Department of Health

Department of Health

Annual Report and Accounts

2016-17

(For the period ended 31 March 2017)

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

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

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

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

Ordered by the House of Commons to be printed on 18 July 2017

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This is part of a series of departmental publications which, along with the Main Estimates 2016-17 and the document Public Expenditure: Statistical Analyses 2016, present the Government's outturn for 2016-17 and planned expenditure for 2017-18.

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Permanent Secretary's Overview

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

This year has been challenging for the health and care system – the NHS has treated more people than ever before and responded to the needs of an ageing population whilst working to live within its means.

However, the system has risen to the challenge and in July 2016, NHS England and NHS Improvement set out a new approach for instilling financial rigour following a difficult financial year (2015-16). This has seen an overall return to financial balance in 2016-17 and the improvement in financial discipline during 2016-17 has set the direction of travel which the health and care system will need to adhere to over the coming years.

Alongside the considerable challenge of meeting the increasing demand on the system, we have seen the quality and safety of care remain stable for patients. In the longer term, we have made progress in addressing the challenges that lay ahead through maintaining our focus on improving and protecting people's health, supporting them to access services in their community and continuing to invest in our research programmes.

2016-17 has seen the Department of Health undergo significant change and although there is still more to do, we have made good progress towards our vision for the Department's future. We have enhanced our role as a Department of State, reviewing our role and purpose and ways of working to ensure we have the correct skills to lead the health and care system effectively.

I would like to take this opportunity to extend my personal thanks to all the staff both within the Department and across the health and care system for their continued and dedicated hard work, passion and commitment to support the Department and the wider health and care system.

Sir Chris Wormald KCB
Permanent Secretary of the Department of Health

Our Role and Purpose

1. The Department of Health (DH) supports Ministers in leading the nation's health and care. As a Department of State, we help people live healthier lives for longer; support the NHS to ensure efficient, productive, safe, timely and high quality hospital care; whilst transforming out of hospital care to keep people living better for longer in their community. In doing this, we remain accountable for the health and care system to Parliament and the taxpayer.

2. We set the strategy and direction for the system by leading the key strategic debates and linking into the wider government agenda. We also create and update the policy, legislative and financial frameworks within which health and care services operate and ensure a robust system of regulation is in place for the professions and allied industries.

3. We have reviewed our role and purpose and ways of working over the past year through the DH2020 change programme, which has ensured we have the skills required to lead the health and care system effectively and enhanced our role as a Department of State, which includes:
    - Providing direct support and advice to Ministers to help shape and deliver policy to meet the Government's objectives;
    - Setting the strategic direction for the system, by leading the key strategic debates and linking into the wider government agenda;
    - Driving accountability, by holding others to account and being held to account by Ministers and Parliament;
    - Acting as the guardians of the frameworks for health and care, including but not limited to legislative, financial, administrative and policy frameworks, designed to ensure the systems work to enable services to be delivered; and
    - Acting as the trouble shooters, who step in and help put things right if the system fails to work as it should.

4. The Department works through a number of Arm's Length Bodies (ALBs), whom we support and hold to account for carrying out their responsibilities, these are set out in further detail in The Accountability Report and include:
    - NHS England (NHSE) and NHS Improvement (NHSI) who collectively lead the NHS in England; ensuring patients receive high quality care in local health systems that are financially sustainable;
    - Health Education England (HEE) who work across England to deliver high quality education and training for a better health and health care workforce;
    - Public Health England (PHE) who protect and improve the nation's health and wellbeing, and reduce health inequalities; and
    - The Care Quality Commission (CQC) who monitor, inspect and regulate health and social care service.

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

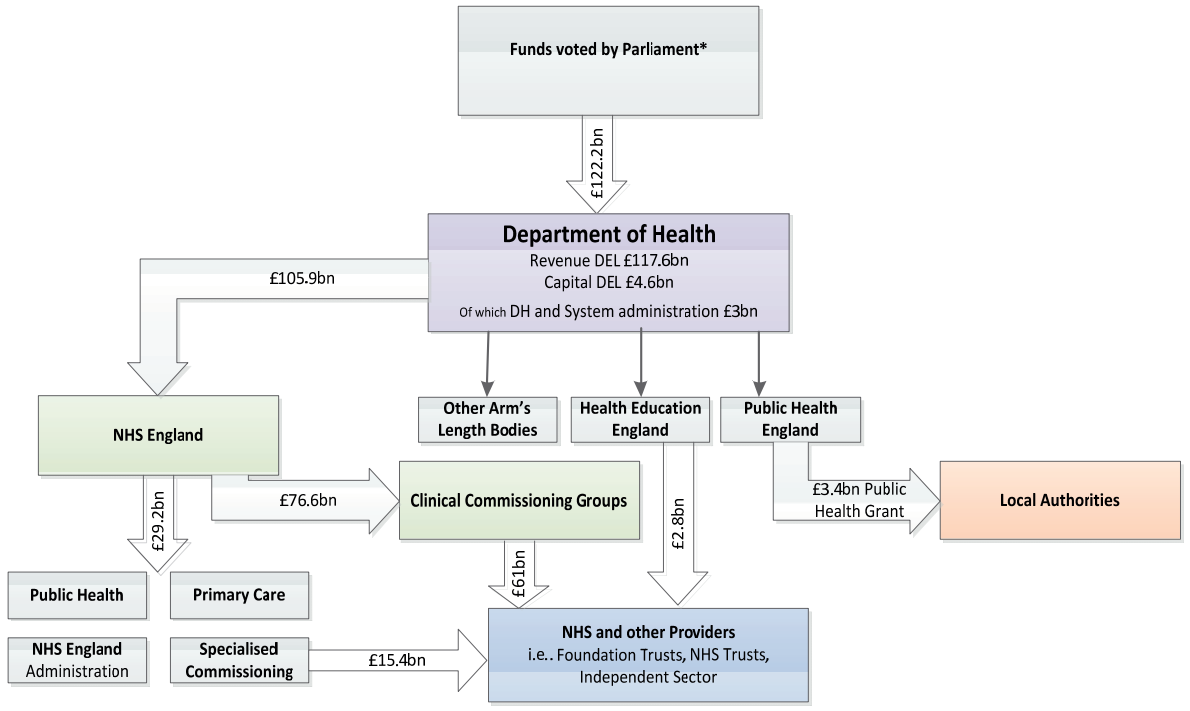
6. The Secretary of State for Health and other Departmental Ministers are accountable to Parliament for the provision of the comprehensive health service in England. To enable the system to work flexibly; the critical day-to-day operational decisions are made by the

professionals working in provider organisations, supported by the strategic and regulatory functions carried out by our ALBs.

7. We secure funds for health and care services and remain accountable for this funding, which is allocated to the most appropriate local level. In the last financial year, the Department has allocated revenue funding of £117.6 billion and invested a further £4.6 billion in capital funding such as new hospitals and equipment. Figure 1 demonstrates how funding flows round the system, using budgeted figures for 2016-17 for contextual purposes.

8. Separately and not shown in Figure 1, The Department is responsible for securing funds for adult social care through the Spending Review settlement, albeit the Department for Communities and Local Government (DCLG) is accountable for the allocation of those funds to local authorities.

Figure 1: Flow of funding in the health and care system, 2016-17 (Budgeted Position)



*This includes National Insurance Contribution funding not voted by Parliament
Note: Budget figures above may not reconcile directly with financial outturn in the Statement of Parliamentary Supply.

Our 2016-17 Achievements - At a glance

500,000 more A&E attendances managed than in 2015-16

Published **Childhood Obesity Strategy** August 2016

87.1% of GP practices offering partial or fully extended opening hours

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

£5.8bn of health and social care budgets pooled into **Better Care Fund**

Childhood vaccination uptake at **around 90%** of the target population

Mental Health First Aid training arranged in over **1,000 schools**

76% of social care and **89%** of primary care providers rated as **Good** or **Excellent** by CQC

Almost **£1bn** invested in infrastructure in the NHS to support research in the **next 5 years**

2.1% increase in NHS workforce.

(Jan 16 – Jan 17)

1.1 million patient appointments booked or cancelled using online services

2016-17 - Key Finance Facts

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

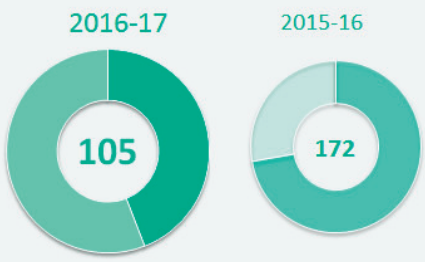
£3.8bn funding increase in NHS sector

(Compared to 2015-16)

The NHS broadly delivered overall **financial balance**

£1.8bn Sustainability and Transformation Fund helping to move NHS Providers to a financially sustainable footing

Reduction in the number of providers in **deficit**



£5.2bn (gross) **investment in capital**

Underlying **CCG overspend of £0.6bn**

£0.7bn pressures absorbed by Non-NHS sector

Performance Summary

9. The Department's Shared Delivery Plan (SDP)[1], covering the period to 2020-21, sets the strategic direction for the health and care system with its core centred on objectives that help people to lead healthier lifestyles, promoting responsibility for their own health and wellbeing and supporting people to age well and remain independent. This requires continued investment in the NHS to enable the provision of safe, high quality health and care services for every stage of a patient's life.

10. The challenges we face in achieving this vision are well known. We have an ageing population coupled with the increasing complexity of illness, contributing to a rising demand across the system. Rapid medical and technological advances allow us to treat more people but at a greater cost. We must therefore respond to these challenges but do so against the backdrop of EU exit negotiations which brings both opportunity and further challenge.

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

12. The NHS continues to treat a record number of patients, with demand for health and care services rising above what would be expected from population growth and demographics alone. Since 2010, the number of people over 80 has risen by 340,000 and life expectancy has increased by 12 months. Every day, the NHS undertakes 5,000 more operations, supports 1,400 more mental health patients and treats 130 more cancer patients than it did six years ago[2].

13. Despite the best efforts of the NHS, many of the waiting time targets in place for core NHS services were not achieved to standard during 2016-17 e.g. A&E, referral to treatment, cancer treatment, diagnostic tests and ambulances.

14. In particular, this year has seen our social care system under increasing pressure with concerns over the financial pressure on local authorities and social care providers. Although the Government has taken action, it is clear there is more to do to create a health and social care system that is sustainable and able to support people in maintaining their wellbeing and independence as well as easing pressure on the NHS.

15. In face of the continuing challenges facing our system, it is important not to lose sight of the longer term transformational and public health focus to support people to remain healthy and where that is not always possible, provide access to the care they need in the most appropriate setting. Whilst transformation activity hasn't made as much progress as originally planned, there has been good progress made on public health e.g. with the publication of the Childhood Obesity Strategy to support children and parents to lead healthier lives, childhood vaccination uptake at around 90% of the target population and almost a quarter of GP practices are now offering full extended access with pre-bookable weekend and evening appointments for every weekday.

[1] https://www.gov.uk/government/publications/department-of-health-shared-delivery-plan-2015-to-2020
[2] https://www.gov.uk/government/publications/nhs-mandate-2017-to-2018

16. Ensuring people have timely access to high quality services; are supported to live healthier lives and access services closer to home; and that these services remain sustainable has proved challenging during the year and it is clear there is certainly more to be done over the coming years.

17. The quality and safety of the care patients receive has remained stable, evidenced by the findings of the Care Quality Commission inspection of hospitals, all GP practices and social care providers that completed this year. Although there is more to do to continue improving services, there has been good progress made particularly in improving the quality of the care provided.

18. Despite the continued rise in activity during the year, the NHS has still balanced its financial budget through a focus on financial rigour and efficiency savings achieved in-year. This contributed to the Department containing all spending within the overall budget authorised by Parliament.

19. A more detailed analysis of the Department's performance in 2016-17 is presented below, including further analysis on the delivery of our key objectives, progress against the objectives set out in our Shared Delivery Plan (SDP) and performance against outcomes frameworks contained in the Secretary of State's Annual Report.

20. The objectives in our current published SDP are cross-cutting and our performance against these cannot be isolated to one specific measure. For the purposes of this Annual Report, the 9 SDP objectives have been grouped into three key themes, with one objective (Maintaining and improving performance against core standards while achieving financial balance) split across two of the themes:

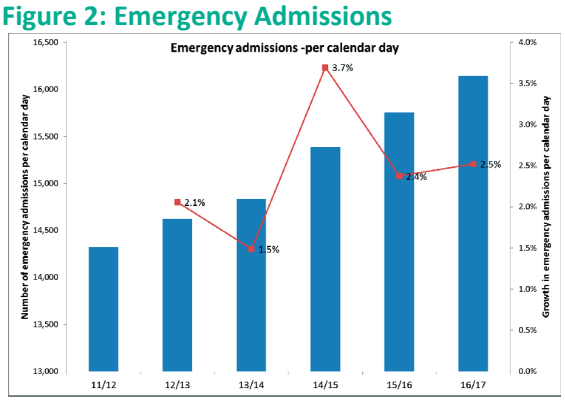
Helping People live healthy lives			
Maintaining and improving performance against core standards	Preventing ill health and supporting people to live healthier lives	Improving out of hospital care	Enabling people and communities to make decisions about their own health and care
Creating a safe, high quality healthcare system			
Creating the safest, highest quality healthcare services	Building and developing the workforce	Supporting research, innovation and growth	Improving services through the use of digital technology, information and transparency
Delivering a financially sustainable system			
Achieving financial balance		Improving efficiency and productivity	

Performance Analysis

Helping people live healthy lives

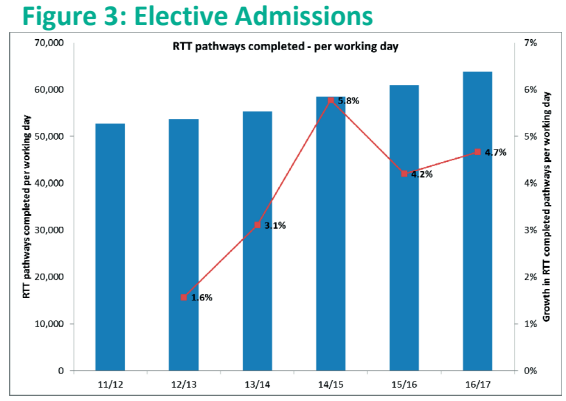
21. Demand for services provided in the health and care system continues to rise above what would typically be expected from population growth and demographics alone. To meet this demand the NHS continues to deliver more activity than ever before, as evidenced by the number and growth in emergency admissions and elective (i.e. non-emergency) treatments over the last 5 years (figures 2 and 3).

Figure 2: Emergency Admissions



Source: Hospital Episode Statistics for Admitted Patient Care, Outpatients and A&E data. M11 – 12 averages.

Figure 3: Elective Admissions



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

22. Compared to 2015-16, the NHS managed 500,000 more A&E attendances, 1.07 million more completed pathways from referral to treatment, 300,000 more ambulance responses, 150,000 more people seen by a specialist for suspected cancer and 1.15 million more diagnostic tests performed. Although the NHS treated more patients than ever, core performance targets were not met (summarised below and in Annex C).

23. National performance for A&E waiting times in 2016-17 is 89.1%, not meeting the standard that 95% of patients should be admitted, transferred or discharged within four hours of arrival in an A&E department. There has also been an increase in the number of emergency admissions from A&E with more patients admitted with higher levels of acute need.

	2016-17	2015-16
National A&E waiting time		
A&E attendances (million)	23.4	22.9
of which: Emergency Admissions (million)	4.3	4.1
National Standard* (%)	95.0	95.0
Actual performance (%)	89.1	91.9

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

24. Demand for Ambulance services increased this year with 5% more emergency calls receiving a face to face response compared to 2015-16, however performance standards were not met for the year as a whole.

Ambulance Responses	2016-17	2015-16
Face to Face responses (million)	6.9	6.6
999 calls (million)	10.0	**
National Standard* (%)	75.0	75.0
Actual performance Red 1 (%)	68.7	72.5

** 75% of calls for life threatening or serious receiving a response within 8 minutes.*
*** Number of 999 calls for 2015-16 was not calculated.*

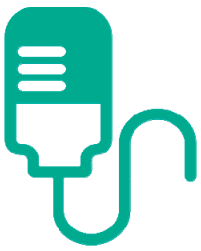
25. Performance against the elective waiting time standard - referral to treatment (RTT) incomplete pathway standard has deteriorated this year with the standard not met in any month of 2016-17. Although there has been a 4.7% rise in activity compared to last year, the underlying waiting list grew by 6% over the year.

Referral to treatment for non-urgent conditions	2016-17	2015-16
Total number of completed pathways (million)	15.7	14.6
Waiting List (million)	3.9	3.7
National Standard* (%)	92	92
Actual performance (%)	90.3	91.5

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

26. The eight cancer waiting time standards are crucial to improve cancer survival rates through early diagnosis and treatment and the majority of these standards were met this year. This includes the standard that 96% of patients should begin first treatment within 31 days of a decision to treat, which was met in every month in 2016-17.

27. Demand has continued to rise, with urgent GP referrals rising by over 200,000 compared to last year and although performance has remained stable over 2016-17, the standard that 85% of patients begin first treatment within 62 days of urgent GP referral for suspected cancer was not met in any month of 2016-17.



Cancer	2016-17	2015-16
Urgent GP referrals for suspected cancer (million)	1.9	1.7
Patients starting treatment for cancer in 2016-17 (thousand)	290	282
National Standard* (%)	96	96
Actual performance (%) March	98.0	97.6

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

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

29. The increasing number of patients has severely tested the resilience of the NHS during the year. The Department, through its national partners including NHS England and NHS Improvement, has worked across the system to support the most challenged providers stabilise performance and this work will continue into the next financial year and include plans to:
    - redesign elective care pathways and referrals process;
    - support local clinical commissioning groups to respond effectively to a winter surge; and
    - provide intensive support for Trusts where resilience is lacking.

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

Preventing ill health

31. The Department has worked to support people live healthier lives and to prevent ill health by putting measures in place this year that will improve the long term health of the public and avert the need to access services in the future. The Public Health Outcomes Framework (PHOF) section of the Secretary of State's Annual Report provides further detail on indicators in this area.

32. The Childhood Obesity Strategy[3] published in August 2016 sets out the Government's intentions to significantly reduce childhood obesity and support people to make healthier choices. This will include implementing measures such as a soft drinks levy and working with the industry to reduce the amount of sugar in certain food groups by 20%.

33. The Government also introduced standardised packaging for tobacco and implemented the new European Union Tobacco Products Directive, a measure designed to reduce the appeal of cigarettes particularly for children. Over time, this work is expected

[3] https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action

to help drive down smoking prevalence and reduce smoking related premature illness and mortality.

34. To further protect and improve people's health in the UK and internationally we have maintained our focus on delivering robust vaccinations programmes, addressing the threat of antimicrobial resistance (AMR).

35. Uptake for most of our immunisation programmes, which protect against 16 different diseases, remains very good with most childhood vaccinations at over 90% uptake amongst the targeted population. NHS England and Public Health England are working to encourage uptake of vaccinations where it remains low.

36. The UK has maintained its commitment to slowing the growth and spread of antibiotic resistance which poses a threat to keeping people healthy in future. There are clear ambitions for the NHS to halve certain healthcare associated blood stream infections and inappropriate antibiotic prescribing by 2020 and we are already seeing reductions in overall antibiotic use by the NHS.

37. Work to prevent ill health extends internationally and the Department has taken steps to improve Global Health Security using the Government's Official Development Assistance funds to tackle antimicrobial resistance, improve the compliance of countries with International Health Regulations, respond to disease outbreaks and invest in researching into vaccines against diseases of epidemic potential (such as Zika and Ebola).

38. During 2016 we were a leading force in securing a comprehensive political declaration on AMR at the UN General Assembly. We appointed a management agent to design and deliver our Fleming Fund country and regional grants, and Fleming Fund fellowships for placements in low and middle income countries. We launched the UK public health rapid support team and invested in 26 R&D projects researching into vaccine development through the UK Vaccine Network to tackle diseases that pose a global threat.

39. With an ageing population, it remains essential to support people to remain healthy as they age and this year the Department and its partners have focused on improving the diagnosis rate for dementia. The latest data indicates that the monthly diagnosis rate has exceeded our ambition of 67%. Work with NHS England to reduce the variation in treatment and support across the country is continuing, including through the launch of the Dementia Atlas in August 2016 which maps out the care available across the country and points to where more progress needs to be made.

40. There are around 800,000 NHS staff who are Dementia Friends[4] and over 100,000 social care staff who have been trained in better supporting people with Dementia.

Dementia Friends
An Alzheimer's Society initiative

41. There has also been significant work with Department of Work and Pensions (DWP) through the Health and Work programme to transform our approach to long term health conditions to better support the health and wellbeing of people in and out of the

[4] https://www.dementiafriends.org.uk/

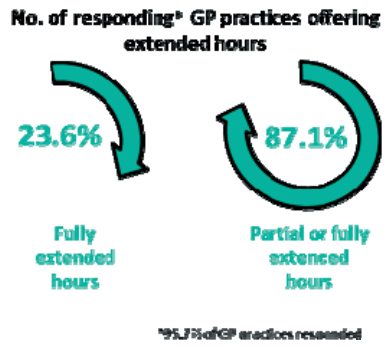
workplace and increase the number of disabled people and/or those with long term conditions in employment.

42. *Improving Lives: The Work, Health and Disability Green Paper*[5], was published in October 2016. This set out the short-term action needed to bring about change across welfare, employers and health systems and invited views on a 10 year strategy for reform. Alongside this publication, we ran a 15 week national consultation, which has received a great number of responses.

Transforming Care in the Community

43. To ensure services remain sustainable over the long term, transforming health and care through integration of services; harnessing technology; life sciences; improving pathways; leadership and clinical behaviours are all essential to ensure patients receive safe care of the highest quality in their community or the hospital based services they access.

44. Work has been ongoing to improve patient access to GP services in the evenings and at weekends to ensure that by 2020, 100% of the population can access enhanced GP services and that NHS commissioners have the capacity to meet local needs. In October 2016, data collection from GP practices on the availability of pre-bookable evening and weekend appointments started to improve our understanding of access across the country. The most recent collection demonstrates that the roll out of extended access is on track.



45. Providing the most appropriate patient support requires us to look across organisational boundaries to identify where and how we can transform our approach. NHS England have encouraged this through the publication of Sustainability and Transformation Plans (STPs)[6]; published for a total of 44 areas with the aim to better integrate and transform the services offered to people across England. STPs bring together over 440 NHS organisations with 152 local authorities to work across organisational boundaries and take advantage of opportunities to improve how services work together.

46. The Five Year Forward View for Mental Health[7] report made it clear that more work was needed to improve mental health services in this country and that a far-reaching programme across organisational boundaries was necessary. In January 2017, the Government published an official response to the report and we have worked to deliver our commitments to improve the support available, not just in the NHS but across wider sections of our society. This included plans to deliver Mental Health First Aid training in all 3,000 secondary schools by 2019, with courses reaching over 1,000 schools already arranged until the end of 2017. An evaluation is planned in 2018 to ensure the programme is being delivered effectively and that there is improved capability to handle mental health concerns at an early stage.

[5] https://www.gov.uk/government/consultations/work-health-and-disability-improving-lives
[6] https://www.england.nhs.uk/stps/
[7] https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

47. Alongside the new measures announced in January 2017, the Improving Access to Psychological Therapies (IAPT) Programme has allowed adults living with common mental health conditions to talk to a mental health professional to help them to manage their conditions. In 2015-16, over 900,000 people accessed IAPT services; over 81% of referrals were seen within 6 weeks, and over 96% were seen within 18 weeks – both above the waiting times targets. The figures for 2016-17 were not available for inclusion within this Annual Report, but quarterly returns suggest waiting times are still being met in the context of increasing referrals to services. By 2020-21, services will be expanded so that at least 1.5 million people can access IAPT treatment.

48. There has been considerable concern in the past about the inappropriate use of police cells for those detained under Section 136 of the Mental Health. The 'Health based Places of Safety scheme' has been designed to replace the use of police cells and ensure people receive an assessment or treatment in an appropriate setting. Since the start of the project we have seen the use of police cells for holding those detained under the Act drop by over 50%, and by over 80% for those participating in the scheme. The further investment announced in January will help to build upon this achievement; by further enhancing crisis services and post-crisis support to reduce the likelihood of a repeat incident. Our aim is to achieve near zero use of police cells for people experiencing a mental health crisis and to eliminate their use altogether for under 18s.

49. A digital programme to develop and trial tools and support for people to stay mentally healthy was also announced with £67.7 million of funding to be invested over the next 3 years. The programme will help people to effectively manage their own mental health.

Social Care

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

51. The social care system has come under increasing scrutiny this year with concerns over the financial pressures on local authorities and social care providers and it is increasingly clear that the Government must take further action to ensure it remains sustainable in future.

52. The first of these steps is to invest an additional £2 billion in funding over the next few years to enable councils to meet adult social care needs generally, stabilise the social care provider market and reduce immediate pressures on the NHS. The funding will build on the approach of the Better Care Fund (now in its second year) to encourage councils to work with NHS colleagues in an integrated way.

53. The Better Care Fund (BCF)[8] is a mandatory pooled budget between clinical commissioning groups and local authorities to support more person-centred, coordinated care. In 2016-17 the BCF increased to a mandated

£5.8bn pooled into **Better Care Fund**

[8] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

minimum of £3.9 billion; however in a clear show of support for continued integration the actual amount pooled by local areas was closer to £5.8 billion.

54. The Integration and Better Care Fund Policy Framework 2017-19[9] published on 31st March 2017, provides detail on what good integration looks like and how it will be measured and will support local areas to integrate further and challenge their established ways of working.

55. Continuing demographic pressures mean that the extra money announced at the Budget will not be enough on its own to stabilise the medium to long term future of social care. Further work is required to address pressures on the social care workforce where recruitment and retention of staff remain a challenge. The Department is working with Skills for Care to support care providers in how we recruit and retain social care staff. The Department is also refreshing the Adult Social Care Recruitment and Retention Strategic Forum, which amongst other things seeks to support the development of apprenticeships and recruitment tools (such as Finders and Keepers).

Creating a safe, high quality healthcare system

Quality and Safety

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

57. The mechanisms to measure quality are more comprehensive than ever before, with the Care Quality Commission (CQC) having a clear picture of quality levels across the country from their full and completed inspection programme of all hospitals, GP surgeries and care home providers (that began in 2014).

Providers inspected by CQC since 2014:	**136** NHS Acute Trusts inspected:
• **136** NHS Acute Trusts • **17** Specialist NHS Trusts • **7,705** GP Surgeries • **29,264** Adult Social Care	• **9%** rated inadequate • **59%** rated as needing improvement • **29%** rated as good • **4%** rated as outstanding

58. CQC published the results of its comprehensive inspection programme, including the State of Care in Hospitals report[10] in March 2017. The report showed most hospitals are delivering good quality care and looking after patients well, but there are some trusts that have blind spots about the quality of care in certain services which must be addressed. There are currently 15 Trusts in Special Measures for quality, the support regime for trusts rated inadequate by CQC. While there continues to be variation in quality in social and primary care too, by the end of 2016-17 the CQC had rated 76% of social care and 89% of primary care providers as good or outstanding.

[9] https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019
[10] http://www.cqc.org.uk/content/state-care-nhs-acute-hospitals

59. NHS Improvement published and implemented its Single Oversight Framework in September 2016[11], which supports provider organisations to achieve and maintain CQC ratings of good or outstanding. Further, NHS Improvement has supported nine trusts to exit Special Measures, the support regime for trusts rated inadequate by CQC.

60. The drive for improved quality of care delivered by hospitals saw a Government commitment for the NHS to provide the same standards of care, seven days a week, for people who need urgent and emergency hospital care. During 2016-17 NHS trusts have been working to achieve the four priority seven day services clinical standards so that 25% of the population have access to care that meets these standards.

61. As the number of patients treated continues to rise, maintaining safety levels is essential and the CQC inspection results show that we have more work to do here with many hospitals lacking effective safety cultures or systems. This year has seen the Department and its partners take steps towards addressing these underlying issues through establishing the Healthcare Safety Investigation Branch (HSIB)[12] and the Learning from Deaths programme[13].

62. HSIB has been established to conduct up to 30 investigations a year into serious incidents in the NHS and began operating from 1 April 2017. These investigations will focus on generating lessons to reduce patient harm and build capability to raise the standards of local investigations. HSIB's approach draws heavily on lessons from other sectors for which safety is a critical priority, such as rail, maritime and aviation.

63. The Learning from Deaths programme was established in response to the CQC report Learning, Candour and Accountability[14]. It found that Learning from Deaths needed higher priority in the NHS to avoid missing opportunities to improve patient care. Guidance was issued in March 2017 to all Trusts on how to learn from in-patient deaths and this learning will be captured in Trusts' annual *Quality Accounts*.

64. The NHS Litigation Authority became NHS Resolution (NHSR) in April 2017 with an enhanced focus on mediation, learning and prevention as well as litigation. It will play a role in broader work to ensure complaints and other feedback in respect of NHS care are handled well and that an improved experience for patients will reduce the likelihood of their bringing a litigation claim against the NHS.

65. Safety in maternity care has also been a priority this year, with *Safer Maternity Care: next steps towards the national maternity ambition*[15], published in October 2016. The plan sets out the actions needed at national and local levels to build on the progress we have already made to improve the safety of maternity services. It also includes £10 million in new funding to enable maternity services to purchase new equipment and undertake training, and to deliver the National Standardised Perinatal Mortality Review Tool (PMRT) which will support maternity and neonatal units in sharing learning from case reviews into every stillbirth and neonatal death. Further detail on perinatal mortality is included within the NHS Outcomes Framework section of the Secretary of State's Annual Report.

[11] https://improvement.nhs.uk/resources/single-oversight-framework/
[12] https://www.gov.uk/government/groups/independent-patient-safety-investigation-service-ipsis-expert-advisory-group
[13] https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/
[14] http://www.cqc.org.uk/content/learning-candour-and-accountability
[15] https://www.gov.uk/government/publications/safer-maternity-care

66. The UK also continued to play a leadership role on international patient safety and we supported Germany to host the second Global Ministerial Summit on Patient Safety in Bonn in March 2017, securing backing from more than 40 countries for an annual global patient safety day.

67. All of these initiatives will help bring us closer to the NHS becoming the world's largest learning organisation so when things do go wrong, lessons are learned and shared quickly.

Investment in Infrastructure, Research and Innovation

68. In order to improve the future quality and safety of services the Department has also maintained a strong focus on investing in infrastructure and research to support innovation.

69. Amongst a range of centrally directed capital investments undertaken across the health and care system during the year, some of the larger capital programmes included:
    - payment of Disabled Facilities Grant funding to Local Authorities;
    - funding for radiotherapy upgrades (Linear Accelerators);
    - funding for Mental Health Places of Safety;
    - continued funding of major hospital builds including over £40 million each for schemes at Brighton and Sussex University Hospitals NHS Trust and West London Mental Health NHS Trust.

70. The National Institute for Health Research (NIHR) continued to provide the support and facilities the NHS needs to conduct first-class research into delivering the highest quality of care. This also plays an important role in maintaining the UK's competiveness as a global destination for research. NIHR have funded a range of research facilities translating research for the benefit of patients with almost £1 billion invested in infrastructure in the NHS to support research in the next five years.

71. To support the NHS in becoming a world-leader in patient safety the Government announced that £17 million of NIHR funding would be invested in three new NIHR Patient Safety Translational Research Centres, which applies advances in basic research with relevance to patient safety into an applied healthcare setting. These will be based in leading NHS and university partnerships over five years from August 2017 and will build on the work of the existing two centres.

NIHR funded infrastructure in 2016-17
20 Biomedical Research Facilities
14 Experimental Cancer Medicine Centres jointly with Cancer Research UK
23 Clinical Research Facilities
3 Patient safety Research centres

72. This year more than 660,000 people across the country participated in clinical research studies supported by the NIHR Clinical Research Network. The

The NIHR Clinical Research Network supported **1,008** commercial studies to recruit participants in 2016-17 – a **10 % increase** on the previous year

NIHR also attracted more investment from the life sciences industry by increasing the number of studies supported by its Clinical Research Network.

73. The Department, via the NIHR is committed to attracting, developing and retaining a highly skilled health and care research workforce. This year, NIHR awarded four Research Professorships, 75 Research Fellowships, more than 250 Academic Clinical Fellowships and 105 Clinical Lectureships.

74. The Department remains committed to the 100,000 genomes project, which is enabling the foundations of the world's first mainstream genomics health service to be established and encouraging investment in the Life Sciences industry.

75. 13 NHS Genomic Medicine Centres have been set up with Genomics England now having one of very few semi-automated systems in the world that codes and understands large quantities of bioinformatics, meaning patients with rare diseases are receiving diagnoses for the first time. The project was initially due to be completed by 31 December 2017, however fewer sequences have been completed than anticipated due to the scientific and operational challenges surrounding the sequencing of cancer genomics. Due to these difficulties, the project has been extended for a further year.

Workforce

76. The commitment and expertise of the health and social care workforce means that the NHS and adult social care is able to continue delivering high quality, safe and effective services. Between January 2016 and January 2017, the size of the NHS workforce increased 2.1% to over 1 million FTE posts; including over 1,700 more doctors and 900 more nurses and health visitors. However, it is recognised that more needs to be done to support the people who work in health and social care and ensure the workforce of the future is able to meet demand.

77. There are currently 140,000 staff from EU27 countries making an important and valued contribution to our health and care system and securing their position has been made a priority in negotiations on exiting the European Union. At the same time, the Department and its ALBs are putting in place measures to enable England to be more self-sufficient in securing the staff it needs in future.

78. During 2016, junior Doctors were involved in industrial action following the British Medical Association, NHS Employers and the Health Secretary agreeing the implementation of a new junior doctor's contract. Around 125,000 planned operations and 1 million outpatient appointments are thought to have been cancelled as a result of the three separate strikes that followed between October 2016 and December 2016.

79. A range of measures have been taken to improve the wellbeing of our junior doctor workforce, not just through stronger limits on working hours in the new contract but also through initiatives to improve their working lives. For example, we have invested £10 million to help support doctors returning from maternity leave and NHS Employers has

published a new code of practice to ensure that junior doctors have earlier notice of their rotation schedules. This work continues as a priority.

80. Alongside this work, we have also made significant progress towards ensuring we have sufficient numbers of staff in future. Reforms to the funding of education for nurses, midwives and allied health professionals are expected to result in up to an additional 10,000 training places at universities by 2020. Additionally, we have allocated the first 500 new medical training places and, subject to the outcome of our consultation, will allocate a further 1,000 in 2017.

81. Through a significant focus on the use of apprenticeships in the NHS we have also increased the number of routes in to practice and the range of advanced practitioner roles our most talented staff can move in to. The launch of new roles, such as the Nursing Associate, increases the mix of skills in the NHS and creates opportunities for staff to concentrate on the tasks they are best qualified to carry out. These measures mean that the NHS is a more attractive place to work which will help ensure health and care continue to be able to recruit and retain the most talented and caring staff.

2,000 new Trainee Nursing Associates
2,000 Nurses ready for employment
900 Nurses back on the front line since 2014

82. However, there has been particular difficulty in building on the number of GPs in practice and despite ongoing work there was a drop in the effective GP workforce, from 34,914 full-time equivalent GPs recorded in March 2016 to 34,372 full time-equivalents in March 2017. Workload is still cited as the biggest factor in why experienced GPs consider leaving the profession and more work is needed to both recruit and retain more GPs whilst continuing our longer term transformational work.

83. There is therefore even greater importance on the work aimed at recruiting additional GPs by 2020 through introducing measures designed to boost recruitment. However, although things are moving in the right direction, there is still an opportunity to attract more medical students to the specialism and ensure that the number of GPs begins to rise again. There has also been ongoing work to help doctors return to practice or to support them to remain in practice. Both schemes have attracted a good number of GPs but it is clear that GPs require support from additional staff.

GP Training places offered by HEE
3,250 GP training places each year
3,019 GP training places filled in 2016-17 (4.3% up on 2015-16)
500 Doctors return to practice

84. Alongside increasing the number of doctors working in primary care, the Government announced a commitment to ensuring a minimum of 5,000 additional staff working in general practice by 2020-21 to broaden the mix of skills and specialisms available to patients and support the work of GPs.

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

Digital Health

85. Alongside work such as the mental health digital programmes, the Department is looking at how to underpin all health and social care services with a strong digital approach that personalises health care and empowers people to make decisions about their own care. The better use of data and technology has the power to improve health, transform quality and reduce the cost of health and care services and remains an essential part of changing the long term approach to delivering services. During the year, 23 Global Digital Exemplars were launched (16 acute and 7 mental health hospitals) who are trailblazing new ways of using digital technology to radically improve patient care.

86. During 2016-17, we designed and implemented a new cross-system governance mechanism for information and technology and appointed to the new role of Chief Clinical Information Officer to oversee delivery of a portfolio of programmes to transform health and care through information and technology (Personalised Health and Care 2020). Through these and other technology developments, amongst other achievements, 1.1 million appointments are now booked or cancelled using patient online services and 1,000 GP surgeries in England now are able to offer free Wi-Fi in 20 CCG areas, a potential reach of over 5 million patients.

87. We have also identified 10 areas of service transformation which will help us build towards a personalised healthcare system and ensure that people are able to manage their own care and access information more easily. The creation of a new NHS apps library in April 2017 which allows patients to access online services to support their self-care is one area in which we can empower people to maintain control over their health.

88. Although it is important that services and patients are able to access healthcare data, it remains important that this is done in a safe, secure and legal way. The Government consulted on the National Data Guardian review, to understand how to manage data appropriately and to further help us understand how to improve the access people have to their own healthcare information. The Government takes cyber security seriously and since 2015, we have ensured that over £50 million has been made available to provide central support to the health and care system through the CareCERT[16] suite of services. This CareCERT service, provided by NHS Digital, is how we were first made aware of the ransomware cyber-attack in May 2017. More detail is included within the Governance Statement.

[16] https://digital.nhs.uk/cyber-security

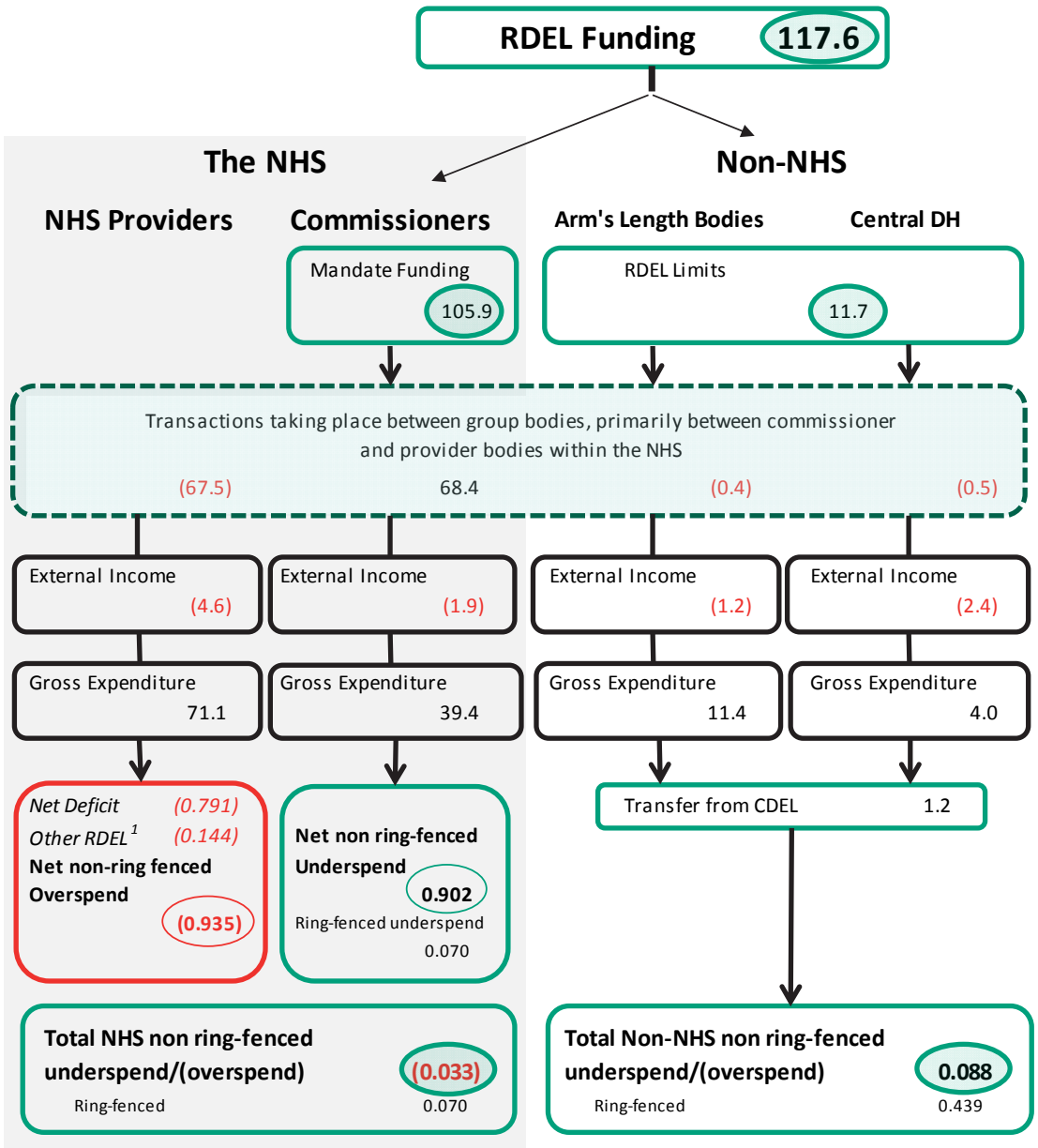
Delivering a financially sustainable system

89. To enable the NHS to treat more patients than ever, funding continues to rise each year in real terms with total gross expenditure in the health and social care system reaching over £130 billion during the year; with £127.1 billion and £5.2 billion spent on revenue and capital respectively across the NHS and non-NHS sectors.

90. The illustrations below provide an overview of how the Department's net revenue funding moves around the system (Figure 4) and on what expenditure was incurred (Figures 5 and 6). Further detail is provided in the Accountability Statements and Financial Statements within this Annual Report and Annex B.

Flow of money around the Health & Care System

Figure 4: Revenue Departmental Expenditure Limit (DEL) – sector breakdown



Figures above are in billions. The Department is funded and expenditure recorded on a net basis.
[1] Other RDEL include adjustments to reflect the correct DEL scoring of income and depreciation of donated assets, PFI spending and provisions which are not included within provider deficit figures.

Figure 5: Revenue DEL – spending breakdown (also see SOPS 1.1)

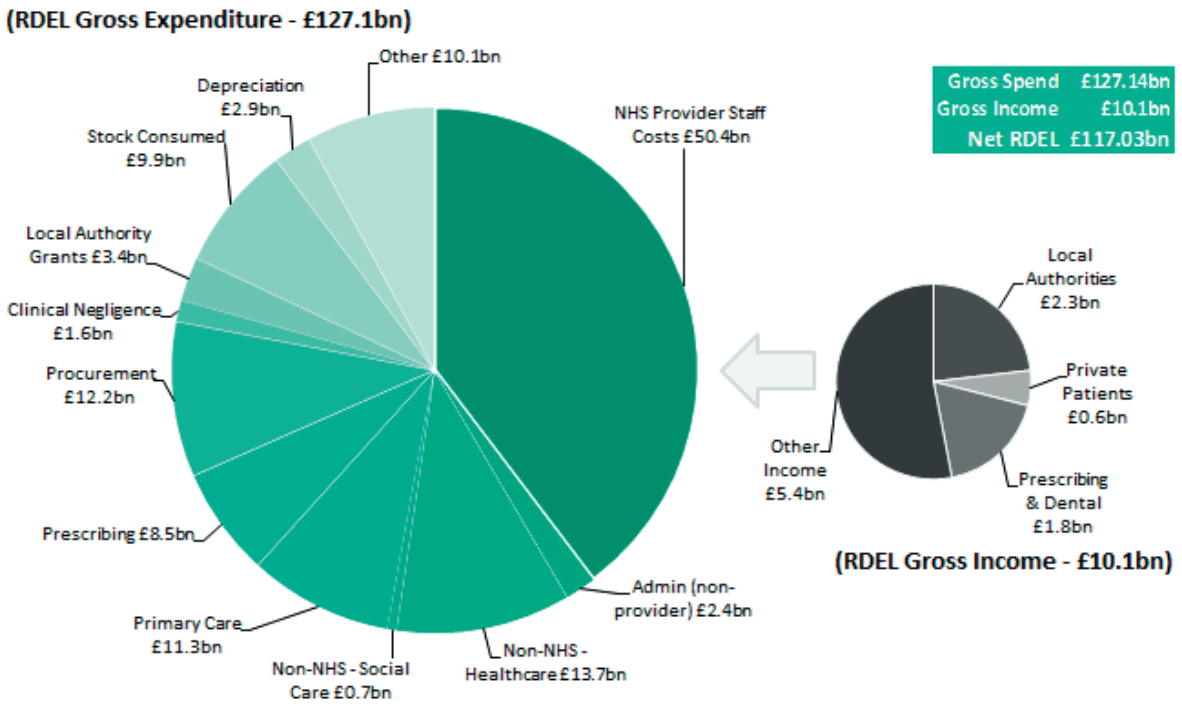
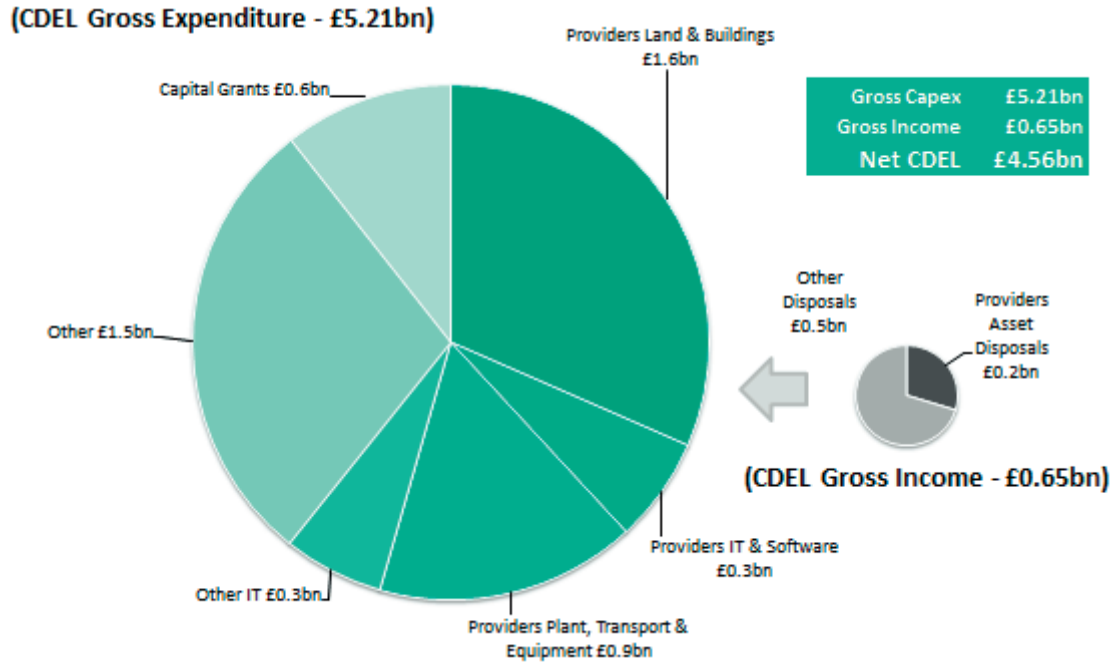


Figure 6: Capital DEL - spending breakdown (also see SOPS 1.2)



The figures in the illustrations above detail the gross RDEL and CDEL expenditure and RDEL and CDEL income for the DH Group. This differs from the presentation in the Statement of Parliamentary Supply (SOPS) notes 1.1 and 1.2 as not all DH Group bodies are detailed on a gross expenditure and income basis.

Department of Health Financial Performance

91. The Department is accountable to Parliament for ensuring that total spending by the Department, NHS England, NHS Improvement, other ALBs and by local bodies is contained within the overall budget authorised by Parliament. To support this, the Department has made NHS England and NHS Improvement responsible for ensuring the NHS overall balances its budget.

92. During 2016-17, the Department contained its resources within all budgets authorised by Parliament and the NHS broadly delivered financial balance for the sector as a whole. The table below details the Parliamentary controls against which performance is measured, with further details provided in the SOPS and Annex B within this Annual Report:

Table 1: Departmental Outturn 2016-17

	Budget £m	Outturn £m	Under/ (Overspend) £m	Key disclosure notes/further detail
Revenue Departmental Expenditure Limit (RDEL)	117,594	117,031	563	SOPS 1.1, Annex B
Capital Departmental Expenditure Limit (CDEL)	4,616	4,556	60	SOPS 1.2, Annex B
Revenue Annually Managed Expenditure (RAME)	16,150	9,508	6,642	SOPS 1.1, Note 16
Capital Annually Managed Expenditure (CAME)	15	13	2	SOPS 1.2

93. The Department's 2015-16 financial position, as outlined in 2015-16 Annual Report[17] emphasised the significant challenges facing the NHS for 2016-17 and beyond. In addition to the work to help people to stay in good health and live independent lives, an additional 3 key components were instigated to support financial recovery and sustainability across the system:

- Extra investment in the NHS and social services;
- Restoring financial discipline; and
- Promoting efficiency and productivity in the NHS Provider sector whilst controlling cost pressures.

94. In spite of the continuing fiscal challenges, the commitment to increase health funding each year was reaffirmed in the 2015 Spending Review.

95. Further, the NHS was given the front loaded Spending Review to fund the levels of demand and workforce productivity set out in its own plan – the Five Year Forward View[18]. In 2016-17, NHS Revenue DEL funding increased by £3.8 billion to allow for major investment in NHS front line services. To facilitate this level of additional NHS funding, £1.2 billion was transferred from the Department's Capital budget as agreed with HM-Treasury whilst a further £0.6 billion has been reinvested from savings in the Department's non-NHS budgets.

96. The Government published its Mandate for NHS England, with a clear expectation that NHS England (NHSE) and NHS Improvement (NHSI) together were to ensure overall financial balance in the NHS during 2016-17. To support this challenge and the need to

[17] https://www.gov.uk/government/publications/department-of-health-annual-report-and-accounts-2015-to-2016
[18] https://www.england.nhs.uk/five-year-forward-view/

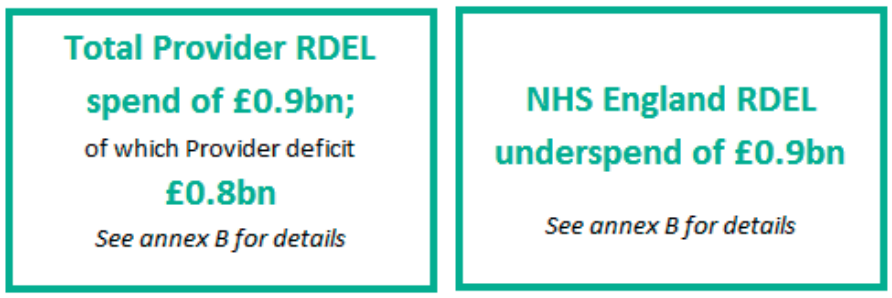
restore immediate financial discipline, a strong recovery plan was agreed by NHSE, NHSI and the Department consisting of the following actions:

- Agreeing "financial control totals" with individual trusts and Clinical Commissioning Groups (CCGs) and incentivising organisations to deliver these;
- Replacing national fines previously imposed on providers with trust-specific initiatives;
- Introducing a new Finance Special Measures regime, aimed at assisting those NHS bodies in severe financial difficulty through agreed recovery plans and packages of intensive support designed to tackle financial failure;
- Setting controls to cap the cost of interim managers in CCGs and Commissioning Support Units to fast-track savings from back-office, pathology and temporary staffing;
- Being more transparent on performance variation by publishing 2015-16 performance ratings for CCGs; and
- Announcing a two-year NHS planning and contracting round for 2017-18 to 2018-19 linked to agreed STPs.
- Creating a central NHS "risk reserve", by NHS England holding back 1% of CCG allocations to cover pressures across the whole NHS.

97. Whilst there is still much to do to ensure financial rigour remains and continues into future years; significant progress has been made against this overall plan with the direction of travel firmly on the right footing. Specific actions taken in-year include:

- NHS Improvement implemented a plan to deliver a significant reduction in the deficit, to be achieved by agreeing control totals with the vast majority (96%) of NHS providers;
- Rewarding NHS providers who successfully met a combination of financial control and performance targets with an allocation of the £1.8 billion Sustainability and Transformation Fund (STF), including a bonus element for those who overachieved on financial performance;
- Placing several challenged NHS providers in financial special measures to ensure they receive dedicated support via a suite of measures to help restore financial discipline and ensure ongoing financial sustainability. NHS Improvement estimate that c£100 million worth of savings have been achieved as a result of this programme, and of those placed into financial special measures this year, three have exited during the year;
- A successful drive to reduce spend on expensive agency staff within NHS providers, resulting in a significant reduction compared to 2015-16;
- These and other measures have helped to stabilise and improve NHS provider finances. A net deficit of c£0.8 billion has been reported at year-end, which although £0.2 billion higher than planned is £1.8 billion lower than 2015-16 reported deficit, as discussed in Annex B;

Figure 7: NHS Financial Outturn



98. This year has also seen a continued focus on improving the efficiency of the system. The NHS through commissioners and providers has made considerable progress to date, delivering the efficiency requirement set in the 2016-17 national tariff. NHS Improvement has made substantial progress in promoting efficiencies in NHS providers through the Operational Productivity programme. This programme is supporting providers to deliver at least £5 billion efficiency savings to 2020-21, through recommendations as identified in Lord Carter's 2016 independent report *Operational Productivity and performance in English NHS acute hospitals: Unwarranted variations*[19].
Some examples where the NHS is implementing the recommendations and delivered savings in 2016-17 include:
    - Promoting uptake of better value generic medicines in hospital pharmacies;
    - Reducing the number of days that medicines supplies are held in stock by non-specialist acute hospitals across England;
    - Development of the NHS procurement price comparison tool to help providers to secure better prices for the equipment and tools that they purchase;
    - Increasing provider buying power of everyday hospital consumables through the Nationally Contracted Products programme; and
    - Improving efficiencies and patient outcomes in trauma and orthopaedics through the Getting it right first time (GIRFT) programme.

99. The net provider deficit was ultimately higher than planned, resulting in the need to fully utilise the risk reserve set aside by NHS England to ensure financial balance was broadly achieved across the NHS in 2016-17. Despite this, the plan to deliver financial balance did not work as well as planned and in response to the rising unplanned demand for acute care, transformational funding earmarked in the NHS' own plans for improving out of hospital care had to be diverted.

100. In addition to the continued need to maintain financial rigour, the focus going forward will be on moderating activity growth through programmes such as the new care models and right care and delivering improved workforce productivity by continuing work for non-specialist acute trusts to implement the 15 recommendations to optimise clinical and non-clinical resources as part of their business as usual. This been extended to include the GIRFT programme to reduce clinical variations across 31 specialities. NHSI has also begun work to identify efficiency and productivity opportunities for specialist, mental health, community and ambulance trusts.

101. Outside of the NHS group, the Department's Non-NHS sector contained revenue expenditure within DEL spending limits, contributing the initial £0.6 billion required to help mitigate the pressures in the NHS, whilst absorbing a starting over-commitment of around £0.4 billion plus emerging pressures of £0.3 billion relating mainly to lower drugs receipts and increased foreign exchange rate costs. This was done without compromising the support of the wider system, whilst safeguarding the interests of patients and the wider public.

102. As part of an agreement with HM Treasury, the Department has planned a time limited and reducing transfer of capital across the current Spending Review period, which in line with wider financial recovery plans will remove the need for unplanned capital reductions. During 2016-17, the Department deployed resources in order to meet the

[19] https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

NHS' overall spending priorities and transferred £1.2 billion from the capital budget to revenue; authorised by Parliament via the in-year Supplementary Estimate process.

103. The level of transfer was assessed prior to the 2016-17 financial year and as such was factored into the process of setting capital budgets across the system, including those non-NHS areas where the Department has direct control. For NHS providers; capital spending continues to be largely decentralised to local organisations that draw up their own investment plans in line with priorities, agreed strategic plans and local affordability assessments. An affordable capital envelope was set for the NHS provider sector and the Department worked closely with NHS Improvement during the year to monitor provider expenditure plans.

104. Overall DH gross capital expenditure during the year was £5.2 billion and remains in line with expenditure levels over the past two years. Whilst NHS capital spending priorities remain for local boards, health and safety expenditure should always be prioritised highly within this total capital spend.

105. Despite NHS Providers' capital expenditure being £126 million higher than the planned affordable envelope, offsetting underspends by non-NHS bodies in the DH Group resulted in a small underspend of £60 million (1.3%) against the total authorised CDEL budget set by Parliament.

106. The Department's Annually Managed Expenditure (AME) budget is set outside the Spending Review and has no immediate impact on the fiscal framework[20] or need for taxes to be raised to cover spending. The budget is materially affected by the need to provide for future costs in cases where the Department is the defendant in legal proceedings brought by claimants seeking damages for the effects of alleged clinical negligence. Note 16 of the Financial Statements has further detail on the clinical negligence schemes and factors effecting the long-term liability valuation.

107. The 2016-17 AME budget assumed a potential change in the methodology for segmentation of the clinical negligence provisions managed by NHS Resolution (NHSR) would take place. NHSR estimated the impact on the provision valuation based on a range of potential factors observed from experience in previous years and the Department set the total AME budget factoring this in. When reviewing the outcome of their analysis, NHSR decided not to proceed with the segmentation approach based upon a range of factors agreed with the NAO. This decision was made after increased budgets had been agreed in the 2016-17 Supplementary Estimate.

108. The impact of segmentation on the AME outturn was therefore zero; creating an underspend against budget. In addition, the results of actuarial work between January and March revealed favourable movements in key assumptions such as inflation in damages settlements, claims numbers, and the propensity for claims to settle with no damages.

109. During 2016-17; the Lord Chancellor's change to the discount rate used to value personal injury settlements significantly increased AME expenditure (see Note 16 to the Financial Statements), but this increase was more than offset by the decision not to segment the clinical negligence provision further based upon underlying data.

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

110. Therefore, in total we underspent on our AME budget by £6.6 billion; £4.6 billion of which related to the provisions managed by NHSR. Excluding the 2016-17 segmentation issue described above, the Department's overall AME underspend would have been equivalent to historic levels.

111. Whilst all of the above contributed to the Department living within its Revenue, Capital and AME Parliamentary controls, the difficulties in getting the NHS' finances on a stable footing have been publicly acknowledged there remains much to do.

112. There remains the need to follow the strong plan to maintain financial recovery in 2017-18 with the emphasis in the longer term being public health supporting people to remain healthy and where that is not always possible to provide access to the care they need in the most appropriate setting.

113. In parallel, there will be a continuing drive to improve the efficiency of NHS providers by reducing unwarranted variation in clinical practice and operating costs through the Carter programme, including the GIRFT programme referenced earlier. Having focused initially on non-specialist acute providers, this work is now being extended to identify efficiency savings opportunities in community, mental health, ambulance and specialist acute providers.

114. As part of this work, in the 2017 Spring Budget the Government announced additional funding; £325 million capital investment for transformation and £100 million capital investment for A&E patient flows. The total £325 million identified for Transformation will be spent across 2017-18 to 2019-20 and will support local health economies to implement their STP. The £100 million capital investment for A&E will be spend in 2017-18 at English hospitals to support the delivery of primary care streaming in all Accident and Emergency Departments by October 2017 in time for next winter.

115. The Budget also contained £2 billion of new funding to support social care in the short-term. Taken all together, councils have access to £9.25 billion more dedicated funding for social care over the next three years, as a result of measures introduced since 2015.

Our performance against other required reporting

Better Regulation

116. The Department is committed to the use of better regulation to achieve our objectives at the least cost to the economy. When we do regulate, it is only where necessary to protect public health and to ensure we provide safe, effective and compassionate care. The Department has set out two better regulation commitments in its SDP: a deregulatory budget and inputting into relevant Cutting Red Tape reviews.

117. We support the Government in its manifesto commitment to deliver £10 billion savings for business, our latest net position is a deficit of £47.8 million due to tobacco legislation agreed in the last Parliament. We are working to identify a forward programme of deregulatory activity, across health and social care, working closely with our regulatory ALBs to understand how their activity will contribute to savings.

118. The Department is working in partnership with Business Energy Industrial Strategy (BEIS) and Department Communities and Local Government (DCLG) to address the findings of the Cutting Red Tape review of care homes. A response and high-level action plan has been published alongside the review and DH is working closely with BEIS, DCLG, sector bodies and providers to reduce areas of unnecessary burden and duplication of inspection and enforcement in the sector. We will engage fully in any further Cutting Red Tape Reviews applicable to us in 2017-18.

Sustainable Development, Sustainable Procurement, Climate Change and Rural Proofing

119. The Government aims to lead by example, managing its estate and activities in a way that supports the principles and objectives of sustainability. All central government departments are required to report their progress in terms of reducing the environmental impact of their operations, through the Greening Government Commitments (GGC)[21].

120. We are committed to long-term sustainable development. Against a cross Government baseline of 2010; the Department and (in-scope) ALBs have reduced our carbon emissions by 46%, our waste tonnage by 27% and our water use by 33%. We also reduced the number of domestic flights taken by staff by 61%. More detail around our performance in these areas is included within Annex D.

46% reduction in greenhouse gas emissions by DH in last 6 years

121. We work closely with other government departments, and also support the health and social care system via the NHS Sustainable Development Unit (SDU)[22]. The SDU assists the health and care system to develop Sustainable Development Management Plans (SDMP) and links sustainability to healthcare improvement. The Sustainable Development Strategy for the Health, Public Health and Social Care System 2014-2020[23] outlines the vision for the health system.

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

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

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

Climate Change Adaptation

124. We are looking at how best to take our sustainable development and climate change work forward, building on the Department's own 2010 Climate Change Plan[24] and the Public Health Outcomes Framework[25] for England 2013-2016, which requires public sector organisations to have a SDMP and to be able to demonstrate that sustainable development is embedded within their activities, and on which all organisations currently delivering NHS services report.

125. We have a Director-level Sustainable Development and Climate Change Steering Group, chaired by the Department's Deputy Chief Medical Officer who is the Department's Sustainable Development and Climate Change Champion.

126. One of the Group's tasks has been to produce a DH Board approved SDMP that will provide a route map for all DH staff and act as a guide for our ALBs in achieving a sustainable future.

127. The SDMP will provide a monitoring and reporting tool through a set of objectives on leadership and governance, policy making, partnerships as well as the GGC. It will be published later in 2017 once formally approved by Ministers. Actions from the SDMP will be implemented as part of the delivery of our SDP.

128. We encourage all staff to think about sustainability, including climate change, in all our policies and in engagement and interactions with our stakeholders and supply chains and we are piloting a tool to help our staff identify how sustainable development and climate change can be addressed in their everyday work, as well as in Impact Assessments. We anticipate rolling this out across the Department following completion of the pilot phase in 2017-18. We are also developing a learning module around sustainable development and climate change, which will form part of the DH Policy Certificate programme.

129. In conjunction with Department for Environment, Food and Rural Affairs (DEFRA), we have produced a National Adaptation Programme (NAP)[26], which sets out what government, businesses and society are doing in response to the top risks identified in the first Climate Change Risk Assessment (CCRA)[27]. We are currently feeding the health-

[24] https://www.gov.uk/government/organisations/department-of-health
[25] http://www.phoutcomes.info/
[26] https://www.gov.uk/government/publications/adapting-to-climate-change-national-adaptation-programme
[27] http://www.defra.gov.uk/environment/climate/government/risk-assessment/

related areas, covering actions to ensure public health protection plans take account of climate change risks, and improve resilience of health and social care facilities (for example mapping flood risks to Health and Social Care assets) into DEFRA's next CCRA.

130. A key part of the Department's national adaption planning to reduce the public health impacts of climate change is in the preparation of climate proof plans to protect public health from the effects of extreme weather and climate change which will lead to an increase in the severity of these extreme weather health impacts. For example, DH has worked closely with Public Health England, NHS England and the Local Government Association to produce the Heatwave Plan for England[28] and the 'Under the Weather' toolkit[29].

Rural Proofing

131. We have been working with DEFRA to develop and promote the Rural Health Proofing tool[30], designed to share good practice on health and health services in rural areas, with a view to its greater use in the NHS. We have collaborated with DEFRA and NHS England about Lord Cameron's rural proofing review and shared with Defra relevant NHS policy developments, such as the GP's minimum practice income guarantee (MPIG). In his review report, Lord Cameron emphasised that all Government policies need to make rural issues a routine policy consideration. The Government's response to the review published in December 2015[31], supported this approach and committed to strengthen departmental rural proofing guidance.

Correspondence and Complaints to the Parliamentary Ombudsman

132. In 2016 we received over 37,000 correspondence cases, responding to over 96% within our target of 18 days. In line with standard reporting, the data shown is for the calendar year 2016 not financial year 2016-17.

96% of DH correspondence cases responded to within 18 day

Table 2: Correspondence Cases 2016

Case type	Due in 2016	Completed on time	Percentage on time
Private Office	14,452	13,462	93.1%
Treat Official	7,399	7,292	98.6%
Departmental Email	15,514	15,330	98.8%
TOTAL	37,365	36,084	96.6%

Excludes *FOI cases*

[28] https://www.gov.uk/government/publications/heatwave-plan-for-england
[29] http://www.sduhealth.org.uk/areas-of-focus/community-resilience/community-resilience-copy.aspx
[30] https://www.gov.uk/rural-proofing-guidance
[31] https://www.gov.uk/government/publications/rural-proofing-government-response-to-lord-camerons-review

133. In 2015-16 the core Department received 6 complaints which were accepted for investigation by the Parliamentary and Health Service Ombudsman (PHSO), no complaints were upheld. (2015-16; being the last year PHSO have data available via published report). The following table summarises the results.

Table 3: PHSO Complaints core Department 2015-16

Enquiries Received	Assessed	Accepted for Investigation	Investigation Upheld/partly Upheld (complied with)	Investigations not Upheld	Investigations resolved without a finding*	Investigations resolved without a finding**
34	16	6	0	1	0	1

* These are complaints where PHSO start an investigation but are able to resolve the complaint without having to formally complete the investigation.
** These are complaints where PHSO end the investigation for a variety of reasons, for example, because the complainant asked them to.

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

Health and Safety

135. The Department of Health recognises its responsibilities, under the Health and Safety at Work Act 1974, for ensuring, so far as is reasonably practicable, the health, safety and welfare of its employees, temporary staff, and visitors to its premises and to others who may be affected by its operations and/or activities. In 2016-17, there were 13 reported accidents; none of which resulted in absence, and 2 classed as a near miss.

Prompt Payment of Undisputed Invoices

136. The Public Contracts Regulations 2015[32] states that contracting authorities must have regard to guidance in relation to the payment of valid and undisputed invoices within 30 days. This requirement has been designed to help ensure that small and medium size businesses that may not be able to fully operate with longer payment terms are not disadvantaged by late payments.

137. The Better Payment Practice Code[33] requires each public organisation to pay 95% of its invoices within agreed terms, normally 30 days. The following table details the percentage of NHS trusts compliant with the requirement to pay 95% of undisputed invoices within 30 days. NHS Foundation Trusts are not required to disclose their performance against Better Payment Practice Code.

[32] http://www.legislation.gov.uk/uksi/2015/102/contents/made
[33] https://www.gov.uk/guidance/prompt-payment-policy

Table 4: Prompt Payment

Financial Year	NHS Trust invoices paid within target [1]
2014-15	83
2015-16	81
2016-17	78

1. By value, total invoices paid within target per NHS Trust financial accounts returns submitted to Department of Health

Official Development Assistance (ODA)

138. The Department of Health's summary of expenditure on ODA is included at Annex E.

Secretary of State for Health Annual Report 2016-17

Introduction

139. The Secretary of State is required by section 247D[34] of the National Health Service Act 2006, (the 2006 Act), to publish an annual report on the performance of the health service in England. The report must include an assessment of the effectiveness of the discharge of the duties under sections 1A and 1C of the 2006 Act.

140. This report comments on services commissioned by the National Health Service Commissioning Board (known as NHS England) and clinical commissioning groups (CCGs), as well as those public health services for which the Secretary of State and local authorities are responsible[35]. This report includes an assessment of how effectively the Secretary of State has discharged his duties under sections 1A (duty as to improvement in quality of services) and 1C (duty as to reducing health inequalities) of the 2006 Act[36].

141. The Secretary of State is under a duty in section 1A of the 2006 Act to act with a view to securing continuous improvement in the quality of services provided to individuals, in particular with a view to securing continuous improvement in the outcomes achieved, and having regard to quality standards prepared by the National Institute for Health and Care Excellence (NICE)[37]. Under section 1C the Secretary of State is under a duty to have regard to the need to reduce inequalities between the people of England with respect to the benefits they can get from the health service. The assessments of the discharge of these duties are set out below specifically in relation to performance of the NHS against key access standards; outcomes frameworks; NICE quality standards; and health inequalities.

Performance of the NHS against key access standards

142. In observing performance of the NHS, service users often cite access to the NHS as being a main indicator of NHS performance. There are a number of operational standards that the NHS is required to deliver in terms of access to NHS services. These are reflected as rights and pledges to patients in the NHS Constitution[38]. During 2016-17, the Secretary of State held regular performance and accountability meetings with the chief executives of NHS England and NHS Improvement (combining Monitor and the NHS Trust Development Authority) to account for their management of the NHS, seeking assurances on delivery of the constitutional standards, and what action they are taking where the standards are not being met. Details of how the NHS has delivered against several of these main access standards are given in the main body of this DH Annual Report under 'Performance Analysis' and Annex C.

Shared Delivery Plan

143. In line with the process other government departments have followed to agree their single departmental plans, the Department's Shared Delivery Plan (SDP)[39]highlights the priorities, objectives, accountabilities and measures that will guide the work of the health

[34] Secretary of State for Health Annual Report on the performance of the health service in England is presented to Parliament pursuant to section 247D subsection (3).
[35] Social care is not a health service but is covered for completeness.
[36] The assessment is required under section 247D (2) of the National Health Service Act 2006
[37] The NICE quality standards duty relates to section 1A(4)
[38] https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[39] https://www.gov.uk/government/publications/department-of-health-shared-delivery-plan-2015-to-2020

and social care system in the coming years. During 2016-17, progress for the Department and the wider system was assessed via the SDP.

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

Outcomes Frameworks

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

146. Collectively, these three outcome frameworks provide a way of holding the Secretary of State to account for the results the Department is achieving with its resources, working with and through the health and care delivery system. Together the outcomes frameworks also highlight common challenges across the health and care system at the national and local level, informing local priorities and joint action whilst reflecting the different ways services are held accountable.

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

Alignment

148. The importance of integrating services to deliver better care and the need to understand the contributions of different parts of the system is central in supporting local planning and delivery of better outcomes. The three frameworks continue to include shared and complementary measures to support these goals. The Department is committed to increasing the alignment of the outcomes frameworks, where appropriate, to encourage integration, joint working and the coordination of local services. NICE quality standards support alignment across the health and care system by, where appropriate, covering all stages of the care pathway.

Progress against outcomes

The NHS Outcomes Framework (NHSOF)

149. The Government's mandate to NHS England outlines the specific objectives they should achieve that year. The first of these includes making improvements to local and national health outcomes, which are measured through the indicators in the NHSOF. Further detail is published on NHS Digital's website[40].

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

[40] http://content.digital.nhs.uk/nhsof

avoidable harm. A range of different analytical approaches are currently used to measure progress across the 45 live indicators in the data set. Work is ongoing to improve transparency by standardising the methods of measurement and reporting. This will also enable more active discussions with NHS England (through the Mandate). As a final measurement approach remains to be finalised, a narrative description of progress across the domains has been provided. Provisional analysis, however, is quite positive with three-quarters of indicators either broadly on trajectory or improving.

Preventing people from dying prematurely

151. Medical and technological advances mean that people are living longer. At age 75 years, both men and women had a higher life expectancy in 2015 than they did in 2010; increasing from 11.1 to 11.6 years for men and from 12.9 to 13.2 years for women.

152. There continues to be a downward trend in the mortality rate for people aged under 75 years for cardiovascular disease (CVD) and cancer, the two main health-related causes of death. Overall, mortality rates for CVD, cancer, liver and respiratory diseases are higher in more deprived areas compared with less deprived areas.

153. People are also surviving longer after diagnosis with cancer. There has been a steady year-on-year increase in the number of cancer patients surviving for both one year and five years after diagnosis. The one-year survival rate among patients followed up in 2015 was 70.4%, up from 66.3% for those followed up in 2010. The five-year survival rate among patients followed up in 2015 was 49.9% compared with 46.3% for patients followed up in 2010.

154. Progress with the Government's national maternity ambition can be seen in the indicator for perinatal mortality, which combines the proportion of births that were stillbirths and where the child died before they were 28 days old (neonatal mortality). The latest data shows a reduction of 12% from 2010 to 2015. More specifically, the stillbirth rate reached 4.4 per 1000 live and still born births in 2015, a reduction of 14% since 2010. According to the Office for National Statistics, the neonatal mortality rate reached 2.6 per 1000 live births in 2015, a slight increase on 2014. Over the five-year period, there was a 10% reduction.

Enhancing quality of life for people with long-term conditions

155. When people do need healthcare, the NHS continues to provide the care people need to live a fulfilling life. The health-related quality of life[41] of people with long-term health conditions has remained stable at around 0.74 since the data series began in 2011-12. Also, the proportion of people with a long-term condition feeling supported to manage their condition remained stable at around 64% between 2014–15 and 2015–16.

156. The employment rate has been rising for both those with long-term conditions and those with mental illness. As a result, the employment gap[42] between people with long-term conditions and the general population has closed from 13.8% in quarter 4 2015 to 11.9%

[41]The NHS Outcomes Framework uses a scale from 0 to 1 to assess mental and physical wellbeing, where 0 represents death and 1 represents perfect health, derived from a standardised outcome tool (the EQ-5D™).
[42] The employment gap is the difference between the average employment rate (labour force survey) and employment rates for groups with specific conditions

in quarter 3 2016. The employment gap for those with mental illness continued to improve, falling from 34.7% to 31.8% over the same period.

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

157. The NHS continues to support people as they recover from injury or episodes of ill health. For example, the proportion of patients with a hip fracture who recovered their mobility at 30 days increased from 34.3% in 2014 to 37% in 2015, while those regaining mobility at 120 days after injury increased from 57.6% to 61.2% over the same period.

Ensuring that people have a positive experience of care

158. Most patients are satisfied with the healthcare that they are receiving. The average hospital in-patient satisfaction score for 2015-16 and 2016-17 were 77.3 and 76.7 out of 100. The percentage of NHS dentistry patients receiving a 'very good' or 'fairly good' service increased from 84.6% to 85.2% in 2015-16 and patients receiving a 'very good' or 'fairly good' service from their General Practice also increased from 84.8% to 85.2%.

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

159. The Department is committed to ensuring that English hospitals and GP surgeries are the safest in the world. The number of deaths from blood clots within 90 days following discharge has continued its downward trend in 2015–16, showing a decrease of 6% compared with the previous year, to 64.3 deaths per 100,000 hospital admissions. The numbers of healthcare-associated infections with both MRSA and *Clostridium difficile* have remained broadly stable over the two most recent years, following major reductions since 2008–09, the first year for which both types of infection are reported in the Frameworks.

Improvement areas for health outcomes

160. Two major health-related causes of death, respiratory disease and liver disease, have both shown increases between 2014 and 2015 by 7% (34.0 deaths per 100,000 population) and 2% (18.3 deaths per 100,000 population) respectively.

161. Adults with serious mental illness continue to have a higher mortality rate than the general population, a trend that we must do more to reverse.

162. We are not yet making sufficient progress in ensuring people are cared for in the most appropriate setting. In 2015-16 the number of emergency admissions per 100,000 population for acute conditions where the condition is expected to be managed in the community, was 3% higher than in 2014-15.

The Public Health Outcomes Framework (PHOF)

163. The strategic vision for public health in England concentrates on two high-level outcomes:
    - Increased healthy life expectancy: this is about not only how long we live, our life expectancy, but also on how well we live, our healthy life expectancy at all stages of the life course, i.e. helping people live healthy lives.
    - Reduced differences in life expectancy and healthy life expectancy between communities.

164. Both of these overarching high level indicators, which cover several aspects of life expectancy and differences in life expectancy across communities, are assessed as being broadly the same or better than they were at the baseline period. Some particular aspects of these indicators are:

- Male healthy life expectancy at birth has improved from 63.0 years in the three-year baseline period 2009–11 to 63.4 years in both 2012–14 and 2013–15.
- Female healthy life expectancy at birth was 64.1 years in the baseline period 2009–11. It then showed a slight decrease to 63.9 years in 2012–14 but returned to 64.1 years in 2013–15.
- The difference in life expectancy at birth across the social gradient from the most to least deprived areas in England has not decreased. For males this was 9.1 years in the baseline period 2010–12, 9.1 years in 2012–14, and then 9.2 years in 2013–15. For females, this difference was 6.8 years in the baseline period 2010–12, then 6.9 years in 2012–14, and then 7.1 years in 2013–15.

165. The PHOF groups a wide spectrum of public health indicators that together focus not only on how long people live, but on how well they live at all stages of life. For the majority of the indicators, the trends for England as a whole are either broadly constant or better than they were at baseline. However, at local authority level there remains considerable variation compared with the values for England as a whole.

Table 5: PHOF Indicators

Rating	Improving the wider determinants of health	Health improvement	Health protection	Healthcare, public health and preventing premature mortality
Better than or on baseline	12	14	3	12
Worse than baseline	3	3	3	3
Rated indicators that are better than or on baseline (%)	80%	82%	50%	80%

1. Within each of the four domains, the individual indicators for a year are compared with the values they had in a defined 'baseline' period which varies indicator to indicator, depending on data availability and judgement, The majority of the supporting indicators are either the same as or showing an improvement on their values in the baseline year.
2. These indicators reflect the position of England as a whole, and not the performance of local authorities for which there is often considerable variation.
3. Correct as at May 2017

166. Further detail on the PHOF and all of the indicator data, can be found at Public Health England's website[43].

Improving wider determinants of health

167. The majority (80%) of the rated indicators for tracking progress in wider factors that affect health and well-being were on or better than baseline. This percentage has not changed significantly over the last four years, though previous years were marginally better than the position in May 2017. Three indicators are currently worse than they were at baseline.

168. School readiness is improving. The percentage of children achieving a good level of development at the end of reception increased from 51.7% in the baseline year 2012–13 to 66.3% in 2014–15 then to 69.3% in 2015–16. The percentage of children achieving the expected level in the phonics screening check increased from 57.9% in the baseline year

[43] http://www.phoutcomes.info/

2011–12 to 76.8% in 2014–15 then to 80.5% in 2015–16. However, despite these national improvements there is a significant degree of variation across different geographical areas in their performance.

169. Currently performing below baseline are the three indicators: the gap in the employment rate between those with a long-term health condition and the overall employment rate; sickness absence; and statutory homelessness.

Health Improvement

170. The majority (82%) of the rated indicators for tracking progress in helping people to live healthy lifestyles and make healthy choices were the same or better than in the baseline period. This percentage is higher than the corresponding figure for last year, but lower than it was in 2014. Three indicators are currently worse than they were in their baseline periods.

171. The successful completion of alcohol treatment improved from 31.4% in the baseline year 2010 to 38.4% in both 2014 and 2015. Hospital admissions caused by unintentional and deliberate injuries in children, aged 0-14 years has improved from 115.2 per 10,000 children in the baseline year 2010–11 to 109.6 in 2014–15 and then to 104.2 in 2015–16.

172. The three indicators worse than they had been in their baseline period at this time are those covering child excess weight, the average number of fruit and vegetable portions consumed daily by adults, and injuries due to falls in people aged 65 years or more.

Health Protection

173. Half of the six indicators for tracking progress in protecting the population's health from major incidents and other threats are either the same or better than the level they were at in their baseline years, with the other half in a worse position.

174. HIV late diagnosis, the incidence and treatment of tuberculosis and adjusted antibiotic prescribing in primary care by the NHS were all equal to or better than they were in the baseline period.

175. Three indicators were worse than they had been in the baseline period, namely the chlamydia detection rate, the overall vaccination coverage (covering a wide range of vaccination programmes), and the numbers of NHS organisations with a board approved sustainable development management plan.

Healthcare, public health and preventing premature mortality

176. The majority (80%) of the rated indicators for tracking progress in reducing numbers of people living with preventable ill health and people dying prematurely were the same or better than they were in the baseline period. This is a deterioration on the 2016 position of 86%.

177. The under-75 mortality rates for cardiovascular disease and for cancer considered preventable are better than baseline, and continue to fall. The under-75 mortality rate for cardiovascular disease considered preventable fell from 56.6 per 100,000 population in the baseline period 2009–11 to 49.2 in 2012–14 and then to 48.1 for the period 2013–15. The mortality rate for cancer considered preventable fell from 87.4 per 100,000 population in the baseline period 2009–11 to 83.0 in 2012–14 and then to 81.1 in 2013–15.

178. Reporting as worse against their baseline are: the excess under-75 mortality rate in adults with serious mental illness, the suicide rate and excess winter deaths.

The Adult Social Care Outcomes Framework (ASCOF)

179. The ASCOF fosters greater transparency in the delivery of adult social care, supporting local people to hold their council to account for the quality of the services they provide.

Table 6: ASCOF Indicators

Rating	Enhancing quality of life for people with care and support needs	Delaying and reducing the need for care and support	Ensuring that people have a positive experience of care and support	Safeguarding vulnerable adults and protecting from avoidable harm
Better than or on trajectory	6	4	0	2
Worse than trajectory	7	3	5	0
Rated indicators that are better than or on trajectory (%)	46.2%	57.1%	0%	100%

1. All indicators are based on 2015-16 data.
2. New Adult Social Care data collections were implemented in 2014-15 resulting in only two-years worth of data being available, which do not allow for comparisons over time.
3. Correct as at May 2017

180. Further detail on the ASCOF and all of the indicator data can be found at NHS Digital's website[44].

Enhancing quality of life for people with care and support needs

181. ASCOF measures cover the quality of life of carers and people who use care services and their experience of care and support including: how safe they feel; the effectiveness of services in supporting them to stay independent for as long as possible; and the choice and control they have over their daily lives. The overall satisfaction of people who use services with their care and support and social care-related quality of life remains as high as last year.

Delaying and reducing the need for care and support

182. Keeping older people well and out of hospital and supporting them to regain their independence after a period of support is a vital part of supporting older people to live full lives and to play an active role in their communities. The effectiveness is best measured by the percentage of older people who were still at home 91 days after discharge from hospital into reablement. In 2015–16, 82.7% were still at home, up from 81.9% in the previous year. Local authorities are continuing to work with local health partners to reduce overall numbers of delayed transfers of care and this will be an area for improvement in 2017–18.

Ensuring that people have a positive experience of care and support

183. The proportion of people who use services who say that those services have made them feel safe and secure has increased in 2015–16 to 85.4% up from 84.5% in the previous year. This may reflect the on-going work of the Care Quality Commission and providers to raise quality and provide care users with a positive experience.

[44] http://content.digital.nhs.uk/catalogue/PUB21900

Safeguarding vulnerable adults and protecting from avoidable harm

184. Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of service users' experience and their care and support. In 2015–16, 69.2% of people who used services reported that they felt safe; an increase from 68.5% in 2014–15.

NICE Quality Standards

185. NICE quality standards are concise sets of prioritised statements designed to drive and measure quality improvements within a particular area of health or care. They are derived from the best available evidence such as NICE guidance. The Department works closely with NICE, NHS England and Public Health England to ensure that NICE's quality standard programme reflects health and care priorities. Over the past year, NICE has published 37 quality standards covering a range of topics, including suspected cancer, antimicrobial stewardship and children's attachment. The Secretary of State has to have regard to NICE quality standards when discharging his section 1A functions.

Quality

186. Placing patients at the centre of all the NHS does has remained a priority of the Secretary of State for Health. Throughout 2016–17 this has included:
    - Listening to patients;
    - Continuing to promote transparency; and
    - Working to make the NHS a truly learning organisation.

187. The work builds on Sir Robert Francis QC's historic and ground-breaking inquiry into failings at the Mid Staffordshire NHS Foundation Trust. The Department published its response - Patients First and Foremost[45] shortly afterwards; and followed this up later that year with a more detailed response - Hard Truths: The Journey to Putting Patients First[46]. In February 2015 it published Culture Change in the NHS[47], a consolidated account of the progress to date in implementing all of the recommendations that had been committed to.

Patient Experience

188. Improving patient experience is a key aim for the NHS. The results of the 2016 hospital inpatient survey published by the CQC indicate that there have been small, but statistically significant, improvements in a number of questions compared with the results from previous surveys (2006, 2011 and 2015). This includes patients' perceptions of: the quality of communication between medical professionals and patients; the standards of hospital cleanliness; and food quality.

189. However, responses to some questions have been less positive. This includes patients' perceptions of: being involved in decisions about their care and treatment; information sharing when leaving hospital; waiting times; and, support after leaving hospital.

190. NHS England uses a subset of the CQC data to publish an Overall Patient Experience Score (OPES). The OPES for inpatient services has remained above 76 out of 100 since 2012-13. Although 2016-17 represents a significant decline from the previous year, it is comparable with the score in 2014-15.

[45] https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report
[46] https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response
[47] https://www.gov.uk/government/publications/culture-change-in-the-nhs

Table 7: OPES Headlines

Access & waiting	Safe, high quality , co-ordinated care	Better information, more choice	Building closer relationships	Clean, friendly, comfortable place to be	Overall patient experience score
82.9	66.1	68.0	85.5	81.1	**76.7**

Previous year overall score was 77.3 out of 100.

Speaking out and learning

191. Since the Freedom to Speak Up Review and publication of the Government's response Learning not Blaming[48], the creation of the National Guardian is one of a number of measures introduced to ensure health and care workers are encouraged to speak up, and do not suffer as a result of doing so. Doctor Henrietta Hughes was appointed as National Guardian in October 2016 and she leads and supports a network of individuals within NHS trusts appointed as 'local freedom to speak up guardians'.

192. A key priority for the Secretary of State has been continual learning in the NHS to prevent mistakes from happening again. This was reinforced by the findings of the CQC report Learning, candour and accountability[49]. The review, commissioned by the Secretary of State, found that learning from deaths was not being given sufficient priority and valuable opportunities for improvements were being missed. The Secretary of State accepted the report's recommendations, which led to the publication of National Guidance on Learning from Deaths[50]. This reflects his commitment that trusts will regularly publish specified information on deaths from 2017–18.

193. In order to improve the quality of investigations of serious patient safety incidents in the NHS, the Healthcare Safety Investigation Branch was established in April 2016 as an independent function within NHS Improvement[51]. A chief investigator was appointed in July 2016 and the new service became operational in April 2017.

A safer environment

194. The NHS is a safe place to give birth, however the Government and the NHS recognise that more can be done and are fully committed to learning lessons when things go wrong to prevent future harm to women and babies. The Department is working with NHS England and other NHS organisations to further improve the safety and quality of maternity services, and to address recommendations made by the Independent National Maternity Review in Better Births[52], and by the Morecombe Bay Investigation. In October 2016 the Secretary of State announced the Safer Maternity Care[53] action plan, designed to dramatically improve the safety of maternity care in the NHS and contribute to achieving the national ambition to halve the rates of stillbirths, maternal and neonatal deaths and brain injuries in babies that happen during or soon after birth by 2030.

195. Recent reductions in MRSA bloodstream infections and cases *of Clostridium diff*icile infection have been attributed to the significant amount of work aimed at reducing

[48] https://www.gov.uk/government/publications/learning-not-blaming-response-to-3-reports-on-patient-safety
[49] http://www.cqc.org.uk/content/learning-candour-and-accountability
[50] https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/
[51] The Branch was established by direction of the Secretary of State as a division of the Trust Development Authority (TDA). As referred to above, the TDA is a special health authority which, with Monitor, forms NHS Improvement
[52] https://www.england.nhs.uk/mat-transformation/mat-review/
[53] https://www.gov.uk/government/publications/safer-maternity-care

healthcare-associated infections. However, this reduction has not been seen in Gram-negative infections, which are growing in incidence and are increasingly resistant to most available antibiotics. The Secretary of State launched new plans in November 2016 to halve Gram-negative healthcare-associated blood stream infections by 2020 with an initial focus on infections caused by *E.Coli.*

196. The Secretary of State wants to ensure the NHS provides the same standards of care, seven days a week, for people who need urgent and emergency hospital care. Throughout 2016-17, NHS trusts were working to achieve the four priority seven-day services clinical standards so that 25% of the population have access to care that meets these standards.

Overall Assessment (section 1A)

197. The Secretary of State's assessment is that **reasonable progress** has been made against the duty under section 1A of the 20016 Act, to act to secure continuous improvement in the quality of services provided to individuals, in particular securing continuous improvement in the outcomes achieved.

198. Across the frameworks there are areas where tangible progress has been made but also areas of concern. For example, whilst there continues to be a downward trend in the mortality rate for both cancer and cardiovascular disease; the excess mortality rate for those with a serious mental illness is increasing.

Health Inequalities

199. The Secretary of State's aim is to bring about measurable and sustained reductions in health inequalities and this is reflected in key strategic documents across the health system, for example: the Shared Delivery Plan, Public Health England's remit letter and the mandate to NHS England. However, it is recognised that this is hugely challenging: health inequalities are deeply rooted, difficult to turn around and driven by a variety of factors not all of which can be tackled by the health system alone.

200. The Secretary of State's assessment of how well his duty to have regard to the need to reduce health inequalities between the people of England has been discharged in 2016–17 is that there has been **reasonably good progress** in embedding the process but there is more to do to see changes in health inequalities in access, outcomes and experience. There is also more to do to support effective action at the local level underpinned by existing and new evidence and knowledge of what works, taking into account trends in inequalities as data become available.

201. During 2015–16, the Secretary of State published a set of NHS Outcomes Framework and Public Health Outcomes Framework metrics for health inequalities assessment. Work to develop the methodology for measuring the indicators continues. In the interim, progress is assessed using inequalities data published by NHS Digital. The data allows the Department to look at how outcomes differ by area deprivation, measured by the Slope Index of Inequality[54] and a limited set of NHSOF indicators showing how some outcomes

[54] The Slope Index of Inequality (SII) is the range between the most and least deprived parts of the population, based on the line of best fit across deprivation deciles. It takes account of inequalities across all deprivation deciles, not just the most and least deprived. Further information on the SII can be found in *NHS Outcomes Framework Indicators for health inequalities assessment* on GOV.UK https://www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016

differ by ethnicity, age and sexual orientation. Across the set of indicators, the data show a mixed picture on inequalities.

202. In relation to inequalities by area deprivation the overarching indicators in the PHOF show that the gaps between people living in the most deprived areas and the least deprived areas remain large and are broadly unchanged from the baseline:
    - Life expectancy at birth: in 2013-15, the gap in life expectancy at birth between the most and least deprived areas was 9.2 years for males, and 7.1 years for females.
    - Healthy life expectancy at birth: the gap in healthy life expectancy at birth between the most and least deprived areas was 18.9 years for males, and 19.6 years for females[55].

203. The other NHSOF assessed indicators show that there is more to do to narrow the gap between the most and least deprived areas[56]:
    - Infant mortality: large inequalities between the most and least deprived areas in infant mortality remain. These had narrowed slightly in 2014, but in 2015 have seen a return to similar levels as 2013.
    - Mortality from cancer and cardiovascular disease under 75: inequalities by area deprivation remained large with a slight widening compared to baseline.
    - Health-related quality of life: compared to baseline, inequalities by area deprivation remained similar or widened slightly for health-related quality of life for people with long-term conditions.
    - Unplanned hospital admissions and emergency hospital admissions: compared to baseline, inequalities by area deprivation remained similar or widened slightly for unplanned hospitalisation for chronic ambulatory care sensitive conditions, and emergency admissions for acute conditions that should not usually require hospital admission.
    - Patient experience of GP services: inequalities by area deprivation continued to widen in patient experience of GP services and patient-reported access to GP services.
    - Large inequalities continue to exist in potential years of life lost from causes considered amenable to healthcare and life expectancy at 75.

Table 8: Health Inequalities Indicators Summary

Indicator	England average (latest)	Inequality by area deprivation (measured by the slope index of inequality)		
		Baseline	Previous	Latest
SDP / PHOF Headline Inequality Indicators				
Life expectancy at birth - males	79.5	9.1	9.1	9.2

[55] These estimates for the Slope Index of Inequality (SII) for Life Expectancy (LE) and Healthy Life Expectancy (HLE) are not comparable to those used in the 2015-16 Report. In 2017 new estimates of LE and HLE and for the SII were added to the PHOF; these were based on the 2015 Indices of Multiple Deprivation rather than 2010 IMD. Revised estimates for 2011-13 and 2012-14 have been shown in the table alongside the new data for 2013-15.

[56] Significance testing has been considered for all indicators and has taken place when it is suitable; this has been reviewed on an individual basis. The headline indicators for the PHOF have been significance tested; the NHSOF indicator trends are reviewed but no significance testing is undertaken. For this report inequalities are reported as:

- reducing where the inequalities gap reduced by over 1%
- increasing where the inequalities gap increased by over 1%
- remained flat where the change in the inequality gap was between -1% and +1%

Indicator	England average (latest)	Inequality by area deprivation (measured by the slope index of inequality)		
		Baseline	Previous	Latest
Years of life	*(2013-15)*	*(2010-12)*	*(2012-14)*	*(2013-15)*
Life expectancy at birth - females *Years of life*	83.1 *(2013-15)*	6.8 *(2010-12)*	6.9 *(2012-14)*	7.1 *(2013-15)*
Healthy life expectancy at birth - males *Years of life*	63.4 *(2013-15)*	18.6 *(2011-13)*	18.9 *(2012-14)*	18.9 *(2013-15)*
Healthy life expectancy at birth - females *Years of life*	64.1 *(2013-15)*	19.1 *(2011-13)*	19.7 *(2012-14)*	19.6 *(2013-15)*
NHSOF Indicators for Health Inequalities Assessment				
Potential years of life lost (PYLL) from causes considered amenable to healthcare - adults *Rate per 100,000 population*	2,817 *(2014)*	3,165 *(2013)*	—	3,194 *(2014)*
Life expectancy at 75 - males *Years of life*	11.4 *(2013-15)*	2.8 *(2012-14)*	—	2.9 *(2013-15)*
Life expectancy at 75 - females *Years of life*	13.1 *(2013-15)*	2.7 *(2012-14)*	—	2.8 *(2013-15)*
Under 75 mortality rate from cardiovascular disease *Rate per 100,000 population*	74.0 *(2015)*	106.5 *(2013)*	103.1 *(2014)*	109.0 *(2015)*
Under 75 mortality rate from cancer *Rate per 100,000 population*	136.4 *(2015)*	103.9 *(2013)*	103.5 *(2014)*	105.5 *(2015)*
Infant mortality *Rate per 1,000 live births*	3.7 *(2015)*	3.0 *(2013)*	2.7 *(2014)*	3.1 *(2015)*
Health-related quality of life for people with long-term conditions *Health status score*	0.741 *(2015-16)*	0.149 *(2013-14)*	0.150 *(2014-15)*	0.153 *(2015-16)*
Unplanned hospitalisation for chronic ambulatory care sensitive conditions *Rate per 100,000 population*	812 *(2015-16)*	978 *(2013-14)*	1,009 *(2014-15)*	1,007 *(2015-16)*
Emergency admissions for acute conditions that should not usually require hospital admission *Rate per 100,000 population*	1,319 *(2015-16)*	932 *(2013-14)*	952 *(2014-15)*	965 *(2015-16)*
Patient experience of GP services *% reporting good experience*	85.2 *(2015-16)*	5.2 *(2013-14)*	6.5 *(2014-15)*	7.4 *(2015-16)*
Access to GP services *% reporting good experience of making appointments*	73.4 *(2015-16)*	5.2 *(2013-14)*	6.8 *(2014-15)*	8.2 *(2015-16)*

204. Where data are available, through the GP Patient Survey, an assessment can also be made for other dimensions of inequality: these are ethnic group, sexual orientation and age[57].

205. Health-related quality of life: for people with long-term conditions the gap between most Black and Minority Ethnic (BME) groups reporting the lowest scores for health-related quality of life and White British people narrowed. However, in 2015-16 there were increases in health inequalities for Bangladeshi people and Gypsies and Irish Travellers compared to White British people.

206. Experience of GP services: there were slight improvements in reported satisfaction of GP services between 2014-15 and 2015-16 for the youngest two age groups. For 18-24s satisfaction improved from 77.2% to 78.6% and for 25-34s from 78.2% to 79.2%. Over the same period, there was also a slight improvement in the experience of bisexual people compared to heterosexual people, with the gap narrowing from 4 percentage points to 3 percentage points.

207. Access to GP services: a high proportion of people reported their experience of making a GP appointment as 'very good' or 'fairly good' across all age groups. For 18-24s satisfaction improved from 65.1% to 66.7% and for 25-34s from 67.2% to 68.1%.

Forward look to 2017-18

208. Over the course of 2017-18, the Department will further develop the use of data and insight to assist improvement in quality and efficiency, and help hospital leaders at Board level to understand what more needs to be done in their organisation to earn the title of 'learning organisation'. As set out in the Department's SDP for 2016-20[58], the Department and its delivery partners across the health and care system are committed to creating the safest, highest quality care healthcare services. The Secretary of State will continue to report on progress in meeting these priorities over the course of 2016-20.

Performance Report Accounting Officer Sign-off

5 July 2017
Sir Chris Wormald
Permanent Secretary

[57] https://indicators.hscic.gov.uk/webview/
[58] https://www.gov.uk/government/publications/department-of-health-shared-delivery-plan-2015-to-2020

Accountability Report

Lead Non-Executive Board Member's Report

Performance and priorities

Gerry Murphy (acting Lead NED)

209. This year, the Department of Health and the Arm's Length Bodies that comprise the health and social system continued to face unprecedented demand and a challenging financial climate in which to deliver improved care quality and safety. Alongside this, the Department itself undertook a significant restructuring programme to become more efficient and effective.

210. Throughout the year, the Department and the Arm's Length Bodies worked through such challenges whilst maintaining continuous focus on performance delivery and progress on the overall transformation agenda.

211. The Board's role is to support, as well as challenge the Department as it executes a complex set of objectives. Non-executive members with experience in the public, charitable and private sectors help officials develop practical proposals for improving the Department's role as guardian of the health and care system.

212. Non-executive members also provide independent perspectives on strategic issues such as financial sustainability, identification and management of critical risks, the implementation of significant organisational changes and the balance between the NHS and wider health concerns such as public health and community care. This year Non-Executive members helped steer the implementation of the Department's own transformation programme announced after the 2015 Spending Review settlement.

213. Peter Sands, as the lead non-executive member, ran a Board Effectiveness Evaluation for 2015-16 and this was finalised in September 2016 with actions that looked ahead into 2016-17 as well as reflecting on the year just finished. Given the number of changes at the Department of Health over 2016-17, the decision was taken not to run a Board Effectiveness Evaluation for 2016-17. The next effectiveness evaluation will take place across September and October 2017 when the reconstituted Board is in place.

214. Topics to which the Board devoted particular attention include:

- Maintaining oversight of the performance of the health and care system, ensuring that high quality outcomes and patient care and safety remain essential to the Department's agenda, whilst operating within the required financial envelope. To this end, as the Departmental Board is reconstituted, it will look to how current and new Non-Executive Board members can have further involvement in overseeing the performance of the Department. The Board will continue to monitor current performance metrics, helping the Department to identify the root causes of performance challenges, and develop and implement plans to mitigate risks and improve outcomes.

- Sustaining focus on longer-term financial sustainability and strategic priorities. The Board engaged with the Spending Review 2015 negotiations and provided

significant input into the Shared Delivery Plan (SDP) - the strategic plan for the health and care system for the period 2016-17 to 2020-21. The SDP is aligned with the objectives and priorities of the Five Year Forward View and sets how these will be achieved by the Department and its Arm's Length Bodies. This integrated plan serves as a key tool for measuring progress on and for holding Arm's Length Bodies to account for delivery. The Board continue to scrutinise and challenge progress reports and oversee the move towards a Single Departmental Plan similar to other Departments.

- Refining the governance approach across the health and care system as a whole so that the Board has effective oversight of not just the Department, but across the system. In particular, we have worked to encourage further integration between social care, the health care system and the public health agenda as we work towards mutually agreed goals.

- Ensuring the Board considers the longer-term challenges and opportunities facing the Department and the wider system. The Board has taken opportunities to engage in horizon scanning across the year, including a presentation to the Departmental Board from Chris Whitty, the Chief Scientific Advisor, on the probable trends in healthcare over the next 10-20 years.

- Enhancing the approach to identifying and managing strategic risks. The Board has conducted several deep dives into the top risks to the Department to ensure the right assessments and mitigating actions are in place. Topics for discussion have included the Department's approach to winter planning and the risks around dealing with a major infectious disease outbreak. The Department's Audit and Risk Committee Chair has continued to hold meetings with Audit Committee chairs from across the Arm's Length Bodies to discuss common risks and issues. This allows audit chairs to come to a shared understanding of challenges facing the system, and the way the different parts of the system need to work together to address them.

Executive Board Non Executive Membership 2016-17

215. Peter Sands stepped down as the lead non-executive member of the Board at the end of April 2017, having served in this capacity for 6 years. Catherine Bell and Chris Pilling also stepped down as non-executive members of the Board at the end of May 2016 and end of November 2016 respectively; both have served in this capacity for over 5 years.

216. The appointment process for new non-executive members is underway and 3 additional members will soon be in place**.** Whilst this recruitment process is ongoing, I am writing this statement as the interim lead non-executive member for the Department.

Accountability Report

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

Corporate Governance Report

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

Directors' Report

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

Who we are

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

Our Ministers at 31 March 2017

Rt Hon Jeremy Hunt MP
Secretary of State for Health

Attended: 1/3 Board meetings

Philip Dunne MP
Minister of State for Health

Attended: 0/2 Board meetings

David Mowat*
Parliamentary Under Secretary of State for Community Health & Care

Attended: 0/2 Board meetings

Nicola Blackwood*
Parliamentary Under Secretary of State for Public Health and Innovation
Attended: 0/2 Board meetings

Lord O'Shaughnessy
Parliamentary Under Secretary of State

Attended: 0/1 Board meetings

*Lost seats in the general election 8th June, New Ministers Steve Brine and Jackie Doyle-Price appointed as Parliamentary Under Secretary of States from 14th June

Our Non-Executive Board Members 2016-17

Gerry Murphy
1 Aug 2014 - present

Attended:
3/3 Board meetings

Chris Pilling
1 April 2011 – 30 November 2016

Attended:
0/2 Board meetings

Peter Sands
1 April 2011 - 30 April 2017

Attended:
3/3 Board Meetings

Catherine Bell
1 January 2011 - 31 May 2016

Attended:
1/1 Board Meetings

Our Executive Board Members

Sir Chris Wormald KCB
Permanent Secretary
Appointed: 4 May 2016
Attended: 3/3 Board meetings (during 2016-17)

Professor Dame Sally C Davies DBE
Chief Medical Officer and lead for Research and Development
Appointed: 1 June 2011
Attended: 0/3 Board meetings

David Williams
Director General for Finance and Group Operations
Appointed: 16 March 2015
Attended: 3/3 Board meetings

Clara Swinson
Director General for Global and Public Health
Appointed: 7 November 2016
Attended: 1/1 Board Meetings

Tamara Finkelstein
Director General for Community Care Group
Appointed: 29 September 2014
Attended: 3/3 Board Meetings

Professor Chris Whitty CB
Chief Scientific Adviser
Appointed: 1 January 2016
Attended: 1/3 Board Meeting

Lee McDonough
Director General for Acute Care and Workforce
Appointed: 28 November 2016
Attended: 1/1 Board Meetings

Other Board Members who served during 2016-17:

Dame Una O'Brien DCB, Permanent Secretary
1 November 2010 – 30 April 2016 Attended 0/0 Board meetings
Felicity Harvey CBE, Director General for Public and International Health
1 April 2012 – 30 June 2016 Attended 1/1 Board meetings
Jon Rouse, Director General for Social Care, Local Government and Care Partnerships
11 March 2013 – 22 July 2016 Attended 1/1 Board meetings
Charlie Massey, Director General for External Relations
1 May 2012 – 30 October 2016 Attended 2/2 Board meetings
Will Cavendish, Director General of Innovation, Growth & Technology
10 June 2014 – 2 October 2016 Attended 0/1 Board meetings

Lord Prior, Parliamentary Under Secretary
12 May 2015 – 8 January 2017 Attended 1/2 Board meetings
Alistair Burt, Minister of State
12 May 215 - 14 July 2016 Attended 0/1 Board meetings
Ben Gummer, Parliamentary Under Secretary
12 May 2015 – 13 July 2016 Attended 0/1 Board meetings
Jane Ellison, Parliamentary Under Secretary
7 October 1013 - 13 July 2016 Attended 0/1 Board meetings
George Freeman, Parliamentary Under Secretary
15 July 2014 - 13 July 2016 Attended 0/1 Board meetings

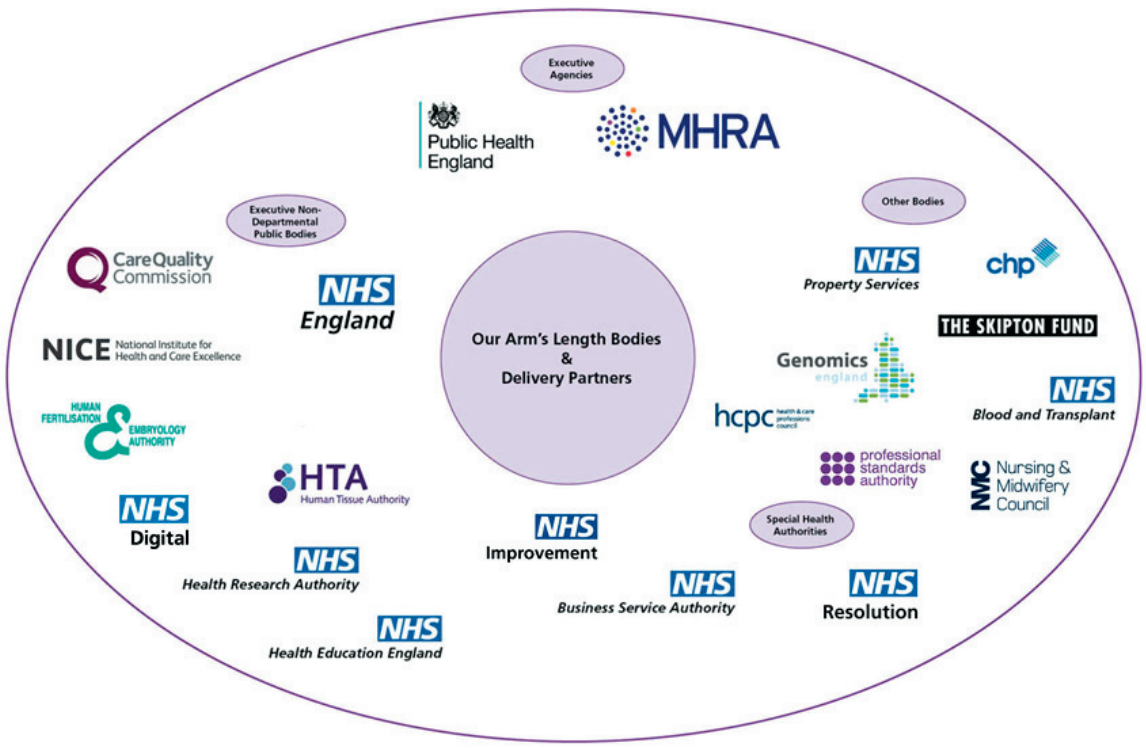
Our Arm's Length Bodies and Delivery Partners

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

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

223. Our ALBs, detailed in Annex F, fall into several distinct types,
    - **Executive non-Departmental Public Bodies (ENDPBs).** Established by primary legislation and have their own statutory functions conferred, rather than delegated by the Secretary of State for Health.
    - **Special Health Authorities (SpHAs).** These are NHS bodies created by order and subject to direction by the Secretary of State for Health.
    - **Limited companies** incorporated under the Companies Act and included in this Annual Report and Accounts.
    - **Other bodies** not included in this Annual Report and Accounts because they receive their funding from other sources.

Figure 8: Our Arm's Length Bodies and Delivery Partners



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

224. Our Permanent Secretary is the Principal Accounting Officer for the Departmental Group which as at 31 March 2017 consisted of:
    - Nine ENDPBs (including NHS England and its 209 Clinical Commissioning Groups (CCGs));
    - Three SpHAs;
    - Seven other bodies;
    - 155 NHS Foundation Trusts (FTs);
    - 81 NHS Trusts (NHSTs); and
    - NHS charities.

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

Departmental Disclosures

226. The Department has a Code for Business Conduct, which incorporates the principles set out in the Civil Service Code[59] and applies to all staff working in the Department, including those who have authority or responsibility for directing or controlling the Department.

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

Register of Interests

228. All staff are required to record and regularly review any potential or actual conflicts of interest or confirm a nil return, alongside any gifts or hospitality declared on the electronic Register of Interests.

229. Our Ministers interests are published on Gov.Uk website by the Cabinet Office[60] whilst our Directors Generals and Directors' record of gifts and hospitality are published as part of the quarterly transparency data also held on Gov.Uk website[61].

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

[59] https://www.gov.uk/government/publications/civil-service-code/the-civil-service-code
[60] https://www.gov.uk/government/publications/list-of-ministers-interests
[61] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/511088/Hospitality_DG_s_PS___SCS2csv.csv/preview

Statement of Principal Accounting Officer's Responsibilities

231. Under the Government Resources and Accounts Act 2000 (the GRAA), the Department of Health is required to prepare Resource Accounts for each financial year in conformity with a HM Treasury direction. This should detail the resources acquired, held or disposed and the use of resources by the Department during the year, all of which is subject to audit by the Comptroller and Auditor General.

232. 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 taxpayers' equity and cash flows for the financial year.

233. HM Treasury has appointed the Permanent Secretary of the Department as Principal Accounting Officer of the Department with responsibilities as set out in Managing Public Money. As required to comply with the Financial Reporting Manual prepared by HM Treasury, the Principal Accounting Officer must:
    - 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.

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

235. In addition, HM Treasury has appointed a separate Accounting Officer to be accountable for the NHS Pension Scheme and NHS compensation for premature retirement scheme Resource Account. These are produced and published as a separate account.

236. The NHS Act 2006 designated Chief Executives of NHS Foundation Trusts as their Accounting Officers for each of their organisations. They produce and publish separate annual accounts and Monitor (the independent regulator of NHS Foundation Trusts) prepares and publishes a consolidated account. The Permanent Secretary's overall responsibility as Principal Accounting Officer draws assurance from the audits of the NHS Foundation Trusts accounts.

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

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

Governance Statement

Scope of Responsibility

239. This Governance Statement covers the Department of Health Group and outlines how responsibility for the management and control of the Department of Health's resources were discharged during the year. This statement covers 2016-17 and is current up to the date this Annual Report was signed.

240. As Principal Accounting Officer for the Departmental Group, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible. This statement sets out how the Department complies with the provisions of the Corporate Governance Code published by HM Treasury and the Cabinet Office.

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

242. Whilst I am personally accountable for the resources provided to the Department and ensuring there is a high standard of financial management across the departmental group, I am supported by an Accounting or Accountable Officer who has been appointed to each of the Arm's Length Bodies (ALBs), Clinical Commissioning Groups (CCGs), NHS Trusts and NHS Foundation Trusts. The process for appointment of these Accounting and Accountable Officers is set out in the relevant legislation and guidance.

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

Departmental Governance

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

245. The Board met on three occasions during 2016-17 and full membership and attendance is outlined in the Director's Report. In addition to the Departmental Board, the Secretary of State gained assurance over the running of the Department through weekly meetings with the Permanent Secretary and the additional focused meetings on his priorities with senior colleagues from our ALBs.

246. The Board provides the collective leadership of the Department and in particular has responsibility for:
    - supporting Ministers and the Department on strategic issues linked to the development and implementation of the Government's objectives for the health and social care system;
    - horizon scanning, ensuring that any strategic decisions are based on a collective understanding of evidence, insight and international experience;
    - setting the overall strategic direction for DH, in the light of Ministerial priorities, the spending round settlement and the business plan;
    - ensuring there is strategic alignment across the bodies accountable to DH for the health and care system;
    - overseeing the sound financial management of the Department, in the context of the Shared Delivery Plan;
    - overseeing the management of risks within the Department and its sponsored bodies, including consideration of the Department's risk register; and
    - overseeing the Department's portfolio of major programmes and projects.

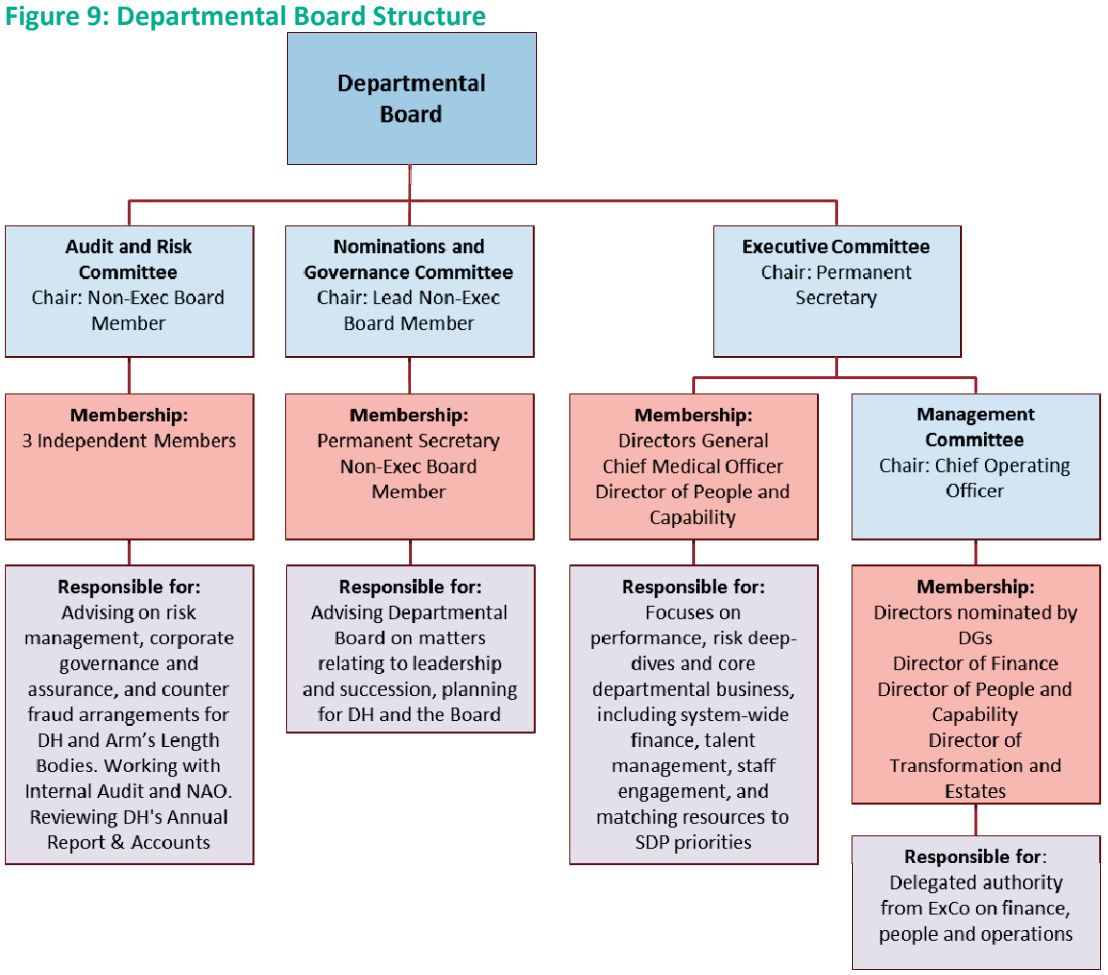
247. All information presented to the Board and its sub-committees is accompanied by a cover note which is cleared by a Senior Civil Servant who has responsibility for the subject matter. Further, the Board and its sub-committees undertake deep dives of specific issues, with the purpose both of improving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

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

249. Given the number of changes at the Department of Health over 2016-17, with the arrival of a new Permanent Secretary and the departure of three Non-Executive Directors (NEDs) including the Lead Departmental NED, the decision was taken not to run a Board Effectiveness Evaluation this year. However, due to the fact the 2015-16 review was finalised in September 2016, the actions identified accounted for both the previous year and looked forward to the rest of 2016-17. To ensure the Board is as effective as possible, the actions identified in the 2015-16 evaluation around reforming the Board have been taken forward. This includes improving the current recruitment of Non-Executive members to draw on a wide range of skills and experience. The next effectiveness evaluation will take place across September and October 2017 when the reconstituted Board is in place.

250. The Departmental Board is supported by the committees shown in the structure chart below. In May 2016 the Board and Committee structure was reviewed and the frequency of the Executive Committee meetings amended to monthly, with a regular time for Directors General (DG) and the CMO to meet found each week. A summary of board attendance can be found in the Director's Report within the Performance Report.

Figure 9: Departmental Board Structure



Assurance Framework, Risk Management and control issues

Core Department

251. The Department operates an accountability process based on compliance with a set of core assurance standards, including risk management. Each DG receives a budget accountability letter setting out their responsibilities for identifying, assessing, communicating, managing and escalating risk in their directorates.

252. DGs are required to identify and record in directorate risk registers the key risks to successful delivery of their business plans and also report on their risks as part of Quarterly Core Accountability Reviews, to which all Senior Civil Servants contribute. These reviews are designed to strengthen individual accountability within the Department for the stewardship of resources and ensure the delivery of corporate objectives.

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

254. The setup of a new Investment and Approvals Committee will manage the approval of major investment and monitor delivery of major projects and will complement the oversight offered through the Quarterly Core Accountability process and support the management of the Portfolio.

Three lines of defence

255. The Department applies the "three lines of defence" principle to its management of risk. Day-to-day operational risk is managed locally by teams best placed to understand and implement mitigations, supported by the use of Group-specific risk registers to identify, escalate and manage risk.

256. Our Executive Committee oversees and agrees the key strategic risks to the health and social care system and challenges and approves proposed mitigations, through the Departmental high level risk register, supported by the Management Committee.

257. The third line of defence is provided by the Audit and Risk Committee (ARC), which has provided independent, non-executive challenge and assessment of the robustness of arrangements in place. This is further underpinned by the independent oversight and challenge of the Government Internal Audit Agency. The ARC has considered the way in which the Department manages risk at its four meetings during 2016-17 and has scrutinised the Department's risk register as a standing agenda item at these meetings. Through this scrutiny the Committee has supported the Board to ensure effective systems were in place to deliver high-quality internal control, governance and risk management. The Chair of the ARC, who also sits as a Non-Executive member of NHS England's Audit and Risk Committee, provides frequent updates to his fellow members of the Departmental Board.

258. Recognising that a number of wider health and care system risks are beyond the direct control of the Department, the ARC regularly challenges Departmental sponsors of ALBs on the risk and accountability of our ALBs. Senior officials from the Department routinely attend audit and risk meetings across our ALBs in order to identify interdependencies between our risks and issues. In 2016-17, four ALBs presented their risk management strategies to the Department's ARC, which has included discussions around IT strategy, cyber security and data management arrangements.

Managing Risk

259. The Departmental high level risk register is used to document and manage risks that present the most significant potential impact on delivery of its objectives, as agreed by the Executive Committee. The severity of each risk is assessed against its likelihood and impact before and after planned mitigating action is taken into account, giving a score out of 25, so the Department is able to give proportionate scrutiny to the most severe risks. A Director General is identified as the owner for each risk on the high level risk register, who is accountable to the Committee and the Departmental Board for the proper reporting and management of that risk.

260. This year the Department has further strengthened how it assures and governs risk by appointing a new non-executive member to the ARC and identified and appointed a Director to the Chief Risk Officer role effective from 1 April 2017.

261. The nature of the health system is that risks are (a) inherent and (b) fast evolving and unpredictable, for example incidents such as Ebola outbreaks. The Department's overall approach to risks is based on constant intelligence and preparation for the unexpected. The Department has applied this approach throughout 2016-17 to manage a developing portfolio of risks, both within the Department and in the wider system. Significant risks actively managed by the Department this year have been:

External risks

- the health and care system's resilience to cyber-attack;
- the global threat of antimicrobial resistance;

System-wide risks

- the financial performance and sustainability of the health and care system;
- system readiness to respond to major infectious disease outbreaks;
- the quality and safety of the care people receive;
- the sustainability of the adult social care system;

Change-based risks

- the Department's workforce has insufficient capacity and/or capability to provide a quality service;
- emerging consequences following the result of the referendum on membership of the European Union are not managed.

262. Some of the key activities in mitigating these risks are set out in the Performance Report. The Executive Committee, ARC and Departmental Board members have challenged and advised on the controls and actions being taken to further mitigate them, through regular discussion of risk overall and through "deep-dive" examination of particular risks.

263. My governance team have prepared a summary report of the governance and control system in the core Department of Health. The report provided information on the key issues for each Directorate and was drawn from material supplied for Quarterly Core Accountability Reviews and DGs' assessments of internal control. The report confirmed that the Department has adequate and effective systems of control in place, and that where issues have arisen during the year assurance arrangements were in place to validate that weaknesses were addressed.

Whistleblowing

264. The Department's whistleblowing policy has been in place since August 2015, and this is based upon best practice in the Civil Service Employee Policy. The policy offers individuals a number of methods of raising a concern and is underpinned by a small network of individuals from various grades, positions and locations, who have been given training on whistleblowing and the departmental policy. The network provides an easily accessible resource for individuals to speak to if they have a whistleblowing concern and are uncertain how to address it. The Department also has a Board-level whistleblowing champion in the Director General for Finance and Group Operations.

265. The Department is undertaking further work to strengthen its whistleblowing arrangements. A Values and Behaviours group, which has consulted widely, is considering what changes could encourage staff to speak out about concerns and create a safe space to challenge. Future reviews of the effectiveness of whistleblowing arrangements will ensure that they are aligned with the work of this group.

Role of Internal Audit

266. The Department's internal audit service continues to be provided by the Health Group Internal Audit Service (HGIAS). HGIAS delivers a shared internal audit service for the Department and 13 of its Arm's Length Bodies, with the exception of NHS England. From October 2016, the HGIAS team moved to be part of the Government Internal Audit Agency (GIAA).

267. HGIAS plays a crucial role in the review of the effectiveness of risk management, controls and governance within the Department by:
- focusing audit activity on the key business risks;
- being available to guide managers and staff through improvements in internal controls;
- auditing the application of risk management and control as part of Internal Audit reviews of key systems and processes; and
- providing advice to management on internal control implications of proposed and emerging changes.

268. The HGIAS team operates in accordance with Public Sector Internal Audit Standards and to an agreed Internal Audit Plan, which has been agreed with the Accounting Officer and the Audit and Risk Committee (ARC). With the agreement of ARC, this Plan is updated as appropriate throughout the year to reflect changes in risk profile.

269. The Head of Internal Audit submits regular reports to the Audit & Risk Committee relating to the adequacy and effectiveness of the Department's systems of internal control, and the management of key business risks, together with recommendations for improvement. These recommendations have been accepted by management and include an agreed timetable for implementation. The status of Internal Audit recommendations and the collection of evidence to verify their implementation are reported to the ARC. The Head of Internal Audit also has direct access to the Permanent Secretary and they meet periodically to review lessons arising from Internal Audit.

Internal Audit Opinion

270. Following completion of planned audit work for 2016-17 for the Department, the Head of Internal Audit has objectively considered the adequacy and effectiveness of the Department's systems of risk management, governance and internal control throughout the year. As such, the Groups Chief Internal Auditor's opinion is that he can give Moderate Assurance to the Department's Principal Accounting Officer in relation to the 2016-17 reporting year. A Moderate Assurance means that in the Internal Auditor's opinion some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

Arm's Length Bodies

271. Each ALB has a Senior Departmental Sponsor (at Director General or Director level) with whom they meet at least quarterly in accountability meetings focusing on operational delivery, financial performance, significant risks and how these are being managed. These risks are considered by the Senior Departmental Sponsor and will also be referenced as appropriate in the overall Departmental Risk Register.

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

273. In relation to NHS England, the Health and Social Care Act 2012 requires the Department to formally set out in a mandate to NHS England its objectives for the health service to be delivered in the financial year. This is one of the formal accountability mechanisms for holding NHS England to account for the money it spends and the outcomes it achieves. The mandate to NHS England for 2016-17 (initially published on 17 December 2015) was republished with updated budgetary figures on 20 March 2017. The mandate for 2017-18 was published on the same date, building on the multi-year mandate established in 2016-17 and focusing on the same seven high-level objectives.

NHS

274. In July 2015, the Secretary of State announced the creation of NHS Improvement, which brings together Monitor, the NHS Trust Development Authority (TDA), the Patient Safety function from NHS England, the Advancing Change team from NHS Improving Quality, and the Intensive Support Teams from NHS Interim Management and Support (IMAS) to make a single integrated enterprise. NHS Improvement came into existence on 1 April 2016. Monitor and the TDA remain as separate legal entities, but since 1 April 2016 the boards of Monitor and TDA have identical membership, and meet jointly as one NHS Improvement Board. New Rules of Procedure have been developed which set out NHS Improvement's governance arrangements.

275. NHS Commissioners, NHS Trusts and NHS Foundation Trusts are all required to operate risk management procedures. For NHS Commissioners, these processes are set and managed by NHS England and further details are included in NHS England's Governance Statement and published in their annual report and accounts. For NHS Trusts the processes are set by NHS Improvement. NHS Foundation Trusts are required, under the terms of their establishment, to maintain adequate systems of internal control and report these in their annual report and accounts.

276. The Department, through its sponsorship discussions with NHS England, and NHS Improvement assess the risks and issues which emerge and they are considered for inclusion in the overall Departmental risk register. The Department and NHS Improvement regularly discuss those providers where there are significant risks and these are then considered for inclusion in the departmental risk register. Having brought Monitor and the TDA together in a single organisation, all NHS Trusts and Foundation Trusts benefit from a more consistent and proactive approach to managing strategic and operational risks under the Single Oversight Framework published in autumn 2016.

Key Governance Issues

Financial Risk and Sustainability

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

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

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

280. An improved monthly monitoring and governance process has been implemented, with a detailed data collection from individual providers and commissioners collated by NHS Improvement and NHS England and returned to the Department within tight timescales. This has informed a monthly governance process, named the "Finance and Efficiency Board" and "Finance and Efficiency Delivery" meeting, that has resulted in improved and effective reporting to senior officials and ministers. This has allowed for increased transparency on emerging risks and pressures, and supported decision making where needed.

281. The Department and the NHS continue to work on efficiency-related activities to put the NHS on a financially sustainable footing by enabling the NHS to live within its means, eliminate organisational deficits and ensure a balanced NHS budget in each year. To support the implementation of NHS England's Five Year Forward View and its goals for sustainable finances, local health and social care systems, including NHS organisations and local councils, have developed STPs which include proposals for transforming health and social care and proposals have now been published for all STP areas.

282. The plan focusses on the five areas: making better use of NHS providers' resources – money, technology, estates and people; this will account for the most substantial savings; reducing in the growth in demand for healthcare services through public health measures, services that better meet people's needs including better services out of hospital and smarter, data-driven commissioning; reducing some NHS costs by limiting pay increases and improving purchasing, Increasing income to the NHS through existing charges and commercial opportunities; and reducing the cost of the architecture that leads and manages the NHS.

Core performance standards

283. As set out in this Annual Report, performance against all operational performance standards (covering A&E admissions, Referral to Treatment and Waiting Times) continued to be very challenging in 2016-17 and a number were missed, more detail is available in the performance summary and annex C.

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

DH 2020

285. The aspiration to transform the Department into a great Department of State began in-year and is heading in the right direction but there remains work to do over the coming year. During 2016-17 the Department reviewed its role and purpose and ways of working through the DH2020 change programme. This process was designed to ensure the Department has the right skills in order to lead the health and care system effectively whilst operating with reduced running costs.

286. Starting with the Senior Civil Service (SCS) and working through all the other grades, staff underwent a rigorous selection process which was designed to ensure that only those who could meet the higher expectations of capability and flexibility required to deliver our work with fewer resources were selected and assigned to roles in the new structure. All staff competing for posts were assessed against a range of factors, including professional skills, the Civil Service core competency framework, and a demonstration of the wider behavioural requirements need for the future Department. This included being able to demonstrate the ability to be deployable to a wide range of roles within professional groupings and a clear commitment to continuing professional development.

287. An early release scheme was run ahead of the selection process, designed to fast-track the voluntary exit of those staff deemed not to have the right skills or behaviours needed for the future Department and minimise the need for any compulsory redundancies. In total 573 staff left the Department through early release or voluntary redundancy.

288. Knowledge management plans were put in place throughout the Department to manage the magnitude of the exits and the resulting transitional period. Knowledge capture guidance was updated and supported with a knowledge management snapshot tool to accommodate the higher volume of activity. Targeted awareness sessions were delivered across teams and knowledge and information management requirements have been built into new processes and ways of working.

Contract management

289. An internal audit review was carried out on contract management in 2016-17 which gave a moderate rating. Following this, Director Generals now report on management of contracts, Service Level Agreements and Memorandums issues within their group as part of the Quarterly Core Accountability Reviews to ensure risks are identified and escalated. The Contract Management team is also working with Groups to validate and strengthen the information held in the DH Contracts Register, to develop a comprehensive view of the DH contract portfolio. Further details on major contracts and outsourced services are discussed in the Accounting Officer's System Statement.

Other Governance Disclosures

290. I confirm a number of other matters as set out below.

Data Issues - WannaCry ransomware attack

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

of support systems. Lessons from this incident will inform the on-going national programme.

292. NHS Digital had already issued a CareCERT bulletin with a system security patch on 25 April, having picked up a specific threat 24 hours earlier and those organisations who implemented the security patch, updated their anti-virus software and re-booted systems across their IT estate were largely unaffected. These actions meant that in total, over 80% of NHS Trusts were unaffected by this attack and 97% were able to run a normal service.

United Kingdom Leaving the European Union

293. Following the result of the referendum on membership of the European Union on 23 June 2016 the Department has worked to contribute to the development of the Government's strategy on leaving the European Union. The Departmental Board and Executive Committee will continue to monitor these developments through the governance process to ensure that emerging consequences on the health and care system are managed in an effective manner.

National Insurance Contributions

294. In the Department's 2015-16 Governance Statement, an error relating to National Insurance Contributions was disclosed. To reduce the risk of this administrative error reoccurring, a revised process was drawn up with the Government Actuary's Department (GAD), HMRC, HM Treasury and the Department, which enables HM Treasury to independently verify the Department's Supplementary Estimate against National Insurance Contributions information provided against that provided by GAD and HMRC. The process was complied with for the Department's 2016-17 Supplementary and 2017-18 Main Estimates, with no re-occurrence of the administrative error.

Information Risk

295. The Department has not identified any major information risk control issues in 2016-17.

296. The Department did not need to formally report any personal data-related incidents to the Information Commissioner's Office in 2016-17. There were six data-related incidents and one of these involved personal data. The Department ensured appropriate corrective action was taken following these incidents, reviewing internal processes and updating them where necessary. There were no incidents that required a report to the Information Commissioner.

Data Issues – NHS Shared Business Service

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

298. A public disclosure to Parliament was made in the publication of the Annual Report and Accounts 2015-16 on 21 July 2016 following the conclusion of the clinical triage of correspondence when there was a clear picture as to the scale of potential for harm to patients as a result of the incident. Until that process had been completed there was no clear picture as to the extent of potential harm, if any, to patients. In the Department's view communicating publically about the incident before this triage process was complete could have caused unnecessary worry among patients and the public given the overall size of the backlog and lack of clarity as to any impact on patients.

299. As a result, a national incident team was immediately established. Management of the incident and repatriation and review of the documentation took place during the year with associated patient-related issues followed up appropriately. The work included returning known correspondence to GPs and undertaking a review of relevant archives to identify further similar correspondence. As of May 2017, the review of the backlog of correspondence identified found 1,788 cases of potential harm to patient. However, no cases of actual harm to patients have yet been identified. Follow-up work will continue during year.

300. The HGIAS has been involved in "real-time" oversight of the remedial work that is being undertaken in relation to the incident. The HGIAS has also reported to the board on the Department's governance arrangements surrounding NHS SBS. This report gave a limited assurance rating. In September 2016, management accepted the report and its recommendations and drew up an action plan in response.

301. The National Audit Office published the report of its investigation into the incident on 27 June 2017. This report made clear that "addressing the patient safety concerns raised by this incident was the primary priority for the Department and NHS England". NHS England's most recent estimate of administrative costs for dealing with the incident amounts to £6.6 million, including payments totalling £2.5 million made to 7,330 GP practices to compensate them for the time spent assessing the potential for patient harm. NHS SBS has borne £2.26 million of the administrative costs of dealing with the incident so far. Negotiations between NHS England and NHS SBS on the settlement of the costs are on-going.

Data Issues – TPP Diagnosis Software

302. In May 2016, the Department of Health was made aware of an issue relating to an online tool used by some GPs to assess the potential risk of cardiovascular disease in patients. The Department immediately launched an investigation, coordinated by the Medicines and Healthcare products Regulatory Agency working with NHS England, NHS Digital (NHSD) and Public Health England (PHE), into the software, the QRISK2 Calculator software supplied by TPP.

303. The Department sought clinical advice which recommended that, although the population-level risk to patients was small, some individual remedial action was warranted in certain circumstances. GPs have since been informed and offered support in reviewing those individual patients who could have been impacted by the issue, enabling them to determine whether any further clinical action is necessary. DH, MHRA, NHSE, NHSD and PHE continue to monitor the implementation of the remedial action.

Fraud, including prescription charge fraud

304. A Health Group Anti-Fraud Strategic Plan has been developed in liaison with NHS England and NHS Protect. Further discussions with other key stakeholders, such as NHS Improvement, have also taken place. It includes an annual action plan with priorities determined from the latest annual intelligent assessment and will be made available to coincide with the launch of the new NHS Counter Fraud Authority in 2017-18.

305. Throughout 2016-17, the DH Anti-Fraud Unit (AFU) has continued to actively engage with cross-government counter fraud work. This has included working in partnership with the

Cabinet Office to develop cross-government standards for fraud investigations and intelligent functions.

306. A great deal of work has been undertaken, both legislative and procedural, to establish the foundations for the new NHS Counter Fraud Authority (NHSCFA) Special Health Authority (SpHA). The NHSCFA will align with DH counter fraud strategy, vision and strategic plans and act as the principal lead for anti-fraud activity affecting the NHS in England. The NHSCFA will also lead, guide and influence the improvement of standards in counter fraud work, in line with Government and Cabinet Office Standards across the NHS and Wider Health Group.

307. Preparatory work for the legislation with government lawyers has ensured the project can move forward following the general election in June 2017. A formal NHS Protect staff consultation on the SpHA was completed on 28 February and the changes were broadly welcomed by staff and a public announcement about the establishment of the NHSCFA was made on 31 March.

308. Since 2015 over 100 separate anti-fraud awareness and Policy Certificate sessions have been delivered by the AFU to both DH and its ALBs. These sessions highlight the importance of tackling fraud and corruption and give all staff details of how any concerns can be reported.

309. As part of a programme of work to combat patient prescription charge fraud, in September 2014, the NHS Business Services Authority (NHSBSA) began a phased programme of post-dispensing checking on behalf of NHS England, issuing Penalty Charge Notices (PCNs) where exemption cannot be confirmed. From September 2014 to March 2017, 1.6 million PCNs have been issued to patients. A third phase of expansion began in April 2016, resulting in the volume of PCNs issued in 2016-2017 increasing to 1 million. Together with targeted publicity campaigns this programme aims to achieve a reduction in overall losses. The level of losses will be re-assessed in the autumn of 2017. The DH remains responsible for policy on prescription charges and for the content of the prescription form itself.

310. NHSBSA is also responsible for undertaking eligibility checking on patients' entitlement to free NHS dental treatment. Since September 2014, 689,770 dental PCNs have been issued of which 385,770 were issued in 2016-17 to patients claiming exemption through schemes relating to low income, tax credits, income-based Jobseeker's Allowance, income-related Employment and Support Allowance, Income Support, Pensions Credit and Universal Credit. To support practice staff and patients, the dental programme issued an updated version of the relevant education pack to all dental practices in early 2017.

311. On dental contractor fraud, NHS England and NHSBSA commenced a work programme to maximise behavioural change amongst dentists and take positive action against those dentists where there is evidence of fraud and/or excessive and inappropriate claiming. Since July 2015, a £12.7 million reduction in claims for short duration courses of treatment (known as splitting) was achieved against a target of £10.9 million, and additional recoveries of £0.3 million for 28 day re-attendance claimants were collected in quarter 1 of 2017. These exercises will continue for 2017-18 and 2018-19 while assessing additional risk areas for future activities and the level of losses will be re-measured during 2018-19.

Compliance with Equality and Human Rights Legislation

312. The responsibility for meeting the requirements of equality and human rights legislation in policy and decision making lies with each team in the Department. They are supported by a Legislation, Equalities & Human Rights Advisor who is responsible for raising awareness and capability among staff through a policy certificate training module and signposting to up to date and authoritative guidance on the Department's intranet.

313. DGs are required to consider compliance with the public sector equality duty, the Secretary of State for Health's inequalities duties and human rights as part of the Quarterly Core Accountability Reviews, to which all Senior Civil Servants contribute.

314. Regular meetings with the Equality and Human Rights Commission are held to discuss respective priorities and the Department's performance in meeting its statutory equality duties. Information about substantive equality issues are also shared with the DH Strategic Partners' Equalities Subgroup.

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

Macpherson Review and Quality Assurance

316. The Macpherson Review[62] made a number of recommendations to ensure that analytical models used in critical areas of our activity are subject to appropriate quality assurance. Since it initially reported we have implemented a comprehensive framework of assurance across the Department and its ALBs to support quality data models. The framework is guided by an oversight committee to maintain systematic on-going processes to regularly update our list of business critical models and to ensure that risks are identified, managed and escalated as necessary. Development of the process was informed by an in-year audit in early 2015 and by advice from our Audit and Risk Committee, as well as complying fully with HM Treasury guidance in the Aqua book. This process is operating fully and is embedded in business process.

Grant Payments to Non-Public Sector Bodies

317. The Department makes a number of grant payments to non-public sector bodies and Local Authorities each financial year to support delivery in line with governing legislation. The Department's central finance team provides ongoing assurance on monitoring the use of those funds, to ensure they represent value for money and they are contributing to outcomes for which the award has been given, this is described more in the Accounting Officer System Statement published alongside this Annual Report.

Conclusion

318. The Audit and Risk Committee has advised me that there is no reason of which it was aware that I should not sign this statement and that there are effective governance arrangements in place.

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

Remuneration and Staff Report

Remuneration Report

319. This Remuneration Report provides details of the remuneration and pension interests of Ministers and the most senior management (Board Members) of the Department. This includes Ministers, Non-Executive Directors and Directors General (DGs)/Senior Officials and is compliant with EPN 492 guidance.

320. The following elements of the Remuneration Report are subject to audit:
- Salaries (including non-consolidated performance pay, pay multiples) and allowances;
- Compensation for loss of office;
- Non-cash benefits;
- Pension increases and values; and
- Cash Equivalent Transfer Values (CETV) and increases;

321. The Constitutional Reform and Governance Act 2010 require Civil Service appointments to be made on merit on the basis of fair and open competition. The Recruitment Principles[63] published by the Civil Service specify the circumstances when appointments may otherwise be made.

322. 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[64].

Remuneration of Ministers 2016-17

323. Lord Prior of Brampton left the Department on the 8 January 2017 to take up an appointment at the Department for Business, Energy & Industrial Strategy (BEIS), replaced by Lord O'Shaughnessy whose appointment commenced on the 3 January 2017. He is unpaid by the Department, instead paid as Chief Whip and as such his remuneration and pension interests will be reported as part of HM Treasury's accounts.

324. A cabinet reshuffle following the resignation of then Prime Minister David Cameron in June 2016 and appointment of his successor Theresa May saw four Ministers leave their posts, three newly appointed and two invited to remain in post as detailed in the Director's Report.

325. Following the General Election in June 2017, David Mowett and Nicola Blackwood both lost their seats and were replaced by Steve Brine and Jackie Doyle-Price. No remuneration was incurred during 2016-17 for the two newest Ministers.

Remuneration of Senior Officials on the Departmental Board

326. The Director's Report outlines the officials sitting on the Departmental Board and their dates of appointment (and where appropriate departure), but their remuneration is detailed in the table below.

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

Salary

327. 'Salary' includes gross salary; performance pay or non-consolidated performance pay; overtime; reserved rights to London Weighting or London allowances; and any other allowance to the extent that it is subject to UK taxation. This report is based on accrued payments made by the Department and this is recorded in these accounts.

328. In respect of Ministers in the House of Commons, Departments bear only the cost of the additional ministerial remuneration; the salary for their services as an MP and various allowances to which they are entitled are borne centrally. The Department does pay legitimate expenses for Ministers which are not a part of the salary or a benefit in kind.

329. 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 the table below.

Non-Consolidated Performance Pay

330. The performance management and reward policy for members of the SCS, including board members, is managed within a central framework set by the Cabinet Office. The framework allows for non-consolidated performance-related awards to be paid to a maximum of the top 25% of performers within the SCS. The Senior Civil Service Performance Management and Reward principles include explanations of how non-consolidated performance awards are determined[65].

331. SCS non-consolidated performance pay is agreed each year following the SSRB recommendations, and is expressed as a percentage of the Department's total base paybill for the SCS. Non-consolidated performance related pay is awarded in arrears.

332. The non-consolidated performance pay included in the 2016-17 figures relates to awards made in respect of the 2015-16 performance year but paid in financial year 2016-17. In a departure from the Department's approach applied in previous years, it was agreed that awards would not be differentiated by grade as in 2015-16. An award of £11,000 was paid to the top 25% performers in each SCS pay band.

Benefits in Kind

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

334. Dame Sally Davies has occasional use of an official car and taxis for the journey between her home and office. The benefit in kind amounted to £140.00 in 2016-17.

[65] https://www.gov.uk/government/collections/senior-civil-service-performance-management-and-reward

335. The tables below provides details of remuneration interests of the Ministers of the Department and senior officials serving on the Departmental Board for the years 2015-16 and 2016-17 and are subject to audit.

Table 9: Remuneration of Ministers of the Department (subject to audit)

	2016-2017				2015-2016			
Ministers	Salary (£)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits to nearest (£'000)[2]	Total to nearest (£'000)	Salary (£)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits to nearest (£'000)[2]	Total to nearest (£'000)
Jeremy Hunt MP Secretary of State	67,505	Nil	19,000	87,000	67,505	Nil	33,000	101,000
Philip Dunne MP *(from 15/07/2016)* Minister of State	21,120	Nil	-	21,000	-	-	-	-
Full year equivalent	*31,680*							
Nicola Blackwood *(from 16/06/2016 to 8/6/2017)* Parliamentary Under Secretary	15,897	Nil	4,000	20,000	-	-	-	-
Full year equivalent	*22,375*							
David Mowat *(from 16/07/2016 to 8/6/2017)* Parliamentary Under Secretary	15,897	Nil	4,000	20,000	-	-	-	-
Full year equivalent	22,375							
Lord David Prior of Brampton[4] *(from 12/05/2015 to 8/1/2017)* Parliamentary Under Secretary	87,563	Nil	18,000	106,000	93,213	Nil	16,000	109,000
Full year equivalent	*105,076*				105,076			
Lord O'Shaughnessy[3] *(from 3/01/2017)* Parliamentary Under Secretary	-	-	-	-	-	-	-	-
Alistair Burt MP[7] *(from 12/5/2015 to 14/7/2016)* Minister of State	9,112	Nil	10,000	19,000	28,103	Nil	18,000	46,000
Full year equivalent	*31,680*				31,680			
Ben Gummer *(from 12/5/2015-13/07/2016)* Parliamentary Under Secretary	7,458	Nil	2,000	9,000	19,849	Nil	5,000	25,000
Full year equivalent	22,375				22,375			
Jane Ellison *(from 7/10/13 to 13/07/2016)* Parliamentary Under Secretary	7,458	Nil	10,000	17,000	22,375	Nil	7,000	29,000
Full year equivalent	22,375							
George Freeman MP[6] *(from 15/7/2014 to 13/7/2016)* Parliamentary Under Secretary	-	-	-	-	-	-	-	-
Norman Lamb MP *(from 5/9/2012 to 8/5/2015)* Minister of State	-	-	-	-	3,321	Nil	1,000	4,000
Full year equivalent					31,680			
Daniel Poulter MP *(from 5/9/2012 to 11/05/2015)* Parliamentary Under Secretary	-	-	-	-	2,526	Nil	1,000	4,000
Full year equivalent					22,375			
Earl Howe[5] *(from 14/5/2010 to 11/05/2015)* Parliamentary Under Secretary	-	-	-	-	9,811	Nil	3,000	13,000
Full year equivalent 105,706					105,076			

1. The Government has determined that Ministers should receive salaries at the same rate as claimed by equivalent ministers in previous governments since 2010. Therefore the serving ministers have agreed to waiver any ministerial increases in their salary for the duration of this Parliament.

2. The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increases or decreases due to a transfer of pension rights.

3. The Minister was appointed on 3 January 2017 . He receives no salary from the Department. He is a paid as a Government Whip and is paid by the Her Majesty's Treasury.

4. Lord Prior's salary includes the Lords Ministers Night Subsistence Allowance(LMNSA). In 2016-17, he received £57,258 Ministerial Salary and £30,305 LMNSA for the period 1/4/2016-8/1/2017 . In 2015-16 he received £57,258 Ministerial Salary and £32,260 LMNSA for the period 12/5/2015-31/3/2016. For the full year he is entitled to receive £68,710 Ministerial Salary and £36,366 LMNSA .

5. Earl Howe left office on 11 May 2015 and his salary and Lords Minister Night subsistence allowance for 2015-16 reflect the period 1/4/2015-11/05/2015. The full ministerial salary for the year was £68,710. The Lords Ministers Night Subsistence Allowance is entitled £36,366 per annum ,however, he only claimed 50% of his entitlement which amounted to £2,053 in 2015-16.

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

7. In 2016-17, the Minister also received payment for loss of office £7,920 and this is shown under Loss of Office payment later in this report

Table 10: Remuneration of Senior Officials on the Departmental Board (subject to audit)

	2016-2017					2015-2016				
Officials	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[2]	Gross Benefits in Kind (to nearest £100)	Pension Benefits to nearest (£'000)[3]	Total (£'000)	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits to nearest (£'000)[3]	Total (£'000)
Will Cavendish *(to 2/10/2016)* Director General	60-65	Nil	Nil	13,000	70-75	120-125	Nil	Nil	42,000	160-165
Full year equivalent	120-125									
Professor Dame Sally Davies Equivalent of Permanent Secretary	205-210	Nil	100	23,000	230-235	205-210	15-20	800	84,000	310-315
Tamara Finkelstein Director General	120-125	10-15	Nil	54,000	185-190	120-125	Nil	Nil	177,000	295-300
Felicity Harvey *(to 30/06/2016)* Director General	30-35	Nil	Nil	4,000	35-40	135-140	10-15	Nil	41,000	185-190
Full year equivalent	135-140									
Charles Massey *(to 30/10/2016)* Director General	75-80	Nil	Nil	29,000	105-110	130-135	Nil	Nil	59,000	190-195
Full year equivalent	130-135									
Lee McDonough *(from 28/11/2016)* Director General	30-35	Nil	Nil	103,000	135-140	-	-	-	-	-
Full year equivalent	120-125									
Una O'Brien *(to 30/4/2016)* Permanent Secretary	10-15	Nil	Nil	0	10-15	160-165	Nil	Nil	60,000	225-230
Full year equivalent	160-165									
Jonathan Rouse *(to 22/07/2016)* Director General	40-45	10-15	Nil	17,000	70-75	140-145	10-15	Nil	56,000	205-210
Full year equivalent	140-145									
Clara Swinson *(from 7/11/2016)* Director General	90-95	5-10	Nil	79,000	180-185	-	-	-	-	-
Full year equivalent	105-110									
David Williams Director General	140-145	Nil	Nil	52,000	190-195	135-140	Nil	Nil	101,000	235-240
Professor Christopher Whitty *(Secondment from 1/1/2016)* [4,5] Director General	120-125	Nil	Nil	232,000	350-355	25-30	Nil	Nil	7,000	30-35
Full year equivalent						110-115				
Christopher Wormald *(from 1/6/2016)* Permanent Secretary	135-140	Nil	Nil	19,000	155-160	-	-	-	-	-
Full year equivalent	165-170									
Richard Douglas *(to 31/5/2015)* Director General	-	-	-	-	-	25-30	10-15	Nil	5,000	40-45
Full year equivalent						140-145				

1. Non Consolidated Performance Related Pay is paid in arrears and disclosed on an accruals basis. Therefore the Non Consolidated Performance Pay paid in 2015-16 relates to the 2014-15 performance year.

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

3. The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contribution made by the individual). The real increases exclude increases due to inflation or any increase or decrease due to transfer of pension rights.

4. Professor Whitty was appointed on 1 January 2016 on secondment from the London School of Hygiene and Tropical Medicine for four days per week. The figures in the table represent the proportion the department pays only not his full salary. In addition, the Department also contributes towards his pension scheme and NI costs which are not included above.

5. Professor Whitty's pension benefit above reflects the 80% proportion that DH contributes towards his pension scheme. In 2015-16 it reflects the 91 days he was employed by the Department.

Department of Health's SCS Reward Strategy 2016-17

336. The remuneration of Senior Civil Servants is determined in accordance with the rules set out in the Civil Service Management Code[66] and in line with the annual SCS framework guidance issued by Cabinet Office. Departments are given some discretion within the broader Cabinet Office pay guidance to develop their pay strategy to meet local needs and these are outlined in an annual reward strategy.

337. The Department's annual SCS Reward Strategy was agreed by the Executive Board and ratified by the Nominations and Governance Committee and stated that from 1 April 2016, 1% of the Senior Civil Service (SCS) paybill was available for consolidated pay awards. The Department continued to target the pay award towards those lower in their respective pay range by applying "breakpoints" in each SCS Pay Band and differentiating

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

the consolidated increases based on where staff were positioned in relation to the respective breakpoint. The breakpoints remained at the levels as set for 2015-16, which for Directors General (SCS3 Pay Band) was £140,000.

338. The pay award was paid as a flat cash rate increase rather than a percentage uplift, this delivered a higher reward to those who earned less in comparison with their peers. SCS below the breakpoint for their respective grade received a consolidated pay award of £1,000 and those above the breakpoint received £250. In line with Cabinet Office guidance, staff in the bottom 10% performance group were ineligible for an award.

Median Earnings

339. Departments are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

Table 11: Median Earnings for Core Department and Public Health England (Executive Agency)

(subject to audit)

Median Earnings 2015-2016 and 2016-2017				
	Core Department		Combined [1]	
	2016-2017	2015-2016	2016-2017	2015-2016
Band of Highest Paid Director's Total remuneration (£000)[2]	205-210	225-230	220-225	225-230
Band of lowest paid	15-20	15-20	15-20	15-20
Median Total Remuneration	£44,800	£40,035	£38,207	£37,829
Ratio	4.6	5.7	5.8	6.0

1. The Medicines and Healthcare Products Regulatory Agency under the terms of its incorporation is not within scope and therefore is not included in determining the median earnings calculation for either year.
2. Salaries for senior management are disclosed in bands of £5000, in accordance with EPN492 guidance.
3. Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include employer pension contributions, severance payments and the cash equivalent transfer value of pensions.

340. No DH core employees in either 2016-17 or 2015-16 received remuneration in excess of the highest paid Director. Banded remuneration ranged from £15,000-£20,000 to £205,000–£210,000 (2015-16, £15,000-£20,000 and £225,000-£230,000).

341. The median earnings for the core Department have increased in 2016-17 compared to 2015-16, this variance is directly related to the change in distribution of the earnings of staff, as a consequence of the voluntary exits of staff following the DH2020 restructure programme during 2016-17. The highest proportion of leavers were from the junior grades and the initial recruitment during this period commenced with more senior grades which has affected the ratio.

342. The lower ratio between the median earnings to the highest earner between 2015-16 and 2016-17 is due to the combined effect of higher median earnings and the lower earnings of the highest earner in 2016-17. The highest earner received a non-consolidated performance related pay award in 2015-16 but not in 2016-17.

Civil Service Pensions

343. Pension benefits are provided through the Civil Service pension arrangements. The Civil Servants and Others Pension Scheme (or Alpha) has been in place since 1 April 2015 and all newly appointed civil servants and the majority of those currently in service are members. The Alpha scheme provides benefits on a career average basis with a normal pension age equal to the member's State Pension Age (or 65 if higher).

344. Prior to Alpha, civil servants participated in the Principal Civil Service Pension Scheme (PCSPS), which has four sections: 3 providing benefits on a final salary basis (classic, premium or classic plus) with a normal pension age of 60; and one providing benefits on a whole career basis (nuvos) with a normal pension age of 65.

345. These statutory arrangements are unfunded with the cost of benefits met by monies voted by Parliament each year. Pensions payable under classic, premium, classic plus, nuvos and alpha are increased annually in line with Pensions Increase legislation. Existing members of the PCSPS who were within 10 years of their normal pension age on 1 April 2012 remained in the PCSPS after 1 April 2015. Those who were between 10 years and 13 years and 5 months from their normal pension age on 1 April 2012 will switch into alpha sometime between before 1 February 2022 with their PCSPS benefits 'banked', with those with earlier benefits in one of the final salary sections of the PCSPS having those benefits based on their final salary when they leave alpha. The pension figures quoted for officials show pension earned in PCSPS or alpha – as appropriate. Where the official has benefits in both the PCSPS and alpha the figure quoted is the combined value of their benefits in the two schemes. Members joining from October 2002 may opt for either the appropriate defined benefit arrangement or a 'money purchase' stakeholder pension with an employer contribution (partnership pension account).

346. Employee contributions are salary-related and range between 3.0% and 8.05% of pensionable earnings for members of classic (and members of alpha who were members of classic immediately before joining alpha) and between 4.6% and 8.05% for members of premium, classic plus, nuvos and all other members of alpha. Benefits in classic accrue at the rate of 1/80th of final pensionable earnings for each year of service. In addition, a lump sum equivalent to three years initial pension is payable on retirement. For premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike classic, there is no automatic lump sum. Classic plus is essentially a hybrid with benefits for service before 1 October 2002 calculated broadly as per classic and benefits for service from October 2002 worked out as in premium. In nuvos a member builds up a pension based on his pensionable earnings during their period of scheme membership. At the end of the scheme year (31 March) the member's earned pension account is credited with 2.3% of their pensionable earnings in that scheme year and the accrued pension is uprated in line with Pensions Increase legislation. Benefits in alpha build up in a similar way to nuvos, except that the accrual rate in 2.32%. In all cases members may opt to give up (commute) pension for a lump sum up to the limits set by the Finance Act 2004.

347. The partnership pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 3.0% and 12.5% up to 30 September 2015 and 8.0% and 14.75% from 1 October 2015 (depending on the age of the member) into a stakeholder pension product chosen by the employee from a panel of providers. The employee does not have to contribute, but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.8% of pensionable salary up to 30 September 2015 and 0.5% of pensionable salary from 1 October 2015 to cover the cost of centrally-provided risk benefit cover (death in service and ill health retirement).

348. 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, 65 for members of nuvos, and the higher of 65 or State Pension Age for members of alpha. (The pension figures quoted for officials show pension earned in PCSPS or alpha – as appropriate. Where the official has benefits in both the PCSPS and alpha the figure quoted is the combined value of their benefits in the two schemes, but note that part of that pension may be payable from different ages).Full details of the Civil Service pension arrangements can be found on the website[67].

Ministerial Pensions

349. Pension benefits for Ministers are provided by the Parliamentary Contributory Pension Fund (PCPF). The scheme is made under statute and the rules are set out in the Ministers Pension Scheme 2015.[68]

350. Those Ministers who are Members of Parliament may also accrue an MP's pension under the PCPF (details of which are not included in this report). A new MP's pension scheme was introduced from May 2015, although members who were aged 55 or older on 1st April 2013 have transitional protection to remain in the previous final salary pension scheme.

351. Benefits for Ministers are payable from State Pension age under the 2015 scheme. Pensions are re-valued annually in line with Pensions Increase legislation both before and after retirement. The contribution rate from May 2015 is 11.1% and the accrual rate is 1.775% of pensionable earnings.

352. The tables below provide the details of the pension interests for the Department's Officials and Ministers for 2015-16 and 2016-17 and are subject to audit.

Cash Equivalent Transfer Values

353. 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.

354. The figures include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the Civil Service pension arrangements. They also include any additional pension benefit accrued to the member as a result of their purchasing additional pension benefits at their own cost. CETVs are worked out in accordance with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

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

355. Similarly, for Ministers, 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.

Real Increase in CETV

356. Remuneration reports show the CETVs of senior staff at the start and end of the reporting year, together with the real increase during that period. The real increase is the increase due to additional benefit accrual (i.e. as a result of salary changes and service) that is funded by the employer or the Exchequer in the case of Ministers and uses common market valuation factors for the start and end periods.

357. Real increases in CETVs will be smaller than the difference between the start and end CETVs because it does not include any increase in the value of the pension due to inflation or due to the contributions paid by the member or the value of any benefits transferred from another pension scheme. Nor does it include any increases (or decreases) because of any changes during the year in the actuarial factors used to calculate CETVs. The tables above include the CETV increases.

Table 12: Pension Interests of Ministers (subject to audit)

	Accrued pension at 65 as at 31/03/17 (£ '000)	Real increase in pension at age 65 (£ '000)	CETV at 31/03/17 (£ '000)	CETV at 31/03/16 (£ '000)	Real increase in CETV (£ '000)
Jeremy Hunt	10-15	0-2.5	155	134	8
Nicola Blackwood[4]	0-5	0-2.5	1	2	1
Philip Dunne[7]	-	-	-	-	-
David Mowat[4]	0-5	0-2.5	5	0	3
Lord Prior of Brampton[5]	0-5	0-2.5	40	18	14
Alistair Burt[3]	5-10	0-2.5	130	117	9
Ben Gummer[2]	0-5	0-2.5	4	3	
Jane Ellison[2]	0-5	0-2.5	23	16	6
Lord O'Shaughnessy[6]	-	-	-	-	-

1.The figures given are based solely on the individual benefits as a Minister and will not reflect any pension in

2. Reflects Ministerial pension for the period 1 April 2016-31 July 2017

3. Reflects Ministerial pension for the period 1 April 2016-14 July 2017

4. Reflects Ministerial pension for the period 16 July 2016-31 March 2017

5. Reflects Ministerial pension for the period 1April 2016 -31 January 2017

6. Minister is paid by the HM Treasury and pension benefit will be reflected in their annual accounts 2016-17

7. Minister does not contribute to the Pension scheme

Table 13: Pension Information of Senior Officials on the Departmental Board (subject to audit)

		Accrued pension at pension age as at 31/03/17 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/03/17	CETV at 31/03/16	Real increase in CETV	Employer contribution to partnership pension account
		£'000	£ '000	£ '000	£ '000	£'000	Nearest £100
Will Cavendish *(to 2/10/2016)*	Director General of Innovation, Growth & Technology	40 - 45	0 -2.5	663	646	9	N/A
Professor Dame Sally Davies[5]	Chief Medical Officer	20-25	0 -2.5	430	410	20	N/A
Tamara Finkelstein	Director General for Community Care	50-55	2.5-5	780	717	27	N/A
Felicity Harvey *(to 30/06/2016)*	Director General of Public Health	60-65 plus lump sum of 185-190	0-2.5 plus lump sum of 0-2.5	1,438	1,440	4	N/A
Charles Massey *(to 30/10/2016)*[2,3]	Director General for Acute Care & Workforce	40-45 plus lump sum of 110-115	0-2.5 plus lump sum of 0	653	616	12	N/A
Lee McDonough *(from 28/11/2016)*	Director General for Acute Care & Workforce	35-40 plus lump sum of	2.5-5 plus lump sum of 12.5-15	741	629	90	N/A
Una O'Brien[4]	Permanent Secretary	-	-	-	1,203	-	N/A
Jonathan Rouse *(to 22/07/2016)*	Director General of Social Care, Local Government and Care Partnerships	10 -15	0 -2.5	126	113	8	N/A
Clara Swinson *(from 7/11/2016)*	Director General for Global & Public Health	25-30 plus lump sum of 60-65	2.5-5 plus lump sum of 7.5-10	342	294	45	N/A
Professor Christopher Witty[1,3]	Chief Scientific Officer	50-55 plus lump sum of 85-90	10-15 plus lump sum of 10-15	734	144	157	N/A
David Williams[2]	Director General for Finance & Group Operations	45-50 plus lump sum of 125-130	2.5-5 plus lump sum of 0	807	748	22	N/A
Christopher Wormald *(from 1/6/2016)*	Permanent Secretary	60-65	0-2.5	867	855	10	N/A

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

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

3. There was a recalculation of the end CETV for 2015-16.

4. Member opted out of the pension scheme as at 31/03/2016.

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

Non-Executive Directors

358. Non-Executive board members are not employees of the Department. They are appointed for a fixed term of three years initially, with the possibility of extension and their fees are not pensionable. They are appointed primarily to support and provide an external source of challenge to Government Departments, and take up roles in Departmental governance. As such they attend and contribute to Departmental Board meetings, which involve a monthly commitment of meetings, and occasional overnight events per year. The Non-Executive Members also make a significant contribution to Departmental business by working through Committees and with senior officials.

359. In line with Cabinet Office guidance, the Departmental Board holds positions for four non-executive board members. The Non-Executive Directors sitting on the Departmental Board during 2016-17 are detailed in the Director's Report. Currently, there is one NED in post and a recruitment exercise to fill the 3 remaining these posts will resume following the election.

360. One of the Non-Executive members chairs the Department's Audit and Risk Committee (4-5 meetings per year). The lead Non-Executive Board Member chairs the Department's Nominations and Governance Committee, which has an additional Non-Executive Member.

Non-Executive Directors of the Department

361. Catherine Bell was initially appointed to the Departmental Board on a 3 year fixed-term contract from 1 January 2011. This was extended until 31 May 2016. She was also appointed a member of the Executive Board from 23 May 2013 until 22 May 2016. She received an annual fee of £30,000 per annum (£15,000 for the Departmental Board and £15,000 for the Executive Board). She claimed fees of £5,000 and expenses of £180 between 1 April 2016 & 31 May 2016 amounting to £5,180.

362. Peter Sands was reappointed for a further 3 years from 1 May 2014 to 30 April 2017. Chris Pilling's appointment was extended for a further period from 1 April 2014 to 30 November 2016. Both Peter Sands and Chris Pulling waived their fees and are reimbursed for their expenses only, neither have made any expense claims in 2016-17.

363. Gerry Murphy was appointed as a Non-Executive Board Member from 1 August 2014 for a 3 year period. He was paid fees of £20,000 per annum (£15,000 as a Non-Executive Director and £5,000 as Chair of the Audit and Risk Committee). He has not made any expense claims for 2016-17.

Compensation for Loss of Office

364. There was one payment made for loss of office during 2016-17 to a minister following the Cabinet reshuffle in July 2016 with Alistair Burt receiving £7,920 in severance pay following his departure on 14 July 2016.

365. In accordance with the Ministerial and Other Pensions and Salaries Act 1991 on leaving office, Ministers who have not attained the age of 65, and are not appointed to a relevant Ministerial or other paid office within three weeks, are eligible for a severance payment of one quarter of the annual ministerial salary being paid. These payments are exempt from tax under the provision of section 291 of the Income Tax (Earnings and Pensions) Act 2003 and the payments are also not pensionable.

Staff Report

366. This Staff Report summarises the core Department's key staffing information and policies, with the staff costs, numbers and exit packages disclosures subject to audit.

367. The core Department employed an average of 1,733 permanent whole time equivalent (WTE) persons during 2016-17 at a total cost of £79.4 million, compared to 1,887 at a cost of £89.0 million in 2015-16. A breakdown of staff numbers and associated costs for the Core Department and Agencies and the overall Departmental Group is included in tables 14 & 15 below.

DH2020 change programme

368. Following the announcement in the 2015 Spending Review of the plan to reduce the Department's running costs by 30% by 2019-20, the Department launched an immediate review of its operating model to determine how to meet the cost and capability challenges for the future. The plan to deliver the changes required were coordinated through the DH2020 change programme, which during 2016-17 focused on restructuring the Department to ensure the right skills were retained or brought in to lead the health and care system effectively, whilst delivering the scale of savings necessary to meet the 2015 Spending Review target.

369. In order to frontload savings and keep to a minimum the period of staff uncertainty and disruption to the business, the Department ran the restructuring and job selection process early in the Spending Review period and completed this process by February 2017.

370. A voluntary exit scheme was run ahead of the selection process and 573 staff were approved to leave the Department on those terms by the end of March 2017. The scheme was designed to ensure we did not approve the exit of any staff believed to have the right skills and behaviours needed for the future Department.

371. Having rigorously applied clear capability criteria to both the approval of voluntary exits and to the selection and assignment of staff to posts in the new structure, the Department identified the need to recruit a range of new staff across all grades and professions with the requisite skills and capability to populate the new structures and commenced a bulk recruitment process in December 2016 following completion of the selection process for existing staff.

372. The Civil Service core competencies and our exacting expectations of capability and flexibility remain at the heart of our approach to new recruitment. New staff being recruited must demonstrate a range of professional expertise with the Department placing particular emphasis on world-class policy making, project and implementation skills, purposeful and disciplined management, and inspiring and confident leaders.

DH Staff

373. The Department's staff grading structure is reflective of seniority within the organisation and covers a range of roles; Administrative (AO); Managerial (EO, Fast stream, HEO, SEO); Senior Management (Grade 6 & 7); Senior Civil Service (SCS1 (Deputy Director), SCS2 (Director), SCS3 (Director General)). Figure 10 outlines the gender distribution of core Departmental staff in post as at 31 March 2017 and is consistent wth ONS reporting methodologies.

374. The core Department has continued to reduce the number of days lost to short-term and long-term sickness, falling from 3,348 and 4,480 days respectively in 2015-16 to 3,103 and 4,312 in 2016-17. Our average number of days lost due to sickness of 4 days is significantly below the civil service average of 7.1 days.

4 days sickness compared to 7.1 days across Civil Service

Equal Opportunities Policy

375. The Department is committed to treating all staff fairly and responsibly. The aim of the Department's equal opportunities policy is to promote equality of opportunity whereby no employee or job applicant is discriminated against on the grounds of their race, colour, ethnic or national origin, sex, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy or maternity status, marital or civil partnership status, responsibility for children or other dependents, work pattern, Trade Union membership or activity.

376. The Department's strategic commitments to equal opportunities and diversity incorporate an extensive range of activities, and include goals to strengthen diversity in the more senior grades, HEO and above; equalities analysis of HR policies and initiatives; a comprehensive suite of equality policies; work-life balance and mental health initiatives; workforce monitoring by diversity characteristics; and targeted action such as career progression support for ethnic minority staff. They are set out in the Department of Health Equality Objectives Action Plan[69] and Annual Equalities Information Report[70].

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

378. The Department uses a range of measures to track progress – including trends in staff survey data, and participation in Civil Service wide and external benchmarking exercises such as the cross-sector Stonewall Workplace Equality Index and expert advice from organisations such as the Business Disability Forum and Equal Approach. The Department also implements the recommendations from the Civil Service Talent Action Plan and the Removing Barriers to Success programme.

Recruitment and Retention of Disabled Persons

379. The Department has a number of policies and activities in place to aid the recruitment and retention of disabled staff. These include: involving the disabled staff network in the assessment (by equality) of workforce policies and guidance; a comprehensive suite of flexible working policies; development of specific guidance for managers and staff, (covering such issues as 'making reasonable adjustments', 'mental health', 'support for carers', 'anti-bullying and harassment' and the 'Guaranteed Interview Scheme'); occupational health support; and accessible IT systems, information, accommodation and facilities. The Department is taking part in a cross-government talent programme to develop the skills required for progression to higher grades.

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

Staff Data

380. The following tables summarise key staff information for the core Department and Departmental Group.

Table 14: Staff costs for the Departmental Group comprise: (subject to audit)

					2016-17 £'000	2015-16 £'000
	Permanently employed staff	Others	Ministers	Special advisors	Total	Total
Salaries and wages	39,354,625	5,484,589	202	222	44,839,638	44,020,088
Social Security costs	3,873,023	85,325	26	34	3,958,408	3,064,140
NHS Pension	4,697,046	87,467	-	-	4,784,513	4,636,466
Other pension costs	67,722	225	-	51	67,998	70,012
Sub-total	**47,992,416**	**5,657,606**	**228**	**307**	**53,650,557**	**51,790,706**
Termination benefits	89,991	9,564	8	-	99,563	88,196
Sub-total	**48,082,407**	**5,667,170**	**236**	**307**	**53,750,120**	**51,878,902**
Less recoveries in respect of outward secondments	(27,400)	(45,078)	-	-	(72,478)	(71,136)
Total Net Costs	**48,055,007**	**5,622,092**	**236**	**307**	**53,677,642**	**51,807,766**

Table 15: Average number of whole-time equivalents employed – Departmental Group (subject to audit)

					2016-17 Number	2015-16 Number
	Permanent staff	Others	Ministers	Special Advisors	Total	Total
Core Department						
Core Department	1,733	136	6	4	1,879	2,064
Executive Agencies						
Public Health England	5,003	342	-	-	5,345	5,354
Other designated bodies						
NHS Providers	1,040,366	103,863	-	-	1,144,229	1,127,808
Special Health Authorities	3,109	158	-	-	3,267	3,140
NHS England Group	20,909	10,108	-	-	31,017	30,535
Non Departmental Public Bodies	9,180	745	-	-	9,925	9,657
Others	4,883	407	-	-	5,290	3,602
Total	**1,085,183**	**115,759**	**6**	**4**	**1,200,952**	**1,182,160**

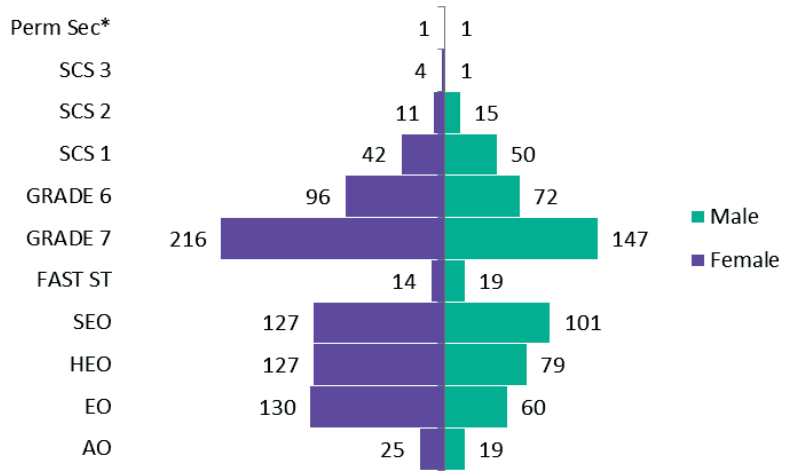
381. Of the above, the following staff were engaged on capital projects:

Table 16: Breakdown of staff engaged on capital projects

Of the above, the following staff were engaged on capital projects:					2016-17 Number	2015-16 Number
	Permanent staff	Others	Ministers	Special Advisors	Total	Total
Core Dept & Agencies	32	2	-	-	34	12
Other designated bodies	2,573	784	-	-	3,357	3,533

382. Further details of staff employed within NHS organisations is available via NHS Digital[71], who publish on a monthly basis a breakdown of staff employed within the NHS Hospital and Community Health Service (HCHS). The data can be broken down by headcount, WTE, organisation, staff group and is the definitive source for NHS staffing information. Details of each NHS organisation can also be found in their own Annual Report and Accounts.

Figure 10: Gender distribution of core Department staff Headcount as at 31st March 2017



*Dame Sally Davies is classified as Permanent Secretary in this presentation, appearing alongside Chris Wormald.

Consultancy, Temporary and Agency workers

383. The table below provides details of expenditure on Consultancy, Agency and Temporary workers by the core Department and bodies within the Departmental Accounting Boundary. The definition for consultancy and temporary agency workers is in line with HM Treasury Guidance. The consultancy values are reported on a resource basis, consistent with the accounts and reconcile to the figures reported in Note 4.

384. The Department utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. This year we spent £4.5 million on consultancy compared to £7.7 million in 2015-16; and £14.2 million on temporary staff this year compared to £13.2 million last year. This is a short term increase relating to additional specialist resource to support the Department's Corporate Services Improvement Programme (CSIP) and transition following the DH2020 restructuring.

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

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

Table 17: Expenditure on Consultancy, Agency and Temporary Workers

	2016-17		2015-16	
	Consultancy £'000	Temporary Agency £'000	Consultancy £'000	Temporary Agency £'000
Total DH Core	4,485	14,219	7,657	13,191
Executive Agencies	-	3,681	-	22,023
Other Designated Bodies	384,816	3,699,483	425,007	4,095,713
Gross Total	**389,301**	**3,717,383**	**432,664**	**4,130,927**
Eliminations	(148)	-	(268)	-
Total Departmental Group (after eliminations)	**389,153**	**3,717,383**	**432,396**	**4,130,927**

The numbers reported above for agency include staff categorised as 'bank staff' by NHS providers. These are not included with NHSI's reported measures and agency spending.

Off-Payroll Engagements

386. Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, departments must publish information on their highly paid and/or senior off–payroll engagements. The information, contained in the three tables below, includes all off-payroll engagements as at 31 March 2017 for more than £220 per day and that last longer than six months for the core Department, its Executive Agencies and its arm's length bodies.

387. The Department has refined the approach taken to off-payroll tax assurance during the financial year and has built on the process review conducted during 2015-16 to ensure compliance with all HMT & HMRC requirements. Regular communications has also been undertaken with our ALB's to provide advice and assistance in ensuring they have also been compliant in this area. All appointments across the core Department, its Executive Agencies and its ALBs have been subject to a risk based assessment regarding the payment of the correct tax by our combined contractor and off-payroll worker base.

388. On the advice of HM Treasury, secondments have been included within our off-payroll figures for the core Department. Secondments engaged as at 31 March 2017 accounted for 30 of the off-payroll workers with 10 having reached six months during the financial year. We had no change of policy relating to the engagement of off-payroll workers during 2016-17 and continue to utilise off-payroll workers only where it is necessary and prudent to do so.

389. It should also be noted that the Department has taken the necessary steps during 2016-17 to ensure compliance with the new HMT rules surrounding off-payroll workers which came into force 6th April 2017. Regular correspondence has been undertaken with HMT, HMRC & Crown Commercial Services to ensure the new requirements have been understood and these have been implemented in a fair and reasonable manner from the start of the 2017-18 financial year by both the Department and our Arm's Length Bodies.

Table 18: Off-payroll engagements

Table a: For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months

	Core Dept & Agencies	ALBs
Number of existing engagements as of 31 March 2017	94	815
Of which…..		
Number that have existed for less than one year at time of reporting	41	336
Number that have existed for between one and two years at time of reporting	23	258
Number that have existed for between two and three years at time of reporting	4	136
Number that have existed for between three and four years at time of reporting	7	77
Number that have existed for four years or more years at time of reporting	19	8

Table b: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months

	Core Dept & Agencies	ALBs
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	53	461
Number of the above which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	53	313
Number for whom assurance has been requested	53	455
Of which…..		
Number for whom assurance has been received	51	412
Number for whom assurance has not been received	2	43
Number that have been terminated as a result of assurance not being received	1	-

Table c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility*, between 1 April 2016 and 31 March 2017

	Core Dept & Agencies	ALBs
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-	23
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	109	320

*For Senior Officials the core Department has included all officials at SCS1 payband or above with significant financial responsibility for budget(s) of £500,000 or more

Exit Packages – Civil Service and Other Compensation Schemes

390. The following table details civil service and other compensation schemes and exit packages. Redundancy and other departure costs have been paid in accordance with the provisions of the Civil Service Compensation Scheme[72]. Where early retirement has been agreed, the additional costs are met by the Department/organisation. Ill-health retirement costs are met by the pension scheme and are not included in the table. The figures disclosed relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure cost may have been accrued or provided for in a previous period. The information in this disclosure note is therefore presented on a different basis to the staff cost and other expenditure notes in the accounts.

Table 19: Exit Packages (subject to audit)

				Core Dept & Agencies				2016-17 Departmental Group
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
≤£10,000	2	25	27	-	434	1,914	2,348	15
£10,001 - £25,000	2	101	103	1	487	760	1,247	7
£25,001 - £50,000	4	210	214	-	429	632	1,061	3
£50,001 - £100,000	6	361	367	-	243	570	813	2
£100,001 - £150,000	4	5	9	-	85	53	138	1
£150,001 - £200,000	2	4	6	-	51	17	68	-
>£200,000	-	3	3	-	2	4	6	-
Total Number	**20**	**709**	**729**	**1**	**1,731**	**3,950**	**5,681**	**28**
Total Cost (£)	**1,422,479**	**37,605,917**	**39,028,396**	**17,161**	**61,791,027**	**91,691,723**	**153,482,750**	**479,778**

				Core Dept & Agencies				2015-16 Departmental Group
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
≤£10,000	1	13	14	1	476	1,614	2,090	12
£10,001 - £25,000	3	20	23	-	528	636	1,164	14
£25,001 - 50,000	2	24	26	-	476	456	932	6
£50,001 - £100,000	11	23	34	-	320	292	612	6
£100,001 - £150,000	3	4	7	-	96	66	162	3
£150,001 - £200,000	-	3	3	-	36	18	54	-
>£200,000	-	-	-	-	12	8	20	-
Total Number	**20**	**87**	**107**	**1**	**1,944**	**3,090**	**5,034**	**41**
Total Cost (£)	**1,363,915**	**3,603,220**	**4,967,135**	**8,000**	**72,164,039**	**68,781,964**	**140,946,003**	**1,222,998**

1. Within the total above, there were 577 exit packages during 2016-17 relating to the DH2020 restructure programme. (565 Voluntary exits, 8 voluntary redundancies, and 4 compulsory redundancies).
2. There are 8 individuals within the Department who have received over £95,000 as an exit package due to entitlement on voluntary or compulsory redundancy arrangements.

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

Other Departures

391. The following table outlines the detail of other departures. A single exit package can be made up of several components, each of which will be counted separately in this table, therefore the total number in the table above will not necessarily match the total number in the table below, which will be the number of individuals.

Table 20: Analysis of Other Departures

	2016-17 Departmental Group	
	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	1,274	60,068
Mutually agreed resignations (MARS) contractual costs	726	15,502
Early retirements in the efficiency of the service contractual costs	20	256
Contractual payments in lieu of notice	1,876	14,153
Exit payments following Employment Tribunals or court orders	59	1,373
Non-contractual payments requiring HMT approval*	22	340
Total	**3,977**	**91,692**

*Includes any non-contractual severance payments made following judicial mediation, and those relating to non-contractual payments in lieu of notice.

Parliamentary Accountability and Audit Report

Regulatory Reporting

Statement of Parliamentary Supply

In addition to the primary statements prepared under IFRS (included in the financial statements), the Government Financial Reporting Manual (FReM) requires the Department to prepare a Statement of Parliamentary Supply (SOPS) and supporting notes to show resource outturn against the Supply Estimate presented to Parliament, in respect of each budgetary control limit.

The SOPS and related notes present the expenditure of the Department on a basis consistent with the aggregate estimate figures presented in the Parliamentary Supply Estimates and **are subject to audit.**

The SOPS reports Departmental expenditure in a way which supports the achievement of macro-economic stability by ensuring that public expenditure is controlled, with the relevant Parliamentary authority, in support of the Government's fiscal framework.

Summary of Resource and Capital Outturn 2016-17 (subject to audit)

								2016-17	2015-16
			Estimate			Outturn			Outturn
	SoPS Note	Voted £'000	Non-Voted £'000	Total £'000	Voted £'000	Non-Voted £'000	Total £'000	Voted outturn compared with Estimate: saving/ (excess) £'000	Total £'000
Departmental Expenditure Limit									
- Resource	1.1	97,568,799	20,025,641	117,594,440	97,005,319	20,025,641	117,030,960	563,480	114,730,499
- Capital	1.2	4,616,033	-	4,616,033	4,556,079	-	4,556,079	59,954	3,631,849
Annually Managed Expenditure									
- Resource	1.1	16,150,267	-	16,150,267	9,507,918	-	9,507,918	6,642,349	29,206,503
- Capital	1.2	15,000	-	15,000	13,349	-	13,349	1,651	9,021
Total Budget		118,350,099	20,025,641	138,375,740	111,082,665	20,025,641	131,108,306	7,267,434	147,577,872
Non-Budget									
- Resource	1.1	-	-	-	-	-	-	-	-
Total		**118,350,099**	**20,025,641**	**138,375,740**	**111,082,665**	**20,025,641**	**131,108,306**	**7,267,434**	**147,577,872**
Total Resource		113,719,066	20,025,641	133,744,707	106,513,237	20,025,641	126,538,878	7,205,829	143,937,002
Total Capital		4,631,033	-	4,631,033	4,569,428	-	4,569,428	61,605	3,640,870
Total		**118,350,099**	**20,025,641**	**138,375,740**	**111,082,665**	**20,025,641**	**131,108,306**	**7,267,434**	**147,577,872**

Net cash requirement 2016-17 (subject to audit)

		2016-17		2016-17	2015-16
	SoPS Note	Estimate £'000	Outturn £'000	Outturn compared with Estimate: saving/ (excess) £'000	Outturn £'000
Net cash requirement	3	101,889,283	99,049,454	2,839,829	95,717,329

Administration Costs 2016-17 (subject to audit)

	2016-17 Estimate £'000	2016-17 Outturn £'000	2015-16 Outturn £'000
Administration Costs	3,023,175	2,394,452	2,553,806

1. Sections outlined in bold are voted totals and/or totals subject to Parliamentary control.

SOPS 1 Net Outturn

SOPS 1.1 Analysis of net resource outturn by section (subject to audit)

											2016-17 £'000	2015-16 £'000
							Outturn			Estimate		Outturn
	Administration			Programme			Total	Net Total	Net total compared to Estimate Savings /(excess)	Net total compared to Estimate, adjusted for virements		Total
	Gross	Income	Net	Gross	Income	Net						
Spending in Departmental Expenditure Limits (DEL)												
Voted:												
NHS England net expenditure	1,497,776	-	1,497,776	14,952,095	-	14,952,095	16,449,871	22,019,224	5,569,353	36,572		16,824,251
NHS Trusts net expenditure	-	-	-	25,259,577	-	25,259,577	25,259,577	26,788,655	1,529,078	-		25,921,074
NHS Foundation Trusts net expenditure	-	-	-	43,232,839	-	43,232,839	43,232,839	37,771,004	(5,461,835)	-		41,375,371
DH Programme and Administration expenditure	400,880	(46,953)	353,927	2,125,760	(900,314)	1,225,446	1,579,373	3,189,832	1,610,459	526,908		2,297,393
Local Authorities	-	-	-	3,433,334	60	3,433,394	3,433,394	3,388,400	(44,994)	-		3,088,182
Public Health England (Executive Agency)	62,391	(3,466)	58,925	1,000,604	(182,473)	818,131	877,056	421,434	(455,622)	-		872,549
Health Education England net expenditure	70,783	-	70,783	2,082,509	-	2,082,509	2,153,292	2,047,492	(105,800)	-		2,003,077
Special Health Authorities expenditure	186,464	(32,542)	153,922	3,504,088	(168,762)	3,335,326	3,489,248	1,451,127	(2,038,121)	-		2,530,619
Non Departmental Public Bodies net expenditure	259,119	-	259,119	271,550	-	271,550	530,669	491,631	(39,038)	-		501,809
	2,477,413	**(82,961)**	**2,394,452**	**95,862,356**	**(1,251,489)**	**94,610,867**	**97,005,319**	**97,568,799**	**563,480**	**563,480**		**95,414,325**
Non-voted:												
NHS England expenditure financed by NI Contributions	-	-	-	20,025,641	-	20,025,641	20,025,641	20,025,641	-	-		19,316,174
	2,477,413	**(82,961)**	**2,394,452**	**115,887,997**	**(1,251,489)**	**114,636,508**	**117,030,960**	**117,594,440**	**563,480**	**563,480**		**114,730,499**
Annually Managed Expenditure (AME)												
Voted:												
NHS England net expenditure	-	-	-	(307,784)	-	(307,784)	(307,784)	300,000	607,784	607,784		(253,797)
NHS Trusts net expenditure	-	-	-	296,447	-	296,447	296,447	951,070	654,623	654,623		295,635
NHS Foundation Trusts net expenditure	-	-	-	728,804	-	728,804	728,804	924,092	195,288	195,288		394,321
DH Programme and Administration expenditure	-	-	-	251,816	(28,632)	223,184	223,184	771,825	548,641	545,875		923,064
Local Authorities	-	-	-	-	-	-	-	-	-	-		-
Public Health England (Executive Agency)	-	-	-	2,223	-	2,223	2,223	22,928	20,705	20,705		(3,455)
Health Education England net expenditure	-	-	-	4,817	-	4,817	4,817	4,679	(138)	-		14,483
Special Health Authorities expenditure[5]	-	-	-	8,557,599	-	8,557,599	8,557,599	13,175,673	4,618,074	4,618,074		27,832,697
Non Departmental Public Bodies net expenditure	-	-	-	2,628	-	2,628	2,628	-	(2,628)	-		3,555
	-	-	-	**9,536,550**	**(28,632)**	**9,507,918**	**9,507,918**	**16,150,267**	**6,642,349**	**6,642,349**		**29,206,503**
Total	**2,477,413**	**(82,961)**	**2,394,452**	**125,424,547**	**(1,280,121)**	**124,144,426**	**126,538,878**	**133,744,707**	**7,205,829**	**7,205,829**		**143,937,002**

Reconciliation to Statement of Comprehensive Net Expenditure											
Net gain/(loss) on transfers by absorption	-	-	-	-	-	-	-				-
Capital Grants	11,276	-	11,276	543,536	-	543,536	554,812				641,145
Research and Development	-	-	-	1,056,049	-	1,056,049	1,056,049				-
Income from Consolidated Fund Extra Receipts	-	-	-	-	(1)	(1)	(1)				(106)
Utilisation of provisions	(24,185)	-	(24,185)	24,185	-	24,185	-				-
IFRIC 12 Adjustment	-	-	-	737,215	(373,801)	363,414	363,414				228,909
Donated asset/government granted income	-	-	-	-	(182,078)	(182,078)	(182,078)				(176,013)
Expenditure presented on net basis[4]	174,942	(174,942)	-	8,397,436	(8,397,436)	-	-				-
Other adjustments	-	-	-	239,737	(53,606)	186,131	186,131				919,050
Net operating cost	**2,639,446**	**(257,903)**	**2,381,543**	**136,422,705**	**(10,287,043)**	**126,135,662**	**128,517,205**				**145,549,987**

1. Under Parliamentary reporting requirements, expenditure for the NHS England Group, NDPBs (including Health Education England), NHS Trusts and Foundation Trusts is shown net of income. This differs from the treatment in the Consolidated Statement of Comprehensive Net Expenditure, where income and expenditure are reported separately on a gross basis.
2. Explanations of variances between Estimates and Outturn are given in Annex B.
3. Note 21 to the accounts provide details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
4. Other adjustments include £239.7 million of expenditure representing the loss relating to the net assets transferred outside the Department's accounting boundary for the eleven charities that have gained independent status during 2016-17. Further details can be found in note 19.1.
5. For 2016-17, following the Government's adoption of the 2010 European System of National and Regional Accounts (ESA 2010), the majority of Departmental expenditure on research and development was re-classified from revenue to capital expenditure. Further detail is presented in Annex A Core Table 1.

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

	2016-17 £'000			2016-17 £'000			2015-16 £'000
	Outturn			Estimate			Outturn
	Gross	Income	Net Total	Net Total	Net total compared to Estimate Savings /(excess)	Net total compared to Estimate adjusted for virements	Net Total
Spending in Departmental Expenditure Limits (DEL)							
Voted:							
NHS England net expenditure	227,416	-	227,416	258,625	31,209	-	182,043
NHS Trusts net expenditure	1,049,501	-	1,049,501	1,047,991	(1,510)	-	1,146,203
NHS Foundation Trusts net expenditure	1,815,837	-	1,815,837	1,681,087	(134,750)	-	1,795,693
DH Programme and Administration expenditure	1,793,899	(438,727)	1,355,172	1,467,757	112,585	59,954	418,424
Local Authorities	9,325	-	9,325	-	(9,325)	-	137,648
Public Health England (Executive Agency)	86,156	(34,477)	51,679	92,501	40,822	-	(13,235)
Health Education England	476	-	476	2,000	1,524	-	287
Special Health Authorities expenditure	14,788	(62)	14,726	30,684	15,958	-	(65,867)
Non Departmental Public Bodies net expenditure	31,947	-	31,947	35,388	3,441	-	30,653
	5,029,345	**(473,266)**	**4,556,079**	**4,616,033**	**59,954**	**59,954**	**3,631,849**
Annually Managed Expenditure (AME)							
Voted:							
NHS England net expenditure	-	-	-	-	-	-	-
NHS Trusts net expenditure	-	-	-	-	-	-	-
NHS Foundation Trusts net expenditure	-	-	-	-	-	-	-
DH Programme and Administration expenditure	13,349	-	13,349	15,000	1,651	1,651	9,021
Local Authorities	-	-	-	-	-	-	-
Public Health England (Executive Agency)	-	-	-	-	-	-	-
Health Education England	-	-	-	-	-	-	-
Special Health Authorities expenditure	-	-	-	-	-	-	-
Non Departmental Public Bodies net expenditure	-	-	-	-	-	-	-
	13,349	**-**	**13,349**	**15,000**	**1,651**	**1,651**	**9,021**
Total	**5,042,694**	**(473,266)**	**4,569,428**	**4,631,033**	**61,605**	**61,605**	**3,640,870**

1. Explanations of variances between Estimate and outturn are given in the Annex B.
2. Note 21 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.

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

		Note	2016-17 £'000 Outturn	2015-16 £'000 Outturn
Total resource outturn in Statement of Parliamentary Supply				
	Budget	SOPS 1.1	126,538,878	143,937,002
	Non-Budget	SOPS 1.1	-	-
			126,538,878	143,937,002
Add:	Capital Grants		554,812	641,145
	Research and Development		1,056,049	-
	PFI/LIFT expenditure under IFRS		2,538,697	2,357,778
	PFI/LIFT income under IFRS		(373,801)	(368,107)
	Other[1]		239,737	1,019,050
			4,015,494	3,649,866
Less:	Income payable to the Consolidated Fund	SOPS4	(1)	(106)
	Donated asset/government granted income		(182,078)	(176,013)
	PFI/LIFT expenditure under UK GAAP		(1,801,482)	(1,760,762)
	Other		(53,606)	(100,000)
			(2,037,167)	(2,036,881)
Net Operating Cost in Consolidated Statement of Comprehensive Net Expenditure after Financing Activities			**128,517,205**	**145,549,987**

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

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

	Note	Estimate	Outturn	2016-17 £'000 Net total outturn compared with Estimate: Savings/(excess)
Resource Outturn	SOPS 1.1	133,744,707	126,538,878	7,205,829
Capital Outturn	SOPS 1.2	4,631,033	4,569,428	61,605
Accruals to cash adjustments:				
Adjustments to remove non-cash items:				
Depreciation		(1,473,086)	(433,777)	(1,039,309)
New provisions and adjustments to previous provisions		(15,679,988)	(10,879,455)	(4,800,533)
Finance leased asset additions			(968)	968
IFRIC12 revenue adjustments			28,143	(28,143)
IFRIC12 capital adjustments			-	-
Adjustment for stockpiled goods			91,131	(91,131)
Non-cash investment additions			(940,722)	940,722
Non-cash investment disposals			908,791	(908,791)
Net gain/loss on transfers by absorption			(35,936)	35,936
Other non-cash items		-	(315,358)	315,358
Adjustments for NDPBs, NHS Trusts, Foundation Trusts, Charities and Other bodies:				
Remove voted resource and capital Department, and expenditure financed by Parliamentary Funding		(94,322,938) 92,016,548	(92,337,101) 89,756,457	(1,985,837) 2,260,091
Adjustments to reflect movements in working balances:				
Increase/(decrease) in inventory			(32,070)	32,070
less transfers from non-current assets			(55,886)	55,886
Increase/(decrease) in receivables			114,576	(114,576)
less movement in current financial assets			(263,140)	263,140
Increase/(decrease) in payables		1,000,000	708,932	291,068
less movement in payables to the Consolidated Fund			(849,559)	849,559
less movement in finance lease/PFI payables			(3,143)	3,143
add capital element of finance lease/PFI payables			3,664	(3,664)
Use of provisions		1,998,648	2,497,159	(498,511)
		121,914,924	119,070,044	2,844,880
Removal of non-voted budget items:				
National Insurance contributions		(20,025,641)	(20,025,641)	-
Other adjustments				
Other cashflow adjustments			5,051	(5,051)
Net cash requirement		**101,889,283**	**99,049,454**	**2,839,829**

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

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

In addition to income retained by the Department, the following income relates to the Department and is payable to the Consolidated Fund (cash receipts being shown in italics)	Outturn 2016-17 £'000		Outturn 2015-16 £'000	
	Income	***Receipts***	**Income**	***Receipts***
Operating income outside the ambit of the Estimate	1	*1*	106	*106*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total income payable to the Consolidated Fund	**1**	***1***	**106**	***106***

Parliamentary Accountability Disclosures

The following disclosures are subject to audit.

Losses and Special Payments (subject to audit)

Table 21: Losses Statement

		2016-17		2015-16	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	70	61,935	84	65,793
	£'000	131,399	194,541	179,501	255,765
Details of losses over £300,000					
Cash losses	Cases	-	1	-	1
	£'000	-	668	-	316
Claims abandoned	Cases	-	1	-	1
	£'000	-	338	-	2,200
Cancellation of Public Dividend Capital (PDC	Cases	2	2	1	1
	£'000	5,884	5,884	346	346
Administrative write-offs	Cases	-	1	-	2
	£'000	-	572	-	1,616
Fruitless payments	Cases	-	1	-	3
	£'000	-	604	-	1,802
Constructive Loss	Cases	4	5	5	5
	£'000	37,380	39,780	116,640	116,640
Store losses	Cases	-	1	-	1
	£'000	-	651	-	392
Bookkeeping losses	Cases	-	-	-	6
	£'000	-	-	-	4,043

Department of Health Share of National Insurance Contribution Losses

Included within its total losses, the Department has recorded a technical loss of £86.5 million which is its share of the overall, cross-Government loss relating to National Insurance Contributions (NICs). Such losses occur when contributions cannot be collected because companies have ceased to exist during the year. Her Majesty's Revenue & Customs (HMRC)

allocates this category of loss to those Departments which are partially funded from NICs, on a proportional basis. It should be noted that the disclosure of this category of loss is a technical requirement which is completely outside the Department's control.

Cancellation of Public Dividend Capital (PDC)

PDC is issued to NHS Trusts and NHS Foundation Trusts under specific statutory powers given to the Department. When functions transfer between NHS Trusts and NHS Foundation Trusts and other group bodies, the outstanding PDC balance and the net assets and liabilities of the closing Trust needs to be transferred to the successor organisation(s).

At this point, the Department may conclude that where the PDC balance is greater than the value of net assets transferring, the excess should be written off. This write off of the PDC represents the final accounting transaction, reflecting the existence of the historic deficits already recognised in the Statement of Financial Performance for the closing Trust i.e. it is not an additional loss to the Taxpayer.

PDC with a value in excess of £20 million can only be written off with the agreement of HM Treasury by formal notice to Parliament, known as a HM Treasury minute.

During 2016-17, the Department gained HM Treasury approval to write off a total of £5.9 million of PDC. £4.8 million of this relates to the dissolution of Manchester Mental Health and Social Care Trust on 1 January 2017, when they were merged with Greater Manchester West Mental Health NHS Foundation Trust to form Greater Manchester Mental Health NHS Foundation Trust. The remaining £1.1 million relates to the dissolution of Birmingham Women's NHS Foundation Trust on 1 February 2017, when they merged with Birmingham Children's Hospital NHS Foundation Trust to form Birmingham Women's and Children's NHS Foundation Trust.

Constructive Losses

Public Health England has reported 3 constructive losses totalling £37 million, relating to the write-off of emergency preparedness stocks due to the stocks passing the expiration date, and write-offs of childhood and adult vaccines in the normal course of business.

The Department reported a constructive loss of £0.4 million in respect of the early decommissioning of the Ambulance Solution Medusa which formed part of the Computer Sciences Corporation (CSC) contract to deliver electronic patient records to the North Midlands and East of England. Under the terms of the contract, CSC were able to claim for Breakage Costs and average profit for the remainder of the contract after the Department issued notice to terminate the service to North West Ambulance Service NHS Trust and West Midlands Ambulance NHS Trust from 31st January 2016.

Other Losses

Losses within the NHS are predominantly within NHS Foundation Trusts (31,977 cases totalling £30.4 million), NHS Trusts (25,390 cases totalling £17.1 million), NHS England Group (436 cases totalling £10.7 million), Non Departmental Public Bodies (3,500 cases totalling £1.7 million) and Special Health Authorities (533 cases totalling £0.8 million).

Table 22: Special Payments (subject to audit)

		2016-17		2015-16	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	43	17,252	24	9,768
	£'000	4,914	26,907	776	23,445
Special Payments over £300,000	Cases	3	4	-	2
	£'000	3,444	3,944	-	2,965

Ex-gratia payments

In February 2007, the NHS Purchasing & Supply Agency ("NHS PASA"), which was abolished in 2010, ran a procurement process for the purchase of Major Incident Response Vehicles for Hazardous Area Response Teams.

The contract was awarded. However, subsequently to this, one of the unsuccessful tenderers claimed that the contract award did not follow due process.

Following legal advice and a mediation process, the Department agreed on an out of court settlement as it appeared that NHS PASA had acted outside its remit. A payment of £2.48 million has been made in 2016-17.

DH procurement governance and assurance processes have since been tightened up and are undertaken in line with Cabinet Office policy and guidance, so this is unlikely to be repeated.

Compensation payments

There were two compensation payments made in the year totalling £0.96 million relating to historical human growth hormone treatment offered by the NHS. Due to the Morland Judgement, which means that patients whose treatment commenced after 1 July 1977 would be successful, each claim was settled. Both amounts were paid in October 2016 and were £0.6 million and £0.36 million respectively.

Other Special Payments

Special payments within the NHS are predominantly within NHS Foundation Trusts (5,740 cases totalling £10.0 million), NHS Trusts (3,866 cases totalling £8.1 million), Special Health Authorities (228 cases totalling £0.1 million) and NHS England Group (7,366 cases totalling £3.6 million).

Other Payments

In the November 2015 Spending Review and Autumn Statement, the then Chancellor George Osborne announced that the Government was committed to changing European Law so that no VAT should be charged on sanitary products. Until EU legislation is changed, the Chancellor announced that the £15 million a year raised from VAT charged on sanitary products would be used to fund women's health and support charities. Three donations have been made by the Department under this funding during 2016-17:

- A donation of £1.0 million was made to Breast Cancer Care to assist in the scale up of their support services to women recovering from breast cancer.
- A donation of £0.6 million was made to Jo's Cervical Cancer Trust to contribute towards the launch of the 'Eradicate Cervical Cancer' campaign targeted at increasing levels of screening.
- A donation of £0.3 million was made to Ovarian Cancer Action to fund the research into pioneering ovarian cancer prevention strategies.

Table 23: Fees and Charges (subject to audit)

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

	2015-16 Departmental Group		
	Fees and Charges Income	Full Cost of Service	Surplus/(Deficit)
	£'000	£'000	£'000
Dental	743,843	2,804,061	(2,060,218)
Prescription	523,539	10,652,434	(10,128,895)
Other Fees and Charges for which the cost of providing the service is over £1million	228,022	324,074	(96,052)
Total	**1,495,404**	**13,780,569**	**(12,285,165)**

The fees and charges information in this note is provided in accordance with the HM Treasury Financial Reporting Manual. The core Department does not provide services for which a fee is charged, therefore all disclosures relate to consolidated bodies. NHS England receives income in respect of Prescription and Dental charges to patients. The financial objective of Prescription and Dental charges is to collect charges only from those patients that are eligible to pay.

Included in the Other fees and charges for which the cost of providing the service is over £1.0 million is £149.6 million (2015-16: £109.0 million) of fees and charges and £197.0 million (2015-16: £220.5 million) of expenditure relating to regulatory income at the Care Quality Commission. The remaining balance relates to services provided by other NDPBs and other ALBs. Further information relating to fees and charges can be obtained from the financial statements of underlying bodies.

Remote Contingent Liabilities (subject to audit)

In addition to IAS 37 contingent liabilities disclosed within the Accounts, the Department discloses for Parliamentary reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to Parliament in accordance with the requirements of Managing Public Money. These comprise:

- items over £300,000 (or lower, where required by specific statute) that do not arise in the normal course of business and which are reported to Parliament by Departmental Minute prior to the Department entering into the arrangement, and;
- all items (whether or not they arise in the normal course of business) over £300,000 (or lower, where required by specific statute or where material in the context of the Annual

Report and Accounts) which are required by the Financial Reporting Manual to be noted in the Annual Report and Accounts.

Quantifiable

The Department of Health has entered into the following quantifiable contingent liabilities by offering indemnities or by giving letters of comfort. HM Treasury's guidance Managing Public Money requires that the full potential costs of such contracts be reported to Parliament.

	1 April 2016		Increase in year	Liabilities crystallised in year	Obligation expired in year	31 March 2017		Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	£'000	No.	£'000
Guarantees	-	-	-	-	-	-	-	-
Indemnities	3,000	2	1,300	-	(2,900)	1,400	2	-
Letters of comfort	-	-	-	-	-	-	-	-
Total	**3,000**	**2**	**1,300**	**-**	**(2,900)**	**1,400**	**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 19 unquantifiable indemnities. None of these are a contingent liability within the meaning of IAS 37 since the possibility of a transfer of economic benefit in settlement is too remote. Full details of these can be found in the Statement of Contingent or Nominal Liabilities held at the Department.

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

5 July 2017
Sir Chris Wormald
Permanent Secretary
Department of Health

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

I certify that I have audited the financial statements of the Department of Health and of its Departmental Group for the year ended 31 March 2017 under the Government Resources and Accounts Act 2000. The Department consists of the core Department and its agency. The Departmental Group consists of the Department and the bodies designated for inclusion under the Government Resources and Accounts Act 2000 (Estimates and Accounts) Order 2016. The financial statements comprise: the Department's and Departmental Group's Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the Statement of Parliamentary Supply and the related notes, and the information in the Remuneration and Staff Report and the Parliamentary Accountability disclosures that are described in those reports and disclosures as having been audited.

Respective responsibilities of the Accounting Officer and auditor

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

Scope of the audit of the financial statements

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

I am required to obtain evidence sufficient to give reasonable assurance that the Statement of Parliamentary Supply properly presents the outturn against voted Parliamentary control totals and that those totals have not been exceeded. The voted Parliamentary control totals are Departmental Expenditure Limits (Resource and Capital), Annually Managed Expenditure (Resource and Capital), Non-Budget (Resource) and Net Cash Requirement. I am also required to

obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects:

- the Statement of Parliamentary Supply properly presents the outturn against voted Parliamentary control totals for the year ended 31 March 2017 and shows that those totals have not been exceeded; and
- the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the Department's and the Departmental Group's affairs as at 31 March 2017 and of the Department's net operating cost and Departmental Group's net operating cost for the year then ended; and
- the financial statements have been properly prepared in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions issued thereunder.

Emphasis of Matter – Provision for Clinical Negligence Scheme for NHS Trusts

Without qualifying my opinion, I draw attention to the disclosures made in note 16 to the financial statements concerning the uncertainties inherent in the claims provision for the Clinical Negligence Scheme for Trusts. As set out in note 16, given the long-term nature of the liabilities and the number and nature of the assumptions on which the estimate of the provision is based, a considerable degree of uncertainty remains over the value of the liability recorded by NHS Resolution. Significant changes to the liability could occur as a result of subsequent information and events which are different from the current assumptions adopted by NHS Resolution

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and Parliamentary Accountability disclosures to be audited have been properly prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

Report

My explanatory report is presented on page 97.

Sir Amyas C E Morse **17 July 2017**

Comptroller and Auditor General

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

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

In 2015-16, a comprehensive plan to secure the long term financial sustainability of the NHS in England was lacking, and the system was experiencing unsustainable pressure. In July 2016 I issued an explanatory report on the Department's accounts for the 2015-16 financial year that reflected my concern at the extent of short-term, non-recurring financial adjustments and activities evident from my audit of the accounts that were being used to help the Department stay within its annual budget[73].

The Government set a clear expectation that 2016-17 should see a return to financial balance in the NHS, delivering efficiencies, productivity and restoring financial discipline across the sector. To that end the Department launched a reset of NHS finances in July 2016. NHS England and NHS Improvement published Strengthening Financial Performance and Accountability[74] in 2016-17. This reset of NHS finances included a £1.8 billion Sustainability and Transformation Fund (STF) for 2016-17 controlled jointly by the Department, HM Treasury, NHS England and NHS Improvement. STF funding was to be available for trusts which met certain agreed financial and performance targets.

In 2016-17, some local NHS organisations have relied on one-off accounting adjustments to meet the requirements for Sustainability and Transformation Funding. My audit has found that, unlike in 2015-16, the Department itself has not been forced to use the same level of significant one-off accounting adjustments to remain within its budget. However, the system at a local level remains under considerable financial pressure and Monitor's Annual Report and Accounts note that "*the NHS still has a long way to go before we can regard it as being on a sustainable footing again*"

The health system's ability to invest in infrastructure and maintain its asset base continues to be affected by the use of capital budgets to support day to day spending and this will have implications for the resilience of the service. Capital to revenue transfers totalled £1.2 billion in 2016-17 and were authorised by Parliament in the Supplementary Estimate in February 2017. The Department plans to cease this practice by the end of 2019-20.

The Department has committed to improving its processes to estimate how much funding it requires. The Department has underspent its Resource Annually Managed Expenditure (RAME) budget of £16.2 billion by £6.7 billion in 2016-17. This budget area relates almost exclusively to the provision for clinical negligence.

The Department is still some way from achieving financial sustainability and many key performance targets have not been achieved. The Department has overseen some overall improvement in the financial position of the healthcare system in 2016-17. However, this improvement is focused on sustaining the system rather than transformation. Moreover Trusts have been told that STF cannot be counted on as being available after 2018-19 in its current format. The Department has more to do to secure the healthcare system's sustainability, as it acknowledges in the 2016-17 Annual Report and Accounts.

[73] https://www.nao.org.uk/wp-content/uploads/2016/07/Department-of-Health-Explanatory-Report.pdf
[74] https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf

Financial Statements

Consolidated Statement of Comprehensive Net Expenditure

This account summarises the expenditure incurred and income generated on an accruals basis. It also includes other comprehensive income and expenditure, including changes to the value of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

For the year ended 31 March 2017

		2016-17		2015-16	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Income from sale of goods and services	5	(167,319)	(5,333,347)	(129,492)	(4,916,339)
Other operating income	5	(1,657,502)	(4,937,002)	(1,888,271)	(4,725,148)
Income received by NHS charities	19	-	(207,838)	-	(227,517)
Total operating income		**(1,824,821)**	**(10,478,187)**	**(2,017,763)**	**(9,869,004)**
Staff costs	3	450,440	53,529,306	426,332	51,646,625
Purchase of goods and services	4	533,451	50,804,328	1,058,839	50,060,641
Depreciation and impairment charges	4	450,984	4,329,242	682,127	4,108,069
Provision expense	4	943,785	11,487,086	1,024,042	30,356,854
Other operating expenditure	4	6,502,520	17,868,670	6,146,313	17,158,746
Grant in Aid to NDPBs		109,751,742	-	105,683,053	-
Funding to Group bodies		331,212	-	291,615	-
Resources expended by NHS charities	19	-	308,592	-	1,140,522
Total operating expenditure		**118,964,134**	**138,327,224**	**115,312,321**	**154,471,457**
Net operating expenditure for the year ended 31 March 2017		**117,139,313**	**127,849,037**	**113,294,558**	**144,602,453**
Finance income		(210,386)	(66,759)	(135,374)	(131,712)
Finance expense		(22,985)	734,927	19,751	1,079,246
Net (gain)/loss on transfers by absorption		35,936	-	1,190	-
Total Net Expenditure for the year ended 31 March 2017		**116,941,878**	**128,517,205**	**113,180,125**	**145,549,987**
Other Comprehensive Net Expenditure					
Items that will not be reclassified to net operating costs:					
Net (gain)/loss on:					
- revaluation of property, plant and equipment		(12,107)	(794,364)	(40,443)	(1,659,558)
- revaluation of intangibles		(5,838)	(7,419)	(5,272)	(5,551)
- revaluation of investments		-	-	(92)	(92)
-revaluation of charitable assets		-	(49,705)	-	8,621
- impairments and reversals taken to revaluation reserve		16,818	1,235,954	1,365	1,118,986
Actuarial (gains)/losses on defined benefit pension schemes		-	17,724	-	(17,107)
Other pensions remeasurements		-	(10,275)	-	(7,165)
Other (gains) and losses		-	(4,806)	-	(331)
Total Comprehensive Expenditure for the year ended 31 March 2017		**116,940,751**	**128,904,314**	**113,135,683**	**144,987,790**

1. In all material respects, the income and expenditure disclosed in the Consolidated Statement of Comprehensive Net Expenditure relates to activities that are continuing.

Consolidated Statement of Financial Position

This statement presents the financial position of the Department. It comprises three main components: assets owned or controlled; liabilities owed to other bodies; and equity, the remaining value of the entity.

As at 31 March 2017

		2016-17		2015-16	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Non-current assets					
Property plant and equipment	6	1,178,425	50,397,679	1,138,911	51,383,835
Investment Property		9,613	142,645	9,604	114,691
Intangible assets	7	231,415	1,293,732	478,398	1,401,314
Charitable non-current assets	19.2	-	106,222	-	93,080
Financial assets- Investments	11	34,679,999	683,342	32,138,987	995,043
Charitable investments	19.3	-	657,154	-	832,335
Other non-current assets	14	150,893	650,185	134,374	621,569
Total non-current assets		**36,250,345**	**53,930,959**	**33,900,274**	**55,441,867**
Current assets					
Assets classified as held for sale		72,320	155,122	28,009	173,924
Inventories	12	144,843	1,242,477	179,279	1,222,183
Trade and other receivables	14	184,877	2,021,510	204,915	1,858,697
Other current assets	14	206,580	1,802,178	380,396	1,644,747
Charitable other current assets	19.2	-	39,699	-	64,616
Other financial assets	14	862,497	20,261	599,357	41,168
Cash and cash equivalents	13	1,877,074	6,789,286	2,804,309	7,680,408
Charitable cash	19.2	-	252,609	-	285,598
Total current assets		**3,348,191**	**12,323,142**	**4,196,265**	**12,971,341**
Total assets		**39,598,536**	**66,254,101**	**38,096,539**	**68,413,208**
Current liabilities					
Trade and other payables	15	(143,997)	(5,360,556)	(120,206)	(5,105,436)
Other liabilities	15	(2,923,876)	(11,807,456)	(3,565,868)	(12,328,634)
Charitable liabilities	19.2	-	(82,103)	-	(131,002)
Provisions	16	(651,342)	(3,954,364)	(536,879)	(3,205,433)
Total current liabilities		**(3,719,215)**	**(21,204,479)**	**(4,222,953)**	**(20,770,505)**
Non-current assets plus/less net current assets/liabilities		**35,879,321**	**45,049,622**	**33,873,586**	**47,642,703**
Non-current liabilities					
Other payables	15	(9,892)	(416,850)	(150,484)	(547,751)
Charitable liabilities	19.2	-	(17,660)	-	(16,128)
Provisions	16	(2,263,132)	(65,250,495)	(2,188,634)	(57,535,844)
Net pension asset/(liability)	16.1	-	(115,779)	-	(93,745)
Financial liabilities	15	-	(11,660,902)	(2,254)	(11,926,657)
Total non-current liabilities		**(2,273,024)**	**(77,461,686)**	**(2,341,372)**	**(70,120,125)**
Total assets less liabilities		**33,606,297**	**(32,412,064)**	**31,532,214**	**(22,477,422)**
Taxpayers' equity and other reserves					
General fund		32,646,301	(44,735,412)	30,399,188	(35,864,671)
Revaluation reserve		959,996	11,211,334	1,133,026	12,110,852
Other Reserves		-	156,093	-	147,898
Total Taxpayers' Equity		**33,606,297**	**(33,367,985)**	**31,532,214**	**(23,605,921)**
Charitable funds	19.2	-	955,921	-	1,128,499
Total Reserves		**33,606,297**	**(32,412,064)**	**31,532,214**	**(22,477,422)**

1. The Departmental Group started reporting a net liabilities position in 2015-16 due to a change in the discount rate prescribed by HM Treasury for long term (>10 years) general provisions. More information is given at Note 1 *Statement of Accounting Policies*.

Sir Chris Wormald
Permanent Secretary 5 July 2017

Consolidated Statement of Cash Flows

The Statement of Cash Flows shows the changes in cash and cash equivalents of the Department during the reporting period. The statement shows how the Department generates and uses cash and cash equivalents. The net cash flows arising from the operating activities provide a key indicator of service costs faced by the Department. The investing activities represent the cash inflows and outflows that have been made for resources which are intended to contribute to the Departments' future public service delivery. Cash flows arising from financing activities include Parliamentary Supply and other cash flows, including borrowing.

For the year ended 31 March 2017

		2016-17		2015-16	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Net cashflow from operating activities					
Net operating cost including financing activities	CSCNE	(116,905,942)	(128,517,205)	(113,178,935)	(145,549,987)
Adjustments for non-cash transactions	4.2	1,243,349	15,389,656	1,695,814	34,605,109
Non-cash movements arising from absorption transfers/FT authorisations		13,578	210	-	-
Adjustments for charities		-	183,329	-	1,015,194
Other non-cash movements in Statement of Financial Position items		-	8,162	-	19,840
(Increase)/decrease in trade and other receivables	14	(85,805)	(327,953)	(43,874)	(301,767)
less movements in receivables relating to items not passing through the CSCNE	14	263,140	79,145	96,003	(49,677)
(Increase)/decrease in inventories	12	34,436	(20,294)	(35,945)	(168,813)
less transfers to inventories from non-current assets	12	55,886	55,886	1,733	1,733
Increase/(decrease) in trade and other payables	15	(761,047)	(662,714)	954,930	1,878,991
less movements in payables relating to items not passing through the CSCNE	15	809,363	996,267	(1,254,375)	(1,246,753)
Use of provisions	16	(286,131)	(2,349,778)	(141,171)	(1,978,653)
Transfer of provisions to payables	16	(445,246)	(464,792)	(164,123)	(178,658)
Cash payments in respect of pensions	16.1	-	(10,668)	-	(11,262)
Other operating cashflows		1	(10,679)	-	60,521
Net cash outflow from operating activities		**(116,064,418)**	**(115,651,428)**	**(112,069,943)**	**(111,904,182)**
Cash flows from investing activities					
Purchase of property, plant and equipment & investment properties	6, 15	(211,745)	(3,532,652)	(134,057)	(3,342,566)
Purchase of intangible assets	7, 15	(100,769)	(373,714)	(136,635)	(405,709)
Proceeds of disposal of property, plant and equipment		5,792	123,117	14,674	167,078
Proceeds of disposal of intangibles		951	2,088	1,293	2,645
Proceeds of disposal of assets held for sale		261,632	422,890	675	185,789
Purchase of investments	11	(3,779,469)	(47,561)	(4,415,022)	(102,526)
Proceeds of disposal of investments	11, 14	743,972	224,738	1,700,947	173,558
Other investing cashflows		-	132,004	27,684	67,066
Net cash outflow from investing activities		**(3,079,636)**	**(3,049,090)**	**(2,940,441)**	**(3,254,665)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year		98,200,000	98,200,000	97,018,928	97,018,928
Financing from the National Insurance Fund		20,025,641	20,025,641	19,316,174	19,316,174
Movement in loans received from DH and Other Bodies		-	19,051	-	18,781
Capital element of payments in respect of finance leases and on-SOFP PFI/LIFT contracts		(3,664)	(440,015)	(3,938)	(468,909)
Other financing cashflows		(5,052)	(30,772)	(3,628)	(20,246)
Net financing		**118,216,925**	**117,773,905**	**116,327,536**	**115,864,728**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**(927,129)**	**(926,613)**	**1,317,152**	**705,881**
Payment of amounts due to the Consolidated Fund		(106)	(106)	(220)	(220)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**(927,235)**	**(926,719)**	**1,316,932**	**705,661**
Cash and cash equivalents at the beginning of the period		2,804,309	7,951,526	1,487,377	7,245,865
Cash and cash equivalents at the end of the period	13, 15, 19.2	**1,877,074**	**7,024,807**	**2,804,309**	**7,951,526**

1. The "Other" lines within the Consolidated Statement of Cash Flows include cash flow items recorded by underlying NHS bodies not separately identified within the Resource Account format. This includes an adjustment for a deferred tax liability to ensure the internal consistency of the Resource Account Consolidated Statement of Cash Flows.

Consolidated Statement of Changes in Taxpayers' Equity

This statement shows the movement in the year within the different reserve accounts held by the Department, analysed into 'general fund reserves' (i.e. those reserves that reflect a contribution from the Consolidated Fund). Financing and the balance from the provision of services are recorded here. The Revaluation Reserve reflects the change in asset values that have not been recognised as income or expenditure. Other earmarked reserves are shown separately where there are statutory restrictions of their use.

For the year ended 31 March 2017

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

1. The 'Comprehensive net expenditure for the year' figures for the General Fund and Charitable Fund exclude the elimination of intercompany trading between NHS Charities, NHS Trusts and NHS Foundation Trusts. This ensures the closing Charitable Fund balance reflects the actual reserves held by the NHS Charities sector. There is no overall impact on the total closing reserve balance of the Departmental Group.
2. The General Fund is used in public sector accounting to reflect the total assets less liabilities of an entity, which are not assigned to another special purpose fund.
3. The Revaluation Reserve is a capital reserve used when an asset has been revalued but for which no cash benefit is received. Revaluations are completed periodically to reflect the fair value of an asset owned by an organisation.
4. Other Reserves are used by NHS bodies to account for a difference between the value of non-current assets, taken over by them at establishment, and the corresponding figure in the opening capital debt. This could arise where opening capital debt is set on estimated values or where there has been an error. Additionally, this may arise to reflect pension assets/liabilities in respect of staff in non-NHS defined benefit pension schemes.
5. Charitable Funds are the reserves associated with NHS Charities consolidated into the Department's Resource Account. They include both restricted, £405.8 million and unrestricted, £550.1 million funds.

For the year ended 31 March 2016

	Note	Core Department & Agencies: General Fund £'000	Revaluation Reserve £'000	Taxpayers' Equity £'000	Departmental Group: General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Taxpayers' Equity £'000	Charitable Funds £'000	Total Reserves £'000
Restated balance at 1 April 2015		28,376,746	1,222,345	29,599,091	(6,786,073)	11,921,037	130,510	5,265,474	2,160,959	7,426,433
Prior period adjustments in local accounts		-	-	-	36,676	(34,698)	1,773	3,751	(4,764)	(1,013)
Net parliamentary funding - drawn down		97,018,928		97,018,928	97,018,928			97,018,928		97,018,928
Net parliamentary funding - deemed		1,634,218		1,634,218	1,634,218			1,634,218		1,634,218
National Insurance contributions		19,316,174		19,316,174	19,316,174			19,316,174		19,316,174
Supply (payable)/receivable adjustment	15	(2,935,817)		(2,935,817)	(2,935,817)			(2,935,817)		(2,935,817)
CFERs and other amounts payable to the Consolidated Fund	15	(106)		(106)	(106)			(106)		(106)
PDC investment adjustment		(346)		(346)	-			-		-
Comprehensive Net Expenditure for the Year		(113,180,125)		(113,180,125)	(144,518,996)			(144,518,996)	(1,030,991)	(145,549,987)
Non-cash adjustments:										
non-cash charges - auditor's remuneration	4	824		824	914			914		914
Movements in Reserves										
Recognised in Statement of Comprehensive Expenditure										
Net gain/(loss) on revaluation of non-current assets			45,807	45,807		1,665,201	-	1,665,201	-	1,665,201
Net gain/(loss) on revaluation of charitable assets				-				-	(8,621)	(8,621)
Reclassification adjustment on disposal of available for sale financial assets			-	-		-	-	-		-
Impairments and reversals			(1,365)	(1,365)		(1,118,986)		(1,118,986)	-	(1,118,986)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme		-		-	12,871		4,236	17,107		17,107
Other pensions remeasurements		-		-	4,079		3,086	7,165		7,165
Other gains and losses		-		-	336		(5)	331		331
Transfers between reserves		163,781	(163,781)	-	345,324	(352,356)	7,032	-	-	-
Other movements		575	34,356	34,931	2,524	35,013	1,184	38,721	12,273	50,994
Other transfers		4,336	(4,336)	-	4,277	(4,359)	82	-	(357)	(357)
Balance at 31 March 2016		**30,399,188**	**1,133,026**	**31,532,214**	**(35,864,671)**	**12,110,852**	**147,898**	**(23,605,921)**	**1,128,499**	**(22,477,422)**

Notes to the Department's Annual Report and Accounts

1. Statement of accounting policies

The financial statements have been prepared in accordance with the 2016-17 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Department of Health for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Department of Health are described below. The policies have been applied consistently in dealing with items considered material to the accounts.

As in previous years the 2016-17 Annual Report and Accounts includes two departures from the FReM, both of which have been agreed with HM Treasury:

- Public Dividend Capital issued by the Department on the creation of new NHS Trusts, or written-off on the dissolution of NHS Trusts, is debited or credited, as appropriate, to the General Fund rather than to the Consolidated Statement of Comprehensive Net Expenditure; and
- Receipts of National Insurance Contributions from the National Insurance Fund are recognised on a cash basis.

The Departmental Group has presented a net liabilities position on the Consolidated Statement of Financial Position due to a change in 2015-16 in the HM Treasury prescribed discount rate for long term (>10 years) general provisions. As the increase in provision value reverses as the date of cash settlement approaches and the discount unwinds, it does not alter the amount of cash ultimately required to settle these liabilities and thus has no bearing on the financial sustainability of the Departmental Group. Parliament has demonstrated its commitment to fund the Department for the foreseeable future. Therefore there is no reason to believe funding will not be available to meet the future liabilities of the Departmental Group.

1.1 Operating segments

Income, expenditure, depreciation and other material items are analysed in the Statement of Operating Costs by Operating Segment (Note 2) and are reported in line with management information used within the Department.

1.2 Accounting convention

The accounts have been prepared under the historical cost convention with modification to account for the revaluation of investment property, property, plant and equipment, intangible assets, stockpiled goods and certain financial assets and financial liabilities.

1.3 Basis of consolidation

The accounts comprise of a consolidation for the core Department, its Departmental agency and other bodies that fall within the Departmental boundary as defined by the FReM and make up the "Departmental Group". Those other bodies include Arm's Length Bodies, NHS Trusts, NHS Foundation Trusts, Clinical Commissioning Groups, NHS Charities and certain limited companies. The Departmental Group includes all entities designated for inclusion by HM Treasury, which in broad terms equate to those bodies that are classified by the Office of National Statistics to the Central Government sector. Transactions between entities included in the consolidated accounts are eliminated. A list of all those entities within the Departmental boundary is given in Note 21.

1.4 Going Concern

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

1.5 Employee Benefits

Recognition of short-term benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Where material, non-consolidated performance pay and annual leave earned but not taken by the year end are recognised on an accruals basis in the financial statements.

Retirement benefit costs:

Civil Service Pensions

Past and present employees of the Department are covered by the provisions of the Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and Other Pension Scheme (CSOPS), which are described in Note 3.

These schemes are unfunded, defined benefit schemes covering civil servants. The schemes are not deisgned in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Department of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For defined contribution schemes, such as Civil Service partnership pensions, the Department recognises the contributions payable for the year.

The Department recognises the full cost of benefits paid under the Civil Service Compensation Scheme, including the early payment of pensions.

NHS Pensions

Past and present employees of the NHS are covered by the provisions of the NHS Pension Schemes[75].

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in the scheme is taken as being equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS body commits itself to the retirement, regardless of the method of payment.

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year. More details can be found in Note 3.

1.6 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Department recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.7 Audit costs

A charge reflecting the cost of audit is included in expenditure. The Department of Health is audited by the Comptroller and Auditor General. No cash charge is made for this service but a notional charge representing the cost of the audit is included in the accounts. This charge covers the audit costs in respect of the Department's Annual Report and Accounts. With the exception of NHS Foundation Trusts, certain Limited Companies and NHS Charities, other consolidated bodies are audited by the Comptroller and Auditor General or a Public Sector Audit Appointments Limited appointed auditor and include expenditure in respect of audit fees in their individual accounts. The accounts of NHS Foundation Trusts are audited by auditors appointed by their board of governors and also include expenditure in respect of audit fees.

1.8 Value added tax

Most of the activities of the Department are outside the scope of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.9 Income

Income principally comprises fees and charges for services provided on a full cost basis, investment income and public repayment work. It includes income Voted during the Estimates process and Consolidated Fund Extra Receipts (CFERs) which fall outside the Ambit of the Vote and must therefore be returned to HM Treasury. Income in respect of services provided is recognised when the service is rendered, stage of completion of the transaction at the end of the reporting period can be measured reliably and it is probable that economic benefit associated with the transaction will flow to the Department. Income is measured at fair value of the consideration receivable. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

National Insurance Contributions are classified as funding rather than income, and are therefore credited to the General Fund upon receipt.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Department;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- collectively a number of items have a total cost of at least £5,000 and individually a cost of more than £250, the assets are functionally interdependent, purchase dates are

broadly simultaneous, disposal dates are anticipated to be simultaneous and assets are under single managerial control.

Where an asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Expenditure incurred on the remaining Informatics programmes held by the Core Department has been split between capital and revenue using a financial model that analyses contractor costs over the life of the project.

Valuation of property, plant and equipment (excluding assets relating to remaining Informatics programmes)

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets in use that are held for their service potential are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date. Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23 , borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is only recognised as an impairment charged to the revaluation reserve when it does not result from a loss in the economic value or service potential to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported in the Consolidated Statement of Changes in Taxpayers' Equity.

Subsequent expenditure

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

1.11 Intangible non current assets

Intangible non-current assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Department's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Department; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible non-current assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent asset basis) and value in use where the asset is income generating.

Recognition and Valuation of intangible assets relating to Informatics programmes

Informatics, formerly known collectively as NHS Connecting for Health, contains a collection of large infrastructure IT Programmes that are used across the NHS to enable a move towards a single, electronic care record for patients and to connect General Practitioners to hospitals, providing secure and audited access to these records by authorised health professionals.

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

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

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

The intangible assets relating to the DH and NHS Digital Informatics programmes, are held at depreciated replacement cost which is calculated by indexing the historic cost of the assets by the movement in appropriate indices between the month of purchase and the Consolidated Statement of Financial Position date. This valuation method is reviewed each year to determine whether it remains the most appropriate index to use.

1.12 Research and development

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to reliably measure the expenditure attributable to the intangible asset during its development.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.13 Depreciation, amortisation and impairments

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

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight-line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which the Department expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each financial year-end, the Department determines whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is an indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year-end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for service potential or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and

losses on revaluations, impairments and sales are treated in the same way as purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for service potential or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the CSCNE.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17 Private Finance Initiative (PFI) and NHS Local Improvement Finance Trust (LIFT) transactions

HM Treasury has determined that Government bodies shall account for infrastructure PFI and NHS LIFT schemes, where the Government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement, as service concession arrangements, following the principles set out in IFRIC 12. Consolidated bodies therefore recognise the PFI/LIFT asset as an item of property, plant and equipment, together with a liability to pay for it, on their Statement of Financial Position.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and
- Payment for the replacement of components of the asset during the contract ‘lifecycle replacement’.

a) Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within ‘operating expenses’.

b) PFI and LIFT assets, liabilities, and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. They are measured initially at fair value or, if lower, at the present value of the minimum lease

payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use. A PFI/LIFT liability is recognised at the same time as the assets are recognised. It is measured initially at the same amount as the initial value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to the CSCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

c) Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the consolidated bodies' criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by consolidated bodies to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment.

Other assets contributed by consolidated bodies to the operator

Other assets contributed (e.g. cash payments, surplus property) by the consolidated bodies to the operator before the asset is brought into use, where these are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the consolidated body, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.18 Inventories and stockpiled goods

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

Strategic goods held for use in national emergencies (stockpiled goods) are held as non-current assets within property, plant and equipment. These stocks are maintained at minimum

capability levels by replenishment to offset write-offs and so are not depreciated, as agreed with HM Treasury.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and which are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Consolidated Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management. Cash, bank and overdraft balances are recorded at current values.

1.20 Provisions

Provisions are recognised when the Department has a present legal or constructive obligation as a result of a past event, it is probable that the Department will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions (general provisions) are subject to three separate discount rates according to the expected timing of cashflows. A short-term rate of *negative 2.70%* (2015-16: *negative 1.55%*) is applied to expected cash flows in a time boundary of between 0 and up to and including 5 years from the Consolidated Statement of Financial Position date. A medium term rate of *negative 1.95%* (2015-16: *negative 1.00%)* is applied to the time boundary of after 5 and up to and including 10 years and a long-term rate of *negative 0.80%* (2015-16: negative 0.80%) is applied to expected cashflows exceeding 10 years (all percentages are in real terms).

1.21 Clinical and non-clinical negligence costs

Clinical and non-clinical negligence costs are managed through schemes run by NHS Resolution (NHSR). The Existing Liability Scheme, Ex-Regional Health Authority Scheme and DH clinical and non-clinical schemes are funded by the Department of Health, whilst the Clinical Negligence Scheme for Trusts, Liability to Third Parties Scheme and Property Expenses Scheme are funded from Trust contributions. The accounts for the schemes are prepared by NHSR in accordance with IAS 37. A provision for these schemes, disclosed in Note 16, is calculated in accordance with IAS 37 by discounting the gross value of all claims received.

Calculation of the provision for each scheme is made using:

- probability factors. The probability of a claim having to be settled is assessed between 10% and 94%. This probability is applied to the gross value to give the probable cost of each claim; and
- a discount factor calculated using HM Treasury's real discount rates noted in Note 1.20 above (i.e. short-term *negative 2.70%,* medium term *negative 1.95%* and long term *negative 0.80%*), 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 17.

Existing Liabilities Scheme (ELS), Ex-Regional Health Authorities (Ex-RHA) Scheme and DH clinical and non-clinical liabilities schemes

Claims are included in the ELS provision on the basis that the incident occurred on or before 31 March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to NHS Resolution with effect from 1 April 1996. Claims against DH clinical and non-clinical liabilities relate to claims against dissolved bodies where there is no successor body and a number of other claims NHS Resolution is managing on behalf of DH.

Clinical Negligence Scheme for Trusts (CNST)

This scheme provides indemnity cover to providers of NHS services, NHS commissioners and Health arm's length bodies for claims arising from incidents involving clinical negligence. Contributions are collected from members to make settlements and administer claims on their behalf. The scheme has been operating since 1 April 1995, and claims are included in the provision where:

- NHS Resolution has assessed the probable cost and time to settlement in accordance with scheme guidelines;
- they are qualifying incidents; and
- the organisation against which the claim is being made remains a member of the scheme.

As at 31 March 2002 all outstanding claims for incidents post 1 April 1995 became the direct responsibility of NHSR. This 'call in' of CNST claims effectively means that member Trusts are no longer reponsible for accounting for claims made against them, although they do remain the legal defendant.

Property Expenses Scheme (PES) and Liability to Third Parties Scheme (LTPS)

The PES and LTPS schemes were introduced in April 1999 following the Secretary of State's decision that NHS Trusts should not insure with commercial companies for non-clinical risks, other than motor vehicles and other defined areas (e.g. PFI schemes).

These schemes are managed and funded via the same mechanisms as CNST except that specific excesses exist for some types of claims. Thus the provision recorded in these accounts relates only to NHSR's proportion of each claim.

Incidents Incurred but Not Reported (IBNR)

IAS 37 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to NHSR as at 31 March 2017 where it can be reasonably predicted that:

- an adverse incident has occurred; and
- a transfer of economic benefit will occur; and
- a reasonable estimate of the likely value can be made.

NHSR uses actuaries, the Government Actuary's Department (GAD), to assess the potential value of IBNRs against each of the schemes it operates. The actuaries review existing claims records and, using an appropriate model, calculate values in respect of IBNRs for all schemes. The provisions and contingent liabilities arising are shown in Notes 16 and 17 respectively. The sums concerned are accounting estimates and, although determined on the basis of information currently available, the ultimate liabilities may vary as a result of subsequent developments.

1.22 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Department, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

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, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts.

1.23 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's investment in NHS Trusts, NHS Foundation Trusts (providers) and the Medicines & Healthcare Products Regulatory Agency is represented by Public Dividend Capital (PDC) which, being issued under statutory authority, is not classed as being a financial instrument.

PDC is held at historic cost less impairments. The decision to impair the Department's PDC investment is taken when the following criteria are met:

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

To allow full elimination of PDC on consolidation, any impairment to the Department's investment must be reversed at group level. This has no overall effect on the consolidation as the losses necessitating the impairment have already been recognised in the provider's financial statements.

Following closure of a provider, any PDC balance not transferred to a successor body is formally written off in the books of both the provider and Department, and no longer appears in the consolidated account.

1.24 Financial assets

Financial assets are recognised on the Consolidated Statement of Financial Position when the Department becomes party to the financial instrument contract or, in the case of trade

receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

As available for sale financial assets, the Department's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the Consolidated Statement of Comprehensive Net Expenditure on de-recognition.

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

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

1.25 Financial liabilities

Financial liabilities are recognised in the Consolidated Statement of Financial Position when the Department becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. The core Department sets the following de minimis threshold levels for the raising of manual accruals: £2,499 for accruals relating to administration budgets and £9,999 for accruals relating to central programme budgets. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

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

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method. This approach to valuing financial instruments is intended to reflect the value at which such instruments could be traded. In the case of loans from DH to NHS bodies, neither party is involved in trading its interest in the loan and as such these loans are measured at historic cost with any unpaid interest at the reporting date accrued separately and not added to the carrying value of the loan.

1.26 Foreign exchange

The functional and presentational currencies of all consolidated bodies are pounds sterling and figures are expressed in thousands of pounds unless expressly stated otherwise.

The large majority of the Department's foreign currency transactions relate to European Economic Area (EEA) medical costs. Due to delays in submission of medical cost claims by member states, the Department estimates annual medical costs and adjusts future years' expenditure when actual costs are claimed. Estimated costs are converted into sterling at average rates calculated using EU published rates. Payments made are valued at prevailing exchange rates. Amounts in the Consolidated Statement of Financial Position at year-end are converted at the exchange rate ruling at the Consolidated Statement of Financial Position date. Exchange rate gains or losses are calculated in accordance with accepted accounting practice.

1.27 NHS Charities

Following the inclusion of NHS Charities (as defined by section 149 of the Charities Act 2011 as amended) in the 2012 Designation Order, the Department consolidates NHS Charities into the Consolidated Annual Report and Accounts. The transactions and balances associated with NHS Charities are reported as separate items within the consolidated financial statements (e.g "Charitable income", "Charitable cash" etc) due to the unique nature of the transactions and as the majority of those transactions are immaterial in the context of the Group account.

1.28 Transfer of Functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the Group are outside the scope of IFRS 3 Business Combinations. When functions transfer between two public sector bodies (except for Department to Department transfers) the FReM requires the application of "absorption accounting". Absorption accounting requires that entities account for their transactions in the period in which those transactions took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Consolidated Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs. For transfers between bodies within the Departmental Group, no net impact arises in the consolidated Resource Account as a consequence of the application of absorption accounting as gains and losses are eliminated on consolidation. A non-eliminating net gain or loss is recognised where transfers involve a non-Departmental counter-party that is within the public sector but outside the DH Group.

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration. Full assessments of the impact of these standards will be completed by the Department in due course.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. IFRS 9 introduces changes to the classification and measurement of financial instruments. Within the scope of IFRS 9, the Department holds investments of around £680 million, as well as trade receivables and other financial assets of around £2.5 billion and trade payables and other financial liabilities of around £13.4 billion. The Department does not have complex financial instruments, and has identified no significant classification issues. The Department is assessing the impact of the change to an expected losses model of impairment.

- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. IFRS 15 introduces changes to the timing of revenue recognition for contracts, matching revenue to performance obligations, and changes to revenue disclosure requirements. Within the scope of IFRS 15, the Department earns external revenue of around £9.5 billion, with over £75 billion of intra-group revenue eliminated on consolidation. Many health care contracts are for relatively short periods of care, for which revenue will continue to be recognised on completion. The Department is assessing the potential impact on revenues from longer term contracts.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The Department is awaiting HM Treasury proposals for the implementation of this standard. The Department currently has commitments under operating leases of over £2.6 billion, which IFRS 16 requires to be recognised as right of use assets and corresponding lease liabilities.

1.30 Critical accounting judgements and key sources of estimation uncertainty

Estimates and the underlying assumptions are reviewed on a regular basis by the Department's senior management. Areas of significant judgement made by management are:-

IAS 37 Provisions - Judgement is made on the best estimate that can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Provisions are discounted according to rates set by HM Treasury, as outlined in Note 16.

Clinical negligence - The Department's most significant provision is for clinical negligence, and estimation is required to calculate the amounts provided for known claims and for IBNR. The estimates and underlying assumptions are reviewed on an ongoing basis by NHS Resolution, supported by its actuaries, the Government Actuary's Department (GAD). Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. The value of the provision is sensitive to changes in discount rates, and a sensitivity analysis is provided in Note 16.

IAS 16 Property, plant and equipment - Assets which are held for their service potential and are in use are held at their current value in existing use. For non-specialised assets, this is interpreted as market value in existing use, defined in the Royal Institution of Chartered Surveyors (RICS) Red Book as Existing Use Value (EUV). For specialised assets, this is interpreted as depreciated replacement cost on a modern equivalent asset basis. Where this applies, underlying bodies may perform a valuation based on an alternative site if this is consistent with the body's requirements to serve the local population. Where a body has taken this approach, it discloses the fact in its own accounting policies.

IAS 36 Impairments - Management make judgement on whether there are any indications of impairments to the carrying amounts of the Department's assets.

2. Statement of Operating Costs by Operating Segment

The reportable segments disclosed within this note reflect the current structure of the Departmental Group as defined in legislation, with the activities of each reportable segment thus reflecting the statutory remit of those bodies. These operating segments are reported to

the Department of Health Departmental Board for financial management purposes. They cover the core Department of Health (which includes Informatics programmes), Public Health England (the Department's executive agency), the NHS (both the NHS commissioning sector and NHS Trusts and NHS Foundation Trusts as providers of healthcare), and all ALBs (both Special Health Authorities and Executive non-Departmental Public Bodies). Other Group Bodies include NHS Property Services Ltd, Community Health Partnerships Ltd, Genomics England Ltd, Nursing and Midwifery Council, Health and Care Professions Council and Skipton Fund Ltd.

Net expenditure by operating segment is regularly reported to the Departmental Board. The information provided to the Departmental Board is presented on a budgeting basis and therefore mirrors the Statement of Parliamentary Supply but can be reconciled to the Consolidated Statement of Comprehensive Net Expenditure as shown in the table below. Multiple transactions take place between reportable segments; primarily between commissioning and provider bodies within the NHS. All intercompany transactions are eliminated upon consolidation as shown in the "Intercompany Eliminations" column of the table below. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure.

2.1 Departmental Group Summary

		2016-17									
		DH Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations £000	Departmental Group £000
Gross expenditure (2.2)		118,692,498	4,508,874	12,290,299	80,920,733	106,893,041	5,785,144	1,427,884	431,287	(191,887,609)	139,062,151
Income (2.3)		(1,806,207)	(236,228)	(3,455,995)	(78,616,765)	(2,233,568)	(304,238)	(1,235,767)	(207,838)	77,551,660	(10,544,946)
Total net expenditure (per CSCNE)		**116,886,291**	**4,272,646**	**8,834,304**	**2,303,968**	**104,659,473**	**5,480,906**	**192,117**	**223,449**	**(114,335,949)**	**128,517,205**
Budgeting adjustments per SoPS2											
Capital Grants		(473,285)	(10,880)	-	-	(70,647)	-	-	-	-	(554,812)
Research and Development		(1,056,049)	-	-	-	-	-	-	-	-	(1,056,049)
Prior period adjustments		-	-	-	-	-	-	-	-	-	-
Other		7,794	-	-	(104,188)	-	(35,936)	(49,005)	(239,737)	53,606	(367,466)
Total adjustments		**(1,521,540)**	**(10,880)**	**-**	**(104,188)**	**(70,647)**	**(35,936)**	**(49,005)**	**(239,737)**	**53,606**	**(1,978,327)**
Budget outturn per SoPS1, of which:		**115,364,751**	**4,261,766**	**8,834,304**	**2,199,780**	**104,588,826**	**5,444,970**	**143,112**	**(16,288)**	**(114,282,343)**	**126,538,878**
	RDEL	115,205,343	4,259,543	276,705	1,174,529	104,896,610	5,437,525	79,336	(16,288)	(114,282,343)	117,030,960
	RAME	159,408	2,223	8,557,599	1,025,251	(307,784)	7,445	63,776	-	-	9,507,918

		2015-16									
		DH Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations £000	Departmental Group £000
Gross expenditure		115,082,485	4,167,806	30,501,682	77,565,079	102,391,172	5,579,290	1,449,705	1,258,508	(182,445,024)	155,550,703
Income		(1,934,218)	(228,138)	(2,389,112)	(74,140,073)	(2,192,507)	(282,347)	(1,168,160)	(227,517)	72,561,356	(10,000,716)
Total net expenditure (per CSCNE)		**113,148,267**	**3,939,668**	**28,112,570**	**3,425,006**	**100,198,665**	**5,296,943**	**281,545**	**1,030,991**	**(109,883,668)**	**145,549,987**
Budgeting adjustments per SoPS3											
Capital Grants		(561,970)	(1,554)	-	-	(78,896)	-	-	-	1,275	(641,145)
Research and Development		-	-	-	-	-	-	-	-	-	-
Prior period adjustments		-	-	-	-	-	-	-	-	-	-
Other		82,144	-	(224,524)	(13,581)	-	223,047	(14,172)	(1,024,754)	-	(971,840)
Total adjustments		**(479,826)**	**(1,554)**	**(224,524)**	**(13,581)**	**(78,896)**	**223,047**	**(14,172)**	**(1,024,754)**	**1,275**	**(1,612,985)**
Budget outturn per SoPS1, of which:		**112,668,441**	**3,938,114**	**27,888,046**	**3,411,425**	**100,119,769**	**5,519,990**	**267,373**	**6,237**	**(109,882,393)**	**143,937,002**
	RDEL	111,930,945	3,941,569	55,349	2,721,469	100,373,566	5,501,952	81,805	6,237	(109,882,393)	114,730,499
	RAME	737,496	(3,455)	27,832,697	689,956	(253,797)	18,038	185,568	-	-	29,206,503

2.2 Departmental Group Detail – Expenditure

	2016-17									
	DH Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations[1] £000	Departmental Group £000
Material Expenditure Items										
Staff costs	148,553	301,887	139,367	50,428,834	1,781,455	577,036	162,539	-	(10,365)	53,529,306
Purchase of healthcare from non-NHS bodies	-	-	-	1,068,066	12,636,738	-	-	-	-	13,704,804
Sustainability and Transformation Fund Expenditure [2]	-	-	-	-	1,800,000	-	-	-	(1,800,000)	-
Purchase of social care	-	-	-	282,276	388,461	-	-	-	-	670,737
Expenditure on Drugs Action Teams	-	-	-	-	325	-	-	-	-	325
Non-GMS Services from GPs	-	-	-	-	-	-	-	-	-	-
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	2,909,509	-	-	-	(141,601)	2,767,908
Consultancy Services	4,485	-	6	259,727	101,264	2,038	21,781	-	(148)	389,153
Establishment	51,890	4,243	16,720	887,157	313,116	64,071	20,295	-	(82,167)	1,275,325
Transport (Business Travel)	15	9,043	2,875	356,331	33,317	17,410	5,262	-	(3,432)	420,821
Premises	12,766	22,230	13,330	2,532,594	82,480	35,354	256,052	-	(306,904)	2,647,902
PFI/Lift and other service concession arrangement charges	-	-	-	870,335	-	-	74,925	-	-	945,260
Business Rates Paid to Local Authorities	7,011	4,426	-	320,781	1,137	4,679	68,771	-	-	406,805
NHS Informatics Major Contracts Costs	168,598	-	-	-	-	35,378	-	-	(8,745)	195,231
Clinical negligence Costs	-	-	-	1,648,896	338	153	-	-	(1,648,782)	605
Education, Training and Conferences	1,589	2,731	534	246,274	140,244	8,381	3,308	-	(14,019)	389,042
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,822,164	-	-	(2,924,741)	1,897,423
Prescribing Costs	-	-	-	-	8,534,616	-	-	-	(8,202)	8,526,414
G/PMS, APMS and PCTMS	-	-	-	-	7,971,342	-	-	-	(32,085)	7,939,257
Pharmaceutical Services	-	-	-	-	1,992,230	-	-	-	(3,180)	1,989,050
General Ophthalmic Services	-	-	-	-	554,399	-	-	-	(299)	554,100
Supplies and Services - Clinical	-	-	-	4,121,322	110,059	124	1,917	-	(258,241)	3,975,181
Supplies and Services - General	-	192,062	202,772	1,199,005	959,381	56,923	122,474	-	(338,944)	2,393,673
Grants to Other Bodies	132,649	34	-	-	27,225	-	-	-	-	159,908
Grants to Local Authorities	43,861	3,387,958	-	-	-	-	-	-	-	3,431,819
Capital Grants	473,285	10,880	-	-	70,647	-	-	-	-	554,812
Movement in provision for impairment of receivables	(1)	248	-	120,340	6,514	3,415	(12,633)	-	(2,133)	115,750
Inventories consumed	-	451,674	1,444,230	9,276,284	3,474	-	-	-	(1,315,878)	9,859,784
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	754,962	-	-	-	-	(754,962)	-
Rentals under operating leases	16,867	11,838	2,955	663,945	291,407	17,061	121,151	-	(456,013)	669,211
Interest charges	462	-	-	942,169	471	1	171,279	-	(173,573)	940,809
Research and development	1,055,618	653	-	197,499	12,937	-	3,665	-	(596,250)	674,122
Depreciation on property, plant and equipment	27,834	27,904	6,612	2,014,467	82,091	10,999	187,354	-	-	2,357,261
Amortisation on intangible assets	354,611	4,635	12,181	179,995	5,857	28,851	767	-	-	586,897
Impairments and reversals	755	35,245	(1,971)	1,307,835	1,839	(24)	41,405	-	-	1,385,084
Provisions provided for in year	868,400	2,940	10,008,115	123,732	(172,193)	6,441	(7,998)	-	-	10,829,437
Non-cash expenditure from movement in pension liability	-	-	-	4,191	104	7,898	-	-	-	12,193
Grant in Aid	109,751,742	-	-	-	-	-	-	-	(109,751,742)	-
Funding to Group Bodies	4,584,207	-	-	-	-	-	-	-	(4,584,207)	-
Provisions - Change in discount rate	72,445	-	492,701	43,113	256	132	36,809	-	-	645,456
Other	744,831	(85)	125,006	645,834	39,790	41,329	44,690	-	(215,090)	1,426,305
Goods and Services from other NHS Bodies	-	-	-	122,116	66,027,029	-	31,907	-	(66,138,766)	42,286
Additional support for delivery of healthcare services	8,450	-	-	-	-	-	-	-	(8,450)	-
DH support for mergers	154,138	-	-	-	-	-	-	-	(154,138)	-
Resources expended by NHS charities	-	-	-	-	-	-	-	431,287	(122,695)	308,592
Non material expenditure categories	7,437	38,328	(175,134)	302,653	185,182	45,330	72,164	-	(31,857)	444,103
Total Gross Expenditure	**118,692,498**	**4,508,874**	**12,290,299**	**80,920,733**	**106,893,041**	**5,785,144**	**1,427,884**	**431,287**	**(191,887,609)**	**139,062,151**

1. Intercompany trading between bodies within the Departmental Group is eliminated upon consolidation. Where immaterial differences exist between the intercompany income and expenditure reported by Group bodies the Department equalises the amounts via central consolidation adjustments to ensure the net operating cost reported by the Departmental Group remains unaffected. The immaterial differences giving rise to these consolidation adjustments may be present in several income and expenditure categories however the consolidation adjustments are made solely to the "Other" category to ensure all other income and expenditure categories are presented exactly as reported by Group bodies. This may result in the "Inter Company Eliminations" figure for the "Other" expenditure and income categories appearing as a positive figure within this note. Further information about expenditure can be found in note 4 to these accounts.

2. The Sustainability and Transformation Fund (STF) is new for 2016-17. This £1,800 million fund is designed to help providers move to a sustainable financial footing. The STF is linked to the achievement of financial controls and performance trajectories for A&E wait times, RTT and 62 day cancer waiting standards. The funding has been included in the NHS England mandate and has been paid to NHS Providers from NHS England.

Material Expenditure Items	DH Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations £000	2015-16 Departmental Group £000
Staff costs	122,704	303,628	120,694	48,674,263	1,741,655	546,291	147,004	-	(9,614)	51,646,625
Purchase of healthcare from non-NHS bodies	-	-	-	944,937	12,130,660	-	-	-	-	13,075,597
Sustainability and Transformation Fund Expenditure	-	-	-	-	-	-	-	-	-	-
Purchase of social care	-	-	-	199,615	420,298	-	-	-	-	619,913
Expenditure on Drugs Action Teams	-	-	-	-	1,908	-	-	-	(1,458)	450
Non-GMS Services from GPs	-	-	-	-	-	-	-	-	-	-
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	3,313,160	-	-	-	(509,099)	2,804,061
Consultancy Services	7,657	-	137	297,055	112,964	1,503	13,348	-	(268)	432,396
Establishment	37,545	1,733	15,896	885,900	329,729	62,932	15,241	-	(105,485)	1,243,491
Transport (Business Travel)	10	9,750	1,912	339,029	24,437	21,553	3,820	-	(5,590)	394,921
Premises	11,346	28,924	9,917	2,523,236	61,846	36,832	351,399	-	(214,991)	2,808,509
PFI/Lift and other service concession arrangement charges	-	-	-	872,753	-	-	75,934	-	-	948,687
Business Rates Paid to Local Authorities	7,091	2,718	-	301,919	1,748	3,596	7	-	-	317,079
NHS Informatics Major Contracts Costs	332,776	-	-	-	-	-	-	-	(14,410)	318,366
Clinical negligence Costs	-	-	-	1,417,348	373	133	-	-	(1,417,582)	272
Education, Training and Conferences	2,505	4,156	218	247,041	142,395	7,694	3,347	-	(17,624)	389,732
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,738,117	-	-	(2,957,721)	1,780,396
Prescribing Costs	-	-	-	-	8,557,135	-	-	-	(9,710)	8,547,425
G/PMS, APMS and PCTMS	-	-	-	-	7,797,894	-	-	-	(33,722)	7,764,172
Pharmaceutical Services	-	-	-	-	2,105,899	-	-	-	(890)	2,105,009
General Ophthalmic Services	-	-	-	-	542,339	-	-	-	(278)	542,061
Supplies and Services - Clinical	-	-	-	4,069,587	176,716	60	3,083	-	(174,028)	4,075,418
Supplies and Services - General	-	250,207	115,755	1,113,054	1,116,437	45,063	71,957	-	(530,177)	2,182,296
Grants to Other Bodies	141,334	5	-	-	29,763	-	-	-	(75,875)	95,227
Grants to Local Authorities	81,366	3,036,236	-	-	-	-	-	-	-	3,117,602
Capital Grants	561,970	1,554	-	-	78,896	-	-	-	(1,275)	641,145
Movement in provision for impairment of receivables	1	565	-	95,653	9,994	180	16,273	-	9,234	131,900
Inventories consumed	-	372,295	712,113	8,826,803	2,871	-	-	-	(653,428)	9,260,654
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	839,407	-	-	-	-	(839,407)	-
Rentals under operating leases	14,216	12,496	2,992	633,823	351,471	18,003	118,420	-	(537,139)	614,282
Interest charges	641	-	-	882,490	690	-	171,204	-	(37,053)	1,017,972
Research and development	1,059,081	1,840	-	188,354	13,400	-	3,232	-	(769,141)	496,766
Depreciation on property, plant and equipment	31,192	20,106	5,953	2,036,342	73,795	9,580	154,882	-	-	2,331,850
Amortisation on intangible assets	521,439	4,175	11,008	150,048	5,455	20,805	-	-	-	712,930
Impairments and reversals	801	104,414	1,982	888,364	336	(7)	67,399	-	-	1,063,289
Provisions provided for in year	613,407	(2,290)	3,860,653	97,742	(124,346)	16,520	(2,364)	-	-	4,459,322
Non-cash expenditure from movement in pension liability	-	-	-	2,874	216	8,453	-	-	-	11,543
Grant in Aid	105,683,053	-	-	-	-	-	-	-	(105,683,053)	-
Funding to Group Bodies	4,200,615	-	-	-	-	-	-	-	(4,200,615)	-
Provisions - Change in discount rate	412,925	-	25,473,368	(647)	341	2	-	-	-	25,885,989
Other	730,838	396	120,461	603,272	40,684	34,719	49,672	-	206,428	1,786,470
Goods and Services from other NHS Bodies	-	-	-	109,208	63,158,933	-	-	-	(63,232,592)	35,549
Additional support for delivery of healthcare services	331,310	-	-	-	-	-	-	-	(331,310)	-
DH support for mergers	149,334	-	-	-	-	-	-	-	(149,334)	-
Resources expended by NHS charities	-	-	-	-	-	-	-	1,258,508	(117,986)	1,140,522
Non material expenditure categories	27,328	14,898	48,623	325,609	171,080	7,261	185,847	-	(29,831)	750,815
Total Expenditure	**115,082,485**	**4,167,806**	**30,501,682**	**77,565,079**	**102,391,172**	**5,579,290**	**1,449,705**	**1,258,508**	**(182,445,024)**	**155,550,703**

2.3 Departmental Group Detail - Income

	2016-17									
	DH Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations £000	Departmental Group £000
Material Income Items										
Income from Local Authorities	-	-	-	(2,341,140)	-	-	(13)	-	-	(2,341,153)
Income from Private patients	-	-	-	(583,983)	-	-	-	-	-	(583,983)
Income from DH/NHS bodies	-	-	(846)	(66,243,101)	-	-	(31,275)	-	66,148,881	(126,341)
Additional income for delivery of healthcare services	-	-	-	(8,450)	-	-	-	-	8,450	-
Sustainability and Transformation Fund Income[1]	-	-	-	(1,800,000)	-	-	-	-	1,800,000	-
Other non-NHS patient care services	-	-	-	(497,612)	-	-	-	-	-	(497,612)
Interest revenue	(213,034)	(409)	-	(13,996)	-	(4)	(13,478)	-	171,105	(69,816)
Prescription Pricing Regulation Scheme	(489,295)	-	-	-	-	-	-	-	-	(489,295)
Prescription Fees and Charges	-	-	-	-	(554,935)	-	-	-	-	(554,935)
Dental Fees and Charges	-	-	-	-	(776,812)	-	-	-	-	(776,812)
Other Fees and Charges	-	(209,176)	(1,830,193)	(185,106)	-	(172,261)	(116,438)	-	1,935,462	(577,712)
PDC Dividend Received	(754,962)	-	-	-	-	-	-	-	754,962	-
Education, training and research	-	(12,298)	(135)	(3,637,638)	(202,160)	(78,627)	-	-	3,597,033	(333,825)
Income from injury costs recovery	-	-	-	(205,653)	-	-	-	-	-	(205,653)
Charitable and other contributions to expenditure	-	-	-	(96,840)	(2,889)	-	-	-	39,190	(60,539)
Rental revenue from operating leases	(20,503)	(8,500)	-	(74,712)	(437)	(442)	(866,553)	-	732,884	(238,263)
Non patient care services to other bodies	(44,887)	-	(1,623,937)	(657,593)	(362,848)	(41,436)	(18,881)	-	1,912,555	(837,027)
Support from DH for mergers	-	-	-	(140,585)	-	-	-	-	140,585	-
Other	(63,843)	-	(16)	(1,598,004)	(328,403)	(10,639)	(171,023)	-	215,880	(1,956,048)
Income received by NHS charities	-	-	-	-	-	-	-	(207,838)	-	(207,838)
Non-material income categories	(219,683)	(5,845)	(868)	(532,352)	(5,084)	(829)	(18,106)	-	94,673	(688,094)
Total Gross Income	**(1,806,207)**	**(236,228)**	**(3,455,995)**	**(78,616,765)**	**(2,233,568)**	**(304,238)**	**(1,235,767)**	**(207,838)**	**77,551,660**	**(10,544,946)**
Total net expenditure (per CSCNE)	**116,886,291**	**4,272,646**	**8,834,304**	**2,303,968**	**104,659,473**	**5,480,906**	**192,117**	**223,449**	**(114,335,949)**	**128,517,205**

1. The Sustainability and Transformation Fund (STF) is new for 2016-17. This £1,800 million fund is designed to help providers move to a sustainable financial footing. The STF is linked to the achievement of financial controls and performance trajectories for A&E wait times, RTT and 62 day cancer waiting standards. The funding has been included in the NHS England mandate and has been paid to NHS Providers from NHS England.

	2015-16									
	DH Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations £000	Departmental Group £000
Material Income Items										
Income from Local Authorities	-	-	-	(2,027,127)	-	-	-	-	-	(2,027,127)
Income from Private patients	-	-	-	(558,194)	-	-	-	-	-	(558,194)
Income from DH/NHS bodies	-	-	-	(63,543,282)	-	-	-	-	63,418,446	(124,836)
Additional income for delivery of healthcare services	-	-	-	(331,310)	-	-	-	-	331,310	-
Sustainability and Transformation Fund Income	-	-	-	-	-	-	-	-	-	-
Other non-NHS patient care services	-	-	-	(544,070)	-	-	-	-	-	(544,070)
Interest revenue	(137,940)	-	-	(20,170)	-	(55)	(12,813)	-	36,700	(134,278)
Prescription Pricing Regulation Scheme	(664,623)	-	-	-	-	-	-	-	-	(664,623)
Prescription Fees and Charges	-	-	-	-	(523,539)	-	-	-	-	(523,539)
Dental Fees and Charges	-	-	-	-	(743,843)	-	-	-	-	(743,843)
Other Fees and Charges	-	(217,914)	(1,582,554)	(164,804)	-	(127,246)	(79,417)	-	1,657,098	(514,837)
PDC Dividend Received	(839,407)	-	-	-	-	-	-	-	839,407	-
Education, training and research	-	(1,724)	-	(3,640,007)	(230,956)	(90,169)	-	-	3,626,497	(336,359)
Income from injury costs recovery	-	-	-	(194,189)	-	-	-	-	-	(194,189)
Charitable and other contributions to expenditure	-	-	-	(80,427)	(3,290)	-	-	-	38,394	(45,323)
Rental revenue from operating leases	(19,051)	(8,500)	-	(81,715)	(302)	(164)	(752,505)	-	627,393	(234,844)
Non patient care services to other bodies	(46,780)	-	(805,340)	(709,978)	(383,512)	(58,171)	(21,908)	-	1,259,865	(765,824)
Support from DH for mergers	-	-	-	(149,334)	-	-	-	-	149,334	-
Other	(54,644)	-	(107)	(1,544,820)	(302,154)	(5,859)	(276,681)	-	487,994	(1,696,271)
Income received by NHS charities	-	-	-	-	-	-	-	(227,517)	-	(227,517)
Non-material income categories	(171,773)	-	(1,111)	(550,646)	(4,911)	(683)	(24,836)	-	88,918	(665,042)
Total Income	**(1,934,218)**	**(228,138)**	**(2,389,112)**	**(74,140,073)**	**(2,192,507)**	**(282,347)**	**(1,168,160)**	**(227,517)**	**72,561,356**	**(10,000,716)**
Total net expenditure (per CSCNE)	**113,148,267**	**3,939,668**	**28,112,570**	**3,425,006**	**100,198,665**	**5,296,943**	**281,545**	**1,030,991**	**(109,883,668)**	**145,549,987**

3. Staff costs

Staff costs for the Departmental Group comprise:

	Permanently employed staff	Others	Ministers	Special advisors	2016-17 £'000 Total	2015-16 £'000 Total
Salaries and wages	39,354,625	5,484,589	202	222	44,839,638	44,020,088
Social Security costs	3,873,023	85,325	26	34	3,958,408	3,064,140
NHS Pension	4,697,046	87,467	-	-	4,784,513	4,636,466
Other pension costs	67,722	225	-	51	67,998	70,012
Sub-total	**47,992,416**	**5,657,606**	**228**	**307**	**53,650,557**	**51,790,706**
Termination benefits	89,991	9,564	8	-	99,563	88,196
Sub-total	**48,082,407**	**5,667,170**	**236**	**307**	**53,750,120**	**51,878,902**
Less recoveries in respect of outward secondments	(27,400)	(45,078)	-	-	(72,478)	(71,136)
Total Net Costs	**48,055,007**	**5,622,092**	**236**	**307**	**53,677,642**	**51,807,766**

1. £31,568k of the termination benefits noted above relate to payments made to staff exiting the Core Department as part of the DH2020 change programme.

Of which:	Charged to revenue budgets	Charged to capital	2016-17 £'000 Total
Core Dept & Agencies	450,440	2,302	452,742
Other designated bodies	53,147,789	146,034	53,293,823
Less elimination of intra-group expenditure	(68,923)	-	(68,923)
Total	**53,529,306**	**148,336**	**53,677,642**

	Charged to revenue budgets	Charged to capital	2015-16 £'000 Total
Core Dept & Agencies	426,332	935	427,267
Other designated bodies	51,287,275	160,206	51,447,481
Less elimination of intra-group expenditure	(66,982)	-	(66,982)
Total	**51,646,625**	**161,141**	**51,807,766**

Staff numbers in the Staff Report are calculated in line with public sector accounts disclosure requirements using a financial year average (using the number of staff at the end of each quarter and averaging them over the year) and use Office for National Statistics categorisation.

Principal Civil Service Pension Scheme (PCSPS)

The Principal Civil Service Pension Scheme (PCSPS) and the Civil Servant and Other Pension Scheme (CSOPS) – known as "Alpha" are unfunded multi-employer defined benefit schemes but bodies within the Departmental Group are unable to identify their share of the underlying assets and liabilities. The scheme actuary valued the PCSPS as at 31 March 2012, this is shown in the Cabinet Office: Civil Superannuation[76].

[76] http://www.civilservicepensionscheme.org.uk/about-us/resource-accounts/

For 2016-17, employers' contributions of £16,685,066 were payable to the PCSPS (2015-16: £18,341,879) at one of four rates in the range 20.0% to 24.5% (2015-16: 20.0% to 24.5%) of pensionable earnings, based on salary bands. The Scheme Actuary reviews employer contributions usually every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2016-17 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employers' contributions of £123,342, (2015-16: £110,093) were paid to one or more of the panel of three appointed stakeholder pension providers. Employer contributions are age-related and range from 8% to 14.75% of pensionable earnings.

Employers also match employee contributions up to 3% of pensionable earnings. In addition, employer contributions of £4,520, 0.5% of pensionable pay, (2015-16: £4,587, 0.8% of pensionable pay up to 30 September 2015 and 0.5% of pensionable pay from 1 October 2015) were payable to the PCSPS to cover the cost of the future provision of lump sum benefits on death in service or ill health retirement of these employees.

NHS Pension Scheme

The NHS Pension scheme is an unfunded, multi-employer defined benefit scheme. Individual NHS bodies are therefore unable to identify their shares of the underlying scheme assets and liabilities. The scheme was actuarially valued as at 31 March 2012[77].

For 2016-17, employers' contributions were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014.

Of the £4,784.5 million (2015-16: £4,636.5 million) against NHS pension costs, £151.7 million is attributable to NHS England Group (2015-16 £145.3 million), £1,625.2 million (2015-16 £1,652.4 million) to NHS Trusts and £2,940.1 million (2015-16 £2,771.1 million) to NHS Foundation Trusts with the balance of £67.5 million (2015-16 £67.7 million) to ALBs.

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

4 Expenditure

4.1 Expenditure

	Note	2016-17 £'000 Core Dept & Agencies	2016-17 £'000 Departmental Group	2015-16 £'000 Core Dept & Agencies	2015-16 £'000 Departmental Group
4.1 (a) Purchase of goods and services					
Rentals Under Operating Leases		24,512	669,211	26,574	614,282
Supplies and services - clinical		-	3,975,181	-	4,075,418
Supplies and services - general		190,985	2,393,673	242,639	2,182,296
Goods and services from other NHS bodies		-	42,286	-	35,549
Multi Professional Education and Training (MPET)		-	1,897,423	-	1,780,396
Additional support for delivery of healthcare services[6]		8,450	-	331,310	-
Purchase of healthcare from non NHS bodies		-	13,704,804	-	13,075,597
Purchase of Social Care		-	670,737	-	619,913
Expenditure on Drug Action Teams		-	325	-	450
General Dental Services (GDS) and Personal Dental Services (PDS)[5]		-	2,767,908	-	2,804,061
Prescribing Costs		-	8,526,414	-	8,547,425
G/PMS, APMS and PCTMS[1]		-	7,939,257	-	7,764,172
Pharmaceutical Services		-	1,989,050	-	2,105,009
General Ophthalmic Services		-	554,100	-	542,061
Consultancy services		4,485	389,153	7,657	432,396
Establishment		56,140	1,275,325	39,244	1,243,491
Transport (Business Travel)		9,058	420,821	9,760	394,921
Premises		35,129	2,647,902	40,303	2,808,509
Education, Training and Conferences		4,320	389,042	6,678	389,732
Insurance		84	41,227	97	39,583
Legal fees		30,862	228,769	20,973	198,806
NHS Informatics Major Contracts Cost		168,598	195,231	332,776	318,366
Audit fees - statutory audit (cash)		4	32,318	-	33,688
Other auditor's remuneration		-	53,252	4	53,606
non-cash items					
Audit fees - non-cash[2]		824	919	824	914
Purchase of goods and services		**533,451**	**50,804,328**	**1,058,839**	**50,060,641**
4.1 (b) Depreciation and impairment charges					
non-cash items					
Depreciation on property, plant and equipment		55,738	2,357,261	51,298	2,331,850
Amortisation on intangible assets		359,246	586,897	525,614	712,930
Impairments and reversals		36,000	1,385,084	105,215	1,063,289
Depreciation and impairment charges		**450,984**	**4,329,242**	**682,127**	**4,108,069**
4.1 (c) Provision expense					
non-cash items					
Non-cash expenditure from movement in pension liability		-	12,193	-	11,543
Provision provided for in year		871,340	10,829,437	611,117	4,459,322
Change in discount rate[7]		72,445	645,456	412,925	25,885,989
Provision expense		**943,785**	**11,487,086**	**1,024,042**	**30,356,854**
4.1 (d) Other operating expenditure					
PFI/LIFT and other service concession arrangements charges		-	945,260	-	948,687
Chair and non-executive Directors' costs		-	81,543	-	78,008
Business rates paid to local authorities		11,437	406,805	9,809	317,079
Clinical negligence		-	605	-	272
Research and development[6]		1,055,448	674,122	1,058,272	496,766
Grants to Local Authorities		3,431,819	3,431,819	3,117,602	3,117,602
Grants to Other bodies		132,683	159,908	141,339	95,227
Capital Grants		484,165	554,812	563,524	641,145
DH support for mergers[6]		154,138	-	149,334	-
Prior period adjustments in local accounts		-	120,238	-	15,948
non-cash items					
Loss on disposal of non-current assets and assets held for sale		34,895	57,971	5,130	35,241
Movement in provision for impairment of receivables		247	115,750	566	131,900
Inventories write down		2,217	12,647	13,034	22,777
Inventories consumed		451,674	9,859,784	372,295	9,260,654
Prior period adjustments in local accounts (non-cash)		-	70,206	-	247,151
Changes in fair value through SoCNE		-	(48,787)	-	(20,331)
Other non-cash expenditure		326	(318)	(16,946)	(15,850)
Other[3,4]		743,471	1,426,305	732,354	1,786,470
Other operating expenditure		**6,502,520**	**17,868,670**	**6,146,313**	**17,158,746**

1. General Medical Services/Personal Medical Services (G/PMS), Alternative Provider Medical Services (APMS) and Primary Care Trust Medical Services (PCTMS) are differing models for providing primary care services.

2. Note 1.7 (audit costs) explains that the Core Department and Agencies audit fee is a notional charge, resulting in its classification as a non cash item.

3. The Core Department & Agencies ''Other'' expenditure figure of £743.5 million (£732.4 million in 2015-16) includes £237.0 million of revenue policy payments (£392.1 million in 2015-16), £153.1 million in respect of outsourcing contracts (£141.1 million in 2015-16) and £123.9 million of Healthy Start – Welfare Foods payments (£139.0 million in 2015-16).

4. A breakdown of the Departmental Group Other figure by sector is provided in Note 2.2 Departmental Group Detail – Expenditure.

5. General Dental Services (GDS) and Personal Dental Services (PDS) are alternative models for dental care.

6. Core Department and Agencies expenditure figures may be greater than those of the Departmental Group due to the elimination of intercompany trading.

7. For more details on 'Change in discount rate' see notes 1.20 and 16.

Note 4.2 Non-cash transactions

The total of non-cash transactions included in the Reconciliation of Operating Costs to Operating Cash flow in the Consolidated Statement of Cash Flows comprises:

	2016-17 £'000 Departmental Group	2015-16 £'000 Departmental Group
Expenditure after financing activities - non-cash items (Note 4 & SOCNE)	25,678,618	44,188,653
Less non-cash income after financing activities (Note 5 & SOCNE)	(300,781)	(168,213)
Total non-cash transactions	**25,377,837**	**44,020,440**
Movement in provision for impairment of receivables	(115,750)	(131,900)
Inventories consumed	(9,859,784)	(9,260,654)
Inventories write down	(12,647)	(22,777)
Less non-cash movements on SoFP balances analysed separately in the Cash Flow statement	**(9,988,181)**	**(9,415,331)**
Total non-cash transactions as per Consolidated Statement of Cash Flows	**15,389,656**	**34,605,109**

5. Income

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Income from sale of goods and services				
Revenue from Patient Care activities				
Income from Local Authorities	-	2,341,153	-	2,027,127
Income from Private patients	-	583,983	-	558,194
Income from Chargeable Overseas Patients	-	81,402	-	69,246
Income from injury costs recovery	-	205,653	-	194,189
Income from other EU states for treatment of their citizens	86,066	86,066	58,572	58,572
Income from DH/NHS bodies	-	126,341	-	124,836
Other non-NHS patient care services	-	497,612	-	544,070
Other Non Trading Income				
Rental revenue from finance leases	-	2,022	-	3,078
Rental revenue from operating leases	24,443	238,263	23,294	234,844
Non-patient care services to other bodies	44,512	837,027	45,902	765,824
Education, training and research	12,298	333,825	1,724	336,359
Income from sale of goods and services	**167,319**	**5,333,347**	**129,492**	**4,916,339**
Other operating income				
Prescription Pricing Regulation Scheme	489,295	489,295	664,623	664,623
Prescription Fees and Charges	-	554,935	-	523,539
Dental Fees and Charges	-	776,812	-	743,843
Other Fees and Charges	206,315	577,712	212,732	514,837
PDC Dividend Received	754,962	-	839,407	-
PDC Commitment Fee	-	-	365	-
Charitable and other contributions to expenditure	-	60,539	-	45,323
Receipt of donations for capital acquisitions	-	35,378	-	35,500
Receipt of grants for capital acquisitions	-	63,318	-	75,406
Profit on disposal	124,881	238,874	1,028	134,203
Dividends	7,356	12,401	104,551	111,222
Income in respect of Staff Costs	-	189,319	-	173,870
Other non-cash income	10,282	16,979	9,823	11,296
Funding from other Government departments	-	176	-	196
Prior period adjustments in local accounts	-	(34,784)	-	(4,981)
Other[1]	64,411	1,956,048	55,742	1,696,271
Other operating income	**1,657,502**	**4,937,002**	**1,888,271**	**4,725,148**

1. A breakdown of the Departmental Group Other figure by sector is provided in Note 2.3 *Departmental Group Detail – Income.*

6. Property, plant and equipment

	Departmental Group 2016-17									
	Land	Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture & Fittings	Plant & Machinery	Transport Equipment	Stockpiled Goods	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation										
At 1 April 2016	**6,672,579**	**39,950,365**	**392,177**	**3,711,594**	**1,831,052**	**643,419**	**8,775,794**	**452,583**	**682,028**	**63,111,591**
Prior period adjustments in underlying accounts	(467)	(114,015)	(664)	(8,038)	(1,408)	201	(19,069)	(161)	-	(143,621)
Additions	2,173	786,622	2,044	391,216	1,498,542	29,903	443,236	13,976	164,644	3,332,356
Donations	15	28,381	-	1,955	100,152	1,001	45,602	246	-	177,352
Impairments and reversals	(424,744)	(2,068,726)	(5,896)	(21,663)	(29,123)	(3,576)	(9,956)	(3,017)	(35,245)	(2,601,946)
Transfers	-	(11)	-	(985)	-	-	-	-	(55,886)	(56,882)
Reclassifications	(23,202)	905,733	(1,426)	110,912	(1,410,926)	40,963	101,550	18,441	-	(257,955)
Revaluation and indexation	122,541	(380,747)	4,068	(6,516)	25	(7,092)	(24,436)	(454)	-	(292,611)
Disposals	(31,563)	(91,030)	(2,737)	(290,899)	(3,319)	(29,115)	(326,096)	(23,993)	(34,022)	(832,774)
At 31 March 2017	**6,317,332**	**39,016,572**	**387,566**	**3,887,576**	**1,984,995**	**675,704**	**8,986,625**	**457,621**	**721,519**	**62,435,510**
Depreciation										
At 1 April 2016	**81,794**	**2,618,658**	**39,340**	**2,394,769**	**-**	**423,053**	**5,889,700**	**280,442**	**-**	**11,727,756**
Prior period adjustments in underlying accounts	(3,945)	(61,635)	(573)	(7,433)	-	(991)	(16,444)	(195)	-	(91,216)
Charged in year	65	1,203,836	11,280	413,031	-	50,792	633,416	44,841	-	2,357,261
Impairments and reversals	53,328	(88,815)	2,008	(4,012)	-	(1,453)	(3,737)	(2,305)	-	(44,986)
Transfers	-	-	-	(507)	-	-	-	-	-	(507)
Reclassifications	(178)	(79,136)	(338)	(25,774)	-	18,904	(48,369)	(6,052)	-	(140,943)
Revaluation and indexation	(32,052)	(1,001,434)	(11,054)	(6,697)	-	(7,447)	(27,836)	(455)	-	(1,086,975)
Disposals	(5,650)	(33,264)	(542)	(278,743)	-	(28,374)	(312,617)	(23,369)	-	(682,559)
At 31 March 2017	**93,362**	**2,558,210**	**40,121**	**2,484,634**	**-**	**454,484**	**6,114,113**	**292,907**	**-**	**12,037,831**
Net book value at 31 March 2017	**6,223,970**	**36,458,362**	**347,445**	**1,402,942**	**1,984,995**	**221,220**	**2,872,512**	**164,714**	**721,519**	**50,397,679**
Net book value at March 2016	6,590,785	37,331,707	352,837	1,316,825	1,831,052	220,366	2,886,094	172,141	682,028	51,383,835
Asset financing:										
Owned - purchased	5,745,470	24,272,384	250,467	1,374,342	1,862,436	206,020	2,310,938	161,808	721,519	36,905,384
Owned - donated	98,950	1,171,989	12,178	9,734	110,866	13,235	278,477	1,100	-	1,696,529
Finance leased	55,586	417,589	21,784	13,006	-	1,121	164,272	1,806	-	675,164
On-Statement of Financial Position PFI contracts	323,964	10,596,400	61,358	5,860	11,693	844	118,825	-	-	11,118,944
PFI residual interests	-	-	1,658	-	-	-	-	-	-	1,658
Net book value at 31 March 2017	**6,223,970**	**36,458,362**	**347,445**	**1,402,942**	**1,984,995**	**221,220**	**2,872,512**	**164,714**	**721,519**	**50,397,679**
Analysis of property, plant and equipment										
Core Dept & Agencies	141,067	195,544	-	17,573	48,169	5,832	48,721	-	721,519	1,178,425
Other designated bodies	6,082,903	36,262,818	347,445	1,385,369	1,936,826	215,388	2,823,791	164,714	-	49,219,254
Net book value at 31 March 2017	**6,223,970**	**36,458,362**	**347,445**	**1,402,942**	**1,984,995**	**221,220**	**2,872,512**	**164,714**	**721,519**	**50,397,679**

1.Stockpiled goods are not depreciated, as agreed with HM Treasury.

2. The Department leases both Richmond House and Wellington House buildings from the Department for Local Government and Communities (DCLG) for no consideration. DCLG in turn leases the assets from the HM Treasury UK Sovereign Sukuk plc, for which HMT is paying the lease costs. As the Department retains control of these properties their value is included in the "Buildings (excluding dwellings)" column above.

Property has been valued as follows:

- The Civil Estate (land and buildings held for use by the core Department) was valued on 1 September 2015 by independent valuers employed by the Department. Since then, Investment Property Databank indices have been applied, as appropriate, to uplift values as at the year end using IAS 16 revaluation model methodology.
- Land and buildings held by NHS bodies are valued, by independent valuers, to a modern equivalent basis as required by HM Treasury, details of which can be found in the individual body accounts.

- All valuations have been undertaken according to Royal Institute of Chartered Surveyors (RICS) guidelines.
- The Retained Estate comprises land and buildings (£23.0m at 31 March 2017) which were primarily intended for use by NHS bodies but which are now surplus to requirements and are therefore held by the Department. The Retained Estate was revalued by professional valuers as at 31 March 2015. Additional valuations were carried out as necessary in circumstances where there were indications that values had substantially changed.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 – 193 years
- Information technology: 1 – 20 years
- Furniture and fittings: 1 – 47 years
- Plant and machinery: 1 – 66 years
- Transport equipment: 1 - 16 years

	Departmental Group 2015-16									
	Land	Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture & Fittings	Plant & Machinery	Transport Equipment	Stockpiled Goods	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation										
At 1 April 2015	**7,525,331**	**38,988,946**	**409,907**	**3,425,374**	**1,738,040**	**638,829**	**8,505,373**	**432,920**	**705,307**	**62,370,027**
Prior period adjustments in underlying accounts	(141,292)	(260,583)	(2,632)	(4,470)	(7,643)	(422)	(2,001)	(307)	-	(419,350)
Additions	8,354	1,087,374	2,394	329,066	1,542,573	33,597	428,816	20,331	83,269	3,535,774
Donations	-	28,292	193	2,084	87,006	1,180	52,180	96	-	171,031
Impairments and reversals	(705,101)	(1,433,009)	(7,505)	(3,781)	(33,613)	(1,250)	(12,828)	(23)	(103,819)	(2,300,929)
Transfers	(750)	53,083	-	3,237	(15,063)	-	(9,608)	-	(1,733)	29,166
Reclassifications	(30,945)	920,853	(19,734)	132,080	(1,479,027)	9,321	148,206	38,255	-	(280,991)
Revaluation and indexation	51,671	620,430	12,197	(524)	16	(333)	(1,745)	(32)	9,967	691,647
Disposals	(34,689)	(55,021)	(2,643)	(171,472)	(1,237)	(37,503)	(332,599)	(38,657)	(10,963)	(684,784)
At 31 March 2016	**6,672,579**	**39,950,365**	**392,177**	**3,711,594**	**1,831,052**	**643,419**	**8,775,794**	**452,583**	**682,028**	**63,111,591**
Depreciation										
At 1 April 2015	**83,801**	**2,827,677**	**39,760**	**2,170,138**	**-**	**404,642**	**5,594,155**	**275,964**	**-**	**11,396,137**
Prior period adjustments in underlying accounts	(11,416)	(182,082)	(2,632)	(2,569)	-	4,627	(890)	(286)	-	(195,248)
Charged in year	68	1,186,861	11,624	400,385	-	48,419	638,197	46,296	-	2,331,850
Impairments and reversals	37,110	(173,474)	(2,555)	1,695	-	58	(5,681)	451	-	(142,396)
Transfers	-	-	-	2,253	-	-	(4,718)	-	-	(2,465)
Reclassifications	(270)	(82,292)	(571)	(9,572)	-	(228)	(10,923)	(3,773)	-	(107,629)
Revaluation and indexation	(27,309)	(932,397)	(6,113)	(574)	-	(173)	(1,318)	(27)	-	(967,911)
Disposals	(190)	(25,635)	(173)	(166,987)	-	(34,292)	(319,122)	(38,183)	-	(584,582)
At 31 March 2016	**81,794**	**2,618,658**	**39,340**	**2,394,769**	**-**	**423,053**	**5,889,700**	**280,442**	**-**	**11,727,756**
Net book value at 31 March 2016	**6,590,785**	**37,331,707**	**352,837**	**1,316,825**	**1,831,052**	**220,366**	**2,886,094**	**172,141**	**682,028**	**51,383,835**
Net book value at 31 March 2015	7,441,530	36,161,269	370,147	1,255,236	1,738,040	234,187	2,911,218	156,956	705,307	50,973,890
Asset financing:										
Owned - purchased	6,140,922	24,577,686	257,152	1,295,857	1,708,018	204,917	2,372,876	170,610	682,028	37,410,066
Owned - donated	87,071	1,177,975	11,464	7,562	104,625	13,266	269,485	1,198	-	1,672,646
Finance leased	59,350	406,347	18,033	8,634	5,923	1,386	139,695	333	-	639,701
On-Statement of Financial Position PFI contracts	303,442	11,169,699	54,466	4,772	12,486	797	104,038	-	-	11,649,700
PFI residual interests	-	-	11,722	-	-	-	-	-	-	11,722
Net book value at 31 March 2016	**6,590,785**	**37,331,707**	**352,837**	**1,316,825**	**1,831,052**	**220,366**	**2,886,094**	**172,141**	**682,028**	**51,383,835**
Analysis of property, plant and equipment										
Core Dept & Agencies	133,834	202,309	-	22,829	32,467	6,601	58,843	-	682,028	1,138,911
Other designated bodies	6,456,951	37,129,398	352,837	1,293,996	1,798,585	213,765	2,827,251	172,141	-	50,244,924
Net book value at 31 March 2016	**6,590,785**	**37,331,707**	**352,837**	**1,316,825**	**1,831,052**	**220,366**	**2,886,094**	**172,141**	**682,028**	**51,383,835**

7. Intangible Non-Current Assets

Intangible non-current assets comprise Purchased Software Licences and Internally Developed Software, Trade Marks and Development Expenditure relating to both the Department and the entities consolidated within these financial statements.

	Departmental Group 2016-17			
	IT & Software £'000	Development Expenditure £'000	Other £'000	Total £'000
Cost or valuation				
At 1 April 2016	**3,704,060**	**160,829**	**142,804**	**4,007,693**
Prior period adjustments in underlying accounts	4,847	(5,706)	2,009	1,150
Additions	281,672	23,453	108,502	413,627
Donations	1,821	-	2,905	4,726
Impairments and reversals	(17,302)	(96)	(11,369)	(28,767)
Transfers	(4,288)	111	(111)	(4,288)
Reclassifications	113,869	15,112	(59,085)	69,896
Revaluation and indexation	14,498	2,412	355	17,265
Disposals	(1,075,099)	(3,181)	(2,243)	(1,080,523)
Other movements	(2)	2	-	-
At 31 March 2017	**3,024,076**	**192,936**	**183,767**	**3,400,779**
Amortisation				
At 1 April 2016	**2,518,830**	**69,865**	**17,684**	**2,606,379**
Prior period adjustments in underlying accounts	3,730	(5,020)	(112)	(1,402)
Charged in year	559,836	22,858	4,203	586,897
Impairments and reversals	(2,743)	27	153	(2,563)
Transfers	(4,548)	-	-	(4,548)
Reclassifications	3,997	1	(135)	3,863
Revaluation and indexation	8,514	1,083	249	9,846
Disposals	(1,073,034)	(2,486)	(1,337)	(1,076,857)
Other movements	(14,568)	-	-	(14,568)
At 31 March 2017	**2,000,014**	**86,328**	**20,705**	**2,107,047**
Net Book Value at 31 March 2017	**1,024,062**	**106,608**	**163,062**	**1,293,732**
Net book value at March 2016	1,185,230	90,964	125,120	1,401,314

Analysis of intangible assets	IT & Software £'000	Development Expenditure £'000	Other £'000	Total £'000
Of the total:				
Core Dept & Agencies	225,328	-	6,087	231,415
Other designated bodies	798,734	106,608	156,975	1,062,317
Net Book Value at 31 March 2017	**1,024,062**	**106,608**	**163,062**	**1,293,732**

1. In 2016-17, £1,037.0 million of nil net book value assets were disposed of as the Informatics Local Service Provider, North Midlands and East, Picture Archiving and Communication System (PACS) and NHS Mail programmes ended.

	Departmental Group 2015-16			
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2015	**4,875,015**	**156,159**	**126,339**	**5,157,513**
Prior period adjustments in underlying accounts	1,048	(31)	2,110	3,127
Additions	237,811	37,007	87,314	362,132
Donations	2,947	-	2,035	4,982
Impairments and reversals	(9,247)	(34)	(4,339)	(13,620)
Transfers	(5,190)	-	(135)	(5,325)
Reclassifications	174,087	(19,147)	(69,203)	85,737
Revaluation and indexation	28,610	116	43	28,769
Disposals	(1,348,413)	(13,241)	(1,360)	(1,363,014)
Other movements	(252,608)	-	-	(252,608)
At 31 March 2016	**3,704,060**	**160,829**	**142,804**	**4,007,693**
Amortisation				
At 1 April 2015	**3,470,870**	**62,544**	**13,718**	**3,547,132**
Prior period adjustments in underlying accounts	373	(31)	(46)	296
Charged in year	691,980	16,887	4,063	712,930
Impairments and reversals	(565)	503	113	51
Transfers	(3,697)	-	(135)	(3,832)
Reclassifications	(5,008)	1,764	18	(3,226)
Revaluation and indexation	23,214	(10)	14	23,218
Disposals	(1,345,651)	(11,792)	(61)	(1,357,504)
Other movements	(312,686)	-	-	(312,686)
At 31 March 2016	**2,518,830**	**69,865**	**17,684**	**2,606,379**
Net Book Value at 31 March 2016	**1,185,230**	**90,964**	**125,120**	**1,401,314**
Net Book Value at 31 March 2015	1,404,145	93,615	112,621	1,610,381

Analysis of intangible assets				
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Of the total:				
Core Dept & Agencies	471,603	1,715	5,080	478,398
Other designated bodies	713,627	89,249	120,040	922,916
Net Book Value at 31 March 2016	**1,185,230**	**90,964**	**125,120**	**1,401,314**

The ranges of estimated useful lives are currently:

- Software licences and Internally Developed Software: 1 - 21 years
- Development expenditure: 1 - 99 years
- Other (licences and trademarks, patents, purchased software etc): 1 - 15 years

The Departmental Group revalues intangible non-current assets associated with Informatics programmes at the end of each financial year, by indexing their original cost using appropriate indices. This valuation method is reviewed annually.

Informatics non-current assets (whether classified as property, plant and equipment or intangible assets) are not added to the relevant organisation's Non-Current Asset Register until confirmation has been received from the appropriate NHS organisation that the relevant system has been deployed successfully.

8. Impairments

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Impairments charged to Consolidated Statement of Comprehensive Net Expenditure				
Property Plant and Equipment impairments	35,245	1,340,841	104,713	1,039,948
Intangible asset impairments	-	19,771	-	13,362
Financial asset impairments	755	19,806	462	6,305
Non Current Assets Held for Sale impairments	-	4,666	40	3,674
Total impairments charged to Consolidated Statement of Comprehensive Net Expenditure	**36,000**	**1,385,084**	**105,215**	**1,063,289**
Impairments charged to Revaluation Reserve				
Property Plant and Equipment impairments	-	1,216,119	1,273	1,118,585
Intangible asset impairments	3,416	6,433	-	309
Financial asset impairments	13,402	13,402	92	92
Total impairments charged to Revaluation Reserve	**16,818**	**1,235,954**	**1,365**	**1,118,986**
Impairments charged to General Fund				
PDC impairments	65,634	-	-	-
Total impairments charged to General Fund	**65,634**	**-**	**-**	**-**
Total impairments charged in year	**118,452**	**2,621,038**	**106,580**	**2,182,275**

9. Commitments

9.1 Capital Commitments

This note discloses commitments to future capital expenditure, not otherwise disclosed elsewhere in the financial statements. Included within capital commitments are non-cancellable contracts and purchase orders which commit the Departmental Group to capital expenditure in a future period. Commitments to expenditure under other forms of agreement such as Memorandums of Understanding may be considered as a capital commitment if they, in exceptional circumstances, effectively commit the Department to the expenditure as it would be reputationally or politically damaging for the Department to withdraw from the agreement. Any future capital funding within the Department's accounting boundary does not represent a capital commitment.

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Contracted capital commitments at 31 March not otherwise included in these financial statements				
Property, plant and equipment	33,604	1,530,895	161,552	1,855,257
Intangible non-current assets	67,522	144,544	46,495	114,321
	101,126	**1,675,439**	**208,047**	**1,969,578**

9.2 Commitments under leases

9.2.1 Operating lease payments

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	5,296	-	5,110
Later than 1 year and not later than 5 years	-	9,040	-	11,453
Later than 5 years	-	15,640	-	16,713
	-	**29,976**	**-**	**33,276**
Buildings:				
Not later than 1 year	18,832	298,262	17,425	334,112
Later than 1 year and not later than 5 years	38,294	796,646	21,308	903,258
Later than 5 years	48,475	1,009,937	1,350	1,039,260
	105,601	**2,104,845**	**40,083**	**2,276,630**
Other:				
Not later than 1 year	204	186,590	94	186,789
Later than 1 year and not later than 5 years	193	304,703	110	302,290
Later than 5 years	-	42,498	-	36,440
	397	**533,791**	**204**	**525,519**

1. Operating lease commitments between bodies with the Departmental Group are eliminated upon consolidation.

9.2.2 Operating Lease receipts

Total future minimum lease receipts under operating leases are given in the table below for each of the following periods.

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	2,470	-	2,117
Later than 1 year and not later than 5 years	-	9,219	-	8,149
Later than 5 years	-	143,925	-	127,034
	-	**155,614**	**-**	**137,300**
Buildings:				
Not later than 1 year	13,572	75,900	17,662	75,794
Later than 1 year and not later than 5 years	35,521	244,709	41,327	250,087
Later than 5 years	25,500	561,727	42,782	604,193
	74,593	**882,336**	**101,771**	**930,074**
Other:				
Not later than 1 year	-	25,309	-	38,675
Later than 1 year and not later than 5 years	-	32,142	-	46,323
Later than 5 years	-	74,052	-	102,400
	-	**131,503**	**-**	**187,398**

1. Future minimum lease receipts under operating leases between bodies with the Departmental Group are eliminated upon consolidation.

9.2.3 Finance lease payments

Total future minimum lease payments under finance leases are given in the table below for each of the following periods.

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Obligations under finance leases for the following periods comprise:				
Land:				
Not later than 1 year	-	295	-	289
Later than 1 year and not later than 5 years	-	1,225	-	1,150
Later than 5 years	-	3,658	-	3,935
	-	**5,178**	**-**	**5,374**
Less interest element	-	(3,268)	-	(3,394)
Present Value of obligations	**-**	**1,910**	**-**	**1,980**
Buildings:				
Not later than 1 year	-	44,586	-	50,931
Later than 1 year and not later than 5 years	-	177,165	-	162,061
Later than 5 years	-	518,743	-	538,562
	-	**740,494**	**-**	**751,554**
Less interest element	-	(332,756)	-	(349,006)
Present Value of obligations	**-**	**407,738**	**-**	**402,548**
Other:				
Not later than 1 year	3,418	47,912	4,557	45,456
Later than 1 year and not later than 5 years	-	107,064	2,451	96,519
Later than 5 years	-	24,920	-	31,219
	3,418	**179,896**	**7,008**	**173,194**
Less interest element	(196)	(24,609)	(643)	(27,182)
Present Value of obligations	**3,222**	**155,287**	**6,365**	**146,012**

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Present Value of obligations under finance leases for the following periods comprise:				
Land:				
Not later than 1 year	-	67	-	76
Later than 1 year and not later than 5 years	-	483	-	406
Later than 5 years	-	1,360	-	1,498
Total Present Value of obligations	**-**	**1,910**	**-**	**1,980**
Buildings:				
Not later than 1 year	-	17,864	-	24,934
Later than 1 year and not later than 5 years	-	79,028	-	66,744
Later than 5 years	-	310,846	-	310,870
Total Present Value of obligations	**-**	**407,738**	**-**	**402,548**
Other:				
Not later than 1 year	3,222	41,390	4,111	38,517
Later than 1 year and not later than 5 years	-	91,198	2,254	80,168
Later than 5 years	-	22,699	-	27,327
Total Present Value of obligations	**3,222**	**155,287**	**6,365**	**146,012**

1. Finance lease commitments between bodies with the Departmental Group are eliminated upon consolidation.

9.2.4 Finance lease receivables

Total future minimum lease payments receivable under finance leases are given in the table below for each of the following periods.

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Gross investments in leases:				
Not later than 1 year	-	1,001	-	1,331
Later than 1 year and not later than 5 years	-	554	-	3,806
Later than 5 years	-	2,345	-	18,859
Less future finance income	-	(1,593)	-	(10,758)
Present Value of minimum lease payments	**-**	**2,307**	**-**	**13,238**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**-**	**2,307**	**-**	**13,238**
Present Value of minimum lease payments:				
Not later than 1 year	-	961	-	683
Later than 1 year and not later than 5 years	-	395	-	1,347
Later than 5 years	-	951	-	11,208
Total Present Value of minimum lease payments	**-**	**2,307**	**-**	**13,238**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**-**	**2,307**	**-**	**13,238**
included in:				
Current finance lease receivables	-	961	-	694
Non-current finance lease receivables	-	1,346	-	12,544
Sub total	**-**	**2,307**	**-**	**13,238**

1. Future minimum lease receipts under finance leases between bodies with the Departmental Group are eliminated upon consolidation.

9.3 Commitments under PFI and LIFT contracts

PFI contracts are held by NHS Property Services Ltd, NHS Trusts and NHS Foundation Trusts. LIFT contracts are held by Community Health Partnerships Ltd and NHS Trusts. Details of PFI and LIFT contracts in respect of each of the following categories are recorded in the individual accounts of relevant NHS Trusts, NHS Foundation Trusts, NHS Property Services Ltd and Community Health Partnerships Ltd.

9.3.1 NHS LIFT schemes deemed to be off-Statement of Financial Position

In this financial year, Community Health Partnerships Ltd reported one off-Statement of Financial Position LIFT scheme with an estimated capital value of £0.9 million (2015-16: one scheme, £0.9 million). The assets which make up this capital value were not assets of Community Health Partnerships Ltd.

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Obligations on off-Statement of Financial Position LIFT schemes for the following periods comprise:				
Not later than 1 year	-	77	-	74
Later than 1 year and not later than 5 years	-	329	-	314
Later than 5 years	-	4,213	-	4,382
	-	**4,619**	**-**	**4,770**

9.3.2 NHS LIFT schemes deemed to be on-Statement of Financial Position

Community Health Partnerships Ltd

In this financial period Community Health Partnerships Ltd reported 295 on-Statement of Financial Position LIFT schemes. (2015-16: 295). The substance of each contract is that Community Health Partnerships Ltd has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The amount included within operating expenses for off-balance sheet PFI transactions and the service element of on-balance sheet PFI transactions is £48.4 million (2015-16: £47.5 million).

NHS Trusts & NHS Foundation Trusts

In this financial year, 2 NHS Trusts (NHST) and 4 NHS Foundation Trusts (NHSFT) (2015-16: 4 NHSTs, 2 NHSFTs), reported on-Statement of Financial Position LIFT schemes. The assets of these schemes are treated as assets of the trusts. The substance of each contract is that the Trust has a finance lease and payments comprise an imputed finance lease charge and a service charge. Details of the individual LIFT schemes are included in the accounts of each NHST/NHSFT.

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

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total obligations under on-Statement of Financial Position LIFT schemes for the following periods comprise:				
Not later than 1 year	-	166,794	-	167,772
Later than 1 year and not later than 5 years	-	652,562	-	649,030
Later than 5 years	-	2,877,505	-	3,017,678
	-	**3,696,861**	**-**	**3,834,480**
Less interest element	-	(1,875,215)	-	(1,974,920)
Present Value of obligations	**-**	**1,821,646**	**-**	**1,859,560**

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Present Value of obligations under on-Statement of Financial Position LIFT schemes for the following periods comprise:				
Not later than 1 year	-	36,256	-	37,005
Later than 1 year and not later than 5 years	-	154,606	-	149,611
Later than 5 years	-	1,630,784	-	1,672,944
Total Present Value of obligations	**-**	**1,821,646**	**-**	**1,859,560**

9.3.3 Charges to the Consolidated Statement of Comprehensive Net Expenditure in respect of NHS LIFT Contracts

The total charges in the period to expenditure in respect of off-Statement of Financial Position NHS LIFT contracts and the service element of on-Statement of Financial Position NHS LIFT contracts was £51.1 million (2015-16: £49.6 million).

Community Health Partnerships Ltd, NHS Trusts and NHS Foundation Trusts with NHS LIFT contracts are committed to the following total charges:

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	52,639	-	51,176
Later than 1 year and not later than 5 years	-	225,582	-	220,349
Later than 5 years	-	834,660	-	891,922
	-	**1,112,881**	**-**	**1,163,447**

9.3.4 PFI Schemes deemed to be off-Statement of Financial Position NHS Trusts & NHS Foundation Trusts

In this financial year 2 NHS Trusts and 5 NHS Foundation Trusts reported off-Statement of Financial Position PFI schemes (2015-16: 2 NHS Trusts, 5 NHS Foundation Trusts).

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Obligations on off-Statement of Financial Position PFI schemes for the following periods comprise:				
Not later than 1 year	-	5,144	-	1,133
Later than 1 year and not later than 5 years	-	20,567	-	4,696
Later than 5 years	-	34,157	-	7,673
	-	**59,868**	**-**	**13,502**

9.3.5 NHS PFI schemes deemed to be on-Statement of Financial Position

NHS Property Services Ltd

In this financial period NHS Property Services Ltd reported 26 on-Statement of Financial Position PFI schemes (2015-16: 26 schemes). The amount included in the Consolidated Statement of Comprehensive Net Expenditure in respect of off-Statement of Financial Position PFI transactions and the service element of on-Statement of Financial Position PFI transactions is £26.6 million (2015-16: £28.5 million).

NHS Trusts

In this financial year, 40 NHS Trusts reported on-Statement of Financial Position PFI Schemes (2015-16: 49 NHS Trusts). The assets of these schemes are treated as assets of the NHS Trust. The substance of each contract is that the Trust has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The amount included within operating expenses in respect of off-Statement of Financial Position PFI transactions and the service element of the on-Statement of Financial Position PFI transactions is £385.4 million. (2015-16: £410.1 million).

NHS Foundation Trusts

The assets of these schemes are treated as assets of the NHS Foundation Trust. The substance of each contract is that the organisation has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The total amount charged in the Consolidated Statement of Comprehensive Net Expenditure in respect of off-Statement of Financial Position PFI transactions and the service element of on-Statement of Financial Position PFI transactions is £482.2 million. (2015-16: £460.5 million).

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total obligations under on-Statement of Financial Position PFI schemes or other service concession arrangements for the following periods comprise:				
Not later than 1 year	-	861,321	-	857,311
Later than 1 year and not later than 5 years	-	3,366,438	-	3,368,870
Later than 5 years	-	14,625,174	-	15,373,699
	-	**18,852,933**	**-**	**19,599,880**
Less interest element	-	(9,199,731)	-	(9,710,197)
Present Value of obligations	**-**	**9,653,202**	**-**	**9,889,683**

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Present Value of obligations under on-Statement of Financial Position PFI schemes or other service concession arrangements for the following periods comprise:				
Not later than 1 year	-	269,318	-	258,233
Later than 1 year and not later than 5 years	-	1,173,324	-	1,125,838
Later than 5 years	-	8,210,560	-	8,505,612
Total Present Value of obligations	**-**	**9,653,202**	**-**	**9,889,683**

9.3.6 Charges to the Consolidated Statement of Comprehensive Net Expenditure in respect of NHS PFI contracts

The total amount charged in the Consolidated Statement of Comprehensive Net Expenditure in respect of off-Statement of Financial Position NHS PFI schemes and the service element of on-Statement of Financial Position NHS PFI schemes was £894.1 million. (2015-16: £899.1 million).

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	875,898	-	892,510
Later than 1 year and not later than 5 years	-	3,580,918	-	3,711,135
Later than 5 years	-	18,322,339	-	20,826,482
	-	**22,779,155**	**-**	**25,430,127**

9.4 Other Financial Commitments

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	1,711,732	2,126,917	2,173,268	2,576,761
Later than 1 year and not later than 5 years	1,780,927	2,638,069	1,056,188	1,845,033
Later than 5 years	127,880	303,453	5,580	378,805
	3,620,539	**5,068,439**	**3,235,036**	**4,800,599**

This note discloses commitments to future expenditure, not otherwise disclosed elsewhere in the financial statements. Included within other financial commitments are non-cancellable contracts and purchase orders which commit the Departmental group to revenue expenditure in a future period. Commitments to expenditure under other forms of agreement such as Memorandums of Understanding may be considered as commitments if they would be reputational or politically damaging for Departmental group bodies to withdraw from the agreement. Any future funding within the Department's accounting boundary does not represent a financial commitment.

In this financial year, the Department has committed expenditure of £2,112.5 million (2015-16: £1,570.5 million) on Research and Development contracts. These contracts are with a number of NHS organisations, universities and private research organisations. The purpose of research and development arrangements varies from the development of the health research workforce and research infrastructure in the NHS and the provision of research support by the NHS to specific research programmes or projects. The overall purpose of the work is to develop an evidence base for improved health care, public health and social care, so leading to better health outcomes, and also promoting economic growth.

Additionally, the Department has entered into a new contract for 2016-17 to support low and middle income countries (LMICs) in tackling antimicrobial resistance (AMR). This has resulted in financial commitments of £231 million (2015-16: £Nil) over the next 4 years.

10. Financial Instruments

As the cash requirements of the Department are met through the Estimates process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body of a similar size.

The Department's investments in NHS Trusts, NHS Foundation Trusts and the Medicines & Healthcare Products Regulatory Agency are represented by Public Dividend Capital (PDC) which, being issued under statutory authority, is not classed as being a financial instrument.

Currency Risk

The Department undertakes certain transactions denominated in foreign currencies, the vast majority of which are transactions relating to European Economic Area (EEA) medical costs.

Due to the lead time in the submission of medical cost claims by member states (as per current EU regulations), the Department estimates annual medical costs and adjusts future years' expenditure when actual costs arise (are claimed). Estimated costs are converted into sterling at average rates calculated using EU published rates. Payments made are valued at prevailing exchange rates. Amounts in the Statement of Financial Position at year-end are converted at the exchange rate ruling at the Statement of Financial Position date, with any exchange rate gains or losses calculated in accordance with accepted accounting practice.

The NHS sector is made up principally of domestic organisations with the great majority of transactions, assets and liabilities being in the UK and sterling based. Exposure to currency rate fluctuations is therefore low.

Liquidity Risk

The income within the Department of Health Group mostly originates from Central Government and remains within the group. Due to the continuing service provider relationship that health bodies have with each other, they are not exposed to the degree of financial risk faced by business entities. NHS Trusts and Foundation Trusts, for example, generate their income from contractual arrangements with their commissioners based either on a tariff for services performed or on assumptions for the amount of work to be carried out.

Interest Rate Risk

The Departmental Group has limited exposure to Interest Rate Risk.

NHS Trusts and NHS Foundation Trusts borrow from government for capital expenditure and working capital requirements for the normal course of business, subject to affordability. These can take the form of either term loans or maturity loans. The borrowings are for 1 – 25 years for capital borrowings and 1 – 7 years for working capital borrowings. Interest is charged at the National Loans rate prevailing on the date of signing the loan agreement, and the rate is fixed for the life of the loan. NHS Trusts and NHS Foundation Trusts therefore have low interest rate fluctuations. NHS Foundation Trusts have the power to enter into loans and working capital facilities with commercial lenders should they wish but they are required to maintain total borrowing within a limit determined by Monitor.

Credit risk

The vast majority of the Departmental Group's income is generated from public sector bodies and as such is exposed to low credit risk.

From a Core Department perspective, no loans to NHS Trusts or NHS Foundation Trusts have been written off since the re-introduction of loan financing for NHS providers in 2004. The financial performance of NHS Trusts and NHS Foundation Trusts is rigorously managed by NHS Improvement.

11. Financial Assets – Investments

	2016-17 £'000								2016-17 £'000			
	Core Dept & Agencies								Departmental Group			
	NHS Trusts		NHS Foundation Trusts		Other Bodies			Total	Other Bodies			Total
	PDC	Loans	PDC	Loans	PDC	Loans	Share Capital		PDC	Loans	Share Capital and Other Investments	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2016	**11,121,752**	**1,889,603**	**14,710,672**	**3,128,620**	**1,328**	**602,872**	**684,140**	**32,138,987**	**1,328**	**683,120**	**310,595**	**995,043**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	-	-	(800)	(800)
Issued	287,986	2,217,153	180,385	1,934,808	-	31,931	67,928	4,720,191	-	31,931	47,561	79,492
Disposals[1]	-	-	-	-	-	-	-	-	-	-	(80)	(80)
Repaid[2]	(23,725)	(570,416)	(5,733)	(488,432)	-	(181,794)	-	(1,270,100)	-	(181,794)	(1,172)	(182,966)
Transfers to and from current receivables	-	(165,258)	-	(463,068)	-	(17,477)	-	(645,803)	-	(7,477)	-	(7,477)
Written off	(4,814)	-	(1,444)	-	-	(269)	-	(6,527)	-	(269)	-	(269)
Revaluation	-	-	-	-	-	-	-	-	-	-	-	-
Changes in fair value through CSCNE	-	-	-	-	-	-	-	-	-	-	295	295
Impairments and reversals	(63,190)	-	(2,444)	-	-	(38)	(13,908)	(79,580)	-	1,663	(34,660)	(32,997)
Reclassifications	(61,840)	(6,608)	61,840	6,608	-	(130,161)	(54,791)	(184,952)	-	(130,161)	(54,791)	(184,952)
Transfers	-	-	-	-	-	-	-	-	-	-	-	-
Other movements	(9,486)	(8,535)	9,669	8,535	-	-	7,600	7,783	-	-	18,053	18,053
Balance at 31 March 2017	**11,246,683**	**3,355,939**	**14,952,945**	**4,127,071**	**1,328**	**305,064**	**690,969**	**34,679,999**	**1,328**	**397,013**	**285,001**	**683,342**

Investments held by Core Dept & Agencies	34,679,999
Less elimination of intra-group investments	(34,263,304)
Investments held by other designated bodies	266,647
Total	**683,342**

1. The issued line records the full value of all new loans let in-year. These loans will comprise a current and non-current element, with the current element being immediately transferred to receivables via the Transfers to and from current receivables line.

2. The Repaid line records repayments of non-current amounts: i.e. repayments of amounts in advance of the date specified in the relevant loan agreements/schedules. The repayment of the current element of financial assets is accounted for in the receivables note.

	2015-16 £'000								2015-16 £'000			
	Core Dept & Agencies								Departmental Group			
	NHS Trusts		NHS Foundation Trusts		Other Bodies		Total		Other Bodies		Total	
	PDC	Loans	PDC	Loans	PDC	Loans	Share Capital		PDC	Loans	Share Capital and Other Investments	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2015	**11,255,039**	**564,321**	**14,352,902**	**2,111,606**	**1,328**	**618,983**	**615,409**	**29,519,588**	**1,328**	**781,564**	**264,002**	**1,046,894**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	-	-	1	1
Issued	291,220	2,139,870	166,218	1,637,403	-	120,717	69,001	4,424,429	-	60,995	50,937	111,932
Disposals	-	-	-	-	-	-	-	-	-	-	(6,197)	(6,197)
Repaid	(129,254)	(743,966)	(103,355)	(437,147)	-	(492)	-	(1,414,214)	-	(121,124)	(1,047)	(122,171)
Transfers to and from current receivables	-	(67,023)	-	(186,841)	-	(135,741)	-	(389,605)	-	(35,741)	-	(35,741)
Written off	-	-	(346)	-	-	(400)	-	(746)	-	(400)	-	(400)
Revaluation	-	-	-	-	-	-	92	92	-	-	92	92
Changes in fair value through CSCNE	-	-	-	-	-	-	-	-	-	-	879	879
Impairments and reversals	-	-	-	-	-	(195)	(362)	(557)	-	(2,174)	(4,226)	(6,400)
Reclassifications	(242,694)	(3,599)	242,694	3,599	-	-	-	-	-	-	-	-
Transfers	-	-	-	-	-	-	-	-	-	-	-	-
Other Movements	(52,559)	-	52,559	-	-	-	-	-	-	-	6,154	6,154
Balance at 31 March 2016	**11,121,752**	**1,889,603**	**14,710,672**	**3,128,620**	**1,328**	**602,872**	**684,140**	**32,138,987**	**1,328**	**683,120**	**310,595**	**995,043**

Investments held by Core Dept & Agencies	32,138,987
Less elimination of intra-group investments	(31,392,543)
Investments held by other designated bodies	248,599
Total	**995,043**

The Department's PDC investment in, and loans to, NHS Trusts and NHS Foundation Trusts eliminate on consolidation, and so are not shown as consolidated Departmental group investments as they are not with bodies external to the Group. With the exception of MHRA, PDC is only issued to bodies within the Departmental Group.

Community Health Partnerships Ltd, NHS Property Services Ltd and Genomics England Ltd are consolidated into the Departmental accounts; therefore the investment by the Core Department in these companies are eliminated from the Departmental Group figures.

The Department's Share Capital investments are measured at fair value. Where the difference between fair value and depreciated historic cost is insignificant, the Department may use depreciated historic cost as a proxy, for example the valuation of MHRA.

The Department reviews the values of its financial investments each year with independent valuations carried out at intervals of no more than three years. The Department's investments in Naga UK Topco Ltd, NHS Shared Business Services, NHS Professionals and Community Health Partnerships Ltd were all last subject to independent valuations in 2014-15. The holding values in the 2016-17 accounts were subject to internal review by assessing changes to the factors underpinning the prior year independent valuations and were found to remain appropriate.

Credit Guarantee Finance (CGF) is a loan guaranteed by banks, monolines or other acceptable financial institutions, provided by the sponsoring Department to a PFI project Special Purpose Vehicle on 'market' terms. Aside from the two pilot CGF loans with NHS PFI projects in Leeds and Portsmouth, the Department does not expect to undertake any further CGF loans. During 2016-17 the Leeds loan was repaid in full (£181.3m)

During 2016-17, the Department increased its shareholding in Genomics England Ltd by £40.0 million, by £6.3 million in Community Health Partnerships, by £2.4 million in NHS Property Services and by £0.4 million in Dementia Discovery Fund.

The Department's investment in Naga UK Topco Ltd was reclassified to assets held for sale (£130.2m loans and £5.5m share capital) and subsequently sold during the year. The profit on disposal was £122.0m.

Investments held by other NHS bodies in 2016-17

The Departmental Group figure for loans to other bodies at 31 March 2017 contains a £91.9 million (2015-16 £90.0 million) working capital loan made by NHS Business Services Authority in support of the outsourcing Supply Chain arrangement. The primary purpose of the working capital loan is to facilitate aggregated capital purchases (and cost savings) for the NHS. Further details relating to investments can be found in the accounts of underlying bodies.

Financing of NHS Trusts and NHS Foundation Trusts

The Department has two means of financing NHS Trusts and NHS Foundation Trusts:

1. **Public Dividend Capital (PDC)** – issued as either structural capital when NHS Trusts are established, or when the Department needs to provide additional financing to NHS Trusts or NHS Foundation Trusts after establishment; and
2. **Loans** – normally made under standard government loan terms, i.e. 6 monthly equal instalments of principal and interest charged on outstanding balances. The primary exception is the Department's new revolving working capital loan facilities under which the full obligation for providers to repay the loans falls due at the end of the loan term. National Loan fund rates of interest (as published by the UK Debt Management Office) are applied.

PDC is held at historic value less impairments. With the exception of loans from DH to NHS bodies, loans are held at amortised cost using the effective interest rate method, less impairments. In the case of loans from DH to NHS bodies, neither party is involved in trading its interest in the loan and as such these loans are measured at historic cost with any unpaid interest at the reporting date accrued separately and not added to the carrying value of the loan. The Department judges that there is no material credit risk associated with either form of investment. The financial performance of NHS Trusts and NHS Foundation Trusts is rigorously managed by NHS Improvement (umbrella organisation of the NHS Trust Development Authority and the independent regulator Monitor), not least through their respective powers of intervention. No loans to NHS Trusts or NHS Foundation Trusts have been written off since the re-introduction of loan financing for NHS providers in 2004.

In March 2015 the Department introduced a new range of interest bearing debt options for interim support to trusts in financial difficulty. These debt options have replaced revenue Public Dividend Capital (PDC) which was seen as a form of free non-repayable cash. This move should incentivise the development and implementation of sustainable recovery plans to a point where existing debt can be serviced. Conditions are also attached requiring trust participation in central savings initiatives, e.g. surplus land disposal and caps on agency spend.

In 2014-15, around 65% of all interim support was issued as revenue PDC whereas in 2015-16 this level fell significantly leaving only a few exceptions; a trend continued in 2016-17. Despite the change, PDC is still issued as financing for central strategic capital and potentially as planned support where trusts have a robust recovery plan in place.

The repayments of NHS provider loans shown in this note represent repayments of non-current amounts. This reflects the nature of the Department's new revolving working capital loan facilities under which the full obligation for providers to repay the loans falls due at the end of the loan term. As a result there is no annual transfer to receivables of amounts expected within the next 12 months, and any repayments received before the end of the loan term are classed as non-current repayments.

12. Inventories and work in progress

	Departmental Group 2016-17					
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2016	**175,157**	**-**	**321,651**	**672,362**	**53,013**	**1,222,183**
Prior period adjustments in underlying accounts	-	-	366	14	438	818
Additions	359,239	-	5,934,712	3,334,044	208,026	9,836,021
Consumed/Disposed of	(391,470)	(55,528)	(5,926,356)	(3,292,113)	(194,317)	(9,859,784)
Written down charged to CSCNE	(2,217)	-	(7,554)	(2,563)	(313)	(12,647)
Transfer (to) / from non-current assets	-	55,528	-	-	358	55,886
Transfers	-	-	-	-	-	-
Reclassification	-	-	-	-	-	-
Other	-	-	-	-	-	-
Balance at 31 March 2017	**140,709**	**-**	**322,819**	**711,744**	**67,205**	**1,242,477**

Analysis of Inventories

Of the total:	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Core Dept & Agencies	140,709	-	-	4,134	-	144,843
Other designated bodies	-	-	322,819	707,610	67,205	1,097,634
	140,709	**-**	**322,819**	**711,744**	**67,205**	**1,242,477**

	Departmental Group 2015-16					
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2015	**135,005**	**-**	**316,373**	**554,415**	**47,577**	**1,053,370**
Prior period adjustments in underlying accounts	-	-	-	(1)	(1)	(2)
Additions	418,017	-	5,568,890	3,158,236	232,004	9,377,147
Consumed/Disposed of	(364,831)	(1,453)	(5,554,835)	(3,112,847)	(226,688)	(9,260,654)
Written down charged to CSCNE	(13,034)	-	(7,090)	(2,494)	(159)	(22,777)
Transfer (to) / from non-current assets	-	1,453	-	-	280	1,733
Transfers	-	-	(1,687)	75,098	-	73,411
Reclassification	-	-	-	-	-	-
Other	-	-	-	(45)	-	(45)
Balance at 31 March 2016	**175,157**	**-**	**321,651**	**672,362**	**53,013**	**1,222,183**

Analysis of Inventories

Of the total:	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Core Dept & Agencies	175,157	-	-	4,122	-	179,279
Other designated bodies	-	-	321,651	668,240	53,013	1,042,904
	175,157	**-**	**321,651**	**672,362**	**53,013**	**1,222,183**

13. Cash and cash equivalents

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Balance at 1 April 2016	**2,804,309**	**7,680,408**	**1,487,377**	**6,977,058**
Net change in cash	(927,235)	(891,122)	1,316,932	703,350
Balance at 31 March 2017	**1,877,074**	**6,789,286**	**2,804,309**	**7,680,408**
The following balances at 31 March were held at:				
Government Banking Service	1,875,958	5,977,551	2,803,635	6,689,983
Commercial banks and cash in hand	1,116	319,518	674	351,418
Short term investments	-	492,217	-	639,007
Balance at 31 March 2017	**1,877,074**	**6,789,286**	**2,804,309**	**7,680,408**

14. Trade Receivables and other current assets

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade receivables	34,065	445,245	36,404	458,631
Deposits and advances	-	6,472	-	2,443
Capital receivables	-	63,248	-	43,321
Interest receivable	23,705	6,889	103	7,000
Other receivables	127,107	1,499,656	168,408	1,347,302
Trade and other receivables	**184,877**	**2,021,510**	**204,915**	**1,858,697**
Pension prepayments maturing in one year	-	-	-	-
Consolidated Fund Extra Receipts receivable	-	-	-	-
Other prepayments and accrued income	206,580	1,613,652	380,396	1,522,771
Current part of PFI and other service concession arrangements prepayments	-	138,714	-	116,378
Capital Prepayments[1]	-	38,286	-	-
Other current assets	-	11,526	-	5,598
Other current assets	**206,580**	**1,802,178**	**380,396**	**1,644,747**
Current part of loans repayable transferred from investments	862,497	5,261	599,357	36,168
Other current financial assets	-	15,000	-	5,000
Other financial assets	**862,497**	**20,261**	**599,357**	**41,168**
Total current receivables	**1,253,954**	**3,843,949**	**1,184,668**	**3,544,612**
Amounts falling due after more than one year:				
Trade receivables	-	13,666	-	40,597
Deposits and advances	-	-	-	-
Capital receivables	-	24,961	-	10,359
Other receivables	150,893	359,667	134,374	274,198
Interest Receivable	-	-	-	-
Pension prepayments maturing after one year	-	-	-	-
Other Prepayments and accrued income	-	65,521	-	124,946
Non-current part of PFI and other service concession arrangements prepayments	-	83,424	-	171,469
Capital Prepayments[1]	-	102,946	-	-
Total non-current receivables	**150,893**	**650,185**	**134,374**	**621,569**
Total receivables at 31 March 2017	**1,404,847**	**4,494,134**	**1,319,042**	**4,166,181**

1. Capital Prepayments lines are new for 2016-17. Figures shown in these lines in 2016-17 will have been recognised against other receivables categories in 2015-16.

15. Trade payables and other current liabilities

	2016-17 £'000		2015-16 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade payables	33,462	3,139,541	40,032	3,208,649
Capital payables	103,837	710,629	60,498	626,211
Other payables	6,698	1,510,386	19,676	1,270,576
Trade and other payables	**143,997**	**5,360,556**	**120,206**	**5,105,436**
Bank Overdraft	-	17,088	-	14,480
VAT	-	11,938	-	13,168
Other taxation and social security	1,849	1,120,888	2,355	935,391
Early retirement costs payable within one year	-	105	-	112
EEA Medical Costs Accrual	459,364	459,364	248,759	248,759
Other accruals	301,412	6,902,147	305,346	7,056,595
Deferred income	71,665	697,107	69,374	641,977
Current part of finance lease	3,222	59,321	4,111	63,527
Current part of imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	313,114	-	294,735
Amount issued from the Consolidated Fund for supply but not spent at year end	2,086,363	2,086,363	2,935,817	2,935,817
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received	1	1	106	106
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Receivable	-	-	-	-
Other amount payable to the Consolidated Fund	-	-	-	-
Current loans payable by NHS Trusts and Foundation Trusts to entities outside the accounting boundary	-	18,742	-	12,215
Pension liabilities	-	100,654	-	99,487
Other current liabilities	-	20,624	-	12,265
Other liabilities	**2,923,876**	**11,807,456**	**3,565,868**	**12,328,634**
Total current payables	**3,067,873**	**17,168,012**	**3,686,074**	**17,434,070**
Amounts falling due after more than one year:				
Finance leases	-	505,614	2,254	487,013
Imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	11,155,186	-	11,439,414
Pension liabilities	-	102	-	230
Financial liabilities	**-**	**11,660,902**	**2,254**	**11,926,657**
Trade payables	-	12,134	-	6,638
EEA Medical Costs Accrual	-	-	150,484	150,484
Other accruals	9,892	18,400	-	11,898
Capital payables	-	2,972	-	4,303
Other payables	-	43,072	-	55,389
Deferred income	-	166,123	-	157,414
Non-current loans payable by NHS Trusts and Foundation Trusts to entities outside the accounting boundary	-	174,149	-	161,625
Other payables	**9,892**	**416,850**	**150,484**	**547,751**
Total non-current payables	**9,892**	**12,077,752**	**152,738**	**12,474,408**
Total payables	**3,077,765**	**29,245,764**	**3,838,812**	**29,908,478**

16. Provisions for liabilities and charges

	2016-17					2015-16				
	Core Dept & Agencies					Core Dept & Agencies				
	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2016	**126,217**	**861,855**	**658,044**	**1,079,397**	**2,725,513**	**129,121**	**759,905**	**372,814**	**725,815**	**1,987,655**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	-	-
Provided in the year	5,791	21,367	683,345	213,933	924,436	16,999	35,369	485,892	141,473	679,733
Provisions not required written back	(4,735)	(18,231)	-	(30,130)	(53,096)	(7,946)	(13,883)	-	(46,787)	(68,616)
Transfers	-	-	-	-	-	-	-	-	-	-
Provisions utilised in the year	(12,553)	(50,870)	(169,248)	(53,460)	(286,131)	(13,009)	(52,221)	(31,384)	(44,557)	(141,171)
Transfer to accruals	-	-	(445,246)	-	(445,246)	-	-	(164,123)	-	(164,123)
Borrowing costs (unwinding of discount)	1,716	(7,044)	(10,200)	(7,919)	(23,447)	1,521	11,828	(5,592)	11,353	19,110
Change in discount rate	7,759	29,010	19,806	15,870	72,445	(469)	120,857	437	292,100	412,925
Balance at 31 March 2017	**124,195**	**836,087**	**736,501**	**1,217,691**	**2,914,474**	**126,217**	**861,855**	**658,044**	**1,079,397**	**2,725,513**

	Early departure costs	Injury Benefits	EEA medical costs	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current	12,623	51,431	260,656	326,632	651,342	12,672	52,147	236,530	235,530	536,879
Non Current	111,572	784,656	475,845	891,059	2,263,132	113,545	809,708	421,514	843,867	2,188,634
Expected timing of cash flow										
Not later than 1 year	12,623	51,431	260,656	326,632	651,342	12,672	52,147	236,530	235,530	536,879
Later than 1 year, not later than 5 years	48,839	220,224	475,845	158,354	903,262	48,860	216,773	421,514	149,712	836,859
Later than 5 Years	62,733	564,432	-	732,705	1,359,870	64,685	592,935	-	694,155	1,351,775
Total	**124,195**	**836,087**	**736,501**	**1,217,691**	**2,914,474**	**126,217**	**861,855**	**658,044**	**1,079,397**	**2,725,513**

	2016-17						2015-16					
	Departmental Group						Departmental Group					
	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
Balance at 1 April 2016	**446,257**	**861,855**	**658,044**	**56,082,162**	**2,692,959**	**60,741,277**	**466,645**	**759,905**	**372,814**	**28,277,786**	**2,613,133**	**32,490,283**
Prior period adjustments in underlying accounts	2,742	-	-	-	6,399	9,141	1,186	-	-	-	534	1,720
Provided in the year[1]	23,760	21,367	683,345	11,668,935	639,504	13,036,911	32,108	35,369	485,892	5,472,291	655,349	6,681,009
Provisions not required written back	(11,860)	(18,231)	-	(1,676,486)	(500,897)	(2,207,474)	(16,813)	(13,883)	-	(1,639,356)	(551,635)	(2,221,687)
Transfers	-	-	-	-	-	-	519	-	-	-	(519)	-
Provisions utilised in the year	(38,334)	(50,870)	(169,248)	(1,707,166)	(384,160)	(2,349,778)	(39,105)	(52,221)	(31,384)	(1,488,454)	(367,489)	(1,978,653)
Transfer to accruals	(2,985)	-	(445,246)	-	(16,561)	(464,792)	(3,120)	-	(164,123)	-	(11,415)	(178,658)
Borrowing costs (unwinding of discount)	5,467	(7,044)	(10,200)	(177,091)	(17,014)	(205,882)	5,975	11,828	(5,592)	46,923	2,140	61,274
Change in discount rate	34,626	29,010	19,806	486,328	75,686	645,456	(1,138)	120,857	437	25,412,972	352,861	25,885,989
Balance at 31 March 2017	**459,673**	**836,087**	**736,501**	**64,676,682**	**2,495,916**	**69,204,859**	**446,257**	**861,855**	**658,044**	**56,082,162**	**2,692,959**	**60,741,277**

	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
Current	41,092	51,431	260,656	2,620,466	980,719	3,954,364	41,447	52,147	236,530	1,760,913	1,114,396	3,205,433
Non Current	418,581	784,656	475,845	62,056,216	1,515,197	65,250,495	404,810	809,708	421,514	54,321,249	1,578,563	57,535,844
Expected timing of cash flow												
Not later than 1 year	41,092	51,431	260,656	2,620,466	980,719	3,954,364	41,447	52,147	236,530	1,760,913	1,114,396	3,205,433
Later than 1 year, not later than 5 years	159,523	220,224	475,845	14,829,681	448,253	16,133,526	157,615	216,773	421,514	10,440,059	559,198	11,795,159
Later than 5 Years	259,058	564,432	-	47,226,535	1,066,944	49,116,969	247,195	592,935	-	43,881,190	1,019,365	45,740,685
Total	**459,673**	**836,087**	**736,501**	**64,676,682**	**2,495,916**	**69,204,859**	**446,257**	**861,855**	**658,044**	**56,082,162**	**2,692,959**	**60,741,277**

1. On 27th February 2017 the Lord Chancellor announced a change to the Personal Injury Discount Rate (PIDR). The Discount rate was lowered from 2.5% to *negative* 0.75%. The new discount rate came into effect on 20th March 2017 and has been applied in calculating the value of Personal Injury provisions. The change in PIDR has contributed to £4,700.0m increase in Clinical Negligence provisions provided for in year.

Discount Rates

Note 1.20 Provisions provides information on the discount rates applied by the Department to expected future cashflows.

HM Treasury's discount rate for long-term provisions is reviewed at the start of each Spending Review period. HM Treasury's discount rates for short-term provisions (with an expected cashflow within 0 to 5 years of the Statement of Financial Position date) and medium-term provisions (with an expected cashflow within 5 to 10 years of the Statement of Financial Position date) are reviewed annually.

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.

NHS England, NHS Foundation Trusts and NHS Trusts retain legal responsibility for all liabilities covered by the clinical negligence schemes: the Ex-Regional Health Authority Scheme (ex RHA), Existing Liabilities Scheme (ELS) and Clinical Negligence Scheme for Trusts (CNST), but NHSR accounts for all the liabilities under these separate schemes. Actuaries appointed by NHSR undertake regular reviews to identify movements in the value of likely future settlements under these schemes, and these are recorded in the NHSR's annual accounts.

Known reported claims are individually valued using likely costs to resolve the claim and probability factors to take account of the potential of a successful defence, whilst incurred but not reported (IBNR) claims are valued using actuarial models to predict likely values. The value of the provision increased by £8,594.5 million in 2016-17 from £56,082.2 million at 31 March 2016 to £64,676.7 million at 31 March 2017. £604.7 million of this increase related to a change in the HMT discount rate. These provisions are also reported in the accounts of NHSR together with other provisions of £321.1 million. These represent the English element of the clinical negligence provision as shown in Whole of Government Accounts.

Due to the long-term nature of the liabilities and the assumptions on which the estimate of the provision is based, some uncertainty about the value of the liability remains. The table below provides a sensitivity analysis to highlight the impact on IBNR provisions were HM Treasury discount rates to be further adjusted by +/- 1.0%. The relationship is not purely linear in all cases, as can be seen by the changes outlined in the table. The clinical negligence provision for IBNR claims recorded in the Statement of Financial Position would reduce by £7,999 million if the discount rate was increased by 1.0%. If the discount rate were to be decreased by 1.0%, the value of IBNR claims would increase by £11,774 million.

Discount rate: sensitivity to change	Estimated IBNR provision £m	Change to original IBNR estimate £m	%
1.0% decrease in the real discount rate	49,232	11,774	31%
Tiered real discount rate structure	37,457	0	0%
1.0% increase in the real discount rate	29,458	(7,999)	-21%

The clinical negligence provision's value is particularly sensitive to changes in the long-term discount rate given its nature. The disclosures above show the impact of a change of 1.0%, however the potential change in the discount rates applied could be significantly more in the

long-term meaning the uncertainty surrounding the valuation of this liability could be significantly greater than the numerical values presented.

Other factors affecting the value of the clinical negligence liability which are subject to estimation and assumption include patterns of delay in reporting incidents, assumptions regarding the severity, frequency and/or value inflation of claims, the differential between Retail Price Index (RPI) and Annual Hourly Earnings index over the long-term and life expectancy.

Clinical negligence claims which may succeed, but are less likely or cannot be reliably estimated, are accounted for as contingent liabilities. (See note 17)

Early Departure

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

Injury Benefits

The Department's Annual Report and Accounts provide for the future costs of permanent Injury Benefits awarded up to April 1997 to NHS staff injured in the course of their duties. From this date, the respective NHS body which employed the injured person has been liable for the costs. The Injury Benefit awards are guaranteed minimum income levels, and are granted for the life of the individual. The award is based on an assessment of the nature of the injury and the effect on the individual's earning capacity which results.

EEA Medical Costs

EEA Medical Costs refer to medical costs incurred by UK Citizens in other European countries which are accounted for as liabilities payable by the UK to those European countries. The obligation to make payment per current EU regulation has not changed in light of the Prime Minister triggering Article 50 in the European Union's (EU) Lisbon Treaty on 29 March 2017.

Other Provisions

These financial statements disclose other provisions of £2,495.9 million, which relate to the following:

NHS Continuing Healthcare

NHS Continuing Healthcare is a package of care arranged and funded by the NHS which can be provided in a range of settings, including a care home or an individual's own home. It is awarded using eligibility criteria depending on whether a person's primary need is a health need. Provisions were previously held with Primary Care Trusts. Following the changes arising from the Health and Social Care Act 2012, these provisions will be accounted for by NHS England Group.

In total, the provision recorded for NHS Continuing Healthcare was £102.5 million, of which £96.0 million was accounted for by NHS England Group. Of the total, £87.8 million was expected to be paid within one year, and £8.2 million between one and five years.

Provision for Support

The Department of Health holds provisions for future support of patients affected by contaminated blood supplies.

The provision for future support of patients who contracted Hepatitis C through blood and blood products in the course of treatment by the NHS totalled £426.2 million of which £15.8 million is expected to be paid within one year, £61.5 million in one to five years and £348.9 million after five years.

The provision for future support of patients who contracted HIV from contaminated blood supplies totalled £208.7 million of which £7.7 million is expected to be paid within one year, £32.3 million in one to five years and £168.7 million after five years.

Other Miscellaneous provisions

The total of other miscellaneous provisions was £1,758.5 million. These relate to a range of issues, including: HGH (human growth hormone), restructuring, redundancy, onerous leases, lease dilapidations and litigation. Of the total other miscellaneous provisions, £868.1 million of payments were expected to be paid within one year, £341.1 million are expected to be paid within one to five years and £549.3 million are expected to be paid in more than 5 years.

16.1 Pensions

Movements in defined benefit obligation and fair value of plan assets

This pension disclosure includes single entity funded defined obligation schemes for Care Quality Commission, a number of NHS Foundation Trusts and NHS England. These are mainly in respect of staff that have transferred from Local Government Pension Schemes to the listed organisations and do not relate to the NHS or Civil Service Pension Schemes disclosed early in the account. Further details can be found in the accounts of these bodies.

Reconciliation of movements in the defined obligation and the fair value of plan assets during the year for the amounts recognised in the Statement of Financial Position:

	2016-17 £'000	2015-16 £'000
Present value of the defined benefit obligation at 1 April 2016	**(578,706)**	**(485,443)**
Prior period adjustments in underlying accounts	-	(101,077)
Current Service Costs	(12,181)	(8,694)
Past Service Costs	(272)	(41)
Interest Costs	(20,334)	(16,237)
Settlements and curtailments	2,157	-
Contribution from scheme members	(3,002)	(2,769)
Remeasurement of the defined benefit obligation:		
Actuarial Gains and (Losses)	(91,026)	29,017
Benefits paid	18,565	14,169
Scheme transfers	-	-
Transfers to/from other bodies	(42,030)	-
Other	(21,545)	(7,631)
As at 31 March 2017	**(748,374)**	**(578,706)**
Plan assets at fair value at 1 April 2016	**484,961**	**396,435**
Prior period adjustments in underlying accounts	(2)	81,412
Interest income	16,961	13,431
Settlements	(1,784)	(2)
Adjustments by the employer	10,668	11,262
Contributions by the plan participants	3,002	2,769
Remeasurement of the defined benefit asset:		
Expected Return on Assets	9,938	6,398
Actuarial Gains and (Losses)	76,283	(14,361)
Changes in the effect of limiting defined benefit asset to the asset ceiling	-	-
Benefits paid	(18,565)	(14,169)
Scheme transfers	-	-
Transfers to/from other bodies	35,318	-
Other	15,815	1,786
As at 31 March 2017	**632,595**	**484,961**
Plan surplus/(deficit) at 31 March 2017	**(115,779)**	**(93,745)**

17. Contingent Assets and Liabilities disclosed under IAS 37

17.1 Contingent Assets

NHS Trusts have contingent assets of £0.7 million (2015-16: £1.2 million). Foundation Trusts have £17.4 million of contingent assets (2015-16: £22.9 million).

17.2 Contingent Liabilities

The contingent liabilities required by IAS37 are detailed below. Further information for all contingent liabilities can be found in the underlying accounts of individual bodies.

Clinical Negligence

The Department is the actual or potential defendant in a number of actions regarding alleged clinical negligence, or liabilities relating to the NHS property or third parties. In some cases, costs have been provided for or otherwise charged to the accounts. In other cases, there is a large degree of uncertainty as to the Department's liability and the amounts involved. Possible total expenditure might be estimated at £35,254.9 million (2015-16: £26,525.5 million), although £33,643.5 million (2015-16: £25,205.1 million) relating to the Clinical Negligence Scheme for Trusts (CNST) would be expected to be met by payments from NHS Trusts.

Other Contingent Liabilities

Within the NHS England Group account (which incorporates Clinical Commissioning Groups and NHS England) at 31 March 2017, there were net contingent liabilities of £43.5 million (2015-16: £34.5 million). These were mainly in respect of continuing care liabilities which transferred from Primary Care Trusts (PCTs) on 1 April 2013.

Injury Benefit Scheme

An investigation into the administration of the Injury Benefits Scheme began in 2006 following a decision by the Pensions Ombudsman. As a result of the review, monies were due to be paid to some 10,000 people who had not received the correct payments due to irregularities in the administration of the Injury Benefits Scheme between 1972 and 2006. Due to difficulties in contacting beneficiaries, it has not been possible to make full payment to all the affected individuals in this financial year. There are still people for whom the Department retains a financial liability but who currently cannot be traced. This financial liability is estimated to be £2.6 million. Although at this stage the Department cannot estimate how many of these claims will be successful or how much benefit will eventually be owed.

Employment Tribunal Cases

The Department is involved in a number of Employment Tribunal cases, following the transfer of functions between the Department and the Departmental Group.

18. Related Party Transactions

Related party transactions associated with the Core Department are disclosed within this note. Details of related party transactions associated with other bodies within the Departmental Group are disclosed in their underlying statutory accounts. As disclosed in Note 21, the Department acts as the parent of the group of organisations (Public Health England, NHS England, Clinical Commissioning Groups, NHS Trusts, NHS Foundation Trusts, Executive Non-Departmental Public Bodies, Special Health Authorities and certain limited companies) whose accounts are consolidated within this Annual Report and Account. It also acts as the sponsor for the trading funds which are not consolidated. These bodies are regarded as related parties with which the Department has had various material transactions during the year.

In addition, the Department had a small number of transactions with other Government Departments and other central Government bodies in 2016-17.

A small number of Ministers, Non-Executive Directors and members of either the Departmental Board, Department of Health Management Committee or the Audit and Risk Committee have connections with a wide range of outside organisations for reasons unrelated to their work in the Department. In the normal course of its business during the year, the Department may enter into business transactions with such outside organisations or related parties. In cases

where an individual within the Department has an outside connection with one of these related parties, the Department is obliged to disclose the extent of its own transactions with those organisations, as set out in the table below:

Individual	DH role	Organisation	Payables with related party 2016-17 £'000	Purchases from related party 2016-17 £'000	Receivables with related party 2016-17 £'000	Sales to related party 2016-17 £'000
Cat Little	Audit &Risk Committee member	Ministry of Justice [1]	-	401	3	78
Phillip Dunne	Minister	Serco PLC [2]	-	3,597	-	4
Professor Chris Whitty	Chief Scientific Advisor	London School of Hygiene & Tropical Medicine [3]	-	184	-	-
Dame Sally Davies	Chief Medical Officer	Cambridge University [4]	-	7,190	-	-
Catherine Bell	Non-Executive Board Member to 31 May 2016	London School of Economics 5	-	5,661	-	-

Sub Note
1. Cat Little is the Group Finance Director for the Ministry of Justice
2. Phillip Dunne's brother in-law is the CEO for Serco PLC
3.Professor Chris Whitty is employed by the London School of Hygiene & Tropical Medicine
4. Dame Sally Davies' Husband is an employee of Cambridge University
5. Catherine Bell has a pro bono appointment as Governor of the London School of Economics

The footnotes above identify those individuals with outside connections to the organisations listed in the table. It is important to note that the financial transactions disclosed were between the Department and the named organisation; not the individuals named in the sub-note whom have not benefited from those transactions.

Apart from where disclosed in this note, no other Minister, Board member, member of the key management personnel or other related party has undertaken any material transactions with the Department during the year. Compensation paid to management, expense allowances and similar items paid in the normal course of business are disclosed in the notes to the accounts and in the Remuneration Report.

The Department had the following transactions with NHS Shared Business Services, an equity investment as per note 21:

Related Party Entity	Relationship with DH	Payables with related party 2016-17 £'000	Purchases from related party 2016-17 £'000	Receivables with related party 2016-17 £'000	Sales to related party 2016-17 £'000	Share Capital issued/(repaid) to by related party 2016-17 £'000	Loans issued/(repaid) to by related party 2016-17 £'000
NHS Shared Business Services	DH Equity Investment (50% Shareholding)	109	2,089	21	66	-	(9,700)

19. NHS Charities

Following the inclusion of NHS Charities (as defined by section 149 of the Charities Act 2011) as amended in the 2012 Designation Order, the Department consolidates NHS Charities (with the exception of those with full independent status) into the Consolidated Annual Report and Accounts. This note shows the income, expenditure, assets, liabilities and reserves associated with the NHS Charities sector in isolation. As such the "Total resources expended" figure will not match that in the Consolidated Statement of Comprehensive Net Expenditure, as this statement incorporates the elimination of inter-company trading with other bodies within the

Departmental Group. The inter-company transactions eliminated between NHS Charities and other Group bodies totalled £122.7 million in 2016-17 (£118.0 million in 2015-16).

During 2016-17, eleven NHS Charities with net assets totalling £239.7 million converted to independent status; a change analogous to the loss of control of a subsidiary (as described in IFRS 10).

The net assets of those charities have been derecognised and a corresponding loss recorded (this can be seen in the Resources expended by NHS charities line in the Consolidated Statement of Comprehensive Net Expenditure (CSCNE)).

From a budgetary perspective, HMT have confirmed that effective transfer of assets to a fully independent charity is treated as a capital grant in kind and is removed from resource budget with the expense scored to capital, the corresponding disposal of the same assets generates a capital credit, meaning the net impact on capital budgets is also nil.

19.1 Charitable Income and expenditure for the year ended 31 March 2017

	NHS Charities 2016-17 £'000	NHS Charities 2015-16 £'000
Total resources expended[1]	431,287	1,258,508
Total incoming resources	(207,838)	(227,517)
Net outgoing / (incoming) resources for the year ended 31 March 2017	**223,449**	**1,030,991**
Other Comprehensive Net Expenditure		
Net (gain) / loss on revaluation of charitable assets	(49,705)	8,621
Total Comprehensive Expenditure for the year ended 31 March 2017	**173,744**	**1,039,612**

1. Includes £239.7 million of expenditure representing the loss relating to the net assets transferred outside the Department's accounting boundary for the eleven charities that have gained independent status in the year.

19.2 Summary Charitable Statement of Financial Position as at 31 March 2017

	2016-17 £'000	2015-16 £'000
Non-current assets		
Charitable investments	657,154	832,335
Other charitable non-current assets	106,222	93,080
Total non-current assets	**763,376**	**925,415**
Current assets		
Charitable cash	252,609	285,598
Other charitable current assets	39,699	64,616
Total current assets	**292,308**	**350,214**
Total assets	**1,055,684**	**1,275,629**
Current charitable liabilities	(82,103)	(131,002)
Non-current assets plus/less net current assets/liabilities	**973,581**	**1,144,627**
Non-current charitable liabilities	(17,660)	(16,128)
Assets less liabilities	**955,921**	**1,128,499**
Total charitable reserves	**955,921**	**1,128,499**

19.3 Charitable Financial Assets - Investments

	NHS Charities 2016-17 £'000	NHS Charities 2015-16 £'000
Balance as at 1 April	**832,335**	**1,766,943**
Prior period adjustments in underlying accounts	(11,543)	(12,029)
Acquisitions	86,713	166,810
Disposals	(100,376)	(188,824)
Net gain/loss on revaluation	65,310	(15,692)
Impairment	-	(484)
Transfers[1]	(216,693)	(890,473)
Other movements	1,408	6,084
Balance as at 31 March	**657,154**	**832,335**

1. Includes £217.7 million relating to investments transferred outside the Department's accounting boundary for the eleven charities that have gained independent status in the year.

19.4 Other Charitable Non-Current Assets

	NHS Charities	
	2016-17	2015-16
	£'000	£'000
Balance as at 1 April	**93,080**	**235,454**
Prior period adjustments in underlying accounts	9,879	(562)
Acquisitions	16,489	2,623
Disposals	(3)	(1,102)
Net gain/loss on revaluation	932	7,071
Impairment	(954)	(877)
Transfers[1]	(13,341)	(148,592)
Other movements	140	(935)
Balance as at 31 March	**106,222**	**93,080**

1. Includes £13.3 million relating to Non-Current Assets transferred outside the Department's accounting boundary for the eleven charities that have gained independent status in the year.

20. Events after the Reporting Period

The Accounts were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller & Auditor General.

Following the tragic fire at Grenfell Tower in London on 14 June 2017, the NHS is urgently reviewing fire safety arrangements in all hospitals and a small number of hospital buildings have been found to be potentially in need of remedial work. Further testing is on-going across the NHS estate and whilst the overall financial implications for the Government is currently unknown they will become clear later in the year.

21. Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2016-17.

(a) Consolidated in the Department's Annual Report and Accounts	Website
Supply Financed Agencies	
Public Health England	
Other Bodies	
Clinical Commissioning Groups	Available on the website of the relevant organisation.
NHS Trusts	Available on the website of the relevant organisation.
NHS Foundation Trusts [4]	Available on the website of the relevant organisation. Additionally the Consolidated Account of Foundation Trusts is available at: https://www.gov.uk/government/publications/nhs-foundation-trusts-consolidated-accounts-201415
Skipton Fund Limited	http://www.skiptonfund.org/home.php
NHS Charities[1]	
Health and Care Professions Council [2]	http://www.hcpc-uk.co.uk/
Wiltshire Health and Care LLP [3]	http://wiltshirehealthandcare.nhs.uk/
Community Health Partnerships Limited	http://www.communityhealthpartnerships.co.uk/home-page
The Nursing and Midwifery Council	http://www.nmc.org.uk/
NHS Property Services Limited	http://www.property.nhs.uk/
Genomics England Limited	http://www.genomicsengland.co.uk/
Special Health Authorities	
NHS Business Services Authority	http://www.nhsbsa.nhs.uk/Index.aspx
NHS Resolution [7]	http://www.nhsla.com/Pages/Home.aspx
National Health Service Trust Development Authority [4]	http://www.ntda.nhs.uk/
Executive Non-Departmental Public Bodies	
Human Fertilisation and Embryology Authority	http://www.hfea.gov.uk/index.html
Care Quality Commission	http://www.cqc.org.uk/
Independent Regulator of NHS Foundation Trusts	https://www.gov.uk/government/organisations/monitor
National Institute for Health and Care Excellence	https://www.nice.org.uk/
Professional Standards Authority for Health and Social Care	https://www.professionalstandards.org.uk/home
Human Tissue Authority	https://www.hta.gov.uk/
NHS England [5]	https://www.england.nhs.uk/
NHS Digital[6]	https://digital.nhs.uk/
Health Research Authority	http://www.hra.nhs.uk/
Health Education England	https://hee.nhs.uk/
DH Advisory Committees/Advisory NDPBs	
These advisory bodies/advisory NDPBs are not separate legal entities, rather they are part of the	
Core Department with their associated costs being included within the Core Department account.	
As such, they are not separately consolidated into these financial statements.	
Administration of Radioactive Substances Advisory Committee	
Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection	
Advisory Committee on Clinical Excellence Awards	
Advisory Committee on Dangerous Pathogens (DH)	
Advisory Group on Hepatitis	
Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment	
Committee on the Medical Aspects of Radiation in the Environment	
Committee on the Mutagenicity of Chemicals in Food, Consumer Products and the Environment	
Committee on the Medical Effects of Air Pollutants (DH)	
Expert Advisory Group on AIDS	
Healthwatch England	
Independent Reconfigurations Panel	
Joint Committee on Vaccination and Immunisation	
The NHS Pay Review Body	
Review Body on Doctors' and Dentists' Remuneration	
Scientific Advisory Committee on Nutrition	
(b) Non-Consolidated	Website
Trading Funds	
Medicines & Healthcare Products Regulatory Agency	http://info.mhra.gov.uk/
NHS Blood and Transplant	http://www.nhsbt.nhs.uk/
DH Equity Investments	
NHS Shared Business Services (50% holding)	https://www.sbs.nhs.uk/

1) NHS charities, as defined by section 43 of the Charities Act 1993, with the exception of those with full independent status which are not subject to consolidation.
2) In 2016-17 the ONS classified the Health and Care Professions Council as public sector under the Department of Health. As a result it now falls within the Department's accounting boundary.
3) This is a Joint Venture created in 2016-17 by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust.
4) As of 1 April 2016, Monitor and the NHS Trust Development Authority, operate as a single organisation, NHS Improvement (NHSI) under a shared executive leadership and Board membership.
5) NHS England is the operating name of the NHS Commissioning Board
6) NHS Digital is the operating name of The Health and Social Care Information Centre.
7) NHS Resolution is the operating name of NHS Litigation Authority.

Annexes – Not subject to audit

Annex A – Regulatory Reporting – Government Core Tables

Government Core Tables

The figures in core tables 1 and 2 are from HM Treasury's public expenditure database OSCAR. This is consistent with Treasury publications.

Core Table 1: Public Spending

£'000

	2007-08 Outturn	2008-09 Outturn	2009-10 Outturn	2010-11 Outturn	2011-12 Outturn	2012-13 Outturn	2013-14 Outturn	2014-15 Outturn	2015-16 Outturn	2016-17 Outturn	2017-18 Plans	2018-19 Plans	2019-20 Plans	2020-21 Plans
Original Resource DEL	84,207,717	90,156,640	97,075,200	100,285,421	101,591,758	103,948,229	106,495,326	110,554,300	114,730,499	118,028,960	120,306,652	122,865,673	125,873,539	129,772,000
Adjustments -														
Spending Review 2010 transfer to DCLG re - PSS (from 2011-12)	-1,782,416	-1,280,872	-1,363,966	-1,471,058	0	0	0	0	0	0	0	0	0	0
Machinery of Government transfer to DCLG - re Learning Disability and Health Reform Grant (from 2013-14)	-1,206,234	-1,253,164	-1,288,752	-1,345,000	-1,325,914	-1,378,364	0	0	0	0	0	0	0	0
Classification change under ESA 10 moving Research and Development to Capital DEL				-886,623	-897,721	-925,357	-1,018,037	-1,020,561	-1,020,481	-998,000	-1,062,500	-1,078,000	-1,093,000	-1,108,000
Revised Resource DEL1,2,3,4	**81,219,067**	**87,622,604**	**94,422,482**	**96,582,740**	**99,368,123**	**101,644,508**	**105,477,289**	**109,533,739**	**113,710,018**	**117,030,960**	**119,244,152**	**121,787,673**	**124,780,539**	**128,664,000**
of which depreciation	*717,673*	*951,571*	*1,185,285*	*1,209,702*	*1,193,265*	*1,131,512*	*1,069,928*	*1,160,382*	*1,114,742*	*1,002,687*	*1,511,000*	*1,531,000*	*1,531,000*	*1,531,000*
Resource AME	**3,679,949**	**1,588,034**	**3,699,212**	**3,206,771**	**3,193,101**	**5,775,113**	**4,261,086**	**3,418,733**	**29,206,503**	**9,507,918**	**14,383,879**	**8,683,879**	**9,315,879**	**10,001,879**
of which depreciation	*548,759*	*386,765*	*2,499,236*	*1,000,777*	*716,384*	*1,145,927*	*1,133,780*	*956,669*	*964,956*	*1,077,584*	*2,065,640*	*2,065,640*	*2,065,640*	*2,065,640*
Total Resource (revised)	**84,899,016**	**89,210,638**	**98,121,694**	**99,789,511**	**102,561,224**	**107,419,621**	**109,738,375**	**112,952,472**	**142,916,521**	**126,538,878**	**133,628,031**	**130,471,552**	**134,096,418**	**138,665,879**
Capital DEL	3,966,103	4,368,533	5,182,275	4,158,605	3,771,268	3,782,882	4,348,909	3,950,694	3,631,849	3,558,079	5,021,481	4,934,459	4,934,459	4,810,000
Classification change under ESA 10 moving Research and Development to Capital DEL				886,623	897,721	925,357	1,018,037	1,020,561	1,020,481	998,000	1,062,500	1,078,000	1,093,000	1,108,000
Revised Capital DEL4	**3,966,103**	**4,368,533**	**5,182,275**	**5,045,228**	**4,668,989**	**4,708,239**	**5,366,946**	**4,971,255**	**4,652,330**	**4,556,079**	**6,083,981**	**6,012,459**	**6,027,459**	**5,918,000**
Capital AME	37,142	13,831	6,441	7,876	0	0	-69,813	-4,938	37,880	13,349	15,000	15,000	15,000	15,000
Total Capital	**4,003,245**	**4,382,364**	**5,188,716**	**5,053,104**	**4,668,989**	**4,708,239**	**5,297,133**	**4,966,317**	**4,690,210**	**4,569,428**	**6,098,981**	**6,027,459**	**6,042,459**	**5,933,000**
Total departmental spending (revised)	**87,635,829**	**92,254,666**	**99,625,889**	**102,632,136**	**105,320,564**	**109,850,421**	**112,831,799**	**115,801,738**	**145,527,033**	**129,028,035**	**136,150,372**	**132,902,371**	**136,542,237**	**141,002,239**
Of which -														
Total DEL	*84,467,497*	*91,039,566*	*98,419,472*	*100,418,266*	*102,843,847*	*105,221,235*	*109,774,307*	*113,344,612*	*117,247,606*	*120,584,352*	*123,817,133*	*126,269,132*	*129,276,998*	*133,051,000*
Total AME	*3,168,332*	*1,215,100*	*1,206,417*	*2,213,870*	*2,476,717*	*4,629,186*	*3,057,493*	*2,457,126*	*28,279,427*	*8,443,683*	*12,333,239*	*6,633,239*	*7,265,239*	*7,951,239*

1. The revised TDEL calculated in this table excludes spending for functions that have transferred out of DH that were originally included within either the Plans or Spending Outturns. This presentation is consistent with HM Treasury publications.

2. SR10 Transfer for Personal Social Services spending has been transferred to Department for Communities and Local Government. This transfer was effective from 2011-12.

3. Machinery Of Government change relating to the Learning Disability and Health Reform Grant which has been transferred to the Department for Communities and Local Government. This transfer was effective from 2013-14.

4. Research and Development was subject to a classification change and now scores as part of the Capital DEL.

Core Table 2: Administration Budgets

£'000

	2010-11 Baseline	2011-12 Outturn	2012-13 Outturn	2013-14 Outturn	2014-15 Outturn	2015-16 Outturn	2016-17 Outturn	2017-18 Plans	2018-19 Plans	2019-20 Plans	2020-21 Plans
Total administration budget	5,425,184	3,540,726	3,670,052	3,121,751	2,872,450	2,553,806	2,392,293	2,526,060	2,433,000	2,354,000	2,354,000

1 The extended administration control began in 2010-11

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

3 These figures include depreciation

Supporting narrative for the core tables can be found within performance section and annex B.

Annex B – Financial Performance Detail

392. The Department has the largest Departmental Expenditure Limit in government. We consolidate the spending of over 450 health and care organisations and cover a wide range of activities; from front-line treatment of patients, training of medical professionals, public health and social care, through to the running costs of each organisation within the group.

Largest DEL Budget in Government

393. Spending for all government departments is measured against a set of metrics that are agreed in HM Treasury's Spending Review. The table below provides a breakdown of the consolidated spending outturn for all bodies in the Departmental group into the main spending metrics.

Table 24: DH Departmental Expenditure – Spending Metrics

Total Department Expenditure Limit (TDEL)	Total Annually Managed Expenditure (TAME)
£120.70bn	**£15.13bn**
Total spending by DH, excluding AME and DEL depreciation & impairments.	Total AME spending by DH, excluding depreciation & impairments.

Revenue Departmental Expenditure Limit (RDEL)	Capital Departmental Expenditure Limit (CDEL)	Annually Managed Expenditure - Revenue (RAME)	Annually Managed Expenditure - Capital (CAME)
£117.59bn	**£4.62bn**	**£16.15bn**	**£0.02bn**
The control total for which current revenue expenditure, net of income, must be contained.	The control for which capital expenditure, e.g. fixed assets additions and capital grants, net of capital disposals must be contained.	A technical control for items that HM Treasury have deemed to be demand-led or exceptionally volatile or that have no real impact on the fiscal framework, requiring no taxes be raised to cover.	A technical control for items that HM Treasury have deemed to be demand-led or volatile. For DH, entirely relates to costs associated with the sale of Plasma Resources UK and the Credit Guarantee Finance scheme.

Administration (Admin)
£3.02bn
Administration budgets cover the costs of all central government administration, excluding depreciation and the costs of direct frontline service provision.

394. The Department contained its resources within all budgets authorised by Parliament as shown in the table below.

Table 25: HM Treasury DEL and AME control totals

	2016-17		
	Budget £m	Outturn £m	Underspend £m
RDEL	117,594	117,031	*563*
CDEL	4,616	4,556	*60*
RAME	16,150	9,508	*6,642*
CAME	15	13	*2*

395. The following narrative, with commentary and supporting tables, provides an explanation of the financial performance of the system, including financial outturn against the Department's own spending controls.

Total Departmental Expenditure Limit TDEL

396. The Department's Total DEL (TDEL); a spending measure consistent with the presentation of spending in HM Treasury publications, calculated as the sum of Revenue Departmental Expenditure Limit (RDEL) plus Capital Departmental Expenditure Limit (CDEL) less depreciation.

397. TDEL spending continues to grow, both over the previous year and cumulatively over 2010-11. Table 25 confirms the 2016-17 TDEL spending outturn and compares that to previous years.

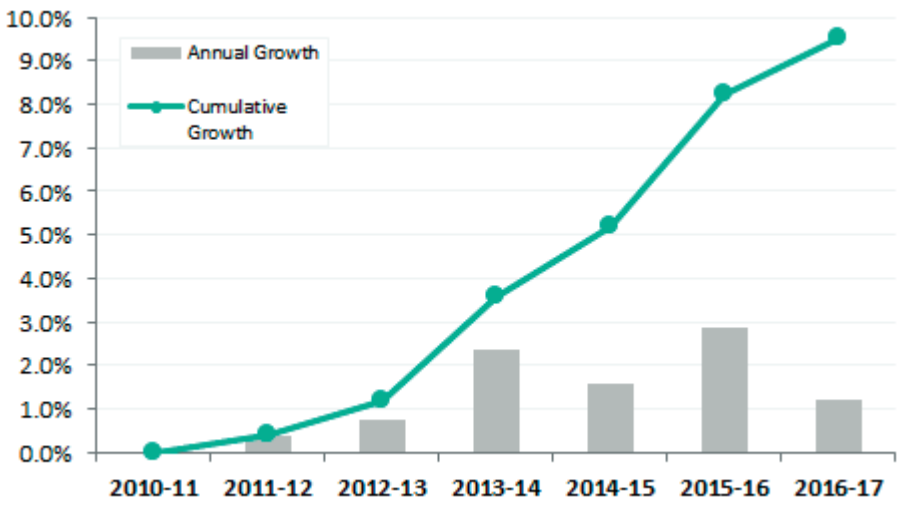
Table 26: Total Departmental Expenditure Limit Spending

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m
TDEL spending	**100,418**	**102,844**	**105,221**	**109,774**	**113,345**	**117,248**	**120,699**
Growth Nominal (£)	-	*2,426*	*2,377*	*4,553*	*3,570*	*3,903*	*3,451*
Growth Nominal (%)	-	*2.4%*	*2.3%*	*4.3%*	*3.3%*	*3.4%*	*2.9%*

398. The Spending Review 2013 re-affirmed the commitment to continue to spend more on the NHS in real terms every year; a commitment measured against the TDEL and in 2016-17 real-terms spending was 1.2% greater than in 2015-16 and 9.5% greater than in 2010-11.

1.2%
Spending growth in real terms over 2015-16

Figure 11: Real Terms Spending Growth



1. Cumulative growth figures are against the 2010-11 baseline
2. GDP Deflators at 31st March 2017 used to calculate real terms growth

Revenue Departmental Expenditure Limit (RDEL)

£117.6bn RDEL Budget

399. The Department's total 2016-17 Revenue DEL (RDEL) represents the consolidated revenue spending of all bodies within the NHS and non-NHS sectors of the Departmental group i.e. NHS healthcare providers and commissioners, and the Department plus its Arm's Length Bodies (ALBs).

400. The spending plans for all government departments are submitted to Parliament for scrutiny and approval as part of the Estimates process. The Department receives the majority of its revenue funding via this Estimates 'vote' process, but also receives an element of funding from National Insurance Contributions, which are not voted on by Parliament in the supply estimates process.

401. In 2016-17, our National Insurance Contributions receipts were in line with the funding set out in the Parliamentary Estimate.

402. The following table summarises the RDEL outturn against budget since 2010-11; highlighting the £0.6 billion underspend in 2016-17.

Table 27: Revenue DEL

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m
RDEL Budget	98,567	101,092	104,097	106,801	110,556	114,523	117,594
RDEL Spending Outturn	**97,469**	**100,266**	**102,570**	**106,495**	**110,554**	**114,730**	**117,031**
Underspends / (Overspends) (£m)	*1,098*	*826*	*1,527*	*305*	*1*	*(207)*	*563*
Underspends / (Overspends) (%)	*1.114%*	*0.817%*	*1.467%*	*0.286%*	*0.001%*	*-0.181%*	*0.479%*
Of which:							
RDEL Depreciation Ring Fence Outturn	*1,210*	*1,193*	*1,132*	*1,070*	*1,160*	*1,115*	*1,003*
RDEL Non Ring Fence Outturn	*96,260*	*99,073*	*101,438*	*105,425*	*109,394*	*113,616*	*116,028*

RDEL: Funding Flows and Sector Breakdown

403. Of the Department's total 2016-17 RDEL budget (£117.6 billion), £105.9 billion was allocated directly to NHS commissioners, with the remainder (£11.7 billion) funding ALBs and the Department's central budgets i.e. the non-NHS sector.

404. NHS healthcare providers are not directly funded, instead they generate income to cover their spending via trading activity with commissioners i.e. commissioners pay providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs, under a national tariff system.

405. Across Government, this 'Internal Market' is unique to the Department of Health and adds an additional layer of complexity as all inter-group trading needs to be eliminated on consolidation when preparing the departmental group account (via an 'Agreement of Balances' exercise).

406. Approximately £72 billion of revenue expenditure in the departmental group sits in the NHS provider sector, spent on staff costs, drugs, clinical negligence and procurement of supplies and services to deliver healthcare. Other significant expenditure includes: primary care (including general practice, dentistry, ophthalmology, pharmaceutical), public health (including grants to local authorities), plus other administration costs from the other sectors within the group.

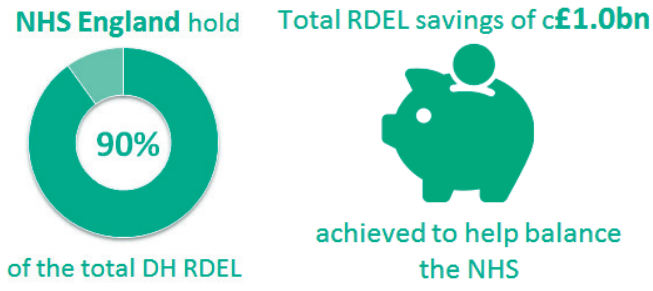
407. The RDEL budget is set net of income and in 2016-17 the departmental group received £10.1 billion of RDEL income from varying sources. This was mainly received by NHS providers and included prescribing and dental charges, trading with Local Authorities and income from treating private patients.

RDEL: Outturn

408. To support the NHS's own plan, NHS Revenue DEL funding increased by £3.8 billion in 2016-17 to allow for major investment in NHS front line services. In addition to new funding provided by the Government, £1.2 billion was transferred from the Department's Capital budget and a further £0.6 billion reinvested from savings in the Department's non-NHS budgets to facilitate this £3.8 billion additional NHS funding.

409. The Government's Mandate to the NHS set a clear expectation that financial balance for the NHS sector as a whole was to be achieved during 2016-17. NHS providers planned for a small deficit during the year, therefore NHS England put aside a risk reserve to offset this and further unplanned deficits that may arise. During the year this contingency was utilised, ensuring the NHS was able to broadly deliver financial balance.

NHS Financial Performance – NHS Commissioners



410. The Government's mandate to NHS England in 2016-17 separately set out NHS England's revenue and capital resource funding limits against spending controls. These spending controls stem from the same controls that HM Treasury apply to the Department of Health. NHS England must ensure that spending is contained within each of these funding limits. The following table provides a breakdown of that spending.

Table 28: NHS RDEL

	Limit £m	Spending Outturn £m	*Under/ (Over) spend £m*
NHS England RDEL	105,702	104,800	*902*
NHS England Depreciation (RF RDEL)[1]	166	96	*70*
Total NHS England RDEL	**105,868**	**104,897**	***971***
of which Admin	*1,832*	*1,595*	*237*

1. Funding for depreciation costs are ring-fenced under HM Treasury spending rules, and cannot be used to fund other "non-ring-fenced" spending.
2. Underspend inclusive of 1% risk reserve

411. As part of their own plan to balance the NHS financial position in 2016-17 and to allow for effective risk management and build in flexibility, commissioners created a £0.8 billion "risk reserve" as 1% of CCG allocations were set aside to cover pressures across the system. Ultimately, this was needed to offset the year-end RDEL pressure in NHS providers.

412. In addition to the release of this reserve, NHS England reported further savings of c£0.1 billion, resulting in total underspend of c£0.9 billion against the key RDEL (excluding depreciation) control.

413. Within this overall position, there was an underlying CCG overspend of c£0.6 billion, but this was offset elsewhere; notably in specialised and other direct commissioning and NHS England central costs.

414. The vast majority of healthcare services are purchased from NHS providers (NHS Trusts and Foundation Trusts); however £12.7 billion of these types of services were purchased from non-NHS healthcare providers in 2016-17. These non-NHS providers include Local Authorities, voluntary sector/not for profit organisations, Devolved Administrations and private sector providers. The following table provides a breakdown of this spending and compares to previous year.

Table 29: Purchase of healthcare from non-NHS providers, breakdown

	2015-16 Restated £m	2016-17 £m
Independent Sector Providers	8,818	9,007
Voluntary sector/Not for profit	545	757
Local authorities	2,869	2,909
Devolved Administrations	n/a	73
Total Spend on all non-NHS bodies	**12,232**	**12,746**
Total RDEL	**114,730**	**117,031**
Spend with private sector as a % of total RDEL	*7.7%*	*7.7%*
Spend on all non-NHS bodies as a % of total RDEL	*10.7%*	*10.9%*

1. The numbers above have been collected separately from audited accounts data and may include estimates.
2. Numbers shown in the table above have been adjusted to show the DEL impact of the spending. This adjustment specifically relates to Continuing Health Care provisions which are attributed to expenditure in accounts as provisions arise but only impact on the DEL when paid.
3. NHS England have carried out further validation work on the 2015-16 numbers previously reported and restated some categories.
4. NHS England and the Department of Health have made changes to the categories for 2016-17. The Voluntary Sector category now includes other not for profit organisations who have social objectives for the benefit of the wider

community, such as Community Interest Companies. A new category has also been included for devolved administrations.

415. Further commentary, together with the consolidated accounts of the NHS England group, is published on NHS England's website.

NHS Financial Performance – NHS Providers

416. At the financial year end, there were 238 provider organisations producing accounts during the year. Together these providers ended 2016-17 with a net financial pressure on the overall Revenue DEL outturn of c£0.9 billion i.e. the reported net deficit, plus technical adjustments relating to the categorisation of provisions, PFI, donated assets and prior period adjustments, detailed further in the table below.

Table 30: NHS providers RDEL Breakdown

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m
Total Provider Deficit	**-458**	**-476**	**-544**	**107**	**842**	**2,448**	**791**
Provisions Adjustment	-106	-163	-120	53	121	74	43
Other Adjustments	-183	3	68	-11	-47	27	101
Total Revenue DEL	**-748**	**-636**	**-596**	**149**	**916**	**2,548**	**935**

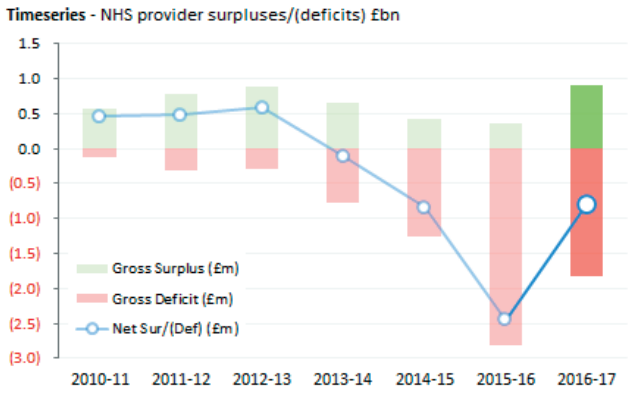
1. Other adjustments – these include adjustments to reflect the correct DEL scoring of income and depreciation of donated assets and of PFI spending.

417. This position includes the benefit of income from the Sustainability and Transformation Fund (STF). This £1.8 billion fund is designed to help providers move to a sustainable financial footing and has been primarily allocated to providers of emergency care that have been under the greatest financial pressure; although an element has been allocated to support providers achieve overall sustainability by driving maximum efficiencies.

418. NHS providers earned payments from this fund by achieving financial and performance targets. 'Financial control totals' were introduced for 2016-17 to establish the minimum level of financial performance for both the sector and individual trusts.

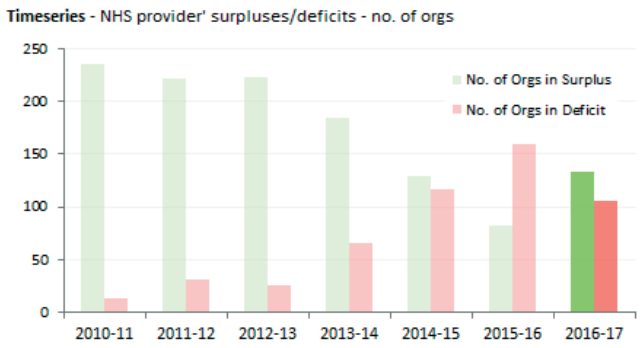
419. At the beginning of the year, NHS Improvement were able to use these controls and the related STF incentive to implement a plan aimed at delivering a net deficit of c£0.6 billion in 2016-17, with 228 trusts (96%) signing up to the controls.

420. NHS provider deficits have been steadily increasing over recent years in the face of considerable challenges, but that trend has been addressed and reversed in 2016-17 with a focus on financial rigour through those actions described earlier in the Performance Analysis. Whilst trusts ultimately reported a position that exceeded NHSI's plan, this represented a significant improvement over 2015-16.



The net deficit now stands at c£0.8 billion, compared to £2.45 billion in 2015-16.

The number of trusts reporting a deficit is now 105 (44%), down from 172 (71%) in 2015-16.



421. In addition, the vast majority of providers, 178 (75%), have reported a year-end position that is equal to or better than their agreed control totals. This is a significant improvement over previous years, for example 128 (54%) trusts reported a year-end positon that was equal to or better than their plan in 2015-16.

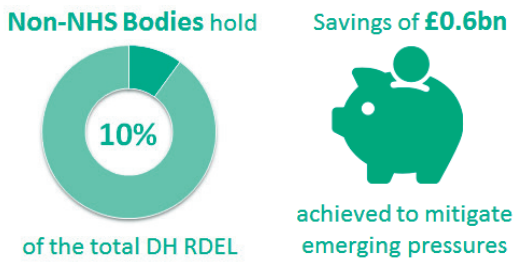
422. The following table provides a breakdown of the reported deficit and position against control totals.

Table 31: Summary of NHS Provider's surplus / (deficit)

	Deficit		Surplus		Net	
	number	£m	number	£m	number	£m
Plan						
Providers with agreed control totals	102	(1,275)	126	642	228	(633)
Remaining providers	6	(155)	4	6	10	(149)
Uncommitted STF & Other adjustments						202
Net	**108**	**(1,430)**	**130**	**648**	**238**	**(580)**
Outturn						
Equal to or better than control totals	59	(830)	119	868	178	39
Did not achieve control totals	39	(797)	11	37	50	(760)
Remaining providers	7	(197)	3	9	10	(189)
Adjustments						120
Net	**105**	**(1,824)**	**133**	**914**	**238**	**(791)**
Variance	***(3)***	***(394)***	***3***	***266***	***0***	***(211)***

1. Other adjustments relate to minor reporting adjustments relating to differences between control totals and reported surplus/(deficit), where reported surplus/(deficit) includes items such as donated asset income and depreciation, changes in provisions discount rates and PFI costs under IFRS that are not included in control totals.

Non NHS Bodies - Financial Performance Revenue DEL Spending



423. Outside of the NHS sector, the Non-NHS bodies (the Department and its ALBs) have actively managed the remainder of the departmental group to mitigate the scale of the impact on the overall financial position and ensure maximum resources are available for frontline patient care.

424. The Non-NHS started the year with a collective budgeted over-commitment of £0.4 billion for which the Department and its Arm's Length Bodies prudently set aside contingency to cover these pressures to ensure financial balance in 2016-17.

425. Additional unforeseen pressures of c£0.3 billion emerged during the year, mostly relating to the Prescription Pricing Regulation Scheme (PPRS) and European Economic Area Medical Costs (EEA) budgets.

426. Overall, the sector operated within DEL spending limits, delivering savings of £0.6 billion against the total RDEL control, to help mitigate system wide pressures. This has been done without compromising the support of the wider system whilst safeguarding the interests of patients and the wider public.

427. The summarised DEL outturn compared to plan for key elements of the non-NHS sector are shown in the table below.

Table 32: Summarised Financial Position for DH's ALBs in 2016-17

	Plan £m	Outturn £m	*Variance £m*
RDEL Non Ring-fenced Spending -			
Public Health England	807	804	*3*
Public Health Local Authority Grants	3,388	3,388	*0*
Health Education England	4,992	4,979	*12*
NHS Litigation Authority	146	69	*77*
NHS Property Services	(153)	(84)	*(69)*
Community Health Partnerships (CHP)	0	15	*(15)*
NHS Digital	233	219	*14*
Other ALBs	476	366	*110*
European Economic Area (EEA) medical costs	580	735	*(155)*
Informatics	229	166	*63*
Public dividend capital (PDC) payments	(997)	(951)	*(46)*
PPRS	(584)	(456)	*(128)*
Other DH Central Budgets	1,265	1,044	*222*
SubTotal Non RF	**10,382**	**10,294**	**88**
RDEL depreciation ring-fence	1,345	906	*439*
Total RDEL	**11,727**	**11,200**	***527***

Capital Departmental Expenditure Limit (CDEL)

£4.6bn
CDEL Budget

428. The Department's total 2016-17 CDEL outturn is the consolidated net capital spending of all bodies within the Departmental group.

429. The total CDEL expenditure in 2016-17 was £4.56 billion, compared with a control limit agreed with HM Treasury of £4.62 billion i.e. an underspend of £60 million (1.3%), shown with historic comparisons in the table below.

Table 33: Capital DEL Outturn[1]

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m
CDEL Budget	5,783	5,250	5,421	5,462	5,034	4,710	4,616
CDEL Spending Outturn	**5,045**	**4,669**	**4,708**	**5,367**	**4,971**	**4,652**	**4,556**
CDEL Underspend	*738*	*581*	*713*	*95*	*63*	*58*	*60*
CDEL Underspend %	*12.76%*	*11.07%*	*13.14%*	*1.75%*	*1.25%*	*1.23%*	*1.30%*

1. All years have been adjusted to take accounts of the impact of the reclassification of research & development expenditure as detailed in paragraph 425.

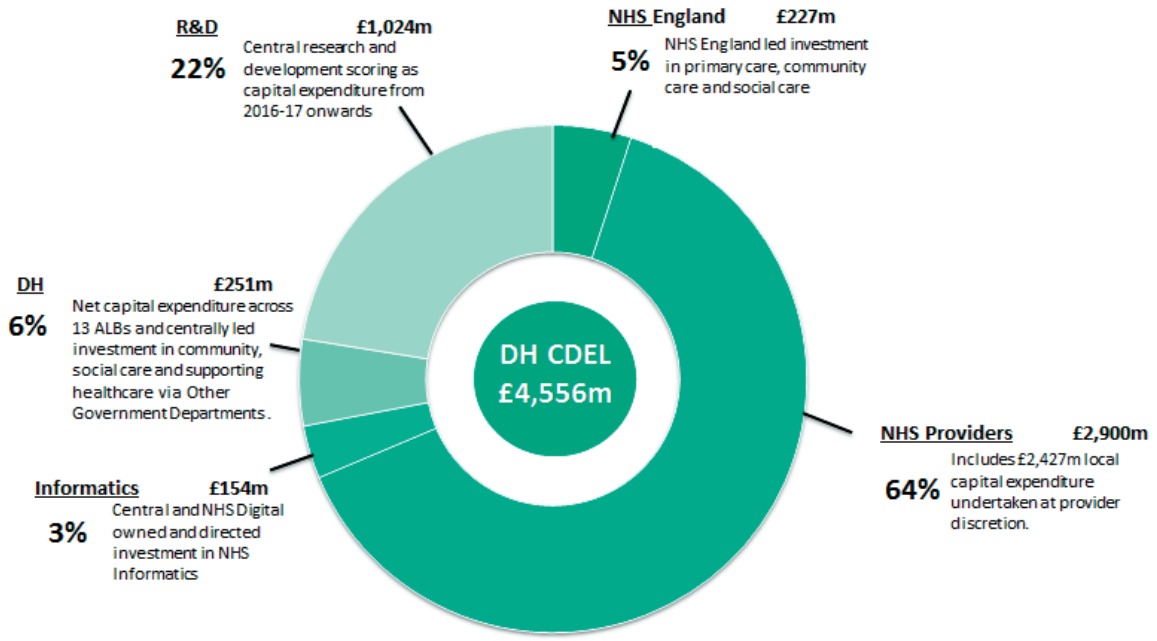
430. For 2016-17, following the Government's adoption of the 2010 European System of National and Regional Accounts (ESA 2010), the majority of Departmental expenditure on research and development was re-classified from revenue to capital expenditure. Further detail is presented in Annex A Core Table 1.

431. As part of prudent forward planning, at the time of the 2015 Spending Review, the need to transfer resources from the capital budget to revenue budgets in order to help meet overall spending priorities was recognised. A facility was agreed with HMT to allow planned transfers, up to a set limit, for each year of the Spending Review. In 2016-17 £1.2

billion of available CDEL budget was transferred to RDEL. This transfer was factored into the process of setting 2016-17 capital budgets across the DH Group, resulting in an available budget of £4.62 billion as shown in the table above.

432. The figure below provides a breakdown of the £4.56 billion capital spend by sector within the DH group for 2016-17.

Figure 12: Capital DEL Spending Breakdown by Sector



NHS Finance - NHS Providers Capital Expenditure

433. NHS providers finance the majority of capital expenditure themselves (84% during 2016-17) by deploying surplus cash reserves, and any capital loans taken out. This investment is shown as the Local Capital Expenditure line in the table below. The Department, and its ALBs, also inject financing to support specific strategic initiatives.

434. As shown in the figure above, NHS provider Capital DEL (CDEL) expenditure was £2.9 billion in 2016-17. The table below shows how this expenditure was financed.

Table 34: Financing of Capital DEL

	2016-17		
	NHS Trusts £m	FTs £m	Total £m
Capital DEL Outturn[1]	**1,064**	**1,836**	**2,900**
Of which:			
Local Capital Expenditure	*796*	*1,631*	*2,427*
DH & ALB led Strategic Initiatives	*195*	*151*	*346*
PFI Residual Interest[2]	*73*	*54*	*127*
Capital DEL Allocation set			**2,774**
Under/(Over) spend			***(126)***

1. NHS CDEL in the table above does not include the net capital investment of NHS Charities
2. HMT's budgeting framework requires PFI residual interest on assets to score to CDEL.

435. The Capital DEL affordable envelope agreed for NHS providers at the beginning of the 2016-17 financial year was £2.77 billion. NHS providers exceeded this Capital DEL target by £126 million. However, there are compensating underspends against Capital DEL budgets elsewhere in the Group which has resulted in an overall Group underspend of £60 million discussed earlier.

436. As mentioned above, the Department and its Arms' Length Bodies have led specific initiatives over the year and issued non-repayable financing in the form of capital Public Dividend Capital (PDC) in support, directly to NHS providers. These allocations are summarised in the table below.

Table 35: Capital PDC Allocations 2016-17

	2016-17		
	NHS Trusts £m	FTs £m	Total £m
Non Programme			
Non Programme PDC	180	63	**243**
DH Programme Initiatives			
Proton Beam	-	47	**47**
Linear Accelerator	11	24	**36**
Genomics Infrastructure	2	9	**10**
Places of Safety (Mental Health)	1	5	**6**
Other Schemes under £5m	1	3	**4**
Total DH led spending initiatives	**195**	**151**	**346**

Overall DH Group Capital Expenditure

437. In summary, despite NHS provider's capital expenditure exceeding the planned affordable envelope by £126 million, offsetting underspends in non-NHS bodies in the Group, alongside planned asset sales and loan repayments resulted in a small underspend of £60 million (1.3%).

RDEL Administration

438. Within the overall RDEL control limit sits a separate RDEL Administration limit, which covers the running costs of the core Department, commissioning sector (NHS England and Clinical Commissioning Groups) and all of the Department's central government Arm's Length Bodies (ALBs).

1/3
Admin Savings since 2011-12

439. The Department and our ALBs continue to reduce administration costs compared to prior years building on the one third savings delivered as a result of the Health and Social Care Act reforms.

440. Over the course of the Spending Review 2015 period, further efficiencies will be delivered across the sector in line with the settlement.

441. The table below shows the administration outturn with spending in 2016-17 reducing by £146 million (or 6.0%) compared to 2015-16, maximising the amount of funding available for frontline services.

Table 36: DH Administration

	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m
Administration Outturn	3,307	3,502	3,036	2,781	2,421	2,275

1. Figures do not include depreciation and as a result will not directly reconcile to Admin outturn as per Statement of Parliamentary Supply (£2,394m).

Annually Managed Expenditure (AME)

442. Details of the Department's total 2016-17 AME budget and expenditure are set out in the table below, which shows the Department underspent by £6.6 billion (41.1%) against its final Revenue AME budget in 2016-17.

£16.2bn
AME Budget

Table 37: Annually Managed Expenditure plans, outturns and under/ (over) spends

	2010-11 £m	2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m
Revenue AME Budget	4,844	3,943	5,868	5,502	6,606	31,272	16,150
RAME Outturn	**3,207**	**3,193**	**5,775**	**4,261**	**3,419**	**29,207**	**9,508**
Underspend/(Overspend) £m	*1,637*	*750*	*93*	*1,241*	*3,187*	*2,065*	*6,642*
Underspend/(Overspend) %	*33.8%*	*19.0%*	*1.6%*	*22.6%*	*48.2%*	*6.6%*	*41.1%*
Capital AME Budget	4	-	-	120	15	15	15
Capital AME Outturn	**8**	**-**	**-**	**(70)**	**(5)**	**9**	**13**
Underspend/(Overspend) £m	*(4)*	*-*	*-*	*190*	*20*	*6*	*2*
Underspend/(Overspend) %	*-122.5%*	*-*	*-*	*158.2%*	*132.9%*	*40.0%*	*11.0%*

443. The Department's AME provision (Revenue and Capital) is set annually outside the Spending Review and the revenue related spending is purely impairments and provisions, which have no real impact on the fiscal framework or need for taxes to be raised to cover the spending. The Department's AME spending is not typical to most government Department's AME spending, which normally will impact on the fiscal framework in the same way as DEL spending.

444. Additionally, the Department's AME is demand-led and volatile, being subject to many variables outside the Department's direct control, such as changes to the discount rates to measure the value of long-term provisions liabilities. Note 16 within the Financial Statements provides further detail and analysis of variables.

445. 2016-17 AME expenditure includes increased provisions liabilities of around £4.7 billion relating to the Lord Chancellor's change in the Personal Injury Discount Rate[78] announced on 27 February 2017, and which took effect on 20 March 2017.

[78] http://www.londonstockexchange.com/exchange/news/market-news/market-news-detail/other/13139570.html

446. At the time of re-setting the AME budget in January 2017 as part of the Supplementary Estimate, a development in the methodology to calculate the provision was being considered following on from an NAO recommendation in the prior year. The final budget had to be set before the outcome of an actuarial review to determine the treatment was finalised. This meant that the budget included a prudent increase, which in the end was not needed, resulting in AME expenditure in 2016-17 being around £6.64 billion lower than the budget.

Annex C – NHS Operational Performance

NHS Operational Performance against waiting time standards

447. Rising demand had a detrimental impact on NHS operational performance against waiting time standards during 2016-17[79], and some standards were missed. The Department, through its national partners including NHS England and NHS Improvement, worked across the system to support the most challenged providers and to take actions designed to stabilise and recover performance.

448. The NHS received £400 million in resilience funding at the start of the 2016-17 financial year to prepare early for winter. £350 million of this funding was in CCG baselines so local health economies could plan and implement initiatives far earlier. The remaining £50million was to support a number of national initiatives such as:
    - Additional resilience funding for ambulance services.
    - Additional resilience funding to support specialised commissioning.
    - The expanded ECIP programme.
    - The winter marketing/communications campaign.

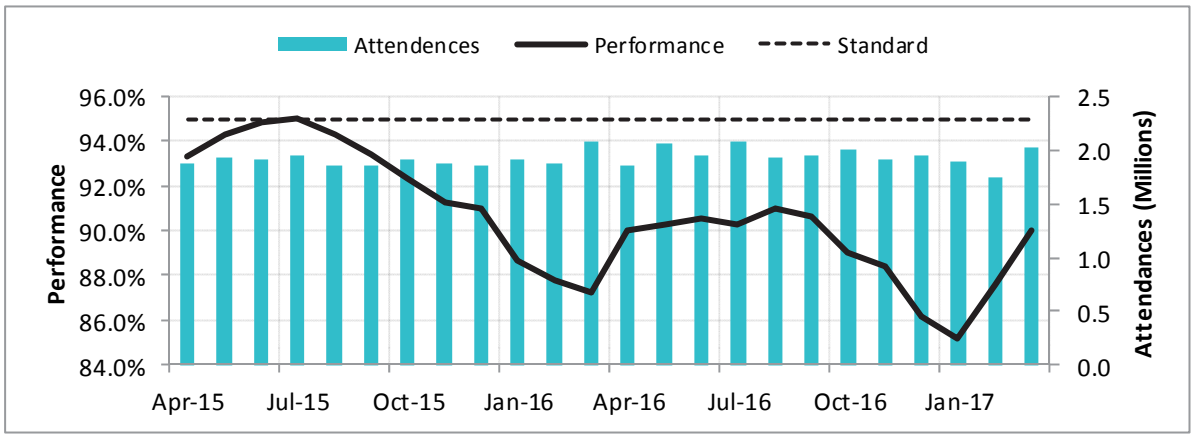
449. The Department will continue to work with and support its national partners on delivery of the productivity improvement and demand management actions needed to maximise elective referral to treatment (RTT) waiting time performance. Actions include:
    - supporting CCGs to meet plans to reduce demand growth and ensuring there is appropriate support and intervention for the worst performing CCGs;
    - prioritising delivery of the NHS Constitution 18 week maximum waiting time right and RTT 92% incomplete standard in the NHSE Mandate and NHSI Remit;
    - redesigning elective care patient pathways and referral management processes and guidance. Universal use of e-referrals by October 2018 so that GPs have the option of requesting specialist 'advice and guidance' to support their decision on whether to refer a patient;
    - delivering the Getting it Right First Time (GRFT) programme, maximising theatre productivity and reducing inappropriate outpatient follow-up appointments;
    - Ensuring intensive support is in place to support the worst performing trusts.

450. National performance for **A&E waiting times** in 2016-17 is 89.1%, not meeting the standard that 95% of patients should be admitted, transferred or discharged within four hours of arrival in an A&E department, and lower than 2015-16 when it was 91.9%. The standard was not met in any month in 2016-17.

451. The drop in performance should be seen in the context of increasing demand for non-elective services. A&E attendances over the latest twelve months were 2.0% higher than in 2015-16, increasing from 22.9 million in 2015-16 to 23.4 million in 2016-17. Over the same period, the number of emergency admissions from A&E increased by 2.9% from 4.1 million in 2015-16 to 4.3 million in 2016-17. Hospital trusts reported that A&E departments are dealing with higher acuity patients requiring admissions and that bed shortages due to delayed transfers of care were impacting patient flow. The number of bed days lost because of delayed transfers of care increased by 24.5% in 2016-17 from 1.8 million in 2015-16 to 2.3 million in 2016-17.

[79] https://www.england.nhs.uk/statistics/statistical-work-areas

Figure 13: A&E waiting times and activity, 2015-16 and 2016-17



452. **Ambulance response times.** Ambulance services are facing unprecedented demand, with 5.0% more emergency calls which received a face-to-face response from the ambulance service in 2016-17 (6.9 million) compared to 2015-16 (6.6 million). Including calls transferred from NHS111, ambulance services deal with more than ten million 999 calls every year. The Department continues to work closely with NHS England and NHS Improvement to monitor and support performance.

453. All three standards were missed for the year as a whole, with performance of 68.7% for the Red 1 standard compared to 72.5% in 2015-16, 62.5% for the Red 2 standard compared to 67.3% in 2015-16, and 90.4% for the transportation standard compared to 92.6% for 2015-16, and were missed in all months in 2016-17.

454. However, performance data against the three Category A national standards (that 75% of Category A Red 1 calls (immediately life threatening) and Category A Red 2 calls (serious but less time critical) should receive a response within eight minutes, and 95% of all Category A calls requiring an ambulance vehicle able to transport the patient should receive a response within 19 minutes) are available only for eight of the eleven Ambulance Services. This is because Yorkshire, West Midlands, and South Western Ambulance Services implemented the Clinical Coding Review trial between April and June 2016, so Category A no longer applies to these three Ambulance Services.

455. Additionally, Red 2 and Category A data from February 2015 to October 2016 will remain incomparable between Ambulance Services, because of the implementation of the Dispatch on Disposition pilot at different trusts. From October 2016, all Ambulance Services except the Isle of Wight are using the same clock start time.

Figure 14: Red 1 and Red 2 response times, 2015-16 and 2016

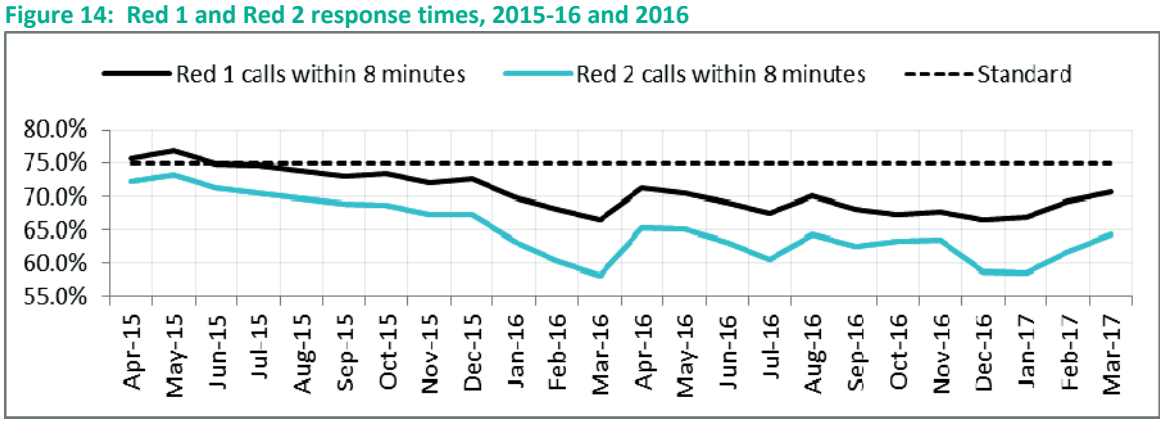
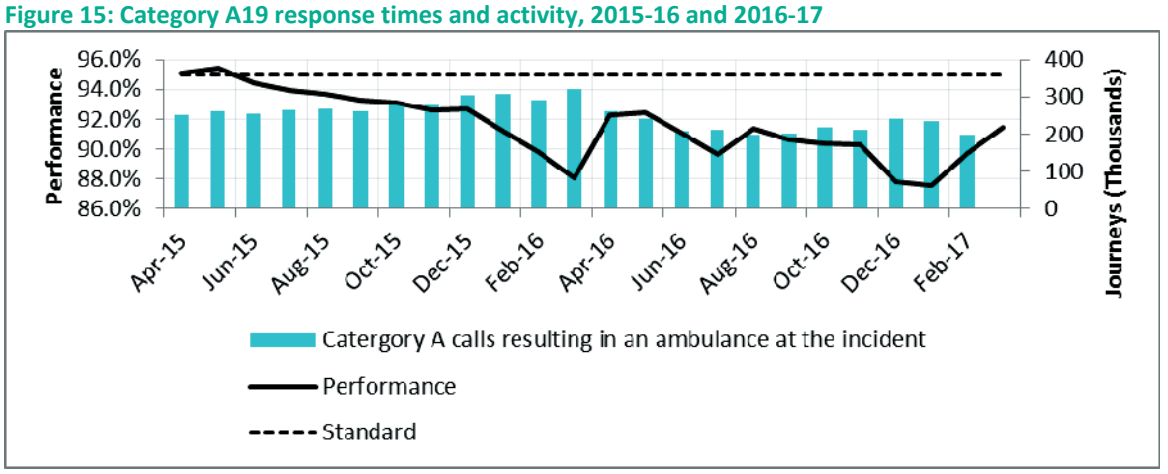


Figure 15: Category A19 response times and activity, 2015-16 and 2016-17

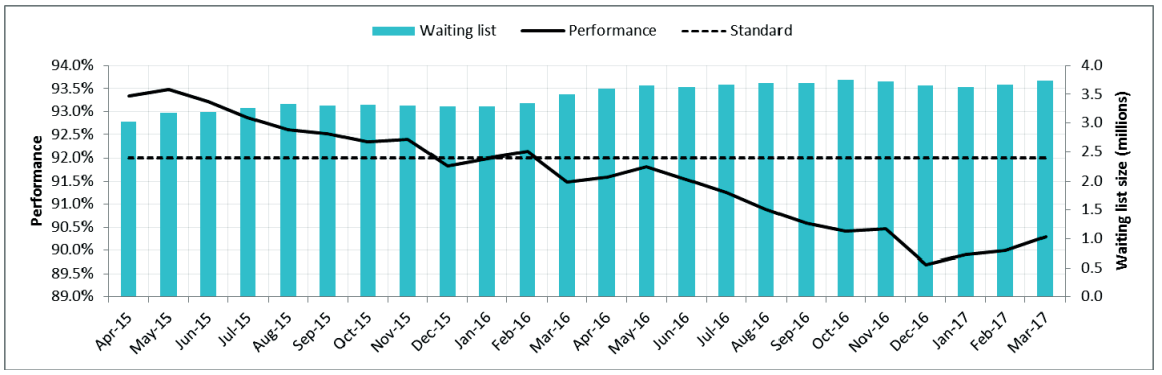


456. Elective waiting times are monitored against the **referral to treatment (RTT) incomplete pathway standard** that a minimum of 92% of patients still waiting to start consultant-led treatment for non-urgent conditions at the end of the month should have been waiting within 18 weeks from referral. Published performance was 90.3% in March 2017, compared to 91.5% in March 2016. The standard was not met in any month in 2016-17. The standard was last met in February 2016. Deteriorating performance against the standard is a result of demand[80] outstripping activity and consequent increase in the national waiting list. Despite an estimated[81] growth of 4.7% in activity, the underlying waiting list has grown by over 220,000 (6%) to almost 3.9 million. The number of patients waiting more than 52 weeks to start treatment also increased, from 886 in April 2016 to 1,529 in March 2017, despite the ambition that it should be reduced to as close to zero as possible.

[80] RTT demand is measured by clock starts for incomplete pathways and activity is measured by completed pathways

[81] A number of providers were not reporting data in 2015/16 but have since returned to reporting data in 2016/17. This means that published figures are not a like-for-like comparison. Figures quoted here are adjusted to include estimates of non-reporters.

Figure 16: Percentage of patients on RTT incomplete pathways waiting within 18 weeks from referral 2012-13 to 2016-17



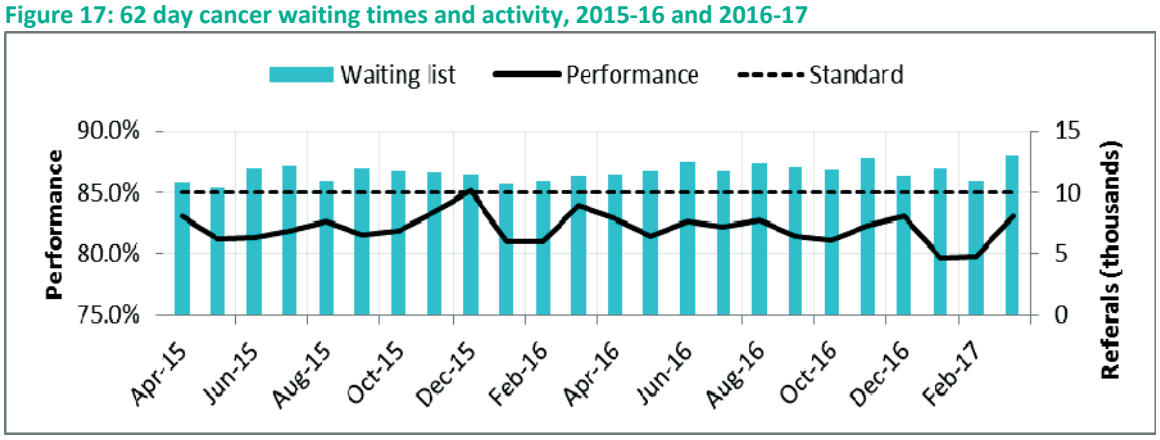
457. Early diagnosis and treatment are crucial to improving survival rates for cancer, and eight **cancer waiting time standards**[82] cover different elements of the pathway to ensure patients benefit from better access to cancer services.

458. The standard that 85% of patients begin first treatment within 62 days of urgent GP referral for suspected cancer was not met in any month of 2016-17, although performance was broadly stable during 2016-17. Demand continued to rise, with urgent GP referrals for suspected cancer increasing by 8.7% from 1.7 million in 2015-16 to 1.9 million in 2016-17. Delays in access to diagnostic tests, especially for endoscopic procedures, also added to the pressures in delivering the 62 day standard. To address this, an additional 200 non-medical endoscopists funded by HEE began training in 2016, and this will significantly increase endoscopy capacity to support improvement in diagnostic test and cancer waiting times. There has already been a clear improvement in endoscopy waiting times during the second half of 2016.

459. The standard that 96% of patients should begin first treatment within 31 days of a decision to treat was met in every month of 2016-17, as were the other standards with a few exceptions. The standard that 93% of patients should be seen by a specialist within a maximum of two weeks from referral for investigation of breast symptoms, even if cancer is not initially suspected, was missed in six months of the year between April and August, and in March 2017.

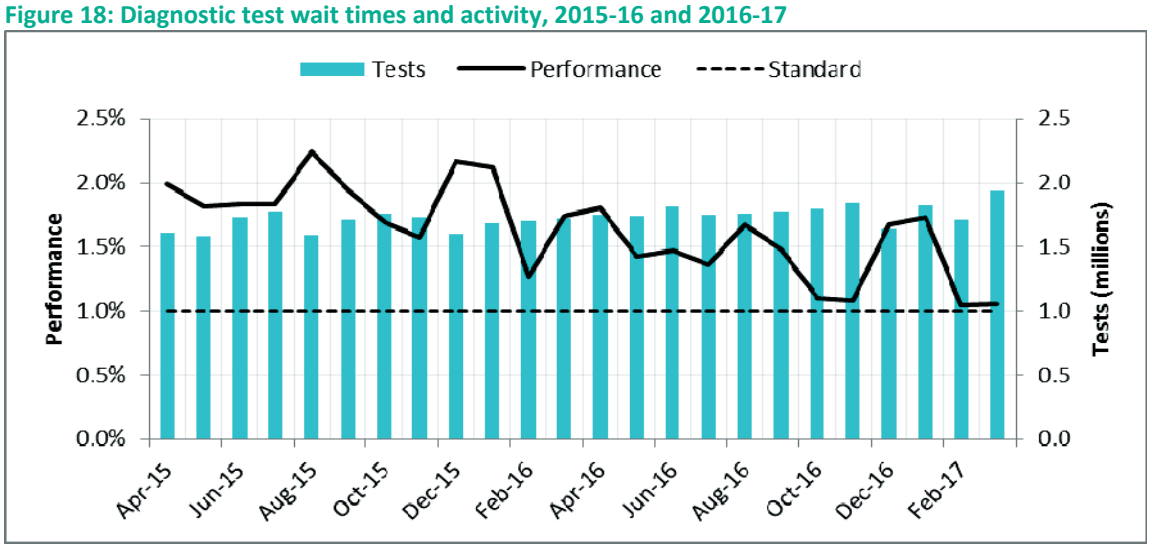
[82] 93% of patients to see a specialist for suspected cancer within two week wait of an urgent GP referral;
- 96% of patients to begin first treatment within 31 days of decision to treat for cancer;
- 85% of patients to begin first treatment within 62 days of an urgent GP referral for cancer;
- 93% of patients to see a specialist within two weeks of referral for investigation of breast symptoms, where cancer is not initially suspected;
- 98% of patients to be treated within 31 days from a decision to treat to a subsequent treatment for cancer (anti-cancer drug regimen);
- 94% of patients to be treated within 31 days from a decision to treat to a subsequent treatment for cancer (radiotherapy);
- 94% of patients to be treated within 31 days from a decision to treat to a subsequent treatment for cancer (surgery);
- 90% of patients to be treated within 62 days from a national screening service to a first treatment for cancer.

Figure 17: 62 day cancer waiting times and activity, 2015-16 and 2016-17



460. Waiting times for **diagnostic tests** are an important contributor to all elective (including cancer) waiting times, because the vast majority of patients require a diagnostic test to determine whether and what treatment is necessary. The standard that less than 1% of patients should be waiting more than six weeks for a diagnostic test at the end of the month was not met in any month for the 15 diagnostic tests measured[83], although the average (median) waiting time remained stable at two weeks. Furthermore, more than 98% of patients were waiting less than six weeks for their diagnostic test in every month of 2016-17. This remains strong performance in the context of significant increases in demand for diagnostics tests - with the number of tests carried out increasing by 5.7 % from 20.2 million in 2015-16 to 21.4 million in 2016-17.

Figure 18: Diagnostic test wait times and activity, 2015-16 and 2016-17



[83]Monthly performance and activity data are collected for 15 diagnostic tests: Magnetic Resonance Imaging; CT; Non Obstetric Ultrasound; Barium Enema; Dexa Scan; Audiology Assessments; Echocardiography; Electrophysiology; Peripheral Neurophys; Sleep Studies; Urodynamics; Colonoscopy; Flexi Sigmoidoscopy; Cystoscopy; Gastroscopy.

Annex D – Other Departmental Information

Sustainability Data

461. The following tables outline the Department's in scope ALBs progress on Greenhouse Gas, Waste and Water Consumption. ALBs not included in these tables are, HTA, HFEA, NHSR & HRA due to the de minimis exclusion. From 2017-18 the Department will also include NHSE and HEE and NHSI within the Greening Government Reporting.

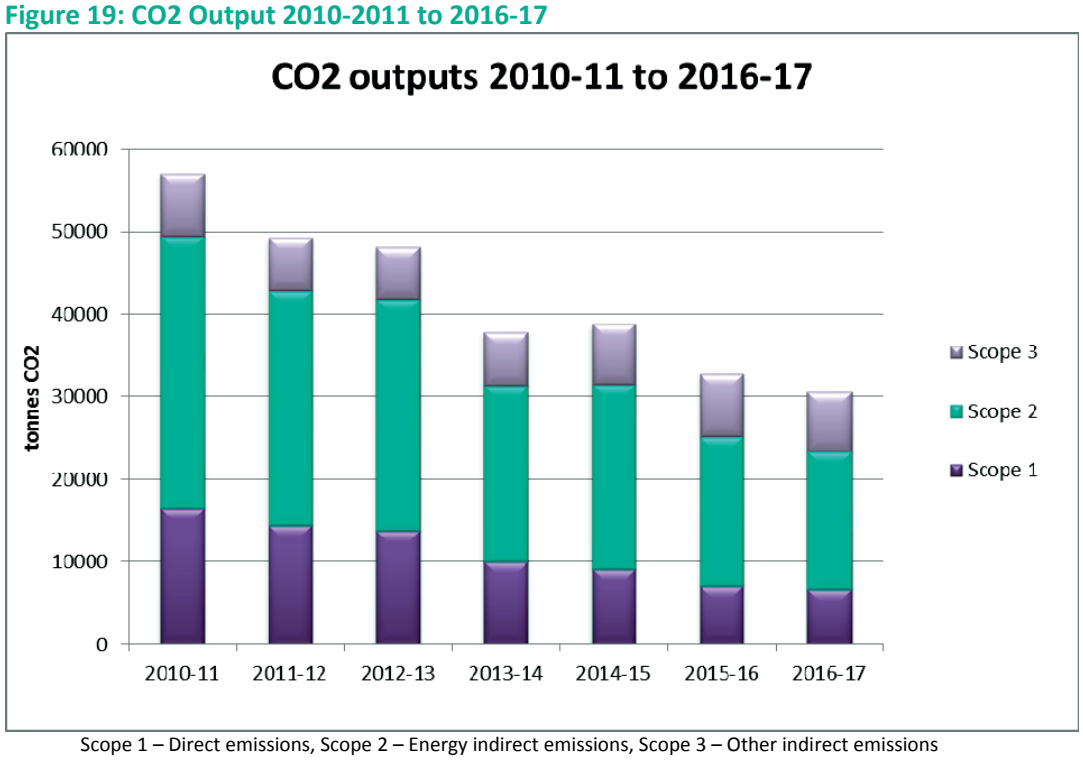
Greenhouse Gas Emissions Performance Commentary

Table 38: Greenhouse Gas Emissions Baseline 2010-11 to 2016-17

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Non Financial Indicators (CO2 tonnes)							
Total Gross Emissions for Scope 1	16,500	14,387	13,802	9,997	9,146	7,076	6,741
Total Gross Emissions for Scope 2	32,919	28,500	27,981	21,342	22,283	18,089	16,674
Total Gross Emissions for Scope 3	7,662	6,400	6,317	6,514	7,377	7,637	7,214
Total Gross Emissions	**57,081**	**49,287**	**48,099**	**37,852**	**38,807**	**32,802**	**30,628**
Related Energy Consumption (mWh)							
Electricity renewable	14,164	15,219	10,606	32,503	31,873	26,798	9,294
Electricity non-renewable	55,527	48,924	50,219	15,404	13,211	12,342	31,171
Gas	75,343	56,872	64,645	43,804	39,620	33,969	34,332
Gas Oil	3,400	3,853	4,594	4,748	5,489	1,315	510
Total inc other	**149,018**	**126,283**	**131,328**	**97,370**	**90,985**	**75,266**	**76,818**
Financial Indicators (£k)							
Expenditure on energy	8,433	7,592	7,993	7,014	7,272	5,944	5,437
Carbon ofsetting costs	352	440	458	147	227	92	112
Expenditure on offical business travel	21,593	17,996	18,040	18,618	19,876	20,003	19,620

1. For sustainability reports for individual organisations, please see their own annual report and accounts.
2. The core Department does not report on Quarry House for energy, waste and water. This is included in the sustainability reporting for Department of Work and Pensions.

Figure 19: CO2 Output 2010-2011 to 2016-17



Scope 1 – Direct emissions, Scope 2 – Energy indirect emissions, Scope 3 – Other indirect emissions

462. The results presented above show the Department has continued to reduce its carbon emissions in 2016-17. We continue to implement initiatives to reduce our carbon footprint, which have included the deployment of energy efficient IT, consolidation of estate, tighter building environment controls and improved Video Conference facilities.

Waste

Table 39: Waste – Financial and Non-Financial Indicators

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Non Financial Indicators (tonnes)							
Total waste -	**4,022**	**2,841**	**4,337**	**2,679**	**2,484**	**2,172**	2,566
Landfill			573	473	585	355	165
Not to landfill			3764	2207	1899	1817	2,401
Incinerated/energy from waste			259	328	316	259	325
Incinerated/energy not recovered			378	334	323	294	**244**
Financial Indicators (£k)							
Total disposal cost (minimum requirement)	**927**	**672**	**561**	**868**	**718**	**978**	671
Hazardous waste - total disposal cost	348	228	244	499	405	621	407
Non-hazardous waste - total disposal cost	578	445	561	369	313	357	264

1. Breakdown of waste data between landfill and non-landfill not collected for 2010-11 and 2011-12.

Figure 20: Waste and Recycling

463. Total waste figures for the Department have decreased again in 2016-17. The spike in 2012-13 was due to extensive refurbishment programmes taking place as part of the transition to the new Health and Social Care system. The proportion of waste recycled across the DH/ALB estate has improved further, with 94% of waste not to landfill, and 6% to landfill.

Water

Table 40: Water Consumption – Financial and Non-Financial Indicators

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Non Financial Indicators (m3)							
Water Consumption -							
Office	69,051	68,077	73,132	63,067	59,826	65,733	64,936
Whole estate	254,719	239,426	297,384	235,336	236,742	179,218	188,793
m3 per FTE/office estate	7.6	7.5	7.6	6.8	5.5	6.0	6.0
Financial Indicators (£k)							
Water supply costs	338	302	347	364	345	277	335

464. As the table above indicates, the Departments water consumption has slightly increased during the year. The benchmark for water consumption is measured per person on a Full Time Equivalent basis. Our performance has however improved from the baseline of 7.9m³ per FTE in 2009-10, to 6.0m³ per FTE in 2016-17. This means the Department is in the good practice category. The Department is working with its facilities suppliers and other organisations on how to continue to reduce its water consumption to meet the best practice target of less than 4m³ per FTE.

Annex E – Department of Health Official Development Assistance

465. The following section focusses on Official Development Assistance (ODA) spend. The definition of ODA is set by the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) and spend data is collected from 30 different DAC members including the UK.

466. The rules set by the OECD ensure international comparability and consistency in the reporting of ODA among the DAC members. Under the rules, spend must be reported on a calendar-year basis to provide comparable data (and take account of the fact that financial years vary across members). The rules also state that ODA spend must be recorded on a cash basis (not accruals).

Table 41: Official Development Assistance

The Department of Health provided £45,480,515 of Official Development Assistance (ODA) in 2016.[84]
The Department of Health did not spend any cross-government ODA funds in 2016.
Global Health Research assistance was focused on the Joint Global Health Clinical Trials Initiative **Global Health Security** assistance was focused on: **The Fleming Fund** - This project is focused on improving data and surveillance of Antimicrobial Resistance (AMR) in low and middle income countries (LMICs) where drug resistant infections have a disproportionate effect. The Fund will improve laboratory capacity and diagnosis in these countries so that the sharing of data on drug resistant infections can be implemented locally, regionally and internationally. In 2016, the most significant areas of ODA spend were: – Grants to multilateral organisations (WHO, OIE and FAO) – Vietnam pilot – Management agent and evaluation supplier costs – Project activities, including secondments, technical advice and events **Vaccines Network** - This project is focused on targeted investments in the most promising vaccines and vaccine technologies that will help combat the world's deadliest diseases. This will help to ensure we have the best responses available to prevent, detect and respond to emerging health threats. In 2016, the most significant areas of spend were: – 6 MRC Intramural bid projects, managed by the National Institute for Health Research Evaluation, Trials and Studies Coordinating Centre (NIHR NETSCC) – £10m Vaccine SBRI competition managed by the Technology Strategy Board (Innovate UK) to support projects seeking to develop vaccines, vaccine platform technologies and manufacturing technologies **UK Public Health Rapid Support Team** - This project is a team of public health specialists who can deploy within 48 hours to investigate a disease outbreak in an LMIC. This is an equal partnership between Public Health England (PHE) and the London School of Hygiene and Tropical Medicine (LSHTM). In 2016 payments were made to both PHE and LSHTM to deliver the project. **International Health Regulations (IHR)** - This project, run by Public Health England, will improve IHR compliance in LMICs through specific work in up to four countries and through wider regional structures. In 2016 payments were made to PHE to deliver the design phase of this project. **ODA admin** – Programme team and legal costs.

[84] Figures are provisional, taken from Provisional UK Official Development Assistance as a Proportion of Gross National Income 2016.

The Framework Convention on Tobacco Control 2030 project (FCTC 2030) - The project aims to improve tobacco control in Low to Middle Income Countries (LMICs) through strengthening the implementation of the WHO Framework Convention Tobacco Control. In 2016, the most significant areas of ODA spend were:

- Grant to the WHO FCTC Secretariat to establish the FCTC2030 project, including a tobacco control expert seconded from the Department of Health
- 15 partner parties countries selected for focused support
- A Ministerial/high level representative tobacco tax summit held with LMIC representatives

Other

The Department of Health pays an annual subscription to the World Health Organisation (WHO) and takes the overall lead for the Government's engagement with the organisation. The annual contribution to WHO's budget is linked to the UN Scales of assessment agreed in New York. These scales are negotiated by the FCO in accordance with the UN Charter and UK membership obligations.

The Department of Health has funded the first twelve months of refugee healthcare costs following their arrival in the UK. These are the estimated healthcare costs of refugees classified as 'Section 95' by the Home Office.

In support of the UK Aid Strategy, **Global Health Research** assistance has delivered the development of new knowledge that promises to improve health by addressing the major causes of mortality or morbidity in developing countries.

The **Global Health Security** Programme contributes to the UK Aid Strategy, specifically, 'strengthening resilience and response to crises.' Our work forms part of the Ross Fund, which will fund work to tackle the most dangerous infectious diseases, including malaria. The fund will also support work to fight diseases of epidemic potential, such as Ebola, neglected tropical diseases, and drug resistant infections.

Framework Convention on Tobacco Control 2030 project (FCTC2030)

Tobacco use is the world's single most preventable cause of death and disease, and by 2030 over 80% of the world's tobacco-related mortality will be in developing countries. It is also a major barrier to social inequities, economic and environmental harm on individuals, families, and national economies.

The UK is also a global leader in Tobacco Control. Investing UK aid to support tobacco control in those countries will help reduce the burden of death and disease, make a reduction in the economic burden and other societal costs attributable to tobacco use, and ultimately make better use of health system resources to improve health and well-being of their populations.

Annex F – Our Arm's Length Bodies and Delivery Partners

Our Executive Agencies

Public Health England (PHE) provides national leadership and expert services to support locally-led public health initiatives and to respond to health protection emergencies. PHE works alongside local government, the NHS and other key partners, supporting the development of the public health workforce, jointly appointing local authority directors of public health, supporting excellence in public health practice and providing a national voice for the profession.

The **Medicines and Healthcare products Regulatory Agency (MHRA) operates** as a trading fund, whose mission is to enhance and safeguard the health of the public by ensuring that medicines and medical devices work and are acceptably safe. It does this by protecting public health through regulation, promotion of public health and improving public health by encouraging and facilitating developments in products.

Our Executive non-Departmental Public Bodies

NHS Commissioning Board (known as NHS England (NHSE))
NHS England sets the framework for commissioning of healthcare services in England. It funds Clinical Commissioning Groups (CCGs) which are responsible for commissioning services for their communities, and ensures that CCGs do this effectively. NHSE also commissions some services nationally. Working with leading health specialists, NHS England brings together expertise to ensure national standards are consistently in place across the country.

Monitor
Monitor remains a legal entity, from 1 April 2016 Monitor, along with the NHS Trust Development Authority operates as a single organisation, **NHS Improvement (NHSI)** under a shared executive leadership and Board membership.

Care Quality Commission (CQC)
The CQC is the independent regulator of health and adult social care providers in England. It ensures that only those providers who have made a legal declaration to meet the 'fundamental standards of quality and safety' and satisfy the registration process may provide care. Once services are registered, CQC monitors and inspects them against the fundamental standards.

National Institute for Health and Care Excellence (NICE)
NICE provides guidance, standards and information to help health, public health and social care professionals deliver the best possible care based on the best available evidence.

NHS Digital (NHSD)
The NHSD (formerly known as NHS Health and Social Care Information Centre) collects, analyses and publishes national data and statistical information. It also delivers the national IT systems and services to support the health and care system.

Human Fertilisation and Embryology Authority (HFEA)
The HFEA is the UK's independent regulator of treatment using gametes and embryos, and embryo research. It sets standards for, and issues licences to, UK fertility clinics and all UK research involving human embryos. It also determines the policy framework for fertility issues.

Human Tissue Authority (HTA)
HTA regulates and ensures that human tissue is used safely and ethically with proper consent. It regulates organisations that remove, store and use tissue for a variety of purposes.

Health Research Authority (HRA)
The HRA promotes and protects the interests of patients and the public in health and social care research. It protects patients and the public from unethical research while enabling them to benefit from participating in research by simplifying the processes for ethical research.

Health Education England (HEE)
HEE is the national leadership organisation for ensuring that the education, training and development of the healthcare workforce support the highest quality public health and patient outcomes.

NHS Improvement (NHSI)[85]
NHSI is the operational name for the organisation that brings together Monitor and NHS Trust Development Authority, with a shared executive leadership and is responsible for overseeing NHS Foundation Trusts, NHS Trusts and independent providers. Supporting providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, helping the NHS to meet its short-term challenges and secure its future.

Our Special Health Authorities

NHS Trust Development Authority (NHS TDA)
The NHS TDA remains a legal entity, however from 1 April 2016, along with Monitor operates as a single organisation, **NHS Improvement (NHSI)** under a shared executive leadership and Board membership.

NHS Business Services Authority (NHSBSA)
The NHSBSA provides a range of critical business support services to NHS organisations, NHS contractors, patients and the public. Its services include payments to community pharmacists and dentists for their NHS work, the administration of the NHS pension scheme, and the management of NHS Supply Chain.

NHS Resolution (NHSR)
NHSR provides indemnity cover for negligence claims against the NHS in England on behalf of member organisations and helps the NHS learn lessons from claims to improve patient and staff safety. It also helps to resolve concerns about the professional practice of doctors, dentists and pharmacists and is responsible for the resolution of appeals and disputes between primary care contractors and NHS England. NHS Resolution was previously known as the **NHS Litigation Authority (NHS LA)**. On 1 April 2017 it became known as NHSR with a stronger focus on prevention, learning and early intervention in incidents.

[85] NHSI is the operational name for Monitor and NHS TDA, it does not have formal entity status

Other bodies included within the Departmental Group

NHS Property Services Ltd (NHSPS)

NHSPS is a limited company wholly owned by the Secretary of State for Health. NHSPS provides strategic and operational management of NHS estates, property and facilities.

Community Health Partnerships Ltd (CHP)

CHP is a limited company wholly owned by the Secretary of State for Health. It was established in 2001 to implement the NHS Local Improvement Finance Trusts (LIFT) programme. It inherited the LIFT shareholdings and property interests previously held by PCTs. From 1 April 2013 the company is included within the DH accounting boundary (having previously been held as an investment by DH). CHP facilitates public-private partnerships to deliver a wide range of health planning and estate services to support health providers and local authorities achieve improvements in the estate.

Genomics England Ltd

Genomics England is a limited company wholly owned by the Secretary of State for Health, set up to deliver the 100,000 Genomes Project. Genomics England will manage contracts for specialist UK based companies, universities and hospitals to supply services on sequencing, data linkage and analysis. It will also strictly manage secure storage of personal data in accordance with existing NHS rules designed to securely protect patient information. Genomics England is funded by the Department of Health in the medium term.

Skipton Fund Ltd

The Skipton Fund was established by the Department of Health on behalf of the Secretary of State for Health to administer an ex gratia payment scheme and make payments to relevant claimants on behalf of UK health administrations to people who were infected with hepatitis C through treatment with NHS blood or blood products prior to September 1991 and other eligible persons.

Nursing & Midwifery Council (NMC)

The NMC is the independent nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland and accountable to Parliament through the Privy Council. The NMC works to (1) protect, promote and maintain the health, safety and well-being of the public, (2) promote and maintain public confidence in the nursing and midwifery professions and (3) promote and maintain proper professional standards and conduct for members of the nursing and midwifery professions. The NMC regulatory responsibilities are to (1) keep a register of all nurses and midwives who meet the requirements for registration, (2) set standards of education, training, conduct and performance so that nurses and midwives are able to deliver high-quality healthcare consistently throughout their careers and (3) take action to deal with individuals whose integrity or ability to provide safe care is questioned, so that the public can have confidence in the quality and standards of care provided by nurses and midwives.

Health & Care Professions Council (HCPC)

The HCPC is the independent regulator of 15 health and care professions in the UK, and for social workers in England. The HCPC is accountable to Parliament through the Privy Council. The HCPC works to safeguard the health and well-being of persons using or needing the services of its registrants. To fulfil this public protection role, the HCPC (1) sets standards for the education and training, professional skills, conduct, performance and ethics of registrants, (2) keeps a register of professionals who meet those standards, (3) approves programmes which

professionals must complete before they can register and (4) takes action when professionals on its register do not meet its standards.

Professional Standards Authority (PSA)

PSA is accountable to Parliament and carries out a range of activities to promote the health and well-being of patients, service users and the public in relation to the regulation of health and social care professionals. The PSA has duties and powers in relation to (1) oversight of nine statutory bodies that regulate health and social care professionals in the UK, (2) provision of advice to, and undertaking investigations for, government, (3) accreditation of the voluntary registers held by non-statutory regulators of health and care professionals and (4) provision of advice to other similar organisations in the UK and overseas.

Other bodies not included in this Annual Report and Accounts

NHS Blood and Transplant (NHSBT)

NHSBT is responsible for the supply of blood, organs, tissues and stem cells. It manages the voluntary donation and processing of around 2 million units of blood per year, as well as organ and tissue donations.

Medicines and Healthcare products Regulatory Agency (MHRA)

The role of the MHRA is described on Page 6.