidance to inspectors that specifically addresses the risk of inconsistent judgements in inspections and enforcement, and should use performance data to monitor trends and identify areas of concern.*	Target implementation date**:** Evaluation of the use of specialist expertise to be completed by December 2012. CQC is making significant enhancements to its compliance regime. These will be completed by September 2012 and include a new framework for risk, which will enable inspectors to assess risk in a timely and systematic way. CQC is recruiting a team of Quality, Risk and Assurance Managers to work with inspectors to ensure levels of consistency and quality are maintained. The managers will work within a quality framework, reporting internally on the quality checks being undertaken and identifying potential improvements. These arrangements will be embedded in a revised corporate governance framework aimed at strengthening decision making within CQC and the way in which risks are escalated to Board level. CQC has an eight-week training and induction programme for new inspectors, designed to equip them with a thorough understanding of how to make judgements about compliance and appropriate enforcement action. This includes spending time shadowing experienced compliance inspectors. All inspectors have access to formal and informal support to aid

	them in making robust decisions. CQC will introduce clearer information for inspectors from June 2012, including guidelines on what triggers the need for specialist involvement. CQC will evaluate the use of clinical and professional associates and experts by experience once the new guidelines are in place. This evaluation will be completed by December 2012 and will inform a decision on whether the right balance has been struck on use of specialist expertise.

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