Department of Health & Social Care

Department of Health and Social Care

Annual Report and Accounts

2019-20

(For the period ended 31 March 2020)

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

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Performance Report

Permanent Secretary's Overview

The Department of Health and Social Care supports its Ministers in setting the strategic direction for the health and care system. Our objectives are delivered in conjunction with our Arm's Length Bodies, to help people lead healthier lives, creating a safe, high-quality health and care system that is financially sustainable. In July 2019 we celebrated the 100th anniversary of the establishment of the Ministry of Health. The Ministry's founding objective of promoting the health of the people, has endured as a core commitment of the Department. We can take great pride in the work that has and continues to go into delivering such aims around the health and care system.

The vital work carried out across the health and care system has been at the forefront of the Government's response to the Coronavirus (COVID-19) pandemic. Guided by the scientific evidence and drawing on emergency preparedness plans, the Department has acted quickly to respond to the biggest health challenge the country has faced in over a generation. The initial stages of the pandemic response were described in the Action Plan published in March 2020, which involved deploying phased actions to contain, delay and mitigate the outbreak, with research informing policy development.

Continuing to be informed by the best available evidence, the Department's response has evolved into a programme of workstreams engaged in significant activities which have sought to; protect the resilience of the NHS and social care sector, ensure resilient supply of Personal, Protective Equipment, medicines, ventilators and oxygen, protect the vulnerable, implement non-pharmaceutical interventions such as local lockdowns, substantially increase testing and tracing capability and capacity, identify and research new treatments for COVID-19. With vaccine development and deployment being at the centre of the Government's Winter Plan, all these activities have sought to supress the virus, protect the NHS and vulnerable, keep education and the economy going, to provide a route back to normality.

The complexities in delivering a pandemic response are significant and work on the COVID-19 response became the single most important operational and policy focus of the whole Department and wider health and care systems, during 2020. As a result 2019-20 has been challenging for the health and care system on many fronts, with continually increasing demand for services. Despite the continuing best efforts of the NHS, key waiting time and performance targets have not been achieved in 2019-20. The system continues to work hard to address the challenges, focusing on the quality of patient care, striking the right balance across performance, transformation, innovation, quality, safety and living within its financial means. Steps were taken toward the delivery of the NHS Long Term Plan in 2019-20 and progress against the delivery of the manifesto commitments made in the 2019 General Election, continues at pace.

While the commentary on the Department's response to COVID-19 understandably impacts all elements of this report, it is important to stress that financial performance of the Department reflects the position at 31 March 2020 and significant detail as to how the Department operated

and performed during 2019-20, prior to the pandemic, is contained within this report. Further detail regarding the financial performance of the Department and further analysis of the Department's pandemic response will be detailed in the 2020-21 Annual Report and Accounts.

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 in such challenging times.

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

Performance Overview

1. This section introduces the role and purpose of the Department, how funding flows from Parliament around the health and social care system and provides a high level performance summary against the Department's strategic objectives.

2. For 2019-20 Her Majesty's Treasury (HM Treasury) has revised minimum financial reporting requirements in light of the unprecedented steps public sector entities are taking in responding to the Coronavirus (COVID-19) outbreak. [1]

3. The revised requirements streamline performance reporting within the 2019-20 Annual Report and Accounts (ARA). They include the removal of the Performance Analysis, which would normally follow the Performance Overview. Where other reporting has been streamlined or omitted in line with the revised HM Treasury minimum reporting requirements, this is identified in the report.

4. COVID-19 has led to both specific and more general impacts on the operations of the Department and Government more widely, in the last quarter of the 2019-20 financial year and beyond. The impact of COVID-19 on the Department is reflected throughout all sections of this ARA accordingly. Specific sections regarding the Department's COVID-19 activities can be found from **paragraph 23** in the Performance Summary, from **paragraph 286** in the Governance Statement and in **Note 20** of the Notes to the Departments Annual Report and Accounts.

5. It is important to emphasise that the remit of the 2019-20 ARA is up to and including 31 March 2020. Therefore, significant levels of information regarding activities and performance over the peak of the pandemic and into the Summer of 2020, will be reported in the 2020-21 Annual Report and Accounts.

Our Role and Purpose

6. 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.

7. We support and advise our Ministers to shape policy and set direction, while remaining accountable for delivering the Government's commitments, co-ordinating the legal, financial and policy frameworks in health and social care and, when necessary, we step in as troubleshooters to take action on complex issues, as can be seen in the Department's response to the COVID-19 pandemic. 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.

[1] Addendum to Government Financial Reporting Manual 2019-20

8. As a Department of State our strategic priorities are:
   - To keep people safe, leading global health and international relations including EU exit;
   - To keep people healthy and independent in their communities, supporting the transformation of NHS primary, community and Mental Health services, and Local Authority public health and adult 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;
   - Ensure accountability of the health and care system to Parliament and the taxpayer, and create an efficient and effective department;
   - To create value by promoting better awareness and adoption of good commercial practice across the Health Family; and
   - To improve health and social care by giving people the technology they need.

9. COVID-19 is the biggest challenge the country and our public sector have faced in a lifetime. DHSC is central to the Government's response and, as a result, the Department has adapted to these unprecedented times. Work on COVID-19 is the single most important operational and policy focus for the whole Department and wider health and social care system.

10. Important wider work continues where we have legal responsibilities to deliver our core corporate functions and in supporting key commitments beyond COVID-19.

11. 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.

12. 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.

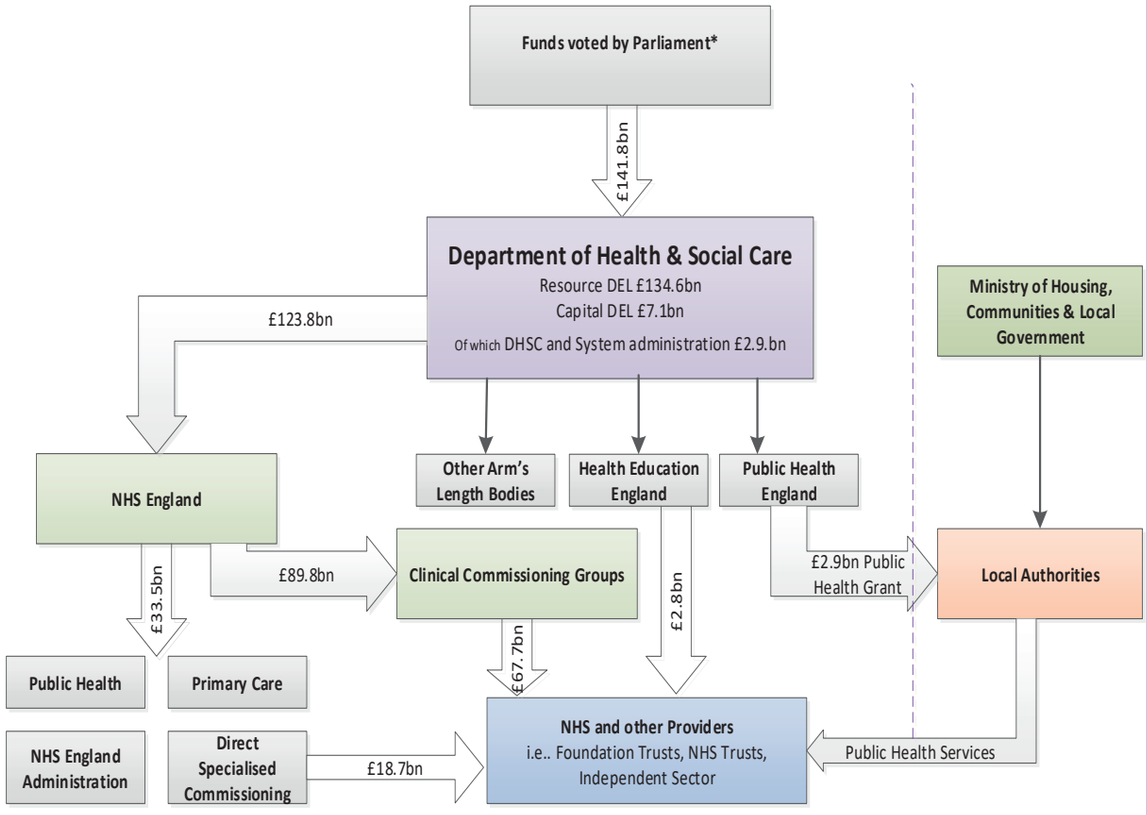
13. The Secretary of State for Health and Social Care and other Departmental Ministers are accountable to Parliament for the provision of the comprehensive health and care service in England. To enable the system to work flexibly; the critical day-to-day operational decisions are made by the professionals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

14. 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 £134.2 billion and invested a further £7.02 billion in capital funding such as new hospitals and equipment, as detailed in **Table 1**.

15. **Figure 1** demonstrates how funding flows round the system, using agreed budget totals for 2019-20 per the Supplementary Estimate for contextual purposes.

16. 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: Funding flows in the health and care system, 2019-20 (per Supplementary Estimate)



*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 are used in this presentation with 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 2019-20 Achievements - At a glance

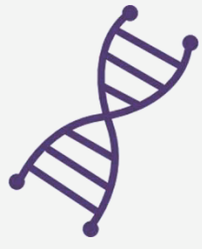
Leading the Government's response to **COVID-19** – the biggest challenge faced by the country in a lifetime

Departmental work towards **EU Exit preparedness**

Over 90% of pharmacies signed up to the **Community Pharmacy Consultation Service**

The establishment of **NHSX** in July 2019

A new **HPV Vaccine for boys** became available from September 2019 with positive reported uptake

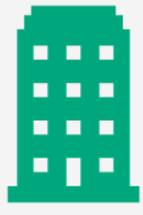


Over **10 million screening appointments** created, saving approx. 10,000 lives each year

The **Prevention Green paper consultation** drew over **1,600 responses**

Spending Round 2019 secured **£1 billion additional funding for adult social care** in 2020-21

All 6 new large hospital schemes underway as part of the **Health Infrastructure Plan**



Dementia 2020 Challenge commitments continued to be met, with a 66.7% diagnosis rate

2019-20 - Key Finance Facts

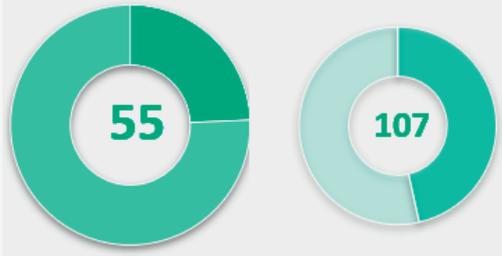
Resources contained **within all budgets** set by Parliament

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

The NHS delivered overall **financial balance**

£1.05bn Financial Recovery Fund supporting NHS providers in deficit to be sustainable

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



£7.5bn (gross) **investment in capital**

Number of CCGs with overspends

£8.6bn underspend against the **AME budgetary control**

Performance Summary

17. This section provides information about the Department's purpose, objectives and performance during 2019-20.

Single Departmental Plan

18. The Department's Single Departmental Plan (SDP)[2] sets out what we aimed to achieve in order to improve the health and care of the nation over the course of the 2019 Parliament. The successful implementation of many of these priorities is reliant on the Department's ALBs and partner organisations. Where these organisations 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 to patients and the public.

19. 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. It provides the foundation for how we have measured our progress and the structure for our quarterly reporting to our Departmental Board and its sub-committees. The structure of the SDP was established prior to the COVID-19 outbreak, though the underlying strategic objectives remain relevant during the pandemic.

20. The SDP is focused both on the short-term objectives that we were committed to deliver across the year, and on the long-term ambitions that the objectives underpin.

Single Departmental Plan 2019-20 Objectives (established prior to COVID-19)

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 safe, leading global health and international relations including EU exit**
2. **Keeping people healthy and independent in their communities, supporting the transformation of NHS primary, community and mental health services, and local authority public health and adult social care**
3. **Supporting the NHS to deliver high-quality, safe and sustainable hospital care and secure the right workforce**
4. **Supporting research and innovation to maximise health and economic productivity**
5. **Ensuring accountability of the health and care system to Parliament and the taxpayer; and create an efficient and effective department**
6. **Creating value (reduce costs and grow income) by driving excellence in commercial practice across the health and social care system**
7. **Improving health and social care by giving people the technology they need led by NHSX**

[2] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan/dhsc-single-departmental-plan

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

22. The challenges we face in delivering our objectives 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.

Coronavirus (COVID-19)

23. The emergence of COVID-19, in the early months of 2020, fundamentally changed the focus and scale of operations in the Department. COVID-19 is the biggest health challenge the country has faced in over a generation and DHSC has led the Government's health-related response.

24. During this period the Department has adapted quickly. Guided by the scientific evidence and advice, and drawing on our emergency preparedness plans, the Department mobilised from an initial emergency operational response to a full Departmental and system-wide response as the initial outbreak of the new virus developed into a pandemic.

25. The objectives of the Department in tackling the virus were initially to deploy phased actions to Contain, Delay and Mitigate the outbreak, using research to inform policy development, working at all times with the Chief Medical Officer.

26. Work on the response to COVID-19 became the single most important operational and policy focus of the whole Department and wider health and care systems, and for the whole of Government into March 2020.

27. The Department produced an Action Plan[3] to provide strategic objectives to tackle the virus and protect life. This represented a consolidation and enhancement of the considerable advice and support that had been provided across the health and social care sector, detailing: our knowledge of the virus and its impact, our preparations and responsibilities for managing infectious outbreaks, actions taken to date and next steps as the Government manage the ongoing impacts of the pandemic.

28. The Coronavirus Act 2020[4] was introduced, progressed through all stages in the House of Commons and Lords and received Royal Assent in March 2020. This was made possible by significant work undertaken across the health and social care system and across government more widely.

29. The Act enabled the Government to respond and manage the effects of the COVID-19 pandemic through: increasing the available health and social care workforce; increasing

[3] https://www.gov.uk/government/publications/coronavirus-action-plan/coronavirus-action-plan-a-guide-to-what-you-can-expect-across-the-uk
[4] http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted

NHS capacity; easing the burden on frontline staff; containing and slowing the virus; managing the deceased with respect and dignity; and supporting people and the industries they rely on.

30. Substantial additional resources and expertise were brought in to support the work of the Department. This continues to be the case progressing beyond the end of the 2019-20 financial year and into the 2020-21 financial year, as part of the Government's response to COVID-19.

31. As part of the Department's mobilisation it rapidly pivoted from its traditional policy role, developing the operational capacity to significantly expand its supply chain customers from 226 NHS providers to over 58,000 customers in different care settings, to supply the necessary personal protective equipment (PPE) to NHS and social care staff[5] and ensure sufficient supply of oxygen, ventilation and medicines to meet patient needs.

32. The key emergency response activity in relation to PPE was to ensure that nationally and locally, supply met demand. This led to the Department, with assistance from the military, tackling issues around the supply and distribution of PPE[6]. Since then the PPE taskforce, led by Lord Deighton, has ensured that the country has a 4 month stockpile for PPE. The Department also published its PPE strategy[7] in September 2020, which aims to stabilise and build resilience.

33. As part of the emergency response, Government quickly ramped up access to ventilators when it became apparent in February and March 2020 that the circa 7,000 ventilators available in the NHS would need to be supplemented[8]. The government set a target of obtaining 30,000 ventilators by the end of June. The Department worked closely with the Cabinet Office to achieve this target.

34. The ventilator strategy blended procurement and production given the constraints of the national and global markets. In the early stage of the response, procurement was the main route to acquiring additional ventilators and then the production strand became more predominant during the Summer. As the NAO have concluded[9], both departments made substantial progress to the 30,000 target by the end of June 2020.

35. Increasing testing and tracing capability and capacity has been key to limiting the spread of the virus, with NHS Test and Trace, launched in May 2020, forming a central part of the country's COVID-19 recovery strategy[10]. In blending national resource with regional, local and community resources, the Department has sought to ensure there is consistent underlying national coverage coupled with rapidly deployable capacity in areas of higher

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921787/PPE_strategy_v4.5_FINAL.pdf
[6] https://committees.parliament.uk/oralevidence/433/pdf/
[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921787/PPE_strategy_v4.5_FINAL.pdf
[8] https://committees.parliament.uk/oralevidence/1033/default/
[9] https://www.nao.org.uk/wp-content/uploads/2020/09/Investigation-into-how-the-Government-increased-the-number-of-ventilators.pdf
[10] https://www.gov.uk/government/publications/developing-nhs-test-and-trace-business-plan/breaking-chains-of-covid-19-transmission-to-help-people-return-to-more-normal-lives-developing-the-nhs-test-and-trace-service

prevalence[11]. Test and Trace's ambitions were to obtain capacity for 500,000 daily tests by the end of October and to deliver self-isolating messages to 80% of contacts within 48 hours of a positive test result.

36. As part of the ongoing response, on 18 August 2020, the Secretary of State for Health and Social Care announced the establishment of the National Institute for Health Protection (NIHP), bringing together health protection elements of Public Health England with the NHS Test and Trace service and the Joint Biosecurity Centre (JBC)'s intelligence and analytical capability. NIHP will be formally established as an ALB of the Department during the Spring of 2021.

37. Since the start of the pandemic, we have taken steps to protect care homes, including increasing the testing available for staff and residents, providing free PPE and investing billions of pounds of additional funding for infection control. In September, the Government published an Adult Social Care Winter Plan[12], which set out measures to prevent and contain the virus, including increasing the Infection Prevention Control funding. As of November 2020, £1.1 billion has been provided to implement infection prevention and control measures. This is in addition to the £4.6 billion that has been made available to Local Authorities in England to address pressures on local services caused by the pandemic, including adult social care.

38. To ensure sufficient NHS capacity we have reprioritised facilities, reconfigured NHS estates, worked with the independent sector and built new Nightingale hospitals. As of November 2020, the NHS has increased staff numbers by 70,000 since last year and has plans in place to allow for local peaks in COVID-19 patients to be safely managed.

39. More broadly, the Department is committed to supporting everyone's wellbeing and mental health throughout this difficult time. In November, we published the Wellbeing and Mental Health Support Plan[13] to strengthen the support and services available to those who need them.

40. In November 2020, the Government published the COVID-19 Winter Plan[14]. This sets out the Government's strategy through to spring 2021 to supress the virus, protect the NHS and vulnerable, keep education and the economy going, and provide a route back to normality. Vaccines are at the centre of the Government's plan, as well as a focus on effective treatments for COVID-19. The Winter Plan is backed by an additional £7 billion for NHS Test and Trace to support increased testing, including community testing and ongoing improvements to tracing, taking the overall funding provided for Test and Trace the 2020-21 financial year to £22 billion.

41. While the Department for Business, Energy and Industrial Strategy is the department leading on vaccinations development, for which orders have been placed on different

[11] https://committees.parliament.uk/oralevidence/1033/default/
[12] https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021
[13] https://www.gov.uk/government/publications/staying-mentally-well-winter-plan-2020-to-2021/staying-mentally-well-this-winter
[14] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/937529/COVID-19_Winter_Plan.pdf

potential vaccines, significant work is underway, led by the NHS, regarding how vaccines will be deployed. Deployment of the recently approved[15] Pfizer/BioNTech, Oxford University/AstraZeneca and Moderna vaccines is being guided by the Joint Committee on Vaccination and Immunisation advice regarding priority groups for COVID-19 vaccination[16].

42. The Department has also set up the Therapeutics Taskforce to identify and research new treatments for COVID-19 . The UK Recovery Trial was the first in the world to discover dexamethasone reduces risk of mortality by 20% for those on oxygen and 35% for ventilated patients. Results from the government-funded REMAP-CAP clinical trial published in January 2020 also showed tocilizumab and sarilumab, normally used to treat rheumatoid arthritis, reduce the relative risk of death for patients entering intensive care by 24%.

NHS Long Term Plan

43. The NHS Long Term Plan[17] aims to improve the quality of patient care and health outcomes and sets out how the additional funding will be spent up to 2023-24. 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 the NHS Long Term Plan Implementation Framework[18] was published, setting out further detail on how the NHS Long term Plan (LTP) will be delivered. A new NHS Bill to support the NHS to deliver the LTP is being developed for introduction once Parliamentary time allows.

44. The NHS Funding Act 2020[19] received Royal Assent in March 2020, making provision regarding the funding of the health service in England in respect of each financial year until the start of the 2024-25 financial year.

Manifesto commitments

45. The manifesto commitments made during the 2019 General Election included £20.5 billion real-terms increase (cash terms £34 billion) between 2018-19 and 2023-24 for NHS England's revenue budget; building six new hospitals by 2025 as well as seed funding to develop proposals for a further 34 hospitals; recruit, train and retain 6,000 more doctors and trainees in general practice; and an additional 50,000 nurses by 2024-25; increase the number of available primary care appointments by 50 million a year by 2024-25 and end hospital car parking charges for those 'in the greatest need' including staff working night shifts. Despite the challenges presented by COVID-19, the effective delivery of these key commitments remains a priority, and the Department continues to drive progress using a strong programme management approach.

NHS services

46. Against an increasing demand for NHS services, the majority of patients were seen and treated promptly in 2019-20. The NHS managed almost 190,000 more A&E attendances in

[15] https://www.gov.uk/government/collections/mhra-guidance-on-coronavirus-covid-19#vaccines-and-vaccine-safety
[16] https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020
[17] https://www.longtermplan.nhs.uk/
[18] https://www.longtermplan.nhs.uk/implementation-framework/
[19] https://services.parliament.uk/Bills/2019-21/nhsfunding.html

2019-20 than in 2018-19, with an increase from 24.8 million to 25 million attendances. The increase is relatively small compared to increases seen in previous years.

47. This is the result of significant decreases in attendances in March 2020 due to the impact of COVID-19, with people advised that they should not leave their homes during the peak of the pandemic unless it was essential to do so, in order to protect critical services. Just as the Department reconfigured itself to provide its pandemic response, the NHS did the same with its hospitals and services as was evident in the establishment of the Nightingale hospitals.

48. On 17 March 2020, NHS England and NHS Improvement instructed service providers to postpone all non-urgent elective operations (by no later than 15th April 2020) to free up approximately 30,000 hospital beds nationally to assist with the COVID-19 response. We recognise the inconvenience and potential distress for patients who had their operations cancelled, however this measure helped free-up the maximum possible inpatient and critical care capacity to allow staff to prepare for, and respond to, the anticipated large numbers of COVID-19 patients who need respiratory support.

49. Patient safety remained our top priority and it was emphasised that emergency admissions, cancer treatment and other clinically urgent care should continue unaffected. Work to step up elective operations and to increase the numbers of people accessing healthcare took place as early as April and included the 'Help Us Help You' campaign,[20] to ensure public awareness that services are and have been open through the pandemic.

50. The percentage of A&E attendances administered, transferred or discharged in less than 4 hours at the end of March 2020 was 84.2% compared to 86.7% at the same point last year. Further detail regarding NHS Operational Performance can be found in **Annex C**. During the early stages of the pandemic the NHS did experience a drop in emergency admissions and A&E attendances. The lowest level equated to 56% of expected volumes of patients. The expected volumes of patients using the NHS has since increased.[21]

51. Over 261,000 more diagnostic tests were performed throughout the year and there was also an increase in people seen by a specialist for suspected cancer. Cancer is a Government priority and survival rates are at a record high; since 2010 rates of survival from cancer have increased year-on-year. At the same time demand for cancer services continues to rise, with an increase in urgent, cancer suspected, GP referrals of 6.3% compared to 2018-19. Over 96% of cancer patients began their first treatment within 31 days of a decision to treat in 2019-20, meeting the standard required. The NHS LTP sets out an ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half to three-quarters of cancer patients.

52. In March 2020 the elective care waiting list was 4.24 million, similar to 4.23 million in March 2019. Performance against the '62-day 85% standard' was 78.8% compared to 79.7% in March 2019. Nevertheless, ongoing service disruption through the pandemic has

[20] https://committees.parliament.uk/oralevidence/433/pdf/
[21] https://committees.parliament.uk/oralevidence/433/pdf/

contributed to significant increases of patients on waiting lists that will be further detailed in the 2020-21 ARA. Further detail regarding the NHS response to COVID-19 can be found in the NHS England ARA.

53. Winter is always the most challenging period for the NHS. In 2019-20, £86 million of capital funding was provided to trusts for schemes designed to support patient care and improvements in performance during winter 2019-20. Schemes were primarily supporting same day emergency care (SDEC), increased capacity in and around the emergency department (ED), and increased diagnostic capacity. In addition, a £240 million Winter Pressures Grant was allocated to local authorities by social care funding to manage the 2019-20 period.

Prevention green paper

54. Prevention remains a high priority for the Department, with responses to the Prevention Green Paper Consultation drawing over 1,600 responses. Smoking prevalence is now at the lowest rate since records began. October 2019 saw the announcement of a new Sexual and Reproductive Health Strategy[22], with work on its development underway. Significant progress has been made on the Childhood Obesity programme across several key areas, including work on The Energy Drinks Impact Assessment.

NHSX

55. July 2019 saw the establishment of NHSX, bringing together policy, strategy, delivery and transformation of technology and data to improve patient care to support delivery of the NHS LTP, and the Secretary of State's Technology Vision[23]. NHSX began consultation on its Tech Plan for health and care in February 2020.

56. NHSX[24] has since been instrumental in facilitating the system-wide collaboration necessary to tackle COVID-19, implementing new technology and working with NHS Digital in enhancing the flow and collection of data to enable staff to deliver the best care. The progress made in a few months has provided a strong-basis for longer-term digital transformation.

People plan

57. In 2019-20, the Department has maintained a significant focus on ensuring we have the right number of staff to deliver safe quality care in the NHS. An Interim People Plan[25] was published in June 2019 which sets out our vision for how we will grow the NHS workforce, transform leadership in the NHS and improve staff health and wellbeing. A full NHS People Plan will be developed and will set out a comprehensive strategy for the NHS workforce and the delivery of the Government's campaign commitments.

58. The Department has been working to improve health and care through better use of primary care and the voluntary sector. To do this, work has been undertaken to strengthen the primary care workforce and access to primary care, including working

[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/841189/government-response-to-health-and-social-care-committee-report-on-sexual-health-print-version.pdf
[23] https://www.gov.uk/government/news/matt-hancock-launches-tech-vision-to-build-the-most-advanced-health-and-care-system-in-the-world
[24] https://www.nhsx.nhs.uk/
[25] https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/

towards meeting the manifesto commitment to expand the number of appointments in general practice by 50 million a year by 2024-25 and growing the general practice workforce by 6,000 more doctors and 26,000 more primary care professionals. The full NHS People Plan is expected to set out a broader strategy for a sustainable general practice workforce including how these commitments will be met.

59. This Government remains committed to delivering 50,000 more nurses in our NHS by 2025. This will be done through a combination of investing in and diversifying our training pipeline, recruiting, and retaining more nurses in the NHS.

Social Care

60. The Department has remained committed to supporting high-quality, affordable social care for all. Additional funding for adult social care worth £1 billion in 2020-21 was announced through the 2019 Spending Round, which will allow the system to respond to demand and cost pressures in 2020-21, while continuing to help stabilise the market. The Department has been working with officials from Ministry of Housing, Communities and Local Government (MHCLG) and HM Treasury to deliver this funding to local authorities.

61. The adult social care workforce is at the front line of the efforts against COVID-19. As a result, the Department is dedicated to ensuring we have a social care workforce that is safe, supported and truly valued. An increased social care workforce is required not only to tackle the short-term challenges of COVID-19, but to address the longer-term goal of meeting our society's future needs.

62. Since its launch in October 2019, the Adult Social Care National Recruitment Campaign has raised the profile of the sector and encouraged people with the right values to apply for vacancies. The Department has also worked with Skills for Care to make it easier for employers to access rapid online induction training for new staff. This includes key elements of the Care Certificate and has been available free of charge since March 2020.

Mental health services

63. The Department has supported the first stages of the expansion and transformation of mental health services in England through the increased investment set out in the NHS Long Term Plan. Implementation of the proposals in the transforming children and young people's mental health Green Paper has continued and the first mental health support teams became operational in a number of schools and colleges. Good progress has been made towards publishing a Mental Health Act White Paper, which will respond to the independent review of the Mental Health Act.

Health Infrastructure Plan

64. The delivery of the Health Infrastructure Plan (HIP)[26] and the manifesto commitment of 40 new hospitals remains a priority. All 6 of the funded HIP1 schemes are progressing through recognised business case stages and support is being given to the organisations by a central portfolio function in the Department, and through direct technical and operational support in NHS Regions. All HIP2 schemes have been allocated seed funding

[26] https://www.gov.uk/government/publications/health-infrastructure-plan

to help them to progress their designs, and the majority of this funding will be drawn down by organisations in 2020-21. The wider capital delivery portfolio includes over 200 NHS capital infrastructure projects, ranging in size and complexity, but including other major schemes delivering a new hospital or significant clinical enhancements.

EU Exit

65. During the year, the Department worked with our ALB partners to ensure the health and social care system was as prepared as possible for EU Exit. This included, in advance of the Withdrawal Agreement being ratified in January 2020 and 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. The Department was successful in mitigating key risks around supply chain and reciprocal healthcare contingency programmes.

66. Following the extension of the Article 50 period to 12 April 2019, then 31 October 2019, and finally to 31 January 2020, the Department re-baselined EU Exit plans and issued appropriate and timely guidance to the health and social care system. The Department's post-exit model and governance was reviewed by the Department's Audit and Risk Committee in February 2020.

67. Plans for implementing and delivering the Withdrawal Agreement at the end of the Transition Period (TP) have been developed and, in some areas, revisited to reflect the impact of the response to COVID-19. The Department is also supporting the negotiations on our future relationship with the EU which were led centrally by Taskforce Europe.

68. The Department's preparations for the end of the TP have been taking place alongside the response to COVID-19 and winter pressures, to ensure the benefits that can be realised outside of the EU are maximised. The Minister of State for Health wrote to the health and social care sector regarding the impact of the UK and EU Trade and Co-operation Agreement on the health and care system[27]. The correspondence confirms that whilst there will be changes at the end of the TP, the agreement reached with the EU ensures that we will continue to benefit from reciprocal healthcare arrangements and maintain close co-operation with the EU in such areas as medicines, health security and professional qualifications.

Financial performance

69. COVID-19 spend in the 2019-20 financial year aside, the NHS balanced its financial budget based on opening expectations of NHS planned spend. Through continuing focus on financial rigour and efficiency, the majority of Trusts have once again met their control totals. This contributed to the Department delivering the 2019-20 financial outturn within the Parliamentary vote per **Table 1**.

[27] https://www.gov.uk/government/publications/letter-to-the-health-and-care-sector-about-the-uk-eu-trade-and-co-operation-agreement/uk-and-eu-trade-and-cooperation-agreement-and-the-governments-preparation-for-end-of-the-transition-period-on-31-december-2020

70. This level of rigour will need to continue in future years to help mitigate against the significant impacts of COVID-19, that are being felt across the health and social care system in the 2020-21 financial year.

71. The Department is accountable to Parliament for ensuring that total spending by all bodies within the Departmental Group is contained within the overall budgets approved by Parliament per **Table 1**.

72. As referenced in the key finance facts earlier in the Performance Report and in **Table 1** below, the Department had an underspend of £8.6 billion on its Resource Annually Managed Expenditure (AME) control total. AME is demand-led and volatile, being subject to many variables outside the Department's direct control, such as changes to the discount rates in measuring the value of long-term provisions liabilities. **Note 16** in the Financial Statements section of this report provides further detail.

Table 1: DHSC Departmental Outturn 2019-20 against Parliamentary & HM Treasury Controls

	Budget £m	Outturn £m	Under/ (Overspend) £m	Key disclosure notes/further detail
Resource Departmental Expenditure Limit (RDEL)	134,628	134,183	444	SOPS 1.1, Annex B
of which: Resource Administration	*2,881*	*2,301*	*580*	*SOPS 1.1, Annex B*
Capital Departmental Expenditure Limit (CDEL)	7,125	7,015	110	SOPS 1.2, Annex B
Resource Annually Managed Expenditure (RAME)	11,420	2,848	8,572	SOPS 1.1
Capital Annually Managed Expenditure (CAME)	15	(6)	21	SOPS 1.2
Net Cash Requirement	118,401	115,164	3,237	SOPS 3
Further HM Treasury Controls:				
Ringfenced Resource DEL[1]	1,145	700	444	Annex B
Non-ringfenced Resource DEL[1]	133,483	133,483	0	Annex B

1. HM Treasury Control budgets are adjusted to reflect HM Treasury approved virement from Ringfenced RDEL to Non-ringfenced RDEL, of £151m.

73. The majority of the Group budget is spent in the NHS, for which the Government agreed a Long Term Settlement in 2018[28]. This funded the ambitions of the NHS's LTP from 2019-20 until 2023-24, and the Government set the clear objectives for the NHS to maximise the use of this funding and return to financial sustainability, measured via five financial tests and supported by a new financial framework.

74. This represented a move away from short-term measures necessary in previous years to a more managed and sustainable plan to return all organisations within the NHS to financial balance. This trajectory was outlined through pre COVID-19 impacted ambitions.

75. 2019-20 was the first year of the LTP period and represented a step towards these longer-term ambitions, where both commissioner and provider sectors moved towards aggregate financial balance and fewer organisations ending the year in deficit. The results in this report, and those published by the NHS, will confirm that significant progress was

[28] https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan

made pre COVID-19, with the NHS once again delivering overall financial balance, with the number of deficits in trusts reduced by half and finances in the vast majority of trusts and commissioners in a much healthier position than seen in previous years. A minority of trusts remain with significant deficit levels, but a number of those have hit their agreed financial targets and were on track to recovery.

76. While the majority of COVID-19 related spend will occur in future financial years, spending impacts have been felt in February and March of this financial year. Those trusts affected and the NHS overall have been fully supported with funding and financing at the right time, and all spending pressures have been met.

77. On the 29 March 2020, the Accounting Officers of DHSC and NHSE obtained a Ministerial Direction[29] relating to COVID-19 spending. This confirmed, spending to combat the pandemic should be continued, even if this resulted in exceeding formal Parliamentary limits. DHSC was able to contain all spending within Parliamentary Supply limits as shown in **Table 1**. The Statement of Parliamentary Supply notes in this report provides further detail on the outturn of the Departmental Group.

78. Further detail regarding the level of spend on COVID-19 in the NHS can be found in **Annex B** of this Report. Detail regarding the level of spend on COVID-19 by the core department is detailed where relevant in the **Notes to the Departmental Annual Report and Accounts**.

Our performance against other required reporting

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

79. 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 on the environmental impact of their operations through the Greening Government Commitments (GGC)[30] reporting.

80. The GGC are a set of targets that cover carbon emissions related to energy use and business travel, water use and waste. The Department is also committed to the elimination of single-use plastics on its estate and reducing the environmental impact of its vehicle fleet. The upcoming GGC report will provide the environmental impact of the Department's operations for 2019-20 in line with the HM Treasury minimum financial reporting requirements for 2019-20 Annual Report and Accounts.

Parliamentary Questions 2019

81. We remain one of the busiest and best performing Departments for Parliamentary Questions across Government, answering 6,234 written parliamentary questions, with over 95 per cent of questions due in 2019 answered within deadline.

[29] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876882/29032020-sofs-to-perm-sec-ministerial-direction.pdf
[30] https://www.gov.uk/government/collections/greening-government-commitments

Freedom of Information (FOI) requests 2019

82. We answered 93 per cent of 933 FOI requests received in 2019 within the statutory 20-working day deadline (or Public Interest Test extension).

Other correspondence

83. As shown in **Table 2**, in 2019 we answered 22,365 letters and emails, responding to 77 per cent within our target rate of 18 working days. In line with standard correspondence reporting across Government, the data shown is for the calendar year 2019. In comparison to 2018 the total volume of such correspondence has dropped (28,808 in the 2018-19 ARA[31]). Percentages of correspondence answered on time has improved for all classes except Private Office correspondence compared to 2018-19.

Table 2: Other classes of correspondence 2019

Case Type	Due in 2019	Answered On Time	Percentage On Time
Private Office	10,741	7,092	66%
Treat Official	3,032	2,651	87%
Departmental Email	8,592	7,548	88%
TOTAL	22,365	17,291	77%

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

84. In 2019, the Department received eleven complaints. These were investigated internally and resolved satisfactorily.

85. As shown in **Table 3**, In 2019 (the last year for which published results are available), the PHSO received 15 enquiries regarding complaints about the core department, of which 2 progressed to assessment. No case progressed to investigation and as such no recommendations were made.

Table 3: PHSO Complaints 2019

Enquiries Received	Assessed	Accepted for Investigation*	Investigation Upheld/Partly Upheld	Investigations not Upheld	Investigations resolved without completion of investigation**	Investigations resolved without a finding***
15	2	0	n/a	n/a	1	n/a

* 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 2018-19 but not completed it until the following year 2019-20. Similarly, it may have completed an investigation in 2019-20 which we originally accepted for investigation in the previous year 2018-19.
** 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.

[31] https://www.gov.uk/government/publications/dhsc-annual-report-and-accounts-2018-to-2019

86. The Department's complaints process follows the PHSO's Principles of Good Complaint Handling[32]. 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.

Prompt Payment of Undisputed Invoices

87. The Public Contracts Regulations 2015[33] state 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.

88. **Table 4** details the percentage and value of undisputed invoices paid by NHS provider organisations within the agreed terms over the last 3 years.

Table 4: Prompt Payment of undisputed invoices

	NHS providers invoices paid within target	
Financial Year	Percentage	Value (£m)
2019-20	81	40,941
2018-19	79	37,856
2017-18	77	34,505

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

90. NHSE and 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

91. The Department of Health and Social Care's summary of expenditure on Official Development Assistance (ODA) is included at **Annex D**. This amounted to £225.1 million in 2019, funding Global Health Research and Global Health Security.

Better Regulation

92. 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.

[32] https://www.ombudsman.org.uk/about-us/our-principles/principles-good-complaint-handling
[33] http://www.legislation.gov.uk/uksi/2015/102/contents/made

93. The Small Business, Enterprise and Employment (SBEE) Act 2015[34] requires Government to set a Business Impact Target (BIT) for the length of the Parliament. A Business Impact Target for the new Parliament is under review.

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

95. The Department is working in partnership with the Better Regulation Executive to promote the use of alternative approaches to regulation where appropriate. Where regulation is required our partnership considers how best to develop proportionate and targeted, regulatory solutions through the use of our policy profession.

[34] http://www.legislation.gov.uk/ukpga/2015/26/contents/enacted

Secretary of State for Health and Social Care Annual Report 2019-20

Introduction

96. The Secretary of State is required by section 247D[35] 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.

97. This report comments on services commissioned by the National Health Service Commissioning Board (known as NHS England or NHSE) and clinical commissioning groups (CCGs), as well as those public health services for which the Secretary of State and local authorities are responsible[36]. 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[37].

98. The Secretary of State is under a duty in section 1A of the 2006 Act for or in connection with the matters listed at 1(a) (the prevention, diagnosis or treatment of illness) and 1(b) (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)[38]. 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 in the following paragraphs specifically in relation to performance of the NHS against key access standards; outcomes frameworks; NICE quality standards; the NHS mandate, and health inequalities.

Performance of the NHS against key access standards

99. 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. Details of how the NHS acute sector has delivered against several of these main access standards are given at **Annex C** (NHS Operational Performance).

Single Departmental Plan

100. In line with the process other government departments have followed to agree their single departmental plans, the Department's Single Departmental Plan[39] (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 the 2019-20 financial year, progress for the Department and the wider system was assessed via the SDP. The SDP is aligned with the outcomes frameworks.

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[35] 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).
[36] Social care is not a health service but is covered for completeness.
[37] The assessment is required under section 247D (2) of the 2006 Act.
[38] The NICE quality standards duty relates to section 1A (4).
[39] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan/dhsc-single-departmental-plan

Outcomes Frameworks

101. 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 outcomes frameworks, describing the outcomes that need to be achieved.

102. 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 while reflecting the different ways services are held accountable.

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

Alignment

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

Progress against outcomes

The NHS Outcomes Framework

105. 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.

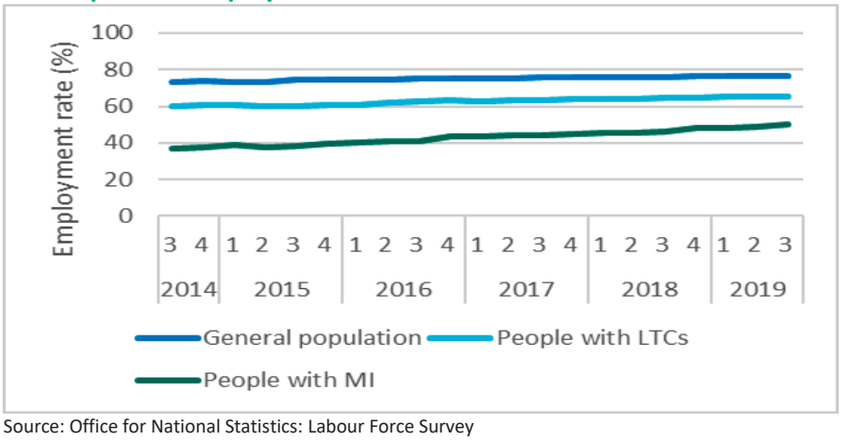
106. The NHSOF comprises five domains:
    - preventing people from dying prematurely;
    - enhancing quality of life for people with long-term conditions;
    - helping people to recover from episodes of ill-health or following injury;
    - ensuring people have a positive experience of care; and
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

Annual indicator data

107. Where people do need healthcare, the NHS continues to provide the care people need to live a fulfilling life. It also endeavours to support people to live as normal a life as possible, particularly helping those with mental illness (MI) and long-term conditions (LTCs) to obtain and stay in employment. The gap in employment rates between the general population and those with a mental illness has significantly reduced over the last five

years as you can see in **Figure 2**. Employment is an important determinant of quality of life. Income does have an impact on this even if it isn't specifically always obviously influencing someone's 'physical state'. Moreover the ability to maintain a job indicates a certain level of health.

Figure 2: Comparative Employment rates



Source: Office for National Statistics: Labour Force Survey

108. In 2019-20, 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 2020. The key changes in each domain are set out below. Full details on the indicators can be found on NHS Digital's website[40].

Preventing people from dying prematurely

109. The national neonatal and stillbirth rate continues to show a general decreasing trend. Between 1999 and 2017, it decreased by 2.2 from 9.1 to 6.9 deaths per 1,000 births.

110. There have also been statistically significant increases in the additional years both women and men aged 75 can expect to live. For men, the number of additional years between 2009-11 was 11.2, compared to 11.6 in 2016-18. For women, the number of additional years between 2009-11 was 13.0, compared to 13.2 in 2016-18.

Enhancing quality of life for people with long-term conditions

111. As outlined earlier in this section, the gap in employment rates between the general population and those with a mental illness has significantly reduced by 10.0 percentage points over five years (from 36.4 in Q3 2014 to 26.4 in Q3 2019), while the corresponding gap in employment rates for those with long-term conditions has reduced by 2.3 percentage points (from 13.2 in Q3 2014 to 10.9 in Q3 2019).

[40] https://digital.nhs.uk/search/category/nhs-outcomes-framework--nhs-of-/category/clinical-indicators-team?sort=relevance&area=data

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

112. The NHS continues to support people as they recover from injury or episodes of ill health. The most recent data (2017)[41], shows the proportion of adults recovering to their previous levels of mobility at 120 days after hip fracture was 64.4%, the highest recorded since the indicator was first measured in 2011 and statistically significant improvement on the 2015 value of 61.2%.

Ensuring that people have a positive experience of care

113. The Government is pleased that most patients are satisfied with their experience of and access to healthcare. Indicators measuring patient experience of hospital care and responsiveness to inpatient personal needs have both seen a slight decline of 0.7% and 2.0% respectively in 2018-19 compared to 2017-18. The percentage of those reporting a good experience of A&E services has slightly decreased by 1.1% in two years (from 82.7 in 2016 to 81.8 in 2018). 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 and data has not been published.

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

114. After small increases in the incidences of MRSA between 2014-15 and 2017-18, the number of incidents of MRSA has decreased by 4.7% in 2018-19. After a small (3.4%) increase in 2017-18, the number of C. *difficile* incidents reduced by 7.7% in 2018-19.

115. There has been a substantial reduction in deaths from venous thromboembolism (VTE) related events within 90 days post discharge from hospital of 16% from 67.7 deaths within 90 days of discharge per 100,000 related admissions in 2010-11 to 57.1 deaths per 100,000 related admissions in 2018-19.

The Public Health Outcomes Framework

116. The Public Health Outcomes Framework has a focus on two high-level outcomes:
    - Increased healthy life expectancy[42].
    - Reduced differences in life expectancy and healthy life expectancy between the most and least deprived areas.

117. 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[43].

118. Life expectancy has improved slightly since 2014[44] and healthy life expectancy has remained relatively stable since 2014, and although there has been a general improvement in life expectancy over the longer term, the rate of improvement has slowed down since 2011 as shown in **Figure 3**.

[41] The most recent information available. Although hip fractures are reported annually, they do so with a 20 month delay.
[42] Healthy life expectancy is a measure not only of how long we live, but also whether we are living in good health.
[43] 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.
[44] Only statistically significant changes are described as improvements or deteriorations.

Figure 3: Life Expectancy at birth, Males and females 2001-03 to 2016-18

119. Of the 107 indicators[45] included in this analysis from the Public Health Outcomes Framework, 68 (64%) have either improved since 2014 or are broadly the same[46] and 39 (36%) have deteriorated in comparison with 2014. For most of the indicators there remains considerable variation across local areas. For details on indicators please refer to the Public Health England website[47].

Improving wider determinants of health indicators

120. The majority of the indicators in this domain have improved or remained constant since 2014.

121. In particular we have seen an increase in children achieving a good level of development at the end of reception, including those children with free school meal status. The number of first time entrants to the youth justice system has decreased, showing an improvement in this indicator.

122. Indicators for pupil absence and the gap in the employment rate between those with a learning disability and the overall employment rate have deteriorated. We are clear that pupils should not be absent from school without good reason. Evidence shows that pupils with higher overall absence tend to do less well in their GCSEs, which has a lasting effect on their life chances[48]. We have put schools in control by supporting them and local authorities, to use their powers to deal with unauthorised absence. Government is continuing to engage with local authorities to try and improve best practice to support people with a learning disability into employment.

[45] Indicators without 2014 data, where statistical significance can't be measured and those under development have been excluded from this analysis.
[46] The most recent data available in the Public Health Outcomes Framework will differ between the indicators
[47] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[48] https://www.gov.uk/government/publications/absence-and-attainment-at-key-stages-2-and-4-2013-to-2014

Health Improvement Indicators

123. The majority of the indicators in this domain have improved or remained constant since 2014.

124. In particular, conceptions among girls under the age of 18, particularly those aged under 16 years, have shown a substantial decrease. The proportion of women smoking at the time of delivery has also declined. Smoking in pregnancy can have detrimental effects for the growth and development of the baby and health of the mother. Smoking is a known risk factor for many diseases including Chronic Obstructive Pulmonary Disease (COPD), heart disease and numerous cancers.

125. Deteriorating indicators include deaths from drug misuse and the number of successful completions of drug treatment for both opiate and non-opiate users. In February 2019, the Home Secretary appointed Professor Dame Carol Black to undertake an independent review of drugs, to inform the government's thinking on what more can be done to tackle the harm that drugs cause. The first phase of Dame Carol's review[49] was published on 27 February 2020, when a second phase of the review was also announced that will focus on prevention, treatment and recovery. The second phase will be taken forward by DHSC and will make policy recommendations including on reducing drug-related deaths.

Health Protection Indicators

126. In contrast to the other three domains, the majority of the indicators in this domain have shown deterioration since 2014.

127. Indicators that have deteriorated since 2014 include the coverage rates for some of the vaccination programmes notably the population vaccination coverage of MMR (measles, mumps and rubella) first dose (2 years old), the second dose at 5 years and Hib/MenC booster (*Haemophilus influenzae* type b/meningococcal group C) at 2 years. DHSC, PHE and NHSE have taken action to reverse this decline in vaccination uptake rates across the board, to push coverage higher. This joint work includes implementing actions from the UK Measles and Rubella Elimination strategy to increase uptake of the MMR vaccine and regain our measles elimination status, with notifications from Child Health Information Services (CHIS) to help General Practices identify children with due and overdue vaccinations. Furthermore, the NHS Long Term Plan's General Practice Vaccine and Immunisation Review has led to changes in the 2020-21 GP contract[50] that aim to improve access to and uptake of vaccines.

128. More widely the Department, Public Health England 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.

[49] https://www.gov.uk/government/publications/review-of-drugs-phase-one-report
[50] https://www.england.nhs.uk/gp/investment/gp-contract/

129. An example of an indicator in this domain that improved, is the reduction in incidences of Tuberculosis.

Healthcare, public health and preventing premature mortality indicators

130. The majority of the indicators in this domain have improved or remained unchanged since 2014.

131. Indicators for preventable sight loss due to age-related macular degeneration and hip fractures in those aged 80 years and over have both shown an improvement.

132. Indicators that have deteriorated include both the mortality rate from a range of communicable diseases including influenza, and the excess Winter deaths measure for those capturing all ages and for those specifically aged 85 years and over. Government has continued to invest in the seasonal flu programme over recent years, including introducing new vaccines offering improved effectiveness and extending the programme to cover all primary school age pupils. This not only protects the children themselves but prevents onward transmission to vulnerable members of the community.

Refresh of the 2016-19 Public Health Outcomes Framework

133. The indicators in the Public Health Outcomes Framework 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 2019. The following changes are in the process of being made to the framework: 10 indicators will remain but with a change to their definition, 11 indicators will be replaced with different indicators on the same topic (including one vaccination indicator) and 21 new indicators are to be added (including 5 vaccination indicators).

The Adult Social Care Outcomes Framework (ASCOF)

134. 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. ASCOF is divided into 4 'key domains' which are described in the following paragraphs and summarised in **Table 5**.

Enhancing quality of life for people with care and support needs (ASCOF indicators 1A to 1J)

135. ASCOF indicators measure 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 indicators also include views of unpaid 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. However, carer-reported quality of life and satisfaction scores have steadily declined over the past three years of reporting.

Delaying and reducing the need for care and support (ASCOF indicators 2A to 2D)

136. Keeping older people well, out of hospital and helping them to regain their independence after a period of support is a vital part of enabling them 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 2018-19, some 82.4% of such people were still at home, this is a similar rate to the rate achieved in 2017-18 which was 82.9%.

137. Making sure people are able to leave hospital as soon as they are medically fit to do so is also important. Latest data shows delayed transfers of care reducing compared to 2017-18, both in total delays per day per 100,000 population which has reduced from 12.3 to 10.3 in 2018-19, and delays attributable to social care which has reduced from 4.3 to 3.1 in 2018-19.

Ensuring that people have a positive experience of care and support (ASCOF indicators 3A to 3D)

138. 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 relatively stable, and was at 64.3% in 2018-19.

Safeguarding vulnerable adults and protecting from avoidable harm (ASCOF indicators 4A to 4B)

139. 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 2018-19, 70.0% of people who used services reported that they felt safe; this has been relatively stable since 2016-17.

140. **Table 5** summarises each ASCOF indicator from 2014-15 to 2018-19. Further detail on the ASCOF and all the indicator data can be found at NHS Digital's website[51].

[51] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof

Table 5: ASCOF Indicators

ASCOF Indicator	2014-15	2015-16	2016-17	2017-18	2018-19	Maximum score
Enhancing quality of life for people with care and support needs						
1A: Social care-related quality of life score	19.1	19.1	19.1	19.1	19.1	24
1B: The proportion of people who use services who have control over their daily life	77.3	76.6	77.7	77.7	77.6	100
1C(1A): The proportion of people who use services who receive self-directed support	83.8	86.9	89.4	89.7	89.0	100
1C(1B): The proportion of carers who receive self-directed support	76.9	77.7	83.1	83.4	83.3	100
1C(2A): The proportion of people who use services who receive direct payments	26.3	28.1	28.3	28.5	28.3	100
1C(2B): The proportion of carers who receive direct payments	67.6	67.4	74.3	74.1	73.4	100
1D: Carer-reported quality of life	7.9		7.7		7.5	12
1E: The proportion of adults with a learning disability in paid employment	6.0	5.8	5.7	6.0	5.9	100
1F: The proportion of adults in contact with secondary mental health services in paid employment	6.8	6.7	-	7.0	8.0	100
1G: The proportion of adults with a learning disability who live in their own home or with their family	74	75.4	76.2	77.2	77.4	100
1H: The proportion of adults in contact with secondary mental health services living independently, with or without support	59.7	58.6	-	57.0	58.0	100
1I(1): The proportion of people who use services who reported that they had as much social contact as they would like	44.8	45.4	45.4	46	45.9	100
1I(2): The proportion of carers who reported that they had as much social contact as they would like	38.5	-	35.5	-	32.5	100
1J: Adjusted Social care-related quality of life – impact of Adult Social Care services	-	-	0.4	0.4	0.4	
Delaying and reducing the need for care and support						
2A(1): Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population	14.1	13.3	12.8	14.0	13.9	
2A(2): Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	658.5	628.2	610.7	585.6	580.0	
2B(1): The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	81.9	82.7	82.5	82.9	82.4	100
2B(2): The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	3.1	2.9	2.7	2.9	2.8	100
2C(1): Delayed transfers of care from hospital, per 100,000	11.1	12.1	14.9	12.3	10.3	
2C(2): Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population	3.7	4.7	6.3	4.3	3.1	
2C(3): Delayed transfers of care from hospital that are jointly attributable to NHS and adult social care, per 100,000 population				0.9	0.8	
2D: The outcome of short-term services: sequel to service	74.3	75.8	77.8	77.8	79.6	100
Ensuring that people have a positive experience of care and support						
3A: Overall satisfaction of people who use services with their care and support	64.7	64.4	64.7	65.0	64.3	100
3B: Overall satisfaction of carers with social services	41.2		39.0		38.6	100
3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for	72.3		70.6		69.7	100
3D(1): Proportion of people who use services who find it easy to find information about services	74.5	73.5	73.5	73.3	69.7	100
3D(2): The proportion of carers who find it easy to find information about support	65.5		64.2		62.3	100
Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm						
4A: The proportion of people who use services who feel safe	68.5	69.2	70.1	69.9	70.0	100
4B: The proportion of people who use services who say that those services have made them feel safe and secure	84.5	85.4	86.4	86.3	86.9	100

1. All indicators are based on 2018-19 data.
2. Correct as at January 2020 (latest available at time of publication).

NICE Quality Standards

141. NICE quality standards are concise sets of prioritised statements designed to drive and measure quality improvements within a particular area of health or care. They are derived from the 'best available evidence' such as NICE guidance. The Department works closely with NICE, NHS England and NHS Improvement and Public Health England to ensure that NICE's quality standard programme reflects health and care priorities. From 1 April 2019 to 31 March 2020, NICE had published 13 new and updated quality standards covering a range of topics, including learning disabilities: care and support of people growing older, flu vaccination: increasing uptake and cerebral palsy in adults. The Secretary of State for Health and Social Care has to have regard to NICE quality standards when discharging his Section 1A functions.

Quality and Patient Safety

Patient Safety

142. The Government is committed to supporting a learning and improvement culture in the NHS so that NHS treatment and care continue to become safer, and are provided to the highest possible standards. Internationally, the NHS is identified as one of the safest healthcare systems in the world[52].

143. In July 2019, NHS England and NHS Improvement (NHSE and NHSI) published the first ever National Patient Safety Strategy. The Strategy, which is to be refreshed annually, could help save almost 1,000 extra lives and £100 million in care costs each year from 2023-24.

144. The impact of the COVID-19 pandemic has reached all areas of delivering the Strategy, however progress continues to be made, including on:
    - the creation of the new National Patient Safety Alerts Committee to oversee the credentialing and approval of issuers of national patient safety alerts, with NHSE and NHSI and the Medicines and Healthcare products Regulatory Agency (MHRA) becoming the first national approvers;
    - publication of the first ever Patient Safety Syllabus for the NHS[53], following consultation by the Academy of Medical Royal Colleges, which ended in March 2020;
    - consultation on a detailed description for the newly created Patient Safety Specialist role in NHS providers; and,
    - publication of a draft Patient Safety Partner Framework for consultation, alongside associated engagement activities in March 2020.

145. The Patient Safety Incident Response Framework (PSIRF)[54] - an integral part of the Patient Safety Strategy - was published in March 2020 and will eventually replace the 2015 Serious Incident Framework. Work to test the PSIRF will inform the final draft and system wide roll-out.

146. In the final quarter of 2019-20, resources within NHSE and NHSI were repurposed to support the response to COVID-19. This work included:
    - supporting the adoption of early warning systems in non-acute settings to help identify and manage COVID-19 patients at risk of deterioration;
    - supporting the use of validated early warning scores that help identify and manage deterioration of expecting mothers with COVID-19 and their babies; and,
    - ensuring safe care for COVID-19 patients with a tracheostomy who are looked after outside of intensive care units.

147. The programme to develop a new patient safety incident management system to replace the current National Reporting and Learning System (NRLS) made significant headway in 2019-20. The Government Digital Service Beta Assessment was passed in early March

[52] https://interactives.commonwealthfund.org/2017/july/mirror-mirror/
[53] https://www.hee.nhs.uk/our-work/patient-safety
[54] Patient Safety Incident Response Framework

2020, allowing the programme to move into the Public Beta phase once the health service is in a position to commence adoption of the new service, to be scheduled as post-pandemic peak activity.

148. From late January 2020, incidents in relation to COVID-19 were retrieved from the NRLS, alongside regular clinical review of patient safety incidents to identify those with potential for national action. National Patient Safety Alerts with the greatest relevance to the pandemic response were prioritised and published. Identified issues were also shared with the National Incident Response command and with specialist cells best placed to take action.

149. The Healthcare Safety Investigations Branch (HSIB) continues to conduct independent investigations of patient safety concerns in NHS-funded care across England with a specific focus on system-wide learning. HSIB has launched 53 national investigations, published 19 reports, and made 69 safety recommendations to system partners, to date.

150. HSIB completed roll out of its maternity investigation approach by the end of April 2019 and in March 2020 published its first national learning report[55] with recommendations for system bodies. Summary of themes arising from the Healthcare Safety Investigation Branch Maternity programme covers eight prominent themes which will be explored in a series of additional reports to be published during 2020-21.

151. The Health Service Safety Investigations Bill[56] was introduced to the House of Lords in October 2019. The Bill - which 'fell' (unable to be carried over to the next session) when the 2019 parliamentary session was dissolved - sought to establish a new independent body with the statutory investigative powers and protections to undertake effective healthcare safety investigations in England. The Government will need to reintroduce the Bill to take forward these proposals when Parliamentary time allows.

152. A strong framework on learning from deaths is in place to support the NHS. NHS acute, mental health and community trusts are required by law to publish locally the numbers of deaths thought to be due to problems in care each quarter, and to evidence the learnings and actions taken to prevent recurrence annually in their Quality Accounts. This requirement is planned to be extended to ambulance trusts in 2021. The Care Quality Commission continues to provide strengthened regulation through inspections that assess compliance by trusts with learning from deaths policy set out in national guidance. This includes how well the NHS engages with bereaved families and carers.

153. Medical Examiners are currently being introduced in the NHS in a non-statutory capacity to scrutinise all non-coronial deaths and DHSC is working closely with the National Medical Examiner to achieve full roll out. This Government is committed to introducing a statutory medical examiner system as soon as parliamentary time allows.

[55] HSIB National Learning Report
[56] https://commonslibrary.parliament.uk/research-briefings/cbp-8691/

154. The National Medical Examiner has published good practice guidelines, and NHSE and NHSI has completed recruitment to regional medical examiner teams to support trusts. The National Medical Examiner's office established the reimbursement system, and 81 acute trusts submitted costs for medical examiners in 2019-20. A total of 574 senior doctors trained as medical examiners with further training courses planned for 2020-21.

155. The National Medical Examiner contributed to the COVID-19 response by: assisting drafting of the Coronavirus Act 2020; publishing guidance for medical practitioners to explain easements during times of excess deaths; and responding to technical queries arising during the COVID-19 response.

156. There is now a standardised process of reviewing the deaths of all children in England, informed by national Child Death Review: statutory and operational guidance[57]. Independent scrutiny of every child death is now performed by a local Child Death Overview Panel, or equivalent, to ensure a uniform, high-standard of reviews locally. From April 2019, anonymised information from these reviews is being submitted to a National Child Mortality Database to inform shared learning.

157. The Department continues to work with other government departments and international governments, as well as the World Health Organization (WHO), to increase global cooperation and action to improve patient safety worldwide. This includes ensuring that all countries implement a UK government-led resolution (adopted by the World Health Assembly in May 2019) by prioritising patient safety and proactively marking World Patient Safety Day on 17 September 2019. The Department continues to support NHSE and NHSI's Medicines Safety Improvement Programme which aims to reduce medication-related harm in the NHS, focusing on areas such as high-risk drugs and vulnerable patients. The programme will contribute to the WHO's Global Patient Safety Challenge target to reduce severe avoidable medication-related harm worldwide by 50 per cent over five years.

Supporting Patients, Families and Staff to raise concerns

158. A national strategy is being developed to help drive improvements in how feedback and concerns from patients, families and their carers are dealt with so that the NHS listens, learns and acts.

159. In October 2019, the Secretary of State supported the National Guardian's Office's second ever Speak Up month which saw events across the country raising awareness of 'Speaking Up' within the NHS. The National Guardian's Office have reported that the speaking up culture through Freedom to Speak Up Guardians is improving nationally. The new Freedom to Speak Up Index 2019[58] has shown that 180 Trusts have improved their index score over the past three years, with a six-percentage point average improvement.

[57] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
[58] https://nhsproviders.org/media/688485/ftsu-index-report-2019-final2.pdf

Monitoring and Regulation of Quality of Care

160. The Care Quality Commission (CQC) monitors, inspects and regulates registered health and social care providers in England. In 2019-20, the CQC embarked on a transformation programme, to improve its digital infrastructure and enable it to make improvements in how it registers, monitors and inspects services.

161. In October 2019, the CQC's annual State of Care report[59], which provides an assessment of health and care services, found that the vast majority of patients continue to receive good, safe care.

162. The CQC is improving its approach to assessment of services for people with mental health and complex needs, gathering information from people who use services and their families early in the inspection process, so their views can influence lines of enquiry that the CQC follow during inspection. **Table 6** shows CQC ratings by type of provider.

Table 6: Percentage of core services rated by CQC as Good or outstanding by service provider*

Rating	Outstanding		Good		Requires Improvement		Inadequate	
Year	2018	**2019**	2018	**2019**	2018	**2019**	2018	**2019**
NHS Acute Trusts	6%	**7%**	60%	**65%**	31%	**25%**	3%	**2%**
Adult social care	3%	**4%**	79%	**80%**	17%	**15%**	1%	**1%**
GP practices	5%	**5%**	91%	**90%**	4%	**4%**	1%	**1%**
NHS mental health trusts	8%	**10%**	70%	**71%**	21%	**17%**	1%	**3%**
Independent mental health trusts	6%	**9%**	72%	**66%**	19%	**21%**	2%	**3%**

* Ratings taken on 31 July in 2018 and 2019 and published in the CQC State of Care (2018-19) report. Percentage figures may not sum due to rounding.

Inquiries and Reviews

163. There are occasions when failures in care or patterns of incidents require investigation to provide system-wide learning.

164. Scrutiny of patient safety continues with publication of the Report of the independent inquiry into the issues raised by Paterson[60] on 4 February 2020, with the Independent Medicines and Medical Devices Safety Review chaired by Baroness Julia Cumberlege which published its report on 8 July 2020.

165. In June 2019, Ministers announced a new independent investigation to review fresh evidence of substandard care at Liverpool Community Health NHS Trust[61] between 2010 and 2014.

166. In November 2019, the existing independent review by NHSE and NHSI which is assessing the quality of investigations relating to failings in maternity care at Shrewsbury and Telford Hospitals NHS Trust (the Ockenden Review) published revised terms of reference to reflect an expansion in its scope to encompass a large number of additional cases[62]. A

[59] https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf
[60] https://www.gov.uk/government/publications/paterson-inquiry-report
[61] https://www.gov.uk/government/news/failings-at-liverpool-community-health-new-investigation-announced
[62] https://improvement.nhs.uk/news-alerts/independent-review-shrewsbury-and-telford-hospital/

criminal inquiry was launched and the emerging findings and recommendations stemming from the independent review were published[63] during the 2020-21 financial year.

167. In February 2020, it was announced that an independent review would be commissioned in relation to maternity services at East Kent Hospitals University NHS Foundation Trust. Dr Bill Kirkup has been appointed to lead the Independent Investigation into East Kent Maternity Services.

Overall Assessment (section 1A)

168. 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 2006 Act, to act to secure continuous improvement in the quality of services provided to individuals, in particular securing continuous improvement in the outcomes achieved.

169. Across the frameworks there are areas where tangible progress has been made, but also areas of concern. For example, while significant progress has been made in helping those with mental illness and long-term conditions to obtain and stay in employment, there has been a deterioration across many of the indicators within the domain of health protection. DHSC, working with its ALB partners and other Government Departments, is taking a coordinated set of actions to reverse the decline in vaccination rates.

Health Inequalities

170. The Secretary of State's legal duty to have regard to the need to reduce health inequalities includes assessment and reporting requirements[64]. For 2019-20, 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[65].

171. Inequalities in people's access, outcomes and experiences of the health service continue to present real challenges. Much of the planning work that has been under development in recent years is being implemented, such as the NHS Long Term Plan and through the PHE Strategy 2020-2025, which includes health inequalities reduction throughout the plans. The publication of the Advancing Our Health: Prevention in the 2020s Green Paper[66] in July 2019 outlined further opportunities for prevention to improve the health and quality of life of people in higher areas of deprivation. Governance arrangements have been strengthened with fortnightly tripartite meetings between NHS England, PHE and DHSC officials. Organisational changes, necessitated by responding to COVID-19 across the health service in the final quarter of 2019-20, saw some programmes paused and the adaptation of others, which will present further challenges ensuring focus on health inequalities remains part of the recovery period.

[63] https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust
[64] 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).
[65] https://www.gov.uk/government/publications/criteria-used-to-measure-success-on-reducing-health-inequalities
[66] https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s

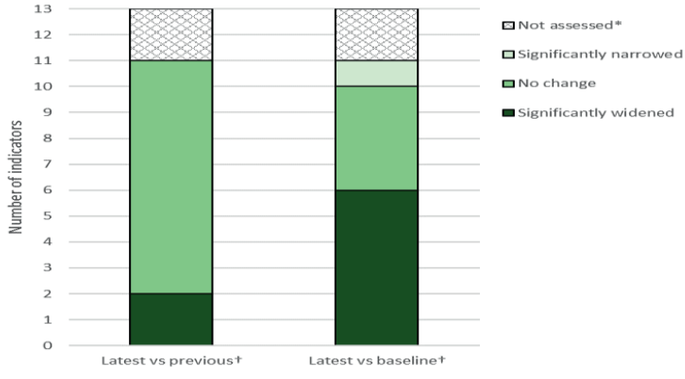
172. Fifteen overarching indicators of how health outcomes differ by area deprivation are drawn from the NHS Outcomes Framework (NHSOF) and Public Health Outcomes Framework (PHOF)[67]. They are used in this assessment which seeks to identify both recent change and change since the inequalities duties 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[68].

173. The English Indices of Multiple Deprivation (IMD) are the official measures of area-based relative deprivation, whereby each area in England is given a deprivation rank from most to least deprived. These are updated regularly, with the 2015 indices now being replaced by the 2019 indices. This report uses the latest set of indices for the latest data, and the 2015 for earlier time periods[69]. By doing this, areas' rankings in the IMD are most relevant to the time period of the indicator being used (e.g. an indicator last measured in 2016 would use the 2015 IMD, and an indicator measured in 2019 would use the 2019 IMD).

174. There is a risk that by doing this changes in inequality are due to differences in the way deprivation is measured between the 2015 IMD and 2019 IMD. Any differences that may arise from measurement change have been highlighted in the text.

175. **Figure 4** summarises the changes seen across this basket of indicators, comparing the latest data with data from the previous time period.

Figure 4: 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

[67] Only thirteen 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').
[68] 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
[69] Two indicators ('Access to GP services' and 'Patient Experience of GP services') use the IMD 2010 to determine the deprivation ranking for the baseline year (2013/14) and the IMD 2015 for the most recent time period (2018/19)

176. Of the 13 indicators, 2 have shown a statistically significant widening of inequality from the previous time period; however, 6 have shown a statistically significant widening of inequality from the baseline time period and only 1 indicator has shown a statistically significant narrowing of inequality.

177. 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:

- in 2016-18, the inequality in life expectancy at birth between the most and least deprived areas was 9.5 years for males and 7.5 years for females.
- in 2016-18 the inequality in healthy life expectancy at birth between the most and least deprived areas was 18.9 years for males and 19.4 for females.
- these inequalities are broadly stable; however, inequality in life expectancy at birth for males and females significantly widened between the baseline period (2010-12) and 2016-18[70].

178. 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 baseline period (2011-13) and 2016-18 for life expectancy at 75 for males and females.
    - Inequalities in under 75 mortality rates from cardiovascular diseases has remained broadly stable since the baseline year (2013).
    - inequalities in under 75 mortality rates from cancer has narrowed between the baseline year (2013) and 2018[71].
    - Inequality in emergency admissions for acute conditions that should not usually require hospital admission significantly widened from the baseline (2013-14) and previous time periods (2017-18).
    - Inequality in unplanned hospital admission for chronic ambulatory care sensitive conditions significantly widened from the baseline (2013-14) and previous time periods (2017-18)[72].
    - Inequality in infant mortality has remained relative stable between baseline (2013) and 2018[73].
    - For access to GP services and experience of GP services, there is a notable increase in inequality between the baseline year (2013-14) and the most recent time period (2018-19); however, it is not possible to accurately assess the statistical significance of this change[74].

[70] 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.
[71] This change was only statistically significant when using IMD 2019 for the most recent time period.
[72] These indicators are calculated using indirectly standardised admission rates. SII estimates may be influenced by the differences in population structures across deprivation deciles.
[73] The impact of using either IMD 2015 or IMD 2019 for the most recent time period for this indicator could not be measured.
[74] Data needed to calculate the confidence intervals for each decile are unavailable. In addition, 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 2018/19 and those prior to 2017/18 could potentially be influenced by this change in survey design.

179. Using data available through the GP Patient Survey[75], an assessment can also be made for other dimensions of inequality. These are: ethnic group, sexual orientation and age. In 2018-19:
    - 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 worst 3 scoring ethnicities for both indicators;
    - younger ages generally reported worse scores than older ages; and
    - individuals who identify as heterosexual reported better scores than those who identify as gay/lesbian or bisexual.

180. The Secretary of State's assessment of how well his health inequalities duty has been fulfilled in 2019-20, affirms that reducing health inequalities is recognised as a priority in the health and care sector. The Secretary of State recognises that reducing health inequalities is challenging and involves complex drivers, many of which lie outside the health and care sector. The recent analyses of disparities in the impact of COVID-19 has further illustrated the issues. A refocusing of efforts is needed to level up health outcomes. Spreading opportunity across the country will be an important part of the economic and social recovery from COVID-19, and is necessary to drive the changes in health outcomes that we want to see.

Forward look to 2020-21

181. The Department and its delivery partners across the health and care system are committed to leading the nation's health and social care to help people live more independent, healthier lives for longer. The Secretary of State will continue to report on progress in meeting the Department's priorities over the course of 2020-21.

Performance Report Accounting Officer Sign-off

22 January 2021
Sir Chris Wormald KCB
Permanent Secretary

[75] https://digital.nhs.uk/data-and-information

Accountability Report

Lead Non-Executive Board Member's Report

Performance and priorities

Kate Lampard

182. The past year has placed extraordinary demands on the Department. In addition to planning for EU Exit, and the work of delivering on the clear set of priorities and commitments arising from the General Election in December 2019, there was also the need to respond quickly and effectively to the Coronavirus (COVID-19) outbreak. The Non-Executive Directors have supported this work through their involvement in different workstreams, general oversight and identifying areas of risk.

183. The Board met four times in 2019-20 and while performance remained its primary focus, a range of topics were covered from cancer screening to workforce, as well as regular reviews of risk. Membership of the Board changed during the year with Prof. Dame Sally Davies stepping down as Chief Medical Officer and Prof. Chris Whitty taking up this role in October 2019. Matthew Gould, CEO of NHSX joined the Board as a formal member in the Summer of 2019. One non-executive board member, Sir Ron Kerr, left the Board during 2019-20 and I thank him for his time and commitment to the Department during his term.

184. Support and challenge outside the formal board meetings is an important part of the non-executive directors' role. Prof. Sir Mike Richards and I have attended regular EU and Trade Assurance Board meetings and all non-executive directors have attended deep dive sessions on various aspects of the Department's work. We continue to operate a well-received mentoring programme for senior civil servants, as well as offering advice and support to members of staff on a more ad hoc basis. Prof. Sir Mike Richards published his report on the independent review of adult screening programmes in England. And we have also continued to strengthen our relationships with the Department's ALBs, through regular attendance at their Board meetings.

185. The Audit and Risk Committee (ARC), chaired by Gerry Murphy, met on four occasions. It regularly discussed the Department's finances and the accounts, internal audit reviews and fraud risk, receiving regular updates from the National Audit Office and challenging the Department to improve performance where this was necessary.

186. My fellow non-executive directors and I would like to pay tribute to the staff of the Department for their fortitude and dedication to their work over the past year. We look forward to continuing our support for them.

Accountability Report

187. 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

188. 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

189. 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

190. 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 2020

The Rt Hon Matt Hancock MP
Secretary of State for Health & Social Care
Chair of the Departmental Board
Appointed 10 July 2018

Helen Whately MP
Minister of State for Care
Appointed 14 February 2020

Edward Argar MP
Minister of State for Health
Deputy Chair of the Departmental Board
Appointed 10 September 2019

Jo Churchill MP
Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care
Appointed 26 July 2019

Nadine Dorries MP
Parliamentary Under Secretary of State for Patient Safety, Suicide Prevention and Mental Health
Appointed 27 July 2019

Lord Bethell of Romford
Parliamentary Under Secretary of State for Innovation (Lords)
Appointed 9 March 2020

Former Ministers who served during 2019-20

- **Jackie Doyle-Price,** Parliamentary under Secretary of State for Mental Health, Inequalities, and Suicide Prevention until 26 July 2019
- **Stephen Hammond,** Minister of State for Health until 25 July 2019
- **Seema Kennedy,** Parliamentary under Secretary of State for Public Health and Primary Care from 4 April to 26 July 2019
- **Chris Skidmore,** Minister of State for Health from 25 July to 9 September 2019
- **Caroline Dinenage,** Minister of State for Care until 13 February 2020
- **Baroness Nicola Blackwood,** Parliamentary Under Secretary of State for Innovation (Lords) until 13 February 2020

Our Non-Executive Board Members 2019-20

Kate Lampard
Lead Non-Executive Director
1 October 2017-present

Michael Mire
Non-Executive Director and member of Audit and Risk Committee
1 November 2017-31 October 2020

Prof. Sir Mike Richards
Non-Executive Director
1 November 2017-31 October 2020

Gerry Murphy
Non-Executive Director and Chair of Audit and Risk Committee
1 August 2014-present

Prof. Dame Sue Bailey
Non-Executive Director
1 November 2017-31 October 2020

Our Executive Board Members

Sir Chris Wormald KCB
Permanent Secretary

David Williams CB*
Second Permanent Secretary, Director General for Finance and Group Operations, and Chief Operating Officer

Prof. Chris Whitty***
Chief Medical Officer and DHSC Chief Scientific Adviser

Matthew Gould**
CEO of NHSX

*David Williams CB was temporarily promoted to Second Permanent Secretary in March 2020
** Matthew Gould became a Board member in May 2019

*** Prof. Chris Whitty became a formal Board member in October 2019 in his role as CMO

Other non-executive directors who served in the Department during 2019-20

- Sir Ron Kerr, non-executive director from 1 November 2017 to 31 December 2019. Attended 2 out of 3 Board meetings.

Other executive directors who served in the Department during 2019-20

- Prof. Dame Sally Davies DBE stepped down as Chief Medical Officer in September 2019.

Other Senior Officials

Clara Swinson CB
Director General for Global Health

Jonathan Marron
Director General for Prevention, Community and Social Care

Lee McDonough
Director General for Acute Care and Workforce

Steve Oldfield
Chief Commercial Officer

Our Arm's Length Bodies and Delivery Partners

191. The Department (DHSC) 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.

192. 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.

193. Our ALBs, detailed in **Annex E**, fall into several distinct types:
    - Executive Non-Departmental Public Bodies (ENDPBs). Established by primary legislation and have their own statutory functions conferred, rather than delegated by the Secretary of State for Health and Social Care.
    - Executive Agencies. Legally part of DHSC but with 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 included in the Departmental Group and therefore as part of this Annual Report and Accounts.

194. Our Permanent Secretary is the Principal Accounting Officer for the Departmental Group which as at 31 March 2020 consisted of:
    - Ten ENDPBs (including NHS England and its 191 Clinical Commissioning Groups (CCGs));
    - Four SpHAs;
    - Eight other bodies;
    - 149 NHS Foundation Trusts (FTs);
    - 74 NHS Trusts (NHSTs); and
    - NHS charities.

195. The activities of our ALBs and delivery partners are consolidated and incorporated in this report, with the exception of the MHRA and NHS Blood and Transplant (NHSBT). NHSBT is designated as outside the Departmental Group by the Office for National Statistics. While the Office for National Statistics has now re-categorised MHRA as falling within the Departmental Group, it will not be incorporated into the Department's accounting boundary until its establishing legislation is revoked.

Departmental Disclosures

196. The Department has a Code for Business Conduct, which incorporates the principles set out in the Civil Service Code[76] and applies to all staff working in the Department, including those who have authority or responsibility for directing or controlling the Department.

197. 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

198. 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.

199. Our Ministers' interests are published on gov.uk website by the Cabinet Office[77] while 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[78].

200. **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.

[76] https://www.gov.uk/government/publications/civil-service-code/the-civil-service-code
[77] https://www.gov.uk/government/publications/list-of-ministers-interests
[78] https://www.gov.uk/government/collections/business-expenses

Statement of Principal Accounting Officer's Responsibilities

201. Under the Government Resources and Accounts Act 2000[79] (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 2020 no.17 (together known as the 'Departmental Group', consisting of the Department and sponsored bodies listed at **note 21** to the accounts).

202. 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.

203. 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.

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

205. 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.

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

206. In addition HM Treasury has appointed a temporary Second Permanent Secretary to be an additional Accounting Officer in the Department. As well as assuming the responsibilities of the Principal Accounting Officer should they be unavailable, the Second Permanent Secretary was initially accountable for ensuring the Department's appropriate and regular deployment of resources in relation to non-COVID-19 activities. As the role has been created to address operational pressures and create further resilience in the Department, the scope of the role is fluid. The appointment does not detract from the Permanent Secretary's overall responsibility as Principal Accounting Officer for the Department's accounts.

207. 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 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.

208. 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[80] published by HM Treasury.

209. The Department published in July 2018 an Accounting Officer System Statement[81] setting out lines of accountability within the Department and the healthcare system bound by the legislative framework of the Health and Social Care Act 2012[82]. This includes the responsibilities and relationships between the Accounting Officers in the Department, its Agencies, Arm's Length Bodies and the NHS.

210. 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.

211. 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.

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

Governance Statement

Scope of Responsibility

212. 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 2019-2020 and is current up to the date this Annual Report was signed.

213. 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, while 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[83] for central Government Departments, published by HM Treasury and the Cabinet Office.

214. The Head of Internal Audit's opinion is that they can give Moderate Assurance to the Department's Principal Accounting Officer in relation to the 2019-20 reporting year regarding the overall adequacy and effectiveness of the Core 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.

215. 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 guardian 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.

216. While 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.

217. Within the Department there is also support via the creation of a Second Permanent Secretary and Accounting Officer during 2019-20. The Second Permanent Secretary will assume my responsibilities as Principal Accounting Officer if I am unavailable. The role has been created to address the operational pressures that have arisen through the Department's COVID-19 pandemic response.

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

218. 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.

Departmental Governance

219. 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.

220. The Departmental Board meets on a quarterly basis. The Board met on four occasions during the 2019-20 financial year. Full membership and attendance is outlined in the Directors' Report. The composition of the Board changed during 2019-20, with the CEO of NHSX becoming a formal member of the Board. Prof. Chris Whitty became a formal Board member on his appointment as Chief Medical Officer. One Non-Executive Director stepped down from the role in 2019.

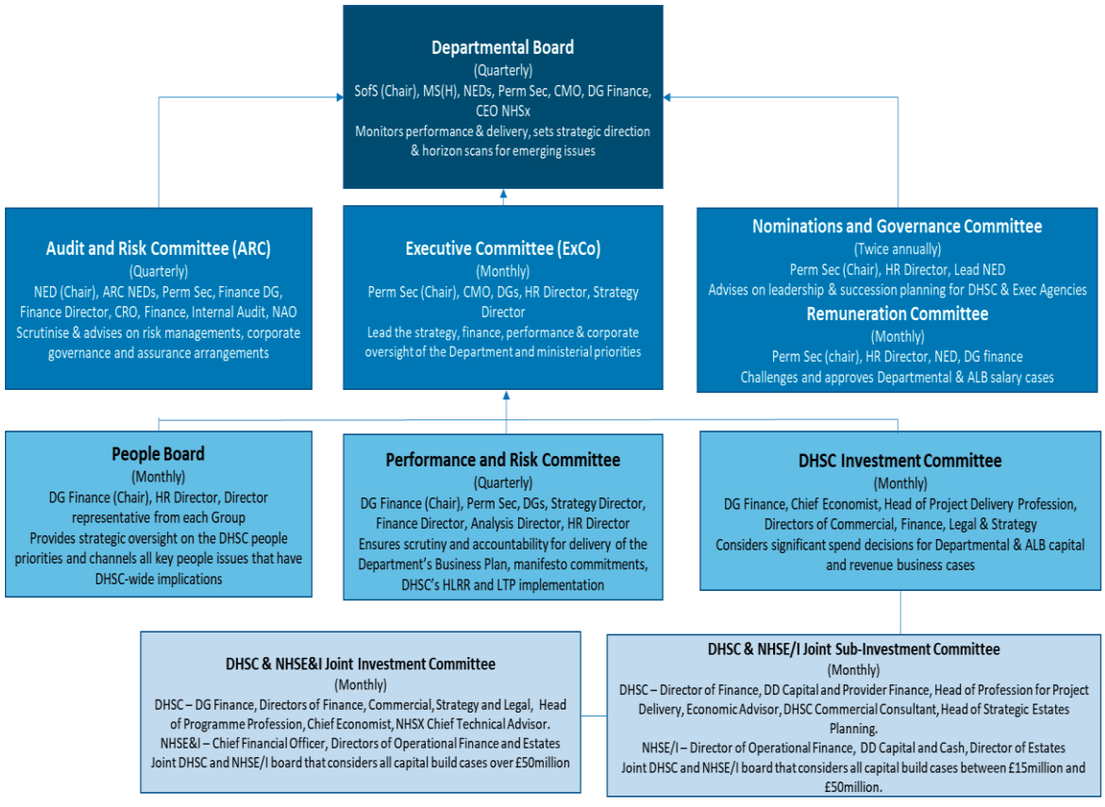
221. The Board advises the Secretary of State and Permanent Secretary and in particular has responsibility for:
    - supporting Ministers and the Department on strategic issues linked to the development and implementation of the Government's objectives for the health and social care system;
    - horizon scanning for emerging issues;
    - ensuring there is strategic alignment across the health and care system;
    - ensuring that any strategic decisions are based on a collective understanding of evidence, insight and experience;
    - 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.

222. The Board 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.

223. 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.

224. The Departmental Board is supported by the committees shown in the structure chart at **Figure 5.**

Figure 5: Departmental Board Structure



225. 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 2019-20 included; 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 meetings and met a further once during the year to discuss a single issue.

226. 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. This role also applies to the approval of senior pay (£150,000 and above) in DHSC's Government-owned companies. The Committee met 10 times in the year.

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

228. 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 reviews the comprehensiveness of assurances and integrity of financial statements. The Committee met 4 times this year.

229. The Strategy Committee used to meet quarterly, as part of the Department's formal governance structure, to discuss strategic medium to long-term planning on the work programme. The Committee last met in July 2019 and no longer operates as a formal committee, with these strategic discussions now incorporated into the Executive Committee meetings, to foster more strategic and holistic meetings.

230. **Table 7** summarises attendance at the Departmental Board and the four committees.

Table 7: Committee Attendance

Name of Board or Committee member[1]	Departmental Board Met 4 times	Executive Committee[3] Met 12 times[4]	Audit and Risk Committee Met 4 times	Nominations and Governance Committee Met 2 times	Remuneration Committee[2] Met 10 times
Ministers					
Rt Hon Matt Hancock MP	1 (out of 4)	-	-	-	-
Caroline Dinenage MP	1 (out of 3)	-	-	-	-
Officials					
Sir Chris Wormald KCB	2	12	1	2	9
Professor Dame Sally Davies DBE[9]	2 (out of 2)	1 (out of 6)	-	-	-
Professor Chris Whitty[10]	1 (out of 2)	10	-	-	-
David Williams CB	4	11	3	-	10
Clara Swinson CB	-	12	3	-	-
Jonathan Marron	-	11	-	-	-
Lee McDonough[8]	-	12	-	-	3 (out of 3)
Steve Oldfield	-	11	-	-	-
Matthew Gould[12]	4	4 (out of 8)	-	-	-
Jenny Richardson	-	12	-	2	9
Hugh Harris	-	12	2	-	-
Non-Executive Directors					
Kate Lampard	4	-	-	2	3
Professor Dame Sue Bailey	4	-	-	-	3
Sir Ron Kerr[11]	3 (out of 3)	-	-	-	1
Professor Sir Mike Richards	3	-	-	-	-
Michael Mire	4	-	3	-	-
Gerry Murphy	2	-	4	-	3
Independent Members [5,6]					
Anne Barnard[7]	-	-	2 (out of 2)	-	-
Graham Clarke[7]	-	-	1 (out of 1)	-	-
Richard Hornby[7]	-	-	0 (out of 1)	-	-

1. Table represents Committee members attendance only. To note, other officers' attendance is not recorded within the table.
2. Attendance of the Remuneration Committee is shared amongst our Non-Executive Directors.
3. Where a Director General could not attend, a deputy attended on their behalf.
4. The total of 12 Executive Committee meetings comprised 11 regular monthly meetings and 1 ad hoc meeting
5. Jacqui Burke stepped down from ARC on 31 August 2019. 1 out of 1 meeting attended.
6. Cat Little stepped down from ARC on 31 October 2019. 2 out of 2 meetings attended.
7. Anne Barnard, Graham Clarke, and Richard Hornby became Independent Members of ARC on 1 January 2020. Anne Barnard attended one meeting as an independent member in a shadow capacity.

8. Lee McDonough became a member of DHSC Remuneration Committee from 20 November 2019.
9. Professor Dame Sally Davies DBE stepped down from the Board and Executive Committee in September 2019.
10. Professor Chris Whitty became a formal Board member in October 2019.
11. Sir Ron Kerr stepped down from the Board on 31 December 2019 with 3 out of 3 Board meetings attended.
12. Matthew Gould became a member of the Board and Executive Committee in May 2019.
13. Numbers in brackets are the maximum number of meetings a member could have attended.

Assurance Framework, Risk Management and control issues

Core Department

231. 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.

232. The Department continues to work with the Infrastructure and Projects Authority (IPA) to reassess its programmes on the Government Major Projects Portfolio (GMPP) with a view to removing those which have concluded and others which now no longer fit the criteria for inclusion. A total of three programmes were removed from the list; Clinical Triage Platform, NHS.UK and Data Processing Services Programme which left the GMPP in March 2020 having concluded the programmes. Part of this includes the work to establish the digital portfolio with NHSX. The Department is also developing a Capital Delivery Portfolio to manage the delivery of key manifesto commitments including the Health Infrastructure Programme and the key hospital builds.

233. The Portfolio dashboard is now part of the regular update to senior governance boards in the department including the Audit and Risk Committee. Familiarisation sessions have also been held with non-executive Directors to improve their understanding of the GMPP and the relationships with the IPA, particularly the link with assurance and Treasury approvals. The Department has worked closely with the IPA in the development of the assessment framework for project delivery standards, in particular the standards for Portfolio.

234. 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. As shown in **Figure 5** the Investment Committee is supported by the DHSC and NHS England and NHS Improvement (NHSE and NHSI) Joint Investment Committee and Joint Sub-Investment Committee with both committee's meeting on a monthly basis also.

Three lines of defence

235. 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.

236. At the second line, our Governance includes the 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.

237. 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 (GIAA). The ARC has considered the way in which the Department manages risk at its four meetings during 2019-20 and reviews and discusses the Department's risk register as a standing agenda item at these meetings.

238. 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 co-opted 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 ARC. 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. Both the NAO and GIAA attend the ARC meetings.

239. 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.

240. ARC has a standing meeting agenda for its four meetings which covers papers and updates on finance, Internal Audit, NAO audits and value for money studies, PAC reports and recommendations, counter fraud, cyber security, high-level risks, the Department's major projects portfolio and GMPP, and EU Exit. In 2019-20 there were presentations from the Medicines and Healthcare products Regulatory Agency, Care Quality Commission and NHS Counter Fraud Authority on risk management strategy and governance. There were also deep dive discussions on NHS winter planning, the Macpherson review of quality assurance of analytical modelling, Executive Senior Managers Pay Framework, the Health and Social Care Network, Medical Examiners programme and the National Proton Beam Therapy Programme.

241. A formal Board Effectiveness Evaluation was not carried out in 2019-20. The Board met quarterly throughout the year to review departmental performance and risk and is

considered to be functioning well. In line with the recommendation from the previous year's Board Effectiveness Evaluation, the Non-Executive Board members have strengthened their relationships with the Department ALBs through regular attendance at their Board meetings.

242. Recognising the additional pressure departments were faced with responding to COVID-19 during Q4 of 2019-20, Cabinet Office did not formally commission departments to complete Board effectiveness evaluations this year. This was on the basis that details of Board meetings were collected for the ARA and that a full independent exercise will be needed for 2020-21.

243. Within DHSC, a substantial reprioritisation of the work and resource of the Department was carried out to ensure the Department could respond to COVID-19. As part of this exercise, it was decided that without the formal commission from Cabinet Office, the Board effectiveness evaluation would be postponed. However, the Secretariat for the Board carried out an informal review of the recommendations from 2018-19 and concurred that progress had been made towards these and the Board was carrying out its functions effectively at each quarterly meeting.

Managing Risk

244. 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 held a formal review meeting with Directors General (DGs) to discuss and agree the Department's high-level risks in May 2019. Following this strategic-level refresh, individual discussions to refresh the new high-level risks took place with senior officials to confirm the scope and focus of our risk monitoring. A new risk register and guidance, and refreshed assurance framework were issued in mid-2019 to take these changes into account.

245. The quarterly performance and risk process, run by the Chief Risk Officer's risk team maintains 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.

246. The nature of the health and care system is that risks can be inherent, fast-evolving and unpredictable. 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 2019-20 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 health and care system's failure to deliver digital transformation and capability;
- the global threat of antimicrobial resistance; and
- the risk relating to pandemics/major infectious disease outbreaks.

System-wide risks

- the risk of demand for NHS services growing beyond that assumed in the Long Term Plan;
- the failure to maintain internal and external financial control of the health and care system;
- the risk 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;
- the growth in demand for NHS services compromises the ability of the 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;
- failure to hold partners' organisations to account 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.

247. 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.

248. In 2019-20 the Directors General, participated in the quarterly Performance and Risk Reporting, and Bi-annual Assurance Meeting (BAM) process. The Departmental Board discusses the quarterly Performance and Risk packs and receives summaries of ARC, and Performance and Risk Committee meetings to provide assurance and an update on the governance and control system in the core Department of Health and Social Care. This confirms 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 of other requirements incumbent on the Department that we are asked to assure via the Governance Statement. In 2019-20 we refreshed the assurance mapping across the Department, aligning more closely with central government advice.

249. A full set of BAM meetings did not take place in 2019-20. In quarter 2 of the financial year, pressures relating to EU Exit and the 2019 General Election meant that BAMs were held for the Acute Care and Workforce and Commercial Director General Groups only. No BAMs were held at quarter 4 due to the Departments COVID-19 response. When meetings were held, 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. Whilst some BAMs did not go ahead, the quarterly performance and risk returns continued as normal to provide the Department with assurance on its performance, key issues and concerns.

250. An outline of the Department's management of the COVID-19 pandemic up to 31 March 2020 is addressed later in the Governance Statement and as part of the Performance Report. The Department operated in 'crisis management' mode during March 2020 and

into April as it acted at pace to save lives during the early stages of the pandemic, deploying phased actions to contain, delay and mitigate the outbreak. The Departmental risk appetite on transactions therefore remained agile in line with changing decision criteria/external factors e.g. demand and supply certainty, market conditions, expected worst case scenarios for NHS capacity and so forth. The Accounting Officer therefore signed-off all arrangements to ensure decisions were taken in the appropriate manner.

251. The pace of COVID-19 decisions in an environment of increased risk appetites is well understood but despite good controls being in place, operating in 'crisis mode' will have created additional risk that may crystallise in the future.

Whistleblowing

252. 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.

253. 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 conducts 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. In 2019-20 less than five formal whistleblowing concerns were raised, but we can say that all cases have been investigated and the investigations have concluded.

254. The Department has seven Speak Out Advisers currently in place, plus a SCS Speak Out lead who works with HR and provides leadership support to the Speak Out Advisers. The Department's HR team uses a well-established Safe to Challenge scorecard to measure progress and identify any hotspots or trends. The scorecard is reviewed quarterly at both the Departmental Performance & Risk Committee and the Executive Committee and a summary is published to all staff every six months on the Department's intranet to highlight support and encourage a 'Safe to Challenge' culture. Our work on creating the right culture encourages people to feel safe to raise and resolve concerns. DHSC's most recent people survey showed the number of people that felt confident to speak up was above the Civil Service average. This is suggestive of an effective policy being in place.

255. Over the course of 2019-2020, the priority in this area has been to focus on promotion of the whistleblowing policy and Speak Out support system. This has included the creation of toolkits for line managers; use of personal blogs; and team-led discussions on the refreshed whistleblowing, bullying, harassment and discrimination, and grievance policies. In the last quarter and in the context of COVID-19 there was additional emphasis on promoting the whistleblowing policy and Speak Out support system to those new to the Department and through virtual platforms.

Role of Internal Audit

256. The Department's internal audit service continues to be provided by a dedicated Health and Social Care team within the Government Internal Audit Agency (GIAA).

257. The team 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.

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

259. 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 resulting action plan is agreed by management and includes a 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

260. Following completion of a programme of risk-based audit work throughout the Department during 2019-20, 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. As such, the Head of Internal Audit's opinion is that she can give 'Moderate' Assurance to the Department's Principal Accounting Officer in relation to the 2019-20 reporting year. Overall, she judged that appropriate measures have been put in place during the year to maintain adequate frameworks and practice in relation to risk management, governance and internal control.

261. The Head of Audit records that the Department has continued to deliver quality policies and programmes to support its overall objective of leading the nation's health and social care system to help people live more independent, healthier lives for longer whilst acknowledging that there have been and continue to be challenges to delivery and achievement of all aims including EU Exit planning and preparations and more lately the impact of COVID-19. Her opinion report notes that DHSC continues to mature in terms of understanding and managing its own organisational and delivery risks. 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. Recommended key areas of focus include:

- Formalising the governance arrangements in respect of the newly formed NHSX (the unit with responsibility for setting national policy and developing best practice for NHS technology, digital and data).
- Developing a stronger understanding of the system-wide risks shared with ALBs.
- Taking further mitigating action to reduce cyber-crime risk, particularly by strengthening the assurance arrangements with related third-party suppliers.
- Addressing non-compliance issues and deviations from procurement policy.
- Further developing an assurance framework and map for the organisation which, should give greater clarity to where lines of defence checks should operate and who is undertaking them.

Arm's Length Bodies

262. 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.

263. 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.

264. 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. This year, the collective health system response to COVID-19 has impacted on ALBs' ability to prioritise the publication of their business plans. However, ALBs continue to work closely with the Department to assure their priorities.

The NHS

265. 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.

266. NHS England has responsibility for the commissioning of health care in England and, under the Mandate to invest its annual budget (of around £120 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. The Department's COVID-19 response represented an appropriate reason for amendments to be made. On 26 March 2020 Revised Financial Directions to NHS England were

published[84]. The revisions made to the directions, first published on 21 May 2019, are listed in Annex B of the revised directions.

267. 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.

268. In April 2019, NHS England and NHS Improvement (NHSE and NHSI) moved to a single leadership model under the Chief Executive Officer (CEO) of NHS England and single Chief Operating Officer (COO) who is also the CEO of NHS Improvement, with the single COO post covering both NHSE and NHSI and reporting directly to the CEO of NHSE and NHSI.

269. In addition, from 1 April 2019, the NHS Leadership Academy transferred from Health Education England to NHS Improvement. This maximises the natural 'fit' between the work of the NHS Leadership Academy and NHSE and NHSI's responsibility for executive and non-executive leadership and talent across the NHS.

270. The NHS Long Term Plan was published in January 2019. Reflecting their new joint working arrangements and shared leadership for Long Term Plan delivery, the 2019-20 mandate to NHS England was incorporated into a single 2019-20 Accountability Framework[85] addressed to both of them. This set the direction for NHSE and NHSI to underpin initial implementation of the Plan. In particular, it set out shared delivery objectives for both NHSE and NHSI for 2019-20, as the NHS transitioned into full plan delivery. It also confirmed their budgets, taking account of the Government's NHS funding settlement to 2023-24.

271. NHSE and NHSI have reported performance to the Secretary of State against each objective in the 2019-20 Accountability Framework. The Secretary of State's own assessment of this performance will be set out in an Annual Assessment for 2019-20, meeting his legal duty to lay in Parliament each year an assessment of NHS England's performance. Measuring delivery against the 2019-20 Accountability Framework will require the assessment to reflect on NHS England's financial performance and how it has achieved milestones for the first year of the NHS Long Term Plan. The Assessment is expected to be published at the same time as this Annual Report and Account.

272. 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.

[84] Revised Financial Directions to NHS England
[85] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803114/accountability-framework-to-nhse-and-nhsi-2019-to-2020.pdf

273. The current assurance and accountability process provides Ministers with a number of legislative and non-legislative mechanisms for holding NHS England and NHS Improvement to account. The Framework Agreements for NHSE and NHSI set out the assurance process, roles and responsibilities of the Department and NHSE and NHSI by which accountability will be achieved.

274. In the current performance regime, the Secretary of State is entitled to hold accountability meetings with the NHS Executive team every quarter. However, pre-COVID-19, the frequency and form of these meetings were under review to avoid duplication with other senior decision making forums. Post COVID-19, and in light of the recent completion of the NHSE and NHSI joint working programme, the Department will work with NHSE and NHSI to review the current reporting processes so that they continue to provide efficient and effective levels of oversight, scrutiny and transparency.

Key Governance Issues

Ministerial Direction on 'Scheme Pays Elections'

275. On 22 November 2019 a Ministerial Direction[86] was obtained by NHSE and NHSI in relation to the proposed 'Scheme Pays Elections' whereby NHSE and NHSI would make payments to clinicians affected by the tapered annual allowance pension tax when they retired. In order to receive this, clinicians would need to use scheme payments to cover any annual allowance tax bill incurred. This direction was agreed by the Department and Permanent Secretary.

276. The intention of the scheme was to ensure that clinicians would volunteer to do extra work given the importance the Government attaches to the NHS and its performance over winter. The Principal Accounting Officer advised the Secretary of State that such a scheme could constitute tax planning and therefore be incompatible with rules regarding regularity and propriety in Managing Public Money. This was detailed in the letter sent by NHSE to the Secretary of State on 18 November 2019[87].

277. The scheme pays election aimed to temporarily address the tapered annual allowance issue in senior clinician pensions throughout winter 2019-20, before a permanent solution was introduced as part of the Budget in March 2020. Due to the terms of the NHS Pension Scheme, senior clinicians could breach the tapered annual allowance, causing them to receive large tax bills and marginal tax rates of in excess of 100 per cent, when conducting extra work.

278. The tapered annual allowance was therefore disincentivising senior clinicians from taking on additional work, which caused capacity issues for the NHS workforce. The ministerial direction allowed NHS England and NHS Improvement to meet the cost of tax bills incurred in 2019-20, to allow senior clinicians to continue working throughout the winter months and avoid reducing their working commitments.

[86] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/847925/matt-hancock-pensions-directions-letter-nov-2019.pdf
[87] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/847924/pensions-letter-simon-stevens-to-matt-hancock.pdf

279. Since the policy was being announced in the pre-2019 General Election period, the scheme was agreed by HM Treasury with collective agreement and its announcement cleared by the Cabinet Secretary.

280. Managing Public Money requires Central Government Departments to follow a Ministerial Direction once issued without 'further ado', which the Department did.

281. When consulting HM Treasury on the planned approach, it noted that it was Her Majesty's Revenue and Customs' (HMRC) view that the scheme constitutes a form of tax planning and could, depending on how the scheme was set up, constitute a form of tax avoidance. Both tax planning and tax avoidance are not permitted under Managing Public Money.

282. Under the scheme all tax due will be paid and there would be no change to the timing of these payments. On this basis it is the Department's view that the scheme constitutes neither tax planning nor tax avoidance, the latter being supported with an independent legal view. The Comptroller and Auditor General disagrees with this view and has reported more on his judgement about this matter in his Report on Account.

283. As part of the Budget in March 2020, the Chancellor announced that the tapered annual allowance thresholds would be increased by £90,000 from 6th April 2020. This has taken 98 per cent of consultants and 96 per cent of GPs outside the scope of the taper based on their NHS income.

Ministerial Direction on COVID-19 Spend

284. On 29 March 2020, the Accounting Officers of DHSC, NHSE and NHSI obtained a Ministerial Direction[88] relating to COVID-19 spending. This confirmed, spending to combat the pandemic should be continued, even if this resulted in exceeding formal Parliamentary limits which ultimately it did not.

285. This was agreed with the Treasury Officer of Accounts, given the proximity to voted Parliamentary limits and the Government's desire not to prevent necessary COVID-19 spending commitments due to budgetary constraints. The Ministerial Direction demonstrated our commitment to spend whatever was necessary and not be constrained by budgetary limits – however, all Departmental spending has involved engagement with HM Treasury and securing agreed funding envelopes. NHSE and NHSI are overseeing the financial discipline and governance of all costs flowing through the NHS. The Direction was sought on 28 March 2020[89].

Coronavirus (COVID-19)

286. COVID-19 is the biggest challenge the country has faced in a lifetime and DHSC has led the Government's response. Guided by the scientific evidence and advice, and drawing on our emergency preparedness plans, the Department mobilised from an initial emergency

[88] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876882/29032020-sofs-to-perm-sec-ministerial-direction.pdf
[89] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876881/20200328-ao-direction.pdf

operational response to a full Departmental and system-wide response as the initial outbreak of the new virus developed into a pandemic.

287. Work on the response to COVID-19 became the single most important focus of the whole Department and wider health and care systems, during the final months of 2019-20 and moving into the 2020-21 financial year through a robust governance structure.

288. The Department has had to act in an agile and dynamic manner throughout the outbreak. Activities undertaken in response to the pandemic have adopted a risk based and proportionate approach to the Department's system of internal controls.

289. The objectives of the Department in tackling COVID-19 were to deploy phased actions to Contain, Delay and Mitigate the outbreak, using research to inform policy development, working at all times with the Chief Medical Officer for England.

290. The Department produced an Action Plan[90] to provide strategic objectives to tackle the virus and protect life in the initial stages of the pandemic. This represented a consolidation and enhancement of the considerable advice and support that had been provided across the health and social care sector to date.

291. The Coronavirus Act 2020[91] which received Royal Assent in March 2020 enabled the Government to respond and manage the effects of the COVID-19 pandemic appropriately.

292. Substantial additional resources and expertise were brought in to support the work of the Department. In developing a structured ongoing response to tackling the virus the Department has continued to evolve its internal structure to support the delivery of the strategic objectives, including the establishment of a Second Permanent Secretary role and the prioritisation of COVID-19 work at Director General and Director levels.

293. The temporary promotion of the Director General for Finance and Group Operations to the role of Second Permanent Secretary and Accounting Officer in the Department has sought to address the operational pressures and create further resilience, as part of the Department's COVID-19 response. The role includes assuming the Principal Accounting Officer responsibilities if the Permanent Secretary is unavailable. Given the fast moving nature of the Department's COVID-19 response, the scope of the role is fluid.

294. On the 18 August 2020 the Secretary of State for Health and Social Care announced the establishment of the National Institute for Health Protection (NIHP), bringing together health protection elements of Public Health England with the NHS Test and Trace service and the Joint Biosecurity Centre (JBC)'s intelligence and analytical capability. NIHP will be established as an ALB of the Department during the Spring of 2021.

295. NIHP will take on existing health protection responsibilities and work with local government, the NHS and the devolved administrations. There will be a clear

[90] https://www.gov.uk/government/publications/coronavirus-action-plan/coronavirus-action-plan-a-guide-to-what-you-can-expect-across-the-uk
[91] http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted

commitment to build on existing teams and functions as well as learning from the best in the world when designing the new organisation. Duncan Selbie's term as Chief Executive of PHE came to a close when the announcement was made, and Michael Brodie has been appointed Chief Executive Officer responsible for overseeing the transfer of PHE's functions to the NIHP and other new homes.

296. Until formal changes are made, PHE continues to operate and deliver its core functions in line with its Framework Agreement under the leadership of Michael Brodie. PHE will continue to be held to account for delivery against its remit letter and agreed business plans through quarterly accountability meetings with DHSC. PHE's governance boards and groups will continue to operate as now, as will PHE's Advisory Board.

297. Further information regarding the Department's activities relating to the pandemic response can be found in the **Performance Summary** at the beginning of these accounts and further detail concerning the Department's performance during the pandemic will be forthcoming in the 2020-21 ARA.

Financial Risk and Sustainability in the NHS

298. Putting the NHS back onto a sustainable financial path is a key priority in the Long Term Plan and is essential to allowing the NHS to deliver the service improvements it sets out. To enable delivery of the plan, the Government previously announced that the NHS will receive a budget increase equivalent to an extra £33.9 billion in cash terms by 2023-24 (compared to 2018-19) to deliver the commitments set out in the plan. This was enshrined in law in March 2020 in the NHS funding Act 2020[92] .

299. This funding and the NHS budget is entrusted to NHS England. This ensures all new commitments within the Long Term Plan are funded within the NHS five year cash settlement. The NHS has costed the Long Term Plan and must deliver its commitments within the agreed financial settlement. The costings and the settlement were based on assumptions pre COVID-19.

300. The current financial pressures across the NHS are the first call on funds. Accordingly, NHSE and NHSI were expected to work together to ensure overall financial balance in 2019-20, productivity growth of at least 1.1 per cent, and to lay the groundwork to put the service onto a more sustainable footing in future years. These objectives are reflected in the five financial tests[93] set out in the NHS Long Term Plan and reflect ambitions established pre COVID-19.

301. NHSE and NHSI have already taken steps to provide some of the structure architecture to enable more effective financial co-operation, including for instance, the appointment of a joint Chief Financial Officer, as well as undertaking work to review and recast the financial framework.

302. As well as taking steps to deliver on the early Long Term Plan commitments, the NHS will put robust plans in place for 2020-21 to 2023-24 that will support delivery of its longer

[92] http://www.legislation.gov.uk/ukpga/2020/5/contents/enacted
[93] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

term ambitions. These plans will ensure effective use of the year-on-year increases in NHS funding that the Government is providing through the NHS funding Act 2020.

303. In order to support more effective oversight of delivery of the overall Long-term Plan, the Government has been working with NHSE and NHSI to determine a set of metrics that reflect the fundamentals underpinning the Plan. The intention originally was for these to be used to monitor progress against intended outcomes on a regular basis. These in turn were to be reviewed, revised and incorporated into the Accountability Framework that would be set for 2020-21 to 2023-24, drawing on the measures which the NHS itself uses for system oversight. However, following the outbreak of the COVID-19 pandemic this process has currently been paused.

304. To tackle the remaining financial challenges, NHSE and NHSI continue collaborating and working with local systems to find the right solutions for the organisation and region through the Joint Finance Advisory Group (JFAG), that brings together finance officials from across the NHS to reach decisions on plans and actions needed to achieve the financial objectives. The JFAG continues to meet on a regular basis.

305. The joint organisation also continues to intervene 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.

306. The Department continues to undertake 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 NHSE and NHSI, and regular ministerial and HM Treasury engagement. This has allowed for increased transparency on emerging risks and pressures, and supported decision making where needed.

307. The impact of the COVID-19 pandemic on the steps being taken towards achieving financial sustainability and the Long Term Plan is being assessed. The announcement made by the Secretary of State for Health and Social Care on 2 April 2020 regarding reform of the NHS Cash Regime in the 2020-21 financial year is described in the Department's Events after the Reporting Period disclosure which can be found in **Note 20** of the Notes to the Department's Annual Report and Accounts.

Core Performance Standards

308. 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 2019-20. More detail is available in the **Performance Summary** and **Annex C**.

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

Contract management

310. During 2019-20, the Contract Management and Commercial Capability (CMCC) Team has maintained work with Director General Groups to ensure that the DHSC Corporate Contracts Register is comprehensive and Directors and Directors General have corporate visibility of the DHSC contract portfolio. Directors General have reported on contracts as part of the Biannual Assurance process, helping to ensure contracts and associated risks are identified and managed.

311. Senior Contract Owners of the highest risk contracts have been reminded of the importance of contract management and their respective roles and responsibilities through the annual Assurance Framework Attestation process. All but one assurance review was completed by the end of March 2020, but has since been completed. The extended period of time to complete the review related to the reorganisation of a contract management function.

312. We have begun enrolling our Operational Contract Managers (OCMs) on to Contract Management Capability Programme Training. This training is provided by the Cabinet Office and is part of the Government's commitment to invest in training to help OCMs understand all elements of the contract life-cycle, manage contracts and relationships with suppliers. Training is based on the Contract Management Professional Standards and accreditation in contract management is offered at three levels: Foundation, Practitioner and Expert.

313. A significant amount of new contracts have been awarded across COVID-19 workstreams. We have been collating details of these contracts through working closely with COVID-19 workstreams and can confirm as at 21 October 2020, over 850 new contracts have been awarded with a total contract value upwards of £15 billion, with figures expected to increase during 2020-21. There is finite contract management capacity in the Commercial Capability and Supplier Management team, to fully undertake our role of governance and oversight of the COVID-19 contract portfolio and to support operational contract managers to ensure they are being managed appropriately. In addition, there are limited amounts of OCMs in the COVID-19 workstreams to standardly undertake operational contract management, and there is a high risk of losing those that we do have as they are loaned from other organisations across government. The Department is recruiting additional staff within the Commercial Group to address this, but these risks are recorded in the Commercial Group risk register.

Quality Assurance of analysis and models

314. 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[94] and the recommendations of the Macpherson Review published in 2013[95]. 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.

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

315. 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, and our programme of work to review and refresh our approach, was presented to our Audit and Risk Committee in September 2019. We continue to have a strong and effective process and we are developing further enhancements to address the way model outputs are used by officials outside analytical teams.

Information Risk

316. The Department has not identified any major information risk control issues in 2019-20. Following an independent audit of GDPR compliance in March 2019 (demonstrating the considerable progress made to a state of 'business as usual'), action continued in 2019-20 to implement the recommendations of the audit and continuously improve handling of data protection issues.

317. The Department has recorded 26 data-related incidents between April 2019 and March 2020, of which two were reported to the Information Commissioner's Office and dealt with to their satisfaction requiring no further follow up. The Department ensured appropriate corrective action was taken following these incidents, including appointing a Director of Data and Information Governance in June 2020 to provide senior leadership, 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

318. 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. The NHS Counter Fraud Authority (NHSCFA) Strategic Intelligence Assessments show that since 2017, there has been year-on-year reductions in fraud loss estimates. Fraud, bribery and corruption against the NHS costs the public purse over £1.21 billion in 2018-19, down from £1.27 billion in 2017-18 which was a reduction from £1.29 billion in 2016-17.

319. Fraud is a hidden crime and to fight it, you have to find it. There is no one solution. Addressing fraud needs a holistic response incorporating detection, prevention and redress, underpinned by a strong understanding of risk. It also requires cooperation and a spirit of collaborative working between organisations. 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 for Finance and Group Operations at Board level, 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 and NHS 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.
- While recognising previous success, there is always more to do. By taking a proactive approach we seek to introduce preventative ways of permanently eradicating whole categories of fraud/financial loss (e.g. prescription fraud where current success in reducing fraud levels through Penalty Charge Notices is now evolving towards prevention through Real Time Exemption Checking) and minimise 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.

320. 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[96]. 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. Throughout the year, this work was given greater focus, utilising 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 and this year were extended to ALBs. DHSC AFU organised workshops for all ALBs to help them adopt the standards and to develop the necessary processes. The health group's efforts in this area have been recognised by the Cabinet Office. This is a hugely positive response, reflecting the engagement of DHSC AFU with the wider ALBs and evidencing a shift towards counter fraud culture across health.

321. 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[97]. 18 cases were investigated in 2019-20.

322. 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. NHSCFA has a resource of 180 full time staff.

323. Other bodies with national coverage, such as NHS England (NHSE) and NHS Improvement (NHSI) and the NHS Business Services Authority (NHSBSA) and NHS Digital routinely

[96] https://www.gov.uk/government/publications/dhsc-counter-fraud-strategic-plan-2017-to-2020
[97] https://www.legislation.gov.uk/ukpga/2002/29/contents

undertake activity to tackle fraud. The Counter Fraud Board has overseen the collation of a consolidated action plan drawing together, for the first time, planned actions across the key national health sector organisations – NHSCFA, NHSBSA, NHSE and NHSI. This will support effort to both identify and consider any gaps in threat coverage and ensure linked actions are aligned and complementary, mitigating the risk of duplication.

324. Local counter fraud work is guided by the NHS Standard Contract[98], the NHSCFA's Standards for Commissioners[99] and Standards for Providers[100] which require all organisations commissioning and providing NHS services to put in place and maintain appropriate counter fraud arrangements.

325. 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). As of January 2020, there were 246 Local Counter Fraud Specialists.

326. This national and local counter fraud activity is having a positive impact. For example, in patient prescription charge evasion the significant fraud reductions have been sustained against 2016-17 levels. The Real Time Exemption Checking project[101] is being rolled out and helping to reduce fraud. Initial trials have been positive and this project will be expanded across more pharmacies over the coming months.

327. NHSBSA and NHSE 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 £27.6 million[102] in the Strategic Intelligence Assessment (SIA) 2020 as compared to the previous year.

Compliance with Equality and Human Rights Legislation

328. 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.

329. Directors General are required to consider compliance with the public sector equality duty[103] 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.

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[98] https://www.england.nhs.uk/nhs-standard-contract/19-20/
[99] https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Commissioners_2019.pdf?v=1.1
[100] https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2019.pdf?v=1.2
[101] https://digital.nhs.uk/news-and-events/news/national-expansion-of-real-time-exemption-checking-service-for-prescriptions
[102] https://cfa.nhs.uk/about-nhscfa/corporate-publications
[103] https://www.england.nhs.uk/wp-content/uploads/2011/12/Paper-NHSCBA-12-2011-4-Meeting-the-Public-Sector-Equality-Duty-Final.pdf

330. Regular meetings are held with a number of key stakeholders across government to discuss respective priorities and the Department's performance in meeting its statutory equality duties.

331. The Department continues to publish summary equality information relating to its policies and workforce annually. This information, along with our current equality objectives, can be found under the 'Equality and Diversity' section of the Department's website[104].

National Audit Office and Public Accounts Committee

332. The National Audit Office (NAO) seeks to confirm the factual accuracy of their value for money and other major reports[105] with the Accounting Officer and Departmental Finance Director (Second Permanent Secretary and Director General – Finance) and the Principal Accounting Officer (Permanent Secretary) where the Department is the primary or third-party client. The Finance Director General, the Principal 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. In 2019-20, DHSC attended four PAC hearings, details of which can be found via the Committee's website[106]. Updates on NAO and PAC activity are provided to the Audit and Risk Committee at its meetings.

Emergency Preparedness, Resilience and Response

333. 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 of Civil Emergencies (NRR). The Department has in place '24/7' arrangements to be able to coordinate services in any emergency that occurs. A training programme was established in 2019-20 to increase the resource capability in the department for responding to emergencies. Horizon scanning is used to identify where there are gaps in response capability and bespoke programmes established to address these. In 2019-20 the Department has responded to a number of high-profile incidents including: Listeria outbreak, Monkeypox, Lassa fever in Sierra Leone, the London Bridge terrorist attack and COVID-19.

334. The Department is the Lead Government Department (LGD) for preparedness for human disease risks, including an influenza pandemic or outbreak of a High Consequence Infectious Disease (HCID). The Department has continued to work across Government and with a range of stakeholders, including expert advisory groups, to ensure that plans to mitigate these risks remain robust and reflect expert advice. These plans have been developed as part of a multi-year cross-government work programme that has been informed by the lessons learned from responding to past incidents, emergency preparedness exercises and the latest expert advice.

335. The Department supported the Government's emergency response to a cyber-attack on Redcar and Cleveland Borough Council's IT systems in February 2020. The Department's role was to understand the impact on health and social care services and consider what

[104] https://www.gov.uk/government/organisations/department-of-health-and-social-care/about/equality-and-diversity
[105] https://www.nao.org.uk/search/type/report/
[106] https://committees.parliament.uk/committee/127/public-accounts-committee

mitigation was being put in place to protect patient care and safety. It also participates in health and cross-government exercises to maintain our skills and response arrangements.

336. The Department's response to COVID-19 is outlined earlier in the Governance Statement and the Performance Report.

Grant Payments to Non-Public Sector Bodies

337. 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

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

Impairment of the Department's loans with NHS providers

339. In accordance with International Financial Reporting Standards the Department subjects its loans to an impairment review upon recognition and in each subsequent accounting period. IFRS 9 states that an asset is credit-impaired when events that have a detrimental impact on the estimated future cash flows have occurred. In September 2020 PDC was issued to NHS providers and circa £13.6 billion of loans were paid back in cash to the Department from NHS providers subsequently.

340. DHSC continuously monitors and controls credit risk within the DHSC Group. DHSC has various levers it can employ in compliance with accounting standards and within its general powers and that of its regulators, coupled with Parliament's demonstrable commitment to funding the DHSC group (such as through its latest multi-year funding settlement), to ensure that any credit risk within the DHSC Group remains minimal. This is evidenced by the operation of this financial regime having ensured no credit risk in relation to intra-group provider loans for the last 16 years. The development of a restructuring framework, facilitated through a revised policy approach to provider loans, does not alter, but enhances this. Therefore, the Department does not consider the approach taken to devising and implementing a restructuring framework as evidence that specific loans or group of loans are required to be impaired.

341. Following the Secretary of State announcement of the conversion of NHS provider debt to PDC in April 2020 and the transfer that followed in September 2020, the NAO reviewed its position on the value of PDC (see **note 11** to the Financial Statements for more details) that led to the Department revising its approach to the recognition of impairment against PDC. In December 2020 the NAO informed the Department that, in its view, some of the loans between the Department and NHS providers that were repaid in September 2020 ought to be impaired as at 31 March 2020. The proposed impairment being the extent to which net assets are negative in NHS providers. The C&AG explains his rationale for this view in his Report on page 123.

342. Had PDC not been issued to facilitate the conversion of loans to PDC, the Department could have given assistance in a number of alternative ways. Since the reintroduction of loan financing for NHS providers in 2004 no loans have been written off and no NHS

provider has defaulted on loan payments. NHS England and NHS Improvement utilises its powers of oversight to support financial improvement at trusts where necessary. Other system-wide mechanisms the Department could have used include extension of the Financial Recovery Fund scheme or a change to the NHS Tariff.

343. The loans between the Department and NHS providers have been fully repaid and the fact there is no indication of increased credit risk means, in the Department's view, adjustment for impairment is not appropriate under accounting standards. The Department feels unable, therefore, to impair these loans. The Department believes adjustment would be misleading to the user of the account and, even if adjustment was made, it would have to be fully reversed in 2020-21 to allow the cash repayment of the loan to be properly accounted for.

344. The Department has calculated that, were it to make the adjustment the C&AG believes is required, the quantum of the impairment would reduce the value of the Department's Core account loans by £2.2 billion. The impact for the Departmental Group would be £ nil as all loans are eliminated upon consolidation.

Special Payment delegated approval

345. HM Treasury provides central government departments with delegated approval values for Special Payments. Where a department incurs a special payment that is below this delegated approval limit it need not seek HM Treasury approval to make the payment unless the payment is novel, contentious or repercussive. The most recent delegated approval letter provided by HM Treasury in 2016 did not include any delegated approval limit for the Department.

346. The Department has operated, since 1996, on the basis that it had an uncapped delegated approval limit for special payments where these were neither novel, contentious or repercussive. Having contacted HM Treasury in August 2020 to clarify the position, HM Treasury informed the Department that, due to the 2016 delegated approval letter not containing any approval limit, effectively the Department had no delegation for special payments of any value.

347. This has led to an unfortunate position whereby all special payments in the 2019-20 financial year that have not obtained separate HM Treasury approval (due to these either being novel, contentious or repercussive or having separate agreed approvals) are irregular. The value of unapproved special payments, across the Departmental group for 2019-20 is approximately £18 million.

348. A delegated approval limit of £95,000 has been agreed, from 1 April 2020, ensuring that there is now clarity over special payment approval limits. The Department has also committed to carry out an exercise reviewing the controls associated with the reporting of special payments, with a particular focus on reporting from the NHS.

University Hospitals of Leicester NHS Trust

349. The University Hospitals of Leicester NHS Trust 2019-20 Annual Report and Account is yet to be completed and published. The work of the Trust and its external auditor has identified significant weaknesses in internal control, including financial governance. Detailed work to review the accounts and accounting records for 2019-20 led to significant concerns being raised by the auditor, including deficiencies in financial systems

and control, governance and financial reporting, in particular the use and authorisation of journals in the accounting ledger.

350. In December 2020 the Trust assessed that the weaknesses in underlying accounting records mean that the Board is currently unable to certify that the annual accounts are true and fair. As a consequence, the external auditor cannot issue an audit report. The Trust is commencing work to review and assure itself over the accuracy of its accounting records and intends to prepare revised 2019-20 accounts in March 2021.

351. The Trust entered the Special Measures for Finance regime in August 2020. This includes the appointment of a Financial Improvement Director to the Trust, senior monthly oversight meetings, external review of the finance function, and board development.

COVID-19 indemnities

352. During the early months of the Department's significant response to the COVID-19 pandemic, it was essential that certain arrangements relating to the Department's Test and Trace programme were put in place at rapid speed. As part of this response, to secure urgent, vital and often novel services during a period when the country was in lockdown, it was necessary to include a relatively broad range of indemnities in some of the contracts awarded.

353. Given the unprecedented urgency required, the Department, in some instances, did not follow its usual process whereby, prior to signing contracts that contain such indemnities, it would seek HM Treasury and Chief Secretary of Treasury approval. There is one contract that was entered into by the Department in 2019-20 where such approval has not been obtained.

354. The Department took the action necessary at the time and in a number of instances where contracts included a broad range of indemnities, it has sought to renegotiate these contracts prospectively.

Data Issues - Data and Cyber Security Programme

355. The WannaCry cyber attack was an unprecedented global ransomware attack, which although not aimed at the NHS, significantly disrupted services during May 2017.

356. The work of cyber security programme has been designed to prevent a similar attack. In February 2020, a study (based on FOI requests to NHS Trusts) showed a striking decrease in ransomware attacks on UK healthcare providers post-WannaCry, especially when compared with a fairly steady rate of ransomware affecting US providers. The National Cyber Security Centre (NCSC) attribute this reduction in attacks to increased national investment in the system and the lessons learned from WannaCry.

357. NHSX and its delivery partners continue to lead a system wide programme to improve cyber resilience across the health and care system. Key progress this year has included supporting NHS organisations to migrate to the Windows 10™ Operating System, which is more secure as well as faster and more efficient to use.

358. Another big step forward has been the deployment of Microsoft™ Defender Advanced Threat Protection (ATP) which now covers most Windows devices in the NHS with game changing ability to detect and prevent cyber threats.

359. NHS Digital has further developed its Cyber Security Operations Centre to provide centralised support, specialist training, advice and threat intelligence to the system to help fill some of the capacity and capability gaps at organisational level and achieve value for money for the system. This includes a new NHS Secure Boundary service which provides visibility and control to local organisations over internet facing traffic, so they can better manage risk.

360. NHSX and NHS Digital have worked with the NCSC to incorporate the requirements of recognised external cyber security standards including Cyber Essentials into the Data Security and Protection Toolkit[107] (DSPT) to form a single data and cyber security standard for the NHS. The DSPT helps organisations understand their data and cyber security risks and measures their compliance with mandatory cyber standards for their type of NHS or social care organisation.

361. NHSX has also used new regulatory levers through the Network Information Systems (NIS) Regulations to increase compliance in the NHS with mandated standards such as responses to High Severity Cyber Security Alerts.

362. NHSX invested over £23 million in 2019-20 to improve the cyber resilience of local infrastructure in NHS Trusts, Foundation Trusts, and Primary Care organisations. This funding was to support organisations making required information technology investments including for network infrastructure, enhanced monitoring capabilities, and improved device management.

363. In total, since WannaCry, over £250 million will be invested nationally to improve cyber security of the health and care system by 2021. This excludes monies local organisations have invested themselves and wider national IT investment which supports better security such as the Microsoft Windows 10™ licensing agreement.

364. NHSX has also worked with the Care Providers Alliance and the Local Government Association to invest over £1.5 million to test different approaches to providing cyber security support and advice for adult social care organisations.

365. In response to COVID-19, NHSX put in place additional measures to prevent a cyber-attack or major IT outage and to make sure that, if such an event did happen, NHSX and its delivery partners can help local organisations get back up and running as quickly as possible.

EU Exit

366. During the year, the Department worked with our ALB partners to ensure the health and social care system was as prepared as possible for EU Exit. This included, in advance of the Withdrawal Agreement being ratified in January 2020, and 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.

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

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.

367. Following the extension of the Article 50 period to the 12 April 2019, the 31 October 2019 and finally the 31 January 2020, the Department also re-baselined EU Exit plans and issued appropriate and timely guidance to the health and social care system. The Department's post-Exit model and governance was reviewed by the Audit and Risk Committee in February 2020.

368. Plans for implementing and delivering the Withdrawal Agreement at the end of the Transition Period (TP) have been developed and, in some areas, revisited to reflect the impact of the response to COVID-19. The Department's preparations for the end of the TP have been taking place alongside the response to COVID-19 and winter pressures, to ensure the benefits that can be realised outside of the EU are maximised.

369. The Department supported the negotiations on our future relationship with the EU which were led centrally by Taskforce Europe. The Minister of State for Health wrote to the health and social care sector regarding the impact of the UK and EU Trade and Co-operation Agreement on the health and care system[108]. The correspondence confirms that whilst there will be changes at the end of the TP, the agreement reached with the EU ensures that we will continue to benefit from reciprocal healthcare arrangements and maintain close co-operation with the EU in such areas as medicines, health security and professional qualifications.

Carillion

370. The Department and NHS England and NHS Improvement continue to provide support to NHS organisations where the Carillion group of companies were providing services as part of a Private Finance Initiative (PFI) contract. This is within the Department's PFI Centre of Best Practice programme of support to Trusts with PFI contracts.

371. Prior to their liquidation, members of the Carillion group of companies provided services to a variety of 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 is currently working with a new contractor to put in place arrangements for the hospital building to be completed[109]. Construction of the facility at Sandwell and West Birmingham Hospitals NHS Trust has resumed.

Screening Programmes

372. Following the publication on 16 October 2019 of Professor Sir Mike Richards' report[110] on adult screening, the Department published a Written Ministerial Statement[111] committing

[108] https://www.gov.uk/government/publications/letter-to-the-health-and-care-sector-about-the-uk-eu-trade-and-co-operation-agreement/uk-and-eu-trade-and-cooperation-agreement-and-the-governments-preparation-for-end-of-the-transition-period-on-31-december-2020

[109] https://www.nao.org.uk/report/investigation-into-the-rescue-of-carillions-pfi-hospital-contracts/

[110] https://www.england.nhs.uk/wp-content/uploads/2019/02/report-of-the-independent-review-of-adult-screening-programme-in-england.pdf

[111] https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2019-10-16/HCWS11

to review the recommendations with NHS England, NHS Improvement and Public Health England and publish an implementation plan. The Government is considering the findings of the review alongside the commitments made in the Government responses to the Independent Breast Screening Review[112], published 14 March 2019, and the Public Accounts Committee report on Health Screening[113], published on 22 July 2019. Covid-19 has delayed this work and a progress update and implementation plan will be published in 2021 to align with the creation of the new National Institute for Health Protection.

373. A key recommendation of the Independent Breast Screening Review was for women identified as having missed a screening invitation and who have developed breast cancer, to be assessed to determine whether they have been caused harm by the breast screening incident. NHS England and Public Health England developed a clinical review process which was issued to relevant Trusts in November 2019 to carry out an initial set of 240 reviews in phase one, and in February 2020 to carry out a further 436 reviews in phase two.

374. By February 2020, 89 of the 99 'phase 1' Trusts (representing 201 women) had confirmed that relevant women had been offered clinical reviews, except for a small number of women on end of life pathways for whom the guidance advised that clinical reviews may be deferred and a small number of Trusts with individual issues requiring further clarity. Where women have confirmed they wish to proceed with clinical reviews, these are being progressed. Clinical reviews for the remaining 39 women in phase 1 and the 436 women in phase 2 have been paused due to the COVID-19 pandemic and will be captured within the adult screening recovery plans being developed by NHS England and NHS Improvement, and Public Health England.

375. Following the cervical screening incidents related to Capita's administration of the call/recall function in 2018 and 2019, the Clinical Advisory Group reviewed the outcome of the screening results for women affected by the 2018 incident and concluded that no harm occurred. Further audits for the 2019 incidents will take place from June 2020, once data is available, with 5,223 people being assessed for harm.

Grenfell

376. NHSE and NHSI have continued to support the implementation of remedial measures to improve the safety of properties where appropriate.

377. The full cost of implementing these remedial works has been challenging to calculate as; some are the responsibility of non-NHS landlords and/or contractors, some are the responsibility 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**.

[112] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/785952/independent-breast-screening-review-report-government-response.pdf

[113] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/819707/CCS207_CCS0719610434-001_Gov_response_to_Public_Accounts_on_the_93_-_98_reports_bookmarked.pdf#page=13

Table 8: Grenfell Remedial Work

Organisation Name	Expenditure (£)	Status
Bradford Teaching Hospitals NHS Foundation Trust	519,000	Remediation completed
Gateshead Health NHS Foundation Trust	360,000	Remediation started
Guy's and St Thomas' NHS Foundation Trust	5,300,000	Remediation plan in place
King's College NHS Foundation Trust	48,000	Remediation completed
Oxford University Hospitals NHS Foundation Trust	770,000	Remediation plan in place
Sheffield Children's NHS Foundation Trust	311,000	Remediation completed
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	35,000	Remediation completed
The Royal Wolverhampton NHS Trust	1,725,000	Remediation started

Source: NHS England and NHS Improvement

Infected Blood Inquiry

378. During 2019, the Infected Blood Inquiry[114] received evidence from the infected and affected via written statements and oral hearings. In February 2020, it heard from expert groups and from senior clinicians. The next set of hearings, originally due to take place in June 2020, have been postponed due to COVID-19. The Cabinet Office, as the sponsor department for the inquiry, continues to coordinate work between the Department and the devolved administrations. The Department is providing full disclosure to the inquiry and has waived its usual right to legal privilege. From April 2019, the Department increased the levels of financial support available to the infected and affected and is looking at ways to improve parity of support across the UK[115]. The Inquiry is expected to conclude in 2021 or 2022.

Independent Medicines and Medical Devices Safety Review

379. The Independent Medicines and Medical Devices Safety Review[116] 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 has made recommendations and identified actions for improvement in the report, published during the 2020-21 financial year on 8 July 2020.

East Kent University NHS Foundation Trust Maternity and Neonatal Services

380. Following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement have commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent University NHS Foundation Trust. Ruth May, Chief Nursing Officer for England, is the Senior Responsible Officer sponsoring the investigation, with close alignment and support from the South East Region.

381. The terms of reference for the independent investigation have been submitted to DHSC and NHS England and NHS Improvement for comment and agreement. The terms of reference and scope of the investigation will be published during the 2020-21 financial year.

[114] https://www.infectedbloodinquiry.org.uk/
[115] https://www.gov.uk/government/news/infected-blood-scandal-increased-financial-support-for-victims-confirmed
[116] https://www.immdsreview.org.uk/about.html

Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust

382. With the increase of cases from the initial 23 being considered through the 2017 terms of reference, which were subsequently revised in 2019 and will lead to the examination of 1,862 cases as part of the review, the Minister of State for Mental Health, Suicide Prevention and Patient Safety asked for the review to do its utmost to enable initial learning in the 2020 calendar year.

383. The review has published emerging findings and recommendations[117] based on the 250 cases reviewed to date including the initial cohort of 23. The report identifies a number of immediate and essential actions to be implemented. The review is ongoing and the Departments response to the findings of the review will be covered in the 2020-21 ARA.

[117] https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

Remuneration and Staff Report

Remuneration Report

384. 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 EPN597 guidance[118].

385. 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.

386. The Constitutional Reform and Governance Act 2010[119] requires Civil Service appointments to be made on merit on the basis of fair and open competition. The Recruitment Principles[120] published by the Civil Service specify the circumstances when appointments may otherwise be made.

387. 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[121].

Remuneration of Ministers 2019-20

388. Following Cabinet re-shuffles;
- Stephen Hammond left his post as Minister of State for Health on 25 July 2019,
- Jacqueline Doyle-Price left her post as Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention on 26 July 2019,
- Seema Kennedy left her post as Parliamentary Under Secretary of State for Public Health and Primary Care on 26 July 2019, having been appointed on 4 April 2019,
- Chris Skidmore was appointed as Minister of State for Health on 25 July 2019 and subsequently left his post on 9 September 2019,
- Jo Churchill was appointed as Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care on 26 July 2019,
- Nadine Dorries was appointed as Parliamentary Under Secretary of State for Mental Health, Suicide Prevention and Patient Safety on 27 July 2019,
- Edward Argar was appointed as Minister of State for Health on 10 September 2019,
- Helen Whately was appointed Minister of State for Care on 14 February 2020,

[118] https://www.civilservicepensionscheme.org.uk/employers/employer-pension-notices/epn597-resource-accounts-201920-disclosure-of-salary-pension-and-compensation-information/
[119] http://www.legislation.gov.uk/ukpga/2010/25/pdfs/ukpga_20100025_en.pdf
[120] https://civilservicecommission.independent.gov.uk/recruitment/recruitment-principles/
[121] https://www.civilservicepensionscheme.org.uk/members/civil-service-compensation-scheme-for-members/

- Caroline Dinenage left her ministerial post as Minister of State for Care on 13 February 2020,
- Baroness Nicola Blackwood left her ministerial position as Parliamentary Under Secretary of State (Lords) on 13 February 2020 and was replaced by,
- Lord Bethell, as Parliamentary Under Secretary of State (Minister for Innovation) from 9 March 2020.

Remuneration of Senior Officials on the Departmental Board

389. 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 10**.

Salary

390. '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.

391. 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.

392. 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

393. 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. This allows for non-consolidated performance-related awards to be paid to the top performers within the SCS. The Senior Civil Service Performance Management and Reward principles include explanations of how non-consolidated performance awards are determined.

394. 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. Remuneration frameworks such as that employed by the Government Commercial Organisation operate differently in focussing on a higher base salary, performance related pay and reduced pension benefits.

395. The non-consolidated performance pay included in the 2019-20 figures relates to awards made in respect of the 2018-19 performance year but paid in financial year 2019-20. It was agreed that awards would not be differentiated by grade (SCS Pay Band 1-3). An award of £13,500 was paid to the top performers in each SCS pay band (Band 1-3).

Benefits in Kind

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

397. Professor Dame Sally Davies DBE has had occasional use of an official car and taxis for the journey between her home and office. The benefit in kind amounted to £38.00 in 2019-20. Likewise, the Department's Permanent Secretary, Sir Chris Wormald KCB received benefit in kind amounting to £28.10 for use of a taxi to come into the office on a Sunday.

398. **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 2018-19 and 2019-20 and are subject to audit.

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

	2019-2020				2018-2019			
Ministers	Salary (£)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1000)	Total (to nearest £1000)	Salary (£)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1000)	Total (to nearest £1000)
Rt Hon Matt Hancock MP *(from 10/07/2018)*	67,505	NIL	17,000	84,000	48,996	NIL	13,000	62,000
Secretary of State								
Full year equivalent					67,505			
Jackie Doyle-Price MP *(from 14/06/17 to 26/07/2019)*	7,158	NIL	2,000	9,000	22,375	NIL	5,000	27,000
Parliamentary Under Secretary of State								
Full year equivalent	22,375							
Caroline Dinenage MP *(from 10/01/2018 to 13/02/2020)*	29,040	NIL	6,000	35,000	31,680	NIL	7,000	39,000
Minister of State								
Full year equivalent	31,680							
Stephen Hammond MP *(from 16/11/2018 to 25/07/2019)* [5]	10,049	NIL	-	10,000	10,560	NIL	3,000	14,000
Minister of State								
Full year equivalent	31,680				31,680			
Baroness Nicola Blackwood *(from 10/01/2019 to 13/02/2020)* [3]	65,879	NIL	14,000	80,000	15,515	NIL	5,000	21,000
Parliamentary Under Secretary of State (Lords)								
Full year equivalent	74,909				68,710			
Jo Churchill MP *(from 26/07/2019)*	14,989	NIL	6,000	21,000	-	-	-	-
Parliamentary Under Secretary of State								
Full year equivalent	22,375							
Nadine Dorries MP *(from 27/07/2019)*	15,217	NIL	4,000	19,000	-	-	-	-
Parliamentary Under Secretary of State								
Full year equivalent	22,375							
Edward Argar MP *(from 10/09/2019)*	16,383	NIL	3,000	20,000	-	-	-	-
Minister of State								
Full year equivalent	31,680							
Helen Whately MP *(from 14/02/2020)*	3,068	NIL	1,000	4,000	-	-	-	-
Minister of State								
Full year equivalent	31,680							
Lord Bethell of Romford *(from 09/03/2020)* [4]	-	NIL	-	-	-	-	-	-
Parliamentary Under Secretary of State (Lords)								
Full year equivalent								
Seema Kennedy MP *(from 04/04/2019 to 26/07/2019)*	7,272	NIL	2,000	9,000	-	-	-	-
Parliamentary Under Secretary of State								
Full year equivalent	22,375							
Chris Skidmore MP *(from 25/07/2019 to 09/09/2019)*	5,280	NIL	0	6,000	-	-	-	-
Minister of State								
Full year equivalent	31,680							
Rt Hon Jeremy Hunt MP *(from 04/09/2012 to 09/07/2018)*	-	-	-	-	18,509	NIL	2,000	21,000
Secretary of State								
Full year equivalent					67,505			
Lord O'Shaughnessy *(from 14/06/2017 to 31/12/2018)* [2]	-	-	-	-	54,438	NIL	12,000	66,000
Parliamentary Under Secretary of State (Lords)								
Full year equivalent					72,530			
Steve Brine MP *(from 14/06/2017 to 25/03/2019)*	-	-	-	-	22,014	NIL	5,000	27,000
Parliamentary Under Secretary								
Full year equivalent					22,375			
Stephen Barclay MP *(from 10/01/2018 to 16/11/18)*	-	-	-	-	21,120	NIL	4,000	25,000
Minister of State								
Full year equivalent					31,680			

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 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)
3. Baroness Nicola Blackwood's salary for 2019-20 includes the Lords Office-holders allowance. (This is a yearly allowance of £3,940 per annum, paid to Ministers whose primary residence is in London, the allowance is taxable and subject to NI but not pensionable) The allowance paid in 2019-20 includes amounts owed for 2018-19. For further detail see note 4 of table 9 in the 2018-19 ARA.
4. Lord Bethell's role as Parliamentary Under Secretary of State (Lords) is unpaid.
5. Member opted out of the pension scheme in April 2019.

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

	2019-2020					2018-2019				
Officials	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[1]	Gross Benefits in Kind (to nearest £100)[2]	Pension Benefits (to nearest £1000)[3]	Total (£'000)	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[1]	Gross Benefits in Kind (to nearest £100)[2]	Pension Benefits (to nearest £1000)[3]	Total (£'000)
Sir Christopher Wormald KCB Permanent Secretary	170-175	15-20	-	87,000	275-280	170-175	15-20	NIL	87,000	270-275
Professor Chris Whitty[4] Chief Medical Officer, Chief Scientific Adviser	160-165	NIL	NIL	36,000	200-205	120-125	NIL	NIL	36,000	155-160
David Williams CB[5] Second Permanent Secretary, Director General	140-145	10-15	NIL	55,000	210-215	140-145	10-15	NIL	35,000	185-190
Full Year Equivalent	155-160									
Clara Swinson CB Director General	125-130	10-15	NIL	63,000	205-210	115-120	NIL	NIL	38,000	155-160
Full Time Equivalent						120-125				
Jonathan Marron Director General	125-130	NIL	NIL	50,000	175-180	125-130	NIL	NIL	50,000	175-180
Lee McDonough[6] Director General	125-130	NIL	NIL	49,000	175-180	120-125	NIL	NIL	13,000	135-140
Steve Oldfield[7] Chief Commercial Officer	235-240	45-50	NIL	7,000	285-290	235-240	10-15	NIL	7,000	250-255
Matthew Gould *(from 20/05/2019)*[8] Chief Executive Officer, NHSX	100-105	10-15	NIL	36,000	150-155	-	-	NIL	-	
Full Year Equivalent	125-130									
Professor Dame Sally Davies DBE *(to 30/09/2019)* Chief Medical Officer (Equivalent of Permanent Secretary)	105-110	NIL	-	N/A	105-110	210-215	NIL	300	N/A	210-215
Full Year Equivalent	210-215									

1. Non Consolidated Performance Pay paid in 2019-20 relates to the 2018-19 performance year.

2. Gross Benefits in Kind are rounded to the nearest £100 for Sir Christopher Wormald and Professor Dame Sally Davies. The minimal amounts of these benefits incurred therefore rounds to 0.

3. Steve Oldfield and Professor Chris Whitty hold a defined contribution pension therefore figures shown represent the Department's contribution to this scheme.

4. Professor Chris Whitty was appointed on 1 January 2016 on secondment from the London School of Hygiene and Tropical Medicine, in 2019-20 he was seconded for 4 days a week between April 2019 and September 2019. The full year equivalent (FYE) for this role is £120-125k. The figures in the table and FYE represent the proportion the Department paid only, not the full salary during this secondment between April and September 2019. He was employed on a full time basis in October 2019. The FYE as CMO is £200-205k. The pension benefit total accruing through his employment with DHSC comprises of two schemes, a NHS pension scheme relating to his secondment and a partnership scheme entered into in October 2019.

5. David Williams was appointed Second Permanent Secretary on 5 March 2020. The FYE disclosed in the table is the annual salary for this role. The FYE for the role of Director General for Finance and Group Operations and Chief Operating Officer is £140-145k.

6. Lee McDonough's pension benefits for 2018-19 has been restated from £12,000 in the 2018-19 ARA to £13,000 in the above table.

7. Steve Oldfield was appointed on 7 October 2017 on loan from the Government Commercial Office (GCO). 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.

8. Matthew Gould's Non Consolidated Performance Pay paid in 2019-20 relates to a position held in the Department for Digital, Culture, Media and Sport during the 2018-19 financial year. DCMS incurred salary costs until 1 June 2020. Salary incurred by the Department includes arrears backdated to April 2019. The position of Chief Executive Officer of NHSX incorporates the NHS England and NHS Improvement role of National Director of Digital and the DHSC role of Director General. For 2019-20 Matthew has been fully remunerated by DHSC as his primary employer, who established his terms of employment on joining the Department on 20 May 2019.

Department of Health and Social Care's SCS Reward Strategy 2019-20

399. The remuneration of Senior Civil Servants (SCS) is determined in accordance with the rules set out in the Civil Service Code[122] and in line with the annual SCS framework guidance issued by Cabinet Office. Departments are given some discretion within the broader Cabinet Office pay guidance to develop their pay strategy to meet local needs and these are outlined in an annual reward strategy.

400. The Department's annual SCS Reward Strategy was agreed by the Executive Committee and stated that from 1 April 2019, 1% of the SCS paybill was available for consolidated pay awards and an additional 0.9% was available to address pay progression and pay anomalies. The Department continued to target the pay award towards those lower in their respective pay range, to address pay equality issues.

401. All eligible SCS members received a 1% consolidated pay award. An additional £1,250 was applied to those whose salary was below the respective DHSC pay band median. An

[122] https://civilservicecommission.independent.gov.uk/code/the-code/

additional award of £1,000 was applied to 'Top Performers' with a salary below the respective DHSC pay band median.

SCS Overtime Policy

402. As the Civil Service continues to support the Government in the country's collective response to the ongoing COVID-19 crisis, Ministerial approval has been sought on a number of flexibilities in relation to the SCS to help ensure we remain able to respond to ongoing challenges during this period. These have now been agreed with Cabinet Office and Ministers and all are available to departments as of February 2020.

403. For night working, departments are able to make payments at a fixed rate across SCS of normal pay plus 15% for hours worked between 8pm and 6am.

404. For weekend working departments can compensate SCS who are required to work weekends with payments for hours worked at normal pay rates. If this is required for a significant period of time with clear rostered hours established, payment can be consolidated into an allowance. Time off in lieu against the hours actually worked can be offered for irregular or short-term weekend working on the COVID-19 response.

405. Payments for both night and weekend work can be made retrospectively for work already undertaken on the COVID-19 response. The Department has implemented these revised conditions from February 2020.

Median Earnings

406. 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)

Median Earnings 2018-2019 and 2019-2020				
	Core Department		Department & Executive Agencies [1]	
	2019-2020	2018-2019	2019-2020	2018-2019
Band of Highest Paid Director's Total remuneration (£000)[2]	280-285	235-240	280-285	235-240
Band of lowest paid	15-20	15-20	15-20	15-20
Median Total Remuneration	£40,869	£40,685	£39,365	£38,975
Ratio	6.9	5.8	7.2	6.1

1. The Medicines and Healthcare Products Regulatory Agency is not consolidated within the Department's ARA and therefore is not included in determining the median earnings calculation for either year.
2.Salaries for senior management are disclosed in bands of £5000, in accordance with EPN597 guidance.

407. The banded remuneration of the highest paid core Department Director in 2019-20 was £280,000-£285,000 (2018-19 £235,000-£240,000). This was 6.9 times the median remuneration of the workforce of £40,869 (2018-19, £40,685).

408. No DHSC core employees in either 2019-20 or 2018-19 received remuneration in excess of the highest paid Director. Banded remuneration ranged from £15,000-£20,000 and £280,000-£285,000 (2018-19 £15,000-£20,000 and £235,000-£240,000).

409. 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.

410. The median earnings for the core Department have marginally increased in 2019-20 compared to 2018-19, with an increase of £184 (In 2018-19 median remuneration had increased £1,101 compared to 2017-18). An overall average award of 2% was made in 2019. Awards levels were dependant on positioning against the mid-point of the salary range, with larger awards made to staff below the salary range mid-point.

411. In regards to the significant pay ratio increase (6.9 in 2019-20 from 5.8 in 2018-19), the banded remuneration of the highest paid director has increased from 2018-19 due to a substantial award of non consolidated performance related pay. See **Table 10** for details.

412. As detailed in **Note 7** to **Table 10**, the Department pays the full costs of the GCO specialists it employs which, in this instance, has led to a significant increase in the ratio in 2019-20 compared to 2018-19.

Civil Service Pensions

413. 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.

414. 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.

415. 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 receiving 'transitional protection'. Those who were between 10 years and 13 years and 5 months from their normal pension age on 1 April 2012 will switch into Alpha sometime between before 1 February 2022 with their PCSPS benefits 'banked', with those with earlier benefits in one of the final salary sections of the PCSPS having those benefits based on their final salary when they leave Alpha.

416. In December 2018 the Court of Appeal ruled that 'transitional protections' gave rise to age discrimination. This became known as the 'McCloud Judgement'. A public consultation has been launched by HM Treasury on the 16 July 2020, closing on 11 October 2020[123]. The consultation sets out the government's proposals for addressing this discrimination along with the government's plans for the future.

[123] https://www.gov.uk/government/consultations/public-service-pension-schemes-consultation-changes-to-the-transitional arrangements-to-the-2015-schemes

417. 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).

418. 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 is 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.

419. 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).

420. The 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 civil service pension scheme website[124].

Ministerial Pensions

421. 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.[125]

422. 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.

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

423. 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.

424. **Tables 12** and **13** provide the details of the pension interests for the Department's Officials and Ministers for 2018-19 and 2019-20 and are subject to audit.

Cash Equivalent Transfer Values

425. 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.

426. 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.

427. 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.

Real Increase in CETV

428. 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.

429. 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 31/03/20 £'000	Real increase in pension at age 65 £'000	CETV at 31/03/20 £'000	CETV at 31/03/19 £'000[4]	Real increase in CETV £'000
Matt Hancock	0-5	0-2.5	44	31	5
Jackie Doyle-Price	0-5	0-2.5	20	18	1
Caroline Dinenage	0-5	0-2.5	29	23	3
Stephen Hammond[2]	-	-	-	-	-
Baroness Blackwood	0-5	0-2.5	18	7	4
Jo Churchill	0-5	0-2.5	11	6	4
Nadine Dorries	0-5	0-2.5	49	43	3
Edward Argar	0-5	0-2.5	8	5	1
Helen Whately	0-5	0-2.5	3	2	1
Lord Bethell[3]	-	-	-	-	-
Seema Kennedy	0-5	0-2.5	2	-	1
Chris Skidmore	0-5	0-2.5	10	9	0

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. Member opted out of the pension scheme in April 2019.
3. Lord Bethell's role as Parliamentary Under Secretary of State (Lords) is unpaid.
4. Caroline Dinenage and Baroness Blackwood CETV's at 31/03/19 have been restated since the 2018-19 disclosure.

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

		Accrued pension at pension age as at 31/03/20 and related lump sum £'000	Real increase in pension and related lump sum at pension age £ '000	CETV at 31/03/20 £ '000	CETV at 31/03/19 £ '000	Real increase in CETV £'000	Employer contribution to partnership pension account[1] Nearest £100
Sir Christopher Wormald KCB	Permanent Secretary	80-85	5-7.5	1,330	1,214	53	0
Professor Chris Whitty[2]	Chief Scientific Adviser and Chief Medical Officer	65-70 plus a lump sum of 145-150	0-2.5k plus a lump sum of 0-2.5	580	1,037	0	15,000
David Williams CB	Second Permanent Secretary, Director General for Finance & Group Operations	60-65 plus a lump sum of 130-135	2.5-5 plus a lump sum of 0-2.5	1,074	994	30	0
Clara Swinson CB	Director General for Global Health Group	35-40 plus a lump sum of 80-85	2.5 -5 plus a lump sum of 0-2.5	589	527	31	0
Jonathan Marron	Director General for Prevention Community and Social Care Group	15-20	2.5-5	233	192	24	0
Lee McDonough[3]	Director General for Acute Care and Workforce Group	45-50 plus a lump sum of 140-145	2.5-5 plus a lump sum of 7.5-10	1,088	989	49	0
Steve Oldfield	Chief Commercial Officer Commercial Group	-	-	-	-	-	7,100
Matthew Gould	Chief Executive Officer, NHSX	55-60	0-2.5	858	804	16	0
Professor Dame Sally Davies DBE[4]	Chief Medical Officer	-	-	-	-	-	-

1. Steve Oldfield and Professor Chris Whitty hold a defined contribution pension therefore figures shown represent the Department's contribution to this scheme.
2. In 2019-20 Professor Chris Whitty contributed to an NHS pension scheme as part of his employment London School of Hygiene and Tropical Medicine and secondment on to the Department. In his employment as CMO from October 2019 contributions were made to pension scheme per note 1. The CETV at 31/03/19 has been restated.
3. Lee McDonough's CETV at 31/03/19 has been restated. In the 2018-19 ARA CETV at 31/03/19 was 1,086
4. Member opted out of the pension scheme as at 6/04/2016.

Non-Executive Directors

430. 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.

431. The Departmental Board holds positions for six Non-Executive Directors. The Non-Executive Directors sitting on the Departmental Board during 2019-20 are detailed in the Directors' Report. There are also three Independent members who sit on the Department's Audit & Risk Committee. Details are shown in **Table 14**.

432. One of the Non-Executive Directors chairs the Department's Audit and Risk Committee (4-5 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's Audit & Risk Committee (subject to audit)

			2019-20		2018-19	
Non-Executive	Position	Term	Fee Received to nearest £1,000	Annual Fee Entitlement to nearest £1,000	Fee Received to nearest £1,000	Annual Fee Entitlement to nearest £1,000
Gerry Murphy	Non-Executive Board Member & Chair Audit & Risk Committee	1 Aug 2017 - 31 Jul 2023	20,000	20,000	20,000	20,000
Kate Lampard	Non-Executive Board Member & Lead Non-Executive	1 Oct 2017 - 30 Sep 2023	20,000	20,000	20,000	20,000
Michael Mire	Non-Executive Board Member & Member of Audit & Risk Committee	1 Nov 2017 - 31 Oct 2020	15,000	15,000	15,000	15,000
Prof Sir Mike Richards	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	15,000	15,000	15,000	15,000
Prof Dame Sue Bailey	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	15,000	15,000	15,000	15,000
*Sir Ron Kerr	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	11,000	15,000	15,000	15,000
Jacqueline Burke	Independent Member of Audit & Risk Committee	1 Sep 2016 - 31 Aug 2019	2,000	5,000	5,000	5,000
Cat Little	Independent Member of Audit & Risk Committee	1 Nov 2016 - 31 Oct 2019	-	Non-remunerated Civil Servant	-	Non-remunerated Civil Servant
Anne Barnard	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2022	1,000	5,000	-	-
Graham Clarke	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2022	1,000	5,000	-	-
Richard Hornby	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2022	-	Non-remunerated Civil Servant	-	-

*Sir Ron Kerr resigned from Non Executive Director role on 31 December 2019

Compensation for Loss of Office (subject to audit)

433. 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[126] and the payments are also not pensionable.

434. There were three payments for loss of office during 2019-20 to Ministers. Stephen Hammond, Minister of State for Health, £7,920 as at 25 July 2019; Jacqueline Doyle-Price, Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention, £5,594 as at 26 July 2019 and Baroness Nicola Blackwood, Parliamentary Under Secretary of State (Lords), £17,742 as at 13 February 2020.

[126] https://www.legislation.gov.uk/ukpga/2003/1/contents

Staff Report

435. 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.

436. The core Department employed an average of 1,588 permanent whole time equivalent (WTE) persons during 2019-20 at a total salaries and wages cost of £73.8 million, compared to 1,462 at a cost of £68.2 million in 2018-19. A breakdown of staff numbers and associated costs for the Core Department together with its Executive Agencies and for the overall Departmental Group are included in **Tables 19** and **20**.

DHSC Staff

437. 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 6** outlines the headcount and gender distribution of core Departmental staff in post as at 31 March 2020 and is consistent with Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment with the Department.

Figure 6: Gender distribution of core Department staff (headcount)

Grade	Female		Male	Total
Perm Sec	0	3	3	
SCS 3	2	2	4	
SCS 2	11	10	21	
SCS 1	47	57	104	
GRADE 6	124	78	202	
GRADE 7	267	189	456	
FAST ST	11	9	20	
SEO	190	132	322	
HEO	219	127	346	
EO	161	101	262	
AO	21	9	30	
	1,053	**717**	**1,770**	

1. In alignment with previous years the CMO is shown as a Permanent Secretary. As confirmed in the Accountability Report, David Williams has been promoted to second permanent secretary.

Staff Sickness

438. The core Department has seen a reduction in the number of days lost to short-term and long-term sickness, falling from 1,706 and 2,871 days respectively in the rolling calendar year up to 31 December 2018 to 1,368 and 2,782 up to December 2019. Some 84 per cent of our staff have no recorded sickness which is better than the civil service average of 81 per cent.

84% of staff with no recorded sickness compared to 81% across Civil Service

Health and Safety

439. The Department of Health and Social Care recognises its responsibilities, under the Health and Safety at Work Act 1974[127], 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 2019-20, there were 10 reported accidents; one of which resulted in absence, and three near misses.

Equal Opportunities Policy

440. 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.

441. The Department's Strategic Commitments to equal opportunities and diversity incorporates 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[128] and Equality Objectives: 2019-23[129].

442. 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.

[127] http://www.hse.gov.uk/legislation/hswa.htm
[128] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401180/DH_equalities_2015_acc.pdf
[129] https://www.gov.uk/government/publications/dhsc-equality-objectives-2019-to-2023

443. We are currently refreshing our DHSC Diversity and Inclusion Strategy and will be launching a two-year plan later this year. This plan will align with the Civil Service D&I Practice Expectations 2020-21.

444. We have made good progress against the 2017 strategy since it was launched, with focus on creating an inclusive culture. Our active staff networks and visible senior Champions have raised the profile of diversity and inclusion in the department, with an aim of increasing knowledge and awareness and contributing to creating an inclusive environment in which individuals can thrive. The Department hosted a variety of internal events throughout the year, for example on National Day for Staff Networks, National Inclusion Week and the Departmental Diversity Day in December 2019. In April 2019 the Department implemented diverse panels for all Senior Civil Service recruitment. Diverse panels for SCS recruitment have a gender balance and a panel member from an ethnic minority background and/or with a visible or invisible disability.

445. In October 2019, DHSC was the first department in the Civil Service to be awarded the Youth Friendly Employer Mark[130] by Youth Employment UK. This was in recognition of the programmes that it offers to young people in work and the community such as the Health Policy Fast Track Scheme, the Apprenticeship Scheme and Schools Outreach Programme. As a member, our aim is to continue to strengthen our efforts and work in collaboration with Youth Employment UK to access specialist training and guidance to develop and inform our early talent strategies.

446. The Department uses a range of measures to track progress – including trends in staff surveys (our People Survey) data. Our Engagement Index Score for 2019 has increased, with a 2 percentage point increase from 2018 for the Inclusion and Fair Treatment theme (82 per cent in 2019 against 80 per cent in 2018).

447. The Departmental Diversity and Inclusion plan implements the recommendations from the Civil Service Diversity and Inclusion strategy entitled 'A Brilliant Civil Service: becoming the UK's most inclusive employer'[131]. In support of this ambition, in April 2019 the Department piloted a new metric to measure inclusion, which was developed in conjunction with the Cabinet Office and the Behavioural Insights team. This has enabled the Department to use the insights from the pilot to inform our forthcoming Diversity and Inclusion Plan refresh. We continue to work with external organisations such as the Business Disability Forum and Stonewall to support our diversity and inclusion ambitions.

Recruitment and Retention of Disabled Persons

448. 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 'Disability Confident Scheme' (which ensures that all applicants with a disability who meet

[130] https://www.youthemployment.org.uk/youth-employment-experts/youth-friendly-employer-mark-media-assets/
[131] https://www.gov.uk/government/publications/a-brilliant-civil-service-becoming-the-uks-most-inclusive-employer

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.

449. The Department, under the Equality Act 2010[132], 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. We have an in-house workplace adjustment team and we provide support through our occupational health service for workplace and specialist assessments. Employees also have access to an Employee Assistance Programme for independent advice from qualified professionals on topics such as physical or mental health, stress and depression. Internally, employees have access to over 65 in-house Mental Health First Aiders that can provide support to colleagues and are skilled in how to give appropriate help and support.

450. In July 2019 the Department's 'Voluntary reporting on disability, mental health and wellbeing workforce report'[133] was published. This report outlined the Department's commitment to meet the Thriving at Work Review[134] recommendations. We continue to measure our progress against the recommendations and aim to fully meet all standards this year. We also signed the Mental Health Commitment at Work[135] in March 2020, demonstrating that mental health remains a priority for us.

451. The Department has been recognised as a Disability Confident Leader since 2017. We promote a variety of training on topics such as 'Becoming Disability Confident' and 'Mental Health at Work' and we have also made 'Unconscious Bias' training a required piece of learning for all staff.

452. The Department has a well-established disability network, EnABLE, and in 2018 the Department was the first across the Civil Service to launch a 'Diversity of Thought' network, which promotes diversity of thinking styles to help staff to be their best at work and to support effective decision making. This network also looks to help to reduce cognitive bias and improve understanding of neuro-divergent conditions including autism, high sensitivity and dyslexia.

453. The Department runs specific targeted information sessions with members of its staff network groups, to encourage applicants to apply for the Civil Service-wide talent schemes – 'Future Leaders Scheme' (FLS) and 'Senior Leaders Scheme' (SLS), and the Civil

[132] https://www.gov.uk/guidance/equality-act-2010-guidance
[133] https://www.gov.uk/government/publications/disability-mental-health-and-wellbeing-support-in-dhsc-workforce-report-2019/voluntary-reporting-on-disability-mental-health-and-wellbeing-workforce-report-2019
[134] https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers
[135] https://www.mentalhealthatwork.org.uk/commitment/

Service wide development scheme 'Positive Action Pathway'. We also offered an additional information session with alumni and current participants to candidates who were eligible for the Disability Empowers Leadership Talent (DELTA) scheme, which is integrated into FLS and SLS to support participants specifically declaring a disability. 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

454. Under The Trade Union (Facility Time Publication Requirements) Regulations 2017[136], 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.

455. 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
50	50

Table 16: Percentage of time spent on facility time

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

Table 17: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£108,716
Total pay bill	£408,316,582
Percentage of the total pay bill spent on facility time*	0.026%

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

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) x 100

456. 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.

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

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 holds formal pay negotiations on an annual basis. In addition to the regular meetings with HR, DTUS also meet quarterly with designated members of the Department's Executive committee.

Staff Data

457. **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)

					2019-20 £'000	2018-19 £'000
	Permanently employed staff	Others	Ministers	Special advisors	Total	Total
Salaries and wages	46,040,610	5,522,550	241	73	51,563,474	48,464,563
Social Security costs	4,835,204	117,396	26	11	4,952,637	4,607,888
NHS Pension	7,833,189	151,516	-	-	7,984,705	5,219,067
Other pension costs	93,768	3,463	-	-	97,231	69,536
Sub-total	**58,802,771**	**5,794,925**	**267**	**84**	**64,598,047**	**58,361,054**
Termination benefits	35,916	8,785	37	17	44,755	46,204
Sub-total	**58,838,687**	**5,803,710**	**304**	**101**	**64,642,802**	**58,407,258**
Less recoveries in respect of outward secondments	(35,790)	(69,223)	-	-	(105,013)	(93,379)
Total Net Costs	**58,802,897**	**5,734,487**	**304**	**101**	**64,537,789**	**58,313,879**

1. Special advisor costs cover the period to August 2019. After this date responsibility for special advisors transferred to the Cabinet Office.
2. From 1 April 2019, the employers' contributions payable to the NHS pension scheme increased to 20.68% from 14.3%. This has led to the majority of the increase in NHS Pension costs above.

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

					2019-20 Number	2018-19 Number
	Permanent staff	Others	Ministers	Special Advisors	Total	Total
Core Department						
Core Department	1,588	172	7	3	1,770	1,746
Executive Agencies						
Public Health England	5,084	242	-	-	5,326	5,277
Other designated bodies						
NHS Providers	1,114,107	110,735	-	-	1,224,842	1,183,448
Special Health Authorities	4,568	493	-	-	5,061	4,309
NHS England Group	24,575	8,978	-	-	33,553	33,091
Non Departmental Public Bodies	8,802	686	-	-	9,488	9,756
Others	7,850	237	-	-	8,087	5,893
Total	**1,166,574**	**121,543**	**7**	**3**	**1,288,127**	**1,243,520**

1. 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.
2. The average number of employees working for other departmental bodies increased from 2018-19 due to the full year impact of the transfer of a facilities management function into NHS Property Services in December 2018.

Of the figures shown in **Table 20,** staff engaged on capital projects are shown in **Table 21.**

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

					2019-20	2018-19
					Number	Number
	Permanent staff	Others	Ministers	Special Advisors	Total	Total
Core Dept & Agencies	55	11	-	-	66	73
Other designated bodies	3,869	577	-	-	4,446	3,878
Total	**3,924**	**588**	**-**	**-**	**4,512**	**3,951**

458. 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.

459. Staff employed in the NHS has increased in 2019-20. This is predominantly due to increased healthcare assistants and support staff, estates and administration and nursing, midwifery and health visiting staff as well as medical and dental staff.

460. Further details of staff employed within NHS organisations is available via NHS Digital[137], 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

461. **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.

462. The Department utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. In 2019-20 the core Department spent £15.2 million on consultancy compared to £19.8 million in 2018-19; and £14.8 million on temporary staff this year compared to £25.4 million last year. These decreases 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.

463. In 2019-20 these costs primarily included EU Exit contingencies such as continuity of medicine supplies and the final costs of the implementation of a new supply chain model under the Procurement Transformation Programme which is now operational and delivering procurement efficiency and value for money for NHS services.

[137] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

464. Bodies within the NHS trade with each other in their operations. Such intra group activity can also include the incurring of expenditure on consultancy services. The overall total spend on consultancy, agency and temporary workers is therefore presented first as a gross figure and secondly net of any associated elimination of intra group purchasing of consultancy.

Table 22: Expenditure on Consultancy, Agency and Temporary Workers

	2019-20		2018-19	
	Consultancy £'000	Temporary Agency £'000	Consultancy £'000	Temporary Agency £'000
Total DHSC Core	15,203	14,842	19,829	25,396
Executive Agencies	-	13,576	-	15,809
Other Designated Bodies	275,003	3,720,978	322,222	3,591,990
Gross Total	**290,206**	**3,749,396**	**342,051**	**3,633,195**
Eliminations	-	-	-	-
Total Departmental Group (after eliminations)	**290,206**	**3,749,396**	**342,051**	**3,633,195**

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

465. 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 23a, b** & **c** includes all off-payroll engagements as at 31 March 2020 for a day-rate of more than £245 and which have duration of more than six months.

466. A regular dialogue has continued between the Department and HMRC throughout the 2019-20 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.

467. 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.

468. 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 two 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.

469. The Department is aware of the issues surrounding the answers to questions in the online Check Employment Status for Tax (CEST) tool concerning substitution and have engaged

with HMRC on this during its initial investigations into historic IR35 assessments made by the Department. While this investigation is currently frozen due to work pressures surrounding COVID-19, it is anticipated this will recommence later in the 2020-21 financial year with the outcomes to be reported in the 2020-21 Annual Report.

470. A communication channel has also been open throughout the year with the Department's 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.

471. On the continued advice of HM Treasury, secondments have been included within the off-payroll figures for the core Department. Secondees engaged as at 31 March 2020 accounted for one of the off-payroll workers with this individual having reached their initial six-month duration during financial year 2019-20.

472. The Department had no change of policy relating to the engagement of off-payroll workers during 2019-20 and continues to utilise them only where it is necessary and prudent to do so.

473. A significant number of contractors have historically been engaged on the Procurement Transformation Programme at the Department which has now completed. 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 2020-21. There have also been a number of contractors recently engaged to work on various aspects of the Departments COVID-19 response. This increase in contractor numbers will be reflected in next years' Annual Report.

474. Across the group, there are nine individuals who are senior 'off-payroll' engagements (see **Table 23c**), four of whom are at NHS Digital (NHSD), two are at the Skipton Fund, two are at Supply Chain Coordination Ltd (SCCL) and the last is at the Health Research Authority (HRA). Details are as follows:

- NHS Digital's Chief Medical Director who took over from an internal interim person. They are on an 18-month secondment to NHSD from United Hospitals Bristol NHS Trust and are paid via the Trust's payroll so there are no outstanding tax issues relevant to this engagement.

- One of NHS Digital's Product Development Directors who started work in January 2020. This individual works for a private consultancy firm (Axio Logic) and is on their payroll so, as above, there are no outstanding tax issues relevant to this engagement. This engagement will conclude on 31 January 2021.

- NHS Digital's Chief Commercial Officer. This was a newly formed position and was filled on an interim basis until a permanent candidate could be sourced. The individual concerned left this role on the 15th November 2019 having held the role for a period of 19 months.

- NHS Digital's Director of Assurance & Risk Management. As above, this role was filled by an off-payroll worker to ensure a quick interim appointment until a permanent candidate could be sourced. The individual concerned left this role on the 28th November 2019 having held the role for a period of 8 months.

- Supply Chain Coordination Limited's Chief Financial Officer. The position was originally filled on an interim basis until a permanent candidate could be sourced. The individual concerned left the post in August 2019, having held the position for 12 months.

- Supply Chain Coordination Limited's Chief Financial Officer. The position was filled on an interim basis until a permanent candidate could be sourced, following the role being vacated by the previous interim Chief Financial Officer. The individual concerned left this role on January 2020, having been appointed in August 2019.

- The two individuals who work for the Skipton Fund are both representatives of solicitors Russell-Cooke LLP, who took on the responsibility of running the company until the time comes when it can be formally closed. The company closed in 2017 but these individuals will be kept on until the conclusion of the ongoing public enquiry into the historic infected blood issues. There are no outstanding tax issues in relation to these engagements.

- The last individual is the Chairman of the Health Research Authority who was appointed in September 2019. As part of the engagement, the individual concerned asked for their host organisation to be reimbursed directly as a recharge rather than receiving their remuneration via the HRA payroll. There are no outstanding tax issues in relation to this engagement.

Table 23: Off-payroll engagements

Table a: For all off-payroll engagements as of 31 March 2020, 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 2020	**53**	-	**983**
Of which…..			
Number that have existed for less than one year at time of reporting	28	-	518
Number that have existed for between one and two years at time of reporting	8	-	172
Number that have existed for between two and three years at time of reporting	6	-	167
Number that have existed for between three and four years at time of reporting	3	-	74
Number that have existed for four years or more years at time of reporting	8	-	52

Table b: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, 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 2019 and 31 March 2020*	**47**	-	**832**
Of which…..			
No. assessed as caught by IR35	7	-	291
No. assessed as not caught by IR35*	40	-	541
No. directly engaged directly (via PSC contracted to department) and are on the departmental payroll	-	-	51
No. of engagements reassessed for consistency / assurance purposes during the year	-	-	108
No. of engagements that saw a change to IR35 status following the consistency review	-	-	24

* Total no of "outside the scope" contractors includes 5 who are almost certain to have this determination but whose status confirmations are in the process of being finalised.

Table c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility*, between 1 April 2019 and 31 March 2020

	Main Dept	Agencies	ALBs
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-	-	9
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*	131	18	447

* For senior officials the core Department has included all officials at payband SCS 1 or above with financial responsibility for budgets for £500,000 or more

Exit Packages – Civil Service and Other Compensation Schemes

475. **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[138]. Where early retirement has been agreed, the additional costs are met by the Department/organisation. Ill-health retirement costs are met by the pension scheme and are not included in the table. The figures disclosed relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure cost may have been accrued or provided for in a previous period. The information in this disclosure note is therefore presented on a different basis to the staff cost and other expenditure notes in the accounts.

Table 24: Exit Packages (subject to audit)

								2019-20
				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	9	9	18	-	309	1,825	2,134	2
£10,001 - £25,000	3	4	7	-	364	336	700	10
£25,001 - £50,000	1	4	5	-	366	169	535	4
£50,001 - £100,000	-	6	6	-	296	102	398	4
£100,001 - £150,000	-	4	4	-	122	23	145	-
£150,001 - £200,000	-	-	-	-	77	8	85	2
>£200,000	-	-	-	-	7	2	9	-
Total Number	**13**	**27**	**40**	**-**	**1,541**	**2,465**	**4,006**	**22**
Total Cost (£)	**123,508**	**1,118,763**	**1,242,271**	**-**	**71,349,820**	**27,947,714**	**99,297,534**	**765,712**

								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**

1. 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 2019-20 or 2018-19.

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

Other Departures

476. **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 (subject to audit)

	2019-20 Departmental Group	
	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	182	5,916
Mutually agreed resignations (MARS) contractual costs	265	7,616
Early retirements in the efficiency of the service contractual costs	32	563
Contractual payments in lieu of notice	1,911	11,306
Exit payments following Employment Tribunals or court orders	84	1,999
Non-contractual payments requiring HMT approval*	13	550
Total	**2,487**	**27,950**

*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

The Parliamentary Accountability and Audit Report brings together the key Parliamentary accountability documents within these Annual Report and Accounts. The report establishes the Department's compliance with principles relating to Supply and Parliamentary control over income and expenditure incurred.

Statement of Parliamentary Supply (subject to audit)

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 2019-20

		2019-20 Estimate			2019-20 Outturn			2019-20	2018-19
	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	111,666,134	22,961,639	134,627,773	111,221,759	22,961,639	134,183,398	444,375	125,278,261
- Capital	1.2	7,125,080	-	7,125,080	7,015,244	-	7,015,244	109,836	5,941,244
Annually Managed Expenditure									
- Resource	1.1	11,419,880	-	11,419,880	2,848,009	-	2,848,009	8,571,871	7,013,965
- Capital	1.2	15,001	-	15,001	(5,563)	-	(5,563)	20,564	(4,801)
Total Budget		130,226,095	22,961,639	153,187,734	121,079,449	22,961,639	144,041,088	9,146,646	138,228,669
Non-Budget									
- Resource	1.1	-	-	-	-	-	-	-	-
Total		**130,226,095**	**22,961,639**	**153,187,734**	**121,079,449**	**22,961,639**	**144,041,088**	**9,146,646**	**138,228,669**
Total Resource		123,086,014	22,961,639	146,047,653	114,069,768	22,961,639	137,031,407	9,016,246	132,292,226
Total Capital		7,140,081	-	7,140,081	7,009,681	-	7,009,681	130,400	5,936,443
Total		**130,226,095**	**22,961,639**	**153,187,734**	**121,079,449**	**22,961,639**	**144,041,088**	**9,146,646**	**138,228,669**

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

Net cash requirement 2019-20

	SoPS Note	2019-20 Estimate £'000	2019-20 Outturn £'000	2019-20 Outturn compared with Estimate: saving/ (excess) £'000	2018-19 Outturn £'000
Net cash requirement	3	118,401,143	115,163,740	3,237,403	106,567,583

1. Against the 2019-20 Net Cash Requirement of £118.4 billion, DHSC underspent by 2.7% (£3.2 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 2019-20

	2019-20 Estimate £'000	2019-20 Outturn £'000	2018-19 Outturn £'000
Administration Costs	2,881,358	2,301,082	2,272,688

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

SOPS 1 Net Outturn

SOPS 1.1 Analysis of net resource outturn by section

	2019-20 £'000						2019-20 £'000	2019-20 £'000		2019-20 £'000	2019-20 £'000	2018-19 £'000
							Outturn			Estimate		Outturn
	Administration			Programme			Total	Net Total	Virements	Total incl. Virements	Outturn vs Estimate	Total
	Gross	Income	Net	Gross	Income	Net					Savings (Excess)	
Spending in Departmental Expenditure Limits (DEL)												
Voted:												
NHS England net expenditure	1,545,410	-	1,545,410	15,640,898	-	15,640,898	17,186,308	19,234,419	(2,048,111)	17,186,308	-	16,598,249
NHS Providers net expenditure	-	-	-	81,526,454	-	81,526,454	81,526,454	79,023,781	2,502,673	81,526,454	-	74,014,271
DHSC Programme and Administration expenditure	230,552	(303)	230,249	1,455,224	(828,867)	626,357	856,606	1,754,281	(767,628)	986,653	130,047	1,107,488
Local Authorities	-	-	-	2,931,555	-	2,931,555	2,931,555	2,931,555	-	2,931,555	-	3,011,064
Public Health England (Executive Agency)	66,462	(17,328)	49,134	1,049,695	(175,283)	874,412	923,546	926,151	1,028	927,179	3,633	1,026,301
Health Education England net expenditure	61,296	-	61,296	1,383,199	-	1,383,199	1,444,495	1,622,276	2,867	1,625,143	180,648	1,819,177
Special Health Authorities expenditure[3]	260,675	(79,791)	180,884	2,673,664	(111,267)	2,562,397	2,743,281	2,833,482	8,142	2,841,624	98,343	4,311,956
Non Departmental Public Bodies net expenditure[3]	239,886	-	239,886	388,407	-	388,407	628,293	549,906	103,314	653,220	24,927	624,829
Arm's Length and Other Bodies net expenditure	(5,777)	-	(5,777)	2,986,998	-	2,986,998	2,981,221	2,790,283	197,715	2,987,998	6,777	838,583
	2,398,504	**(97,422)**	**2,301,082**	**110,036,094**	**(1,115,417)**	**108,920,677**	**111,221,759**	**111,666,134**	**-**	**111,666,134**	**444,375**	**103,351,918**
Non-voted:												
NHS England expenditure financed by NI Contributions	-	-	-	22,961,639	-	22,961,639	22,961,639	22,961,639	-	22,961,639	-	21,926,343
	2,398,504	**(97,422)**	**2,301,082**	**132,997,733**	**(1,115,417)**	**131,882,316**	**134,183,398**	**134,627,773**	**-**	**134,627,773**	**444,375**	**125,278,261**
Annually Managed Expenditure (AME)												
Voted:												
NHS England net expenditure	-	-	-	294,489	-	294,489	294,489	325,000	-	325,000	30,511	(19,733)
NHS Providers net expenditure	-	-	-	1,070,401	-	1,070,401	1,070,401	1,650,161	-	1,650,161	579,760	1,134,119
DHSC Programme and Administration expenditure	-	-	-	798,449	(12,943)	785,506	785,506	1,670,373	-	1,670,373	884,867	(437,113)
Public Health England (Executive Agency)	-	-	-	(2,033)	-	(2,033)	(2,033)	5,000	-	5,000	7,033	(2,181)
Health Education England net expenditure	-	-	-	68	-	68	68	5,000	-	5,000	4,932	(44)
Special Health Authorities expenditure[3]	-	-	-	675,203	-	675,203	675,203	7,367,000	-	7,367,000	6,691,797	6,405,024
Non Departmental Public Bodies net expenditure[3]	-	-	-	3,536	-	3,536	3,536	11,000	-	11,000	7,464	6,373
Arm's Length and Other Bodies net expenditure	-	-	-	20,839	-	20,839	20,839	386,346	-	386,346	365,507	(72,480)
	-	**-**	**-**	**2,860,952**	**(12,943)**	**2,848,009**	**2,848,009**	**11,419,880**	**-**	**11,419,880**	**8,571,871**	**7,013,965**
Total	**2,398,504**	**(97,422)**	**2,301,082**	**135,858,685**	**(1,128,360)**	**134,730,325**	**137,031,407**	**146,047,653**	**-**	**146,047,653**	**9,016,246**	**132,292,226**

Reconciliation to Statement of Comprehensive Net Expenditure												
Net gain/(loss) on transfers by absorption	-	-	-	-	-	-	-					(6,204)
Capital Grants	132,462	-	132,462	677,041	-	677,041	809,503					597,953
Research and Development[5]	-	-	-	1,230,741	-	1,230,741	1,230,741					1,184,510
Income from Consolidated Fund Extra Receipts	-	-	-	-	(571,133)	(571,133)	(571,133)					-
Utilisation of provisions	(18,256)	-	(18,256)	18,256	-	18,256	-					-
IFRIC 12 Adjustment	-	-	-	288,225	(393,331)	(105,106)	(105,106)					(34,478)
Donated asset/government granted income	-	-	-	-	(166,275)	(166,275)	(166,275)					(404,202)
Expenditure presented on net basis[1]	236,752	(236,752)	-	8,786,061	(8,786,061)	-	-					-
Other adjustments	-	-	-	1,400	(31,853)	(30,453)	(30,453)					(41,861)
Net operating cost	**2,749,462**	**(334,174)**	**2,415,288**	**146,860,409**	**(11,077,013)**	**135,783,396**	**138,198,684**					**133,587,944**

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. Profits on disposal of £34 million have been transferred to Capital in line with HM Treasury 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 £444 million consists of a £444 million underspend against the ringfence control.

SOPS 1.2 Analysis of net capital outturn by section

	2019-20 £'000			2019-20 £'000		2019-20 £'000	2019-20 £'000	2018-19 £'000
	Outturn					Estimate	Outturn vs Estimate	Outturn
	Gross	Income	Net Total	Net Total	Virements	Total incl. Virements	Savings (Excess)	Net Total
Spending in Departmental Expenditure Limits (DEL)								
Voted:								
NHS England net expenditure	265,530	-	265,530	253,869	11,661	265,530	-	221,233
NHS Providers net expenditure	4,498,029	-	4,498,029	4,918,643	(338,115)	4,580,528	82,499	3,928,404
DHSC Programme and Administration expenditure	1,982,481	(171,367)	1,811,114	1,465,168	345,946	1,811,114	-	1,658,348
Local Authorities	-	-	-	-	-	-	-	-
Public Health England (Executive Agency)	140,976	(241)	140,735	160,468	(19,492)	140,976	241	(70,475)
Health Education England net expenditure	1,557	-	1,557	2,000	-	2,000	443	467
Special Health Authorities expenditure[2]	24,318	(146)	24,172	39,124	-	39,124	14,952	(49,815)
Non Departmental Public Bodies net expenditure[2]	118,533	-	118,533	172,739	(42,505)	130,234	11,701	95,246
Arm's Length and Other Bodies net expenditure	155,574	-	155,574	113,069	42,505	155,574	-	157,836
	7,186,998	**(171,754)**	**7,015,244**	**7,125,080**	**-**	**7,125,080**	**109,836**	**5,941,244**
Annually Managed Expenditure (AME)								
Voted:								
NHS England net expenditure	-	-	-	-	-	-	-	-
NHS Providers net expenditure	-	-	-	-	-	-	-	-
DHSC Programme and Administration expenditure	(5,563)	-	(5,563)	15,001	-	15,001	20,564	(4,801)
Public Health England (Executive Agency)	-	-	-	-	-	-	-	-
Health Education England net expenditure	-	-	-	-	-	-	-	-
Special Health Authorities expenditure[2]	-	-	-	-	-	-	-	-
Arm's Length and Other Bodies net expenditure[2]	-	-	-	-	-	-	-	-
Non Departmental Public Bodies net expenditure	-	-	-	-	-	-	-	-
	(5,563)	**-**	**(5,563)**	**15,001**	**-**	**15,001**	**20,564**	**(4,801)**
Total	**7,181,435**	**(171,754)**	**7,009,681**	**7,140,081**	**-**	**7,140,081**	**130,400**	**5,936,443**

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.

Material variances between the Estimate and Outturn

477. 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.

478. 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 £90 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.

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

480. 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:			Explanation of other significant variance
					Elimination Variance	Other Variance	Other Variance	
		£m	£m	£m	£m	£m	%	
A	NHS England net expenditure	19,234	17,186	2,048	1,829	219	1%	
B	NHS Providers net expenditure	79,024	81,526	(2,503)	(1,924)	(578)	-1%	
C	DHSC Programme and Administration expenditure	1,754	857	898	180	718	41%	DHSC expenditure was circa £700m lower than anticipated when setting the Supplementary Supply Estimate, of which circa £300m relates to the ring fenced budget for depreciation expenditure.
D	Local Authorities	2,932	2,932	0	0	0	0%	
E	Public Health England (Executive Agency)	926	924	3	(11)	13	1%	
F	Health Education England net expenditure	1,622	1,444	178	183	(5)	0%	
G	Special Health Authorities expenditure	2,833	2,743	90	32	58	2%	
H	Non Departmental Public Bodies net expenditure	550	628	(78)	(73)	(5)	-1%	
I	Arm's Length and Other Bodies (Net)	2,790	2,981	(191)	(215)	24	1%	
J	NHS England expenditure financed by NI Contributions	22,962	22,962	0	0	0	0%	
Total RDEL		**134,628**	**134,183**	**444**	**0**	**444**		

1. Annex B includes a more detailed explanation of the Department's administrative spend.
2. Totals in the table may not sum due to roundings.

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	325	294	31	9%	
K	NHS Providers net expenditure	1,650	1,070	580	35%	***See note 1***
L	DHSC Programme and Administration expenditure	1,670	786	885	53%	***See note 1***
M	Public Health England (Executive Agency)	5	(2)	7	141%	
N	Health Education England net expenditure	5	0	5	99%	
O	Special Health Authorities expenditure	7,367	675	6,692	91%	Underspend relates to lower than forecast clinical negligence provisions.
P	Non Departmental Public Bodies net expenditure	11	4	7	68%	***See note 1***
R	Arm's Length and Other Bodies (Net)	386	21	366	95%	***See note 1***
Total RAME		**11,420**	**2,848**	**8,572**		

1. The Estimate reflects the best estimate of provisions and impairment expenditure for the DHSC group. This type of expenditure is demand led and can result in significant variances at year end.
2. Totals in the table may not sum due to roundings.

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	266	(12)	-5%	
B	NHS Providers net expenditure	4,919	4,498	421	9%	Capital additions were lower than had been anticipated when setting the Supplementary Supply Estimate. In addition to the NHS Provider capital expenditure planned with NHS Improvement, the Supplementary Supply Estimate added potential further capital expenditure expected to be financed from DHSC capital asset proceeds. This additional capital expenditure did not occur and the capital receipt was not received.
C	DHSC Programme and Administration expenditure	1,465	1,811	(346)	-24%	Capital reciepts were lower than had been anticipated at the Supplementary Supply Estimate due to ongoing delays in disposing capital assets caused in part by third parties outside HM Government control.
D	Local Authorities	0	0	0	0%	
E	Public Health England (Executive Agency)	160	141	20	12%	Capital plans were revised in Quarter 4 after the Supplementary Supply Estimate had been set.
F	Health Education England net expenditure	2	2	0	22%	
G	Special Health Authorities expenditure	39	24	15	38%	Capital additions were lower than had been anticipated when setting the Supplementary Supply Estimate.
H	Non Departmental Public Bodies net expenditure	173	119	54	31%	Capital plans were revised in Quarter 4 after the Supplementary Supply Estimate had been set.
I	Arm's Length and Other Bodies (Net)	113	156	(43)	-38%	Capital additions were higher than had been anticipated when setting the Supplementary Supply Estimate
Total CDEL		**7,125**	**7,015**	**110**		

1. Totals in the table may not sum due to roundings.

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	DHSC Programme and Administration expenditure	15	(6)	21	137%	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**	**(6)**	**21**		

1. Totals in the table may not sum due to roundings.

SOPS 2 Reconciliation of net resource outturn to net operating expenditure

		Note	2019-20 £'000 Outturn	2018-19 £'000 Outturn
Total resource outturn in Statement of Parliamentary Supply				
	Budget	SOPS 1.1	137,031,407	132,292,226
	Non-Budget	SOPS 1.1	-	-
			137,031,407	132,292,226
Add:	Capital Grants		809,503	597,953
	Research and Development[1]		1,230,741	1,184,510
	PFI/LIFT expenditure under IFRS		2,326,972	2,318,247
	PFI/LIFT income under IFRS		(393,331)	(369,349)
	Gain on transfers by absorption		-	-
	Other		1,400	157,665
			3,975,285	3,889,026
Less:	Income payable to the Consolidated Fund	SOPS4	(571,133)	-
	Donated asset/government granted income[3]		(166,275)	(404,202)
	PFI/LIFT expenditure under UK GAAP		(2,038,747)	(1,983,376)
	Loss on transfers by absorption		-	(6,204)
	Other[1]		(31,853)	(199,526)
			(2,808,008)	(2,593,308)
Net Operating Cost in Consolidated Statement of Comprehensive Net Expenditure after Financing Activities			**138,198,684**	**133,587,944**

1. 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.
2. Included in the 'Other' line are profits on disposal of £34 million which have been transferred to Capital in line with HM Treasury budgetary guidance.
3. 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

	Note	2019-20 £'000 Estimate	Outturn	Net total outturn compared with Estimate: Savings/(excess)
Resource Outturn	SOPS 1.1	146,047,653	137,031,407	9,016,246
Capital Outturn	SOPS 1.2	7,140,081	7,009,681	130,400
Accruals to cash adjustments:				
Adjustments to remove non-cash items:				
Depreciation		(638,417)	(262,275)	(376,142)
New provisions and adjustments to previous provisions		(12,406,205)	(13,426,228)	1,020,023
Finance leased asset additions			(1,094)	1,094
IFRIC12 revenue adjustments			12,839	(12,839)
Adjustment for stockpiled goods			65,564	(65,564)
Non-cash investment additions			(92,574)	92,574
Non-cash investment disposals			23	(23)
Net gain/loss on transfers by absorption			(182,600)	182,600
Other non-cash items		-	8,872,787	(8,872,787)
Adjustments for NDPBs, NHS Trusts, Foundation Trusts, Charities and Other bodies:				
Remove voted resource and capital		(111,058,492)	(110,195,327)	(863,165)
Add cash grant-in-aid, PDC, loans and share capital from Core Department, and expenditure financed by Parliamentary Funding		108,172,330	106,338,989	1,833,341
Adjustments to reflect movements in working balances:				
Increase/(decrease) in inventory			(110,232)	110,232
less transfers from non-current assets			(35,826)	35,826
Increase/(decrease) in receivables			9,850,023	(9,850,023)
less movement in Consolidated Fund receivables			-	-
less movement in PFI and other service concession arrangement prepayments			-	-
less movement in current financial assets			(10,058,423)	10,058,423
add PFI prepayments outward cash payments			-	-
(Increase)/decrease in payables		750,000	576,453	173,547
less movement in overdraft			-	-
less movement in payables to the Consolidated Fund			(596,465)	596,465
less movement in finance lease/PFI payables			-	-
add capital element of finance lease/PFI payables			-	-
Use of provisions		3,355,832	3,163,428	192,404
		141,362,782	137,960,150	3,402,632
Removal of non-voted budget items:				
Consolidated Fund Standing Services			-	-
National Insurance contributions		(22,961,639)	(22,961,639)	-
Other adjustments				
Net cash transferred under absorption accounting			68,606	(68,606)
Other cashflow adjustments			96,623	(96,623)
Net cash requirement		**118,401,143**	**115,163,740**	**3,237,403**

1. Other non-cash items mainly relate to the impact of the change in the discount rate on provisions (£9.4bn) offset by the unwinding of discounts on provisions (£0.5bn).

SOPS 4 Income payable to the Consolidated Fund

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

	Outturn 2019-20 £'000		Outturn 2018-19 £'000	
	Income	*Receipts*	Income	*Receipts*
Operating income outside the ambit of the Estimate	571,133	*571,133*	3,858	*3,858*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total income payable to the Consolidated Fund	**571,133**	***571,133***	**3,858**	***3,858***

During the period the Department received cash that HM Treasury has determined is surrenderable to the Consolidated Fund. The income associated with the transfer of this cash has been recognised in accordance with IFRS 15 which requires the recognition of income only when it is highly probable the income will be received. The value of income recognised in the period is £571 million and is included within other contract income.

Parliamentary Accountability Disclosures (subject to audit)

The following disclosures are all subject to audit.

Regularity of Expenditure

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

		2019-20		2018-19	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	306	65,602	144	122,484
	£'000	89,564	180,994	471,920	396,507
Cases over £300,000					
Cash losses	Cases	-	1	-	2
	£'000	-	586	-	3,597
Claims abandoned	Cases	-	2	-	2
	£'000	-	2,327	-	816
Cancellation of Public Dividend Capital (PDC)	Cases	-	-	3	-
	£'000	-	-	159,245	-
Administrative write-offs	Cases	-	2	-	-
	£'000	-	1,019	-	-
Fruitless payments	Cases	-	6	-	5
	£'000	-	10,381	-	3,090
Constructive Loss	Cases	3	3	4	4
	£'000	2,829	2,829	216,467	216,467
Store losses	Cases	-	2	-	3
	£'000	-	986	-	1,247
Bookkeeping losses	Cases	-	-	-	-
	£'000	-	-	-	-

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 £76.1 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 £9.5 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 one 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.

In 2019-20 while a Minute was prepared it was not laid in Parliament prior to the 31 March 2020, due to prioritisation of the COVID-19 response and therefore no PDC has been written off. This Minute will be laid in 2020-21 and reflected in the accounts accordingly.

Constructive Losses

As part of the country's response to the COVID-19 pandemic the Government closed all schools on 20 March 2020. At that time the Department had contracted to pay for produce to be delivered to schools as part of the School Fruit and Vegetable Scheme (SFVS) up until 3 April 2020. The Department donated £355k of this produce to a charity providing food for the vulnerable. Produce with a value of £49k was unused as it was not possible to arrange for it be donated. The total loss relating to SFVS therefore totalled £404k.

As £990k of costs were incurred through contractual arrangements with third parties in line with Government policy to prepare for a possible no-deal EU Exit on 31 October 2019 and

subsequently 31 January 2020. The contracted services were not utilised following the decision to stand down no-deal preparation in January 2020. This expenditure was necessary to ensure that an Express Freight Service (EFS) were in place and could be operationalised to support suppliers in bringing goods into the UK in the event of a no deal EU Exit. The costs related to the establishment of processes and securing infrastructure and freight capacity. Due consideration was given to the risk to the public purse should the capacity secured not be needed, at the time of contracting, and clauses allowed for some mitigation of nugatory costs as a result of standing down services. However, to secure the services required it was necessary to commit to a certain level of costs, and it was assessed that this financial risk was outweighed by the systemwide risks to patient care a potential shortage of medical supplies following a no-deal exit presented.

The above narrative disclosure relates 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 27: Analysis of Losses by Sector

	2019-20	2018-19	2019-20	2018-19
	Cases Number		Value £'000	
DHSC Core	182	67	87,686	263,822
Public Health England	124	77	1,878	208,098
NHS England Group	8,240	70,988	2,436	5,849
NHS Providers	53,615	49,218	83,893	68,292
NDPBs	3,346	2,010	4,606	8,973
Special Health Authorities	94	127	110	718
Other Group entities	1	-	385	-
Eliminations	-	(3)	-	(159,245)
Departmental Group	**65,602**	**122,484**	**180,994**	**396,507**

Table 28: Special Payments

		2019-20		2018-19	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	109	7,937	94	9,660
	£'000	23,934	42,952	29,349	49,243
Cases over £300,000	Cases	28	29	35	40
	£'000	22,107	23,014	27,201	29,649

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.

All 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

	2019-20	2018-19	2019-20	2018-19
	Cases		Value	
	Number		£'000	
DHSC Core	105	88	23,925	29,345
Public Health England	4	6	9	4
NHS England Group	32	1,121	221	748
NHS Providers	7,637	8,273	18,535	18,990
NDPBs	9	3	115	43
Special Health Authorities	149	169	118	113
Other Group entities	1	-	29	-
Departmental Group	**7,937**	**9,660**	**42,952**	**49,243**

Other Payments

There have been no other payments made by the Core Department for 2019-20 or in 2018-19.

Fees and Charges

Table 30: Fees and Charges

	2019-20		
	Departmental Group		
	Fees and Charges Income	Full Cost of Service	Surplus/(Deficit)
	£'000	£'000	£'000
Dental	848,292	2,958,262	(2,109,970)
Prescription	614,126	10,491,869	(9,877,743)
Other Fees and Charges for which the cost of providing the service is over £1million	375,149	314,484	60,665
Total	**1,837,567**	**13,764,615**	**(11,927,048)**

	2018-19		
	Departmental Group		
	Fees and Charges Income	Full Cost of Service	Surplus/(Deficit)
	£'000	£'000	£'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)**

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 2019-20, the NHS prescription charge for each medicine or appliance dispensed was £9.00. 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. The fees and charges information in this note is provided in accordance with the HM Treasury

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 2019-20, the charge for Band 1 treatments was £22.70, for Band 2 was £62.10 and for Band 3 was £269.30.

Included in the 'Other fees and charges' (for which the cost of providing the service is over £1.0 million) is £204.0 million (2018-19: £204.3 million) of fees and charges and £199.1 million (2018-19: £208.7 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

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 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 2019		Increase in year	Liabilities crystallised in year	Obligation expired in year	31 March 2020		Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	£'000	No.	£'000
Guarantees	156	1	-	-	-	156	1	-
Indemnities	1,400	1	1,500	-	(1,400)	1,500	1	-
Letters of comfort	-	-	-	-	-	-	-	-
Total	**1,556**	**2**	**1,500**	**-**	**(1,400)**	**1,656**	**2**	**-**

Unquantifiable

The Department 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 nine 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 nine, one is considered to be confidential, details of the remaining eight 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 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)

4. 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.

5. The Department holds an insurable risk for professional indemnity or malpractice on behalf of the Human Tissue Authority (HTA).

6. The Department has undertaken to meet the cost of compensation payments arising from injury claims in relation to the immunisation of voluntary donors with specialised immunoglobulin.

7. The Department has undertaken to meet the legal costs of medical, scientific and nursing staff engaged on clinical trials approved by NHS Blood and Transplant.

8. The Department has undertaken to cover any damages arising from NHS Blood and Transplant clinical trials activity.

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**.

22 January 2021
Sir Chris Wormald KCB
Permanent Secretary
Department of Health and Social Care

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

Qualified 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 2020 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) Order 2019. 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, except for the effects of the matter described in the basis for qualified opinion section:

- 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 2020 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.

Emphasis of Matter – Material uncertainty regarding property valuation

I draw attention to the disclosures made in note 6 to the financial statements which state that the valuation of property, plant and equipment is subject to material uncertainty arising from the impact of Covid-19 on markets. My opinion is not modified in respect of this matter.

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 2020 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 qualified opinion.

Basis for qualified opinion on the financial statements

The Department for Health and Social Care has not applied the requirements of IFRS 9 'Financial Instruments' to its intra-group loan balances with NHS Trusts and Foundation Trusts, recognised within the Department's Statement of Financial Position. This standard requires that an impairment for expected credit losses is recognised for loans held at amortised cost, considering all reasonable and supportable information, including that which is forward-looking.

The Department has not recognised such an impairment. However, for some trusts within the group, there was little or no prospect of repayment of these loans without the Department itself providing financing to do so. The Department's records indicate that, had this information been taken into the account, the carrying value of these loans at the reporting date would have been approximately £2.2 billion lower, with a corresponding increase in the Department's impairment charges recognised in operating expenditure and a reduction in Taxpayers' equity. I have not qualified my opinion on the Departmental Group financial statements as the loans are eliminated on consolidation. Further details can be found in my report on page 123.

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the Department of Health and Social Care's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Department of Health and Social Care have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Department of Health and Social Care's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

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.
- Conclude on the appropriateness of the Department of Health and Social Care'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 Department of Health and Social Care's, or where relevant, the group's, ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my 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 report. However, future events or conditions may cause the Department of Health and Social Care, or where relevant, the group, to cease to continue as a going concern.

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.

Gareth Davies
Comptroller and Auditor General

26 January 2021

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

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

Introduction and background

1.1 The Department of Health and Social Care ('the Department') supports ministers in leading the health and social care system in England. One of the Department's key responsibilities is to act as the guardian for the health and care framework: to ensure that the legislative, financial, administrative and policy frameworks for the health and social care system are fit for purpose and working together.

1.2 Under the *Government Resources and Accounts Act 2000*, I am responsible for auditing, certifying and reporting on the Department's financial statements. I am reporting on the Department's financial statements for the year ended 31 March 2020 to draw attention to four key matters for my audit. These are the qualification of my 'true and fair' opinion on the 'Core Department & Agencies' Statement of Financial Position ('SoFP'), the financial reporting and governance issues that have arisen at University Hospitals of Leicester NHS Trust ('UHL'), and the implications of the ministerial direction on senior clinicians' pensions, and special payments. I have not qualified my 'true and fair' or 'regularity' opinions in respect of the last three matters.

1.3 In my report I also reflect on the impact of the COVID-19 pandemic, which I anticipate will have a more significant impact on the Department's financial statements in 2020-21.

Qualification of the True and Fair Opinion on the Department's Core Statement of Financial Position

1.4 I have qualified my opinion on the 'Core Department & Agencies' Statement of Financial Position (SoFP). This SoFP records the financial position of the Core Department and its Agencies[1] and is therefore different to the consolidated position for the overall 'Departmental Group' which records the financial results for all the entities within the DHSC departmental boundary[2]. The 'Core Department & Agencies' SoFP is an important aid to transparency in that it shows the position of DHSC as an investor and debt holder for the commissioners and providers of healthcare as well as the other bodies in the DHSC Group.

1.5 My qualification relates to a misstatement in the carrying value of assets held in the 'Core Department & Agencies' SoFP at 31 March 2020 relating to loans to NHS providers[3]. Accounts preparers are required to consider at each reporting date whether there are indicators of impairment and, following appropriate consideration, whether such items should have an adjustment made (impairment) to their carrying value. An impairment could flow for example from a situation in which loans ceased to be collectable.

1 As set out in Note 21 to the Annual Report & Accounts on page 210 this includes the results of the Core Department and Public Health England.
2 The entities which fall within the Departmental boundary and thus form part of the Departmental Group accounts are set out in Note 21 to the Annual Report & Accounts on page 210.
3 Loans to NHS providers (which includes NHS Trusts and NHS Foundation Trusts) form part of 'Investments and other financial assets' within the current assets of the Core Department SoFP on page 133 of the Annual Report and Accounts.

1.6 I note that the Department has disclosed in note 11 to the financial statements that it has reconsidered the approach to valuation of Public Dividend Capital (PDC) invested in NHS providers, which has resulted in a prior period adjustment and impairment to the valuation of the PDC held by the Core Department of £9.4bn. I have considered the valuation of the PDC alongside the valuation of the loans given to NHS providers. These are investments by the Department in the same entities where the financial position of the NHS providers, as indicated by the net assets held, I consider to be the most relevant indicator of a Trust's ability to repay in the absence of additional support from the Department.

1.7 In my report in February 2020 on the NHS Financial Management and Sustainability[4] I said:

Financially distressed trusts are increasingly relying on short-term loans from the Department with little or no prospect of paying them back*. Some trusts continue to rely on borrowing from the Department just to meet their running costs. Extra financial support to trusts in difficulty has continued to increase year-on-year. Most of this support (£3.3 billion out of £3.6 billion issued in 2018-19) is interim revenue support, rather than 'normal course of business' loans. By 31 March 2019, outstanding debt issued by the Department to these trusts was £10.9 billion, up from £8.0 billion on 31 March 2018. Where trusts have been unable to repay loans in line with their initial agreements, they have been able to agree new repayment plans, but the profile of loans and interest repayments indicates that there is no realistic prospect of this debt being repaid.*

1.8 In my view, financial distress of individual Trusts, illustrated where Trusts have negative net assets and, in some cases, have agreed new repayment plans, is a clear indicator of increased credit risk which points towards the carrying value of these loans needing to be considered for impairment in the Core Department SoFP at 31 March 2020. I am further of the view that an impairment is necessary to avoid these loans being recorded at a value that is materially misstated. I have calculated the value of the misstatement to be £2.2 billion based upon a realistic and appropriate valuation approach which looks at the net asset position of each individual NHS Provider to which the Department has issued loan finance. Where the NHS Provider has more liabilities than assets the net figure is an appropriate measure of impairment because it reflects the reduced ability of any trust to repay this debt in addition to any impairment already taken to PDC.

1.9 The Department disagrees with my opinion as it considers that the subsequent repayment of the loans in September 2020 provides evidence that the loans were not impaired at the balance sheet date. I consider that the repayment of the loans in September 2020 does not provide evidence that the loans were not impaired as it was only possible as a result of the issue of new PDC by the Department, such that the Department have had to inject the cash themselves to facilitate repayment. Where the Trusts were in a negative net asset position prior to the new issue of the PDC, the PDC will be impaired at inception indicating that the circumstances giving rise to impairment had already occurred.

[4] NHS financial management and sustainability [HC 44 5 February 2020]

1.10 In these circumstances, where there is a disagreement of this type on a matter that is material to the financial statements of the Core Department, I qualify my opinion insofar as it relates to the carrying value of these loans. My opinion on the Departmental Group SoFP is unaffected because intra-group transactions and balances are extinguished as the accounts of individual components of the Group are consolidated.

1.11 I should add that, as set out in Note 1.22, the Department has amended its impairment policy in respect of Public Dividend Capital (PDC). PDC being the investment by the Core Department into NHS providers. PDC will now be impaired where the value of net assets of an NHS provider falls below the value of the PDC issued to it. This new approach has been applied to the PDC in issue forming part of the Core Department SoFP reporting date. A fresh issue of PDC by the Department in 2020-21 has been used by NHS providers to repay the loans issued to them by the Department. This PDC has been impaired upon issue where the value of net assets of NHS Provider was negative.

The financial reporting and governance issues at University Hospitals of Leicester NHS Trust

1.12 I have previously reported on the use of technical accounting adjustments and other measures that NHS bodies have taken to achieve a desired financial outturn. These were matters that my predecessor reported on in the Department's group accounts in 2015-16 and 2016-17.[5] I also have also commented on the use of performance-related funding streams and the risks it creates where payment is conditional on the delivery of control totals in other reports about the financial management and sustainability of the NHS in England.[6]

1.13 The risk that the management of local NHS bodies override controls to meet control totals when reporting their financial results is a significant risk for my audit of the Departmental group, the Consolidated Provider Accounts ('CPA') and the accounts of individual local NHS bodies. Audits of local NHS bodies are carried out by local auditors appointed by those bodies. I maintain oversight and overall direction of the CPA and Departmental group audit through regular liaison with local auditors of NHS bodies.

1.14 In 2020, the auditor of University Hospitals of Leicester NHS Trust (UHL) notified me of significant issues that are indicative of management override of control at that Trust. The draft financial statements that UHL submitted for audit included prior year adjustments of £46 million. UHL's auditor subsequently identified further significant technical accounting issues in the trust's accounting records for 2019-20. These include but are not limited to: non or inaccurate recognition of expenditure and payables; disagreement over the classification of a significant lease agreement; material errors in the valuation of the property estate; and inappropriate recognition of income.

5 Department of Health Annual Report and Accounts 2015-16, HC332 published 21 July 2016 and Department of Health Annual Report and Accounts 2016-17, HC11 published 18 July 2017.
6 'NHS financial management and sustainability', Report of the Comptroller & Auditor General, HC44 published 5 Feb 2020.

1.15 The auditor also identified an unusually high level of manual intervention in the accounting records, including over 270,000 manual journals, and has been unable to conclude as to whether the accounting records are appropriately stated. The auditor also noted that adjustments appear to have been made in the 2018-19 financial statements at the request of UHL's management to achieve a certain outcome rather than to represent accurately the economic reality of transactions into which UHL entered. The auditor's findings relate to accounting judgements and manual intervention associated with the previous senior leadership regime at UHL and continued failures in the management and control of accounting records. As at the date of this report, UHL's management are not prepared to sign the draft 2019-20 accounts as 'true and fair' and the auditor is of the view that the accounts are not true and fair.

1.16 I understand that UHL have commenced work on reviewing the underlying accounting records and preparing a new set of 2019-20 financial statements, with a view to completing the audit of these by the end of March 2021. In effect the local audit will commence again at a significant cost to UHL while it attempts to manage its day-to-day business, preparing accounts for 2020-21 as well as supporting an on-going audit of the 2019-20 accounts.

1.17 The position at UHL is, to my knowledge, unprecedented. An NHS trust has failed to comply with the Secretary of State's direction to prepare true and fair accounts and to maintain appropriate accounting records. Moreover, the restatement of the 2018-19 financial statements reflects both financial control failures and a series of actions taken by UHL in the preparation of those accounts that do not reflect the actual substance of the financial transactions entered into by the trust. In completing the audit, the local auditor will need to consider their duties under the Code of Audit Practice in relation not only to their 'true and fair' opinion and their value for money arrangements conclusion, but also to their additional reporting powers.

1.18 The failure of UHL to produce accounts and the reasons for that failure are sufficient to prompt me to report. I have considered the impact of the issues reported at UHL on my audit opinions for the CPA and the Departmental Group and, taking account of alternative procedures I have been able to perform, concluded that the issues are not material to the CPA or the Departmental Group. I have also considered the risk that the issues identified at UHL are indicative of widespread issues across the health system. Aside from UHL, all auditors of local health bodies have concluded their audits for 2019-20 and whilst some have identified issues indicative of management override linked to the incentives present in the system, these are of a different scale and none have impacted the audit opinions at the local level.

1.19 In its decisions about the approach taken to provider sustainability funding in 2019-20, NHS England and NHS Improvement took steps to begin to move away from a system of financial performance incentives. Significant changes were then made to the financial regime for the duration of the COVID-19 pandemic, including a further move away from local control totals and incentive funding, towards a system of block contracts and rebates for additional COVID-19 related expenditure. While this shift removes the incentive for one-off accounting treatments and judgements to meet published control totals, there is potential for different incentives, for example those concerning the classification of COVID-19 related expenditure, to take their place. Any incentives re-

introduced as part of successor arrangements for 2021-22 must be carefully balanced and cognisant of the risks to which I refer above. I stress that no pressures imposed by a financial control framework explain or justify the type of conduct identified at UHL.

Ministerial direction on senior clinicians' pensions

1.20 In the late Autumn of 2019, NHS England became increasingly concerned at problems NHS Trusts were reporting in securing enough senior doctor time to staff the Winter rotas. Analysis and reporting in the system identified the impact of tax arrangements for senior level pay as being a significant part of the problem. An approach to deal with these impacts and secure this senior doctor time was designed but was considered to fall outside the scope of what NHS England could do within the relevant rules. A Ministerial Direction was therefore sought to give NHS England (and the Department more generally) the approval of the Secretary of State to the planned action. This was given in November 2019 during the General Election. The Direction specified that the arrangements planned could only be for one year and were limited to a cohort of highly paid clinicians deemed essential for delivering the likely level of Winter activity in 2019-20.

1.21 A ministerial direction does not make regular what would otherwise be irregular, but it does move the accountability for such decisions from the Accounting Officer to the minister issuing the direction. I have concluded, for the reasons set out below, that I should not qualify my regularity opinion in relation to this matter but for the purposes of transparency I believe it appropriate to draw attention to the scheme and its operation in this report.

1.22 Before turning to the specifics of the NHS scheme I should briefly set out the underlying issue. The pensions annual allowance is a limit to the amount of contributions that a taxpayer can contribute to a defined contribution pension scheme and the total amount of benefits that a taxpayer can build up in a defined benefit pension each year while still receiving tax relief. The annual allowance applies across all pension schemes to which a given taxpayer belongs. Above the annual allowance taxpayers lost £1 of the annual allowance for every £2 of adjusted income that they earned for tax purposes between £150,000 and £210,000. This is known as the 'tapered annual allowance'.

1.23 If an individual taxpayer exceeds their annual allowance in a given tax year, they will not receive tax relief on any contributions they pay that exceed the limit and they will suffer an annual allowance tax charge. This charge is added to the rest of their taxable income for the tax year in question when determining their tax liability. Clinicians, in common with other highly paid individuals in other roles, reported that they suffered a financial penalty for taking on additional work once they had exceeded the relevant limits.

1.24 On 18 November 2019, the Chief Executive of NHS England wrote to the Secretary of State. In his letter, he drew attention to the *'sustained concern across the NHS about the operational impact of pensions tax penalties on the availability of clinical staff'* and indicated that action needed to be taken to '*prevent large numbers of senior clinicians reducing their sessional commitments, including in A&E departments, general practice and undertaking waiting list operations*'.[7]

1.25 The deferral of the budget and the dissolution of Parliament for the 2019 General Election meant that a change in the legislation that governs the pensions annual allowance was unlikely. The Chief Executive of NHS England therefore noted an '*urgent operational requirement to remediate further the situation, so as to try and remove barriers to needed clinical staffing over the winter period*'. The proposed solution was for NHS employers to compensate clinical staff for pension benefits they would lose as a result of using a 'Scheme Pays' arrangement to settle an annual allowance tax charge.

1.26 The solution applies only to annual allowance tax charges arising from an increase in the benefits accrued in the NHS Pension Scheme during the tax year ended 5 April 2020. For the tax year ended 5 April 2021, the Chancellor increased the thresholds for the tapered annual allowance and, as a result, it is anticipated that the risk to the supply of clinical staff over the 2021 winter period has been mitigated.

1.27 The Chief Executive of NHS England requested a ministerial direction because the proposed solution on the pensions annual allowance risked breaching the requirements of paragraph 5.6.1 of HM Treasury's *Managing Public Money*. This states that:

'Public sector organisations should not engage in, or connive at, tax evasion, tax avoidance or tax planning. If a public sector organisation were to obtain financial advantage by moderating the tax paid by a contractor, supplier or other counterparty, it would usually mean that the Exchequer as a whole would be worse off – thus conflicting with the accounting officer's duties. Thus artificial tax avoidance schemes should normally be rejected. It should be standard practice to consult HMRC about transactions involving non-standard approaches to tax before going ahead'.

1.28 On 22 November 2019, the Secretary of State gave the direction that had been requested.[8] In his direction he noted that, '*The proposals which you plan to introduce for 'Scheme Pays' for the 2019-20 tax year constitutes an example of tax planning. Depending on the detail of how you put the proposed approach into practice, the scheme could constitute tax avoidance […] the proposed measure is therefore incompatible with paragraph 5.6.1 of* Managing Public Money'. The direction was given not only to the Chief Executive of NHS England but also to the Permanent Secretary of the Department and the Chief Executive of NHS Improvement.

7 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/847924/pensions-letter-simon-stevens-to-matt-hancock.pdf
8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/847925/matt-hancock-pensions-directions-letter-nov-2019.pdf

1.29 As at 31 March 2020, the Department has recognised a liability of £258.0 million to compensate senior clinical staff for pension benefits that they would otherwise have lost by using the 'Scheme Pays' arrangement for the NHS Pension Scheme to settle their annual allowance charges that had arisen during the tax year ended 5 April 2020. This liability is disclosed separately in note 16 of the Department's financial statements and the circumstances surrounding the ministerial direction have been disclosed in the Governance Statement on page 59. The £258.0 million is the consolidated total for the Departmental Group; the component CPA and NHS England accounts recognise a share of this total.

1.30 As part of my audit of the Department's financial statements, I requested copies of the Department's assessment of whether these arrangements constituted tax planning, tax avoidance or tax evasion. I also requested copies of the Department's consultation with HMRC about these arrangements, given that it relates to a non-standard approach to tax. In November 2020, the Department provided its documentation of consultation with HM Treasury and HMRC. This consultation is dated November 2019. It indicates that HMRC considered that the scheme was '*an example of tax planning tending towards tax avoidance'* and that '*the arrangements are clearly designed to give a group of taxpayers an advantage that was not envisaged by Parliament'*. I note in a contribution to a subsequent set of public answers to Frequently Asked Questions about how the scheme would work HMRC commented, '*that under current tax law, if all tax and NICs is paid at the time it is due, it is perfectly legitimate for an NHS employer to make a payment equal to the amount of any reduction in NHS Pension Scheme benefits arising from any 2019/20 annual allowance tax charge where the Scheme Pays mechanism has been used*.'

1.31 In my opinion the transactions included in the Department's financial statements to recognise this liability are irregular. This is because the payments are contrary to paragraph 5.6.1 of *Managing Public Money* and constitute a form of tax planning which will leave the Exchequer as a whole worse off. The Secretary of State's direction alone does not regularise the scheme, because the latter was not approved by Parliament. Furthermore, the arrangements are novel and contentious and potentially precedent setting.

1.32 I have not modified my regularity opinion in this respect because the liability that the Department has recognised as at 31 March 2020 does not exceed the quantitative materiality that I have set for my audit of the financial statements. I have also considered whether this matter is material by nature and concluded that it is not material by nature. In reaching this conclusion I have had regard to the disclosures made in the relevant parts of the DHSC group financial statements and to the objective of the arrangement. The latter was to ensure the supply of clinical staff during Winter 2019-20 when the Government, given the dissolution of Parliament, was unable to change the underlying tax rules. I note that the Department were transparent about the scope and intent of the Direction at the time and took the action required by Managing Public Money to secure the necessary Ministerial approval.

1.33 Although I have not qualified my regularity opinion with respect to this matter, I consider it important to bring Parliament's attention to the arrangement.

Special payments

1.34 During 2019-20, 7,937 special payments were made across the Departmental Group with an aggregate value of £43m. Most of these special payments were made by NHS providers. Such transactions are subject to greater thresholds of approval than other payments and, in line with *Managing Public Money*, Departments are required to consult HM Treasury (HMT) about special payments unless there are specific agreed delegation arrangements in place. Throughout 2019-20 the Department was operating on the basis that, unless special payments were novel, contentious or repercussive, it had an uncapped delegated limit for such payments as it had done since that position was originally agreed with HMT in 1996.

1.35 However, during the year it came to light that the most recent delegated authority letter issued to the Department by HMT in 2016 failed to include any delegated approval limit. The Department have set out in its Governance Statement on page 70 its estimate of the value of unapproved special payments across the Departmental Group in 2019-20, which is approximately £18 million. The Department has notified HMT of this matter and HMT have raised concerns that the Department has not collated special payments made by their Arm's Length Bodies, including NHS providers. HMT intends to undertake a deep-dive audit of special payments in 2021 to ensure lessons are learned and has reset the Department's delegated limit to £95,000 for 2020-21.

1.36 Whilst payments without appropriate authority are irregular, I have not modified my regularity opinion in this respect because the payments that the Department has recognised do not exceed the quantitative materiality that I have set for my audit of the financial statements. I have also considered whether this matter is material by nature and concluded that it is not material by nature. In reaching this conclusion I have had regard to the disclosures made in the Governance Statement and to the fact that this appears to have been an administrative error which went unidentified by both the Department and HMT. There is nothing to suggest that the Department was not acting in good faith in accordance with delegation which it believed to be in place.

1.37 Although I have not qualified my regularity opinion with respect to this matter, I consider it important to bring this to Parliament's attention.

Impact of the COVID-19 pandemic

1.38 All of the issues that I have outlined in this report pre-date the COVID-19 pandemic. This is evidence of the pressure that the health and social care system was under before the pandemic. This pressure has become even more acute since the end of 2019-20 and into the 2020-21 financial year.

1.39 On 28 March 2020, both the Permanent Secretary of the Department and the Chief Executive of NHS England wrote a letter to the Secretary of State seeking confirmation to continue to approve and spend money on Covid-19 issues as needed.[9] In response on 29 March 2020, the Secretary of State issued a second ministerial direction to the Permanent Secretary of the Department and the Chief Executive of NHS England.[10] This permitted them to ensure that, *'the availability of funding is not a barrier or delay to the actions that we need to take […] even where this means spending in excess of formal Departmental Expenditure Limits'*.

1.40 In the event, this direction was not required for the 2019-20 financial year. As disclosed in the Statement of Parliamentary Supply on page 102, the Department has not exceeded its Departmental Expenditure Limits for 2019-20. My audit in 2019-20 has only considered Covid-19 related spend up to 31 March 2020. The full impact of the Covid-19 pandemic and the Department's response will be reflected more significantly in the 2020-21 financial statements. My audit of the 2020-21 Departmental Group accounts will consider the expenditure incurred by the Departmental Group on new areas that exhibit new and significant risk. These include but are not limited to: NHS Test and Trace; procurement and storing of personal protective equipment; and the COVID-19 vaccination roll-out.

1.41 I have already reported on aspects of the Department's response in my Value for Money work programme. My on-going work on the pandemic response will inform my audit of the 2020-21 financial statements.

Gareth Davies
Comptroller and Auditor General

26 January 2021

National Audit Office
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9 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876881/20200328-ao-direction.pdf
10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876882/29032020-sofs-to-perm-sec-ministerial-direction.pdf

Financial Statements

Consolidated Statement of Comprehensive Net Expenditure

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

For the period ended 31 March 2020

		2019-20			2018-19
		Core Dept & Agencies	Departmental Group	Restated Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Income from contracts	5	(1,614,566)	(9,883,068)	(864,599)	(9,331,532)
Other non-contract operating income	5	(684,731)	(1,285,084)	(710,748)	(1,537,123)
Income received by NHS charities	19	-	(153,216)	-	(147,366)
Total operating income		**(2,299,297)**	**(11,321,368)**	**(1,575,347)**	**(11,016,021)**
Staff costs	3	441,981	64,289,117	424,272	58,089,888
Purchase of goods and services	4	1,035,670	65,998,002	1,702,378	63,401,613
Depreciation and impairment charges	4	421,622	4,083,234	1,689,251	3,971,461
Provision expense	4	1,521,308	4,567,520	397,368	8,945,051
Other operating expenditure	4	6,204,810	9,077,770	5,883,014	8,753,764
Grant in Aid to NDPBs		127,548,939	-	116,755,131	-
Funding to Group bodies		629,036	-	506,892	-
Resources expended by NHS charities	19	-	78,644	-	162,813
Total operating expenditure		**137,803,366**	**148,094,287**	**127,358,306**	**143,324,590**
Net operating expenditure for the year ended 31 March 2020		**135,504,069**	**136,772,919**	**125,782,959**	**132,308,569**
Finance income		(372,633)	(89,819)	(300,850)	(68,807)
Finance expense		25,438	1,515,584	(55,152)	1,348,182
Net (gain)/loss on transfers by absorption		-	-	23,767	6,204
Total Net Expenditure for the year ended 31 March 2020		**135,156,874**	**138,198,684**	**125,450,724**	**133,594,148**
Other Comprehensive Net Expenditure					
Items that will not be reclassified to net operating costs:					
Net (gain)/loss on:					
- revaluation of property, plant and equipment		2,338	(1,563,970)	(12,777)	(842,579)
- revaluation of intangibles		(23,830)	(49,200)	(1,495)	(4,103)
- revaluation of investments		-	-	-	-
-revaluation of charitable assets		-	21,173	-	(10,470)
- impairments and reversals taken to revaluation reserve	20	1,014,048	11,500	852,157	
- equity instruments measured at fair value through OCI		(126,735)	(111,761)	71,000	(4,182)
Actuarial (gains)/losses on defined benefit pension schemes		-	(10,540)	-	6,588
Other pensions remeasurements		-	11,068	-	(5,006)
Other (gains) and losses		-	680	-	(27,518)
Total Comprehensive Expenditure for the year ended 31 March 2020		**135,008,667**	**137,510,182**	**125,518,952**	**133,559,035**

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. 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.
3. The 2018-19 Statement of Comprehensive Net Expenditure has been restated for Core Department and Agencies for depreciation and impairment charges by £1.45 billion to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and Note 11.

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 2020

		2019-20		2018-19		As at 1 April 2018	
				Restated		Restated	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets							
Property plant and equipment	6	1,019,606	54,640,754	1,091,925	53,040,791	1,237,947	52,371,283
Investment Property		92,820	232,854	93,582	249,057	16,870	224,491
Intangible assets	7	162,111	1,812,382	255,989	1,689,156	236,431	1,442,861
Charitable non-current assets	19.2	-	7,080	-	11,052	-	79,944
Financial assets - investments	11	23,585,729	815,533	30,752,228	678,673	30,126,548	750,366
Charitable investments	19.3	-	299,160	-	321,692	-	398,585
Other non-current assets	14	251,452	868,583	210,870	771,179	223,932	895,752
Total non-current assets		**25,111,718**	**58,676,346**	**32,404,594**	**56,761,600**	**31,841,728**	**56,163,282**
Current assets							
Assets classified as held for sale		-	53,146	-	35,696	2,899	75,184
Inventories	12	251,503	1,651,737	209,860	1,496,452	161,348	1,321,990
Trade and other receivables	14	316,068	2,797,324	399,910	3,183,395	158,736	1,879,730
Other current assets	14	304,264	1,887,509	79,820	1,447,244	286,760	2,012,382
Charitable other current assets	19.2	-	22,028	-	23,215	-	31,025
Investments and other financial assets	14	13,724,360	17,870	3,665,937	28,269	1,784,501	22,210
Cash and cash equivalents	13	1,460,785	9,111,920	1,933,440	8,682,028	1,709,068	7,562,137
Charitable cash	19.2	-	238,966	-	218,242	-	230,219
Total current assets		**16,056,980**	**15,780,500**	**6,288,967**	**15,114,541**	**4,103,312**	**13,134,877**
Total assets		**41,168,698**	**74,456,846**	**38,693,561**	**71,876,141**	**35,945,040**	**69,298,159**
Current liabilities							
Trade and other payables	15	(87,679)	(6,527,633)	(126,090)	(6,422,184)	(142,063)	(5,507,774)
Other liabilities	15	(3,316,237)	(15,018,838)	(3,529,142)	(14,050,394)	(3,381,420)	(13,173,813)
Charitable liabilities	19.2	-	(47,078)	-	(35,271)	-	(43,740)
Provisions	16	(494,657)	(3,848,461)	(507,091)	(3,586,672)	(408,335)	(3,670,948)
Total current liabilities		**(3,898,573)**	**(25,442,010)**	**(4,162,323)**	**(24,094,521)**	**(3,931,818)**	**(22,396,275)**
Non-current assets plus/less net current assets/liabilities		**37,270,125**	**49,014,836**	**34,531,238**	**47,781,620**	**32,013,222**	**46,901,884**
Non-current liabilities							
Other payables	15	(180,135)	(826,931)	(156,343)	(755,913)	(19,296)	(431,678)
Charitable liabilities	19.2	-	(212)	-	(68)	-	(6,858)
Provisions	16	(3,135,645)	(85,343,056)	(2,359,957)	(83,853,147)	(2,887,680)	(77,858,429)
Net pension asset/(liability)	16.1	-	(144,153)	-	(128,661)	-	(114,834)
Financial liabilities	15	-	(10,739,278)	-	(11,080,519)	-	(11,401,073)
Total non-current liabilities		**(3,315,780)**	**(97,053,630)**	**(2,516,300)**	**(95,818,308)**	**(2,906,976)**	**(89,812,872)**
Total assets less liabilities		**33,954,345**	**(48,038,794)**	**32,014,938**	**(48,036,688)**	**29,106,246**	**(42,910,988)**
Taxpayers' equity and other reserves							
General fund		32,192,105	(61,558,911)	30,296,520	(61,127,673)	27,305,385	(56,375,479)
Revaluation reserve		681,935	12,641,317	764,848	12,314,826	1,800,861	12,619,978
Other Reserves		1,080,305	358,856	953,570	237,297	-	155,338
Total Taxpayers' Equity		**33,954,345**	**(48,558,738)**	**32,014,938**	**(48,575,550)**	**29,106,246**	**(43,600,163)**
Charitable funds	19.2	-	519,944	-	538,862	-	689,175
Total Reserves		**33,954,345**	**(48,038,794)**	**32,014,938**	**(48,036,688)**	**29,106,246**	**(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 HM Treasury for long term (>10 years) general provisions. More information is given at Note 1 *Statement of Accounting Policies*.
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.
3. The Statement of Financial Position for 2018-19 and 2017-18 has been restated for the Core Department and Agencies to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and Note 11. Financial assets – investments have been restated by £7.9 billion in 2017-18 and, cumulatively, £9.4 billion in 2018-19.

Sir Chris Wormald KCB
Permanent Secretary 22 January 2021

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 2020

		2019-20		Reclassified 2018-19	
		Core Dept & Agencies	Departmental Group	Restated Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Net cashflow from operating activities					
Net expenditure for the year	SOCNE	(135,156,874)	(138,198,684)	(125,450,724)	(133,594,148)
Adjustments for non-cash transactions	4.2	1,964,229	9,103,344	2,236,234	12,824,995
Adjustments for net finance costs		(371,607)	890,841	(299,994)	912,502
Other non cash movements in Statement of Financial Position items		6	(47,180)	-	(53,476)
Less movements arising from absorption transfers		-	-	23,767	6,204
Non-cash movements arising from application of accounting standards		-	-	-	(14,142)
Adjustments for charities		-	2,112	-	140,210
(Increase)/decrease in trade and other receivables[3]	14	(10,239,607)	(141,199)	(1,902,608)	(620,013)
(Increase)/decrease in inventories	12	(41,643)	(155,285)	(48,512)	(174,462)
Increase/(decrease) in trade and other payables[4]	15	(227,524)	803,670	268,796	1,794,672
Adjustment for working capital amount arising from absorption transfers		-	-	1,717	-
Adjustment for working capital balances in the SoFP not flowing through the SoCNE		10,725,531	653,570	1,728,019	37,980
Use of provisions		(318,745)	(2,831,040)	(241,643)	(2,814,434)
Transfer of provisions to payables		(463,721)	(487,893)	(528,684)	(556,768)
Cash payments in respect of pensions		-	(14,625)	-	(14,440)
Other operating cashflows		(72,714)	(65,774)	6,259	(24,133)
Net cash outflow from operating activities		**(134,202,669)**	**(130,488,143)**	**(124,207,373)**	**(122,149,453)**
Cash flows from investing activities					
Purchase of property, plant and equipment & investment properties		(193,873)	(4,529,563)	(220,609)	(4,057,058)
Purchase of intangible assets		(111,113)	(614,724)	(106,519)	(591,751)
Proceeds of disposal of property, plant and equipment		145,499	231,084	11,905	337,006
Proceeds of disposal of intangibles		12	1,093	106	2,795
Proceeds of disposal of assets held for sale		16,314	117,337	16,443	124,021
Purchase of investments		(4,231,723)	(43,113)	(4,661,875)	(24,160)
Proceeds of disposal of investments		797,371	34,517	640,214	128,023
Interest Received from group bodies		349,213	-	290,746	-
Interest Received from external bodies		261	58,264	387	48,881
Other investing cashflows		272	23,325	(69,968)	24,714
Net cash outflow from investing activities		**(3,227,767)**	**(4,721,780)**	**(4,099,170)**	**(4,007,529)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year	SOCTE	114,000,000	114,000,000	106,600,000	106,600,000
Financing from the National Insurance Fund	SOCTE	22,961,639	22,961,639	21,926,343	21,926,343
Net Movements of Capital element of Loans		-	27,578	20,220	121,037
Capital element of payments in respect of finance leases and on-balance sheet PFI contracts		-	(436,967)	-	(433,034)
Interest paid to external bodies		-	(896,121)	-	(931,137)
Other financing cashflows		-	3,380	1,705	(14,032)
Net financing		**136,961,639**	**135,659,509**	**128,548,268**	**127,269,177**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**(468,797)**	**449,586**	**241,725**	**1,112,195**
Payment of amounts due to the Consolidated Fund		(3,858)	(3,858)	(17,353)	(17,353)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**(472,655)**	**445,728**	**224,372**	**1,094,842**
Cash and cash equivalents at the beginning of the period		1,933,440	8,875,254	1,709,068	7,780,412
Cash and cash equivalents at the end of the period		**1,460,785**	**9,320,982**	**1,933,440**	**8,875,254**

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.
2. The 2018-19 Consolidated Statement of Cash Flows has been reclassified to ensure consistency with the 2019-20 Statement of Cash Flows which includes interest paid and received as separate lines in the cash flow. There is no impact on the Statement of Financial Position of this reclassification.
3. These amounts reflect the total movements in trade receivables and other current assets in Note 14.
4. These amounts reflect the total movements in trade payables and other liabilities in Note 15.
5. The Statement of Cash Flows for 2018-19 has been restated for the Core Department and Agencies to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and Note 11. This has impacted the net expenditure for the year and adjustments for non-cash transactions by an equal and opposite amount of £1.45 billion.

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 2020

		Core Dept & Agencies				Departmental Group					
					Restated						
	Note	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
Restated balance at 31 March 2019		30,296,520	764,848	953,570	32,014,938	(61,127,673)	12,314,826	237,297	(48,575,550)	538,862	(48,036,688)
Prior period adjustments in local accounts		-	-	-	-	(1,352)	855	619	122	1,381	1,503
Net parliamentary funding - drawn down		114,000,000			114,000,000	114,000,000			114,000,000		114,000,000
Net parliamentary funding - deemed		2,209,086			2,209,086	2,209,086			2,209,086		2,209,086
National Insurance contributions		22,961,639			22,961,639	22,961,639			22,961,639		22,961,639
Supply (payable)/receivable adjustment	15	(1,045,346)			(1,045,346)	(1,045,346)			(1,045,346)		(1,045,346)
CFERs and other amounts payable to the Consolidated Fund[6]	15	(571,133)			(571,133)	(571,133)			(571,133)		(571,133)
PDC investment adjustment		(606,125)			(606,125)	-			-		-
Comprehensive Net Expenditure for the Year		(135,156,874)			(135,156,874)	(138,200,093)			(138,200,093)	1,409	(138,198,684)
Non-cash adjustments:											
non-cash charges - auditor's remuneration	4.1	912			912	1,018			1,018		1,018
Movements in Reserves											
Recognised in Statement of Comprehensive Expenditure											
Net gain/(loss) on revaluation of non-current assets			21,492	-	21,492		1,613,170	-	1,613,170	-	1,613,170
Net gain/(loss) on revaluation of charitable assets					-				-	(21,173)	(21,173)
Fair value gains/(losses) on equity instruments designated at FV through OCI				126,735	126,735			111,761	111,761		111,761
Impairments and reversals			(20)		(20)		(1,014,048)		(1,014,048)	-	(1,014,048)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme		-		-	-	8,674		1,866	10,540		10,540
Other pensions remeasurements		-		-	-	(17,964)		6,896	(11,068)		(11,068)
Other gains and losses		-		-	-	(968)		288	(680)		(680)
Transfers between reserves		101,530	(101,530)	-	-	243,040	(239,752)	(3,288)	-	-	-
Other movements		(965)	6	-	(959)	(17,258)	(30,873)	(25)	(48,156)	(535)	(48,691)
Other transfers		2,861	(2,861)	-	-	(581)	(2,861)	3,442	-	-	-
Balance at 31 March 2020		**32,192,105**	**681,935**	**1,080,305**	**33,954,345**	**(61,558,911)**	**12,641,317**	**358,856**	**(48,558,738)**	**519,944**	**(48,038,794)**

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, £194.1 million and unrestricted, £325.8 million funds.
6. CFERs recognised in the year relate to a proportion of the cash received by DHSC during the year, deemed as surrenderable to the Consolidated Fund by HM Treasury, for which IFRS 15 permits recognition.
7. The opening balance of the General Fund as at 31 March 2019 has been restated for the Core Department and Agencies by £9.4 billion to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and Note 11.

For the period ended 31 March 2019

	Note	Core Department & Agencies				Departmental Group					
					Restated						
		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 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)
Effect of prior period adjustment		(7,942,810)	-	-	(7,942,810)	-	-	-	-	-	-
Restated balance at 1 April 2018		27,305,385	1,800,861	-	29,106,246	(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		-	(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)/receivable adjustment	15	(2,209,086)			(2,209,086)	(2,209,086)			(2,209,086)		(2,209,086)
Excess Vote - Prior Year		-			-	-			-		-
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		(125,450,724)			(125,450,724)	(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											
Fair value losses on equity investments designated at FV through OCI		-		(71,000)	(71,000)	-		4,182	4,182		4,182
Net gain/(loss) on revaluation of non-current assets			14,272	-	14,272		846,682	-	846,682	-	846,682
Net gain/(loss) on revaluation of charitable assets					-				-	10,470	10,470
Impairments and reversals			(11,500)		(11,500)		(852,157)		(852,157)	-	(852,157)
Net Actuarial Gain/(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	-	-	-
Restated balance at 31 March 2019		**30,296,520**	**764,848**	**953,570**	**32,014,938**	**(61,127,673)**	**12,314,826**	**237,297**	**(48,575,550)**	**538,862**	**(48,036,688)**

1. The opening balances as at 31 March 2018 for Core Department and Agencies have been restated to reflect the change in impairment of Public Dividend Capital as detailed in Note 1.22 and Note 11. Comprehensive Net Expenditure has increased by £1.45 billion in 2018-19 as a result of this restatement.

Notes to the Department's Annual Report and Accounts

1. Statement of accounting policies

The financial statements have been prepared in accordance with the 2019-20 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 and have been applied consistently in dealing with items considered material to the accounts.[139]

The 2019-20 Annual Report and Accounts includes three departures from the FReM, all of which have been agreed with HM Treasury:

- Public Dividend Capital issued by the Core 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.
- Receipts of National Insurance Contributions from the National Insurance Fund are recognised on a cash basis; and
- Transfers of former Primary Care Trust assets from NHS Property Services to NHS providers under the Asset Transfer Policy announced in May 2019, occured via a modified absorption approach, in which the gain/loss on transfer is recognised directly in reserves.

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.

[139] In Line with the guidance offered in IFRS Practice Statement 2: Making Materiality Judgements published September 2017.

1.2 Accounting convention

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

1.3 Basis of consolidation

The accounts comprise of a consolidation for the core Department of Health and Social Care, 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.[140]

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

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

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

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 and Grant-in-Aid

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.

Grant-in-Aid

The provision of Grant-in-Aid by the Department to its Non-Departmental Public Bodies (NDPBs), matches the recipient's cash needs and is accounted for on a cash basis in the period in which it is paid. These payments finance NDPBs operating expenditure. These transactions are eliminated at the DHSC Group level as indicated in **Note 2.2**.

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

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 significant source of revenue from services provided by the Department relates to the delivery of healthcare. Further detail is provided in **Note 5**. 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 amounts of revenue generated through the provision of healthcare activities external to the DHSC Group is detailed in the 'Revenue from Patient Care activities' section of **Note 5**. The Department has judged the delivery of healthcare to predominantly involve the satisfaction of performance obligations over a period of time under IFRS 15 as healthcare is received and consumed simultaneously by the patient as the services are being provided. 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.

IFRS 15 is applicable to revenue in respect of fees and charges (such as dental and prescription charges) in line with the adaptation in IFRS 15 which states that the definition of a contract includes revenue received under legislation and regulations. Revenue for these charges is recognised when the performance event occurs e.g. the issue of a prescription or payment for dental treatment.

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.[141]

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

[141] Further detail regarding the Estimate process can be found in the 2019-20 Main Supply Estimate. Page 9, paragraph 22, provides further detail the surrendering of income outside the ambit.

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
- 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. Further detail is provided in **Note 6**. 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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. In line with the FReM, specialised assets are therefore valued as their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. The MEA method assumes that the existing asset would be replaced with a modern asset of equivalent

capacity and function. This asset need not be restricted to the current location and thus, where it would meet the contractual location requirements of the service being provided, an alternative site may instead be used as the basis of valuation.

Valuation guidance issued by the Royal Institution of Chartered Surveyors (RICS) states that valuations are performed net of VAT where the VAT is recoverable by the entity. This commonly applies to schemes procured under a Private Finance Initiative (PFI), where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

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.

Where there is a material valuation uncertainty this is disclosed in **Note 1.29**.

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.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Consolidated Statement of Comprehensive Net Expenditure in the period in which it is incurred.

Derecognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met.

The sale must be highly probable and the asset available for immediate sale in its present condition. Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount.

Assets are derecognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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 and investment properties are not depreciated/amortised. Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction or development and residual interests in off-Statement of Financial Position Private Finance Initiative (PFI) contract assets are not depreciated until the asset is brought into use or reverts to the Department, respectively.

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. The ranges of estimated useful lives have been provided in **Note 6** for property, plant and equipment, and in **Note 7** for intangible non-current assets. 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 the 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 commencement 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. Further information about the method of calculating the cost of inventories can be obtained from the financial statements of underlying group bodies.

Strategic goods held for use in national emergencies (stockpiled goods) are held as non-current assets within property, plant and equipment at minimum capability levels by replenishment to offset write-offs. The Department holds a number of different categories of stockpiled goods, however the majority relate to pharmaceuticals and related consumables. Where there is no active market for partially expired pharmaceuticals and related consumables, or where cost is not materially different to market value, they are held at historic cost as a proxy for fair value and are not depreciated over their useful life. The remaining categories of stockpiled goods are held at current value in existing use.

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 negative 0.50% (2018-19: positive 0.29%) in real terms. 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 0.51% (2018-19 positive 0.76%) 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 0.55% (2018-19 positive 1.14%) 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% (2018-19 positive 1.99%) 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% (2018-19 positive 1.99%) 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 1.9% (2018-19 2.0%) 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% (2018-19 2.0%) 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 2.00% (2018-19 2.1%) 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, while the Clinical Negligence Scheme for Trusts, Liability to Third Parties Scheme and Property Expenses Scheme are funded from Trust contributions.

In 2019-20 NHSR was commissioned to deliver a future liability scheme established on 1 April 2019 called Clinical Negligence Scheme for General Practice (CNSGP). Additionally NHSR provides management and oversight of arrangements resulting from a transfer of liabilities from Medical Defence Organisations. The transfer of assets and liabilities from the Medical Defence Organisations to the DHSC Group have been accounted for under IFRS 3 Business Combinations, requiring the subsequent measurement of assets and liabilities in accordance with other applicable IFRS.

The accounts for the schemes are prepared by NHSR in accordance with IAS 37. Further detail as to the management of the schemes can be found in NHSR's 2019-20 Annual Report and Accounts[142]. 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 1.19** above (i.e. short-term positive 0.51%, medium term positive 0.55% , long-term positive 1.99% and very long-term positive 1.99%) 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

[142] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901085/nhs-resolution-2019-20-annual-report-and-accounts.pdf

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.

Clinical Negligence Scheme for General Practice (CNSGP)

The CNSGP is a newly established future liability scheme for general practice in 2019-20. The scheme covers claims arising in general practice in relation to incidents that occur on or after 1 April 2019. The accounting for the scheme will follow the accounting treatment and valuation practices employed for NHSR's existing protfolio of indemnity schemes.

During 2019-20 NHSR provided interim management and oversight of arrangements resulting from the transfer of 'in scope' liabilities from specific Medical Defence Organisations to the DHSC Group, as the basis of an existing liability arrangement for GPs, for claims relating to incidents prior to 1 April 2019. These liabilities are accounted for by NHSR under IAS 37. **Note 20** provides further detail regarding the evolution of the claims handling responsibility beyond 2019-20, though this has no impact on the accounting for the liabilities.

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 2020 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

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. Following the transfer of debt to PDC in September 2020, the NAO reviewed its position on the value of PDC which led to the Department revising its approach to the recognition of impairment against PDC. PDC is now impaired, on an individual NHS provider basis, where the net assets of those NHS providers is below the level of PDC issued to that Trust or Foundation Trust, irrespective of whether subsequent PDC write-offs are likely to occur. Where such adjustment is made the impairment is expensed in the Core Department SoCNE. **Note 11** provides detail of the change in application of the policy.

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. 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).

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 Department's 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.

Assets transferred under the Asset Transfer Policy[143] as approved by the SoS have applied a modified form of absorption accounting, with corresponding gains or losses debiting or crediting as appropriate the General Fund rather than the Consolidated Statement of Comprehensive Net

[143] Further detail can be found in the NHS property: guidance for NHS trusts and foundation trusts on requesting transfers of estate in the ownership of NHS property companies.

Expenditure. This treatment represents an HM Treasury agreed FReM departure, with all other transfers being accounted for in line with the FReM.

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 2019-20.

IFRS 16 – Leases - The FReM has deferred the Department's adoption of IFRS 16 until 2022-23. The Department continues to liaise closely with HM Treasury to discuss and further refine the impacts of implementing new accounting standards.

- 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 implemented 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 does not meet this criteria and has not adopted IFRS 16 for the consolidated Annual Report and Accounts in 2019-20. The necessary adjustments have been made, in respect of these limited companies, to disapply IFRS 16 for 2019-20 in the consolidated financial statements.
- 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.
- 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 reassess 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 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 interpreted by the FReM.
- The new Standard will be applied retrospectively, with the cumulative effect of adopting IFRS 16 being recognised at the date of initial application as an adjustment to the opening balance of the general fund. Prior periods will not be restated. The DHSC Group will be accounting for short-term leases and leases of low-value assets using the practical expedients offered in the Standard. Instead of recognising a right-of-use asset and lease liability, the payments in relation to these are recognised as an expense in income and expenditure on a straight-line basis over the lease term.

IFRS 17 – Insurance Contracts which replaces IFRS 4 Insurance Contracts. The Standard is expected to be effective for accounting periods beginning on or after 1 January 2023, following the International Accounting Standards Board decision to defer the effective date. The standard is still subject to HM Treasury interpretation and adaptation and the Department continues to liaise closely with HM Treasury to discuss and further refine the impacts of implementing the new Standard. It is therefore too early for the Department to provide an estimate of the impact of adopting IFRS 17.

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 estimation uncertainty or significant judgement made by management are:

- 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.

- Property valuations are based on a number of key assumptions including an estimate of future rental income, anticipated future costs, and a discount rate. The valuers also compare their valuations to market data for other similar assets.

  The outbreak of COVID-19 has significantly affected the UK economy and, while the valuations applied to property, plant and equipment can still be relied upon and are the most appropriate for the Annual Report and Accounts, less certainty can be attached to the valuations than would otherwise be the case. Given the unknown future impact of COVID19, the Department will keep the valuation of its property assets under frequent review.

  The Royal Institute of Chartered Surveyors (RICS), the body setting standards for property valuations, issued guidance to valuers in March 2020 highlighting that the uncertain impact of COVID-19 on markets might cause a valuer to conclude that there is a material uncertainty which the valuer would then declare in their report. Valuers have continued to apply their professional judgement but this declares the additional uncertainty attached to current valuations.

- Useful lives of PPE - as shown in **Note 6**, property plant and equipment (PPE) which is material to these consolidated accounts and where we disclose, for each category of PPE, the lowest minimum and the highest maximum in the ranges of useful lives. They are reviewed regularly to ensure that the assets' useful lives are defined accurately and that the depreciation charges are calculated correctly.

- IAS 36 Impairments - Management makes judgement on whether there are any indications of impairments to the carrying amounts of the Department's assets.

- IFRS 9 impairments – The Department considers the level of credit risk in NHS providers to be low and, as such, has not impaired loans between the Core Department and NHS providers.

- PDC impairment – The Department estimates the value of PDC impairment with reference to the net assets of NHS providers as a proxy for carrying value of the PDC investment in the DHSC Core account.

- 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**.

- IFRS 15 Revenue from Contract with Customers - The Department makes judgement on the timing of income recognised from the delivery of healthcare over time (see **Note 1.8**).

- Intra-group transactions and balances between group bodies are eliminated upon consolidation. Where differences are identified in the amounts recorded, adjustments are made to these amounts to ensure all intragroup balances eliminate. Any difference between these amounts and the amounts recognised as expenditure and payables are not further adjusted as these net amounts are not material. We are satisfied that the gross mismatches which net together to this immaterial position do not constitute a material error.

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

		2019-20										
		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)		137,715,416	4,091,236	3,653,288	93,934,432	125,391,084	5,087,857	3,859,385	151,807	(224,274,634)	149,609,871
Income (2.3)		(2,426,375)	(243,875)	(2,202,613)	(92,114,440)	(2,143,767)	(425,705)	(3,666,598)	(153,216)	91,965,402	(11,411,187)
Total net expenditure (per CSCNE)		**135,289,041**	**3,847,361**	**1,450,675**	**1,819,992**	**123,247,317**	**4,662,152**	**192,787**	**(1,409)**	**(132,309,232)**	**138,198,684**
Budgeting adjustments per SoPS2											
Capital Grants		(742,181)	(5,124)	-	-	(62,198)	-	-	-	-	(809,503)
Research and Development		(1,230,741)	-	-	-	-	-	-	-	-	(1,230,741)
Prior period adjustments		-	-	-	-	-	-	-	-	-	-
Other		558,294	-	182,600	265,064	-	-	(165,976)	(1,400)	34,385	872,967
Total adjustments		**(1,414,628)**	**(5,124)**	**182,600**	**265,064**	**(62,198)**	**-**	**(165,976)**	**(1,400)**	**34,385**	**(1,167,277)**
Budget outturn per SoPS1, of which:		**133,874,413**	**3,842,237**	**1,633,275**	**2,085,056**	**123,185,119**	**4,662,152**	**26,811**	**(2,809)**	**(132,274,847)**	**137,031,407**
	RDEL	133,112,423	3,844,269	958,072	1,028,114	122,890,366	4,658,550	(27,259)	(2,809)	(132,278,328)	134,183,398
	RAME	761,990	(2,032)	675,203	1,056,942	294,753	3,602	54,070	-	3,481	2,848,009

		2018-19									
		Restated 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	Restated Eliminations And Adjustments £000	Departmental Group £000
Gross expenditure		126,973,391	4,252,052	11,396,110	86,751,702	114,963,893	5,405,291	1,470,499	308,632	(206,848,798)	144,672,772
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)
Total net expenditure (per CSCNE)		**125,339,827**	**4,011,615**	**7,099,714**	**1,621,045**	**112,865,910**	**4,999,164**	**89,940**	**161,266**	**(122,600,537)**	**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)
Prior period adjustments		-	-	-	-	-	-	-	-	-	-
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:		**123,612,867**	**4,011,058**	**7,077,368**	**2,065,047**	**112,817,410**	**4,999,164**	**106,658**	**3,601**	**(122,400,947)**	**132,292,226**
	RDEL	124,049,973	4,013,239	672,344	918,373	112,837,143	4,992,832	153,856	3,601	(122,363,100)	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

1. The 2018-19 DHSC Core and Eliminations and Adjustments values have been restated by £1.45 billion to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and Note 11. This has no impact on the overall Departmental Group balances.

2.2 Departmental Group Detail – Expenditure

	2019-20									
	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	119,849	322,132	268,279	60,584,273	2,126,458	592,843	289,405	-	(14,122)	64,289,117
Purchase of healthcare from non-NHS bodies	-	-	-	1,486,478	14,412,050	-	-	-	-	15,898,528
Provider Sustainability Fund and Financial Recovery Fund Expenditure	-	-	-	-	2,595,848	-	-	-	(2,595,848)	-
Purchase of social care	-	-	-	196,159	705,362	-	-	-	-	901,521
Expenditure on Drugs Action Teams	-	-	-	-	240	-	-	-	-	240
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	3,089,173	-	-	-	(130,911)	2,958,262
Consultancy Services	15,203	-	2,563	199,359	45,790	1,712	25,579	-	-	290,206
Establishment	131,825	16,954	22,637	978,734	408,760	55,597	10,936	-	(105,510)	1,519,933
Transport (Business Travel)	-	8,992	4,943	221,295	66,646	13,410	4,670	-	(12,854)	307,102
Premises	4,398	28,836	18,631	2,959,256	79,995	31,985	282,843	-	(196,175)	3,209,769
PFI/LIFT and other service concession arrangement charges	-	-	-	1,006,979	-	-	86,387	-	-	1,093,366
Business Rates Paid to Local Authorities	3,962	6,659	-	464,704	1,022	4,550	86,864	-	5,419	573,180
NHS Informatics Major Contracts Costs	81,707	-	-	-	-	112,093	-	-	(3,383)	190,417
Clinical negligence Costs	-	-	-	1,952,131	240	114	-	-	(1,951,895)	590
Education, Training and Conferences	5,122	2,408	34,232	287,452	95,360	9,242	4,683	-	(20,154)	418,345
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,040,435	-	-	(2,869,572)	1,170,863
Prescribing Costs	-	-	-	-	8,540,631	-	-	-	(7,497)	8,533,134
G/PMS, APMS and PCTMS	-	-	-	-	9,153,611	-	-	-	(45,596)	9,108,015
Pharmaceutical Services	-	-	-	-	1,961,271	-	-	-	(2,536)	1,958,735
General Ophthalmic Services	-	-	-	-	547,797	-	-	-	(296)	547,501
Supplies and Services - Clinical	-	-	-	14,311,312	406,322	166	5,175	-	(1,915,955)	12,807,020
Supplies and Services - General	-	687,859	103,378	1,451,363	934,232	103,281	2,318,500	-	(485,243)	5,113,370
Grants to Other Bodies	189,401	4,600	-	-	30,722	-	-	-	-	224,723
Grants to Local Authorities	62,430	2,931,555	-	-	-	-	-	-	-	2,993,985
Capital Grants	742,181	5,124	-	-	62,198	-	-	-	-	809,503
Movement in expected credit loss allowance (non credit impaired)	1,799	(662)	17	100,574	913	938	112,356	-	(22,107)	193,828
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	610,758	-	-	-	-	(610,758)	-
Rentals under operating leases	20,294	4,057	8,725	751,875	311,535	15,045	135,693	-	(547,075)	700,149
Interest charges	1,026	-	-	1,168,738	38	-	164,003	-	(353,145)	980,660
Research and development	1,182,084	435	71	231,005	15,106	-	5,014	-	(775,750)	657,965
Depreciation on property, plant and equipment	17,924	33,366	7,314	2,161,910	145,988	15,271	230,365	-	470	2,612,608
Amortisation on intangible assets	179,743	3,946	19,982	238,209	3,337	49,004	2,087	-	-	496,308
Impairments and reversals	155,470	31,173	1,249	927,900	-	1,526	10,122	-	(153,122)	974,318
Provisions provided for in year	1,491,820	426	11,933,982	129,934	330,677	654	(3,704)	-	428	13,884,217
Non-cash expenditure from movement in pension liability	-	-	-	12,538	186	7,752	4,391	-	-	24,867
Grant in Aid	127,548,939	-	-	-	-	-	-	-	(127,548,939)	-
Funding to Group Bodies	4,608,564	-	-	-	-	-	-	-	(4,608,564)	-
Funding for additional pensions uplift	-	-	-	-	2,341,827	-	-	-	(2,341,827)	-
Provisions - Change in discount rate	29,062	-	(9,381,770)	25,200	(279)	32	(13,809)	-	-	(9,341,564)
Other	1,025,578	(264)	97,424	1,121,561	37,525	23,515	74,614	-	(33,756)	2,346,197
Goods and Services from other NHS Bodies	-	-	137	82,953	76,696,103	-	6,328	-	(76,761,530)	23,991
Additional support for delivery of healthcare services	10,679	-	-	-	55,079	-	-	-	(55,079)	10,679
DHSC support for mergers	26,940	-	-	-	-	-	-	-	(26,940)	-
Resources expended by NHS charities	-	-	-	-	-	-	-	151,807	(73,163)	78,644
Non material expenditure categories	59,416	3,640	511,494	271,782	189,321	8,692	16,883	-	(11,649)	1,049,579
Total Gross Expenditure	**137,715,416**	**4,091,236**	**3,653,288**	**93,934,432**	**125,391,084**	**5,087,857**	**3,859,385**	**151,807**	**(224,274,634)**	**149,609,871**

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) and Financial Recovery Fund (FRF) for providers in deficit are both 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. Additionally, marginal rate emergency tariff (MRET) funding adjustments were paid to NHS trusts that agreed a control total.
3. During 2019-20, transactions relating to the Supply Chain function transferred to Supply Chain Coordination Limited from NHS Business Services Authority. This has resulted in the expenditure relating to this function being included in the Other Group Bodies column above for 2019-20 (included in Special Health Authorities in 2018-19).

	2018-19									
	Restated 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	Restated 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 and Financial Recovery 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 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	1,459,790	-	(2,045)	1,052,612	541	871	17,782	-	(1,450,703)	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)	-
Funding for additional pensions uplift	-	-	-	-	-	-	-	-	-	-
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
DH 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 Expenditure	**126,973,391**	**4,252,052**	**11,396,110**	**86,751,702**	**114,963,893**	**5,405,291**	**1,470,499**	**308,632**	**(206,848,798)**	**144,672,772**

1. The 2018-19 DHSC Core and Eliminations and Adjustments values for impairments and reversals have been restated by £1.45 billion to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and Note 11. This has no impact on the overall Departmental Group balances.

2.3 Departmental Group Detail - Income

	2019-20									
	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	-	-	-	(2,030,054)	-	-	(667)	-	-	(2,030,721)
Income from Private patients	-	-	-	(671,423)	-	-	-	-	-	(671,423)
Income from injury costs recovery	-	-	-	(210,132)	-	-	-	-	-	(210,132)
Income from DHSC/NHS bodies	-	-	-	(76,190,567)	-	-	(55,952)	-	76,120,148	(126,371)
Other non-NHS patient care services	-	-	-	(597,655)	-	-	(1)	-	-	(597,656)
Income for additional pension uplift	-	-	-	(2,341,827)	-	-	(1,646)	-	2,343,473	-
Non patient care services to other bodies	(1,430)	-	(101,239)	(761,089)	(291,944)	(45,113)	(2,592,213)	-	2,935,313	(857,715)
Education, training and research	-	(1,842)	(706)	(3,840,456)	(13,753)	(138,016)	(1,393)	-	3,527,963	(468,203)
Provider Sustainability Fund and Financial Recovery Fund Income	-	-	-	(2,595,848)	-	-	-	-	2,595,848	-
Support from DHSC for mergers	-	-	-	(26,940)	-	-	-	-	26,940	-
Prescription Pricing Regulation Scheme	(722,809)	-	-	-	-	-	-	-	-	(722,809)
Fees and Charges	-	(233,370)	(2,096,802)	(221,367)	(1,462,418)	(226,651)	(121,537)	-	2,426,295	(1,935,850)
Other Contract Income	(588,009)	-	(1,540)	(1,730,779)	(272,801)	(7,155)	(160)	-	725,355	(1,875,089)
Non-material contract income	(70,144)	-	(2,125)	(311,440)	(9,373)	(3,824)	(4,315)	-	14,122	(387,099)
Income from contracts	(1,382,392)	(235,212)	(2,202,412)	(91,529,577)	(2,050,289)	(420,759)	(2,777,884)	-	90,715,457	(9,883,068)
Non-Contract Income										
Rental revenue from operating leases	(10,447)	(7,771)	-	(96,671)	(176)	(606)	(755,611)	-	480,538	(390,744)
PDC Dividend Received	(610,758)	-	-	-	-	-	-	-	610,758	-
Charitable and other contributions to expenditure	-	-	-	(95,069)	(1,711)	-	-	-	22,537	(74,243)
Apprenticeship training grant (non-cash)	(104)	(620)	-	(59,887)	(544)	(379)	-	-	-	(61,534)
Other non-contract income	(18,399)	-	(201)	(54,453)	(91,047)	(2,168)	(97,036)	-	(268,384)	(531,688)
Non-material non-contract income	(31,914)	-	-	(221,126)	-	(1,779)	(23,407)	-	51,351	(226,875)
Other non-contract operating income	(671,622)	(8,391)	(201)	(527,206)	(93,478)	(4,932)	(876,054)	-	896,800	(1,285,084)
Income received by NHS charities	-	-	-	-	-	-	-	(153,216)	-	(153,216)
Finance income	(372,361)	(272)	-	(57,657)	-	(14)	(12,660)	-	353,145	(89,819)
Total income	**(2,426,375)**	**(243,875)**	**(2,202,613)**	**(92,114,440)**	**(2,143,767)**	**(425,705)**	**(3,666,598)**	**(153,216)**	**91,965,402**	**(11,411,187)**

1. The Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) for providers in deficit are both 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. Additionally, marginal rate emergency tariff (MRET) funding adjustments were paid to NHS trusts that agreed a control total.

2. During 2019-20, transactions relating to the Supply Chain function transferred to Supply Chain Coordination Limited from NHS Business Services Authority. This has resulted in the income relating to this function being included in the Other Group Bodies column above for 2019-20 (included in Special Health Authorities in 2018-19).

	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 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)
Income for additional pension uplift	-	-	-	-	-	-	-	-	-	-
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 and Financial Recovery 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 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)**

3. Staff costs

Staff costs for the Departmental Group comprise:

	2019-20 £'000	2018-19 £'000
	Total	Total
Salaries and wages	51,563,474	48,464,563
Social Security costs	4,952,637	4,607,888
NHS Pension	7,984,705	5,219,067
Other pension costs	97,231	69,536
Termination benefits	44,755	46,204
Sub-total	**64,642,802**	**58,407,258**
Less recoveries in respect of outward secondments	(105,013)	(93,379)
Total Net Costs	**64,537,789**	**58,313,879**

1. A more detailed analysis of staff costs can be found in the Accountability Report.

Of which:			2019-20 £'000
	Charged to revenue budgets	Charged to capital	Total
Core Dept & Agencies	441,981	3,049	445,030
Other designated bodies	63,861,305	245,623	64,106,928
Less elimination of intra-group expenditure	(14,169)	-	(14,169)
Total	**64,289,117**	**248,672**	**64,537,789**

			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**

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[144].
For 2019-20, employers' contributions of £19,275,399 were payable to the PCSPS (2018-19: £13,811,900) at one of four rates in the range 26.6% to 30.3% (2018-19: 20.0% to 24.5%) of pensionable earnings, based on salary bands. The Scheme Actuary reviews employer contributions, usually every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2019-20, to be paid when the member retires and not the benefits paid during this period to existing pensioners.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employers' contributions of £105,953 (2018-19: £88,132) were paid to the appointed stakeholder pension provider. 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 £1,483, 0.5% of pensionable pay, (2018-19: £2,399, 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[145].

For 2019-20, employers' contributions were payable to the NHS Pension Scheme at the rate of 20.68% (2018-19: 14.3%) of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HM Treasury Valuation Directions, stemming from the latest full scheme valuation.

Of the £7,984.7 million (2018-19: £5,219.1 million) against NHS pension costs, £268.7 million is attributable to NHS England Group (2018-19: £175.9 million), £7,594.7 million is attributable to NHS providers (2018-19: £4,962.5 million) with the balance of £121.3 million (2018-19: £80.7 million) to ALBs.

[144] https://www.civilservicepensionscheme.org.uk/about-us/scheme-valuations/
[145] https://www.nhsbsa.nhs.uk/sites/default/files/2019-06/NHS%20Pension%20Scheme%20-%202016%20Valuation%20Report.pdf

4. Expenditure

4.1 Expenditure

	Note	2019-20 £'000		2018-19 £'000	
		Core Dept & Agencies	Departmental Group	Restated Core Dept & Agencies	Departmental Group
4.1 (a) Purchase of goods and services					
Rentals Under Operating Leases		23,227	700,149	27,490	708,830
Supplies and services - clinical		-	12,807,020	-	12,501,137
Supplies and services - general		684,543	5,113,370	636,437	4,956,515
Total Goods and services from other NHS bodies		-	23,991	-	26,870
Multi Professional Education and Training (MPET)		-	1,170,863	-	1,539,046
Additional support for delivery of healthcare services		10,679	10,679	795,834	12,124
Purchase of healthcare from non NHS bodies		-	15,898,528	-	15,061,831
Purchase of Social Care		-	901,521	-	830,687
Expenditure on Drug Action Teams		-	240	-	629
General Dental Services (GDS) and Personal Dental Services (PDS)		-	2,958,262	-	2,788,494
Prescribing Costs		-	8,533,134	-	8,227,200
G/PMS, APMS and PCTMS		-	9,108,015	-	8,492,641
Pharmaceutical Services		-	1,958,735	-	1,930,193
General Ophthalmic Services		-	547,501	-	553,286
Consultancy services		15,203	290,206	19,829	342,051
Establishment		148,843	1,519,933	89,832	1,380,907
Transport (Business Travel)		8,992	307,102	9,044	310,666
Premises		33,720	3,209,769	35,847	2,908,546
Education, Training and Conferences (cash)		7,530	418,345	5,301	366,336
Insurance		123	46,821	296	41,363
Legal fees		20,088	217,684	17,696	188,293
NHS Informatics Major Contracts Cost		81,810	190,417	63,966	163,309
Audit fees - statutory audit (cash)		-	29,878	-	28,336
Auditor remuneration - other		-	34,821	4	41,426
non-cash items					
Audit fees - statutory audit - non-cash		912	1,018	802	897
Purchase of goods and services		**1,035,670**	**65,998,002**	**1,702,378**	**63,401,613**
4.1 (b) Depreciation and impairment charges					
non-cash items					
Depreciation on property, plant and equipment		51,290	2,612,608	57,369	2,441,073
Amortisation on intangible assets		183,689	496,308	172,092	451,540
Impairments and reversals		186,643	974,318	1,459,790	1,078,848
Depreciation and impairment charges		**421,622**	**4,083,234**	**1,689,251**	**3,971,461**
4.1 (c) Provision expense					
non-cash items					
Non-cash expenditure from movement in pension liability		-	24,867	-	20,469
Provision provided for in year		1,492,246	13,884,217	1,346,245	9,648,089
Provisions change in discount rate		29,062	(9,341,564)	(948,877)	(723,507)
Provision expense		**1,521,308**	**4,567,520**	**397,368**	**8,945,051**
4.1 (d) Other operating expenditure					
PFI/LIFT and other service concession arrangements charges		-	1,093,366	-	1,036,640
Chair and non-executive Directors' costs		-	79,923	-	80,379
Business rates paid to local authorities		11,695	573,180	5,148	537,863
Clinical negligence		-	590	-	254
Research and development		1,180,543	657,965	1,108,415	635,827
Grants to Local Authorities		2,993,985	2,993,985	3,070,284	3,070,284
Grants to Other bodies		194,001	224,723	155,819	183,200
Capital Grants		747,305	809,503	549,517	597,953
DHSC support for mergers		26,940	-	60,131	-
Prior period adjustments in local accounts		-	(6,557)	-	(7,219)
non-cash items					
Loss on disposal of non-current assets and assets held for sale		3,202	20,466	207,017	220,996
Movement of expected credit loss allowance (non-credit impaired)		1,137	193,828	(219)	127,111
Inventories write down		1,395	15,725	4,109	15,158
Loan Write Off		53	53	6	6
Apprenticeship training grant (non-cash)		724	61,535	537	22,745
Prior period adjustments in local accounts (non-cash)		-	(4,577)	-	(24,452)
Changes in fair value through SoCNE		-	5,787	(762)	(10,161)
Other non-cash expenditure		12,125	12,078	10,768	10,846
Other		1,031,705	2,346,197	712,244	2,256,334
Other operating expenditure		**6,204,810**	**9,077,770**	**5,883,014**	**8,753,764**

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 and Agencies 'Other' expenditure figure of £1,031.7 million (£712.2 million in 2018-19) includes £170.7 million of revenue policy payments (£131.3 million in 2018-19), £302.4 million in respect of outsourcing contracts (£166.2 million in 2018-19) and £126.6 million of Healthy Start – Welfare Foods payments (£94.3 million in 2018-19), which relate to the Core Department.
4. Other expenditure also includes £521 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.
10. The Department made payments in 18-19 to organisations who employ staff on terms and conditions fully aligned to Agenda for Change and directly deliver Local Authority commissioned public health services. In 19-20 payments made were only in respect of Local Authority commissioned public health services support for delivery of healthcare services.
11. DHSC Core expenditure in relation to the COVID-19 pandemic totals £22.1m. This relates to the purchase of personal protective equipment and the provision of COVID-19 testing services. The expenditure of £22.1m comprises of £5.6m public health services support for delivery of healthcare services referenced in Note 10 above, plus £9.5m within Establishment costs, £3.0m in Education, Training & Conferences, £2.0m in Consultancy Services and £2.0m in Other.
12. DHSC Core Department and Agency expenditure in impairment and reversals has been restated by £1.45 billion for 2018-19 to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and Note 11.

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:

	2019-20 £'000	Restated 2018-19 £'000
	Departmental Group	Departmental Group
Expenditure after financing activities - non-cash items (Note 4 & SOCNE)	9,491,591	13,646,531
Less non-cash income after financing activities (Note 5 & SOCNE) (Restated in 2018-19)	(178,694)	(679,267)
Total non-cash transactions (Restated in 2018-19)	**9,312,897**	**12,967,264**
Movement in expected credit loss allowance	(193,828)	(127,111)
Inventories write down	(15,725)	(15,158)
Less non-cash movements on SoFP balances analysed separately in the Cash Flow statement	**(209,553)**	**(142,269)**
Total non-cash transactions as per Consolidated Statement of Cash Flows (Restated in 2018-19)	**9,103,344**	**12,824,995**

1. The 2018-19 amounts have been restated to reflect the revised Statement of Cash Flows format.

5. Income

5.1 Income

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Income from contracts				
Revenue from Patient Care activities				
Income from Local Authorities	-	2,030,721	-	2,081,618
Income from Private patients	-	671,423	-	647,618
Income from Chargeable Overseas Patients	-	93,301	-	91,252
Income from injury costs recovery	-	210,132	-	209,012
Income in respect of EEA claims	70,144	70,144	62,956	62,956
Income from DHSC/NHS bodies	-	126,371	-	140,627
Other non-NHS patient care services	-	597,656	-	576,560
Other contract income				
Non-patient care services to other bodies	1,430	857,715	1,011	1,212,587
Education, training and research	1,842	468,203	2,406	380,790
Prescription Fees and Charges	-	614,126	-	591,960
Dental Fees and Charges	-	848,292	-	856,384
Other Fees and Charges	230,332	473,432	217,761	448,383
Income in respect of Staff Costs	-	223,654	-	204,222
Prescription Pricing Regulation Scheme	722,809	722,809	573,526	573,526
Other Contract Income	588,009	1,875,089	6,939	1,254,037
Income from contracts	**1,614,566**	**9,883,068**	**864,599**	**9,331,532**
Other non-contract operating income				
Rental revenue from finance leases	-	693	-	357
Rental revenue from operating leases	18,405	390,744	18,945	328,569
PDC Dividend Received	610,758	-	647,232	-
Charitable and other contributions to expenditure	-	74,243	-	54,240
Receipt of donations for capital acquisitions	-	100,905	-	313,446
Receipt of grants for capital acquisitions	-	1,866	-	2,987
Profit on disposal	7,275	67,819	1,440	291,727
Dividends	12,509	21,862	7,282	12,584
Other non-cash income	12,130	36,344	10,768	102,218
Apprenticeship training grant (non-cash)	724	61,534	537	22,745
Funding from other Government departments	-	5,001	-	2,598
Prior period adjustments in local accounts	-	(7,615)	-	18,916
Other non contract income	22,930	531,688	24,544	386,736
Non-contract income	**684,731**	**1,285,084**	**710,748**	**1,537,123**

1. Other Contract Income includes £409 million in the provider sector, which represents a proportion of the incidental non-clinical sales and services.
2. During the period the Department received cash that HM Treasury has determined is surrenderable to the Consolidated fund. The income associated with the transfer of this cash has been recognised in accordance with IFRS 15 which requires the recognition of income only when it is highly probable the income will be received. The value of income recognised in the period is £571 million and is included within other contract income.

6. Property, plant and equipment

	Departmental Group 2019-20									
	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 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**
Prior period adjustments in underlying accounts	425	(140,111)	(3,466)	(256)	(729)	(11,628)	6,748	(97)	-	(149,114)
Additions	13,162	973,617	2,219	644,318	2,281,371	26,549	648,393	29,581	120,153	4,739,363
Donations	175	25,782	190	3,317	69,131	2,917	61,264	80	-	162,856
Impairments and reversals	(498,494)	(1,374,967)	(9,897)	(21,976)	(40,234)	(107)	(13,603)	-	(29,738)	(1,989,016)
Transfers	10,858	(137)	-	-	-	-	2,216	-	(35,826)	(22,889)
Reclassifications	(52,439)	1,378,384	1,135	183,581	(1,930,196)	27,717	189,369	22,070	-	(180,379)
Revaluation and indexation	274,482	(260,310)	98	(500)	506	(2,328)	1,723	(53)	-	13,618
Disposals	(90,685)	(72,231)	(1,047)	(264,873)	(3,002)	(28,668)	(343,418)	(28,845)	(23,349)	(856,118)
At 31 March 2020	**5,923,052**	**40,247,728**	**353,871**	**5,217,512**	**3,666,586**	**679,949**	**10,055,098**	**499,831**	**537,535**	**67,181,162**
Depreciation										
At 1 April 2019	**27,780**	**2,130,875**	**34,390**	**2,985,329**	**-**	**471,896**	**6,494,322**	**277,458**	**-**	**12,422,050**
Prior period adjustments in underlying accounts	(1,789)	(165,063)	(5,266)	(1,494)	-	(10,602)	7,214	(72)	-	(177,072)
Charged in year	87	1,345,103	11,037	539,395	-	45,584	621,687	49,715	-	2,612,608
Impairments and reversals	24,986	(59,949)	(2,106)	1,190	-	(244)	340	840	-	(34,943)
Transfers	-	(147)	-	-	-	-	2,227	-	-	2,080
Reclassifications	-	(50,352)	(1,451)	(2,359)	-	(363)	(3,139)	(15,463)	-	(73,127)
Revaluation and indexation	(42,593)	(1,497,859)	(8,623)	(1,661)	-	(390)	827	(53)	-	(1,550,352)
Disposals	-	(11,536)	(436)	(262,312)	-	(27,861)	(330,523)	(28,168)	-	(660,836)
At 31 March 2020	**8,471**	**1,691,072**	**27,545**	**3,258,088**	**-**	**478,020**	**6,792,955**	**284,257**	**-**	**12,540,408**
Net book value at 31 March 2020	**5,914,581**	**38,556,656**	**326,326**	**1,959,424**	**3,666,586**	**201,929**	**3,262,143**	**215,574**	**537,535**	**54,640,754**
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
Asset financing:										
Owned - purchased	5,414,245	25,621,154	250,448	1,906,610	3,343,638	179,941	2,700,775	213,430	537,535	40,167,776
Owned - donated	78,706	1,252,666	12,747	14,425	303,841	16,078	280,195	1,349	-	1,960,007
Finance leased	44,244	439,797	11,350	31,251	10,840	5,808	146,062	795	-	690,147
On-Statement of Financial Position PFI contracts	377,386	11,243,039	49,595	7,138	8,267	102	135,111	-	-	11,820,638
PFI residual interests	-	-	2,186	-	-	-	-	-	-	2,186
Net book value at 31 March 2020	**5,914,581**	**38,556,656**	**326,326**	**1,959,424**	**3,666,586**	**201,929**	**3,262,143**	**215,574**	**537,535**	**54,640,754**
Analysis of property, plant and equipment										
Core Dept & Agencies	93,194	173,944	-	17,238	164,905	4,719	28,071	-	537,535	1,019,606
Other designated bodies	5,821,387	38,382,712	326,326	1,942,186	3,501,681	197,210	3,234,072	215,574	-	53,621,148
Net book value at 31 March 2020	**5,914,581**	**38,556,656**	**326,326**	**1,959,424**	**3,666,586**	**201,929**	**3,262,143**	**215,574**	**537,535**	**54,640,754**

1. Where there is no active market for partially expired pharmaceuticals and related consumables, or where cost is not materially different to market value, they are held at historic cost as a proxy for fair value and are not depreciated over their useful life.
2. The Department leases Wellington House 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 HM Treasury is paying the lease costs. As the Department retains control of this property its 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 was transferred to Parliamentary Estates in September 2019.

	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**

Property has been valued as follows:

- Land and buildings held by NHS bodies are valued, by independent valuers, to a modern equivalent basis as required by HM Treasury[146], details of which can be found in the individual body accounts. The value of land and buildings held by NHS providers at 31 March 2020 was £37,894.0m.

- The Civil Estate (land and buildings held for use by the Core Department) was valued on 6 March 2020 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. The value of the Civil Estate at 31 March 2020 was £96.4m.

- The Retained Estate comprises land and buildings to the value of £88.8m at 31 March 2020 (£76.8m within Investment Property and the remaining balance within Land and Buildings) which were primarily intended for use by NHS bodies but which are now surplus to requirements and are therefore held by the Department. The Retained Estate was revalued by professional valuers as at 31 March 2015. Additional valuations were carried out as necessary in circumstances where there were indications that values had substantially changed.

- All valuations have been undertaken according to the Royal Institute of Chartered Surveyors (RICS) guidelines. The outbreak of COVID-19 has significantly affected the UK economy. As at 31 March 2020, there is a shortage of market evidence for comparison purposes to inform opinions on value.
  Although auditors of all DHSC Group bodies have concluded that valuations recognised in the financial statements are materially accurate, in many cases reports obtained from the valuers contained a material uncertainty disclosure. The external auditors often referenced the additional uncertainty in their audit report, either within the description of a key audit matter where the auditor has issued an enhanced audit report or within an emphasis of matter paragraph.
  Property assets in these consolidated accounts are valued at £44 billion. Given the scale of the group bodies reporting uncertainties this year, the valuations of property are reported as being subject to valuation uncertainty. Consequently, less certainty and a higher degree of caution should be attached to the valuations than would normally be the case.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 – 169 years
- Information technology: 1 – 20 years
- Furniture and fittings: 1 – 35 years
- Plant and machinery: 1 – 35 years
- Transport equipment: 1 – 15 years

[146] Per Chapter 7 of HM Treasury's 2019-20 Financial Reporting Manual

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 2019-20			
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2019	**3,885,698**	**295,214**	**281,853**	**4,462,765**
Prior period adjustments in underlying accounts	(2,286)	(71)	(221)	(2,578)
Additions	355,196	42,873	185,510	583,579
Donations	926	-	2,493	3,419
Impairments and reversals	(6,645)	(5,748)	(2,721)	(15,114)
Transfers	-	-	-	-
Reclassifications	177,756	(2,741)	(149,101)	25,914
Revaluation and indexation	31,606	738	1,652	33,996
Disposals	(447,772)	(6,638)	(5,223)	(459,633)
Other movements	(9,019)	-	-	(9,019)
At 31 March 2020	**3,985,460**	**323,627**	**314,242**	**4,623,329**
Amortisation				
At 1 April 2019	**2,611,102**	**133,788**	**28,719**	**2,773,609**
Prior period adjustments in underlying accounts	(2,139)	64	(220)	(2,295)
Charged in year	457,993	32,974	5,341	496,308
Impairments and reversals	14,687	(80)	3	14,610
Transfers	-	-	-	-
Reclassifications	2,138	8	(1,761)	385
Revaluation and indexation	(15,888)	540	144	(15,204)
Disposals	(443,229)	(6,268)	(4,104)	(453,601)
Other movements	(2,865)	-	-	(2,865)
At 31 March 2020	**2,621,799**	**161,026**	**28,122**	**2,810,947**
Net Book Value at 31 March 2020	**1,363,661**	**162,601**	**286,120**	**1,812,382**
Net book value at 31 March 2019	1,274,596	161,426	253,134	1,689,156

Analysis of intangible assets				
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Of the total:				
Core Dept & Agencies	123,946	23,170	14,995	162,111
Other designated bodies	1,239,715	139,431	271,125	1,650,271
Net Book Value at 31 March 2020	**1,363,661**	**162,601**	**286,120**	**1,812,382**

	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**

The ranges of estimated useful lives are currently:

- Software licences and Internally Developed Software: 1 – 20 years
- Development expenditure: 1 – 12 years
- Other (licences and trademarks, patents, purchased software etc): 1 – 11 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

	2019-20 £'000		2018-19 £'000	
			Restated	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Impairments charged to Consolidated Statement of Comprehensive Net Expenditure				
Property Plant and Equipment impairments	29,672	940,048	7,391	1,057,639
Intangible asset impairments	1,435	29,701	600	21,858
Financial asset and PDC impairments	155,536	2,847	1,451,799	(949)
Non Current Assets Held for Sale impairments	-	1,722	-	300
Total impairments charged to Consolidated Statement of Comprehensive Net Expenditure	**186,643**	**974,318**	**1,459,790**	**1,078,848**
Impairments charged to Revaluation Reserve				
Property Plant and Equipment impairments	-	1,014,025	11,147	851,793
Intangible asset impairments	20	23	667	678
Financial asset impairments	-	-	(314)	(314)
Total impairments charged to Revaluation Reserve	**20**	**1,014,048**	**11,500**	**852,157**
Impairments charged to General Fund				
PDC impairments	606,125	-	(96,141)	-
Total impairments charged to General Fund	**606,125**	**-**	**(96,141)**	**-**
Total impairments charged in year	**792,788**	**1,988,366**	**1,375,149**	**1,931,005**

The above table includes both impairments and impairment reversals. In 2019-20 there was no formal write off of PDC as this process has been postponed until 2020-21 due to the COVID-19 pandemic. Therefore, there has been no reversal of PDC impairments in 2019-20. The figure in 2018-19 includes the reversal of 2017-18 impairments where the PDC was formally written off in 2018-19.

Financial asset and PDC impairments charged to the Statement of Comprehensive Net Expenditure for Core Department and Agencies have been restated in 2018-19 by £1.45 billion to reflect the change in impairment of Public Dividend Capital as described in **Note 1.22** and **Note 11**.

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.

	2019-20 £'000		2018-19 £'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	188,777	2,009,467	231,919	1,475,782
Intangible non-current assets	9,558	100,256	11,204	109,438
	198,335	**2,109,723**	**243,123**	**1,585,220**

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.

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	10,794	-	3,773
Later than 1 year and not later than 5 years	-	12,504	-	6,321
Later than 5 years	-	20,773	-	16,320
Total	**-**	**44,071**	**-**	**26,414**
Buildings:				
Not later than 1 year	18,791	372,353	18,956	356,864
Later than 1 year and not later than 5 years	38,963	1,015,297	47,989	979,617
Later than 5 years	28,739	1,265,491	35,286	1,207,894
Total	**86,493**	**2,653,141**	**102,231**	**2,544,375**
Other:				
Not later than 1 year	387	193,984	488	195,504
Later than 1 year and not later than 5 years	121	369,245	483	322,300
Later than 5 years	-	62,513	-	62,581
Total	**508**	**625,742**	**971**	**580,385**

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.

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	4,981	-	3,445
Later than 1 year and not later than 5 years	-	14,362	-	11,616
Later than 5 years	-	199,558	-	177,758
Total	**-**	**218,901**	**-**	**192,819**
Buildings:				
Not later than 1 year	16,469	126,587	17,557	131,373
Later than 1 year and not later than 5 years	30,030	419,064	50,573	418,730
Later than 5 years	29,894	901,076	26,574	881,105
Total	**76,393**	**1,446,727**	**94,704**	**1,431,208**
Other:				
Not later than 1 year	-	21,717	-	15,328
Later than 1 year and not later than 5 years	-	31,959	-	17,223
Later than 5 years	-	18,802	-	12,617
Total	**-**	**72,478**	**-**	**45,168**

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.

	2019-20 £'000		2018-19 £'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	-	181
Later than 1 year and not later than 5 years	-	727	-	726
Later than 5 years	-	1,187	-	1,339
	-	**2,095**	**-**	**2,246**
Less interest element	-	(1,298)	-	(1,368)
Present Value of obligations	**-**	**797**	**-**	**878**
Buildings:				
Not later than 1 year	-	49,416	-	46,421
Later than 1 year and not later than 5 years	-	188,148	-	180,016
Later than 5 years	-	473,514	-	497,197
	-	**711,078**	**-**	**723,634**
Less interest element	-	(301,024)	-	(321,261)
Present Value of obligations	**-**	**410,054**	**-**	**402,373**
Other:				
Not later than 1 year	-	56,830	-	52,649
Later than 1 year and not later than 5 years	-	124,254	-	115,776
Later than 5 years	-	40,222	-	48,889
	-	**221,306**	**-**	**217,314**
Less interest element	-	(29,693)	-	(25,738)
Present Value of obligations	**-**	**191,613**	**-**	**191,576**

1. Finance lease commitments between bodies with the Departmental Group are eliminated upon consolidation.

	2019-20 £'000		2018-19 £'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	-	80	-	70
Later than 1 year and not later than 5 years	-	452	-	395
Later than 5 years	-	265	-	413
Total Present Value of obligations	**-**	**797**	**-**	**878**
Buildings:				
Not later than 1 year	-	24,444	-	21,279
Later than 1 year and not later than 5 years	-	100,156	-	88,747
Later than 5 years	-	285,454	-	292,347
Total Present Value of obligations	**-**	**410,054**	**-**	**402,373**
Other:				
Not later than 1 year	-	50,007	-	46,971
Later than 1 year and not later than 5 years	-	108,667	-	102,489
Later than 5 years	-	32,939	-	42,116
Total Present Value of obligations	**-**	**191,613**	**-**	**191,576**

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.

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Gross investments in leases:				
Not later than 1 year	303	3,698	423	6,102
Later than 1 year and not later than 5 years	424	4,414	727	3,778
Later than 5 years	-	18,355	-	19,207
Less future finance income	(43)	(7,988)	(101)	(8,590)
Present Value of minimum lease payments	**684**	**18,479**	**1,049**	**20,497**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**684**	**18,479**	**1,049**	**20,497**
Present Value of minimum lease payments:				
Not later than 1 year	275	3,112	419	5,500
Later than 1 year and not later than 5 years	409	2,234	630	1,530
Later than 5 years	-	13,133	-	13,467
Total Present Value of minimum lease payments	**684**	**18,479**	**1,049**	**20,497**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**684**	**18,479**	**1,049**	**20,497**
included in:				
Current finance lease receivables	275	3,112	419	5,500
Non-current finance lease receivables	409	15,367	630	14,997
Sub total	**684**	**18,479**	**1,049**	**20,497**

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 (2018-19: one scheme, £0.9 million). The assets which make up this capital value were not assets of Community Health Partnerships Ltd.

	2019-20 £'000		2018-19 £'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	-	62	-	63
Later than 1 year and not later than 5 years	-	248	-	249
Later than 5 years	-	3,721	-	3,783
	-	**4,031**	**-**	**4,095**

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 297 on-Statement of Financial Position LIFT schemes. (2018-19: 296). 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 £53.9 million (2018-19: £51.9 million).

NHS Providers

In this financial year, 6 NHS providers (2018-19: 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:

	2019-20 £'000		2018-19 £'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	-	164,312	-	163,190
Later than 1 year and not later than 5 years	-	646,243	-	649,778
Later than 5 years	-	2,432,367	-	2,570,066
	-	**3,242,922**	**-**	**3,383,034**
Less interest element	-	(1,504,991)	-	(1,625,608)
Present Value of obligations	**-**	**1,737,931**	**-**	**1,757,426**

	2019-20 £'000		2018-19 £'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	-	40,127	-	36,835
Later than 1 year and not later than 5 years	-	176,651	-	170,045
Later than 5 years	-	1,521,153	-	1,550,546
Total Present Value of obligations	**-**	**1,737,931**	**-**	**1,757,426**

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 £57.4 million (2018-19: £55.3 million).

Community Health Partnerships Ltd and NHS providers with NHS LIFT contracts are committed to the following total charges:

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	58,093	-	56,553
Later than 1 year and not later than 5 years	-	247,300	-	241,198
Later than 5 years	-	664,420	-	724,290
	-	**969,813**	**-**	**1,022,041**

9.3.4 PFI Schemes deemed to be off-Statement of Financial Position

NHS Providers

In this financial year 7 NHS providers reported off-Statement of Financial Position PFI schemes (2018-19: 8 NHS providers).

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Obligations on off-Statement of Financial Position PFI schemes for the following periods comprise:				
Not later than 1 year	-	5,794	-	6,122
Later than 1 year and not later than 5 years	-	22,607	-	24,088
Later than 5 years	-	20,506	-	30,268
	-	**48,907**	**-**	**60,478**

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 (2018-19: 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 £32.5 million (2018-19: £30.9 million).

NHS Providers

In this financial year, 151 NHS providers reported on-Statement of Financial Position PFI Schemes (2018-19: 150 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 £1,003.5 million. (2018-19: £950.4 million).

	2019-20 £'000		2018-19 £'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	-	860,470	-	862,769
Later than 1 year and not later than 5 years	-	3,400,546	-	3,416,649
Later than 5 years	-	12,264,464	-	13,018,742
	-	**16,525,480**	**-**	**17,298,160**
Less interest element	-	(7,703,249)	-	(8,174,338)
Present Value of obligations	**-**	**8,822,231**	**-**	**9,123,822**

	2019-20 £'000		2018-19 £'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	-	308,737	-	290,470
Later than 1 year and not later than 5 years	-	1,362,879	-	1,302,274
Later than 5 years	-	7,150,615	-	7,531,078
Total Present Value of obligations	**-**	**8,822,231**	**-**	**9,123,822**

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 £1,036.0 million. (2018-19: £981.4 million).

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	954,353	-	942,866
Later than 1 year and not later than 5 years	-	3,950,932	-	3,938,097
Later than 5 years	-	16,787,049	-	17,511,296
	-	**21,692,334**	**-**	**22,392,259**

9.4 Other Financial Commitments

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	2,184,755	2,803,953	1,914,720	2,417,285
Later than 1 year and not later than 5 years	1,335,963	2,092,378	1,856,214	2,728,216
Later than 5 years	232,246	320,897	237,860	399,095
Total	**3,752,964**	**5,217,228**	**4,008,794**	**5,544,596**

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 £2,128 million (2018-19: £2,182 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 all 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. Interest rates for interim revenue support loans are set based on the individual financial situation of the provider concerned. 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.

11. Financial Assets – Investments

	2019-20 £'000						2019-20 £'000			
	Core Dept & Agencies						Departmental Group			
	NHS Healthcare Providers		Other Bodies			Restated 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
Restated balance at 1 April 2019	**18,009,509**	**10,485,812**	**1,328**	**600,792**	**1,654,787**	**30,752,228**	**1,328**	**289,781**	**387,564**	**678,673**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	-	-
Issued	908,379	3,146,361	-	206,529	63,028	4,324,297	-	28,039	29,025	57,064
Disposals	-	-	-	-	-	-	-	-	(9,290)	(9,290)
Repaid	(1,273)	(313,565)	-	(97,586)	-	(412,424)	-	(21,632)	(2,224)	(23,856)
Transfers to and from current receivables	-	(10,552,235)	-	108,842	-	(10,443,393)	-	(1,159)	-	(1,159)
Written off	-	-	-	(53)	-	(53)	-	(53)	-	(53)
Revaluation	-	-	-	-	-	-	-	-	-	-
Changes in fair value through other comprehensive income	-	-	-	-	126,735	126,735	-	-	111,761	111,761
Changes in fair value through CSCNE	-	-	-	-	-	-	-	-	(860)	(860)
Other Impairments and reversals	(761,742)	-	-	81	-	(761,661)	-	81	(2,928)	(2,847)
Other movements	-	-	-	-	-	-	-	-	6,100	6,100
Balance at 31 March 2020	**18,154,873**	**2,766,373**	**1,328**	**818,605**	**1,844,550**	**23,585,729**	**1,328**	**295,057**	**519,148**	**815,533**

Investments held by Core Dept & Agencies	23,585,729
Less elimination of intra-group investments	(22,967,512)
Investments held by other designated bodies	197,316
Total	**815,533**

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).
3. The opening balance for Core Department and Agencies has been restated by £9.4 billion to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and below.

	2018-19 £'000						2018-19 £'000			
	Core Dept & Agencies						Departmental Group			
	NHS Healthcare Providers		Other Bodies			Restated 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 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**
Effect of prior period adjustment	(7,942,810)	-	-	-	-	(7,942,810)	-	-	-	-
Restated balance at 1 April 2018	**18,717,330**	**9,317,202**	**1,328**	**477,215**	**1,613,473**	**30,126,548**	**1,328**	**390,170**	**358,868**	**750,366**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	(1,101)	(1,101)
Impact of applying IFRS 9 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)
Revaluation	-	-	-	-	-	-	-	-	-	-
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	(1,354,562)	-	-	95	(877)	(1,355,344)	-	95	(877)	(782)
Other Movements	-	-	-	-	-	-	-	-	2,368	2,368
Restated balance at 31 March 2019	**18,009,509**	**10,485,812**	**1,328**	**600,792**	**1,654,787**	**30,752,228**	**1,328**	**289,781**	**387,564**	**678,673**

Investments held by Core Dept & Agencies	30,752,228
Less elimination of intra-group investments	(30,276,532)
Investments held by other designated bodies	202,977
Total	**678,673**

1. The opening balance for Core Department and Agencies has been restated to reflect the change in impairment of Public Dividend Capital as described in Note 1.22 and below. Other impairments and reversals for Core Department and Agencies was also restated by £1.45 billion as a result of this change. The total Core Department and Agencies balance and elimination of intra-group investments have also been restated for the changes.

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 2019-20 which included Supply Chain Coordination Ltd. There has been no change in the valuation reflected in the accounts in 2019-20 based on materiality grounds. Core Department and Agencies share capital of £1.8 billion includes £906.5 million in respect of NHS Property Services Ltd and £256 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 2019-20, the Department increased its shareholding in Genomics England Ltd by £50.0 million and £2.5 million in Community Health Partnerships Ltd.

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. National Loan fund rates of interest (as published by the UK Debt Management Office) are applied to all capital loans and revenue loans/working capital facilities in the normal course of business. During 2019-20 the primary exception were the Department's revolving working capital loan facilities and revenue support loans under which the full principal falls due at the end of the loan term. The interest rate applied to interim support revenue loans/working capital facilities was either 1.5% or 3.5% depending on the provider's financial situation.

Loans are held at amortised cost using the effective interest rate method, less impairments.

The Department accounts for the PDC carrying value in the DHSC Core account in line with the Government Financial Reporting Manual (FReM), that requires PDC to be held at historic cost less impairment. In the past the Department has agreed an interpretation of this FReM requirement with the NAO, whereby impairment of PDC is only recognised when a decision is made resulting in functions changing between NHS providers (through merger or dissolution of a Trust or Foundation Trust) and where the net assets of the body holding the PDC are lower than the value of the PDC issued. Following NAO challenge in this area the Department has reconsidered the way in which it applies the FReM requirement to impair its PDC.

PDC is now impaired, on an individual NHS provider basis, where the net assets of those NHS providers is below the level of PDC issued to that Trust or Foundation Trust, irrespective of whether subsequent PDC write-offs are likely to occur. Where such adjustment is made the impairment is expensed in the Core Department SoCNE. Where the Department expects that such impairment will result in write-off of PDC, this element of the impairment is recognised through reserves, reversing any previous impairment taken through the Core Department SoCNE. This treatment mirrors that of the subsequent write-off which is also recognised through reserves in line with an HM Treasury agreed FReM divergence (see **note 1** for further details). The divergence recognises that where net assets are below the value of the PDC reserve in a dissolved Trust, this reflects the existence of historic deficits already recognised in the Statement of Financial Performance for the closing Trust and is not an additional loss to the Taxpayer.

In 2019-20 the value of impairment taken through the SoCNE is £156 million and the value of impairment taken through reserves is £606 million.

This revised approach of the FReM requirement does not directly correlate with the recoverability of the Department's PDC investment and is not indicative of future write-offs and nor is it any reflection of the going concern or financial viability of individual NHS providers or indeed the sector as a whole. Impairment of PDC relates solely to the DHSC Core account, has no impact at the group level and does not represent any loss to the taxpayer. The impairment methodology now applied does, however, better reflect the cumulative impact of the NHS provider net asset position on the value of the Department's PDC investment.

The Department has calculated this impairment based on the net assets of NHS providers as at 31 March 2020. For those NHS providers whose net assets fell below the value of PDC issued (capped at an individual NHS provider level at the total value of PDC issued to that provider), the difference between the PDC issued and net assets was £10.1 billion as at 31 March 2020. If this impairment calculation took into account those NHS providers that have net assets greater than PDC reserves, i.e. considering the NHS provider sector as a whole, the cumulative impairment as at 31 March 2020 would be £1.7 billion.

The Department has applied this new application of the FReM requirements retrospectively, ensuring that the 2017-18 and 2018-19 Department Core equivalent impairment is presented on a consistent basis. The cumulative impact of the change in application of policy leads to a cumulative £10.1 billion impairment of PDC, reflected in this note as an impairment of PDC in 2017-18 of £7.9 billion, a PDC impairment in 2018-19 of £1.4 billion and a PDC impairment in 2019-20 of £0.8 billion reducing the value of the Department's Core Investment in PDC.

Reforms to the NHS Cash Regime

On the 2nd of April 2020, the Health Secretary made a public announcement of the Reforms to the NHS Cash Regime effective from 1 April 2020. Interim revenue loans, including working capital facilities and interim capital debt at 31 March 2020 are to be extinguished during 2020-21. Providers have been issued Public Dividend Capital (PDC) to affect the repayment of outstanding balances as at 31 March 2020. Consequently, the relevant loan balances held with providers, which at the end of March 2020 totalled £13.4bn, are now included in 'current part of loans repayable transferred from investments' in the 2019-20 accounts and represent amounts falling due within one year to reflect that the financial asset for DHSC and the financial liability for the NHS provider will be derecognised as the rights to cashflows expire for DHSC and the provider discharges its liability for the loan, on utilisation of the PDC issued by DHSC to the provider, to repay the loan balance outstanding in 2020-21.

12. Inventories and work in progress

	Departmental Group 2019-20					
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2019	**203,401**	**-**	**366,063**	**815,338**	**111,650**	**1,496,452**
Prior period adjustments in underlying accounts	-	-	-	31,535	1	31,536
Additions	461,219	-	6,588,674	4,201,815	640,188	11,891,896
Consumed/Disposed of	(418,349)	(35,764)	(6,512,615)	(4,179,771)	(641,755)	(11,788,254)
Written down charged to CSCNE	(1,395)	-	(9,602)	(4,670)	(58)	(15,725)
Transfer (to) / from non-current assets	-	35,764	-	-	62	35,826
Transfers	-	-	-	(36,382)	36,382	-
Reclassification	-	-	-	-	-	-
Other	-	-	-	6	-	6
Balance at 31 March 2020	**244,876**	**-**	**432,520**	**827,871**	**146,470**	**1,651,737**

Analysis of Inventories

Of the total:	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Core Dept & Agencies	244,876	-	-	6,627	-	251,503
Other designated bodies	-	-	432,520	821,244	146,470	1,400,234
	244,876	**-**	**432,520**	**827,871**	**146,470**	**1,651,737**

	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
Transfers	-	-	-	-	-	-
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	Pandemic Flu and Pre Pandemic Flu	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'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**

13.1 Cash and cash equivalents

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Balance at 1 April 2019	**1,933,440**	**8,682,028**	**1,709,068**	**7,562,137**
Net change in cash	(472,655)	429,892	224,372	1,119,891
Balance at 31 March 2020	**1,460,785**	**9,111,920**	**1,933,440**	**8,682,028**

The following balances at 31 March were held at:

Government Banking Service	1,460,746	8,679,337	1,933,436	8,001,531
Commercial banks and cash in hand	39	227,148	4	286,616
Short term investments	-	205,435	-	393,881
Balance at 31 March 2020	**1,460,785**	**9,111,920**	**1,933,440**	**8,682,028**

14. Trade Receivables and other current assets

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade receivables	224,097	1,993,766	287,480	2,352,520
Deposits and advances	-	5,148	-	5,076
Capital receivables	5,693	82,355	8,056	121,916
Interest receivable	-	4,159	30	4,863
Other receivables	86,278	711,896	104,344	699,020
Trade and other receivables	**316,068**	**2,797,324**	**399,910**	**3,183,395**
Contract Assets	33,764	86,740	-	18,434
Other prepayments and accrued income	270,500	1,513,943	79,820	1,183,884
arrangements prepayments	-	176,470	-	144,240
Capital Prepayments	-	102,796	-	97,552
Other current assets	-	7,560	-	3,134
Other current assets	**304,264**	**1,887,509**	**79,820**	**1,447,244**
Current part of loans repayable transferred from investments	13,724,360	7,870	3,665,937	8,269
Other current financial assets	-	10,000	-	20,000
Investments and other financial assets	**13,724,360**	**17,870**	**3,665,937**	**28,269**
Total current receivables	**14,344,692**	**4,702,703**	**4,145,667**	**4,658,908**
Amounts falling due after more than one year:				
Trade receivables	-	216,860	-	193,303
Deposits and advances	-	9,173	-	5,065
Capital receivables	-	44,587	5,693	43,575
Contract Assets	-	5,162	-	4,351
Other receivables	251,452	309,375	205,177	267,063
Other Prepayments and accrued income	-	33,648	-	36,972
Non-current part of PFI and other service concession arrangements prepayments	-	47,566	-	37,666
Capital Prepayments	-	202,212	-	183,184
Total non-current receivables	**251,452**	**868,583**	**210,870**	**771,179**
Total receivables at 31 March 2020	**14,596,144**	**5,571,286**	**4,356,537**	**5,430,087**

1. 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.
2. Trade receivables includes the expected credit loss on receivables under the IFRS 9 expected credit loss model.
3. 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.
4. Other prepayments and accrued income for the department includes £162.4 million of prepayments in respect of COVID-19 for ventilators, personal protective equipment and testing.
5. In advance of the new NHS capital funding model being introduced from 2020-21, some loans have been moved to 'current part of loans repayable transferred from investments' which now totals £13.7 billion. For further information, please see the disclosure under Note 11: Investments above.

15. Trade payables and other current liabilities

	2019-20 £'000		2018-19 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade payables	20,441	2,904,352	25,865	3,304,009
Capital payables	59,892	1,178,670	94,062	921,589
Other payables[2]	7,346	2,444,611	6,163	2,196,586
Trade and other payables	**87,679**	**6,527,633**	**126,090**	**6,422,184**
Bank Overdraft	-	29,904	-	25,016
VAT	-	33,786	-	25,331
Other taxation and social security	2,254	1,229,190	2,091	1,169,353
Deferred tax liability	-	17	-	-
EEA Medical Costs Accrual	781,709	781,709	743,725	743,725
Contract liabilities	10,645	807,288	-	630,425
Other accruals	466,821	9,410,573	505,871	8,595,580
Deferred income	438,330	531,710	64,511	119,047
Current part of finance lease	-	74,531	-	68,320
Current part of imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	348,864	-	327,305
Amount issued from the Consolidated Fund for supply but not spent at year end	1,045,346	1,045,346	2,209,086	2,209,086
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received	571,133	571,133	3,858	3,858
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Receivable	-	-	-	-
Current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	49,761	-	23,832
Loans payable by DHSC to group bodies	-	-	-	-
Pension liabilities	-	92,011	-	92,264
Other current liabilities	(1)	13,015	-	17,252
Other liabilities	**3,316,237**	**15,018,838**	**3,529,142**	**14,050,394**
Total current payables	**3,403,916**	**21,546,471**	**3,655,232**	**20,472,578**
Amounts falling due after more than one year:				
Finance leases	-	527,933	-	526,507
Imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	10,211,298	-	10,553,943
Pension liabilities	-	47	-	69
Financial liabilities	**-**	**10,739,278**	**-**	**11,080,519**
Trade payables	-	6,655	-	2,297
Contract liabilities	-	83,523	-	70,350
Other accruals	7,300	11,164	8,164	10,884
Capital payables	119,226	128,998	127,959	130,621
Other payables	-	192,001	-	164,613
Deferred income	33,389	108,219	-	82,476
Non-current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	296,371	-	294,672
Loans payable by DHSC to group bodies	20,220	-	20,220	-
Other payables	**180,135**	**826,931**	**156,343**	**755,913**
Total non-current payables	**180,135**	**11,566,209**	**156,343**	**11,836,432**
Total payables as at 31 March 2020	**3,584,051**	**33,112,680**	**3,811,575**	**32,309,010**

1. Contract Liabilities are recognised where an entity has received consideration from a customer before performance obligations have been fully met.
2. Other payables falling due within one year includes £975 million relating to the provider sector and £993 million relating to the commissioner sector. These amounts arise from a significant number of entities within each sector and as such are not material individually.

16. Provisions for liabilities and charges

	2019-20						2018-19					
	Core Dept & Agencies						Core Dept & Agencies					
	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
Balance at 1 April 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**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	-	-	-	-
Provided in the year	17,346	29,459	526,823	940,585	22,771	1,536,984	8,064	49,025	853,432	434,844	48,180	1,393,545
Provisions not required written back	(5,451)	(29,169)	-	-	(10,118)	(44,738)	(3,906)	(14,650)	-	-	(28,744)	(47,300)
Transfers	-	-	-	-	-	-	-	-	-	-	-	-
Provisions utilised in the year	(11,958)	(48,875)	(142,676)	(75,132)	(40,104)	(318,745)	(11,914)	(49,396)	(101,036)	(42,607)	(36,690)	(241,643)
Transfer to accruals	-	-	(454,782)	-	(8,939)	(463,721)	-	-	(498,838)	-	(29,846)	(528,684)
Borrowing costs (unwinding of discount)	308	(1,809)	6,594	18,566	753	24,412	115	(13,146)	(16,874)	(19,871)	(6,232)	(56,008)
Change in discount rate	(3,003)	15,877	4,551	12,125	(488)	29,062	(1,140)	(88,414)	(66,356)	(671,092)	(121,875)	(948,877)
Balance at 31 March 2020	**104,244**	**676,835**	**808,110**	**1,864,269**	**176,844**	**3,630,302**	**107,002**	**711,352**	**867,600**	**968,125**	**212,969**	**2,867,048**

	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	11,503	48,556	298,349	88,571	47,678	494,657	11,725	50,072	321,329	48,821	75,144	507,091
Non Current	92,741	628,279	509,761	1,775,698	129,166	3,135,645	95,277	661,280	546,271	919,304	137,825	2,359,957
Expected timing of cash flow												
Not later than 1 year	11,503	48,556	298,349	88,571	47,678	494,657	11,725	50,072	321,329	48,821	75,144	507,091
Later than 1 year, not later than 5 years	46,078	200,999	509,761	348,236	38,647	1,143,721	46,142	206,458	546,271	194,931	26,483	1,020,285
Later than 5 Years	46,663	427,280	-	1,427,462	90,519	1,991,924	49,135	454,822	-	724,373	111,342	1,339,672
Total	**104,244**	**676,835**	**808,110**	**1,864,269**	**176,844**	**3,630,302**	**107,002**	**711,352**	**867,600**	**968,125**	**212,969**	**2,867,048**

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. The value of the provision recognised during the period (£941 million) has increased significantly as compared to that recognised in 2018-19 (£435 million). This change is largely due to an increase in the financial support provided from 1 April 2019 to those infected, together with a change in estimated life expectancy of those infected.

	2019-20							2018-19						
	Departmental Group							Departmental Group						
	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
Balance at 1 April 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**
Prior period adjustments in underlying accounts	(2,596)	4,995	-	-	-	(9,345)	(6,946)	(116,278)	258,872	-	-	-	(152,405)	(9,811)
Provided in the year	26,769	52,743	526,823	14,618,037	940,585	799,728	16,964,685	29,564	62,329	853,432	10,222,650	434,844	564,684	12,167,503
Provisions not required written back	(8,844)	(34,927)	-	(2,727,116)	-	(309,581)	(3,080,468)	(8,923)	(18,934)	-	(2,186,143)	-	(305,414)	(2,519,414)
Transfers	(9,000)	-	-	-	-	9,000	-	-	-	-	-	-	-	-
Provisions utilised in the year	(29,012)	(62,560)	(142,676)	(2,324,251)	(75,132)	(197,409)	(2,831,040)	(28,135)	(61,305)	(101,036)	(2,359,866)	(42,607)	(221,485)	(2,814,434)
Transfer to accruals	(4,035)	(3,703)	(454,782)	-	-	(25,373)	(487,893)	(4,957)	(3,560)	(498,838)	-	-	(49,413)	(556,768)
Borrowing costs (unwinding of discount)	1,506	(721)	6,594	507,811	18,566	1,168	534,924	1,428	(12,389)	(16,874)	422,384	(19,871)	(7,805)	366,873
Change in discount rate	3,124	34,699	4,551	(9,378,201)	12,125	(17,862)	(9,341,564)	(2,612)	(93,324)	(66,356)	268,759	(671,092)	(158,882)	(723,507)
Balance at 31 March 2020	**279,043**	**950,148**	**808,110**	**83,766,855**	**1,864,269**	**1,523,092**	**89,191,517**	**301,131**	**959,622**	**867,600**	**83,070,575**	**968,125**	**1,272,766**	**87,439,819**

	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	31,825	67,022	298,349	2,714,960	88,571	647,734	3,848,461	41,460	65,852	321,329	2,423,853	48,821	685,357	3,586,672
Non Current	247,218	883,126	509,761	81,051,895	1,775,698	875,358	85,343,056	259,671	893,770	546,271	80,646,722	919,304	587,409	83,853,147
Expected timing of cash flow														
Not later than 1 year	31,825	67,022	298,349	2,714,960	88,571	647,734	3,848,461	41,460	65,852	321,329	2,423,853	48,821	685,357	3,586,672
Later than 1 year, not later than 5 years	124,174	270,732	509,761	12,165,686	348,236	356,449	13,775,038	127,008	277,478	546,271	11,714,046	194,931	282,138	13,141,872
Later than 5 Years	123,044	612,394	-	68,886,209	1,427,462	518,909	71,568,018	132,663	616,292	-	68,932,676	724,373	305,271	70,711,275
Total	**279,043**	**950,148**	**808,110**	**83,766,855**	**1,864,269**	**1,523,092**	**89,191,517**	**301,131**	**959,622**	**867,600**	**83,070,575**	**968,125**	**1,272,766**	**87,439,819**

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. The value of the provision recognised during the period (£941 million) has increased significantly as compared to that recognised in 2018-19 (£435 million). This change is largely due to an increase in the financial support provided from 1 April 2019 to those infected, together with a change in estimated life expectancy of those infected.

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 Report and Accounts[147]. Additionally this year, the provision includes liabilities relating to the Clinical Negligence Scheme for General Practice (CNSGP) which covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019 and the Existing Liabilities for General Practice (ELGP) under which NHS Resolution carry out the Secretary of State's oversight and governance responsibilities, under the interim arrangements relating to existing liabilities agreed with two medical defence organisations (MDOs).

A new scheme, the Clinical Negligence Scheme for Coronavirus (CNSC), was launched on 3 April 2020 in response to the need for government to provide indemnity cover for clinical negligence arising from the NHS healthcare arrangements put in place to respond to the COVID-19 pandemic. Any clinical negligence liabilities arising prior to or after this date from these coronavirus-related NHS activities are covered by CNSC by direction from Secretary of State under section 11 of the Coronavirus Act 2020 or, prior to the commencement of that section, under general powers to provide indemnity for clinical negligence. No provision is made in the 2019-20 financial accounts for additional liabilities arising under these indemnity arrangements. This is due to the proximity of these activities to year end where the volume of COVID-19 related hospital admissions increased during March 2020, and elective activity was scaled back or cancelled from 17 March 2020.

The majority (approximately 70%) of the CNST provision is as a result of claims arising from the brain damage of babies at birth from negligent care. The Early Notification scheme requires the notification by providers of maternity care of cases where there is a risk of brain damage at birth. The number of cases reported to the scheme was lower for March 2020 compared to the same time in previous years. However, this may be due to extended time lags in reporting of incidents because of the impact of the pandemic on frontline priorities, and also because of the

[147] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901085/nhs-resolution-2019-20-annual-report-and-accounts.pdf

changes in reporting requirements for the maternity incentive and Early Notification schemes during March and April 2020 respectively. At this stage, it is therefore too early to assess whether there will be a change in the level of risk in relation to brain damage at birth cases, the most significant factor in the provision valuation. Consequently, it is considered that the likely impact of the pandemic on the incidence of claims on or before 31 March 2020 is immaterial to the 2019-20 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, while incurred but not reported (IBNR) claims are valued using actuarial models to predict likely values. The value of the provision increased by £696 million in 2019-20 from £83,071 million at 31 March 2019 to £83,767 million at 31 March 2020. £9,378 million of this (a decrease) is related to a change in the provision for discounting (mainly due to the impact of changing inflationary expectations over the year), and a £10,074 million (increase) is net movement on provisions created and written back in the year, utilised, and unwinding of discount. Of the overall increase of £696 million, £1,307 million relates to liabilities arising from the general practice indemnity arrangements put in place during the financial year.

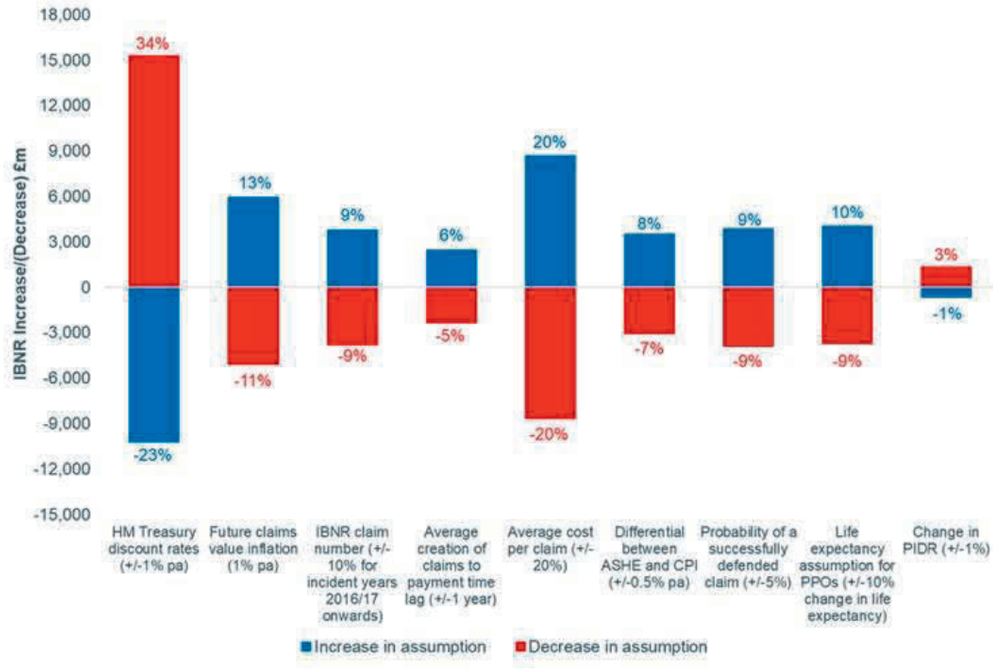
Full details of the changes above and, specifically the impact of inflationary expectations, (applied before discounting at the HM Treasury nominal discount rate) can be found in the Annual Report and Accounts of NHSR.

The provisions above are also reported in the accounts of NHSR together with other provisions of £286 million. These represent the English element of the clinical negligence provision as shown in Whole of Government Accounts.

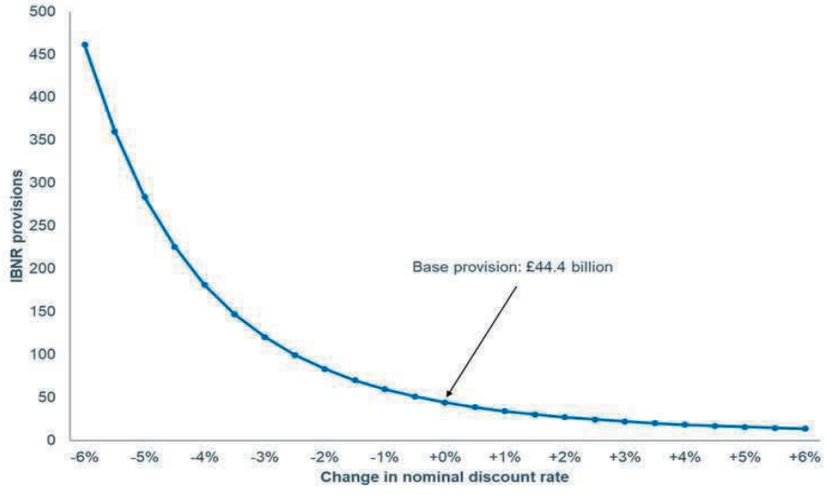
Due to the long-term nature of the liabilities and the assumptions on which the estimate of the provision is based, some uncertainty about the value of the liability remains. This is particularly relevant to the IBNR element of the provision (the largest single element of total provisions, and therefore where uncertainty has the greatest effect).

The following tables show the impacts of adjusting the key assumptions used for the IBNR estimate for CNST.

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, but they do capture future values that could plausibly occur. Each change is shown separately, but in practice combinations are possible, as different assumptions can be correlated.



The graph below highlights the sensitivity of the IBNR provision to changes in the HM Treasury discount rates prescribed. The relationship is not purely linear in all cases, as can be seen by the changes outlined in the graph.

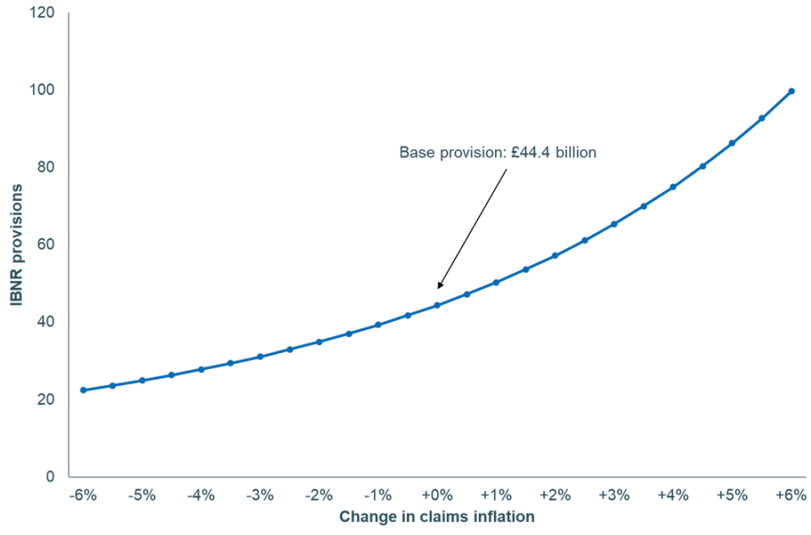


The clinical negligence provision's value is particularly sensitive to changes in the long-term discount rate given its nature. The disclosures above show the impact of percentage changes.

For the clinical schemes, the changes in discount rates this year have had a relatively small impact on the IBNR provisions. This is because a large proportion (by value) of the IBNR provisions are expected to be paid in more than 10 years' time and the long-term discount rate hasn't changed since last year.

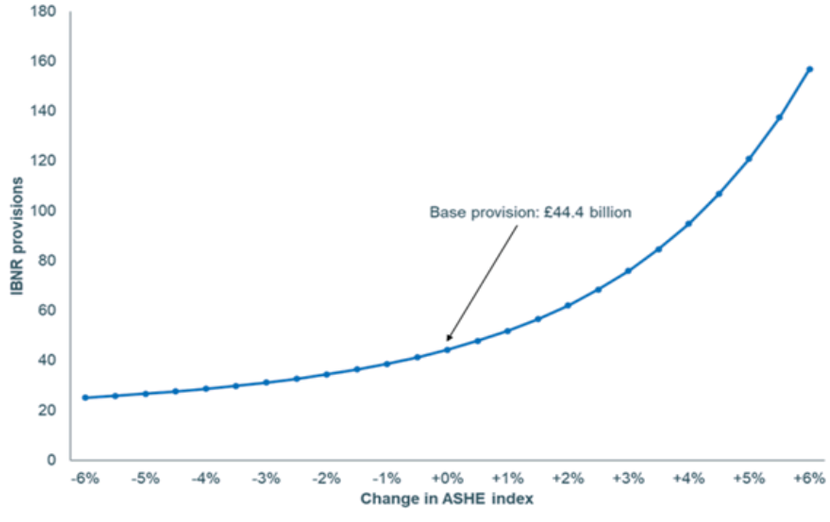
Other factors affecting the value of the clinical negligence liability which are subject to estimation and assumption include patterns of delay in reporting incidents, assumptions regarding the severity, frequency and/or value inflation of claims, the differential between the Consumer Price Index (CPI) and Annual Hourly Earnings index over the long-term and life expectancy. The following graphs shows the impact of adjusting some of these other key assumptions used for the IBNR estimate for CNST.

The following graph shows the sensitivity to future claims value inflation assumption



The following graph shows the sensitivity to the differential between ASHE and CPI.

The ASHE index, used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers.



The HM Treasury PES discount rate note from December 2019 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 for the IBNR provision and settled PPO claims. Further information including additional detail regarding key assumptions and areas of uncertainty is available in NHSR'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 £1,523.1 million, which includes 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 £120.1 million, of which £120.1 million was accounted for by NHS England Group. Of the total, £48.2 million was expected to be paid within one year, and £71.9 million between one and five years.

Other Miscellaneous provisions

The total of other miscellaneous provisions was £1,403.0 million. These relate to a range of issues, including: HGH (human growth hormone), restructuring, redundancy, lease dilapidations, litigation and a provision to account for the future payments NHS England has committed to make towards clinicians' pension tax bills.

Other miscellaneous provisions include £258 million relating to the clinicians' annual allowance pensions tax scheme. Where a clinician receives an 'annual allowance' pensions tax bill, they can elect to use the 'Scheme Pays' option, where the payment of this tax liability is carried out by the NHS Pension Scheme with a corresponding reduction in clinicians' future pension benefits. Under the 2019/20 annual allowance pension tax scheme, where Scheme Pays is used, NHS England will make a payment to clinicians of equal value to the lost pension benefits from the NHS Pension Scheme arising from a pension tax charge for 2019/20. Payments to replace the lost pension benefits will be made when clinicians start to draw benefits from the NHS Pension Scheme. The commitment to make these payments is made by the employing Trust, with an equivalent commitment from NHS England to fund this obligation.

Of the total other miscellaneous provisions £599.5 million is expected to be paid within one year, £284.6 million in one to five years and £518.9 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 earlier 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:

16.1.1 Pensions: Movements in defined benefit obligation and fair value of plan assets

	2019-20 £'000	2018-19 £'000
Present value of the defined benefit obligation at 1 April 2019	**(880,685)**	**(808,255)**
Prior period adjustments in underlying accounts	(82)	-
Current Service Costs	(17,132)	(16,522)
Past Service Costs	(2,724)	(369)
Interest Costs	(21,233)	(21,220)
Settlements and curtailments	-	(29)
Contribution from scheme members	(3,059)	(3,232)
Remeasurement of the defined benefit obligation:		
Actuarial Gains and (Losses)	79,896	(34,194)
Benefits paid	21,294	20,392
Scheme transfers	(3,599)	(2,660)
Transfers to/from other bodies	-	(14,596)
Other	6,696	-
As at 31 March 2020	**(820,628)**	**(880,685)**
Plan assets at fair value at 1 April 2019	**752,024**	**693,421**
Prior period adjustments in underlying accounts	(1,349)	-
Interest income	16,222	18,304
Settlements	(16)	(13)
Adjustments by the employer	14,625	14,440
Contributions by the plan participants	3,059	3,232
Remeasurement of the defined benefit asset:		
Expected Return on Assets	(8,777)	5,316
Actuarial Gains and (Losses)	(69,356)	27,606
Changes in the effect of limiting defined benefit asset to the asset ceiling	(4,639)	(310)
Benefits paid	(21,294)	(20,392)
Scheme transfers	-	2,028
Transfers to/from other bodies	-	8,392
Other	(4,024)	-
As at 31 March 2020	**676,475**	**752,024**
Plan surplus/(deficit) at 31 March 2020	**(144,153)**	**(128,661)**

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 £16.6 million (2018-19: £20.0 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, assuming that damage payments were awarded on all claims rather than taking into account the probability of damages being paid, might be estimated at £48,171.0 million (2018-19: £49,321.6 million), although £45,319.2 million (2018-19: £47,546.6 million) relating to the Clinical Negligence Scheme for Trusts (CNST) would be expected to be met by payments from NHS providers.

A new scheme, the Clinical Negligence Scheme for Coronavirus (CNSC), was launched on 3 April 2020 in response to the need for government to provide indemnity cover for clinical negligence arising from the NHS healthcare arrangements put in place to respond to the COVID-19 pandemic. Any clinical negligence liabilities arising prior to or after this date from these coronavirus-related NHS activities are covered by CNSC by direction from Secretary of State under section 11 of the Coronavirus Act 2020 or, prior to the commencement of that section, under general powers to provide indemnity for clinical negligence. No additional contingent liabilities are disclosed in the 2019-20 accounts for additional liabilities arising under these indemnity arrangements. This is due to the proximity of these activities to year end where the volume of COVID-19 related hospital admissions increased during March 2020, and elective activity was scaled back or cancelled from 17 March 2020.

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 £1.5 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.

Liabilities in respect of contractual obligations

The Department holds contractual liabilities in respect of redundancy payments and entitlements and it also holds liabilities in respect of commercial contract obligations. These liabilities include contractual indemnities the Department has entered into as part of its response to COVID-19

Investigations

The Department holds an indemnity in respect of an investigation and has provided an indemnity in respect of an Inquiry.

Other Contingent Liabilities

Within the NHS England Group account (which incorporates Clinical Commissioning Groups and NHS England) at 31 March 2020, there were contingent liabilities of £43.0 million (2018-19: £27.6 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 2020 had net contingent liabilities of £52.5 million (2018-19: £92.8 million).

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.

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 2019-20.

A small number of Ministers, Non-Executive Directors and members of either: The Departmental Board, Executive Committee, People Board 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
			2019-20 £'000	2019-20 £'000	2019-20 £'000	2019-20 £'000
Prof. Dame Sally Davies	Chief Medical Officer until September 2019	Cambridge University[1]	-	9,710	-	-
Prof. Dame Sally Davies	Chief Medical Officer until September 2019	Medical Research Council[2]	-	15,231	-	9,500
Prof. Sir Mike Richards	Non Executive Board Member	Cancer Research[3]	-	461	210	10
Jenny Richardson	Director of Human Resources	Medicines & Healthcare Products Regulatory Agency[4]	-	68,580	-	2,822
Prof. Dame Sue Bailey	Non Executive Board Member	Salford University[5]	-	139	-	-
Cat Little	Audit & Risk Committee member	Ministry of Defence[6]	-	1,037	-	-
Richard Hornby	Audit & Risk Committee member	Cabinet Office [7]	430	16,463	-	193

Sub note
1. Prof. Dame Sally Davies' husband is an employee of Cambridge University
2. Prof. Dame Sally Davies is a council member of the Medical Research Council
3. Prof. Sir Mike Richards is a trustee of Cancer Research
4. Jenny Richardson's husband is Chief Operating Officer of Medicines & Healthcare Products Regulatory Agency
5. Prof. Dame Sue Bailey is a Council member of Salford University
6. Cat Little was Director General of Finance at Ministry of Defence until the end of 2019
7. Richard Hornby is Chief Financial Officer at Cabinet Office

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	Relationship with DHSC	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
		2019-20 £'000	2019-20 £'000	2019-20 £'000	2019-20 £'000	2019-20 £'000	2019-20 £'000
NHS Shared Business Services Ltd.	DHSC Equity investment (50% shareholding)	1	3,224	-	19	-	2,906
Medicines & Healthcare Products Regulatory Agency	Non Consolidated Trading Funds	-	68,580	-	2,822	-	-
NHS Blood & Transplant Agency	Public Corporation	-	78,537	8,838	9,063	-	-

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.

19.1 Charitable Income and expenditure for the period ended 31 March 2020

	NHS Charities	
	2019-20	2018-19
	£'000	£'000
Total resources expended	151,807	308,632
Total incoming resources	(153,216)	(147,366)
Net outgoing / (incoming) resources for the year ended 31 March 2020	**(1,409)**	**161,266**
Other Comprehensive Net Expenditure		
Net gain/loss on revaluation of charitable assets	21,173	(10,470)
Total Comprehensive Expenditure for the year ended 31 March 2020	**19,764**	**150,796**

19.2 Summary Charitable Statement of Financial Position as at 31 March 2020

	NHS Charities	
	2019-20	2018-19
	£'000	£'000
Non-current assets		
Charitable investments	299,160	321,692
Other charitable non-current assets	7,080	11,052
Total non-current assets	**306,240**	**332,744**
Current assets		
Charitable cash	238,966	218,242
Other charitable current assets	22,028	23,215
Total current assets	**260,994**	**241,457**
Total assets	**567,234**	**574,201**
Current charitable liabilities	(47,078)	(35,271)
Non-current assets plus/less net current assets/liabilities	**520,156**	**538,930**
Non-current charitable liabilities	(212)	(68)
Assets less liabilities	**519,944**	**538,862**
Total charitable reserves	**519,944**	**538,862**

19.3 Charitable Financial Assets - Investments

	NHS Charities 2019-20 £'000	NHS Charities 2018-19 £'000
Balance as at 1 April	321,692	398,585
Prior period adjustments in underlying accounts	1,372	148
Acquisitions	47,876	46,905
Disposals	(49,310)	(53,636)
Net gain/loss on revaluation	(21,671)	11,830
Transfers	(1,377)	(82,139)
Other movements	578	(1)
Balance as at 31 March	**299,160**	**321,692**

19.4 Other Charitable Non-Current Assets

	NHS Charities 2019-20 £'000	NHS Charities 2018-19 £'000
Balance as at 1 April	11,052	79,944
Prior period adjustments in underlying accounts	(14)	81
Acquisitions	9	2,793
Disposals	(4,659)	(141)
Net gain/loss on revaluation	498	(1,360)
Transfers	-	(70,054)
Other movements	194	(211)
Balance as at 31 March	**7,080**	**11,052**

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.

COVID-19

The Department's response to COVID-19 began during the 2019-20 financial year and has continued into the 2020-21 financial year. The Department took important steps, at a rapid pace, to ensure that the NHS front line received the support it needed in terms of personal protective equipment provision, testing facilities and ventilator capacity. The Department needed to meet the growing demand on services at the time as well as to prepare for the predicted peak of COVID-19 cases in the UK.

Actions taken beyond the year-end have included:

- Central DHSC purchasing of personal protective equipment and ventilators. While Supply Chain Coordination Limited (SCCL) has continued to procure consumables and capital equipment for NHS providers, since March 2020 DHSC has supplemented this procurement centrally with the vast majority of the spend falling within the 2020-21 financial year. On 20 May 2020, the Core Department entered into a COVID-19 Facility with SCCL for £2 billion, due for repayment on 31 December 2021. This was further extended to £3.5 billion on 29 May 2020, to £4.5 billion in September 2020, and to £5.5bn in November 2020. No balances in the 2019-20 account require adjustment in relation to this facility. This arrangement will also have no impact on the Departmental Group position as amounts drawn down will be eliminated at group level.
- Entering into contracts with private sector organisations for test and trace services. These services included the purchase of testing kits, setting up testing labs, staffing the testing facilities and development of tracing infrastructure. To secure these urgent, vital services during a period when the country was in lockdown, it was necessary to include a relatively broad range of indemnities in some of these contracts.
- Launching the new Clinical Negligence Scheme for Coronavirus (CNSC) on 3 April 2020. This was in response to the policy decision to provide indemnity cover for clinical negligence arising from the NHS healthcare arrangements put in place to respond to the COVID-19 pandemic. Any clinical negligence liabilities arising prior to or after this date from these coronavirus-related NHS activities are covered by CNSC by direction from Secretary of State under section 11 of the Coronavirus Act 2020 or, prior to the commencement of that section, under general powers to provide indemnity for clinical negligence.
- The announcement of the NHS and Social Care Coronavirus Life Assurance Scheme 2020 on 27 April 2020 by the Secretary of State for Health. The scheme is for the eligible staff who are performing vital frontline NHS or social care work during the Coronavirus (COVID-19) outbreak, recognising the increased risks they are facing. In the event of a staff member dying due to COVID-19 a lump sum payment of £60,000 will be made to their estate, if they meet the qualifying work-related criteria for the scheme. The life assurance scheme is non-contributory, meaning there is no cost to staff or employers. The scheme is managed by the NHS BSA and has been implemented from 25 March 2020. The value of the compensations in 2019-20 is not expected to be material to the accounts.
- On Tuesday 18 August 2020, the Secretary of State for Health and Social Care, Matt Hancock, announced the establishment of a new organisation called The National Institute for Health Protection (NIHP). NIHP will bring together health protection work in the UK, combining the health protection elements of PHE with the NHS Test and Trace service and

the Joint Biosecurity Centre (JBC)'s intelligence and analytical capability. NIHP will be established during the Spring of 2021 as an ALB of the Department of Health and Social Care. The PHE functions and directorates that will transfer to the new organisation, and new homes, are under discussion and for future agreement. This announcement has no effect on the 2019-20 accounts.

There is no evidence that balances held in the 2019-20 account relating to COVID-19 expenditure require adjustments. Equally, no provisions or contingent liabilities under either of the indemnity schemes above are required to be made in the 2019-20 financial accounts.

COVID-19 has and will continue to materially increase the amount of expenditure the Department incurs compared to previous financial years, which will be observable from the Department's 2020-21 Statement of Comprehensive Net Expenditure (SoCNE). In responding to the COVID-19 pandemic the Department has also materially increased the purchasing and utilisation of inventory compared to previous financial years, as well as its purchases of plant, property and equipment. Whilst these elements of COVID-19 response will materially increase the value of current and non-current assets on the Statement of Financial Position, they will impact on the SoCNE through utilisation and write off of inventory as well as depreciation and impairment of non-current assets.

GP Indemnity Scheme

On 6 April 2020 the Department introduced the Existing Liabilities Scheme for General Practice (ELSGP). Claims arising from the historical liabilities within scope of the interim arrangements with the Medical and Dental Defence Union of Scotland have, from that date, been handled by NHS Resolution on behalf of the Secretary of State. Claims for liabilities within scope of the interim arrangements with the Medical Protection Society will be handled under the ELSGP from the start of the 2021-22 financial year.

NHS Cash Regime

Subsequent to the Statement of Financial Position date, on 2 April 2020, the Secretary of State for Health and Social Care made a public announcement of the Reforms to the NHS Cash Regime effective from 1 April 2020. Consequently, the relevant loan balances held with providers, which at the end of March 2020 totalled £13.4bn, are now included in 'current part of loans repayable transferred from investments' and represent amounts falling due within one year. NHS providers have been issued Public Dividend Capital during 2020-21 with which they have repaid the relevant loan balances totalling £13.4bn.

21. Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2019-20.

(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/home-page
The Nursing and Midwifery Council	http://www.nmc.org.uk/
NHS Property Services Limited	http://www.property.nhs.uk/
Genomics England Limited	http://www.genomicsengland.co.uk/
Supply Chain Coordination Limited	https://www.supplychain.nhs.uk/sccl/
Special Health Authorities	
NHS Business Services Authority	http://www.nhsbsa.nhs.uk/Index.aspx
NHS Counter Fraud Authority[3]	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/index.html
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/

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
Office of the National Data Guardian for Health & Social Care[8]
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) Office of the National Data Guardian for Health & Social Care has been added to the designation order in 2019-20.
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

£'000

		2015-16 Outturn[1]	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Plan
Resource DEL							
A	NHS Commissioning Board	16,824,251	16,449,871	16,232,918	16,598,249	17,186,308	21,811,931
B	NHS Providers	67,296,445	68,492,416	70,750,505	75,607,340	81,526,454	81,538,000
C	DHSC Programme and Administration	2,297,393	1,579,373	1,747,178	1,107,488	856,606	5,628,619
D	Local Authorities (Public Health)	3,088,182	3,433,394	3,090,533	3,011,064	2,931,555	3,279,000
E	Public Health England	872,549	877,056	822,586	1,026,301	923,546	813,883
F	Health Education England	2,003,077	2,153,292	2,056,903	1,819,177	1,444,495	1,851,619
G	Special Health Authorities	2,530,619	3,489,248	4,034,160	2,718,887	2,743,281	4,995,290
H	Non Departmental Public Bodies	501,809	530,669	576,362	624,829	628,293	294,979
I	Arm's Length Bodies [1]	-	-	-	838,583	2,981,221	945,700
J	NHS Commissioning Board financed from National Insurance contributions (non voted)	19,316,174	20,025,641	21,338,869	21,926,343	22,961,639	23,676,504
Total Resource DEL		**114,730,499**	**117,030,960**	**120,650,014**	**125,278,261**	**134,183,398**	**144,835,525**
	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.	(1,020,481)					
Total Resource DEL (adjusted for classification changes)		**113,710,018**	**117,030,960**	**120,650,014**	**125,278,261**	**134,183,398**	**144,835,525**

£'000

		2015-16 Outturn[1]	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Plan
Capital DEL							
A	NHS Commissioning Board	182,043	227,416	227,820	221,233	265,530	305,000
B	NHS Providers	2,941,896	2,865,338	3,045,549	3,928,404	4,498,029	5,741,488
C	DHSC Programme and Administration	418,424	1,355,172	1,782,811	1,658,348	1,811,114	1,820,985
D	Local Authorities (Public Health)	137,648	9,325	15,456	-	0	0
E	Public Health England	(13,235)	51,679	70,695	(70,475)	140,735	124,850
F	Health Education England	287	476	628	467	1,557	2,000
G	Special Health Authorities	(65,867)	14,726	16,738	(49,815)	24,172	70,372
H	Non Departmental Public Bodies	30,653	31,947	78,155	95,246	118,533	25,900
I	Arm's Length Bodies [1]	-	-	-	157,836	155,574	140,505
Total Capital DEL		**3,631,849**	**4,556,079**	**5,237,852**	**5,941,244**	**7,015,244**	**8,231,100**
	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.	1,020,481					
Total Capital DEL (adjusted for classification changes)		**4,652,330**	**4,556,079**	**5,237,852**	**5,941,244**	**7,015,244**	**8,231,100**

£'000

		2015-16 Outturn[1]	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Plan
Resource AME							
K	NHS Commissioning Board	(253,797)	(307,784)	17,784	(19,733)	294,489	100,000
L	NHS Providers	689,956	1,025,251	662,491	1,134,119	1,070,401	1,875,161
M	DHSC Programme and Administration	923,064	223,184	491,136	(437,113)	785,506	706,718
N	Public Health England	(3,455)	2,223	4,623	(2,181)	(2,033)	5,000
O	Health Education England	14,483	4,817	(17,647)	(44)	68	5,000
P	Special Health Authorities	27,832,697	8,557,599	11,990,518	6,405,024	675,203	7,219,000
Q	Non Departmental Public Bodies	3,555	2,628	3,406	6,373	3,536	6,000
R	Arm's Length Bodies [1]	-	-	-	(72,480)	20,839	85,000
Total Resource AME		**29,206,503**	**9,507,918**	**13,152,311**	**7,013,965**	**2,848,009**	**10,001,879**

£'000

		2015-16 Outturn[1]	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Plan
Capital AME							
K	NHS Commissioning Board	0	0	0	0	0	0
L	NHS Providers	0	0	0	0	0	0
M	DHSC Programme and Administration	9,021	13,349	0	(4,801)	(5,563)	15,000
N	Public Health England	0	0	0	0	0	0
O	Health Education England	0	0	0	0	0	0
P	Special Health Authorities	0	0	0	0	0	0
Q	Non Departmental Public Bodies	0	0	0	0	0	0
R	Arm's Length Bodies [1]	-	-	-	-	0	0
Total Capital AME		**9,021**	**13,349**	**0**	**-4,801**	**-5,563**	**15,000**

1.The structure of the Estimate changed in 2018-19 with the creation of an additional line in order to provide greater transparency for its reader.

Core Table 2: Administration Budgets

£'000

		2015-16 Outturn	2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Plan
Administration Budgets							
A	NHS Commissioning Board	1,596,259	1,497,776	1,560,979	1,508,274	1,545,410	1,671,753
B	NHS Providers	-	-	-	-	-	-
C	DHSC Programme and Administration	277,065	353,927	208,067	230,029	230,249	373,125
D	Local Authorities (Public Health)	-	-	-	-	0	-
E	Public Health England	155,611	58,925	50,661	48,778	49,134	53,012
F	Health Education England	68,254	70,783	65,304	59,943	61,296	63,119
G	Special Health Authorities	160,269	153,922	159,191	178,184	180,884	204,701
H	Non Departmental Public Bodies	296,348	259,119	259,311	248,219	239,886	190,841
I	Arm's Length Bodies	-	-	-	(739)	(5,777)	1,200
Total Administration Budget		**2,553,806**	**2,394,452**	**2,303,513**	**2,272,688**	**2,301,082**	**2,557,751**

Supporting narrative for the core tables can be found within performance section and **Annex B.**

Annex B – Financial Performance Detail

481. 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

482. Spending for all Government Departments is measured against a set of metrics as 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.

Table 31: DHSC Departmental Expenditure – Spending Metrics

Total Department Expenditure Limit (TDEL)	Total Annually Managed Expenditure (TAME)
£140.61bn	£9.39bn
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)
£134.63bn	£7.13bn	£11.42bn	£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)
£2.47bn
Administration budgets cover the costs of all central government administration, excluding depreciation and the costs of direct frontline service provision.

483. The Department contained its resources within all budgets authorised by Parliament as shown in **Table 32**. Budgets were also contained within HM Treasury controls following a HM Treasury approved virement from ring fenced RDEL into non-ringfenced RDEL, of £151 million.

Table 32: Parliamentary DEL and AME control totals

	2019-20		
	Budget £m	Outturn £m	Underspend £m
RDEL	134,628	134,183	444
CDEL	7,125	7,015	110
RAME	11,420	2,848	8,572
CAME	15	(6)	21
Further HM Treasury controls:			
Ringfenced RDEL	*1,145*	*700*	*444*
Non-ringfenced RDEL	*133,483*	*133,483*	*0*

1. Totals in the table may not sum due to roundings.

484. 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

485. 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.

486. TDEL spending continues to grow, both over the previous year and cumulatively since Spending Review 2015. **Table 33** confirms the 2019-20 TDEL spending outturn and compares that to previous years.

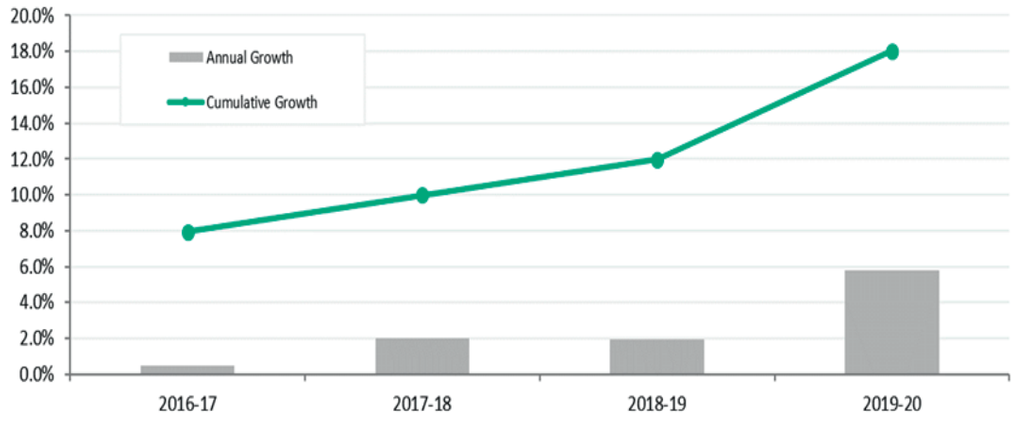
Table 33: Total Departmental Expenditure Limit Spending

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m
TDEL spending	**117,248**	**120,584**	**125,154**	**130,300**	**140,498**
Growth Nominal (£)	*3,903*	*3,336*	*4,570*	*5,146*	*10,198*
Growth Nominal (%)	*3.4%*	*2.8%*	*3.8%*	*4.1%*	*7.8%*

487. As shown in **Figure 7**, in 2019-20, the Departmental real-terms spending was 5.8% greater than in 2018-19 and 18% greater than in 2015-16.

5.8%
Spending growth in real terms over 2018-19

Figure 7: Real Terms Spending Growth



1. Cumulative growth figures are against the 2015-16 baseline
2. GDP Deflators at 1st June 2020 used to calculate real terms growth

488. The TDEL expenditure growth results from the funding secured in the 2015 Spending Review and 2019 Spending Round, the NHS Long Term Plan multi-year funding commitment and additional capital allocations made in the 2017 Budget and later in Summer 2019.

NHS Total Departmental Expenditure Limit

489. 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.

490. **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	260	305			
NHS TDEL measure at SR15 [1]	**98,100**	**101,318**	**106,711**	**110,114**	**112,634**	**115,711**	**119,903**			
*Nominal cumulative **NHS TDEL** Growth v 2014-15 baseline*		*3,218*	*8,611*	*12,014*	*14,534*	*17,611*	*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	-281	-177	0	0	0
NHS RDEL Budget at per NHSE Mandate					**114,421**	**123,377**	**129,681**	**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**	***123,377***	***129,681***	***136,134***	***142,841***	***151,318***
Plus NHS providers deficit and NHS charities			935	1,038	826	1,009				
Plus Net commissioner and NHSE underspend			-902	-970	-916	-636				
Net NHS RDEL Outturn [3]	**97,098**	**100,572**	**105,735**	**109,605**	**114,331**	***123,750***	***129,681***	***136,134***	***142,841***	***151,318***
NHSE CDEL	189	182	240	228	221	266	305			
NHS TDEL	**97,287**	**100,754**	**105,975**	**109,833**	**114,552**	**124,016**	**129,986**			

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, 2019-20 and 2020-21 Financial Directions to the NHS

Resource Departmental Expenditure Limit (RDEL)

491. The Department's total 2019-20 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).

£134.6bn RDEL Budget

492. 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.

493. In 2019-20, our National Insurance Contributions receipts were in line with the funding set out in the Parliamentary Estimate.

494. **Table 35** summarises the RDEL outturn against budget since 2015-16; highlighting the £444 million underspend in 2019-20.

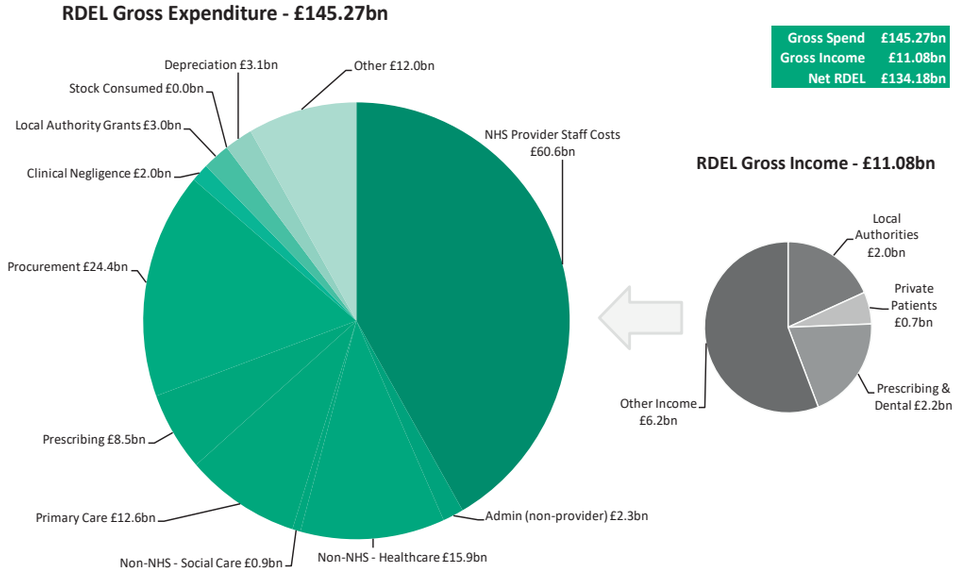
Table 35: Resource DEL

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m
RDEL Budget	114,523	117,594	121,342	125,924	134,628
RDEL Spending Outturn	**114,730**	**117,031**	**120,650**	**125,278**	**134,183**
Underspends / (Overspends) (£m)	*(207)*	*563*	*692*	*646*	*444*
Underspends / (Overspends) (%)	*-0.181%*	*0.479%*	*0.570%*	*0.513%*	*0.330%*
Of which:					
RDEL Depreciation Ring Fence Outturn	*1,115*	*1,003*	*734*	*919*	*700*
RDEL Non Ring Fence Outturn	*113,616*	*116,028*	*119,916*	*124,359*	*133,483*

1. Totals in the table may not sum due to roundings.

495. A breakdown of RDEL expenditure can be found in **Figure 8**.

Figure 8: 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

496. Of the Department's total £134.6 billion 2019-20 RDEL budget, £123.5 billion was allocated directly to NHS commissioners, with the remaining £11.1 billion funding ALBs and the Department's central budgets, i.e. the non-NHS sector.

497. 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.

498. 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).

499. Approximately £81 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.

500. The RDEL budget is set net of income and in 2019-20 the Departmental Group received around £11 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

501. The NHS's Long Term Plan includes clear ambitions to maximise use of taxpayers' investment in the NHS, measured via five 'Financial Tests'. These tests include objectives to deliver financial balance across all NHS commissioners and providers and reduce the number of organisations in deficit. The results in these accounts, and those published by the NHS themselves, will confirm that significant progress has been made with the NHS once again delivering overall financial balance, with the number of deficits in trusts reduced by half and finances in the vast majority of trusts and commissioners in a much healthier and sustainable position that seen in previous years.

502. The NHS spending outturn recorded in these accounts includes £620 million of COVID-19 related spending. This spending has been fully funded via a combination of savings achieved in NHS England centrally managed programmes and DHSC managed non-NHS budgets, with the NHS once again able to report financial balance against adjusted funding envelopes.

Net NHS RDEL

503. The following sections provide detail on the financial performance of the NHS in 2019-20.

504. Overall, the NHS has once again delivered a balanced budget, one of the Government's key tests of NHS financial performance. This measure excludes spending on the COVID-19 response in the NHS which has been fully covered from within the overall DHSC RDEL budget.

505. **Table 36** below provides a breakdown of the spending positions against the agreed NHS budget.

Table 36: NHS Reported Position against Budget

	(£m)
NHS RDEL Budget Outturn per SOPS 1 Net Outturn[1]	
NHS England Group[2]	122,741
NHS Providers	1,008
Net NHS RDEL Outturn[1]	**123,749**
Adjusted for COVID-19 spend[3]	(445)
Net NHS reported position	**123,304**
Net NHS RDEL Budget	**123,377**
Net variance against NHS Budget	***73***

1. Excludes RDEL Depreciation ringfence.
2. Includes CCGs and other bodies within the NHSE Group.
3. Includes £620m of net spending offset by £175m specific funding.

NHS Financial Performance – NHS England Group

506. The Government's revised 2019-20 Accountability Framework with NHS England and NHS Improvement[148], sets 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. **Table 37** provides a breakdown of NHS England spending against these resource limits.

Table 37: NHS England Spending against Resource Limits

	RDEL (excluding depreciation and impairments) £m	RDEL RF (depreciation and impairments) £m	AME £m	Technical £m
NHS RDEL Budget Outturn per SOPS 1 Net Outturn	122,741	149	295	62
Adjusted for COVID-19 impact on NHSE spending	(360)			
Net NHSE Reported Position	**122,381**	**149**	**295**	**62**
Resource Limits per NHS Financial Directions	**123,377**	**166**	**325**	**200**
Net Variance against Resource Limits	***996***	***17***	***30***	***138***

507. As required by the 2019-20 Accountability Framework, all spending has been contained to within the agreed Resource Limits. The overall non-ringfenced RDEL position for NHS England is a managed underspend of c£1 billion. This is adjusted for c£360m worth of net COVID-19 impact on NHS England group spending, as budget cover for that spending is held outside of the agreed NHS budget. This underspend offsets the provider RDEL position of c£1 billion (further details are below).

508. 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 2019-20. These non-NHS providers include Local

[148] https://www.gov.uk/government/publications/nhs-accountability-framework-2019-to-2020

Authorities, voluntary sector/not for profit organisations, Devolved Administrations and private sector providers. **Table 38** provides a breakdown of this spending and compares to 2018-19.

Table 38: NHS England's Purchase of healthcare from non-NHS Providers

	2018-19 £m	2019-20 £m
Independent Sector Providers	9,180	9,692
Voluntary sector/Not for profit	1,619	1,705
Local authorities	2,899	2,984
Devolved Administrations	50	49
Total NHSE Spend on all non-NHS bodies	**13,749**	**14,430**
Total DHSC RDEL	**125,278**	**134,183**
Spend with private sector as a % of total RDEL	7.3%	7.2%
Spend on all non-NHS bodies as a % of total RDEL	11.0%	10.8%

1. The numbers above have been collected separately from audited accounts data and may include estimates.
2. Numbers shown in the table 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. Totals in the table may not sum due to roundings.

509. Further commentary, together with the consolidated accounts of the NHS England group, is published on NHS England's website.

NHS Financial Performance – NHS Providers

510. At the 2019-20 financial year-end, there were 226 provider organisations producing accounts during the year[149]. Together these providers ended 2019-20 with a net financial pressure on the overall Resource DEL outturn of circa £1.0 billion. **Table 39** provides a summary of the NHS providers' financial position against RDEL spending controls and the reported deficit position over time.

Table 39: NHS Providers RDEL Breakdown

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m
NHS Providers' RDEL Outturn per SOPS 1 Net Outturn[1]	2,548	935	1,038	826	1,008
Provisions Adjustment	(74)	(43)	(39)	23	50
Other Adjustments[2]	(27)	(101)	(8)	(22)	(159)
Aggregate Net Deficit	**2,448**	**791**	**991**	**827**	**899**
Unallocated sustainability funding	0	0	(25)	0	(144)
Adjustment for COVID-19 impact on providers' deficit	0	0	0	0	(85)
Reported Net Deficit	***2,448***	***791***	***966***	***827***	***669***

1. Excludes RDEL Depreciation ringfence.
2. Other adjustments – these include adjustments to reflect the correct DEL scoring of income and depreciation of donated assets and of PFI spending.
3. Totals in the table may not sum due to roundings.

511. Despite the challenging environment, the majority of providers continue to demonstrate that strong, effective and sustainable financial management is possible. Many trusts

[149] 223 providers remained at the year-end as three demised during the year, so not in existence at 31 March 2020

reported a position that was in line or in some cases better than their plan, but others missed their plans to varying degrees of significance. Overall the sector continues to report an improving position, with the majority of trusts now out of deficit and the sector as a whole reporting an improved net aggregate deficit position in comparison to previous years.

512. All provider spending on the COVID-19 response in 2019-20 has been reimbursed by NHS England, other than c£85m which relates to holiday pay accruals not calculated until accounts had been finalised.

513. **Table 40** provides a breakdown of the reported deficit and position against control totals.

Table 40: Summary of NHS Provider's surplus / (deficit)

	Deficit		Surplus		Net	
	number	£m	number	£m	number	£m
Equal to or better than control totals	18	(550)	159	542	**177**	**(8)**
Exceeded control totals	31	(788)	14	25	**45**	**(764)**
Others	4	(222)	0	0	**4**	**(222)**
Adjustments[1]						**94**
Aggregate Surpluses and Deficits	**53**	**(1,560)**	**173**	**567**	**226**	**(899)**
Unallocated sustainability funding						***144***
Adjustment for COVID-19 impact on providers' deficit						***85***
Reported Provider Deficit	***53***	***(1,560)***	***173***	***567***	***226***	***(669)***

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 roundings.

Non-NHS Bodies - Financial Performance Resource DEL Spending

514. Outside of the NHS sector, the Department's non-NHS sector contained resource expenditure within DEL spending limits, this was extremely challenging, and some hard decisions were taken to reduce the non-NHS risk without compromising the support of the wider system, while safeguarding the interests of patients and the wider public.

9%
of total DHSC RDEL

515. In recognition of the financial challenges involving significant baseline pressures associated with the 2019 Spending Round, together with additional cost pressures arising in year, during the year HM Treasury allocated additional funding of £420m from their central reserve. In addition to this, and as previously committed by HM Government, DHSC was provided funding for the change in the Personal Injury Discount Rate (PIDR) – this is separately disclosed in **Table 41**.

516. While the majority of non-NHS expenditure on COVID-19 will fall into 2020-21, in 2019-20 the non-NHS sector incurred revenue expenditure of approximately £68 million. This mainly related to the utilisation of goods stockpiled for pandemics, publicity campaigns and some of the early repatriation/isolation costs. These were met from headroom arising late in the year from a small number of high value, demand led budgets.

517. The summarised RDEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 41**.

Table 41: Summarised Financial Position for DHSC's ALBs in 2019-20

	Plan £m	Outturn £m	Variance £m
RDEL Non Ring-fenced Spending -			
Public Health England	795	795	1
Public Health England Covid-19		49	(49)
Public Health Local Authority Grants	2,932	2,932	0
Health Education England	4,112	4,103	10
NHS Resolution	151	134	17
NHS Resolution (2019-20 reserve claim for Personal Injury Discount Rate)	350	271	79
NHS Property Services	(51)	(77)	26
Community Health Partnerships (CHP)	17	(1)	18
NHS Digital	374	371	3
Other ALBs	486	461	26
European Economic Area (EEA) medical costs	752	790	(38)
PPRS	(762)	(729)	(33)
DHSC Covid-19	0	19	(19)
Other DHSC Central Budgets	1,903	1,628	275
Subtotal DHSC & other ALBs Non Ring-fence	**11,060**	**10,746**	**314**
Public dividend capital (PDC) payments and loan interest	(954)	(1,013)	59
Total Non-NHS Non Ring-fence	**10,106**	**9,733**	**373**
RDEL depreciation ring-fence	979	536	442
Total RDEL	**11,085**	**10,269**	**815**

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)

518. The Department's total 2019-20 CDEL outturn is the consolidated net capital spending of all bodies within the Departmental group.

519. **Table 42** summarises the CDEL outturn against budget since 2015-16; highlighting the £110 million (1.54%) underspend in 2019-20.

£7.1bn
CDEL Budget

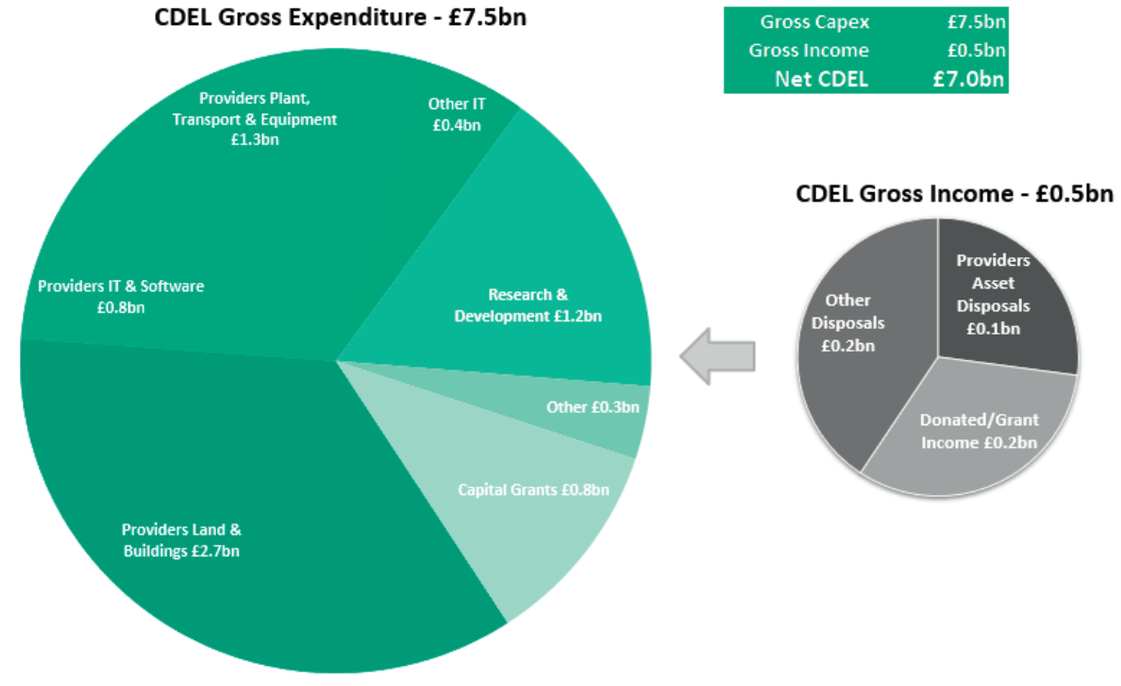
Table 42: Capital DEL Outturn[1]

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m
Opening CDEL Budget	3,690	3,618	4,535	4,905	5,894
R&D Adjustment	1,020	998	1,063	1,078	1,231
CDEL Budget	4,710	4,616	5,598	5,983	7,125
CDEL Spending Outturn	**4,652**	**4,556**	**5,238**	**5,941**	**7,015**
CDEL Underspend	*58*	*60*	*360*	*42*	*110*
CDEL Underspend %	*1.23%*	*1.30%*	*6.43%*	*0.70%*	*1.54%*

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.

520. **Figure 9** provides a breakdown of 2019-20 capital spend (CDEL) by expenditure type.

Figure 9: Capital DEL - spending breakdown (also see SOPS 1.2)

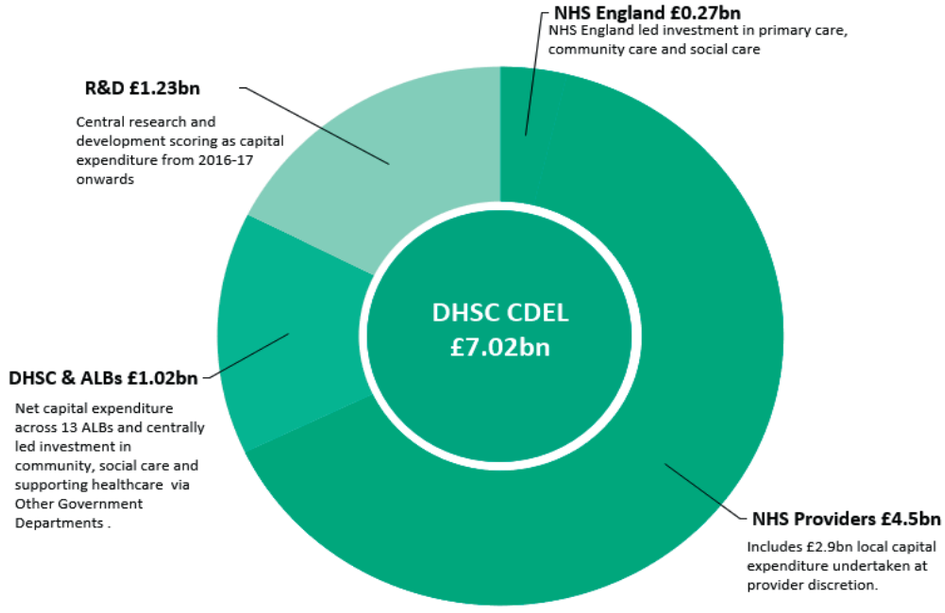


Note: Changes to the disclosures in the chart for 2019-20 are:

- Donated/Grant capital income and expenditure are included in the analysis; and
- Research and Development is shown as a separate category, in 2018-19 this was in 'other'.

521. **Figure 10** provides a breakdown of 2019-20 capital spend (CDEL) by sector within the DHSC group.

Figure 10: Capital DEL spending breakdown by sector



NHS Finance - NHS Providers Capital Expenditure

522. As shown in **Figure 10**, NHS provider Capital DEL (CDEL) expenditure, net of NHS charities capital movements, was £4,503 million in 2019-20. This is significantly higher than the equivalent level of net investment in 2018-19 (£3,932 million) and the preceding years shown in **Core Table 1**. This reflects a continued increase in the level of central capital financing made available for strategic programmes of investment, including those related to transforming the NHS estate and delivering digital technology improvements. Also, there was a more stable financial environment, allowing the NHS to confidently allocate more cash to longer-term capital investment programmes. At the time of publication of this report, the total expenditure includes £67 million of locally incurred costs relating to COVID-19 response, for which funding has been provided by the Department.

523. NHS providers finance the majority of capital expenditure themselves (77% during 2019-20) by deploying surplus cash reserves, and through capital loans taken out. This investment is shown as the Local Capital Expenditure line in **Table 43**. The Department, and its ALBs, also coordinate financing to support specific strategic initiatives.

524. **Table 43** shows the 2019-20 NHS provider CDEL outturn of £4,503 million was financed.

Table 43: Financing of Capital DEL

	2019-20 £m
Capital DEL Outturn	**4,503**
Of which	
Local Capital Expenditure[1]	3,449
DHSC & ALB led initiatives	896
PFI Residual Interest[2]	158

1. NHS CDEL in the table does not include the net capital investment of NHS Charities.
2. HM Treasury's budgeting framework requires PFI residual interest on assets to score to CDEL.

525. The Department and its Arm's Length Bodies have led specific initiatives over the year and issued non-repayable financing in the form of capital Public Dividend Capital (PDC) directly to NHS providers amounting to £804 million. **Table 43** refers to this.

526. Further details of these investments can be found in the report 'Financial Assistance under Section 40 of the National Health Service Act 2006' which is published alongside the Annual Report. Allocations are summarised in **Table 44.** There have been several large schemes supporting:

- continued transformation of the delivery of healthcare estate, including a new £8m 13-bed unit in Hull for young people with mental health issues in the area, run by the Humber Teaching NHS Foundation Trust, which opened in January 2020.
- advancing the use of information technology;
- renewal of aged diagnostic equipment; and
- funding to support urgent & emergency care over the winter period, as recommended in the NHS Five Year Forward View.

Table 44: Capital PDC Allocations 2019-20

	2019-20 Total £m
Non-Programme	92
Non-Programme PDC	**92**
DHSC Programme Initiatives PDC	
STP Capital Transformation Funding	247
Health System Led Technology Investment	108
Urgent & Emergency Care (Winter Capital)	86
Diagnostics – General	84
Global Digital Exemplars	63
Proton Beam Therapy	33
Electronic Prescribing	31
Energy Efficiency Funding	29
Digital Aspirants	28
Local Health Care Record Exemplars	24
Cyber	21
Diagnostics - Endoscopy and Colonoscopy equipment	13
COVID-19 Response (1)	9
Beyond Places of Safety	7
Urgent & Emergency Care (Winter Capital - Mental Health)	7
Electronic Rostering	6
Other Schemes under £5m	8
Total Programme	**804**
Total PDC	**896**

1. Total PDC Issued within 2019-20 to cover COVID-19 response related capital investments. Further retrospective payments are being made during the 2020-21 financial year to support the NHS's COVID-19 response in 2019-20.

Overall DHSC Group Capital Expenditure

527. In summary, the capital expenditure across the NHS sector and non-NHS sector resulted in an overall underspend of £110 million across the Departmental Group capital DEL limit. This underspend was after having incurred capital expenditure on COVID-19 of £96 million, of which £82 million was in the NHS and £14 million in the non-NHS sector. Work to assess the full impact of COVID-19 on capital expenditure is on-going.

RDEL Administration

528. 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).

529. In 2019-20, DHSC underspent by £576 million against the total Resource Administration limit of £2,881 million. Circa £323 million of this related to underspends in budget limit ring-fenced for depreciation and impairments expenditure.

530. **Table 45** shows the administration outturn between 2015-16 and 2019-20. Spending on administration increased in 2019-20 by circa £27 million (1.2%) compared to 2018-19, this is mainly explained by increased expenditure on NHS and public sector employer pensions contributions.

Table 45: DHSC non-ringfenced Administration

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m
Administration Outturn	2,421	2,275	2,222	2,189	2,212

1. Figures do not include depreciation and as a result will not directly reconcile to Admin outturn as per Statement of Parliamentary Supply (£2,301m).

Annually Managed Expenditure (AME)

£11.4bn
AME Budget

531. Details of the Department's total 2019-20 AME budget and expenditure are set out in **Table 46**, which shows the Department underspent by £8.6 billion (75%) against its final Resource AME budget.

Table 46: Annually Managed Expenditure plans, outturns and under/ (over) spends

	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m
Resource AME Budget	31,272	16,150	27,940	12,926	11,420
RAME Outturn	**29,207**	**9,508**	**13,152**	**7,014**	**2,848**
Underspend/(Overspend) £m	*2,065*	*6,642*	*14,788*	*5,912*	*8,572*
Underspend/(Overspend) %	*6.6%*	*41.1%*	*52.9%*	*45.7%*	*75.1%*
Capital AME Budget	15	15	15	15	15
Capital AME Outturn	**9**	**13**	**0**	**(5)**	**(6)**
Underspend/(Overspend) £m	*6*	*2*	*15*	*20*	*21*
Underspend/(Overspend) %	*40.0%*	*13.3%*	*100.0%*	*132.0%*	*137.1%*

532. 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 Departments' AME spending, which normally will impact on the fiscal framework in the same way as DEL spending.

533. 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.

534. The final AME budget in 2019-20 was set at £11.4 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.

535. As a result of favourable reductions, including assumptions around inflationary costs, the estimated quantum of future clinical negligence expenditure was lower than had been forecast.

Annex C – NHS Operational Performance

NHS Operational Performance against waiting time standards

536. The COVID-19 pandemic has placed unprecedented demands on acute care, particularly on intensive care units (ICUs). This required additional resource for the NHS in treating these patients, including reorganisation of hospital facilities, development of the Nightingale Hospitals, redeployment of existing staff and a drive to bring in recently retired and newly graduated staff to fight the pandemic. Increases in demand and changes to supply not only affects patients with COVID-19, but is also likely to have large knock-on effects on the NHS for some time to come.

537. On 17 March 2020, NHS England and NHS Improvement instructed service providers to postpone all non-urgent elective operations to free up approximately 30,000 hospital beds nationally to assist with the COVID-19 response. While acknowledging the inconvenience and potential distress for patients who had their operations cancelled, this measure helped to increase capacity for inpatient and critical care allowing staff to prepare for, and respond to, the anticipated large numbers of COVID-19 patients who need respiratory support. Patient safety remained our top priority and it was emphasised that emergency admissions, cancer treatment and other clinically urgent care should continue unaffected.

538. Toward the end of April 2020, evidence suggested that we had come through the peak of the first wave of COVID-19, and with the NHS well placed to provide world-leading care for those who still had the virus, we looked to bring back non-urgent services, as well as reassuring and encouraging the public to access the care they need, as soon as they need it.

539. To enable the NHS to focus on the response to COVID-19, recommendations flowing from the Clinical Review of Standards (CRS) have been delayed. Revised timing and handling plans are under discussion with NHSE and NHSI.

A&E Waiting Times

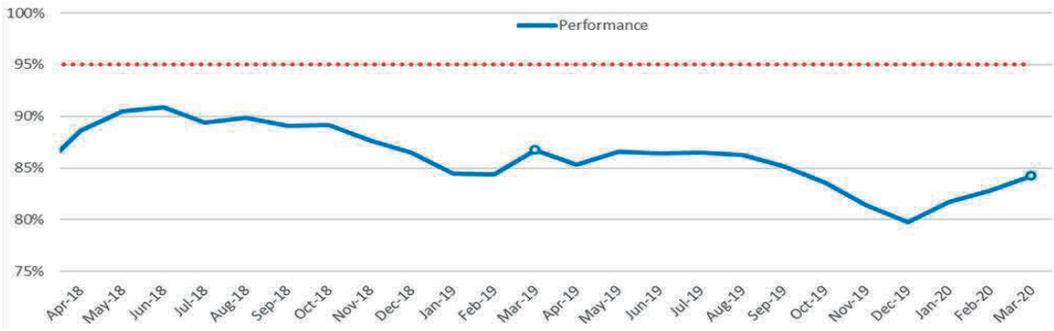
540. National performance for A&E waiting times[150] in 2019-20 was 84.2%. This did not meet the standard that 95.0% of patients should be admitted, transferred or discharged within four hours of arrival in an A&E department. Performance was lower than 2018-19 when it was 86.7 %. The standard has not been met since July 2015.

541. The decline in performance as shown in **Figure 11** should be seen in the context of continued increasing demand for non-elective services. A&E attendances in 2019-20 were 0.8% higher than in 2018-19, increasing to 25.0 million from 24.8 million in 2018-19. Over the same period, the total number of emergency admissions from A&E increased by 0.6% from 6.37 million in 2018-9 to 6.41 million in 2019-20.

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

542. Data for trusts undertaking the Clinical Review of Standards (CRS) field testing have been removed from the whole of the A&E time series. As a result the time series here is on a comparable 'like for like' basis across the full period of the data reported.

Figure 11: A&E waiting times and activity, 2018-19 and 2019-20



Ambulance Response Programme

543. **Figure 12** and **Table 47** show data against the ambulance response time categories for the 11 ambulance trusts. In March 2020, one of the six national response time standards was met (the Category 1 90th centile standard for life threatening calls). This standard has been met consistently since reporting began against this performance framework in December 2017. In March 2020, ambulance services received a record number of daily 999 calls (over 27,900), however a reduction in the number of incidents where a patient was transported to an Emergency Department suggests that alternatives to A&E are being used in order to avoid taking patients to hospitals that are facing increased pressures due to the COVID-19 pandemic.

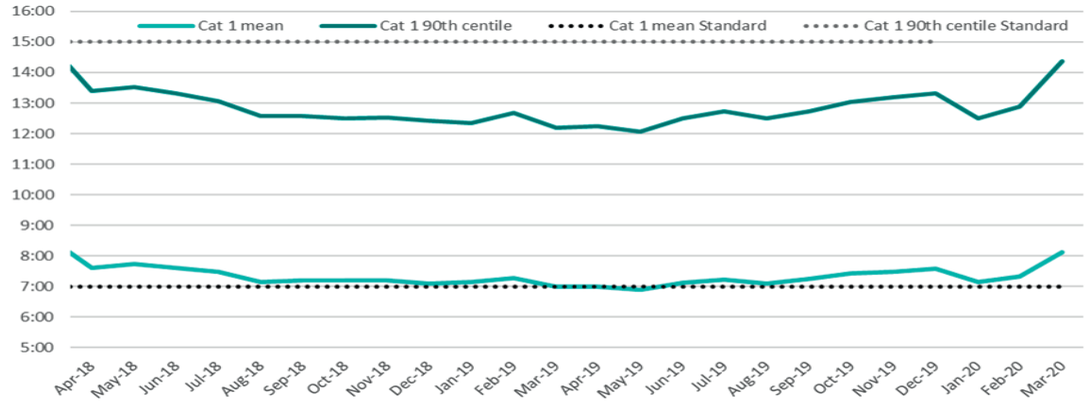
544. In the year 2019-20, performance against national response time standards has varied. The Category 1 mean standard has been met twice and the Category 4 standard has been met three times.

545. The NHS Long Term Plan focuses on safely reducing conveyance to A&E in order to reduce pressure on emergency departments. This is achieved through increased rates of 'hear and treat' (advising patients over the phone) and 'see and treat' (treating patients at the scene), as well as transporting patients to alternative locations, such as urgent treatment centres. Ambulance dispatchers can also directly refer patients to a wide range of community-based services via the CAS (clinical assessment service) integrated urgent care system and other digital tools. There is also a focus on reducing handover delays to free up vehicles to attend to new 999 calls, through intensive support to the poorest performing acute hospitals.

Table 47: Ambulance Response Performance

Performance	Apr-20	Apr-19	Change	
Category 1a: Mean response time ≤ 7 minutes	**07m08**	06m59	▼	00m09
Category 1b: 90th percentile ≤ 15 minutes	**12m27**	12m15	▼	00m12
Category 2a: Mean response time ≤ 18 minutes	**18m28**	21m29	▲	-03m01
Category 2b: 90th percentile ≤ 40 minutes	**00h38**	00h43	▲	-05m35
Category 3: 90th percentile ≤ 120 minutes	**01h29**	02h30	▲	-01h01
Category 4: 90th percentile ≤ 180 minutes	**02h25**	03h06	▲	-41m00

Figure 12: Ambulance response times (mins) and activity from 2018-19 and 2019-20



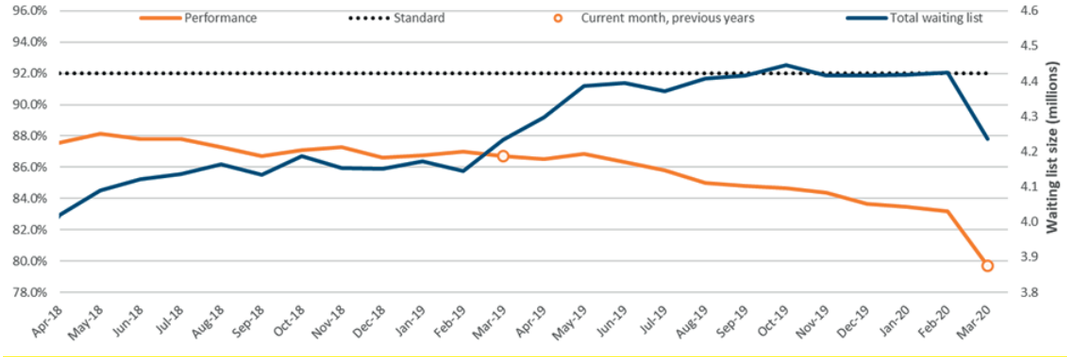
Referral to Treatment

546. Elective waiting times are monitored against the referral to treatment (RTT) incomplete pathway standard[151], 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 79.7% in March 2020, compared to 86.7% in March 2019. **Figure 13** shows that the standard was not met in any month of 2018-19 or 2019-20 (to month 9) and was last met in February 2016.

547. Deteriorating performance against the standard is a result of a continued mismatch between demand and activity. However, the effects of COVID-19 were evident towards the end of 2019-20, for example, a reduction in GP referrals was reported 4.1% lower than 2018-19. First outpatients were similar at 19.0 million in 2018-19 and 19.1 million in 2019-20.

548. Also shown in **Figure 13**, waiting list reported by NHS England was 4.24 million in March 2020, lower than February 2020 at 4.43 million, potentially due to reduced referrals following the initial impact of COVID-19 and similar to March 2019 at 4.23 million.

Figure 13: Percentage of patients on RTT incomplete pathways waiting within 18 weeks from referral and waiting list, 2018-19 and 2019-20



[151] https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

Cancer Waiting Times

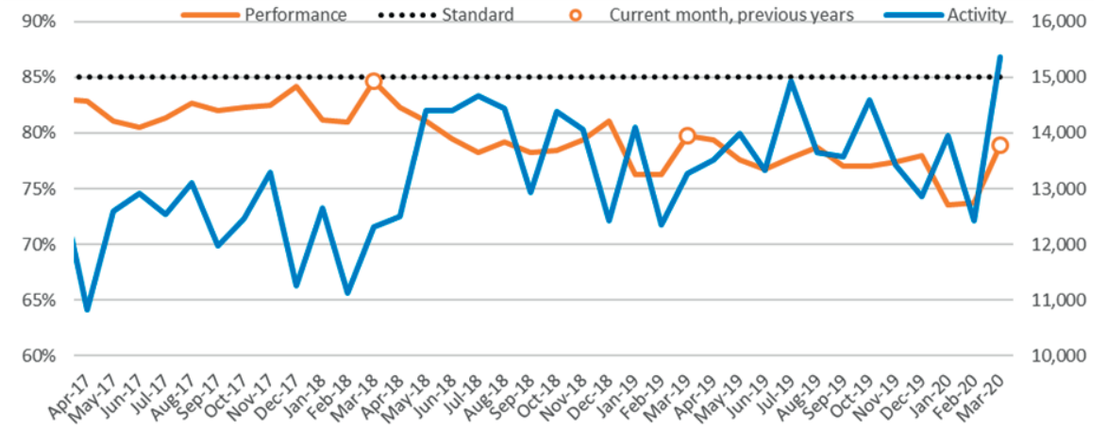
549. Early diagnosis and treatment are crucial to improving survival rates for cancer, and a number of key cancer waiting time standards[152] cover different elements of the pathway, to ensure patients benefit from better access to cancer services.

550. Priority has continued to be given to patient appointments and treatment for cancer, and the drive to improve survival rates through earlier diagnosis has meant that demand and activity have been rising for a number of years. The NHS has continued this throughout the COVID-19 pandemic.

551. As shown in **Figure 14**, 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 2019-20 or 2018-19 and was last met in December 2015. Demand continued to rise, with urgent GP referrals for suspected cancer increasing by 6.3% from 2.25 million in 2018-19 to 2.39 million in 2019-20.

552. As part of the Clinical Review of Standards (CRS), NHS England intends to recommend a new 28-day 'faster diagnosis standard' which aims to ensure that patients receive a cancer diagnosis or are cleared within 28 days of their first GP appointment. A new timetable for CRS recommendations will be agreed with NHSE and NHSI.

Figure 14: 62-day cancer waiting times and activity, 2018-19 and 2019-20



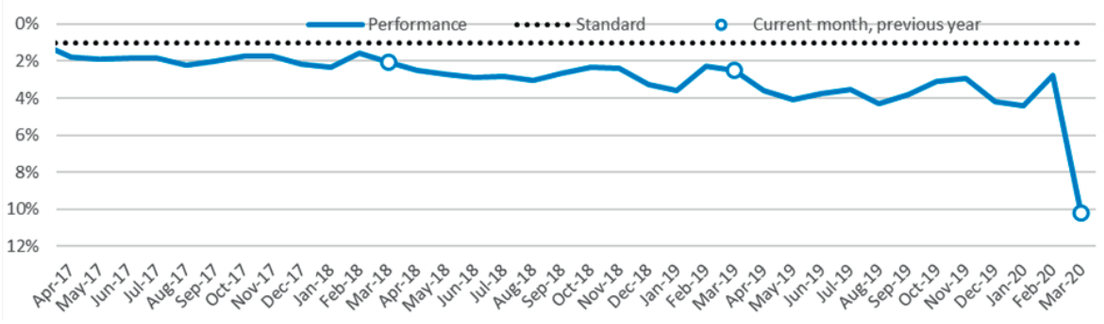
Diagnostic Tests

553. Waiting times for diagnostic tests[153] 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 15**, 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 2018-19 was just over two weeks.

[152] https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
[153] https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/

554. The majority of patients waited fewer than six weeks for their diagnostic test in 2018-19 and 2019-20. The number of tests carried out increased by 1.1% from 23.0 million in 2018-19 to 23.2 million in 2019-20. A drop in performance in March 2020 correlated with the NHS's planned response to COVID-19.

Figure 15: Diagnostic test wait times and activity, 2018-19 and 2019-20

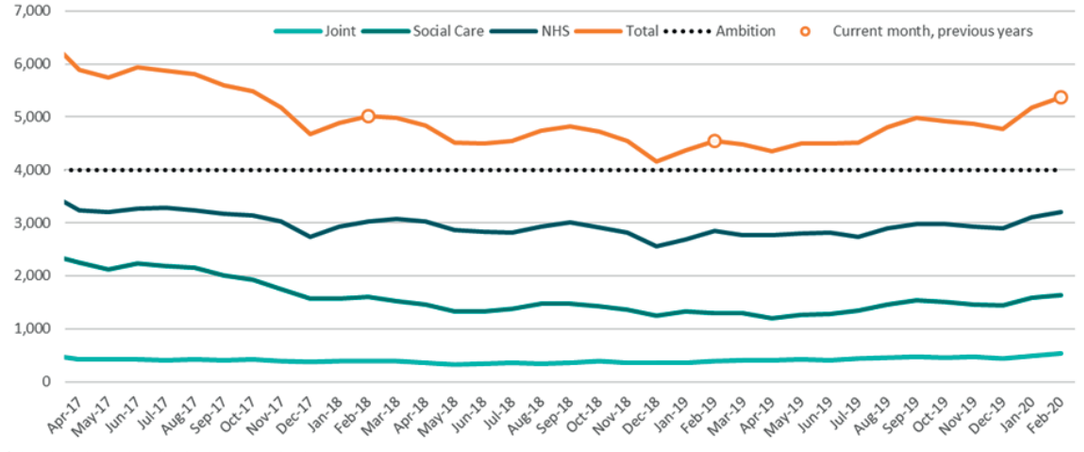


Delayed Transfers of Care

555. 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 transfer of care in 2019-20 was 1.61 million (from April 2019 to end of February 2020). Data was not collected in March 2020 as the NHS focussed on responding to the additional pressures of COVID-19. This compares to 1.53 million in 2018-19 (also excluding March to provide a like for like comparison), an increase of 5.2%.

556. As shown in **Figure 16**, in February 2020, delayed transfers of care accounted for 5,370 occupied beds per day compared with the 6,660 baseline in February 2017 – a decrease of 1,290 (-19.4%).

Figure 16: DTOC and lost 'bed days', 2018-19 and 2019-20



**DTOC data not collected in March 2020*

Annex D – Department of Health and Social Care Official Development Assistance

557. 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.

558. 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).

559. **Table 48** shows how the Department spent ODA funding in the 2019 calendar year.

Table 48: Official Development Assistance

The Department of Health and Social Care provided £225,082,027 of Official Development Assistance (ODA) in 2019.[154]
The Department of Health and Social Care did not spend any cross-government ODA funds in 2019.
The NIHR[155] **Global Health Research** (GHR) portfolio was established to support high-quality applied health research for the direct and primary benefit of people in low and middle-income countries (LMICs). The portfolio aims are delivered through a mix of researcher-led and commissioned calls delivered by NIHR and through partnerships with other global health research funders, through initiatives to develop and advance global health research and career pathways both in LMICs and in the UK. Together these activities have positioned the NIHR as a key player in supporting high-quality global health research. The programme and funding portfolio continued to expand in 2019, focussing on: **NIHR Global Health Research Units and Groups** – The NIHR continues to support 13 Global Health Research Units and 40 Global Health Research Groups to generate high-quality global health research focussing on health issues that affect the poorest people in LMICs, through equitable partnerships between UK and LMIC researchers. **NIHR Research and Innovation for Global Health Transformation (RIGHT)** – this programme funds interdisciplinary applied health research in key areas in ODA-eligible countries where a strategic and targeted investment can result in a transformative impact. The first call for equitable partnerships between UK and LMIC researchers launched in 2018 with a focus on Epilepsy, Severe and Stigmatising Skin Diseases, and Infection-related Cancers. NIHR commissioned two research partnerships focusing on Epilepsy, five on Severe and Stigmatising Skin Diseases, and one on Infection-related Cancers, all of which began work in 2019. A second RIGHT call with a focus on Global Mental Health launched in early 2019, and 6 LMIC-UK partnerships were commissioned to begin work in Autumn 2020. In 2019, **the NIHR Global Health Policy and Systems Research (Global HPSR) programme** was launched with the aim to support research into health systems which is directly and primarily of benefit to people in LMICs. This will be driven by effective equitable partnerships between LMIC and UK researchers, who together will engage stakeholders; identify and address priorities for research in health policy and health systems; and develop plans for capacity strengthening and knowledge sharing. The programme comprises

[154] Figures are provisional, taken from https://www.gov.uk/government/statistics/statistics-on-international-development-provisional-uk-aid-spend-2019

[155] National Institute for Health Research https://www.nihr.ac.uk/

of three funding calls. In the first call for Global HPSR Development Awards, 17 equitable research consortia led jointly by LMIC and UK researchers were funded to: identify and engage relevant stakeholders (policy makers and LMIC communities); undertake a needs-assessment and identify local priorities for research, with the aim that Development Awards will support an application for future research funding. The Development Award research consortia begin work in Spring 2020.

NIHR Global Research Professorships –This programme funds research leaders of the future with a position affiliated to a UK university to promote effective translation of research and to strengthen research leadership at the highest academic levels, providing support for a small team as the building blocks of an independent academic research career in global health. In 2019, the NIHR funded the first two Global Professorships undertaking research which aims to specifically and primarily benefit individuals in LMICs.

NIHR Global Health Research Partnerships
In 2019, the NIHR established **three new multi-year funding partnerships** addressing health challenges relevant to people in LMIC settings in areas of unmet need:

- The NIHR-Wellcome Global Health Research partnership was created to support eligible high-quality awards jointly with the Wellcome Trust and includes
    - Three Fellowship schemes for applicants from LMICs, International Master's Fellowships, Training Fellowships for PhD-level applicants and Intermediate Fellowships for early career post-doctoral awards;
    - Three major award schemes for applicants from LMICs or the UK: Investigator Awards, Collaborative Awards and Senior Research Fellowships.

  Launched in July 2019, by the end of the year the partnership had jointly funded nine Fellowships directly to LMIC applicants and four Collaborative Major Awards with areas of global health research priority including; mental health, multimorbidity, non-communicable diseases, nutrition and snakebite.
- A partnership with Grand Challenges Canada co-funds a Global Mental Health program which aims to support high impact research innovations that improve treatments and/or expand access to care for people, especially youths living with or at risk of mental disorder in LMIC settings.
- Thirty awards were supported through the Royal Society of Tropical Medicine and Hygiene (RSTMH) small grants scheme for early career researchers - with 80% of these awards to LMIC nationals, covering 23 different research institutes across sub-Saharan Africa, Latin America and southeast Asia and researching topics such as neglected tropical diseases and chronic respiratory disease.

NIHR support to established high-quality global health research initiatives – in 2019 the NIHR made contributions to three programmes which aim to develop effective, affordable products to address diseases that directly affect at-risk populations in LMICs:

- Global Antibiotic Research and Development Partnership (GARDP) for developments of severe bacterial infections in neonates;
- Coalition for Epidemic Preparedness Innovations (CEPI) supporting vaccine development against emerging infectious diseases, that threaten life, health and prosperity with a specific focus in LMIC settings; and
- With the European and Developing Country Clinical Trials Partnership (EDCTP) to support research to improve management of co-infections, poverty-related diseases, diarrhoeal diseases and lower respiratory tract infections.

These strategic investments contribute to the portfolio of high-quality global health research focused on health issues of people living in LMICs supported through the Global Health Research ODA budget in 2019.

Global Health Security assistance was focused on:
The Fleming Fund - This project supports LMICs 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 is improving laboratory capacity and diagnosis and building sustainable surveillance systems at a country level. This is being done through a One Health approach, covering human and animal health and agriculture sectors, in places where drug resistant infections have a disproportionate effect. In 2019, the most significant areas of ODA spend were:

- Surveillance and data: development of country grants in 24 priority countries, of which 16 country grants and 8 regional grants were active in supporting the collection of AMR data. 250 laboratories were assessed and 132 were supported (including human, animal and environmental).
- Global guidance, protocols and governance: support to the key tripartite multilateral organisations WHO, OIE, and FAO. Five global protocols and guidance for AMR surveillance were developed and implemented in countries with the direct support of Fleming Fund.
- 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 (GRAM) project to share data on the burden of morbidity and mortality, where 47 data sharing agreements were finalised or agreed in principle. The GRAM project also published a study on the global burden of sepsis, providing the first global estimates of sepsis incidence and mortality across 195 countries and territories (https://www.thelancet.com/infographics/sepsis-gbd).
- Partnerships, capacity building and technical assistance: 82 fellows have been selected and fellowship workshops have been held in 13 countries. The first 3 ODI economic fellows were posted to countries and regional organisations and the Commonwealth Partnerships for Antimicrobial Stewardship scheme supported 626 clinical staff in 4 countries to improve their Antimicrobial Stewardship knowledge.
- Adaptive management, learning and evaluation: Management agent and evaluation supplier costs. The second formative deliverable was produced by the independent evaluation supplier supporting DHSC and the Management Agent to adapt and improve programme delivery based on learning to date.

UK Vaccine Network - This project is focused on targeted investments to support the development of new vaccines and vaccine technologies for diseases of epidemic potential in LMICs. In 2019, the most significant areas of spend were:

- Pre-clinical and Clinical stage vaccine development projects, funded through three Small Business Research Initiative (SBRI) competitions managed by Innovate UK;
- Clinical-stage vaccine development projects funded through a Biotechnology and Biological Sciences Research Council (BBSRC) / Medical Research Council (MRC) Intramural Centre competition and managed by the National Institute for Health Research (NIHR, NETSCC);
- 2 vaccine manufacturing research hubs funded through an Engineering and Physical Sciences Research Council (EPSRC) managed competition;
- A financial commitment to the Coalition for Epidemic Preparedness Innovations (CEPI);
- A research competition run by BBSRC to support One Health approaches to accelerate vaccine development; and
- An Epidemiology for Vaccinology competition run by NIHR (CCF) which seeks to develop epidemiological models, tools and technologies to assist with development and clinical trialling of vaccines in outbreak situations in LMICs.

UK Public Health Rapid Support Team (UK-PHRST) - 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 2019 the UK-PHRST main efforts were concentrated on supporting the Ebola Virus Disease outbreak in the Democratic Republic of the Congo, setting up new epidemiolocal centres as the disease progressed and helping with national preparedness in neighbouring Rwanda. Additional capacity was provided via a team of reservists allowing support to be given to other disease outbreaks when the majority of the world's response efforts were focussed on DRC. This included deployment to an outbreak of Lassa fever in Nigeria and efforts in Mozambique working with the UK Emergency Medical team post cyclone. Activity in research and capacity building were undertaken with results expected in 2020.

International Health Regulations (IHR) Strengthening Project - 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 2019 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 2019, GAMRIF's spend included the disbursement to:

- Bilateral research partnerships. This includes a programme between the UK and China, to support 14 projects delivered and managed by Innovate UK, which advances innovations for AMR. Additionally, there is a partnership between the UK and Argentina to support five research projects that are advancing AMR and the environment research. Funding was disbursed to BBSRC for the management of this programme for the UK.
- Three global research initiatives, where GAMRIF partners with research institutions that will support international research competitions. This includes five projects with CARB-X to advance research on vaccines and alternatives for humans, 11 projects under the InnoVet AMR programme with Canada's International Development Research Centre (IDRC) on vaccines and alternatives for animals, and finally 17 bacterial vaccinology projects with the BactiVac Network.
- Funding towards two product development partnerships (PDPs), including to the Foundation for Innovative New Diagnostics (FIND) and the Global Antimicrobial Research and Development Partnership (GARDP).

ODA admin – This budget funds all DHSC staff supporting ODA funded activities and their associated costs. It also funds overheads for IT and accommodation, and commercial and advisory legal support 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 LMICs.

Funded through ODA spend, the FCTC 2030 five-year project has completed four years and is directly supporting the implementation of the WHO Framework Convention on Tobacco Control in 15 LMICs. Late in year four, project support was extended to support nine additional LMICs after an open application process.

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 2019 (year four of the project), the most significant areas of ODA spend were related to:

- Delivering key objectives in accordance with the agreed FCTC 2030 year four work programme.
- Funding activities at country level with Partner Parties working to their own individual workplans depending on their focus areas.
- Financial resources allocated for WHO Regional Offices on projects to advance FCTC 2030 priorities at regional level.

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 asylum seeker's healthcare costs following their arrival in the UK. These are the estimated healthcare costs of asylum seekers classified as 'Section 95', 'Section 98' and Unaccompanied Asylum-Seeking Children 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 E – Our Arm's Length Bodies and Delivery Partners

Organisation	Status	Website
Our Executive Agencies		
Public Health England	Executive Agency	https://www.gov.uk/government/organisations/public-health-england
Medicines and Healthcare products Regulatory Agency[1]	Executive Agency	https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency
Our Executive non-Departmental Public Bodies (NDPBs)		
NHS Commissioning Board (known as NHS England)[2]	NDPB	https://www.england.nhs.uk/
NHS Improvement[2]	NDPB	https://improvement.nhs.uk/
Monitor[2]	NDPB	https://improvement.nhs.uk/
Care Quality Commission	NDPB	https://www.cqc.org.uk/
National Institute for Health and Care Excellence	NDPB	https://www.nice.org.uk/
NHS Digital	NDPB	https://digital.nhs.uk/
Human Fertilisation and Embryology Authority	NDPB	https://www.hfea.gov.uk/
Human Tissue Authority	NDPB	https://www.hta.gov.uk/
Health Research Authority	NDPB	https://www.hra.nhs.uk/
Health Education England	NDPB	https://www.hee.nhs.uk/
Our Special Health Authorities		
NHS Counter Fraud Authority	Special Health Authority	https://cfa.nhs.uk/
NHS Trust Development Authority[2]	Special Health Authority	https://improvement.nhs.uk/
NHS Business Services Authority	Special Health Authority	https://www.nhsbsa.nhs.uk/
NHS Resolution	Special Health Authority	https://resolution.nhs.uk/
NHS Blood and Transplant[1]	Special Health Authority	https://www.nhsbt.nhs.uk/
Other bodies included within the Departmental Group		
NHS Property Services Ltd	Limited company owned by DHSC	https://beta.companieshouse.gov.uk/company/07888110
Community Health Partnerships Ltd	Limited company owned by DHSC	https://beta.companieshouse.gov.uk/company/04220587
Supply Chain Coordination Ltd	Limited company owned by DHSC	https://beta.companieshouse.gov.uk/company/10881715
Genomics England Ltd	Limited company owned by DHSC	https://beta.companieshouse.gov.uk/company/08493132
Skipton Fund Ltd[3]	Limited company operated by third party	https://beta.companieshouse.gov.uk/company/05084964
Nursing & Midwifery Council	Professional regulator	https://www.nmc.org.uk/
Health & Care Professions Council	Professional regulator	https://www.hcpc-uk.org/
Professional Standards Authority for Health and Social Care	Independent body accountable to parliament	https://www.professionalstandards.org.uk/home

Notes

1. NHS Blood and Transplant is not included in this Annual Report and Accounts as it is designated as outside the Departmental Group by the Office for National Statistics. MHRA has now been re-categorised as falling within the Departmental Group but it will not be incorporated into the Department's accounting boundary until its establishing legislation is revoked.
2. Monitor and the NHS Trust Development Authority remain legal entities. However, since 1 April 2016, they have operated as a single organisation, NHS Improvement. In April 2019, NHS England and NHS Improvement moved to a single leadership model under the Chief Executive Officer of NHS England and single Chief Operating Officer, who is also the CEO of NHS Improvement.
3. Partners of Russel-Cooke LLP took over as Directors of Skipton Fund Ltd in September 2018, in agreement with the Department, to provide any outstanding legal and administrative functions. The Skipton Fund retained its £500,000 reserve fund, originally provided by the Department, to cover these operational costs, and it provides quarterly reports to the Department.