Department of Health & Social Care

Department of Health and Social Care

Annual Report and Accounts

2018-19

(For the period ended 31 March 2019)

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

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

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This is part of a series of departmental publications which - along with the Main Estimates 2018-19 and the document Public Expenditure: Statistical Analyses 2018 - present the Government's outturn for 2018-19 and planned expenditure for 2019-20.

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Performance Report

Permanent Secretary's Overview

The Department of Health and Social Care supports its Ministers in leading the nation's health and care to help people live more independent, healthier lives for longer. 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.

In 2018 we celebrated the 70th year of the NHS, with the announcement of the long-term funding settlement, some £33.9 billion increase in revenue spending in cash terms by 2023-24. The NHS Long Term plan published in January 2019 sets out how this additional funding will be spent to address the challenges within the NHS both of today and the future, building an NHS fit for the future with prevention at the heart of our future healthcare system.

2018-19 has been challenging for the health and care system, with ever increasing demand for NHS services, treating more patients than ever before. This means that despite the continuing best efforts of the NHS, key waiting time and performance targets have again not been achieved in 2018-19. The system continues to work hard to address the challenges, focusing on the quality of patient care, striking the right balance across performance, transformation, quality and safety and living within its financial means.

Against this backdrop however, the health and care system has delivered financial balance by focusing on financial rigour and efficiency, with the majority of NHS provider organisations meeting their control totals in 2018-19 which has contributed to the Department delivering overall financial balance.

July 2019 sees the 100th anniversary of the Ministry of Health, established with the aim to 'promote the health of the people throughout England and Wales'. We have much to look back on with pride and to this day our strategic aim remains similar, as we prepare for the challenge ahead for the Department and the health and care system.

It remains a great privilege to lead the Department and I would like to take this opportunity to thank 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 health and care system.

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

Our Role and Purpose

1. The Department of Health and Social Care (DHSC) supports the Government's Health and Social Care Ministers in leading the nation's health and care to help people live more independent, healthier lives for longer.

2. We support and advise our Ministers to shape policy and set direction, while remaining accountable for delivering the Government's commitments, coordinating the legal, financial and policy frameworks in health and social care and, when necessary, we step in as troubleshooters to take action to solve complex issues. In doing all this, we work closely with our partners in the health and care system, our Arm's Length Bodies (ALBs) and agencies, local authorities, across Government, and with both patients and the public. We are accountable for the health and care system to Parliament and the taxpayer.

3. As a Department of State our strategic priorities are:
   - to keep people healthy and support economic productivity and sustainable public services;
   - to transform primary, community and social care;
   - to support the NHS to deliver high quality, safe and sustainable hospital care and secure the right workforce;
   - to stay at the cutting edge of research and innovation to maximise health and economic productivity;
   - to ensure accountability of the health and care system; and
   - to create value by promoting better awareness and adoption of good commercial practice.

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

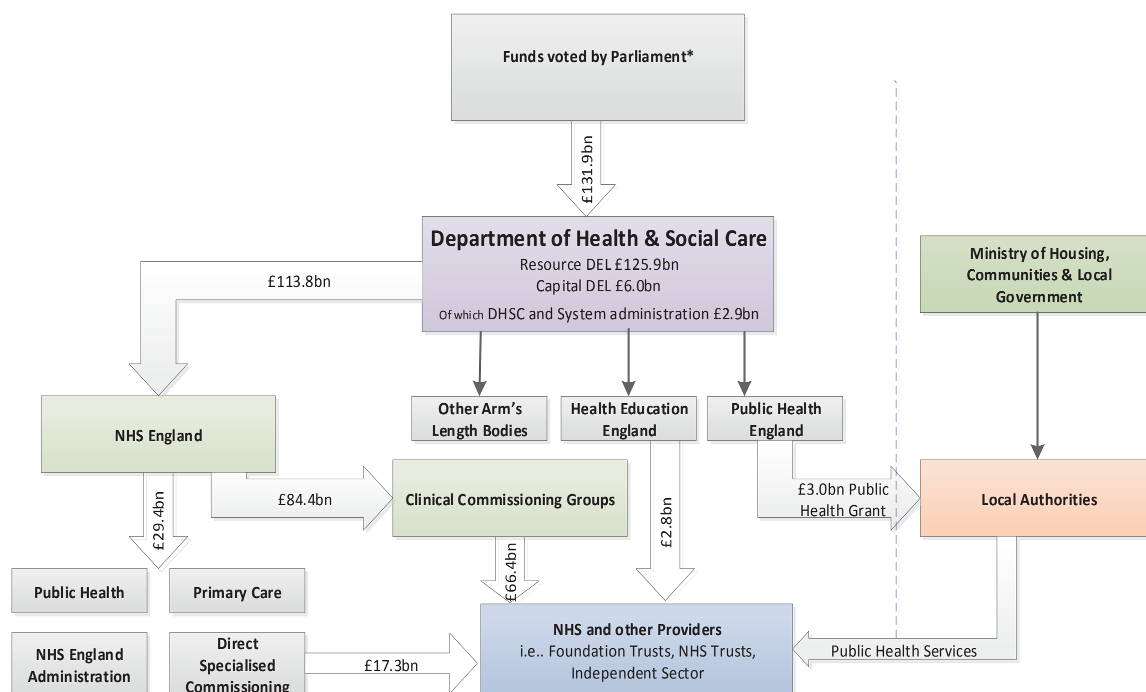
5. The Department has prioritised building strong governance and boards in each of these organisations and its other ALBs, and, where necessary, acting as a national co-ordinating mechanism.

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

7. 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 expenditure of £125.3 billion and invested a further £5.94 billion in capital funding such as new hospitals and equipment. **Figure 1** demonstrates how funding flows round the system, using budgeted figures for 2018-19 for contextual purposes.

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

Figure 1: Flow of funding in the health and care system, 2018-19 (Budgeted Position)



*This includes funding from National Insurance Contributions that are not included in the parliamentary vote on DHSC budget. This funding is received directly from HMRC via the National Insurance Fund which is provided for in legislation.
Budgeted figures used in this presentation, actual figures used by exception where allocations are not included in budgets.
Dashed line indicates boundary of consolidation for DHSC and shows Local Authority funding to Health.

Our 2018-19 Achievements - At a glance

Over 986,000 more A&E attendances managed than in 2017-18

Parity of esteem for **mental health** with **90% of CCGs having met the Mental Health Investment Standard**

98.8% of population has access to weekend and evening appointments at GP/nearby

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

New system for **organ and tissue donation** launched **August 2018**

Annual flu vaccination delivered in England to **more people than ever before.**

100,000 genomes sequenced by December 2018.

83.5% of social care providers rated as **Good** or **Outstanding** by CQC

Over **870,250** participants recruited for vital health research through NIHR Clinical Research Network

3,473 Doctors accepted into **GP specialty training** [10% higher than 2017-18]

Published **2nd chapter** of the **Childhood Obesity Plan** (In June 2018)

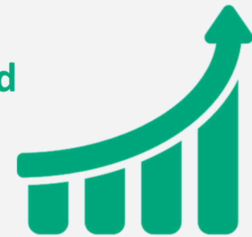
2018-19 - Key Finance Facts

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

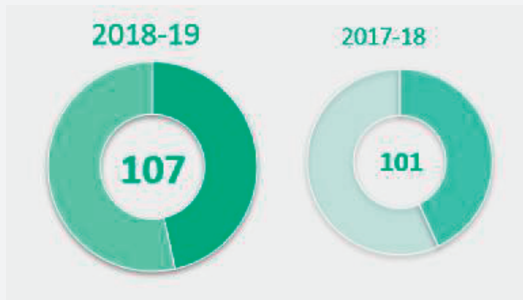
NHS Long Term Plan securing extra **£33.9bn to the NHS** by 2023-24, from 2019-20.

The NHS delivered overall **financial balance**

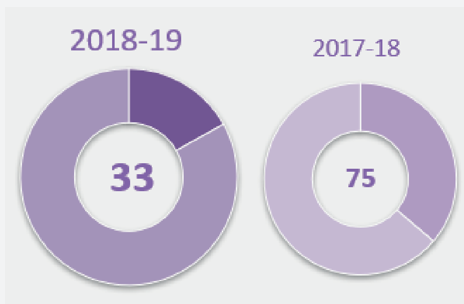
£2.45bn Provider Sustainability Fund helping to sustain NHS providers



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



£6.1bn (gross) **investment in capital**



Number of CCGs with overspends

£5.9bn underspend against the **AME budgetary control**

Performance Summary

9. This performance summary and the role and purpose section provide information about the Department, our purpose and how we have performed during 2018-19.

10. The Department has a Single Departmental Plan (SDP)[1], which sets out the work we are committed to achieving to improve the health and social care system over the course of this Parliament. The Department's national partner organisations are key to the successful implementation of many of these priorities and where they are accountable for delivery, there is a clear line of sight from the SDP to the organisation's business plan through to commissioners, providers and ultimately, patients and the public.

11. The SDP was developed in conjunction with our ministerial team and sets out the strategic direction for the health and social care system with clear objectives, milestones and metrics to deliver the Secretary of State's priorities and the NHS Five Year Forward View[2]. It provides the foundation for how we measure our progress and the structure for our quarterly reporting to our Departmental Board and its sub-committees.

Single Departmental Plan 2018-19 Objectives

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

1. **Keeping people healthy and supporting economic productivity and sustainable public services**
2. **Transforming primary, community and social care to keep people living better for longer in their community**
3. **Supporting the NHS to deliver high quality, safe and sustainable hospital care and securing the right workforce**
4. **Support research and innovation to maximise health and economic productivity**
5. **Ensuring accountability of the health and care system to Parliament and the taxpayer; and creating an efficient and effective Department of Health and Social Care**
6. **Creating value (reduced costs and growing income) by promoting better awareness and adoption of good commercial practice across the DHSC and our Arm's Length Bodies**

12. The SDP is focussed both on the short-term objectives that we are committed to deliver across the year, and on the long-term ambitions that they underpin. In this report we will give an overview of performance in 2018-19 against both the short and long-term progress on our six strategic objectives.

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

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

14. The challenges we face in delivering our objectives and achieving the right balance in doing so are well known and are shared by health and care systems across the world. An ageing population coupled with the increasing complexity of illness, contributes to rising demand for services across the system. Rapid medical and technological advances allow us to treat more people but historically has often been at greater cost. Recent breakthroughs offer the potential for technology to both improve outcomes and reduce costs. We must therefore respond to these challenges, but we do so against the backdrop of ongoing EU Exit negotiations, bringing both challenge and opportunity.

15. The demand for services provided in the health and care system continues to rise above population and demographic growth as better diagnosis and medical advancement means more treatment is possible, 24.8 million people attended an A&E facility in England in 2018-19, an increase of 4.1% compared with 2017-18. There has been a continuing rise in demand for cancer services, with urgent referrals for suspected cancer increased by 15.7% compared to 2017-18.

16. Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2018-19, including A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards. The summer of 2018 was the joint hottest on record, with the government issuing hot weather warnings in May, June and July. The heat contributed to increased demand, impacting upon performance. Despite lower performance against key performance metrics, over 780,000 more people were treated within 4 hours compared to last year.

17. The winter period, always the most challenging for the NHS, saw an increase of over 400,000 attendances (5.1%). £145 million was allocated to help support local NHS plans to manage the 2018-19 winter period. Despite this increased demand, over 380,000 more patients were seen within 4 hours, compared to last winter.

18. In 2018, we celebrated the 70th year of the NHS with both the funding and the plans to put the NHS on a firm footing for the future. In June 2018, a long-term funding settlement for the NHS was announced, amounting to a £33.9 billion increase in revenue spending in cash terms by 2023-24. But funding alone is not enough to equip the NHS to address the challenges of today or those of the future. The NHS Long Term Plan, published in January 2019[3] takes that role, placing prevention at the heart of the plan for the future of our healthcare system.

19. The NHS Long Term Plan aims to improve the quality of patient care and health outcomes, it sets out how the additional funding will be spent over the next 5 years. The plan focuses on building an NHS fit for the future by; enabling everyone to get the best start in life, helping communities to live well and helping people to age well. In July 2019

[3] https://www.gov.uk/government/news/nhs-long-term-plan-launched

the NHS Long Term Plan Implementation Framework[4] was published, setting out further detail how the NHS Long Term Plan will be delivered.

20. Prevention remains a high priority for the Department, smoking prevalence is now at the lowest rate since records began, we have successfully achieved our goal of sequencing 100,000 whole genomes to improve diagnosis and treatments for patients with rare diseases and cancer, with a new ambition set to sequence 5 million genomes over the next 5 years. We have published the next chapter for tackling childhood obesity and targeted action for Anti-Microbial Resistance (AMR) including the Government's 10-year AMR vision and national action plan.

21. Despite increasing activity during the year, the NHS balanced its financial budget through continuing focus on financial rigour and efficiency, with the majority of Trusts once again meeting their control totals. This contributed to the Department delivering the 2018-19 financial outturn within the Parliamentary vote. This level of rigour will need to continue in future years to support long-term financial sustainability. More widely the Department's 'going concern basis' is addressed in the statement of accounting policies, note 1.

22. 2018-19 saw an increased focus on the use of technology, with the publication of the Secretary of State's Technology Vision 'The future of healthcare: our vision for digital, data and technology in health and care'[5] in October 2018 and the announcement in February 2019 of the planned establishment of NHSX, bringing together policy, strategy, delivery and transformation of technology and data to improve patient care to support delivery of the NHS Long Term Plan.

23. In 2018-19, we have maintained a significant focus on ensuring we have the right number of staff to deliver safe quality care in the NHS. Work to develop an NHS People Plan was undertaken and an Interim People Plan[6] was published on 4 June 2019; a final People Plan will be published following the conclusion of the Autumn 2019 Spending Review. Focus on retention and recruitment of NHS staff has continued with some success in increasing training places for GPs and allied health professionals. The Department recognises the incredible contribution social care workers make to our society, an adult social care recruitment campaign, 'Every Day is Different' launched in February 2019[7].

24. During the year, the Department has worked with our ALB partners to ensure the health and social care system is as prepared as possible for EU Exit. This has included putting in place transitional arrangements for any new relationship with the EU should a withdrawal agreement be ratified, and also in accordance with Government policy and our duties to protect public health, taking action to prepare for the potential consequences of a 'No Deal' EU Exit, and the potential risks to patient care. This included work on the continuity of supply of medical products after exit-day, in line with the cross-government reasonable worst-case planning assumptions. Following the extension of the Article 50 period to the

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[4] https://www.longtermplan.nhs.uk/implementation-framework/
[5] https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care
[6] https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/
[7] https://www.everydayisdifferent.com/home.aspx

12 April 2019 and then 31 October 2019, the Department has also re-baselined EU Exit plans and issued appropriate and timely guidance to the health and social care system.

25. In 2018-19, total spend on EU Exit programmes was £52 million. This included £35.3 million of expenditure on the continuity of supply programme and £0.8 million for other no deal programmes. The resources required for EU Exit preparations have been kept under review throughout the year. The Department was supported by £21.1 million of additional funding, announced by HM Treasury in the 2018 Spring Statements. Preparations for the UK's departure from the EU will continue through 2019-20 and £50 million of additional funding from HM Treasury has been made available for this purpose. We will continue to review the resources required as events develop and seek to minimise costs wherever possible.

26. A more detailed analysis of the Department's performance in 2018-19 is presented in the following section, including further analysis on the delivery of our key objectives and progress against the objectives set out in our SDP. The SDP includes some longer-term objectives meaning some areas are more mature in terms of deliverables than others and the presentation of analysis that follows reflects this. Details of our performance against outcomes frameworks are contained in the Secretary of State's Annual Report section of this Report.

Performance Analysis

27. This performance review covers the performance of the health and care system in 2018-19, including delivery of our six objectives and progress against the Single Departmental Plan (SDP).

Objective 1: Keeping people healthy and supporting sustainable public services

28. The Department continues to focus on keeping people healthy for as long as possible and the NHS Long Term Plan[8] presents a step change in our ambitions, placing preventative services and primary and community care at the centre of the plans for the future of the NHS. The NHS Long Term Plan proposes a set of new evidence-based NHS prevention programmes, including to further cut smoking, reduce obesity, limit alcohol-related A&E admissions and lower air pollution and a set of specific actions, including to cut smoking in pregnancy, provide better support to people with learning disabilities and/or autism and provide outreach services to people experiencing homelessness.

29. While progress is being made to reduce health inequalities, we are clear that we can go much further. Therefore, NHS England will base its five-year funding allocations to local areas on more accurate assessment of health inequalities and unmet need. In order to receive that funding, all major national programmes and every local area will be required to set out specific measurable goals and mechanisms by which they will narrow health inequalities over the next five and ten years.

30. We are also prioritising the use of digital technologies in order to keep people healthier for longer and to ensure they are treated in the most convenient settings, which is set out in more detail under Objective 2.

Promoting Healthy Behaviours

31. Work to promote healthy behaviours and improve outcomes continued in 2018-19, key achievements include:
    - Publication of the Tobacco Control Delivery Plan in June 2018[9] which set out actions for meeting the aims of the tobacco control plan for England, and how progress will be monitored.

    - Smoking prevalence has reduced to 14.9% in 2017 - the lowest ever recorded level.[10]
    - In April 2018, we launched a £6 million scheme (jointly with Department for Work & Pensions) to improve outcomes for children with alcohol dependent parents[11].
    - We fully established the Northern Ireland abortion scheme. All women resident in Northern Ireland can access funded services in England, and those who meet eligibility criteria also have travel and accommodation funded.

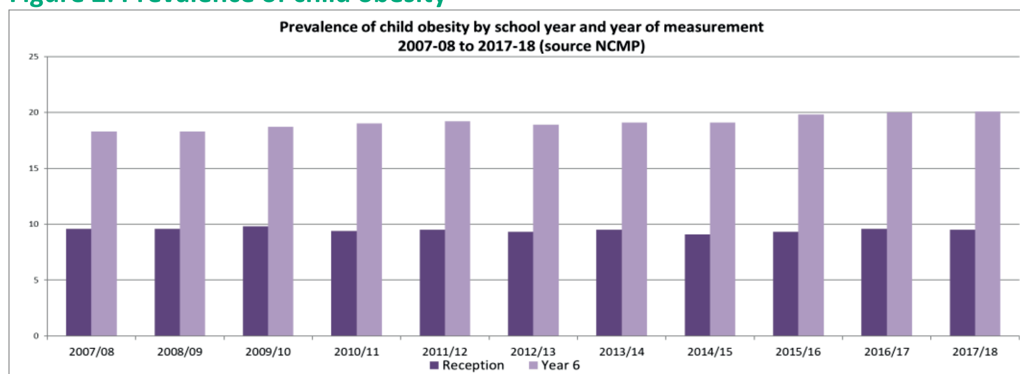
[8] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf
[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714365/tobacco-control-delivery-plan-2017-to-2022.pdf
[10] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2018/content
[11] https://www.gov.uk/government/news/new-support-to-help-children-living-with-alcohol-dependent-parents

- Approved homes in England as a class of place where early medical abortion can be performed, increasing choice and patient safety.

32. The latest available data (for the 2017-18 school year) shows that the prevalence of child obesity remains high: 9.5% for children in reception (aged 4-5) and 20.1% for children in year 6 (aged 10-11)[12] compared with 9.6% and 20.0%, respectively in 2016-17. To support action to address this issue, the Department published the Second Chapter of the Childhood Obesity Plan[13] in June 2018. Building on the first chapter, this sets out a range of proposals to support a new national ambition to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030.

33. These proposals included consulting on a number of measures, including: restricting promotions of high fat, salt and sugar products by location and by price; further advertising restrictions including 9pm watershed; mandating calorie labelling in the out of home sector; and ending the sale of energy drinks to children. Other measures included encouraging schools to adopt an active mile initiative and developing a Trailblazer Programme with local authority partners to test innovative action to tackle childhood obesity, share learning on what works and consider further action Government can take to better enable local action to create healthier environments. The prevalence of childhood obesity can be seen in **Figure 2**.

Figure 2: Prevalence of child obesity



Note: These are latest available figures.

34. The Government delivers several Healthy Food Schemes – Healthy Start, School Fruit & Vegetable and the Nursery Milk schemes, which aim to provide children with nutritional support and to encourage good eating habits from an early age. The schemes are delivered through 13 contracts, which are managed on behalf of DHSC by the NHS Business Services Authority (BSA).

Healthy Food Schemes
300,000 people taking up Healthy Start vouchers
46,000 Childcare settings registered for the nursery milk scheme
442 million pieces of fruit & veg distributed to **2 million** children across 16,600 schools

[12] https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme
[13] https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2

35. Several significant issues were handled during the year, including:
    - The withdrawal of Capespan, which led to a large gap in supply of citrus fruits and carrots, solutions were developed to ensure continuity of supply;
    - the transfer of over 135,000 Universal Credit records to Healthy Start, which involved linking APIs between DHSC and the Department for Work and Pensions (DWP), agreements on data sharing and handling the impact on existing Healthy Start provision;
    - legislation to support the transfer of new Pension Credit beneficiaries to Healthy Start and (separately) to support the devolution of Healthy Start to Scotland;
    - an audit of Nursery Milk, which highlighted recommendations to improve the end to end process to reduce fraud and error, which are now being put in place; and
    - processing of nearly 200 cases of fraud and error in claims for the Nursery Milk Scheme.

Health Ethics

36. Plans for a non-statutory scheme for medical examiners to be rolled out from April 2019 were announced by means of a written ministerial statement in June 2018[14]. A series of national events have been held to disseminate further details of implementation with the ambition to scrutinise all deaths (in NHS acute trusts) by the end March 2020, and all deaths by the end March 2021. A National Medical Examiner has been appointed and plans for regional structure to support the independence of the system have been published.

37. In response to our consultation on how to address the shortage of organ and tissue donors, we announced plans for a new system for organ and tissue donation in August 2018[15]. A new donor register, expected to come into effect in Spring 2020 will mean that everyone is considered an organ donor after their death unless they have explicitly recorded a wish not to be or if they are from a specifically excluded group (children under 18; individuals who lack the mental capacity to understand the changes; and people who have not lived in England for at least 12 months before their death).

Public Health, Screening and Immunisations and Global Health

38. We have maintained our focus on delivering excellent national immunisation programmes, which protect against 16 different diseases. There have been positive developments such as high uptake of the new Meningococcal B vaccine, which was reported as a National Statistic for the first time this year and achieving 92.3% uptake at age 12 months. We also announced in July 2018 the human papillomavirus (HPV) vaccine will be extended to boys aged 12 and 13 (school year 8) in England, which will help prevent more cases of HPV-related cancers in men and women. The seasonal flu vaccination programme was successfully delivered, and the vaccine was offered to more people than ever before. We achieved the highest uptake figure for children aged 2-9 years and for healthcare workers (70.3%). In addition, early data suggests vaccine

[14] https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-06-11/HCWS755

[15] https://www.gov.uk/government/news/new-system-of-consent-for-organ-and-tissue-donation-announced

effectiveness was up on last season, with vaccines that were well matched to dominant circulating strains and a newly available, more effective adjuvanted influenza vaccine being offered to those aged 65 and over.

39. Vaccinations are a key part of the prevention strategy in the NHS Long Term Plan, and Public Health England annual surveys show parents have high levels of confidence in the national childhood immunisation programmes. Despite overall coverage remaining high, there has been a small but continued decline across many of the vaccination programmes:
    - Coverage has seen small declines in 9 of the 12 routine vaccinations measured at age 12 months, 24 months and five years in England compared to the previous year.
    - Coverage for the Measles Mumps and Rubella (MMR) vaccine as measured at two years decreased in 2017-18 for the fourth year in a row to 91.2%, the lowest it has been since 2011-12.
    - The first dose of the MMR vaccine as measured at age 5 remains broadly stable - at 94.9%, dropping just below the World Health Organisation (WHO) target of 95%[16] (met for the first time the previous year at 95%). However, uptake of the second MMR dose by age five years was 87.2%, below the WHO 95% target required to sustain elimination in the long run. In January, Public Health England published a UK measles and rubella elimination strategy, which includes achieving and sustaining very high coverage of the MMR vaccine.

40. DHSC, NHS England and Public Health England are working together to better understand local variation in vaccine uptake and to ensure that healthcare providers address it. Steps include the introduction of local immunisation co-ordinators who understand the issues in their local area and are able to drive the uptake in a way that suits their area's unique circumstances.

41. The UK has maintained its commitment to slowing the growth and spread of antibiotic resistance, which poses a threat to keeping people healthy in the future. The Government has published a 20-year vision and a 5-year national action plan for how the UK will contribute to containing and controlling Antimicrobial Resistance (AMR) by 2040. The plans build on progress already made in reducing the antimicrobial use in humans by 7.3% and 40% in animals and set out how the UK will continue to play its part by modelling best practice and innovative approaches at home, sharing good practice and learning from others and supporting progress internationally. Human health targets, include:
    - reducing the number of drug-resistant infections by 10% (5,000 infections) by 2025.
    - reducing UK antimicrobial use in humans by 15% by 2024.
    - preventing at least 15,000 patients from contracting infections as a result of their healthcare each year by 2024.

42. We have continued with wider efforts to tackle Antimicrobial Resistance (AMR), including the announcement of £32 million of capital funding in October 2018[17] for research into

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[16] https://app.powerbi.com/view?r=eyJrIjoiZTI3NWZhNzItMTIyZS00OWM2LTg0MzMtOGY5YTJjMGY0MjI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

[17] https://www.gov.uk/government/news/32-million-competition-launched-for-amr-research

AMR to strengthen the UK's AMR research capability and working with other nations to strengthen our international resilience. In September 2018, we launched the new Commonwealth Partnerships for Antimicrobial Stewardship (AMS) scheme[18], funded by the Department's Fleming Fund, which will see NHS and national teams working together to help to keep antibiotics working better for longer and stop the emergence of superbugs. The Department also joined forces with the Argentinian Government in October 2018, to lead on an exercise to test G20 world leaders on how they would tackle the spread of an infection that is resistant to antibiotics.[19]

43. We continue to engage closely with our expert committees to understand the infectious and environmental risks, ensuring their advice supports effective mitigations to minimise both the spread of infection through vaccination, good prescribing practice and impacts of hazards such as pollution.

44. The Independent Breast Screening Review (IBSR[20]) report was published on 13 December 2018 with 15 recommendations. The Government published a response on 14 March 2019[21] accompanied by a Ministerial Statement. The Government accepted all of the recommendations, which also took into account findings from the recent investigation into adult screening programmes conducted by the National Audit Office, published on 1 February 2019[22]. The Public Accounts Committee (PAC) published a report on 10 May 2019[23] on Adult Health Screening highlighting similar issues about improvements needed to our national screening programmes and how they are delivered. Some IBSR recommendations are also contingent on the findings of the ongoing Professor Sir Mike Richards' Review of screening programmes due to report in summer 2019, with advice from the UK National Screening Committee on how the upper age limit for breast screening should be defined. The Department is working closely with NHSE and PHE to deliver and monitor progress of the commitments in the Government's response to IBSR. The expert committee on blood safety and infection threats continues its work to ensure emerging risks are mitigated.

45. We have responded to a number of incidents during the year. This includes the Novichok poisoning in Salisbury and Amesbury, clinical waste, infectious disease outbreaks such as Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome Coronavirus (MERS – CoV). This has required us to work closely with NHS England and Public Health England to co-ordinate the response across the health sector. We have also collaborated with other Government departments including the Home Office and Department for Environment, Food and Rural Affairs (Defra) to ensure that there is a consistent approach to incidents across sectors.

46. In December 2018, 150 DHSC staff were recruited to be part of a Volunteer Emergency Response Team. By the end of March 2019, all 150 had completed introductory training and an exercise to familiarise themselves with emergency response procedures.

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[18] https://www.gov.uk/government/news/nhs-to-partner-with-commonwealth-nations-to-stop-superbugs
[19] https://www.gov.uk/government/news/world-leaders-to-take-part-in-crisis-simulation-of-amr-pandemic
[20] https://www.gov.uk/government/publications/independent-breast-screening-review-report
[21] https://www.gov.uk/government/publications/independent-breast-screening-review-government-response
[22] https://www.nao.org.uk/report/investigation-into-adult-health-screening/
[23] https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/1746/174606.htm#_idTextAnchor003

47. DHSC is contributing to a cross Government programme reviewing the lessons from the Salisbury attack. This is being led by the Home Office and started in January 2019. DHSC has also reviewed the risks in the Government's National Security Risk Assessment (NSRA). Changes to the NSRA and the preparedness to respond to the risks will be considered in 2019-20.

48. In November 2017, the Command Paper 'Improving Lives: the future of work, health and disability'[24] set out the vision to see 1 million more disabled people in work between 2017 and 2027. This means increasing the number of disabled people in work from 3.5 million in 2017 to 4.5 million in 2027. In the two years since the start of the goal (2017-2019), disability employment has increased by 404,000. However, we cannot attribute all of the increase directly to policy action because some of the change would have been as a result of natural growth in the labour market. We will consult later in 2019 on ways to reduce the number of people who leave work each year for health reasons. We also continue to drive forward the implementation of the recommendations of the Stevenson/Farmer 'Review of Mental Health and Employers'[25], including by launching a framework to support organisations to record and voluntarily report information on disability, mental health and wellbeing in the workplace in November 2018.

49. In January 2019[26], the Secretary of State for the Environment, Food and Rural Affairs launched an ambitious new strategy to clean up our air and address one of the biggest threats to public health in the UK - behind only cancer, obesity and heart disease. The measures set out in the new Clean Air Strategy plan to cut the costs of air pollution to society by £1.7 billion every year by 2020, rising to £5.3 billion every year from 2030. The UK plans to set an ambitious, long-term target to reduce people's exposure to particulate matter (PM), which the World Health Organization (WHO) has identified as the most damaging pollutant. This comes on top of a commitment to halve the number of people living in areas breaching WHO guidelines on PM by 2025.[27]

Preparing for Exiting the EU

50. Following the decision in December 2018 for 'no deal' preparations to become the operational focus of Government, the Department put in place refined governance and assurance arrangements for managing the EU Exit Portfolio and operational response, working with cross-government dependencies where necessary. We also worked with the Devolved Administrations, Crown Dependencies and Overseas Territories to ensure they were effectively and appropriately factored into Exit planning.

51. By the end of the reporting year, the Department had effectively responded to the extension of the Article 50[28] period to 12 April 2019, with all 'no deal' plans reviewed and amended to reflect the later leaving date.

[24] https://www.gov.uk/government/publications/improving-lives-the-future-of-work-health-and-disability
[25] https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers
[26] https://www.gov.uk/government/publications/clean-air-strategy-2019
[27] https://www.gov.uk/government/news/government-launches-world-leading-plan-to-tackle-air-pollution
[28] https://www.instituteforgovernment.org.uk/explainers/article-50-options

52. We have continued to manage our relationship with the EU; ensuring that whilst we remain a member, we drive UK Government priorities. We have also been leading non-EU international engagement on health, including successfully representing UK interests at the World Health Assembly.

Objective 2: Transforming primary, community and social care to keep people living better for longer in their community

53. Primary medical and community services are vital to ensuring that people can stay healthier for longer. This is why the reforms set out in the NHS Long Term Plan will be backed by a new guarantee that over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget. This commitment creates a ringfenced local fund worth at least an extra £4.5 billion a year in real terms by 2023-24. This commitment means the annual real terms spend on these services will be at least £4.5 billion higher by 2023-24.

54. The first major step forward is delivering the NHS Long Term Plan followed with the publication of the new five-year contract for general practice on 31 January 2019[29]. This will see billions of pounds invested to improve access to family doctors, expand services at local practices and provide longer appointments for patients who need them.

55. Enabling people to live independent lives for longer is also at the heart of our approach to adult social care. The Green Paper on adult social care remains a priority for the Department and we will be publishing it at the earliest opportunity, setting out our proposals to enable the social care sector to meet the challenges of rising demand from an ageing population, and a growth in the number of people living with disabilities. It will also bring forward proposals to allow greater risk pooling to help protect people from the highest costs.

Primary and Community Care

56. GPs are the main way that the majority of the population experience the NHS, currently providing around 307 million face-to-face appointments each year. The NHS Long Term Plan looks at how we can further develop the GP offer, including giving every patient the right to online GP consultations and redesigned hospital support which will avoid up to a third of outpatient appointments.[30]

57. We continue to invest in our GP workforce, to ensure that we can recruit and retain the GPs that we need, and this must continue to be a priority. The difficulty in building on the number of GPs in practice has continued; although we are encouraged to see as at March 2019 there were 34,736 full time

GP Recruitment & Retention
3,250 GP minimum training places available each year
3,473 GP training places filled in 2018-19 (10% up on 2017-18)
500 Doctors return to practice by 2020-21

[29] https://www.england.nhs.uk/publication/gp-contract-five-year-framework/
[30] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

equivalent (FTE) doctors (including locums) working in General Practice[31], equating to a net increase of 312 FTE GPs since March 2018.

58. The core issue remains the retention of those working in primary care. Support for GPs who might otherwise leave general practice has continued throughout 2018-19. This has included:
    - setting up local initiatives to support GPs to remain in the workforce through the establishment of a Local GP Retention Fund (£7 million). As at the end of September 2018, 144 schemes were either live or in development.
    - the establishment of seven intensive support sites in areas of the country (with £3 million investment) that have issues with retention and critically have a strong level of local leadership in place.

59. There are also ongoing actions to recruit more GPs. In 2018-19, 3,473 doctors were accepted into GP specialty training, exceeding Health Education England's target of 3,250 per year and a 10 per cent increase on last year. Despite these initiatives, our ambition of 5,000 more doctors in general practice by 2020 remains extremely challenging.

60. The Clinical Negligence Scheme for General Practice (CNSGP)[32] was launched on 1 April 2019. NHS Resolution are the operator of CNSGP and are handling claims that occur from 1 April 2019 onwards. As at 1 April 2019, commercial discussions with Medical Defence Organisations (MDOs) were ongoing, on arrangements in relation to the establishment of an Existing Liabilities Scheme, with one MDO having agreed terms. This scheme will provide indemnity for in-scope incidents of clinical negligence occurring prior to the introduction of the CNSGP.

61. The new five-year GP contract announced in January 2019[33] sets out an ambitious five-year reform programme for General Practice, including the introduction of Primary Care Networks across the country from July 2019[34]; and funding for up to 20,000 additional clinicians such as physiotherapists and pharmacists to work in primary care by 2023-24. This builds on the extra clinical staff already working alongside GPs in Primary Care. It will mean bigger teams of staff, providing a wider range of care options for patients, and freeing up more time for GPs to focus on those with more complex needs. As of March 2019, there were 96,495 FTE non-GP staff - an increase of 2,324 FTE since March 2018. This included an increase (691 FTE) in staff with direct patient care responsibilities including pharmacists and physician associates. Over this period, the number of nurses increased by 313 FTE and the number of admin/non-clinical staff increased by 1,320 FTE.

62. We have made encouraging progress towards delivering the Government commitment that by 2019 everyone will be able to 'get routine weekend or evening appointments at either their own GP surgery or one nearby'. According to the latest CCG Improvement and

[31] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-31-march-2019-experimental-statistics
[32] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-general-practice/
[33] https://www.england.nhs.uk/publication/gp-contract-five-year-framework/
[34] https://www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/

Assessment Framework (CCG IAF) data published by NHS England in February 2019[35], the NHS had made evening and weekend appointments available to over 99.8 per cent of the population, seven days a week. This means an estimated 9 million additional appointments per year.

63. DHSC and NHS England are continuing to test a new way of providing NHS dental services that shifts the focus of NHS dentistry from treatment and repair to prevention and improving oral health. Over 70 dental practices are participating in the programme, involves testing of a new clinical approach focussed on prevention, and a new remuneration system. Over 25 more practices have been recruited between January and April 2019, and work continues to test the sustainability of the proposed system.

64. We published the Dementia 2020 Challenge: 2018 Review Phase 1 in February 2019[36], which showed that the Challenge is largely on track to meet the commitments. Ten areas for revised actions were identified for 2019-20. The dementia diagnosis rate remains above the ambition of 66.7%, at 67.9% at the end of February 2019.

65. In December 2018 we announced that we would be reviewing the current adult autism strategy and working with DfE will extend this to children. The refreshed strategy will be published in November 2019. Building the Right Support[37] set a target to reduce the number of mental health inpatients with a learning disability and/or autism by 35-50% against a 2015 baseline, by March 2019. The published Assuring Transformation data shows that in February 2019, there were 2,295 mental health inpatients with a learning disability and/or autism at the end of the reporting period, over 20% fewer than in 2015. The NHS Planning Guidance requires a reduction of 35% during 2019-20, with a 50% reduction due by March 2023-24.

66. In response to the recommendations of the second annual report of the Learning Disabilities Mortality Review[38], the Department and strategic partners are taking forward actions to support improved outcomes for people with a learning disability, including a consultation on mandatory learning disability and autism training for health and social care staff, to ensure people's needs are understood, and reasonable adjustments can be made to support them.

67. The Government's first strategy to tackle loneliness in England was published on 15 October 2018[39] . The strategy set out a number of commitments across nine government departments (including DHSC), working with a range of partners, to identify opportunities to tackle loneliness and build more integrated communities. The Government has also established the £11.5 million Building Connections Fund to support projects able to reduce or prevent loneliness. DHSC contribution to the Fund is £0.5 million.

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[35] https://www.england.nhs.uk/publication/ccg-iaf-data-extract/
[36] https://www.gov.uk/government/publications/dementia-2020-challenge-progress-review
[37] https://www.england.nhs.uk/learning-disabilities/natplan
[38] https://www.gov.uk/government/publications/government-response-to-the-learning-disabilities-mortality-review-leder-programme-2nd-annual-report
[39] https://www.gov.uk/government/news/pm-launches-governments-first-loneliness-strategy

Mental Health

> **Investment in mental health:**
> **£12.155 bn** spent on mental health in 2018-19
> **£179 m** increase on 2017-18

68. Overall, the quarterly performance data published by NHSE[40] shows that progress has been made in delivering on commitments in the Five Year Forward View for Mental Health[41]. We have continued to make progress towards delivering parity of esteem, with 90% of CCGs having met the Mental Health Investment Standard in 2017-18. Access and recovery standards for 2018-19[42] have been met as follows:
    - For Improving Access to Psychological Therapies (IAPT) services, 88.9% of people referred to these services were seen within 6 weeks, whilst 99% of people were seen within 18 weeks in March 2019[43]. This performance is surpassing the target waiting time standards of 75% and 95% respectively.
    - 53.1% of people receiving treatment in IAPT services are considered to have 'recovered' in March 2019. This meets the target of at least 50% of people who complete treatment should move to recovery.
    - In March 2019, 76.2% of people with first episode psychosis started treatment with a specialist Early Intervention in Psychosis (EIP) service within two weeks. This exceeds the waiting time element of the EIP standard, which was set at 53% for 2018-19.[44]
    - Progress is being made to meet the eating disorder access and waiting time standards for Children and Young Persons (CYP) - 95% of CYP referred for assessment or treatment for an eating disorder should receive NICE-approved treatment within 1 week if the case is urgent, and 4 weeks if the case is routine/non-urgent by 2020. In quarter 4 2018-19, 80.6% of urgent cases were seen within 1 week, and 82.4% of routine cases within 4 weeks[45].
    - At least 9,000 women accessed new specialist perinatal mental health care services in 2018-19.[46]

69. In October 2018, the UK Government hosted a global ministerial mental health summit in partnership with the Organisation for Economic Co-operation and Development (OECD), with support from the World Health Organization (WHO). The Secretary of State for Health and Social Care set out the government's aspiration to encourage others across the world to put mental health on an equal footing with physical health.[47] Key political figures, innovators, experts, policy-makers and people with lived experience of mental health from around the world came together at the 2-day summit to agree global action to tackle mental ill-health.

70. In October 2018, the Prime Minister announced the first Minister for Suicide Prevention in the UK. Jackie Doyle-Price, Minister for Mental Health, Inequalities and Suicide Prevention is working across national and local government to reduce suicides and

[40] https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/
[41] https://www.england.nhs.uk/mental-health/taskforce/imp/
[42] https://www.england.nhs.uk/publication/mental-health-five-year-forward-view-dashboard/
[43] https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services
[44] https://www.england.nhs.uk/statistics/statistical-work-areas/eip-waiting-times/
[45] https://www.england.nhs.uk/statistics/statistical-work-areas/cyped-waiting-times/
[46] https://www.england.nhs.uk/2019/04/specialist-mental-health-support-for-new-mums-available-in-every-part-of-england/
[47] https://www.gov.uk/government/news/matt-hancock-calls-for-world-to-unite-in-responding-to-the-challenge-of-mental-health

published the first Cross-Government Suicide Prevention Workplan in January 2019[48]. The comprehensive and ambitious Workplan sets out extensive commitments across Government and the NHS up to 2020 and beyond to address suicide.

71. In December 2018, we announced that the NHS will work with schools and colleges to make expert mental health support available to more than 470,000 children and young people across England. New mental health support teams will be based in and near schools and colleges in 25 areas and will start giving support in 2019. Each designated team will support up to 8,000 children and young people in around 20 schools and colleges in trailblazer sites covering between one fifth and one quarter of the country by 2023-24. The first Education Mental Health Practitioners began their training in January 2019 at seven universities nationwide and mental health support teams will be operational by the end of 2019[49].

72. Following the publication of the final report from the Independent Review of the Mental Health Act 1983, the government will introduce a new Mental Health Bill to transform mental health care. The Department, with the Ministry of Justice, will provide a formal response via a white paper by the end of this calendar year. In December 2018[50], we announced two major changes; that those detained under the Act will be allowed to nominate a person of their choice to be involved in decisions about their care; and that people will also be able to express their preferences for care and treatment and have these listed in statutory 'advance choice' documents.

73. The roll out of Liaison & Diversion[51] is on track to cover 100% of the population by 2020-21. Coverage is currently at 92% as at 31 March 2019. These services identify people with mental health and substance misuse problems, directing them into services and away from custody where appropriate. Joint work with the Ministry of Justice, Public Health England and NHS England on extending Community Sentence Treatment Requirements progressed over the year, with an evaluation of the findings from five 'testbed' sites expected in early 2019-20.

Social Care

74. The Government has responded to the pressures facing councils by giving them access to up to £3.6 billion more dedicated funding for adult social care in 2018-19 and up to £3.9 billion for 2019-20 compared to the 2015-16 baseline. As a result of these measures, spending on adult social care could increase by 8% in real terms during the Spending Review period, from 2015-16 to 2019-20. The Autumn Budget also announced a further £410 million to improve social care for older people, people with disabilities and children in 2019-20.

75. This additional funding means that in total the Government has given councils access to around £10 billion more adult social care funding from 2017-18 to 2019-20.

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[48] https://www.gov.uk/government/news/first-ever-cross-government-suicide-prevention-plan-published
[49] https://www.gov.uk/government/news/nhs-and-schools-in-england-will-provide-expert-mental-health-support
[50] https://www.gov.uk/government/news/government-commits-to-reform-the-mental-health-act
[51] https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/

76. Additional funding is only part of the answer and Government has recognised that as people live longer than ever before, sometimes with complex care needs, the social care system must be sustainable in the longer term. That is why the Government has committed to publishing a Green Paper at the earliest possible opportunity setting out its proposals for reform.

77. Despite challenges around market pressures, quality in adult social care remains good overall; with the latest data showing that 83.5% of all social care provider locations were rated Good or Outstanding on 1 April 2019.

78. Both the NHS and social care have been working hard to reduce delays and free up beds, as we believe that nobody should stay in a hospital bed longer than necessary. Better Care Fund plans have supported delivery of those ambitious targets and from February 2017 to March 2019, there have been more than 2,182 fewer people delayed in an NHS bed per day. We want to continue to drive down Delayed Transfers of Care (DTOC) and for 2019-20, the national ambition will remain for no more than 4,000 delayed days per day (reported as 'DTOC beds').

79. The Better Care Fund (BCF)[52] requires local authorities and clinical commissioning groups to pool budgets for the purposes of integrated care. They can also make voluntary contributions to the BCF pool. The majority of local areas choose to pool more than the mandated minimum, taking the total pooled to nearly £8 billion in 2018-19.

80. We want people of all ages to lead fuller, healthier and more active lives. But there is also a huge opportunity to support a new generation of businesses to thrive in the growing global market for products and services that support older people. In recognition of this, the Prime Minister announced the Ageing Society Grand Challenge mission[53] in May 2018: to ensure people can enjoy at least five extra years of healthy, independent years of life by 2035, whilst narrowing the gap of the experience between the richest and the poorest.

81. To support this the Government has committed £98 million to a Healthy Ageing competition as part of the Industrial Strategy Challenge Fund[54]. This will aim to stimulate well-designed innovations that support people to enjoy active and independent lives for longer.

Medicines and Pharmacy

82. The NHS Long Term Plan sets the ambition to better utilise the skill set and reach of community pharmacy, to deliver more services to help people stay well in the community and relieve pressure on other parts of the NHS. Negotiations have started on the community pharmacy contractual framework for 2019-20 and beyond. This is exploring the possible roll-out of a national minor illness service through NHS 111 and the piloting of referrals to community pharmacy from other settings, such as general practice and the online platform nhs.uk. Interim arrangements - from 1 April 2019 - have been agreed to

[52] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[53] https://www.gov.uk/government/publications/industrial-strategy-the-grand-challenges/industrial-strategy-the-grand-challenges
[54] https://www.ukri.org/innovation/industrial-strategy-challenge-fund/healthy-ageing/

maintain the 2018-19 funding level of £2.6 billion. These interim arrangements will be replaced by the new substantive arrangements once negotiated.

83. Throughout 2018-19, the Department and the NHS have focused efforts on ensuring that the medicines budget is used as efficiently as possible, whilst ensuring that patients continue to have access to safe and cost-effective medicines.

84. The Pharmaceutical Price Regulation Scheme (PPRS), saw companies repay the Department £615 million in relation to sales covered by the PPRS, in respect of the 2018 calendar year as part of the voluntary agreement to control medicines spend by health services across the UK. This was apportioned over the four UK countries, and reinvested in the NHS for patients' benefit.

85. On 1 January 2019 a new 5-year deal commenced with the pharmaceutical industry, the 2019 voluntary Scheme for Branded Medicines Pricing and Access[55], replacing the PPRS, with the aim to give patients in the UK faster access to new medicines. The NHS is expected to save around £930 million on its medicines bill for 2019 as a result. All savings income is accrued for in the quarter to which it relates. The figure for 2019 should be available by end of January 2020. This deal marks a voluntary agreement between the government and the Association of the British Pharmaceutical Industry (ABPI).

86. We announced a review into overprescribing in the NHS in December 2018, to ensure that all patients, but particularly those who have been prescribed multiple medicines are receiving the most appropriate treatment for their needs. Total NHS spending on medicines (excluding discounts) has grown from £13 billion in 2010-11 to £18.2 billion in 2017-18 which represents the largest NHS spend behind pay. The review will look at potential over prescribing, as well as communications on prescriptions between primary and secondary care and where prescriptions are being made for conditions where other forms of care may be more effective.

Digital Transformation

87. In order to keep people healthier for longer and to ensure they are treated in the most convenient settings, we have prioritised the use of digital technologies in healthcare. We are responsible for setting the strategic direction and developing the policy for technology, data and digitally enabled health and care and delivering the Digital Transformation Portfolio of national technology programmes and live services. Over the last year we have:
    - published the Secretary of State's Technology Vision 'The future of healthcare: our vision for digital, data and technology in health and care' in October 2018[56]. As a result, digital services and IT systems used by the NHS will have to meet a clear set of open standards to ensure they can talk to each other across organisational boundaries and can be continuously upgraded;
    - created a world-leading code of conduct for data-driven health and care technology in February 2019;

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[55] https://www.gov.uk/government/publications/voluntary-scheme-for-branded-medicines-pricing-and-access

[56] https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care

- taken steps to ensure NHS workforce have access to and use of modern technology by banning the NHS from buying fax machines with a complete phase-out by April 2020; and
- required NHS trusts to phase out pagers by the end of 2021.

88. Cyber security is critical in ensuring that clinicians, services and patients are able to access healthcare data in a safe, legal and secure way, and that they feel confident in doing so.

89. In total, over £250 million will have been invested nationally to improve the cyber security of the health and care system between 2016 and 2021. This excludes both investment by local organisations and wider national IT investment that supports better security, such as Microsoft licensing for NHS organisations.

90. The Department of Health and Social Care has also been supporting NHS organisations to upgrade their existing Microsoft Windows operating systems, allowing them to reduce potential vulnerabilities and increase cyber resilience; procured a new Cyber Security Operations Centre to boost our capability to prevent, detect and respond to cyber-attacks; and implemented a stronger regulatory framework to help drive improvement.

91. NHS Digital is leading work to educate the health system through security-trained technical specialists who will provide training (to be rolled out over the summer) for boards and senior leaders. This training will lead to behavioural changes, making everyone more cyber-aware/secure, which in turn will mean that technology provision, business decisions, and clinical decisions will be made with 'cyber in mind'.

92. The use of data offers the potential to improve the health and care system and unlock new treatments and medical breakthroughs. To ensure these benefits are realised in a safe, secure and legal way, we are implementing data security standards for local organisations, we introduced a national data opt-out for the use of confidential patient data beyond an individual's direct care in May 2018 and have put the role and office of the National Data Guardian (NDG) on a statutory footing from 1 April 2019. The Health and Social Care (National Data Guardian) Act 2018[57] gives the NDG the power to publish formal guidance, and give advice, assistance and information, about the processing of health and adult social care data in England. The Act also imposes a duty on public bodies within the health and adult social care sector (and private organisations who contract with them to deliver health or adult social care services) to have regard to the NDG's formal guidance.

93. On 1 July 2019, NHSX[58] became operational as a joint unit between NHS England, NHS Improvement and the Department of Health and Social Care to:
    - speed up the transformation of the NHS and social care, driven by technology, in line with the NHS Long Term Plan and the Secretary of State's Tech Vision;
    - support people to stay well and drive their own care by giving them easy access to great digital services and their data;

[57] http://www.legislation.gov.uk/ukpga/2018/31/contents/enacted
[58] https://www.gov.uk/government/news/nhsx-new-joint-organisation-for-digital-data-and-technology

- enable NHS staff to focus on the patient, by reducing other demands on their time through the use of technology;
- make the NHS the best place for health and care technology entrepreneurs by creating an environment where innovation flourishes.

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

94. The NHS Long Term Plan sets out the ways in which, around the country, approaches to delivering care are changing, in part to address demand, but also because times are changing – and our knowledge about different ways of working is increasing. There are examples across the country of how changes in approach can better meet the needs of patients and reduce the inefficiencies and complications that can frustrate both the people being cared for and the NHS workforce. The NHS Long Term Plan proposes rolling out these different ways of working, ensuring that we can all benefit from the highest quality of care.

Inspection and Patient Safety

95. The Care Quality Commission (CQC) continues to inspect hospitals, GP surgeries and care home providers across the country and in 2018-19 carried out 135 inspections of NHS Acute Trusts and Specialist NHS Trusts, 2,090 inspections of GP Practices and 21,218 inspections of providers of Adult Social Care locations. Figures are based on interim figures from the CQC for April 2018 - March 2019.

96. On 1 April 2018 the updated Care Quality Commission (Reviews and Performance Assessment) Regulations 2018[59] came into force. These regulations enable the CQC to rate all registered service providers of regulated activities with a small number of exceptions.

97. The Use of Resources (UoR) assessment[60] was incorporated into the CQC's regulatory approach for NHS Trusts in the summer 2018 following a successful pilot in 2017. The UoR assesses how well non-specialist acute NHS Trusts are using their resources to provide high quality, efficient and sustainable care. For the first time, quality and use of resource ratings are brought together, enabling the CQC to generate a combined rating.

Locations* inspected by CQC in 2018-19:	Of the **78** NHS Acute Trusts rated during 2018-19:
• **113** non-specialist NHS Acute Trusts • **22** Specialist NHS Trusts • **2,090** GP Surgeries • **21,218**** Adult Social Care	• **6.4%** rated inadequate • **50%** rated as needing improvement • **38.5%** rated as good • **5%** rated as outstanding

*Providers for NHS Acute Trusts **Includes hospices from April 2017

[59] http://www.legislation.gov.uk/uksi/2018/54/contents/made
[60] https://www.cqc.org.uk/what-we-do/how-we-do-our-job/how-we-rate-trusts-their-use-resources

98. Maternity care has continued to be a focus for the Department, following the publication in November 2017 of Safer Maternity Care: progress and next steps[61]. In December 2018, we published plans to ensure that mothers and new babies will be offered better support as we look to make the NHS one of the best places in the world to give birth[62]. A set of new measures will improve safety, quality and continuity of care to halve stillbirths, maternal and infant deaths and serious brain injuries in new-born babies by 2025.

99. The Department continued to provide funding for Sands, the Stillbirth and Neonatal Death charity, to work with other baby loss charities and Royal Colleges to roll out the National Bereavement Care Pathway[63] to reduce the variation in the quality of bereavement care provided by the NHS. Twenty-one Wave 2 pilot sites were added to the existing 11 sites in April 2018 making a total of 32 sites. The new pilot sites are located in a wider range of settings and have more of a focus on community-based bereavement care.

100. In February 2019, Health Education England published the first Maternity Support Worker Competency, Education and Career Development Framework[64] as part of the Department's package of measures aimed at training 3,000 more midwives and professionalising the maternity support worker role.

101. The Healthcare Safety Investigation Branch (HSIB) began its work in April 2017 to conduct high-level investigations of serious patient safety incidents in the NHS in England with a specific focus on system-wide learning and improvement. HSIB is expected to conduct up to 30 investigations a year. To date, HSIB has launched 32 national investigations of which, 21 have progressed to full investigation and it has published 9 reports. HSIB has issued 30 recommendations and has received 27 responses.

102. In April 2018, HSIB began rolling out its approach to the investigations of unexplained severe brain injury, intrapartum stillbirths, early neonatal and maternal deaths in England so that the NHS learns quickly from what went wrong and uses this to prevent future tragedies. At the end of February 2019, HSIB had 303 active maternity investigations live across 78 trusts. At the end of March 2019, rollout was completed across 130 Trusts.

103. The draft Health Services Safety Investigations Bill (HSSI), providing for the establishment of a new independent body to investigate serious incidents in the NHS in England, with the statutory investigative powers and protections to undertake effective healthcare safety investigations, has undergone pre-legislative scrutiny by a Joint Committee of both Houses, and the Committee published its report on 2 August 2018[65]. The Government published its response to the Joint Committee's recommendations on 4 December 2018[66].

[61] https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps
[62] https://www.gov.uk/government/news/wide-ranging-new-maternity-plans-announced-by-the-government
[63] https://nbcpathway.org.uk/
[64] https://www.hee.nhs.uk/news-blogs-events/news/framework-launched-boost-maternity-care-support-services
[65] https://www.parliament.uk/business/committees/committees-a-z/joint-select/draft-health-service-safety-investigations-bill/news/health-service-safety-investigations-bill-report-published-17-19/
[66] https://www.gov.uk/government/publications/government-response-to-health-service-safety-investigations-bill-report

104. A cross-system 'Learning from Deaths' Programme Board[67] continues to monitor progress made against CQC's recommendations for change and government commitments. This includes; publication of Guidance for NHS Trusts on working with bereaved families and carers in July 2018[68], guidance to support use of a new mortality review tool for mental health trusts in November 2018; and statutory and operational guidance for CCGs and local authorities to implement new child death review arrangements in October 2018.

105. The Government also published its response to the second annual report of the Learning Disabilities Mortality Review Programme[69]. This set out a clear plan of action to help address the inequality in life expectancy between people with learning disabilities and the wider population.

106. The CQC continues to inspect progress made by Trusts in implementing National Guidance on Learning from Deaths published in March 2017. In a review of the first year of trusts implementing the guidance, the CQC found good awareness of the guidance however there was variation in the way the guidance is being implemented. The Learning from Deaths programme will be an important supporting mechanism for the roll out of a new medical examiner system from April 2019 under which medical examiners will scrutinise the cause of death for all non-coronial cases[70].

107. The Paterson Inquiry[71] was established in December 2017 to investigate the circumstances and practices around Ian Paterson. The Inquiry is expected to report at the end of 2019, which is a change to its original timetable (Summer 2019). This is due to the considerable number of former patients and family members who have come forward to give evidence, and the volume of evidence gathered from other witnesses.

108. The Gosport Independent Panel reported in June 2018. Following that report the Department has:
    - Issued a response document[72] in November 2018 setting out the lessons learned in government and the NHS from the report and pointing to further action;
    - Put in place arrangements to ensure effective and appropriate support to the police assessment of evidence process being conducted under Operation Magenta;
    - Worked with the police, Bishop James Jones and other agencies to ensure that the families of those affected by the issues at Gosport during the period covered by the report are informed of developments and supported.

109. The Department is overseeing implementation of the review recommendations to support a just and learning culture in healthcare following Professor Sir Norman Williams' rapid policy review into the issues relating to gross negligence manslaughter in healthcare. The report was published in June 2018[73] and the Department accepted all

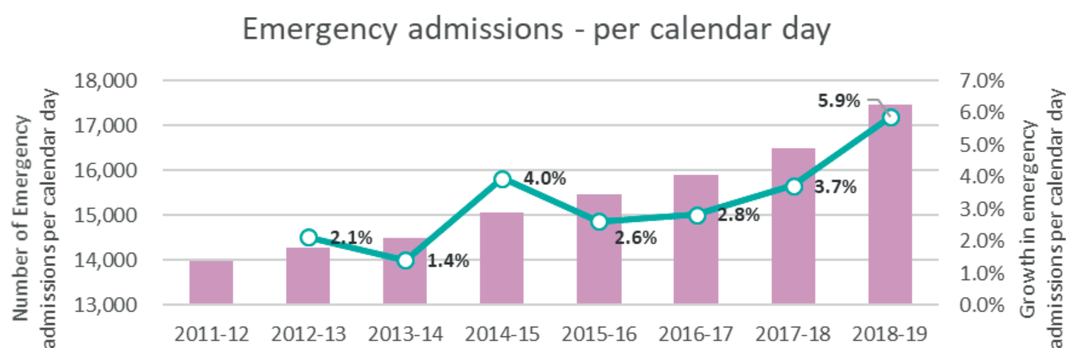
[67] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
[68] https://www.england.nhs.uk/publication/learning-from-deaths-guidance-for-nhs-trusts-on-working-with-bereaved-families-and-carers/
[69] https://www.gov.uk/government/publications/government-response-to-the-learning-disabilities-mortality-review-leder-programme-2nd-annual-report
[70] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
[71] https://www.gov.uk/government/news/government-launches-independent-national-inquiry-into-convicted-surgeon-ian-paterson
[72] https://www.gov.uk/government/publications/gosport-independent-panel-report-government-response
[73] https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare

recommendations. Implementation is based on three broad strands of work: clarity and consistency of application of gross negligence manslaughter in healthcare; NHS investigations; and professional regulation. Arrangements for responding to the recommendations of the review have been set in train and we are taking forward work to implement the recommendations of the Williams review, and aim to publish a number of associated documents shortly.

Performance of the Healthcare System

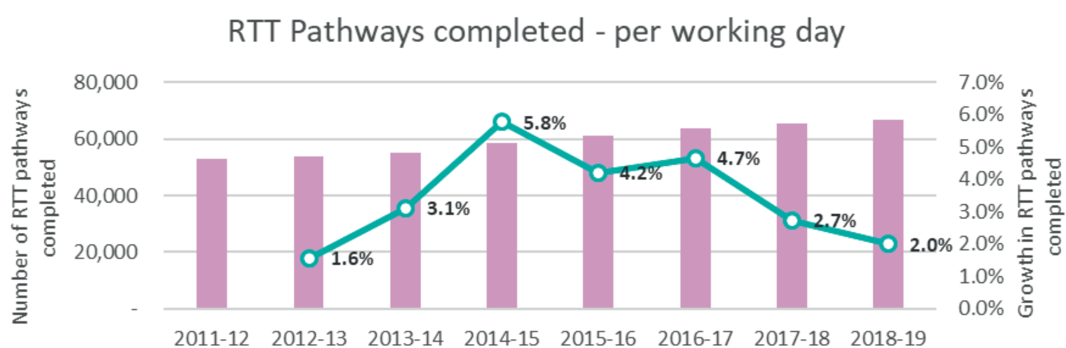
110. Demand for services provided in the health and care system continues to rise above population and demographic growth as better diagnosis and medical advancement means more treatment is possible. To meet this demand the NHS continues to deliver more activity than ever before - as evidenced in **Figures 3 and 4** - by the growth in emergency admissions and elective (i.e. non-emergency) treatments since 2010-11.

Figure 3: Emergency Admissions



Source: A&E attendances & Emergency Admission Statistics[74].

Figure 4: Elective Treatments



Source: NHS England Consultant Led Referral to Treatment Statistics[75]. Data adjusted for non-submitting Trusts and exclusion of sexual health services from 2013.

111. Compared with 2017-18, the NHS managed nearly 987,000 (4.2% increase) more A&E attendances in 2018-19, and an increase of 15.7% in people seen by a specialist for

[74] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
[75] https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

suspected cancer. Although the NHS treated more patients than ever, despite the extensive efforts of everyone working the NHS, core performance targets[76] were not met. Further details can be found in **Annex C**.

112. In 2018-19, 24.8 million people attended an A&E in England, with 21.9 million people being either admitted, transferred, or discharged within four hours of attending – more than ever before in the history of the NHS. This activity, including an increase of over 352,000 (5.9% or 965 per day) admissions via hospital Emergency Departments to hospital, has put pressure on hospital bed capacity. During 2018-19, cross-system action was successful in reducing the number of hospital beds occupied by patients with a delayed transfer of care (DTOC), and in 2018-19 the NHS has focused on those patients who have stayed in a hospital bed for 21 days or more with an ambition to reduce these by 25%.

113. Increased activity has meant further challenges for the NHS in meeting the A&E waiting times national standard. In 2018-19, national performance was 88.0%, not meeting the standard that 95% of patients should be admitted, transferred or discharged within four hours of arrival in an A&E department. The NHSE mandate deliverable that the majority of trusts meeting the 95% standard in March was not achieved.

National A&E waiting time	2018-19	2017-18
A&E attendances (million)	24.8	23.8
of which: Emergency Admissions (million)	4.77	4.46
National Standard* (%)	95.0	95.0
Actual performance in March (%)	86.6	84.6

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

114. NHS England implemented an improved ambulance performance framework from July 2017 following the Secretary of State's approval of the Ambulance Response Programme[77] (ARP). By December 2017, all ten mainland trusts were reporting against the new ARP response time standards (Isle of Wight began reporting against these for the first time in December 2018). Further details of the performance against the new standards can be found in **Annex C**.

115. Performance against the elective waiting time standard - referral to treatment (RTT) incomplete pathway standard was 86.7% in March 2019 compared to 87.2% in March 2018. The standard was last met in February 2016. Both activity and the waiting list has increased. The waiting list stands at 4.23 million (4.34 million including non-reporters), the majority of patients continue to be seen within the waiting times standards[78].

[76] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
[77] https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
[78] https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

Referral to treatment for non-urgent conditions	2018-19	2017-18
Total number of completed pathways (million)	16.4	15.8
Waiting List –including estimates for non-reporting trusts (million)	4.34	4.10
National Standard* (%)	92.0	92.0
Actual performance (%)	86.7	87.2

*92% of patients on RTT incomplete pathways waiting within 18 weeks from referral to start consultant-led treatment

116. Cancer is a priority for this Government and survival rates are at a record high. Since 2010 rates of survival from cancer have increased year-on-year. Around 7,000 people are alive today who would not have been had mortality rates stayed the same as in 2010. In 2018-19, the standard that 96% of patients should begin first treatment within 31 days of a decision to treat, was met in every month (except January 2019) and saw 96.8% of patients treated within 1 month across the year. NHS England will begin performance managing Trusts against a new 28-day faster diagnosis standard in April 2020.

117. There has been a continuing rise in demand for cancer services, with urgent GP referrals rising by over 15.7% compared to the same period last year. The key performance target of 85% of patients beginning first treatment within 62 days of urgent GP referral for suspected cancer has been met in only one month since April 2014 (December 2015), with performance for the year at 79.1%. Further detail on cancer performance is available in **Annex C**.

Cancer	2018-19	2017-18
Urgent GP referrals for suspected cancer (million)	2.24	1.94
Patients starting treatment for cancer in year (thousand)	311	289
National Standard* (%)	96	96
Actual annual performance (%)	96.8	97.5

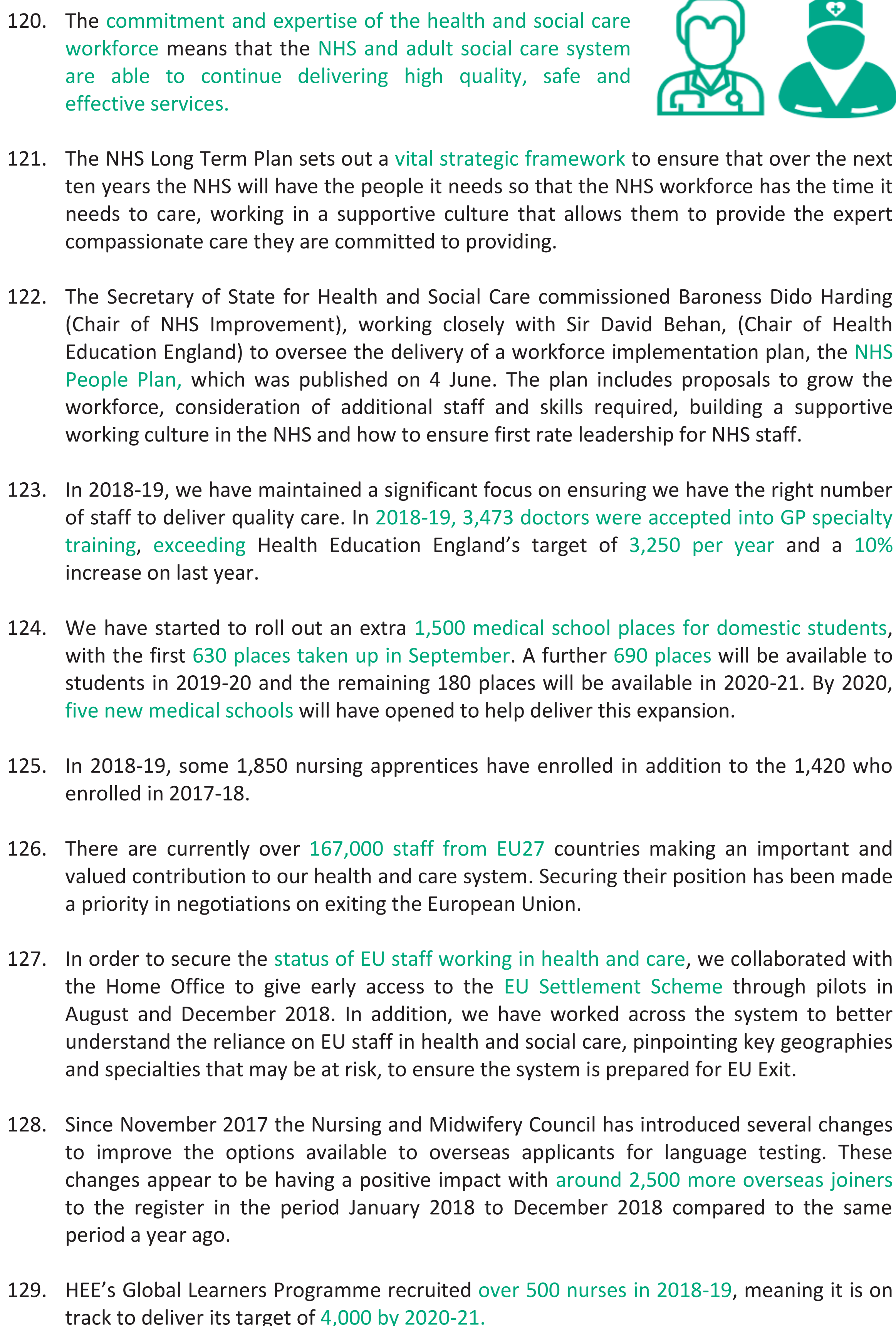
*96% of patients to begin 1st treatment within 31 days of decision to treat

118. 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.

119. The Secretary of State launched the HEE Cancer Workforce Plan in December 2018[79]. The Plan has three main strands; the first focuses on immediate and ongoing actions to make better use of the existing cancer workforce. The second strand focuses on the expansion of clinical skills over the next three years to transform and support growth of the cancer workforce. The final strand of the plan sets out HEE's longer-term ambition to increase the numbers of medical and post-graduate trainees over the next 3 to 15 years.

[79] https://www.hee.nhs.uk/our-work/workforce-strategy-england/cancer-workforce-plan

Workforce



120. The commitment and expertise of the health and social care workforce means that the NHS and adult social care system are able to continue delivering high quality, safe and effective services.

121. The NHS Long Term Plan sets out a vital strategic framework to ensure that over the next ten years the NHS will have the people it needs so that the NHS workforce has the time it needs to care, working in a supportive culture that allows them to provide the expert compassionate care they are committed to providing.

122. The Secretary of State for Health and Social Care commissioned Baroness Dido Harding (Chair of NHS Improvement), working closely with Sir David Behan, (Chair of Health Education England) to oversee the delivery of a workforce implementation plan, the NHS People Plan, which was published on 4 June. The plan includes proposals to grow the workforce, consideration of additional staff and skills required, building a supportive working culture in the NHS and how to ensure first rate leadership for NHS staff.

123. In 2018-19, we have maintained a significant focus on ensuring we have the right number of staff to deliver quality care. In 2018-19, 3,473 doctors were accepted into GP specialty training, exceeding Health Education England's target of 3,250 per year and a 10% increase on last year.

124. We have started to roll out an extra 1,500 medical school places for domestic students, with the first 630 places taken up in September. A further 690 places will be available to students in 2019-20 and the remaining 180 places will be available in 2020-21. By 2020, five new medical schools will have opened to help deliver this expansion.

125. In 2018-19, some 1,850 nursing apprentices have enrolled in addition to the 1,420 who enrolled in 2017-18.

126. There are currently over 167,000 staff from EU27 countries making an important and valued contribution to our health and care system. Securing their position has been made a priority in negotiations on exiting the European Union.

127. In order to secure the status of EU staff working in health and care, we collaborated with the Home Office to give early access to the EU Settlement Scheme through pilots in August and December 2018. In addition, we have worked across the system to better understand the reliance on EU staff in health and social care, pinpointing key geographies and specialties that may be at risk, to ensure the system is prepared for EU Exit.

128. Since November 2017 the Nursing and Midwifery Council has introduced several changes to improve the options available to overseas applicants for language testing. These changes appear to be having a positive impact with around 2,500 more overseas joiners to the register in the period January 2018 to December 2018 compared to the same period a year ago.

129. HEE's Global Learners Programme recruited over 500 nurses in 2018-19, meaning it is on track to deliver its target of 4,000 by 2020-21.

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

131. The NHS employed 13,800 apprentices from April 2017 to March 2018 towards an annual target of 27,500 for 2017-18, meaning the NHS did not meet the annual target in 2018-19. This is the latest available data. Apprenticeships offer an important means to increasing the number of routes in to practice and the range of advanced practitioner roles our most talented staff can move in to.

132. We recognise the need to do all we can to make sure the NHS can reap the benefits high quality apprenticeships offer. We have been working closely with employers and our delivery partners to support a wide programme of activities to help NHS employers to get the most from the apprenticeship agenda, to meet their apprentice target and spend their apprentice levy contributions. All of these workstreams are accountable to the Department's NHS Apprenticeship Oversight Group which meets regularly to review progress and inform future work plans. Membership of the NHS Apprenticeship Oversight Group includes Health Education England, Education and Skills Funding Agency, Skills for Health and NHS Employers who have significant workstreams within the NHS apprentice agenda.

133. The launch of new roles, such as the Nursing Associate (NA), increases the mix of skills in the NHS and creates opportunities for staff to concentrate on the tasks they are best qualified to carry out. These measures mean that the NHS is a more attractive place to work which will help ensure health and care continue to be able to recruit and retain the most talented and caring staff. The Nursing Associates programme will be expanded to deliver 12,500 associates in training by 2019. 2,000 Nursing Associates were recruited as part of HEE's pilot cohorts in 2018.

134. Since 2014, HEE have led a Nursing Return to Practice campaign, 5,422 returners have started on the programme since the campaign commenced and 3,533 have completed and have been made available for employment.

135. Alongside this, we have made further progress in reducing the reliance on the use of agency staff within the NHS and increasing the use of bank staff, who bring better continuity, safer care and better value for money for the taxpayer. As well as allowing staff to work more flexibly, staff banks are more cost effective than agencies, and increasing bank fill rates has contributed to total reduction in agency spend from £3.6 billion in 2015-16, to £2.4 billion in 2018-19. Agency spend currently stands at 4.4% of total pay bill, down from 4.6% in 2017-18 and from 7.8% at its peak in 2015. This is the lowest in almost a decade.

136. We have supported NHSI to deliver a more cost-effective service, while improving patient care, through the Operational Productivity[80] and Getting It Right First Time[81] programmes. In 2018-19, NHS Improvement, supported by the Department, made an estimated £1.8 billion of savings. We have invested £19 million of capital funding to support electronic prescribing and pharmacy infrastructure and have delivered a new strategy for electronic rostering, building on the publication of the Secretary of State's Tech Vision[82] earlier this year.

137. The adult social care workforce is absolutely vital, and the Department recognises the incredible contribution care workers make to our society. On 12 February 2019, we launched a new national adult social care recruitment campaign in conjunction with Skills for Care 'Every Day is Different'[83], aiming to raise the profile of the sector and encourage people with the right values to apply for vacancies. The upcoming Adult Social Care Green Paper will include a vision for the workforce and proposals to boost recruitment and retention.

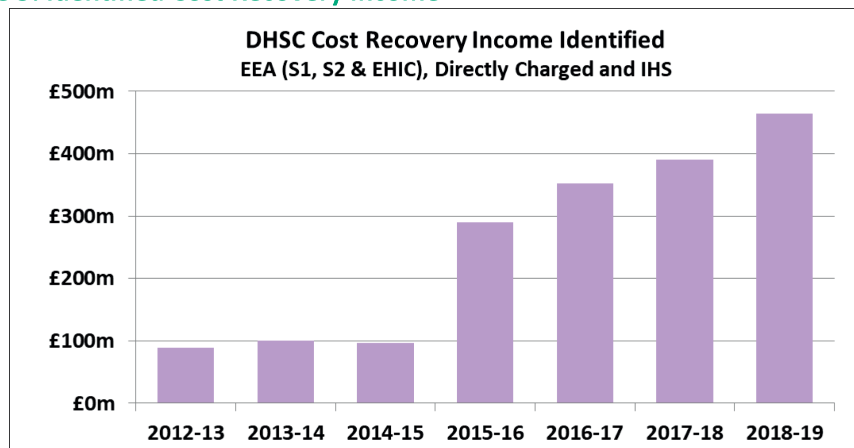
138. Improving the capability of the workforce through continued skills development is a vital investment in the future and helps other people to recognise social care as a skilled career option. The Department continues to fund Skills for Care[84], to deliver initiatives to build sector capability and skills in these areas.

139. During 2018-19 the Department has continued its partnership with Think Ahead[85], a graduate training programme to attract high-potential graduates and 'career changers' into social work in mental health services. In 2018, the first cohort of participants graduated from the programme, and took up employment as Mental Health social workers in a range of health and social care settings.

140. One important route for the NHS to use its resources as efficiently as possible is to ensure that where it treats people who are not entitled to free NHS care, those costs are recovered for the benefit of the NHS. As shown in **Figure 5,** in 2018-19, income of £464 million was identified from overseas visitors and migrants not entitled to free NHS care, through the immigration healthcare surcharge, direct charging and recovery of payments from EEA countries for treatment of their citizens by the NHS. On 8 January 2019, the rates of the immigration surcharge doubled, better reflecting the cost to the NHS of treating patients.

[80] https://www.gov.uk/government/publications/productivity-in-nhs-hospitals
[81] https://gettingitrightfirsttime.co.uk/
[82] https://www.gov.uk/government/news/matt-hancock-launches-tech-vision-to-build-the-most-advanced-health-and-care-system-in-the-world
[83] https://www.skillsforcare.org.uk/Recruitment-retention/National-recruitment-campaign.aspx
[84] https://www.skillsforcare.org.uk/Home.aspx?gclid=EAIaIQobChMI7fmI2MDl2wIVUzPTCh35EguPEAAYASAAEgIWOPD_BwE
[85] https://thinkahead.org/

Figure 5: Identified Cost Recovery Income

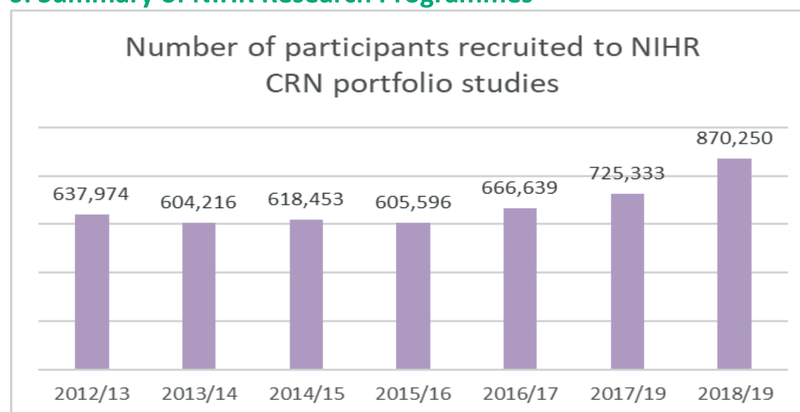


Objective 4: Support research and innovation to maximise health and economic productivity

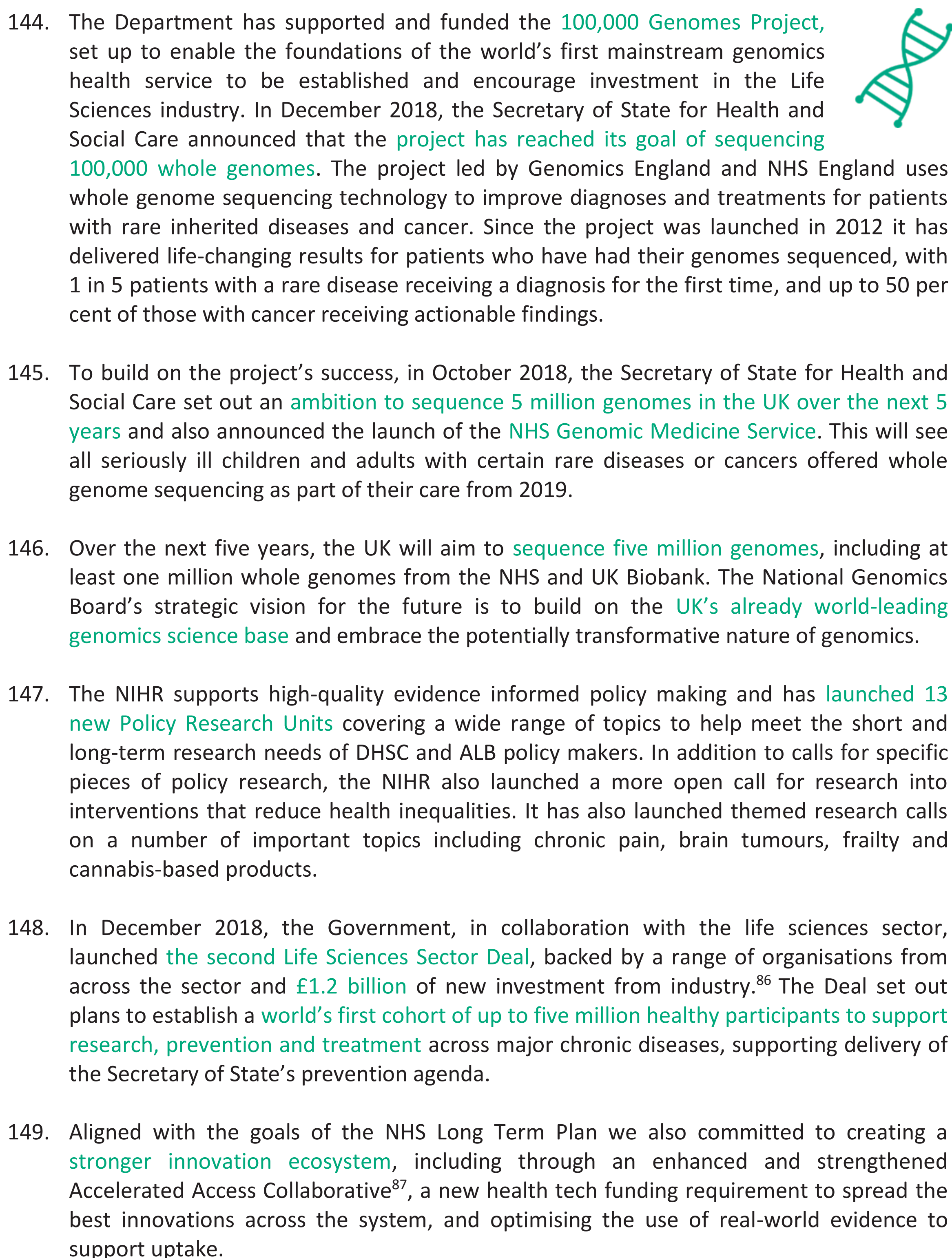
141. In order to ensure that our health and care system delivers the best possible outcomes, we must ensure that our approaches are underpinned by a strong culture of evidence-based innovation. Throughout 2018-19, the Department has maintained its focus on investing in infrastructure and research. Through the National Institute for Health Research (NIHR)

142. The NIHR continues to provide the funding, support and facilities the NHS needs to conduct first-class research into delivering the highest quality of care. This also plays an important role in maintaining the UK's competitiveness as a global destination for research. The NIHR enables and facilitates recruitment of patients and other participants into research through its funded research infrastructure in the NHS, which includes NIHR Biomedical Research Centres, NIHR Clinical Research Facilities and through the NIHR Clinical Research Network. See **Figure 6.**

Figure 6: Summary of NIHR Research Programmes



143. The number of people taking part in clinical research supported by the NIHR Clinical Research Network has increased to 870,250 in 2018-19.



144. The Department has supported and funded the 100,000 Genomes Project, set up to enable the foundations of the world's first mainstream genomics health service to be established and encourage investment in the Life Sciences industry. In December 2018, the Secretary of State for Health and Social Care announced that the project has reached its goal of sequencing 100,000 whole genomes. The project led by Genomics England and NHS England uses whole genome sequencing technology to improve diagnoses and treatments for patients with rare inherited diseases and cancer. Since the project was launched in 2012 it has delivered life-changing results for patients who have had their genomes sequenced, with 1 in 5 patients with a rare disease receiving a diagnosis for the first time, and up to 50 per cent of those with cancer receiving actionable findings.

145. To build on the project's success, in October 2018, the Secretary of State for Health and Social Care set out an ambition to sequence 5 million genomes in the UK over the next 5 years and also announced the launch of the NHS Genomic Medicine Service. This will see all seriously ill children and adults with certain rare diseases or cancers offered whole genome sequencing as part of their care from 2019.

146. Over the next five years, the UK will aim to sequence five million genomes, including at least one million whole genomes from the NHS and UK Biobank. The National Genomics Board's strategic vision for the future is to build on the UK's already world-leading genomics science base and embrace the potentially transformative nature of genomics.

147. The NIHR supports high-quality evidence informed policy making and has launched 13 new Policy Research Units covering a wide range of topics to help meet the short and long-term research needs of DHSC and ALB policy makers. In addition to calls for specific pieces of policy research, the NIHR also launched a more open call for research into interventions that reduce health inequalities. It has also launched themed research calls on a number of important topics including chronic pain, brain tumours, frailty and cannabis-based products.

148. In December 2018, the Government, in collaboration with the life sciences sector, launched the second Life Sciences Sector Deal, backed by a range of organisations from across the sector and £1.2 billion of new investment from industry.[86] The Deal set out plans to establish a world's first cohort of up to five million healthy participants to support research, prevention and treatment across major chronic diseases, supporting delivery of the Secretary of State's prevention agenda.

149. Aligned with the goals of the NHS Long Term Plan we also committed to creating a stronger innovation ecosystem, including through an enhanced and strengthened Accelerated Access Collaborative[87], a new health tech funding requirement to spread the best innovations across the system, and optimising the use of real-world evidence to support uptake.

[86] https://www.gov.uk/government/publications/life-sciences-sector-deal/life-sciences-sector-deal-2-2018
[87] https://www.england.nhs.uk/ourwork/innovation/accel-access/

150. Taken together, the two Life Sciences Sector Deals put in place the foundations for the future growth of life sciences in the UK, which will deliver huge benefits to the people of this country through a stronger economy and a stronger NHS.

151. In line with the Government's Challenge on Dementia, and the commitment to maintain spending on dementia research at £60 million annually to March 2020, we have maintained spending on dementia research and are on track to meet this. In 2018-19, government research funders spent a total of £83 million, through the NIHR, Medical Research Council (MRC) and the Economic and Social Research Council. We are on track to realise the aspiration for funding for dementia research from all sources (including charity and industry) to double by 2025, as the UK Dementia Research Institute (UKDRI) comes on line with a total of £190 million government and £100 million of charity investment.

152. The NIHR continues to support world-class Global Health Research (GHR) funded by DHSC. This includes 53 NIHR GHR Units and Groups, delivering a portfolio of applied health research in a wide-range of topics, including a unique focus on non-communicable diseases. The programme supports over 150 NIHR GHR trainees in the UK and low and middle-income countries (LMIC) settings and two NIHR GHR Professorships and is developing a portfolio of work in underfunded areas such as mental health and stigmatising skin diseases. The NIHR has also partnered with other major funders in global health research including the World Health Organisation (WHO), Medical Research Council (MRC) and the Wellcome Trust.

153. As part of preparations for leaving the European Union, the Department has been working in close cooperation with other government departments to ensure that the UK has the best possible environment for basic, biomedical, health, and life sciences research. This includes access to, and mobility of the research leaders and the technical and research delivery workforce; access to EU research funding; the regulation of clinical trials, data and devices; rare diseases research; and clinical trials supplies.

154. The Department completed a comprehensive assessment of clinical trial and clinical investigation supplies, in partnership with NHS England, to gain a greater understanding of the degree to which clinical trials in the UK might be impacted by the UK's exit from the EU, and of the contingency arrangements being put in place by trial sponsors.

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

155. As a Department of State, one of our core functions is to ensure that we, and the health and care system as a whole, are accountable to Parliament and the public for the work we do, and the outcomes delivered for patients and services. Through 2018-19, this has involved direct policy, communications and parliamentary support on high-profile issues including, but not limited to; EU Exit, NHS performance, health and care workforce, technology and social care.

156. In 2018-19, we continued to manage the biggest direct post-bag of all Government Departments and answered 79% of all correspondence within 18 working days. We received twice as many Parliamentary Questions as the next busiest Department, with

99% answered within deadline, putting us amongst the top performers across Government on both measures.

Parliamentary and Public Accountability in 2018-19
7,682 written parliamentary questions
99% answered on time
27,182 letters and emails to Ministers and the Department
79% responded to within 18 working days of receipt

157. As part of holding ourselves accountable to patients, service users and the public, in May 2018, we also published a statement setting out how the Department of Health and Social Care had complied with the public sector equality duty in 2018[88]. More information on DHSC governance and public sector equalities duty is provided within the Governance Statement and Accountability Report sections of this Annual Report.

158. The remaining parts of this objective are covered within Delivering a Financially Sustainable System, which follows Objective 6.

Objective 6. Creating value (reduced costs and growing income) by promoting better awareness and adoption of good commercial practice across the DHSC and our Arm's Length Bodies.

159. Work to drive improvement in the Department's commercial capability has continued throughout 2018-19, ensuring that across the Department we are well placed to deliver value-for-money, commercial outcomes for the NHS and the taxpayer.

160. An improved commercial capability through training and development schemes, targeted at upskilling both commercial and non-commercial professionals across the health system (for example contract management training, talent programme for commercial colleagues and Government Commercial Function support offer) will unlock value across the healthcare system so that it can continue to invest in front line services.

161. By March 2019, 79 contracts had been awarded to the value of £302 million, with savings delivered calculated as being worth £20 million (6.6%). A recent review of SME spend arrived at a total of 22%, just short of the 2022 target of 23%, and an improvement from the previous figure of below 20%.

162. The Procurement Transformation Programme (PTP) designed and implemented the new operating model for the NHS Supply Chain, which went live on April 2018. The aim of the new model is to help drive out unwarranted variation and deliver savings of £2.4 billion back into frontline services and patient care by 2022-23.

163. This will be achieved by increasing the centralised procurement of non-medical supplies from 40% of all spend to 80% under the Future Operating Model (FOM). Cumulative

[88] https://www.gov.uk/government/publications/dhsc-public-sector-equality-compliance-2018

savings were ahead of expectations for 2018-19 with £558 million reported against a business case target of £344 million.

Delivering a Financially Sustainable System

Our achievements in 2018-19:

- Managing our resources and staying within our Parliamentary controls.
- Delivering stable NHS finances and overall financial balance against a backdrop of rising demands.
- Funding and delivering a new pay award for NHS staff and investing £1 billion in health service transformation schemes.
- Working with NHS leaders to ensure an NHS Long Term Plan that will make best use of the Government's £33.9 billion increased spending commitment.

Introduction

164. The money we spend aims to help people to live more independent, healthier lives for longer. However, we must live within our means, which requires us to manage spending within the agreed annual funding levels set by Parliament.

165. The Department of Health and Social Care (DHSC) is therefore accountable to Parliament for ensuring that total spending by all bodies within the Departmental Group is contained within the overall budget it authorises – our departmental expenditure limits (DEL) and annually managed expenditure (AME).

166. During 2018-19, the Department contained its resources within all budgets authorised by Parliament (see **Table 1**). Specific detail and further breakdown of that performance is confirmed in the Statement of Parliamentary Supply (SOPS), Accountability Statements and Financial Statements sections. **Annex B** provides explanatory notes of the figures set out in those statements.

Table 1: DHSC Departmental Outturn 2018-19 against Parliamentary & HM Treasury Controls

	Budget £m	Outturn £m	Under/ (Overspend) £m	Key disclosure notes/further detail
Resource Departmental Expenditure Limit (RDEL)	125,924	125,278	646	SOPS 1.1, Annex B
of which: Resource Administration	*2,878*	*2,273*	*605*	*SOPS 1.1, Annex B*
Capital Departmental Expenditure Limit (CDEL)	5,983	5,941	42	SOPS 1.2, Annex B
Resource Annually Managed Expenditure (RAME)	12,926	7,014	5,912	SOPS 1.1
Capital Annually Managed Expenditure (CAME)	15	-5	20	SOPS 1.2
Net Cash Requirement	109,448	106,568	2,880	SOPS 3
Further HM Treasury Controls:				
Ringfenced Resource DEL	1,531	919	612	Annex B
Non-ringfenced Resource DEL	124,393	124,359	34	Annex B

Note: Figures may not sum due to rounding.

Resource Departmental Expenditure Limit

167. The Department's Resource Departmental Expenditure Limit (RDEL) covers all day-to day spending and administration costs, of all bodies within the Departmental Group[89]. The largest proportion goes towards healthcare in the NHS (hospitals, community services and primary care), it also provides for public health schemes (for example, childhood vaccinations) and some adult social care provision. It also covers central costs such as the Department's own running costs, the cost of regulatory oversight (for example, the quality and safety of care provided in hospitals and other healthcare and social care settings), and wider system support (for example, provision of business services such as NHS payroll or prescription payment).

The NHS Resource Budget

168. As noted above, most of the Department's resource budget is allocated to the NHS to fund healthcare services in England. This budget funds the day-to-day spending of all NHS commissioning and provider organisations, for example it is used to pay for hospital services (doctors, nurses, porters, supplies); community health services (nurses working in the community, healthcare assistants, health visitors and allied health professionals) and primary care services (GPs, dentists and opticians).

169. The NHS resource budget increased in cash terms by £5 billion (4.6%) in 2018-19 and will increase by a further £33.9 billion by 2023-24. **Figure 8** shows the annual NHS resource funding growth across the NHS Long Term Plan period.

170. This significant funding increase is allowing the NHS to fund the growing costs of frontline healthcare, directly tackle some of the financial problems seen in the most challenged areas, and fund a pay award for Agenda for Change staff working in the NHS.

171. Recovering finances in the NHS continues to be a major focus. A growing deficit in 2015-16 needed to be halted and disciplined financial management was reintroduced to stabilise finances and secure the immediate future of our health service. NHS leaders devised a plan of action and that has been ongoing since July 2016, involving a series of controls and levers designed to exert tighter control over local organisations. This approach has been broadly successful in doing what it set out to achieve – notably we have seen a stabilising of finances across NHS providers with the majority of trusts demonstrating strong, effective and sustainable financial management. We are now moving into the next phase, with plans to go further to achieve financial sustainability across the NHS set out in the NHS's own Long Term Plan.

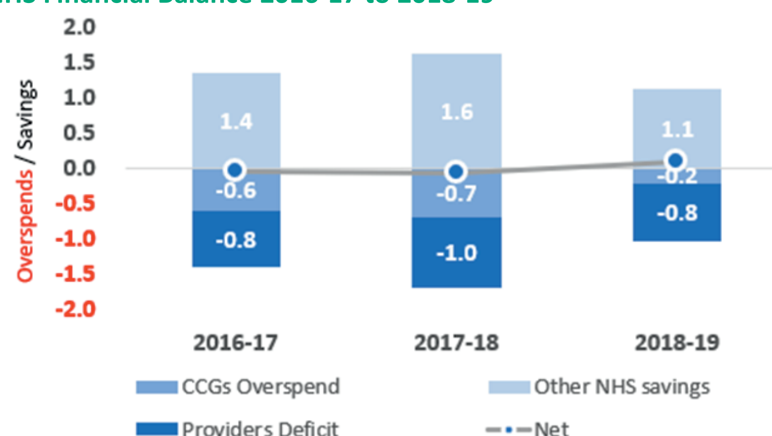
172. For 2018-19, NHS England and NHS Improvement continued to work closely to build plans with individual providers and commissioners that aggregated to a balanced plan for the NHS. This plan built on the improvements made in previous years, but also included a known amount of material risk, particularly in the provider sector where meeting controls required the delivery of stretching efficiencies.

[89] Departmental Group outlined in Accountability Report and Note 21 of the accounts

173. It was apparent mid-way through the year that the NHS provider deficit was likely to be higher than planned. The main pressure for providers continued to be increasing staffing costs driven by growing emergency patient numbers. Equally, some clinical commissioning groups (CCGs) reported overspends as these increased patient volumes meant increased commissioning costs beyond those planned for.

174. The overspends in both providers and commissioners were identified early and, as a result, the NHS leadership intervened and by delivering further underspends in central commissioning budgets covered the higher than planned deficit. As a result, and for the third consecutive year, the NHS has once again delivered financial balance (see **Figure 7**). However, we recognised that continuing this approach was not sustainable, but equally there were no quick fixes. New, long-term sustainable solutions will take time and effort, with those organisations facing the greatest challenges being assessed, supported and assisted by NHS Improvement and NHS England.

Figure 7: Net NHS Financial Balance 2016-17 to 2018-19



175. Backed by the Government's funding for the NHS, a new strategy has been developed to take the health system forward: the NHS Long Term Plan. This allows new, long-term sustainable solutions, which will take time and effort, to be introduced. A new financial framework that is better able to support and encourage the health system to develop in a more sustainable way with a rebalancing of its finances will form part of this. Ending 2018-19 in a stable financial position has been very important as the financial assumptions in the NHS Long Term Plan were dependent on this being the case.

176. For a more detailed analysis of the financial performance of NHS commissioners (NHS England and CCGs) and NHS providers, please refer to NHS England's Annual Report and Account and the Consolidated NHS Providers Account, respectively.

Non-NHS Budgets

177. Sitting outside of the budgets for the NHS front-line, the Department and our arm's-length bodies hold a series of non-NHS budgets, for example, public health grant monies, workforce education and training budgets. In addition to a £540 million transfer from these budgets to front-line NHS services, the non-NHS financial position came under further pressure from events arising during the year, including:

- Increased NHS workforce support activity requiring additional initiatives to increase supply of future workforce, and a slower completion rate of movement from bursary-funded education courses to loans.
- Delays in implementation of the increase to the Immigration Health Surcharge, meaning less income was received than had been initially planned for.
- Price, volume and foreign exchange pressures on demand-led reciprocal healthcare commitments, which has been particularly prevalent since the EU referendum.
- A one-off receipt expected from sales in 2018-19 were delayed for reasons beyond the department's control.

178. While many of the pressures, including those above, were managed, this ultimately did not prove possible for all the pressures arising in the system. HM Treasury agreed to provide reserve funding for unexpected and one-off issues, including additional pressures driven by preparation for a No-Deal EU Exit and so provided support from their central reserve.

179. Through closely controlled management of central budgets and with the additional HM Treasury support, the Department's non-NHS sector has once again lived within agreed spending limits. This was achieved without compromising on wider system support and while safeguarding patients and the wider public.

Capital Departmental Expenditure Limit

180. Like its revenue counterpart, the Department's capital funding is split between the NHS and non-NHS sectors. On the NHS side it allows NHS organisations to invest in their own local capital scheme priorities using the cash reserves they get from their patient-caring activity and through capital loans from the Department. It also provides for spending on primary, community and social care NHS facilities by NHS England. In the non-NHS sector, it provides for spending on research and development, spending through the Disabled Facilities Grant and more strategic investments by the Department and our arm's-length bodies.

181. In 2018-19, NHS provider organisations invested £3.0 billion in local priority schemes. This provided new facilities and allowed the maintenance and upgrade of existing estates, equipment and IT. This increased investment (up from £2.4 billion in 2017-18) reflects increased levels of available funding generated locally, allowing providers to direct resources towards capital schemes rather than having to spend it on day-to-day patient service costs. Against the available NHS CDEL budget this resulted in a small overspend. However, this was off-set by underspending on capital elsewhere in the system.

182. In addition to the local capital spending the Department has been supporting Sustainability and Transformation Partnership (STP) capital investment schemes throughout 2018-19 from central sources. This year saw the announcement of a further £1.0 billion of funding for 81 schemes to transform and modernise NHS services. This is in addition to the previously announced £1.4 billion of funding, all of which will be utilised to deliver transformational capital investment projects by 2022-23. The current STP capital funding has now been awarded to over 150 schemes.

183. Furthermore, the Department allocated £142 million of extra capital in 2018-19 to 86 NHS provider organisations to address pressures in the NHS over the 2018-2019 winter period. The funding has allowed investment to increase bed numbers, A&E capacity, same-day

emergency care, and acute mental health services, supporting the NHS Winter Plan. Within the £1.0 billion of STP capital, we provided £36.3 million to fund new ambulance fleet and infrastructure to help staff provide improved emergency care during the winter.

184. The Department's capital budget has also had to manage the financial consequences of the collapse of Carillion. This meant absorbing the capital costs of two major projects (one in Liverpool and one in the Midlands). Since these costs fell outside of our control, HM Treasury provided some extra funding to alleviate this pressure.

185. The Department has continued to run down its transfer of capital budget to support revenue expenditure. A judgement was taken at the 2015 Spending Review that it was in the best interests of patients to move some capital funds to support patient care each year while the NHS got to grips with its financial problems. This was not an ideal solution but was pragmatic. In 2018-19 the Department transferred £0.5 billion of capital across to support the revenue side, down from £1 billion the previous year.

186. Overall across both local and central capital expenditure the Department has delivered a balanced position against its capital DEL control.

187. Recognising that the current capital regime presents challenges both nationally and locally in effectively planning and forecasting capital investment, the Department is working closely with NHS Improvement, NHS England and HM Treasury to review the capital regime of the NHS to ensure funding is deployed in the most effective manner. The proposed reforms will be set out in detail alongside the capital settlement at the 2019 Spending Review and will look to remove the existing fragmentation of funding sources, short-termism of capital decision-making and uncertainty for local health economies. We will be looking for improvements to the governance process for managing the capital budget with the aim of better controlling and maximising budgets each year. Working with NHS England and NHS Improvement, the Department is considering options for increasing control over providers' capital spending, including through the role of regional teams.

Annually Managed Expenditure

188. The Department's Annually Managed Expenditure (AME) budget is set annually outside of the Spending Review and has no immediate impact on the fiscal framework or need for taxes to be raised to cover spending. Expenditure that counts against this budget is demand-led, can be volatile and subject to many variables outside of the Department's direct control. The major element of our AME expenditure continues to be provision for clinical negligence claims.

189. In setting our final AME budget limit for 2018-19, actuarial advisors, commissioned by NHS Resolution (NHSR), provided analysis of potential scenarios for clinical negligence expenditure, to provide a prudent level of budget cover ranging from £7.0 billion to £13.7 billion (a 95% range). The budget was set based on a mid-range scenario of £10.6 billion. Because of favourable reductions compared with the prudent estimate used to set the budget limit, NHSR's 2018-19 AME was £6.4 billion.

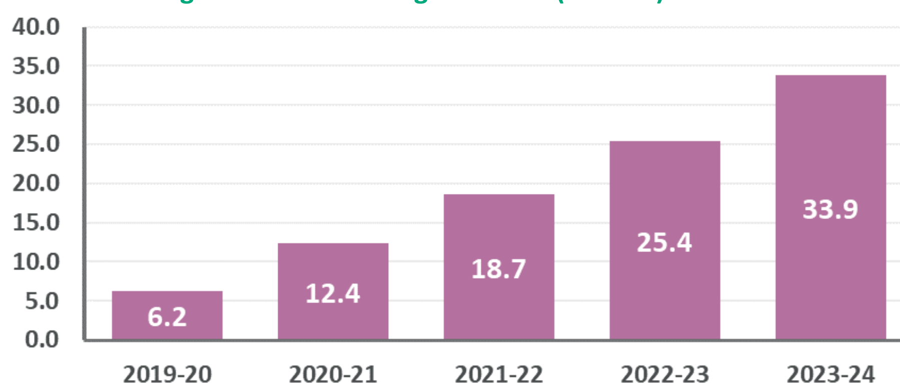
190. DHSC Group 2018-19 AME was £7.0 billion, an underspend of £5.9 billion against the £12.9 billion final budget.

191. The difficulties in predicting clinical negligence expenditure, given the many variables that are outside our direct control have resulted in large underspends over the last three years. Nevertheless, we are always working on improving the forecasting of these budgets with NHSR and their actuarial advisors.

The NHS Long Term Plan: The Next Ten Years

192. In June 2018 the Prime Minister announced the development of a ten-year strategic plan for the NHS – led by clinicians and supported by local health and care systems – which would set out their vision to place the service onto a sustainable pathway so that it can continue to deliver world-class care. The Plan was underpinned by a spending commitment: a £33.9 billion increase in revenue spending by 2023-24. In response, in January 2019, the NHS leadership published its NHS Long Term Plan setting out how the NHS will spend the increase, transforming patient care and making sure every penny of taxpayers' money is spent wisely.

Figure 8: NHS Long Term Plan Funding Increases (£billion)



193. The certainty of funding has also enabled the development of a new financial framework. We now expect local health systems to work together to set out medium-term plans that rebalance the finances across the NHS over the next few years, including the return of all NHS providers to a surplus position by 2023-24. This is just one of five key financial tests the Government has set for the NHS to deliver on so that the NHS will:
    - Return to financial balance (test 1).
    - Achieve cash-releasing productivity growth of at least 1.1% a year (test 2).
    - Reduce the growth in demand for care through better integration and prevention (test 3).
    - Reduce unjustified variation in performance (test 4).
    - Make better use of capital investment and its existing assets to drive transformation (test 5).

194. Some of the changes that are being introduced to support NHS providers and commissioners to achieve their financial tests include:
    - A £1.05 billion Financial Recovery Fund to support systems' and organisations' efforts to make all NHS services sustainable.
    - Revisions to the NHS tariff payment system that will move funding away from activity-based payments and ensure most funding is population-based, making it easier to redesign care across providers, support the move to more preventive and anticipatory care models, and reduce transaction costs.

- An accelerated turnaround process supporting the 30 worst financially performing trusts.

Full details on these and the other changes that are being introduced can be found in the NHS Long Term Plan (chapter six)[90].

195. As part of the 2019 Spending Review, the Government has said that it will consider proposals from the NHS for a multi-year capital funding deal to further support system transformation. In return for this, the Government expects that the NHS will make best use of its existing assets and its existing capital investment funds.

Our performance against other required reporting

Sustainable Development, Sustainable Procurement, Climate Change, Rural Proofing and Sustainable Construction

196. 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 via the Building Research Establishment (BRE) in terms of reducing the environmental impact of their operations, through the Greening Government Commitments (GGC)[91]. BRE undertake an analysis of the data and raise any issues where there appear to be any inconsistencies or changes to ensure data is robust. The GGC are a set of agreed targets that cover carbon emissions related to energy use and business travel, water use and waste.

197. The Department had its first audit of Sustainability Data in 2013, and again in Spring 2016. We are in the process of arranging another review of Sustainability Reporting with internal audit which will be done as soon as possible.

198. Between these audits, we undertook significant 'in-house' work on our governance arrangements including written governance procedures, a year-end data review and sign off procedures, and addressed all IA recommendations. In 2016 we were rated 'substantive' (highest rating) with only a couple of very minor points to address.

199. We are committed to long-term sustainable development. At 2018-19 (against a 2009-10 baseline) the Department and its in-scope ALBs have reduced our carbon emissions by 58%, our waste tonnage by 32% (with only 5% to landfill) and our water use by 37%. We also reduced the number of domestic flights taken by staff by 49%. More detail around our performance in these areas is included within **Annex D**.

200. The staff led Green Network group has been in place since 2017. They work closely with estates colleagues on issues relating to sustainability within the Department.

[90] https://www.longtermplan.nhs.uk/online-version/chapter-6-taxpayers-investment-will-be-used-to-maximum-effect/
[91] https://www.gov.uk/government/publications/greening-government-commitments-2017-to-2018-annual-report

201. We work closely with other government departments, and also support the health and social care system via the NHS Sustainable Development Unit (SDU)[92]. The SDU assists the health and care system to develop Sustainable Development Management Plans (SDMP) and links sustainability to healthcare improvement. The SDU has outlined the vision for a sustainable health and care system in The Sustainable Development Strategy for the Health, Public Health and Social Care System 2014-2020[93], which was published in 2014.

202. 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.

203. 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.

204. The Department has no matters to report relating to biodiversity on its estate. We have no sites that sit within sites of special scientific interest (SSSIs) or areas of outstanding natural beauty (AONBs) or similar. We only have urban offices/brownfield sites, with no significant green space.

Climate Change Adaptation

205. We are looking at how best to take our sustainable development and climate change work forward, building on the Greening Government Commitments and the UN's 2030 Sustainable Development Goals. The Department and its ALBs have worked to make sure that health is represented in cross Government strategies seeking to develop our society in a healthy and sustainable manner, including the Clean Growth Strategy[94] and the 25-year Environment Plan[95]. The need to tackle air pollution was recognised in the Secretary of State's prevention vision document and the NHS Long Term Plan. To this end, DHSC and DEFRA co-launched the new Clean Air Strategy[96] in January 2019 in which the UK became the first industrialised economy to set a target based on the World Health Organisation's air pollution guidelines.

206. 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 will be using the Sustainable Development Goals to help our staff identify how sustainable development and climate change can be addressed in their everyday work. An important step in bringing the Department's sustainability work together and engaging

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[92] https://www.sduhealth.org.uk/
[93] https://www.sduhealth.org.uk/policy-strategy/engagement-resources.aspx
[94] https://www.gov.uk/government/publications/clean-growth-strategy
[95] https://www.gov.uk/government/publications/25-year-environment-plan
[96] https://www.gov.uk/government/publications/clean-air-strategy-2019

with staff was the publication of DHSC's Sustainable Development Management Plan which was approved by the Management Committee and launched in September 2018.

207. Working closely with DEFRA, a second National Adaptation Programme (NAP)[97] was published in July 2018. The NAP sets out what government, businesses and society are doing in response to the top risks identified in the second Climate Change Risk Assessment. The broad health objectives are in place to ensure all relevant public health protection plans are brought together into a single adverse weather plan that takes account of climate change risks, to update our understanding of climate risks to health in light of the 2018 publication of new climate projections and improve resilience of health and social care facilities.

Rural Proofing

208. In the course of the last year the Department has sought to better understand the particular considerations of health and care in a rural context. We are now looking to refresh the Department's focus on consideration of rural health and care in the policy making process.

209. We will work with DEFRA and NHS England on responding to the recently published House of Lords report on rural economy.[98]

Sustainable Construction

210. The Department recently completed works to refit its new headquarters building at 39 Victoria Street. Sustainable construction best practice was at the centre of the project, with a "very good" BREEAM[99] rating achieved. 94% of labour was locally sourced, 93% of project spend was within 40 miles, 99% of waste from construction avoided landfill, 100% of sub-contractors were Small/Medium enterprises, all timber used was FSC Chain of Custody certificated. Sustainable furniture was used with 80% UK sourced raw materials. IT was reused or recycled wherever possible. The same standards are being applied to the Departments' current project to refit space at Quarry House.

Parliamentary Questions 2018

211. We received twice as many written parliamentary questions (7,668) as the next busiest Department, with over 99 per cent answered within deadline.

Freedom of Information (FOI) requests

212. We answered 94 per cent of 1,029 FOI requests due between 1 April 2018 and 31 March 2019 within the statutory 20 working day deadline (or Public Interest Test extension).

[97] https://www.gov.uk/government/publications/climate-change-second-national-adaptation-programme-2018-to-2023
[98] https://publications.parliament.uk/pa/ld201719/ldselect/ldrurecon/330/33002.htm
[99] BREEAM is the world's leading sustainability assessment method for masterplanning projects, infrastructure and buildings. It recognises and reflects the value in higher performing assets across the built environment lifecycle, from new construction to in-use and refurbishment.

Complaints to DHSC and the Parliamentary and Health Service Ombudsman (PHSO)

213. As shown in **Table 2**, in 2018 we answered 28,808 letters and emails, responding to 78 per cent within our target rate of 18 working days. In line with standard correspondence reporting, data shown is for the calendar year 2018 and not the financial year 2018-19.

Table 2: Correspondence Cases 2018

Case Type	Due in 2018	Completed On Time	Percentage On Time
Private Office	13,627	10,482	77%
Treat Official	4,506	3,464	77%
Departmental Email	10,675	8,430	79%
Total	28,808	22,376	78%

214. As shown in **Table 3**, In 2017-18 (the last year for which published results are available) The Parliamentary and Health Service Ombudsman (PHSO) received 12 enquiries regarding complaints about the core department, of which two progressed to assessment. Neither case progressed to investigation for the following reasons:

- The PHSO did not find a case for maladministration and therefore closed the complaint at this stage.
- DHSC had been incorrectly identified as the lead department.

215. As no complaints progressed to investigation, no recommendations were made by the Ombudsman regarding the handling of complaints.

Table 3: PHSO Complaints core Department 2017-18

Enquiries Received	Assessed	Accepted for Investigation	Investigation Upheld/Partly Upheld	Investigations not Upheld	Investigations resolved without completion of investigation	Investigations resolved without a finding
12	2	0	0	0	0	0

* Number of cases accepted for investigation by the PHSO in a financial year differs from the number of investigations completed in the same year. This is because the statistics only provide a snapshot of the casework flow at a given time. For example, the PHSO may have accepted a complaint for investigation in 2017-18 but not completed it until the following year 2018-19. Similarly, it may have completed an investigation in 2017-18 which we originally accepted for investigation in the previous year 2016-17.

** Complaints where PHSO starts an investigation but is able to resolve the complaint without having to formally complete the investigation.

*** These are complaints where the PHSO ends the investigation for a variety of reasons, for example at the complainant's request.

216. The Department's complaints process follows the PHSO's Principles of Good Complaint Handling[100]. We have a three-tier process that first aims to resolve the issue at local level by the person who originally dealt with the issue. If this fails, the complaint will be escalated to a senior manager in that area. If there is no resolution at this stage, the complaint may be escalated to the Complaints Manager for investigation. Once the DHSC complaints process has been exhausted, complainants may then ask an MP to refer the complaint to the PHSO on their behalf.

[100] https://www.ombudsman.org.uk/about-us/our-principles/principles-good-complaint-handling

Prompt Payment of Undisputed Invoices

217. The Public Contracts Regulations 2015[101] 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.

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

Table 4: Prompt Payment of undisputed invoices

	NHS Providers invoices paid within target [1,2]	
Financial Year	Percentage	Value (£m)
2018-19	79	37,856
2017-18	77	34,505

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

220. NHSI discusses performance with providers with poor or deteriorating working capital position and supports individual providers in seeking ways to improve this position.

Official Development Assistance

221. The Department of Health and Social Care's summary of expenditure on Official Development Assistance (ODA) is included at **Annex E**. This amounted to £194.5 million in 2018, funding Global Health Research and Global Health Security.

Better Regulation

222. The Department is committed to the use of better regulation to achieve our objectives of improving the public's health and care while at the same time minimising costs to business. When we do regulate, it is where necessary to protect public health and to ensure we provide safe, effective and compassionate care. We support the recognition of wider impacts of regulation beyond the costs to business.

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

224. The Small Business, Enterprise and Employment (SBEE) Act 2015[102] requires Government to set a Business Impact Target (BIT) for the length of the Parliament. A £9 billion target to regulate more efficiently has already been announced. An interim target for the first three years of the Parliament (i.e. up to June 2020) has been set. The Government intend to take the same approach as during the last Parliament and have set this at the midpoint

[101] http://www.legislation.gov.uk/uksi/2015/102/contents/made
[102] http://www.legislation.gov.uk/ukpga/2015/26/contents/enacted

of the overall target (i.e. a net saving of £4.5 billion to business). The Government have confirmed that departments will not be set a target of deregulatory savings for this Parliament.

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

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

Secretary of State for Health and Social Care Annual Report 2018-19

Introduction

227. The Secretary of State is required by section 247D[103] 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.

228. 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[104]. 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[105].

229. The Secretary of State is under a duty in section 1A of the 2006 Act for or in connection with the matters listed at 1a (the prevention, diagnosis or treatment of illness) and 1b (the protection or improvement of public health), 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)[106]. 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 obtain 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

230. There are a number of operational standards that the NHS is required to deliver in terms of access to NHS services. These are reflected as 'rights and pledges' to patients in the NHS Constitution. During 2018-19, the Secretary of State held regular performance and accountability meetings with the chief executives of NHS England and NHS Improvement, to account for their management of the NHS, seeking assurances on delivery of the constitutional standards, and what action they are taking where the standards are not being met. Details of how the NHS acute sector has delivered against several of these main access standards are given at **Annex C** (NHS Operational Performance).

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[103] Secretary of State for Health & Social Care Annual Report on the performance of the health service in England is presented to Parliament pursuant to section 247D subsection (3).
[104] Social care is not a health service but is covered for completeness.
[105] The assessment is required under section 247D (2) of the National Health Service Act 2006 (H
[106] The NICE quality standards duty relates to section 1A (4).

Single Departmental Plan

231. In line with the process other government departments have followed to agree their single departmental plans, the Department's Single Departmental Plan[107] (SDP) highlights the priorities, objectives, accountabilities and measures that will guide the work of the health and social care system in the coming years. During financial year 2018-19, progress for the Department and the wider system was assessed via the SDP.

232. The SDP is aligned with the outcomes frameworks. 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

233. 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.

234. Collectively, these three outcomes 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.

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

Alignment

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

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[107] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan/department-of-health-and-social-care-single-departmental-plan

Progress against outcomes

The NHS Outcomes Framework

237. The NHS Outcomes Framework (NHSOF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The Framework provides an overview of how the NHS is performing.

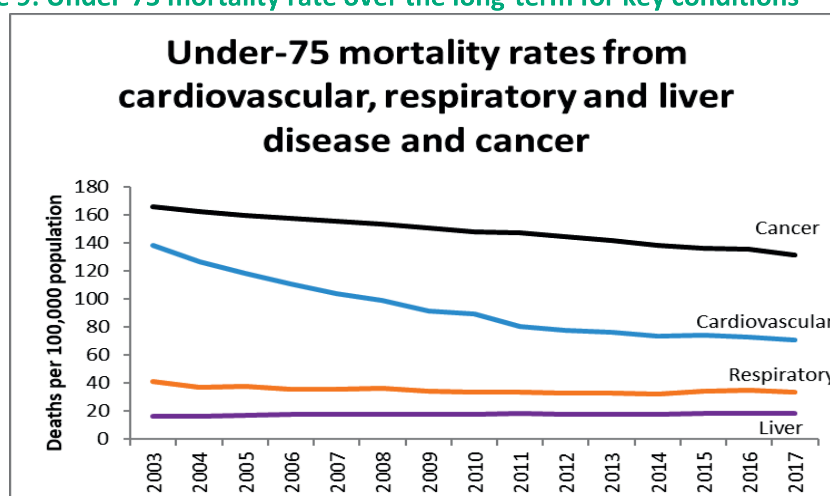
238. The NHSOF comprises five domains:

- 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; and
- treating and caring for people in a safe environment and protecting them from avoidable harm.

Annual indicator data

239. People are living longer due to medical and technological advances and the Government wants to ensure that trend continues. This is why the Government monitors the under-75 mortality rate over the long-term for key conditions, such as cardiovascular disease, cancer and respiratory and liver disease. We have seen significant decreases in the under-75 mortality rate for cardiovascular disease, respiratory disease and cancer between 2003 and 2017. The under-74 mortality rate for liver disease, however, has risen year on year since 2013. See **Figure 9** and following paragraphs.

Figure 9: Under-75 mortality rate over the long-term for key conditions



Source: NHS Digital

240. In 2018-19, the majority of indicators remained stable or did not change significantly compared to the previous year, although a small number showed more significant changes. The data in this section comes from various sources, such as NHS Digital and Office of National Statistics and is the latest data available at 1 May 2019. The key

changes in each domain are set out below. Full details on the indicators can be found on NHS Digital's website[108].

Preventing people from dying prematurely

241. The under-75 mortality rates for cardiovascular disease (CVD) and for cancer continue to improve steadily. There have been significant decreases in the under-75 mortality rate for both conditions since 2003. For cardiovascular disease, there has been a significant decrease of 48.8%, from 138.2 deaths per 100,000 population in 2003 to 70.8 per 100,000 in 2017. For cancer, there has been a significant decrease of 20.5%, from 165.8 deaths per 100,000 population in 2003 to 131.8 per 100,000 in 2017.

242. However, the under 75 mortality rate from liver disease has continued to increase. The rate has risen significantly by 12.7%, from 16.6 deaths per 100,000 population in 2003 to 18.7 per 100,000 in 2017 see **Figure 9**.

243. In November 2018, we published our Vision for Prevention[109], setting out how we will put prevention at the heart of our health and social care system for the long term. While people are living longer lives than ever before, for many people, too many of these extra years are spent in poor health. This new strategy will help us improve the health of the whole population, while closing the gap between the richest and poorest, so that by 2035 we can ensure people can enjoy at least five extra years of healthy, independent life.

Enhancing quality of life for people with long-term conditions

244. When people do need healthcare, the NHS continues to provide the care people need to live a fulfilling life. There was a significant decrease in the unplanned admission rate for 0-18-year olds for asthma, diabetes and epilepsy. The rate reduced from 346 admissions per 100,000 of population in 2003-04, to 286 admissions per 100,000 of population in 2017-18, a decrease of 17.3%.

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

245. The NHS continues to support people as they recover from injury or episodes of ill health. There has been a significant improvement in the number of children aged 10 and under admitted to hospital for tooth extractions due to decay of 7.1% from 456.9 admissions per 100,000 population in 2011-12 to 424.6 in 2017-18.

Ensuring that people have a positive experience of care

246. The Government is pleased that most patients are satisfied with their experience of and access to healthcare. There has been a slight improvement year-on-year in hospitals' responsiveness to inpatients' needs, rising from 67.4% in 2003-04 to 69.6% in 2015-16. However, a slight dip in 2016-17 has not been fully offset – the 2017-18 figure is 68.6%. We cannot comment on trends for a number of indicators in this domain as changes to definitions or underlying surveys in previous years mean that NHS Digital cannot provide a time series analysis for these indicators.

[108] https://digital.nhs.uk/search/category/nhs-outcomes-framework--nhs-of-/category/clinical-indicators-team?sort=relevance&area=data
[109] https://publichealthmatters.blog.gov.uk/2018/11/05/matt-hancock-my-vision-for-prevention/

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

247. The Department is committed to ensuring that English hospitals and GP surgeries are the safest in the world. Among the 'severe or death' patient safety incidents, those due to medication remained relatively stable in 2017-18 but have reduced by around 50% since the start of recording in 2008.

248. There has been a substantial reduction in deaths from venous thromboembolism (VTE) related events within 90 days post discharge from hospital of 15.4% from 72.1 deaths within 90 days of discharge per 100,000 related admissions 2007-08 to 61.0 in 2017-18.

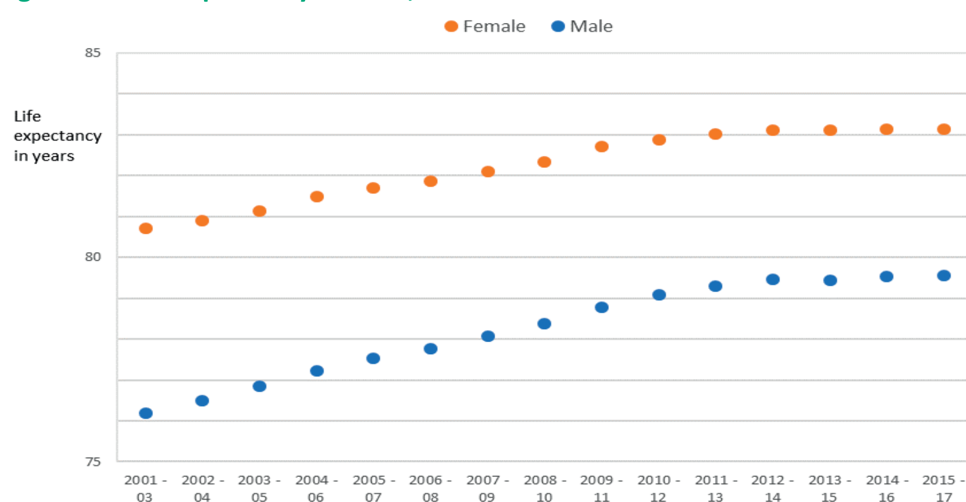
The Public Health Outcomes Framework

249. The strategic vision for public health in England concentrates on two high-level outcomes:
    - Increased healthy life expectancy[110].
    - Reduced differences in life expectancy and healthy life expectancy between communities.

250. Throughout this section, assessment of progress on indicators is made by comparing the most recent value of an indicator to the value it had in 2014[111].

251. Life expectancy and healthy life expectancy at birth have remained relatively stable since 2014[112]. However, there has been a general improvement in life expectancy over the longer term, though the degree of improvement has slowed down considerably since 2011 as shown in **Figure 10**.

Figure 10: Life Expectancy at birth, Males and females 2001-03 to 2015-17



[110] Is about not only how long we live, our life expectancy, but also on how well we live, our healthy life expectancy at all stages of the life course; helping people live healthy lives.

[111] For simplicity and topicality, we have chosen a fairly recent year 2014 for our assessment of *subsequent* progress. Depending on the indicator, the values for 2014 refer to the 2014 calendar year itself, or to the 2014-15 financial year or to the 3 year period from 2013-15. For brevity these are all referred to as the position in 2014.

[112] Only statistically significant changes are described as improvements or deteriorations.

252. Of the 115 indicators included in this analysis from the Public Health Outcomes Framework, 76 (66%) have either improved since 2014 or are broadly the same and 39 (34%) have deteriorated in comparison with 2014. That is, approximately two thirds have improved or remained unchanged while one third have deteriorated in comparison with 2014. However, for most of the indicators there remains considerable variation across local areas. For details on indicators please refer to the Public Health England (PHE) website[113].

Improving wider determinants of health indicators

253. More than half of the indicators in this domain have improved or remained constant.

254. In particular we have seen an increase in children achieving a good level of development at the end of reception. Also, the percentage of Year-1 pupils achieving the expected level in the phonics screening check has increased. Both indicators are continuing a longer-term upward trend. First time entrants to the youth justice system and the percentage of working days lost due to sickness absence have also improved.

255. One of the deteriorating indicators is the number of households in temporary accommodation awaiting a settled home, which has increased. The government is undertaking a significant programme of work backed by £1.2 billion, to tackle homelessness. This includes supporting Local Authorities in the implementation of the Homelessness Reduction Act[114], increasing access to the private rented sector for families in temporary accommodation and supporting London boroughs to procure temporary accommodation more efficiently.

Health Improvement Indicators

256. More than half of the indicators in this domain have improved or remained constant.

257. In particular smoking prevalence among adults has declined substantially. Smoking is a known risk factor for many diseases including Chronic Obstructive Pulmonary Disease (COPD), heart disease and numerous cancers. Conceptions among girls aged under 18 years old, particularly those aged under 16 years, have also shown a substantial decrease. The number of people self-reporting they are satisfied with their life has shown a substantial improvement.

258. However, further work is needed in seeking improvement across indicators showing deterioration, such as the coverage for the screening programmes for breast and cervical cancer. The Government is concerned by the number of drug-related deaths and is supporting local areas to develop a more joined up approach to commissioning, while delivering the range of services that are essential to supporting recovery and preventing drug-related deaths. As set out in the NHS Long Term Plan (LTP), DHSC is working with NHS England (NHSE) and Public Health England (PHE) to radically overhaul our cancer screening programmes, and to reverse the declines in screening coverage wherever possible. The LTP also states how we will modernise the bowel and cervical screening

[113] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[114] http://www.legislation.gov.uk/ukpga/2017/13/contents/enacted

programmes. Sir Mike Richards is currently leading a review of the current cancer screening programmes and diagnostic capacity.

Health Protection Indicators

259. In contrast to the other three domains, more than half of the indicators in this domain have shown deterioration.

260. Indicators that have deteriorated include the chlamydia detection rates and the coverage rates for some of the vaccination programmes notably the population vaccination coverage for PCV (pneumococcal conjugate vaccine) booster and the population vaccination coverage of MMR (measles, mumps and rubella) first dose (measured at 2 years old). PHE commissioned an external peer review of the chlamydia screening programme to ensure it continues to be informed by best available evidence. This review recommended the programme place a greater focus on harm reduction from untreated chlamydia and proposed changes to the programme were due to go out to public consultation towards the end of May 2019.

261. More widely DHSC, PHE and NHSE are taking action to reverse the slight declines in vaccination uptake that have been seen in recent years, and to push coverage even higher. Actions include ensuring access to vaccination is optimal, promoting the value of vaccination, reminding the public of the dangerous diseases they prevent, and working with both the Department for Education to ensure pupils know the facts, and with the Department for Digital, Culture, Media and Sport to tackle online misinformation about vaccines.

262. Indicators in this domain which have improved include reductions in the incidences of Tuberculosis (TB) and reductions in the late diagnosis of human immunodeficiency virus (HIV).

Healthcare, public health and preventing premature mortality indicators

263. More than half of the indicators in this domain have improved or remained unchanged.

264. Indicators for suicide rate, for preventable sight loss due to diabetic eye disease and for hip fractures in people over 80 years have shown an improvement.

265. Indicators that have deteriorated include both the mortality rate from a range of communicable diseases including influenza, and the excess winter deaths measure for both all ages and for those specifically aged 85 years and over. The causes of excess winter deaths are complex and vary from year to year, depending on the interplay of factors such as outdoor winter temperatures and how much circulating influenza there is. Over the years since 2013-14 excess winter deaths have shown considerable variability from year to year, and while the latest figure for 2016-17 is above the longer-term average, and above the value for 2013-14, it is considerably lower than the worst recent year for winter deaths, which was 2014-15.

266. The indicators in the PHOF are reviewed every three years to ensure that they continue to be relevant and meet the needs of users. PHE ran a consultation on the framework

between 21 January and 22 February this year. PHE are planning to update the indicators during Summer 2019.

The Adult Social Care Outcomes Framework (ASCOF)

267. 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.

268. **Table 5** shows selected data. Further detail on the ASCOF and all the indicator data can be found at NHS Digital's website[115].

Table 5: ASCOF Indicators

Rating	Enhancing quality of life for people with care and support needs	Delaying and reducing the need for care and support	Ensuring that people have a positive experience of care and support	Safeguarding vulnerable adults and protecting from avoidable harm
Better than or on trajectory	11	6	2	2
Worse than trajectory	3	1	3	0
Rated indicators that are better than or on trajectory (%)	79%	86%	40%	100%

1. Most indicators are based on 2017-18 data. Five are based on 2016-17 data from the Survey of Adult Carers in England, which is a biennial publication.
2. Correct as at May 2019

Enhancing quality of life for people with care and support needs

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

Delaying and reducing the need for care and support

270. 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 2017-18, 83% of such people were still at home. Latest data shows delayed transfers of care reducing compared to 2016-17, both in total delays per 100,000 population, and delays attributable to social care or both social care and the NHS.

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

Ensuring that people have a positive experience of care and support

271. Understanding how people who use services, and their carers, feel about the support they receive and the availability of information during a difficult time is crucial to maintaining their wellbeing. The overall satisfaction of people who use services has remained stable at 65% since 2016-17.

Safeguarding vulnerable adults and protecting from avoidable harm

272. 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 2017-18, 70% of people who used services reported that they felt safe; effectively a stable level compared to 2016-17.

NICE Quality Standards

273. 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, NHSE and PHE to ensure that NICE's quality standard programme reflects health and care priorities. Over the past year, NICE has published 18 new and updated quality standards covering a range of topics, including eating disorders, emergency and acute medical care for over 16s and air pollution. The Secretary of State has to have regard to NICE quality standards when discharging his Section 1A functions.

Quality and Patient Safety

Patient Safety Strategy

274. The Department is continuing apace to build upon the range of initiatives developed to take forward the Francis agenda. In July 2018 Dr Aidan Fowler was appointed as the new NHS National Director of Patient Safety and in September 2018 the Secretary of State announced a new National Patient Safety Strategy to cement patient safety into the NHS Long Term Plan. The strategy, to be introduced in 2019, will support the NHS to tackle safety-specific challenges including a 50% reduction in harm in key areas of patient safety by 2023-24 and beyond.

System Regulation

275. The Care Quality Commission (CQC) monitors, inspects and regulates registered health and social care providers in England. In July 2018, as further development of its inspection and regulation function, the CQC introduced a combined rating taking into account the 'Use of Resources' assessment of high quality, efficient and sustainable care to provide an overall rating for each acute Trust in England.

276. In October 2018 the CQC's annual State of Care report, which provides an assessment of health and care, found that quality overall has been largely maintained from last year, and in some cases, improved (as the table below shows), despite the continuing challenges that providers face.

277. CQC found that demand for care continues to rise, largely from an ageing population and an increasing number of people living with chronic conditions or multiple conditions such

as diabetes and cancer. Safety remains a concern in NHS acute hospitals and mental health services; while many services struggle to recruit, retain and develop their staff to meet the needs of the people they care for. Providers are beginning to embrace new technology, which is improving people's quality of care, and the way services work together.

Table 6: CQC ratings of health and social providers 2017-18 and 2018-19**

Year of assessment	**2018-19**	2017-18	**2018- 19**	2017-18	**2018-19**	2017-18	**2018-19**	2017-18
Rating	Outstanding		Good		Requires Improvement		Inadequate	
NHS Acute Trusts*	**4**	1	**30**	13	**39**	35	**5**	7
Specialist NHS Trusts*	**2**	0	**8**	0	**0**	0	**0**	0
Mental health NHS Trusts*	**4**	0	**21**	16	**11**	8	**1**	1
GP surgeries	**52**	45	**1,481**	1,806	**300**	340	**147**	162
Adult social care locations (total)	**376**	269	**5,856**	7,674	**3,669**	3,933	**639**	741

**NHS trusts are recorded at provider-level and as such the total number of locations inspected will be greater than the number of providers.*
*** to 11 Jan 2019, the most recent available data.*

278. In the 2018-19 reporting period NHS Improvement continued to provide Trusts in special measures for quality with increased oversight and enhanced support to address their care quality issues. As of 31 March 2019, there were 13 Trusts in special measures for quality reasons, with 27 having exited since the programme began in 2013. However, 4 of those 27 Trusts re-entered the programme. NHS England and NHS Improvement continues to provide increased oversight and enhanced support to Trusts in special measures for quality reasons.

Programmes

279. The Employment Rights Act 1996 (NHS Recruitment - Protected Disclosure) Regulations 2018/579[116] came into force in May 2018 to better protect NHS staff who raise concerns around discrimination in job applications.

280. And in response to the Gosport Panel Inquiry, Government will legislate, subject to parliamentary time, for annual reporting by NHS Trusts as to the level of staff speaking up and for Trusts to publish a report on how whistleblowing concerns are handled within their Trust.

281. CQC inspections now assess a trust's compliance with the national guidance on Learning from Deaths, including how well they engage with families and carers when things do go wrong. To support this approach, in July 2018 the National Quality Board worked with families to publish Guidance for NHS trusts on working with bereaved families and carers[117] to improve how Trusts engage with the bereaved and learn when things go wrong.

282. The process of reviewing the deaths of all children in England is being standardised and is informed by new national Child Death Review: statutory and operational guidance[118]. An

[116] http://www.legislation.gov.uk/uksi/2018/579/contents/made
[117] https://www.england.nhs.uk/publication/learning-from-deaths-guidance-for-nhs-trusts-on-working-with-bereaved-families-and-carers/
[118] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

independent scrutiny of every child death will be performed by a local Child Death Overview Panel (CDOP), or equivalent, which will ensure a uniform, high-standard of reviews locally. Anonymised information from the reviews will be submitted to the National Child Mortality Database from April 2019, to enable findings from local reviews to inform shared learning.

283. A national system of Medical Examiners (MEs) is to be introduced to provide independent medical scrutiny of all non-coronial deaths. MEs will be able to direct deaths to the specific mortality reviews outlined under the National Learning from Deaths Programme as necessary, ensuring that deaths are appropriately reflected upon and learned from.

284. In October 2018, the Secretary of State and Minister of State for Care supported the National Guardians Office first ever "Speak Up" month which saw more than 100 events across the country raising awareness of "Speaking Up" within the NHS.

285. DHSC continues to work with other government departments and international governments in order to harness global cooperation and sharing of best practice so that all people around the world can have access to safe and quality healthcare.

286. DHSC is working with NHS Improvement to establish a national Medicine Safety Programme, which will look to reduce the burden of severe, avoidable harm related to medication by 50 per cent over 5 years and will also seek to engage with the international community to share resources and improve the safety of medication globally, under the WHO's Medication Without Harm Challenge[119].

Inquiries and Reviews

287. The Department is overseeing implementation of the review recommendations to support a just and learning culture in healthcare following Professor Sir Norman Williams' rapid policy review into the issues relating to gross negligence manslaughter (GNM) in healthcare. The report was published in June 2018[120] and the former Secretary of State accepted all recommendations. Implementation is based on three broad strands of work: clarity and consistency of application of GNM in healthcare; NHS investigations; and professional regulation.

288. The Independent Breast Screening Review (IBSR) was announced on 2 May 2018. It was charged with looking into a serious failing in the national breast screening programme in England, which resulted in many thousands of women aged between 68 and 71 not being invited to their final breast screening between 2009 and May 2018. The Review reported in December 2018[121] and highlighted a change in policy on the upper age limit for screening that had inadvertently given rise to a Serious Incident. The Review made 15 recommendations for the Department of Health and Social Care, Public Health England and NHS England, and the Government published its formal response[122] in March 2019.

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[119] https://www.who.int/patientsafety/medication-safety/en/
[120] https://www.gov.uk/government/groups/professor-sir-norman-williams-review
[121] https://www.gov.uk/government/publications/independent-breast-screening-review-report
[122] https://www.gov.uk/government/publications/independent-breast-screening-review-government-response

289. In addition to the Williams review, Tom Kark QC led a review which considered the effectiveness of the Fit and Proper Persons Requirement. The report of the review was published in February 2019[123] and the Government has initially accepted two key recommendations designed to help set consistent expectations for leaders and support the whole NHS in upholding these standards. Baroness Harding has been commissioned to consider how best to implement its recommendations through the system-wide NHS People Plan process, which she chairs, and which is set out in the NHS Long Term Plan.

290. June 2018 also saw publication of the Gosport Independent Panel report[124] on events at Gosport War Memorial Hospital from the late 1980's to 2001. The Government published its response to the report Learning from Gosport[125] in November 2018 and has put in place a number of measures since the events described in the report, including stronger measures to ensure the safety of controlled drugs, and an independent, clinically led inspectorate and the introduction of Medical Examiners from 2019.

291. Scrutiny of patient safety continues with publication of the Independent Medicines and Medical Devices Safety Review, chaired by Baroness Julia Cumberlege; and the report into the practice of former breast surgeon Ian Paterson, are both expected to report in 2019-20.

292. The Healthcare Safety Investigation Branch (HSIB) continues to conduct independent investigations into safety incidents and disseminate learning across the NHS in order to reduce patient harm.

293. During 2018, HSIB launched 21 national investigations and published 9 reports on a range of patient safety issues. To date, HSIB has issued 30 safety recommendations, the majority aimed at national bodies. HSIB also made a further 15 Safety Observations and 1 Safety Action. The CQC will take these actions into account in its inspections, where appropriate and NHS Improvement will help to ensure system improvements to patient safety are implemented.

294. In April 2018 HSIB's remit was extended to deliver maternity investigations to all regions in England by April 2019. These maternity investigations have a dual purpose, to provide the family of the baby or mother who was harmed with a full account of what happened in the individual case, as well as generate system learning. HSIB launched 440 maternity investigations of which 369 progressed to full investigation. HSIB will publish a thematic review of all maternity investigations in due course.

Overall Assessment (section 1A)

295. The Secretary of State's assessment is that, against the challenges of an ageing population and an increase in the complexity and number of patients with long-term conditions, reasonable progress has been made against the duty under section 1A of the 2016 Act, to act to secure continuous improvement in the quality of services provided to individuals, in particular securing continuous improvement in the outcomes achieved.

[123] https://www.nhsemployers.org/news/2019/02/recommendations-from-the-kark-review
[124] https://www.gosportpanel.independent.gov.uk/panel-report/
[125] https://www.gov.uk/government/publications/gosport-independent-panel-report-government-response

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

Health Inequalities

297. The Secretary of State's legal duty to have regard to the need to reduce health inequalities includes assessment and reporting requirements.[126] For 2018-19, the criteria for assessment and supporting indicators remained as set out in the Secretary of State's letter to health system leaders in February 2016.[127]

298. Inequalities in people's access, outcomes and experiences of the health service continue to present real challenges. During 2018-19 there has been renewed focus on ensuring consideration of inequalities is given at every opportunity. Some of many examples include agreeing a Long Term Plan for the NHS with clear commitments for reducing inequalities over the next 5 and 10 years, and publishing the Secretary of State's vision Prevention is Better than Cure[128].

299. Public Health England and members of the Cardiovascular Disease Prevention System Leadership Forum launched 10-year ambitions including one to significantly reduce the gap in amenable CVD deaths between the most and least deprived areas by 2029. PHE also published an inequalities strategy for cancer screening in May 2018 and guidance to improve access to screening for people with serious mental illness in March 2019.

300. Fifteen overarching indicators of how health outcomes differ by area deprivation are drawn from the NHS Outcomes Framework (NHSOF) and Public Health Outcomes Framework (PHOF).[129] They are used in this assessment which seeks to identify both recent change and change since the inequalities duties were introduced under the Health and Social Care Act 2012. In 2017-18 a number of methodological improvements were made to ensure consistency of reporting of inequalities across PHE, NHS England, and DHSC, including use of an agreed baseline for each indicator and standardised significance testing.[130]

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[126] In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service. NHS Act 2006 (as amended).

[127] https://www.gov.uk/government/publications/criteria-used-to-measure-success-on-reducing-health-inequalities

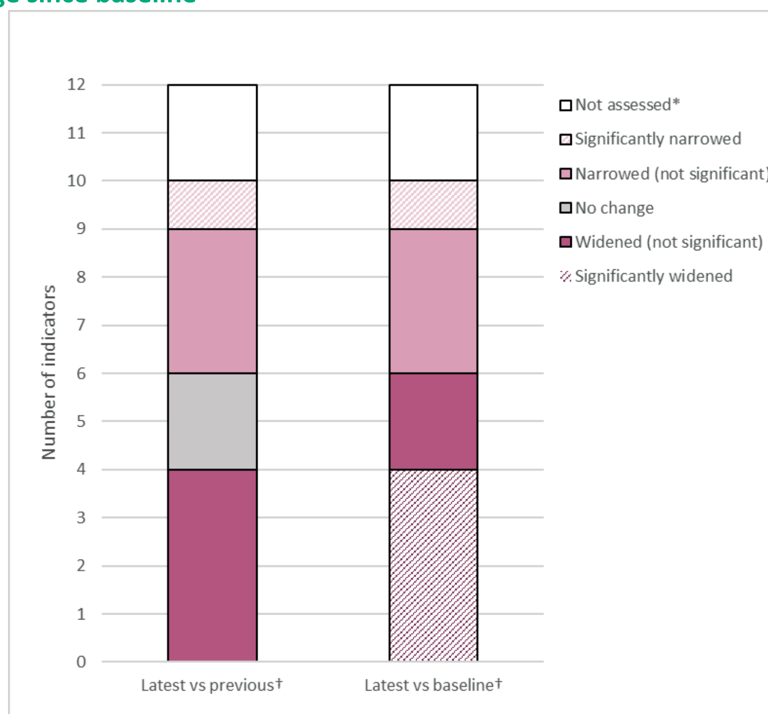
[128] https://www.gov.uk/government/news/health-secretary-launches-prevention-is-better-than-cure-vision

[129] Only twelve of the fifteen selected indicators are presented in this report; two of the indicators are no longer updated by NHS Digital ('Potential years of life lost (PYLL) from causes considered amenable to healthcare – adults' and 'Health-related quality of life for people with long-term conditions') and at the time of the publication of this report, data has not yet been released by NHS Digital for a further indicator ('Infant mortality rate').

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

301. **Figure 11** summarises the changes seen across this basket of indicators, comparing the latest data with data from the previous time period, i.e. looking at recent change, and comparing with the baseline period. The full data is available at **Table 50** in **Annex D**.

Figure 11: Change across the basket of Health Inequalities Indicators: recent change and change since baseline



* Assessment not possible due to data availability
† Previous and baseline years differ across indicators

302. Most of the indicators have not exhibited statistically significant changes. Only 1 out of the 12 indicators showed a statistically significant change from the previous time period (significantly narrowed) and 5 out of 12 showed statistically significant changes from the baseline time period (1 x significantly narrowed and 4 x significantly widened).

303. In relation to inequalities by area deprivation, the overarching indicators in the PHOF show that the gaps between people living in the most deprived areas and the least deprived areas remain:

- these inequalities are broadly stable since the baseline year and the previous time period; however, inequality in life expectancy at birth for males and females significantly widened between 2010-12 and 2015-17[131].
- in 2015-17, the inequality in life expectancy at birth between the most and least deprived areas was 9.4 years for males and 7.4 years for females.
- in 2015-17 the inequality in healthy life expectancy at birth between the most and least deprived areas was 19.1 years for males and 18.8 for females.

[131] 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, HLE and SII were added to the PHOF; these were based on the 2015 Indices of Multiple Deprivation rather than 2010 IMD.

304. The NHSOF covers a wider range of indicators that include health outcomes, access to services and patient experience. These indicators provide a mixed picture:
- inequalities significantly widened between 2011-13 and 2015-17 for life expectancy at 75 for males and females;
- inequality widened in unplanned hospitalisation for chronic ambulatory care sensitive conditions between 2013/14 to 2017/18; however, this change is not statistically significant;
- inequalities in under 75 mortality rates from cardiovascular diseases and from cancer have narrowed between 2013 and 2017; however, these changes are not statistically significant;
- inequalities in emergency admissions for acute conditions that should not usually require hospital admission significantly narrowed between 2016/17 and 2017/18; and
- for access to GP services and experience of GP services, there is a notable increase in the slope index of inequality between the baseline year (2013/14) and the most recent time period (2017/18); however, it is not possible to accurately assess the statistical significance of this change[132].

305. Using data 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[133]. In 2017-18:
- there remained inequalities in access to GP services and experience of GP services for different ethnic groups. Since the baseline year (2013/14), respondents from Bangladeshi and Pakistani ethnic groups have always been in the poorest 3 scoring ethnicities for both indicators;
- younger ages generally reported lower scores than older ages; and
- individuals who identify as heterosexual reported higher scores than those who identify as gay/lesbian or bisexual.

306. The Secretary of State's assessment of how well his health inequalities duty has been fulfilled in 2018-19 is that, while there has been good progress in embedding issues around inequalities in key policies during the year, increased focus is needed throughout the health and care system to reverse the current trend of widening inequalities across a range of areas. There is a solid basis for the system to take work forward that will have a real impact on reducing inequalities in the years to come.

Forward look to 2019-20

307. Over the course of 2019-20, 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[134], the Department and its delivery partners across the health and care system are committed to

[132] Data needed to calculate the confidence intervals for each decile are unavailable
[133] https://digital.nhs.uk/data-and-information
[134] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan

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 2019
Sir Chris Wormald KCB
Permanent Secretary

Accountability Report

Lead Non-Executive Board Member's Report

Kate Lampard

Performance and priorities

308. The Non-Executive Director team has been working together since November 2017. We bring wide expertise to the Department including clinical, financial and legal experience.

309. Membership of the Board changed during the year with the Rt Hon Matt Hancock MP appointed Secretary of State for Health and Social Care in July 2018. Stephen Hammond MP was appointed as Minister for Health in November 2018 and Baroness Nicola Blackwood was appointed as the new Parliamentary Under Secretary of State for Health (Lords) in January 2019.

310. The Board is chaired by the Secretary of State. He has sought to ensure that the Board focusses on holding the Department to account for robust and effective planning and delivery of its strategic goals. Meetings have covered a range of topics from workforce issues to the Government's Major Project Portfolio. Non-Executive Directors have also met with senior Directors from the Department for 'deep dive' sessions to explore in greater depth and to offer advice and challenge on major strategic issues such as the NHS Long Term Plan and planning for leaving the EU.

311. The Non-Executive Directors have also used their experience to provide insight and support to the wider Department. This year we have established a mentoring programme for senior civil servants; Ron Kerr carried out a review into performance management in the NHS; and we have strengthened ties with the Department's ALBs. We have also attended a range of other departmental meetings to provide advice on and further oversight of progress in relation to EU Exit planning.

Accountability Report

312. 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

313. 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

314. 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. Details of our Board and its committees can be found within the Governance Statement.

Who we are

315. The Department of Health and Social Care is led by a ministerial team and a staff of civil servants. Our non-executive board members are independent of the Department and government and provide advice and challenge to our Ministers and senior staff.

Our Ministers at 31 March 2019

Rt Hon Matt Hancock MP*
Secretary of State for Health and Social Care

Chair of the Board
3/3 Board meetings attended

Stephen Hammond MP**
Minister of State for Health

Not a formal member of the Board, though 2/2 Board meetings attended

Caroline Dinenage MP
Minister of State for Care

Deputy chair of the Board
4/4 Board meetings attended

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

Not a formal member of the Board.

Baroness Blackwood***
Parliamentary Under Secretary of State for Health (Lords)

Not a formal member of the Board.

*Rt Hon Matt Hancock MP was appointed as the new Secretary of State for Health and Social Care in July 2018, replacing Rt Hon Jeremy Hunt MP who was appointed to Secretary of State for Foreign and Commonwealth Affairs. The first board meeting of 2018 was chaired by the Rt Hon Jeremy Hunt MP.
** Stephen Hammond MP was appointed as the new Minister of State for Health in November 2018.
*** Baroness Nicola Blackwood was appointed as the new Parliamentary Under Secretary of State for Health (Lords) in January 2019.

Former Ministers who served during 2018-19

- **Rt Hon Jeremy Hunt MP,** Secretary of State for Health and Social care until July 2018. 1/1 Board meetings attended.
- **Stephen Barclay MP,** Minister of State for Health until November 2018. 1/1 Board meetings attended.
- **Steve Brine MP,** Parliamentary Under Secretary of State (Public Health and Primary Care) until 25 March 2019 – Not a formal member of the Board.
- **Lord O'Shaughnessy,** Parliamentary Under Secretary of State for Health (Lords) until December 2018. 1/1 Board meetings attended.

Our Non-Executive Board Members 2018-19

Kate Lampard
Lead Non-Executive Director
1 October 2017-Present
4/4 Board meetings attended

Gerry Murphy
Non-Executive Director
1 August 2014- Present
4/4 Board meetings attended

Prof. Dame Sue Bailey
Non-Executive Director
1 November 2017-Present
4/4 Board meetings attended

Sir Ron Kerr
Non-Executive Director
1 November 2017-Present
4/4 Board meetings attended

Prof. Sir Mike Richards
Non-Executive Director
1 November 2017-Present
4/4 Board meetings attended

Michael Mire
Non-Executive Director
1 November 2017- Present
2/4 Board meetings attended

Our Executive Board Members

Sir Chris Wormald KCB
Permanent Secretary

4/4 Board meetings attended

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

3/4 Board meetings attended

David Williams
Director General for Finance and Group Operations, and Chief Operating Officer

4/4 Board meetings attended

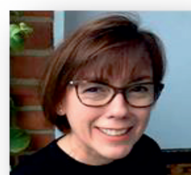
Other senior officials

Clara Swinson**
Director General for Global and Public Health

Not a formal member of the Board
0/1 Board meetings attended

Jonathan Marron**
Director General for Community and Social Care

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



Lee McDonough**
Director General for Acute Care and Workforce

Not a formal member of the Board
0/1 Board meetings attended

* Dame Sally Davies will step down as Chief Medical Officer at the end of September 2019 and will move into her new position as Master of Trinity College, Cambridge in October 2019.
** Clara Swinson, Jonathan Marron and Lee McDonough were formal members of the Board until October 2018 when Board composition changed.

Professor Chris Whitty
Chief Scientific Officer

Not a formal member of the Board.
0/0 Board meetings attended

Steve Oldfield
Chief Commercial Officer

Not a formal member of the Board.
0/0 Board meetings attended

Our Arm's Length Bodies and Delivery Partners

316. 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.

317. 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.

318. Our ALBs, detailed in **Annex F**, fall into several distinct types as shown in **Figure 12**:
    - Executive Non-Departmental Public Bodies (ENDPBs). Established by primary legislation and have their own statutory functions conferred, rather than delegated by the Secretary of State for Health and Social Care.
    - Executive Agencies. Which are legally part of the Department but have greater operational independence.
    - Special Health Authorities (SpHAs). These are NHS bodies created by order and subject to direction by the Secretary of State for Health and Social Care.
    - Limited companies incorporated under the Companies Act and included in this Annual Report and Accounts.
    - Other bodies not included in this Annual Report and Accounts because they receive their funding from other sources.

Figure 12: Our Arm's Length Bodies and Delivery Partners

Notes: 1. Since April 2016, Monitor and NHS TDA operate as NHS Improvement.
2. Supply Chain Coordination Limited (SCCL) is a wholly-owned company. No company logo exists at time of publication. Details can be found in Annex F.
3. MHRA and NHS Blood and Transplant (NHSBT) are designated as outside the Departmental Group by the Office for National Statistics and are therefore not consolidated or incorporated in these accounts.

319. Our Permanent Secretary is the Principal Accounting Officer for the Departmental Group which as at 31 March 2019 consisted of:
   - Ten ENDPBs (including NHS England and its 195 Clinical Commissioning Groups (CCGs));
   - Four SpHAs;
   - Eight other bodies;
   - 150 NHS Foundation Trusts (FTs);
   - 77 NHS Trusts (NHSTs); and
   - NHS charities.

320. 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

321. The Department has a Code for Business Conduct, which incorporates the principles set out in the Civil Service Code[135] and applies to all staff working in the Department, including those who have authority or responsibility for directing or controlling the Department.

[135] https://www.gov.uk/government/publications/civil-service-code/the-civil-service-code

322. 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

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

324. Our Ministers' interests are published on Gov.Uk website by the Cabinet Office[136] whilst our Directors General and Directors' record of gifts and hospitality are published as part of the quarterly transparency data also held on Gov.Uk website[137].

325. 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.

[136] https://www.gov.uk/government/publications/list-of-ministers-interests
[137] https://www.gov.uk/government/publications/dhsc-senior-officials-business-expenses-and-hospitality-2018-to-2019

Statement of Principal Accounting Officer's Responsibilities

326. Under the Government Resources and Accounts Act 2000[138] (the GRAA), HM Treasury has directed the Department of Health and Social Care to prepare, for each financial year, consolidated resource accounts detailing the resources acquired, held or disposed and the use of resources during the year by the Department (inclusive of its executive agency, Public Health England) and its sponsored non-departmental and other Arm's Length public bodies (including NHS bodies) designated by order made under the GRAA by Statutory Instrument 2018 no.1335 (together known as the 'Departmental Group', consisting of the Department and sponsored bodies listed at note 21 to the accounts).

327. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Department and the Departmental Group and of the net resource outturn, application of resources, changes in taxpayers' equity and cash flows of the departmental group for the financial year.

328. In preparing the accounts, the Principal Accounting Officer of the Department is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:
    - observe the Accounts Direction issued by HM Treasury, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
    - ensure that the Department has in place appropriate and reliable systems and procedures to carry out the consolidation process;
    - make judgements and estimates on a reasonable basis, including those judgements involved in consolidating the accounting information provided by departmental group bodies;
    - state whether applicable accounting standards, as set out in the Government Financial Reporting Manual, have been followed, and disclose and explain any material departures in the accounts;
    - prepare the accounts on a going concern basis; and
    - confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

330. 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.

331. The Principal Accounting Officer has also appointed the Chief Executives, or equivalents, of its sponsored non-departmental and other arm's length public bodies as Accounting

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

Officers of those bodies. The Principal Accounting Officer of the Department is responsible for ensuring that appropriate systems and controls are in place to ensure that any funds that the Department makes available to its sponsored bodies are applied for the purposes intended and that such expenditure and the other income and expenditure of the sponsored bodies are properly accounted for, for the purposes of consolidation within the resource accounts. Under their terms of appointment, the Accounting Officers of the sponsored bodies are accountable for the use, including the regularity and propriety, of the grants received and the other income and expenditure of the sponsored bodies.

332. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Principal Accounting Officer is answerable, for keeping proper records and for safeguarding the assets of the Department or non-departmental or other arm's length public body for which the Principal Accounting Officer is responsible, are set out in Managing Public Money[139] published by HM Treasury.

333. The Department published in July 2018 an Accounting Officer System Statement[140] 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[141]. This includes the responsibilities and relationships between the Accounting Officers in the Department, its Agencies, Arm's Length Bodies and the NHS.

334. 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.

335. 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.

[139] https://www.gov.uk/government/publications/managing-public-money
[140] https://www.gov.uk/government/publications/department-of-health-accounting-officer-system-statement
[141] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Governance Statement

Scope of Responsibility

336. This Governance Statement covers the Department of Health and Social Care Group and outlines how responsibility for the management and control of the Department of Health and Social Care's resources were discharged during the year. This statement covers 2018-19 and is current up to the date this Annual Report was signed.

337. 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[142] for central Government Departments, published by HM Treasury and the Cabinet Office. The Head of Internal Audit's opinion is that he can give Moderate Assurance to the Department's Principal Accounting Officer in relation to the 2018-19 reporting year regarding the overall adequacy and effectiveness of the Department's systems of risk management, governance and internal control for the year as a whole. The Board is satisfied that we have complied with the principles in 'Corporate Governance in Central Government Departments: Code of Good Practice'. No concerns have been raised about the quality of information received by the board or its sub-committees.

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

339. 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.

340. 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.

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

Departmental Governance

341. 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.

342. The Departmental Board meets on a quarterly basis. The Board met on four occasions during the 2018-19 financial year. Full membership and attendance is outlined in the Directors' Report. The composition of the Board changed during 2018, with the appointment of a new Secretary of State. Board membership changed at this point to reduce the number of Directors Generals who are formal members of the Board. A full team of six Non-Executive Directors have been in post since the start of 2018-19 period.

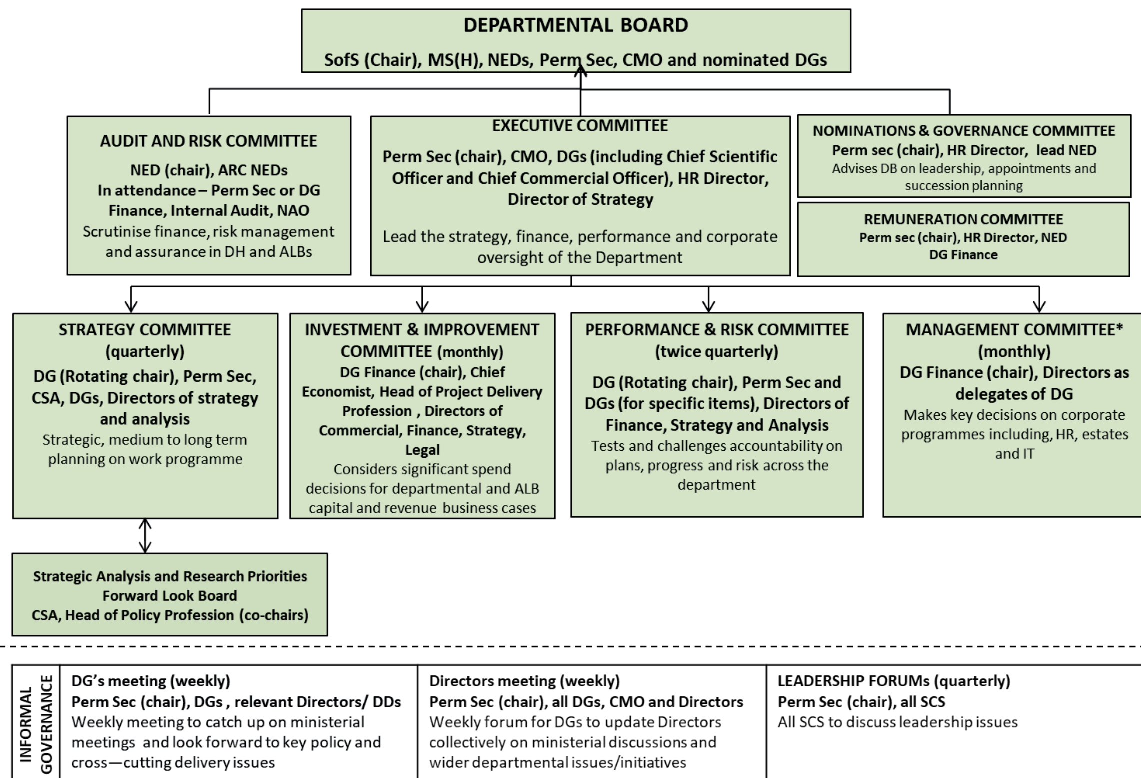
343. The Board advises the Secretary of State and Permanent Secretary and in particular has responsibility for:
    - supporting ministers and the Department on strategic issues linked to the development and implementation of the Government's objectives for the health and social care system;
    - horizon scanning, ensuring that any strategic decisions are based on a collective understanding of evidence, insight and international experience;
    - ensuring there is strategic alignment across the health and care system;
    - overseeing the sound financial management of the Department, in the context of the Single Departmental Plan;
    - overseeing the management of risks within the Department and its ALBs, including consideration of the Department's risk register; and
    - overseeing the Department's portfolio of major programmes and projects.

344. 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.

345. The Board also has responsibility for monitoring performance against key metrics, including efficiency metrics and corporate risks. 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.

346. The Departmental Board is supported by the committees shown in the structure chart at **Figure 13.** The Executive Committee agreed to temporarily suspend meetings of the Management Committee, Performance and Risk Committee and Strategy Committee, in quarter 3 in order to prioritise more Departmental resource to EU Exit preparations.

Figure 13: Departmental Board Structure



*The Management Committee did not meet after November 2018 in 2018/19 and was replaced by the People Board which began proceedings in May 2019.

347. The Executive Committee oversees strategy, finance, performance and corporate issues in the Department. It reports to the Departmental Board on a quarterly basis including reports from the various sub-committees. Issues discussed at the Executive Committee in 2018-19 include: business planning, financial sustainability, risk and legal risk, and a number of HR items including performance management and pay. The Committee met 11 times this year for formal monthly meetings (every month except August). The Committee met an additional 5 times during the year to discuss single issues including Performance Management and EU Exit.

348. The DHSC Remuneration Committee acts on behalf of the Secretary of State and has ultimate accountability for the ALBs' Executive and Senior Manager Pay Framework. Its role and purpose is to ensure ALBs adhere to the Framework, ensure governance processes are followed and challenge and scrutinise the approvals that are presented to them. The Committee met 14 times in the year.

349. The Nominations and Governance Committee advises on matters relating to leadership and succession planning for the Department. The Nominations Governance Committee discussed the end of year performance assessments and ratings for the Directors General, along with a discussion on their talent management and development. The Committee met once this year.

350. The Audit and Risk Committee advises the Accounting Officer and Departmental Board on risk management, corporate governance and assurance arrangements in the Department and its subordinate bodies and review the comprehensiveness of assurances and integrity of financial statements. The Committee met 4 times this year.

351. **Table 7** summarises attendance at the four committees.

Table 7: Committee Attendance [(1)]

		Executive Committee (3, 4)	Remuneration Committee (2)	Nominations and Governance Committee	Audit and Risk Committee
Sir Chris Wormald KCB	Permanent Secretary	11/16	14/14	1/1	1/4
Professor Dame Sally Davies DBE	Chief Medical Officer	3/16			
David Williams	Director General for Finance and Group Operations	16/16	14/14		4/4
Clara Swinson	Director General for Global and Public Health	16/16			
Lee McDonough	Director General for Acute Care and Workforce	15/16			
Professor Chris Whitty	Chief Scientific Officer	13/16			
Jonathan Marron	Director General Community and Social Care	15/16			
Steve Oldfield	Chief Commercial Officer	15/16			
Jenny Richardson (5)	Director of HR	9/16	8/14	0/0	
Hugh Harris(5)	Director of Strategy	10/16			
Kate Lampard	Lead Non-Executive Director		1/1	1/1	
Professor Dame Sue Bailey	Non-Executive Director		6/6		
Professor Mike Richards	Non-Executive Director		0/0		
Sir Ron Kerr	Non-Executive Director		1/1		
Michael Mire (6)	Non-Executive Director		4/4		1/1
Gerry Murphy	Non-Executive Director		2/2		4/4
Jacqui Burke	Independent Member				4/4
Cat Little	Independent Member				3/4

1. Table represents Committee members attendance only. To note, other officer's attendance is not recorded in the above table.
2. Attendance of the Remuneration Committee is shared amongst our Non-Executive Directors.
3. Where a DG could not attend, a deputy attended on their behalf.
4. The total of 16 Executive Committee meetings comprised 11 regular monthly meetings and 5 ad hoc meetings.
5. Jenny Richardson, Director of HR and Hugh Harris, Director of Strategy both joined the Department in August 2018.
6. Michael Mire became a formal member of ARC in November 2018

Assurance Framework, Risk Management and control issues

Core Department

352. The Department operates an accountability process based on compliance with a set of core assurance standards, including risk management. Each Director General (DG) receives an accountability letter from the Permanent Secretary, setting out their responsibilities for identifying, assessing, communicating, managing and escalating risk in their directorates. These letters also outline accountability for their allocated budget, delivery of business plan objectives, and sponsorship responsibilities for ALBs.

353. The Department continued to work with the Infrastructure and Projects Authority (IPA) in the management of programmes and projects on the Government Major Projects Portfolio (GMPP) and strengthened the support provided to Senior Responsible Owners (SROs) and programmes through the Major Projects Leadership Academy and Project Leadership Programme.

354. In the year, the Department aligned its programme and project reporting to the GMPP reporting commissioned each quarter by the IPA to ensure consistency of approach. At the same time a change in process was introduced to alleviate the burden of data collection from programmes and projects whereby those on GMPP need only return updates once when commissioned. Progress has been made in developing a dashboard to provide consistent updates to governance.

355. The DHSC Investment Committee now meets monthly to consider capital and revenue business cases above the disclosure threshold limits delegated to DHSC by HM Treasury as set out in the Department's Financial Control Framework. As well as reviewing live cases, the Investment Committee endorses the pipeline of forward cases and sets expectations on the circumstances for resubmission of previously agreed cases.

Three lines of defence

356. The Department applies the 'three lines of defence' principle to its management of risk. At the first line, day-to-day operational risk is managed locally by teams best placed to understand and implement mitigations, including through an effective system of Senior Responsible Officer (SROs), programme and assurance boards and budget managers working with a set of defined financial controls. This is supported by the use of Group-specific risk registers to identify, escalate and manage risk and an updated assurance framework that captures assurance activities against each of the Department's high-level risks.

357. At the second line our Governance includes the Strategy, Performance and Investment Committees, providing cross-departmental scrutiny and assurance of delivery plans and risk management. The Executive Committee continues to oversee and agree the key strategic risks to the health and social care system, challenging and agreeing proposed mitigations, through the Departmental high-level risk register. This second line of defence is supported by a cross-department quarterly monitoring and reporting framework which brings together an assessment of the Department's progress against business plan objectives with its most recent assessment of the top risks it faces. It should be noted that there was a deliberate reduction in both the Strategy Committee and Performance and Risk Committee in-year due to EU Exit.

358. The third line of defence comprises the oversight of the Departmental Board, which includes independent Non-Executive Directors and is provided by the Audit and Risk Committee (ARC). This has provided independent, non-executive challenge and assessment of the robustness of arrangements in place. This is further underpinned by the independent oversight and challenge of the Health Group Internal Audit Service (HGIAS), part of the Government Internal Audit Agency. The ARC has considered the way in which the Department manages risk at its four meetings during 2018-19 and has scrutinised the Department's risk register as a standing agenda item at these meetings.

359. Through this scrutiny the Committee has supported the Board to ensure effective systems were in place to deliver high-quality internal control, governance and risk management. The Chair of the ARC, who also sits as a Non-Executive member of NHS England's Audit and Risk Committee, provides a quarterly update to his fellow members of the Departmental Board on the activities of the Committee. Our third line of defence is further strengthened by other independent assurance processes, such as NAO reviews and the scrutiny of the Health and Social Care Select Committee.

360. 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. ARC has a standing meeting agenda for its four meetings

which covers papers and updates on finance, Internal Audit, NAO, PAC reports and recommendations, counter fraud, cyber security, high-level risks, Department's major projects portfolio and GMPP, and EU Exit. In 2018-19 there were presentations from Public Health England and NHS Property Services on their risk management strategy and governance. There were also deep dive discussions on NHS Winter planning, the Science Hub programme and Official Development Assistance-funded Global Health Research Programme.

361. This year's annual Board Effectiveness Evaluation was led by the lead Non-Executive Board member, Kate Lampard. The evaluation reflected on progress made in the last year and identified a series of objectives for 2019-20. Overall, the evaluation has shown that the Board is functioning well. There has been particular success in embedding the non-executive director engagement strategy, which has enabled the Non-Executive Directors to extend their influence within and beyond the Board meetings. Going forward, there is an opportunity to increase the oversight that the Board and the Non-Executive Directors have of the Department's ALBs.

Managing Risk

362. The Department's Director of Strategy undertakes the role of Chief Risk Officer (CRO). As part of discharging responsibility for ensuring an appropriate approach to risk management within the Department, the CRO has held a formal review of the Department's high-level risks with all DGs. Discussions on refreshing our high-level risks have taken place with senior officials to ensure that we are monitoring the right areas, and a new risk register will be issued early in 2019-20 to take any changes into account.

363. The twice-quarterly scheduled Performance and Risk Committee, run by the Chief Risk Officer's risk team discusses the high-level risk register, including agreeing risk scores. This approach has led to stronger links between the central teams and risk owners, as well as a peer challenge process. This has improved our understanding of our risk exposure and the cross-cutting nature of risks across the system.

364. The nature of the health system is that risks can be inherent, fast-evolving and unpredictable, for example incidents such as cyber-attacks. The Department's overall approach to risks is based on constant intelligence and preparation for the unexpected. The Department has continued to apply this approach throughout 2018-19 to manage a developing portfolio of risks, both within the Department and in the wider system. Significant risks actively managed by the Department this year have included:

External risks

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

System-wide risks

- the financial performance and sustainability of the health and care system;
- the risk that that the system does not recruit and retain the right numbers and skills of staff needed to deliver care, across primary, secondary and social care;
- system readiness to respond to major infectious disease outbreaks;

- the growth in demand for NHS services compromises the ability of system to deliver performance standards within our means;
- the risk that there is a loss of sustainable quality and safety of the care people receive;
- the risk that our partnerships with ALBs are insufficient to deliver our key objectives; and
- the sustainability of the adult social care system.

Change-based risks

- the risk that the Department's workforce has insufficient capacity and/or capability to provide a quality service; and
- the risk that the health and care system is not fully prepared to deliver a smooth and orderly exit from the EU.

365. 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.

366. In 2018-19 the Directors General (DGs) (including the Chief Medical Officer) with budget accountability, participated in the quarterly Performance Reporting and Biannual Assurance Meeting (BAM) process. Summaries of the BAM, ARC and Performance and Risk Committee meetings are shared with the Board to provide assurance and an update on the governance and control system in the core Department of Health and Social Care. They have adhered to the Corporate Core Assurance Standards, covering duties expected of ALB sponsors, management of plans and resources, risk management and a range other requirements incumbent on the Department that we are asked to assure via the Governance Statement. In 2019-20 we will develop further year end reporting of DGs and Directors against Accountability Letters and are refreshing assurance mapping across the Department. The BAM reports confirmed that the Department has adequate and effective systems of control in place, and that where issues have arisen during the year assurance arrangements were in place to validate that weaknesses were addressed. With an established team of Non-Executive Directors now in place, we will carry out a more robust Board evaluation process for 2019-20 that is led by our Lead Non-Executive Director which will reflect on whether the Board is operating effectively, and what improvements are required.

Whistleblowing

367. The Department's whistleblowing policy has been in place since August 2015 and is based upon best practice developed by Civil Service Employee Policy which includes reporting biannually on all whistleblowing concerns received to the Cabinet Office. The policy offers employees a number of methods to raise a concern and is underpinned by a small network of individuals from various grades, positions and locations, who have been given training on whistleblowing and the Department's policy. The network provides an easily accessible resource for employees to speak to if they have a whistleblowing concern and are uncertain how to address it.

368. The Department also has a Board-level Whistleblowing and Speak Out Champion in the Director General for Finance and Group Operations. When a report of a whistleblowing concern is received, the Department establishes an investigation to establish if it falls

under whistleblowing. If a case of whistleblowing is established, the Department will investigate following usual protocols. Figures of five or less whistleblowing concerns are not published to protect anonymity.

369. Expanding further on the Speak Out strategy, the Department appointed ten Speak Out advisers and a senior SCS Speak Out adviser who works with HR and provides leadership support to the Speak Out advisers. The Department has strengthened the employee offer and HR reviewed, refreshed and published; whistleblowing, bullying, harassment and discrimination (BHD), and grievance policies - which included joining the cross-government Mediation and Investigation Services. This also included tool kits for line managers who are dealing with issues. The Department's HR team has created a scorecard to measure progress and identify any hotspots or trends which are discussed regularly at Executive Committee meetings and every six months publishes a high-level version of the scorecard on the Department's internal intranet page to highlight support and encourage a 'Safe to Challenge' culture.

Role of Internal Audit

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

371. 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.

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

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

Internal Audit Opinion

374. Following completion of a programme of risk-based audit work throughout the Department during 2018-19, the Head of Internal Audit has objectively considered the overall adequacy and effectiveness of the Department's systems of risk management,

governance and internal control for the year as a whole. As such, the Head of Internal Audit's opinion is that he can give Moderate Assurance to the Department's Principal Accounting Officer in relation to the 2018-19 reporting year. A Moderate Assurance means that in the Head of Internal Audit's opinion some improvements are required to enhance the adequacy and effectiveness of the framework of risk management, governance and control.

Arm's Length Bodies

375. 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.

376. 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.

377. The objectives and deliverables of the Department's ALBs are set through their annual business planning process. The Department uses the ALB mandates, remit letters and business plans to hold its ALBs to account. In 2019-20, ALBs have been asked to reflect priorities arising from EU Exit and the NHS Long Term Plan, as applicable to them.

The NHS

378. NHS England shares responsibility with the Secretary of State for Health and Social Care for promoting a comprehensive health system in England, designed to secure improvement in physical and mental health, and in the prevention, diagnosis and treatment of ill-health. 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.

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

380. The 2018-19 Mandate[143] continues the multi-year approach first established in 2016-17 following public consultation, maintaining the objectives, 2020 goals and annual deliverables from the 2017-18 mandate. The main substantial change is to extend an existing objective to include support for implementation of EU Exit with regards to health and care. Along with the provision of an additional £2.8 billion of funding for the NHS in Budget 2017, the Government's decision to maintain a stable mandate for 2018-19 was

[143] https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019

intended to support NHS England, and the wider NHS, to recover performance of important patient access standards.

381. NHS England is required to report performance against the mandate to the Secretary of State. Performance of the 2018-19 Mandate has been assessed against each objective and will be set out in the 2018-19 Annual Assessment, which the Secretary of State is required to lay in Parliament each year.

382. The Framework Agreement for NHS England sets out the assurance process, roles and responsibilities of the Department and NHS England by which accountability will be achieved. NHS England and the Department have a programme of accountability meetings.

383. During 2018-19 NHS England strengthened its joint working arrangements with NHS Improvement to bring the two organisations as closely together, in strategic and operational terms, as is permitted under the legislation governing their activities.

384. In 2019-20, NHS England and NHS Improvement will move to a single leadership model under the Chief Executive Officer (CEO) of NHS England and single Chief Operating Officer (COO) who will also be the CEO of NHS Improvement, with the single COO post covering both NHS England and NHS Improvement and reporting directly to the CEO of NHS England.

385. NHS Improvement is the operational name for an organisation that brings together: Monitor, the NHS Trust Development Authority (TDA), the Patient Safety function from NHS England, the Advancing Change team from NHS Improving Quality, and the Intensive Support Teams from NHS Interim Management and Support (IMAS), to make a single integrated enterprise. Monitor and the TDA remain as separate legal entities but the boards of Monitor and TDA have identical membership and meet jointly as one NHS Improvement Board. NHS Improvement is responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care. Rules of Procedure set out NHS Improvement's governance arrangements.

386. 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.

387. Through its sponsorship discussions the Department assesses the risks and issues and considers these for inclusion in the overall Departmental risk register. The Department and NHS Improvement regularly discuss those providers with significant risks. NHS Trusts and Foundation Trusts now benefit from a more consistent and proactive approach to

managing strategic and operational risks under the Single Oversight Framework published in autumn 2016[144].

388. The Department sent an annual remit letter to NHS Improvement for 2018-19 which set out their objectives for the coming year for which they are held to account.

389. The Framework Agreement for NHS Improvement sets out the assurance process, roles and responsibilities of the Department and NHS Improvement by which accountability will be achieved. NHS Improvement and the Department have a programme of accountability meetings, with four scheduled at Ministerial level every year.

390. Strategic oversight on future collaboration started before 1 April 2019 by having a degree of cross-membership between the NHS England and NHS Improvement boards. Non-voting, Associate Non-Executive Directors (NEDs) were appointed in February 2018 to attend the corresponding board and NHS England and NHS Improvement ran boards in common to facilitate faster progress towards shared management of financial performance across the system and to provide greater oversight of shared national and regional functions.

391. To improve the mechanism for monitoring NHS finances and ensuring the system works better as a whole, NHS England and NHS Improvement undertook a programme of work to review areas of closer alignment. This looked at options to tighten financial controls and proposed more productive system design and transformation between the two organisations.

392. NHS England and NHS Improvement worked closely together to align what they do by providing a more joined-up support for local health systems and establish integrated teams to carry out most of their functions. However, there are limits on how far NHS England and NHS Improvement can work together. Currently, legislative proposals are being consulted on to bring the two organisations more closely together beyond the limits of the current legislation.

393. As the joint operating model is still embedding across the system NHS England and NHS Improvement are focusing on stability of core delivery functions supporting the wider system and will ensure that all senior positions will remain staffed throughout the transition period.

Key Governance Issues

Financial Risk and Sustainability

394. Since 2016, 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.

395. The NHS developed its own financial strategy for delivering financial balance and sustainability into future years as part of the 'financial re-set' in July 2016. The measures

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

from this reset have remained in place throughout 2017-18 and into 2018-19 and are detailed in the financial performance section of this Annual Report. This has resulted in a continued stabilisation of finances in the majority of NHS providers, including a reduction in the overall deficit; the size of individual deficits; and, the number of trusts reporting a deficit. However, financial challenges remain in a minority of organisations who are disproportionately driving the overall deficit for the provider sector.

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

397. To tackle the remaining financial challenges, NHS England and NHS Improvement are collaborating and working with local systems to find right solutions for the organisation and region. NHS England and NHS Improvement have created their own Joint Finance Advisory Group, that brings together finance officials from across the NHS to reach decisions on plans and actions needed to achieve the financial objectives.

398. NHS Improvement is also intervening where necessary to provide additional support to the most challenged providers to get back on track. This includes tackling underlying structural issues, improving patient flow to reduce delayed transfers of care, resolving disputes with commissioners, maximising operational productivity opportunities or undertaking reconfiguration, to make best use of services across local areas, and placing those with most need into financial special measures.

399. The Department has implemented a governance and oversight process to ensure that this investment is used in the most efficient and effective way and to hold the NHS to account for delivery of agreed financial objectives. This includes our 'Cross System Efficiency & Finance Board' with NHS England and NHS Improvement, and regular ministerial and HM Treasury engagement. This has allowed for increased transparency on emerging risks and pressures, and supported decision making where needed.

400. The next stages in the NHS's strategy are set out in the NHS Long Term Plan (LTP), which was published by NHS England on 7 January 2019. Government is supporting the LTP with funding set to increase by £33.9 billion in cash terms by 2023-24. The delivery approach being taken to the Plan is fundamentally different from Spending Review 2015 and will require a recasting of the financial framework.

401. Sustainability is built in to the planning process and the Government has set clear objectives for the NHS in the form of five financial tests[145] which the plan had to meet (see Long Term Plan paragraph 6.3 on page 100). These are set out earlier in this report in the 'Delivering a Financially Sustainable System' section of the Performance Report.

[145] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

Core Performance Standards

402. 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 2018-19 and a number were missed, more detail is available in the performance summary and **Annex C**.

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

Contract management

404. During 2018-19, Directors General have continued to report on contracts as part of the Biannual Assurance process. This is helping to ensure we have corporate visibility of all contracts and that associated risks are identified and managed. The Contract Management & Commercial Capability Team has been working throughout the year with Groups to ensure that the DHSC Corporate Contracts Register is comprehensive and we continue to engage Directors and Directors General to ensure we have visibility of the DHSC contract portfolio. The most recent Internal Audit, completed in May 2018, received a 'substantial' rating and all recommendations have been actioned. We have formally communicated to the Senior Contract Owners of the highest risk contracts, the importance of Contract Management and their respective roles and responsibilities and we are on track to complete contract assurance reviews on all Gold and Silver contracts in 2018-19.

Quality Assurance of analysis and models

405. Our Department has a comprehensive framework of assurance for analytical models used in critical areas of our activity, guided by an oversight committee of senior analysts and operating in line with HM Treasury guidance in the Aqua book[146] and the recommendations of the Macpherson Review published in 2013[147]. We have reviewed and refreshed our framework this year, to provide refreshed training and new tools to officials engaged in analytical work, to maintain systematic processes to regularly update our list of business-critical models and to ensure that risks are identified, managed and escalated as necessary.

406. In addition, the oversight committee has developed rapid response approaches to checking of factual data used in public statements and is working with officials in our ALBs to ensure that existing processes evolve to reflect current mechanisms and working practices across the Department and its ALBs. Our framework was considered in full by our Audit and Risk Committee in the development phase in 2014, is embedded in routine business process and is also continuing to evolve to reflect new needs. Our analytical oversight committee will provide a formal update to Audit and Risk Committee later this year, to report on progress and seek their views on further enhancements to our framework.

[146] https://www.gov.uk/government/publications/the-aqua-book-guidance-on-producing-quality-analysis-for-government
[147] https://www.gov.uk/government/publications/review-of-quality-assurance-of-government-models

Information Risk

407. The Department has not identified any major information risk control issues in 2018-19 with independent audit reporting evidencing the progress made from the implementation of new data protection legislation to a state of 'business as usual'.

408. The Department has recorded ten data related incidents in 2018-19, none of which were reported to the Information Commissioner's Office. The Department ensured appropriate corrective action was taken following these incidents, reviewing internal processes and updating them where necessary and drafting, publishing and communicating new guidance on data protection and information management to mitigate the risk of further occurrence.

Fraud, including prescription charge fraud

409. Fraudulent activity in the NHS means that the money intended for patient care, and funded by the taxpayer, ends up in the pockets of those who did not legitimately earn it. It means fewer resources are available to be spent on frontline health services such as patient care, health care facilities, doctors, nurses and other staff. There is a reduced ability to invest in new and improved equipment and technology, fewer clinical interventions, and a general diminution in the sustainability of an NHS which remains free at the point of delivery. Clearly the majority of activity and individuals within the NHS are correct and honest. However, the NHS Counter Fraud Authority (NHSCFA) assesses that fraud, bribery and corruption against the NHS costs the public purse over £1.27 billion in 2017-18, down from £1.29 billion in 2016-17.

410. Our response to the fraud problem reflects the very nature of the fraud problem itself; it is system wide, flexible and inclusive. We have been capturing and sharing fraud experiences and best preventative practices so that, wherever possible, all organisations are alerted to risks in a timely manner and fraud is prevented. Our response to tackling fraud has and continues to be based on the following principles:

- It is centrally driven and managed, with clear lines of accountability up to the Director General Finance, the DHSC-chaired Counter Fraud Board and out to each constituent organisation or wider sector of the health and social care group (e.g. NHS England/Improvement and NHS Business Services Authority).
- It relies on a collaborative approach between organisations and a clear senior management commitment to developing a consistent and organised mechanism for sharing both information about identified and potential risks and best practice.
- It recognises that reducing fraud/financial loss is the responsibility of all staff and therefore supports the development of a clear assurance framework that is underpinned by consistent guidance and clear escalation routes. Everyone needs a clear understanding of how and what to report which then allows specialist counter fraud staff to take matters further.
- Whilst recognising previous success, it takes fraud reduction to the next stage by proactively seeking to introduce preventative ways of permanently eradicating whole categories of fraud/financial loss (e.g. prescription fraud) and minimising the opportunity for new categories of fraud to arise.
- In the context of increased funding for the NHS during a difficult financial situation, it recognises that work on fraud and other types of financial loss is critical to maintaining a sustainable NHS.

411. Our work to counter fraud at a national level incorporates the DHSC Anti-Fraud Unit (DHSC AFU). This sets the counter fraud policy and strategy for the Department and the wider health group[148]. Its goal is to prevent and deter fraud, corruption and bribery by raising awareness and working in partnership with all parts of DHSC, its ALBs and companies. In 2018, this work was given greater focus and support through the launch of the Cabinet Office's revised Functional Standards for Counter Fraud. These standards set the expectations for the management of fraud, bribery and corruption risk in Government.

412. The DHSC AFU also offers an in-house investigation service for its health group partners on serious and complex cases and provides investigatory advice for handling cases which do not meet its prioritisation criteria. Wherever possible, the DHSC AFU seeks to recover funds lost through fraud by making use of its powers under the Proceeds of Crime Act 2002[149].

413. Also operating at a national level, the NHSCFA spearheads the fight against NHS fraud and implements the Department's strategic plan under the sponsorship of the DHSC AFU.

414. Other bodies with national coverage, such as NHS England/Improvement and the NHS Business Services Authority (NHSBSA) and NHS Digital routinely undertake activity to tackle fraud.

415. Local counter fraud work is guided by the NHS Standard Contract[150], the NHSCFA's Standards for Commissioners[151] and Standards for Providers[152] which require all organisations commissioning and providing NHS services to put in place and maintain appropriate counter fraud arrangements.

416. Local counter fraud specialists support NHSCFA on national issues, get national fraud prevention messages out and identify, report and investigate individual cases (e.g. payroll and procurement and commissioning fraud).

417. This national and local counter fraud activity is having a positive impact. For example, historic activity to reduce patient prescription charge evasion and loss assessments informed the introduction in September 2014 of a phased programme of post-dispensing checking by NHS Business Services Authority on behalf of NHS England and issuing Penalty Charge Notices where exemption cannot be confirmed. This has contributed to a £93.5 million reduction in patient prescription charge evasion in the NHSCFA's Strategic Intelligence Assessment 2019[153] as compared to the previous year. These findings have also informed the development of electronic checks to confirm a person's eligibility for free NHS prescriptions prior to the dispensing of their prescription items. This Real-Time Exemption Checking project aims to reduce error and prevent fraud. NAO have undertaken an investigation into penalty charge notices in health in the final quarter of

148 https://www.gov.uk/government/publications/dhsc-counter-fraud-strategic-plan-2017-to-2020
149 https://www.legislation.gov.uk/ukpga/2002/29/contents
150 https://www.england.nhs.uk/nhs-standard-contract/19-20/
151 https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Commissioners_2018.pdf?v=1.0
152 https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2018.pdf?v=1.0
153 https://cfa.nhs.uk/resources/downloads/documents/corporate-publications/NHSCFA_Strategic_Intelligence_Assessment_2017_18_v1.0.pdf

the year, prompted by concerns on the impact on individual's health of receiving a notice, particularly in the vulnerable. The Department accepts that changes in system are required to mitigate these risks and to appropriately balance minimising fraud with protecting individuals. Fraud loss estimates in some other areas of the Strategic Intelligence Assessment 2019 have increased, where this has occurred it is due to higher expenditure figures and does not reflect an increase in detected fraud.

418. Similarly, NHS Business Services Authority is also responsible for undertaking eligibility checking on patients' entitlement to free NHS dental treatment. The Authority have sought to reduce patient error through distributing posters and booklets to dental practices and providing guidance materials for those issued with penalties. NHS Counter Fraud Authority has estimated a £0.5 million reduction in dental patient charge evasion. This estimate will be revised with a more robust assessment following a loss measurement exercise being undertaken by NHS Counter Fraud Authority in 2018-19 and to be reported on in its 2020 Strategic Intelligence Assessment.

419. The NHSBSA and NHS England have also implemented measures to mitigate fraud losses identified in one particular area of Dental Contractor payments (28-day split course treatments). The NHSCFA have estimated that this activity has reduced the level of dental contractor fraud losses by £32.6 million[154] in the SIA 2019 as compared to the previous year. This estimate will be revised with a more robust assessment following a loss measurement exercise being undertaken in 2018-19 and to be reported on in its 2020 Strategic Intelligence Assessment.

Compliance with Equality and Human Rights Legislation

420. The responsibility for meeting the requirements of equality and human rights legislation in policy and decision-making lies with each team in the Department. They are supported by the System Oversight, Performance and Legislation team who are responsible for raising awareness and capability among staff through a policy certificate training module and signposting to up-to-date and authoritative guidance on the Department's intranet. There is also a lead Senior Civil Servant (SCS) for each of the protected characteristics to further support staff in making decisions on equalities, promote good practice and give visibility to equality issues.

421. Directors General are required to consider compliance with the public sector equality duty[155] and evidence of this is provided in submissions to Ministers. The System Oversight and Secretariat team provide second line assurance on compliance with the Duty.

422. 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.

423. The Department continues to publish summary equality information relating to its policies and workforce annually. This information, along with our current equality

[154] https://cfa.nhs.uk/about-nhscfa/corporate-publications
[155] https://www.england.nhs.uk/wp-content/uploads/2011/12/Paper-NHSCBA-12-2011-4-Meeting-the-Public-Sector-Equality-Duty-Final.pdf

objectives, can be found under the 'Equality and Diversity' section of the Department's website[156].

National Audit Office and Public Accounts Committee

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

Emergency Preparedness, Resilience and Response

425. The Department works closely with NHS England and Public Health England to ensure that the health sector is able to respond to threats and hazards set out in the government's National Risk Register. The Department has in place '24/7' arrangements to be able to coordinate services in any emergency that occurs. In 2018-19, the Department has responded to a number of high-profile incidents, including the poisoning incident in Salisbury and Amesbury and disposal of clinical waste. The Department participates in health and cross-government exercises to maintain our skills and response arrangements.

Grant Payments to Non-Public Sector Bodies

426. The Department makes a number of grant payments to non-public sector bodies and Local Authorities each financial year to support delivery in line with governing legislation. The Department's central finance team owns the governance process to ensure that all relevant approvals are given before there is any financial commitment and that the Department adheres to the Cabinet Office Minimum Standards in grant-making. This is described in more detail in the Accounting Officer's System Statement.

Other Governance Disclosures

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

Data Issues - Data and Cyber Security Programme

428. The Department leads a robust ongoing Data and Cyber Security Programme, along with its Arm's-Length Bodies, to improve the cyber security of the health and care system and address vulnerabilities.

429. DHSC and NHSX are agreeing spending priorities to utilise £150 million between 2018-19 and 2020-21 with input from HMT and the Government Digital Service to improve the security of local infrastructure, support nationally procured and locally deployed interventions to address common weaknesses across the NHS. DHSC and NHSX have also been supporting NHS organisations to upgrade their existing Microsoft Windows operating systems, allowing them to reduce potential vulnerabilities and increase cyber resilience; procured a new Cyber Security Operations Centre to boost our capability to prevent, detect and respond to cyber attacks; and implemented a stronger regulatory

[156] https://www.gov.uk/government/organisations/department-of-health-and-social-care/about/equality-and-diversity

framework to help drive improvement. The Data Security and Protection Toolkit[157] has been updated and now incorporates all of the relevant standards for health and care in one place for 2019-20.

430. NHS Digital is leading work to educate the system through security-trained technical specialists, training for boards and senior leaders, and cyber training being rolled out over the summer. This shifts behaviour to be more cyber-aware/secure, meaning technology provisions, business decisions and clinical decisions will be made with cyber security in mind.

431. In total, over £250 million will have been invested nationally to improve the cyber security of the health and care system between 2016 and 2021. This includes both investment by local organisations and wider national IT investment that supports better security, such as Microsoft licensing for NHS organisations.

United Kingdom Leaving the European Union

432. The Government has reached agreement with the EU on an extension until 31 October 2019 at the latest, with the option to leave earlier as soon as a deal has been ratified. Although Parliament has rejected leaving without a deal, this remains the legal default at the end of the extension period. As of May 2019, no deal measures (including the Operational Response Centre and Volunteer Emergency Response Team) remain in place but on hold. Following confirmation of the extension in April 2019, governance arrangements to steer and assure work across the Department and ALBs were revised and workstreams began to review their approach, objective and target risk. The Departmental Board, Executive Committee and Audit and Risk Committee continue to monitor progress and the SRO-led Assurance Board continues to meet monthly, with additional focused sessions on key workstreams.

Carillion

433. The Department and NHS Improvement continue to provide support to NHS organisations to ensure that where the Carillion group of companies were providing services, suitable alternative arrangements are being made.

434. Prior to their liquidation, members of the Carillion group of companies provided services to a variety of private finance initiative (PFI) companies that were, in turn, party to PFI contracts with NHS Trusts. Two of these PFI contracts, where the construction of the hospital building was incomplete, were terminated in the 2018-19 financial year. The Royal Liverpool and Broadgreen University Hospitals NHS Trust and the Sandwell and West Birmingham Hospitals NHS Trust are making arrangements for the incomplete hospital buildings to be completed.

Screening Programmes

435. Following the breast screening incident that was announced on 2 May 2018 where potentially thousands of women aged between 68 and 71 had not been invited to their final breast screening between April 2014 and May 2018, an Independent Breast

[157] https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit

Screening Review (ISBR) was commissioned. This Review reported on 13 December 2018[158]. The Department published their response[159] on 14 March accompanied by a Ministerial Statement. The Government accepted all 15 recommendations which also took account of the findings from the recent investigation into adult screening programmes (bowel cancer, breast cancer, cervical cancer, and abdominal aortic aneurysm) conducted by the National Audit Office, published on 1 February 2019.[160]

436. The Public Accounts Committee report on Adult Health Screening[161] (published 10 May 2019) highlighted similar issues about improvements needed to national screening programmes and how they are delivered. Some IBSR recommendations are contingent on the findings of the ongoing Professor Sir Mike Richards Review of screening programmes (due to report in summer 2019) and advice from the UK National Screening Committee on how the upper age limit for breast screening should be defined. The Department is working closely with NHSE and PHE to deliver and monitor progress of the commitments in the Government's response to IBSR.

437. On 15 November 2018, Ministers informed the public about a separate incident affecting the cervical screening programme, where 43,220 letters inviting women to their routine appointments were not sent as they should have been in 2018. Further analysis by NHS England also identified 4,508 letters informing women of the results of their smear tests had not been sent. Letters were subsequently sent to all women who had not been referred for colposcopy or who had not had the required follow up screening test and no harm was identified.

438. In its 2018-19 Annual Report and Accounts, NHS England has noted an incident related to the national cervical screening programme (page 101). We await further advice from NHS England.

Grenfell

439. Following the Grenfell Tower tragedy, the Department, NHS Improvement, NHS England and the NHS property companies (NHS Property Services (NHS PS) and Community Health Partnerships Ltd (CHP)) set out immediately to provide assurance to the Government and the public as to the safety of the NHS estate, with particular emphasis on those buildings considered to be at the highest risk – over two storeys, overnight inpatient accommodation, and with cladding that could be of the type used in Grenfell Tower.

440. NHS Improvement coordinated a large-scale effort to check cladding where necessary, with the help of the local fire and rescue service and supported the implementation of remedial measures to improve the safety of properties where appropriate.

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[158] http://breastscreeningreview2018.independent.gov.uk/
[159] https://www.gov.uk/government/publications/independent-breast-screening-review-government-response
[160] https://www.nao.org.uk/wp-content/uploads/2019/01/Investigation-into-the-management-of-health-screening.pdf
[161] https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/1746/174602.htm

441. The full cost of implementing these remedial works has been challenging to calculate: some are the responsibility of non-NHS landlords and/or contractors, some of the NHS, and some buildings were scheduled for repair and other works anyway. Without detailing the locations of the buildings in question, the cost of the Grenfell remedial work can be summarised as shown in **Table 8**.

Table 8: Grenfell Remedial Work

Organisation Name	Expenditure £
Bradford Teaching Hospitals NHS Foundation Trust	£518,000
Guy's and St Thomas' NHS Foundation Trust	£300,000
King's College Hospital NHS Foundation Trust	£48,000
Oxford University Hospitals NHS Foundation Trust	£770,000
Sheffield Children's NHS Foundation Trust	£311,000
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	£35,000
The Royal Wolverhampton NHS Trust	£431,000

Source NHS England and NHS Improvement

Gosport

442. On 20 June 2018, the Gosport Independent Panel published its report[162] on events at Gosport War Memorial Hospital from the late 1980s to 2001. This report follows four years of work by the Chair, The Right Reverend James Jones KBE and his Panel, and it has drawn on previous reviews and also on important new material unearthed by the Panel. The Government published its response in November 2018[163]. This included commitments on whistleblowing and on the supervision of controlled drugs.

Infected Blood Inquiry[164]

443. Evidence is being taken from affected families and will continue for several months into autumn, with DHSC due to give evidence from Spring 2020. Cabinet Office is the sponsor department for the inquiry and DHSC will provide support. The Department will provide full disclosure to the inquiry. Up to £30 million has been announced to support those affected and the inquiry will run for several years.

The Phoenix Partnership (TPP)

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

445. After being informed of the error by TPP, NHS Digital acted swiftly to rectify it. TPP apologised unreservedly for its role in this matter and committed to work with NHS Digital so that errors of this nature did not occur again. There was never any risk to patient care as a result of this error.

[162] https://www.gosportpanel.independent.gov.uk/panel-report/
[163] https://www.gov.uk/government/publications/gosport-independent-panel-report-government-response
[164] https://www.infectedbloodinquiry.org.uk/

446. NHS Digital made the Information Commissioner's Office (ICO) and the National Data Guardian for Health and Care aware and wrote to affected GP practices and all affected patients. NHS Digital are continuing to manage patient enquiries and complaints relating to this period. NHS Digital have received written confirmation from the ICO that they will not be taking any formal enforcement action in relation to this matter.

Primodos, Sodium Valproate, Surgical Mesh

447. The Independent Medicines and Medical Devices Safety Review looked at what happened when patients raised safety concerns in the cases of Primodos, Sodium Valproate and surgical mesh, and whether the processes pursued to date have been sufficient and satisfactory. Baroness Cumberlege will make recommendations on a future process to identify critical issues and maintain public confidence that decisions have been taken fairly. We have also attended a number of PAC sessions on topics including NHS correspondence handling and the NHS contract with Capita.

Remuneration and Staff Report

Remuneration Report

448. This Remuneration Report provides details of the remuneration and pension interests of Ministers and the most senior management of the Department. This includes Ministers, Non-Executive Directors and Directors General (DGs)/Senior Officials and is compliant with EPN 571 guidance[165].

449. 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.

450. The Constitutional Reform and Governance Act 2010[166] require Civil Service appointments to be made on merit on the basis of fair and open competition. The Recruitment Principles[167] published by the Civil Service specify the circumstances when appointments may otherwise be made.

451. Unless otherwise stated in the following paragraphs, the officials covered by this report hold appointments which are open-ended. Early termination, other than for misconduct, would result in the individual receiving compensation as set out in the Civil Service Compensation Scheme[168].

Remuneration of Ministers 2018-19

452. Following a Cabinet re-shuffle, Jeremy Hunt left his post as Secretary of State for Health and Social Care on 9 July 2018. Matt Hancock was appointed as Secretary of State for Health and Social Care from 10 July 2018. Stephen Barclay left his post as Minister of State for Health on 16 November 2018. Stephen Hammond was appointed as Minister of State for Health from 16 November 2018. Steve Brine stepped down as Parliamentary Under Secretary of State (Public Health and Primary Care) on 25 March 2019.

453. Lord O'Shaughnessy stepped down as Parliamentary Under Secretary of State for Health (Lords) on 31 December 2018. Baroness Nicola Blackwood was appointed Parliamentary Under Secretary of State for Health (Lords) on 10 January 2019.

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[165] https://www.civilservicepensionscheme.org.uk/employers/employer-pension-notices/epn571-resource-accounts-2018-19-disclosure-of-salary-pension-and-compensation-information/
[166] http://www.legislation.gov.uk/ukpga/2010/25/pdfs/ukpga_20100025_en.pdf
[167] http://civilservicecommission.independent.gov.uk/civil-service-recruitment/
[168] https://www.civilservicepensionscheme.org.uk/members/civil-service-compensation-scheme-for-members/

Remuneration of Senior Officials on the Departmental Board

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

Salary

455. '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.

456. 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.

457. However, the arrangement for Ministers in the House of Lords is different, in that they do not receive a salary but rather an additional remuneration which cannot be quantified separately from their Ministerial salaries. This total remuneration, as well as the allowances to which they are entitled, is paid by the Department and is therefore shown in full in **Table 9**.

Non-Consolidated Performance Pay

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

459. SCS non-consolidated performance pay is agreed each year following the Senior Salaries Review Body (SSRB) recommendations, and is expressed as a percentage of the Department's total base pay bill for the SCS. Non-consolidated performance related pay is awarded in arrears.

460. The non-consolidated performance pay included in the 2018-19 figures relates to awards made in respect of the 2017-18 performance year but paid in financial year 2018-19. It was agreed that awards would not be differentiated by grade. An award of £10,500 was paid to the top 25 per cent performers in each SCS pay band.

Benefits in Kind

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

462. Professor 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 £266.20 in 2018-19.

463. **Tables 9 and 10** provide details of remuneration interests of the Ministers of the Department and senior officials serving on the Departmental Board for the years 2017-18 and 2018-19 and are subject to audit.

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

	2018-2019				2017-2018			
					Restated[3]			
Ministers	Salary (£)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £'000)	Total (to nearest £'000)	Salary (£)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £'000)	Total (to nearest £'000)
Jeremy Hunt MP *(from 04/09/2012 to 09/07/2018)*	18,509	Nil	2,000	21,000	67,505	Nil	16,000	84,000
Secretary of State								
Full year equivalent	67,505							
Matt Hancock MP *(from 10/07/2018)*	48,996	Nil	13,000	62,000	-	-	-	-
Secretary of State								
Full year equivalent	67,505							
Lord O'Shaughnessy[2] *(from 14/06/2017 to 31/12/2018)*	54,438	Nil	12,000	66,000	55,273	Nil	16,000	71,000
Parliamentary Under Secretary								
Full year equivalent	72,530				72,530			
Steve Brine MP *(from 14/06/2017 to 25/03/2019)* [3]	22,014	Nil	5,000	27,000	17,838	Nil	5,000	23,000
Parliamentary Under Secretary								
Full year equivalent	22,375				22,375			
Jackie Doyle-Price MP *(from 14/06/17)*	22,375	Nil	5,000	27,000	16,992	Nil	5,000	22,000
Parliamentary Under Secretary								
					22,375			
Caroline Dinenage MP *(from 10/01/2018)*	31,680	Nil	7,000	39,000	5,830	Nil	2,000	8,000
Minister of State								
					31,680			
Stephen Barclay MP *(from 10/01/2018 to 16/11/18)*	21,120	Nil	4,000	25,000	7,154	Nil	2,000	9,000
Minister of State								
Full year equivalent	31,680				31,680			
Stephen Hammond MP *(from 16/11/2018)*	10,560	Nil	3,000	14,000	-	-	-	-
Minister of State								
Full year equivalent	31,680							
Baroness Nicola Blackwood[4] (from 10/1/2019)								
(previously from 16/07/2016 to 8/06/2017)	15,515	Nil	5,000	21,000	4,226	Nil	1,000	5,000
Parliamentary Under Secretary								
Full year equivalent	68,710				22,375			
Philip Dunne MP *(from 15/07/2016 to 9/01/2018)*	-	-	-	-	24,526	Nil	-	25,000
Minister of State								
Full year equivalent					31,680			
David Mowat *(from 16/07/2016 to 8/06/2017)*	-	-	-	-	4,226	Nil	1,000	5,000
Parliamentary Under Secretary								
Full year equivalent					22,375			

1. The Government has determined that Ministers should receive salaries at the same rate as claimed by equivalent ministers in previous governments since 2010. Therefore the serving ministers have agreed to waiver any ministerial increases in their salary for the duration of this Parliament.
2. Lord O'Shaughnessy's salary for 2017-18 & 2018-19 includes the Lords Office-holders allowance. (This is a yearly allowance of £3,820 per annum, paid to Ministers whose primary residence is in London, the allowance is taxable and subject to NI but not pensionable). Up to 13 June 2017 he received no salary from the Department and was paid as a Government Whip by Her Majesty's Treasury.
3. Due to an administrative error by DHSC, Steve Brine was overpaid by £1,865 in July 2017. This overpayment is no longer included in the 2017-18 remuneration which has been restated above to show the correct remuneration.
4. Baroness Nicola Blackwood will be due Lords Office-holders allowance, confirmation of the amount is outstanding and will be disclosed in 2019-20

Table 10: Remuneration of Senior Officials of the Department (subject to audit)

Officials	2018-2019 Salary (£'000)	2018-2019 Non Consolidated Performance Related Pay (£'000)[1]	2018-2019 Gross Benefits in Kind (to nearest £100)	2018-2019 Pension Benefits (to nearest £'000)	2018-2019 Total (£'000)	2017-2018 Salary (£'000)	2017-2018 Non Consolidated Performance Related Pay (£'000)[1]	2017-2018 Gross Benefits in Kind (to nearest £100)	2017-2018 Pension Benefits (to nearest £'000)[3]	2017-2018 Total (£'000)
Sir Christopher Wormald Permanent Secretary	170-175	15-20	Nil	87,000	270-275	165-170	Nil	Nil	58,000	225-230
Professor Dame Sally Davies Chief Medical Officer (Equivalent of Permanent Secretary)	210-215	Nil	300	N/A	210-215	210-215	Nil	300	N/A	210-215
David Williams Director General	140-145	10-15	Nil	35,000	185-190	135-140	10-15	Nil	25,000	175-180
Clara Swinson Director General	115-120	Nil	Nil	38,000	155-160	105-110	5-10	Nil	122,000	235-240
Full time equivalent	120-125									
Jonathan Marron Director General	125-130	Nil	Nil	50,000	175-180	95-100	10-15	Nil	41,000	145-150
Full time equivalent						125-130				
Lee McDonough Director General	120-125	Nil	Nil	12,000	135-140	120-125	5-10	Nil	195,000	325-330
Full year equivalent										
Steve Oldfield[2,4] Chief Commercial Officer	235-240	10-15	Nil	7,000	250-255	-	-	-	-	-
Professor Chris Whitty[3,4] Chief Scientific Adviser	120-125	Nil	Nil	36,000	155-160	-	-	-	-	-
Tamara Finkelstein *(to 19/06/17)*[5] Director General	-	-	-	-	-	25-30	Nil	Nil	6,000	30-35
Full year equivalent						120-125				

1. Non Consolidated Performance Related Pay paid in 2018-19 relates to the 2017-18 performance year.

2. Steve Oldfield was appointed on 7 October 2017 on loan from the Government Commercial Office (GCO). He holds a defined contribution pension and figures shown for pension equate only to employer contributions to the scheme held by Standard Life & Legal & General. DHSC pay the full employment costs for GCO specialists employed in their departments including pensions, national insurance, PRP and other benefits that can be monetised. His salary includes a non-consolidated pay award.

3. Professor Chris Whitty was appointed on 1 January 2016 on secondment from the London School of Hygiene and Tropical Medicine, in 2018-19 he was seconded for four days a week. The figures in the table represent the proportion the Department paid only, not the full salary. In addition the Department contributes towards his pension scheme and NI costs, which are not included above.

4. Professor Chris Whitty and Steve Oldfield are not included in 2017-18 disclosures as neither were Departmental Board members and therefore not subject to disclosure requirements. For 2018-19 following a change in membership of our Board and committees, Director General and equivalent staff are included as senior management of the Department.

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

Department of Health and Social Care's SCS Reward Strategy 2018-19

464. The remuneration of Senior Civil Servants is determined in accordance with the rules set out in the Civil Service Code[169] and in line with the annual SCS framework guidance issued by Cabinet Office. The Department is given discretion to develop our pay strategy to meet local needs and these are outlined in an annual reward strategy.

465. 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 2018, one per cent of the SCS paybill was available for consolidated pay awards. The Department continued to target the pay award towards those lower in their respective pay range, to address pay equality issues, by applying 'breakpoints' in each SCS Pay Band and differentiating the consolidated increases based on where staff were positioned in relation to the respective breakpoint. The breakpoints remained at the levels as set for 2016-17, which for Directors General (SCS3 Pay Band) was £140,000.

466. The pay award was paid as a fixed cash sum increase rather than a percentage uplift; this delivered a higher reward to those who earned less in comparison with their peers. SCS

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

below the breakpoint for their respective grade received a consolidated pay award of £1,250 and those above the breakpoint received £500. In line with Cabinet Office guidance, staff in the bottom 10 per cent performance group were ineligible for an award.

Median Earnings

467. Departments are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. See **Table 11**.

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

	Core Department		Department & Executive Agencies	
	2018-19	2017-18	2018-19	2017-18
Band of Highest Paid Director's Total remuneration (£000)[2]	235-240	210-215	235-240	215-220
Band of lowest paid	15-20	15-20	15-20	15-20
Median Total Remuneration	£40,685	£39,584	£38,975	£38,589
Ratio	5.8	5.4	6.1	5.6

1. Salaries for senior management are disclosed in bands of £5,000, in accordance with EPN571 guidance.
2. The pay multiple uses a median based on civil service pay, i.e. it excludes staff who are paid under arrangements outside the Department's control, e.g. seconded staff.

468. The banded remuneration of the highest paid core Department Director in 2018-19 was £235,000-£240,000 (2017-18 £210,000-£215,000). This was 5.8 times the median remuneration of the workforce of £40,685 (2017-18, £39,584).

469. No DHSC core employees in either 2018-19 or 2017-18 received remuneration in excess of the highest paid Director. Banded remuneration ranged from £15,000 to £20,000 and £235,000 - £240,000 (2017-18 £15,000-£20,000 and £210,000-£215,000).

470. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions

471. The median earnings for the core Department have increased in 2018-19 compared to 2017-18. This variance is directly related to the change in distribution of the earnings of staff, which has affected the ratio.

472. The higher ratio between the median earnings to the highest earner between 2017-18 and 2018-19 is due to the change in distribution of earnings and numbers of staff and a change in the composition of senior officials.

473. For the 2018 pay award an overall amount of 1.5% was spent on pay increases (as opposed to 1% in 2017) and larger awards were made to lower paid staff. In addition, minimums at all grades were raised and maximums were frozen. The combination of these factors would have seen the overall median increase.

Civil Service Pensions

474. Pension benefits are provided through the Civil Service pension arrangements. The Civil Servants and Others Pension Scheme (or Alpha) has been in place since 1 April 2015 and all newly appointed civil servants and the majority of those currently in service are

members. The Alpha scheme provides benefits on a career average basis with a normal pension age of 65 or the member's State Pension Age, whichever is the higher.

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

476. 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 1 June 2015 and 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).

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

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

479. Pension age is 60 for members of classic, premium and classic plus, 65 for members of Nuvos, and either 65 or State Pension Age, whichever is the higher, for members of

Alpha. Full details of the Civil Service pension arrangements can be found on the website[170].

Ministerial Pensions

480. 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.[171]

481. 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 1 April 2013 have transitional protection to remain in the previous final salary pension scheme.

482. 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.

483. **Tables 12** and **13** provide the details of the pension interests for the Department's Officials and Ministers for 2017-18 and 2018-19, including the total pension payable to the member under both the pre-2015 and post-2015 Ministerial pension schemes and are subject to audit.

Cash Equivalent Transfer Values

484. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

485. 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.

486. Similarly, for Ministers, the pension figures shown related to the benefits that the individual has accrued as a consequence of their total Ministerial service, not just their current appointment as a Minister.

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[170] http://www.civilservicepensionscheme.org.uk
[171] http://qna.files.parliament.uk/ws-attachments/170890/original/PCPF%20MINISTERIAL%20SCHEME%20FINAL%20RULES.doc

Real Increase in CETV

487. 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.

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

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

	Accrued pension at age 65 as at 31/03/19 £'000	Real increase in pension at age 65 £'000	CETV at 31/03/19 £'000	CETV at 31/03/18[2] £'000	Real increase in CETV £'000
Jeremy Hunt	10-15	0-2.5	195	191	1
Matt Hancock	0-5	0-2.5	31	21	4
Lord O'Shaughnessy	0-5	0-2.5	27	17	4
Steve Brine	0-5	0-2.5	9	4	2
Jackie Doyle-Price	0-5	0-2.5	18	13	2
Caroline Dinenage	0-5	0-2.5	22	15	3
Stephen Barclay	0-5	0-2.5	17	13	1
Stephen Hammond	0-5	0-2.5	3	0	2
Baroness Blackwood	0-5	0-2.5	9	6	1

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

2. The figures for 2017-18 are restated as the factors for calculating CETVs were changed by Government Actuary in 2018, therefore CETV at the end of 31/3/18 may be different.

Table 13: Pension Information of Senior Officials of the Department (subject to audit)

		Accrued pension at pension age as at 31/03/19 and related lump sum £'000	Real increase in pension and related lump sum at pension age £ '000	CETV at 31/03/19 £ '000	CETV at 31/03/18 £ '000	Real increase in CETV £'000	Employer contribution to partnership pension account Nearest £100
Christopher Wormald	Permanent Secretary	75-80	5-7.5	1,214	1,013	52	0
Professor Dame Sally Davies[1]	Chief Medical Officer	-	-	-	-	-	-
David Williams	Director General for Finance & Group Operations	55-60 plus a lump sum of 125-130	0-2.5	994	865	12	0
Clara Swinson	Director General for Global & Public Health	35-40 plus a lump sum 75-80	0-2.5	527	435	14	0
Jonathan Marron	Director General for Community and Social Care	15-20	2.5-5	192	137	24	0
Lee McDonough	Director General for Acute Care & Workforce	45-50 plus a lump sum of 145-150	0-2.5 plus a lump sum 2.5-5	1,086	969	11	0
Steve Oldfield[2]	Chief Commercial Officer	-	-	-	-	-	7,100
Professor Chris Whitty[3]	Chief Scientific Adviser	50-55 plus a lump sum of 110-115	2.5-5.0	830	682	127	0

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

2.Steve Oldfield holds a defined contribution pension, therefore figures shown represent the Department's contribution to this scheme held by Standard Life & Legal & General.

3. All pension figures represent the 80% proportion that the Department contributes towards members pension entitlement.

Non-Executive Directors

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

490. The Departmental Board holds positions for six Non-Executive Directors. The Non-Executive Directors sitting on the Departmental Board during 2018-19 are detailed in the Directors' Report. There are also two Independent members of Audit & Risk Committee. Details are shown in **Table 14**.

491. One of the Non-Executive Directors chairs the Department's Audit and Risk Committee (4 meetings per year). The lead Non-Executive Director chairs the Department's Nominations and Governance Committee, which has an additional Non-Executive Director.

Table 14: Non-Executive Directors and Members of the Department (subject to audit)

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

Compensation for Loss of Office (subject to audit)

492. 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[172] and the payments are also not pensionable.

493. During 2018-19 there were two payments for loss of office to Ministers. Firstly, £17,177.50 for Lord O'Shaughnessy who stood down as Parliamentary Under Secretary of State for Health (Lords) on 31 December 2018 and secondly, £5,593.75 for Steve Brine who stood down as Parliamentary Under Secretary of State (Public Health and Primary Care) on 25 March 2019.

172 https://www.legislation.gov.uk/ukpga/2003/1/contents

Staff Report

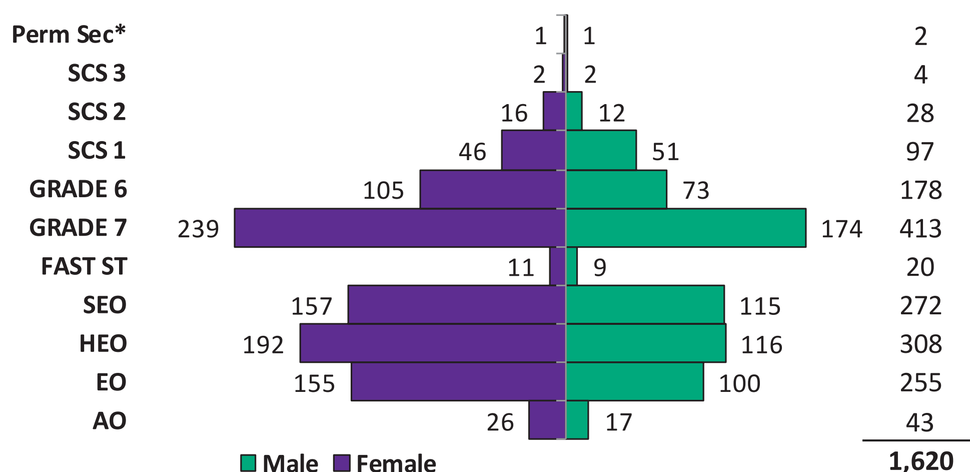
494. This Staff Report summarises the core Department's key staffing information and policies, with the staff costs, numbers and exit packages disclosures subject to audit.

495. The core Department employed an average of 1,462 permanent whole time equivalent (WTE) persons during 2018-19 at a total salaries and wages cost of £68.2 million, compared to 1,369 at a cost of £62.1 million in 2017-18. A breakdown of staff numbers and associated costs for the Core Department and Agencies and the overall Departmental Group is included in **Tables 19 and 20**.

DHSC Staff

496. 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 14** outlines the headcount and gender distribution of core Departmental staff in post as at 31 March 2019 and is consistent with Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment with the Department.

Figure 14: Gender distribution of core Department staff (headcount) as at 31st March 2019



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

Staff Sickness

497. The core Department has continued to reduce the number of days lost to short-term and long-term sickness, falling from 1,766 and 3,601 days respectively in the rolling calendar year up to October 2017 to 1,643 and 2,944 up to October 2018. Our average number of days lost due to sickness of 3.7 days is significantly below the civil service average of 6.8 days. 80 per cent of our staff have no recorded sickness.

3.7 days sickness compared to 6.8 days across Civil Service

Health and Safety

498. The Department of Health and Social Care recognises its responsibilities, under the Health and Safety at Work Act 1974[173], 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 2018-19, there were 20 reported accidents; four of which resulted in absence, and four near misses.

Equal Opportunities Policy

499. The Department is committed to treating all staff fairly and responsibly. The aim of the Department's equal opportunities policies are 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, membership or activity.

500. 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; continue equalities analysis of HR policies and initiatives; a comprehensive suite of equality policies; support work-life balance and mental health initiatives; continue workforce monitoring by diversity characteristics; and take targeted action as required. They are set out in the Department's Equality Objectives Action Plan[174] and Annual Equalities Information Report[175].

501. At an operational level, the Department's Equal Opportunities Policy underpins the development and implementation of all policies, guidance and activities. We recognise that our people are at the heart of what we do and proactively creating a culture of inclusion is a key strand of our Departmental People strategy. To support this, we launched our DHSC Diversity and Inclusion strategy in 2017. This sets out how we will achieve our vision to be a diverse and inclusive place to work where everyone can achieve their potential. The five themes of our strategy are:
    - Culture - creating an inclusive culture where difference is valued , the power of diversity is harnessed and everyone has equal opportunity to achieve their potential;
    - Capability - to build capability and confidence across our workforce to ensure DHSC is a trusted, diverse organisation for which people are proud to work and leaders are inclusive by instinct;
    - Data and insight - we encourage everyone to provide diversity information to support more evidence based solutions to our diversity;
    - Talent - we identify and act to remove barriers to progress to ensure everyone has equal opportunity to fulfil their potential; and
    - Social Mobility – we take action to support improved diversity and social mobility in our workforce.

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[173] http://www.hse.gov.uk/legislation/hswa.htm
[174] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401180/DH_equalities_2015_acc.pdf
[175] https://www.gov.uk/government/collections/dh-workforce-equality-information

502. We have made good progress against the strategy since it was launched, with focus on creating an inclusive culture. Achievements include the Department being named as one of Business in the Community's Best Employers for Race in November 2018, and we continue to work with external organisations such as Stonewall, the Business Disability Forum, and 'a:gender' to support and evaluate our progress. Robust diversity and inclusivity governance structures ensure the Department is making consistent progress in all areas.

503. The Department uses a range of measures to track progress – including trends in staff surveys (our People Survey) data. Our Engagement Index Score continues to increase (63 per cent in 2018, an increase of 18 points since 2016) and 72 per cent of respondents agreed that "Equality, Diversity and Inclusion are actively practised in the Department", an increase of 3 points from 2017.

504. The Department also implements the recommendations from the Civil Service Diversity and Inclusion strategy entitled 'A Brilliant Civil Service: becoming the UK's most inclusive employer'[176]. In support of this, from April 2019, the Department is piloting a new metric to measure inclusion, which has been developed in conjunction with the Cabinet Office, the Behavioural Insights team, and the Chartered Institute of Personnel and Development.

Recruitment and Retention of Disabled Persons

505. The Department has a number of policies and activities in place to aid the recruitment and retention of disabled staff. These include: involving the disabled staff network, and other staff networks, in the assessment (by equality) of workforce policies and guidance; a comprehensive suite of flexible working policies; development of specific guidance for managers and staff, (covering such issues as; 'making reasonable adjustments', 'mental health', 'support for carers', 'anti-bullying, harassment and discrimination' and the 'Guaranteed Interview Scheme' (which ensures that all applicants with a disability who meet the minimum criteria for a job are automatically listed for interview)); occupational health support and mental health first aiders; and accessible IT systems, information, accommodation and facilities.

506. The Department, under the Equality Act 2010[177], provides support to employees with a disability or health condition in the form of reasonable workplace adjustments. A workplace adjustment can be a change that removes a barrier or a disadvantage for employees with disability or health condition, which covers both physical, mental and learning disability conditions. This could be a physical feature or a change in working arrangements. What constitutes a workplace adjustment will vary depending on the individual and each request will need to be considered on a case-by-case basis. Equality law recognises that bringing about equality for people with a disability may mean changing the way in which employment is structured, the removal of physical barriers and/or providing extra support.

[176] https://www.gov.uk/government/publications/a-brilliant-civil-service-becoming-the-uks-most-inclusive-employer
[177] https://www.gov.uk/guidance/equality-act-2010-guidance

507. The Department makes Unconscious Bias training a required piece of learning for all staff, including those taking part in recruitment and selection exercises. It also promotes further learning on topics such as 'Becoming Disability Confident' and 'Mental Health at Work'. We have also been recognised as being a Disability Confident Leader organisation. We are committed to meeting the recommendations set out in the Thriving at Work Review[178] and to make good progress against these.

508. The Department runs specific targeted information sessions with members of its staff network groups - including our disability network 'Enable' - to encourage applicants to apply for the Civil Service-wide talent schemes – 'Future Leaders Scheme' and 'Senior Leaders Scheme', and the Civil Service wide development scheme 'Positive Action Pathway'. The Department also runs a reverse mentoring scheme, which pairs people from protected characteristic groups (including disability) with senior Civil Servants, to help them better understand the challenges and barriers that they face in progression and development.

Trade Union Facility Time

509. Under The Trade Union (Facility Time Publication Requirements) Regulations 2017[179], the Department has a statutory requirement to disclose information (see **Tables 15 - 18**) as prescribed by schedule 2 of the above Regulation. The format of these tables is as prescribed by the Regulations.

510. The disclosure has been compiled in line with the Regulations, therefore the information discloses the trade union facility time utilised by the Core Department and Public Health England staff only. The statutory reporting requirement is met through each entity's underlying Annual Report and Accounts, where an entity is in scope of this requirement.

Table 15: Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
39	39

Table 16: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	4
1-50%	35
51-99%	0
100%	0

Table 17: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£100,827
Total pay bill	£373,927,728
Percentage of the total pay bill spent on facility time*	0.027%

* calculated as: (total cost of facility time ÷ total pay bill x 100)

[178] https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

[179] http://www.legislation.gov.uk/uksi/2017/328/made

Table 18: Paid Trade Union Activities

Description	Figures
Time spent on paid trade union activities as a percentage of total paid facility time hours*	0%

* total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours)

511. With regard to engagement, officials from the Department's HR team meet formally with Departmental Trade Union Side (DTUS) regularly where all 'people matters' are covered. The meetings are 'joint meetings' with MHRA and the Unions represented are PCS, FDA, Prospect, Unite and UCU. The Department also engages directly with DTUS on areas such as pay and reward, policy changes and re-structures and hold formal pay negotiations on an annual basis. In addition to the regular meetings with HR, DTUS also meet quarterly with designated members of the Departments Executive committee.

Staff Data

512. **Tables 19, 20 and 21** summarise key staff information for the Departmental Group.

Table 19: Staff costs for the Departmental Group comprise: (subject to audit)

					2018-19 £'000	2017-18 £'000
	Permanently employed staff	Others	Ministers	Special Advisors	Total	Total
Salaries and wages	43,207,401	5,256,760	247	155	48,464,563	46,009,959
Social Security costs	4,507,438	100,405	27	18	4,607,888	4,365,486
NHS Pension	5,123,577	95,490	-	-	5,219,067	4,979,998
Other pension costs	67,894	1,604	4	34	69,536	62,113
Sub-total	**52,906,310**	**5,454,259**	**278**	**207**	**58,361,054**	**55,417,556**
Termination benefits	42,751	3,420	17	16	46,204	55,574
Sub-total	**52,949,061**	**5,457,679**	**295**	**223**	**58,407,258**	**55,473,130**
Less recoveries in respect of outward secondments	(37,485)	(55,894)	-	-	(93,379)	(86,429)
Total Net Costs	**52,911,576**	**5,401,785**	**295**	**223**	**58,313,879**	**55,386,701**

Table 20: Average number of whole-time equivalents employed – Departmental Group (subject to audit)

					2018-19 Number	2017-18 Number
	Permanent staff	Others[1]	Ministers	Special Advisors	Total	Total
Core Department						
Core Department	1,462	275	7	2	1,746	1,526
Executive Agencies						
Public Health England	5,009	268	-	-	5,277	5,283
Other designated bodies						
NHS Providers	1,076,946	106,502	-	-	1,183,448	1,157,547
Special Health Authorities	3,887	422	-	-	4,309	3,865
NHS England Group	24,011	9,080	-	-	33,091	31,710
Non Departmental Public Bodies	9,042	714	-	-	9,756	9,698
Others	5,603	290	-	-	5,893	4,913
Total	**1,125,960**	**117,551**	**7**	**2**	**1,243,520**	**1,214,542**

1. The calculation of the average WTE equivalent included in the Core Department in 'Others' has been updated in 2018-19 and now includes all non-permanent workers. Given the impact on the prior year would not have been significant, prior year figures have not been restated.
2. Staff numbers 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 using Office for National Statistics categorisation.

Of the figures shown in **Table 20**, the following staff were engaged on capital projects, **Table 21**:

Table 21: Breakdown of staff engaged on capital projects (subject to audit)

					2018-19 Number	2017-18 Number
	Permanent staff	Others	Ministers	Special Advisors	Total	Total
Core Dept & Agencies	46	27	-	-	73	46
Other designated bodies	3,386	492	-	-	3,878	3,893
Total	**3,432**	**519**	**-**	**-**	**3,951**	**3,939**

513. The increase in the Core Department's staff numbers related to additional staffing needs to support priority policy work, which included preparations for EU Exit. All additions to core staffing levels are robustly governed in the context of supporting Departmental priorities.

514. Staff employed in the NHS has increased in 2018-19. This is predominantly due to increased medical and dental, healthcare assistants and support and healthcare science staff.

515. Further details of staff employed within NHS organisations is available via NHS Digital[180], who publish on a monthly basis a breakdown of staff employed within the NHS Hospital and Community Health Service (HCHS). The data can be broken down by headcount, WTE, organisation, staff group and is the definitive source for NHS staffing information. Details of each NHS organisation can also be found in their own Annual Report and Accounts.

Consultancy, Temporary and Agency workers

516. **Table 22** provides details of expenditure on Consultancy, Agency and Temporary workers by the Core Department and bodies within the Departmental Accounting Boundary. The definition for consultancy and temporary agency workers is in line with HM Treasury Guidance. The consultancy values are reported on a resource basis, consistent with the accounts and reconcile to the figures reported in Note 4 of the financial statements.

517. The Department utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. In 2018-19 the Core Department spent £19.8 million on consultancy compared to £12.4 million in 2017-18; and £25.4 million on temporary staff this year compared to £21.9 million last year. These increases related to programmes of a short-term nature that required specialist support not available within the Department and with an agreed date by which the need for this support would end.

518. In 2018-19 these costs primarily included; a) The implementation of a new supply chain model under the Procurement Transformation Programme which is now operational and

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

delivering procurement efficiency and value for money for NHS services; b) EU Exit contingencies such as continuity of medicine supplies; c) Renegotiation of the Prescription Pricing Regulation Scheme (PPRS) with a new five year agreement now in place (the 2019 Voluntary Scheme for Branded Medicines Pricing and Access); and d) Resources related to the Department's Corporate Services Improvement Programme (CSIP).

519. 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 22: Expenditure on Consultancy, Agency and Temporary Workers

	2018-19		2017-18	
	Consultancy	Temporary Agency	Consultancy	Temporary Agency
	£'000	£'000	£'000	£'000
Total DHSC Core	19,829	25,396	12,402	21,932
Executive Agencies	-	15,809	-	17,702
Other Designated Bodies	322,222	3,591,990	358,619	3,403,310
Gross Total	**342,051**	**3,633,195**	**371,021**	**3,442,944**
Eliminations	-	-	(51)	(478)
Total Departmental Group (after eliminations)	**342,051**	**3,633,195**	**370,970**	**3,442,466**

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

Off-Payroll Engagements

520. In line with HM Treasury requirements, Departments must publish information on their highly paid and/or senior off-payroll engagements. This information, contained in **Tables 23 a, b & c** includes all off-payroll engagements as at 31 March 2019 for a day-rate of more than £245 and which have duration of more than six months.

521. A regular dialogue has continued between the Department and HMRC throughout the 2018-19 financial year to ensure ongoing compliance with the IR35 rule changes which came into force from April 2017. This dialogue also ensures that the changes continue to be understood and implemented in a fair and reasonable manner by the Department. In relation to the Department's ALBs, we understand HMRC have been conducting inspections in relation to IR35 and we await the final outcome from these reviews before commenting further. The Department has also ensured that when its off-payroll workers transition to a different role they are re-assessed for IR35 purposes to ensure their tax status has not changed due to their change in work areas. A total of 14 contractors working in core DHSC have been reassessed due to such changes.

522. The figures for the core Department show the vast majority of contractors are determined to be "outside the scope" of IR35. The bulk of these determinations relate to workers in 2 key project areas – Procurement Transformation Programme (PTP) and the Corporate Services Improvement Programme (CSIP) where the roles in question are fairly agile and project managers are happy for a level of substitution to take place as long as the tasks identified are completed to agreed timescales. As such, the online Check Employment Status for Tax (CEST) tool identifies these workers as "outside the scope" of IR35.

523. A communication channel has also been open throughout the year with the Departments ALBs to offer advice and assistance to them in ensuring that they have continued to meet their compliance requirements relating to the new rules. All appointments across the core Department, its agencies & ALBs have been assessed for IR35 purposes via the online CEST tool to ensure the payment of the correct tax by our combined contractor and off-payroll worker base.

524. On the continued advice of HMT, secondments have been included within the off-payroll figures for the core Department. Secondees engaged as at 31 March 2019 accounted for 9 of the off-payroll workers with 2 of these having reached their initial six-month duration during financial year 2018-19.

525. The Department had no change of policy relating to the engagement of off-payroll workers during 2018-19 and continues to utilise them only where it is necessary and prudent to do so. A significant number of contractors have been engaged on the Procurement Transformation Programme at the Department which is ending in the next 6 months which will see a number of these contractors leave the Department. However, in line with most Government Departments, there have been a significant number of contractors engaged to complete work associated with exiting the European Union. This number may well increase during the 2019-20 financial year.

526. There are three individuals who are senior “off-payroll” engagements (**see Table 23c**), two of whom are at NHS Digital, the third at NHS Supply Chain Co-ordination Limited (SCCL):
- One is NHS Digital’s Head of Assurance and Risk who has been with them since 1 March 2019 and is on a secondment from PWC and is on the PWC payroll and paying tax as an employee of theirs. It is not clear at this stage how long this secondment will last.
- The second individual is NHS Digital’s Chief Commercial Officer who is working for them via an agency and has been doing so for a period of more than 12 months. The recruitment of a permanent employee into this role has not been prioritised by NHS Digital – they have focussed their recruitment efforts into other higher priority areas and where a more immediate solution was required rather than recruiting into a role where a high quality interim was already in place. The fact they have an interim in place is also helpful as there is uncertainty in how the commercial activities of NHS Digital will fit in with the work of the new NHSX joint work unit (between the Department and NHS Digital) and where the role this interim is filling will ultimately sit. As such, with an interim is place NHS Digital have a larger degree of flexibility than they would have if a permanent employee was in post.
- The third individual is the Chief Financial Officer of SCCL. He commenced work with the company at the end of August 2018. At that time, whilst the plans to form the company were in place there was no existing finance team and nobody internally with the right level of seniority to fulfil the role. As such, the decision was taken to appoint an interim to ensure continuity of service. While plans are in place to move this individual onto payroll this has taken a long time due to the seniority of the role and the need to get ministerial approval. It is anticipated that this approval will happen before the parliamentary summer recess.

Table 23: Off-payroll engagements

Table a: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months	Main Dept	Agencies	ALBs
Number of existing engagements as of 31 March 2019[1]	**91**	-	**883**
Of which…..			
Number that have existed for less than one year at time of reporting	51	-	392
Number that have existed for between one and two years at time of reporting	14	-	350
Number that have existed for between two and three years at time of reporting	9	-	67
Number that have existed for between three and four years at time of reporting	6	-	36
Number that have existed for four years or more years at time of reporting	11	-	38

Table b: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months	Main Dept	Agencies	ALBs
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019[1]	**78**	-	**556**
Of which…..			
No. assessed as caught by IR35	1	-	222
No. assessed as not caught by IR35	74	-	334
No. directly engaged directly (via PSC contracted to department) and are on the departmental payroll	-	-	1
No. of engagement reassessed for consistency / assurance purposes during the year	14	-	217
No. of engagements that saw a change to IR35 status following the consistency review	-	-	134

Note: Total no of contractors does not equal the total of "caught" & "not caught" by IR35. This is because 3 were "unable to determine" from the CEST tool and currently in discussion with HMRC.

Table c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility [1], between 1 April 2018 and 31 March 2019	Main Dept	Agencies	ALBs
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-	-	3
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[1]	126	15	455

1. 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

527. **Table 24** 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[181]. 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

[181] https://www.civilservicepensionscheme.org.uk/members/civil-service-compensation-scheme-for-members/

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 24: Exit Packages (subject to audit)

								2018-19
				Core Dept & Agencies				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	8	1	9	-	369	1,670	2,039	14
£10,001 - £25,000	11	8	19	-	400	349	749	8
£25,001 - £50,000	11	7	18	-	318	191	509	3
£50,001 - £100,000	7	5	12	-	274	101	375	1
£100,001 - £150,000	-	-	-	-	92	12	104	-
£150,001 - £200,000	-	-	-	-	51	10	61	-
>£200,000	1	-	1	-	11	7	18	2
Total Number	38	21	59	-	1,515	2,340	3,855	28
Total Cost (£)	1,331,690	791,046	2,122,736	-	61,516,334	30,556,794	92,073,128	955,202

								2017-18
				Core Dept & Agencies				Departmental Group
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
≤£10,000	12	11	23	-	475	1,872	2,347	17
£10,001 - £25,000	6	6	12	-	556	456	1,012	5
£25,001 - 50,000	5	1	6	-	413	318	731	4
£50,001 - £100,000	3	6	9	-	253	167	420	2
£100,001 - £150,000	2	-	2	-	76	23	99	2
£150,001 - £200,000	1	-	1	-	50	13	63	-
>£200,000	-	-	-	-	5	1	6	-
Total Number	29	24	53	-	1,828	2,850	4,678	30
Total Cost (£)	1,008,803	642,548	1,651,351	-	63,222,683	41,076,539	104,299,222	653,735

1. Within the total above, there were 6 exit packages during 2017-18 relating to the DH 2020 restructure programme. (5 Voluntary exits, 1 compulsory redundancy), these occurred as individuals failed to secure a post during 2016-17 and were entitled to a redeployment period of 3 months and subsequent notice period.
2. There are no individuals within the Core Department who have received over £95,000 as an exit package due to entitlement on voluntary or compulsory redundancy arrangements in 2018-19 or 2017-18.

Other Departures

528. **Table 25** outlines the detail of other departures. A single exit package can be made up of several components, each of which will be counted separately. Therefore, the total number in Table 25 will not necessarily match the total number in **Table 24**, which will be the number of individuals.

Table 25: Analysis of Other Departures

	2018-19	
	Departmental Group	
	Agreements	Total value of agreements
	Number	£'000
Voluntary redundancies including early retirement contractual costs	241	9,626
Mutually agreed resignations (MARS) contractual costs	350	8,291
Early retirements in the efficiency of the service contractual costs	11	392
Contractual payments in lieu of notice	1,752	9,132
Exit payments following Employment Tribunals or court orders	53	2,377
Non-contractual payments requiring HMT approval*	22	739
Total	**2,429**	**30,557**

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

Parliamentary Accountability and Audit Report

Statement of Parliamentary Supply

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

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

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

Summary of Resource and Capital Outturn 2018-19 (subject to audit)

		2018-19			2018-19			2018-19	2017-18
		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	103,997,778	21,926,343	125,924,121	103,351,918	21,926,343	125,278,261	645,860	120,650,014
- Capital	1.2	5,983,307	-	5,983,307	5,941,244	-	5,941,244	42,063	5,237,852
Annually Managed Expenditure									
- Resource	1.1	12,926,334	-	12,926,334	7,013,965	-	7,013,965	5,912,369	13,152,311
- Capital	1.2	15,000	-	15,000	(4,801)	-	(4,801)	19,801	-
Total Budget		122,922,419	21,926,343	144,848,762	116,302,326	21,926,343	138,228,669	6,620,093	139,040,177
Non-Budget									
- Resource	1.1	-	-	-	-	-	-	-	-
Total		122,922,419	21,926,343	144,848,762	116,302,326	21,926,343	138,228,669	6,620,093	139,040,177
Total Resource		116,924,112	21,926,343	138,850,455	110,365,883	21,926,343	132,292,226	6,558,229	133,802,325
Total Capital		5,998,307	-	5,998,307	5,936,443	-	5,936,443	61,864	5,237,852
Total		122,922,419	21,926,343	144,848,762	116,302,326	21,926,343	138,228,669	6,620,093	139,040,177

1. Explanations of variances between Estimates and Outturn are given in tables a to d below.

Net cash requirement 2018-19 (subject to audit)

Net Cash Requirement 2018-19

	SoPS Note	2018-19 Estimate £'000	2018-19 Outturn £'000	2018-19 Outturn compared with Estimate: saving/ (excess) £'000	2017-18 Outturn £'000
Net cash requirement	3	109,448,070	106,567,583	2,880,487	102,009,695

1. Against the 2018-19 Net Cash Requirement of £109.5 billion, DHSC underspent by 2.6% (£2.9 billion). This underspend is in line with previous years and reflects the complexities of the cash usage and allocations across 500 bodies in the DHSC Group.

Administration Costs 2018-19 (subject to audit)

Administration Costs 2018-19

	2018-19 Estimate £'000	2018-19 Outturn £'000	2017-18 Outturn £'000
Administration Costs	2,877,794	2,272,688	2,303,513

1. In 2018-19, DHSC underspent by £605 million against the total Resource Administration limit of £2.9 billion, circa £330 million related to underspends in the element of the budget limit ring-fenced for depreciation and impairments expenditure.
2. 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)

			2018-19 £'000			2018-19 £'000	2018-19 £'000			2018-19 £'000	2017-18 £'000
							Outturn			Estimate	Outturn
			Administration			Programme	Total	Net Total[7]	Net total compared to Estimate Savings /(excess)[6]	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	1,508,274	-	1,508,274	15,089,975	-	15,089,975	16,598,249	16,698,213	99,964	99,964	16,232,918
NHS Providers net expenditure	-	-	-	74,014,271	-	74,014,271	74,014,271	73,501,178	(513,093)	-	70,750,505
DHSC Programme and Administration expenditure	231,685	(1,656)	230,029	1,281,278	(403,819)	877,459	1,107,488	2,525,771	1,418,283	494,534	1,747,178
Local Authorities	-	-	-	3,011,064	-	3,011,064	3,011,064	3,010,910	(154)	-	3,090,533
Public Health England (Executive Agency)	55,205	(6,427)	48,778	1,148,956	(171,433)	977,523	1,026,301	798,904	(227,397)	4,956	822,586
Health Education England net expenditure	59,943	-	59,943	1,759,234	-	1,759,234	1,819,177	1,792,140	(27,037)	3,080	2,056,903
Special Health Authorities expenditure	253,662	(75,478)	178,184	4,684,717	(550,945)	4,133,772	4,311,956	4,313,649	1,693	37,587	4,034,160
Non Departmental Public Bodies net expenditure	248,219	-	248,219	376,610	-	376,610	624,829	568,874	(55,955)	-	576,362
Arm's Length and Other Bodies net expenditure[7]	(739)	-	(739)	839,322	-	839,322	838,583	788,139	(50,444)	5,739	
	2,356,249	**(83,561)**	**2,272,688**	**102,205,427**	**(1,126,197)**	**101,079,230**	**103,351,918**	**103,997,778**	**645,860**	**645,860**	**99,311,145**
Non-voted:											
NHS England expenditure financed by NI Contributions	-	-	-	21,926,343	-	21,926,343	21,926,343	21,926,343	-	-	21,338,869
	2,356,249	**(83,561)**	**2,272,688**	**124,131,770**	**(1,126,197)**	**123,005,573**	**125,278,261**	**125,924,121**	**645,860**	**645,860**	**120,650,014**
Annually Managed Expenditure (AME)											
Voted:											
NHS England net expenditure	-	-	-	(19,733)	-	(19,733)	(19,733)	100,000	119,733	119,733	17,784
NHS Providers net expenditure	-	-	-	1,134,119	-	1,134,119	1,134,119	1,200,000	65,881	65,881	662,491
DHSC Programme and Administration expenditure	-	-	-	(424,011)	(13,102)	(437,113)	(437,113)	688,334	1,125,447	1,124,074	491,136
Public Health England (Executive Agency)	-	-	-	(2,181)	-	(2,181)	(2,181)	5,000	7,181	7,181	4,623
Health Education England net expenditure	-	-	-	(44)	-	(44)	(44)	5,000	5,044	5,044	(17,647)
Special Health Authorities expenditure	-	-	-	6,405,024	-	6,405,024	6,405,024	10,600,000	4,194,976	4,194,976	11,990,518
Non Departmental Public Bodies net expenditure	-	-	-	6,373	-	6,373	6,373	5,000	(1,373)	-	3,406
Arm's Length and Other Bodies net expenditure[7]	-	-	-	(72,480)	-	(72,480)	(72,480)	323,000	395,480	395,480	
	-	**-**	**-**	**7,027,067**	**(13,102)**	**7,013,965**	**7,013,965**	**12,926,334**	**5,912,369**	**5,912,369**	**13,152,311**
Total	**2,356,249**	**(83,561)**	**2,272,688**	**131,158,837**	**(1,139,299)**	**130,019,538**	**132,292,226**	**138,850,455**	**6,558,229**	**6,558,229**	**133,802,325**
Reconciliation to Statement of Comprehensive Net Expenditure											
Net gain/(loss) on transfers by absorption	-	-	-	(6,204)	-	(6,204)	(6,204)				(7,521)
Capital Grants	5,803	-	5,803	592,150	-	592,150	597,953				588,988
Research and Development[5]	-	-	-	1,184,510	-	1,184,510	1,184,510				1,132,586
Income from Consolidated Fund Extra Receipts	-	-	-	-	-	-	-				(13,126)
Utilisation of provisions	(19,722)	-	(19,722)	19,722	-	19,722	-				-
IFRIC 12 Adjustment	-	-	-	334,871	(369,349)	(34,478)	(34,478)				(110,682)
Donated asset/government granted income	-	-	-	-	(404,202)	(404,202)	(404,202)				(155,038)
Expenditure presented on net basis[1]	210,643	(210,643)	-	8,678,248	(8,678,248)	-	-				-
Other adjustments[4]	-	-	-	157,665	(199,526)	(41,861)	(41,861)				262,012
Net operating cost after financing activities	**2,552,973**	**(294,204)**	**2,258,769**	**142,119,799**	**(10,790,624)**	**131,329,175**	**133,587,944**				**135,499,544**

1. Under Parliamentary reporting requirements, expenditure for the NHS England Group, NDPBs (including Health Education England), NHS Providers and Arm's Length and Other Bodies 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 tables a to d below.
3. Note 21 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.

4. Other adjustments include £157.7 million of expenditure representing the loss relating to the net assets transferred outside the Department's accounting boundary for the two charities that have gained independent status during 2018-19. Further details can be found in note 19.1. In addition, profits on disposal of £199.5 million have been transferred to Capital in line with HMT budgeting guidance.
5. From 2016-17, following the Government's adoption of the 2010 European System of National and Regional Accounts (ESA 2010), the majority of Departmental expenditure on research and development was re-classified from resource to capital expenditure. Further detail is presented in Annex A Core Table 1.
6. The total Resource DEL underspend of £646 million consists of a £612 million underspend against the ringfence control. This is not cash backed, and cannot be used to fund healthcare services.
7. Prior to 2018-19, the outturn position for Arm's Length and other Bodies was included as part of DHSC Programme and Administration expenditure line.

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

			2018-19 £'000			2018-19 £'000	2017-18 £'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	221,233	-	221,233	253,930	32,697	-	227,820
NHS Providers net expenditure	3,928,404	-	3,928,404	3,555,459	(372,945)	-	3,045,549
DHSC Programme and Administration expenditure	1,681,072	(22,724)	1,658,348	1,902,568	244,220	-	1,782,811
Local Authorities	-	-	-	-	-	-	15,456
Public Health England (Executive Agency)	(68,972)	(1,503)	(70,475)	(43,357)	27,118	27,118	70,695
Health Education England net expenditure	467	-	467	2,000	1,533	-	628
Special Health Authorities expenditure	48,305	(98,120)	(49,815)	25,879	75,694	14,945	16,738
Non Departmental Public Bodies net expenditure	95,246	-	95,246	125,602	30,356	-	78,155
Arm's Length and Other Bodies net expenditure[3]	157,836	-	157,836	161,226	3,390	-	
	6,063,591	**(122,347)**	**5,941,244**	**5,983,307**	**42,063**	**42,063**	**5,237,852**
Annually Managed Expenditure (AME)							
Voted:							
NHS England net expenditure	-	-	-	-	-	-	-
NHS Providers net expenditure	-	-	-	-	-	-	-
DHSC Programme and Administration expenditure	(4,801)	-	(4,801)	15,000	19,801	19,801	-
Public Health England (Executive Agency)	-	-	-	-	-	-	-
Health Education England net expenditure	-	-	-	-	-	-	-
Special Health Authorities expenditure	-	-	-	-	-	-	-
Non Departmental Public Bodies net expenditure	-	-	-	-	-	-	-
Arm's Length and Other Bodies net expenditure[3]	-	-	-	-	-	-	
	(4,801)	**-**	**(4,801)**	**15,000**	**19,801**	**19,801**	**-**
Total	**6,058,790**	**(122,347)**	**5,936,443**	**5,998,307**	**61,864**	**61,864**	**5,237,852**

1. Explanations of variances between Estimate and outturn are given in tables a to d below.
2. Note 21 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
3. Prior to 2018-19, the outturn position for Arm's Length and other Bodies was included as part of DHSC Programme and Administration expenditure line.

Material variances between the Estimate and Outturn

529. At the start of each financial year, we estimate our income and expenditure for each of the bodies within our Departmental Group, and we monitor these throughout the year. Due to the size and complexity of our budget, there will inevitably be some variances in our Estimate.

530. HM Treasury designates that Estimates are prepared on a consolidated basis, meaning that all intra-group transactions are removed. Across Government, the DHSC 'Internal Market' of circa £80 billion is unique to the DHSC and adds an additional layer of complexity, as all inter-group trading needs to be eliminated on consolidation when preparing the DHSC Estimate. These mainly relate to transactions between NHS Commissioners and NHS Providers.

531. NHS Providers are not directly funded, instead they generate income to cover their spending via trading activity with Commissioners. Commissioners pay Providers for each patient seen or treated, considering the complexity of the patient's healthcare needs, under a national tariff system.

532. In setting the Parliamentary Estimate, DHSC takes a pragmatic approach and eliminates only the material transactions between Departmental group bodies.

533. In line with the guidance published by the Parliamentary Scrutiny Unit for Estimates Memoranda, significant other variances over £10 million and 10% have been explained in tables A to D below

Further Explanation of SOPS 1.1 and 1.2

Table a: Comparison of Resource DEL Estimate and Outturn

	RESOURCE DEL	ESTIMATE	OUTTURN	TOTAL VARIANCE	Of which: Elimination Variance	Other Variance	Other Variance	Explanation of other significant variance
		£m	£m	£m	£m	£m	%	
A	NHS England net expenditure	16,698	16,598	100	(303)	403	2%	
B	NHS Providers net expenditure	73,501	74,014	(513)	(348)	(165)	0%	
C	DHSC Programme and Administration expenditure	2,526	1,107	1,418	810	608	24%	The other variance relates primarily to an underspend of c£500m against depreciation spend.
D	Local Authorities	3,011	3,011	(0)	0	(0)	0%	
E	Public Health England (Executive Agency)	799	1,026	(227)	(26)	(202)	-25%	Forecast PHE impairments were not included in the Estimate against PHE.
F	Health Education England net expenditure	1,792	1,819	(27)	74	(102)	-6%	
G	Special Health Authorities expenditure	4,314	4,312	2	(62)	64	1%	
H	Non Departmental Public Bodies net expenditure	569	625	(56)	(67)	11	2%	
I	Arm's Length and Other Bodies (Net)	788	839	(50)	(79)	29	4%	
J	NHS England expenditure financed by NI Contributions	21,926	21,926	(0)	0	(0)	0%	
Total RDEL		125,924	125,278	646	0	646		

Table b: Comparison of Resource AME Estimate and Outturn

RESOURCE AME		ESTIMATE	OUTTURN	TOTAL VARIANCE		Explanation of significant variances
		£m	£m	£m	%	
J	NHS England net expenditure	100	(20)	120	120%	New provisions not as high as anticipated.
K	NHS Providers net expenditure	1,200	1,134	66	5%	
L	DH Programme and Administration expenditure	688	(437)	1,125	164%	New provisions not as high as anticipated and discount rate changes not in line with forecast.
M	Public Health England (Executive Agency)	5	(2)	7	144%	
N	Health Education England net expenditure	5	(0)	5	101%	
O	Special Health Authorities expenditure	10,600	6,405	4,195	40%	Underspend relates to lower than forecast clinical negligence provisions.
P	Non Departmental Public Bodies net expenditure	5	6	(1)	-27%	
R	Arm's Length and Other Bodies (Net)	323	(72)	395	122%	Various movements on provisions/impairments, largely driven by NHS Property Services.
Total RAME		**12,926**	**7,014**	**5,912**		

Table c: Comparison of Capital DEL Estimate and Outturn

CAPITAL DEL		ESTIMATE	OUTTURN	TOTAL VARIANCE		Explanation of significant variances
		£m	£m	£m	%	
A	NHS England net expenditure	254	221	33	13%	
B	NHS Providers net expenditure	3,555	3,928	(373)	-10%	NHS Provider capital expenditure was higher than forecast in the Parliamentary Estimate.
C	DH Programme and Administration expenditure	1,903	1,658	244	13%	DHSC capital expenditure was lower than forecast in the Parliamentary Estimate.
D	Local Authorities	0	0	0	0%	
E	Public Health England (Executive Agency)	(43)	(70)	27	-63%	Capital additions were lower than had been anticipated in setting the forecast in the Parliamentary Estimate.
F	Health Education England net expenditure	2	0	2	77%	
G	Special Health Authorities expenditure	26	(50)	76	292%	Special Health Authority capital disposals were higher than had been forecast in the Parliamentary Estimate.
H	Non Departmental Public Bodies net expenditure	126	95	30	24%	Lower than anticipated capital expenditure.
I	Arm's Length and Other Bodies (Net)	161	158	3	2%	
Total CDEL		**5,983**	**5,941**	**42**		

Table d: Comparison of Capital AME Estimate and Outturn

CAPITAL AME		ESTIMATE	OUTTURN	TOTAL VARIANCE		Explanation of significant variances
		£m	£m	£m	%	
J	NHS England net expenditure	0	0	0	0%	
K	NHS Providers net expenditure	0	0	0	0%	
L	DH Programme and Administration expenditure	15	(5)	20	133%	CAME transactions were lower than anticipated
M	Public Health England (Executive Agency)	0	0	0	0%	
N	Health Education England net expenditure	0	0	0	0%	
O	Special Health Authorities expenditure	0	0	0	0%	
P	Non Departmental Public Bodies net expenditure	0	0	0	0%	
R	Arm's Length and Other Bodies (Net)	0	0	0	0%	
Total CAME		**15**	**(5)**	**20**		

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

		Note	2018-19 £'000 Outturn	2017-18 £'000 Outturn
Total resource outturn in Statement of Parliamentary Supply				
	Budget	SOPS 1.1	132,292,226	133,802,325
	Non-Budget	SOPS 1.1	-	-
			132,292,226	133,802,325
Add:	Capital Grants		597,953	588,988
	Research and Development[2]		1,184,510	1,132,586
	PFI/LIFT expenditure under IFRS		2,318,247	2,164,246
	PFI/LIFT income under IFRS		(369,349)	(366,680)
	Other[1]		157,665	262,012
			3,889,026	3,781,152
Less:	Income payable to the Consolidated Fund	SOPS4	-	(13,126)
	Donated asset/government granted income		(404,202)	(155,038)
	PFI/LIFT expenditure under ESA 10		(1,983,376)	(1,908,248)
	Loss on transfers by absorption		(6,204)	(7,521)
	Other[3]		(199,526)	-
			(2,593,308)	(2,083,933)
Net Operating Cost in Consolidated Statement of Comprehensive Net Expenditure after Financing Activities			**133,587,944**	**135,499,544**

1. The 'Other' line relates to a loss generated on recognition of the net assets of two NHS Charities that have converted to independent status during 2018-19. 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 to capitalise costs that do not meet the criteria to be capitalised in departmental account but meet the ESA10 definition of research and development.
3. Profits on disposal of £199.5 million have been transferred to Capital in line with HMT budgetary guidance.
4. Donated assets/government granted income does not agree to note 5.1 as some of this income is included in income received by NHS charities.

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

	Note	Estimate	Outturn	Net total outturn compared with Estimate: Savings/(excess)
				2018-19 £'000
Resource Outturn	SOPS 1.1	138,850,455	132,292,226	6,558,229
Capital Outturn	SOPS 1.2	5,998,307	5,936,443	61,864
Accruals to cash adjustments:				
Adjustments to remove non-cash items:				
Depreciation		(941,911)	(261,495)	(680,416)
New provisions and adjustments to previous provisions		(13,634,926)	(9,477,744)	(4,157,182)
IFRIC12 revenue adjustments			17,257	(17,257)
Adjustment for stockpiled goods			21,112	(21,112)
Non-cash investment additions			(29,751)	29,751
Net gain/loss on transfers by absorption			(1,421)	1,421
Other non-cash items		-	295,985	(295,985)
Adjustments for NDPBs, NHS Trusts, Foundation Trusts, Charities and Other bodies:				
Remove voted resource and capital		(99,079,761)	(99,346,530)	266,769
Add cash grant-in-aid, PDC, loans and share capital from Core Department, and expenditure financed by Parliamentary Funding		96,798,657	95,864,965	933,692
Adjustments to reflect movements in working balances:				
Increase/(decrease) in inventory			118,664	(118,664)
less transfers from non-current assets			(2,791)	2,791
Increase/(decrease) in receivables			2,171,471	(2,171,471)
less movement in current financial assets			(1,881,436)	1,881,436
(Increase)/decrease in payables		1,000,000	(517,153)	1,517,153
less movement in payables to the Consolidated Fund			18,922	(18,922)
Use of provisions		2,383,592	3,193,550	(809,958)
		131,374,413	128,412,274	2,962,139
Removal of non-voted budget items:				
National Insurance contributions		(21,926,343)	(21,926,343)	-
Other adjustments				
Other cashflow adjustments			81,652	(81,652)
Net cash requirement		**109,448,070**	**106,567,583**	**2,880,487**

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

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

	Outturn 2018-19 £'000		Outturn 2017-18 £'000	
	Income	*Receipts*	Income	*Receipts*
Income outside the ambit of the Estimate	3,858	*3,858*	17,354	*17,354*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total income payable to the Consolidated Fund	**3,858**	***3,858***	**17,354**	***17,354***

Parliamentary Accountability Disclosures

The following disclosures are subject to audit

Regularity of Expenditure (subject to audit)

We are custodian of taxpayers' funds and have a duty to Parliament to ensure the regularity and propriety of our activities and expenditure. We manage public funds in line with HM Treasury's Managing Public Money. The disclosures made within the Parliamentary Accountability and Audit Report are indicative of this.

The importance of operating with regularity and the need for efficiency, economy, effectiveness and prudence in the administration of public resources to secure value for public money, is the responsibility of our Accounting Officer whose responsibilities are also set out in Managing Public Money. The manner in which the Accounting Officer and the wider Department discharges its responsibilities in the administration of public resources are detailed within the Statement of Accounting Officer Responsibilities and the Governance Statement.

Losses and Special Payments

Table 26: Losses Statement (subject to audit)

		2018-19		Restated 2017-18	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	144	122,484	91	58,079
	£'000	471,920	396,507	195,083	229,166
Cases over £300,000					
Cash losses	Cases	-	2	-	2
	£'000	-	3,597	-	981
Claims abandoned	Cases	-	2	1	2
	£'000	-	816	391	14,913
Cancellation of Public Dividend Capital (PDC)1	Cases	3	-	2	-
	£'000	159,245	-	65,735	-
Administrative write-offs	Cases	-	-	-	1
	£'000	-	-	-	13,804
Fruitless payments	Cases	-	5	-	1
	£'000	-	3,090	-	832
Constructive Loss	Cases	4	4	3	3
	£'000	216,467	216,467	39,446	39,446
Store losses	Cases	-	3	-	1
	£'000	-	1,247	-	457
Bookkeeping losses	Cases	-	-	-	-
	£'000	-	-	-	-

1. Prior year numbers have been restated to remove the cancellation of PDC losses from the Departmental Group column, given it relates to an intra-group transaction.

Department of Health and Social Care Share of National Insurance Contribution Losses

Included within its total losses, the Department has recorded a technical loss of £91.4 million which is its share of the overall, cross-Government loss relating to National Insurance Contributions (NICs). Such losses occur when contributions cannot be collected because companies have ceased to exist during the year. Her Majesty's Revenue & Customs (HMRC) allocates this category of loss to those Departments which are partially funded from NICs, on a proportional basis. It should be noted that the disclosure of this category of loss is a technical requirement which is completely outside the Department's control.

Losses resulting from Foreign Exchange Transactions

Included within its total losses, the Department has recorded a loss of £3.9 million relating to losses realised on the settlement of European Economic Area (EEA) liabilities. These losses represent the accounting entries required to reflect the movement in exchange rates between the prior year end and the settlement date on EEA accruals denominated in foreign currency. It is not practicable to identify the individual number of cases and therefore 1 loss has been recorded in the total losses category above but it is highly unlikely that the amount relating to any individual case would be above the £300,000 threshold for individual disclosure. It should be noted that the disclosure of this category of loss is a technical requirement which is completely outside the Department's control.

Cancellation of Public Dividend Capital (PDC)

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

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

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

During 2018-19, the Department gained HM Treasury approval to write off a total £159.2 million of PDC. £127.0 million of this relates to the dissolutions of Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust on 1 October 2017 when they were merged to form Manchester University NHS Foundation Trust. The remaining £32.2 million relates to the dissolution of Heart of England Foundation Trust which was acquired by University Hospitals Birmingham NHS Foundation Trust on 1 April 2018.

Constructive Loss

£8.9 million was incurred in line with Government policy to prepare for a no-deal EU Exit but will not be utilised following the change in the UK's planned departure date from 12 April to 31 October 2019. This expenditure was necessary to ensure that a dedicated direct channel for high priority medical supplies was available to the NHS in the event of disruption at borders following a no-deal EU Exit. Careful consideration was given to the risk to the public purse

should the capacity secured not be needed, however this risk was outweighed by the systemwide risks to patient care that a shortage of medical supplies following a no-deal exit presented.

Other Losses

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

Prescription and Dental Charge Easements (disclosed to explain significant year on year movements)

For the first time, included within total losses, are penalty charge notices issued by NHS Business Services Authority on behalf of NHS England to individuals who obtained exemptions for prescription or dental charges for which it was subsequently confirmed that they were not eligible. The National Health Service Act 2006 entitles the NHS to issue such notices. In some exceptional circumstances "easements" are offered to specific patients (e.g. for vulnerable individuals) such that the penalty charge notices are not pursued for payment. The number and value of easements issued in 2018-19 are considered "claims abandoned". However, given no individual easement exceeds £300,000 they are included solely within the total number and value of losses. The 2017-18 comparatives have not been restated on materiality grounds which explains the significant increase in the number of losses year-on-year.

Table 27: Analysis of Losses by Sector

	2018-19	Restated[1] 2017-18	2018-19	Restated[1] 2017-18
	Cases Number		Value £'000	
DHSC Core	67	36	263,822	155,249
Public Health England	77	55	208,098	39,834
NHS England Group	70,988	488	5,849	21,285
NHS Providers	49,218	52,665	68,292	75,125
NDPBs	2,010	4,461	8,973	2,815
Special Health Authorities	127	377	718	984
Eliminations	(3)	(3)	(159,245)	(66,126)
Departmental Group	**122,484**	**58,079**	**396,507**	**229,166**

1. As detailed in Table 26, prior year losses have been restated.

Table 28: Special Payments (subject to audit)

		2018-19		2017-18	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	94	9,660	43	15,428
	£'000	29,349	49,243	26,260	55,137
Cases over £300,000	Cases	35	40	15	25
	£'000	27,201	29,649	25,003	35,858

Special Payments

Special Payments are transactions that Parliament could not have anticipated when passing legislation or approving Supply Estimates for the Department. Examples include: extra contractual payments to contractors, ex-gratia payments to contractors, other ex-gratia payments, compensation payments, and extra statutory and extra regulatory payments.

Certain Core Department cases over £300,000 have not been disclosed on confidentiality grounds.

As per paragraph A4.13.7 of HM Treasury's *Managing Public Money* (MPM) the Department ensures that any proposal to keep a special payment confidential is carefully justified in line with MPM requirements.

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

Table 29: Special Payments by Sector

	2018-19	2017-18	2018-19	2017-18
	Cases Number		Value £'000	
DHSC Core	88	38	29,345	26,191
Public Health England	6	5	4	69
NHS England Group	1,121	6,983	748	5,914
NHS Providers	8,273	8,299	18,990	22,701
NDPBs	3	-	43	-
Special Health Authorities	169	97	113	157
Other Group entities	-	6	-	105
Departmental Group	**9,660**	**15,428**	**49,243**	**55,137**

Other Payments

There have been no other payments made by the Core Department for 2018-19 (2017-18: £Nil)

Fees and Charges

Table 30: Fees and Charges (subject to audit)

	2018-19 Departmental Group		
	Fees and Charges Income £'000	Full Cost of Service £'000	Surplus / (Deficit) £'000
Dental	856,384	2,788,494	(1,932,110)
Prescription	591,960	10,157,393	(9,565,433)
Other Fees and Charges for which the cost of providing the service is over £1million	371,960	344,270	27,690
Total	**1,820,304**	**13,290,157**	**(11,469,853)**

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

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

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2018-19, the NHS prescription charge for each medicine or appliance dispensed was £8.80. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £29.10 for three months or £104.00 for a year.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into three bands depending on the level and complexity of care provided. In 2018-19, the charge for Band 1 treatments was £21.60, for Band 2 was £59.10 and for Band 3 was £256.50.

Included in the 'Other fees and charges' (for which the cost of providing the service is over £1.0 million) is £204.3 million (2017-18: £193.7 million) of fees and charges and £208.7 million (2017-18: £197.0 million) of expenditure relating to regulatory income at the Care Quality Commission. The remaining balance relates to services provided by other NDPBs and other ALBs. Further information relating to fees and charges can be obtained from the financial statements of underlying bodies.

Remote Contingent Liabilities (subject to audit)

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

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

Quantifiable

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

	1 April 2018		Increase in year	Liabilities crystallised in year	Obligation expired in year	31 March 2019		Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	£'000	No.	£'000
Guarantees	156	1	-	-	-	156	1	-
Indemnities	5,929	4	-	(70)	(4,459)	1,400	1	-
Letters of comfort	-	-	-	-	-	-	-	-
Total	**6,085**	**5**	**-**	**(70)**	**(4,459)**	**1,556**	**2**	**-**

Unquantifiable

The Department of Health and Social Care has entered into a number of unquantifiable or unlimited contingent liabilities with various health bodies and private companies. Where the Department has chosen to indemnify another organisation within the Departmental Group, entering into these arrangements does not increase the overall exposure of the Group to potential liabilities.

There were 17 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.

Of the 17, 8 are considered to be confidential and 1 is immaterial, details of the remaining 8 can be found below:

1. The Department has an exemption certificate in place with the Medicines and Healthcare products Regulatory Agency (MHRA) regarding the National Institute of Biological Standards and Control (NIBSC). This relates to any liability to its employees as defined in section (1) of the Employers' Liability (Compulsory Insurance) Act 1969. The Department would indemnify the Board in the event of any legal act incurring liability for damages, providing the action arose from the proper discharge of its statutory duties.

2. The Department has agreed to indemnify MHRA should the organisation be unable to cover the costs of legal cases.

3. The Department is bearing an insurable risk for professional indemnity or malpractice on behalf of the Human Fertilisation and Embryology Authority (HFEA).

4. The Department has undertaken to indemnify members of its expert advisory committees:
- Advisory Committee on Dangerous Pathogens (ACDP) (and their associated Working Groups);
- New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG);
- Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI);
- The Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO)

5. The Department has undertaken to indemnify members of the following committees:

- Committee for Carcinogenicity;
- Committee for Mutagenesis;
- Committee for Medical Effects of Radiation;
- Committee for Medical Aspects of Air Pollution;
- Administration of Radioactive Substances Advisory Committee

The Department would pay the legal costs and damages of any member who was personally subjected to any action arising out of the business activities of these committees and associated sub-committees.

6. The Department holds an insurable risk for professional indemnity or malpractice on behalf of the Human Tissue Authority (HTA).

7. A letter of comfort has been issued to the Care Quality Commission (CQC) in respect of potential future pension liabilities that may arise in respect of early cessation costs or inherited deficits.

8. The Chancellor has announced that the Government will guarantee funding for UK recipients only of certain EU projects receiving funding after the United Kingdom has left the European Union in a No Deal scenario. The Department is responsible for a European Union funded programme, the Third EU Health Programme.

These liabilities are unquantifiable due to their underlying nature and uncertainty around future events that may lead to the remote obligation crystallising.

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

5 July 2019
Sir Chris Wormald KCB
Permanent Secretary
Department of Health and Social Care

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

Opinion on financial statements

I certify that I have audited the financial statements of the Department of Health and Social Care and of its Departmental Group for the year ended 31 March 2019 under the Government Resources and Accounts Act 2000. The Department comprises the core Department and its agency. The Departmental Group consists of the Department and the bodies designated for inclusion under the Government Resources and Accounts Act 2000 (Estimates and Accounts) (Amendment) Order 2018. The financial statements comprise: the Department's and Departmental Group's Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them.

I have also audited the Statement of Parliamentary Supply and the related notes, and the information in the Accountability Report that is described in that report as having been audited.

In my opinion:

- the financial statements give a true and fair view of the state of the Department's and the Departmental Group's affairs as at 31 March 2019 and of the Department's total net expenditure and Departmental Group's total net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions issued thereunder.

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

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

Opinion on regularity

In my opinion, in all material respects:

- the Statement of Parliamentary Supply properly presents the outturn against voted Parliamentary control totals for the year ended 31 March 2019 and shows that those totals have not been exceeded; and
- the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent of the Department of Health and Social Care in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

I am required to conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Department of Health and Social Care's ability to continue as a going concern for a period of at least twelve months from the date of approval of the financial statements. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern. I have nothing to report in these respects.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Principal Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Government Resources and Accounts Act 2000.

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for

one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the group's and the Department of Health and Social Care's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the group financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

I am required to obtain evidence sufficient to give reasonable assurance that the Statement of Parliamentary Supply properly presents the outturn against voted Parliamentary control totals and that those totals have not been exceeded. The voted Parliamentary control totals are Departmental Expenditure Limits (Resource and Capital), Annually Managed Expenditure (Resource and Capital), Non-Budget (Resource) and Net Cash Requirement. I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Other Information

The Accounting Officer is responsible for the other information. The other information comprises information included in the annual report, but does not include the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000;
- in the light of the knowledge and understanding of the group and the parent and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report or the Accountability Report; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.

Gareth Davies **10 July 2019**
Comptroller and Auditor General

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

Financial Statements

Consolidated Statement of Comprehensive Net Expenditure

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

For the period ended 31 March 2019

		2018-19		Represented[2] 2017-18	
	Notes	Core Dept & Agencies £'000	Departmental Group £'000	Core Dept & Agencies £'000	Departmental Group £'000
Income from contracts	5	(864,599)	(9,331,532)	(735,741)	(7,575,383)
Other non-contract operating income	5	(710,748)	(1,537,123)	(805,275)	(2,408,008)
Income received by NHS charities	19	-	(147,366)	-	(151,638)
Total operating income		**(1,575,347)**	**(11,016,021)**	**(1,541,016)**	**(10,135,029)**
Staff costs	3	424,272	58,089,888	404,965	55,201,860
Purchase of goods and services	4	1,702,378	63,401,613	880,101	61,720,027
Depreciation, amortisation and impairment charges	4	238,548	3,971,461	234,850	3,469,590
Provision expense	4	397,368	8,945,051	1,533,753	15,436,029
Other operating expenditure	4	5,883,014	8,753,764	5,707,323	8,064,046
Grant in Aid to NDPBs		116,755,131	-	112,888,699	-
Funding to Group bodies		506,892	-	749,321	-
Resources expended by NHS charities	19	-	162,813	-	304,692
Total operating expenditure		**125,907,603**	**143,324,590**	**122,399,012**	**144,196,244**
Net operating expenditure for the year ended 31 March 2019		**124,332,256**	**132,308,569**	**120,857,996**	**134,061,215**
Finance income		(300,850)	(68,807)	(227,652)	(39,210)
Finance expense		(55,152)	1,348,182	(37,964)	1,477,539
Net loss on transfers by absorption		23,767	6,204	-	7,521
Total Net Expenditure for the year ended 31 March 2019		**124,000,021**	**133,594,148**	**120,592,380**	**135,507,065**
Other Comprehensive Net Expenditure					
Items that will not be reclassified to net operating costs:					
Net (gain)/loss on:					
- revaluation of property, plant and equipment		(12,777)	(842,579)	(73,261)	(2,200,182)
- revaluation of intangibles		(1,495)	(4,103)	(6,209)	(6,358)
- revaluation of investments		-	-	(782,054)	(47)
- revaluation of charitable assets		-	(10,470)	-	(7,184)
- impairments and reversals taken to revaluation reserve		11,500	852,157	3,143	516,480
- equity instruments measured at fair value through OCI		71,000	(4,182)	-	-
Actuarial losses / (gains) on defined benefit pension schemes		-	6,588	-	(13,350)
Other pensions remeasurements		-	(5,006)	-	(592)
Other (gains) and losses		-	(27,518)	-	852
Total Comprehensive Expenditure for the year ended 31 March 2019		**124,068,249**	**133,559,035**	**119,733,999**	**133,796,684**

1. In all material respects, the income and expenditure disclosed in the Consolidated Statement of Comprehensive Net Expenditure relates to activities that are continuing.
2. The format of the Statement of Comprehensive Net Expenditure has been revised following the application of IFRS 15 *Revenue from Contracts with Customers*. Income is now split between income arising from contracts and other non-contract operating income. Prior year balances are not restated, in accordance with the initial first year application requirement to recognise any effect of the change from 1 April 2018.
3. Core Department - recovery of costs treated as income in 2017-18, have now been reflected as credits to expenditure in 2018-19 following a review of income as part of the IFRS 15 implementation. Prior year figures have not been recategorised on materiality grounds. Whilst there is no impact on 'Total Net Expenditure for the year' the current and prior year income and expenditure figures are not fully comparable as a result.
4. Per the FReM 6.2 PDC dividend income should be presented as a form of finance income. However, dividend income has been included under operating income, so it can be separately identified as shown in note 5 income.

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 2019

		2018-19		2017-18	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Non-current assets					
Property plant and equipment	6	1,091,925	53,040,791	1,237,947	52,371,283
Investment Property		93,582	249,057	16,870	224,491
Intangible assets	7	255,989	1,689,156	236,431	1,442,861
Charitable non-current assets	19.2	-	11,052	-	79,944
Financial assets- Investments	11	40,145,741	678,673	38,069,358	750,366
Charitable investments	19.3	-	321,692	-	398,585
Other non-current assets	14	210,870	771,179	223,932	895,752
Total non-current assets		**41,798,107**	**56,761,600**	**39,784,538**	**56,163,282**
Current assets					
Assets classified as held for sale		-	35,696	2,899	75,184
Inventories	12	209,860	1,496,452	161,348	1,321,990
Trade and other receivables	14	399,910	3,183,395	158,736	1,879,730
Other current assets	14	79,820	1,447,244	286,760	2,012,382
Charitable other current assets	19.2	-	23,215	-	31,025
Other financial assets	14	3,665,937	28,269	1,784,501	22,210
Cash and cash equivalents	13	1,933,440	8,682,028	1,709,068	7,562,137
Charitable cash	19.2	-	218,242	-	230,219
Total current assets		**6,288,967**	**15,114,541**	**4,103,312**	**13,134,877**
Total assets		**48,087,074**	**71,876,141**	**43,887,850**	**69,298,159**
Current liabilities					
Trade and other payables	15	(126,090)	(6,422,184)	(142,063)	(5,507,774)
Other liabilities	15	(3,529,142)	(14,050,394)	(3,381,420)	(13,173,813)
Charitable liabilities	19.2	-	(35,271)	-	(43,740)
Provisions	16	(507,091)	(3,586,672)	(408,335)	(3,670,948)
Total current liabilities		**(4,162,323)**	**(24,094,521)**	**(3,931,818)**	**(22,396,275)**
Non-current assets plus/less net current assets/liabilities		**43,924,751**	**47,781,620**	**39,956,032**	**46,901,884**
Non-current liabilities					
Other payables	15	(156,343)	(755,913)	(19,296)	(431,678)
Charitable liabilities	19.2	-	(68)	-	(6,858)
Provisions	16	(2,359,957)	(83,853,147)	(2,887,680)	(77,858,429)
Net pension liability	16.1	-	(128,661)	-	(114,834)
Financial liabilities	15	-	(11,080,519)	-	(11,401,073)
Total non-current liabilities		**(2,516,300)**	**(95,818,308)**	**(2,906,976)**	**(89,812,872)**
Total assets less liabilities		**41,408,451**	**(48,036,688)**	**37,049,056**	**(42,910,988)**
Taxpayers' equity and other reserves					
General fund		39,690,033	(61,127,673)	35,248,195	(56,375,479)
Revaluation reserve		764,848	12,314,826	1,800,861	12,619,978
Other Reserves[2]		953,570	237,297	-	155,338
Total Taxpayers' Equity		**41,408,451**	**(48,575,550)**	**37,049,056**	**(43,600,163)**
Charitable funds	19.2	-	538,862	-	689,175
Total Reserves		**41,408,451**	**(48,036,688)**	**37,049,056**	**(42,910,988)**

1. The Departmental Group started reporting a net liabilities position in 2015-16 due to a change in the discount rate prescribed by HMT for long term (>10 years) general provisions. More information is given at Note 1 *Statement of Accounting Policies*. This net liabilities position has increased in 2018-19 mostly due to additional provisions raised in the year.
2. Other Reserves in the Core Department relate to fair value gains on equity instruments designated as fair value through other comprehensive income under IFRS 9 *Financial Instruments*.

Sir Chris Wormald KCB
Permanent Secretary 5 July 2019

Consolidated Statement of Cash Flows

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

For the period ended 31 March 2019

		2018-19		2017-18	
	Notes	Core Dept & Agencies £'000	Departmental Group £'000	Core Dept & Agencies £'000	Departmental Group £'000
Net cashflow from operating activities					
Net operating cost including financing activities	CSCNE	(123,976,254)	(133,587,944)	(120,592,380)	(135,499,544)
Adjustments for non-cash transactions	4.2	791,347	12,832,322	1,731,231	19,094,081
Non-cash movements arising from absorption transfers/FT authorisations		1,717	-	-	(11,465)
Non-cash movements arising from application of accounting standards		-	(14,142)	-	-
Adjustments for charities		-	140,210	-	243,933
Other non-cash movements in Statement of Financial Position items		-	(53,476)	-	6,296
(Increase)/decrease in trade and other receivables	14	(1,902,608)	(620,013)	(1,049,082)	(315,940)
less movements in receivables relating to items not passing through the CSCNE	14	1,873,279	(6,930)	943,910	186,492
(Increase)/decrease in inventories	12	(48,512)	(174,462)	(16,505)	(79,513)
less transfers to inventories from non-current assets	12	2,791	2,791	146	146
Increase/(decrease) in trade and other payables	15	268,796	1,794,672	465,014	1,268,574
less movements in payables relating to items not passing through the CSCNE	15	(146,939)	45,023	(114,823)	(227,367)
Use of provisions	16	(241,643)	(2,814,434)	(493,999)	(2,955,692)
Transfer of provisions to payables	16	(528,684)	(556,768)	(620,040)	(651,906)
Cash payments in respect of pensions	16.1	-	(14,440)	-	(13,925)
Other operating cashflows		6,259	(24,133)	796	10,374
Net cash outflow from operating activities		**(123,900,451)**	**(123,051,724)**	**(119,745,732)**	**(118,945,456)**
Cash flows from investing activities					
Purchase of property, plant and equipment & investment properties	6, 15	(220,609)	(4,057,058)	(116,790)	(3,577,991)
Purchase of intangible assets	7, 15	(106,519)	(591,751)	(112,021)	(453,254)
Proceeds of disposal of property, plant and equipment		11,905	337,006	7,295	302,143
Proceeds of disposal of intangibles		106	2,795	470	5,225
Proceeds of disposal of assets held for sale		16,443	124,021	9,435	191,820
Purchase of investments	11	(4,661,875)	(24,160)	(4,200,428)	(16,409)
Proceeds of disposal of investments	11, 14	640,214	128,023	573,269	30,105
Other investing cashflows		(69,968)	83,858	-	197,434
Net cash outflow from investing activities		**(4,390,303)**	**(3,997,266)**	**(3,838,770)**	**(3,320,927)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year		106,600,000	106,600,000	102,100,000	102,100,000
Financing from the National Insurance Fund		21,926,343	21,926,343	21,338,869	21,338,869
Movement in loans received from DHSC and Other Bodies		20,220	101,137	-	24,476
Capital element of payments in respect of finance leases and on-SOFP PFI/LIFT contracts		-	(394,683)	(3,028)	(416,529)
Other financing cashflows		(14,084)	(71,612)	(19,344)	(24,827)
Net cash inflow from financing activities		**128,532,479**	**128,161,185**	**123,416,497**	**123,021,989**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**241,725**	**1,112,195**	**(168,005)**	**755,606**
Payment of amounts due to the Consolidated Fund		(17,353)	(17,353)	(1)	(1)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**224,372**	**1,094,842**	**(168,006)**	**755,605**
Cash and cash equivalents at the beginning of the period	13	1,709,068	7,780,412	1,877,074	7,024,807
Cash and cash equivalents at the end of the period	13, 15, 19.2	**1,933,440**	**8,875,254**	**1,709,068**	**7,780,412**

1. The 'Other' lines within the Consolidated Statement of Cash Flows include cash flow items recorded by underlying NHS bodies which are not separately identified within the Departmental Annual Report and Accounts format. This line also includes an adjustment for a deferred tax liability to ensure the internal consistency of the Departmental Consolidated Statement of Cash Flows.
2. Due to the immateriality of interest paid and received and dividends received, these are not separately disclosed on the face of the cash flow. Interest payable of £981 million (2017-18: £964 million), interest receivable of £75 million (2017-18: £45 million) and dividend income of £13 million (2017-18: £32 million) have been included in net operating cost.
3. Some individual lines of the cash flow are not directly comparable with the prior year as loan interest has moved between receivables and investments as part of the move to valuing DHSC loans via amortised cost using the effective interest method as part of the transition to IFRS 9. See Note 1.23 and Note 11 for further detail.

Consolidated Statement of Changes in Taxpayers' Equity

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

For the period ended 31 March 2019

		Core Dept & Agencies				Departmental Group					
	Note	General Fund £'000	Revaluation Reserve £'000	Other Reserves[6] £'000	Taxpayers' Equity £'000	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Taxpayers' Equity £'000	Charitable Funds £'000	Total Reserves £'000
Balance at 31 March 2018		35,248,195	1,800,861	-	37,049,056	(56,375,479)	12,619,978	155,338	(43,600,163)	689,175	(42,910,988)
Changes in accounting policy		-	-	-	-	-	-	-	-	-	-
Restated Balance at 1 April 2018		35,248,195	1,800,861	-	37,049,056	(56,375,479)	12,619,978	155,338	(43,600,163)	689,175	(42,910,988)
Prior period adjustments in local accounts		-	-	-	-	18,780	(79,075)	-	(60,295)	(144)	(60,439)
Adjustment due to application of IFRS 9[6]		-	(1,024,570)	1,024,570	-	(11,442)	(86,070)	86,070	(11,442)	-	(11,442)
Adjustment due to application of IFRS 15		-	-	-	-	(2,369)	-	-	(2,369)	-	(2,369)
Net parliamentary funding - drawn down		106,600,000			106,600,000	106,600,000			106,600,000		106,600,000
Net parliamentary funding - deemed		2,176,668			2,176,668	2,176,668			2,176,668		2,176,668
National Insurance contributions		21,926,343			21,926,343	21,926,343			21,926,343		21,926,343
Supply payable adjustment	15	(2,209,086)			(2,209,086)	(2,209,086)			(2,209,086)		(2,209,086)
CFERs and other amounts payable to the Consolidated Fund	15	(3,858)			(3,858)	(3,858)			(3,858)		(3,858)
PDC investment adjustment		(63,104)			(63,104)	-			-		-
Comprehensive Net Expenditure for the Year		(124,000,021)			(124,000,021)	(133,432,882)			(133,432,882)	(161,266)	(133,594,148)
Non-cash adjustments:											
non-cash charges - auditor's remuneration	4.1	802			802	897			897		897
Movements in Reserves											
Recognised in Statement of Comprehensive Expenditure											
Net gain on revaluation of non-current assets			14,272	-	14,272		846,682	-	846,682	-	846,682
Net gain on revaluation of charitable assets					-				-	10,470	10,470
Fair value losses on equity instruments designated at FV through OCI				(71,000)	(71,000)			4,182	4,182		4,182
Impairments and reversals			(11,500)		(11,500)		(852,157)		(852,157)	-	(852,157)
Net Actuarial Loss on Defined Benefit Pension Scheme		-		-	-	(5,717)		(871)	(6,588)		(6,588)
Other pensions remeasurements		-		-	-	8,828		(3,822)	5,006		5,006
Other gains and losses		-		-	-	27,298		220	27,518		27,518
Transfers between reserves		14,213	(14,213)	-	-	161,617	(152,887)	(8,730)	-	-	-
Other movements		(119)	(2)	-	(121)	(1,053)	18,637	(1,590)	15,994	627	16,621
Other transfers		-	-	-	-	(6,218)	(282)	6,500	-	-	-
Balance at 31 March 2019		**39,690,033**	**764,848**	**953,570**	**41,408,451**	**(61,127,673)**	**12,314,826**	**237,297**	**(48,575,550)**	**538,862**	**(48,036,688)**

1. The 'Comprehensive net expenditure for the year' figures for the General Fund and Charitable Fund exclude the elimination of intercompany trading between NHS Charities and NHS Providers. This ensures the closing Charitable Fund balance reflects the actual reserves held by the NHS Charities sector. There is no overall impact on the total closing reserve balance of the Departmental Group.
2. The General Fund is used in public sector accounting to reflect the total assets less liabilities of an entity, which are not assigned to another special purpose fund.
3. The Revaluation Reserve is a capital reserve used when an asset has been revalued but for which no cash benefit is received. Revaluations are completed periodically to reflect the fair value of an asset owned by an organisation.
4.Other Reserves are used by NHS bodies to account for a difference between the value of non-current assets, taken over by them at establishment, and the corresponding figure in the opening capital debt. This could arise where opening capital debt is set on estimated values or where there has been an error. Additionally, this may arise to reflect pension assets/liabilities in respect of staff in non-NHS defined benefit pension schemes.
5. Charitable Funds are the reserves associated with NHS Charities consolidated into the Departmental Annual Report and Accounts. They include both restricted, £204.0 million and unrestricted, £334.9 million funds.
6. The transfer in the Core Department represents the creation of an OCI reserve for equity instruments designated at fair value through OCI on transition to IFRS 9 *Financial Instruments.*

For the period ended 31 March 2018

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

Notes to the Department's Annual Report and Accounts

1. Statement of accounting policies

The financial statements have been prepared in accordance with the 2018-19 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 circumstances of the Department of Health and Social Care (DHSC) for the purpose of giving a true and fair view has been selected. The policies adopted by the Department of Health and Social Care are described below. The policies have been applied consistently in dealing with items considered material to the accounts.[182]

As in previous years the 2018-19 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. Therefore, the Department of Health and Social Care's Annual Report and Accounts are produced on a going concern basis.

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.

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

1.3 Basis of consolidation

The accounts comprise of a consolidation for the core Department of Health and Social Care (formerly Department of Health), its Departmental agency and other bodies that fall within the Departmental boundary as defined by the FReM and make up the 'Departmental Group'. Those other bodies include Arm's Length Bodies, NHS Trusts, NHS Foundation Trusts, Clinical Commissioning Groups, NHS Charities and certain Limited Companies. The Departmental Group 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 Employee Benefits

Recognition of short-term benefits

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

Retirement benefit costs:

Civil Service Pensions

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

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

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

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

NHS Pensions

Past and present employees of the NHS are covered by the provisions of the NHS Pension Schemes.[183]

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

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

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.

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.

1.5 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.

1.6 Audit costs

A charge reflecting the cost of audit is included in expenditure. The Department of Health and Social Care is audited by the Comptroller and Auditor General. No cash charge is made for this service but a notional charge representing the cost of the audit is included in the accounts. This charge covers the audit costs in respect of the Department's Annual Report and Accounts. With the exception of NHS Foundation Trusts, certain Limited Companies and NHS Charities, other consolidated bodies are audited by the Comptroller and Auditor General or appoint an auditor under local audit arrangements as is the case for NHS Trusts and Clinical Commissioning Groups. Expenditure in respect of audit fees is included in their individual accounts. The accounts of NHS Foundation Trusts are audited by auditors appointed by their board of governors and also include expenditure in respect of audit fees.

1.7 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.

1.8 Revenue

IFRS 15 *Revenue from Contracts with Customers* is applied to annual reporting periods beginning on or after 1 January 2018.

The transition to IFRS 15 has been completed in accordance with the provisions of the Standard. IFRS 15 has been applied retrospectively with recognition of the cumulative effect of differences between closing balances from the 2017-18 financial year and opening balances in 2018-19, the initial year of IFRS 15 application, being recognised in the opening balance of the general fund. In making the transition to IFRS 15, the Standard has been applied retrospectively only to contracts not completed as at 1 April 2018. The Department is required to disclose detail regarding the impacts of applying IFRS 15, which has been provided in note 5.2

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Where consideration is received

for performance obligations to be satisfied in the following year, revenue is deferred with a contract liability being recognised.

A signficant source of revenue from services provided by the Department relates to the delivery of healthcare. Where NHS providers contract with commissioners to deliver spells of healthcare, these sums are eliminated for the purpose of delivering a DHSC Group position. The amounts of revenue generated and eliminated within the DHSC Group is indicated by note 2.1. The Department has judged the delivery of health care to predominantly involve the satisfaction of performance obligations over a period of time under IFRS 15. Subsequently revenue is recognised on the basis of measuring the progress made towards the complete satisfaction of the delivery of the spell of healthcare being administered at a local level. Where revenue includes amounts subject to uncertainty, estimates are constrained to levels that would not entail a significant reversal of revenue being recognised per the requirements of the Standard. Revenue from the sale of distinct tangible goods such as non-current assets is recognised only when performance obligations under the contract are met, and is measured as the sums due under the sale contract. Further detail regarding the specific judgements made by individual entities in relation to their material revenue streams can be found in their underlying account.

There are sources of income that the Department receives which are outside the scope of IFRS 15 as adapted and interpreted by the FReM. Where this is the case the Department recognises the income when it can be measured reliably and it is probable that economic benefit associated with the transaction will flow to the Department in line with the IFRS Conceptual Framework.

Income is Voted on through 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.[184]

The value of the benefit received when the Department accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

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

1.9 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

[184] Further detail regarding the Estimate process can be found in the 2018/19 Main Supply Estimate. Page 9, paragraph 22, provides further detail the surrendering of income outside the ambit.

- 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.

1.10 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.

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

1.11 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.

1.12 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.

1.13 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.

1.14 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.

1.15 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 Consolidated Statement of Comprehensive Net Expenditure (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.

1.16 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.

1.17 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.

1.18 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.

1.19 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 0.29% (2017-18: positive 0.10%) in real terms. From 2018-19 onwards general provisions are subject to four separate nominal discount rates as prescribed by HM Treasury, according to the expected timing of cashflows. A nominal short-term rate of positive 0.76% (2017-18 a real rate of negative 2.42%) 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 nominal medium term rate of positive 1.14% (2017-18 a real rate of negative 1.85%) is applied to the time boundary of after 5 and up to and including 10 years. A nominal long-term rate of positive 1.99% (2017-18 a real rate of negative 1.56%) is applied to the time boundary of after 10 and up to and including 40 years from the Consolidated Statement of Financial Position date. A nominal very long term rate of positive 1.99% (2017-18 a real rate of negative 1.56%) is applied to expected cashflows exceeding 40 years from the Consolidated Statement of Financial Position date.

In using nominal rates there is a need to inflate cashflows as such rates do not take a measure of inflation into account unlike real discount rates. HM Treasury have provided the Office of Budget Responsibility (OBR) Consumer Price Index (CPI) forecasted inflation rates to be employed to expected cash flows, except where the Department has judged there is a reasoned basis for alternative rates to be employed. Where such a basis does not exist; an OBR CPI inflation rate of 2.00% is applied to all relevant expected cashflows up to and including 1 year from the date of the Consolidated Statement of Financial Position. An OBR CPI inflation rate of 2.00% is applied to all relevant expected cashflows in a time boundary of after 1 and up to and including 2 years from the Consolidated Statement of Financial Position date. An OBR CPI inflation rate of 2.10% is applied to all relevant cashflows exceeding 2 years from the Consolidated Statement of Financial Position date.

1.20 Clinical and non-clinical negligence costs

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

Calculation of the provision for each scheme is made using:

- probability factors. The probability of a claim having to be settled is assessed between 10% and 94%. This probability is applied to the gross value to give the probable cost of each claim; and
- a discount factor calculated using HM Treasury’s nominal discount rates noted in Note 1.20 above (i.e. short-term positive 0.76%, medium term positive 1.14% , long term negative 1.99% and very long term positive 1.99%), RPI of 3.6% and claims inflation (varying between schemes) of between 4% 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 DHSC clinical and non-clinical liabilities schemes

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

Clinical Negligence Scheme for Trusts (CNST)

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

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

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

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

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

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

Incidents Incurred but Not Reported (IBNR)

IAS 37 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to NHSR as at 31 March 2019 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.

1.21 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. Remote contingent liabilities are disclosed elsewhere in the annual report and accounts as part of the Department's Parliamentary Accountability Disclosures.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Department. A contingent asset is disclosed where an inflow of economic benefits is probable.

1.22 Financial instruments

IFRS 9 *Financial Instruments* are applied to annual reporting periods on or after 1 January 2018. The transition to IFRS 9 has been completed in accordance with the transitional provisions of the Standard requiring any difference between the closing balances from the 2017-18 financial year and opening balances in 2018-19 to be recognised in the opening balance of the general

fund. The Department is required to disclose detail regarding the impacts of applying IFRS 9, which has been provided in note 10.2

There are specific financial transactions the Department engages in that sit outside the scope of IFRS 9 and IAS 32 Financial Instruments: Presentation.

The Department of Health and Social Care mainly relies on Parliamentary voted funding and receipt of a proportion of National Insurance Contributions to finance its operations. Such transactions are accounted for as funding rather than generating a financial instrument.

The Department's investment in NHS Providers and the Medicines & Healthcare products Regulatory Agency is represented by Public Dividend Capital (PDC) which, being issued under statutory authority, is not classed as being a financial instrument.

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

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

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

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

The Department holds investments in private limited companies and other items such as receivables and payables that arise from its operations and cash resources that do give rise to financial instruments under IFRS 9.

1.23 Financial assets

Financial assets are recognised on the Consolidated Statement of Financial Position when the Department becomes party to the financial instrument contract and the right to receive or pay cash is unconditional 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.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.23.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.23.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Per the provisions of IFRS 9, the Department has elected to irrevocably designate its equity instruments to be measured at fair value through other comprehensive income. The Department's equity instruments relates to its investment in private limited companies as detailed in note 11. The election ensures that an accounting treatment consistent with prior financial years is maintained under transition to IFRS 9.

1.23.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

The Department does not enter into speculative transactions such as interest rate swaps.

1.23.4 Impairments of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated per the irrevocable election), lease receivables and contract assets, the Department recognises a loss allowance representing expected credit losses on the financial instruments.

The Department adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Department therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS

bodies (excluding NHS charities), and therefore does not expect the recognition of loss allowances for stage 1 or stage 2 impairments against such bodies to arise.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in the Consolidated Statement of Comprehensive Net Expenditure as an impairment gain or loss.

Note 10 provides further detail regarding the Departments limited exposure to different categories of risks in relation to its financial instruments.

1.24 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.

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. In the case of loans from DHSC to NHS bodies, that would be the nominal rate charged on the loan. Such loans are a financial liability measured at amortised cost for NHS bodies, corresponding to the financial asset recognised at amortised cost by the core Department. Further detail is provided in note 11.

1.25 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.

1.26 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.

1.27 Transfer of Functions

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

1.28 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 2018-19. The FReM has deferred the Department's adoption of IFRS 16 Leases, until 2020-21. The Department continues to liaise closely with HM Treasury to discuss and further refine the impacts of implementing new accounting standards.

- IFRS 16 Leases – Application has been deferred for accounting periods beginning on or after 1 January 2019, as the Standard is yet to be adopted by the FReM.
- The Departmental Group contains limited companies who report under EU adopted IFRS following the Companies Act 2006. As the Standard is EU adopted those entities will implement IFRS 16 in the 2019-20 financial year. HM Treasury have published criteria for departments to early adopt IFRS 16, for departments whose accounting boundary contains entities who are required to adopt IFRS 16 following the Companies Act 2006. DHSC do not meet this criteria and will not be early adopting IFRS 16 for the consolidated Annual Report and Accounts in 2019-20.
- Entities are assessing the extent to which arrangements, other than those currently identified as containing a lease per the necessary judgements made under IAS 17 and IFRIC 4, may be identified as a right of use asset under the revised recognition criteria developed under IFRS 16. The finalisation of the HM Treasury public sector interpretations and adaptations for IFRS 16 will enable entities to conclude such assessments.
- As the Department engages in a number of sub leasing arrangements, it is expected that the finance lease receivable will increase under IFRS 16. On application of IFRS 16 entities are required to reasses subleasing arrangements on the basis of the right of use asset generated by the head lease than with regard to the underlying asset of the arrangement. However as the sub leasing arrangements are predominantly internal to the Group, this impact will eliminate on consolidation.
- The Department currently has commitments under operating leases of over £3.1 billion, which IFRS 16 requires to be recognised on the Statement of Financial Position as right of use assets with corresponding lease liabilities on transition to the Standard as currently interpreted by the FReM.

1.29 Critical accounting judgements and key sources of estimation uncertainty

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

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

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

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

- IAS 36 Impairments - Management make judgement on whether there are any indications of impairments to the carrying amounts of the Department's assets.

2. Statement of Operating Costs by Operating Segment

The reportable segments disclosed within this note reflect the current structure of the Departmental Group as defined in legislation, with the activities of each reportable segment thus reflecting the statutory remit of those bodies. These operating segments are reported to the Department of Health and Social Care Departmental Board (Chief Operating Decision Maker) for financial management purposes. They cover the Core Department of Health and Social Care, 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, Skipton Fund Ltd and Supply Chain Coordination 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

2018-19		DHSC Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Eliminations And Adjustments £000	Departmental Group £000
Gross expenditure (2.2)		125,522,688	4,252,052	11,396,110	86,751,702	114,963,893	5,405,291	1,470,499	308,632	(205,398,095)	144,672,772
Income (2.3)		(1,633,564)	(240,437)	(4,296,396)	(85,130,657)	(2,097,983)	(406,127)	(1,380,559)	(147,366)	84,248,261	(11,084,828)
Total net expenditure (per CSCNE)		**123,889,124**	**4,011,615**	**7,099,714**	**1,621,045**	**112,865,910**	**4,999,164**	**89,940**	**161,266**	**(121,149,834)**	**133,587,944**
Budgeting adjustments per SoPS2											
Capital Grants		(547,539)	(1,978)	-	-	(48,500)	-	-	-	64	(597,953)
Research and Development		(1,184,510)	-	-	-	-	-	-	-	-	(1,184,510)
Other		5,089	1,421	(22,346)	444,002	-	-	16,718	(157,665)	199,526	486,745
Total adjustments		**(1,726,960)**	**(557)**	**(22,346)**	**444,002**	**(48,500)**	**-**	**16,718**	**(157,665)**	**199,590**	**(1,295,718)**
Budget outturn per SoPS1, of which:		**122,162,164**	**4,011,058**	**7,077,368**	**2,065,047**	**112,817,410**	**4,999,164**	**106,658**	**3,601**	**(120,950,244)**	**132,292,226**
	RDEL	122,599,270	4,013,239	672,344	918,373	112,837,143	4,992,832	153,856	3,601	(120,912,397)	125,278,261
	RAME	(437,106)	(2,181)	6,405,024	1,146,674	(19,733)	6,332	(47,198)	-	(37,847)	7,013,965

2017-18		DHSC Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Eliminations And Adjustments £000	Departmental Group £000
Gross expenditure		122,176,127	4,150,281	16,404,909	82,371,399	110,941,269	5,697,704	1,485,953	428,625	(197,982,484)	145,673,783
Income		(1,530,736)	(246,624)	(3,908,234)	(80,809,995)	(2,178,882)	(383,770)	(1,342,103)	(151,638)	80,377,743	(10,174,239)
Total net expenditure (per CSCNE)		**120,645,391**	**3,903,657**	**12,496,675**	**1,561,404**	**108,762,387**	**5,313,934**	**143,850**	**276,987**	**(117,604,741)**	**135,499,544**
Budgeting adjustments per SoPS2											
Capital Grants		(533,242)	(866)	-	-	(54,917)	-	-	-	37	(588,988)
Research and Development		(1,132,586)	-	-	-	-	-	-	-	-	(1,132,586)
Other		(17,469)	-	-	315,454	-	-	(11,618)	(262,012)	-	24,355
Total adjustments		**(1,683,297)**	**(866)**	**-**	**315,454**	**(54,917)**	**-**	**(11,618)**	**(262,012)**	**37**	**(1,697,219)**
Budget outturn per SoPS1, of which:		**118,962,094**	**3,902,791**	**12,496,675**	**1,876,858**	**108,707,470**	**5,313,934**	**132,232**	**14,975**	**(117,604,704)**	**133,802,325**
	RDEL	118,538,318	3,898,168	506,157	1,215,258	108,689,686	5,328,175	63,981	14,975	(117,604,704)	120,650,014
	RAME	423,776	4,623	11,990,518	661,600	17,784	(14,241)	68,251	-	-	13,152,311

2.2 Departmental Group Detail – Expenditure

										2018-19
	DHSC Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Eliminations And Adjustments £000	Departmental Group £000
Material Expenditure Items										
Staff costs	119,431	304,841	211,705	54,688,814	1,949,260	588,163	240,613	-	(12,939)	58,089,888
Purchase of healthcare from non-NHS bodies	-	-	-	1,328,232	13,733,599	-	-	-	-	15,061,831
Provider Sustainability Fund Expenditure	-	-	-	-	2,450,000	-	-	-	(2,450,000)	-
Purchase of social care	-	-	-	183,333	647,354	-	-	-	-	830,687
Expenditure on Drugs Action Teams	-	-	-	-	629	-	-	-	-	629
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	2,919,876	-	-	-	(131,382)	2,788,494
Consultancy Services	19,829	-	392	226,950	64,142	2,431	28,307	-	-	342,051
Establishment	89,795	-	24,419	907,403	387,220	54,893	8,341	-	(91,164)	1,380,907
Transport (Business Travel)	4	9,046	5,674	224,264	61,325	18,091	6,317	-	(14,055)	310,666
Premises	5,882	31,138	13,923	2,726,630	82,340	35,226	264,962	-	(251,555)	2,908,546
PFI/Lift and other service concession arrangement charges	-	-	-	953,809	-	-	82,831	-	-	1,036,640
Business Rates Paid to Local Authorities	4,016	-	-	441,435	1,762	4,560	80,684	-	5,406	537,863
NHS Informatics Major Contracts Costs	63,966	-	-	-	-	99,441	-	-	(98)	163,309
Clinical negligence Costs	-	-	-	1,994,619	219	121	-	-	(1,994,705)	254
Education, Training and Conferences	1,961	3,117	1,673	269,610	92,258	8,365	2,611	-	(13,259)	366,336
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,370,835	-	-	(2,831,789)	1,539,046
Prescribing Costs	-	-	-	-	8,236,936	-	-	-	(9,736)	8,227,200
G/PMS, APMS and PCTMS	-	-	-	-	8,526,114	-	-	-	(33,473)	8,492,641
Pharmaceutical Services	-	-	-	-	1,935,054	-	-	-	(4,861)	1,930,193
General Ophthalmic Services	-	-	-	-	553,598	-	-	-	(312)	553,286
Supplies and Services - Clinical	-	-	-	13,722,363	412,684	111	10,186	-	(1,644,207)	12,501,137
Supplies and Services - General	-	641,664	2,122,145	1,433,529	896,927	100,773	156,143	-	(394,666)	4,956,515
Grants to Other Bodies	155,129	690	-	-	27,381	-	-	-	-	183,200
Grants to Local Authorities	59,220	3,011,064	-	-	-	-	-	-	-	3,070,284
Capital Grants	547,539	1,978	-	-	48,500	-	-	-	(64)	597,953
Movement in provision for impairment of receivables	-	-	-	-	-	-	-	-	-	-
Movement in expected credit loss allowance (non credit impaired)	56	(275)	5,175	99,362	7,660	1,041	57,006	-	(42,914)	127,111
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	647,232	-	-	-	-	(647,232)	-
Rentals under operating leases	20,660	8,273	4,680	715,736	349,633	17,816	128,023	-	(535,991)	708,830
Interest charges	856	-	-	1,109,294	48	-	165,139	-	(294,028)	981,309
Research and development	1,108,978	404	-	268,212	15,235	-	3,818	-	(760,820)	635,827
Depreciation on property, plant and equipment	21,901	35,468	9,766	2,010,926	127,107	12,795	222,640	-	470	2,441,073
Amortisation on intangible assets	168,250	3,842	22,268	217,953	4,419	34,177	631	-	-	451,540
Impairments and reversals	9,087	-	(2,045)	1,052,612	541	871	17,782	-	-	1,078,848
Provisions provided for in year	1,347,018	(773)	8,131,499	168,908	(2,595)	2,843	1,189	-	-	9,648,089
Non-cash expenditure from movement in pension liability	-	-	-	10,107	119	7,656	2,587	-	-	20,469
Grant in Aid	116,755,131	-	-	-	-	-	-	-	(116,755,131)	-
Funding to Group Bodies	4,431,902	-	-	-	-	-	-	-	(4,431,902)	-
Provisions - Change in discount rate	(948,877)	-	269,108	(6,743)	(275)	(131)	(36,589)	-	-	(723,507)
Other	712,113	(10,006)	132,570	1,032,781	35,545	39,243	54,752	-	259,336	2,256,334
Goods and Services from other NHS Bodies	-	-	18,175	81,758	71,213,864	-	5,218	-	(71,292,145)	26,870
Additional support for delivery of healthcare services	795,834	-	-	-	-	-	-	-	(783,710)	12,124
DHSC support for mergers	60,131	-	-	-	-	-	-	-	(60,131)	-
Resources expended by NHS charities	-	-	-	-	-	-	-	308,632	(145,819)	162,813
Non material expenditure categories	(27,124)	211,581	424,983	242,573	185,414	5,970	(32,692)	-	(35,219)	975,486
Total Gross Expenditure	**125,522,688**	**4,252,052**	**11,396,110**	**86,751,702**	**114,963,893**	**5,405,291**	**1,470,499**	**308,632**	**(205,398,095)**	**144,672,772**

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 Provider Sustainability Fund (PSF) is linked to the achievement of financial controls and performance trajectories. The funding has been included in the NHS England mandate and has been paid to NHS providers from NHS England.

										2017-18
	DHSC Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Eliminations And Adjustments £000	Departmental Group £000
Material Expenditure Items										
Staff costs	106,371	298,594	176,755	52,029,780	1,843,108	576,723	182,298	-	(11,769)	55,201,860
Purchase of healthcare from non-NHS bodies	-	-	-	1,106,065	13,096,155	-	-	-	-	14,202,220
Sustainability and Transformation Fund Expenditure	-	-	-	-	1,800,000	-	-	-	(1,800,000)	-
Purchase of social care	-	-	-	181,890	599,274	-	-	-	-	781,164
Expenditure on Drugs Action Teams	-	-	-	-	712	-	-	-	-	712
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	2,944,521	-	-	-	(132,952)	2,811,569
Consultancy Services	12,402	-	141	247,470	85,476	1,555	23,977	-	(51)	370,970
Establishment	59,275	-	19,635	879,495	366,933	50,192	8,640	-	(91,676)	1,292,494
Transport (Business Travel)	2	9,116	3,886	191,694	43,073	17,497	4,087	-	(12,862)	256,493
Premises	14,431	31,700	11,359	2,565,557	69,460	39,741	242,440	-	(228,168)	2,746,520
PFI/Lift and other service concession arrangement charges	-	-	-	919,873	-	-	79,470	-	-	999,343
Business Rates Paid to Local Authorities	9,860	-	-	422,887	782	4,742	39,676	-	180	478,127
NHS Informatics Major Contracts Costs	74,747	-	-	-	-	81,139	-	-	(2,543)	153,343
Clinical negligence Costs	-	-	-	1,945,373	189	139	-	-	(1,945,842)	(141)
Education, Training and Conferences	6,256	3,358	980	255,104	150,834	6,366	3,208	-	(15,753)	410,353
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,715,198	-	-	(2,941,896)	1,773,302
Prescribing Costs	-	-	-	-	8,560,895	-	-	-	(7,818)	8,553,077
G/PMS, APMS and PCTMS	-	-	-	-	8,274,354	-	-	-	(32,146)	8,242,208
Pharmaceutical Services	-	-	-	-	1,906,991	-	-	-	(4,398)	1,902,593
General Ophthalmic Services	-	-	-	-	556,015	-	-	-	(195)	555,820
Supplies and Services - Clinical	-	-	(2)	13,509,327	225,588	44	2,368	-	(1,624,408)	12,112,917
Supplies and Services - General	-	634,584	1,770,240	1,386,737	821,514	82,876	139,516	-	(272,846)	4,562,621
Grants to Other Bodies	164,774	-	-	-	26,038	-	-	-	(70,700)	120,112
Grants to Local Authorities	59,098	3,090,533	-	-	-	-	-	-	-	3,149,631
Capital Grants	533,242	866	-	-	54,917	-	-	-	(37)	588,988
Movement in provision for impairment of receivables	62	798	-	123,420	19,774	1,053	33,876	-	(1,656)	177,327
Movement in expected credit loss allowance (non credit impaired)	-	-	-	-	-	-	-	-	-	-
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	687,324	-	-	-	-	(687,324)	-
Rentals under operating leases	21,407	10,746	3,658	672,378	326,071	17,045	133,054	-	(533,608)	650,751
Interest charges	209	-	-	1,022,838	43	-	167,013	-	(225,951)	964,152
Research and development	1,118,264	592	-	197,335	11,856	-	2,417	-	(744,492)	585,972
Depreciation on property, plant and equipment	19,060	26,611	6,480	1,982,766	97,308	12,908	206,097	-	-	2,351,230
Amortisation on intangible assets	106,444	4,926	12,281	199,309	5,985	35,150	280	-	-	364,375
Impairments and reversals	37,330	40,479	(1,006)	606,107	23	121	70,931	-	-	753,985
Provisions provided for in year	1,327,427	2,329	(1,874,977)	117,264	49,853	(15,214)	(21,403)	-	-	(414,721)
Non-cash expenditure from movement in pension liability	-	-	-	8,876	144	8,362	-	-	-	17,382
Grant in Aid	112,888,699	-	-	-	-	-	-	-	(112,888,699)	-
Funding to Group Bodies	4,705,464	-	-	-	-	-	-	-	(4,705,464)	-
Provisions - Change in discount rate	203,997	-	15,599,270	6,084	(291)	(30)	24,338	-	-	15,833,368
Other	635,854	(9,251)	121,343	895,100	42,357	39,348	61,513	-	124,829	1,911,093
Goods and Services from other NHS Bodies	-	-	-	93,337	68,784,452	-	42,613	-	(68,884,133)	36,269
Additional support for delivery of healthcare services	-	-	-	-	-	-	-	-	-	-
DH support for mergers	83,942	-	-	-	-	-	-	-	(83,942)	-
Resources expended by NHS charities	-	-	-	-	-	-	-	428,625	(123,933)	304,692
Non material expenditure categories	(12,490)	4,300	554,866	118,009	176,865	22,749	39,544	-	(32,231)	871,612
Total Expenditure	**122,176,127**	**4,150,281**	**16,404,909**	**82,371,399**	**110,941,269**	**5,697,704**	**1,485,953**	**428,625**	**(197,982,484)**	**145,673,783**

2.3 Departmental Group Detail - Income

										2018-19
	DHSC Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Eliminations And Adjustments £000	Departmental Group £000
Material Income Items										
Contract Income										
Income from Local Authorities	-	-	-	(2,081,423)	-	-	(195)	-	-	(2,081,618)
Income from Private patients	-	-	-	(647,618)	-	-	-	-	-	(647,618)
Income from injury costs recovery	-	-	-	(209,012)	-	-	-	-	-	(209,012)
Income from DHSC/NHS bodies	-	-	-	(71,358,939)	-	-	(52,073)	-	71,270,385	(140,627)
Other non-NHS patient care services	-	-	-	(576,143)	-	-	(417)	-	-	(576,560)
Non patient care services to other bodies	(1,011)	-	(2,123,075)	(691,998)	(274,915)	(31,480)	(416,357)	-	2,326,249	(1,212,587)
Education, training and research	-	(2,406)	-	(3,741,051)	(13,624)	(134,372)	(773)	-	3,511,436	(380,790)
Provider Sustainability Fund Income	-	-	-	(2,450,000)	-	-	-	-	2,450,000	-
Support from DHSC for mergers	-	-	-	(60,131)	-	-	-	-	60,131	-
Prescription Pricing Regulation Scheme	(573,526)	-	-	-	-	-	-	-	-	(573,526)
Fees and Charges	-	(220,721)	(2,170,635)	(206,247)	(1,448,344)	(221,853)	(123,741)	-	2,494,814	(1,896,727)
Other Contract Income	(6,865)	-	-	(1,636,574)	(242,500)	(8,275)	(5,175)	-	645,352	(1,254,037)
Non-material contract income	(62,956)	-	(2,428)	(297,338)	(7,581)	(984)	(82)	-	12,939	(358,430)
Income from contracts	(644,358)	(223,127)	(4,296,138)	(83,956,474)	(1,986,964)	(396,964)	(598,813)	-	82,771,306	(9,331,532)
Non-Contract Income										
Rental revenue from operating leases	(10,826)	(8,858)	-	(88,558)	(232)	(502)	(659,501)	-	439,908	(328,569)
PDC Dividend Received	(647,232)	-	-	-	-	-	-	-	647,232	-
Charitable and other contributions to expenditure	-	-	-	(118,600)	(2,839)	-	-	-	67,199	(54,240)
Apprenticeship training grant (non-cash)	(85)	(452)	-	(21,631)	(349)	(228)	-	-	-	(22,745)
Other operating income (2017-18)	-	-	-	-	-	-	-	-	-	-
Other non-contract income	(18,723)	-	(258)	(47,008)	(107,599)	(6,507)	(92,611)	-	(114,030)	(386,736)
Non-material non-contract income	(11,490)	(8,000)	-	(848,805)	-	(1,911)	(17,245)	-	142,618	(744,833)
Other non-contract operating income	(688,356)	(17,310)	(258)	(1,124,602)	(111,019)	(9,148)	(769,357)	-	1,182,927	(1,537,123)
Income received by NHS charities	-	-	-	-	-	-	-	(147,366)	-	(147,366)
Finance income	(300,850)	-	-	(49,581)	-	(15)	(12,389)	-	294,028	(68,807)
Total income	**(1,633,564)**	**(240,437)**	**(4,296,396)**	**(85,130,657)**	**(2,097,983)**	**(406,127)**	**(1,380,559)**	**(147,366)**	**84,248,261**	**(11,084,828)**

1. The Provider Sustainability Fund (PSF) is linked to the achievement of financial controls and performance trajectories. The funding has been included in the NHS England mandate and has been paid to NHS Providers from NHS England.

	DHSC Core £000	Public Health England £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Eliminations And Adjustments £000	Departmental Group £000
										2017-18 (Represented)
Material Income Items										
Contract Income										
Income from Local Authorities	-	-	-	(2,114,236)	-	-	-	-	-	(2,114,236)
Income from Private patients	-	-	-	(614,367)	-	-	-	-	-	(614,367)
Income from injury costs recovery	-	-	-	(201,905)	-	-	-	-	-	(201,905)
Income from DHSC/NHS bodies	-	-	847	(68,299,282)	-	-	(45,228)	-	68,220,469	(123,194)
Other non-NHS patient care services	-	-	-	(555,487)	-	-	-	-	-	(555,487)
Non patient care services to other bodies	(39,852)	-	(1,748,254)	(745,849)	(326,041)	(37,057)	(4,722)	-	1,929,847	(971,928)
Education, training and research	-	(1,923)	(154)	(3,653,604)	(177,657)	(120,593)	-	-	3,596,823	(357,108)
Sustainability and Transformation Fund Income	-	-	-	(1,800,000)	-	-	-	-	1,800,000	-
Support from DHSC for mergers	-	-	-	(75,975)	-	-	-	-	75,975	-
Prescription Pricing Regulation Scheme	(409,723)	-	-	-	-	-	-	-	-	(409,723)
Fees and Charges	-	(224,916)	(2,159,502)	(205,882)	(1,383,296)	(215,290)	(103,681)	-	2,416,148	(1,876,419)
Other Contract Income	-	-	-	-	-	-	-	-	-	-
Non-material contract income	(62,717)	-	(1,137)	(291,588)	(6,875)	(468)	-	-	11,769	(351,016)
Income from contracts	(512,292)	(226,839)	(3,908,200)	(78,558,175)	(1,893,869)	(373,408)	(153,631)	-	78,051,031	(7,575,383)
Non-Contract Income									-	
Rental revenue from operating leases	(24,009)	-	-	(88,058)	(267)	(567)	(1,013,181)	-	675,746	(450,336)
PDC Dividend Received	(686,799)	-	-	-	-	-	-	-	686,799	-
Charitable and other contributions to expenditure	-	-	-	(105,839)	(2,695)	-	-	-	56,655	(51,879)
Apprenticeship training grant (non-cash)	-	(70)	-	(6,255)	(98)	(76)	-	-	-	(6,499)
Other operating income (2017-18)	(54,608)	-	(34)	(1,645,436)	(281,953)	(9,496)	(101,183)	-	615,394	(1,477,316)
Other non-contract income	-	-	-	(3,627)	-	-	-	-	-	(3,627)
Non-material non-contract income	(34,641)	(10,450)	-	(383,024)	-	(205)	(58,304)	-	68,273	(418,351)
Other non-contract operating income	(800,057)	(10,520)	(34)	(2,232,239)	(285,013)	(10,344)	(1,172,668)	-	2,102,867	(2,408,008)
Income received by NHS charities	-	-	-	-	-	-	-	(151,638)	-	(151,638)
Finance income	(218,387)	(9,265)	-	(19,581)	-	(18)	(15,804)	-	223,845	(39,210)
Total income	**(1,530,736)**	**(246,624)**	**(3,908,234)**	**(80,809,995)**	**(2,178,882)**	**(383,770)**	**(1,342,103)**	**(151,638)**	**80,377,743**	**(10,174,239)**

3. Staff costs

Staff costs for the Departmental Group comprise:

	2018-19 £'000 Total	2017-18 £'000 Total
Salaries and wages	48,464,563	46,009,959
Social Security costs	4,607,888	4,365,486
NHS Pension	5,219,067	4,979,998
Other pension costs	69,536	62,113
Termination benefits	46,204	55,574
Sub-total	**58,407,258**	**55,473,130**
Less recoveries in respect of outward secondments	(93,379)	(86,429)
Total Net Costs	**58,313,879**	**55,386,701**

1. A more detailed analysis of staff costs can be found in the Accountability Report.

Of which:			2018-19 £'000
	Charged to revenue budgets	Charged to capital	Total
Core Dept & Agencies	424,272	2,558	426,830
Other designated bodies	57,678,618	221,433	57,900,051
Less elimination of intra-group expenditure	(13,002)	-	(13,002)
Total	**58,089,888**	**223,991**	**58,313,879**

			2017-18 £'000
	Charged to revenue budgets	Charged to capital	Total
Core Dept & Agencies	404,965	2,259	407,224
Other designated bodies	54,808,694	182,582	54,991,276
Less elimination of intra-group expenditure	(11,799)	-	(11,799)
Total	**55,201,860**	**184,841**	**55,386,701**

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 2016, this is shown in the Cabinet Office: Civil Superannuation[185].

For 2018-19, employers' contributions of £13,811,900 were payable to the PCSPS (2017-18: £12,816,861) at one of four rates in the range 20.0% to 24.5% (2017-18: 20.0% to 24.5%) of pensionable earnings, based on salary bands. The Scheme Actuary reviews employer

[185] https://www.civilservicepensionscheme.org.uk/about-us/scheme-valuations/

contributions, usually every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2018-19, to be paid when the member retires and not the benefits paid during this period to existing pensioners.

From 1 April 2019, employers' contributions are payable at one of four rates in the range 26.6% to 30.3%.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employers' contributions of £88,132 (2017-18: £Nil) were paid to one or more of the panel of three appointed stakeholder pension providers. Employer contributions are age-related and range from 8% to 14.75% of pensionable earnings.

Employers also match employee contributions up to 3% of pensionable earnings. In addition, employer contributions of £2,399, 0.5% of pensionable pay, (2017-18: £2,115, 0.5% of pensionable pay) were payable to the PCSPS to cover the cost of the future provision of lump sum benefits on death in service or ill health retirement of these employees.

NHS Pension Scheme

The NHS Pension scheme is an unfunded, multi-employer defined benefit scheme. Individual NHS bodies are therefore unable to identify their shares of the underlying scheme assets and liabilities. The scheme was actuarially valued as at 31 March 2016[186].

For 2018-19, employers' contributions were payable to the NHS Pension Scheme at the rate of 14.3% (2017-18: 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.

From 1 April 2019, the employers' contributions payable to the NHS pension scheme increased to 20.68%.

Of the £5,219.1 million (2017-18: £4,980.0 million) against NHS pension costs, £175.9 million is attributable to NHS England Group (2017-18: £164.8 million), £4,962.5 million is attributable to NHS Providers (2017-18: £4,744.4 million) with the balance of £80.7 million (2017-18: £70.8 million) to ALBs.

[186]https://www.nhsbsa.nhs.uk/sites/default/files/2019-06/NHS%20Pension%20Scheme%20-%202016%20Valuation%20Report.pdf

4. Expenditure

4.1 Expenditure

	Note	2018-19 £'000 Core Dept & Agencies	2018-19 £'000 Departmental Group	2017-18 £'000 Core Dept & Agencies	2017-18 £'000 Departmental Group
4.1 (a) Purchase of goods and services					
Rentals Under Operating Leases		27,490	708,830	30,071	650,751
Supplies and services - clinical		-	12,501,137	-	12,112,917
Supplies and services - general		636,437	4,956,515	629,940	4,562,621
Total Goods and services from other NHS bodies		-	26,870	-	36,269
Multi Professional Education and Training (MPET)		-	1,539,046	-	1,773,302
Additional support for delivery of healthcare services[10]		795,834	12,124	-	-
Purchase of healthcare from non NHS bodies		-	15,061,831	-	14,202,220
Purchase of Social Care		-	830,687	-	781,164
Expenditure on Drug Action Teams		-	629	-	712
General Dental Services (GDS) and Personal Dental Services (PDS)[6]		-	2,788,494	-	2,811,569
Prescribing Costs		-	8,227,200	-	8,553,077
G/PMS, APMS and PCTMS[1]		-	8,492,641	-	8,242,208
Pharmaceutical Services		-	1,930,193	-	1,902,593
General Ophthalmic Services		-	553,286	-	555,820
Consultancy services		19,829	342,051	12,402	370,970
Establishment		89,832	1,380,907	59,277	1,292,494
Transport (Business Travel)		9,044	310,666	9,118	256,493
Premises		35,847	2,908,546	40,724	2,746,520
Education, Training and Conferences (cash)		5,301	366,336	9,620	410,353
Insurance		296	41,363	285	42,480
Legal fees		17,696	188,293	13,049	190,615
NHS Informatics Major Contracts Cost		63,966	163,309	74,769	153,343
Audit fees - statutory audit (cash)		-	28,336	-	27,857
Auditor remuneration - other		4	41,426	22	42,760
non-cash items					
Audit fees - statutory audit - non-cash[2]		802	897	824	919
Purchase of goods and services		**1,702,378**	**63,401,613**	**880,101**	**61,720,027**
4.1 (b) Depreciation and impairment charges					
non-cash items					
Depreciation on property, plant and equipment		57,369	2,441,073	45,671	2,351,230
Amortisation on intangible assets		172,092	451,540	111,370	364,375
Impairments and reversals		9,087	1,078,848	77,809	753,985
Depreciation and impairment charges		**238,548**	**3,971,461**	**234,850**	**3,469,590**
4.1 (c) Provision expense					
non-cash items					
Non-cash expenditure from movement in pension liability		-	20,469	-	17,382
Provision provided for in year		1,346,245	9,648,089	1,329,756	(414,721)
Provisions change in discount rate[8]		(948,877)	(723,507)	203,997	15,833,368
Provision expense		**397,368**	**8,945,051**	**1,533,753**	**15,436,029**
4.1 (d) Other operating expenditure					
PFI/LIFT and other service concession arrangements charges		-	1,036,640	-	999,343
Chair and non-executive Directors' costs		-	80,379	-	82,597
Business rates paid to local authorities		5,148	537,863	10,035	478,127
Clinical negligence		-	254	-	(141)
Research and development		1,108,415	635,827	1,117,135	585,972
Grants to Local Authorities		3,070,284	3,070,284	3,149,631	3,149,631
Grants to Other bodies		155,819	183,200	164,774	120,112
Capital Grants		549,517	597,953	534,108	588,988
DHSC support for mergers		60,131	-	83,942	-
Prior period adjustments in local accounts		-	(7,219)	-	(33,495)
non-cash items					
Loss on disposal of non-current assets and assets held for sale		207,017	220,996	2,075	13,818
Movement in provision for impairment of receivables		-	-	860	177,327
Movement of expected credit loss allowance (non-credit impaired)[9]		(219)	127,111	-	-
Inventories write down		4,109	15,158	1,434	13,588
Loan Write Off		6	6	-	-
Apprenticeship training grant (non-cash)		537	22,745	70	6,499
Prior period adjustments in local accounts (non-cash)		-	(24,452)	-	37,721
Changes in fair value through SoCNE		(762)	(10,161)	-	(76,905)
Other non-cash expenditure		10,768	10,846	12,224	9,771
Other[3,4]		712,244	2,256,334	631,035	1,911,093
Other operating expenditure		**5,883,014**	**8,753,764**	**5,707,323**	**8,064,046**

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 1.6 (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 £712.2 million (£631.0 million in 2017-18) includes £131.3 million of revenue policy payments (£122.3 million in 2017-18), £166.2 million in respect of outsourcing contracts (£162.0 million in 2017-18) and £94.3 million of Healthy Start – Welfare Foods payments (£114.5 million in 2017-18).
4. Other expenditure also includes £475 million of transport costs in the Provider sector relating to expenditure such as fuel costs, vehicle parts and other fleet related costs.
5. A breakdown of the Departmental Group Other figure by sector is provided in Note 2.2 Departmental Group Detail – Expenditure.
6. General Dental Services (GDS) and Personal Dental Services (PDS) are alternative models for dental care.
7. Core Department and Agencies expenditure figures may be greater than those of the Departmental Group due to the elimination of intercompany trading.
8. For more details on 'Change in discount rate' see Notes 1.19 and 16.
9. Movement of expected credit loss allowance (non-credit impaired) is the impairment of trade and other receivables under the IFRS 9 Expected Credit Loss Model. This shows the movement of the impairment due to changes in credit risk expected in the following twelve-month period. Any revision to the expected returns due to a triggering event under stage three (e.g. bankruptcy) continue to be recorded as impairments of financial assets under the Impairments and Reversal line. Under IFRS 9 prior year restatement of the Movement in provision for impairment of receivables line is not required.
10. Additional support for delivery of healthcare services consists of payments made to organisations who employ staff on terms and conditions fully aligned to Agenda for Change.
11. Core Department - recovery of costs treated as income in 2017-18, have now been reflected as credits to expenditure in 2018-19 following a review of income as part of the IFRS 15 implementation. Prior year figures have not been recategorized on materiality grounds. Whilst there is no impact on 'Total Net Expenditure for the year' the current and prior year income and expenditure figures are not fully comparable as a result.

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:

	2018-19 £'000 Departmental Group	2017-18 £'000 Departmental Group
Expenditure after financing activities - non-cash items (Note 4 & SOCNE)	13,646,531	19,601,744
Less non-cash income after financing activities (Note 5 & SOCNE)	(671,940)	(316,748)
Total non-cash transactions	**12,974,591**	**19,284,996**
Movement in provision for impairment of receivables	-	(177,327)
Movement in expected credit loss allowance	(127,111)	-
Inventories write down	(15,158)	(13,588)
Less non-cash movements on SoFP balances analysed separately in the Cash Flow statement	**(142,269)**	**(190,915)**
Total non-cash transactions as per Consolidated Statement of Cash Flows	**12,832,322**	**19,094,081**

5. Income

5.1 Income

	2018-19 £'000		2017-18 (Represented[2]) £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Income from contracts				
Revenue from Patient Care activities				
Income from Local Authorities	-	2,081,618	-	2,114,236
Income from Private patients	-	647,618	-	614,367
Income from Chargeable Overseas Patients	-	91,252	-	86,836
Income from injury costs recovery	-	209,012	-	201,905
Income in respect of EEA claims	62,956	62,956	62,717	62,717
Income from DHSC/NHS bodies	-	140,627	-	123,194
Other non-NHS patient care services	-	576,560	-	555,487
Other contract income				
Non-patient care services to other bodies	1,011	1,212,587	39,573	971,928
Education, training and research	2,406	380,790	1,923	357,108
Prescription Fees and Charges	-	591,960	-	575,963
Dental Fees and Charges	-	856,384	-	807,333
Other Fees and Charges	217,761	448,383	221,805	493,123
Income in respect of Staff Costs	-	204,222	-	201,463
Prescription Pricing Regulation Scheme	573,526	573,526	409,723	409,723
Other Contract Income	6,939	1,254,037	-	-
Income from contracts	**864,599**	**9,331,532**	**735,741**	**7,575,383**
Other non-contract operating income				
Rental revenue from finance leases	-	357	-	1,953
Rental revenue from operating leases	18,945	328,569	20,192	450,336
PDC Dividend Received	647,232	-	687,324	-
Charitable and other contributions to expenditure	-	54,240	-	51,879
Receipt of donations for capital acquisitions	-	313,446	-	66,479
Receipt of grants for capital acquisitions	-	2,987	-	8,057
Profit on disposal	1,440	291,727	8,662	275,037
Dividends	7,282	12,584	24,831	32,158
Other non-cash income	10,768	102,218	11,598	34,070
Apprenticeship training grant (non-cash)	537	22,745	70	6,499
Funding from other Government departments	-	2,598	-	205
Prior period adjustments in local accounts	-	18,916	-	392
Other operating income (prior year)	-	-	52,598	1,477,316
Other non contract income	24,544	386,736	-	3,627
Non-contract income	**710,748**	**1,537,123**	**805,275**	**2,408,008**

1. Other Contract Income includes £395 million in the Provider sector, which represents a proportion of the incidental non-clinical sales and services.
2. The format of the Income note has been revised following the application of IFRS 15 *Revenue from Contracts with Customers*. Income is now split between income arising from contracts and other non-contract operating income. Prior year balances are not restated, in accordance with the initial first year application requirement to recognise any effect of the change from 1 April 2018.
3. Core Department - recovery of costs treated as income in 2017-18, have now been reflected as credits to expenditure in 2018-19 following a review of income as part of the IFRS 15 implementation. Prior year figures have not been recategorized on materiality grounds. Whilst there is no impact on 'Total Net Expenditure for the year' the current and prior year income and expenditure figures are not fully comparable as a result.

5.2 Effect of application of IFRS 15 Revenue from Contracts With Customers (IFRS 15)

Due to the nature of trading in the Departmental Group the vast majority of revenue performance obligations are straightforward and therefore the income recognition has not changed significantly as a result of the application of IFRS 15.

Revenue comprises a small proportion of total incoming resources (with the vast majority being funding) and therefore revenue has a much smaller impact on the economic position of the group as would be compared to other organisations of a similar size.

As disclosed in the Consolidated Statement of Changes in Taxpayers' Equity, the impact on group reserves of applying IFRS 15 on 1 April 2018 was £2.4 million.

The level of cumulative catch up, and the difference in revenue recognised during the period under IFRS 15 compared to IAS 18 are insignificant to Core Department and Agencies and the Departmental Group.

On application of IFRS 15, the analysis of trade receivables and other current assets, and trade payables and other current liabilities reflects the categorisation as laid down in the standard. In accordance with IFRS 15 prior period balances have not been restated and as a result the analysis between periods is not fully comparable.

As required by the FReM, the Department has employed the Practical Expedient C5 on transition to IFRS 15 regarding retrospective application. The use of this expedient has had no significant effect on the financial statements.

6. Property, plant and equipment

Departmental Group 2018-19	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 2018	**6,323,808**	**39,868,075**	**356,535**	**4,199,733**	**2,466,088**	**653,545**	**9,146,660**	**462,170**	**669,790**	**64,146,404**
Prior period adjustments in underlying accounts	(20,552)	(300,719)	(5,686)	(5,396)	(7,241)	(3,266)	(2,421)	(253)	-	(345,534)
Additions	34,586	887,560	21,757	535,595	2,084,962	28,928	521,020	28,795	76,636	4,219,839
Donations	645	21,939	17	1,459	319,377	1,546	45,075	623	-	390,681
Impairments and reversals	(155,477)	(1,518,269)	(6,580)	(3,067)	(111,794)	(354)	(3,340)	(55)	(18,321)	(1,817,257)
Transfers	(5,432)	(1,719)	-	(3)	-	(50)	(384)	-	(1,986)	(9,574)
Reclassifications	(27,511)	1,023,811	7,019	130,252	(1,460,200)	11,623	156,708	31,745	-	(126,553)
Revaluation and indexation	156,330	(184,081)	(2,639)	(6,129)	(321)	(2,486)	(14,237)	(271)	2,350	(51,484)
Disposals	(40,829)	(78,896)	(5,784)	(178,543)	(1,132)	(23,989)	(346,675)	(45,659)	(222,174)	(943,681)
At 31 March 2019	**6,265,568**	**39,717,701**	**364,639**	**4,673,901**	**3,289,739**	**665,497**	**9,502,406**	**477,095**	**506,295**	**65,462,841**
Depreciation										
At 1 April 2018	**37,872**	**2,014,959**	**38,427**	**2,688,903**	**-**	**451,635**	**6,254,418**	**288,907**	**-**	**11,775,121**
Prior period adjustments in underlying accounts	(20,442)	(295,183)	(5,685)	(3,163)	-	(3,230)	(2,596)	(253)	-	(330,552)
Charged in year	68	1,249,260	9,891	484,272	-	46,248	606,347	44,987	-	2,441,073
Impairments and reversals	19,526	64,285	7,590	(14)	-	212	370	206	-	92,175
Transfers	-	(557)	-	-	-	(27)	(567)	-	-	(1,151)
Reclassifications	(15)	(29,803)	(359)	(651)	-	(513)	(9,895)	(11,474)	-	(52,710)
Revaluation and indexation	(9,214)	(845,781)	(14,490)	(6,414)	-	(1,666)	(16,221)	(277)	-	(894,063)
Disposals	(15)	(26,305)	(984)	(177,604)	-	(20,763)	(337,534)	(44,638)	-	(607,843)
At 31 March 2019	**27,780**	**2,130,875**	**34,390**	**2,985,329**	**-**	**471,896**	**6,494,322**	**277,458**	**-**	**12,422,050**
Net book value at 31 March 2019	**6,237,788**	**37,586,826**	**330,249**	**1,688,572**	**3,289,739**	**193,601**	**3,008,084**	**199,637**	**506,295**	**53,040,791**
Net book value at 31 March 2018	6,285,936	37,853,116	318,108	1,510,830	2,466,088	201,910	2,892,242	173,263	669,790	52,371,283
Asset financing:										
Owned - purchased	5,718,280	24,989,564	249,552	1,644,457	2,844,085	177,146	2,437,705	196,708	506,295	38,763,792
Owned - donated	97,818	1,249,527	13,346	11,125	292,844	15,502	271,649	1,689	-	1,953,500
Finance leased	54,668	468,203	17,678	25,801	19,325	794	150,303	1,240	-	738,012
On-Statement of Financial Position PFI contracts	367,022	10,879,532	47,673	7,189	133,485	159	148,427	-	-	11,583,487
PFI residual interests	-	-	2,000	-	-	-	-	-	-	2,000
Net book value at 31 March 2019	**6,237,788**	**37,586,826**	**330,249**	**1,688,572**	**3,289,739**	**193,601**	**3,008,084**	**199,637**	**506,295**	**53,040,791**
Analysis of property, plant and equipment										
Core Dept & Agencies	174,016	237,311	-	21,136	110,458	5,936	36,773	-	506,295	1,091,925
Other designated bodies	6,063,772	37,349,515	330,249	1,667,436	3,179,281	187,665	2,971,311	199,637	-	51,948,866
Net book value at 31 March 2019	**6,237,788**	**37,586,826**	**330,249**	**1,688,572**	**3,289,739**	**193,601**	**3,008,084**	**199,637**	**506,295**	**53,040,791**

1. Stockpiled goods are not depreciated, as agreed with HM Treasury.
2. The Department leases both Richmond House and Wellington House buildings from the Ministry of Housing, Communities and Local Government (MHCLG) for no consideration. MHCLG in turn leases the assets from the HM Treasury UK Sovereign Sukuk plc, for which HMT is paying the lease costs. As the Department retains control of these properties their value is included in the 'Buildings (excluding dwellings)' column above.
3. Richmond House was vacated by the Department on 1 December 2017 and the building will be transferred to Parliamentary Estates in July 2019.
4. As noted within the Governance Statement in this Annual Report, under the Carillion heading, Property, Plant and Equipment increased during the year as a result of two PFI contracts being terminated and the assets being brought into the ownership of the group.

	Land	Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture & Fittings	Plant & Machinery	Transport Equipment	Stockpiled Goods	Total
										Departmental Group 2017-18
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation										
At 1 April 2017	**6,317,332**	**39,016,572**	**387,566**	**3,887,576**	**1,984,995**	**675,704**	**8,986,625**	**457,621**	**721,519**	**62,435,510**
Prior period adjustments in underlying accounts	(52,298)	(388,649)	(2,624)	(276)	(683)	(4,687)	(3,730)	(5)	-	(452,952)
Additions	23,757	723,331	2,662	470,606	1,748,537	22,044	465,460	25,040	26,829	3,508,266
Donations	-	29,592	350	2,900	58,635	2,584	49,248	758	-	144,067
Impairments and reversals	(231,808)	(1,050,407)	(29,256)	(11,178)	(81,542)	(727)	(16,691)	(1)	(60,081)	(1,481,691)
Transfers	(5,495)	(45,148)	-	-	(178)	178	(19)	-	(146)	(50,808)
Reclassifications	(75,852)	790,433	(1,804)	67,931	(1,242,372)	3,549	137,206	20,302	(805)	(301,412)
Revaluation and indexation	402,455	859,029	3,250	(10,844)	1,796	(2,322)	(6,513)	(74)	(11,190)	1,235,587
Disposals	(54,283)	(66,678)	(3,609)	(206,982)	(3,100)	(42,778)	(464,926)	(41,471)	(6,336)	(890,163)
At 31 March 2018	**6,323,808**	**39,868,075**	**356,535**	**4,199,733**	**2,466,088**	**653,545**	**9,146,660**	**462,170**	**669,790**	**64,146,404**
Depreciation										
At 1 April 2017	**93,362**	**2,558,210**	**40,121**	**2,484,634**	-	**454,484**	**6,114,113**	**292,907**	-	**12,037,831**
Prior period adjustments in underlying accounts	(49,958)	(403,732)	(2,627)	(273)	-	(3,065)	(7,443)	(9)	-	(467,107)
Charged in year	28	1,187,414	10,340	439,614	-	50,077	619,492	44,265	-	2,351,230
Impairments and reversals	2,379	(282,841)	3,516	(354)	-	(305)	(1,448)	361	-	(278,692)
Transfers	-	(45,164)	-	-	-	-	(4)	-	-	(45,168)
Reclassifications	(31)	(65,376)	(1,091)	(19,498)	-	(4,864)	(18,070)	(7,907)	-	(116,837)
Revaluation and indexation	(7,908)	(908,559)	(11,444)	(10,831)	-	(2,623)	(8,015)	(76)	-	(949,456)
Disposals	-	(24,993)	(388)	(204,389)	-	(42,069)	(444,207)	(40,634)	-	(756,680)
At 31 March 2018	**37,872**	**2,014,959**	**38,427**	**2,688,903**	-	**451,635**	**6,254,418**	**288,907**	-	**11,775,121**
Net book value at 31 March 2018	**6,285,936**	**37,853,116**	**318,108**	**1,510,830**	**2,466,088**	**201,910**	**2,892,242**	**173,263**	**669,790**	**52,371,283**
Net book value at 31 March 2017	6,223,970	36,458,362	347,445	1,402,942	1,984,995	221,220	2,872,512	164,714	721,519	50,397,679
Asset financing:										
Owned - purchased	5,794,852	25,060,882	231,196	1,470,529	2,253,069	186,260	2,326,030	170,023	669,790	38,162,631
Owned - donated	101,951	1,267,067	13,853	12,213	67,915	14,746	279,742	1,555	-	1,759,042
Finance leased	47,089	436,559	17,568	23,339	7,228	743	144,124	1,685	-	678,335
On-Statement of Financial Position PFI contracts	342,044	11,088,607	53,665	4,749	137,876	161	142,346	-	-	11,769,448
PFI residual interests	-	1	1,826	-	-	-	-	-	-	1,827
Net book value at 31 March 2018	**6,285,936**	**37,853,116**	**318,108**	**1,510,830**	**2,466,088**	**201,910**	**2,892,242**	**173,263**	**669,790**	**52,371,283**
Analysis of property, plant and equipment										
Core Dept & Agencies	168,626	257,086	-	12,695	81,384	6,318	42,048	-	669,790	1,237,947
Other designated bodies	6,117,310	37,596,030	318,108	1,498,135	2,384,704	195,592	2,850,194	173,263	-	51,133,336
Net book value at 31 March 2018	**6,285,936**	**37,853,116**	**318,108**	**1,510,830**	**2,466,088**	**201,910**	**2,892,242**	**173,263**	**669,790**	**52,371,283**

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[187], details of which can be found in the individual body accounts.

[187] Per Chapter 7 of HM Treasury's 2018-19 Financial Reporting Manual

- All valuations have been undertaken according to Royal Institute of Chartered Surveyors (RICS) guidelines.
- The Retained Estate comprises land and buildings (£89.0m at 31 March 2019) which were primarily intended for use by NHS bodies but which are now surplus to requirements and are therefore held by the Department. The Retained Estate was revalued by professional valuers as at 31 March 2015. Additional valuations were carried out as necessary in circumstances where there were indications that values had substantially changed.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 – 193 years
- Information technology: 1 – 21 years
- Furniture and fittings: 1 – 36 years
- Plant and machinery: 1 – 35 years
- Transport equipment: 1 – 15 years

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 2018-19
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2018	**3,348,136**	**246,659**	**222,336**	**3,817,131**
Prior period adjustments in underlying accounts	(31)	-	6,924	6,893
Additions	441,224	51,300	179,179	671,703
Donations	1,483	-	12,038	13,521
Impairments and reversals	(2,433)	(1,674)	(18,150)	(22,257)
Transfers	(22)	-	-	(22)
Reclassifications	142,126	(4,567)	(108,872)	28,687
Revaluation and indexation	10,172	10,157	(9,689)	10,640
Disposals	(54,994)	(6,661)	(1,913)	(63,568)
Other movements	37	-	-	37
At 31 March 2019	**3,885,698**	**295,214**	**281,853**	**4,462,765**
Amortisation				
At 1 April 2018	**2,239,039**	**111,139**	**24,092**	**2,374,270**
Prior period adjustments in underlying accounts	(39)	-	-	(39)
Charged in year	416,810	30,065	4,665	451,540
Impairments and reversals	1,044	(766)	1	279
Transfers	(23)	-	-	(23)
Reclassifications	1,088	(203)	-	885
Revaluation and indexation	6,280	211	46	6,537
Disposals	(53,133)	(6,658)	(85)	(59,876)
Other movements	36	-	-	36
At 31 March 2019	**2,611,102**	**133,788**	**28,719**	**2,773,609**
Net Book Value at 31 March 2019	**1,274,596**	**161,426**	**253,134**	**1,689,156**
Net book value at 31 March 2018	1,109,097	135,520	198,244	1,442,861

Analysis of intangible assets				
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Of the total:				
Core Dept & Agencies	231,003	12,773	12,213	255,989
Other designated bodies	1,043,593	148,653	240,921	1,433,167
Net Book Value at 31 March 2019	**1,274,596**	**161,426**	**253,134**	**1,689,156**

			Departmental Group	
				2017-18
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2017	**3,024,076**	**192,936**	**183,767**	**3,400,779**
Prior period adjustments in underlying accounts	(1,757)	348	383	(1,026)
Additions	295,279	33,153	143,308	471,740
Donations	431	-	10,540	10,971
Impairments and reversals	(34,771)	(204)	(13,406)	(48,381)
Transfers	(9)	-	-	(9)
Reclassifications	149,229	28,953	(101,415)	76,767
Revaluation and indexation	23,377	532	97	24,006
Disposals	(107,660)	(9,059)	(938)	(117,657)
Other movements	(59)	-	-	(59)
At 31 March 2018	**3,348,136**	**246,659**	**222,336**	**3,817,131**
Amortisation				
At 1 April 2017	**2,000,014**	**86,328**	**20,705**	**2,107,047**
Prior period adjustments in underlying accounts	(478)	(897)	30	(1,345)
Charged in year	332,857	27,777	3,741	364,375
Impairments and reversals	(1,479)	(110)	284	(1,305)
Transfers	(6)	-	-	(6)
Reclassifications	(3,347)	6,681	6	3,340
Revaluation and indexation	17,167	393	88	17,648
Disposals	(105,631)	(9,033)	(762)	(115,426)
Other movements	(58)	-	-	(58)
At 31 March 2018	**2,239,039**	**111,139**	**24,092**	**2,374,270**
Net Book Value at 31 March 2018	**1,109,097**	**135,520**	**198,244**	**1,442,861**
Net Book Value at 31 March 2017	1,024,062	106,608	163,062	1,293,732

Analysis of intangible assets				
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Of the total:				
Core Dept & Agencies	222,714	4,588	9,129	236,431
Other designated bodies	886,383	130,932	189,115	1,206,430
Net Book Value at 31 March 2018	**1,109,097**	**135,520**	**198,244**	**1,442,861**

The ranges of estimated useful lives are currently:

- Software licences and Internally Developed Software: 1 – 23 years
- Development expenditure: 1 – 12 years
- Other (licences and trademarks, patents, purchased software etc): 1 – 15 years

The Departmental Group revalues intangible non-current assets associated with Informatics programmes at the end of each financial year, by indexing their original cost using appropriate indices. This valuation method is reviewed annually.

Informatics non-current assets (whether classified as property, plant and equipment or intangible assets) are not added to the relevant organisation's Non-Current Asset Register until confirmation has been received from the appropriate NHS organisation that the relevant system has been deployed successfully.

8. Impairments

	2018-19 £'000		2017-18 £'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	7,391	1,057,639	77,688	704,801
Intangible asset impairments	600	21,858	-	44,689
Financial asset impairments	1,096	(949)	121	(885)
Non Current Assets Held for Sale impairments	-	300	-	5,380
Total impairments charged to Consolidated Statement of Comprehensive Net Expenditure	**9,087**	**1,078,848**	**77,809**	**753,985**
Impairments charged to Revaluation Reserve				
Property Plant and Equipment impairments	11,147	851,793	-	513,337
Intangible asset impairments	667	678	2,387	2,387
Financial asset impairments	(314)	(314)	756	756
Total impairments charged to Revaluation Reserve	**11,500**	**852,157**	**3,143**	**516,480**
Impairments charged to General Fund				
PDC impairments (Note 11)	(96,141)	-	93,611	-
Total impairments charged to General Fund	**(96,141)**	**-**	**93,611**	**-**
Total impairments charged in year	**(75,554)**	**1,931,005**	**174,563**	**1,270,465**

The above table includes both impairments and impairment reversals.

9. Commitments

9.1 Capital Commitments

This note discloses commitments to future capital expenditure, not otherwise disclosed elsewhere in the financial statements. Included within capital commitments are non-cancellable contracts and purchase orders which commit the Departmental Group to capital expenditure in a future period. Commitments to expenditure under other forms of agreement such as Memorandums of Understanding may be considered as a capital commitment if they, in exceptional circumstances, effectively commit the Department to the expenditure as it would be reputationally or politically damaging for the Department to withdraw from the agreement.

Any future capital funding within the Department's accounting boundary does not represent a capital commitment.

	2018-19 £'000		2017-18 £'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	231,919	1,475,782	37,546	1,338,696
Intangible non-current assets	11,204	109,438	26,875	117,391
	243,123	**1,585,220**	**64,421**	**1,456,087**

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.

	2018-19 £'000		2017-18 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	3,773	-	4,006
Later than 1 year and not later than 5 years	-	6,321	-	8,310
Later than 5 years	-	16,320	-	21,019
	-	**26,414**	**-**	**33,335**
Buildings:				
Not later than 1 year	18,956	356,864	11,065	318,978
Later than 1 year and not later than 5 years	47,989	979,617	35,540	879,758
Later than 5 years	35,286	1,207,894	41,719	966,326
	102,231	**2,544,375**	**88,324**	**2,165,062**
Other:				
Not later than 1 year	488	195,504	474	193,114
Later than 1 year and not later than 5 years	483	322,300	806	324,255
Later than 5 years	-	62,581	-	75,110
	971	**580,385**	**1,280**	**592,479**

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.

	2018-19 £'000		2017-18 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	3,445	-	3,192
Later than 1 year and not later than 5 years	-	11,616	-	11,247
Later than 5 years	-	177,758	-	155,603
	-	**192,819**	**-**	**170,042**
Buildings:				
Not later than 1 year	17,557	131,373	551	97,069
Later than 1 year and not later than 5 years	50,573	418,730	1,349	289,974
Later than 5 years	26,574	881,105	-	758,759
	94,704	**1,431,208**	**1,900**	**1,145,802**
Other:				
Not later than 1 year	-	15,328	-	17,357
Later than 1 year and not later than 5 years	-	17,223	-	21,534
Later than 5 years	-	12,617	-	56,482
	-	**45,168**	**-**	**95,373**

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.

	2018-19 £'000		2017-18 £'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	-	181	-	185
Later than 1 year and not later than 5 years	-	726	-	741
Later than 5 years	-	1,339	-	1,742
	-	**2,246**	-	**2,668**
Less interest element	-	(1,368)	-	(1,689)
Present Value of obligations	-	**878**	-	**979**
Buildings:				
Not later than 1 year	-	46,421	-	43,025
Later than 1 year and not later than 5 years	-	180,016	-	167,047
Later than 5 years	-	497,197	-	478,001
	-	**723,634**	-	**688,073**
Less interest element	-	(321,261)	-	(314,164)
Present Value of obligations	-	**402,373**	-	**373,909**
Other:				
Not later than 1 year	-	52,649	-	46,352
Later than 1 year and not later than 5 years	-	115,776	-	109,799
Later than 5 years	-	48,889	-	23,549
	-	**217,314**	-	**179,700**
Less interest element	-	(25,738)	-	(23,949)
Present Value of obligations	-	**191,576**	-	**155,751**

1. Finance lease commitments between bodies with the Departmental Group are eliminated upon consolidation.

	2018-19 £'000		2017-18 £'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	-	70	-	61
Later than 1 year and not later than 5 years	-	395	-	344
Later than 5 years	-	413	-	574
Total Present Value of obligations	**-**	**878**	**-**	**979**
Buildings:				
Not later than 1 year	-	21,279	-	18,113
Later than 1 year and not later than 5 years	-	88,747	-	76,425
Later than 5 years	-	292,347	-	279,371
Total Present Value of obligations	**-**	**402,373**	**-**	**373,909**
Other:				
Not later than 1 year	-	46,971	-	40,121
Later than 1 year and not later than 5 years	-	102,489	-	95,891
Later than 5 years	-	42,116	-	19,739
Total Present Value of obligations	**-**	**191,576**	**-**	**155,751**

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.

		2018-19 £'000		2017-18 £'000
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Gross investments in leases:				
Not later than 1 year	423	6,102	-	1,211
Later than 1 year and not later than 5 years	727	3,778	-	3,777
Later than 5 years	-	19,207	-	20,062
Less future finance income	(101)	(8,590)	-	(9,205)
Present Value of minimum lease payments	**1,049**	**20,497**	-	**15,845**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**1,049**	**20,497**	-	**15,845**
Present Value of minimum lease payments:				
Not later than 1 year	419	5,500	-	595
Later than 1 year and not later than 5 years	630	1,530	-	1,465
Later than 5 years	-	13,467	-	13,785
Total Present Value of minimum lease payments	**1,049**	**20,497**	-	**15,845**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**1,049**	**20,497**	-	**15,845**
included in:				
Other current receivables	419	5,500	-	595
Other non-current receivables	630	14,997	-	15,250
Sub total	**1,049**	**20,497**	-	**15,845**

1. Future minimum lease receipts between bodies with the Departmental Group are eliminated upon consolidation.

9.3 Commitments under PFI and LIFT contracts

PFI contracts are held by NHS Property Services Ltd and NHS Providers. LIFT contracts are held by Community Health Partnerships Ltd and NHS Providers. Details of PFI and LIFT contracts in respect of each of the following categories are recorded in the individual accounts of relevant NHS Providers, NHS Property Services Ltd and Community Health Partnerships Ltd.

9.3.1 NHS LIFT schemes deemed to be off-Statement of Financial Position

In this financial year, Community Health Partnerships Ltd reported one off-Statement of Financial Position LIFT scheme with an estimated capital value of £0.9 million (2017-18: one scheme, £0.9 million). The assets which make up this capital value were not assets of Community Health Partnerships Ltd.

	2018-19 £'000		2017-18 £'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	-	63	-	77
Later than 1 year and not later than 5 years	-	249	-	329
Later than 5 years	-	3,783	-	4,213
	-	**4,095**	-	**4,619**

9.3.2 NHS LIFT schemes deemed to be on-Statement of Financial Position

Community Health Partnerships Ltd

In this financial period Community Health Partnerships Ltd reported 296 on-Statement of Financial Position LIFT schemes. (2017-18: 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 LIFT transactions and the service element of on-balance sheet LIFT transactions is £51.9 million (2017-18: £50.0 million).

NHS Providers

In this financial year, 6 NHS Providers (2017-18: 6 NHS Providers), reported on-Statement of Financial Position LIFT schemes. The assets of these schemes are treated as assets of the trusts. The substance of each contract is that the Trust has a finance lease and payments comprise an imputed finance lease charge and a service charge. Details of the individual LIFT schemes are included in the accounts of each NHS Provider.

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

	2018-19 £'000		2017-18 £'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	-	163,190	-	165,494
Later than 1 year and not later than 5 years	-	649,778	-	648,633
Later than 5 years	-	2,570,066	-	2,715,227
	-	**3,383,034**	-	**3,529,354**
Less interest element	-	(1,625,608)	-	(1,744,468)
Present Value of obligations	-	**1,757,426**	-	**1,784,886**

	2018-19 £'000		2017-18 £'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	-	36,835	-	37,358
Later than 1 year and not later than 5 years	-	170,045	-	160,771
Later than 5 years	-	1,550,546	-	1,586,757
Total Present Value of obligations	-	**1,757,426**	-	**1,784,886**

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 £55.3 million (2017-18: £53.0 million).

Community Health Partnerships Ltd and NHS Providers with NHS LIFT contracts are committed to the following total charges:

	2018-19 £'000		2017-18 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	56,553	-	54,615
Later than 1 year and not later than 5 years	-	241,198	-	234,116
Later than 5 years	-	724,290	-	782,742
	-	**1,022,041**	-	**1,071,473**

9.3.4 PFI Schemes deemed to be off-Statement of Financial Position

NHS Providers

In this financial year 8 NHS Providers reported off-Statement of Financial Position PFI schemes (2017-18: 8 NHS Providers).

	2018-19 £'000		2017-18 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Obligations on off-Statement of Financial Position PFI schemes for the following periods comprise:				
Not later than 1 year	-	6,122	-	6,425
Later than 1 year and not later than 5 years	-	24,088	-	25,131
Later than 5 years	-	30,268	-	36,417
	-	**60,478**	-	**67,973**

9.3.5 NHS PFI schemes deemed to be on-Statement of Financial Position

NHS Property Services Ltd

In this financial period NHS Property Services Ltd reported 27 on-Statement of Financial Position PFI schemes (2017-18: 27 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 £30.9 million (2017-18: £29.5 million).

NHS Providers

In this financial year, 150 NHS Providers reported on-Statement of Financial Position PFI Schemes (2017-18: 153 NHS Providers). The assets of these schemes are treated as assets of the NHS Provider. The substance of each contract is that the Trust has a finance lease, and payments comprise an imputed finance lease charge and a service charge. The amount included within operating expenses in respect of off-Statement of Financial Position PFI transactions and the service element of the on-Statement of Financial Position PFI transactions is £950.4 million. (2017-18: £916.8 million).

		2018-19 £'000		2017-18 £'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	-	862,769	-	872,363
Later than 1 year and not later than 5 years	-	3,416,649	-	3,431,408
Later than 5 years	-	13,018,742	-	14,025,967
	-	**17,298,160**	-	**18,329,738**
Less interest element	-	(8,174,338)	-	(8,885,205)
Present Value of obligations	-	**9,123,822**	-	**9,444,533**

		2018-19 £'000		2017-18 £'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	-	290,470	-	289,408
Later than 1 year and not later than 5 years	-	1,302,274	-	1,265,931
Later than 5 years	-	7,531,078	-	7,889,194
Total Present Value of obligations	-	**9,123,822**	-	**9,444,533**

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 £981.4 million. (2017-18: £946.3 million).

		2018-19 £'000		2017-18 £'000
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	942,866	-	919,727
Later than 1 year and not later than 5 years	-	3,938,097	-	3,871,709
Later than 5 years	-	17,511,296	-	18,168,124
	-	22,392,259	-	22,959,560

9.4 Other Financial Commitments

		2018-19 £'000		2017-18 £'000
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	1,914,720	2,417,285	1,678,115	2,169,532
Later than 1 year and not later than 5 years	1,856,214	2,728,216	2,019,596	2,908,664
Later than 5 years	237,860	399,095	141,184	296,928
	4,008,794	5,544,596	3,838,895	5,375,124

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 reputationally or politically damaging for Departmental group bodies to withdraw from the agreement. Any future funding within the Department's accounting boundary does not represent a financial commitment.

In this financial year, the Department is committed to expenditure of £2,182 million (2017-18: £2,293.9 million) on Research and Development contracts. These contracts are with a number of NHS organisations, universities and private research organisations. The purpose of research and development arrangements varies from the development of the health research workforce and research infrastructure in the NHS and the provision of research support by the NHS to specific research programmes or projects. The overall purpose of the work is to develop an evidence base for improved health care, public health and social care, so leading to better health outcomes, and also promoting economic growth.

10. Financial Instruments
10.1 Risk profile

As the cash requirements of the Department are met through the Estimates process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body of a similar size.

The Department's investments in NHS Providers and the Medicines & Healthcare products Regulatory Agency are represented by Public Dividend Capital (PDC) which, being issued under statutory authority, are not classed as being a financial instrument.

Currency Risk
The Department undertakes certain transactions denominated in foreign currencies, the vast majority of which are transactions relating to European Economic Area (EEA) medical costs.

Due to the lead time in the submission of medical cost claims by member states (as per current EU regulations), the Department estimates annual medical costs and adjusts future years' expenditure when actual costs arise (are claimed). Estimated costs are converted into sterling at average rates calculated using EU published rates. Payments made are valued at prevailing exchange rates. Amounts in the Statement of Financial Position at year-end are converted at the exchange rate ruling at the Statement of Financial Position date, with any exchange rate gains or losses calculated in accordance with accepted accounting practice.

The NHS sector is made up principally of domestic organisations with the great majority of transactions, assets and liabilities being in the UK and sterling based. Exposure to currency rate fluctuations is therefore low.

Liquidity Risk
The income within the Department of Health and Social Care Group mostly originates from Central Government and remains within the group. Due to the continuing service provider relationship that health bodies have with each other, they are not exposed to the degree of financial risk faced by business entities. NHS Trusts and Foundation Trusts, for example, generate their income from contractual arrangements with their commissioners based either on a tariff for services performed or on assumptions for the amount of work to be carried out.

Interest Rate Risk
The Departmental Group has limited exposure to Interest Rate Risk.

NHS Trusts and NHS Foundation Trusts borrow from government for capital expenditure and working capital requirements for the normal course of business, subject to affordability. These can take the form of either term loans or maturity loans. The borrowings are for 1 – 25 years for capital borrowings and 1 – 7 years for working capital borrowings. For capital loans and normal course of business revenue loans, interest is charged at the National Loans rate prevailing on the date of signing the loan agreement, and the rate is fixed for the life of the loan. A range of factors are taken into account when setting the interest rates for interim revenue support loans. NHS Foundation Trusts have the power to enter into loans and working capital facilities with commercial lenders should they wish but the amounts NHS Foundation Trusts can borrow are governed by Monitor.

Credit risk

The vast majority of the Departmental Group's income is generated from public sector bodies and as such is exposed to low credit risk.

From a Core Department perspective, no loans to NHS Trusts or NHS Foundation Trusts have been written off since the re-introduction of loan financing for NHS providers in 2004. The financial performance of NHS Trusts and NHS Foundation Trusts is rigorously managed by NHS Improvement (umbrella organisation of the NHS Trust Development Authority and the independent regulator Monitor), not least through their respective powers of intervention.

10.2 Application of IFRS 9 Financial Instruments (IFRS 9)

The vast majority of the Departmental Group's financial assets and liabilities are simple financial instruments measured at Amortised Cost both under IAS 39 Financial Instruments: Recognition and Measurement and IFRS 9. Consequently, there have been minimal changes to financial asset and financial liability categorisation and measurement as a result of the application of IFRS 9.

Per note 1.23.2 the Department has made the irrevocable election for its equity investments on implementation of IFRS 9. Previously these were held as 'available for sale' under IAS 39 and using the election will continue to be accounted for at Fair Value through Other Comprehensive Income.

As a result of the transition to IFRS 9 there has also been a minimal impact on the valuation of other financial investments as a result of applying the effective interest rate method to investments as disclosed in Note 11 – Financial Assets – Investments.

IFRS 9 requires the use of an Expected Credit Loss model for the measurement of financial assets which are impaired due to credit risk. The resultant expected credit loss provision is broadly similar in value to the provision for impairment of receivables in the prior year.

As disclosed in the Consolidated Statement of Changes in Taxpayers' Equity, the impact of the change in measurement basis on application of IFRS 9 was £11.4 million.

For further details on individual Entities' transitions to IFRS 9 please see the Annual Report and Accounts of the individual entities.

11. Financial Assets – Investments

	2018-19 £'000						2018-19 £'000			
	Core Dept & Agencies						Departmental Group			
	NHS Healthcare Providers		Other Bodies			Total	Other Bodies			Total
	PDC	Loans	PDC	Loans	Share Capital		PDC	Loans	Share Capital and Other Investments	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2018	**26,660,140**	**9,317,202**	**1,328**	**477,215**	**1,613,473**	**38,069,358**	**1,328**	**390,170**	**358,868**	**750,366**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	(1,101)	(1,101)
Impact of applying IFRS9 to opening balances	-	40,216	-	1,083	-	41,299	-	30	346	376
Issued	809,424	3,583,488	-	185,523	113,191	4,691,626	-	13,065	25,260	38,325
Disposals	-	-	-	-	-	-	-	(95,000)	(6,353)	(101,353)
Repaid	(3,438)	(261,526)	-	(31,313)	-	(296,277)	-	(18,813)	(2,496)	(21,309)
Transfers to and from current receivables	-	(2,193,568)	-	(31,805)	-	(2,225,373)	-	(1,805)	(1,230)	(3,035)
Written off	(159,245)	-	-	(6)	-	(159,251)	-	(6)	-	(6)
Changes in fair value through other comprehensive income	-	-	-	-	(71,000)	(71,000)	-	-	4,182	4,182
Changes in fair value through CSCNE	-	-	-	-	-	-	-	-	8,597	8,597
Expected credit loss impairments	-	-	-	-	-	-	-	2,045	-	2,045
Other Impairments and reversals	96,141	-	-	95	(877)	95,359	-	95	(877)	(782)
Other movements	-	-	-	-	-	-	-	-	2,368	2,368
Balance at 31 March 2019	**27,403,022**	**10,485,812**	**1,328**	**600,792**	**1,654,787**	**40,145,741**	**1,328**	**289,781**	**387,564**	**678,673**

Investments held by Core Dept & Agencies	40,145,741
Less elimination of intra-group investments	(39,670,045)
Investments held by other designated bodies	202,977
Total	**678,673**

1. The issued line records the full value of all new loans let in-year and interest arising. 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 more than 12 months 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 (Note 14).

	2017-18 £'000 Core Dept & Agencies						2017-18 £'000 Departmental Group			
	NHS Healthcare Providers		Other Bodies			Total	Other Bodies			Total
	PDC	Loans	PDC	Loans	Share Capital		PDC	Loans	Share Capital and Other Investments	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2017	**26,199,628**	**7,483,010**	**1,328**	**305,064**	**690,969**	**34,679,999**	**1,328**	**397,013**	**285,001**	**683,342**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	4,617	4,617
Issued	622,325	3,435,666	-	63,483	92,036	4,213,510	-	13,483	16,008	29,491
Disposals	-	-	-	-	-	-	-	-	(2,700)	(2,700)
Repaid	(2,467)	(252,254)	-	(25,065)	-	(279,786)	-	(25,065)	(1,526)	(26,591)
Transfers to and from current receivables	-	(1,349,220)	-	133,733	-	(1,215,487)	-	3,733	(1,690)	2,043
Written off	(65,735)	-	-	-	-	(65,735)	-	-	-	-
Revaluation	-	-	-	-	782,054	782,054	-	-	47	47
Changes in fair value through CSCNE	-	-	-	-	-	-	-	-	2,651	2,651
Other Impairments and reversals	(93,611)	-	-	-	(877)	(94,488)	-	1,006	(877)	129
Reclassifications	-	-	-	-	49,291	49,291	-	-	49,291	49,291
Other Movements	-	-	-	-	-	-	-	-	8,046	8,046
Balance at 31 March 2018	**26,660,140**	**9,317,202**	**1,328**	**477,215**	**1,613,473**	**38,069,358**	**1,328**	**390,170**	**358,868**	**750,366**

Investments held by Core Dept & Agencies	38,069,358
Less elimination of intra-group investments	(37,597,842)
Investments held by other designated bodies	278,850
Total	**750,366**

The Department's PDC investment in, and loans to, NHS Providers eliminate on consolidation, and so are not shown as consolidated Departmental group investments as they are not with bodies external to the Group. With the exception of MHRA (which is not consolidated into the Department's Annual Report and Accounts) PDC is only issued to bodies within the Departmental Group.

Community Health Partnerships Ltd, NHS Property Services Ltd, Genomics England Ltd and Supply Chain Coordination Ltd are consolidated into the Departmental accounts; therefore the investment by the Core Department in these companies are eliminated from the Departmental Group figures.

The Department's Share Capital investments are measured at fair value. Where the difference between fair value and depreciated historic cost is insignificant, the Department may use depreciated historic cost as a proxy, for example the valuation of MHRA.

The Department reviews the values of its financial investments each year with independent valuations carried out at intervals of no more than three years. The Department's investments in Genomics England Ltd, NHS Shared Business Services, NHS Property Services Ltd and Community Health Partnerships Ltd were all subject to independent valuations in 2017-18 with

an internal review carried out in 2018-19. The Core Department and Agencies share capital of £1.7 billion includes £906.5 million in respect of NHS Property Services Ltd and £253.5 million in Community Health Partnerships Ltd.

Credit Guarantee Finance (CGF) is a loan guaranteed by banks, monolines or other acceptable financial institutions, provided by the sponsoring Department to a PFI project Special Purpose Vehicle on 'market' terms. Aside from one pilot CGF loan with NHS PFI projects in Portsmouth, the Department does not expect to undertake any further CGF loans.

During 2018-19, the Department increased its shareholding in Genomics England Ltd by £82.7 million. It purchased £21 million of shares in Supply Chain Coordination Ltd which started trading on 1 April 2018.

Financing of NHS Providers

The Department has two means of financing NHS Trusts and NHS Foundation Trusts:

1. **Public Dividend Capital (PDC)** – issued as either structural capital when NHS Trusts are established, or when the Department needs to provide additional financing to NHS Trusts or NHS Foundation Trusts after establishment; and
2. **Loans** – normally made under standard government loan terms, i.e. 6 monthly equal instalments of principal and interest charged on outstanding balances. The primary exception is the Department's revolving working capital loan facilities under which the full obligation for providers to repay the loans falls due at the end of the loan term. National Loan fund rates of interest (as published by the UK Debt Management Office) are applied.

PDC is held at historic value less impairments. Loans are held at amortised cost using the effective interest rate method, less impairments. As detailed in the credit risk section of note 10.1, the Department judges that there is no material credit risk associated with either form of investment.

12. Inventories and work in progress

	Departmental Group 2018-19					
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2018	**156,901**	**-**	**339,534**	**732,301**	**93,254**	**1,321,990**
Prior period adjustments in underlying accounts	-	-	1,105	(364)	22	763
Additions	447,546	-	6,231,396	3,661,702	432,553	10,773,197
Consumed/Disposed of	(396,938)	(97)	(6,197,748)	(3,575,604)	(416,733)	(10,587,120)
Written down charged to CSCNE	(4,109)	-	(8,224)	(2,693)	(132)	(15,158)
Transfer (to) / from non-current assets	-	97	-	-	2,694	2,791
Reclassification	-	-	-	7	(8)	(1)
Other	1	-	-	(11)	-	(10)
Balance at 31 March 2019	**203,401**	**-**	**366,063**	**815,338**	**111,650**	**1,496,452**

Analysis of Inventories

Of the total:	Adult and Childhood Vaccines £'000	Pandemic Flu and Pre Pandemic Flu £'000	Drugs £'000	Consumables £'000	Other £'000	Total £'000
Core Dept & Agencies	203,401	-	-	6,459	-	209,860
Other designated bodies	-	-	366,063	808,879	111,650	1,286,592
	203,401	**-**	**366,063**	**815,338**	**111,650**	**1,496,452**

	Departmental Group 2017-18					
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2017	**140,709**	**-**	**322,819**	**711,744**	**67,205**	**1,242,477**
Prior period adjustments in underlying accounts	-	-	612	3	18	633
Additions	411,380	-	6,088,413	3,167,696	316,420	9,983,909
Consumed/Disposed of	(393,754)	(4)	(6,064,076)	(3,144,168)	(289,576)	(9,891,578)
Written down charged to CSCNE	(1,434)	-	(8,234)	(3,820)	(100)	(13,588)
Transfer (to) / from non-current assets	-	4	-	-	142	146
Reclassification	-	805	-	855	(855)	805
Other	-	(805)	-	(9)	-	(814)
Balance at 31 March 2018	**156,901**	**-**	**339,534**	**732,301**	**93,254**	**1,321,990**

Analysis of Inventories

Of the total:	Adult and Childhood Vaccines £'000	Pandemic Flu and Pre Pandemic Flu £'000	Drugs £'000	Consumables £'000	Other £'000	Total £'000
Core Dept & Agencies	156,901	-	-	4,447	-	161,348
Other designated bodies	-	-	339,534	727,854	93,254	1,160,642
	156,901	**-**	**339,534**	**732,301**	**93,254**	**1,321,990**

13.1 Cash and cash equivalents

	2018-19 £'000		2017-18 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Balance at 1 April 2018	**1,709,068**	**7,562,137**	**1,877,074**	**6,789,286**
Net change in cash	224,372	1,119,891	(168,006)	772,851
Balance at 31 March 2019	**1,933,440**	**8,682,028**	**1,709,068**	**7,562,137**

The following balances at 31 March were held at:				
Government Banking Service	1,933,436	8,001,531	1,709,068	7,093,321
Commercial banks and cash in hand	4	286,616	-	301,629
Short term investments	-	393,881	-	167,187
Balance at 31 March 2019	**1,933,440**	**8,682,028**	**1,709,068**	**7,562,137**

14. Trade Receivables and other current assets

	2018-19 £'000		2017-18 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade receivables	287,480	2,352,520	23,638	752,724
Deposits and advances	-	5,076	-	4,176
Capital receivables	8,056	121,916	8,208	78,469
Interest receivable	30	4,863	41,368	7,767
Other receivables	104,344	699,020	85,522	1,036,594
Trade and other receivables	**399,910**	**3,183,395**	**158,736**	**1,879,730**
Contract Assets[4]	-	18,434	-	-
Other prepayments and accrued income	79,820	1,183,884	286,760	1,827,176
Current part of PFI and other service concession arrangements prepayments	-	144,240	-	118,870
Capital Prepayments	-	97,552	-	62,388
Other current assets	-	3,134	-	3,948
Other current assets	**79,820**	**1,447,244**	**286,760**	**2,012,382**
Current part of loans repayable transferred from investments[5]	3,665,937	8,269	1,784,501	7,210
Other current financial assets	-	20,000	-	15,000
Other financial assets	**3,665,937**	**28,269**	**1,784,501**	**22,210**
Total current receivables	**4,145,667**	**4,658,908**	**2,229,997**	**3,914,322**
Amounts falling due after more than one year:				
Trade receivables	-	193,303	-	116
Deposits and advances	-	5,065	-	4,214
Capital receivables	5,693	43,575	13,698	34,429
Contract Assets[4]	-	4,351	-	-
Other receivables	205,177	267,063	210,234	465,022
Other Prepayments and accrued income	-	36,972	-	50,905
Non-current part of PFI and other service concession arrangements prepayments	-	37,666	-	35,386
Capital Prepayments	-	183,184	-	305,680
Total non-current receivables	**210,870**	**771,179**	**223,932**	**895,752**
Total receivables at 31 March 2019	**4,356,537**	**5,430,087**	**2,453,929**	**4,810,074**

1. Following application of IFRS 15 *Revenue from Contracts with Customers* the recognition point for income has changed to being at the point performance obligations have been completed. In accordance with the initial first year application requirement to recognise any effect of the change from 1 April 2018, prior year balances have not been restated.
2. Trade receivables includes the total expected return arising from items on an entity's sales ledger, as well as contract income recognised in line with IFRS 15 expected on contracts for which obligations have been fulfilled and there is no barrier to receiving the due consideration on the contract except for the passage of time. Items recognised as a contract receivable (within trade receivables) under IFRS 15 may have previously been recognised as accrued income in the prior year e.g. due to invoices not yet raised on the sales ledger.
3. Trade receivables includes the expected credit loss on receivables under the IFRS 9 expected credit loss model. This is equivalent to provision for impairment of receivables in 2017-18. There is no requirement to restate this balance under IFRS 9.
4. Contract Assets represents the total contract income for which performance obligations are fulfilled, but an event other than the passage of time exists meaning that consideration is not yet due. These items may have previously been recognised as accrued income in the prior year.
5. The level of debt on NHS provider balance sheets has increased in recent years, as can be seen on the current part of loans repayable transferred from investments line. The Department is currently considering its next steps following the recommendations provided in an independent review on NHS financing. Any changes will support sustainable long-term financial recovery and fit as part of the wider financial architecture to support delivery of the NHS Long Term Plan. The NHS LTP and its associated 5 year funding settlement introducing an additional £33.9 billion into the NHS by 2023-24, represents the Government commitment to continue to fund core activity of the NHS.

15. Trade payables and other current liabilities

	2018-19 £'000		2017-18 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade payables	25,865	3,304,009	25,129	2,947,924
Capital payables	94,062	921,589	103,956	899,710
Other payables	6,163	2,196,586	12,978	1,660,140
Trade and other payables	**126,090**	**6,422,184**	**142,063**	**5,507,774**
Bank Overdraft	-	25,016	-	11,944
VAT	-	25,331	-	29,536
Other taxation and social security	2,091	1,169,353	1,917	1,086,669
Deferred tax liability	-	-	-	148,023
EEA Medical Costs Accrual	743,725	743,725	769,238	769,238
Contract liabilities[1]	-	630,425	-	-
Other accruals	505,871	8,595,580	360,756	7,665,026
Deferred income	64,511	119,047	55,487	745,671
Current part of finance lease	-	68,320	-	58,295
Current part of imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	327,305	-	326,766
Amount issued from the Consolidated Fund for supply but not spent at year end	2,209,086	2,209,086	2,176,668	2,176,668
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received	3,858	3,858	17,354	17,354
Current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	23,832	-	27,800
Pension liabilities	-	92,264	-	102,473
Other current liabilities	-	17,252	-	8,350
Other liabilities	**3,529,142**	**14,050,394**	**3,381,420**	**13,173,813**
Total current payables	**3,655,232**	**20,472,578**	**3,523,483**	**18,681,587**
Amounts falling due after more than one year:				
Finance leases	-	526,507	-	498,345
Imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	10,553,943	-	10,902,653
Pension liabilities	-	69	-	75
Financial liabilities	**-**	**11,080,519**	**-**	**11,401,073**
Trade payables	-	2,297	-	3,681
Contract liabilities[1]	-	70,350	-	-
Other accruals	8,164	10,884	9,028	23,978
Capital payables	127,959	130,621	10,268	13,421
Other payables	-	164,613	-	18,681
Deferred income	-	82,476	-	182,350
Non-current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	294,672	-	189,567
Loans payable by DHSC to group bodies	20,220	-	-	-
Other payables	**156,343**	**755,913**	**19,296**	**431,678**
Total non-current payables	**156,343**	**11,836,432**	**19,296**	**11,832,751**
Total payables at 31 March 2019	**3,811,575**	**32,309,010**	**3,542,779**	**30,514,338**

1. Contract Liabilities are recognised where an entity has received consideration from a customer before performance obligations have been fully met. These items would have previously been recognised as deferred income in the prior year.

16. Provisions for liabilities and charges

	2018-19 Core Dept & Agencies						2017-18 Core Dept & Agencies					
	Early departure costs	Injury Benefits	EEA medical costs	Contaminated Blood[1]	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Contaminated Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2018	**115,783**	**827,933**	**697,272**	**1,266,851**	**388,176**	**3,296,015**	**124,195**	**836,087**	**736,501**	**634,947**	**582,744**	**2,914,474**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	-	-	-	-
Provided in the year	8,064	49,025	853,432	434,844	48,180	1,393,545	7,095	35,902	840,537	542,074	13,379	1,438,987
Provisions not required written back	(3,906)	(14,650)	-	-	(28,744)	(47,300)	(4,282)	(19,119)	-	-	(85,830)	(109,231)
Provisions utilised in the year	(11,914)	(49,396)	(101,036)	(42,607)	(36,690)	(241,643)	(12,463)	(49,589)	(235,162)	(34,475)	(162,310)	(493,999)
Transfer to accruals	-	-	(498,838)	-	(29,846)	(528,684)	-	-	(620,040)	-	-	(620,040)
Borrowing costs (unwinding of discount)	115	(13,146)	(16,874)	(19,871)	(6,232)	(56,008)	295	(7,849)	(19,885)	(5,172)	(5,562)	(38,173)
Change in discount rate	(1,140)	(88,414)	(66,356)	(671,092)	(121,875)	(948,877)	943	32,501	(4,679)	129,477	45,755	203,997
Balance at 31 March 2019	**107,002**	**711,352**	**867,600**	**968,125**	**212,969**	**2,867,048**	**115,783**	**827,933**	**697,272**	**1,266,851**	**388,176**	**3,296,015**

	Early departure costs	Injury Benefits	EEA medical costs	Contaminated Blood	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Contaminated Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current	11,725	50,072	321,329	48,821	75,144	507,091	11,934	50,325	247,714	45,387	52,975	408,335
Non Current	95,277	661,280	546,271	919,304	137,825	2,359,957	103,849	777,608	449,558	1,221,464	335,201	2,887,680
Expected timing of cash flow												
Not later than 1 year	11,725	50,072	321,329	48,821	75,144	507,091	11,934	50,325	247,714	45,387	52,975	408,335
Later than 1 year, not later than 5 years	46,142	206,458	546,271	194,931	26,483	1,020,285	47,355	213,890	449,558	184,487	80,608	975,898
Later than 5 Years	49,135	454,822	-	724,373	111,342	1,339,672	56,494	563,718	-	1,036,977	254,593	1,911,782
Total	**107,002**	**711,352**	**867,600**	**968,125**	**212,969**	**2,867,048**	**115,783**	**827,933**	**697,272**	**1,266,851**	**388,176**	**3,296,015**

1. The modelling of the future cash flows for contaminated bloods indicates the majority of future outflows fall in the long term (between 11 and 40 years) and are therefore more sensitive to discount rate changes.

	2018-19 Departmental Group							2017-18 Departmental Group						
	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Contaminated Blood[1]	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Contaminated Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2018	**431,044**	**827,933**	**697,272**	**76,702,791**	**1,266,851**	**1,603,486**	**81,529,377**	**459,673**	**836,087**	**736,501**	**64,676,682**	**634,947**	**1,860,969**	**69,204,859**
Prior period adjustments in underlying accounts	(116,278)	258,872	-	-	-	(152,405)	(9,811)	3,926	-	-	-	-	(3,844)	82
Provided in the year	29,564	62,329	853,432	10,222,650	434,844	564,684	12,167,503	28,526	35,902	840,537	1,792,647	542,074	474,525	3,714,211
Provisions not required written back	(8,923)	(18,934)	-	(2,186,143)	-	(305,414)	(2,519,414)	(13,169)	(19,119)	-	(3,678,093)	-	(418,551)	(4,128,932)
Provisions utilised in the year	(28,135)	(61,305)	(101,036)	(2,359,866)	(42,607)	(221,485)	(2,814,434)	(41,857)	(49,589)	(235,162)	(2,227,542)	(34,475)	(367,067)	(2,955,692)
Transfer to accruals	(4,957)	(3,560)	(498,838)	-	-	(49,413)	(556,768)	(12,702)	-	(620,040)	-	-	(19,164)	(651,906)
Borrowing costs (unwinding of discount)	1,428	(12,389)	(16,874)	422,384	(19,871)	(7,805)	366,873	1,722	(7,849)	(19,885)	552,103	(5,172)	(7,532)	513,387
Change in discount rate	(2,612)	(93,324)	(66,356)	268,759	(671,092)	(158,882)	(723,507)	4,925	32,501	(4,679)	15,586,994	129,477	84,150	15,833,368
Balance at 31 March 2019	**301,131**	**959,622**	**867,600**	**83,070,575**	**968,125**	**1,272,766**	**87,439,819**	**431,044**	**827,933**	**697,272**	**76,702,791**	**1,266,851**	**1,603,486**	**81,529,377**

	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Contaminated Blood	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Contaminated Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current	41,460	65,852	321,329	2,423,853	48,821	685,357	3,586,672	38,455	50,325	247,714	2,598,231	45,387	690,836	3,670,948
Non Current	259,671	893,770	546,271	80,646,722	919,304	587,409	83,853,147	392,589	777,608	449,558	74,104,560	1,221,464	912,650	77,858,429
Expected timing of cash flow														
Not later than 1 year	41,460	65,852	321,329	2,423,853	48,821	685,357	3,586,672	38,455	50,325	247,714	2,598,231	45,387	690,836	3,670,948
Later than 1 year, not later than 5 years	127,008	277,478	546,271	11,714,046	194,931	282,138	13,141,872	155,576	213,890	449,558	12,885,310	184,487	349,371	14,238,192
Later than 5 Years	132,663	616,292	-	68,932,676	724,373	305,271	70,711,275	237,013	563,718	-	61,219,250	1,036,977	563,279	63,620,237
Total	**301,131**	**959,622**	**867,600**	**83,070,575**	**968,125**	**1,272,766**	**87,439,819**	**431,044**	**827,933**	**697,272**	**76,702,791**	**1,266,851**	**1,603,486**	**81,529,377**

1. The modelling of the future cash flows for contaminated bloods indicates the majority of future outflows fall in the long term (between 11 and 40 years) and are therefore more sensitive to discount rate changes.

Discount Rates

Note 1.19 Provisions provides information on the discount rates applied by the Department to expected future cashflows. HM Treasury inform departments of the short (with an expected cashflow within 0 to 5 years of the Statement of Financial Position date), medium (with an expected cashflow within 5 to 10 years of the Statement of Financial Position date) long term and very long term provisions discount rates to be employed via guidance issued annually.

Clinical Negligence

The Department of Health and Social Care provides for future costs in a number of cases where it is the defendant in legal proceedings brought by claimants seeking damages for the effects of alleged clinical negligence.

NHS England, NHS Foundation Trusts and NHS Trusts retain legal responsibility for all liabilities covered by the clinical negligence schemes: the Ex-Regional Health Authority Scheme (ex RHA), Existing Liabilities Scheme (ELS) and Clinical Negligence Scheme for Trusts (CNST), but NHS Resolution (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 £6,368 million in 2018-19 from £76,703 million at 31 March 2018 to £83,071 million at 31 March 2019. £269 million of this increase is related to a change in the HMT discount rate, and a £6,099 million net movement on provisions created and written back in the year, utilised, and unwinding of discount. These provisions are also reported in the accounts of NHSR together with other provisions of £305 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. This is particularly relevant to the IBNR element of the provision (the largest single element of total provisions, and therefore where uncertainty has the greatest effect). The table below provides a sensitivity analysis to highlight the impact on IBNR provision 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 £11,168 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 £16,919 million.

Discount rate: sensitivity to change	Estimated IBNR provision	Change to original IBNR estimate	
	£m	£m	%
1.0% decrease in the nominal discount	63,433	16,919	36
Tiered nominal discount rate structure	46,514		
1.0% increase in the real discount rate	35,346	(11,168)	(24)

The clinical negligence provision's value is particularly sensitive to changes in the long-term discount rate given its nature. The disclosures above show the impact of a change of 1.0%, however the potential change in the discount rates applied could be significantly more in the long-term meaning the uncertainty surrounding the valuation of this liability could be significantly greater than the numerical values presented.

Other factors affecting the value of the clinical negligence liability which are subject to estimation and assumption include patterns of delay in reporting incidents, assumptions regarding the severity, frequency and/or value inflation of claims, the differential between Retail Price Index (RPI) and Annual Hourly Earnings index over the long-term and life expectancy. The following table shows the impact of adjusting some of these other key assumptions used for the IBNR estimate for CNST. In each case the base assumption used for the accounting estimates is shown in the middle row of the table. The ranges of the sensitivity tests shown below are based on the variability observed in past data. They do not represent the maxima or minima of past observed values, nor the range of possible outcomes. Each change is shown separately, but in practice combinations are possible. Again, it should be noted that the relationship between changes in the value of assumptions and the IBNR provision is not always linear.

Claims value inflation: sensitivity to change	**Estimated IBNR provision**	**Change to original IBNR estimate**	
	£m	**£m**	**%**
All rates -2%	36,439	(10,075)	(22)
Base assumptions	46,514		
All rates +2%	60,259	13,745	30
Average costs of claim: sensitivity to change	**Estimated IBNR provision £m**	**Change to original IBNR estimate £m**	**%**
Reduction in average claim values of 20%	37,408	(9,106)	(20)
Base assumptions	46,514		
Increase in average claim values of 20%	55,620	9,106	20
Probability of a successfully defended claim: sensitivity to change	**Estimated IBNR provision £m**	**Change to original IBNR estimate £m**	**%**
All probabilities -5%	50,661	4,147	9
Base assumptions	46,514		
All probabilities +5%	42,367	(4,147)	(9)

The HM Treasury PES discount rate note from December 2018 states that all cash flows should be assumed to increase in line with the Office for Budget Responsibility (OBR) Consumer Price Index (CPI) inflation rates unless three specific conditions are met. NHS Resolution have determined that in relation to Clinical Negligence the three conditions have been met and have therefore used alternative inflation measures. Further information and detail is available in NHS Resolution's Annual Report and Accounts.

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 for historic liabilities under EU regulations in force at the Statement of Financial Position date is unaffected by the current position of the United Kingdom's departure from the European Union.

Contaminated Blood

The Contaminated Blood payment scheme is for individuals who were infected with HIV and/or hepatitis C following treatment with NHS-supplied blood or blood products before September 1991. These financial statements provide for the future cost of payments for which scheme beneficiaries are eligible. Beneficiaries receive lump sum and annual payments which vary depending on the stage of their condition with annual payments linked to increases in the consumer price index.

Other Provisions

These financial statements disclose other provisions of £1,272.8 million, which include 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 £73.3 million, of which £73.3 million was accounted for by NHS England Group. Of the total, £64.7 million was expected to be paid within one year, and £8.6 million between one and five years.

Other Miscellaneous provisions

The total of other miscellaneous provisions was £1,199.4 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 £620.6 million is expected to be paid within one year, £273.5 million in one to five years and £305.3 million after five years.

16.1 Pensions

Movements in defined benefit obligation and fair value of plan assets

This pension disclosure includes single entity funded defined obligation schemes for Care Quality Commission, a number of NHS Foundation Trusts and NHS England. These are mainly in respect of staff that have transferred from Local Government Pension Schemes to the listed organisations and do not relate to the NHS or Civil Service Pension Schemes disclosed early in the account. Further details can be found in the accounts of these bodies.

Reconciliation of movements in the defined obligation and the fair value of plan assets during the year for the amounts recognised in the Statement of Financial Position:

	2018-19 £'000	2017-18 £'000
Present value of the defined benefit obligation at 1 April 2018	**(808,255)**	**(748,374)**
Prior period adjustments in underlying accounts	-	1,730
Current Service Costs	(16,522)	(17,243)
Past Service Costs	(369)	(277)
Interest Costs	(21,220)	(19,973)
Settlements and curtailments	(29)	387
Contribution from scheme members	(3,232)	(3,264)
Remeasurement of the defined benefit obligation:		
Actuarial Gains and (Losses)	(34,194)	8,940
Benefits paid	20,392	19,702
Scheme transfers	(2,660)	-
Transfers to/from other bodies	(14,596)	(49,883)
As at 31 March 2019	**(880,685)**	**(808,255)**
Plan assets at fair value at 1 April 2018	**693,421**	**632,595**
Prior period adjustments in underlying accounts	-	(833)
Interest income	18,304	15,232
Settlements	(13)	(192)
Adjustments by the employer	14,440	13,925
Contributions by the plan participants	3,232	3,264
Remeasurement of the defined benefit asset:		
Expected Return on Assets	5,316	3,159
Actuarial Gains and (Losses)	27,606	4,410
Changes in the effect of limiting defined benefit asset to the asset ceiling	(310)	(798)
Benefits paid	(20,392)	(19,702)
Scheme transfers	2,028	-
Transfers to/from other bodies	8,392	42,361
As at 31 March 2019	**752,024**	**693,421**
Plan deficit at 31 March 2019	**(128,661)**	**(114,834)**

17. Contingent Assets and Liabilities disclosed under IAS 37

17.1 Contingent Assets

The Core Department has lodged a civil litigation claim seeking damages linked to civil actions around a breach of competition regulations. No further information is disclosed to ensure any prejudice of the position of the entities in relation to this activity is avoided.

NHS Providers have contingent assets of £20.0 million (2017-18: £29.4 million).

17.2 Contingent Liabilities

Unless there are compelling grounds for non-disclosure due to confidentiality considerations, 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, 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 £49,321.6 million (2017-18: £46,119.2 million), although £47,546.6 million (2017-18: £44,298.6 million) relating to the Clinical Negligence Scheme for Trusts (CNST) would be expected to be met by payments from NHS Providers.

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 £2.35 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.

Ebola

Following the Ebola outbreak in 2013 to 2016, the Department has entered into an agreement with the Ministry of Defence to cover the cost of specialist quarantine equipment in the event of an outbreak of highly infectious disease. This equipment would be required to transfer civilians by RAF aircraft using an Air Transportable Isolator (ATI) to stop the spread of infection. The liability would materialise in the event of an outbreak and the likelihood of this occurring is uncertain.

Other Contingent Liabilities

Within the NHS England Group account (which incorporates Clinical Commissioning Groups and NHS England) at 31 March 2019, there were contingent liabilities of £27.6 million (2017-18: £42.4 million). These were mainly in respect of continuing care liabilities which transferred from Primary Care Trusts (PCTs) on 1 April 2013.

NHS Providers at 31 March 2019 had net contingent liabilities of £92.8 million (2017-18: £47.6 million).

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 Accounts. 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 2018-19.

A small number of Ministers, Non-Executive Directors and members of either: The Departmental Board, Department of Health and Social Care Management Committee or the Audit and Risk Committee, have connections with a wide range of outside organisations for reasons unrelated to their work in the Department. In the normal course of its business during the year, the Department may enter into business transactions with such outside organisations or related parties. In cases where an individual within the Department has an outside connection with one of these related parties, the Department is obliged to disclose the extent of its own transactions with those organisations, as set out in the table below:

Individual	DHSC role	Organisation	Payables with related party	Purchases from related party	Receivables with related party	Sales to related party
			2018-19 £'000	2018-19 £'000	2018-19 £'000	2018-19 £'000
Prof. Dame Sally Davies	Chief Medical Officer	Cambridge University[1]	-	37,396	-	-
Prof. Dame Sally Davies/Dr Louise Wood	Chief Medical Officer/Director of Science, Research & Evidence	UK Research & Innovation (Medical Research Council)[2]	-	14,753	-	14,350
Prof. Sir Mike Richards	Non Executive Board Member	Cancer Research[3]		461	-	589
Jenny Richardson	Director of Human Resources	Medicines & Healthcare Products Regulatory Agency[4]	-	37,306	2	2,312

Sub Note
1. Prof. Dame Sally Davies' husband is an employee of Cambridge University
2. Prof. Dame Sally Davies and Dr Louise Wood are council members of UKRI
3. Prof. Sir Mike Richards is a trustee of Cancer Research
4. Jenny Richardson's partner is Chief Operating Officer of Medicines & Healthcare Products Regulatory Agency

The footnotes above identify those individuals with outside connections to the organisations listed in the table. It is important to note that the financial transactions disclosed were between

the Department and the named organisation; not the individuals named in the sub-note whom have not benefited from those transactions.

Apart from where disclosed in this note, no other Minister, Board member, member of the key management personnel or other related party has undertaken any material transactions with the Department during the year. Compensation paid to management, expense allowances and similar items paid in the normal course of business are disclosed in the notes to the accounts and in the Remuneration Report.

The non-consolidated trading fund and Public Corporations are regarded as related and transactions with the Department have been disclosed along with transactions with NHS Shared Business Services Limited, an equity investment, as set out in the table below: (See note 21 for details)

Related Party Entity	Payables with related party	Payables with related party	Purchases from related party	Receivables with related party	Sales to related party	Share capital issued/repaid to/by related party	Loans issued/(repaid to)/by related party
		2018-19	2018-19	2018-19	2018-19	2018-19	2018-19
		£'000	£'000	£'000	£'000	£'000	£'000
NHS Shared Business Services Ltd.	DHSC Equity investment (50% shareholding)	38	1,660	2	240	-	(971)
Medicines & Healthcare Products Regulatory Agency	Non Consolidated Trading Funds	-	37,306	2	2,312	-	-
NHS Blood & Transplant Agency	Public Corporation	-	81,151	-	17,677	-	-

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.

During 2018-19, two NHS Charities with net assets totalling £157.7 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 period ended 31 March 2019

	NHS Charities	
	2018-19	2017-18
	£'000	£'000
Total resources expended[1]	308,632	428,625
Total incoming resources	(147,366)	(151,638)
Net outgoing / (incoming) resources for the year ended 31 March 2019	**161,266**	**276,987**
Other Comprehensive Net Expenditure		
Net gain/loss on revaluation of charitable assets	(10,470)	(7,184)
Total Comprehensive Expenditure for the year ended 31 March 2019	**150,796**	**269,803**

1. Includes £157.7 million of expenditure representing the loss relating to the net assets transferred outside the Department's accounting boundary for the two charities that have gained independent status in the year.

19.2 Summary Charitable Statement of Financial Position as at 31 March 2019

	NHS Charities	
	2018-19	2017-18
	£'000	£'000
Non-current assets		
Charitable investments	321,692	398,585
Other charitable non-current assets	11,052	79,944
Total non-current assets	**332,744**	**478,529**
Current assets		
Charitable cash	218,242	230,219
Other charitable current assets	23,215	31,025
Total current assets	**241,457**	**261,244**
Total assets	**574,201**	**739,773**
Current charitable liabilities	(35,271)	(43,740)
Non-current assets plus/less net current assets/liabilities	**538,930**	**696,033**
Non-current charitable liabilities	(68)	(6,858)
Assets less liabilities	**538,862**	**689,175**
Total charitable reserves	**538,862**	**689,175**

19.3 Charitable Financial Assets - Investments

		NHS Charities
	2018-19	2017-18
	£'000	£'000
Balance as at 1 April	**398,585**	**657,154**
Prior period adjustments in underlying accounts	148	883
Acquisitions	46,905	59,912
Disposals	(53,636)	(75,974)
Net gain/loss on revaluation	11,830	5,109
Transfers[1]	(82,139)	(240,930)
Other movements	(1)	(7,569)
Balance as at 31 March	**321,692**	**398,585**

1. Includes £82.1 million relating to investments transferred outside the Department's accounting boundary for the two charities that have gained independent status in the year.

19.4 Other Charitable Non-Current Assets

		NHS Charities
	2018-19	2017-18
	£'000	£'000
Balance as at 1 April	79,944	106,222
Prior period adjustments in underlying accounts	81	15
Acquisitions	2,793	79
Disposals	(141)	(1,500)
Net gain/loss on revaluation	(1,360)	2,075
Impairment	-	(17)
Transfers[1]	(70,054)	(26,680)
Other movements	(211)	(250)
Balance as at 31 March	**11,052**	**79,944**

1. Includes £70.1 million relating to Non-Current Assets transferred outside the Department's accounting boundary for the two 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.

Subsequent to the Statement of Financial Position date, on the 1 April 2019, NHS Resolution is operating a new state-backed indemnity scheme for general practice in England called the Clinical Negligence Scheme for General Practice (CNSGP). It covers clinical negligence liabilities arising in general practice in relation to incidents that occur on or after 1 April 2019. The value of the liability in 2019-20 is not expected to be material to the accounts, however, the business impact in 2019-20 will be a staged increase in staffing to manage the additional scheme.

In addition, the Department of Health and Social Care has reached agreement with the Medical Protection Society Limited (MPS), one of the medical defence organisations (MDOs), in relation to existing in-scope liabilities for general practice in England for incidents prior to 1 April 2019. NHS Resolution has oversight of the arrangements for the new existing liabilities scheme and, for an interim period, claims handling will be retained by the MPS. Disclosure of any estimate of the financial impact is considered to be commercially sensitive.

Following the extension of Article 50 to 12 April 2019 and then 31 October 2019, the Department has re-baselined EU Exit plans and continued to prepare the Health and Social Care system for exiting the European Union.

21. Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2018-19.

(a) Consolidated in the Department's Annual Report and Accounts	Website
Supply Financed Agencies	
Public Health England	https://www.gov.uk/government/organisations/public-health-england
Other Bodies	
Clinical Commissioning Groups	Available on the website of the relevant organisation.
NHS Providers (NHS Trusts and NHS Foundation Trusts)	Available on the website of the relevant organisation. Additionally the Consolidated Account of NHS Providers is available at: https://improvement.nhs.uk/
Skipton Fund Limited	http://www.skiptonfund.org/home.php
NHS Charities[1]	Available on the website of the relevant organisation.
Health and Care Professions Council	http://www.hcpc-uk.co.uk/
Wiltshire Health and Care LLP[2]	http://wiltshirehealthandcare.nhs.uk/
Community Health Partnerships Limited	http://www.communityhealthpartnerships.co.uk/
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/
Supply Chain Coordination Limited[3]	https://www.supplychain.nhs.uk/sccl/
Special Health Authorities	
NHS Business Services Authority	http://www.nhsbsa.nhs.uk/
NHS Counter Fraud Authority	https://cfa.nhs.uk/
NHS Litigation Authority[4]	http://www.nhsla.com/Pages/Home.aspx
National Health Service Trust Development Authority[5]	http://www.ntda.nhs.uk/
Executive Non-Departmental Public Bodies	
Human Fertilisation and Embryology Authority	http://www.hfea.gov.uk/
Care Quality Commission	http://www.cqc.org.uk/
Monitor[5]	https://www.gov.uk/government/organisations/monitor
National Institute for Health and Care Excellence	https://www.nice.org.uk/
Professional Standards Authority for Health and Social Care	https://www.professionalstandards.org.uk/home
Human Tissue Authority	https://www.hta.gov.uk/
NHS Commissioning Board[6]	https://www.england.nhs.uk/
The Health and Social Care Information Centre[7]	http://www.hscic.gov.uk/home
Health Research Authority	http://www.hra.nhs.uk/
Health Education England	https://hee.nhs.uk/
DHSC Expert Committees/Advisory NDPBs	

These advisory bodies/advisory NDPBs are not separate legal entities, rather they are part of the Core Department account. As such they are not separately consolidated into these financial statements.
Administration of Radioactive Substances Advisory Committee
Advisory Committee on Antimicrobial Prescribing, Resistance and Healthcare Associated Infection
Advisory Committee on Borderline Substances
Advisory Committee on Clinical Excellence Awards
Advisory Committee on Dangerous Pathogens (DH)
Advisory Group on Hepatitis
Advisory Committee on Safety of Blood, Tissues and Organs
Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment
Committee on the Medical Aspects of Radiation in the Environment
Committee on the Mutagenicity of Chemicals in Food, Consumer Products and the Environment
Committee on the Medical Effects of Air Pollutants (DH)
Expert Advisory Group on AIDS
Healthwatch England
Independent Reconfigurations Panel
Joint Committee on Vaccination and Immunisation
The NHS Pay Review Body
Review Body on Doctors' and Dentists' Remuneration
Scientific Advisory Committee on Nutrition

(b) Non-Consolidated	Website
Trading Funds	
Medicines & Healthcare products Regulatory Agency	http://info.mhra.gov.uk/
Public Corporation	
NHS Blood and Transplant	http://www.nhsbt.nhs.uk/
DHSC Equity Investments	
NHS Shared Business Services (50% holding)	https://www.sbs.nhs.uk/

1) Charitable trusts, the trustees of which are an NHS Foundation Trust (as established under section 30 of the National Health Service Act 2006(a)), charitable trusts, the trustees of which are appointed for NHS Foundation Trusts in pursuance of an order under section 51 of the National Health Service Act 2006 and English NHS charities as defined by section 149(7) of the Charities Act 2011(c), with the exception of those with full independent status which are not subject to consolidation.
2) Wiltshire Health and Care LLP is a partnership formed by three Foundation Trusts.
3) Supply Chain Coordination Ltd commenced trading on 1 April 2018. It manages the NHS Supply Chain model which was previously the responsibility of NHS Business Services Authority.
4) The NHS Litigation Authority is known as NHS Resolution.
5) As of 1 April 2016, Monitor and the NHS Trust Development Authority, operate as a single organisation, NHS Improvement (NHSI) under a shared executive leadership and Board membership.
6) NHS Commissioning Board is known as NHS England.
7) The Health and Social Care Information Centre is known as NHS Digital.
8) The Department of Health & Social Care registered office is 39 Victoria Street, London, SW1H 0EU

Annexes – Not subject to audit - presented for further information

Annex A – Regulatory Reporting – Government Core Tables

The figures in **core tables 1 and 2** are from HM Treasury's public expenditure database OSCAR. This is consistent with HM Treasury publications.

Core Table 1: Public Spending

		2014-15 Outturn[1]	2015-16 Outturn[1]	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Plan
							£'000
Resource DEL							
A	NHS Commissioning Board	15,726,719	16,824,251	16,449,871	16,232,918	16,598,249	20,842,142
B	NHS Providers	65,647,034	67,296,445	68,492,416	70,750,505	75,607,340	77,306,061
C	DHSC Programme and Administration	2,928,574	2,297,393	1,579,373	1,747,178	1,107,488	1,797,155
D	Local Authorities (Public Health)	2,862,060	3,088,182	3,433,394	3,090,533	3,011,064	2,932,000
E	Public Health England	790,932	872,549	877,056	822,586	1,026,301	956,674
F	Health Education England	1,976,586	2,003,077	2,153,292	2,056,903	1,819,177	1,762,628
G	Special Health Authorities	1,460,047	2,530,619	3,489,248	4,034,160	2,718,887	2,530,452
H	Non Departmental Public Bodies	473,371	501,809	530,669	576,362	624,829	350,382
I	Arm's Length Bodies [1]	-	-	-	-	838,583	2,429,500
J	NHS Commissioning Board financed from National Insurance contributions (non voted)	18,688,977	19,316,174	20,025,641	21,338,869	21,926,343	22,694,373
Total Resource DEL		**110,554,300**	**114,730,499**	**117,030,960**	**120,650,014**	**125,278,261**	**133,601,367**
	Adjusted for classification change under ESA10 moving Research and Development to Capital DEL. For 2016-17 onwards the outturn/plans already include the reclassification adjustment.	(1,020,561)	(1,020,481)				
		109,533,739	**113,710,018**	**117,030,960**	**120,650,014**	**125,278,261**	**133,601,367**

		2014-15 Outturn[1]	2015-16 Outturn[1]	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Plan
							£'000
Capital DEL							
A	NHS Commissioning Board	189,190	182,043	227,416	227,820	221,233	305,000
B	NHS Providers	3,306,831	2,941,896	2,865,338	3,045,549	3,928,404	3,671,180
C	DHSC Programme and Administration	429,562	418,424	1,355,172	1,782,811	1,658,348	1,559,871
D	Local Authorities (Public Health)	131,666	137,648	9,325	15,456	-	0
E	Public Health England	33,938	(13,235)	51,679	70,695	(70,475)	120,900
F	Health Education England	190	287	476	628	467	2,000
G	Special Health Authorities	(167,538)	(65,867)	14,726	16,738	(49,815)	32,057
H	Non Departmental Public Bodies	26,855	30,653	31,947	78,155	95,246	107,932
I	Arm's Length Bodies [1]	-	-	-	-	157,836	121,419
Total Capital DEL		**3,950,694**	**3,631,849**	**4,556,079**	**5,237,852**	**5,941,244**	**5,920,359**
	Adjusted for Classification change under ESA10 moving Research and Development to Capital DEL. For 2016-17 onwards the outturn/plans already includes the reclassification adjustment.	1,020,561	1,020,481				
		4,971,255	**4,652,330**	**4,556,079**	**5,237,852**	**5,941,244**	**5,920,359**

		2014-15 Outturn[1]	2015-16 Outturn[1]	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Plan
							£'000
Resource AME							
K	NHS Commissioning Board	(152,068)	(253,797)	(307,784)	17,784	(19,733)	100,000
L	NHS Providers	691,782	689,956	1,025,251	662,491	1,134,119	1,875,161
M	DHSC Programme and Administration	356,482	923,064	223,184	491,136	(437,113)	676,372
N	Public Health England	11,753	(3,455)	2,223	4,623	(2,181)	5,000
O	Health Education England	(10)	14,483	4,817	(17,647)	(44)	5,000
P	Special Health Authorities	2,506,540	27,832,697	8,557,599	11,990,518	6,405,024	8,367,000
Q	Non Departmental Public Bodies	4,254	3,555	2,628	3,406	6,373	5,000
R	Arm's Length Bodies [1]	-	-	-	-	(72,480)	386,346
Total Resource AME		**3,418,733**	**29,206,503**	**9,507,918**	**13,152,311**	**7,013,965**	**11,419,879**

1.The structure of the Estimate changed in 2018-19 with the creation of an additional line in order to provide greater transparency for the reader of the Estimate.

Core Table 2: Administration Budgets

		2014-15 Outturn	2015-16 Outturn	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Plan
							£'000
Administration Budgets							
A	NHS Commissioning Board	1,713,067	1,596,259	1,497,776	1,560,979	1,508,274	1,881,549
B	NHS Providers	-	-	-	-	-	-
C	DHSC Programme and Administration	257,542	277,065	353,927	208,067	230,029	456,476
D	Local Authorities (Public Health)	223,000	-	-	-	-	-
E	Public Health England	145,221	155,611	58,925	50,661	48,778	51,386
F	Health Education England	79,438	68,254	70,783	65,304	59,943	61,276
G	Special Health Authorities	150,480	160,269	153,922	159,191	178,184	154,556
H	Non Departmental Public Bodies	304,400	296,348	259,119	259,311	248,219	260,357
I	Arm's Length Bodies	-	-	-	-	(739)	1,000
Total Administration Budget		**2,873,148**	**2,553,806**	**2,394,452**	**2,303,513**	**2,272,688**	**2,866,600**

Supporting narrative for the core tables can be found within performance section and **Annex B.**

Annex B – Financial Performance Detail

534. The Department has the largest Departmental Expenditure Limit (DEL) 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

535. Spending for all government departments is measured against a set of metrics that are agreed in HM Treasury's Spending Review. **Table 31** provides a breakdown of the consolidated budgets for all bodies in the Departmental group into the main spending metrics, including those for which Parliament formally vote each financial year.

Table 31: DHSC Departmental Expenditure Budgets – Spending Metrics

Total Department Expenditure Limit (TDEL)	Total Annually Managed Expenditure (TAME)
£130.38bn	**£11.35bn**
Total spending by DHSC, excluding AME and DEL depreciation & impairments.	Total AME spending by DHSC, excluding depreciation & impairments.

Resource Departmental Expenditure Limit (RDEL)	Capital Departmental Expenditure Limit (CDEL)	Annually Managed Expenditure - Resource (RAME)	Annually Managed Expenditure - Capital (CAME)
£125.92bn	**£5.98bn**	**£12.93bn**	**£0.02bn**
The control total for which current resource expenditure, net of income, must be contained.	The control for which capital expenditure, e.g. fixed assets additions and capital grants, net of capital disposals must be contained.	A technical control for items that HM Treasury have deemed to be demand-led or exceptionally volatile or that have no real impact on the fiscal framework, requiring no taxes be raised to cover.	A technical control for items that HM Treasury have deemed to be demand-led or volatile. For DHSC, entirely relates to costs associated with the sale of Plasma Resources UK and the Credit Guarantee Finance scheme.

Administration (Admin)
£2.46bn
Administration budgets cover the costs of all central government administration, excluding depreciation and the costs of direct frontline service provision.

536. The Department contained its resources within all budgets authorised by Parliament as shown in **Table 32**.

Table 32: Parliamentary & HM Treasury control totals

	2018-19		
	Budget £m	Outturn £m	Underspend £m
RDEL	125,924	125,278	646
CDEL	5,983	5,941	42
RAME	12,926	7,014	5,912
CAME	15	(5)	20
Further HM Treasury controls:			
Ringfenced RDEL	*1,531*	*919*	*612*
Non-ringfenced RDEL	*124,393*	*124,359*	*34*

537. 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

538. The Department's Total DEL (TDEL); a spending measure, not formally managed, consistent with the presentation of spending in HM Treasury publications, calculated as the sum of Resource Departmental Expenditure Limit (RDEL) plus Capital Departmental Expenditure Limit (CDEL) less depreciation.

539. TDEL spending continues to grow, both over the previous year and cumulatively since SR15. **Table 33** confirms the 2018-19 TDEL spending outturn and compares that to previous years.

Table 33: Total Departmental Expenditure Limit Spending

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m
TDEL spending	**117,248**	**120,584**	**125,154**	**130,300**
Growth Nominal (£)	*3,903*	*3,336*	*4,570*	*5,146*
Growth Nominal (%)	*3.4%*	*2.8%*	*3.8%*	*4.1%*

540. As shown in **Figure 15**, in 2018-19, the Departmental real-terms spending was 2.2% greater than in 2017-18 and 13.7% greater than in 2015-16.

2.2%
Spending growth in **real terms** over 2017-18

Figure 15: Real Terms Spending Growth

1. Cumulative growth figures are against the 2015-16 baseline
2. GDP Deflators at 28 June 2019 used to calculate real terms growth

NHS Total Departmental Expenditure Limit

541. The majority of the Department of Health and Social Care's budget is allocated to fund the NHS. In June 2018, the Prime Minister set out a new multi-year funding plan for the NHS to regain core performance, lay the foundations for service improvements and provide the financial security to develop a 10-year plan.

542. **Table 34** provides an explanation of the adjustments made to the NHS budget since the 2015 Spending Review.

Table 34: NHS Outturn versus SR Baseline

	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
1. NHS Funding as announced in SR 2015										
NHS RDEL Budget (exc Depreciation)	97,800	101,018	106,451	109,854	112,374	115,451	119,598			
NHS CDEL Budget	300	300	260	260	260	305	305			
NHS TDEL measure at SR15 [1]	**98,100**	**101,318**	**106,711**	**110,114**	**112,634**	**115,756**	**119,903**			
*Nominal cumulative **NHS TDEL** Growth v 2014-15 baseline*		*3,218*	*8,611*	*12,014*	*14,534*	*17,656*	***21,803***			
2. Additional NHS RDEL funding adjustments announced in a) Autumn Budget 2017, b) NHS Mandate and c) HM Government Long Term Settlement										
NHS RDEL Budget (exc Depreciation) at SR15	**97,800**	**101,018**	**106,451**	**109,854**	**112,374**	**115,451**	**119,598**			
(a) 2017-18 Autumn Budget [2]	0	0	0	337	1,601	901	0			
(b) NHS Mandate Adjustments [3, 4]	-702	-446	-749	-655	-172	-736	-793			
NHS RDEL as per NHS Mandate	**97,098**	**100,572**	**105,702**	**109,536**	**113,803**	**115,616**	**118,805**			
(c) Additional NHS funding as per LTS					800	5,191	8,202	133,283	139,990	148,467
NHS RDEL Budget (exc Depreciation) at LTS [5]					**114,603**	**120,807**	**127,007**	**133,283**	**139,990**	**148,467**
*Nominal cumulative **NHS RDEL** Growth v 2018-19 baseline (excluding pensions)*						*6,204*	*12,404*	*18,680*	*25,387*	***33,864***
3. Further budget changes since LTS										
NHS RDEL Budget (exc Depreciation) at LTS					**114,603**	**120,807**	**127,007**	**133,283**	**139,990**	**148,467**
Adjustment for NHS Pensions [5]					0	2,851	2,851	2,851	2,851	2,851
NHS Mandate Adjustments [6]					-182	-96	-1	0	0	0
NHS RDEL Budget at per NHSE Mandate					**114,421**	**123,562**	**129,857**	**136,134**	**142,841**	**151,318**
4. Latest reported outturn	Actual					Plan				
NHS RDEL Budget	**97,098**	**100,572**	**105,702**	**109,536**	**114,421**	***123,562***	***129,857***	***136,134***	***142,841***	***151,318***
Plus NHS providers deficit and NHS charities			935	1,038	826					
Plus Net commissioner and NHSE underspend			-902	-970	-916					
Net NHS RDEL Outturn [3]	**97,098**	**100,572**	**105,735**	**109,605**	**114,331**	***123,562***	***129,857***	***136,134***	***142,841***	***151,318***
NHSE CDEL	189	182	240	228	221	305	305			
NHS TDEL	**97,287**	**100,754**	**105,975**	**109,833**	**114,552**	**123,867**	**130,162**			

Notes to table:

1. Paragraph 11.6 of the Spending Review and Autumn Statement 2015 publication - https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015
2. Paragraph 7.2 of the Autumn Budget 2017 publication: https://www.gov.uk/government/publications/autumn-budget-2017-documents/autumn-budget-2017
3. In order to be comparable with SR15 (i.e. 2016-17 to 2020-21), NHS RDEL NRF outturns for 2013-14 to 2015-16 have been adjusted to apply a transfer of function from NHSE to Local Authorities for 0-5 years commissioning that occurred halfway through 2015-16, across all years; and net NHS overspends have been removed as these did not form part of the SR baseline
4. Mandate adjustments are as published in the annual Financial Directions to NHS England
5. NHS Long Term Settlement and pensions funding details are set out in the 2019-20 Financial Directions to NHS England - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803055/financial-directions-to-nhs-england-2019-to-2020.pdf
6. Details of 2018-19 changes are set out in the 2018-19 Financial Directions to NHS England - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803076/revised-financial-directions-to-nhs-england-2018-to-2019.pdf Details for later years are contained in the 2019-20 directions.

Resource Departmental Expenditure Limit

£125.9bn RDEL Budget

543. The Department's total 2018-19 Resource DEL (RDEL) represents the consolidated resource 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).

544. 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.

545. In 2018-19, our National Insurance Contributions receipts were in line with the funding set out in the Parliamentary Estimate.

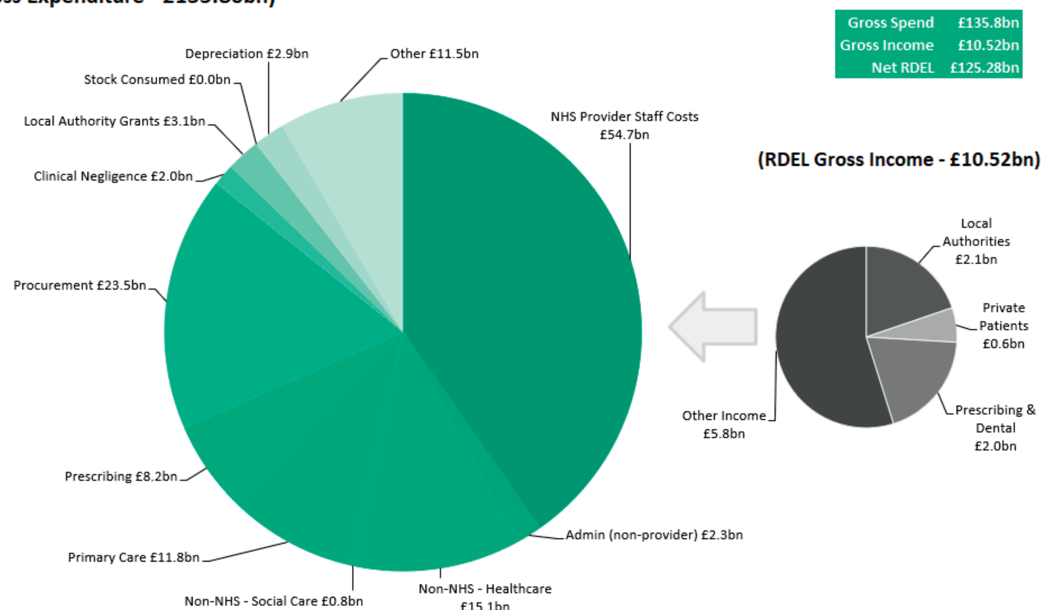
546. **Table 35** summarises the RDEL outturn against budget since 2015-16; highlighting the £646 million underspend in 2018-19.

Table 35: Resource DEL

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m
RDEL Budget	114,523	117,594	121,342	125,924
RDEL Spending Outturn	**114,730**	**117,031**	**120,650**	**125,278**
Underspends / (Overspends) (£m)	*(207)*	*563*	*692*	*646*
Underspends / (Overspends) (%)	*-0.181%*	*0.479%*	*0.570%*	*0.513%*

547. A breakdown of RDEL expenditure can be found in **Figure 16**.

Figure 16: Resource DEL – spending breakdown (also see SoPS 1.1)



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

RDEL: Funding Flows and Sector Breakdown

548. Of the Department's total 2018-19 RDEL budget (£125.9 billion), £113.8 billion was allocated directly to NHS commissioners, with the remainder (£12.1 billion) funding ALBs and the Department's central budgets i.e. the non-NHS sector.

549. 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.

550. Across Government, this 'Internal Market' is unique to the Department of Health and Social Care and adds an additional layer of complexity as all inter-group trading needs to be eliminated on consolidation when preparing the Departmental Group account (via an 'Agreement of Balances' exercise).

551. Approximately £76 billion of resource 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.

552. The RDEL budget is set net of income and in 2018-19 the Departmental Group received around £10 billion of RDEL income from varying sources. This was mainly received by NHS providers and included prescribing and dental charges, trading with Local Authorities and income from treating private patients.

RDEL: Outturn

553. 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 2018-19. 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 deliver financial balance.

NHS Financial Performance – NHS Commissioners

554. The Government's mandate to NHS England in 2018-19[188] separately set out NHS England's resource and capital funding limits against spending controls. These spending controls stem from the same controls that HM Treasury apply to the Department of Health and Social Care. NHS England must ensure that spending is contained within each of these funding limits. **Table 36** provides a breakdown of that spending.

90%
of total DHSC RDEL

Table 36: NHS RDEL

	Limit £m	Spending Outturn £m	Under/(Over) spend £m
NHS England RDEL	113,621	112,705	916
NHS England Depreciation (RF RDEL)[1]	166	132	34
Total NHS England RDEL	113,787	112,837	950
of which Admin	*1,821*	*1,588*	*233*
Total NHS England AME	100	(20)	120

1. Funding for depreciation costs are ring-fenced under HM Treasury spending rules and cannot be used to fund other "non-ring-fenced" spending.

555. The overall non-ringfenced DEL position for NHS England is a managed underspend of £0.92 billion against the planned underspend of £0.27 billion, a positive variance to plan of £0.65 billion. A further underspend of £0.03 billion on rinfenced budgets resulted in a combined underspend of £0.95 billion against the agreed RDEL spending control.

556. The vast majority of healthcare services are purchased from NHS providers (NHS Trusts and Foundation Trusts); however, £14 billion of these types of services were purchased from non-NHS healthcare providers in 2018-19. These non-NHS providers include Local Authorities, voluntary sector/not for profit organisations, Devolved Administrations and private sector providers. **Table 37** provides a breakdown of this spending and compares to 2017-18.

[188] https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019

Table 37: Purchase of healthcare from non-NHS Providers

	2017-18 £m	2018/19 £m
Independent Sector Providers	8,765	9,180
Voluntary sector/Not for profit	1,564	1,619
Local authorities	2,737	2,899
Devolved Administrations	43	50
Total Spend on all non-NHS bodies	**13,109**	**13,749**
Total RDEL	**120,650**	**125,278**
Spend with private sector as a % of total RDEL	7.3%	7.3%
Spend on all non-NHS bodies as a % of total RDEL	10.9%	11.0%

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. Table may not sum due to roundings.

557. Further commentary, together with the consolidated accounts of the NHS England group, is published on NHS England's website.

NHS Financial Performance – NHS Providers

558. At the 2018-19 financial year-end, there were 230 provider organisations producing accounts during the year. Together these providers ended 2018-19 with a net financial pressure on the overall Resource DEL outturn of circa £0.8 billion, £0.4 billion over plan. **Table 38** details the reported net deficit, plus Resource DEL scoring adjustments relating to the categorisation of provisions, PFI, donated assets and prior period adjustments.

Table 38: NHS Providers RDEL Breakdown

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m
Total Provider Deficit	**2,448**	**791**	**991**	**827**
Provisions Adjustment	74	43	39	(23)
Other Adjustments[1]	27	101	8	22
Total Resource DEL	**2,548**	**935**	**1,038**	**826**

1. Other adjustments – these include adjustments to reflect the correct DEL scoring of income and depreciation of donated assets and of PFI spending.
2. Totals in the table may not sum due to rounding.

559. Despite the challenging environment, the majority of providers continue to demonstrate that strong, effective and sustainable financial management is possible. Whilst trusts ultimately reported a position that exceeded NHSI's plan, the financial performance of the provider sector improved from 2018-19.

560. The majority of providers, 150 (65%) continue to report a year-end position that is equal to or better than their agreed control totals.

561. **Table 39** provides a breakdown of the reported deficit and position against control totals.

Table 39: Summary of NHS Provider's surplus / (deficit)

	Deficit		Surplus		Net	
	number	£m	number	£m	number	£m
Plan						
Providers with agreed control totals	76	(1,011)	125	1,060	201	49
Remaining providers	28	(1,097)	1	0	29	(1,097)
Uncommitted STF & Other adjustments						653
Net	**104**	**(2,107)**	**126**	**1,060**	**230**	**(394)**
Outturn						
Equal to or better than control totals	32	(345)	118	1,869	150	1,524
Exceeded control totals	46	(1,112)	5	20	51	(1,092)
Remaining providers	29	(1,298)	0	0	29	(1,298)
Adjustments						39
Net	**107**	**(2,755)**	**123**	**1,889**	**230**	**(827)**
Variance	***3***	***(648)***	***(3)***	***829***	***0***	***(433)***

1. Other adjustments relate to minor reporting adjustments relating to differences between control totals and reported surplus/(deficit), where reported surplus/(deficit) includes items such as donated asset income and depreciation, changes in provisions discount rates and prior period adjustments not included in control totals.
2. Totals in the table may not sum due to rounding.

Non-NHS Bodies - Financial Performance Resource DEL Spending

10%
of total DHSC RDEL

562. Outside of the NHS sector, the Department's non-NHS sector contained resource expenditure within DEL spending limits, absorbing a material starting over-commitment, primarily as a result of the contributions made as part of the 2015 Spending Review (SR15) and transferring an additional £540 million of funding to NHS budgets to support core NHS front-line services. This was extremely challenging, and some hard decisions were taken to reduce the non-NHS risk without compromising the support of the wider system, whilst safeguarding the interests of patients and the wider public.

563. During 2018-19, unmanageable pressures emerged relating to:
- Increasing NHS workforce support activity requiring additional initiatives to increase supply of future workforce, and a slower completion rate of movement from bursary-funded education courses to loans.
- Delays in implementation of the increase to the Immigration Health Surcharge, meaning less income was received than had been initially planned for.
- Price, volume and foreign exchange pressures on demand-led reciprocal healthcare commitments, which has been particularly prevalent since the EU referendum.

564. Despite our efforts, these pressures could not be closed in totality and HM Treasury agreed that the Department provided reserve funding for unexpected and one-off issues, including additional pressures driven by preparation for No-Deal EU Exit. In addition, as committed by HM Government, DHSC was provided funding for the change in the Personal Injury Discount Rate (PIDR) – this is separately disclosed in **Table 40**.

565. Overall, the sector operated within RDEL spending limits, ensuring financial balance across the non-NHS sector. This has been done without compromising the support of the wider system, whilst safeguarding the interests of patients and the wider public.

566. The summarised RDEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 40**.

Table 40: Summarised Financial Position for DHSC's ALBs in 2018-19

	Plan £m	Outturn £m	Variance £m
RDEL Non Ring-fenced Spending -			
Opening over-commitment	(120)		(120)
Public Health England	776	758	18
Public Health Local Authority Grants	3,011	3,011	(0)
Health Education England	4,439	4,445	(6)
NHS Resolution	146	25	121
NHS Resolution (2018-19 reserve claim for Personal Injury Discount	400	368	32
NHS Property Services	(156)	(108)	(48)
Community Health Partnerships (CHP)	20	11	9
NHS Digital	372	371	1
Other ALBs	1,210	1,067	143
European Economic Area (EEA) medical costs	730	724	6
PPRS	(558)	(569)	11
Agenda for Change	796	796	0
Other DHSC Central Budgets	692	884	(192)
Subtotal DHSC & other ALBs Non Ring-fence	**11,757**	**11,782**	**(25)**
Public dividend capital (PDC) payments and loan interest	(985)	(955)	(30)
Total Non-NHS Non Ring-fence	**10,772**	**10,827**	**(55)**
RDEL depreciation ring-fence	1,365	787	578
Total RDEL	**12,137**	**11,615**	**522**

1. Includes NHS Provider ring-fence as this is excluded from the NHS Mandate.
2. Table may not sum due to roundings.

Capital Departmental Expenditure Limit (CDEL)

567. The Department's total 2018-19 CDEL outturn is the consolidated net capital spending of all bodies within the Departmental group.

£6.0bn
CDEL Budget

568. **Table 41** summarises the CDEL outturn against budget since 2015-16; highlighting the £42 million (0.7%) underspend in 2018-19.

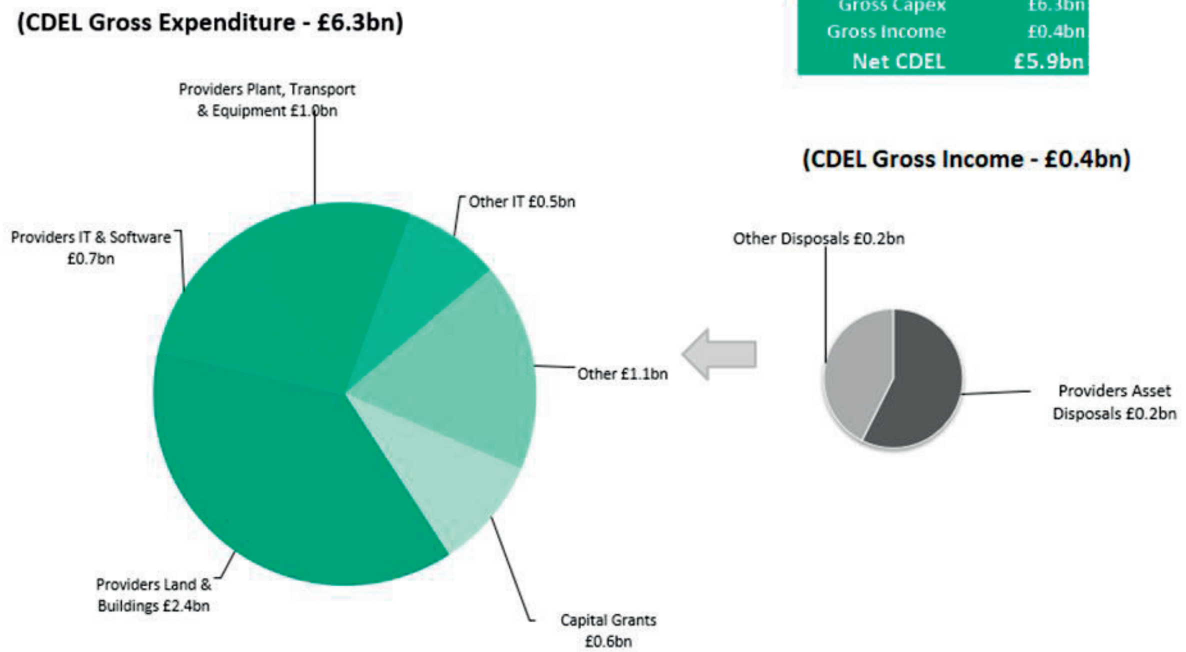
Table 41: Capital DEL Outturn[1]

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m
CDEL Budget	4,710	4,616	5,598	5,983
CDEL Spending Outturn	**4,652**	**4,556**	**5,238**	**5,941**
CDEL Underspend	*58*	*60*	*360*	*42*
CDEL Underspend %	*1.23%*	*1.30%*	*6.43%*	*0.70%*

1. All years have been adjusted to take account of the reclassification of research & development expenditure to capital under ESA 10.
2. Totals in the table may not sum due to rounding.

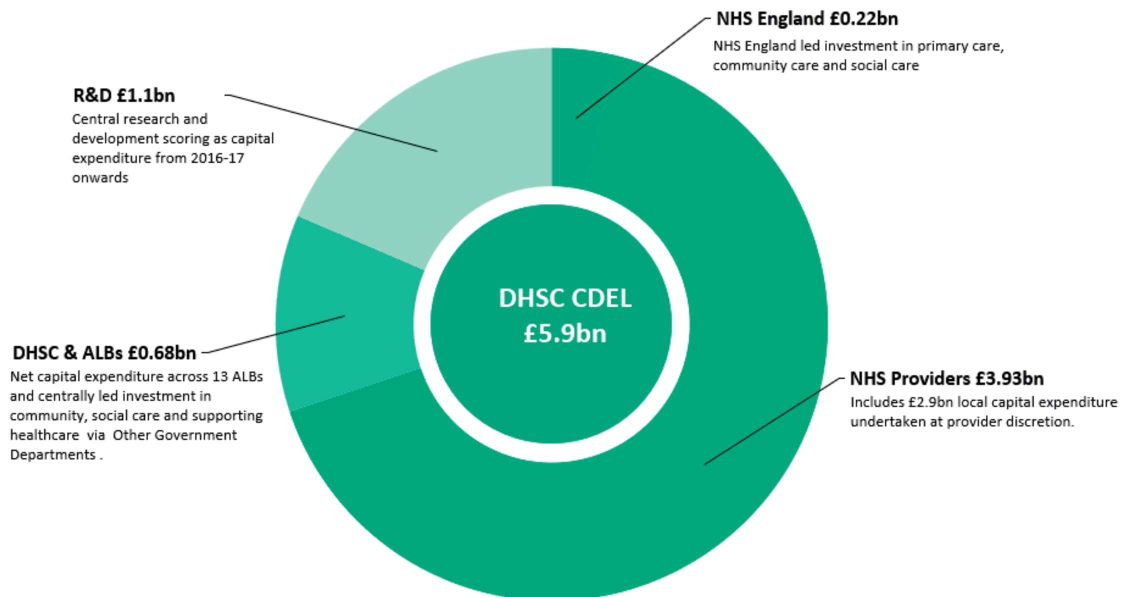
569. **Figure 17** provides a breakdown of 2018-19 capital spend (CDEL) by expenditure type.

Figure 17: Capital DEL - spending breakdown (also see SOPS 1.2)



570. **Figure 18** provides a breakdown of 2018-19 capital spend (CDEL) by sector within the DHSC group.

Figure 18: Capital DEL spending breakdown by sector



NHS Finance - NHS Providers Capital Expenditure

571. As shown in **Figure 18**, NHS provider capital expenditure (CDEL), net of charities contributions, was £3.932 billion in 2018-19. This is significantly higher than the equivalent level of net investment in 2017-18 (£3.063 billion), reflecting increased levels of available funding generated locally, which allows the NHS to confidently allocate more cash to longer-term capital investment programmes. There was also an increased level of central capital financing for strategic programmes of investment.

572. NHS providers finance the majority of capital expenditure themselves (76% during 2018-19) by deploying surplus cash reserves, and any capital loans taken out. This investment is shown as the Local Capital Expenditure line in **Table 42**. The Department, and its ALBs, also inject financing to support specific strategic initiatives.

573. **Table 42** shows how the 2018-19 NHS provider CDEL outturn of £3.932 billion was financed.

Table 42: Financing of Capital DEL

	2018-19 £m
Capital DEL Outturn	**3,932**
Of which	
Local Capital Expenditure[1]	2,992
DHSC & ALB initiatives	790
PFI Residual Interest[2]	150
Capital DEL Allocation Set	**3,555**
Variance Under/(Over)	***(377)***

1. Capital Expenditure, financed from internally generated funds; cash from surpluses, depreciation, and monies loaned (from DHSC or externally).
2. HMT's budgeting framework requires PFI residual interest on assets to score to CDEL.

574. The Capital DEL affordable envelope for NHS providers for 2018-19 was £3.555 billion. NHS provider investment levels resulted in an overspend against this Capital DEL target of £377 million.

575. The increased investment has been driven by a range of factors including:
- The impact on CDEL, following the collapse of Carillion plc, the transfer of assets into public ownership at Sandwell and West Birmingham Hospitals NHS Trust and The Royal Liverpool and Broadgreen University Hospitals NHS Trust;
- NHS providers utilising increased available internally generated cash resources to fund increased levels of capital expenditure.

576. As mentioned previously, the Department and its Arm's Length Bodies have led specific initiatives over the year and issued non-repayable financing in the form of Public Dividend Capital (PDC), directly to NHS providers amounting to £543 million.

577. Further details of these investments can be found in the report 'Financial Assistance under Section 40 of the National Health Service Act 2006' for 2018-19, which is published alongside this Annual Report. There have been a several large schemes supporting continued transformation of the delivery of healthcare, through advancing use of information technology and A&E reconfigurations, as recommended in the NHS Five Year Forward View. These allocations are summarised in **Table 43**.

Table 43: Capital PDC Allocations 2018-19

	2018-19 Total £m
Non-Programme	
Non-Programme PDC	**247**
DHSC Programme Initiatives PDC	
Urgent & Emergency Care (Winter Capital)	141
STP Capital Transformation Funding	80
Health System Led Technology Investment	68
Global Digital Exemplars	66
Linear Accelerator Investment	46
Proton Beam Therapy	36
Cancer Transformation Fund	28
Secondary Care WIFI	25
Electronic Prescribing	16
Local Health Care Record Exemplars	15
Perinatal Mental Health	9
Other Schemes under £5m	13
Total Programme	**543**
Total PDC	**790**

Overall DHSC Group Capital Expenditure

578. In summary, the NHS sector capital expenditure overspend of £340 million netted off with underspends in the non-NHS sectors results in an overall underspend of £42 million across the Departmental Group capital DEL limit.

RDEL Administration

579. 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).

580. In 2018-19, DHSC underspent by £605 million against the total Resource Administration limit of £2.9 billion, circa £330 million related to underspends in the element of the budget limit ring-fenced for depreciation and impairments expenditure.

581. The Department and our ALBs continue to reduce administration costs compared to prior years building on the one third savings delivered as a result of the Health and Social Care Act 2012 reforms.

582. Over the course of the Spending Review 2015 period, further efficiencies will be delivered across the sector in line with the settlement.

583. **Table 44** shows the non-ringfenced administration outturn with spending in 2018-19 reducing by around £33 million (1.5%) compared to 2017-18, maximising the amount of funding available for frontline services.

Table 44: DHSC non-ringfenced Administration

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m
Administration Outturn	2,421	2,275	2,222	2,189

1.Figures do not include depreciation and as a result will not directly reconcile to Admin outturn as per Statement of Parliamentary Supply (£2,273m).

Annually Managed Expenditure (AME)

£12.9bn

AME Budget

584. Details of the Department's total 2018-19 AME budget and expenditure are set out in **Table 45**, which shows the Department underspent by £5.9 billion (45.7%) against its final Resource AME budget.

Table 45: Annually Managed Expenditure plans, outturns and under/ (over) spends

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m
Resource AME Budget	31,272	16,150	27,940	12,926
RAME Outturn	**29,207**	**9,508**	**13,152**	**7,014**
Underspend/(Overspend) £m	*2,065*	*6,642*	*14,788*	*5,912*
Underspend/(Overspend) %	*6.6%*	*41.1%*	*52.9%*	*45.7%*
Capital AME Budget	15	15	15	15
Capital AME Outturn	**9**	**13**	**0**	**(5)**
Underspend/(Overspend) £m	*6*	*2*	*15*	*20*
Underspend/(Overspend) %	*40.0%*	*13.3%*	*100.0%*	*132.0%*

585. The Department's AME provision (Resource and Capital) is set annually outside the Spending Review and the resource 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.

586. 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.

587. The final AME budget in 2018-19 was set at £12.9 billion. The main element of DHSC's AME relates to clinical negligence expenditure in NHS Resolution (NHSR). The AME budget for NHSR was re-set as part of the Supplementary Estimates and included an estimate of expenditure based on the mid-range of several scenarios produced by NHSR's actuarial advisors.

588. As a result of favourable reductions, including the number of clinical negligence claims and reductions in cost, the estimated quantum of future clinical negligence expenditure at the end of 2018-19 was around £4.2 billion lower than had been forecast.

Annex C – NHS Operational Performance

NHS Operational Performance against waiting time standards

589. The Department, through its arm's length bodies; including NHS England and NHS Improvement, worked to support NHS providers and to take actions designed to stabilise and recover performance.

590. The NHS Long Term Plan (LTP) launched on 7 January 2019 by the NHS and supported by the Government with investment of £33.9 billion in cash terms by 2023-24, will transform patient care and make sure every penny of taxpayers' money is spent wisely. This long-term funding will allow the NHS to get back on the path to delivering core performance standards. It will help drive the reforms that deliver a better and more sustainable NHS with improved care for patients.

591. Under the LTP, the local NHS is being allocated sufficient funds over the next five years to; grow the amount of planned surgery year on year, to cut long waits, and reduce the waiting list. The phasing of this will be determined annually through the planning guidance process. It will redesign outpatient services and reduce the need for face to face appointments in hospitals, saving patients time and freeing up medical and nursing time. For urgent care it means 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online and increasing use of same day emergency care. By 2023, the clinical assessment service (CAS) will act as the single point of access for patients, carers and health professionals, for integrated urgent care and discharge from hospital care, further reduce delayed transfers of care (DTOC), in partnership with local authorities.

592. We recognise the pressure that winter places on the NHS. It is thanks to the efforts and dedication of hard-working frontline staff that last winter (December 2018 to March 2019) 3,144 more people a day were seen in A&E and admitted or discharged within four hours compared to the previous winter.

593. The Department will support its partners by:
    - delivering against cancer waiting times standards;
    - introducing a new cancer waiting times target that, by 2020, NHS cancer patients will be given a definitive diagnosis or the 'all clear' within 28 days of being referred by a GP.
    - eliminating long waits for treatment.

A&E Waiting Times

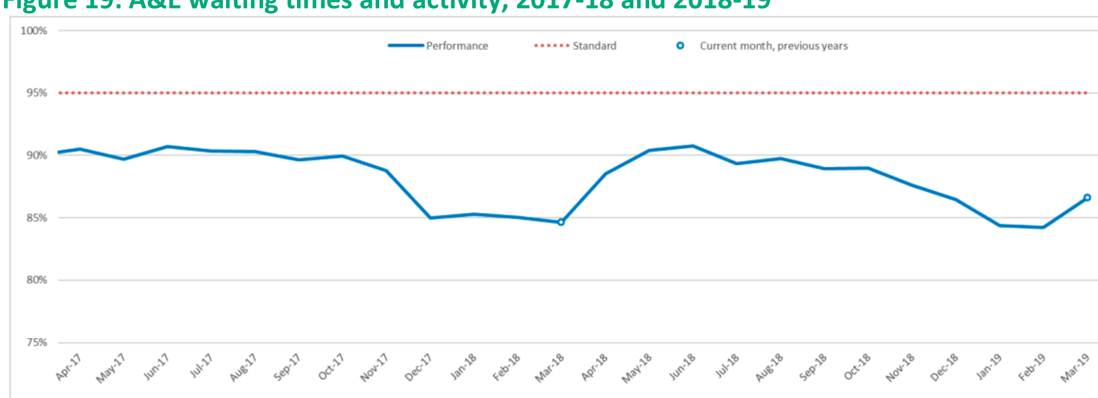
594. National performance for A&E waiting times[189] in 2018-19 was 88.0%. This did not meet the standard that 95.0% of patients should be admitted, transferred or discharged within four hours of arrival in an A&E department. Performance was lower than 2017-18 when it was 88.3% and is the lowest ever recorded performance. The standard has not been met since July 2015 (95.0%).

[189] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

595. The decline in performance as shown in **Figure 19** should be seen in the context of increasing demand for non-elective services. A&E attendances in 2018-19 were 4.2% higher than in 2017-18, increasing from 23.8 million in 2017-18 to 24.8 million. Over the same period, the total number of emergency admissions from A&E increased by 5.9% from 6.0 million in 2017-18 to 6.4 million in 2018-19.

596. Tackling long stays in hospital will reduce risk of patient harm, unwarranted cost, and improve our ability to deliver high quality services. This ambition would free up at least 4,000 beds compared to 2017-18. Shorter stays benefit patients who would otherwise be stuck in hospital when they are well enough to leave, as well as freeing up beds for those who are sicker. Many older people, particularly those who are frail and may have dementia, actually deteriorate while in hospital - a stay of more than 10 days leads to 10 years' muscle ageing for people most at risk.

Figure 19: A&E waiting times and activity, 2017-18 and 2018-19



Ambulance Response Programme

597. Following an independent evaluation of extensive trials covering 14 million emergency 999 calls. In July 2017 the Secretary of State approved NHS England's recommendation to implement an improved ambulance performance framework.

598. The previous Red1/Red2/A19 standards have been replaced by six standards over the new call categories of C1 to C4.

599. For C1 (life threatening calls, for time-critical events needing immediate intervention), and C2 (emergency calls, for potentially serious conditions needing rapid assessment) the mean response and 90th centile are measured as seen in **Figure 20**. The standards[190] for C1 and C2 calls are as follows (**Table 46** sets out performance comparisons between 2017-18 and 2018-19 data):

- C1: 7 minutes mean response time
- C1: 15 minutes 90th centile response time
- C2: 18 minutes mean response time
- C2: 40 minutes 90th centile response time

Table 46: Ambulance Response Performance

Category	Mar-19	Mar-18	Change
Cat 1 mean	7:00	8:35	▲ -01:35
Cat 1 90th centile	12:11	14:56	▲ -02:45
Cat 2 mean	21:15	27:44	▲ -06:30
Cat 2 90th centile	43:12	59:17	▲ -16:05
Cat 3 90th centile	145:11	179:36	▲ -34:25
Cat 4 90th centile	183:45	217:22	▲ -33:37

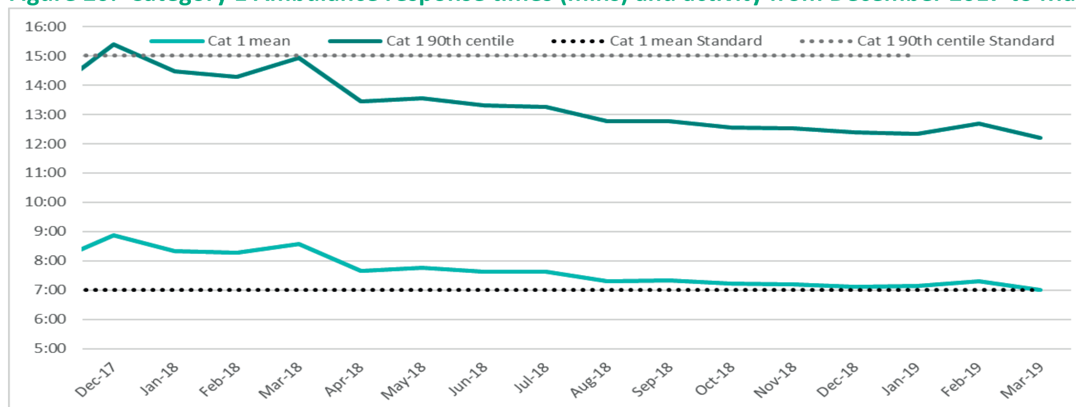
600. For C3 (urgent calls, needs treatment to relieve suffering) and C4 (non-urgent calls, needs face-to-face or telephone assessment), the 90th centile is measured. The standards for C3 and C4 calls are as follows:
    - C3: 120 minutes 90th centile response time
    - C4: 180 minutes 90th centile response time

601. By December 2017, all trusts were reporting against the ARP standards; data for 2017-18 therefore only includes performance for four months (from December 2017 to March 2018). Data for 2018-19 includes the full 12 months.

602. The C1 90th standard was met in every month of 2018-19 and for three of the four months reported against in 2017-18. Since August 2018, all trusts have met this standard (except for Isle of Wight when they began reporting in December 2018). The C1 mean was met for the first time in March 2019. C3 was met once and C4 was met twice in 2018-19. The C2 standard has not been met.

603. NHSE carried out a review of the Ambulance Response Programme implementation, which was published in September 2018[191]. Recommendations of the review included use of an ambulance balanced scorecard to support system wide understanding of ambulance performance, and further development of clinical quality indicators for sepsis, falls, and mental health.

Figure 20: Category 1 Ambulance response times (mins) and activity from December 2017 to March 2019



[191] https://www.england.nhs.uk/publication/the-ambulance-response-programme-review/

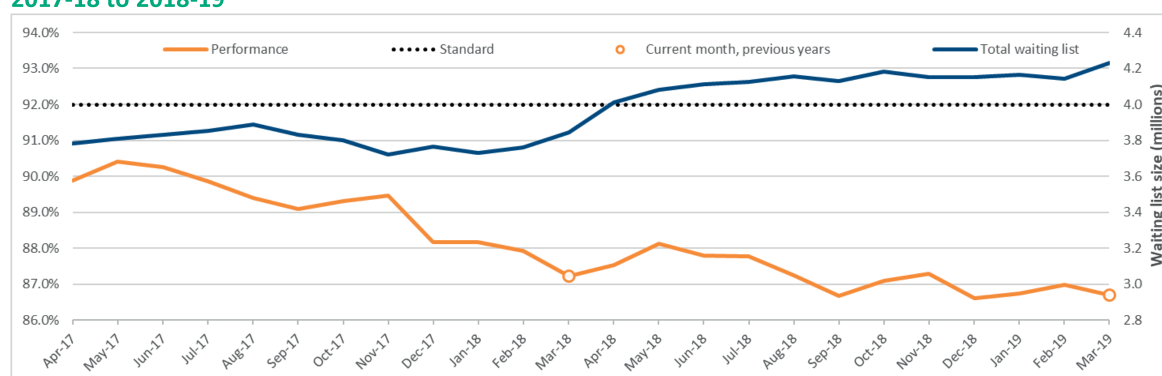
Referral to Treatment

604. Elective waiting times are monitored against the referral to treatment (RTT) incomplete pathway standard, in that a minimum of 92% of patients still waiting to start consultant-led treatment for non-urgent conditions at the end of the month, should have been waiting less than 18 weeks from referral. Published performance was 86.7% in March 2019, compared to 87.2% in March 2018. **Figure 21** shows that the standard was not met in 2018-19 and was last met in February 2016. The number of people waiting for elective treatment has continued to increase throughout 2018-19.

605. Deteriorating performance against the standard is a result of a mismatch between demand and activity and the reduced capacity to treat more complex patients. GP referrals show only slight increases when comparing 2017-18 and 2018-19, however other referrals have increased. 2018-19 saw the number of 1st outpatients increase by 3.7% to 19.1 million, compared to the 18.4 million in the same period in 2017-18.

606. Also shown in **Figure 21,** NHS England's reported waiting list was 4.23 million in March 2019 compared to 3.85 million in March 2018, an increase of 10.0%. Once the data for 'non-reporters' is added to the waiting list this increases from 4.10 million in March 2018 to 4.34 million in March 2019.

Figure 21: Percentage of patients on RTT incomplete pathways waiting within 18 weeks from referral, 2017-18 to 2018-19



Cancer Waiting Times

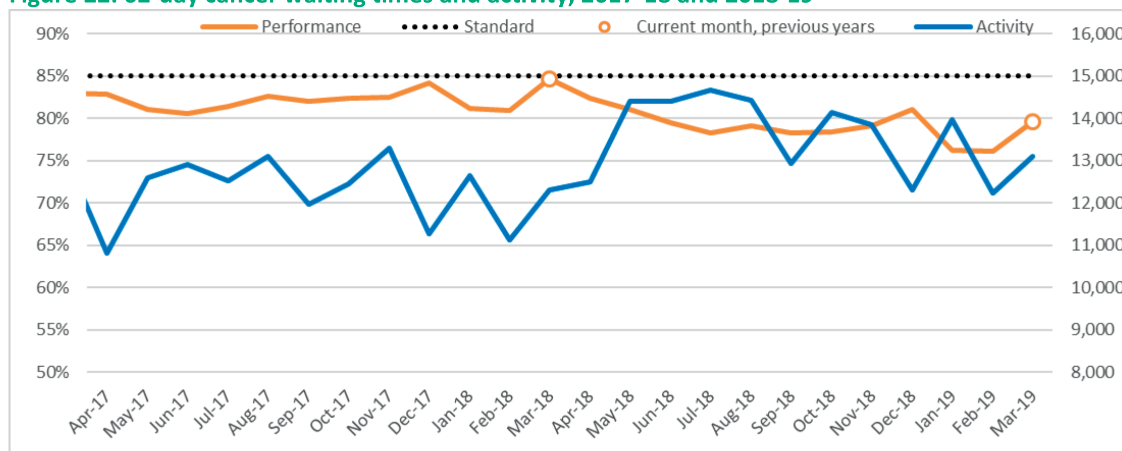
607. Early diagnosis and treatment are crucial to improving survival rates for cancer, and currently eight cancer waiting time standards[192] cover different elements of the pathway, to ensure patients benefit from better access to cancer services.

608. As shown in **Figure 22**, the standard that 85% of patients begin first treatment within 62 days of an urgent GP referral for suspected cancer was not met in any month of 2018-19 or any month of 2017-18 and was last met in December 2015. Demand continued to rise, with urgent GP referrals for suspected cancer increasing by 15.7% from 1.94 million in 2017-18 to 2.24 million in 2018-19 over the same period.

[192] 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.

609. NHS England plans to start performance managing trusts against the new 28-day faster diagnosis standard from April 2020. The standard is that patients should receive a cancer diagnosis or all clear within 28 days of their first GP appointment. The new Cancer Waiting Times system will be able to measure the new standard (in piloted trusts) from April 2018 with a view to collecting data from all trusts from April 2019. The new faster diagnosis standard will assist the recovery of the 62 day from GP urgent referral to a first treatment for cancer (85%) standard.

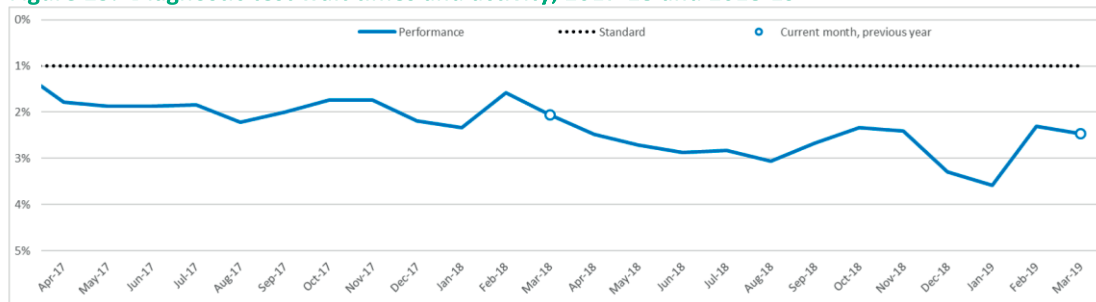
Figure 22: 62-day cancer waiting times and activity, 2017-18 and 2018-19



Diagnostic Tests

610. Waiting times for diagnostic tests[193] are an important contributor to all NHS (including cancer) treatment, because the vast majority of patients require a diagnostic test to determine whether and what treatment is necessary. As shown in **Figure 23**, the standard that less than 1% of patients should be waiting more than six weeks for a diagnostic test at the end of the month was not met in any month for the 15 diagnostic tests measured, although the average (median) waiting time in March 2019 was 2.1 weeks. Furthermore, 96% of patients were waiting less than six weeks for their diagnostic test in every month of 2018-19. This performance needs to be seen in the context of significant increases in demand for diagnostics tests - with the number of tests carried out increasing by 5.0% from 21.9 million in 2017-18 to 23.0 million in 2018-19.

Figure 23: Diagnostic test wait times and activity, 2017-18 and 2018-19



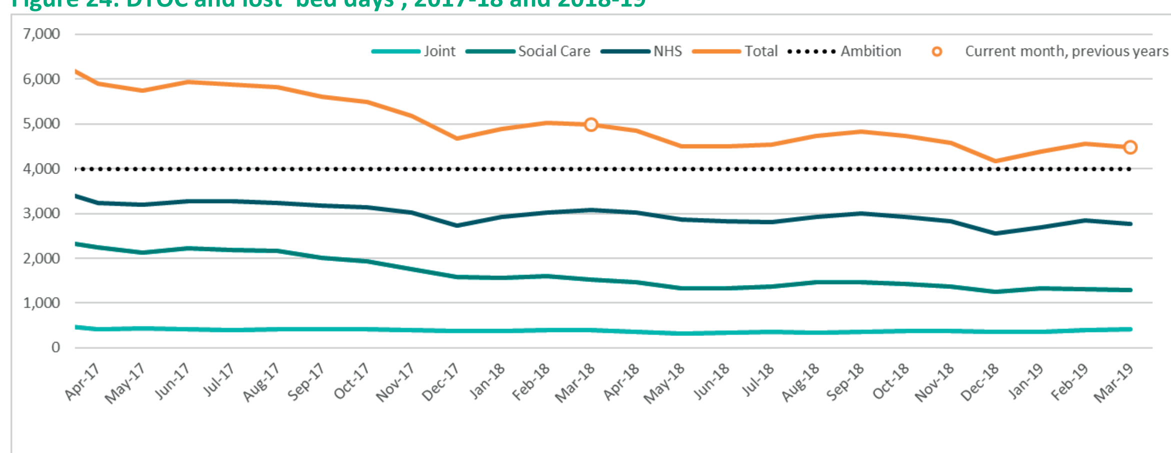
193 https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/

Delayed Transfers of Care

611. A delayed transfer of care (DTOC) is defined as when a patient is ready to depart from hospital care but is still occupying a bed. This Government is clear that no-one should stay in a hospital bed longer than necessary. The number of bed days lost because of delayed transfers of care decreased by 15.9% in 2018-19, from 1.98 million in 2017-18 to 1.67 million in 2018-19.

612. As shown in **Figure 24**, in March 2019, delayed transfers of care accounted for 4,478 occupied beds per day compared with 4,984 in March 2018 – a decrease of 10.1%. All local systems are continuing to implement the High Impact Change Actions to reduce DTOC (as referenced in the Five Year Forward View Next Steps Document and the Better Care Fund Policy Framework[194]).

Figure 24: DTOC and lost 'bed days', 2017-18 and 2018-19



[194]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

Annex D – Other Departmental Information

Sustainability Data

613. **Tables 47-49** outline the progress on greenhouse gas emissions, waste and water consumption for the bodies within the Departmental Group that are in scope. ALBs not included in these tables are HTA, HFEA, NHS Resolution & HRA due to de minimis exclusion.

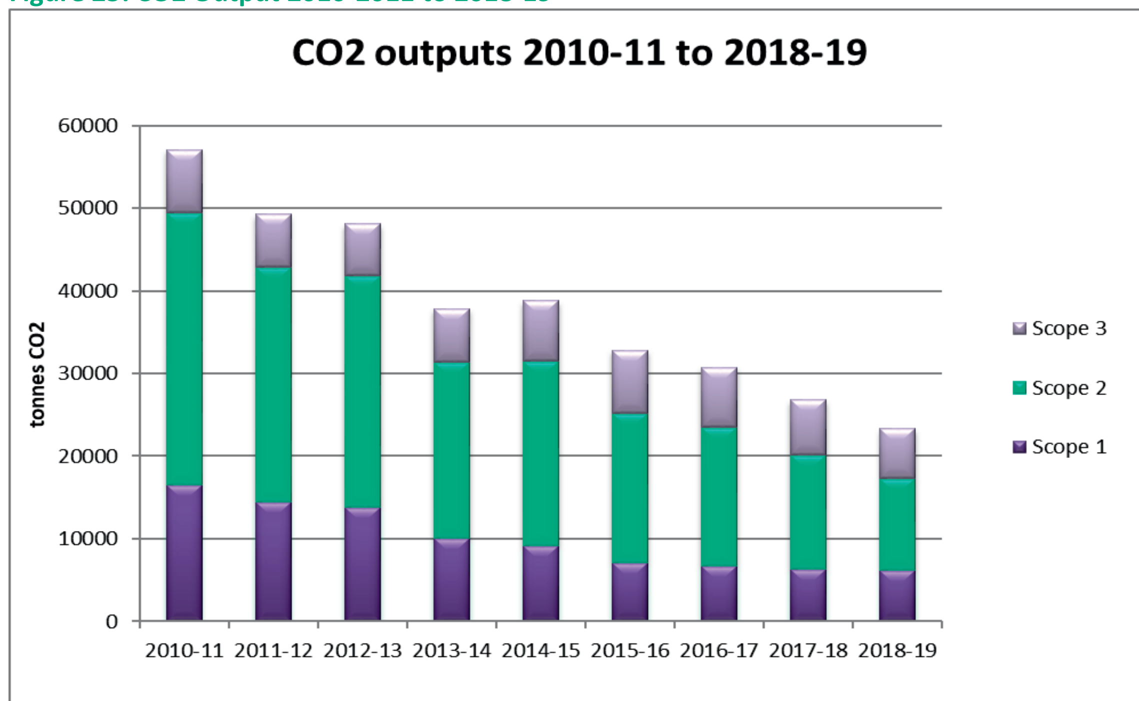
Greenhouse Gas Emissions Performance Commentary

Table 47: Greenhouse Gas Emissions Baseline 2010-11 to 2018-19

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Non Financial Indicators (CO2 tonnes)									
Total Gross Emissions for Scope 1	16,500	14,387	13,802	9,997	9,146	7,076	6,741	6,361	7,922
Total Gross Emissions for Scope 2	32,919	28,500	27,981	21,342	22,283	18,089	16,788	13,720	10,756
Total Gross Emissions for Scope 3	7,662	6,400	6,317	6,514	7,377	7,637	7,214	6,738	5,306
Total Gross Emissions	**57,081**	**49,287**	**48,099**	**37,852**	**38,807**	**32,802**	**30,743**	**26,819**	**23,984**
Related Energy Consumption (mWh)									
Electricity renewable	14,164	15,219	10,606	32,503	31,873	26,798	9,294	71	15
Electricity non-renewable	55,527	48,924	50,219	15,404	13,211	12,342	31,171	38,954	37,981
Gas	75,343	56,872	64,645	43,804	39,620	33,969	34,332	31,080	36,788
Gas Oil	3,400	3,853	4,594	4,748	5,489	1,315	510	1,279	2,595
Total inc other	**149,018**	**126,283**	**131,328**	**97,370**	**90,985**	**75,266**	**76,818**	**72,039**	**78,216**
Financial Indicators (£k)									
Expenditure on energy	8,433	7,592	7,993	7,014	7,272	5,944	5,437	5,618	5,922
Carbon ofsetting costs	352	440	458	147	227	92	112	168	153
Expenditure on offical business travel	21,593	17,996	18,040	18,618	19,876	20,003	19,620	19,584	20,861

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 25: CO2 Output 2010-2011 to 2018-19



Scope 1 – Direct emissions, Scope 2 – Energy indirect emissions, Scope 3 – Other indirect emissions

614. The results presented in **Figure 25** show the Department has continued to reduce its carbon emissions in 2018-19. 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.

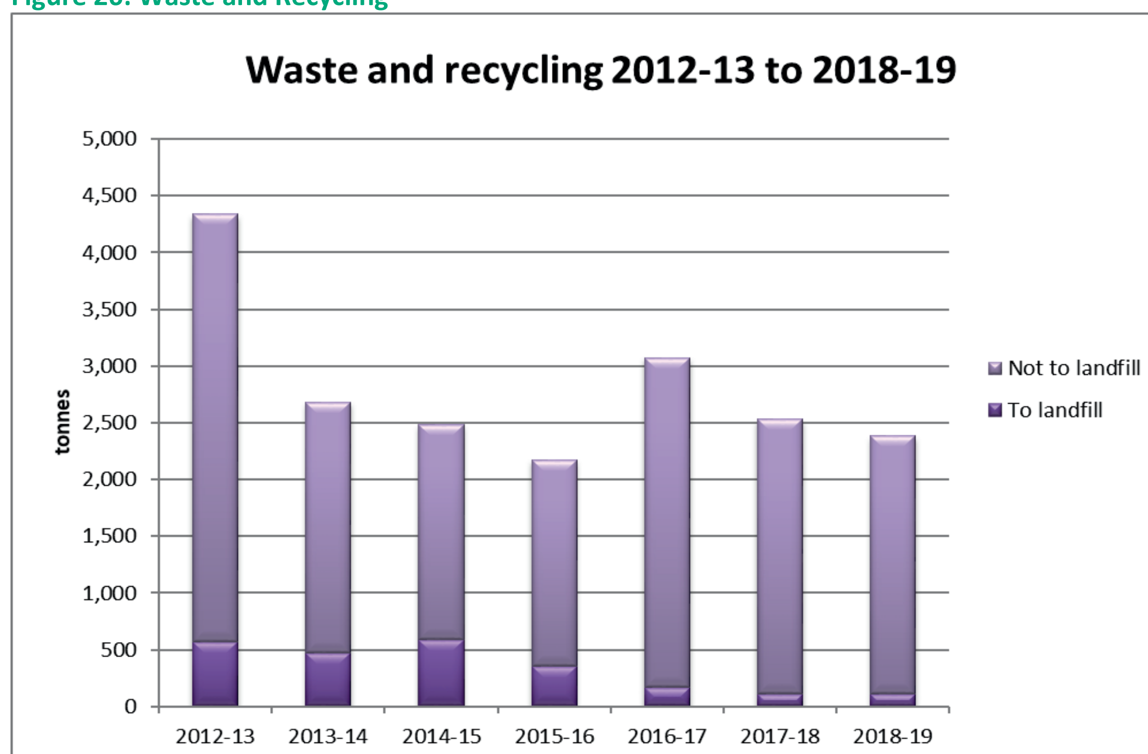
Waste

Table 48: Waste – Financial and Non-Financial Indicators

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Non Financial Indicators (tonnes)									
Total waste -	**4,022**	**2,841**	**4,337**	**2,679**	**2,484**	**2,172**	**3,074**	**2,532**	**2,386**
Landfill			573	473	585	355	165	111	114
Not to landfill			3,764	2,207	1,899	1,817	2,909	2,421	2,272
Incinerated/energy from waste			259	328	316	259	325	312	337
Incinerated/energy not recovered			378	334	323	294	244	163	158
Financial Indicators (£k)									
Total disposal cost (minimum requirement)	**927**	**672**	**805**	**868**	**718**	**978**	**730**	**582**	**607**
Hazardous waste - total disposal cost	349	227	244	499	405	621	457	311	23
Non-hazardous waste - total disposal cost	578	445	561	369	313	357	273	271	584

1. Breakdown of waste data between landfill and non-landfill not collected for 2010-11 and 2011-12.

Figure 26: Waste and Recycling



615. As shown in **Figure 26**, total waste figures for the Department have decreased in 2018-19. The spike in 2012-13 was due to extensive refurbishment programmes taking place as part of the transition to the new Health and Social Care system. The proportion of waste recycled across the DHSC/ALB estate remains high, with 95% of waste not to landfill, and 5% to landfill.

Water

Table 49: Water Consumption – Financial and Non-Financial Indicators

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-8	2018-19
Non Financial Indicators (m3)									
Water Consumption -									
Office	69,051	68,077	73,132	63,067	59,826	65,733	64,936	67,559	68,441
Whole estate	254,719	239,426	297,384	235,336	236,742	179,218	188,793	237,757	177,382
m3 per FTE/office estate	7.6	7.5	7.6	6.8	5.5	6.0	6.0	6.0	6.0
Financial Indicators (£k)									
Water supply costs	338	302	347	364	345	277	335	410	369

616. As shown in **Table 49** indicates, the Departments water consumption (office estate) has increased in 2018-19. The benchmark for water consumption is measured per person on a Full Time Equivalent basis. Our performance has improved from the baseline of 7.9m^3 per FTE in 2009-10, to 6.0m^3 per FTE in 2018-19. The Department is working with its facilities suppliers and other organisations on how to reduce its water consumption still further to meet the best practice target of less than 4m^3 per FTE.

Health Inequalities

617. **Table 50** gives a comprehensive breakdown of health inequalities indicators. More information on health inequalities is given in the Secretary of State's Annual Report section of this Report.

Table 50: Health Inequalities Indicators Summary

Indicator	England average (latest)	Inequality by area deprivation* (measured by the slope index of inequality)		
		Baseline	Previous	Latest
Public Health Outcomes Framework (PHOF) Headline Inequality Indicators				
Life expectancy at birth - males *Years of life*	79.6 *(2015-17)*	9.1 *(2010-12)*	9.4 *(2014-16)*	9.4 *(2015-17)*
Life expectancy at birth - females *Years of life*	83.1 *(2015-17)*	6.8 *(2010-12)*	7.3 *(2014-16)*	7.4 *(2015-17)*
Healthy life expectancy at birth - males *Years of life*	63.4 *(2015-17)*	18.6 *(2011-13)*	*19.1 (2014-16)*	*19.1 (2015-17)*
Healthy life expectancy at birth - females *Years of life*	63.8 *(2015-17)*	19.1 *(2011-13)*	*19.1 (2014-16)*	*18.8 (2015-17)*
NHS Outcomes Framework (NHSOF) Indicators for Health Inequalities Assessment				
Life expectancy at 75 - males *Years of life*	*11.5 (2015-17)*	*2.7 (2011-13)*	*2.9 (2014-16)*	*3.0 (2015-17)*
Life expectancy at 75 - females *Years of life*	*13.1 (2015-17)*	*2.6 (2011-13)*	*2.9 (2014-16)*	*3.0 (2015-17)*
Under 75 mortality rate from cardiovascular disease *Rate per 100,000 population*	*70.8 (2017)*	*106.5 (2013)*	*106.9 (2016)*	*104.9 (2017)*
Under 75 mortality rate from cancer‡ *Rate per 100,000 population*	*131.8 (2017)*	*103.9 (2013)*	*103.5 (2016)*	*100.7 (2017)*

Indicator	England average (latest)	Inequality by area deprivation* (measured by the slope index of inequality)		
		Baseline	Previous	Latest
Unplanned hospitalisation for chronic ambulatory care sensitive conditions *Rate per 100,000 population*	*823 (2017/18)*	*978 (2013/14)*	*971 (2016/17)*	*987 (2017/18)*
Emergency admissions for acute conditions that should not usually require hospital admission *Rate per 100,000 population*	*1,324 (2017/18)*	*932 (2013/14)*	*925 (2016/17)*	*891 (2017/18)*
Patient experience of GP services *% reporting good experience*[†§]	*83.8 (2017/18)*	*5.1 (2013/14) (IMD2010)*	*7.2 (2016/17)*	*8.9 (2017/18)*
Access to GP services *% reporting good experience of making appointments*[†§]	*68.7 (2017/18)*	*5.2 (2013/14) (IMD2010)*	*8.8 (2016/17)*	*8.7 (2017/18)*

* Area deprivation is based on IMD 2015 unless otherwise stated

‡ Data for 2016 does not match that published in the 2017-18 Annual Report for this indicator due to changes in NHS Digital's methodology for counting deaths. The effect of these changes is reported to be minimal https://files.digital.nhs.uk/79/2031FC/nhs-out-fram-ind-feb-19-comm.pdf

These indicators are calculated using indirectly standardised admission rates. SII estimates may be influenced by the differences in population structures across deprivation deciles.

† It has not been possible to update baseline data for these indicators to reflect changes introduced with the 2015 updating of the Index of Multiple Deprivation.

§ Changes to the ordering of questions in the 2017/18 GP Patient Survey may have had an impact on how respondents answered the questions that inform these indicators. Observed differences between 2017/18 and those of previous years could potentially be influenced by this change in survey design.

Annex E – Department of Health and Social Care Official Development Assistance

618. 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.

619. 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).

620. **Table 51** shows how the Department spent ODA funding in the 2018 calendar year.

Table 51: Official Development Assistance

The Department of Health and Social Care provided £194,500,000 of Official Development Assistance (ODA) in 2018.[195]
The Department of Health and Social Care did not spend any cross-government ODA funds in 2018.
Global Health Research assistance is delivered through the National Institute for Health Research (NIHR) Global Health Research programme to support high-quality applied health research for the direct and primary benefit of people in low and middle-income countries. The programme and funding portfolio continued to expand in 2018, focussing on: **NIHR Global Health Research Units and Groups** – this programme supports the production of outstanding global health research focussing on health issues that affect the poorest and most vulnerable people in low- and middle-income countries (LMIC), through equitable partnerships of UK and LMIC researchers who are either established in the global health field (Units) or expanding into it (Groups). The programme is directly commissioned by the NIHR and 13 Units and 20 Groups began work in 2017 and a further 20 Groups began in 2018. **NIHR global health research partnerships** – In 2018, the NIHR joined with other UK and global funders to support six new multi-year funding partnerships. The new partnerships address health challenges in a number of underfunded areas including adolescent health, diagnostics and orthotics in low resource settings, and research for health in humanitarian crises. New global partnerships include the World Bank's Global Road Safety Facility to support research to address the global burden of road deaths and injuries, and the Special Programme for Research and Training in Tropical Diseases'(TDR's) Structured Operational Research and Training Initiative (SORT IT) to support research training to address AMR. These strategic partnerships contribute to the wide range of high-quality research programmes addressing global health issues for the primary benefit of patients and the public in LMICs. **NIHR support to global health research priority initiatives** – in 2018 the NIHR supported four established programmes which aim to develop effective, affordable products to address diseases that directly affect at-risk populations in LMICs, such as treatments for malaria and tuberculosis (TB) with the Medicines for Malaria Venture (MMV) and Global Alliance for TB Drug Development, and the Foundation for Innovative New Diagnostics (FIND), and clinical research for poverty-related disease (PRD) epidemics with the

[195] Figures are provisional, taken from https://www.gov.uk/government/statistics/statistics-on-international-development-provisional-uk-aid-spend-2018

European and Developing Country Clinical Trials Partnership (EDCTP).

Global Health Security assistance was focused on:

The Fleming Fund - This project supports low and middle income countries (LMIC) in Africa and Asia to generate, share and use Antimicrobial Resistance (AMR) data, to enable countries to optimise the use of antibiotics and reduce drug resistance. The Fund will improve laboratory capacity and diagnosis and build sustainable surveillance systems at a country level through a One Health approach, covering human and animal health and agriculture, in places where drug resistant infections have a disproportionate effect. In 2018, the most significant areas of ODA spend were:

- Surveillance and data: development of country grants in 24 priority countries, of which 4 grants were active and implementing in Ghana, Uganda, Nepal and Vietnam, and two regional grants supporting the collection of existing AMR data
- Global guidance, protocols and governance: support to the key tripartite multilateral organisations WHO, OIE, and FAO
- Awareness and advocacy: South Centre grant to raise awareness of drug resistance and push for action with G77 developing countries and support to the Global Burden of Disease AMR project to share data on the burden of morbidity and mortality
- Partnerships, capacity building and technical assistance: an economic fellowships programme through ODI and support to the Commonwealth Partnerships for Antimicrobial Stewardship scheme
- Adaptive management, learning and evaluation: Management Agent and evaluation supplier costs

Vaccines Network - This project is focused on targeted investments in the most promising vaccines and vaccine technologies that will help combat the world's deadliest diseases. In 2018, the most significant areas of spend were:

- 22 pre-clinical and 11 clinical stage vaccine development projects, funded through three Small Business Research Initiative (SBRI) competitions managed by Innovate UK;
- 6 clinical-stage vaccine development projects funded through a BBSRC/MRC Intramural Centre competition and managed by NIHR (NETSCC);
- 2 vaccine manufacturing research hubs funded through an EPSRC-managed competition; and
- A financial commitment to the Coalition for Epidemic Preparedness Innovations (CEPI)

UK Public Health Rapid Support Team (UKPHRST) - This project is a DHSC funded partnership between Public Health England (PHE) and the London School of Hygiene and Tropical Medicine (LSHTM). It consists of a rapidly deployable team of public health specialists who investigate significant disease outbreaks in LMICs at the request of the country. The deployment includes capacity building in the LMICs and a research element. In 2018 the UKPHRST deployed to Bangladesh for an outbreak of diphtheria, twice to Nigeria for Lassa fever and have been a part of the UKs response efforts to the EVD outbreaks in DRC, deploying to DRC several times and also neighbouring Rwanda to help with preventative activities. Eight research projects were completed and capacity building in Sierra Leone included several seminars for health professionals.

International Health Regulations (IHR) - This project, funded by DHSC and run by Public Health England (PHE), aims to improve IHR compliance in LMICs through specific work in Sierra Leone, Pakistan, Bangladesh, Myanmar and Ethiopia and Zambia - through wider local regional structures. In 2018 activities in capacity building, training and health system assessment were carried out.

Global AMR Innovation Fund (GAMRIF) – this project is focused on developing new international research and development (R&D) partnerships to support early-stage AMR R&D that will advance novel One Health AMR solutions for the benefit of people in LMICs. In 2018, GAMRIF's spend included:

- disbursements to Innovate UK and BBSRC for delivery and management of two separate bilateral research calls with China and Argentina respectively;
- disbursements to CARB-X, the International Development Research Centre, and the BactiVac Network for delivery and management of three different global research initiatives;
- project-specific disbursements to Foundation for Innovative New Diagnostics (FIND) and Global

Antimicrobial Research and Development Partnership (GARDP), two product development partnerships (PDPs).

ODA admin – Programme team and legal costs.

The Framework Convention on Tobacco Control 2030 (FCTC 2030) project.

Tobacco use is the world's single most preventable cause of death and disease, and by 2030, over 80% of the world's tobacco-related mortality will be in low and middle income countries (LMICs).

Funded through ODA spend, the FCTC 2030 five-year project has completed three years and is directly supporting the implementation of the WHO Framework Convention on Tobacco Control in 15 LMICs. This support is helping to reduce the burden of death and disease from tobacco, and enable countries to make better use of health system resources to improve health and well-being of their populations.

The project continues to receive praise from the countries participating, the global public health and development communities, and continues to help raise the UK's profile as global leaders in tobacco control and strengthens its global reach.

In 2018 (year three of the project), the most significant areas of ODA spend were related to:

- Delivering key objectives in accordance with the agreed FCTC 2030 year three work programme.
- Funding activities at country level with Partner Parties working to their own individual workplans depending on their focus areas.
- Annual planning meeting bringing together the FCTC 2030 Partner Parties.

Other

The Department of Health and Social Care pays an annual subscription to the World Health Organisation (WHO) and takes the overall lead for the Government's engagement with the organisation. The annual contribution to WHO's budget is linked to the UN Scales of assessment agreed in New York. These scales are negotiated by the FCO in accordance with the UN Charter and UK membership obligations. The Department of Health and Social Care has funded the first twelve months of refugee healthcare costs following their arrival in the UK. These are the estimated healthcare costs of refugees classified as 'Section 95' by the Home Office.

In support of the UK Aid Strategy, **Global Health Research** assistance has delivered the development of new knowledge that promises to improve health by addressing the major causes of mortality or morbidity in LMICs.

The **Global Health Security** Programme contributes to the UK Aid Strategy, specifically, 'strengthening resilience and response to crises', to ensure a world safe and secure from infectious disease threats and promotion of Global Health as an international security priority.

Annex F – Our Arm's Length Bodies and Delivery Partners

Our Executive Agencies

Public Health England (PHE) provides national leadership and expert services to support locally-led public health initiatives and to respond to health protection emergencies. PHE works alongside local government, the NHS and other key partners, supporting the development of the public health workforce, jointly appointing local authority directors of public health, supporting excellence in public health practice and providing a national voice for the profession.

The Medicines and Healthcare products Regulatory Agency (MHRA) operates as a trading fund, whose mission is to enhance and safeguard the health of the public by ensuring that medicines and medical devices work and are acceptably safe. It does this by protecting public health through regulation, promotion of public health and improving public health by encouraging and facilitating developments in products.

Our Executive non-Departmental Public Bodies

NHS Commissioning Board (known as NHS England (NHSE))

NHS England sets the framework for commissioning of healthcare services in England. It funds Clinical Commissioning Groups (CCGs), which are responsible for commissioning services for their communities and ensures that CCGs do this effectively. NHSE also commissions some services nationally. Working with leading health specialists, NHSE brings together expertise to ensure national standards are consistently in place across the country.

Monitor

Monitor remains a legal entity, however from 1 April 2016 Monitor, along with the NHS Trust Development Authority has operated as a single organisation, **NHS Improvement (NHSI)** under a shared executive leadership and Board membership.

Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care providers in England. It ensures that only those providers who have made a legal declaration to meet the 'fundamental standards of quality and safety' and satisfy the registration process may provide care. Once services are registered, CQC monitors and inspects them against the fundamental standards.

National Institute for Health and Care Excellence (NICE)

NICE provides guidance, standards and information to help health, public health and social care professionals deliver the best possible care based on the best available evidence.

NHS Digital (NHSD)

NHSD (formerly known as the Health and Social Care Information Centre), collects, analyses and publishes national data and statistical information. It also delivers the national IT systems and services to support the health and care system.

Human Fertilisation and Embryology Authority (HFEA)

The HFEA is the UK's independent regulator of treatment using gametes embryos and embryo research. It sets standards for, and issues licences to, UK fertility clinics and all UK research involving human embryos. It also determines the policy framework for fertility issues.

Human Tissue Authority (HTA)
HTA regulates and ensures that human tissue is used safely and ethically with proper consent. It regulates organisations that remove, store and use tissue for a variety of purposes.

Health Research Authority (HRA)
The HRA promotes and protects the interests of patients and the public in health and social care research. It protects patients and the public from unethical research, while enabling them to benefit from participating in research by simplifying the processes for ethical research.

Health Education England (HEE)
HEE is the national leadership organisation for ensuring that the education, training and development of the healthcare workforce support the highest quality public health and patient outcomes.

NHS Improvement (NHSI)[196]
NHSI is the operational name for the organisation that brings together Monitor and NHS Trust Development Authority, with a shared executive leadership and is responsible for overseeing NHS Foundation Trusts, NHS Trusts and independent providers. NHSI supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, helping the NHS to meet its short-term challenges and secure its future.

Our Special Health Authorities

NHS Counter Fraud Authority (NHS CFA)
From 1 November 2017, the NHSCFA became a new special health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group. As a special health authority focused entirely on counter fraud work, the NHSCFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care.

NHS Trust Development Authority (NHS TDA)
The NHS TDA remains a legal entity, however from 1 April 2016, along with Monitor has operated as a single organisation, **NHS Improvement (NHSI)** under a shared executive leadership and Board membership.

NHS Business Services Authority (NHS BSA)
The NHSBSA provides a range of critical business support services to NHS organisations, NHS contractors, patients and the public. Its services include payments to community pharmacists and dentists for their NHS work, the administration of the NHS pension scheme, administration of European Health Insurance Card scheme, the administration of the England Infected Blood Support scheme, managing the social work bursaries scheme in England and the management of NHS Supply Chain.

[196] NHSI is the operational name for Monitor and NHS TDA, it does not have formal entity status.

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 (NHSLA)**. On 1 April 2017 it became known as NHSR with a stronger focus on prevention, learning and early intervention in incidents.

Other bodies included within the Departmental Group

NHS Property Services Ltd (NHSPS)

NHSPS is a limited company, wholly owned by the Secretary of State for Health and Social Care. NHSPS provides strategic and operational management of NHS estates, property and facilities.

Community Health Partnerships Ltd (CHP)

CHP is a limited company wholly owned by the Secretary of State for Health and Social Care. It was established in 2001 to implement the NHS Local Improvement Finance Trusts (LIFT) programme. It inherited the LIFT shareholdings and property interests previously held by PCTs. From 1 April 2013 the company is included within the DHSC accounting boundary (having previously been held as an investment by DHSC). CHP facilitates public-private partnerships to deliver a wide range of health planning and estate services, to support health providers and local authorities achieve improvements in the estate.

Supply Chain Coordination Ltd (SCCL)

SCCL is a limited company wholly owned by the Secretary of State for Health and Social Care. The Company became operational in 2018 and has been administering the NHS Supply Chain pursuant to an agency arrangement with the NHS Business Services Authority (BSA). With effect from 1 April 2019, SCCL replaced BSA as the principal administrator of the NHS Supply Chain. SCCL will also manage and coordinate the financial administration of the National Health Service Supply Chain.

Genomics England Ltd

Genomics England is a limited company, wholly owned by the Secretary of State for Health and Social Care, set up to deliver the 100,000 Genomes Project. Genomics England will manage contracts for specialist UK based companies, universities and hospitals to supply services on sequencing, data linkage and analysis. It will also strictly manage secure storage of personal data in accordance with existing NHS rules, designed to securely protect patient information. Genomics England is funded by the Department of Health and Social Care in the medium term.

Skipton Fund Ltd

The Skipton Fund was established by the Department of Health and Social Care on behalf of the Secretary of State for Health and Social Care to administer an ex gratia payment scheme and make payments to relevant claimants on behalf of UK health administrations, to people who were infected with hepatitis C through treatment with NHS blood or blood products prior to September 1991 and other eligible persons. This function is now performed by the NHS Business Services Authority.

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 (designated as outside the Departmental Group by the Office for National Statistics)

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 1.4 million units of blood per year, as well as organ and tissue donations.

Medicines and Healthcare products Regulatory Agency (MHRA)

The role of the MHRA is described at the start of **Annex F**.

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