Presented to the House of Commons pursuant to Section 6 of the Government Resources and Accounts Act 2000.

Department of Health

Resource Accounts 2009-10

(For the year ended 31 March 2010)

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ANNUAL REPORT

1 The Accounting Boundary

1.1 These Resource Accounts present the financial results for the Department of Health. They consolidate the financial information of organisations within the Department's Resource Accounting Boundary. As such, this consolidation includes the Department itself, the NHS Purchasing and Supply Agency, those Special Health Authorities that are not funded by trading activities, Strategic Health Authorities, and Primary Care Trusts. The relationship between organisations within this boundary is substantially different from the concept of a group in the commercial sector as it is based on in-year budgeting 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.

1.2 A wide range of organisations lie outside the Department's Resource Accounting boundary, but remain within the much broader parameters of the Departmental Budgeting boundary. The latter is significantly different from the Department's Resource Accounting Boundary, in that it also includes the Special Health Authorities that receive their funding directly from trading activities, Non-Departmental Public Bodies, NHS Trusts and NHS Foundation Trusts. By far the majority of this group of organisations operate as providers of healthcare, and work within what may be described as a trading environment with commissioners.

1.3 Note 36 to the financial statements provides a comprehensive list of all organisations within the Departmental Budgeting Boundary, indicating those inside and outside the Resource Accounting boundary. A reconciliation between the financial results of the organisations within the two boundaries is given on page 21.

2 Summary of Financial Results

2.1 These Accounts show how the Department's activities have been funded, and its resources deployed, during the 2009-10 financial year. For the first time, and in a significant change to previous years, the financial statements and supporting notes have been prepared in accordance with the requirements of International Financial Reporting Standards (IFRS).

2.2 Consequently, in order that direct comparisons can be made between the two years' results, the 2008-09 financial figures included for comparative purposes in the 2009-10 accounts, have been restated to reflect the changes arising out of the switch from UK Generally Accepted Accounting Practice (UKGAAP) to IFRS. It is not therefore possible to compare the 2008-09 comparators directly with the published 2008-09 DH Resource Account (HC456). However, any 2008-09 Budgeting or Parliamentary Estimates figures included in these Accounts have not been restated to reflect the change to IFRS, and therefore remain on a UKGAAP basis.

2.3 The Department has two primary sources of funding: Parliamentary (Supply) funding and National Insurance Contributions, with the latter treated as operating income. In 2009-10, National Insurance Contributions amounted to just over £18 billion. HM Treasury 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.

2.4 The Department must contain expenditure within a series of controls operated by HM Treasury and Parliament. HM Treasury controls relate to expenditure by organisations within the budgeting boundary and Parliamentary controls relate to expenditure by organisations within the accounting boundary. HM Treasury also operates controls over the Department's running costs through the Administration Cost Limit (ACL).

2.5 In 2009-10, the Department met all its financial duties, managing resources within the budgets set by HM Treasury and the amounts voted by Parliament. The following paragraphs summarise performance in 2009-10 for revenue, capital and administration expenditure.

REVENUE

Revenue expenditure within the budgeting boundary:

2.6 The Department is required to manage the revenue expenditure of all organisations included in the budgeting boundary within its Revenue Departmental Expenditure Limit (RDEL). Expenditure within the budgeting boundary in 2009-10 was £98,781 million, an increase of £6,643 million or 7.2% compared to the prior year. This increase was largely driven by increases in allocations to the NHS (both general allocations and allocations for Family Health Services) of around £5.4 billion and increases in central spending, including expenditure of around £470 million on antiviral medicines to respond specifically to the swine flu pandemic and more generally in terms of pandemic flu preparedness.

2.7 Expenditure was £1,407 million, or 1.4%, less than the total DEL provision for the year of £100,188 million.

2.8 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 certain impairments and Credit Guarantee Finance. Expenditure that was scored against the AME budget in 2009-10 was £2,478 million, an increase of £2,103 million or more than five times the amount in the prior year. This increase resulted from asset impairments due to market valuations (both planned and as a result of prevailing economic conditions) and changes in valuation methodology.

Revenue expenditure within the resource accounting boundary:

2.9 Net expenditure within the accounting boundary increased by £7,866 million or 10.6%, from £74,518 million in 2008-09 to £82,384 million in 2009-10. In addition to the expenditure noted in paragraph 2.6, technical items accounted for almost £1 billion of the total increase and included:

- An increase of around £400 million on asset impairments due to changes in valuation methodologies and market valuations for bodies within the Resource Accounting Boundary (mainly PCTs); and
- A reduction of around £600 million in National Insurance Contributions, which has the impact of increasing expenditure. This has no impact on spending power but merely changes the balance between sources of funding.

Expenditure was £1,939 million or 2.3% less than provision for the year of £84,323 million.

CAPITAL

Capital expenditure within the resource budgeting boundary

2.10 The Department is required to manage the capital expenditure of all bodies inside the budgeting boundary within a Capital Departmental Expenditure Limit (CDEL) set by HM Treasury. The 2009-10 CDEL provision was £5,376 million and expenditure was £5,173 million, resulting in an underspend of £203 million or 3.8%. Compared with the prior year, expenditure increased by £804 million or 18.4%, this increase was largely as a result of:

- increased capital investment by NHS Trusts and NHS Foundation Trusts of around £300 million;
- increased capital investment by SHAs and PCTs of around £300 million; and
- capital expenditure on flu counter-measures in response to the swine flu pandemic of around £250 million.

Capital expenditure within the resource accounting boundary

2.11 Whereas the HM Treasury control is largely exercised over expenditure by organisations within the budgeting boundary, Parliamentary control is exercised over expenditure within the accounting boundary. The main difference is that the former includes all capital expenditure by NHS Trusts and NHS Foundation Trusts whereas the latter only includes the net lending to these organisations and excludes expenditure financed by internally generated resources.

2.12 Net capital expenditure in 2009-10 was £2,681 million compared with provision of £3,521 million, an underspend of £839 million or 23.9%. Compared with the prior year, expenditure increased by £1,417 million. This was largely due to the increases in spending by the

Department on pandemic flu and increased capital investment by PCTs and SHAs as noted above, together with a net increase of around £600 million in the net lending to NHS Trusts and NHS Foundation Trusts primarily to finance increased capital spending.

2.13 Within the public spending framework, underspends may be available to be carried forward for utilisation in future years, subject to agreement with HM Treasury and scrutiny on the basis of need, realism and the wider fiscal position.

DEPARTMENT OF HEALTH ADMINISTRATION

2.14 The running costs of the Department must be managed within an Administration Cost Limit (ACL) set by HM Treasury. The ACL for 2009-10 was £218.2 million and expenditure was £216.8 million, resulting in an underspend of £1.4 million or 0.6%. Compared with the prior year, expenditure decreased by £3.5 million or 1.6%.

2.15 In addition to the running costs charged to the ACL, total administration expenditure includes around £10.4 million for other costs, mainly related to spend on frontline or in support of frontline services. The budget for total administration costs in 2009-10 was £231.2 million and expenditure was £227.2 million, resulting in an underspend of £4.0 million or 1.7%. Compared with the prior year, expenditure decreased by £1.1 million or 0.5%.

3 The Financial Statements

3.1 These Resource Accounts are prepared for the financial year 1 April 2009 to 31 March 2010. 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.

3.2 The financial statements 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 the financial statements and gives an opinion as to whether they provide a true and fair view. That opinion is provided with these accounts.

3.3 The rules for completing the accounts are given 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.

3.4 The FReM reflects the rules in professional accounting standards to the extent that they are appropriate to the public sector. Until 2008-09, the Manual reflected UK accounting standards (as embodied in UK GAAP). From 2009-10, however, HM Treasury have required Government Departments to adopt IFRS. This follows a similar change by UK Listed companies. In recent years, new international standards have been issued as International Financial Reporting Standards (IFRS), whereas older standards, many of which remain in use, are described as International Accounting Standards (IAS). Other than where referring to a specific standard, these terms can be used interchangeably.

3.5 Whilst there are many similarities between UK GAAP and IFRS, there are also some notable differences. There have been a number of significant changes, both in the way some of the Primary Accounting Statements are described (e.g. the Balance Sheet is replaced by the Consolidated Statement of Financial Position) and in the format of those statements (e.g. the inclusion of prior year comparators in more detail than previous years). One particular effect of introducing the new standards is that in some circumstances, assets and liabilities are recognised in the Statement of Financial Position under international standards when they would not have been recognised under UK GAAP. In addition to supporting consistency in accounting practice, a further important purpose of introducing these new international standards has been to improve transparency and understanding of the accounts.

3.6 The financial statements consist of six primary statements, which provide summary information, and accompanying notes. The six primary statements, together with the related notes 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 for each Request for Resources (RfR); a summary of the cash required to finance expenditure; and a summary of income both appropriated-in-aid of expenditure and surrendered to the Consolidated Fund.
- **Operating Cost Statement**. This shows net resources (administration costs, programme costs and income) consumed by organisations within the Resource Accounting Boundary during the year, analysed by Request for Resources.
- **Consolidated Statement of Financial Position (formerly the Balance Sheet)**. This shows the assets, liabilities and taxpayers' equity of organisations within the Resource Accounting Boundary at the beginning and end of the year.
- **Consolidated Statement of Cash Flows**. This shows how cash has been used during the year on operating, investing and financing activities.
- **Statement of Changes in Taxpayer's Equity**. This shows the changes in the General Fund and reserves in the year.
- **Consolidated Statement of Operating Costs by Departmental Strategic Objectives**. This shows expenditure attributed to the Department's agreed strategic objectives.

3.7 There are prior period adjustments to the opening balances of these accounts following the adoption of IFRS. Note 2 'First Time adoption of IFRS' provides a detailed analysis of the impact of IFRS implementation.

3.8 As noted in paragraph 1.1 above, the results of the NHS Purchasing and Supply Agency (PASA) have been consolidated into the Department's 2009-10 accounts. However, PASA ceased to exist as a separate entity on 31 March 2010 following the adoption of a new Commercial Operating Model for the Department of Health. Its functions were transferred to other bodies: the commodity procurement teams moved to the Office of Government Commerce's trading arm, Buying Solutions, to increase economies of scale for the NHS; the Centre of Evidence-based Purchasing moved to the National Institute for Health and Clinical Excellence, and other functions moved to the Department of Health itself.

3.9 The Department's Resource Account is published each year by HM Treasury, and is an essential part of the Department's accountability to Parliament and the public for financial performance and use of resources. The other key elements of financial accountability published during the year are as follows:

- **Estimates –** The Estimates are the Government's requests for resources from Parliament and are presented annually in the following cycle:
  - Main Supply Estimates start the supply procedure and are presented at the beginning of the financial year to which they relate;
  - Winter Supplementary Estimates are presented in November, and reflect changes to the Supply, and the funds that are required by the Department, that have been identified during the year; and
  - Spring Supplementary Estimates are presented in February, and represent the final changes to Supply and funding required by the Department in year.

  Supply Estimates are presented to Parliament by HM Treasury and can be found on their website: www.hm-treasury.gov.uk

- **Public Expenditure Outturn White Paper –** This is published by HM Treasury in July. For each Department, this shows provisional expenditure against the Departmental Expenditure Limits and the Administration Cost Limit, which covers the Department's running costs. This is used to determine the level of underspend that may be available to be carried forward for spending in the current or future years, subject to agreement with HM Treasury. The White Paper can be found on the HM Treasury website: www.hm-treasury.gov.uk.

4 Management and Governance of the Department

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

4.2 The Permanent Secretary, Sir Hugh Taylor, is also the Principal Accounting Officer for the Department. He is responsible for leading the Department – ensuring that it operates effectively, that Ministers receive the advice and support they need, and that there is effective cross-government working.

4.3 The NHS Chief Executive, Sir David Nicholson, is the Additional Accounting Officer for NHS expenditure (Request for Resources 1). He 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. The Chief Medical Officer is the most senior professional advisor to both Department of Health and wider Government Ministers on medical and public health issues. The former Chief Medical Officer, Professor Sir Liam Donaldson, retired at the end of May 2010. Professor Dame Sally Davies will take on the duties of the Chief Medical Officer on an interim basis until a substantive appointment is made.

Ministers

4.4 The following Ministers were responsible for the Department in 2009-10:

- Secretary of State for Health with overall responsibility for the work of the Department:
  - Rt. Hon Andy Burnham, MP (from 6 June 2009)
  - Rt. Hon Alan Johnson, MP (until 5 June 2009)
- Ministers of State with responsibilities for the NHS and Social Care, including long term care, disability and mental health:
  - Mike O'Brien QC, MP, Minister of State for Health Services (from 8 June 2009)
  - Gillian Merron MP, Minister of State for Public Health (from 8 June 2009)
  - Phil Hope MP, Minister of State for Care Services (continuous)
  - Ben Bradshaw, MP, Minister of State for Health Services (until 7 June 2009)
  - Rt. Hon Dawn Primarolo MP, Minister of State for Public Health (until 5 June 2009)
- Parliamentary Under Secretaries with responsibility for Health, Social Care and Public Health:
  - Ann Keen MP, Parliamentary Under Secretary of State for Health Services (continuous)
  - Lord Ara Darzi, Parliamentary Under Secretary of State (until 20 July 2009)
  - Baroness Thornton, Parliamentary Under Secretary of State (from 19 February 2010)

Board Structure and Membership

4.5 The Department of Health is led by a small Departmental Board (DB), which is chaired by the Permanent Secretary. The DB supports the Permanent Secretary in the discharge of his responsibilities as Principal Accounting Officer, within the framework set by the Secretary of State.

4.6 The Departmental Board Membership at 31 March 2010 was:

Sir Hugh Taylor KCB	Permanent Secretary
Sir David Nicholson KCB CBE	NHS Chief Executive
Sir Liam Donaldson KB	Chief Medical Officer
David Behan CBE	Director General of Social Care, Local Government and Care Partnerships

Richard Douglas CB	Director General Finance & Chief Operating Officer
Julie Baddeley	Non Executive member
Jon Rouse	Non Executive member (since 1 August 2009)
Mike Wheeler	Non Executive member
Derek Myers	Non Executive member (until 31 July 2009)

4.7 The Departmental Board is responsible for:

- setting the standards and values for the Department;
- agreeing the Department's forward plan and ensuring its delivery; and
- ensuring that the Department is well managed with good governance and control arrangements, including effective management of risk.

4.8 The Departmental Board is supported by:

- the **Corporate Management Board**, which is chaired by the Permanent Secretary, and includes all of the Department's Directors General. This Board supports the Permanent Secretary in his personal responsibility for Departmental expenditure and provides leadership for the Department;
- the **NHS Management Board**, which is chaired by the NHS Chief Executive, and includes Strategic Health Authority Chief Executives and senior staff from the Department. This Board supports the NHS Chief Executive in his responsibility as the Additional Accounting Officer for NHS expenditure (Request for Resources 1) and provides leadership for the NHS, ensures effective two-way communication, manages NHS performance, and shapes policy and strategy for the NHS;
- the **Audit Committee**, which is chaired by a DH Non-Executive Director, and comprises other non-executive members of the DB. The Audit Committee advises the Accounting Officers and the Departmental Board on risk management, corporate governance and assurance arrangements in the Department and its subsidiary bodies;
- the **Performance Committee**, which is chaired by the Director General for Finance & Chief Operating Officer. This Committee monitors performance against Departmental Strategic Objectives, Value for Money targets and critical programme, project, and financial targets on behalf of the Departmental Board. It provides a source of challenge on each of these areas to the separate boards that have primary responsibility for their delivery;
- the **Committee for the Regions**, which is chaired by the Director General of Social Care, Local Government and Care Partnerships. The purpose of this committee is to assure the Departmental Board that the Department's priorities in the regions are being delivered. Its remit is to hold the Department's regional operations to account for the delivery of the Department's six regional business roles as set out in the Business Planning Guidance 2009-11, and to govern the Department's work to improve the business model for regional delivery of health and well-being; and
- the **Equality & Human Rights Assurance Group**, which is chaired by a DH Non Executive Director and comprises the Directors General with responsibilities for the major policy and operational activity relating to equality and human rights. The purpose of the group is to oversee the Department's performance against the Single Equality Scheme action plan and, through that, to ensure compliance with equality legislation on behalf of the Department.

Remuneration of Ministers and senior officials

4.9 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.

Appointment of senior officials

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

Pension Liabilities

4.11 The transactions and balances of the NHS Pension Scheme are not consolidated in the Department of Health Resource 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

4.12 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 these financial statements: separate accounts are prepared for the scheme, and details can be found at: http://www.civilservice.gov.uk/pensions

Employment of Disabled Persons policy

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

Equal Opportunities policy

4.14 The Department of Health is committed to treating all staff fairly and responsibly. The aim of the Department's Equal Opportunities Policy is to promote equality of opportunity, whereby no employee or job applicant is discriminated against either directly or indirectly on grounds such as race, colour, ethnic or national origin, sex, marital status, responsibility for children or other dependants, disability, age, work pattern, sexual orientation, gender reassignment, Trade Union membership or activity, religion or belief. Line managers are responsible for promoting equal opportunities within their own work teams and for ensuring business compliance with equal opportunities legislation.

Sickness absence data

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

2009-10

	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	5,382	5,880	11,262	2,462	4.6	2,862	1,545	54
Connecting for Health	2,703	2,828	5,531	1,206	4.6	1,258	717	57
Strategic Health Authorities			16,080	3,224	5.0			
Primary Care Trusts			1,978,345	202,579	9.8			

Sickness absence is based on available staff days on Headcount basis

4.16 In respect of Primary Care Trusts and Strategic Health Authorities, final data relating to the last quarter of 2009-10 was not available at the date of these accounts. Consequently, the data used in the above table relates to the 12 month period 1 January 2009 to 31 December 2009. Data for the period 1 January to 31 March 2009 is considered to be a reasonable proxy for the same three-month period in 2010.

4.17 NHS Connecting for Health, responsible for implementing the National Programme for IT in the NHS, is a programme managed by the Department's Director General for Informatics and Chief Information Officer.

Provision of information to, and consultation with, employees

4.18 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 Corporate Management Board 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.

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

4.19 Other than those disclosed in Note 33 (Related Party Transactions), there are no company directorships or significant interests held by Board members.

Department of Health Workforce

4.20 The average number of staff employed by the Core Department (excluding NHS Connecting for Health) grew during 2009-10 by 233 or 7.4%, with the growth in permanent staff being some 6.5%, and growth in the non-permanent workforce being 9.9%. When NHS Connecting for Health staff are included, the overall level of growth decreases to 6%. The overall increase has been partially driven by the recruitment of staff to support the Department's response to pandemic flu, and by the transfer into the Department of staff from the Purchasing and Supply Agency (PASA) following the abolition of that organisation.

4.21 A further reason for the increase is that programme-funded civil servants have been included in the staff numbers for the first time. In previous years, the primary control has focused on those staff funded from the Administration Cost Limit (ACL). However, in the current economic climate, it is important that the Department can correctly identify and control all of its workforce, however they are financed or classified. Figures for 2008-09 have been restated in Note 10 to the Accounts to include the same categories so that a direct comparison can be made between the years.

4.22 The number of non-permanent workers has increased, in part because of the recruitment controls introduced late in 2009 as managers sought to fill their vacancies on a short-term basis, but also because of new high priority work such as the Department's response to the swine flu pandemic. A data cleansing exercise undertaken by the Department has also

identified a number of non-permanent staff who were not previously recorded in the figures, but should have been. The impact of this error has been reflected in the restated numbers for 2008-09.

4.23 Recognising the need to reduce staffing costs on a permanent basis to reflect planned future reductions in budgets, the Department's Corporate Management Board agreed during the year to:

- A programme of work, beginning in February 2010, to significantly reduce the number of non-permanent workers employed by the Department by the end of 2010-11;
- The introduction of central recruitment controls from November 2009; and
- A minimum of a 20% reduction in the SCS pay bill over the next three years.

4.24 In terms of actual, as opposed to average, numbers, since these controls were introduced, the number of permanent admin funded staff has fallen from 2,327 at the end of December 2009, to 2,281 at the end of March 2010. There had been a further reduction in this number to 2,245 by the end of May 2010 (the latest period for which data are available).

4.25 In May 2010, further controls were applied across central Government, including a recruitment freeze into the civil service in respect of all non-front line posts.

4.26 In the interests of improving transparency, for the first time during 2009-10, the Department published details of the travel related business expenses incurred by the most senior officials (a number of whom are seconded in from NHS organisations) and Non-Executive Directors of the Department on a quarterly basis. The expenses incurred reflect work conducted at both a regional and national level with a range of external partners. This expenses information can be found on the Department's website: http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/Departmentdirectors/DH_110759

DH and ALB Administration costs

4.27 The Department of Health's budget was protected from the initial round of spending reductions announced by the Government as part of the measures to deal effectively with the overall budget deficit. Notwithstanding this, the Department and its ALBs have taken a cut in their budgets of 5% in real terms for 2010-11, and a further 3% reduction has now been agreed. This drive to reduce administration costs is in line with spending reductions across all other Government departments.

NHS Administration costs

4.28 As part of the commitment to cut the cost of NHS administration, and transfer resources to the frontline, the June 2010 Revision to the 2010-11 NHS Operating Framework included a statement to the effect that "The overall ceiling for management costs in PCTs and SHAs will now be set at two thirds of 2008-09 management costs (£1,509 million). The ceiling will therefore be £1,006 million". The £1,855 million of management costs, as reported in the 2009-10 accounts for PCTs and SHAs must therefore be reduced by approximately £850 million. This will start with an overall reduction of £222 million in 2010-11, followed by a further reduction of £350 million in 2011-12, with the balance being achieved by 2013-14.

MANAGEMENT COMMENTARY

5 Departmental strategic objectives

5.1 The Department's overall aim is to improve the health and well-being of the people of England. The Department's medium-term objectives were defined by its Public Service Agreements (PSAs) as agreed with HM Treasury in previous Spending Review.

5.2 The Department led in respect of two PSAs during 2009-10, namely *Promoting better health and well-being* (PSA 18) and *Ensuring better care* (PSA 19). The Department contributed to a further six PSAs led by other departments. The two PSAs led by DH were consistent with the three Departmental Strategic Objectives (DSOs) for 2009-10:

- **Better health and well-being for all** – this covered the Department's objectives to help people stay healthy and well, empowering them to live independently, and to tackle health inequalities;
- **Better care for all** – this covered the Department's objectives to provide the best possible health and social care services, offering safe and effective care, when and where people need help, and empowering them in their choices; and
- **Better value for all** – this covered the Department's objectives to deliver affordable, efficient and sustainable services which contribute to the wider local and national economy.

The Government has now abolished the PSA system and will be replacing this with a new performance framework

5.3 For 2009-10, the Departmental Board agreed a number of key priorities to support each of the Department's DSOs:

DSO: Better health and well-being for all

Key priorities:

- creating a fairer society by enabling local services to reduce health inequalities;
- engaging with citizens to co-produce better health and well-being outcomes;
- contributing to world-class science and innovation;
- preparing for an influenza pandemic; and
- working with and through DH delivery partners at central, regional and local levels to influence the wider determinants of health and well-being.

DSO: Better care for all

Key priorities:

- implementing *High Quality Care for All*;
- embedding a new regulation system across health and social care; and
- developing proposals to reform social care through the care and support Green Paper.

DSO: Better value for all

Key priorities:

- improving value for money; and
- delivering sustainability.

5.4 The three DSOs focus on the work needed to help improve the health and well-being of the nation. However, in order to achieve a sustainable improvement in these areas, the

Department must also continue to develop as an organisation. Three further business objectives support this development activity:

Business objective: Improving the Department's capability

Key priorities:

- sustaining an effective strategy to work closely with stakeholders, partners and other Government Departments, through staff induction, training and development and direct frontline engagement;
- embedding the use of evidence and analysis in policy making, including improved training and development, more effective engagement with delivery chain partners and stakeholders in planning policy implementation, improved use of impact assessments, and consistent integration of both policy and policy prioritisation; and
- leading and managing the Department effectively, and supporting staff at all levels to develop and succeed.

Business objective: Improving support to Ministers and accountability to Parliament

Key priorities:

- continuously and measurably improving the service provided to Ministers; and
- improving the quality, timeliness and transparency of external reporting.

Business objective: Promoting equality and diversity

Key priorities:

- embedding consideration of equality and human rights across all areas of the Department's business; and
- improving the information and analytical base needed to support work in respect of equality and human rights.

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

- setting direction for the NHS, adult social care and public health;
- supporting delivery;
- leading health and well-being for Government;
- accounting to Parliament and the public; and
- supporting staff to succeed

Progress against each of these objectives is addressed below.

Setting direction for the NHS, adult social care and public health

5.6 The Department has general responsibility for standards of health care in the country, including the NHS, sets the strategic framework for adult social care, and influences local authority spend on adult social care. The Department also sets the direction on promoting and protecting the public's health, taking the lead on issues such as environmental hazards to health, infectious diseases, health promotion and education, the safety of medicines and ethical matters.

The Department's work in setting direction includes:

- Defining the overall strategy in relation to the NHS, adult social care and public health;
- Developing and implementing policy;
- Legislation and regulation, including the promotion of Bills through Parliament;
- Setting the NHS Operating Framework; and

- Input into Local Area Agreements

Supporting delivery

5.7 The Department is responsible for finding the best way to support and mobilise the health and social care system to deliver improvements for patients and the public. Work in this area includes:

- a comprehensive performance management system;
- managerial and professional leadership for external groups;
- building capacity and capability; and
- ensuring value for money for the taxpayer.

5.8 Key performance indicators in the wider health and social care system have been measured and tracked through the appropriate management and programme boards. The performance of the Department itself is reviewed by the Corporate Management Board using a performance scorecard. This includes metrics on delivery, stakeholder feedback, resources, and business improvement. Target and performance data are obtained in consultation with Directors General and linked to the delivery of Directorate-level operational plans.

5.9 The Department's Performance Committee also monitors performance against DSOs, Value for Money targets, and critical programme, project and financial targets on behalf of the Departmental Board; it provides a source of challenge on each of these areas to the boards that have primary responsibility for their achievement.

Leading health and well-being for Government

5.10 The Department has led on the integration of health and well-being issues into cross-Government policies, and the incorporation of wider public policy into health and social care services. The Department's work cuts across both the public and private sector 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 integrating 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).

Accounting to Parliament and the public

5.11 As a Government Department, the Department of Health is responsible for supporting Ministers in accounting to the public and Parliament. This work includes:

- preparing annual Resource Accounts and NHS Summarised Accounts;
- answering Parliamentary questions - both written and oral - and dealing with other Parliamentary business, debates and enquiries;
- responding to Freedom of Information requests;
- responding to letters, emails, and phone calls from the public and members of Parliament; and
- communicating to the public through the media and by visits and speeches.

Supporting our staff to succeed

5.12 The Department can only meet its objectives through highly skilled, professional and motivated staff, supported by the right tools and infrastructure to support them to succeed. This work includes:

- the provision of training and development opportunities; and

- the provision of effective and efficient support functions such as IT, HR, accommodation and finance.

The Department's approach to learning and development is guided, in particular, by two of its corporate values, namely valuing people and valuing purpose, and by the need to sustain improvements in organisational capability and performance.

6 Dealing With Risks and Uncertainties

6.1 The Department's high-level risk register is the focal point of overall risk management within DH. This register is updated and reviewed quarterly by the Departmental Board and the Audit Committee, with supporting Committees and Boards reviewing risks that fall within their area of responsibility. The Department's Risk Forum, comprising Directors from all directorates, also reviews the register and advises the Departmental Board on the risks contained within it.

6.2 The Department has continued to build on the improvements made last year in terms of updating its policies and procedures for the identification and management of fraud. In particular this year, the Department has:

- reviewed and updated its anti-fraud policy, and fraud response plan, building on the role of Counter Fraud Services;
- clarified roles and responsibilities (especially relating to delegated authorities) in respect of fraud management, and;
- commissioned its internal Assurance Strategy and Audit (ASA) team to undertake a specific fraud risk assessment. This will become an annual exercise.

6.3 Key areas of the Department's work in relation to which risks were recorded on the high-level risk register during 2009-10, were:

- Improving and protecting the health of the nation – including the work on contingency plans for the influenza pandemic and taking action to continue to address healthcare associated infections and reduce health inequalities;
- Improving the capacity, capability and efficiency of the health and social care system, and implementation of the NHS Next Stage Review; and
- Ensuring that system reform, service modernisation, IT investment (including information security) and staff contracts deliver improved value for money.

6.4 During the first half of 2009-10, seven cases of suspected procurement fraud were identified. These have been referred to the NHS Counter Fraud Service for full investigation, and could potentially result in a financial loss to the Department. They have exposed a number of weaknesses in DH procurement, finance and IT systems. The Department took immediate action to address these system weaknesses and other identified risks, introducing a number of IT changes and additional management checks.

7 Developing the Department

Capability Review

7.1 In response to the Capability Review undertaken by the Cabinet Office in June 2007, the Department implemented a Development Plan to address the areas identified for improvement. The July 2009 Capability re-Review confirmed the scale and breadth of the improvements achieved since 2007, highlighting particular strengths in delivery and key aspects of leadership and strategic capability.

7.2 However, the Department recognises that it needs to do more to strengthen its capability in key areas, not least as it continues its preparations to deal responsibly with the current challenging financial climate. As will be the case for all other Government departments and the wider public sector, the next few years will bring significant financial challenges for DH.

The Department will have to become smaller, more efficient and productive, and lead and manage change effectively.

7.3 The Department has therefore put in place *Preparing for the Future* plans for 2010-11, which update the second year of the 2009-11 Business Plan to reflect the changed financial realities. In particular, the plans involve scaling back, re-configuring or stopping work in the expectation of significantly reduced budgets in future. They also recognise the importance of continuing to build capability and sustain our progress as a healthy organisation as financial resources tighten. The Department will monitor its progress against these plans on a regular basis and revise them, where necessary, as circumstances change during the course of 2010-11.

7.4 There is clear evidence of a link between engaged staff and high levels of organisational performance, so the Department considers employee engagement to be a key element in how it develops its capability. In the 2009 Civil Service People Survey the Department's employee engagement index[1] was calculated at 60 per cent; one per cent higher than the civil service benchmark. While the questions in the 2009 survey were not directly comparable to previous DH annual staff surveys, many of the results are encouraging. DH scores better than the civil service benchmark figures in over 80% of the core questions and the number of staff who feel valued for the work they do has risen from 51% (March 2009) to 72%.

8 Review of the Year

8.1 This section provides a brief review of the Department's activities and achievements during 2009-10.

Setting direction for the NHS, for adult social care and public health

8.2 The Department's Departmental Strategic Objectives (DSOs) are set out in section 5.2.

8.3 Progress against these DSOs is measured using a set of 44 indicators, against which the Department reports on an annual basis. Where relevant, the DSOs and their indicators have been cascaded to both the NHS and Local Government as part of their new performance frameworks. In line with the Department's strategic approach, these indicators have not been cascaded as targets.

8.4 The Department holds the NHS to account through the publication of the NHS Operating Framework. The NHS Operating Framework for 2009-10 maintained the five priorities agreed as part of the 2007 Comprehensive Spending Review:

- improving cleanliness and reducing healthcare acquired infections;
- improving access through fulfilling the 18 week pledge and longer GP opening;
- keeping adults and children well, improving their health and reducing inequalities;
- improving patient experience, staff satisfaction and engagement; and
- preparing to respond in a state of emergency, such as an outbreak of pandemic flu.

8.5 The NHS Operating Framework for 2010-11 was published in December 2009, and this confirmed that these five priorities remained in place for the final year of the three year spending review period. However, a short revision to the 2010-11 NHS Operating framework

[1] The 'Employee Engagement Index' was a new element in the 2009 Civil Service People Survey. This measures how engaged employees are with their work and is calculated from responses to five key questions in the Survey:

- I am proud when I tell others I am part of the Department
- I would recommend the Department as a great place to work
- I feel a strong personal attachment to the Department
- The Department inspires me to do the best in my job
- The Department motivates me to help it achieve its objectives

was published in June 2010, setting out the initial priorities of the new Government. This revision should be read in tandem with the original document relating to 2010-11. The revision sets out those areas which are subject to immediate change, including stopping the central performance management of targets around the second priority listed above, namely improving access through fulfilling the 18 week pledge and longer GP opening.

8.6 *'High Quality Care for All'*, the final report of the NHS Next Stage Review, described an NHS that gives patients and the public more choice, works in partnership and has the quality of care at the heart of everything it does. During 2009-10, the Department made strong progress in delivering the commitments set out in this Report, working in a spirit of co-production with the NHS. *'High Quality Care for All: The journey so far'*, published in July 2009, set out the progress achieved across each dimension of quality - patient experience, patient safety and clinical effectiveness.

8.7 Beyond the NHS, the Department continued to develop policy in relation to social care and the wider care system. Demand for care and support services is increasing, and expectations rising, as people tend towards more personalised and flexible services. During 2009-10, the Department continued to lead a cross-Whitehall programme to fundamentally review the care and support system in England.

Supporting delivery

8.8 The Department continued to support the health and social care systems in delivering sustainable improvements. The following were achieved in 2009-10:

- A swift and strong response to the recent swine flu pandemic: Preparedness planning involved building capability and capacity in relation to clinical countermeasures (including the development of a suitable infrastructure to enable the rapid distribution of antiviral medicines) and implementing plans to both inform the public and support management of the country's response. These arrangements were mobilised very quickly to deliver both clinical advice and antiviral treatment to thousands of members of the public. The Department's response also included the decision to purchase sufficient quantities of swine flu vaccine to immunise the population, using advance purchase agreements.

  As the pandemic progressed, it became increasingly clear that swine flu would prove to be less virulent than first feared. The European Medicines Agency (EMEA) advised that just one dose of the swine flu vaccine would be sufficient to confer immunity, rather than the two doses per person that had been envisaged at the start of the outbreak. Both of these factors meant that the requirement for vaccines was significantly lower than the level originally anticipated, leading to the Department holding excess inventory.

  The worldwide surplus of swine flu vaccine means that there is no active market in which excess pandemic flu inventory can be sold. The Department has recognised a total loss of £128 million in this financial year in respect of the excess inventory it currently holds (£98.4 million), and inventory it will receive in 2010-11 under the same purchase agreements (£29.6 million). This treatment recognises the likely market value and value in use of the inventory. The vaccine itself, which remains medically effective, will be retained as a strategic reserve for possible future use. The Department has recognised a further £72.9 million loss in respect of antiviral medicines made available to the NHS during the swine flu pandemic. In some cases, the Department has been unable to obtain documentary evidence that the antiviral medicines returned from the NHS had been stored in accordance with the terms of the respective Wholesale Dealers Licence (WDL). This does not mean that these antiviral medicines were not stored by the NHS in compliant conditions, but rather that the Department does not have the documentary evidence to prove that this was the case. This inventory will also be retained for possible future use.

  The Department has recognised a further loss in 2009-10 of £23.5 million in relation to date-expired inventory.

- A continuing reduction in Health Care Acquired Infections. The number of cases of MRSA bloodstream infections fell, with an annual reduction of 34% between 2007-08 and 2008-09 (the latest period for which data are available) and the number of *C.difficile* infections fell by 35% over the same period. This means that the target to reduce *C.difficile* infections by 30% by 2010-11 was met two years early.
- Continuing delivery by the NHS against the 18 weeks pledge at a national level, that is, 18 weeks from GP referral to the start of treatment standard. The NHS sustained performance against the published minimum operating standards of 90% of admitted patients and 95% of non-admitted patients starting their treatment within a maximum of 18 weeks of referral.
- Over three-quarters of GP practices across the country have extended their opening hours, offering their patients improved access to routine appointments.
- Significant increases in public satisfaction with the NHS in Britain. Satisfaction levels are now at their highest point since data gathering on satisfaction began, with 58% reporting that they are "Very" or Quite" satisfied. This represents a 19% increase compared to 2001 figures. It is noticeable that the levels of satisfaction reported in this survey are higher amongst those who have recently used NHS services. For example, while 51% of the general population reports that they are satisfied ("Very" or "Quite") with in-patient services, the level of satisfaction rises to 66% amongst those who have used the services within the past 12 months. For out-patient services, whilst 61% of respondents overall report that they are satisfied with the service received, the level of satisfaction increases to 72% for those who have used the service within the past year. This increase is evident across the whole range of services reviewed.

Leading health and well-being for Government

8.9 In providing leadership across Government on health and well being, the Department:

- Continued the F.A.S.T stroke campaign – one of the most successful public awareness campaigns ever run by the Department – an initiative to publicise the early warning signs of stroke and demonstrate the importance of rapid action;
- Ensured that the public were well-informed about how to protect themselves and their families, and to access treatment, during the swine flu pandemic;
- Embedded and expanded Change4Life – a national movement designed to help parents make healthier food choices for their children and encourage more activity;
- devised a new "Quit kit", which boosted orders for NHS support materials by 500% from people who want to stop smoking. From research into the prevalence of smoking, the cost of smoking to the NHS, and estimates of the number of people who stopped smoking (and have not started again), DH estimates that the one-year return on each £1 spent in 2008 on the 'Smokefree' campaign is £1.60. For 2009, with lower campaign costs and an increase in the number of people who have stopped smoking, the estimated returns on each £1 invested are £2.99 (one-year) and £7.83 (three years); and
- Launched a new campaign, supported by leading health charities, to raise awareness of alcohol-related health problems and ultimately reduce the rates of alcohol related hospital admissions by encouraging behaviour change.

Accounting to Parliament and the public

8.10 The Department continues to be one of the busiest in Whitehall in terms of accountability. In 2009-10 it:

- Completed the transition to International Financial Reporting Standards with the production of these Resource Accounts;
- Achieved the laying of an unqualified 2008-09 Resource Account to a pre-recess deadline in July 2009, three months earlier than in previous years, improving the quality of in year accounting and demonstrating greater fiscal responsibility;
- Published a total of 53 Impact Assessments, 19 of which accompanied regulations which came into force during the 2009-10 financial period, and a further 34 which were part of the

policy development process. It should be noted that IAs are no longer placed in the libraries of the Houses of Parliament;

- Completed 149 Equality Impact Assessments in total during this period: 125 screening assessments and 24 full assessments;
- Answered 1,984 Freedom of Information (FOI) requests. The Department responded to 98% of these within deadline, including permitted extensions, against a cross-Government average of 86% (source: Ministry of Justice FOI Annual Report 2009 Publications - Ministry of Justice); and
- Answered 4,400 Parliamentary questions, dealt with 11 Health Select Committee inquiries and 7 Public Accounts Committee hearings. DH also dealt with inquiries from other Select Committees: 3 from the Lords Science and Technology Committee on pandemic flu, genomic medicine and nanotechnologies in food; one from the Commons Science and Technology Committee on homeopathy, and one from the Welsh Affairs Committee on cross border health care.

Supporting our staff to succeed

8.11 The Department's work in this area focussed largely on the Development Plan, which was built around a major programme of staff engagement. This was used to help develop the Department's four core values. The Department:

- **Values people**: the Department cares about people and puts their health and well-being at the heart of everything we do;
- **Values purpose**: the Department focuses its actions and decisions on achieving shared goals;
- **Values working together**: DH works together as one department with our partners and stakeholders; and
- **Values accountability**: DH takes responsibility and is open to challenge.

8.12 These values have been at the heart of the Department's work during the year and have been used by managers to develop their ways of working and by the Department to test and refine the way it carries out its business.

Forward Look

8.13 The Department's Business Plan for 2010-11 was initially framed within the context of the 2007 Comprehensive Spending Review, the Department's Capability Review and the subsequent Development Plan. Further details can be found in the Department of Health Business Plan on the Department's website: www.dh.gov.uk

8.14 However, all future planning, both in the Department, and across wider Government is being reviewed in light of the outcome of the 2010 General Election and the need to respond effectively to reducing the national budget deficit. The new Secretary of State for Health has outlined his five priorities for the future, in addition to the overarching drive to reduce the running and management costs of the Department, Arms Length Bodies and the NHS:

A patient-led NHS

- Ensuring the NHS responds to people's needs, for example by giving patients a voice through locally elected representatives sitting on the boards of Primary Care Trusts. Patients will be able to choose any healthcare provider, including registering with any GP they want to; and patients will be able to make more decisions about their own care.

Shifting focus and resources to deliver better health outcomes

- Patients will be able to rate hospitals according to the quality of care; and data about the performance of health care providers will be published online.

A more autonomous and accountable system – empowering professionals in the NHS

- Strengthening GPs' powers, enabling them to commission care on a patient's behalf. Doctors and nurses will have more freedom to use their professional judgement about what is right for their patients.

Improved public health through a new public health delivery system

- The NHS will work with a range of partners, focusing on improving people's health through prevention, personalisation and partnership models of delivery. GPs will be given greater incentives to improve local primary care. Local communities will have greater influence over improving public health for their areas.

A focus on reforming long-term care

- Establishing a commission on long-term care to consider a range of funding options including a voluntary insurance scheme; elderly people will be helped to live at home for longer.

8.15 The Department will be working with the new Ministerial team to develop these priorities as part of on-going business planning, especially as this is informed by the outcomes of the 2010 Spending Review.

9 Use of Financial Resources

Revenue expenditure

9.1 Across the three Requests for Resources, the Department underspent in 2009-10 by a total of £1,939 million on total resource provision of £84,323 million. Table one shows the breakdown of the under spend by RfR.

Table One - 2009-10 Overall Revenue Spending Approved by Parliament

Expenditure Type	Provision	Outturn	Under/ (over) Spend
	£m's	£m's	£m's
Request for Resources 1			
Securing health for those who need it	80,853	79,124	1,729
Request for Resources 2			
Securing social care for those who need it and at national level, protecting, promoting and improving the nation's health	3,455	3,246	209
Request for Resources 3			
Office of the Independent Regulator for NHS Foundation Trusts	16	14	2
Total Resources	**84,323**	**82,384**	**1,939**

1) Figures may not sum due to rounding

9.2 Within the centrally managed programmes, the significant variations are shown in Table Two below.

Table Two: Significant Variations on Centrally Managed Programmes

Budget	Provision £m's	Outturn £m's	Variance £m's	Explanation
RfR1				
Strategic health authorities and primary care trusts unified budgets and central allocations	96,990	95,139	1,851	Mainly the planned underspend in PCTs and SHAs.
Strategic health authority and primary care trusts grants to local authorities	126	167	(41)	Expenditure higher than forecast at Spring Supply
Hospital financing for credit guarantee finance pilot projects and certain health authority and primary care trust impairments.	641	440	201	Lower than forecast expenditure on impairments for bodies within the Resource Accounting Boundary (mainly PCTs)
Grant in aid to Non-departmental Public Bodies and repayments and repayment of interest	(1,258)	(998)	(260)	Lower than planned receipt of Provider dividends. The dividend is lower due to NHS Trust and Foundation Trust impairments due to market valuations and the change in asset methodologies
RfR2				
NHS Purchasing and Supplies Authority	59	40	19	Lower than planned expenditure on PASA. This is linked to the forecast of costs due to the cessation of PASA as a DH ALB,
Other services including medical, scientific and technical services, grants to voluntary bodies, information services and health promotion activities.	299	310	(11)	Expenditure was higher than planned at Spring Supply. This was mainly due to additional costs related to the Archer Report.
Welfare food and European Economic Area and other countries medical costs	872	698	174	This estimate line covers Welfare Foods and European Economic Area Medical (EEA) costs, both of which are demand-led. Expenditure on EEA is highly volatile due to its demand led nature and risks of foreign exchange movements. The provision was set based on a prudent estimate of exchange rate risks.
Grant in Aid funding Non Departmental Public Bodies and special health authorities	399	363	36	Lower than planned grant in aid funding. Mainly due to lower than planned transition costs for the Care Quality Commission.
RfR3				
Office of the Independent Regulator for NHS Foundation Trusts	16	14	2	Lower than planned Grant in Aid funding was required as the regulator had surplus cash available from 2008-09.

1) Figures may not sum due to rounding

9.3 The total expenditure for which the Department is responsible includes not only voted sums but spending by organisations outside the resource accounting boundary. In 2009-10, the Department was responsible for managing a total resource budget of £100,188 million and total resource spending was £98,781 million. Table three below reconciles total resource spending to the net resource outturn shown in Table one above.

Table Three: Revenue Reconciliation between Estimates, Accounts and Budgets

	2009-10 £m's	2008-09 £m's
Net Resource Outturn (Estimates)	**82,384**	**74,518**
Adjustments to remove:		
Provision voted for earlier years		
Adjustments to additionally include:		
Consolidated Fund Extra Receipts in the OCS	(9)	(339)
Net Operating Cost (Accounts)	**82,375**	**74,178**
Adjustments to remove:		
Capital Grants to Local Authorities and Third Parties	(493)	(258)
Profit & (Loss) on disposal	1	1
Voted expenditure outside the budget (mainly National Insurance Contributions, Grant in Aid, IFRS non-budget items and PDC dividends)	18,321	19,734
Adjustments to additionally include:		
Other Consolidated Fund Extra Receipts	9	
Resource consumption of Non Departmental Public Bodies	369	503
Other adjustments (mainly Trust and Foundation Trust surplus before interest and dividends)	677	(1,646)
Resource Budget Outturn (Budget) of which;	**101,259**	**92,513**
Departmental Expenditure Limit (DEL)	98,781	92,138
Annually Managed Expenditure	2,478	375

1) Figures may not sum due to rounding

9.4 The principle reason for the difference between net resource accounting expenditure and net budgeting expenditure is the receipt of National Insurance Contributions (NICs) of just around £18 billion. NICs are treated as operating income as per the FReM but are excluded from budgets. The Department does not have any control over the amount of NICs it receives, the level being determined by HM Revenue and Customs.

9.5 The primary financial control that HM Treasury applies to the Department is the Departmental Expenditure Limit (DEL). Table Four provides a breakdown of 2009-10 Revenue DEL performance across the main Department of Health spending sectors.

Table Four: 2009-10 Revenue DEL Position by Sector

	2009-10 DEL Under/(over) Spend £m's
2009-10 Total Revenue DEL Provision	**100,188**
2009-10 Revenue DEL expenditure	**98,781**
2009-10 Revenue DEL underspend	**1,407**
2009-10 Revenue DEL Underspend as a % of Provision	**1.4%**
Breakdown of 2009-10 Revenue DEL underspend:	
NHS Bodies (Primary Care Trusts, Strategic Health Authorities, NHS Trusts and Foundation Trusts)	*1,945*
Central Programme	*(540)*
Central Administration	*1*

1) Figures may not sum due to rounding

9.6 In this sector presentation, the planned central over-commitment of £540 million is due to 2008-09 PCT and SHA underspends repaid in 2009-10 without drawdown of end year flexibility (EYF) from Treasury mitigated by planned underspends in PCTs and SHAs.

9.7 In accordance with Treasury's guidance *"Supply Estimates: a guidance manual"*, departments are required to produce taut Parliamentary Estimates and are only able to access end year flexibility on the basis of realism and need. It was not necessary to draw down EYF in 2009-10 as there was sufficient surplus within the NHS to meet the Department's overall spending control.

9.8 Within the Revenue DEL control is a further financial control for Departmental Administration, known as the Administration Cost Limit (ACL). Net expenditure on Departmental ACL was £216.8 million, compared with a provision of £218.2 million, an underspend of £1.4 million or 0.6%. The total administration costs in the resource account amount to £227.2 million, compared to a provision of £231.2 million, an underspend of £4.0 million or 1.7%. In addition to ACL expenditure, total administration includes around £10.4 million for other costs, mainly related to spend on frontline or in support of frontline services.

Expenditure Type	Provision	Outturn	Under/ (over) Spend
	£m's	£m's	£m's
Administration cost limit	218.2	216.8	1.4
Other administration	13.0	10.4	2.6
Total Resources	**231.2**	**227.2**	**4.0**

1) Figures may not sum due to rounding

Capital Expenditure

9.9 The Department underspent in 2009-10 by a total of £839 million on total provision of £3,521 million. Table Five shows the breakdown of the under spend by RfR.

Expenditure Type	Provision £m's	FY Outturn £m's	Under/(over) Spend £m's
Acquisition of Property, Plant and Equipment (PPE), intangibles and financial assets	2,781	2,195	586
Proceeds from the disposal of PPE, intangibles and financial assets	(229)	(104)	(126)
Investments (issued & repaid)	969	590	379
Total Resources	**3,521**	**2,681**	**839**

1) Figures may not sum due to rounding

9.10 As with revenue expenditure, the Department is responsible for capital spending by organisations outside the resource accounting boundary. Table Six below reconciles this total capital expenditure to the total capital resources approved by Parliament shown in Table Five.

Table Six: Capital Reconciliation between Estimates, Accounts and Budgets

	2009-10 £m's	2008-09 £m's
Net Capital Outturn (Resource Account)	**2,681**	**1,264**
Adjustments to remove:		
(Gains) /losses from sale of capital assets	-	(1)
IFRS expenditure that does not score against the capital budget	(303)	-
Adjustments to additionally include		-
Capital spending by non departmental public bodies	67	-
Capital grants	493	258
Other adjustments	(212)	207
Capital expenditure of NHS Trusts and FTs	3,014	2,690
Less net PDC and loans to trusts and FTs	(560)	(35)
Capital Budget Outturn (Budget) of which;	**5,180**	**4,383**
Departmental Expenditure Limit (DEL)	5,173	4,369
Annually Managed Expenditure	6	14

1) Figures may not sum due to rounding

9.11 Table Seven provides a breakdown of 2009-10 Capital DEL performance across the main Departmental spending sectors.

Table Seven: 2009-10 Capital DEL Position by Sector

	2009-10 DEL Under(over) Spend £m's
2009-10 Total Capital DEL Provision	5,376
2009-10 Capital DEL expenditure	5,173
2009-10 Capital DEL underspend	203
2009-10 Capital DEL Underspend as a % of Provision	3.8%
Breakdown of 2009-10 Capital DEL underspend:	
NHS Bodies (Primary Care Trusts, Strategic Health Authorities, NHS Trusts and Foundation Trusts)	*160*
Central Programme	*43*

1) **Figures may not sum due to rounding**

NHS Trust and NHS Foundation Trust financial performance

9.12 The financial results of NHS Trusts and NHS Foundation Trusts, as providers of healthcare, are not consolidated into these Resource Accounts. Rather than being funded directly by Government, these bodies receive their income through trading activity with healthcare commissioners.

9.13 NHS Trusts reported a deficit in their 2009-10 Summarised Accounts of £1,385 million. However, when impairment adjustments are taken into account the financial performance changes to a surplus of £165 million. Similarly, NHS Foundation Trusts reported a deficit in 2009-10 of £735 million. When impairment adjustments are taken into account their financial performance changes to a surplus of £415 million.

Impairments

9.14 Impairments of non-current assets result when assets fall in value, either because there has been a deterioration in the service potential of an asset beyond normal depreciation, or because of price reductions in the wider economy. An impairment can either be charged against the revaluation surplus for the asset, to the extent that there is a surplus against that asset in the reserves, or, where there is not such a revaluation surplus, (or there is insufficient to cover the impairment), it is charged to expenditure.

9.15 NHS Trusts and NHS Foundation Trusts are required to carry their assets at fair value, which must be kept up to date. These bodies were required to adopt a new valuation approach for their non-current assets in either 2008-09 or 2009-10. Under this, the valuation is applied to a modern equivalent asset, rather than to the asset that actually exists. Both this change of approach and the price falls in the wider economy have been the major causes of 2009-10 impairments.

Comparison to 2008-09

9.16 As noted previously, one of the most important impacts of the transition to IFRS has been to bring PFI, Local Improvement Finance Trust (LIFT) and other service concession arrangements onto the Statement of Financial Position. PFI and LIFT assets are included in the individual accounts of the relevant underlying NHS organisation, and are not consolidated into the Department of Health Resource Account. The restated 2008-09 accounts of the individual organisations will include the effect of bringing PFI and LIFT schemes onto the Statement of Financial Position, so no substantial movement between 2008-09 and 2009-10 should be expected.

10 Public Interest and Other Issues

Public Dividend Capital

10.1 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.

10.2 The rules governing PDC for NHS Trusts and NHS Foundation Trusts are laid out in the NHS Act 2006. The Act allows for the use of PDC as originating capital for NHS Trusts and initial PDC for NHS Foundation Trusts. It also sets out the Secretary of State's powers in determining the conditions under which PDC is issued to NHS Trusts. With the consent of the Treasury, the Secretary of State may determine:

- the dividend which is payable at any time on any Public Dividend Capital issued, or treated as issued, to an NHS Trust or NHS Foundation Trust under this Act;
- the amount of any such Public Dividend Capital which must be repaid at any time; and
- any other terms on which any Public Dividend Capital is so issued, or treated as issued.

10.3 The NHS Act 2006 also sets out how initial PDC is determined for NHS Foundation Trusts and the powers the Secretary of State holds in determining terms under which PDC is treated as having been issued and the dividend payable. Under the current financial regime 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 as 3.5% of the average net relevant assets of each NHS Trust and NHS Foundation Trust and is calculated with reference to the actual average net relevant assets taken from the underlying accounts of those bodies.

Payment of Suppliers

10.4 The Department complies with 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.

10.5 In 2009-10, the core Department paid 99.3% (215,153) of its invoices in accordance with the 30 day policy. The comparable figures for 2008-09 were 99.52% (184,418 invoices). In the same period, the core Department paid 95.78% (207,536) of bills in accordance with the new 10-day policy (95.77% in 2008-09). The prompt payment performance of other members of the Departmental family can be found in their published annual accounts.

External auditor

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

Data Loss Incidents

10.7 There were two recorded instances of personal data loss in the Core Department during 2009-10. Both were reported to the Information Commissioner. Internal processes were reviewed and updated where necessary. NHS organisations record data loss incidents in their individual published accounts.

Contingent Liabilities

10.8 Note 31 to the Accounts states that the Department has £94.4million of contingent liabilities which are disclosed under parliamentary reporting requirements but which are not disclosed under IAS37, as the likelihood of payment resulting is remote.

10.9 In addition to these quantifiable indemnities, there are a further 30 unquantified indemnities. These indemnities mainly relate to potential legal action against organisations or individuals. The Department monitors the potential risks relating to these remote contingencies.

10.10 In addition, the Department has reported operational contingent liabilities IAS37 as shown in Note 30.

Policy and achievement on environmental matters

10.11 As a Department of State, DH has a role to play in helping Government set an example by changing what is bought, how energy is used and considering the environmental impact of its activities.

10.12 The Department is working with DEFRA and other Government Departments on the Adapting to Climate Change (ACC) programme. The outputs of this programme are to be published later this year.

10.13 DH also produced various guidance documents in conjunction with the Health Protection Agency (HPA) and its Health Emergency Preparedness Division aimed at dealing with disruptive environmental challenges and managing incidents.

10.14 The Department is a partner in the Research Council-led 'Living with Environmental Change' (LWEC) Initiative. DH is committed to working with LWEC partners to scope key research needs in relation to the health impacts of climate change and a move to a low carbon society. Working with the National Institute of Health Research, and the Wellcome Trust, DH co-funded an international study in relation to the health benefits of tackling climate change. This study also looked at the health impact of various mitigation strategies both in the UK and in the developing World. Results were published by the Lancet in November 2009.

10.15 Acting as part of a cross government global health strategy, DH has committed to working with international partners, (WHO and EU) to develop evidence on the health impacts of climate change and raise awareness in both the public and policy makers.

10.16 A National Heatwave Plan, which was first launched in 2004, is updated yearly based upon the latest available evidence. This contains guidance for the health and social care sector on protecting vulnerable people from the effects of heat and how local authorities can keep urban areas cool.

Sustainable Development Activities

Sustainable Development Action Plan

10.17 As required by the Sustainable Development Commission (SDC), the Department's strategy for delivering sustainable development in the period 2008 -11 was published in October 2008, and this is supported by a Sustainable Development Action Plan, which was published in July 2009.

10.18 In January 2010, an assessment of the Department's Sustainable Development action plan for 2009-11 was carried out by the SDC. Feedback was very positive with the Department being one of only four to receive a green traffic light rating, and the only department to receive green traffic lights in all five areas of the assessment. The progress report is available on the Department's website at www.dh.gov.uk.

Sustainable Operations

10.19 In common with all other Government Departments, the Department continues to work towards achieving the Sustainable Operations on the Government Estate (SOGE) targets issued in 2006. These targets cover carbon emissions from offices and transport, natural resource protection, sustainable production and consumption and procurement. Data collected annually by the SDC indicates that in most areas the Department will meet all these targets by the due dates.

10.20 The Department successfully applied for funds from the DECC Low Carbon Technology Programme in late 2009. The award of £325,000 will enable the Department to pilot a new lighting system in one of its buildings, and to install sub-meters to better measure its energy consumption.

10.21 Under the Greening IT Action Plan, a new ICT desktop and central document storage infrastructure has been installed, with deployment expected to be complete by mid 2010. Other projects in progress include server consolidation and improved remote access services. The Plan's objective is to achieve carbon neutrality in ICT operations by 2012 through a 40% reduction in carbon emissions and approved offsetting for the balance.

Sustainable Procurement

10.22 The past year has seen significant changes across procurement within the Department and the NHS in response to the procurement capability review in 2008. The Department continues to make progress against the sustainable procurement flexible framework and has assumed the lead on sustainable procurement policy for the NHS.

Developing Sustainable Development in the NHS

10.23 The Department's Energy and Sustainability Capital Fund (£100 million) has been allocated and it is anticipated that this will produce significant revenue and carbon savings for the NHS. For example, £99.963 million was allocated to NHS Trusts within the timeframe available and this is calculated to generate annual revenue savings (based on 2007-08 energy costs) of £13.96 million per annum and savings of over 126,000 tonnes CO2/annum.

10.24 The Department's Business Case policy and procedures for capital procurement schemes, both public and private, have been updated to include the Building Research Establishment's Environmental Assessment Method (BREEAM) for Healthcare requirements for new builds and refurbishment.

10.25 The Carbon Trust is entering the fourth phase of the NHS Carbon Management Programme, and this has already identified annual revenue savings in excess of £20 million per annum and savings of 185,000 tonnes CO2/annum. These programmes are being implemented over a five-year period.

People

10.26 The Department's Health & Well-being Board was established in Summer 2008 and the Health & Well-Being policy for Department staff was published in December 2008. Since then, an extensive range of initiatives designed to promote health and well-being, including policies relating to mental health and volunteering, has been introduced. In addition, the Department has incorporated Sustainable Development awareness into its staff induction programmes, as well as embedding it into Professional Skills for Government (PSG), which now forms a key component of the Promotion Gateway process.

Sir Hugh Taylor

15 July 2010

Permanent Secretary

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

Department of Health Departmental report 2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports

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

Department of Health Autumn Performance Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091854

HMT Public Expenditure White Paper
http://www.hm-treasury.gov.uk/pespub_pesa08.htm

Chief Executive Report to the NHS
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099689

Finance Directors report to SofS on NHS financial Performance Quarter 4
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_100193

Annual Report of the Chief Medical Officer: On the state of Public Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206

The NHS Operating Framework 2009-10 Revised 21 June 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

The NHS Operating Framework 2009-10
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445

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, detailing the resources acquired, held or disposed of during the year, 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 expenditure on hospital and community health services, family health services, some central health services, the drugs bill and NHS Trusts' external financing; 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.

   These appointments do not detract from the Permanent Secretary's overall responsibility as Accounting Officer for the Department's accounts.

5. 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 2009, the Senior Pay Strategy Committee was chaired by Sir Hugh Taylor (Permanent Secretary). The other members were Sir David Nicholson (NHS Chief Executive), Sir Liam Donaldson (Chief Medical Officer), Julie Baddeley (Non Executive Director), Harbhajan Brar (Director of Human Resources), Simon Reeve (FDA) and Kent Woods (Chief Executive, Medicines and Healthcare Products Regulatory Agency - MHRA).

6. For awards made from 1 April 2009, the average basic pay award for members of the SCS was 1.5% of the existing paybill for such staff.

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 2009 the relevant Committee was chaired by Sir Hugh Taylor (Permanent Secretary). The other members were Sir David Nicholson (NHS Chief Executive), Sir Liam Donaldson (Chief Medical Officer), Julie Baddeley (Non-Executive Director) and Harbhajan Brar (HR Director).

8. In the cases of the four 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 regarding pay and 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 Mark Britnell and 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 to these two members of staff is subject to recommendation from the Department's Pay Committees. As a Doctor, the remuneration of Professor Dame Sally Davies is subject to recommendation from the Doctors' and Dentists' Review Body.

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 - DEPARTMENTAL BOARD MEMBERS AND CORPORATE MANAGEMENT BOARD MEMBERS

11. This Remuneration Report covers Ministers, non-Executive Directors and all officials sitting on the Departmental Board (DB) or the Corporate Management Board (CMB). 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 16 officials sitting on the DB or CMB. Twelve held permanent Senior Civil Service contracts during this period and four were seconded into the Department.

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	
Christine Connelly	Director General – Chief Information Officer	22 September 2008	
Sir Liam Donaldson	Chief Medical Officer	21 September 1998	
Richard Douglas	Director General of Finance and Chief Operating Officer	1 May 2001	
David Harper	Director General of Health Improvement and Protection	14 October 2003	
Sian Jarvis	Director General of Communications	1 April 2004	
Sir David Nicholson	NHS Chief Executive	1 September 2006	
Una O'Brien	Director General of Policy and Strategy	1 October 2007	

Sir Hugh Taylor	Permanent Secretary	18 December 2006	
Gary Belfield	Acting Director General of Commissioning and System Management	15 June 2009	
Secondments			
Mark Britnell	Director General of Commissioning and System Management	1 June 2007- 30 September 2009	South Central Strategic Health Authority
Dame Sally Davies	Director General of Research and Development	1 May 2005	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

13. Table 1 provides details of remuneration interests of DB and CMB members (provided on page 33).

14. Table 2 provides details of pension interests of DB and CMB members (provided on page 34).

Salary

15. '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. For the performance year 2008-09, the Permananent Secretary, NHS Chief Executive and Chief Medical Officer agreed to forego voluntarily their non-consolidated performance pay (which would have been paid in 2009-10) in line with Permanent Secretaries in other Government Departments.

Non-Consolidated performance pay

16. 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 for 2009-10, 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 DH's total base pay for SCS. In 2009-10, this 'pot' was limited by the Cabinet Office to a maximum of 8.6% and related to awards for performance year 2008-09. Individual non-consolidated performance pay awards were categorised into four tranches depending on performance during 2008-09 and ranged from zero to £15,000.

Benefits in Kind

17. The monetary value of benefits in kind covers any payments (for business expenses or otherwise) 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.

18. Five members received payments deemed by the HMRC to be benefits in kind. In line with Departmental policy, Sir David Nicholson receives an allowance for the extra costs of living away from his home base. Sir David Nicholson is based in Leeds and the payment covers 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 2009-10 Sir David Nicholson received £47,338 (gross). He is also entitled to one return journey per week from his home base to London, this amounted to £6,307 (gross).

19. David Flory has been on secondment from North East Strategic Health Authority since 1st June 2007. He is entitled to accommodation and travel expenses for living away from home. Now that the secondment has gone beyond two years, these expenses are accounted for as a benefit in kind, which in 2009/10 amounted to £37,572 (net). 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 £1,902.

20. Sir Bruce Keogh is entitled to claim one return journey per week from his home base to London. This amounted to £7,633 (gross) in 2009-10.

21. Sir Hugh Taylor, Sir Liam Donaldson and Sir David Nicholson have the benefit of a Government car. In 2009-10 this was assessed as a benefit of £16,129 for Sir Hugh Taylor, £6,647 for Sir Liam Donaldson and £12,670 for Sir David Nicholson. This is a provisional assessment of their benefits, pending confirmation by HMRC. Sir Hugh Taylor and Sir Liam Donaldson ceased to have the benefit of a Government car from April 2010 and Sir David Nicholson will cease to do so from August 2010.

Civil Service Pensions

22. 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 changes in the Retail Prices Index (RPI). Members joining from October 2002 may opt for either the appropriate defined benefit arrangement or a good quality 'money purchase' stakeholder pension with a significant employer contribution (partnership pension account).

23. Employee contributions are set at the rate of 1.5% of pensionable earnings for classic and 3.5% for premium, classic plus and nuvos. 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' 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 upated in line with RPI. In all cases, members may opt to give up (commute) pension for lump sum up to the limits set by the Finance Act 2004.

24. 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).

25. 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 60 for members of classic, premium and classic plus and 65 for members of nuvos.

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

Cash Equivalent Transfer Values

27. 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 within the guidelines and framework prescribed by the Institute and Faculty of Actuaries 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

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

The following tables are subject to audit.

Table 1 - Remuneration interests of DB and CMB Members

	2008-09				2009-10			
	Salary (inc non-consol perf pay[3])	Full Year Equivalent Salary (inc non-consol perf pay[3])	Benefit in Kind (gross)	Benefit in Kind (net)	Salary (inc non-consol perf pay[5])	Full Year Equivalent Salary (inc non-consol perf pay[5])	Benefit in Kind (gross[6])	Benefit in Kind (net)[6]
	£ '000	£ '000	nearest £100	nearest £100	£ '000	£ '000	nearest £100	nearest £100
Dame Christine Beasley	155-160	155-160	Nil	Nil	155-160	155-160	Nil	Nil
David Behan	200-205	200-205	Nil	Nil	195 -200	195-200	Nil	Nil
Mark Britnell[1]	235-240	235-240	31,900	25,000	125-130	235-240	Nil	Nil
Clare Chapman	265-270[4]	265-270[4]	Nil	Nil	250-255	250-255	Nil	Nil
Christine Connelly	100-105	195-200	Nil	Nil	200-205	200-205	Nil	Nil
Dame Sally Davies[1]	225-230	225-230	Nil	Nil	225-230	225-230	Nil	Nil
Sir Liam Donaldson	210-215	210-215	Nil	Nil	205-210	205-210	6,600	6,600
Richard Douglas	150-155	150-155	Nil	Nil	150-155	150-155	Nil	Nil
David Flory[1, 6]	215-220	215-220	800	800	215-220	215-220	40,307	39,474
David Harper	150-155	150-155	Nil	Nil	145-150	145-150	Nil	Nil
Sian Jarvis	140-145	140-145	Nil	Nil	145-150	145-150	Nil	Nil
Sir Bruce Keogh[1]	185-190	185-190	Nil	Nil	200-205	200-205	7,600	6,800
Sir David Nicholson	225-230	225-230	46,900	27,900	210-215	210-215	66,300	46,500
Una O'Brien	135-140	135-140	Nil	Nil	140-145	140-145	Nil	Nil
Sir Hugh Taylor	165-170	165-170	Nil	Nil	155-160	155-160	16,100	16,100
Gary Belfield	N/A	N/A	N/A	N/A	120-125	145-150	Nil	Nil

(1) Each of these individuals is or was seconded into the Department from NHS organisations and are or were paid by their employing authority. 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. For the two members of staff from organisations outside the Resource Accounting boundary, the amounts reimbursed in 2009-10 were £188,844.65 to North West London Hospitals NHS Trust for Dame Sally Davies and £262,623.61 to UCL Hospitals NHS Trust for Sir Bruce Keogh.

(2) No members received non-cash remuneration elements or compensation for loss of office in 2008-09 or 2009-10.

(3) Performance pay is awarded in arrears; therefore, the non-consolidated performance pay included in this column relates to 2007-08 performance year payable in 2008-09. Details of start and end dates for those not serving the full term can be found in paragraph 12.
(4) Clare Chapman receives contractual non consolidated performance pay of £27,500 per annum subject to satisfactory performance. This is paid in the year to which it is related.
(5) Performance pay is awarded in arrears; therefore, non consolidated performance pay awards for the year 2008-09 were actually paid in 2009-10. Similarly those for 2009-10 will be paid in 2010-11.
(6) The net Benefit in Kind is the amount received by the individual. The gross Benefit in Kind is the amount received by the individual plus the tax and National Insurance paid by the Department to HM Revenue & Customs.

Table 2 - Pension interests of DB and CMB Members

		Accrued pension at pension age as at 31/3/10 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/3/10	CETV at 31/3/09	Real increase in CETV
		£'000	£ '000	£ '000	£ '000	£'000
Dame Christine Beasley	Chief Nursing Officer	55-60 plus lump sum of 170-175	2.5 - 5 plus lump sum of 7.5-10	1,215	1,165	54
David Behan	Director General of Social Care, Local Government and Care Partnerships	5-10	0-2.5	129	83	36
Mark Britnell[2]	Director General of Commissioning and System Management	30-35 plus lump sum of 100-105	2.5 5 plus lump sum of 10-12.5	559	466	57
Clare Chapman	Director General of Workforce	10-15	2.5-5	185	119	49
Christine Connelly	Director General, Chief Information Officer	5-10	2.5-5	85	27	49
Dame Sally Davies[2,6]	Director General of Research and Development	70-75 plus lump sum of 215-220	0-2.5 plus lump sum of 2.5-5	Nil[6]	1,696	Nil[6]
Sir Liam Donaldson	Chief Medical Officer	100-105 plus lump of 310-315	2.5-5 plus lump sum of 12.5-15	2,477	2,296	108
Richard Douglas	Director General of Finance and Chief Operating Officer	55-60 plus lump sum of 165-170	2.5-5 plus lump sum of 7.5-10	1,116	1,010	49
David Flory[2]	Director General of NHS Finance, Performance and Operations	15-20 plus lump sum of 55-60	2.5-5 plus lump sum of 7.5-10	365	290	47
David Harper	Director General of Health Improvement and Protection	45-50 plus lump sum of 145-150	0-2.5 plus lump sum of 5-7.5	1,014	908	47
Sian Jarvis	Director General of Communications	15-20 plus lump sum of 45-50	0-2.5 plus lump sum of 2.5-5	251	220	16
Sir Bruce Keogh[2]	NHS Medical Director	70-75 plus lump sum of 220-225	0-2.5 plus lump sum of 2.5-5	1,684	1,519	89
Sir David Nicholson[5]	NHS Chief Executive	95-100	90-95	1,734	141	474
Una O'Brien	Director General of Policy and Strategy	35-40 plus lump sum of 105-110	2.5-5 plus lump sum of 7.5-10	680	581	60
Sir Hugh Taylor	Permanent Secretary	70-75 plus lump sum of 220-225	2.5-5 plus lump sum of 10-15	1,781	1,649	79
Gary Belfield	Acting Director General of Commissioning and System Management	55-60	5-7.5	804	689	79

(1) No automatic lump sum payable to premium scheme members
(2) Each of these individuals is or was seconded into the Department and are or were members of pension schemes operated by their employing authority. Please see the Resource Accounts of their employing authority for details of the scheme that they are or were in.
(3) The 'CETV at start date' figure may be different from the closing figure in last year's accounts. This is due to the CETV factors being updated to comply with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008.
(4) There were no employer contributions to partnership pension accounts.
(5) CETV at 31/3/09 is based on DH service only. CETV at 31/3/2010 includes previous service transferred in from NHS pension scheme.
(6) Under the NHS Pension Scheme rules, the pension cannot be transferred for those over pension age so CETV value is nil.

B - MINISTERS

29. 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.
30. The following Ministers were in post during 2009-10 financial year:

Minister		**Date Appointed**
Ben Bradshaw MP	Minister of State	30 June 2007**
Lord Ara Darzi	Parliamentary Under Secretary	29 June 2007***
Rt Hon Alan Johnson MP	Secretary of State	29 June 2007*
Andy Burnham	Secretary of State	6 June 2009
Ann Keen MP	Parliamentary Under Secretary	30 June 2007
Phil Hope	Minister of State	6 October 2008
Rt Hon Dawn Primarolo MP	Minister of State	30 June 2007*
Mike O'Brien MP	Minister of State	8 June 2009
Gillian Merron MP	Minister of State	8 June 2009
Baroness Thornton	Parliamentary Under Secretary	19 February 2010

* until 5th June 2009. ** until 7 June 2009 ***until 20 July 2009

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

32. Table 3 provides details of remuneration interests of Ministers.

Table 3 - Remuneration interests of Ministers

	2008-09		**2009-10**			
	Salary £	**Lords Office Holders' Allowance** £	**Salary** £	**Full Year Equivalent Salary** £	**Lords Office Holders' Allowance** £	**FYE Lords Office Holders' Allowance** £
Ben Bradshaw	41,071		10,162	40,646		
Lord Ara Darzi*	44,085	23,247	13,253	43,630	7,015	22,968
Phil Hope	17,594		40,646	40,646		
Alan Johnson	79,179		19,589	78,356		
Ann Keen	31,174		30,851	30,851		
Dawn Primarolo	41,071		10,162	40,646		
Mike O'Brien	N/A		30,485	40,646		
Gillian Merron	N/A		31,301	40,646		
Baroness Thornton	N/A		5,050	72,326	3,185	38,280
Andy Burnham	N/A		58,767	78,356		

*Lord Ara Darzi worked part time at 0.6 of a full time equivalent

No Ministers received compensation for loss of office in 2009-10

33. Table 4 provides details of pension interests of Ministers.

Table 4 – Pension interests of Ministers

	Real increase in pension	Pension at End Date	CETV at Start Date (31/03/09)	CETV at End Date (31/03/10)	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
Ben Bradshaw *	0	7	78	85	1	2
Lord Ara Darzi	1	3	24	41	3	13
Phil Hope	1	4	43	63	5	11
Alan Johnson	0	9	139	149	1	3
Ann Keen	1	2	22	38	4	10
Dawn Primarolo *	1	12	208	227	1	9
Mike O'Brien	1	11	166	203	4	24
Gillian Merron	1	5	54	66	4	7
Baroness Thornton	0	4	54	58	1	2
Andy Burnham	1	6	41	55	6	6

* The 'CETV at start date' figure may be different from the closing figure in last year's accounts. This is due to the CETV factors being updated to comply with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008.

Salary

34. 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 (£64,766 from 1st April 2009, £63,291 from 1st April 2008, £61,820 from 1st November 2007) 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.

35. 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

36. 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).

37. 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.

38. Benefits for Ministers are payable at the same time as MPs' benefits become payable under the PCPF or, for those who are not MPs, on retirement from Ministerial office from age 65. Pensions are re-valued annually in line with changes in the Retail Prices Index. 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.

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

Cash Equivalent Transfer Values

40. 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 within the guidelines and framework prescribed by the Institute and Faculty of Actuaries 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

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

C - NON EXECUTIVE DIRECTORS

42. The Department appointed two Non Executive Directors to the Departmental Board for the first time in 2005. A third Non Executive Director joined the Departmental Board in June 2006. Guidance about the reimbursement for Non Executive Directors is available from Cabinet Office and reimbursement ranges from simply reimbursing expenses to significant payments for quite substantial roles.

43. Non Executive Directors are not employees of the Department. The Non Executive Directors are appointed for a fixed term of three years initially with the possibility of extension. They are appointed primarily to attend DB meetings which involve an estimated time commitment of eleven four-hour meetings and two overnight events per year. One of the Non Executive Directors chairs the Department's Audit Committee (4-5 meetings per year) and another chairs the Equality and Human Rights Assurance Group. The Non Executives also make a significant contribution to meetings of the Performance Committee, and in work through Committees and with senior officials on other departmental business.

44. 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.

45. Derek Myers was a Non Executive Director until 31st July 2009. He was not personally reimbursed for his role as a Non Executive Director. His employer was reimbursed by £500 for every day worked; £2,500 was paid in 2009-10. Julie Baddeley and Mike Wheeler receive a fee of £2,000 per day, with payments to Julie Baddeley expected to total £36,000 in 2009-10 and £23,000 to Mike Wheeler. Jonathan Rouse became a Non Executive Director from 1st August 2009. His employer was reimbursed £750 per day, with payments of £5,250 made in 2009-10. All these amounts exclude VAT.

46. Non Executive Directors fees are not pensionable.

Sir Hugh Taylor

15 July 2010

Permanent Secretary

Department of Health

Richmond House

79 Whitehall

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

1. This Note sets out the nature of the relationship between Accounting Officers in the Department of Health, its Agencies and the NHS. It refers to *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. These are covered by the Request for Resources 2 and Request for Resources 3 in the Department's Estimates and Accounts. As Head of the Department, he takes responsibility for the consolidation of the Department's Accounts and for the voted cash requirement, and has the Department-wide responsibility for the good management of the Department as a whole, including a high standard of financial management. This includes the parts of the Department managing the NHS (as distinct from the NHS itself) and the Department's Agencies, since they are parts of the Department operating in support of the Secretary of State. The Principle 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 expenditure on hospital and community health services, family health services, some central health services, the drugs bill and NHS Trusts' external financing. These are covered by the Request for Resources 1 in the Department's Estimates and Accounts. He is responsible for carrying out the duties set out in Chapter 3 of *Managing Public Money*. He is also the Accounting Officer for the Summarised Accounts of NHS Trusts, Primary Care Trusts, Strategic Health Authorities, and Special Health Authorities where required.

4. This year the Permanent Secretary agreed with the Chief Executive of the Purchasing and Supply Agency within the Department of Health a budget for administration costs to cover the Purchasing and Supply responsibilities, and delegated to him immediate responsibility for the good management of the Agency. The Chief Executive was designated as an Agency Accounting Officer and his responsibilities were set out in the Agency's Framework Documents and his letters of designation as Agency Accounting Officer. Purchasing and Supply Agency ceased to exist on the 31 March 2010.

5. The Chief Executive of the Medicines & Healthcare Products Regulatory Agency is accountable for the expenditure relating to this Trading Fund. He is responsible for carrying out the duties set out in Chapter 3 of *Managing Public Money* for the Agency. His accountability is 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.

8. The Chief Executives of Non Departmental Public Bodies are designated as Accounting Officers who are accountable to Parliament through either the Permanent Secretary or the NHS Chief Executive, depending upon 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 those bodies.

STATEMENT ON INTERNAL CONTROL

Scope of Responsibility

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

2. This Statement is given in respect of the Resource Account for the Department of Health, which incorporates the transactions and net assets of the core Department, its Executive Agencies and other bodies falling within the Departmental boundary for resource accounting purposes. This includes English NHS bodies except NHS Trusts and NHS Foundation Trusts (although the Department's investment in them is included) and certain Special Health Authorities. As Principal Accounting Officer for the Department, I acknowledge my overall personal responsibility for ensuring that the Department, its Executive Agency and other Arms Length and NHS bodies maintain a sound system of internal control. I am supported in exercising this responsibility by the Additional Accounting Officer (the Chief Executive of the NHS) for the resources voted by Parliament for the NHS (RfR1). Both mine and the Additional Accounting Officer's roles and responsibilities are set out in a Memorandum of Understanding between us both. In particular, I have drawn on the overall statements of internal control for Strategic Health Authorities, Primary Care Trusts and NHS Trusts, which he has approved, to support this Statement on Internal Control.

The purpose of the system of internal control

3. The Department of Health's system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve the Department's policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:
   - identify and prioritise the risks to the achievement of Departmental policies, aims and objectives
   - evaluate the likelihood of those risks being realised and the impact should they be realised,
   - manage them efficiently, effectively and economically, and
   - regularly review the risks being managed.

4. The system of internal control (which accords with the Treasury guidance) was in place in the Department of Health for the financial year ending 31 March 2010, and has remained in place up to the date of final approval of the Department's Annual Report and Resource Accounts.

Capacity to handle risk

5. The internal control system is based on a clear risk management framework and accountability process that is embedded in the Department and its Agencies via delivery and business planning processes.

6. Leadership of the system of internal control has been demonstrated by senior staff, in that they have visibly owned and supported risk assessment and control activity as a key requirement of their delivery against the Department's objectives and priorities. The Department of Health is managed by the Departmental Board within the strategic framework set by ministers. The Board is at the apex of the Department's governance system maintaining an oversight of strategy, performance and risk. It is supported by:
   - the NHS Management Board which provides leadership for the NHS and supports the NHS Chief Executive in the discharge of his responsibilities as the Additional Accounting Officer;
   - the Corporate Management Board (CMB) which provides leadership for the work of the Department and supports the Permanent Secretary in the discharge of his responsibilities as Principal Accounting Officer. The CMB has two sub Committees - the Corporate Management and Improvement Committee and the Policy Committee;
   - the Audit Committee which provides advice to the Principal Accounting Officer, the Additional Accounting Officer, and the Department's Board on risk management, corporate governance, and assurance arrangements in the Department and its subsidiary bodies;
   - the Performance Committee (see paragraph 20);
   - the Committee for the Regions which supports the Department's presence in the regions in respect of the delivery of local health and social care; and

- the Equality and Human Rights Assurance Group which oversees the Department's performance against the Single Equality Scheme action plan and, through that, compliance with equality legislation on behalf of the Departmental Board, and provides a source of challenge across the Department.

7. The Department's policy is to know about its risks; have clear accountabilities and robust and consistent procedures in place for the management of them; and to have staff at all levels who possess the necessary competencies in risk management. The Department's risk framework makes clear that all staff have a responsibility for identifying, assessing, addressing, monitoring and reviewing risks to the achievement of objectives in the areas of work for which they are responsible.

8. The Department's policy and guidance on risk management is kept under review to ensure that it is fully in line with the latest Office of Government Commerce and Treasury guidance. The risk policy is underpinned by a single IT system for capturing and monitoring information about risks, supported by an electronic desk-based training tool, and a Department of Health specific one-day training course. Its implementation is overseen by the Risk Forum with director level representatives from all directorates across the Department.

The risk and control framework

9. Within the Department, I operate an accountability process based around compliance with five core assurance standards:
   - risk management
   - planning and delivery
   - resource management
   - policy development, and
   - governance of Arms Length Bodies (ALBs).

10. Risk management has been integrated into the Departmental Business Planning process and further improvements have been implemented to link Directorate level operational risks with strategic risks in the corporate risk register and that of our Public Service Agreement (PSA) risks. The Department initiated Preparing for the Future, to update the second year of the Department's existing 2009-11 Business Plan. Preparing for the Future has a clear focus on the corporate issues and challenges that the Department and individual directorates face in 2010-11. In their Preparing for the Future plans, directorates set out key risks or dependencies that could affect successful delivery and were expected to assess the risk potential for all significant programmes of work, particularly where investment decisions would be required.

11. These plans provide a firm foundation for taking forward work on embedding the Assurance Framework. Progress in addressing key corporate challenges will be monitored through the quarterly scorecard, while implementation of Preparing for the Future plans will be reviewed in quarterly stocktake meetings with Directors General. Similarly, my 2010-11 Budget Accountability letters, issued to Directors General in April 2010, were accompanied by guidance on the Department's updated corporate core assurance standards, which sets out how Directorates can judge and report on their compliance against the five standards.

12. The Departmental Board is responsible for the ownership and management of high level strategic risks. Throughout the year the Board, supported by its Audit Committee and other Committees, and advised by the Risk Forum, has maintained an overview on these high-level risks, presented in a high-level risk register. There has been continuing challenge to the assessments of likelihood and impact of the risks identified and contained in the high-level risk register. When appropriate, some risks have been removed from the register to be overseen by one of the Department's Boards and Committees or managed at Directorate level, and new risks added. The Department continues to be responsible for high risk activity, including, for example, leadership of work across Government on the flu pandemic.

13. Directorate level operational risks are monitored using the Enterprise Project Management system, and reviewed on a monthly basis using the directorate performance scorecards linked to each directorate's risk register. Where necessary, operational risks are escalated to the departmental performance scorecard, and the corporate risk register, on the basis of a monthly risk review.

14. The Department's Audit Committee advises the Accounting Officers and the Board on the quality of risk management, corporate governance and internal control in the Department. The Audit Committee considers the risk management requirements of subordinate bodies and the key governance information

flowing to the Chief Executives from these bodies. It has reviewed this statement in draft and its comments on evidence of assurances received have been reflected in the final version.

15. Within the Department, the Internal Audit (IA) team provides an independent assurance function on the robustness of governance and internal control processes. The Head of Internal Audit's Annual Opinion is as follows:

> "I have formed my opinion based on the findings of internal audit activity carried out throughout 2009-10 and input from management on their control and monitoring activities. My opinion is set in the context of the requirements of the Government Internal Audit Standards (GIAS).
>
> The Department has continued to develop and embed systems of internal control, governance and risk management. The Department has, however, also recognised that these systems benefit from regular review and continued evolution. There are currently reviews underway to further strengthen governance arrangements and risk management processes. This is a positive continuation of the work already undertaken and the benefits achieved to date and will help to ensure that they remain fit for purpose in the significantly changing financial context that the Department will have to operate within in the future.
>
> The Department has also responded in the right way to internal control weaknesses around the 'Purchase to Pay' process, which includes parts of the finance, procurement and IT systems. These came to light during the year and had led to a number of significant instances of fraud being identified and referred to the NHS Counter Fraud Service for investigation.
>
> The Department has taken positive and decisive action to deal with the control weakness and further regular testing by internal audit has demonstrated based on the evidence reviewed, that the action put in place has appropriately corrected the current control deficiencies. The Department is also undertaking a fundamental review of the procurement process for the future that, if implemented as intended, is likely to result in some clear changes to the business model used for procurement. Internal Audit will continue to contribute to this review.
>
> Overall, in my opinion, subject to the Department effectively implementing its action plan in respect of the purchase to pay process, the systems of governance, risk management and internal control operating during 2009/10 were satisfactory."

16. Directors General are required to provide me with assurance statements at the end of the financial year which address the extent to which the five core assurance standards have been met in their Directorates. An electronic Statement of Internal Control (SIC) quarterly self assessment tool supports this process and has helped ensure that this is more firmly embedded in the quarterly accountability cycle and supports continuous business improvement.

17. In addition to the Department's internal processes, I gain assurance from:
    - assessments by Strategic Health Authorities which, as part of their role of performance management of PCTs and NHS Trusts, identify local risks to delivery, where necessary coordinate mitigation actions, and report into NHS Management Board discussions;
    - work by the Care Quality Commission during the year;
    - reports from the National Audit Office (Annex A) resulting from their work in the Department and the NHS, and the Public Accounts Committee (Annex B);
    - the Department's DH Internal Audit report for 2009-10;
    - Gateway reviews of large projects; and
    - assessments of the Department's work by other external units, including for example the Prime Minister's Delivery Unit.

Review of effectiveness

18. As Principal Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors and the executive managers within the Department who have responsibility for the development and maintenance of the internal control framework, and other comments made by external auditors in their management letter and other reports.

19. By means of a summary report (prepared by my Governance Team), I have reviewed the assurance statements provided to me by Directors General, which recorded the position in their business groups over the year. This report indicates that internal control and assurance arrangements are being generally strengthened.

20. The Performance Committee (a sub-committee of the Board) has ensured proper governance in respect of the Department's Strategic Objectives, PSAs (including the Department's contribution to the cross-government PSA led by other departments), finance, major programmes, and value for money. The Committee has been successful in delivering these priorities and in challenging areas of poor performance and where there has been a need to tighten reporting requirements. It has therefore added value to the Department's accountability arrangements, and reported on performance to the Departmental Board.

21. In July 2009, the Cabinet Office's Capability re-Review confirmed the effectiveness of the work we undertook through our Development Plan in response to the June 2007 Capability Review. Clear and effective accountability arrangements were followed for delivering the Plan and overseeing its progress. Directors General and relevant Directors had Delivery Agreements detailing their responsibilities for delivering specific aspects of the Plan, and progress was monitored through formal governance arrangements including a Steering Group, as a sub-committee of the Departmental Board, as well as the Corporate Management Board and the Corporate Management and Improvement Committee where appropriate.

22. The Department met all the requirements of the Cabinet Office Data Handling Review (DHR) by the deadline of October 2009, achieving level 1 of Her Majesty's Government Information Assurance Maturity Model (IAMM) at the same time.

23. To achieve level 1, staff with responsibilities for handling personal data completed the mandatory e-learning on protecting information. We will be re-testing staff on their learning by the end of September, and thereafter on an annual basis. Further targeted training was provided by us to Information Asset Owners (IAOs) to enable them to respond to quarterly assessment requests.

24. Appropriate information management policies were also put in place which were supported through a programme of mandatory training. In addition, the Department's Corporate Assurance Standard for resource management was updated to incorporate information management and assurance, embedding information risk reporting within the Department's corporate governance arrangements. As part of this arrangement, IAOs are now required quarterly and annually to provide a formal assessment of how they manage information within their span of control.

25. Work has continued to identify the nature, size and location of the personal data sets, identify and review the risks to the data, and mitigate the risks to an acceptable level. In tandem, a regime for assessing compliance with DHR and IAMM requirements, and recovering from incidents was introduced.

26. Similar activity on information security is taking place across our delivery chain, Arms' Length Bodies (ALBs) and the NHS. The management of information risk was incorporated into existing assurance arrangements, the core assurance standards for ALBs and the Information Governance Toolkit for the NHS. The DH Information Assurance Team is undertaking a programme of visits to ALBs and discussions with third party suppliers to extend the coverage and quality of information assurance.

27. During 2009-10, the Department reported two personal data security incidents. In both cases, we advised the Information Commissioner of the steps that had been taken to strengthen procedures. NHS bodies report data losses and security independently.

28. Our improved assurance processes led to the identification of potential problems with two Departmental websites. One came to attention through the quarterly information risk reporting process, the other as part of the re-appraisal carried out in connection with a change to the system. Both systems were closed for a period and re-opened after the completion of remedial work.

29. The NHS National Programme for IT is run as a managed programme by NHS Connecting for Health which is part of the Department's Informatics Directorate. During 2009-10 the delivery strategy for the Programme was updated in collaboration with the NHS to reflect a more flexible 'connect all' approach which supports the maturing IT requirements of the NHS and took account of the increasingly ambitious and innovative

direction for using digital technologies across health and social care. NHS Connecting for Health is also responsible for managing a range of business critical IT systems for the NHS which includes cancer screening services and information management systems for GP and other clinical professionals. In May 2008, the termination of the Local Service Provider (LSP) contract with Fujitsu was announced and during 2009-10 negotiations have concluded for BT to take over responsibility for the deployed acute services and CSC to take over the deployed Picture Archiving and Communications System services. This has successfully ensured any disruption to the delivery of the Programme was kept to a minimum.

30. The control issues first identified during 2007-08 in respect of the Department's overall compliance with the equality and human rights legislation continued to be addressed through a comprehensive programme of work including restructuring of equality functions and delivery mechanisms alongside the development of a strengthened Single Equality Scheme. The updated Scheme was published on 17June 2009 and set out the steps the Department is taking to meet and sustain its responsibilities under the Gender, Race and Disability Equality (General and Specific) Duties both as an employer and a Department of State for the period 2009-2012. The Single Equality Scheme anticipates and addresses work being led within the Department that will contribute to cross-Government work to develop and prepare for implementation and enactment of the Equality Bill.

31. In my statement last year, I reported that the account in which prescription charges are recorded, the NHS Business Services Authority (BSA) Pharmaceutical Account, has been qualified for many years on the grounds of regularity, due to patients falsely claiming that they are entitled to free prescriptions.

32. It should be noted that the introduction of a penalty charge system for prescription charge evasion in 1999 has had an impact on reducing fraud loss, with the percentage of patients fraudulently claiming exemption from charges falling to 2% in 2007-08 (compared with 5.1% in 1998-99). The level of patients fraudulently claiming exemption is measured on a periodic basis. The most recent measurement exercise was undertaken in 2007-08, and this showed a small growth in the percentage of patients claiming fraudulently (from 1.6% to 2%). This small growth in the level of fraudulent claims also gave rise to an increase in fraud loss (to £100 million) although this figure is also driven by year on year increases in prescription volumes and prescription charges. This loss figure therefore provides a robust estimation of losses calculated at a specific point in time. However, it should not be assumed that this represents the additional revenue that could be generated if fraud were to be eliminated [1] .

33. During the past year, the NHS Counter Fraud Service and Department of Health considered options for reducing prescription fraud. However, it was not cost effective to implement any major actions to address prescription fraud because of plans for significant changes to prescription charging policy. The previous Government announced a policy intention to phase out prescription charges for people with long-term conditions and the Department of Health was engaged throughout 2009 in supporting an external review (carried out by Professor Sir Ian Gilmore, President of the Royal College of Physicians) that considered how this policy could be implemented. This review was published by the Department of Health on 27 May 2010 and the new Government has stated that any future changes would need to be considered in the light of the Department's funding settlement.

34. NHS Counter Fraud Service and the Department of Health are continuing discussions on how best to tackle prescription charge fraud. Any proposals to reduce prescription charge fraud will be considered within the context of any future changes to prescription charging policy and will need to take account of cost of measures of fraud versus the likely additional income generated from these measures.

35. For the Department's Arm's Length Bodies (ALBs), I have reviewed a summary of the key points raised in the Statement of Internal Control that each body's Accounting Officer makes as part of their annual accounts, and of the opinions of their external auditors. I have similarly reviewed assurance statements provided by the senior member of staff in the Department responsible for sponsoring each body. On this basis I have concluded that at least minimum assurance standards are being met. In June 2009, we discovered a backlog of General Social Care Council (GSCC) conduct cases. This was followed up by a

[1]Evidence suggests that patients would be likely to change their behaviour in a "fraud proof" system. For example, a person committing fraud persistently who requires more than 14 prescriptions a year, may choose to cap their expenditure by purchasing a prescription pre-payment certificate rather than paying £7.20 for each prescription item. In addition, a 2008 Commonwealth Fund survey of people with long term conditions reported that 7% did not have their prescriptions dispensed and 4% avoided visiting the doctor on the grounds of cost.

subsequent review by the Council for Healthcare Regulatory Excellence (CHRE). A transformation plan was agreed for the GSCC which is helping to radically change the organisation to make it more effective and efficient. The GSCC are confident that they have now appointed a strong executive team to build on progress already made.

36. For the Department's Regional Public Health Offices, I have been assured that appropriate controls are in place in each of the regions and there are no significant control issues to report.

37. The Statements of Internal Control prepared for the NHS Summarised Accounts, approved by the NHS Chief Executive as Additional Accounting Officer for RfR1, have been drawn on in compiling this Statement. The significant control issues disclosed by the NHS Bodies are included in the NHS SIC.

38. For NHS Trusts and Primary Care Trusts, Strategic Health Authorities have collated information from the Accountable Officers' own statements on Internal Control and Internal Audit reports in their area. These show that, at 31 March 2010, 99% of PCTs provided evidence that an adequate system of internal control was in place, while 1% (1 PCT) were unable to do so.

39. In 2009-10, expenditure remained within the sums voted by Parliament and the Department of Health resources limit set by HM Treasury. Overall, there was a planned net surplus of £1.28 billion for PCTs and SHAs. The aggregate surplus delivered in 2009-10 by SHAs and PCTs of £1.34billion will be carried forward to 2010-11, and be deployed in a planned and managed way.

40. The Department will recognise a £72.9 million loss in 2009-10 in respect of antiviral medicines made available to the NHS during the swine flu pandemic. This is because the Department cannot, in all cases, provide sufficient documentary evidence that the antiviral medicines have been stored by the NHS in conditions which fully comply with the requirements of the respective Wholesale Dealers Licence. This inventory is considered to have preserved its medical effectiveness and has therefore been retained for potential future use.

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

Significant internal control issues

42. Three SHAs, 86 PCTs and 66 NHS Trusts (which are outside the Department's resource accounting boundary), together disclosed a total of 515 significant control issues in their statements of internal control. Of these, 224 were in organisations which had failed to meet the core Standards for Better Health, 97 were for missing other national performance targets, 70 were for data security incidents, 31 for under-achieving against World Class Commissioning assurance and 21 for financial performance issues. A further 72 significant control issues were reported for uncategorized issues such as limited assurance on internal audit reports, health and safety issues and non-compliance with other statutory requirements. Overall, there was a small reduction, from 528 to 515, in the total number of significant control issues reported in 2009-10 compared to 2008-09. Assurances have been received from every SHA Accountable Officer that all the significant control issues in NHS organisations have been identified in each region, and that appropriate action plans are in place, sufficient to ensure that these issues will not continue or recur in 2010-11. None of the issues were considered to need singular attention and specific disclosure in the Resource Accounts.

43. During the first half of 2009-10, seven cases of suspected procurement fraud were identified. These have been referred to the NHS Counter Fraud Service for full investigation, and could potentially result in a financial loss to the Department. These cases have exposed a number of weaknesses in DH Procurement, Finance and IT systems.

44. The Department took immediate action to address these system weaknesses and other identified risks, introducing a number of IT changes and additional management checks and processes. Alongside this, investigations and subsequent processes are continuing and we intend to pursue recovery of losses.

45. Internal Audit carried out substantive testing of transactions around the areas identified as well as a review of the systems, processes and key controls and made recommendations for improvement, which we have

taken forward. In addition, they are carrying out a series of regular reviews to ensure that the new procedures and processes are being adhered to.

46. The Department has also initiated a project looking at options for a new procurement business model for implementation by April 2011.

Conclusion

47. I conducted my review of the effectiveness of the system on internal control in the Department of Health jointly described above, in parallel with that of the NHS Chief Executive as Additional Accounting Officer. Within the NHS, Strategic Health Authorities will continue to monitor and review the ongoing development and embedding of systems of internal control by PCTs and NHS Trusts.

48. A number of robust actions have been taken to address the weaknesses identified in relation to the suspected procurement fraud and work continues on the identifying the best policy option to reduce the amount of prescription fraud.

In the Department overall, leadership of the system of internal control has been shown by senior staff in visibly owning and supporting risk assessment and control activity, in particular in support of the delivery programmes for PSA targets and other priorities.

Sir Hugh Taylor

Permanent Secretary and Principal Accounting Officer

15 July 2010

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSE OF COMMONS

I certify that I have audited the financial statements of the Department of Health for the year ended 31 March 2010 under the Government Resources and Accounts Act 2000. These comprise the Statement of Parliamentary Supply, the Operating Cost Statement and the Statement of Financial Position, the Statement of Cashflows, the Statement of Changes in Taxpayer's Equity, the Statement of Net Operating Costs by Departmental Strategic Objectives 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 the financial statements in accordance with applicable law and 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 circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Department; and the overall presentation of the financial statements.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on Regularity
In my opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on Financial Statements
In my opinion:

- the financial statements give a true and fair view of the state of the Department's affairs as at 31 March 2010 and of its net cash requirement, net resource outturn, net operating cost, net operating costs applied to departmental strategic objectives, changes in taxpayers' equity and cash flows 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: Consolidated Statement of Operating Costs by Departmental Strategic Objectives
In forming my opinion on the financial statements, which is not qualified, I have considered the adequacy of the disclosures in Note 1.24, which sets out the methodology applied to analyse the Department's resources by objective for the purposes of preparing the Consolidated Statement of Operating Costs by Departmental Strategic Objectives. This information reported in this statement is collected at a local level and subject to Departmental review. The extent of judgement required in this process means that significantly different, yet still defensible, allocations of income and expenditure could have been reported to provide indicative spend.

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 within the Annual Report comprising "Management and governance of the Department", "Departmental strategic objectives", "Dealing with risks and uncertainties", "Developing the Department" and "Public interest and other issues" 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
- the financial statements are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report
I have no observations to make on these financial statements.

Amyas CE Morse
Comptroller and Auditor General

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP
23 July 2010

Statement of Parliamentary Supply

for the year ended 31 March 2010

Summary of Resource Outturn 2009-10

		Estimate			Outturn			2009-10	2008-09
Request for Resources	Note	Gross Expenditure £'000	A -in- A £'000	Net Total £'000	Gross Expenditure £'000	A -in- A £'000	Net Total £'000	Net total outturn compared with Estimate savings /(excess) £'000	Net Total £'000
1	3	103,127,639	22,275,066	80,852,573	100,626,664	21,502,760	79,123,904	1,728,669	71,434,390
2	3	3,546,461	91,907	3,454,554	3,333,993	88,066	3,245,927	208,627	3,067,723
3	3	16,097	-	16,097	14,300	-	14,300	1,797	15,674
Total resources	4	**106,690,197**	**22,366,973**	**84,323,224**	**103,974,957**	**21,590,826**	**82,384,131**	**1,939,093**	**74,517,787**
Non-operating cost A-in-A	5			**760,288**			**445,655**	**(314,633)**	**1,024,637**

Net cash requirement 2009-10

				2009-10	2008-09
	Note	Estimate £'000	Outturn £'000	outturn compared with estimate Saving/ (excess) £'000	Outturn £'000
Net cash requirement	5	83,525,122	80,720,663	2,804,459	72,306,071

Summary of the income payable to the Consolidated Fund

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

		Forecast 2009-10 £'000		Outturn 2009-10 £'000	
	Note	Income	Receipts	Income	Receipts
Total	6	-	-	8,996	*176*

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

The notes on pages 54-113 form part of these accounts

Operating Cost Statement

for the year ended 31 March 2010

		2009-10							2008-09
		Core Department			Consolidated				
	Notes	Staff Costs £'000	Other Costs £'000	Income £'000	Staff Costs £'000	Other Costs £'000	Income £'000	Core Department £'000	Consolidated £'000
Administration Costs:									
Staff costs	10	137,086			137,086			134,342	134,342
Other administration costs	11		97,358			97,358		100,728	100,728
Operating income	13			(7,216)			(7,216)	(5,201)	(5,201)
Programme Costs									
Request for Resources 1									
Securing health care for those who need it.									
Staff Costs	10	178,459			8,809,703			131,825	8,025,663
Programme Costs	12		4,523,369			91,816,961		6,779,478	85,852,605
Income	13			(1,162,798)			(21,511,744)	(1,387,210)	(22,633,502)
Request for resources 2:									
Securing social care and child protection for those who need it and, at national level, protecting, promoting and improving the nation's health.									
Staff Costs	10	7,391			28,893			4,271	20,620
Programme Costs	12		3,057,045			3,070,656		2,871,375	2,890,868
Income	13			(80,861)			(80,862)	(73,487)	(73,597)
Request for resources 3:									
Office of the Independent Regulator for NHS Foundation Trusts									
Staff Costs	10	-			-			-	-
Programme Costs	12		14,300			14,300		15,674	15,674
Income	13			-			-	-	-
Totals		322,936	7,692,072	(1,250,875)	8,975,682	94,999,275	(21,599,822)	8,571,795	74,328,200
Net Operating Cost	4,12			**6,764,133**			**82,375,135**	**8,571,795**	**74,328,200**

The notes on pages 54-113 form part of these accounts

Consolidated Statement of Financial Position

as at 31 March 2010

		2010 £'000		2009 £'000		1 April 2008 £'000	
	Note	Core Department	Consolidated	Core Department	Consolidated	Core Department	Consolidated
Non-current assets							
Property plant and equipment	15	1,177,158	8,422,510	1,089,633	8,720,252	736,611	8,646,071
Intangible assets	16	1,542,567	1,618,101	1,442,651	1,500,766	1,403,854	1,446,397
Financial assets	17	24,529,424	24,580,024	23,937,145	23,980,987	23,852,377	23,900,035
Other non-current assets	19	153,540	227,508	142,251	204,814	130,686	187,156
Total non-current assets		**27,402,689**	**34,848,143**	**26,611,680**	**34,406,819**	**26,123,528**	**34,179,659**
Current assets:							
Assets classified as held for sale	21	12,852	101,233	21,087	88,407	30,339	100,558
Inventories	18	215,634	306,594	109,097	194,051	168,037	240,405
Trade and other receivables	19	164,294	1,095,027	83,224	962,580	216,068	1,239,076
Other current assets	19	224,967	551,982	329,847	710,717	291,529	928,688
Financial assets	19	167,342	169,990	152,424	154,987	152,176	155,492
Cash and cash equivalents	20	1,237,866	1,336,715	1,676,501	1,745,219	2,245,086	2,452,244
Total current assets		**2,022,955**	**3,561,541**	**2,372,180**	**3,855,961**	**3,103,235**	**5,116,463**
Total assets		**29,425,644**	**38,409,684**	**28,983,860**	**38,262,780**	**29,226,763**	**39,296,122**
Current liabilities							
Trade and other payables	22	(409,793)	(4,967,874)	(328,130)	(4,787,953)	(40,194)	(4,550,590)
Other liabilities	22	(2,164,477)	(3,905,593)	(2,428,723)	(3,932,068)	(3,081,717)	(4,601,903)
Provisions	23	(406,243)	(2,314,662)	(407,546)	(2,071,330)	(399,335)	(2,049,898)
Total current liabilities		**(2,980,513)**	**(11,188,129)**	**(3,164,399)**	**(10,791,351)**	**(3,521,246)**	**(11,202,391)**
Non-current assets plus/less net current assets/liabilities		**26,445,131**	**27,221,555**	**25,819,461**	**27,471,429**	**25,705,517**	**28,093,731**
Non-current liabilities:							
Other payables	22	(198,331)	(267,840)	(180,045)	(297,303)	(182,075)	(244,353)
Provisions	23	(968,683)	(14,621,870)	(1,200,104)	(13,611,191)	(1,210,814)	(12,325,793)
Financial liabilities	22	(63,057)	(2,030,926)	(49,978)	(1,761,084)	(48,243)	(1,446,889)
Total non-current liabilities		**(1,230,071)**	**(16,920,636)**	**(1,430,127)**	**(15,669,578)**	**(1,441,132)**	**(14,017,035)**
Assets less liabilities		**25,215,060**	**10,300,919**	**24,389,334**	**11,801,851**	**24,264,385**	**14,076,696**
Taxpayers' equity							
General fund		24,945,431	8,443,322	23,933,968	9,335,814	23,802,320	10,898,654
Revaluation reserve		269,629	1,738,797	455,366	2,325,744	462,065	3,025,686
Donated asset reserve		-	118,800	-	140,293	-	152,356
Total Taxpayer's Equity		**25,215,060**	**10,300,919**	**24,389,334**	**11,801,851**	**24,264,385**	**14,076,696**

***Sir Hugh Taylor* (Accounting Officer)**
Permanent Secretary and Principal Accounting Officer
15 July 2010

The notes on pages 54-113 form part of these accounts.

Consolidated Cash Flows Statement

	Note	2009-10 £'000	2008-09 £'000
Net cash flow from operating activities			
Net operating cost	14	(82,375,135)	(74,328,200)
Adjustments for non-cash transactions	11	5,026,980	4,871,983
(Increase)/decrease in trade and other receivables	19	(11,409)	482,836
less movements in receivables relating to items not passing through the OCS	19	21,747	(32,901)
(Increase)/decrease in inventories	18	(112,543)	(61,036)
Increase/(decrease) in trade payables	22	393,825	(394,650)
less movements in payables relating to items not passing through the OCS	22	10,360	364,086
Use of provisions	23	(1,453,158)	(1,716,610)
Consumption of stockpile goods		113,705	-
Net cash outflow from operating activities		**(78,385,628)**	**(70,814,492)**
Cash flows from investing activities			
Purchase of property, plant and equipment	15, 22	(1,361,245)	(912,925)
Purchase of intangible assets	16, 22	(444,598)	(303,567)
Proceeds of disposal of property, plant and equipment		100,866	164,976
Proceeds of disposal of intangibles		697	53
Purchase of investments	17	(931,882)	(941,211)
Disposal of investments	17, 19	341,653	892,090
Other		-	(3,081)
Net cash outflow from investing activities		**(2,294,509)**	**(1,103,665)**
Cash flows from financing activities			
From the Consolidated Fund (Supply) - current year		80,350,000	71,587,705
Advances from the Contingencies Fund		-	-
Repayments to the Contingencies Fund		-	-
Capital element of payments in respect of finance leases and on-balance sheet PFI contracts		-	-
Other		(40,441)	(53,982)
Net financing		**80,309,559**	**71,533,723**
Net increase/(decrease) in cash and cash equivalents in the period before receipts and payments to the Consolidated Fund		**(370,578)**	**(384,434)**
Receipts due to the Consolidated Fund which are outside the scope of the Department's activities		-	-
Payment of amounts due to the Consolidated Fund		(39,403)	(320,897)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipt and payment to the Consolidated Fund		**(409,981)**	**(705,331)**
Cash and cash equivalents at the beginning of the period		1,742,289	2,447,620
Cash and cash equivalents at the end of the period	20	**1,332,308**	**1,742,289**

The notes on pages 54-113 form part of these accounts.

Statement of Changes in Taxpayer's Equity

for the year end 31 March 2010

		Core Department				Consolidated			
	Note	General Fund £'000s	Revaluation Reserve £'000	Donated Asset Reserve £'000	Total Reserves £'000	General Fund £'000s	Revaluation Reserve £'000	Donated Asset Reserve £'000	Total Reserves £'000
Balance at 1 April 2009		23,933,968	455,366	-	24,389,334	9,335,814	2,325,744	140,293	11,801,851
Changes in taxpayers' equity for 2009/10									
Net gain/(loss) on revaluation of property, plant and equipment			4,664	-	4,664		320,217	5,828	326,045
Net gain/(loss) on revaluation of Assets held for Sale			-	-	-		-	-	-
Net gain/(loss) on revaluation of intangible assets			112,102	-	112,102		112,149	-	112,149
Net gain/(loss) on revaluation of investments			(21,908)	-	(21,908)		(21,712)	-	(21,712)
Impairment			(81,738)	-	(81,738)		(751,251)	(17,592)	(768,843)
Impairment reversal			-	-	-		-	-	-
Receipt of donated assets				-	-			8,443	8,443
Release of reserves to the OCS		-	-	-	-	-	(3,719)	(9,203)	(12,922)
Non-cash changes - cost of capital	11,12	992,672			992,672	504,053			504,053
Non cash changes - auditor's remuneration	11,12	567			567	729			729
Transfers between reserves		198,857	(198,857)	-	-	228,283	(242,784)	(8,969)	(23,470)
Net operating cost for the year		(6,764,133)			(6,764,133)	(82,375,135)			(82,375,135)
Total recognised income and expense for 2009/10		**(5,572,037)**	**(185,737)**	**-**	**(5,757,774)**	**(81,642,070)**	**(587,100)**	**(21,493)**	**(82,250,663)**
Net parliamentary funding - drawn down		6,182,625			6,182,625	80,350,000			80,350,000
Net parliamentary funding - deemed		1,702,795			1,702,795	1,702,795			1,702,795
Supply payable/(receivable) adjustment	22	(1,332,132)			(1,332,132)	(1,332,132)			(1,332,132)
CFERs payable to the Consolidated Fund	22	(9,080)			(9,080)	(9,080)			(9,080)
PDC investment adjustment		43,844			43,844	43,844			43,844
Consolidated fund standing services		-			-	-			-
Net finances from the contingencies fund		-			-	-			-
Other Transfers		(4,552)	-	-	(4,552)	(5,849)	153	-	(5,696)
Balance at 31 March 2010		**24,945,431**	**269,629**	**-**	**25,215,060**	**8,443,322**	**1,738,797**	**118,800**	**10,300,919**

Prior year: for the year end 31 March 2009

		Core Department				Consolidated			
	Note	General Fund £'000s	Revaluation Reserve £'000	Donated Asset Reserve £'000	Total Reserves £'000	General Fund £'000s	Revaluation Reserve £'000	Donated Asset Reserve £'000	Total Reserves £'000
Balance at 1 April 2008		23,802,320	462,065	-	24,264,385	10,898,654	3,025,686	152,356	14,076,696
Changes in taxpayers' equity for 2008/09									
Net gain/(loss) on revaluation of property, plant and equipment			10,273	-	10,273	96	113,772	1,917	115,785
Net gain/(loss) on revaluation of intangible assets			(8,275)	-	(8,275)	-	(8,266)	-	(8,266)
Net gain/(loss) on revaluation of investments			-	-	-	-	59	1,062	1,121
Impairment			-	-	-		(746,534)	(12,839)	(759,373)
Impairment reversal			-	-			-	-	
Receipt of donated assets				-	-			8,765	8,765
Release of reserves to the OCS		-	-	-	-	61	(974)	(7,360)	(8,273)
Non-cash changes - cost of capital	11,12	1,137,180			1,137,180	726,967			726,967
Non cash changes - auditor's remuneration	11,12	565			565	706			706
Transfers between reserves		8,697	(8,697)	-	-	52,686	(57,999)	(3,608)	(8,921)
Net operating cost for the year		(8,571,802)			(8,571,802)	(74,328,200)			(74,328,200)
Total recognised income and expense for 2008/09		**(7,425,360)**	**(6,699)**	**-**	**(7,432,059)**	**(73,547,684)**	**(699,942)**	**(12,063)**	**(74,259,689)**
Net parliamentary funding - drawn down		7,167,585			7,167,585	71,587,705			71,587,705
Net parliamentary funding - deemed		2,421,161			2,421,161	2,421,161			2,421,161
Supply payable/(receivable) adjustment	22	(1,702,795)			(1,702,795)	(1,702,795)			(1,702,795)
CFERs payable to the Consolidated Fund	22	(339,487)			(339,487)	(339,487)			(339,487)
PDC investment adjustment		10,544			10,544	10,544			10,544
Consolidated fund standing services		-			-	-			-
Net finances from the contingencies fund		-			-	-			-
Other Transfers		-	-	-	-	7,716	-	-	7,716
Balance at 31 March 2009		**23,933,968**	**455,366**	**-**	**24,389,334**	**9,335,814**	**2,325,744**	**140,293**	**11,801,851**

Consolidated Statement of Operating Costs by Departmental Strategic Objectives

for the year ended 31 March 2010

	2009-10 £m	2008-09 £m
Objective I		
Better health and well being for all	31,990	30,346
Objective II		
Better care for all	70,896	65,470
Other	1,089	1,225
	103,975	97,041
Total Income	(21,600)	(22,713)
Net Operating Cost	**82,375**	**74,328**

Note

This Statement analyses operating costs between two of the Department's three strategic objectives. The third objective, better value for money, underlies the other two and does not incur its own separate costs. As Departmental and NHS activity can contribute to both of the objectives at the same time, the Statement provides only a high level indicative analysis of spend between them. The figures should not be taken as absolute.

The method of attribution of operating costs to the objectives has been agreed with HM Treasury to avoid delay in publication of the accounts. 2009-10 operating costs have been attributed to the objectives on a basis determined from 2008-09 programme budgeting and reference cost data, which are the latest available, and from 2009-10 prescription and personal social services expenditure. Programme budgeting data collects NHS costs by type of disease and reference costs record costs of hospital admissions and treatments. The limitations of the approach mean that significantly different, yet still defensible, allocations of expenditure could have been reported.

The great majority of the Department's income is National Insurance Contributions received from HM Revenue and Customs. As this income is not subject to the Department's control and does not result from its activities, it is not possible to meaningfully attribute it between the objectives. HM Treasury have therefore exempted the Department of Health from this attribution.

The notes on pages 54-113 form part of these accounts.

NOTES TO THE DEPARTMENTAL RESOURCE 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 these Resource Accounts have been prepared in accordance with the 2009-10 FReM issued by HM Treasury. The financial statements are prepared on a going concern basis and provide a true and fair view of the state of affairs of the Department of Health at the end of the financial year, and of the results for the year. The functional currency is pounds sterling and figures are expressed in thousands of pounds.

The accounting policies contained in the FReM follow International Financial Reporting Standards (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 on the advice of the Financial Reporting Advisory Board. Where the FReM permits a choice of accounting policy, the policy that is judged to be most appropriate to the particular circumstances of the Department, for the purpose of giving a true and fair view, has been selected. The 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 as 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 two primary statements in addition to those required under International Financial Reporting Standards:

- The Statement of Parliamentary Supply and its supporting notes show outturn against Estimate for the net resource requirement and net cash requirement.
- The Consolidated Statement of Operating Costs by Departmental Strategic Objectives and supporting notes analyse the Department's expenditure by the objectives agreed with Ministers (see 1.1).

HM Treasury requires Government bodies to follow International Financial Reporting Standards, in place of UK Financial Reporting Standards, from 2009-10. The effect of the transition to the new standards on the Department of Health is shown in Note 2. The prior year comparators provided throughout the financial statements are 2008-09 figures restated on an IFRS basis. Three sets of figures are given in the Statement of Financial Position to show the opening and closing positions for 2008-09 as well as the closing position for 2009-10.

The 2009-10 Resource Accounts include nine 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 Operating Cost Statement.
- Income from NHS bodies received by the Department or bodies within the accounting boundary is excluded and netted off the relevant expenditure.
- National Insurance Contributions are recognised on a cash basis.
- In the Consolidated Statement of Operating Costs by Departmental Strategic Objectives, the 2009-10 net operating cost has been allocated against 2009-10 objectives, using 2008-09 programme budgeting and reference costs data as a means of attribution. Income is not analysed over the strategic objectives.
- An Operating Segments note has been provided to analyse income and expenditure across the headings of: NHS, DH Programme and DH Administration, as reported to, and used by, the senior management of the Department.
- In the Analysis of net operating cost by spending body, Note 14, the Department has grouped the spending bodies, rather than listing them individually.
- A complete set of notes to the 1 April 2008 Statement of Financial Position is not provided.
- Some NHS organisations that are consolidated into the Department's Resource Account receive donations that are held on trust. For 2009-10, HM Treasury has agreed that NHS bodies should not consolidate the

NHS charitable funds for which they are trustees. Consequently, these charitable funds are not consolidated into this Resource Account.

- The revaluation of stockpiled goods to reflect the change in Value Added Tax from 15% to 17.5% on 1 January 2010 has been taken to the Operating Cost Statement, rather than the Revaluation Reserve as advised by HM Treasury.

1.1 Consolidated Statement of Operating Costs by Departmental Strategic Objectives

The strategic objectives are those published in the Department's Strategic Framework, which outlines how the high-level objectives of the Department complement the wider Government performance framework set out in the 2007 Comprehensive Spending Review. As Departmental and NHS activity can contribute to different objectives at the same time, the Statement provides a high-level attribution of operating costs against two of the three objectives. The third objective, better value for money, underlies the other two and does not incur its own separate costs. The 2009-10 net operating cost has been attributed to the two objectives on a basis determined from 2008-09 programme budgeting and reference costs data, which are the latest available, and from 2009-10 prescription and personal social services expenditure.

1.2 Operating segments

Besides the analysis of expenditure by Departmental objectives, presented in The Consolidated Statement of Operating Costs by Departmental Strategic Objectives, income and expenditure is also analysed in the operating segments note (Note 24.2) across the headings of: NHS, DH Programme and DH Administration, as reported to, and used by, senior decision makers of the Department.

1.3 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 and inventories.

1.4 Basis of consolidation

The basis of consolidation of the Department's Resource 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 International Financial Reporting Standards 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 36 gives a list of the Department of Health bodies that are consolidated and those that are not.

More information on the individual entities within the Departmental family can be found in the annual reports and accounts of these entities and in the summarised accounts of Strategic Health Authorities, Primary Care Trusts, NHS Foundation Trusts and NHS Trusts.

Some NHS organisations received donations that are held on trust. These funds are administered by trustees. For 2009-10, as agreed with HM Treasury, NHS bodies do not consolidate the NHS charitable funds for which they are trustees.

1.5 Staff costs

Short-term employee benefits

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, on the grounds of immateriality, is recognised when paid. Leave that has been earned but not taken at the year end is not accrued, as it is not material.

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 which is described at Note 10.1. The defined benefit schemes are unfunded and are non-contributory except in respect of dependents' benefits. The Department recognises the expected costs of these elements on a systematic and rational basis over the period during which it benefits from the employees' services by payment to the Principal Civil Service Pension Scheme (PCSPS) of amounts calculated on an

accruing basis. Liability for payment of future benefits is a charge on the PCSPS. In respect of the defined contribution schemes, the Department recognises the contributions payable for the year.

The 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 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
The scheme is an unfunded, defined benefit scheme that 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. Full details can be found in Note 10.1.

1.6 Administration and programme costs

The Operating Cost Statement is analysed between administration and programme costs, as defined by HM Treasury. Administration costs reflect the costs of running the Department. Programme costs reflect non-administration costs, including payments of grants and other disbursements by the Department, as well as certain staff costs where they relate directly to service delivery.

1.7 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.

1.8 Capital charge

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

- donated assets, and cash balances under the Office of the Paymaster General and the Government Banking Service, for which the charge is nil, and
- investments comprising PDC or other forms of equity investment, for which the charge is applied to their underlying assets at a rate agreed with HM Treasury.

1.9 Audit costs

A charge reflecting the cost of audit is included in operating costs. The Department of Health is audited by the Comptroller and Auditor General. No charge is made for this service but a notional charge representing the cost of the audit is included in the accounts. This charge covers audit costs in respect of the main Department accounts, and the audit of all the Summarised Accounts prepared under s232 of the NHS Act 2006. Other Group bodies are audited by the Comptroller and Auditor General or the Audit Commission-appointed auditor and are charged audit fees (Note 12).

1.10 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.

1.11 Income

Income comprises charges for services provided on a full cost basis, investment income and National Insurance contributions. It includes Appropriations-in-Aid (A-in-A) and Consolidated Fund Extra Receipts

(CFERs) that are treated as income, but excludes those that are treated as capital. Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Income is analysed in the notes between that which, under HM Treasury's administrative cost-control regime, can be offset against gross administrative costs in determining the outturn against the administration cost limit, and that which cannot.

National Insurance contributions are recognised within consolidated entries rather than within entries for the core Department.

1.12 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
- the item cost at least £5,000;

or

- Collectively, a number of items have a 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 a large 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.

Valuation

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 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 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 recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported in the Statement of Changes in Taxpayers' Equity.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.13 Intangible non-current assets

Intangible 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 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. 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, there is the technical feasibility, intention and availability of resources to complete the asset; the ability to use or sell the asset to generate probable future economic benefits or service potential, and the ability to measure the development expenditure. The amount initially recognised 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.

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.

Expenditure incurred on the National Programme for IT has been split between capital and revenue expenditure using a financial model that analyses contractor costs over the life of the project. The capitalised expenditure is recognised as property, plant and equipment or as intangible assets, as appropriate.

1.14 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 and amortisation are 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 reporting period end, the Department checks whether there is any indication that any of its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, 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.

If there has been an impairment loss, the asset is written down to its fair value, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.15 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to offset the expenditure. On sale of donated assets, the net book value is transferred from the Donated Asset Reserve to the General Fund.

1.16 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 met when the asset is available for immediate sale in its present condition; management is committed to the sale, as evidenced by commitment to a plan for the sale, with active marketing at a reasonable price; and a completed sale within one year from the date of classification is highly probable. 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.

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.

1.17 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 Operating Cost Statement.

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 accounted for separately. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

1.18 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 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. Subsequently, the assets are measured at fair value. 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 Operating Cost Statement.
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 in the Consolidated Statement of Financial Position.

Other assets contributed by consolidated bodies to the operator
Assets contributed (e.g. cash payments, surplus property) by the consolidated bodies to the operator before the asset is brought into use, which 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.

1.19 Inventories

Inventories are held at fair value. 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.

In line with HM Treasury guidance, revaluations of stockpiled goods included in the Property, Plant and Equipment Note are taken to the Operating Cost Statement rather than the Revaluation Reserve.

1.20 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 that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the 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.

1.21 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.

1.22 Clinical and non-clinical negligence costs

Clinical and non-clinical negligence costs are managed through schemes run by the NHS Litigation Authority. The Existing Liability Scheme and Ex-Regional Health Authority schemes are funded by the Department of Health, and the Clinical Negligence Scheme for Trusts, Liability to Third Parties and Property Expenses Schemes from Trust contributions. The accounts for the schemes are prepared in accordance with IAS 37. A provision for these schemes, disclosed in Note 23, is calculated in accordance with IAS 37 by discounting the gross value of all claims received.

The calculation 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 30**.**

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

Claims are included in the ELS provision on the basis that the incident ocurred on or before 31st March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to the 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 2010 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 2010 where the following can be reasonably forecast:

- that an adverse incident has occurred; and
- 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 23 and 30 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.

1.23 Contingent liabilities

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.

Where the time value of money is material, contingencies are disclosed at their present value.

In addition to contingent liabilities disclosed in accordance with IAS 37, the Department discloses for Parliamentary reporting and accountability purposes certain contingent liabilities where the likelihood of a transfer of economic benefit is remote. These comprise:

— items over £100,000 (or lower, where required by specific statute) that do not arise in the normal course of business and which are reported to Parliament by Departmental Minute prior to the Department entering into the arrangement

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

Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to Parliament.

1.24 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.

1.25.1 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 operating cost statement on de-recognition.

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 Operating Cost Statement.

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 has 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 Operating Cost Statement.

1.25.2 Financial liabilities

Financial liabilities are recognised on 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. 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 Operating Cost Statement.

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.

1.25 Foreign exchange

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.

1.26 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 34

1.27 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 www.hm-treasury.gov.uk. Losses and special payments are disclosed in Note 32.

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.

1.28 Accounting standards issued that have been adopted early

The amendment to IFRS 8 Operating segments that was included in the April 2009 Improvements to IFRS has been adopted early. As a result, total assets are not reported by operating segment.

1.29 Accounting standards that have been issued but have not yet been adopted

The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2010-11. None of them are expected to impact upon the DH financial statements.

IAS 27 (Revised) *Consolidated and separate financial statements*

Amendment to IAS 32 *Financial instruments: Presentation on classification or rights issues*

Amendment to IAS 39 *Eligible hedged items*

IFRS 3 (Revised) *Business combinations*

IFRIC 17 *Distributions of Non-cash Assets to Owners*

IFRIC 18 *Transfer of assets from customers*

2 First time adoption of IFRS

	Core Department			Consolidated		
	General fund	Revaluation reserve	Donated asset reserve	General fund	Revaluation reserve	Donated asset reserve
	£'000	£'000	£'000	£'000	£'000	£'000
Taxpayers' equity at 31 March 2009 under UK GAAP	23,950,695	431,536	-	9,629,175	2,190,402	129,614
adjustments to previously stated UK GAAP figures	-	-	-	(30,635)	-	-
Restated Taxpayers' equity at 31 March 2009	**23,950,695**	**431,536**	-	**9,598,540**	**2,190,402**	**129,614**
Adjustments for IFRS Changes:						
Private finance initiative	-	-	-	1,065	33,996	-
LIFT	-	-	-	(94,720)	37,580	-
Accrued employee benefits	-	-	-	(14,139)	-	-
Leases	(2,531)	-	-	(491)	2,634	-
IFRIC12 adjustments	-	-	-	(32,422)	5,530	5,062
Discounting long term assets and liabilities	(14,196)	-	-	(14,350)	-	-
Revaluation of NPFiT		23,830			23,830	
Others	-	-	-	(107,669)	31,772	5,617
Taxpayers' equity at 1 April 2009 under IFRS	**23,933,968**	**455,366**	**-**	**9,335,814**	**2,325,744**	**140,293**

	Core Department	Consolidated
	£'000	£'000
Net Operating cost for 2008-09 under UK GAAP	8,579,653	74,178,300
adjustments to previously stated UK GAAP figures	-	30,439
Restated Net Operating cost for 2008-09 under UK GAAP	**8,579,653**	**74,208,739**
Adjustments for:		
Private finance initiative	-	15,653
LIFT	-	41,964
Leases	856	919
Accrued employee benefits	-	9
Discounting long term assets and liabilities	8,367	8,404
Cost of capital	(25,778)	(28,635)
Amortisation	8,697	8,697
Others	-	72,450
Net operating cost for 2008-09 under IFRS	**8,571,795**	**74,328,200**

The adoption of IFRS as the basis for these accounts led to a reduction in taxpayers' equity from £11,919 million to £11,802 million at 1 April 2009 and increased operating costs from £74,209 million to £74,328 million for 2008-09. These changes are primarily due to different treatment of PFI, LIFT, finance leases, employee benefits and costs of capital under IFRS. Details are shown below.

The total cashflow is the same under both UK GAAP and IFRS.

Explanation of transition to IFRS
The move to IFRS from UK Generally Accepted Accounting Practice (UK GAAP) has resulted in a number of assets and liabilities being brought onto the Statement of Financial Position:

PFI and LIFT

IFRIC 12 *'Service Concession Arrangements'* provides accounting guidance to the private sector operators of public-to-private service concession arrangements. HM Treasury has adopted mirror accounting rules to those in IFRIC 12 for use by the public sector grantors of the arrangements. Since the public sector grantors have the rights to control the infrastructure assets within these arrangements, they must recognise them, and the related liabilities, on their Statements of Financial Position.

As a result of these rules, NHS bodies now recognise Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) assets and liabilities on their Statements of Financial Position. The full accounting policy for these transactions, including their impact on the Operating Cost Statement, is at note 1.18. The effect of

bringing the assets and liabilities onto the Statement of Financial Position and the effect that this treatment would have had on the 2008-09 operating costs, had it been in place in 2008-09, are shown in the above table.

Finance leases
IAS 17 '*Leases*' gives a broader definition of finance leases than under UK GAAP. Also, IFRIC 4 *"Determining whether an Arrangement contains a Lease"*, specifically describes circumstances when a lease should be recognised even though the arrangement does not take the legal form of a lease.

These two changes from UK GAAP have resulted in the Department and NHS bodies recognising more leases and their associated liabilities on their Statements of Financial Position. The full accounting policy for finance leases, including their impact on the Operating Cost Statement, is at note 1.18. The effect of bringing the assets and liabilities onto the Statement of Financial Position and the effect that this treatment would have had on the 2008-09 operating costs, had it been in place in 2008-09, are shown in the above table.

Accrued employee benefits
The move to IFRS requires the recognition of accrued employee benefits under IAS 19 *"Employee Benefits".* This is the recognition of remuneration earned by employees but not yet taken, for instance performance related pay and annual leave earned but not taken. The effect of bringing the liability onto the Statement of Financial Position and the effect that this treatment would have had on the 2008-09 operating costs, had it been in place in 2008-09, are shown in the above table.

Cost of capital
A charge, reflecting the cost of capital used, is included in operating costs. Since the charge is calculated on the average carrying amount of assets and liabilities, as described in note 1.8, the above changes impact on the cost of capital charge. The effect this would have had on the 2008-09 operating costs, had the above changes been in place in 2008-09, is shown in the above table.

The date of transition to IFRS is 1 April 2008.
In line with HM Treasury advice, Prior Period Adjustments (PPAs) arising from the adoption of IFRS were not included in spring Supplementary Estimates for 2009-10 on the basis that the PPA numbers could have been misleading, particularly where transactions may well have pre-dated the 2001-02 cut off point for reporting PPAs, as only part of an obligation would have been included. PPAs arising from a change in accounting policy related to other than IFRS were included in the Estimates in line with conventional arrangements

3 Analysis of net resource outturn by section:

This note compares outturn with the figures approved by Parliament.

	Admin	Other Current	Grants	Gross Resource Expenditure	A-in-A	Outturn Net Total	Estimate	Net total Outturn compared with Estimate savings /(excess)	Prior year outturn
								2009-10 £'000	2008-09 £'000
Request for Resources 1:									
Securing health care for those who need it.									
Spending in Departmental Expenditure Limits(DEL)									
Central government spending									
Strategic health authorities and primary care trusts unified budgets and central allocations	-	96,773,348	373,901	97,147,249	(2,008,381)	95,138,868	96,989,957	1,851,089	88,973,923
		96,773,348	**373,901**	**97,147,249**	**(2,008,381)**	**95,138,868**	**96,989,957**	**1,851,089**	**88,973,923**
FHS-Pharmaceutical Services	-	1,156,967	-	1,156,967	-	1,156,967	1,145,000	(11,967)	1,093,558
FHS-Prescription charges income	-	-	-	-	(431,794)	(431,794)	(431,000)	794	(439,710)
FHS-General Ophthalmic Services	-	467,552	-	467,552	-	467,552	470,000	2,448	430,001
Research and Development	-	892,801	-	892,801	(9,707)	883,094	893,866	10,772	817,478
	-	**2,517,320**	**-**	**2,517,320**	**(441,501)**	**2,075,819**	**2,077,866**	**2,047**	**1,901,327**
Support for Local Authorities									
Strategic health authority and primary care trusts grants to local authorities	-	-	166,728	166,728	-	166,728	125,840	(40,888)	196,391
	-	**-**	**166,728**	**166,728**	**-**	**166,728**	**125,840**	**(40,888)**	**196,391**
Spending in Annually Managed Expenditure (AME)									
Central Government spending									
Hospital financing for credit guarantee finance (CGF) pilot projects and certain DH, PCT and SHA impairments	**-**	**461,755**	**-**	**461,755**	**(22,140)**	**439,615**	**640,559**	**200,944**	**74,999**
Non-budget (not DEL or AME)									
Grant in aid to Non-departmental Public Bodies and repayment of interest	-	250	7,058	7,308	(1,005,402)	(998,094)	(1,258,097)	(260,003)	(1,109,952)
National Insurance Contributions	-	-	-	-	(18,025,336)	(18,025,336)	(18,025,336)	-	(18,602,298)
IFRS Non-budget changes	-	326,304	-	326,304	-	326,304	301,784	(24,520)	-
	-	**326,554**	**7,058**	**333,612**	**(19,030,738)**	**(18,697,126)**	**(18,981,649)**	**(284,523)**	**(19,712,250)**
	-	**100,078,977**	**547,687**	**100,626,664**	**(21,502,760)**	**79,123,904**	**80,852,573**	**1,728,669**	**71,434,390**

The restatement of the 2008-09 Resource Account to IFRS did not require the restatement of outturn against estimates for Note 3 as this was reported to Parliament and therefore cannot be retrospectively amended.

The £326,304,000 shown for IFRS non budget changes represent the costs incurred for IFRIC12 that are not included in budgets but are included in the financial accounts. These are mainly PFI and LIFT service concessions.

								2009-10 £'000	2008-09 £'000
	Admin	Other Current	Grants	Gross Resource Expenditure	A-in-A	Outturn Net Total	Estimate	Net total Outturn compared with Estimate savings /(excess)	Prior year outturn
Request for Resources 2: Securing social care for adults who need it and, at a national level, protecting, promoting and improving the nation's health.									
Spending in Departmental Expenditure Limits(DEL)									
Central Government Spending									
Central Department	222,096	12,321	-	**234,417**	(7,204)	227,213	231,177	3,964	228,383
NHS Purchasing and Supplies Agency	-	40,498	-	**40,498**	(1)	40,497	59,165	18,668	35,594
Other Services, including medical, scientific and technical services, grants to voluntary bodies, information services and health promotion activities	-	252,098	63,508	**315,606**	(5,685)	309,921	299,186	(10,735)	391,684
Healthy start programme and European Economic Area and other countries medical costs	-	771,802	-	**771,802**	(73,678)	698,124	871,766	173,642	699,054
Other Personal Social Services	-	53,310	207,666	**260,976**	(502)	260,474	246,355	(14,119)	229,312
Medicines and Healthcare Products Regulatory Agency loans, repayment of loans and interest on loans	-	(381)	-	**(381)**	(996)	(1,377)	(848)	529	(211)
Support for local Authorities									
AIDS support grant	-	-	24,896	24,896	-	24,896	24,900	4	22,945
Extra Care housing grant	-	-	40,000	40,000	-	40,000	40,000	-	40,001
Area Based Grant	-	-	968,291	968,291	-	968,291	968,326	35	942,970
Learning Disabilities	-	-	31,000	31,000	-	31,000	31,000	-	14,000
Transforming Personalisation, Prevention & Well-being (TPPW)	-	-	192,000	192,000	-	192,000	192,000	-	82,000
Stroke Strategy	-	-	15,000	15,000	-	15,000	15,000	-	15,000
Common Assessment Framework	-	-	11,000	11,000	-	11,000	11,000	-	-
Social Care Infrastructure	-	-	16,000	16,000	-	16,000	16,000	-	15,000
Social Care Capital	-	-	27,727	27,727	-	27,727	27,727	-	27,727
Mental Health Capital	-	-	22,593	22,593	-	22,593	22,593	-	22,593
	222,096	**1,129,648**	**1,619,681**	**2,971,425**	**(88,066)**	**2,883,359**	**3,055,347**	**171,988**	**2,766,052**
Non-budget									
Grant in Aid funding Non-departmental public bodies and special health authorities	-	-	362,568	362,568	-	362,568	399,207	36,639	301,671
Spending in Departmental Expenditure Limits(DEL)									
	222,096	**1,129,648**	**1,982,249**	**3,333,993**	**(88,066)**	**3,245,927**	**3,454,554**	**208,627**	3,067,723

	Admin	Other Current	Grants	Gross Resource Expenditure	A-in-A	Outturn Net Total	Estimate	Net total Outturn compared with Estimate savings /(excess)	Prior year outturn
Request for Resources 3:									
Office of the Independent Regulator for NHS Foundation Trusts									
Non-budget									
Grant in aid funding to the Office of the Independent Regulator for NHS Foundation Trusts	-	-	14,300	14,300	-	14,300	16,097	1,797	15,674
Resource Outturn	**222,096**	**101,208,625**	**2,544,236**	**103,974,957**	**(21,590,826)**	**82,384,131**	**84,323,224**	**1,939,093**	**74,517,787**
Reconciliation to Operating Cost Statement									
Income from Consolidated Fund Extra Receipts - RfR1	-	-	-	-	(8,984)	(8,984)	-	8,984	(339,468)
Income from Consolidated Fund Extra Receipts - RfR2	-	-	-	-	(12)	(12)	-	12	(19)
Net operating cost	**222,096**	**101,208,625**	**2,544,236**	**103,974,957**	**(21,599,822)**	**82,375,135**	**84,323,224**	**1,948,089**	**74,178,300**

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

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

4.1 Reconciliation of net resource outturn to net operating cost

		2009-10 £'000			2008-09 £'000
	Note	Outturn	Supply Estimate	Outturn compared with Estimate	Outturn
Net Resource Outturn	3	82,384,131	84,323,224	1,939,093	74,517,787
Non-supply income (CFERS)	6	(8,996)	-	8,996	(339,487)
Non-supply expenditure		-	-	-	
IFRS adjustment	2				149,900
Net Operating Cost		**82,375,135**	**84,323,224**	**1,948,089**	**74,328,200**

4.2 Reconciliation of net resource Outturn against final Administration Budget

	2009-10 £'000		2008-09 £'000
	Budget	Outturn	Outturn
Gross Administration Budget	223,426	222,096	225,515
Income allowable against Administration Budget	(5,235)	(5,263)	(5,191)
Net outturn against final Administration Budget	**218,191**	**216,833**	**220,324**

5 Reconciliation of resources to cash requirement

	Note	Estimate £'000	Outturn £'000	Net Total outturn compared with Estimate saving/(excess) £'000
Net Resource Outturn	3	84,323,224	82,384,131	1,939,093
Capital		4,280,856	2,195,081	2,085,775
Investments			931,882	(931,882)
Non operating A-in-A - proceeds of asset disposals		(760,288)	(445,655)	(314,633)
Accruals adjustments				
Non-cash items	11	(5,728,845)	(5,026,980)	(701,865)
Changes in working capital other than cash and current provisions		-	(437,907)	437,907
Changes in payables falling due after more than one year	22	-	(240,379)	240,379
Use of provision	23	1,410,175	1,453,158	(42,983)
Consumption of Stockpile Goods			(113,705)	113,705
Other		-	21,037	(21,037)
Net cash requirement		**83,525,122**	**80,720,663**	**2,804,459**

Explanation of variances
The department stayed within its overall cash limit, with an underspend of £2.8 billion or 3.4%. The cash underspend is consistent with the net revenue (£1,939m) and net capital (£839m) underspends in the resource account.

6 Analysis of income payable to the Consolidated Fund

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

		Forecast 2009-10 £'000		Outturn 2009-10 £'000	
	Note	**Income**	**Receipts**	**Income**	**Receipts**
Operating income and receipts-excess A-in-A		-	-	-	-
Other operating income and receipts not classified as A-in-A		-	-	8,996	*176*
Total income payable to the Consolidated Fund		**-**	**-**	**8,996**	***176***

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

		2009-10	2008-09
	Note	**£'000**	**£'000**
Operating income	13	21,599,822	22,712,300
Gross income		21,599,822	22,712,300
Income authorised to be appropriated-in-aid		(21,590,826)	(22,372,813)
Operating income payable to the Consolidated Fund	6	**8,996**	**339,487**

8 Non-operating income – Excess Appropriations-in-Aid

The Department did not receive any Non-operating Income - Excess Appropriations-in-Aid in 2009-10 or 2008-09

	2009-10 £'000
Principal repayment of voted loans	-
Proceeds on disposal of fixed assets	-
Other	-
Non - operating income excess A-in-A	**-**

9 Non-operating income not classified as Appropriations-in-Aid

The Department did not receive any Non-operating income not classified as Appropriations-in-Aid in 2009-10 or 2008-09

	2009-10 Income £'000
Other	-

Received income relating to more than one year	2009-10 £'000
Receivable in the year	-
Recognised in the year	-
Carried forward	-
Total	-

10 Staff numbers and related Costs

10.1 Staff costs consist of

						2009-10 £'000	2008-09 £'000
	Total	Permanently employed staff	Others	Ministers	Special Advisors	Total	
Salaries and Wages	7,658,326	6,586,827	1,071,109	250	140	6,931,476	
Social Security costs	503,178	489,026	14,115	22	15	463,088	
NHS Pension	840,027	818,548	21,479	-	-	775,526	
Other pension costs	38,828	38,642	165	1	20	51,454	
Sub-total	**9,040,359**	**7,933,043**	**1,106,868**	**273**	**175**	**8,221,544**	
Less recoveries in respect of Outward Secondments	(14,995)	(14,995)	-	-	-	**(11,825)**	
Total Net Costs	**9,025,364**	**7,918,048**	**1,106,868**	**273**	**175**	**8,209,719**	
Of which Core Department Revenue Expenditure is	322,936	144,155	178,333	273	175	270,438	
Of which Core Department Capital Expenditure is	40,540	516	40,024	-	-	28,742	
Of which NHS Bodies Revenue Expenditure is	8,652,746	7,766,340	886,406	-	-	7,910,539	
Of which NHS Bodies Capital Expenditure is	9,142	7,037	2,105	-	-	0	

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 on the Civil Service Pension website(www.civilservice-pensions.gov.uk).

For 2009-10, employers' contributions of £23,713,604 were payable to the PCSPS (2008-09 £22,844,975) at one of four rates, in the range 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. From 2010-11, the rates will continue to be in the range 16.7% to 24.3%. The contribution rates are set to meet the cost of the benefits accruing during 2009-10, to be paid when the member retires, and not the benefits paid during this period to existing pensioners.

The costs described in the preceding paragraph are included in the "other pension costs" line in note 10.1 and are the Core Department's contributions. The breakdown of the £39 million (2008-09 £51 million) is approximately: Core Department £24 million (2008-09 £23 million), PCTs £12 million (2008-09 £21 million), Arms Length Bodies £2 million (2008-09 £1 million) and a contribution to the Nursing and Midwifery Council pension scheme of £1 million. In 2008-09 SHAs accounted for £6 million of other pension costs.

Employees can opt to open a partnership pension account, which is a stakeholder pension with an employer contribution. Employers' contributions of £89,860 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 12.5% of pensionable pay. Employers also match employee contributions up to 3% of pensionable pay. In addition, employer contributions of £5,618, 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 or ill health retirement of these employees.

Contributions due to the partnership pension providers at the date of the Statement of Financial Position were £17,203. Contributions prepaid at that date were £Nil.

Three individuals retired early on ill-health grounds; the total additional accrued pension liabilities in the year amounted to £8,200.

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 the pension scheme website at www.nhsbsa.nhs.uk/pensions.

For 2009-10, 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 10.1.

Of the £840 million (2008-09 £776 million) against NHS pension costs in note 10.1 £798million (2008-09 £741 million) is attributable to PCTs, £20 million (2008-09 £17 million) to SHAs, £15 million (2008-09 £14 million) to the ALBs and £7m (2008-09 £4m) to Connecting for Health

During 2009-10 there were 308 early retirements from Primary Care Trusts and Strategic Health Authorities on the grounds of ill-health (2008-09:353). The estimated additional pension liabilities of these ill-health retirements (calculated on an average basis and borne by the NHS Pensions Scheme) will be £15,924,000 (2008-09: £19,190,000).

10.2 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 working in the Department as well as in agencies and other bodies included within the consolidated Departmental Resource Account.

	2009-10 Number					2008-09 Number
	Total	Permanent staff	Others	Ministers	Special Advisers	Total
Core Department	3,403	2,471	924	6	2	3,170
Connecting for Health	1,449	25	1,424	-	-	1,407
Primary Care Trusts	222,395	203,742	18,653	-	-	210,225
Strategic Health Authorities	3,865	3,061	804	-	-	3,115
Special Health Authorities	4,700	4,169	531	-	-	4,386
Supply financed agency	206	177	29	-	-	288
Total whole time equivalent persons	**236,018**	**213,645**	**22,365**	**6**	**2**	**222,591**

For the first time, figures relating to the Core Department in the table above include programme and non-Administration Cost Limit funded civil servants. Figures for 2008-09 have therefore been restated, as these categories of staff were not included in the corresponding note last year.

The “Others” category of staff for the Core Department includes various categories of non-permanent worker i.e. civil servants with short term contracts, contractors, agency staff and consultants. In relation to programme funded non-permanent workers, a data cleansing exercise has identified a number of staff who were not previously recorded in the figures, but should have been. The number relating to this category of staff in 2008-09 has therefore been restated to reflect the impact of this error.

Part of the reduction in staff numbers in the “supply financed agency” line is accounted for by a corresponding increase in the Core Department line this year, as staff transferred into the Department from PASA, which ceased to exist on 31st March 2010.

Connecting for Health (implementing the National Programme for IT in the NHS – NPfIT) is a programme managed by the Department’s Director General for Infomatics and Chief Information Officer. 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.

Staff numbers in the accounts are calculated using a financial year average.

11 Other administration costs

The following is an analysis of other administration costs of the Core Department

	Note	2009-10 £'000	2008-09 £'000
Rental under operating leases:			
Hire of plant and machinery		13	303
Other operating leases		11,629	11,011
Interest Charges		26	37
Research and Development Expenditure		112	229
Non cash items (See Note b below):			
Depreciation		7,845	10,590
Amortisation		6,450	5,552
Profit on disposal of property plant and equipment		-	-
Loss on disposal of property plant and equipment		41	73
Profit on disposal of intangible non current assets		-	-
Loss on disposal of intangible non current assets		-	-
Impairment/permanent diminuation of asset values		1,357	114
Impairment reversal		-	-
Cost of capital charges		3,678	3,460
Auditors' remuneration	a	567	565
Provision provided for in year	23	2,069	62
Unwinding of discount on provisions	23	550	494
Other non-cash		-	-
Building and related costs		14,461	14,962
General office expenditure		17,464	23,615
Other expenditure		31,096	29,661
Total		**97,358**	**100,728**

Note a -The audit fee represents the cost of the audit of the Department's Consolidated Accounts and the Summarised Accounts of the NHS 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 Cash Flow Statement and the reconciliation of resources to net cash requirement comprises:

	2009-10 £'000	2008-09 £'000
Other administration costs - non-cash items (Note 11)	22,557	20,910
Programme costs - non-cash items (Note 12)	5,013,626	4,858,433
Other non-cash amounts charged to operating expenditure	-	-
Less non-cash income: -deferred donation income released from the Donated Asset Reserve	(9,203)	(7,360)
Other: Stock Write-off, bad debt expenses	-	-
Total non-cash transactions	**5,026,980**	**4,871,983**

12 Programme Costs

	Note	2009-10 £'000 Core Department	2009-10 £'000 Consolidated	2008-09 £'000 Core Department	2008-09 £'000 Consolidated
Current grants and other current expenditure		4,601,496	88,456,561	6,398,308	82,610,006
Rental under operating leases:					
Hire of plant and machinery		44	371	29	442
Other operating leases		13,886	345,420	9,691	262,145
Interest Charges		4,673	145,696	3,502	125,140
PFI Service Charges		-	71,164	-	54,752
Research and Development expenditure		853,966	869,079	845,801	848,229
Non cash items (See Note b above):					
Depreciation		96,860	444,831	57,338	419,725
Amortisation		505,023	523,936	460,172	473,912
Profit on disposal of property plant and equipment		(1,169)	(4,625)	(10,644)	(10,644)
Loss on disposal of property plant and equipment		4,122	4,379	9,004	7,145
Profit on disposal of intangible non current assets		-	(86)	-	-
Loss on disposal of intangible non current assets		-	85	-	215
Impairment/permanent diminuation of asset values		259,051	842,941	6,507	206,023
Impairment reversals		(2,922)	(2,922)	-	-
Cost of capital charges		988,994	500,375	1,133,720	723,507
Write-(on)/off of investment		-	-	-	-
Provision provided for in year	23	237,723	2,705,070	704,427	2,949,634
Unwinding of discount on provisions	23	32,967	(520)	33,147	73,250
Audit fees		-	162	-	141
Other Non-cash expenditure		-	-	15,525	15,525
Total		**7,594,714**	**94,901,917**	**9,666,527**	**88,759,147**

Auditors' remuneration

	2009-10 £'000	2008-09 £'000
Auditors' Remuneration - Audit Fees	38,702	37,387
Auditors' Remuneration - Other Fees	7,325	5,612

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

The £2.7 billion reduction in “Current Grants and other current expenditure” in the Core Department between the two years is a result of the transfer of Payment by Results Market Forces Factor funding to be managed by the NHS from 2009-10.

13 Income

Operating Income analysed by classification and activity, is as follows:	RfR1	RfR2	RfR3	2009-10 £'000 Total	2008-09 £'000 Total
Administration Income:					
Allowable within the administration cost limit	-	5,263	-	5,263	5,191
Not allowable within the administration cost limit	-	1,953	-	1,953	10
Total Administration Income	**-**	**7,216**	**-**	**7,216**	**5,201**
Programme Income:					
Fees and charges to external customers	152,512	-	-	152,512	139,655
Fees and charges to other departments	10,885	-	-	10,885	77,894
Prescription, dental and ophthalmic charges	1,046,994	-	-	1,046,994	1,029,712
National Insurance Contribution	18,025,336	-	-	18,025,336	18,941,620
Non-cash income	-				-
Rental income (operating cost and finance lease)	72,000	-	-	72,000	54,301
PDC Dividend Received	998,283	-	-	998,283	1,201,878
Other	1,205,734	80,862	-	1,286,596	1,262,039
Total Programme Income	**21,511,744**	**80,862**	**-**	**21,592,606**	**22,707,099**
Total Income*	**21,511,744**	**88,078**	**-**	**21,599,822**	**22,712,300**
* Of which Core Department is	1,162,798	88,077	-	1,250,875	1,465,898

14 Analysis of net operating cost by spending body

	2009-10 £'000 Estimate	Outturn	2008-09 £'000 Outturn
Spending body:			
Core Department	231,177	227,201	228,364
Purchasing and Supplies Agency	59,165	40,497	35,594
Entities within departmental boundary	81,267,029	79,490,423	71,412,056
Local authorities	1,594,901	1,608,969	1,411,548
Other bodies	1,170,952	1,008,045	1,090,738
Net Operating Cost	**84,323,224**	**82,375,135**	**74,178,300**

Note: 'Core Department' refers to Administration costs of the Core Department only.

Note: Entities within the Departmental boundary include all NHS bodies, i.e. both consolidated and not consolidated in the Department Resource Accounts as listed in Note 36.

15 Property, plant and equipment

2009-10

	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 2009	1,997,619	5,645,042	31,629	1,011,569	196,015	174,618	424,975	16,231	462,750	9,960,448
Additions-purchased	34,565	553,984	6,590	238,000	254,343	32,269	58,940	2,011	471,839	1,652,541
Additions-donated	150	3,209	-	54	2,307	180	2,012	90	-	8,002
Impairment transferred to Revaluation Reserve	(214,373)	(568,285)	(2,823)	(1,042)	(4,526)	(676)	(751)	(4)	-	(792,480)
Impairment transferred to Operating Cost Statement	(103,831)	(499,799)	(1,726)	-	(6,522)	-	-	-	(227,478)	(839,356)
Impairment reversals	6,915	18,757	1,041	3	-	514	85	4	-	27,319
Transfers	1,197	6,578	-	719	(7,436)	(23)	(43)	-	(113,705)	(112,713)
Reclassifications to assets held for sale	(39,733)	(31,853)	(6,951)	(273)	(29)	(52)	(128)	(215)	-	(79,234)
Reclassifications	12,822	135,364	2,401	34,108	(208,584)	(2,734)	12,560	167	-	(13,896)
Revaluation and indexation	171,076	158,949	2,310	(57)	1,160	293	1,529	1	21,093	356,354
Disposals	(16,048)	(11,955)	(2,192)	(42,841)	(4,495)	(2,830)	(8,078)	(1,094)	(16,599)	(106,132)
At 31 March 2010	**1,850,359**	**5,409,991**	**30,279**	**1,240,240**	**222,233**	**201,559**	**491,101**	**17,191**	**597,900**	**10,060,853**
Depreciation										
At 1 April 2009	-	464,251	2,643	484,514	-	76,090	201,456	11,242	-	1,240,196
Charged in year	464	205,260	846	177,731	-	18,118	48,421	1,314	-	452,154
Impairment transferred to Operating Cost Statement	-	(518)	-	2,443	-	1,570	2,841	42	-	6,378
Impairment transferred to Revaluation Reserve	-	(2,594)	-	-	-	-	-	-	-	(2,594)
Impairment reversals	-	9	-	-	-	-	-	-	-	9
Transfers	-	(124)	-	768	-	-	(322)	(1)	-	321
Reclassifications to assets held for sale	-	(4,313)	(126)	(261)	-	(38)	(83)	(213)	-	(5,034)
Reclassifications	-	596	(358)	882	-	(2,786)	796	127	-	(743)
Revaluation and indexation	-	933	-	262	-	116	1,227	-	-	2,538
Disposals	-	(1,288)	(102)	(42,628)	-	(2,564)	(7,214)	(1,086)	-	(54,882)
At 31 March 2010	**464**	**662,212**	**2,903**	**623,711**	**-**	**90,506**	**247,122**	**11,425**	**-**	**1,638,343**
Net Book Value At 31 March 2010	**1,849,895**	**4,747,779**	**27,376**	**616,529**	**222,233**	**111,053**	**243,979**	**5,766**	**597,900**	**8,422,510**
At 31 March 2009	1,997,619	5,180,791	28,986	527,055	196,015	98,528	223,519	4,989	462,750	8,720,252
Asset financing:										
Owned	1,741,340	3,044,255	26,638	614,505	221,924	105,260	187,924	5,766	597,900	6,545,512
Finance Lease	4,754	221,374	738	2,024	-	5,658	54,820	-	-	289,368
On-balance sheet PFI contracts	100,981	1,470,653	-	-	309	135	1,235	-	-	1,573,313
PFI residual interests	2,820	11,497	-	-	-	-	-	-	-	14,317
Net book value at 31 March 2010	**1,849,895**	**4,747,779**	**27,376**	**616,529**	**222,233**	**111,053**	**243,979**	**5,766**	**597,900**	**8,422,510**

2008-09

	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 2008	2,479,310	5,556,830	25,266	768,626	153,255	159,965	366,649	15,013	169,371	9,694,285
Additions-purchased	66,607	625,060	4,223	179,052	189,610	25,551	51,288	1,458	189,696	1,332,545
Additions-donated	-	5,827	-	43	1,359	527	769	16	-	8,541
Impairment transferred to Revaluation Reserve	(513,489)	(271,562)	(961)	(1,072)	(2,559)	(289)	(297)	(11)	-	(790,240)
Impairment transferred to Operating Cost Statement	(29,565)	(144,278)	(15)	-	-	-	-	-	-	(173,858)
Impairment reversals	-	-	-	-	-	-	-	-	-	-
Transfers	(17,379)	(17,277)	(142)	(100)	(176)	(31)	(135)	(1)	-	(35,241)
Reclassifications to assets held for sale	(13,648)	(8,112)	-	-	-	-	-	-	-	(21,760)
Reclassifications	8,128	110,232	5,199	92,074	(146,072)	(8,090)	8,721	868	107,286	178,346
Revaluation and indexation	40,780	59,067	123	(1,471)	1,038	3,069	6,179	147	-	108,932
Disposals	(23,125)	(66,004)	(928)	(25,583)	(440)	(6,084)	(8,199)	(1,259)	(3,603)	(135,225)
At 31 March 2009	**1,997,619**	**5,849,783**	**32,765**	**1,011,569**	**196,015**	**174,618**	**424,975**	**16,231**	**462,750**	**10,166,325**
Depreciation										
At 1 April 2008	-	452,295	2,616	349,158	-	74,949	158,753	10,443	-	1,048,214
Charged in year	-	222,125	1,704	143,792	-	15,681	45,554	1,458	-	430,314
Impairment transferred to Operating Cost Statement	-	180	-	1,834	-	1,365	2,679	484	-	6,542
Impairment transferred to Revaluation Reserve	-	-	-	-	-	-	-	-	-	-
Impairment reversals	-	-	-	-	-	-	-	-	-	-
Transfers	-	(1,816)	-	(38)	-	(31)	(113)	(2)	-	(2,000)
Reclassifications to assets held for sale	-	(673)	-	-	-	-	-	-	-	(673)
Reclassifications	-	7,125	363	14,771	-	(11,948)	262	(20)	-	10,553
Revaluation and indexation	-	(1,010)	(3)	155	-	1,515	1,860	95	-	2,612
Disposals	-	(9,234)	(901)	(25,158)	-	(5,441)	(7,539)	(1,216)	-	(49,489)
At 31 March 2009	**-**	**668,992**	**3,779**	**484,514**	**-**	**76,090**	**201,456**	**11,242**	**-**	**1,446,073**
Net Book Value At 31 March 2009	**1,997,619**	**5,180,791**	**28,986**	**527,055**	**196,015**	**98,528**	**223,519**	**4,989**	**462,750**	**8,720,252**
At 31 March 2008	2,479,310	5,104,535	22,650	419,468	153,255	85,016	207,896	4,570	169,371	8,646,071
Asset financing:										
Owned	1,906,167	3,442,607	28,155	526,748	196,015	92,256	147,886	4,989	462,750	6,807,573
Finance Lease	12,832	297,165	831	307	-	6,122	73,527	-	-	390,784
On-balance sheet PFI contracts	77,195	1,388,082	-	-	-	150	2,106	-	-	1,467,533
PFI residual interests	1,425	52,937	-	-	-	-	-	-	-	54,362
Net book value at 31 March 2009	**1,997,619**	**5,180,791**	**28,986**	**527,055**	**196,015**	**98,528**	**223,519**	**4,989**	**462,750**	**8,720,252**

Footnote

1) Stockpiled goods are not depreciated as agreed with HM Treasury
2) For NHS land, buildings and dwellings the opening cost/valuation is the closing net book value of the previous year. For these assets, the depreciation section of the note reflects in-year adjustments only.
3) PCT and SHA PPE balances at 31 March 2009 were presented in gross terms, showing both the gross value of assets and the year's depreciation charge. The Department adopts a policy of eliminating cumulative depreciation against gross carrying amounts such that the net book value of PPE is carried forward from one year to another for PCTs and SHAs only. This policy is permitted by IAS 16 in view of the incidence of property revaluations in NHS bodies each year. The closing net book value of PPE in 2008-09 equals the opening net book value in 2009-10.

The net book value of PPE assets comprises:

	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 2009-10	73,872	96,440	3,934	316,446	14,797	9,221	64,548	-	597,900	**1,177,158**
Other NHS Bodies 2009-10	1,776,023	4,651,339	23,442	300,083	207,436	101,832	179,431	5,766	-	**7,245,352**
Core Department 2008-09	174,414	100,721	3,304	264,065	21,499	6,958	55,922	-	462,750	**1,089,633**
Other NHS Bodies 2008-09	1,823,205	5,080,070	25,682	262,990	174,516	91,570	167,597	4,989	-	**7,630,619**

Revaluation Reserve surplus in respect of Core Department PPE assets

	£'000
As at 1 April 2009	301,303
Movement in year	(222,740)
As at 31 March 2010	78,563

Property has been valued as follows:

- The Civil Estate (land and buildings held for use by the core Department) was valued at 1 September 2005 by independent valuers employed by the Department. Since then, Investment Property Databank indices have been applied, as appropriate, to uplift values to year-end dates. A full professional valuation will be undertaken in September 2010.
- Land and buildings held by NHS bodies were valued, by independent valuers, to a modern equivalent basis as required by 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 (land and buildings primarily intended for use by NHS bodies but now surplus to requirements and held by the Department) was valued as at 31 March 2005 by professional valuers, and revalued as at 31 March 2010. Additional valuations were carried out as necessary between these two dates where there had been any indication that values had substantially changed.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 - 115 years
- Transport equipment: 1 - 15 years
- Information technology: 1 - 20 years
- Plant and machinery: 1 - 35 years
- Furniture and fittings: 1 - 54 years

As a result of the reclassification of Pandemic Flu stock and Emergency Preparedness stock to stockpiled goods in 2009-10, an additional column has been included in Note 15 Property, Plant and Equipment.

Explanation of material impairments in the Core Department

Stockpiled Goods - Inventory Losses

The worldwide surplus of swine flu vaccine means that there is no active market in which the Department's excess pandemic flu inventory can be sold. Consequently, the value of unused vaccine must be impaired to zero. The Department has therefore recognised an impairment and constructive loss of £98.40 million in this financial year in respect of this excess inventory. The vaccine itself, which remains medically effective, will be retained as a strategic reserve for possible future use if the virus mutates.

The Department has recognised a further £72.90 million impairment and store loss in respect of antiviral medicines made available to the NHS during the swine flu outbreak. In some cases, the Department has been unable to obtain documentary evidence that antiviral medicines returned from the NHS had been stored in accordance with the terms of the respective Wholesale Dealers Licence (WDL). This does not mean that these

antiviral medicines were not stored by the NHS in compliant conditions, but rather that the Department does not have the documentary evidence to prove that this was the case.

A further £7.94 million store loss has been recognised to take account of date-expired vaccine inventory. This mainly relates to vaccine purchased a number of years ago as part of preparations for an outbreak of avian influenza.

The Department holds countermeasures inventory for use in the event of an accidental or malicious release of chemical, biological, radiological or nuclear material. As with all inventory, each of the relevant countermeasures has a shelf-life assigned to it at the time of manufacture. Some inventory has been retained, despite its assigned shelf-life having expired, with a view to testing its continued efficacy. As this testing had not been completed at the date of these accounts, the value of this inventory is considered to be impaired to zero value. The total value of the impairment and corresponding store loss recognised in these accounts is £48.24 million.

Land, Buildings and Dwellings
DH Core land reduced in value during 2009-10 as a result of £102 million impairments, recognised both during the year and as part of a specific year end exercise.

16 Intangible Non-Current Assets

Intangible non-current assets comprise: Purchased Software Licences, Trade Marks, Development Expenditure, and National Programme for IT for the Department and entities consolidated within these statements.

				2009-10
	Software Licences	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2009	2,440,534	51,149	1,693	2,493,376
Additions-purchased	526,703	7,405	1,005	535,113
Additions-donated	-	441	-	441
Impairment transferred to Revaluation Reserve	(29)	(84)	-	(113)
Impairment reversal	-	-	-	-
Transfers	840	(1)	-	839
Reclassification assets held for sale	-	-	-	-
Reclassification	792	(264)	(209)	319
Revaluation and indexation	94,561	-	-	94,561
Disposals	(2,185)	(2,270)	-	(4,455)
At 31 March 2010	**3,061,216**	**56,376**	**2,489**	**3,120,081**
Amortisation				
At 1 April 2009	978,638	13,178	794	992,610
Charged in year	525,393	4,683	310	530,386
Impairment transferred to Operating Cost Statement	281	221	-	502
Impairment reversal	-	-	-	-
Transfers	-	-	-	-
Reclassification assets held for sale	(5)	-	-	(5)
Reclassification	250	(454)	38	(166)
Revaluation and indexation	(17,588)	-	-	(17,588)
Disposals	(1,557)	(2,202)	-	(3,759)
At 31 March 2010	**1,485,412**	**15,426**	**1,142**	**1,501,980**
Net book value at 31 March 2010	**1,575,804**	**40,950**	**1,347**	**1,618,101**
Net book value at 31 March 2009	1,461,896	37,971	899	1,500,766

Analysis of intangible non current assets as at 31 March 2010

The net book value of intangible non current assets comprises:	Software Licenses £'000	Development Expenditure £'000	Other £'000	Total £'000
Core Department at 31 March 2010	1,514,852	27,715	-	1,542,567
Other NHS Bodies 31 March 2010	60,952	13,235	1,347	75,534
Core Department at 31 March 2009	1,414,936	27,715	-	1,442,651
Other NHS Bodies 31 March 2009	46,960	10,256	899	58,115

				2008-09
	Software Licences £'000	Development Expenditure £'000	Other £'000	Total £'000
Cost or valuation				
At 1 April 2008	1,894,055	74,568	706	1,969,329
Additions-purchased	573,786	28,993	331	603,110
Additions-Donated	1	223	-	224
Impairment transferred to the Revaluation Reserve	(2)	(37)	-	(39)
Impairment reversal	-	-	-	-
Transfers	142	-	-	142
Reclassification assets held for sale	-	-	-	-
Reclassification	(17,455)	(52,009)	656	(68,808)
Revaluation and indexation	(9,732)	-	-	(9,732)
Disposals	(261)	(589)	-	(850)
At 31 March 2009	**2,440,534**	**51,149**	**1,693**	**2,493,376**
Amortisation				
At 1 April 2008	511,227	11,454	251	522,932
Charged in year	477,278	2,126	217	479,621
Impairment transferred to the Operating Cost Statement	129	(11)	263	381
Impairment reversal	-	-	-	-
Transfers	(5)	-	-	(5)
Reclassification assets held for sale	-	-	-	-
Reclassification	(8,334)	-	63	(8,271)
Revaluation and indexation	(1,466)	-	-	(1,466)
Disposals	(191)	(391)	-	(582)
At 31 March 2009	**978,638**	**13,178**	**794**	**992,610**
Net book value at 31 March 2009	**1,461,896**	**37,971**	**899**	**1,500,766**

Revaluation Reserve surplus in respect of Core Department Intangible assets

	£'000
As at 1 April 2009	23,830
Movement in year	58,775
As at 31 March 20010	82,605

The ranges of estimated useful lives are currently:

- Software licences : 1 – 10 years
- Development expenditure: 2 - 25 years

The Department values National Programme for IT (NPfIT) intangible non-current assets by indexing the original cost of these assets, using the difference between the Retail Price Index (RPI) in the month of purchase, and the RPI operating at the year end. RPI is considered the most appropriate measure of indexation for this group of assets, as no other indexation factor is available that more accurately reflects the commercial environment in the compter services sector. This valuation method will be reviewed annually to ascertain whether RPI remains the most appropriate index to use.

17 Financial Assets – Investments

2009-10

	In NHS Trusts PDC	NHS Loans	Foundation Trusts PDC	Foundation Trusts Loans	In Other Bodies PDC	In Other Bodies Loans	In Other Bodies Share Capital	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2009	12,428,425	427,125	10,053,903	274,130	1,328	544,804	251,272	23,980,987
Issued:								
To newly established bodies	528,237	-	-	-	-	10,205	15,300	553,742
To existing bodies	331,629	232,774	123,214	209,354	-	9,406	-	906,377
Repaid:								
By continuing bodies	(111,916)	(38,709)	(22,610)	(8,875)	-	(5,030)	-	(187,140)
Written off:								
By or on behalf of dissolved bodies	(484,684)	-	-	-	-	-	-	(484,684)
Other:								
Revaluation	-	-	-	-	-	33,066	(54,974)	(21,908)
Loan repayable within 12 months transferred to receivables	-	(137,056)	-	(28,535)	-	(3,925)	-	(169,516)
Impairment	-	-	-	-	-	(756)	-	(756)
Impairment reversal	-	-	-	-	-	2,922	-	2,922
Reclassification	(944,474)	(9,817)	944,474	9,817	-	-	-	-
Balance as at 31 March 2010	**11,747,217**	**474,317**	**11,098,981**	**455,891**	**1,328**	**590,692**	**211,598**	**24,580,024**
Investments held by Core Department	11,747,217	474,317	11,098,981	455,891	1,328	561,310	190,380	24,529,424
Investments held by other NHS bodies	-	-	-	-	-	29,382	21,218	50,600

The Department can analyse its investments in other bodies as follows:								**Percentage Shareholding**
MHRA (Medicines and Healthcare products Regulatory Agency)					1,328	1,328	500	100%
Community Health Partnerships					-	10,000	82,100	100%
Plasma Resources UK Ltd					-	32,966	92,306	100%
Credit Guarantee Fund (CGF)					-	491,842	-	-
SBS					-	21,766	7,000	50%
LIFT companies					-	-	-	
Other					-	3,408	8,474	

2008-09

	In NHS Trusts PDC	NHS Loans	Foundation Trusts PDC	Foundation Trusts Loans	In Other Bodies PDC	In Other Bodies Loans	In Other Bodies Share Capital	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as at 1 April 2008	14,721,836	470,548	7,791,446	144,836	1,328	545,494	224,570	23,900,058
Issued:								
To newly established bodies	-	-	-	-	-	-	-	-
To existing bodies	422,145	228,720	141,893	130,351	-	2,430	-	925,539
Repaid:								
By continuing bodies	(580,656)	(116,215)	(25,159)	(15,705)	-	-	-	(737,735)
Written off:								
By or on behalf of dissolved bodies	-	-	-	-	-	-	-	-
Other:								
Revaluation	-	-	-	-	-	6,866	26,702	33,568
Loan repayable within 12 months transferred to receivables	-	(130,031)	-	(20,928)	-	(4,028)	-	(154,987)
Impairment	-	-	-	-	-	(2,922)	-	(2,922)
Impairment reversal	-	-	-	-	-	-	-	-
Reclassification	(2,134,900)	(25,897)	2,145,723	35,576	-	(3,036)	-	17,466
Balance as at 31 March 2009	**12,428,425**	**427,125**	**10,053,903**	**274,130**	**1,328**	**544,804**	**251,272**	**23,980,987**
Investments held by Core Department	12,428,425	427,125	10,053,903	274,130	1,328	522,180	230,054	23,937,145
Investments held by other NHS bodies	-	-	-	-	-	22,624	21,218	43,842

Investments held by other NHS bodies

In addition Primary Care Trusts have investments of £38,600,000 in LIFT companies. Details of these investments can be found in their individual accounts. The Information Centre also has an investment of £12,000,000 in a Joint Venture arrangement known as Dr Foster Intelligence.

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.

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
	£'000	£'000	£'000	£'000	£'000	£'000
Net Assets at 31 March 2010	13,933,058	15,786,200	51,035	45,204	51,639	(892)
Turnover	28,378,120	27,890,600	112,540	120,981	1,270	47,377
Surplus/profit for the year (before financing)	(2,782,543)	(765,300)	12,071	30,877	1,706	564
Net Assets at 31 March 2009	17,890,646	16,537,600	37,947	30,056	43,933	(1,456)
Turnover	30,160,396	22,765,200	112,812	81,519	2,780	25,586
Surplus/profit for the year (before financing)	(2,812,550)	174,700	26,081	15,823	1,948	(1,878)

The figures for Plasma Resources UK are for its financial year end of 31 December 2009 and those for SBS for the eight months ended 31 December 2009.

The figures for Foundation Trusts and Community Health Partnerships are based on unaudited 2009-10 data.

18 Inventories and work in progress

Core Department	Emergency preparedness	Adult and Childhood Vaccines	Work in progress	Essential Medicines	Pandemic Flu Counter-measures	Other	2009-10 £'000 Total
Balance as at 1 April 2009	6,125	102,733	239	-	-	-	109,097
Additions	9,954	322,234	-	56,503	-	-	388,691
Consumed/Disposed of	(3,940)	(274,533)	-	-	(113,705)	-	(392,178)
Written down charged to Operating Cost Statement	-	(3,442)	-	-	-	-	(3,442)
Revaluation	-	-	-	-	-	-	-
Transfer (to) / from non-current assets	-	-	-	-	113,705	-	113,705
Consumables and Raw Materials	-	-	(239)	-	-	-	(239)
Work in progress	-	-	-	-		-	-
Other	-	-	-	-		-	-
Balance as at 31 March 2010	**12,139**	**146,992**	**-**	**56,503**	**-**	**-**	**215,634**

Consolidated	Emergency preparedness	Adult and Childhood Vaccines	Work in progress	Essential Medicines	Pandemic Flu Counter-measures	Other	Total
Balance as at 1 April 2009	6,125	102,733	239	-	-	84,954	194,051
Additions	9,954	322,234	-	56,503	-	1,045,694	1,434,385
Consumed/Disposed of	(3,940)	(274,533)	-	-	(113,705)	(1,039,688)	(1,431,866)
Written down charged to Operating Cost Statement	-	(3,442)	-	-	-	-	(3,442)
Revaluation	-	-	-	-	-	-	-
Transfer (to) / from non-current assets	-	-	-	-	113,705	-	113,705
Consumables and Raw Materials	-	-	(239)	-	-	-	(239)
Work in progress	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-
Balance as at 31 March 2010	**12,139**	**146,992**	**-**	**56,503**	**-**	**90,960**	**306,594**

Core Department	Emergency preparedness	Adult and Childhood Vaccines	Work in progress	Essential Medicines	Pandemic Flu Counter-measures	Other	2008-09 £'000 Total
Balance as at 1 April 2008	105,667	62,365	-	-	-	-	168,032
Additions	9,928	294,573	-	-	-	-	304,501
Consumed/Disposed of	(15,671)	(250,273)	-	-	-	-	(265,944)
Written down charged to Operating Cost Statement	(2,348)	(3,932)	-	-	-	-	(6,280)
Revaluation	15,835	-	-	-	-	-	15,835
Transfer (to) / from non-current assets	(107,286)	-	-	-	-	-	(107,286)
Consumables and Raw Materials	-	-	239	-	-	-	239
Work in progress	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-
Balance as at 31 March 2009	**6,125**	**102,733**	**239**	**-**	**-**	**-**	**109,097**

2008-09
£'000

Consolidated	Emergency preparedness	Adult and Childhood Vaccines	Work in progress	Essential Medicines	Pandemic Flu Counter-measures	Other	Total
Balance as at 1 April 2008	105,667	62,365	-	-	-	72,373	240,405
Additions	9,928	294,573	-	-	-	905,951	1,210,452
Consumed/Disposed of	(15,671)	(250,273)	-	-	-	(893,370)	(1,159,314)
Written down charged to Operating Cost Statement	(2,348)	(3,932)	-	-	-	-	(6,280)
Revaluation	15,835	-	-	-	-	-	15,835
Transfer (to) / from non-current assets	(107,286)	-	-	-	-	-	(107,286)
Consumables and Raw Materials	-	-	239	-	-	-	239
Work in progress	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-
Balance as at 31 March 2009	**6,125**	**102,733**	**239**	**-**	**-**	**84,954**	**194,051**

Pandemic flu countermeasures inventory and Emergency Preparedness inventory included in note 17 to the 2008-09 Resource Account have been reclassified as Stockpiled goods and included in Note 15, Property, Plant and Equipment in these accounts. All prior years have been adjusted.

19 Trade Receivables and other current assets

19.1 Analysis by type

	2009-10 £'000		2008-09 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Amounts falling due within one year:				
Trade receivables	69,213	751,019	83,150	684,207
Deposits and advances	-	-	-	-
Capital receivables - property plant and equipment	-	-	-	-
Capital receivables - intangible non current assets	-	-	-	-
Other receivables	95,081	344,008	74	278,373
Pension prepayments maturing in one year	-	-	-	-
Consolidated Fund Extra Receipts Receivable	8,904	8,904	84	84
Other prepayments and accrued income	216,063	541,102	329,763	706,581
Current part of loans repayable transferred from investments	167,342	169,990	152,424	154,987
Current part of PFI prepayments	-	1,976	-	4,052
	556,603	**1,816,999**	**565,495**	**1,828,284**
Amounts falling due after more than one year:				
Trade receivables and advances for house purchases	-	19,035	-	9,397
Deposits and advances	-	-	-	-
Capital receivables - property plant and equipment	-	-	-	-
Capital receivables - intangible non current assets	-	-	-	-
Other receivables	138,586	174,124	124,828	155,829
Pension prepayments maturing after one year	-	-	-	-
Prepayments and accrued income	14,954	34,349	17,423	39,588
	153,540	**227,508**	**142,251**	**204,814**
Total receivables	**710,143**	**2,044,507**	**707,746**	**2,033,098**

19.2 Intra-Government balances

	Amounts falling due within one year £'000 2009-10	Amounts falling due after more than one year £'000 2009-10	Amounts falling due within one year £'000 2008-09	Amounts falling due after more than one year £'000 2008-09
Balances with other central government bodies	86,313	3,334	14,537	-
Balances with local authorities	120,222	12,920	235,846	4,030
Balances with NHS Trusts	398,700	9,934	331,195	34
Balances with Public Corporations and Trading Funds	38,487	-	5,746	1,763
Subtotal: Intra-government balances	**643,722**	**26,188**	**587,324**	**5,827**
Balances with bodies external to government	1,173,277	201,320	1,240,960	198,987
Total receivables at 31 March 2010	**1,816,999**	**227,508**	**1,828,284**	**204,814**

20 Cash and cash equivalents

	2009-10 £'000		2008-09 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Balance as at 1 April 2009	1,676,501	1,745,219	2,245,086	2,452,244
Net change in cash	(438,635)	(408,504)	(568,585)	(707,025)
Balance at 31 March 2010	**1,237,866**	**1,336,715**	**1,676,501**	**1,745,219**
The following balances at 31 March were held at:				
Office of HM Paymaster General	1,215,715	1,313,264	1,676,500	1,739,301
Commercial banks and cash in hand	22,151	23,451	1	5,918
Short term investments	-	-	-	-
Balance at 31 March 2010	**1,237,866**	**1,336,715**	**1,676,501**	**1,745,219**

21 Assets classified as held for sale

2009-10

	Land £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Information Technology £'000	Furniture & Fittings £'000	Plant and Machinery £'000	Transport Equipment £'000	Stockpiled goods £'000	Total £'000
As at 1 April 2009	43,550	44,763	-	-	-	94	-	-	88,407
Assets held for sale in year	41,994	39,526	-	-	-	102	-	-	81,622
Assets sold in year	(18,012)	(33,313)	-	-	-	(162)	-	-	(51,487)
Impairment of assets held for sale	(3,348)	(6,741)	-	-	-	(1)	-	-	(10,090)
Reversal of impairments of assets held for sale	472	61	-	-	-	-	-	-	533
Assets no longer held for sale (for reasons other than sale)	(2,611)	(5,134)	-	-	-	(7)	-	-	(7,752)
Gain/(loss) on transfer to assets held for sale	-	-	-	-	-	-	-	-	-
Transfer to Foundation Trusts	-	-	-	-	-	-	-	-	-
As at 31 March 2010	**62,045**	**39,162**	**-**	**-**	**-**	**26**	**-**	**-**	**101,233**
Liabilities associated with assets held for sale at 31 March 2010	-	-	-	-	-	-	-	-	-

Amount attributable to Core Department:

	Land £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Information Technology £'000	Furniture & Fittings £'000	Plant and Machinery £'000	Transport Equipment £'000	Stockpiled goods £'000	Total £'000
Core Department 2009-10	8,690	4,162	-	-	-	-	-	-	12,852

2008-09

	Land £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Information Technology £'000	Furniture & Fittings £'000	Plant and Machinery £'000	Transport Equipment £'000	Stockpiled goods £'000	Total £'000
As at 1 April 2008	42,055	58,503	-	-	-	-	-	-	100,558
Assets held for sale in year	30,583	21,476	-	-	-	94	-	-	52,153
Assets sold in year	(26,741)	(30,363)	-	-	-	-	-	-	(57,104)
Impairment of assets held for sale	(1,687)	(4,515)	-	-	-	-	-	-	(6,202)
Reversal of impairments of assets held for sale	(14)	(19)	-	-	-	-	-	-	(33)
Assets no longer held for sale (for reasons other than sale)	(646)	(319)	-	-	-	-	-	-	(965)
Transfer to Foundation Trusts	-	-	-	-	-	-	-	-	-
As at 31 March 2009	**43,550**	**44,763**	**-**	**-**	**-**	**94**	**-**	**-**	**88,407**
Liabilities associated with assets held for sale at 31 March 2009	-	-	-	-	-	-	-	-	-

Amount attributable to Core Department:

	Land £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Information Technology £'000	Furniture & Fittings £'000	Plant and Machinery £'000	Transport Equipment £'000	Stockpiled goods £'000	Total £'000
Core Department 2008-09	13,648	7,439	-	-	-	-	-	-	21,087

The Department holds a total value of £75.5 million of Retained Estates on behalf of the NHS, of which £12.8 million are planned to be sold to third parties.

22 Trade Payables and other current liabilities

22.1 Analysis by type

	2009-10 £'000		2008-09 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Amounts falling due within one year:				
Bank Overdraft	783	4,407	-	2,930
VAT	1,484	2,777	1,495	2,648
Other taxation and social security	3,628	121,976	3,284	105,936
Trade payables	99,352	4,332,323	59,192	4,130,345
Capital payables - property plant and equipment	-	574	-	1,780
Capital payables - intangible non current assets	291,894	291,894	240,365	240,365
Other payables	18,547	343,083	28,573	415,463
Early retirement costs payable within one year	-	-	-	-
Accruals and deferred income	801,256	2,333,984	669,144	2,007,117
Current part of finance lease	16,114	57,559	12,518	38,831
Current part of imputed finance lease element of on Statement of Financial Position PFI contracts	-	43,678	-	32,324
Amount issued from the Consolidated Fund for supply but not spent at year end	1,332,132	1,332,132	1,702,795	1,702,795
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received and receivable	9,080	9,080	165	165
Excess cash receipts surrenderable to the Consolidated Fund	-	-	39,322	39,322
Investment payables	-	-	-	-
	2,574,270	**8,873,467**	**2,756,853**	**8,720,021**
Amounts falling due after more than one year:				
Finance leases	63,057	271,222	49,978	344,096
Imputed finance lease element of on Statement of Financial Position PFI contracts	-	1,759,704	-	1,416,988
Trade payables	-	5,594	-	13,346
Other payables	198,331	262,246	180,045	283,957
	261,388	**2,298,766**	**230,023**	**2,058,387**
Total payables	**2,835,658**	**11,172,233**	**2,986,876**	**10,778,408**

22.2 Intra-Government balances

	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
	2009-10	2009-10	2008-09	2008-09
Balances with other central government bodies	1,567,892	103	1,746,752	348
Balances with local authorities	197,567	1,572	200,305	7,798
Balances with NHS Trusts	1,262,403	4,982	1,203,765	13,092
Balances with Public Corporations and Trading Funds	93,446	-	34,177	-
Subtotal: Intra-government balances	**3,121,308**	**6,657**	**3,184,999**	**21,238**
Balances with bodies external to government	5,752,159	2,292,109	5,535,022	2,037,149
Total payables at 31 March	**8,873,467**	**2,298,766**	**8,720,021**	**2,058,387**

23 Provisions for liabilities and charges

	Core Department					Consolidated					
	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
Balance At 1 April 2009	67,670	662,950	694,566	182,464	1,607,650	353,614	662,950	694,566	13,365,261	606,130	15,682,521
Provided in the year	15,599	59,980	403,709	63,111	542,399	32,662	59,980	403,709	3,229,027	253,584	3,978,962
Provisions utilised in the year	(70,151)	(48,084)	(351,774)	(36,024)	(506,033)	(113,952)	(48,084)	(351,774)	(786,991)	(152,357)	(1,453,158)
Provisions not required written back	-	(11,237)	(278,396)	(12,974)	(302,607)	(3,929)	(11,237)	(278,396)	(865,851)	(112,410)	(1,271,823)
Unwinding of discount	1,660	14,585	15,280	1,992	33,517	8,886	14,585	15,280	(41,991)	3,270	30
Balance as at 31 March 2010	**14,778**	**678,194**	**483,385**	**198,569**	**1,374,926**	**277,281**	**678,194**	**483,385**	**14,899,455**	**598,217**	**16,936,532**

	Core department					Consolidated					
	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
2009-10											
Current	5,489	47,261	241,693	111,800	406,243	35,297	47,277	241,693	1,641,183	349,212	2,314,662
Non Current	9,289	630,933	241,692	86,769	968,683	241,984	630,917	241,692	13,258,272	249,005	14,621,870
Expected timing of cash flow											
Less than 1 year	5,489	47,261	241,693	111,800	406,243	35,297	47,261	241,693	1,641,183	349,228	2,314,662
1 to 5 Years	9,032	179,124	193,354	3,448	384,958	124,716	179,124	193,354	4,222,765	119,558	4,839,517
Over 5 Years	257	451,809	48,338	83,321	583,725	117,268	451,809	48,338	9,035,507	129,431	9,782,353
Subtotal	**14,778**	**678,194**	**483,385**	**198,569**	**1,374,926**	**277,281**	**678,194**	**483,385**	**14,899,455**	**598,217**	**16,936,532**

Prior year

	Core Department					Consolidated					
	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
Balance At 1 April 2008	76,645	647,698	716,616	169,190	1,610,149	401,280	647,698	716,616	11,910,823	699,274	14,375,691
Provided in the year	1,376	60,137	584,482	93,888	739,883	19,560	60,137	584,482	2,640,613	272,871	3,577,663
Provisions utilised in the year	(10,056)	(50,217)	(622,298)	(58,058)	(740,629)	(66,512)	(50,217)	(622,298)	(769,225)	(208,358)	(1,716,610)
Provisions not required written back	(1,996)	(8,898)	-	(24,500)	(35,394)	(9,283)	(8,898)	-	(449,023)	(160,763)	(627,967)
Unwinding of discount	1,701	14,230	15,766	1,944	33,641	8,569	14,230	15,766	32,073	3,106	73,744
Balance as at 31 March 2009	**67,670**	**662,950**	**694,566**	**182,464**	**1,607,650**	**353,614**	**662,950**	**694,566**	**13,365,261**	**606,130**	**15,682,521**

	Core department					Consolidated					
	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
2008-09											
Current	9,085	45,273	248,138	105,050	407,546	44,553	45,289	248,138	1,388,181	345,169	2,071,330
Non Current	58,585	617,677	446,428	77,414	1,200,104	309,061	617,661	446,428	11,977,080	260,961	13,611,191
Prior year: expected timing of cash flow											
Less than 1 year	9,085	45,273	248,138	105,050	407,546	44,553	45,273	248,138	1,388,181	345,185	2,071,330
1 to 5 Years	27,346	171,481	446,428	47,762	693,017	144,996	171,481	446,428	3,862,179	180,382	4,805,466
Over 5 Years	31,239	446,196	-	29,652	507,087	164,065	446,196	-	8,114,901	80,563	8,805,725
Subtotal	**67,670**	**662,950**	**694,566**	**182,464**	**1,607,650**	**353,614**	**662,950**	**694,566**	**13,365,261**	**606,130**	**15,682,521**

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, (the last two being outside the Resource Accounting boundary), 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 essentially made up of two aspects, these being the value of new claims received in year, and an allowance for claims incurred during the year which are yet to be reported. Known reported claims are individually valued on the basis of likely costs to resolve the claim and probability factors to take account of the potential for a successful defence. Incurred but not reported (IBNR) claims are valued using actuarial models to predict likely values. In essence, therefore, the clinical negligence provision included in these Resource Accounts reflects an actuarially determined assessment of incidents that have occurred, including those yet to be reported, where it is more than 50% probable that the claim will be successful, and the amount of the claim can be reliably estimated. The amount provided is calculated on a percentage expected probability basis. Expenditure is likely to be incurred over a period of more than 20 years.

The NHSLA reviews its actuarial models twice each year in order to compare previous forecasts to actual activity. During 2009-10, the value of new provisions recorded in year was higher than in 2008-09, mainly as a result of movements in the actuarial forecasts relating to IBNR claims. For the second successive financial year, the number of new claims reported increased by approximately 10%. This has led to variations in actuarial forecasts for IBNR claims.

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 2010 include £35,584,000 for the RHA scheme, £2,020,799,000 under the ELS and £12,843,072,000 for CNST.

Of the total £14,899,455,000 clinical negligence provisions, £1,641,183,000 is expected to be payable within 1 year, £4,222,765,000 in 1 to 5 years and £9,035,507,000 after 5 years. This estimate is based on the anticipated timing and progress through the legal process.

Early Departure

This Account provides for the additional future costs, beyond the normal benefit awards for which employees are eligible under the terms of their pension scheme, arising from compensation payments for termination of employment through redundancy, severance or early retirement. The provision also takes account of arrangements with pension schemes under which employees could make prepayments to meet future liabilities. On the basis of the age of retirees, expenditure is likely to be incurred over a period of up to nine years.

The provision mainly relates to early retirement liabilities in Primary Care Trusts totalling £255,336,000. Of the total, £28,777,000 is expected to be payable within 1 year, £112,646,000 in 1 to 5 years and £113,913,000 after 5 years.

Further amounts of £4,474,000 are included in Strategic Health Authorities, of which £590,000 is expected to be payable within 1 year, £2,029,000 in 1 to 5 years, and £1,855,000 after 5 years; £2,693,000 in Special Health Authorities and Agency of which £441,000 is expected to be payable within 1 year, £1,009,000 in 1 to 5 years and £1,243,000 after 5 years; and £14,778,000 in the Department of Health, of which £5,489,000 is expected to be payable within 1 year, £9,032,000 in 1 to 5 years and £257,000 after 5 years.

Injury Benefits

The Resource 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 in nature and are granted for the life of the individual. The award is based on an assessment of the nature of the injury and the effect on the earning capacity of that individual as a result. Total claim provided for is £678,194,000 of which £47,261,000 is expected to be payable within 1 year, £179,124,000 in 1 to 5 years and £451,809,000 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 £483,385,000 of which £241,693,000 is expected to be payable within 1 year and £193,354,000 in 1 to 5 years and £48,338,000 after 5 years.

Other

This account has other provisions of £598,217,000. These include the following:

A Provision has been made for future support for patients who contracted HIV from contaminated blood supplies. Total claim provided for is £54,448,000 of which £7,600,000 is expected to be payable within 1 year, and £35,616,000 in 1 to 5 years and £11,232,000 after 5 years.

Other legal claims against Primary Care Trusts are £28,505,000 of which £9,443,000 is expected to be payable within 1 year, £7,692,000 in 1 to 5 years and £11,370,000 after 5 years. Further amounts of £5,206,000 are included in Strategic Health Authorities all of which is expected to be payable within 1 year.

Restructuring provisions by Primary Care Trusts are £14,797,000 of which £12,510,000 is expected to be payable within 1 year, £2,053,000 in 1 to 5 years and £234,000 after 5 years. Further amounts of £3,697,000 are included in Strategic Health Authorities all of which is expected to be payable within 1 year.

This Account provides for a scheme for persons infected by Hepatitis C contracted through blood and blood products in the course of treatment by the NHS. The amount provided is £37,881,000 of which £7,000,000 is expected to be payable within 1 year and £30,881,000 in 1 to 5 year.

Other miscellaneous provisions are £453,683,000 of which £303,771,000 payable within 1 year, £43,317,000 in 1 to 5 years and £106,595,000 after 5 years.

Within the 'Other Miscellaneous' category of provisions £5,136,000 relates to NHS equal pay claims. This is a significant reduction from the opening balance of £12,463,000. Following the judgement in the important test case of Hartley and Others v Northumbria Healthcare NHS Foundation Trust and Others, in April 2009, the number of equal pay claims, and the associated financial risk to either the NHS or the Department, has reduced significantly. The Core Department had no outstanding equal pay claims, and has therefore made no provision for equal pay in these accounts.

24 Notes to the Consolidated Statement of Operating Costs

24.1 Notes to the Consolidated Statement of Operating Costs by Departmental Strategic Objectives

Programme grants and other current expenditure (excluding administration costs) have been allocated as follows:

	2009-10	2008-09
	£m	£m
Objective 1-Better health and well being for all	31,990	30,346
Objective 2-Better care for all	70,896	65,470
Other	855	991
	103,741	**96,807**

This Note apportions costs across the Department's strategic objectives for 2009-10.

Costs have been apportioned using the best available data, primarily:

- programme budgeting data which collects NHS costs by disease; category;
- reference cost data that records the costs of hospital admissions and treatments;
- prescription costs;
- personal social services expenditure as recorded.

The programme budgeting and reference cost data sources are from 2008-09 and all other sources from 2009-10. Spend in the "other" category consists of EEA medical costs, Welfare Foods.

24.2 Operating Segments

The operating segments in this note are those used by the Departmental Board for financial management purposes. The operating segments are:

- NHS, which here covers
  - Strategic Health Authorities, and
  - Primary Care Trusts.

- DH Programme, which covers
  - the Department's own programme expenditure, including social care grants,
  - the Department's administration costs that are not charged to the Departmental Administration Cost Limit,
  - NHS Purchasing and Supply,
  - Special Health Authorities, and
  - Non-Departmental Public Bodies

- DH Administration, which covers those costs that are charged to the Departmental Cost Limit.

National Income Contributions are treated as central funding rather than being allocated to a particular segment.

	NHS		DH Programme		DH Admin		Total	
	2009-10	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10	2008-09
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Expenditure	95,959,949	87,002,807	7,780,591	9,804,128	234,417	233,565	103,974,957	97,040,500
Income	(2,323,611)	(2,304,782)	(1,243,659)	(1,460,697)	(7,216)	(5,201)	(3,574,486)	(3,770,680)
NI income	(18,025,336)	(18,941,620)					(18,025,336)	(18,941,620)
Net expenditure	75,611,002	65,756,405	6,536,932	8,343,431	227,201	228,364	82,375,135	74,328,200

This note has been prepared in accordance with the divergence to the FReM granted by HM Treasury that is from the full requirements to present operating costs and income by Departmental Strategic Objective.

25 Capital Commitments

	2009-10 £'000		2008-09 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Property, plant and equipment	200,555	451,421	188,487	446,497
Intangible non-current assets	2,403,581	2,414,137	2,724,833	2,727,733
Total contracted capital commitments at 31 March for which no provision has been made	**2,604,136**	**2,865,558**	**2,913,320**	**3,174,230**

The vast majority of Core Department capital commitments relate to contracts entered into by Connecting for Health for the delivery of the National Programme for IT (see note 28 for further details). The Department has a Capital Commitment for the purchase of residual interests in Independent Sector Treatment Centres(ISTC) schemes. The total capital commitment is £169 million falling due under leases over the next 5 years.

26 Commitments under leases

26.1 Operating leases

£127 million of the Department's minimum payments relate to the rental of office accommodation. The Department rents accommodation in 13 buildings and the term of the leases expire in the period 2011-2018.

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

26.1 Operating Leases

	2009-10 £'000		2008-09 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Payments recognised as an expense				
Minimum lease payments	25,572	328,408	21,034	261,713
Contingent rents	-	17,972	-	2,881
Sub-lease payments	-	11,053	-	9,307
Total	25,572	357,433	21,034	273,901

	2009-10 £'000		2008-09 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Total future minimum lease payments under non-cancellable operating leases				
Land:				
Expiry within 1 year	-	-	-	-
Expiry after 1 year but not more than 5 years	-	-	-	318
Expiry thereafter	-	-	-	-
	-	**-**	**-**	**318**
Buildings:				
Expiry within 1 year	25,226	43,622	19,786	32,951
Expiry after 1 year but not more than 5 years	82,865	131,145	48,387	91,242
Expiry thereafter	34,509	83,704	36,191	74,621
	142,600	**258,471**	**104,364**	**198,814**
Other:				
Expiry within one year	132	188,795	173	137,744
Expiry after 1 year but not more than 5 years	144	558,622	144	409,236
Expiry thereafter	-	1,095,499	-	1,086,014
	276	**1,842,916**	**317**	**1,632,994**

Receipts recognised as revenue

26.1 (continued)

	2009-10 £'000		2008-09 £'000	
	Core Department	**Consolidated**	**Core Department**	**Consolidated**
Minimum lease receipts	1,858	72,530	1,919	72,320
Contingent rents	-	355	-	243
Sub-lease receipts	-	92	-	-
Total	**1,858**	**72,977**	**1,919**	**72,563**

	2009-10 £'000		2008-09 £'000	
	Core Department	**Consolidated**	**Core Department**	**Consolidated**
Total future minimum lease receipts under non-cancellable operating leases				
Land:				
Expiry within 1 year	-	-	-	-
Expiry after 1 year but not more than 5 years	-	-	-	-
Expiry thereafter	-	-	-	-
	-	**-**	**-**	**-**
Buildings:				
Expiry within 1 year	1,798	1,890	1,858	2,105
Expiry after 1 year but not more than 5 years	6,881	7,249	6,818	7,186
Expiry thereafter	1,873	2,057	3,734	4,010
	10,552	**11,196**	**12,409**	**13,300**
Other:				
Expiry within one year	-	61,278	-	49,268
Expiry after 1 year but not more than 5 years	-	156,939	-	122,595
Expiry thereafter	-	462,371	-	400,396
	-	**680,588**	**-**	**572,259**

26.2 Finance leases

The Department's significant finance leases are the Ambulance Radio Programme, where leased assets include terminal equipment radio dispatchers and associated voice systems, and 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 £69,030,000 and the lease expires in 2019-20. The minimum payments of the Renal Programme are £16,865,000 and the lease expires in 2016-17. Commitments under finance leases are as follows:

Minimum lease payments:	**2009-10 £'000**		**2008-09 £'000**	
	Core Department	**Consolidated**	**Core Department**	**Consolidated**
Buildings:				
Rentals due within 1 year	1,965	51,465	984	39,249
Rentals due after 1 year but within 5 years	7,745	171,437	2,758	226,756
Rentals due thereafter	989	142,780	4,734	214,142
	10,699	**365,682**	**8,476**	**480,147**
Less interest element	(1,864)	(118,352)	(2,047)	(166,656)
	8,835	**247,330**	**6,429**	**313,491**
Other:				
Rentals due within 1 year	14,998	16,319	13,176	15,145
Rentals due after 1 year but within 5 years	45,990	55,514	38,541	50,018
Rentals due thereafter	25,265	25,265	22,557	22,611
	86,253	**97,098**	**74,274**	**87,774**
Less interest element	(15,917)	(16,816)	(13,744)	(15,425)
	70,336	**80,282**	**60,530**	**72,349**
Land:				
Rentals due within 1 year	-	750	-	87
Rentals due after 1 year but within 5 years	-	-	-	341
Rentals due thereafter	-	-	-	3,722
	-	**750**	**-**	**4,150**
Less interest element	-	-	-	(2,600)
	-	**750**	**-**	**1,550**

Present value of minimum lease payments:	**2009-10**		**2008-09**	
	Core Department	**Consolidated**	**Core Department**	**Consolidated**
Buildings:				
Rentals due within 1 year	1,862	45,022	933	29,140
Rentals due after 1 year but within 5 years	6,293	143,869	2,325	150,368
Rentals due thereafter	680	58,439	3,171	133,983
	8,835	**247,330**	**6,429**	**313,491**
Other:				
Rentals due within 1 year	14,252	15,345	12,509	14,158
Rentals due after 1 year but within 5 years	38,739	47,592	32,650	42,779
Rentals due thereafter	17,345	17,345	15,371	15,412
	70,336	**80,282**	**60,530**	**72,349**
Land:				
Rentals due within 1 year	-	750	-	11
Rentals due after 1 year but within 5 years	-	-	-	44
Rentals due thereafter	-	-	-	1,495
	-	**750**	**-**	**1,550**

26.3 Finance lease receivables

Amounts receivable under finance leases

Gross investments in leases

	2009-10 £'000		2008-09 £'000	
	Core Department	**Consolidated**	**Core Department**	**Consolidated**
Within 1 year	-	195	-	-
Between one and five years	-	944	-	-
After five years	-	9,785	-	-
Less future finance income	-	(1,169)	-	-
Present value of minimum lease payments	**-**	**9,755**	**-**	**-**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Statement of Financial Position	**-**	**9,755**	**-**	**-**

Of minimum lease payments

	2009-10 £'000		2008-09 £'000	
	Core Department	**Consolidated**	**Core Department**	**Consolidated**
Within 1 year	-	181	-	-
Between one and five years	-	886	-	-
After five years	-	8,688	-	-
Less future finance income	-	-	-	-
Present value of minimum lease payments	**-**	**9,755**	**-**	**-**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Statement of Financial Position	**-**	**9,755**	**-**	**-**
included in:				
Current finance lease receivables	-	181	-	-
Non-current finance lease receivables	-	9,574	-	-
Sub total	**-**	**9,755**	**-**	**-**

Rental revenue

Contingent rent	-	1,601	-	-
Other	-	63	-	-
Total rental revenue	**-**	**1,664**	**-**	**-**

27 Commitments under PFI and LIFT contracts

LIFT schemes deemed to be off Statement of Financial Position

In this financial year, 2 PCTs reported off-Statement of Financial Position LIFT schemes over £1,000,000 (2008-09 2 PCTs). The estimated capital value of these schemes over £1,000,000 is £5,894,000 (2008-09 £19,888,000). The assets which make up this capital value are not assets of the PCTs. The amount included within operating expenses for these schemes is £1,093,000 (2008-09 £1,146,000).

Details of the individual NHS LIFT schemes are included in the accounts of each PCT.

LIFT schemes deemed to be on Statement of Financial Position

In this financial year, 76 PCTs reported on-Statement of Financial Position LIFT schemes (2008-09 60 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 £36,354,000 (2008-09 £27,711,000).

Details of the individual LIFT schemes are included in the accounts of each PCT.

Total obligations for the on-Statement of Financial Position NHS LIFT Schemes due:

27.1 NHS LIFT Schemes on -Statement of Financial Position

	31 March 2010 £000s	31 March 2009 £000s
Not later than one year	106,051	80,748
Later than one year, not later than five years	431,737	325,594
Later than five years	2,387,227	1,945,323
Sub total	**2,925,015**	**2,351,665**
Less: interest element	(1,679,541)	(1,280,410)
Total	**1,245,474**	**1,071,255**

27.2 Charges to Expenditure

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 £37,514,000 (2008-09 £28,857,000).

The PCTs are committed to the following total charges:

27.2 NHS Scheme Charges to Expenditure

	31 March 2010 £000s	31 March 2009 £000s
NHS LIFT Scheme Expiry		
Not later than one year	20,012	12,955
Later than one year, not later than five years	79,606	52,260
Later than five years	1,092,562	814,431
Total	**1,192,180**	**879,646**

PFI Schemes deemed to be off Statement of Financial Position

In this financial year, 1 PCT reported an off-Statement of Financial Position PFI scheme with a value over £1,000,000 (2008-09 2 PCTs). The estimated capital value of these schemes is £1,200,000 (2008-09 £12,434,000). The assets which make up this capital value are not assets of the PCT. The amount included within operating expenses for this scheme is £450,000 (2008-09 £418,000).

Details of individual PFI schemes are included in the accounts of each PCT.

PFI schemes deemed to be on Statement of Financial Position

In this financial year, 28 PCTs reported on-Statement of Financial Position PFI schemes (2008-09 22 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 £29,256,000 (2008-09 £25,477,000).

Charges to Expenditure

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 £33,650,000 (2008-09 £25,895,000).

Details of individual PFI schemes are included in the accounts of each PCT.

The PCTs are committed to the following total charges:

27.3 PFI Schemes on -Statement of Financial Position

	31 March 2010 £000s	31 March 2009 £000s
Not later than one year	44,883	30,671
Later than one year, not later than five years	176,373	118,193
Later than five years	937,989	643,448
Sub total	**1,159,245**	**792,312**
Less: interest element	(616,581)	(414,255)
Total	**542,664**	**378,057**

27.4 PFI Scheme Charges to Expenditure

	31 March 2010 £000s	31 March 2009 £000s
NHS LIFT Scheme Expiry		
Not later than one year	9,891	15,357
Later than one year, not later than five years	36,153	50,372
Later than five years	674,442	733,718
Total	**720,486**	**799,447**

28 Other Financial Commitments

	2009-10 £'000		2008-09 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Expire within 1 year	885,558	921,110	323,133	323,283
Expire within 2 to 5 years	1,859,607	1,943,850	1,160,462	1,160,556
Expire thereafter	298,782	366,257	586,778	586,778
	3,043,947	**3,231,217**	**2,070,373**	**2,070,617**

At the end of the reporting period, Connecting for Health had entered into various contracts which if delivered according to the terms of those contracts would result in commitments of £2,068,129,000 (2008-09: £2,070,373,000) over the next 6 years. The contracts relate to the National Programme for IT, which is being delivered by the NHS Connecting for Health, part of the Department of Health, which is bringing modern computing systems into the NHS to improve patient care and service. Over the life of the programme, NHS Connecting for Health will connect over 30,000 GPs in England, almost 300 hospitals and give patients access to their personal health and care information, transforming the way NHS works. The contracts are such that the

obligation to pay does not arise until the suppliers have implemented the solution to the required locations and it has been accepted after a period of live running.

29 Financial Instruments

As the cash requirements of the Department are met through the Estimates process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body of a similar size. The majority of financial instruments relate to contracts for non-financial items in line with the Department's purchase and usage requirements and the Department is therefore exposed to little credit, liquidity or market risk.

30 Contingent Assets and Liabilities disclosed under IAS 37

30.1 Contingent Assets

The Department has no contingent assets.

30.2 Contingent Liabilities

The Department is the actual or potential defendant in a number of actions regarding alleged clinical negligence. In some cases, costs have been provided for or otherwise charged to the accounts. In other cases, there is large degree of uncertainty as to the Department's liability and to the amounts involved. Possible total expenditure might be estimated at £7.28 billion (2008-09: £6.52 billion), although £6.62 billion (2008-09: £5.79 billion) relating to the Clinical Negligence Scheme for Trusts (CNST), Property Expense Scheme (PES) and Liability to Third Parties Scheme (LTPS) would be expected to be met by payments receivable from NHS Trusts.

Within Primary Care Trusts' accounts at 31 March 2010, there were net contingent liabilities of £46,993,000 (2008-09: £46,761,000). These include potential liabilities for continuing care, equal pay and data challenges to providers. Primary Care Trusts have provided for these liabilities where they can reasonably estimate the likely value of potential claims received. Where these obligations cannot be reliably estimated a contingent liability has been recorded.

The joint venture contract between the Information Centre 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 IC would be obliged to buy out their share of the business, at market value, if no other buyer can be found.

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. It has not been possible to make full payment to all the affected individuals in this financial year. There are 60 cases where the Department is seeking information from the Estate and around 50 people for whom the Department has no current address. An information campaign seeking claims from individuals who may also have been affected has resulted in 1,136 information packs being issued and in excess of 217 claims being made. Although at this stage the Department cannot estimate how many of these claims will be successful nor how much benefit will eventually be owed, to date 17 claims have been successful, totalling £1,477,085.81.

Within Strategic Health Authorities' accounts at 31 March 2010, there were net contingent liabilities of £10,961,000 (2008-09: £11,003,000). These relate to Agenda for Change grade reviews, college pension costs for former NHS Employees, redundancies, asbestos claims and claims on Liabilites to Third Party Schemes (LTPS).

31 Contingent Liabilities not required to be disclosed under IAS 37 but included for Parliamentary reporting and accountability

31.1 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 2009		Increase in year	Liabilities crystallised in year	Obligation expired in year	31 March 2010		Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	£'000	No.	£'000
Guarantees:	-	-	-	-	-	-	-	-
Indemnities:	96,400	3	-	-	(2,050)	94,350	3	94,350
Letters of comfort			-	-	-	-	-	-
	96,400	**3**	**-**	**-**	**(2,050)**	**94,350**	**3**	**94,350**

31.2 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 30 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.

32 Losses and Special Payments and other Accounting Notes

	2009-10 Total		2008-09 Total	
	Cases	£'000	Cases	£'000
Total	40,072	944,851	18,963	131,480
Cases over £250,000				
Cancellation of Public Dividend Capital (PDC)	1	484,685	-	-
Administrative write-offs	-	-	-	-
Fruitless payments	1	29,600	1	7,649
Constructive Loss	3	109,110	-	-
Store losses	5	149,752	2	13,144

Department of Health share of National Insurance Contributions Losses

Included in total losses, the Department has recorded a technical loss of £166,576,000, which is its share of the overall loss relating to National Insurance Contributions. Such losses occur when contributions become uncollectible from companies ceasing to exist during the year. Her Majesty's Revenue & Customs (HMRC) allocates this category of loss to those Departments which are partially funded from these contributions, on a proportional basis. It should be noted that the disclosure of the National Insurance Contributions 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 £484,685,000 relating to PDC cancelled in 2009-10. This was in respect of the outstanding PDC of five NHS Trusts which were dissolved on 1 April 2009 and subsequently merged to form two new NHS Trusts. A total of £528,237,000 PDC was issued to these new organisations in the form of Originating Capital by means of a Statutory Instrument. The £43,552,000 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

Pandemic Flu
The worldwide surplus of swine flu vaccine means that there is no active market in which the Department's excess pandemic flu inventory can be sold. Consequently, the value of unused vaccine must be impaired to zero. The Department has therefore recognised a total constructive loss of £98.40 million in this financial year in respect of this excess inventory. This accounting entry recognises the likely market value and value in use of the inventory. The vaccine itself, which remains medically effective, will be retained as a strategic reserve for possible future use if the virus mutates.

The Department has recognised a further £72.90 million impairment and store loss in respect of antiviral medicines made available to the NHS during the swine flu outbreak. In some cases, the Department has been unable to obtain documentary evidence that antiviral medicines returned from the NHS had been stored in accordance with the terms of the respective Wholesale Dealers Licence (WDL). This does not mean that these antiviral medicines were not stored by the NHS in compliant conditions, but rather that the Department does not have the documentary evidence to prove that this was the case. The Department will therefore write this inventory off financially, but will again retain it for possible future use.

The Department has recognised a fruitless payment loss of £29.60 million in respect of a provision made in these Resource Accounts for pandemic flu inventory it will receive in 2010-11 under existing purchase agreements.

A further £23.50 million store loss has been recognised to take account of date-expired vaccine inventory. This mainly relates to vaccine purchased a number of years ago as part of preparations for an outbreak of avian influenza.

Emergency Preparedness
The Department holds countermeasures inventory for use in the event of an accidental or malicious release of chemical, biological, radiological or nuclear material. As with all inventory, each of the relevant countermeasures has a shelf-life assigned to it at the time of manufacture. Some inventory has been retained, despite its assigned shelf-life having expired, with a view to testing its continued efficacy. As this testing had not been completed at the date of these accounts, the value of this inventory is considered to be impaired to zero value. The total value of this store loss recognised in these accounts is £50.28 million.

A further £3.08 million store loss has been recorded in respect of childhood and adult vaccine inventory. This loss arose following a national campaign relating to Haemophilus influenza type b vaccine between September 2007 and March 2009. The date of surplus inventory from this campaign expired in December 2009. An estimate of the number of doses required was based on uptake data received from the NHS and the Health Protection Agency. However, demand far exceeded this initial estimate, and further material was purchased to meet the higher demand. A subsequent fall in demand resulted in the surplus vaccine inventory.

Retained estate losses
The Department has recorded a total constructive loss of £10.71 million in respect of the Retained Estate. This relates principally to operating leases on buildings for which neither the Department nor the NHS has any further use, but where a financial obligation remains in respect of the lease. To mitigate this loss, the Department has sub-let a number of these buildings.

32(b) Special Payments

	2009-10 Total		2008-09 Total	
	Cases	£'000	Cases	£'000
Total	1,802	33,601	1,059	31,993
Details Of Cases Over £250,000	12	29,804	7	26,135

Ex Gratia Payments

The Department of Health has made an ex-gratia payment totalling £855,000 relating to a court case involving the closure of a care home in 1999. The payment is an out-of-court settlement of a case that had been lodged with the European Court of Human Rights. The care home was closed by urgent cancellation of registration under the Registered Homes Act 1984. Although an appeal by care home owners to the Registered Homes Tribunal was successful this was not heard in sufficient time to prevent the business becoming unviable.

Establishing the Family Restoration fund for Former Child Migrants

The Prime Minister announced on 24 February, as part of the UK National apology to former child migrants, the establishment of a fund to enable former child migrants to be reunited with their families. The majority of surviving child migrants (around 1500) live in Australia, with much smaller numbers in Canada and New Zealand. Some former Rhodesian child migrants live in Zimbabwe and a few are in South Africa. An unknown number have returned to the UK. Most are elderly, although some are in late middle age, having been sent as children in the 1960s. Many have still not been reunited with their families and we anticipate that the fund will be used to a large extent to facilitate trips to the UK for family occasions which will, sadly, commonly be funerals or visits to ill relatives. The fund will be used to reimburse the costs to former child migrants of rebuilding relationships with their families. This might mean paying for travel and accommodation to attend, for example, the funeral of a parent or sibling.

Equally, it might involve paying the costs of flying immediate family members to the countries where child migrants live, to enable them to meet for the first time or attend family events (weddings, funerals etc). We have agreed that it can be used to reimburse the costs of UK passports for those former child migrants who no longer have them. Having secured a total of £5,000,000 (from discretionary Department of Health programme budgets and including a £1,000,000 transfer from DCSF), HM Treasury are allowing us to make a Payment in Advance of Need of £3,500,000 in financial year 2009-10. The rest of the payment will be made in future years, the bulk of it in 2010-11, from Department of Health discretionary programme budgets.

Department of Health legal services have been involved at every stage and have advised that, in order to ensure that the Fund can support all former child migrants, we will need to make grants under two different powers: section 70 of the Charities Act 2006 and reliance on the Appropriation Act. This will ensure that funding will be available to support those child migrants either sent from or returning to, Wales, Northern Ireland and Scotland. Officials in the other countries of the UK have been informed of the arrangements. A third party will administer the Fund, under the terms of a grant agreement. The agreement will set out the criteria for accessing the Fund, governance arrangements etc. The Grant letter transferring the money to the third party sets out clearly the accounting arrangements that must be applied in respect of these funds, as well as other issues relevant to the administration of the Fund.

Losses and Compensation Arising from ISTC. National Decontamination and PFI Schemes (£24.04 million)

ISTC Schemes

In 2007 the Department, following consultation with HM Treasury, carried out a revalidation of all schemes in wave 2 of its Independent Sector Treatment Centre procurement programme. As a result of this revalidation the Department announced in November 2007 that a number of the schemes would be cancelled or significantly re-scoped.

The Department's Resource Accounts for the years 2007-08 and 2008-09 set out details of payments for wasted costs made in those years in accordance with the framework referred to below. In 2009-10 the Department has continued to receive and validate further claims for ex-gratia compensation payments in accordance with its "Framework for the identification and validation of claims arising from phase 2 ISTC schemes cancelled or re-scoped as a result of the revalidation" published in March 2008. Details are set out in the following table:

	2009-10 £m Paid	2009-10 £m Accrued
North East Diagnostics - Alliance Medical and Care UK	3.20	-
Essex - Care UK	2.70	-
Cumbria/Lancs, GM CATS "A", NE Yorks/N Lincs (combined)	-	4.00
East Diagnostics	-	2.95
London South/GC09	-	0.14
Decontamination scheme - Dorset, Somerset, North Devon	0.30	-
PFI scheme - Leicester Pathway	-	10.75
Totals	6.20	17.84

The accruals shown in the above table in respect of East Diagnostics and the combined claim relating to Cumbria & Lancashire and two other schemes, represent claims where, at the year end, validation was complete but settlements had not been concluded.

The Department has now completed the validation of all claims received for wasted bid costs in respect of wave 2 of the ISTC programme and does not anticipate receiving any further such claims.

National Decontamination Schemes

During the year, the Department received a claim for wasted bid costs in connection with a procurement that formed part of the National Decontamination Programme. This related to the Dorset, Somerset and North Devon scheme, which the NHS collaboration cancelled in August 2008. The Department considered and validated the claim by reference to the principles set out in the ISTC Framework referred to above. The amount paid as a result is set out in the above table.

PFI schemes

An accrual has been made in relation to a claim for wasted bid costs relating to the Leicester "Pathway" PFI scheme. The procurement was cancelled by the University Hospitals of Leicester NHS Trust in 2007. The Department began to validate a claim for wasted bid costs in March 2010, in accordance with its "Framework for the identification and validation of heads of claim arising from cancelled or re-scoped PFI schemes" published in February 2007. The validation had not been completed at the year-end. The amount of the accrual is £10,750,000.

PCT Special Payments

There were 3 special payments over £250,000 made in 2009-10. Two of these special payments were made by Wandsworth PCT and one special payment by Harrow PCT.
Wandsworth PCT made a compensation payment of £582,487 regarding an employer's liability claim following a death in service relating to asbestos contact in the 1970's. The NHS Litigation Authority is dealing with the case, however, the claim pre-dates insurance cover.
Wandsworth PCT also had to pay the staff costs of £330,000 for a social enterprise that provided prison healthcare in order to maintain service following the liquidation of the social enterprise.
Harrow PCT made a compensation payment of £500,000 following an employment tribunal.

33 Related Party Transactions

The Department is the parent of the executive agencies and other bodies within the group and sponsor of trading funds, executive non-Departmental public bodies disclosed in Note 36. These bodies are regarded as related parties with which the Department has had various material transactions during the year.

In addition the Department has had a small number of transactions with other Government Departments and other central Government bodies.

Other related parties transactions and the extent of the transactions are summarised below:

	Sub Note	Payables with related party 2009-10 £000's	Purchases from related party 2009-10 £000's	Receivables with related party 2009-10 £000's	Sales to related party 2009-10 £000's
Cambridge University	1,5	-	2,356	-	-
Picker Europe	2	-	160	-	-
Tesco PLC	3	-	20	-	-
Job Centre Plus (Department of Works and Pensions)	4	521	24,836	32	4,317
Marie Curie	6	-	394		
Thames Valley University	7	-	306	-	22
Queen's Nursing Institute	8	-	65	-	-
SBS	9	-	4,608	1	81
University of Newcastle	10	4	4,113		
London Borough of Croydon	11	-	2,622		
King's Fund	12	-	1,712	-	49
University of Birmingham	13	-	10,389	-	16
Imperial College	14	-	6,216	-	2,420
London School of Economics	15	-	1,309	-	39
Wigan Borough Council	16	-	2,039	-	-

Sub Note
1) Sally Davies' husband is employed by Cambridge University as an academic clinician
2) Bruce Keogh is a Trustee for the charity Picker Europe
3) Clare Chapman is a shareholder in Tesco PLC
4) Clare Chapman is a non executive director of Job Centre Plus
5) Clare Chapman is a Board Advisor on Cambridge University Judge Business School
6) Chris Beasley is a Trustee for Marie Curie.
7) Chris Beasley is a Pro-Vice Chancellor for Thames Valley University
8) Chris Beasley is a Fellow of the Queen's Nursing Institute
9) Shared Business Services is a joint venture between the Department of Health and Steria
10) Liam Donaldson is the Chancellor of Newcastle University
11) Jonathon Rouse is Chief Executive Officer of the London Borough of Croydon
12) Mark Britnall is a Senior Associate of the King's Fund
13) Mark Britnall is a Senior Fellow at the University of Birmingham
14) Lord Darzi has a non financial interest in Academic Health Science Centre, Imperial College, London
15) Baroness Thornton is a governor at the London School of Economies
16) Andy Burnham received rent abatement from Wigan Council

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.

34 Third Party Assets

	1 April 2009 £'000	Gross inflows £'000	Gross (outflows) £'000	31 March 2010 £'000
Monetary assets				
Bank balances	31,584	1,049	(27,193)	5,440
Monies on deposits	-	-	-	-
Total	31,584	1,049	(27,193)	5,440

The above monetary assets, at 31 March 2010, are £3,237,000 which is held by PCTs at bank and in hand in respect of monies held by PCTs on behalf of patients and £2,203,000 which is held by the Department of Health in an Escrow account.

35 Events after the Reporting Period

Following The Department of Health published a White Paper on 12 July: "Equity and excellence: Liberating the NHS", which sets out the Government's plans for the future direction and priorities for the whole health system. In particular:

- In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning services to local consortia of GP practices.
- A statutory NHS Commissioning Board will be created to support GP consortia, and this will provide leadership for quality improvement and promote patient and carer involvement and choice. The Board will be established in shadow form in 2011, and will go live in April 2012. The Secretary of State will set clear financial controls and associated financial instructions for this Commissioning Board. These will be in line with the Department's continued Parliamentary accountability for expenditure and HM Treasury requirements.
- Strategic Health Authorities will be abolished as statutory bodies during 2012-13. The Department will radically reduce its own NHS functions, and from 2012, the NHS Commissioning Board will perform those national functions relevant to its new role that are currently carried out by the Department of Health.
- Following establishment of the GP consortia and the NHS Commissioning Board, Primary Care Trusts will no longer have NHS commissioning functions. Therefore, to realise administrative cost savings, and to achieve greater alignment with local government responsibilities for local health and well being, the Government will transfer PCT health improvement functions to Local Authorities, and abolish PCTs from 2013.
- Autonomy in commissioning will be matched by autonomy for providers. Within three years, the Department will support all NHS Trusts to become foundation trusts. Providers will no longer be part of a system of top-down management. They will instead be governed by a stable, transparent and rules-based system of regulation. The Department will develop Monitor, the current independent regulator of foundation trusts, into an economic regulator from April 2012, with responsibility for all providers of NHS care from April 2013.
- The Government has guaranteed that health spending will increase in real terms in every year of this Parliament. With that protection comes the same obligation for the NHS to cut waste and transform productivity.
- Creating a new Public Health Service within the Department of Health.

Arms Length Bodies

Given the wider system reforms outlined in the White Paper – *'Equity and excellence: Liberating the NHS'* the Department is reviewing the scope and functions of its Arms Length Bodies. Subject to Parliamentary approval, organisations that do not need to exist will be abolished, and functions that need to remain will be streamlined either within existing organisations or brought within the Department to cut costs and remove duplication and burdens on the NHS.

The structural changes outlined will have a significant impact on organisations and their staff. For the purposes of IAS 10, it is not possible to disclose the extent and nature of all costs associated with this transaction. However, the NHS operating framework for 2010-11 set a reduced ceiling for SHA and PCT management costs, the achievement of which will require a saving of approximately £850 million to be made over the next four years. This reduction will start with savings of £222 million in 2010-11, followed by a further reduction of £350 million in 2011-12, with the balance being achieved by 2013-14.

Changes to pension indexation

It was announced in the Budget on 22 June 2010 that the Government intends to adopt the Consumer Price Index (CPI) for the indexation of public service pensions from April 2011. This will have an impact upon the future operation of the pension schemes that the Department of Health provides to employees.

The Accounts were authorised for issue by the Accounting Officer on the 23 July 2010.

36 Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2009-10:

Consolidated in the Department's Resource Accounts	Not Consolidated
Supply financed agencies	
NHS Purchasing and Supply Agency*	
	Trading Funds
	Medicines & Healthcare Products Regulatory Agency
	Executive Non-Departmental Public Bodies
	Appointments Commission
	Human Fertilisation and Embryology Authority
	General Social Care Council
	Alcohol Education Research Council
	Health Protection Agency****
	Care Quality Commission
	Independent Regulator of NHS Foundation Trusts
	Council for Healthcare Regulatory Excellence
	Human Tissue Authority
	Postgraduate Medical Education and Training Board**
Other Bodies	
Strategic Health Authorities	NHS Trusts
Primary Care Trusts	Food Standards Agency
Special Health Authorities:	NHS Blood and Transplant
NHS Business Services Authority	NHS Direct
The Information Centre	NHS Professionals***
National Institute for Health and Clinical Excellence	Social Care Institute for Excellence
NHS Litigation Authority	NHS Foundation Trusts
National Treatment Agency for substance misuse	
National Patient Safety Agency	
NHS Institute for Innovation and Improvement	

* NHS Purchasing and Supply Agency ceased to exist at 31 March 2010

** On 1st April 2010 the Postgraduate Medical Education and Training Board merged with the General Medical Council

*** NHS Professionals Special Health Authority was abolished on 1 April 2010 and replaced by NHS Professionals Limited

**** Health Protection Agency took over the functions of the National Biological Standards Board on the 1 April 2009

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**
Statement of Financial Position	Balance sheet
Non-current	Fixed
Inventories	Stocks
Receivables	Debtors
Payables	Creditors
Property, plant and equipment	Tangible assets

GLOSSARY OF GOVERNMENTAL TERMS

Administration Cost 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

Appropriations-in-Aid (A–in-A) Expected income that arises during the normal course of business that the Department is authorised to retain. The income is voted by Parliament in the Estimate and is available to offset against expenditure in the current financial year. Any Excess A-in-A over the authorised limit must be surrendered to the Consolidated Fund. These are included within the Operating Cost Statement and disclosed separately in the Summary of Resource Outturn.

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

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

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

Core Department. The Department of Health only. It does not include any of the bodies listed in Note 37.

Cost of Capital Charge A charge to reflect the opportunity cost of Government funding invested in assets of the Department and included to ensure that the full cost of services is reflected in departmental accounts. It is calculated at a rate of 3.5% (2008-09 3.5%) on the average net assets (capital employed) held by the Department over the year. The charge is included in the Operating Cost Statement and apportioned between administration and programme costs.

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.

Non-budget Expenditure that is not included in either DEL or AME. For the Department of Health this includes the grant in aid to non-departmental public bodies, NHS Trusts and Foundation Trusts Public Dividend Capital issues and repayments and NHS Trusts and Foundation Trusts loans and repayments and repayment of interest.

Non-operating Cost A-in-A Comprises proceeds from sales of assets and repayment of voted loans which can be retained by the Department. These are included in the Summary of Resource Outturn.

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.

Request for Resources (RfR) The basic unit of Parliamentary control for which resources to the Department are granted. Each RfR within the Estimate represents an accruals based measure of expected expenditure within the Department for items which fall within that RfR. The Summary of Resource Outturn, the Operating Cost Statement and Note 2 analyse net resource outturn by RfR.

Annex B

NAO REPORTS PRINCIPALLY FOR DEPARTMENT OF HEALTH

Supporting people with autism through adulthood (June 2009)

The National Audit Office (NAO) reported that Government departments and local health and social care organisations did not have enough information on the number of adults with autism and that they lacked a full understanding and awareness of the condition, limiting their ability to plan and deliver services effectively.

Over 80 per cent of NHS organisations and local authorities surveyed by the NAO did not know how many adults in their area had low-functioning autism, and only 12 per cent were able to give numbers for adults with high-functioning autism. GPs and social care staff had low awareness of autism and how to diagnose it, with 80 per cent of GPs surveyed reporting that they need additional guidance and training in order to identify and treat patients with autism more effectively.

The NAO report also reported that adults with high-functioning autism in particular were often not getting appropriate support, as health and social care services traditionally cater only for people with a learning disability, a physical illness or disability or a mental health problem. Eligibility criteria for learning disability services, which usually exclude people with an IQ of 70 or above, mean that people with high-functioning autism may be unable to access these services. Similarly, adults with autism are not usually eligible for mental health services unless they develop a mental illness (which autism is not). The NAO concluded that providing specialised support could improve outcomes for this group of people and their carers, and potentially enhance value for money, as the costs of establishing such support could be outweighed over time by overall savings.

Reducing healthcare associated infections in hospitals in England (June 2009)

The NAO report stated that the Department had met its target to reduce MRSA bloodstream infections by 50 per cent by 2008 and had made encouraging progress towards its target to reduce Clostridium difficile (c difficile) infections. However, the report also said that blood stream infections due to other causes may be increasing and that there were no national data that capture information on some of the most common healthcare associated infections, such as urinary tract infections and pneumonia.

The report stated that the Department introduced a target to reduce MRSA across all NHS Trusts by 50 per cent by 2008 and C. difficile by 30 per cent by 2010-11 and that MRSA had been reduced by 57 per cent and C. difficile by 41 per cent by the end of March 2008. While a quarter of NHS Trusts had reduced MRSA by more than 80 per cent, in 12 per cent of trusts there was an increase in MRSA infections. 29 per cent of trusts reduced C. difficile by more than 50 per cent, but in 19 per cent of hospital trusts the numbers of C. difficile infections increased.

Since the introduction of targets to reduce MRSA and C. difficile, the Department has spent some £120 million on central initiatives to tackle healthcare associated infections. There had also been unquantifiable administrative costs and local expenditure on the drive to reduce infection rates. These central initiatives, together with action at NHS Trust level have led to savings on treatment of between £141 million and £263 million, as well as reducing discomfort, disability and, for some, death that might have been caused by these avoidable infections.

Services for people with rheumatoid arthritis (July 2009)

The NAO reported that too many people with rheumatoid arthritis were not being diagnosed or treated quickly enough, and some services for people with the disease were not sufficiently coordinated. Delay in treatment is detrimental to patients' health, their quality of life and, with three quarters of people of working age at the time of being diagnosed, both the local and national economy.

The report estimated that approximately 580,000 adults in England currently suffer from the disease, with a further 26,000 new cases diagnosed each year. The NAO estimated that the cost to the economy of sick leave and work-related disability for people with rheumatoid arthritis was £1.8 billion a year and direct costs to the

NHS were an estimated £560 million annually. Better coordinated services would lead to earlier identification of new cases, productivity gains for the economy, and improved outcomes for patients.

The NAO also reported that early diagnosis is the key to the successful treatment of rheumatoid arthritis (ideally within three months of symptom onset), The average length of time from symptom onset to treatment is currently nine months, compared to the clinically recommended period of three months, and this has not improved in the past five years. However, public awareness of the disease, at the time of the report, was low. Between half and three quarters of people with rheumatoid arthritis delay seeking medical help from their GP for three months or more following symptom onset and around a fifth delay for a year or more. Rheumatoid arthritis is difficult to diagnose and requires specialist knowledge. Few GPs have the specialist expertise required to diagnose the condition which can lead to further delays, with patients on average visiting their GP four times before being referred to a specialist for diagnosis and treatment.

Young people's sexual health: the National Chlamydia Screening Programme (November 2009)

The report by the NAO found that the delivery of the Government's programme to control chlamydia infection in young people had not to date demonstrated value for money. The Department implemented the Programme in three phases but in 2008-09, six years after the Programme's launch, testing levels were only just beginning to reach the point where they are likely to significantly reduce the prevalence of chlamydia. According to the report, the devolved delivery, through Primary Care Trusts, had resulted in duplication and inefficiency.

In 2007-08, five years after the Programme's launch, 4.9 per cent of under-25s were being tested under the Programme, against a target of 15 per cent. In 2007, the Department made the Programme a priority for PCTs, which led to a significant increase in activity. Average testing levels rose to 15.9 per cent by the end of 2008-09, against a target of 17 per cent. Combined with testing in other settings such as genito-urinary medicine (GUM) clinics, overall testing rates in around half of PCTs had reached 26 per cent or more, the point at which testing was expected to begin to significantly reduce chlamydia prevalence.

There are no exact figures available on the costs of the Programme, but the NAO estimated that around £100 million had been spent to date. PCTs have had little guidance on costs to help them deliver the Programme efficiently and spending had varied from place to place. The NAO reported that there had been duplication of effort, with, for example, 45 different brands developed for the Programme in different parts of England.

The NAO estimated that savings of £17 million could have been made in 2008-09, if all PCTs had delivered tests for £33 (the Health Protection Agency's calculation of an achievable cost per test in established local programmes), rather than the average of £56 per test, in that year.

Improving dementia services in England – an Interim Report (January 2010)

The NAO reported that the Department had developed an ambitious and comprehensive strategy for dementia, with strong national leadership, but that there had not been a robust approach to implementation. Despite the Department stating, since 2007, that dementia was a national priority, it had not been given the levers or urgency normally expected by the NAO for such a priority and there is a risk that value for money will remain poor unless these weaknesses are addressed urgently.

The strategy, Living Well with Dementia, was published in February 2009. Because of the timing, dementia was not included in the Department's tier 1 Vital Signs indicators for the NHS, through which it monitors performance centrally. Other levers built into the NHS' devolved management arrangements, such as joined-up commissioning and comprehensive performance information, are not yet fully developed.

The NAO reported that the Department did not have evidence on current and future costs and benefits and that the strategy was likely to cost much more than the estimated £1.9 billion over ten years. The report found some examples of excellent practice which could already be making a difference if adopted across the country. However, it was not clear that services were making best use of money; it would not be clear until a baseline audit was completed, how the first £60 million of additional baseline funding for primary care trusts to implement the dementia strategy had been spent, or whether it had actually been spent on dementia.

Progress in improving stroke care (February 2010)

The NAO reported that the Department's strategy for stroke care increased the priority and awareness of the condition and started to improve patients' care and outcomes. The report stated that actions taken since 2006 had improved the value for money of stroke care; but improvements had not been universal and improvements in follow-up care had not matched those of acute care services.

The National Stroke Strategy was underpinned by strong national leadership and performance indicators as well as £59 million of central funding over the first two years, £30 million of which was allocated to local authorities specifically to provide support services to stroke patients and their carers. With this clear focus from Ministers and the Department, the NHS has started to deliver better care from stroke services, and outcomes for patients are also improving. The NAO estimated that stroke patients' chances of dying within ten years have reduced from 71 to 67 per cent since 2006.

Patients treated in a specialist stroke unit are more likely to survive, have fewer complications and regain their independence, and all relevant hospitals in England now have such a unit, although the services provided and time spent in the unit vary. Stroke patients should be immediately admitted to a specialist stroke unit; however in 2008 only 17 per cent of stroke patients reached the stroke unit within four hours of arrival at hospital. Brain imaging is also very important for stroke patients but many patients were not given a scan quickly enough and access at weekends and evenings was significantly more limited.

The report found that there was better awareness of the symptoms of stroke, and that it is treated as a medical emergency, following the Department's 'Stroke: Act FAST' advertising campaign, launched in February 2009. The number of calls categorised as being a suspected stroke during April to June 2009 increased by 54 per cent in comparison with the same period in 2008.

However, the NAO also reported that health and social care services were not working as well together as they could. A third of patients were not getting a follow-up appointment within six weeks and only a half of stroke survivors in the NAO's survey said that they were given advice on further stroke prevention when leaving hospital.

Major trauma care in England (February 2010)

The NAO reported that there was unacceptable variation in major trauma care in England depending upon where and when people are treated. Care for patients who have suffered major trauma, for example following a road accident or a fall, had not significantly improved in the last 20 years despite numerous reports identifying poor practice, and services were not being delivered efficiently or effectively.

The report found that survival rates varied significantly from hospital to hospital, with a range from five unexpected survivors to eight unexpected deaths per 100 trauma patients, reflecting the variable quality of care. The NAO estimated that 450 to 600 lives could be saved each year in England if major trauma care was managed more effectively.

For best outcomes care should be led by consultants experienced in major trauma, but major trauma is most likely to occur at night and at weekends, when consultants are not normally in the emergency department: only two hospitals had 24-hour consultant care, seven days a week, according to the report.

The NAO said that major trauma care was not coordinated and that there were no formal arrangements for taking patients directly for specialist treatment or transferring them between hospitals. CT scanning is very important for major trauma patients, however, a significant number of patients that need a scan do not receive one.

The report also found that not enough patients that need a critical care bed were given one and that access to rehabilitation services, which can improve patients' recovery, quality of life and reduce the length of hospital stay, varies across the country. The costs of major trauma care are not well understood. The estimated annual lost economic output from deaths and serious injuries from major trauma was between £3.3 and £3.7 billion, when the report was published.

The Community Pharmacy Contractual Framework and the retained pharmacy margin (March 2009)

The NAO published a technical review of the operation of the Community Pharmacy Contractual Framework over the four years since its introduction in April 2005.

Annex C

PUBLIC ACCOUNTS COMMITTEE REPORTS PRINCIPALLY FOR THE DEPARTMENT

End of life care (May 2009)

The Committee found that the provision of end of life care is becoming increasingly complex, with people living longer and the incidence of frailty and multiple conditions in older people rising. People approaching the end of their life often require a complex mix of health and social care services provided in hospitals, care homes, hospices and their own home. End of life care is delivered by many people, including families and friends, specialist palliative care staff, and generalist staff such as doctors, nurses and social workers, for whom end of life care represents a varying proportion of their role.

The Committee concluded that while most people express a preference to die at home, 60% die in an acute hospital even when there is no clinical need for them to be there. They recommended that people should have the right to die in the place of their choice and that the End of Life Care Programme team should work with PCTs and SHAs to develop the means to share information on patient preferences.

Financial Management in the NHS: Report on the NHS Summarised Accounts 2007-08 (May 2009)

The Committee found that the Department and the NHS achieved a surplus of £1,674 million in 2007-08, representing almost 2% of total available resources and the equivalent of about one week's funding for the whole NHS. The surplus represents funding that was made available by Parliament for healthcare in 2007-08 but which was not used.

The Committee also found that the Department and the NHS face a number of challenges, going forward, including changes to the financial reporting framework and timetable, and further system reforms under which a quality element will be introduced into how NHS organisations are funded. The surplus generated and better financial management should, if maintained, help deal with the financial implications of meeting these challenges.

The Committee concluded that whilst some contingency planning is sensible, there is a real risk that patients lose out because the NHS is not spending its allocated funding on treating them. Managing this risk requires NHS bodies to be more adept at forecasting demand for healthcare, budgeting in a way that best matches resources to activity levels, while having the flexibility to shift resources quickly as new priorities arise.

NHS Pay Modernisation in England: Agenda for Change (June 2009)

The Committee found that Agenda for Change, the pay modernisation programme for 1.1 million NHS staff in England, representing a pay bill of £28 billion in 2007-08, was implemented between December 2004 and December 2006. It was expected to bring about new ways of working which would contribute to improve patient care and to more efficient delivery of services. In the business case, the Department predicted that Agenda for Change would bring about total savings of £1.3 billion over the first five years.

The Committee concluded that the simplification of the pay system was a considerable achievement requiring a major job evaluation process to assess each role within the NHS and to transfer staff to new pay bands. The new pay system replaced previous complex pay arrangements which prevented staff developing new roles and obstructed the creation of modern team-working, focused on patient care.

The Committee recommended that the Department should identify and promote good practice examples, where Trusts have used Agenda for Change to make measurable improvements in efficiency and patient care, for example, by staff taking on new roles and working more flexibly.

The Committee was concerned that, between 2001 and 2005, NHS productivity fell by 2.5% a year on average, as measured by the Office for National Statistics (ONS) and therefore recommended that the Department should set a timetable with ONS to reach an agreed methodology for measuring NHS productivity that fully reflects improvements in the quality of healthcare.

Reducing Alcohol Harm: health services in England for alcohol misuse (July 2009)

The Committee found that in 2004, alcohol harm became subject to a national government strategy, which was updated by the Department and the Home Office in 2007.

The Committee were advised that PCTs are free to decide for themselves how much to spend on services to address alcohol harm, but were concerned that many PCTs did not, in fact know what they spend on such services. Across England there was little correlation between need and expenditure. The Committee concluded that where services were commissioned there was frequently a lack of performance monitoring and examination of whether what was provided represented value for money.

The Committee also concluded that the Department had yet to demonstrate its ability to effectively influence local commissioners, the drinks industry, and people's drinking behaviour and that the Department also needed to work more closely with the other government departments responsible for policies affecting alcohol consumption, such as taxation and licensing.

Supporting people with autism through adulthood (October 2009)

The Committee were advised that the traditional configuration of health and social care services has meant that adults with high-functioning autism may fail to access appropriate support, potentially only doing so if they develop more serious problems later. These problems can be exacerbated by poor knowledge of autism amongst health and social care staff assessing the needs of people with autism and their carers.

The Committee heard that despite the fact that many people with autism have skills which could be valuable to employers, only around 15% of people with autism are in full-time employment. The Committee found that there was a lack of awareness and knowledge of autism among potential employers and Jobcentre Plus staff, which can result in poor decision-making and job outcomes for adults with autism.

The Committee concluded that the effectiveness of services for adults with autism could be improved by raising levels of knowledge and awareness amongst decision-makers and service providers and, more specifically, that there was scope to provide targeted services for adults with high-functioning autism, which could improve the quality of life for them and their carers.

Reducing Healthcare Associated Infections in Hospitals in England (November 2009)

The Committee found that the Department's hands on approach to what seemed, in 2004, to be an intractable problem, had been successful in reducing Meticillin resistant Staphylococcus aureus (MRSA) bloodstream and C. difficile infections. Hospitals' cleanliness had improved and the priority given to reducing these two targeted infections had started to have an impact on hospital trusts overall infection prevention and control.

However, the Committee also found that this progress had not been matched on other healthcare associated infections. The best available evidence from voluntary reporting of other healthcare associated bloodstream infections suggested that these infections may be increasing. The Committee concluded that as a result of the Department's decision to disregard a key recommendation from previous Committee reports - to introduce mandatory surveillance of all hospital acquired infections - that there was still no robust comparable data on the extent and risks of at least 80% of healthcare associated infections.

The Committee also concluded that there had been limited progress in improving information on, and understanding of, hospital antibiotic prescribing and the evidence that was available on other bloodstream infections, which can be just as serious as MRSA, suggested the problem may be growing and that antibiotic resistant organisms were increasing.

Services for people with rheumatoid arthritis (February 2010)

The Committee found that too many people with the disease are not diagnosed early enough and, once diagnosed, they do not always get the services they need to help them live as well as possible with the condition. Starting treatment within three months can stop the disease getting worse, and yet the time between experiencing symptoms and receiving treatment is typically nine months, unchanged since 2003. The barriers to gaining early treatment arise from people's low awareness of the disease, causing them to delay seeking medical help, and from GPs failing to spot the early symptoms and refer quickly enough for diagnosis by a specialist. People with rheumatoid arthritis visit a GP on average four times before referral, and a fifth visit a GP eight or more times before referral.

The Committee also found that people don't always get the services they need once they have been diagnosed. There are big variations in spending on rheumatoid arthritis across Primary Care Trusts and access to the range of services needed to manage rheumatoid arthritis varies. There are differences in the quality and breadth of services available, in particular significant gaps in access to psychological services. People also find it difficult getting timely access to help when they experience a flare-up.

Not diagnosing the disease early enough makes it harder for people to remain in work. Three quarters of people with rheumatoid arthritis are diagnosed when of working age, and one third of people stop working within two years of being diagnosed. People with the disease often lack the right support mechanisms to help them maintain their independence and make an economic contribution to society. In November 2008 the Government accepted the finding of a Review of the health of Britain's working age population that steps were needed to help people with musculoskeletal conditions, but this has yet to filter through to action on the ground.

Young people's sexual health: the National Chlamydia Screening Programme (January 2010)

The Committee heard that in 2003 the Department launched the National Chlamydia Screening Programme, which aims to identify, treat and control the infection in young people aged under 25. Since the Programme's launch an estimated £100 million has been spent but the Department does not yet know what effect, if any, this has had on reducing the prevalence of the infection.

The Committee reported that during the financial year 2007–08, five years after the Programme was launched, only 5% of 15 to 24 year-olds were tested, against a target of 15% and that when it became clear that very little was happening the Department introduced a new requirement for PCTs to test 17% of their 15–24 year-old population, which drove the testing rate up to around 16% in 2008–09.

The Committee concluded that the Department's lack of urgency in pressing PCTs to reach a high volume of testing meant that the Programme had not yet reached the level of activity where models predict that the prevalence of chlamydia will be significantly reduced. As a result, more young people than necessary were still being infected and potential savings to the NHS in treating the consequences of chlamydia infection may have been lost.

The Committee reported that the Department had missed an opportunity to refine the Programme and to improve its cost-effectiveness, during the lengthy rollout. When PCTs increased their activity to meet the 17% target, a fragmented and inefficient programme became even more wasteful of taxpayers' money.

Progress in improving stroke care (March 2010)

The Committee welcomed the demonstrable improvements in stroke care which the Department had achieved since the first report. The Committee heard that the Department and NHS had increased the priority given to stroke, particularly the speed of the acute hospital response and congratulated the Department on the excellent Stroke – Act F.A.S.T. media campaign and the impact this has had on raising staff and public awareness.

However, the Committee found that improvements had not been universal. The likelihood of receiving a timely brain scan or accessing specialist care is dependent on where and when you have a stroke. Similarly, they found that the proportion of patients treated in a specialist stroke unit, although improving, was still well short of the Department's target of 90%, with some regions showing extremely wide variations.

The Committee also found that the improvements in hospital care were not yet matched by progress in delivering more effective support once stroke survivors leave hospital. Many patients discharged from hospital continued to struggle to obtain follow-up care and access to community rehabilitation services remained a post-code lottery.

There are also a number of systemic problems restricting further development of stroke services, such as a lack of effective joint working between health and social care and limitations in out-of-hours hospital care. There is an opportunity for the Department to consolidate its experience from implementing this strategy and its efforts to improve the quality of care in other disease areas to ensure that these challenges are overcome.

Improving Dementia Services in England – an Interim Report (March 2010)

The Committee reported that in February 2009 the Department launched an ambitious and comprehensive five-year National Dementia Strategy aimed at helping people to live well with dementia. The Department estimated that the Strategy would cost £1.9 billion to implement over 10 years, and that this would be funded largely through efficiency savings. National and regional leadership was put in place and initial seed funding of £150 million was allocated to PCTs to assist implementation over the first two years.

The Committee concluded that the Department had failed to match previous assurances to make dementia a national priority and raise the quality of dementia care with a robust approach to implementation and that it failed to ignite passion, pace and drive or to align leadership, funding, incentives and information to help deliver the Strategy. There had also been a delay in the appointment of a national clinical director, a role that has proved very effective in developing and implementing other national strategies, until January 2010.

The Committee reported that improvements that it had identified in 2007 as urgently needed, some of which could have been adopted straight away, were not afforded the urgency and priority that they had been led to expect. Whilst the Department now states that improving dementia services is the greatest health and social care challenge it faces, the Committee feels badly let down by the Department's lack of urgency.

Annex D

In previous years, the Department has published the Departmental Report in June. In 2009-10, in accordance with HM Treasury guidance, (PES 2010 09 issued 18th June 2010), Departmental Reports will not be published this year. However, a number of the tables contained within the Departmental Reports are included in this annex to the Resource Account.

Finance numbers presented in this Annex are on an "aligned basis" and match those published by HM Treasury (in Public Expenditure Statistical Analyses). They do, however, differ from those included in the main body Resource Account, as these are presented on a pre-aligned basis. Details of HMT's technical change in reporting arrangements under alignment are given below.

In order to simplify financial reporting in the Public Sector, HM Treasury's cross-government initiative - the Alignment Project, was launched. The project's aims are to create a single, coherent financial framework, that is effective, efficient and transparent, enhances accountability to Parliament and the public, and underpins the Government's fiscal framework, incentivises good value for money, and supports delivery of excellent public services by allowing managers to manage.
The financial regime changes needed to implement the aims of the project were published in March 2009 in the parliamentary memorandum "Alignment (Clear Line of Sight) Project". The main changes to the budgeting framework are as follows:

- Net creation of provisions will score as Annually Managed Expenditure (AME) rather than against Departmental Expenditure Limits (DEL)
- Cost of capital charges will be removed from the DEL.
- Profit and loss on disposal of assets will score as Revenue DEL rather than Capital DEL.

The aggregate expenditure core tables in this Annex present expenditure on the new aligned basis. One consequence is that total DEL reported expenditure figures are generally lower than the equivalent figures reported in the Departmental Report 2009 (DR2009).

Whilst the changes under alignment affect the total level of reported NHS expenditure, they do not increase or decrease the spending power of the NHS. They are all cost neutral technical changes. Therefore, for example, revenue allocations to PCTs for 2009-10 and 2010-11 announced in December 2008 and fully reported in DR2009 are unaffected by these changes.

The Resource Account will be published on an aligned basis from 2011-12.

The following tables are outside the scope of the audit of the Resource Account.

Core Table 1 – Department of Health public spending

£ million

	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 estimated outturn	2010-11 plan
Consumption of resources							
NHS	66,960	72,750	76,658	82,329	88,761	95,957	99,459
Personal social services	2,108	2,070	1,820	1,865	1,383	1,474	1,904
NHS pensions [1] [2]	6,396	9,281	10,226	10,174	13,396	12,822	17,676
NHS and PSS (AME)	(760)	616	1,233	3,612	1,530	4,263	2,402
Credit guarantee finance (AME) [3]	21	48	70	68	58	623	108
Total Department of Health resource budget	**74,725**	**84,765**	**90,007**	**98,049**	**105,127**	**115,139**	**121,548**
Of which:							
Department of Health Departmental Expenditure Limit (DEL)	69,068	74,821	78,478	84,194	90,144	97,431	101,364
of which:							
Near cash	68,609	74,313	77,488	83,460	89,156	96,426	100,244
Depreciation	459	507	990	734	987	1,004	1,120
Capital spending							
NHS [4]	2,606	2,133	2,875	3,753	4,228	5,240	4,749
Personal social services	83	92	121	213	141	153	148
NHS and PSS (AME)	229	292	-	-	-	-	-
Credit guarantee finance (AME) [3]	-	357	89	37	14	9	4
Total Department of Health capital budget	**2,919**	**2,874**	**3,084**	**4,003**	**4,382**	**5,402**	**4,900**
Of which:							
Department of Health Departmental Expenditure Limit (DEL)	2,689	2,225	2,995	3,966	4,369	5,393	4,897
Total public spending in Department of Health [5]	**77,133**	**87,009**	**91,870**	**100,770**	**108,152**	**115,854**	**124,622**
Of which:							
NHS [6] [7]	69,120	74,386	78,558	85,365	92,037	100,204	103,089
Personal social services [8]	2,180	2,153	1,926	2,062	1,504	1,625	2,052
NHS pensions	6,396	9,281	10,226	10,174	13,396	12,822	17,676
NHS and PSS (AME) [9]	(562)	832	1,071	3,131	1,201	1,194	1,802
Credit guarantee finance (AME) [3] [10]	-	357	89	37	14	9	4
Spending by local authorities on functions relevant to the Department							
Current	**16,059**	**17,243**	**17,874**	**18,505**	**19,578**	**20,198**	**-**
Of which:							
Funded by grants from the Department of Health	2,148	2,141	1,772	1,795	1,215	1,258	-
Capital	**209**	**300**	**278**	**306**	**250**	**330**	**-**
Of which:							
Financed by grants from the Department of Health	140	122	181	159	164	274	-

Source: HM Treasury public expenditure database (COINS)

Footnotes

(1) NHS pensions is the resource budget of the pension scheme, and it is included in core table 1 because it is part of the Department of Health resource budget. Figures reflect the requirement specified by Financial Reporting Standard 17 - Retirement Benefits.
(2) Employers' National Insurance Contributions increased from 7% to 14% from 1 April 2004.
(3) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury. This line also includes some funding for PCT impairments.
(4) Includes funding available to NHS foundation trusts from 2004-05.
(5) Total public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £458/507/990/733/971/994/1,119 million (this excludes impairments funded in AME which is outside the DEL).
(6) NHS public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £446/497/975/718/952/993/1,119 million (this excludes impairments funded in AME which is outside the DEL).
(7) For a more detailed breakdown of NHS expenditure in England see core table 2 and core table 3.
(8) Personal social services public spending calculated as the total of the resource budget plus the capital budget, less depreciation of £12/10/14/16/20/20 million.
(9) Total NHS and PSS (AME) is calculated as the total of the resource budget plus the capital budget, less impairments of £32/76/162/481/329/306/599 million.
(10) Total credit guarantee finance is calculated as the total of the resource budget plus the capital budget, less impairments of £21/48/70/68/58/623/108 million.
(11) Figures are presented net of receipts £-4,066/-5,296/-4,490/-3,606/-3,589/-3,033/-3,220 million.
(12) Figures may not sum due to rounding.

Core Table 2 – Department of Health Resource Budget

£ million

	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 estimated outturn	2010-11 plan
Consumption of resources by activity							
National Health Service (NHS)	**66,960**	**72,750**	**76,658**	**82,329**	**88,761**	**95,957**	**99,459**
Of which:							
Hospital and community health services	**63,470**	**69,526**	**74,280**	**79,712**	**86,134**	**93,043**	**97,618**
of which:							
Health authorities unified budget and central allocations and grants to local authorities	63,470	69,526	74,280	79,712	86,134	93,043	97,618
Family health services	**2,129**	**2,131**	**1,021**	**1,022**	**1,084**	**1,174**	**-**
of which:							
General dental services [1]	1,246	1,038	19	-	-	-	-
General ophthalmic services	341	358	381	400	430	470	-
Pharmaceutical services	966	1,162	1,033	1,054	1,094	1,135	0
Prescription charges income	(422)	(427)	(412)	(432)	(440)	(431)	-
Central health and miscellaneous services	**1,064**	**806**	**1,081**	**1,321**	**1,264**	**1,476**	**1,600**
of which:							
Welfare foods	119	104	110	97	101	122	120
European Economic Area medical costs	442	343	523	748	641	742	947
Other central health and miscellaneous services	503	359	448	476	521	613	532
Departmental administration including agencies	**296**	**287**	**275**	**274**	**280**	**264**	**241**
Personal social services (PSS)	**2,108**	**2,070**	**1,820**	**1,865**	**1,383**	**1,474**	**1,904**
Of which:							
Centrally funded services	**238**	**191**	**242**	**256**	**309**	**245**	**588**
Local authority personal social services grants	**1,871**	**1,880**	**1,578**	**1,609**	**1,074**	**1,228**	**1,316**
of which:							
Training Support Programme	55	-	-	-	-	-	-
Specific grants: AIDS/HIV	17	17	16	16	20	22	26
Specific grants: Mentally Ill	131	133	132	148	-	-	-
Carers Grant	125	185	185	185	-	-	-
Preserved Rights Grant	435	340	298	275	-	-	-
Residential Allowance Grant	406	217	-	-	-	-	-
National Training Strategy	29	92	108	108	-	-	-
Delayed Discharge	100	100	100	100	-	-	-
Access and Systems Capacity Grant	484	643	546	546	-	-	-
Human Resources Development Strategy	24	63	50	50	-	-	-
Assistive Technology	-	-	30	50	-	-	-
Prevention Service	-	-	20	39	-	-	-
Individual Budget Pilots	-	-	3	3	-	-	-
Area Based Grant	-	-	-	-	943	968	988
Learning Disabilities: closure of campuses	-	-	-	-	14	31	51
Transforming, Personalisation, Prevention and Well-being	-	-	-	-	82	192	237
Grants for children	65	91	90	89	-	-	-
Stroke Strategy	-	-	-	-	15	15	15
NHS - superannuations - England and Wales	**6,396**	**9,281**	**10,226**	**10,174**	**13,396**	**12,822**	**17,676**
NHS and PSS (AME)	**(760)**	**616**	**1,233**	**3,612**	**1,530**	**4,263**	**2,402**
Credit guarantee finance [2]	**21**	**48**	**70**	**68**	**58**	**623**	**108**
Total Department of Health resource budget	**74,725**	**84,765**	**90,007**	**98,049**	**105,127**	**115,139**	**121,548**

Source: HM Treasury public expenditure database (COINS)

Footnote

(1) General dental services (GDS) data represents the net cost, after taking account of patient charge income, for non-discretionary services only. Outturn trends are affected by the progressive movement of dental practices into personal dental service pilots. From April 2006, provision for GDS is included within the general hospital and community health services and discretionary health service resources as dental care is now commissioned from funds devolved to PCTs. The GDS provision identified for 2006-07 represents the costs of completing payments in respect of GDS services delivered up to March 2006.

(2) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury. The peaks in expenditure are due to impairments in PCTs and trusts also recorded in this line and not due to credit guarantee finance.

(3) Figures are presented net of receipts £-3,557/-4,096/-3,323/-3,098/-3,378/-2,846/-3,190 million.

(4) Figures may not sum due to rounding.

Core Table 3 – Department of Health Capital Budget

£ million

	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 estimated outturn	2010-11 plan
National Health Service (NHS)	**2,606**	**2,133**	**2,875**	**3,753**	**4,228**	**5,240**	**4,749**
Of which:							
Hospital and community health services [1]	**2,574**	**2,093**	**2,839**	**3,711**	**4,158**	**5,139**	**4,712**
of which:							
Health authorities unified budget and central allocations and grants to local authorities	2,574	2,093	2,839	3,711	4,158	5,139	4,712
Central health and miscellaneous services	**16**	**21**	**20**	**22**	**50**	**80**	**20**
Departmental administration including agencies	**16**	**19**	**17**	**21**	**20**	**20**	**17**
Personal social services (PSS)	**83**	**92**	**121**	**213**	**141**	**153**	**148**
Of which:							
Centrally funded services (including credit approvals)	**58**	**67**	**74**	**147**	**32**	**14**	**26**
Local authority PSS grants	**25**	**25**	**47**	**66**	**108**	**139**	**121**
of which:							
AIDS/HIV capital grants	-	-	2	3	3	3	3
Improving Information Management	25	25	25	25	-	-	-
Common Assessment Framework	-	-	-	-	-	11	11
Social Care Infrastructure	-	-	-	-	15	16	17
Mental Health Capital Grant	-	-	-	-	23	23	23
Social Care Capital Grant	-	-	-	-	28	47	28
Extra Care Housing Grant	-	-	20	38	40	40	-
Infrastructure Support Grant	-	-	-	-	-	-	40
NHS (AME)	**229**	**292**	**-**	**-**	**-**	**-**	**-**
Credit guarantee finance (AME) [2]	**-**	**357**	**89**	**37**	**14**	**9**	**4**
Total Department of Health capital budget	**2,919**	**2,874**	**3,084**	**4,003**	**4,382**	**5,402**	**4,900**

Source: HM Treasury public expenditure database (COINS)

Footnotes
(1) Includes funding available to NHS foundation trusts from 2004-05.
(2) HM Treasury funding available for private finance initiative (PFI) schemes, which is repaid by the PFI partner once the scheme is operational. Please note: subject to final agreement with HM Treasury.
(3) Figures are presented net of receipts £-509/-1,200/-1,167/-507/-211/-187/-31 million.
(4) Figures may not sum due to rounding.

Core Table 4 – Total capital employed by the Department of Health

£ million

	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 estimatedoutturn	2010-11 plan
Within the Departmental account [1] [2] [3] [4]	14,333	14,551	16,266	14,082	11,949	12,188	12,462
Investment outside accounting boundary [5] [6]	32,692	33,596	35,238	37,769	35,043	35,744	36,549
Total capital employed	**47,026**	**48,147**	**51,504**	**51,851**	**46,992**	**47,932**	**49,011**

Source: Department of Health

Footnotes
(1) This includes all entities within the DH resource accounting boundary, such as the central DH, SHAs and PCTs.
(2) Source: DH consolidated resource accounts.
(3) Includes the NHS Litigation Authority which moved inside the accounting boundary in 2000-01.
(4) Includes the Health Development Agency which moved inside the accounting boundary in 2002-03.
(5) This includes, for example, NHS trusts and the National Blood Authority.
(6) In 2000-01, part of NHS supplies (the Purchasing and Supply Agency) moved inside the boundary and, from 2001-02, Rampton, Broadmoor and Ashworth Special Health Authorities moved outside the accounting boundary.

Core Table 5 – Department of Health Administration Costs

£ million

	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 estimated outturn	2010-11 plan [1]
Administration expenditure							
Paybill	113	114	118	117	120	123	N/a
Other	151	128	112	114	107	98	N/a
Total administration expenditure	**264**	**243**	**230**	**230**	**227**	**221**	**215**
Administration income	(9)	(9)	(5)	(5)	(5)	(5)	(4)
Total administration budget	**255**	**234**	**225**	**225**	**222**	**216**	**211**
Analysis by activity:							
Central Department	255	234	225	225	222	216	211
Other	-	-	-	-	-	-	-
Total administration budget	**255**	**234**	**225**	**225**	**222**	**216**	**211**

Source: HM Treasury public expenditure database (COINS)

Footnotes
(1) 2010-11 figures include adjustments as part of the alignment project to align budget, estimate and resource account figures.
(2) Figures may not sum due to rounding.

Core Table 6 – Department of Health Staff Numbers

Financial year average

	2004-05 actual	2005-06 actual	2006-07 actual	2007-08 actual	2008-09 actual	2009-10 plan	2009-10 estimated outturn	2010-11 plan
Department of Health (gross control area) [1] [3]								
Core Department of Health (full-time equivalents)	2,050	2,245	2,250	2,178	2,372	2,245	2,537	2,195
Other	-	-	-	-	-	-	-	-
Designated to transfer from the Department (full-time equivalents)	139	119	65	50	34	-	-	-
Agencies								
Medicines and Healthcare products Regulatory Agency (full-time equivalents) [4]	781	819	854	909	923	977	972	977
NHS Purchasing and Supply Agency (full-time equivalents) [5]	332	350	321	282	289	314	-	-
NHS Estates [6]	314	-	-	-	-	-	-	-
Total Department of Health	**3,616**	**3,533**	**3,490**	**3,419**	**3,468**	**3,536**	**3,282**	**3,172**

Source: Department of Health (core) - Business Management System (BMS); executive agency - HR system

Footnotes
(1) Actual figures are an average across the financial year and are compiled on the same basis as in departmental resource accounts. In particular, they include ministers and special advisers. From 2008-09, they do not include Connecting for Health civil servants.
(2) The Department announced a major Change Programme in March 2003, under which it committed to reduce its workforce from 3,645 full-time equivalent posts to 2,245. The reduction of 1,400 was to consist of 680 transfers to other organisations and the removal of 720 posts. This Change Programme predated the 2004 Spending Review, but it was agreed that the Department could adopt the programme's target reduction as its Spending Review (Gershon) target. By the end of December 2007, the Department's full-time equivalent staffing was 2,189 (excluding ministers and special advisers), representing a reduction of 1,456 from March 2003. This consisted of 637 transfers and 819 posts removed.
(3) The Medicines Control Agency and the Medical Devices Agency merged with effect from 1 April 2003 to become the Medicines and Healthcare products Regulatory Agency (MHRA).
(4) The Procurement Policy and Advisory Unit and the Centre for Evidence-based Purchasing joined the NHS Purchasing and Supply Agency (PASA) from the core Department from 2004-05 following an organisational review. During 2006-07, some PASA activities and associated staffing were outsourced to DHL/NHS Supply Chain. PASA officially disbanded in March 2010 with staff transferred to OGC Buying Solutions and DH (PICD) earlier in the financial year.
(5) NHS Estates became a Trading Fund on 1 April 1999. Figures from 2003-04 include staff in Inventures. NHS Estates was abolished on 31 March 2005.
(6) Future planned staff numbers are subject to change.

(7) The staff numbers shown in the 2009-10 Resource Account do not match those presented in Core Table 6 as they are prepared on a different basis at different points in time.

Core Table 7 - Department of Health identifiable expenditure on services, by country and region

£ million

	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 plan	2010-11 plan
North East	3,581	3,908	4,138	4,482	4,899	5,228	5,501
North West	9,524	10,344	10,919	11,959	12,771	13,867	14,483
Yorkshire and the Humber	6,646	7,306	7,602	8,229	9,007	9,692	10,046
East Midlands	4,971	5,452	5,798	6,443	7,007	7,659	7,893
West Midlands	6,705	7,270	7,921	8,605	9,255	10,080	10,453
Eastern	6,434	6,910	7,351	7,848	8,638	9,612	10,008
London	11,468	12,129	12,215	13,766	14,792	16,117	16,296
South East	9,635	10,146	11,018	11,868	12,849	14,359	14,750
South West	6,087	6,686	6,923	7,643	8,291	9,233	9,359
Total England	**65,051**	**70,151**	**73,886**	**80,844**	**87,509**	**95,849**	**98,790**
Scotland	27	30	34	38	42	46	50
Wales	(168)	(193)	(191)	(162)	(164)	(156)	(149)
Northern Ireland	4	4	4	5	5	6	6
Total UK identifiable expenditure	**64,914**	**69,992**	**73,733**	**80,726**	**87,392**	**95,744**	**98,697**
Outside UK	555	470	666	907	815	701	797
Total identifiable expenditure	**65,469**	**70,463**	**74,398**	**81,633**	**88,208**	**96,444**	**99,494**
Non-identifiable expenditure	-	-	-	-	-	3	3
Total expenditure on services	**65,469**	**70,463**	**74,398**	**81,633**	**88,208**	**96,447**	**99,497**

Source: HM Treasury public expenditure statistical analyses (PESA)

Footnote
(1)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 paid to individuals and private sector enterprises.
(2)The figures are estimates.

Core Table 8 - Department of Health identifiable expenditure on services, by country and region, per head

£ per head

	2004-05 outturn	2005-06 outturn	2006-07 outturn	2007-08 outturn	2008-09 outturn	2009-10 plan	2010-11 plan
North East	1,408	1,533	1,619	1,748	1,903	2,032	2,132
North West	1,397	1,512	1,593	1,742	1,857	2,000	2,079
Yorkshire and the Humber	1,312	1,430	1,478	1,589	1,728	1,839	1,889
East Midlands	1,158	1,260	1,329	1,464	1,581	1,705	1,740
West Midlands	1,259	1,359	1,476	1,599	1,710	1,853	1,913
Eastern	1,167	1,242	1,311	1,386	1,508	1,667	1,720
London	1,552	1,627	1,626	1,822	1,941	2,100	2,106
South East	1,186	1,240	1,338	1,428	1,533	1,708	1,742
South West	1,207	1,314	1,351	1,476	1,592	1,755	1,763
Total England	**1,298**	**1,390**	**1,456**	**1,582**	**1,701**	**1,850**	**1,893**
Scotland	5	6	7	7	8	9	10
Wales	(57)	(65)	(64)	(54)	(55)	(52)	(49)
Northern Ireland	2	2	2	3	3	3	3
Total UK identifiable expenditure	**1,085**	**1,162**	**1,217**	**1,324**	**1,424**	**1,549**	**1,586**

Source: HM Treasury public expenditure statistical analyses (PESA)

Footnotes
(1)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 paid to individuals and private sector enterprises.
(2)The figures are estimates.

Core Table 9 - Department of Health identifiable expenditure on services by function, by country and region, 2008-09

£ million

	Health			Social protection				
	Central and other health services	**Medical services**	**Total health**	**Incapacity, disability and injury benefits**	**Old age - pensions**	**Survivors - widow's benefits**	**Total social protection**	**Grand total**
North East	52	4,944	4,997	18	(129)	13	(98)	4,899
North West	137	12,900	13,037	48	(349)	36	(266)	12,771
Yorkshire and the Humber	95	9,100	9,195	33	(246)	25	(188)	9,007
East Midlands	73	7,081	7,154	25	(192)	19	(147)	7,007
West Midlands	97	9,338	9,434	34	(238)	24	(180)	9,255
Eastern	91	8,744	8,835	32	(255)	26	(197)	8,638
London	155	14,867	15,022	54	(316)	32	(230)	14,792
South East	134	13,055	13,189	47	(431)	44	(341)	12,849
South West	87	8,435	8,522	30	(291)	30	(231)	8,291
Total England	**921**	**88,463**	**89,385**	**322**	**(2,447)**	**249**	**(1,876)**	**87,509**
Scotland	-	-	-	-	40	2	42	42
Wales	-	-	-	-	(183)	19	(164)	(164)
Northern Ireland	-	-	-	-	5	0	5	5
UK identifiable expenditure	**921**	**88,463**	**89,385**	**322**	**(2,584)**	**270**	**(1,992)**	**87,392**
Outside UK	**655**	**-**	**655**	**-**	**153**	**8**	**161**	**815**
Total identifiable expenditure	**1,576**	**88,463**	**90,040**	**322**	**(2,432)**	**278**	**(1,832)**	**88,208**
Not identifiable expenditure	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total	**1,576**	**88,463**	**90,040**	**322**	**(2,432)**	**278**	**(1,832)**	**88,208**

Source: HM Treasury public expenditure statistical analyses (PESA)

Footnotes

(1) The functional categories used are the standard United Nations Classifications of the Functions of Government (COFOG) categories. These are not the same as the strategic priorities used elsewhere in the report.

Performance Data Tables

Indicator	Indicator belongs to PSA/DSO	Statement on the data	OGDs
All-age-all-cause mortality (AAACM)	PSA 18.1	In the period 2006-2008, AAACM rates have fallen to 692.3 deaths per 100,000 population for males, which is 25.7 per cent below the 1995-97 baseline average, and fallen to 490.6 deaths per 100,000 population for females, which is 19.1 per cent below the 1995-97 baseline. Data for 2006-2008 also shows that life expectancy at birth in England continues to increase for both males, 77.7 years, and females, 81.9 years.	
Gap in All-age-all-cause mortality	PSA 18.2	In the period 2006-2008, spearhead group life expectancy rose to 75.8 years for males and 80.4 years for females. However, the relative gap in life expectancy was 7 per cent wider than the 2005-07 baseline gap of 4 per cent for males; and was 14 per cent wider than the 2005-07 baseline gap of 11 per cent for females.	
Smoking prevalence	PSA 18.3	The percentage of the overall population in 2008 aged 16 or over who smoked was 21 per cent and in the routine and manual occupations was 29 per cent. In 2008-09 the rate of stop smoking service clients who successfully quit smoking at the four-week follow-up was 813 quitters per 100,000 population, an increase of 4 per cent on the baseline.	
Adults supported, through social care, to live independently at home	PSA 18.4	Data for 2008-09 shows that 3,204 people per 100,000 population were supported through social care to live independently at home. In 2008-09, changes in reporting the data has allowed the inclusion of some 1,000 additional schemes (Information Centre estimate) providing information and advice, telecare, drop-in services and transport, comparisons cannot be made with previous years.	DWP (17.5)
Improving Access to Psychological Therapies	PSA 18.5	The IAPT programme has been rolled out to 112 primary care trusts (PCTs) and at quarter 3 of 2009–10, those offered treatment has risen to 9.98 per cent and those receiving psychological therapies had risen to 5.33 per cent.	
Self-reported experience of patients and users	PSA 19.1	The 2008-09 Adult In-patient Survey reported an overall patient experience score of 76.0, an increase compared to the in-patient baseline of 75.3 in 2007-08. The 2009-10 Outpatient Survey reported an overall patient experience score of 78.6, a 1.9 point increase on the score of 76.7 reported in the previous survey in	
18 weeks (admitted and non-admitted)	PSA 19.2	In December 2009, 93.3 per cent of admitted patients and 97.9 per cent of non-admitted patients began	
18 weeks (admitted and non-admitted)	PSA 19.3	treatment within 18 weeks of referral. The median time waited for admitted patients was 7.7 weeks and for non-admitted patients it was 4.2 weeks. Reducing waiting times for receiving diagnostic tests has been pivotal to delivering treatment within a maximum of 18 weeks from referral. Stage of treatment waiting time data for the 15 key diagnostics tests shows that the number of waits over 6 weeks at the end of December 2009 was 5,400 – which is 1.1 per cent of the total number of waits compared to the 86,000 in December 2007. Patients can expect to wait around 2.3 weeks for one of the 15 key diagnostic tests, compared to 3.0 weeks in December 2009	
Pregnant women assessed for health and social care needs by 12 weeks	PSA 19.4	At quarter 1 of 2009–10, the proportion of women assessed was 78.9 per cent, this is an increase from the 2008-09 baseline of 73.5 per cent.	
Adults with Long-term conditions supported to be independent and in control of their conditions	PSA 19.5	Data source for this indicator had changed to the 2009-10 GP Patient Survey, which is due to be published in late June 2010.	
Access to GP services	PSA 19.6	The 2008-09 GP Patient Survey published in June 2009 showed 91 per cent of patients were either 'very satisfied' or 'fairly satisfied' with overall experience, this data has set the new baseline and direct comparisons should not be made between quarterly and annual results from previous years.	
HCAI – MRSA	PSA 19.7	At quarter 4 in 2009-10 there were 482 cases reported, which is 75 per cent below the average quarterly total (1,925) in the 2003-04 baseline year.	
HCAI – *Clostridium difficile* infections	PSA 19.8	At quarter 2 in 2009-10 there were 6,406 *C. difficile* cases reported (all cases for age 2 and over) and 6,342 *C.difficile* cases by quarter 4 in 2009-10. The quarter 4 total is 24 per cent below the corresponding quarter in the previous year (2008-09) and data for 2009-10 showed a 54 per cent reduction from the 2007-08 baseline of 55,498 cases.	

Indicator	Indicator belongs to PSA/DSO	Statement on the data	OGDs
Self-reported measure of people's overall health	DSO 1.1	In the 2008 Place Survey and the 2008 Health Survey for England, 76 per cent of the adult population living in private households in England described their health, in general, as being 'very good' or 'good'.	
Mortality from suicide and injury of undetermined intent	DSO 1.3	In the period 2006-2008, data shows a reduction to 7.8 per 100,000 population (an overall reduction of 15.2 per cent). The three-year average rate fell between the periods 2005-2007 and 2006-2008, although the single year rate increased between the period 2007-2008 (from 7.5 to 8.0 deaths per 100,000).	
Child and Adolescent Mental Health Services	DSO 1.4	At quarter 3 of 2009–10, the number of PCTs in England fully compliant to the four sub-measures were as follows: (i) 94 provided a full range of CAMHS; (ii) 120 provided access for 16 to 17 year olds; (iii) 130 provided 24-hour cover; and (iv) 81 provided a full range of universal services. This shows that 39.5 per cent of PCTs were compliant on all measures, an increase of 11.2 per cent compared to quarter 2. Year 2 data for 2008-09 showed that 36 per cent of LAs scored the maximum 16 out of 16, compared with 19 per cent from	DofE
Mortality from heart disease, stroke and related diseases	DSO 1.6	In the period 2006-2008, the England rate was 74.8 deaths per 100,000 population (a decrease of 47.1 per cent) and the gap was 22.6 deaths per 100,000 population (a decrease of 38.4 per cent).	
Mortality from cancer	DSO 1.7	In the period 2006-2008, the England rate was 114.0 deaths per 100,000 population (a decrease of 19.3 per cent) and the inequalities gap was 18.6 deaths per 100,000 population (an increase from 18.0 deaths per 100,000 in the period 2005-2007, but a decrease of 10.5 per cent since the baseline).	
Pandemic flu	DSO 1.8	The NHS response was tested last year when an outbreak of novel influenza infection occurred in April 2009 and a global swine flu pandemic was declared by the World Health Organization on 11 June 2009. The NHS had plans in place to respond to a pandemic which included advanced purchase agreements to the first supplies of the licensed swine flu vaccine; operating the National Pandemic Flu Service with over 1.1 million courses of antivirals collected through the service to reduce pressure on GPs and front-line healthcare services; and information leaflets on swine flu were delivered to UK households in May 2009, with television, newspaper and radio advertisements and information online to inform the wider public about the virus. A further respiratory hand hygiene campaign was run between October 2009 and February 2010.	
Healthy life expectancy at age 65	DSO 1.9	Data for the period 2005-07 data shows that healthy life expectancy for adults over 65 years was 14.6 years for females and 12.9 years for males. ONS has changed their methodology in collecting data for healthy life expectancy, moving from a three-point scale on self-assessing health to a five-point scale to meet EU equivalent surveys for international comparisons, and for the same period, the revised data shows 11.0 years for females and 9.9 years for males.	DWP
Older people discharged to own home or residential care for rehabilitation	DSO 1.11	The provisional baseline data for 2008 shows that 78.2 per cent of people aged 65 years and over (almost 29,000 individuals) were still at home 91 days following discharge from hospital into rehabilitation/intermediate care where the intention was for that person to return to their own home.	
Levels of childhood obesity	DSO 1.13	The 2008 Health Survey for England (HSE) shows that the estimated prevalence of obesity among 2 to 10-year-olds is 13.9 per cent in 2008, having remained at 15.5 per cent for both 2006 and 2007.	DofE
Hospital admissions for alcohol-related harm	DSO 1.14	The final rate for 2008–09 shows 1,583 admissions per 100,000 which is a reduction of 17 admissions per 100,000 population (1 per cent) on the projected rate of 1,600 for 2008–09.	HO
Drug users recorded as being in effective treatment	DSO 1.15	In the period 2008-2009 some 165,873 individuals were recorded in effective treatment which shows a 4.3 per cent improvement on the 2007-08 baseline.	HO
Prevalence of breastfeeding at 6-8 weeks	DSO 1.16	At quarter 3 of 2009-10, the England 6-8 week breastfeeding rate was 49.1 per cent and coverage has improved steadily so that now 86.0 percent of infants due a check have had their breastfeeding status	DofE

Annex D

Indicator	Indicator belongs to PSA/DSO	Statement on the data	OGDs
Hospital admissions caused by unintended and deliberate injuries to children and young people	DSO 1.17	The latest 2008–09 data shows 117.4 admissions per 10,000 population aged 0 to 17 years in England, a decrease of 3.41 per cent in the admission rate.	DofE
Under 18s conception rate	DSO 1.18	Provisional 2008 under-18 conception data shows there were 40.4 conceptions per 1,000 females aged 15 to 17 against the1998 baseline figure of 46.6 conceptions. Overall, England's rate fell by 13.3 per cent between 1998-2008 and there has been a decline of 24.4 per cent in the rate of conceptions leading to birth. The data for England and Wales shows that for the first three quarters of 2009, the rate of conceptions leading to abortions for 16 to 19-year-olds have been lower than rates for each of the corresponding quarters in 2008.	DofE
Prevalence of chlamydia	DSO 1.19	Data from the end of December 2009 shows that 13.8 per cent of the target population were screened and compared to 10.1 per cent national coverage in the same period in 2008 (April to December) and, in testing volumes, this represents a 40 per cent increase.	
Adults with moderate to severe learning disabilities in settled accommodation	DSO 1.20	The provisional baseline data in 2008-09 showed that 64.5 per cent of people with learning disabilities were in settled accommodation.	CO
Adults in contact with secondary mental health services in employment	DSO 1.21	The Department commissioned a one-off Employment and Accommodation Survey in February 2010 to improve the MHMDS data quality. The results showed that 9.6 per cent of adults in contact with secondary	CO
Adults in contact with secondary mental health services in settled accommodation	DSO 1.22	mental health services were in employment and 84.4 per cent were in settled accommodation, which established the baseline for these indicators.	CO
Adults with moderate to severe learning disabilities in employment	DSO 1.23	The provisional baseline data in 2008-09 shows that 6.8 per cent of people with learning disabilities were in employment i.e. defined as 'paid work'.	CO
Delayed transfers of care	DSO 2.26	In 2008-09 this decreased to 11.9 per 100,000 population from the 2006-07 baseline of 14.9 per 100,000 population.	
Timeliness of social care assessment	DSO 2.31	The data for 2008–09 shows an increase to 79.8 per cent from the 2006-07 baseline of 76 per cent.	
Timeliness of social care packages	DSO 2.32	The data for 2008–09 shows an increase to 90.7 per cent from the 2006-07 of 89.3 per cent.	
Proportion of all deaths that occur at home	DSO 2.33	The data in 2008 shows an increase to 19.9 per cent from the 2005 baseline of 18.4 per cent.	
Adults receiving social care through direct payment (and/or individual budget)	DSO 2.34	The data for 2007-08 shows an increase to 5.6 per cent from the 2006-07 baseline of 4.5 per cent of clients receiving social care through a direct payment or individual budget. Carers have been included in this indicator and therefore the indicator is not comparable with previous years, however, the number of people receiving direct payments (users) has increased by over 19,000 (29 per cent) since 2007–08.	
Carers receiving a 'carers' break' or specific service to carers, or advice and information	DSO 2.37	The baseline data for 2008-09 shows an increase to 23.1 per cent of carers receiving a carer's break, a specific service or advice and information from the 2006-07 baseline of 20.7.	
Patient and user-reported respect and dignity	DSO 2.38	The 2008-09 Adults In-patient Survey shows that the proportion of respondents who were 'always' treated with respect and dignity had increased margianlly from 78 per cent in 2007-08 to 79 per cent, and respondents reporting they were not treated with respect and dignity remained unchanged at 3 per cent.	
Parents' experience of services for disabled children	DSO 2.39	The 2009-10 national sample survey of parents of disabled children in England provided figures from 145 local authorities and 150 PCTs and shows that the national overall score increased to 61 points from the 2008-09 baseline of 59 points.	DofE
Emergency bed days	DSO 3.40	In 2008–09, there were 29.1 million emergency bed days, which is a 10.4 per cent decrease on the 2003–04 baseline year.	
Financial balance (PCT)	DSO 3.41	As reported in the PCT audited financial monitoring and accounts forms in 2008–09, the NHS ended the 2008–09 year with a net surplus in PCT accounts of £448 million. At quarter 2 of 2009–10, PCTs are forecasting an overall surplus of £300 million and four PCTs are forecasting a gross deficit totalling £36 million, compared with 2008–09 when only one PCT ended the year with a deficit of £7 million.	

Indicator	Indicator belongs to PSA/DSO	Statement on the data	OGDs
Prescribing indicator	DSO 3.42	The NHS has demonstrated considerable progress with increasing low-cost prescribing for lipid modification, (statins for the treatment of high cholesterol), increasing low cost proton pump inhibitor prescribing (treat gastric conditions such as peptic ulcer disease and gastric reflux) and increasing low-cost prescribing for drugs affecting the rennin angiotensin system (ACE inhibitors – drugs for hypertension/high blood pressure). The NAO has estimated that the NHS has saved £443 million in 2009 (relative to a 2005 baseline) resulting from cost-effective prescribing of ACEs and ARBs, statins, PPIs, and clopidogrel for some common conditions such as high blood pressure, high cholesterol and gastric problems. The largest savings has been made on statins, with £323 million saved in 2009.	
Public confidence in local NHS	DSO 3.43	The baseline for the composite survey data at June 2009 showed a score of 63.8 out of 100 for services that are organised with a focus on the individual, the organisation arranges services with a focus on dignity and respect for the patient, and the organisation makes use of patient and public feedback and learns from	
NHS estate energy/carbon efficiency	DSO 3.44	The data for 2008-09 shows that the level of total (primary) energy consumption has increased by 0.31 per cent while the size of the NHS estate has increased by 19.82 per cent in the same period as a result of capital investment in NHS premises and new technologies. This is equivalent to a 16.28 per cent increase in the level of energy efficiency (Gj/m2) with less energy being used per area between 1999-2000 and 2008-09. 57 per cent of the NHS facilities has achieved the more demanding level of 35 to 55 GJ/100 m3 (gigajoules per 100 m3) energy performance for new capital developments and major redevelopments/refurbishments compared to the 1999-2000 baseline of 27 per cent. Similarly, in 2008-09 there has been been a decrease to 43 per cent of the NHS achieving the 55 to 65 GJ/100 m3 for existing facilities compared to the 1999-2000 baseline of 73	
For legacy targets:			
Infant mortality	SR2004 T2	In the period 2006-2008, the infant mortality rate among the routine and manual group was 16 per cent higher than in the total population, compared to the 1997-1999 baseline of 13 per cent.	
Life expectancy at birth	SR2002 T11	The data for the period 2006-2008 shows that 90 per cent of males and 88 per cent of females in the lowest fifth were in the spearhead group. The relative gap in this period for life expectancy was 5 per cent wider than the 2005-2007 baseline gap of 2 per cent for males; and was 14 per cent wider than the 2005-2007 baseline gap of 12 per cent for females.	
Hospital admissions for Serious accidental injury	CSR1998 T3	The 2007-08 data shows an increase of 2.9 per cent to 325.2 admissions per 100,000 population from the 1995-96 baseline of 315.9 admissions per 100,000 population.	
Death rate by accidents	CSR1998 T4	The data for the period 2006-2008 shows a 0.7 per cent increase of 15.9 deaths per 100,000 from the 1995-97 baseline of 15.8 deaths per 100,000 population.	

Comprehensive Spending Review 2007 efficiency

The Comprehensive Spending Review (CSR) settlement required the Department to secure value for money savings of £8.2 billion by 2010-11 when compared with a baseline of 2007-08. This is in line with requirements for all Government departments. The 2009 Budget statement announced that additional savings of £5 billion across public services, including £2.3 billion from the Department, will be delivered in 2010-11.

Priority project	£ million Cumulative savings
Patient pathways [(1)]	**576**
Of which:	
Non-elective admissions	23
Non-elective length of stay	158
Elective length of stay	350
A&E attendances	46
Pharmaceuticals [(2)]	**356**
Of which:	
Generic prescribing	160
Pharmacist reimbursement	197
Procurement [(3)]	**645**
Workforce [(4)]	**1,051**
Gershon [(5)]	820
Total [(6)]	**2,628**

Footnotes
(1) Patient pathways savings are for 2008-09 to quarter 3 2009-10 inclusive due to data availability. The 2009-10 data used is provisional and therefore subject to revision.
(2) Pharmaceutical Price Regulation Scheme (PPRS) pharmaceuticals savings have not yet been quantified. Pharmaceutical savings are for 2008-09 to quarter 3 2009-10 inclusive.
(3) Procurement savings are for 2008-09 due to data availability.
(4) Workforce savings are for 2008-09 due to data availability.
(5) Gershon over-delivery savings total £820 million over the total CSR period.
(6) Gershon savings are not included in the total.
(7) Figures may not sum due to rounding.

Public Accounts Committee Recommendations

Report title	Recommendation	Progress
Reducing Alcohol Harm: Health services in England for alcohol misuse	(1) General practitioners (GPs) have an important role to play in identifying alcohol misuse and advising people to cut down, but are not doing so consistently. A new scheme to encourage such work is likely to have only limited effects. Since April 2008, the Department has funded a new £8 million a year Directed Enhanced Service to pay GP practices to undertake alcohol screening, but this only applies to newly registered patients. The Department should review the results of the new service after the first year and assess whether, in the light of its limited coverage, the numbers of people screened make this a meaningful and cost-effective intervention.	On 6 January 2010, NHS Employers announced that they had reached agreement with the British Medical Association's General Practitioners Committee that the two-year clinical Directed Enhanced Service, including alcohol, that was due to end on 31 March 2010, will continue for a further year.
	(2) Only around 1 in 18 people who are dependent on alcohol receive treatment and the availability of specialist services differs widely across England. The Department has announced a scheme to provide pilot sites with additional funding and support for specialist services. At the end of the pilots, the Department should publish the results, showing what has been achieved and assessing whether a national expansion of the model would provide a cost-effective means to tackle the demonstrable variations and gaps in service provision that currently exist across English regions and between primary care trusts (PCTs).	The National Alcohol Treatment Monitoring Service data for the numbers in treatment from 2008–09 and the first three-quarters of 2009–10 show a rising trend. The total for the first nine months of 2009–10 is already just over 100,000.
	(3) While there is increasing evidence about the effectiveness of different types of treatment, there is frequently a lack of monitoring of whether what is provided by the public, private and voluntary sectors represents value for money. The Department, working with the National Treatment Agency for Substance Misuse, should put in place systems to regularly appraise the performance of current services, and publish a compendium of good practice which has been shown to be cost-effective.	PCTs will have first published their performance against the full set of Vital Signs in autumn 2009, as mandated by the Department, and strategic health authorities (SHAs) will have used this evidence in considering the appropriateness of PCTs' plans for 2010–11. **Outstanding action**: Resources permitting, the Department will consider commissioning and publishing a compendium of evidence-based good practice examples of specialist treatment during 2010, drawing on *Models of Care for Alcohol Misusers* (DH, June 2006).
	(4) People who are dependent on alcohol often need immediate medical care, combined with wider long-term counselling and practical support, but services are often not joined up, increasing the risk that people will simply relapse into their former drinking habits. The Department should develop detailed proposals for 'stepped care' for alcohol misuse, including practical ways in which PCTs should work with other service providers, including those responsible for social care, housing, employment.	New National Institute for Health and Clinical Excellence (NICE) guidance to cover the full range of care and support required for people with alcohol misuse problems will be published in three parts to address different levels of intervention. First guidance, *Alcohol Use Disorders in Adults and Young People: Prevention and early identification* , was issued in March 2010.
	(5) By July 2008, only 3 per cent of alcoholic products had fully complied with the drinks industry voluntary labelling scheme. If a significant improvement is not evident from the planned 2009 review of compliance, the Department should consider a mandatory labelling scheme.	UK-wide consultation on options for action to improve unit and health information on labels was launched on 15 February 2010 and will run until 9 May 2010.

Report title	Recommendation	Progress
Supporting People with Autism through Adulthood	(1) The Department of Health is currently developing an adult autism strategy for publication in 2010. For this strategy to be effective, it should set out how each of the recommendations made in the Comptroller and Auditor General's report will be implemented, including a specific timeframes and indicators to measure progress and performance. The National Audit Office should revisit this topic in 2011 to review progress in implementing the strategy.	On 3 March 2010, the Department published *'Fulfilling and Rewarding Lives': The strategy for adults with autism in England (2010)* . This strategy looks at how the public sector provides the support and services that people with autism need to live independently. It was developed by the Department working alongside other government departments and with advice from an established external reference group. Responses from an earlier consultation exercise to gather the views of people with autism, their families, carers and professionals also influenced the final publication. The strategy is to be supported by an annual delivery plan to address the actions needed to be taken nationally, regionally and locally to secure implementation, including timelines and milestones.
	(2) Local organisations are not making effective use of existing information to plan and provide appropriate services to adults with autism and their carers. To remedy this: (a) NHS bodies and local authorities should collate local learning disability and mental health data to identify and record all adults with autism known to services; (b) local organisations should use Joint Strategic Needs Assessments (JSNAs) to identify the needs of adults with autism in their area, and make greater use of pooled budgets and joint commissioning to develop and deliver effective, integrated services; and (c) directors of children's and adult services should work together, using routine Schools Census data, to identify future demand for adult services from pupils with autism and Special Educational Needs approaching school-leaving age.	(a) Building on this work, the NHS Information Centre (NHS IC) issued invitations to tender to short-listed potential providers, to deliver much clearer information on the prevalence of autism in the population. The procurement exercise is now nearing its conclusion and the NHS IC is looking to award the contract by the end of March 2010. The Department hopes to publish the findings in spring 2011. (b) The JSNA good practice guidance has not been published. The Department hopes to publish more comprehensive, revised JSNA guidance at the end of 2010, pending and reflecting policy direction from the next government around efficiency and the place of joint local authority/PCT need assessment as the first step in the commissioning cycle for health and well-being. The Department has, however, launched a web-based JSNA 'Community of Practice' (CoP) as part of the Improvement and Development Agency's 'Healthy Community' CoP to enable those who join to access good practice and to debate issues. The National Autistic Society would be very welcome to join and start a sub-strand on assessing needs of adults with ASC in the JSNA. (c) The Department for Children, Schools and Families is leading on this work.

Report title	Recommendation	Progress
End of Life Care	(1) Most people express a preference to die at home but 60 per cent die in an acute hospital, even where there is no clinical need for them to be there. People should have the right to die in the place of their choice. The End of Life Care Programme team should work with PCTs and SHAs to develop the means to share information on patient preferences. In line with the Department's strategy, trusts should agree plans with their SHAs for increasing the availability of community services, such as 24-hour district nursing, and access to advice and medication out of hours to help reduce the number of unnecessary hospital admissions. People in care homes should have equal access to these services.	As well as continuing to support the implementation of the End of Life Care Strategy, which will help make this choice a reality, the Department has also consulted on the proposed inclusion in the NHS Constitution of a new right to die at home. Establishing such a right would depend on progress in implementing the strategy.The eight pilot sites that were selected in the summer of 2009 are developing a range of local solutions that will be formally evaluated, with the results disseminated nationally.The Department has also established end-of-life care as one of the first work streams for its quality and productivity challenge. The end-of-life care work stream identified the shifting of care into the community as a key area for supporting quality care and delivering cost efficiencies.
	(2) People who die in hospital are not always afforded the end-of-life care they deserve, including effective pain management and being treated with dignity and respect. Because someone is approaching the end of life it should not mean we abandon concern for their quality of life; end-of-life care should seek to sustain people's quality of life as a priority. PCTs should seek assurance from the hospitals they commission services from that their staff have received sufficient education and training in end-of-life care. NHS hospitals that care for people who are approaching the end of their life, should employ a specialist palliative care team and promote the use of the Liverpool Care Pathway (LCP) across relevant hospital wards.	The Department has developed, with Skills for Care and Skills for Health, competences and core principles in end-of-life care, which will support the training and development of social care staff. These underpin work undertaken with e-Learning for Healthcare to develop an e-learning package accessible to health and social care staff, which was formally launched in January 2010. Pilots to support the dissemination of training in communication skills have also been established. These will report by the end of 2010, and will be formally evaluated.The National Cancer Action Team has been undertaking a stock-take of supportive and palliative care services in England to assess whether the guidance was followed by December 2009, to be followed up by a series of visits with cancer networks and SHA cancer leads to discuss the results. A report of the findings, incorporating examples of good practice in the networks, is due to be published in summer 2010.
	(3) Lack of co-ordination between health and social care services means that peoples' preferences for care are not always communicated effectively. People nearing the end of their life should be allocated a single health or social care professional contact to improve the co-ordination of care between services and providers. PCTs should require providers to develop care plans for all those who wish to have one. The Department's planned survey of bereaved relatives should also include consideration of how a patient's care is co-ordinated across settings and between providers.	Marie Curie Cancer Care's Delivering Choice Programme has explored another option via the development of a co-ordination centre, which had positive outcomes. This model involved non-clinical staff taking responsibility for co-ordinating packages of care, and acting as a point of contact for patients and carers. The quality markers and measures for end-of-life care highlight the important role a key worker can play in supporting effective co-ordination of care. The Department is exploring mechanisms to improve co-ordination through the piloting of end-of-life care registers, which would enable effective capture of information about patient preferences and care, and ensure that this was available to all relevant organisations. Eight pilot sites were selected by the Department and the National End of Life Care Programme team in summer 2009. *High Quality Care for All: NHS Next Stage Review final report*, re-affirms the Department's commitment that, over the next two years, every one of the 15 million people with one or more long-term conditions should be offered a personalised care plan. To progress this further the Department is providing a range of tools and resources, including support for the workforce with a forthcoming e-learning tool, a train the trainer programme and workforce guides. There will also be support available to PCTs from summer 2010 as part of the wider quality, innovation, productivity and prevention programme. Carers are already entitled to a carer's assessment from social services. A comprehensive package of e-learning training material for health and social care staff was formally launched in January 2010, and pilots to support the dissemination of communications skills have been established and will report by the end of 2010.The Department agrees with the Public Accounts Committee that the planned survey of bereaved relatives should include consideration of how well care is co-ordinated. It is intended that the survey will cover the whole care pathway identified in the Department's End of Life Care Strategy. A pilot project to inform the implementation of the national survey was commissioned in July 2009, and is expected to report at the beginning of 2011.

(4) There is a lack of education and training in basic end-of-life care. Improving the skills of health and social care staff should be a priority. In particular, the Department should work with the relevant professional bodies to put in place appropriate training. PCTs and local authorities should commission hospices and voluntary groups to provide education for community and care home staff by, for example, building on the work already being undertaken by Marie Curie and St Christopher's Hospice. The new Care Quality Commission (CQC) should provide assurance about the skills level of staff in health and social care organisations, as part of the new registration, inspection and monitoring regime.	Competence frameworks and a suite of e-learning modules based on communications skills, assessment, advance care planning and symptom management, including an integrated module providing examples of practical applications, have been developed with a range of health and social care organisations. This work is now being made accessible to all levels of health and social care staff. As part of the funding to support the End of Life Care Strategy, the Department has made funding available to SHAs to support training plans, and the quality markers for end-of-life care reflect the need for organisations to ensure that workers have access to appropriate training. The Department agrees that the CQC has an important role to play in assuring that workers have the appropriate skills. A new registration framework for health and adult social care providers has been introduced from this year. Since 1 April 2010, all NHS providers of regulated activities have been required to register against 16 safety and quality registration requirements, which set out the essential levels of safety and quality of care that people who use services have a right to expect. All adult social care and independent sector healthcare providers of regulated activities will be required to register against the registration requirements from 1 October 2010. The 16 safety and quality registration requirement regulations include a duty to ensure that workers have the necessary qualifications, skills and experience for their role, and a duty to support workers through training, development, supervision and appraisal, regardless of the basis for their employment. After a public consultation on its guidance about compliance with the registration requirements, the CQC published the final version on 1 April 2010.
(5) PCTs have limited understanding of the local demand for and the cost-effectiveness of their commissioning of end-of-life care services. Trusts should use the commissioning guidance provided by the End of Life Care Programme and benchmarking information provided by the NAO, to assist them in allocating resources more effectively. Trusts should also consider whether work similar to that done in Sheffield for the NAO would improve their understanding of demand and supply and accordingly their commissioning of end-of-life care services.	Further support for PCTs will be provided through the End of Life Care Strategy implementation work. The quality markers and measures for end-of-life care are intended to support commissioners of services. The Department is also exploring metrics for end-of-life care community services as part of the Transforming Community Services programme, to support commissioning decisions based around the care pathway set out in the End of Life Care Strategy. The Department will be working with key stakeholders to develop an End of Life Care Intelligence Network, which will support the commissioning and provision of services through the development of improved information on end-of-life care. The network's work programme was established in January 2010. The National End of Life Care Programme and NICE have also been working in partnership to produce a guide for commissioners to support them in commissioning end-of-life care for dementia patients, which was published in April 2010.
(6) There is a risk that the additional £286 million committed to improving end-of-life care will not be used as intended. The Department should require PCTs to account for how the additional funding is spent. Such information should be used to provide feedback to trusts to allow them to benchmark their performance in improving service quality.	In the case of end-of-life care, the Department agrees with the Public Accounts Committee that PCTs should account for their spending, and that information should be provided to them to support benchmarking. Due to the lack of priority accorded to end-of-life care in the past, the Department made the commitment in the End of Life Care Strategy to monitor the additional funding. PCTs have been requested to provide returns setting out how they have invested the new funding to support implementation of the main elements of the strategy. The results of this data collection will be made available nationally to support comparative benchmarking.

(7) There has been limited formal evaluation of the patient benefits associated with approaches intended to improve end-of-life care such as the Gold Standards Framework (GSF). The Department should commission clinical evaluations to determine whether use of such approaches results directly in higher quality care. The planned survey of bereaved relatives may be appropriate in the evaluation of the LCP and aspects of the GSF and Preferred Priorities for Care. Other approaches need to be developed to evaluate the experience of the increasing number of elderly people who live alone.	There is an international research programme in place for the LCP, which includes utilising the views of bereaved relatives as a means of assessing care. This is already providing data on the benefits to patients. The LCP team has also instituted a regular National Care of the Dying Audit of Hospitals to assess quality of care. A research study is also under way on the use of the Preferred Priorities for Care. The study is being run across the NHS North West SHA by the International Observatory on End of Life Care at Lancaster University. This is building on several smaller studies, and will evaluate the impact on patients, staff and carers. The National GSF Centre has a long-standing evaluation and research programme based at the University of Birmingham. Improving patient outcomes is key to the evaluation of the GSF, including issues such as dying in the preferred place of care. This was the focus of an After Death Analysis snapshot undertaken in 2009, which was supported by the National End of Life Care Programme and which reported in February 2010. Some GSF evaluation studies involve interviewing patients and their carers, which confirmed very positive perceived benefits. There are areas that require further research, and plans exist to address this, including proposed studies seeking the views of bereaved carers.
(8) Some 70 per cent of independent hospices have only one-year contracts with the NHS and for 97 per cent the funding they receive does not cover fully the costs of the NHS services they provide. PCTs should put in place three-year rolling contracts to enable hospices to better plan their use of resources and develop their services. These contracts should cover the costs of the NHS services provided, including relevant overheads. Hospices should be commissioned to provide wider support, for example, training of care home staff and the provision of outreach services to improve the quality of care for more people in the last year of life.	The Department undertook a survey of PCT expenditure on specialist palliative care in 2008, and made the results available to PCTs to help inform their commissioning decisions and the levels of funding they make available to hospices. The Department will be repeating this survey in 2011, providing a further benchmark for PCTs.
(9) More people could be supported to die in their homes or in a care home if there was a more responsive system for providing the equipment and support services needed. The Department should review how requests for equipment and other assistance that support people to remain in their homes are handled, and identify ways of improving the speed and flexibility of the provision of such services. PCTs should check that residents in care homes are provided with the same access to GPs and other health professionals as they would have if they were living in their own homes.	There has already been a general review on access to equipment: the Transforming Community Equipment and Wheelchair Services Programme, which was launched in 2006. This has led to the design of a new model for community equipment delivery, tested in the North West and the Transforming Community Equipment and Wheelchair Services Programme supported a further ten local authorities and their health partners to implement a retail model for community equipment. There may be specific issues that need to be addressed as a result of local demands and service configurations in relation to end-of-life care, for which a Departmental top-down approach would not be appropriate. To support local service development, the National End of Life Care Programme will identify, and disseminate, existing examples of innovative practice where approaches have been developed to resolve these issues.

NHS Pay Modernisation in England: Agenda for Change	(1) Agenda for Change (AfC) has not yet brought about service wide changes in the ways in which staff work despite the new pay system having been in place for nearly three years. The Department should identify and promote good practice examples of where trusts have used AfC to make measurable improvements in efficiency and patient care, for example, by staff taking on new roles and working more flexibly. Trusts should also identify a champion at board level to highlight such opportunities and provide the necessary leadership to drive productivity improvements from staff working differently.	The Department agrees that support at board level is crucial and ministers wrote to the NHS in May 2008 requiring each NHS board to have a named 'board champion' with key responsibility for the Knowledge and Skills Framework (KSF), the key mechanism to promote staff gaining the competences to take on new roles, work differently and improve productivity. By October 2008, nearly 70 per cent of organisations had board champions. The Department will continue to monitor progress.
	(2) In spite of the KSF having been re-launched twice, by autumn 2008 only 54 per cent of staff had received an annual knowledge and skills review. Full implementation of the framework is crucial to bringing about improvements in patient care and efficiency. The Department and SHAs should simplify the guidance and processes that serve to support the framework (in partnership with the NHS trade unions), and highlight examples of what it has achieved in trusts where it has been implemented well. In keeping with good management practice across the public and private sector, all trusts should ensure that every member of staff has received a KSF annual review by 1 April 2010.	To address these concerns, NHS Employers, on behalf of the parties on the NHS Staff Council (the employers and staff side body that oversees AfC), commissioned an independent review of the KSF. The review, which considered the KSF structure, processes, and barriers to implementation, produced its report in January 2010. The NHS Staff Council considered its recommendations at its meeting in March. It will make proposals for maximising the usage and benefits of the KSF and increasing appraisal rates across the NHS.
	(3) Between 2001 and 2005 NHS productivity, as measured by the Office for National Statistics (ONS), fell by 2.5 per cent a year on average, as growth in the amount of healthcare provided failed to keep pace with the growth in NHS staffing and resources. The Department and the NHS need to close this gap by having in place clear and transparent measures of productivity to identify areas where the pace of reform needs to be stepped up. Specifically: (a) the Department should provide a clear framework to enable trusts to separate improvements in service quality which are attributable to greater productivity from the impact of increases in resources. The Department and SHAs would then have the means to challenge trusts on whether their productivity improvement plans are sufficiently challenging and sustainable; and (b) the Department should, after discussions which have lasted several years, set a timetable with the ONS to reach an agreed methodology for measuring NHS productivity that fully reflects improvements in the quality of healthcare.	The Department partially agrees with this recommendation. It does not believe it will ever be able to measure the quality of NHS care comprehensively. It will, however, continue to work with the ONS and the Centre for Health Economics at the University of York to improve the measurement of NHS inputs and outputs and extend the measurement of the quality of care.
Financial Management in the NHS: Report on the NHS Summarised Accounts 2007-08	There are no outstanding recommendations from this report.	
Reducing Healthcare Associated Infection in Hospitals in England		The Department's responses to the Public Accounts Committee's recommendations were published on 28 January 2010 at: www.official-documents.gov.uk/document/cm77/7793/7793.pdf
Young People's Sexual Health: The National Chlamydia Screening Programme		The Department's responses to the Public Accounts Committee's recommendations were published on 25 March 2010 at: www.chlamydiascreening.nhs.uk/ps/media/news.html

Parliamentary Ombudsman

Area	In hand at 1 April 2008	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 31 March 2009
Department of Health	0	0	1	0	0	0%	0%	0%	1
Commission for Social Care Inspection	0	0	0	0	0	0%	0%	0%	0
General Social Care Council	0	0	0	0	0	0%	0%	0%	0
Healthcare Commission	359	0	153	14	440	36%	8%	56%	58

Footnote
(1) The Department aims to respond to complaints about the Department within 20 working days. In addition to processing complaints, the Head of Complaints also makes practice recommendations when a comp,aint is upheld. Details of how to make a complaint can be found at: www.ombudsman.org.uk.
(2) For the period 1 April 2008 to 31 March 2009, the Head of Complaints processed 117 complaints about the Department. For the same period, the Parliamentary and Health Service Ombudsman accepted one Department of Health referral for investigation which has yet to be reported on. The case related to the Postgraduate Medicla Education and Training Baord, which is now an independent regulatory body. Further details can be found in the Parliamentary and health Service Ombudsman's annual report for 2008-09.

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