Department of Health & Social Care

Department of Health and Social Care

Annual Report and Accounts

2021-22

(For the period ended 31 March 2022)

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

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

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

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

Ordered by the House of Commons to be printed on 26th January 2023

HC1043

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This is part of a series of departmental publications which - along with the Main Estimates 2021-22 and the document Public Expenditure: Statistical Analyses 2021 - present the Government's outturn for 2021-22 and planned expenditure for 2022-23.

This publication is also available on our website at: www.gov.uk/official-documents

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CORRECTION SLIP

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Correction:

Page 263

Paragraph 12 of the Report of the Comptroller and Audit General to the House of Commons

Text reads:

12. There was insufficient evidence to support the balances transferred to UKHSA by the Department and PHE on 1 October 2021. The Department transferred £794 million of NHS Test and Trace inventory to UKHSA but did not perform period-end stock counts over these assets. The Department also transferred £1.5 billion of NHS Test and Trace accruals and UKHSA has not been able to evidence the validity of the balances transferred due to weaknesses in the accruals controls and record keeping. Public Health England ("PHE") transferred £957 million of inventory and stockpiled goods to UKHSA. Although PHE performed period-end stock counts over its vaccine inventories of £761 million before transfer on 1 October 2021, it did not perform such stock counts over stockpiled goods of £254 million transferred at the same date.

Text should read:

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Date of correction: 9 February 2023

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Performance Report

Permanent Secretary's Overview

The Department of Health and Social Care supports its Ministers in leading the nation's health and care system. Our objectives are delivered in conjunction with our Arm's Length Bodies, to help people live more independent and healthier lives, for longer, creating a safe and high-quality health and care system that is financially sustainable.

In 2021-22, COVID-19 has continued to be the most significant challenge the country and the public sector has met in a lifetime. The Department is not in the same position as it was before COVID-19, and we have faced many competing demands. Our key priorities for the reporting year were developed to help the Department manage this and articulate our vision of how we enable everyone to live more independent, healthier lives for longer.

Throughout the year, as well as responding to challenges such as the Omicron variant at pace and pressures on the health and care system – in part due to the spike in flu and ongoing high levels of COVID-19 - the Department has focused on returning to a steadier state of work, delivering ministerial policies, publishing legislative reform, and improving governance across the whole of the Department and its arm's length bodies.

In 2021-22, we saw the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID) become fully operational. The changes in the Department's structure have brought together expert advice and evidence to help shape policy development and implementation, with the aim of supporting the UK population as we adapt to new public health challenges.

Continuing to develop and improve our health and care system is key to addressing the backlogs built up during the pandemic. To this end, the Department worked on investments in the New Hospitals Programme, the Health and Care Act 2022, and the Elective Recovery Plan during 2021-22. The establishment of Integrated Care Boards will aim to strengthen partnerships between the NHS and local authorities and support a change of culture towards greater collaboration and joint working. Together with the 'Plan for Patients' recently announced, the system is working hard to tackle the health inequalities and challenges that we face.

We are acutely aware that the pandemic will continue to have lasting consequences. It is still critical that we, and the wider health and care system, continue to reflect and learn the lessons from the pandemic. The UK COVID-19 inquiry was set up in 2022 to examine the UK's preparedness and response to the COVID-19 performance, and to learn lessons for the future.

2021-22 continued to prove a challenging backdrop against which the Annual Report and Accounts were produced. The Comptroller and Auditor General (C&AG) has qualified his opinion in several respects, namely; inventory existence, UKHSA control and governance, and an excess vote. These matters are discussed in more detail in the Governance Statement and the C&AG's certificate and Report on Account. These areas also provide detail on where previous qualifications have been lifted, for instance in regard to accruals, fraud risk and regularity. We will continue to work towards lifting the remaining qualifications and believe the circumstances in which they have arisen to be exceptional.

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 and sets out how funding flows from Parliament around the health and social care system.

Our Role and Purpose

2. The vision of the Department of Health and Social Care (DHSC) is to enable everyone to live more independent, healthier lives, for longer. To achieve this vision, the Department has four core roles:
   - Provide world-class advice to ministers that is supported by expert research and analysis. We are accountable to Parliament and to the public and we strive to achieve the highest standards of good governance in everything we do.
   - Drive transformation of the health and care system by setting the strategy, shaping policy, securing the funding, and developing the legislation that supports it.
   - Work with our agencies and partners to deliver health and care services to improve and protect everyone's health and wellbeing. We think ahead to ensure that services can respond to changing needs. We are there in the last resort to take the action necessary to safeguard the nation's health.
   - Work with other Government Departments, our agencies, and partners locally, regionally, nationally, and internationally to contribute to the Government's wider health, economic and social goals.

3. COVID-19 has made our objectives crucial, as we serve a nation that is more passionate than ever about effective health and care systems. We have many competing demands on us as a Department, whether that be COVID-19, health and social care reforms, manifesto commitments and our long-term plans. That's why for 2021-22, we developed a set of key priorities to help us clearly articulate our vision of how we enable everyone to live more independent, healthier lives for longer. These priorities are set out in the **Performance Summary** section.

4. The Department works through its ALBs, which 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 and NHS Improvement (NHSE and NHSI), who legally merged as a result of the Health and Care Act 2022 following royal assent in April 2022, and who collectively lead the NHS in England ensuring patients receive high-quality care in local health systems that are financially sustainable;
   - National Institute for Health and Care Excellence (NICE), which drives best practice in the health and care system through the development of recommendations and guidance, including on the clinical and cost-effective use of medicines;
   - UK Health Security Agency (UKHSA), which brought together functions from Public Health England (PHE), NHS Test and Trace and the Joint Biosecurity

Centre. The UKHSA is responsible for planning, preventing, and responding to pandemics and external health threats, and providing intellectual, scientific, and operational leadership at national and local level, as well as on the global stage;

- The Care Quality Commission (CQC) which monitors, inspects, and regulates health and social care services to make sure they meet fundamental standards of quality and safety; and,
- Medicines and Healthcare products Regulatory Agency (MHRA) which protects and improves public health through the effective regulation of medicines, medical devices, and blood components for transfusion in the UK, underpinned by science and research.

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

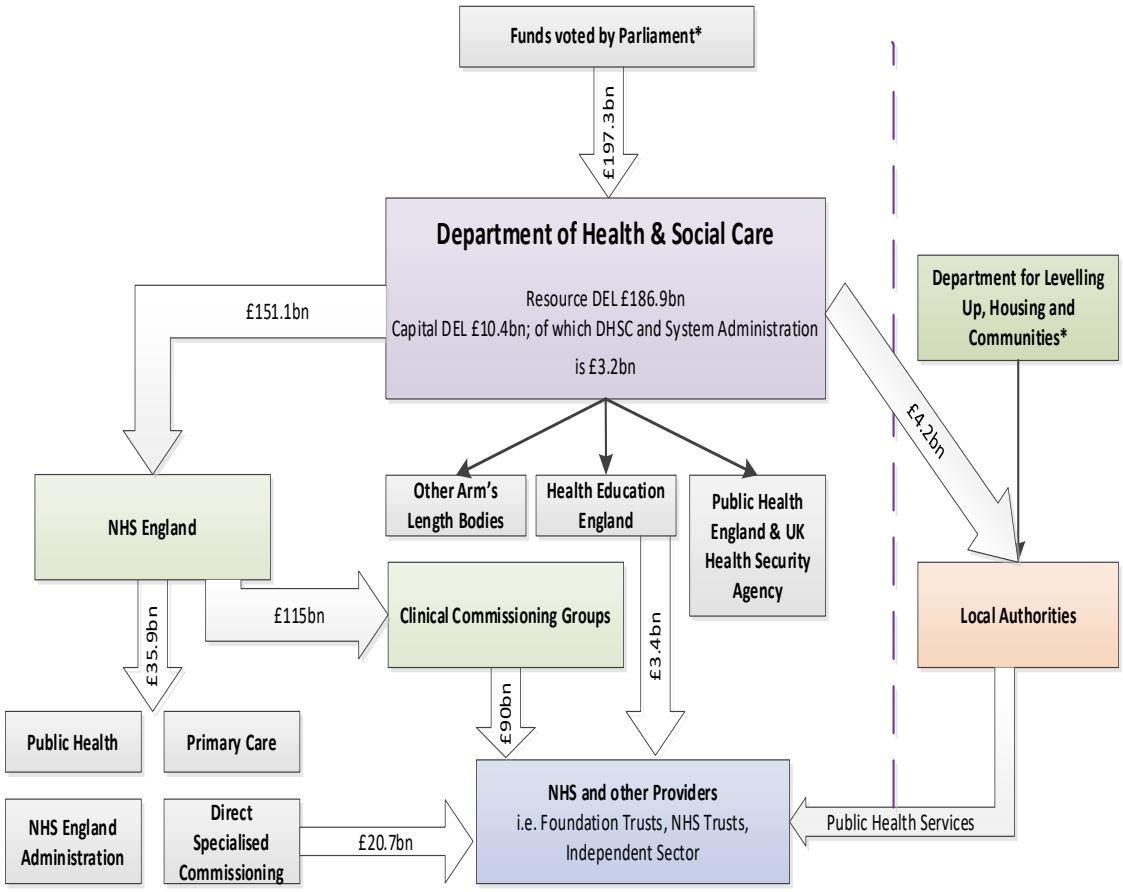
6. The Secretary of State for Health and Social Care and other Departmental Ministers are accountable to Parliament for the provision of the comprehensive health and care service in England. To enable the system to work flexibly, the critical day-to-day operational decisions are made by the professionals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

7. We secure funds for health and care services and remain accountable for this funding, which is allocated to the most appropriate local level. During the 2021-22 financial year, the Department had a revenue expenditure limit of £186.9 billion and invested a further £10.4 billion to fund capital items such as new hospitals and equipment, as detailed in **Table 9** on **page 66**.

8. **Figure 1** demonstrates how funding flows round the system, using agreed budget totals for 2021-22 per the Supplementary Estimate.

9. 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), now called the Department for Levelling Up, Housing and Communities (DLUHC), remains accountable for the allocation of those funds to local authorities.

Figure 1: Funding flows in the health and care system, 2021-22 (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 2021-22 Achievements - At a glance

Operationally **established OHID and UKHSA**

Worked towards the **introduction** of the **Health and Care Act 2022**

Launched the **Maternity Disparities Taskforce**

Worked towards the publication of the **Draft Mental Health Bill 2022**

Published, and implemented, the **'Living with COVID' Strategy**

Distributed **9.9 billion** items of PPE **between April 2021 and March 2022**

Publication of the **Elective Recovery Plan**

Vaccinated **91.8% of the population** with their **first dose of COVID-19 vaccine** (age 12 and over)

2021-22 - Key Finance Facts

Resources and cash contained **within all in-year DEL and AME budgets** set by Parliament

£

£40.4bn COVID-19 funding **secured** to deal with the **pandemic**.

£

£15.8bn COVID-19 funding secured to provide **testing, analysis** and **tracking** activities to help **prevent** the **spread of COVID-19**

37% spending **growth** in real terms over **2017-18**

£9.7bn (gross) **investment in capital**

£

£13.7bn COVID-19 funding to the NHS to support **frontline response** during **2021-22**

£

£5.9bn COVID-19 funding secured to procure **179m doses** and deploy **89m** vaccinations

£1.1bn invested on the **New Hospitals Programme** and **Hospital Upgrades**

Performance Summary

10. This section provides a high-level performance summary against the Department of Health and Social Care's strategic priorities during 2021-22.

11. COVID-19 is the biggest challenge the country and our public sector have faced in a lifetime. DHSC has been central to the Government's response and, as a result, the Department has continued to adapt in these unprecedented times. Although the impact of the pandemic has changed in comparison to 2019-20 and 2020-21, the response has remained the main priority for the Department of Health and Social Care throughout the year. This was reflected following the emergence of the Omicron strain of the virus, with the purchasing of additional vaccines and antivirals, as well as further funding being provided to the NHS and Adult Social Care to support the overall response. More widely, COVID-19 has led to both specific and more general impacts on the operations of the Department and the Government.

12. Focus throughout 2021-22 has also moved to one of living with COVID-19 as well recovery from the pandemic, wider priorities, and manifesto commitments. There has also been the development of work on a broad range of other key priorities and policies, including the progress of the Heath and Care Bill (now Act) through Parliament, the establishment of the Office of Health Improvement and Disparities and the UK Health Security Agency, as well as important work within Social Care reform.

13. The latter stages of 2021-22 also saw the Department working closely with health sector colleagues, the Devolved Administrations and across Government to contribute to the UK Government's support to Ukraine.

14. The Performance sections within this document provide an overview of performance from areas within the Department's five priority outcomes for 2021-22, along with other topical areas of note from across the year. The five priority outcomes for 2021-22 are outlined in the following paragraph. The Performance Summary is also supported by the **Performance Analysis** section of the Annual Report and Accounts, which begins on **page 9**.

Priority Outcomes

15. The Department's Outcome Delivery Plan 2021-22 set out the five priority outcomes that contribute to our delivery plan, how success will be measured and how the Department will ensure continuous improvement. The analysis section is structured according to these priority outcomes.

16. As a Department of State our strategic priorities in 2021-22 were to:
    - Protect the public's health through the health and social care system's response to COVID-19.

- Improve healthcare outcomes by providing high-quality and sustainable care at the right time in the right place and by improving infrastructure and transforming technology.
- Improve healthcare outcomes through a well-supported workforce.
- Improve, protect and level up the nation's health, including reducing health disparities.
- Improve social care outcomes through an affordable, high-quality, and sustainable adult social care system.

17. As a result of the pandemic, the role and purpose of the Department changed significantly, moving from that of a policy-focused department to one much more involved in operational delivery and front-line response to the pandemic. Progressively, as we move forward with the Living with COVID strategy the Department is returning to steady state ways of working.

Performance Analysis

Introduction

18. The performance analysis section aims to provide an evidence-based, analytical overview of how the Department has performed against its key objectives during 2021-22.

19. Due to the minimum financial reporting requirements that were developed during the 2019-20 Annual Report and Accounts (ARA) process in response to the COVID-19 outbreak, which remained in place for the 2020-21 financial year, the Performance Analysis section has not been included in the last two ARAs.

20. The analysis covers the key areas that can be measured within each of the five priority outcomes, as outlined earlier in the **Performance Overview**. Whereas certain priority and sub outcomes, such as the Department's response to the COVID-19 pandemic and urgent and emergency care, allow a more immediate overview of performance, other areas including cancer outcomes and the reduction of health disparities have much longer lead times. As such, there aren't regular data publications from these areas. Where relevant, this has been reflected in the following paragraphs.

Priority Outcome 1 - Protect the public's health through the health and social care system's response to COVID-19

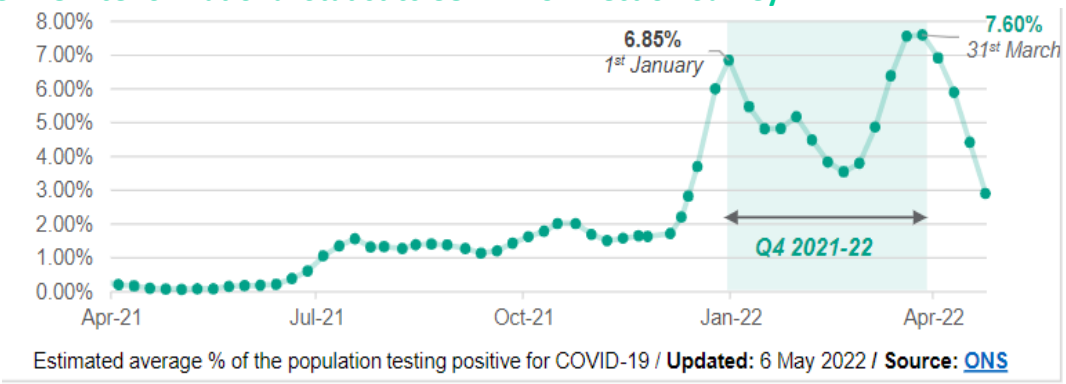
21. The response to the Coronavirus pandemic remained the key strategic priority for the Department in 2021-22.

22. Over the reporting year the Department continued to act flexibly, being guided by scientific evidence and advice, and adapted to new challenges such as the emergence of the Omicron variant in November 2021. By the end of 2021-22,

work on the response to COVID-19 continued to remain one of the Department's key strategic priorities, however the success of our national vaccination programme has enabled the United Kingdom to implement its 'Living with Covid' Strategy with an emphasis on continued cautious behaviours.

23. The prevalence of COVID-19 infection amongst the population is measured by the Office for National Statistics through their COVID-19 infection survey. Published weekly, this data shows the percentage of people who have tested positive for COVID-19 on a polymerase chain reaction (PCR) test at a point in time. As shown in **Figure 2**, during the winter Omicron peak and at the beginning of Q4, 6.85% of the population in England were estimated to be positive for COVID-19. Also shown in **Figure 2**, infection peaked on 31 March 2022 when 7.6% of the population were estimated to be positive for COVID-19. On 22 February 2022, the Government published the 'Living with COVID-19' strategy. The strategy outlined key principles to be able to manage COVID-19 like other respiratory illnesses, which were:
    - Removing domestic restrictions while encouraging safer behaviours through public health advice, in common with longstanding ways of managing most other respiratory illnesses;
    - Protecting people most vulnerable to COVID-19: vaccination guided by Joint Committee on Vaccination and Immunisation (JCVI) advice, and deploying targeted testing;
    - Maintaining resilience: ongoing surveillance, contingency planning and the ability to reintroduce key capabilities such as mass vaccination and testing in an emergency; and
    - Securing innovations and opportunities from the COVID-19 response, including investment in life sciences.

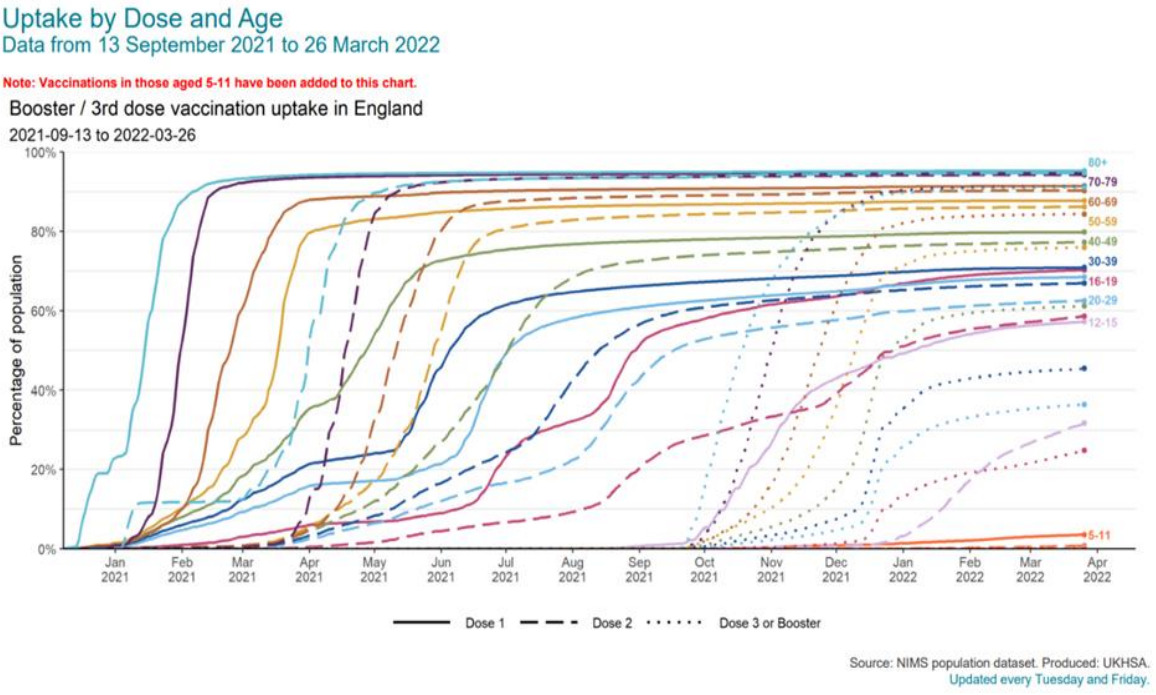
Figure 2: Office for National Statistics COVID-19 Infection Survey



Source: ONS

24. The success of the vaccine strategy has been key to enabling the 'Living with COVID-19' strategy. **Figure 3** shows percentages (as of 31 March 2022) of the English population (12+) who had received a vaccination.

Figure 3: Vaccination uptake by dosage and age



25. The number of patients in hospital with COVID-19 was relatively low at the beginning of 2021-22 when compared to other stages of the pandemic, with a seven-day average of 287 admissions at the end of Q1 (30 June 2021). As expected, this figure increased over Autumn and Winter, reaching a seven-day average of over 2,000 admissions a day by the end of Q3. At the end of 2021-22, this was at over 2,100 admissions a day, however, has since steadily declined during the first part of 2022-23. At the peak of infection on 31 March 2022, 6,214 (43%) of the 14,428 confirmed COVID-19 patients occupying beds in England were being treated primarily for COVID-19.

26. The number of deaths within 28 days of a positive COVID-19 test also followed a similar trend. As expected, this peaked during the winter period and during the first month of Q4, when a seven-day average of over 250 deaths per-day was reached. By the end of 2021-22, over 146,000 people had died within 28 days of a positive COVID-19 test during the COVID-19 pandemic, up from 112,200 at the end of 2020-21.

27. The work of the Department in tackling the virus covers eight areas which are regularly reviewed: NHS Resilience (covered throughout this section of the report); Social Care Resilience (also covered from **paragraph 28** onwards); Supply and Distribution of Key Products (covered in the broader PPE section, **paragraph 202** onwards); UKHSA; Vaccines; Antivirals and Treatments; Non-pharmaceutical Action; and International. The Department's response aligns with the Government's 'Living with COVID-19' Strategy.

Social Care Resilience

28. The Department continued to support care providers in protecting people in adult social care from COVID-19 transmission by extending funding for infection prevention control measures and rapid testing to March 2022. This was followed by an additional £60 million to local authorities to support the adult social care response to Omicron in January 2022.

29. The 'Living with COVID Strategy' set out a range of measures designed to maintain the balance of keeping vulnerable service users safe, whilst maintaining as many freedoms as possible, such as, care home visiting. Other measures included free PPE (until March 2023), vaccination in line with the JCVI advice, and targeted testing. The strategy is supported by updated Infection, Prevention, and Control guidance which provides specific advice on managing COVID-19. For instance, the Spring Booster programme began on Monday 21 March 2022 inviting people aged 75 years and over and residents in care homes for older adults to get an additional COVID-19 booster jab to help maintain a high level of protection against serious illness.

The UK Health Security Agency (UKHSA)

30. Rapidly implementing testing and tracing capability and capacity from a standing start was key to limiting the spread of the virus during the early stages of the pandemic. This included building capacity and distribution channels to ensure universal testing could be offered as soon as possible and managing demand to ensure testing was available for the most clinically vulnerable at the first opportunity.

31. By the end of March 2022, the Test & Trace service had enabled nearly 500 million tests to be taken, including over 200 million PRC tests, assisting with clinical decision making and enabling the public to take protective behaviours.

32. Following the announcement of 'Living with COVID-19', UKHSA is now re-prioritising providing testing for vulnerable individuals in high-risk settings such as hospitals and care homes.

33. UKHSA will also maintain sufficient resilience to respond to future surges with ongoing surveillance, contingency planning, and the ability to reintroduce key capabilities such as mass testing in an emergency.

Vaccines and Treatments, Research and Deployment

34. The Department's work on vaccines and treatments started early on in the pandemic, with the Department coordinating and launching, via the National Institute for Health Research (NIHR) and in partnership with UK Research and Innovation (UKRI), a rapid response research call, which funded the Oxford University/AstraZeneca vaccine and the RECOVERY trial in Spring 2020.

35. Through NIHR, the Department used the UK's research infrastructure to fund and run studies in vaccine and treatments that changed the global approach. UK trial results proved the Oxford University/AstraZeneca and Novavax vaccines worked, and the RECOVERY trial proved the first treatment, dexamethasone, reduced COVID-19 mortality.

36. The Vaccine Taskforce[1], led by the Department for Business, Energy and Industrial Strategy (BEIS), was established to accelerate progress on the development of COVID-19 vaccines. Following the development of various vaccines, the Government authorised the use of the Pfizer/BioNTech, the Oxford University/AstraZeneca, and the Moderna vaccines.

37. Significant work, led by the NHS, was undertaken on vaccination deployment. As of 31 March 2022, 91.8% of the population had had their first dose, 86% of the population had had their second dose of the vaccine and 67.5% of the population have had their booster or third dose of the vaccine. The population reflects individuals aged 12 and over who had received a vaccination.

38. The Department also worked to ensure vaccine supply could meet demand, ensuring vaccination deployment was initially focused on those at greatest risk: residents in a care home for older adults and their carers, those over 80 years old, frontline health and social care workers and the at-risk population. There were also targeted communications to tackle vaccine hesitancy, particularly amongst high-risk groups.

39. The Antivirals Taskforce was launched in April 2021, with the aim of developing and procuring effective and novel antivirals for treatment against COVID-19 at the earliest stage of infection.

40. In December 2021, the Taskforce procured an additional 4.25 million doses of antivirals to supplement the 730,000 initially secured. As of March 2022, 17,429 patients have now accessed treatments through COVID-19 medicines delivery units (CMDUs) and the PANORAMIC trial has recruited over 20,000 patients. The Government continue to identify and supply other treatments, alongside the vaccination programme, to enable the long-term management of COVID-19 and its clinical impacts.

41. In addition, throughout the pandemic, the Medical Healthcare products Regulatory Agency (MHRA) provided guidance for industry on flexible approaches to regulation. This guidance covered a wide range of areas including; Clinical trials, Marketing authorisations, Pharmacovigilance, Inspections and good practice, and medical devices, as well as blood components for transfusion. The Department

[1] The Vaccine Taskforce transferred to the Department on 1 August 2021.

worked rapidly with MHRA and other healthcare partners and stakeholders to rapidly identify where flexibilities in the regulation of medicines and medical devices was possible. By doing so the Department supported the healthcare products supply chain and wider response to the COVID-19 outbreak in the UK.

Non-Pharmaceutical Interventions

42. On 8 December 2021, the Prime Minister announced a move to 'Plan B' following the rapid spread of the Omicron variant. Face masks became compulsory in most public indoor venues and NHS Covid Passes became mandatory in specific settings. The measures introduced helped to control the spread of COVID-19, bought time to assess the variant and allowed the NHS to rapidly expand the booster programme to strengthen defences. England fully returned to 'Plan A' on 27 January 2022, thanks to the success of the booster programme.

43. The Living with COVID Strategy set out the Government's plan for removing the remaining legal restrictions while protecting people most vulnerable to COVID-19 and maintaining resilience. The Department's objective in the next phase of the COVID-19 response is to enable the country to manage COVID-19 like other respiratory illnesses, while minimising mortality and retaining the ability to respond if a new variant emerges or during periods of waning immunity, that could again threaten to place the NHS under unsustainable pressure.

Protecting the Most Vulnerable

44. The shielding programme introduced at the height of the pandemic supported almost 3.8 million people identified as clinically extremely vulnerable, providing them with advice to minimise their risk of infection and support to enable people to stay at home. The shielding advice and support were paused in April 2021 and ended in September 2021 following the success of the COVID-19 vaccination programme and the emergence of proven treatments, for which the clinically extremely vulnerable were a high priority.

45. In February 2021, the Department announced a new predictive risk model (QCOVID) to help clinicians identify other adults with risk factors that make them more vulnerable to COVID-19. Over 1.5 million people were identified and prioritised for vaccination because of this work. The QCOVID model was updated in July 2021.

Protecting the UK from Global Threats

46. The Department continued to respond to global threats and worked collaboratively with the World Health Organization, industry and other philanthropic foundations on genomics and surveillance of COVID-19 variants. The Department undertook steps to inform, build and implement border health policy with the aim of protecting the nations' health and limiting impact to the economy. The operational aspects of the Borders & Managed Quarantine Service (MQS) Programme were closed in March 2022 after final border controls were removed

by agreeing to remove the distinction by vaccination status at the border and associated testing measures.

47. The Government's Living with Covid publication set out the plan for removing the remaining legal restrictions while protecting those people most vulnerable to COVID-19. Domestic certification was removed as a requirement in England from 1 April 2022. The COVID-19 pass will be needed for international travel to countries continuing to require evidence of vaccination status.

Priority Outcome 2 - Improve healthcare outcomes by providing high-quality and sustainable care at the right time in the right place and by improving infrastructure and transforming technology.

48. Due to its broad nature, Priority Outcome 2 is assessed via multiple different component parts. This helps to provide a broader analysis across the different contributing factors which make up this Outcome.

49. DHSC's ambition was to manage the immediate pressures of COVID-19 while supporting the NHS to deliver long term transformation. This required investment in the NHS and acute services first, in order to then address the strategic challenges of an aging population, multi-morbidities and the need to support health and wellbeing across the whole life course, in line with the NHS Long Term Plan (LTP).

50. The component parts of this priority outcome include, but are not limited to:
    i. Supporting people with mental health conditions, learning disabilities and autism. (**paragraph 94 onwards**)
    ii. Levelling up to tackle health disparities and socio-economic inequalities across the country.
    iii. Improving the quality of NHS services and health outcomes.
    iv. Improving uptake of bowel, breast and cancer screening to enable the earlier detection and treatment of disease. (**paragraph 61 onwards**)
    v. Reducing the number of stillbirths, maternal and neonatal deaths and neonatal brain injuries to improve safety outcomes for mothers and babies. (**paragraph 111 onwards**)
    vi. Continue to push increased primary and community care access in areas where provision has historically been more limited and improve access for vulnerable groups. (**paragraph 67 onwards, and paragraph 83 onwards**)
    vii. Increase the number of children supported by mental health support teams in schools and provide more children and young people with access to community mental health services. (**paragraph 94 onwards**)

viii. Progress the Health and Care Bill that will implement reforms to meet policy ambitions of the Secretary of State, DHSC, NHS England and NHS Improvement.

ix. Work with NHSX[2] to help manage increasing demand to restore elective care, including setting up new 'care at home' models. (**paragraph 52 onwards**)

51. We also recognise the impact that these individual areas can have on performance across the system as a whole. For example, we know that general practices have been incredibly busy, and that some patients have struggled to access care in a timely way. Demand is high and includes patients who have delayed contacting their practice during the pandemic and those who need care in the community while they are on long waiting lists for elective care. The latest GP Patient Survey results (2022) suggest that around 1 in 10 patients who did not take or were not offered an appointment by their GP practice when they contacted them went to A&E (11%) or called a helpline such as NHS111 (10.9%). Of patients who had tried to contact an NHS service while their GP practice was closed, 30.1% had gone to A&E and 56.5% had called a helpline such as NHS111. Action is underway to take the pressure of general practice, for example, by expanding the range of services available from community pharmacies, expanding the general practice workforce through the Additional Roles Reimbursement Scheme, and reducing unnecessary bureaucracy for GPs. However, if patients go to emergency services because they are unable to get care from their general practice, this puts further pressure on other parts of the health system. Similarly, the key driver of long A&E waits is consistently high levels of bed occupancy in hospitals, including from COVID-19 pressures and difficulties in discharging patients to community services once they are medically fit to leave hospital. This reduction in the flow of patients through hospital increases crowding in A&E and drives long waits for admission.

Elective care

52. The COVID-19 pandemic placed considerable strain on the delivery of elective care, meaning that many patients are now waiting longer for treatment than they were before the pandemic began.

53. In the two years since the pandemic began, the elective waiting list in England grew from 4.4 million to a record high of 6.5 million patients in March 2022.

54. The Government will tackle this elective backlog in the biggest catch-up programme in the NHS's history. The Government plans to spend up to £8 billion in the following three years, from 2022-23 to 2024-25, which could deliver the equivalent of around nine million more checks, scans, and procedures. In addition, a further £5.9 billion will be provided by the Spending Review for capital investment to support diagnostics, technology, and elective recovery.

[2] To note – as of 2022 NHSX is now referred to as the Digital Transformation Directorate.

55. In addition to those already on the waiting lists, it is estimated that over 10 million patients who might otherwise have come forward for treatment did not, including a small proportion of these for cancer diagnosis and treatment. There is still enormous uncertainty around whether and when these people will seek treatment, making it very difficult to estimate the impact this will have on both their outcomes and the overall waiting list.

56. This funding will also mean the NHS in England can aim to deliver around 30% more elective activity by 2024-25 compared to 2019-20.

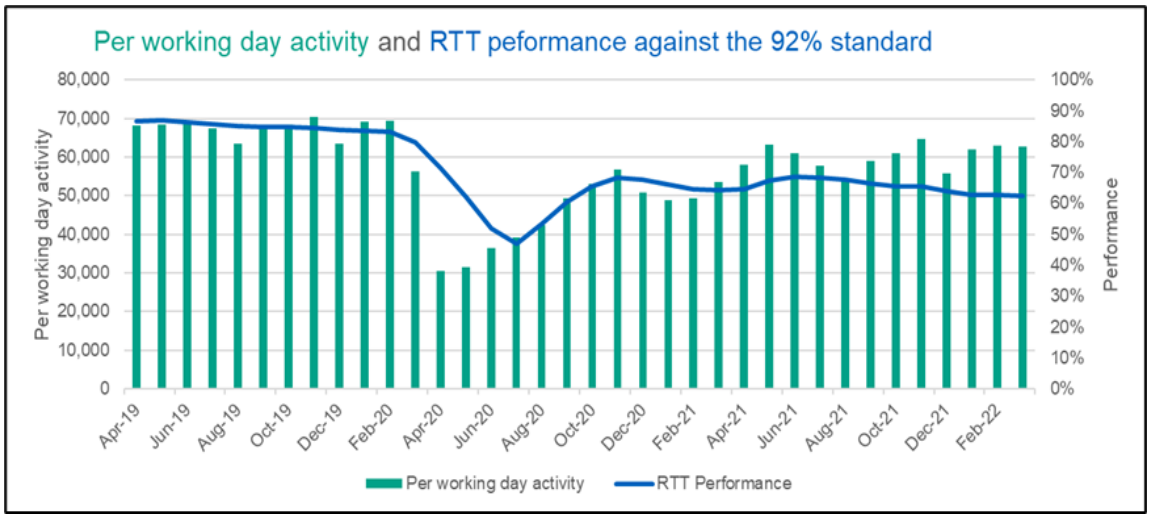
57. In February 2022, the NHS published the Delivery Plan for Tackling the COVID-19 Backlog of Elective Care. This plan sets out a clear vision for how the NHS will recover and expand elective services over the next three years.

58. The number of patients waiting longer than two years for elective treatment stood at over 22,000 in January 2022. In line with the ambitions of the Delivery Plan, the Government has made great strides in reducing this by over 60%. As of July 2022, the Government had virtually eliminated two-year waits (aside from some highly specialised complex procedures in fields such as Trauma and Orthopaedic and Neurosurgical and Gynaecology, and in a very small number of specific, highly specialised areas that may need tailored plans to tackle the backlog, or where patient choice has been applied). In July 2022, the number of patients waiting over 104 weeks for treatment stood at 2,885.

59. The COVID-19 pandemic placed considerable strain on the delivery of elective care, meaning that many patients are now waiting longer for treatment than they were before it began. In March 2022, 306,000 patients were waiting a year or more for treatment compared to 1,600 in February 2020 before the pandemic.

60. As shown in **Figure 4**, in England, current per working day activity levels in March 2022 are over 91% of pre-pandemic levels, from 71% at the peak of pressures in January/February 2021.

Figure 4: Per working day activity (total completed pathways) and RTT performance – *Standard 92%*



Source: RTT Waiting Times data

Diagnostic Overview

61. At the 2021 Spending Review, the Department announced £2.3 billion of capital investment to increase the volume of diagnostic activity and to roll out up to 160 Community Diagnostic Centres (CDCs) by March 2025 to help clear the backlog of people waiting for clinical tests, such as MRI, ultrasound, and CT scans. CDCs increase diagnostic capacity, supporting faster, earlier diagnosis and reduced waiting times for better patient outcomes.

62. The funding for diagnostics transformation is projected to deliver 17 million more diagnostic tests over the next three years and will increase our annual capacity by 9 million tests by March 2025 – this would be a 39% increase in the number of scans the NHS can deliver every year relative to those delivered in 2021-2022.

63. By taking action to keep non-COVID services going, the NHS has delivered nearly 28 million planned operations and procedures, and over 42 million key diagnostic tests, during the pandemic (i.e., between March 2020 and March 2022).

64. During the 2021-22 financial year, nearly 23 million diagnostic tests and over 15 million operations and procedures were delivered by the NHS in England. This compares to 18 million diagnostics tests and 11.5 million operations and procedures during the 2020-21 financial year, increases of 28% and 33% respectively.

65. In March 2022, NHS staff began treatment for over 1.4 million patients and completed over 2 million diagnostic tests.

66. NHSE have made an assessment of what may be driving demand in both planned and unplanned diagnostic activity. These include:

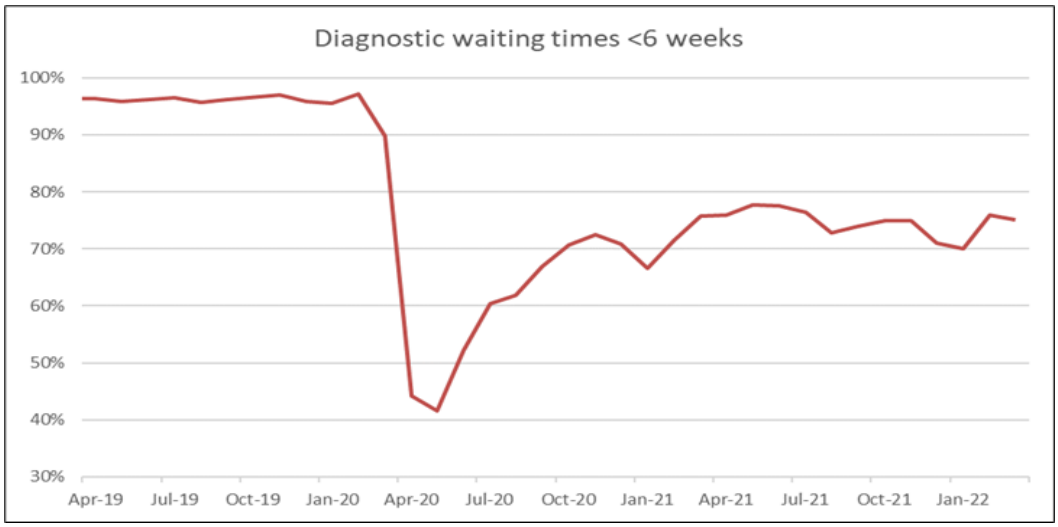
- Clinician behaviour (lower thresholds for requesting tests, testing to reduce the need to admit patients for observation, increased delegation to more junior staff);
- Patients who have delayed presentation during the pandemic needing more testing;
- The rise in virtual consultations meaning that diagnostic tests have replaced physical examinations;
- Patients who are not able to access primary care using urgent and emergent care (UEC) services instead;
- New therapies, policies and pathways e.g., genomics, cancer, driving increased testing;
- The length of elective waiting lists means that more patients are receiving multiple re-tests while waiting for treatment.

Community Diagnostic Centres (CDCs)

67. In 2021-22, local systems have focussed on launching the new CDCs, with patients who would otherwise have required tests in acute hospitals being diverted to CDCs. This has supported the system given the high volumes of urgent and emergency patients requiring diagnostics on acute sites and the need to provide COVID secure facilities for elective diagnostics wherever possible. The expansion in capacity is to support our ambition, set out in the Delivery Plan, that that 95% of patients needing a diagnostic test receive it within six weeks by March 2025. Further detail on performance against this 95% target is set out in **Figure 5**.

68. CDCs have already delivered over 785,000 additional tests and scans of which over 450,000 have been imaging tests and 33,000 endoscopies, both directly relevant to cancer, since July 2021. In 2022-23, an additional 3 million tests are anticipated.

Figure 5: Waiting times for diagnostic tests and procedures less than 6 weeks – *Standard 95%*



Source: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

Cancer

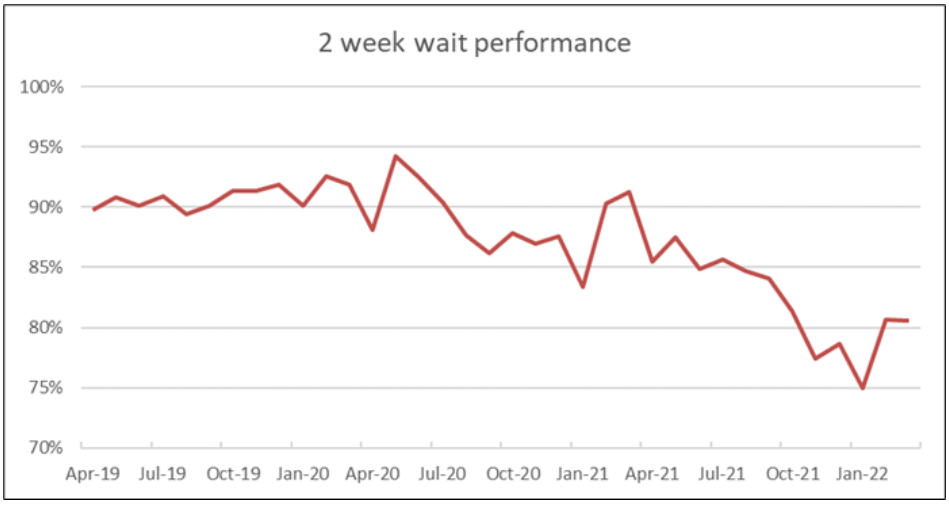
69. Cancer performance across the various standards, measured by NHSE, is illustrated in Figures 6 to 9. Performance remains negatively impacted by the pandemic and the increased number of referrals that we are seeing coming through the system.

70. The success of the national 'Help Us, Help You' communications campaign has however resulted in a significant rise in the number of people coming forward for cancer treatment – with referral levels now consistently above pre-pandemic levels - for example, referrals were at 138% of pre-pandemic (March 2020) levels in March 2022.

71. Cancer remains a top priority as services recover. The Elective Recovery Delivery Plan committed the NHSE to reducing the 62-day cancer backlog back down to pre-pandemic levels by March 2023; and to meeting the 75% Faster Diagnosis Standard by March 2024.

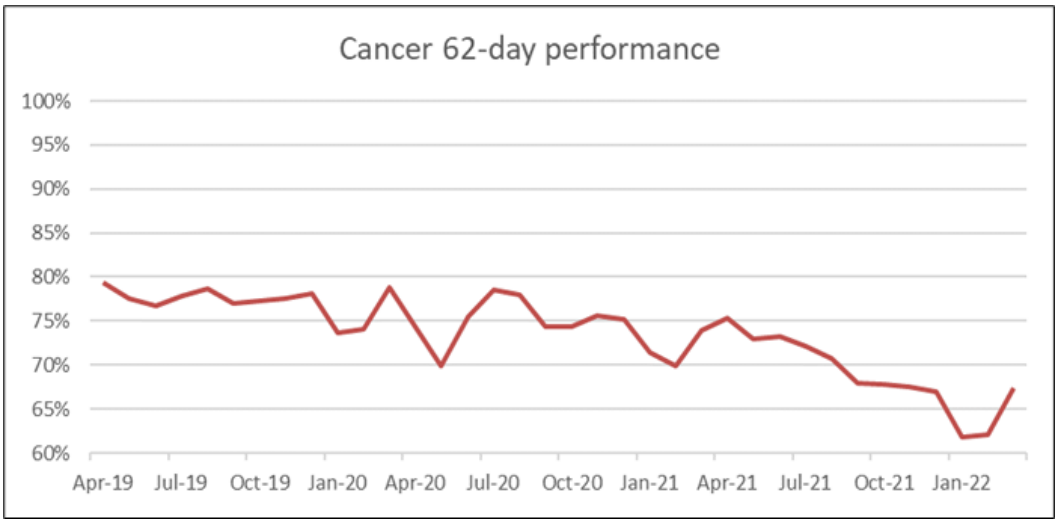
72. **Figures 6** to **9** demonstrate performance against some of the key cancer metrics used as measures of success against DHSC's stated ambition of improving healthcare outcomes. Not all metrics have been reported for the same length of time, hence why not all graphs are shown over the same time period – for those graphs going back to early 2020 dips in performance associated to the COVID-19 pandemic limiting access to or otherwise putting pressure on services can be seen, with some improvement more recently as services begin to recover from the impact of the pandemic, returning to a more steady business as usual state.

Figure 6: Cancer waiting time: Two Week Wait From GP Urgent Referral to First Consultant Appointment – *Standard 93%*



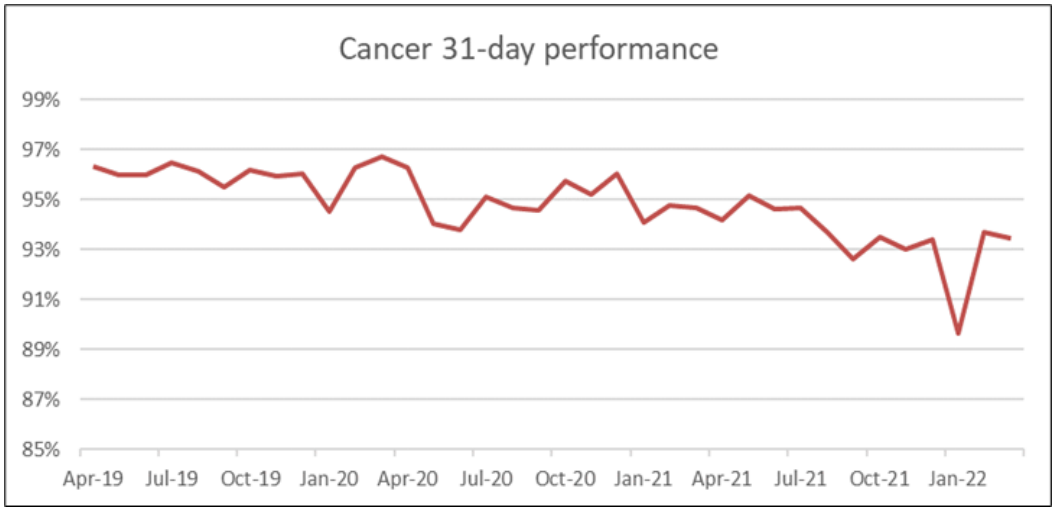
Source: National Cancer Waiting Times data

Figure 7: Cancer waiting time: Two Month Wait from GP Urgent Referral to a First Treatment for Cancer – *Standard 85%*



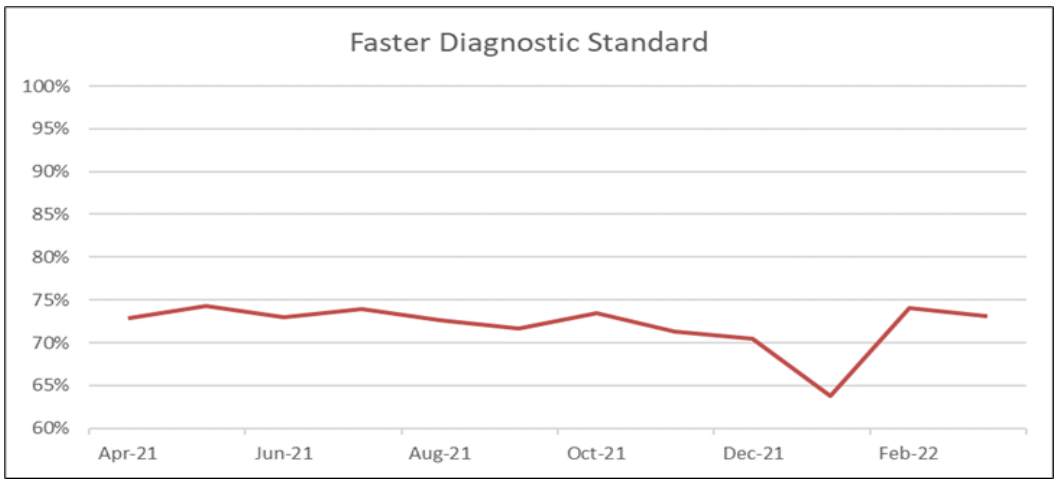
Source: National Cancer Waiting Times data

Figure 8: Cancer waiting time: One Month Wait from a Decision to Treat to a First Treatment for Cancer – *Standard 96%*



Source: National Cancer Waiting Times data

Figure 9: Cancer waiting time: Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded – *Standard 75%*



Source: National Cancer Waiting Times data

Urgent and Emergency care

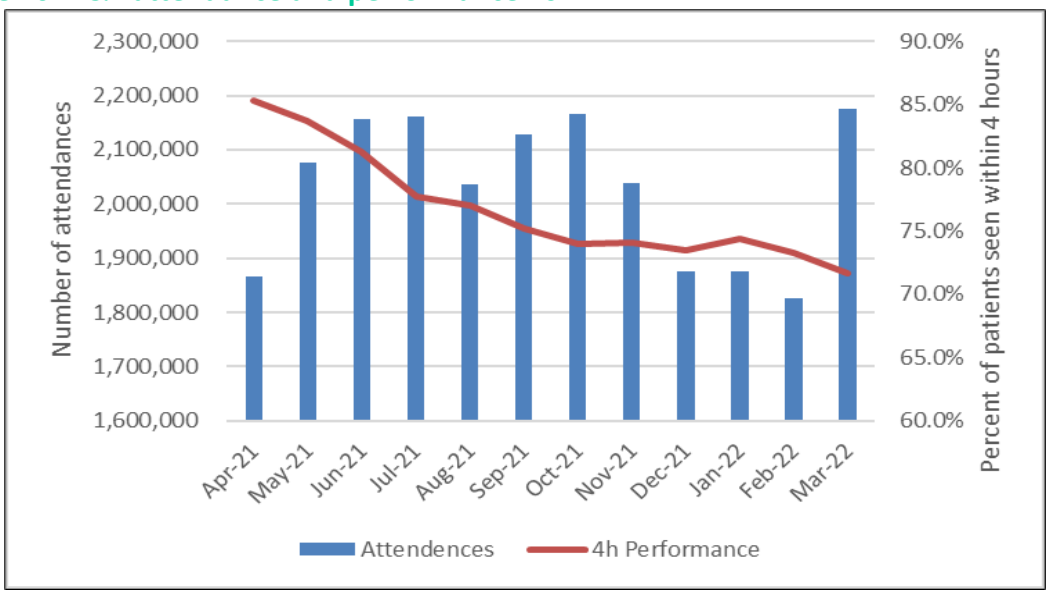
73. COVID-19 had a significant impact on urgent and emergency care performance in 2021-22, including by reducing available bed capacity, and lowering productivity through the need of infection prevention and control and social distancing measures, and the impact on the NHS workforce.

74. These impacts are reflected in performance statistics. National performance for A&E waiting times in 2021-22 was 76.7%, against the standard that 95.0% of patients should be admitted, transferred, or discharged within four hours of arrival in an A&E department. The average performance was lower than 2019-20 and 2020-21, where performance was 84.2% and 86.8% respectively.

75. In March 2022, 22,500 patients were waiting over 12 hours for admission following decision to admit (DTA). This was an increase on March 2021, when the figure was 688. In addition to this, 136,000 were waiting over four hours following DTA in March 2022, up from 50,900 in the same month in 2021. However, there was a considerable increase in attendances to A&E during 2021-22, with 2.1 million attendees in March 2022 compared to 1.7 million in March 2021, an increase of 29%.

76. Whilst there was more A&E activity in 2021-22 compared to 2020-21, activity in 2021-22 remained just below the levels seen prior to the beginning of the COVID-19 pandemic. **Figure 10** displays 2021-22 A&E attendance levels along with performance across the year against the four-hour standard.

Figure 10: A&E attendance and performance 2021-22

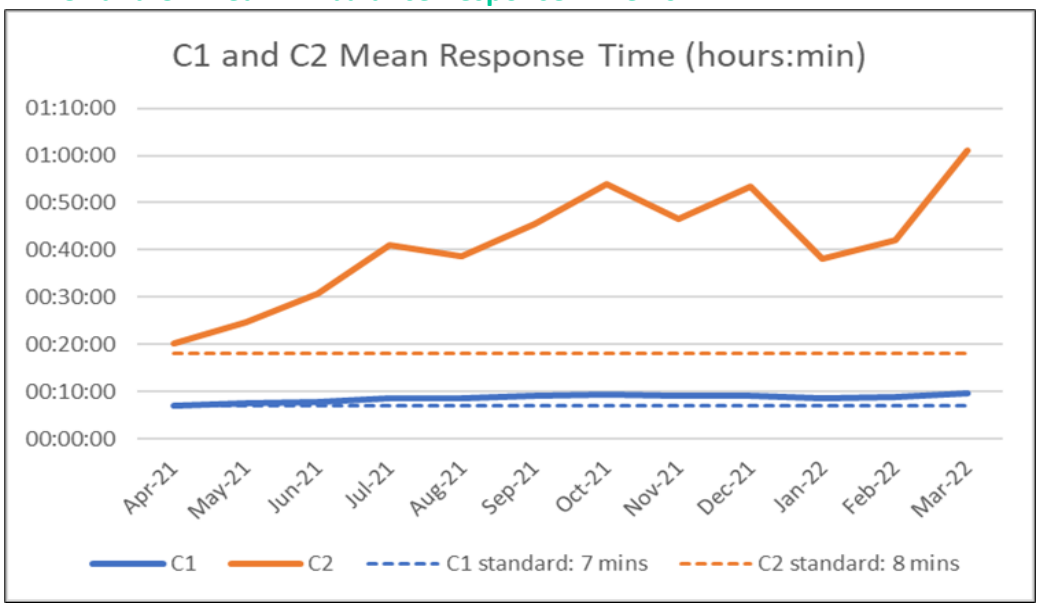


Source: Statistics » A&E Attendances and Emergency Admissions (england.nhs.uk)

77. Ambulance response time performance reflected the wider challenges we saw across the emergency care pathway – none of the six national ambulance standards were met over the year, with average Category 1 response times at 8m 39s (against the target of 7m), and Category 2 mean responses at 41m 18s (against the target of 18m). By month, the Category 1 mean standard was met once (April 2021), whilst Category 1 90th centile (i.e., the response time for 90% of these incidents) was met three times. The Category 2 mean, and Category 2, 3 and 4 90th centile standards were never met. A range of factors have contributed to this, including the return of near pre-pandemic levels of demand, the need for infection prevention and control measures which reduce productivity, and significant ambulance resource lost to delays in handing patients over to hospital.

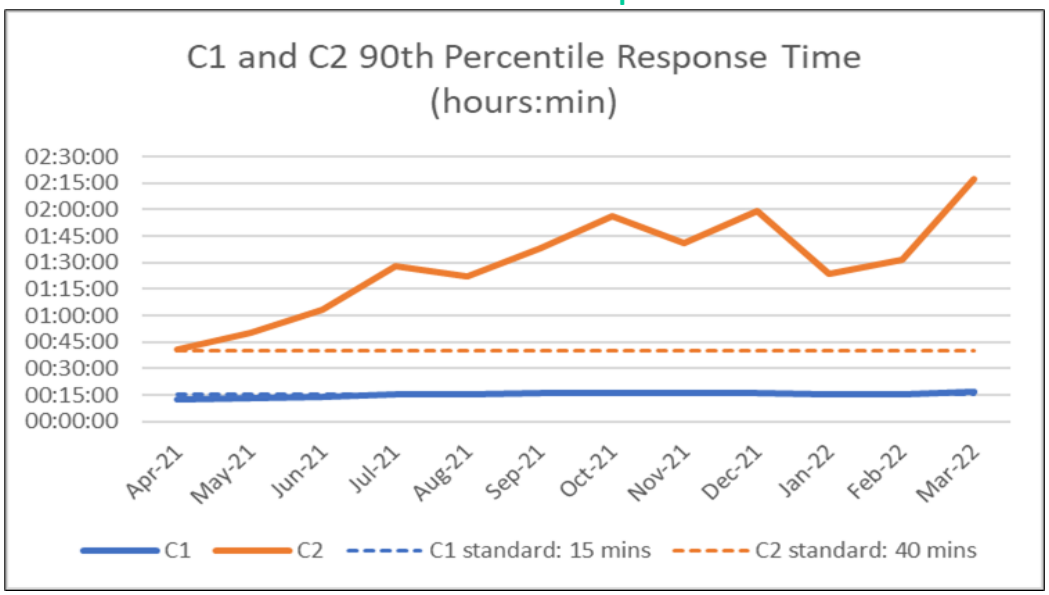
78. **Figures 11** to **13** show more related information.

Figure 11: C1 and C2 Mean Ambulance Response Time 2021-22



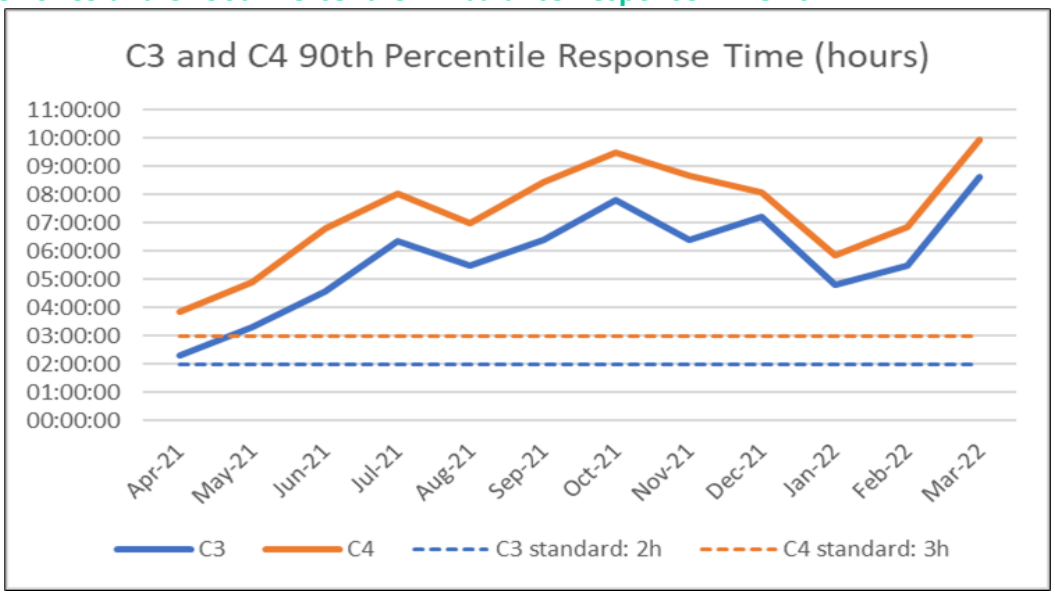
Source: Statistics » Ambulance Quality Indicators (england.nhs.uk)

Figure 12: C1 and C2 90th Percentile Ambulance Response Time 2021-22



Source: Statistics » Ambulance Quality Indicators (england.nhs.uk)

Figure 13: C3 and C4 90th Percentile Ambulance Response Time 2021-22

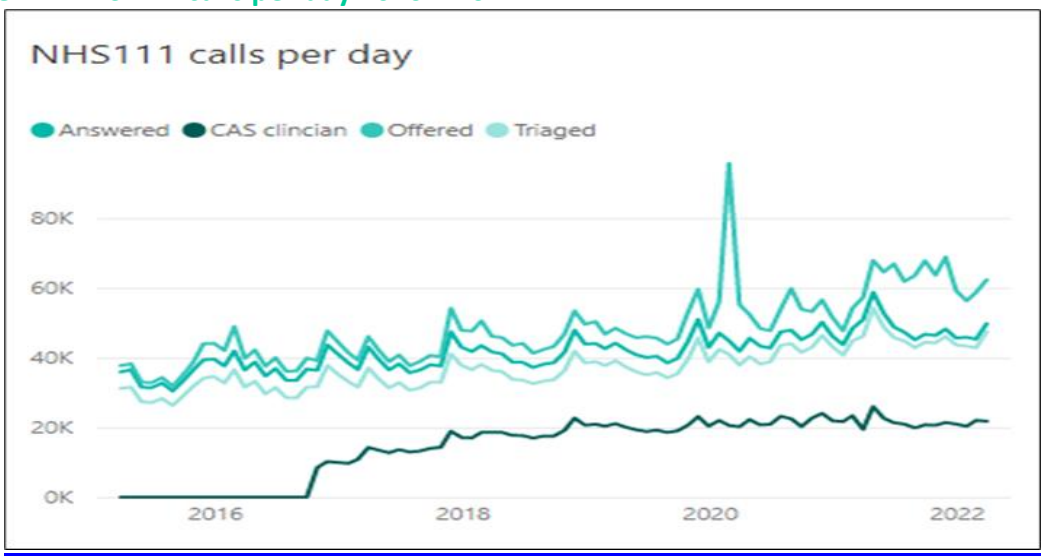


Source: Statistics » Ambulance Quality Indicators (england.nhs.uk)

79. However, the NHS made significant progress on safely reducing patient conveyance to A&E by ambulance services, helping patients to be treated closer to home and reducing pressures on emergency departments. In particular, rates of 'hear and treat' (closing incidents with advice over the phone) increased from 8.6% in April 2021 to 13% by March 2022, and overall conveyance of ambulance patients to A&E for further treatment, fell from 54% in April 2021 to 50.7% in March 2022.

80. As shown in **Figure 14**, in April 2022, calls answered per day by NHS111 were almost 50,000, over 12% higher than April 2019 (pre pandemic).

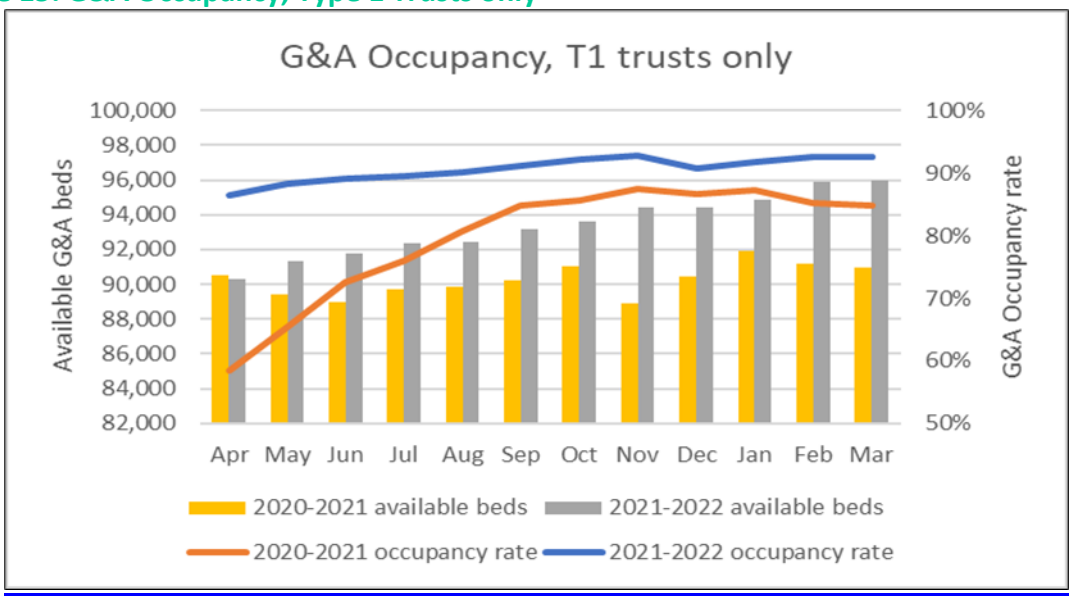
Figure 14: NHS 111 calls per day 2016 – 2022



Source: Statistics » Integrated Urgent Care Aggregate Data Collection (IUCADC including NHS111) Statistics Apr 2021-Mar 2022 (england.nhs.uk)

81. As shown in **Figure 15**, General and Acute (G&A) bed occupancy levels remained high but at a steady level throughout 2021-22, reaching a maximum occupancy of c.93% in November 2021, February 2022, and March 2022 (Type 1 acute trusts only). Overall, bed occupancy in 2021-22 was higher than 2020-21, this should be seen in the context of the continued COVID-19 pandemic alongside an increase in demand for non-elective services and A&E attendances returning to nearly pre-pandemic levels after lockdown restrictions were lifted.

Figure 15: G&A Occupancy, Type 1 Trusts only



Source: Statistics » Bed Availability and Occupancy (england.nhs.uk)

82. In September 2021, the NHS set out its Urgent and Emergency Care Recovery 10 Point Action Plan, which incorporated actions across urgent, primary, and community care to better manage emergency care demand and capacity and improve performance. This included building the capacity of NHS 111 to act as the 'front door' to the emergency care system, and £98 million was invested in NHS 111 over 2021-22. In July 2021, £55 million was also invested in ambulance services for winter 2021-22 to increase call handling and operational response capacity. This was alongside a £4.4 million capital investment to keep an additional 154 ambulances on the road over winter 2021-22.

General Practice

83. The Department's aim for 2021-22 was to support general practice to recover services and continue to make progress towards delivering 50 million more appointments a year. It was important to balance this with maximising the continued safe delivery of general practice services and ensuring general practice teams were able to contribute to the NHS response to COVID-19, including supporting the delivery of the COVID-19 vaccination programme and continuing to help practices respond to demand and existing pressures.

84. The General Practice Patient Survey 2021 showed that in England, despite the disruption caused by the pandemic, when people were able to access the care they needed they were often positive about that care. In 2021, 83% of patients described their overall experience of their GP practice as good. This was a 1.2% increase from the previous year (81.8% in 2020).

85. At the start of 2021, general practice appointment numbers were recovering, and by May 2021, had returned to pre-pandemic levels. Excluding COVID-19 vaccination appointments, an estimated 319.8 million appointments were booked across general practice in England in the twelve months up to March 2022.

86. This was supported by the NHS England and Improvement (NHSE and NHSI) Access Improvement Programme (AIP) which, over the course of 2021-22, supported over 900 practices whose patients were experiencing the greatest access challenges – some of which had been exacerbated by the pandemic – including long waiting times or poor patient experience and outcomes.

87. In addition, GP contract arrangements during 2021-22 provided stability and assurance to general practice by allowing practices to focus on the COVID-19 response (including the vaccination programme) via contractual easements, and subsequent clinical priorities relating to pandemic recovery. This included a phased approach to contractual arrangements, with interim arrangements announced in April 2021, and further arrangements announced in June 2021 and August 2021. Additional funding was made available for long COVID and weight management enhanced services.

88. Alongside this, in October 2021, the Government and NHSE and NHSI published a package of measures and made £250 million available for a Winter Access Fund to support practices and increase capacity over the winter. This included expanding the NHSE and NHSI AIP to support a further 200 practices through a new intensive form of the programme. The Government alongside NHSE and NHSI, and NHSX also rapidly developed a short-term telephony solution to help practices manage demand and capacity on their phone systems by enabling use of Microsoft Teams for outbound calls, which freed up incoming call lines. This was at no additional cost to practices and will run until April 2023, while a longer-term strategic solution is developed.

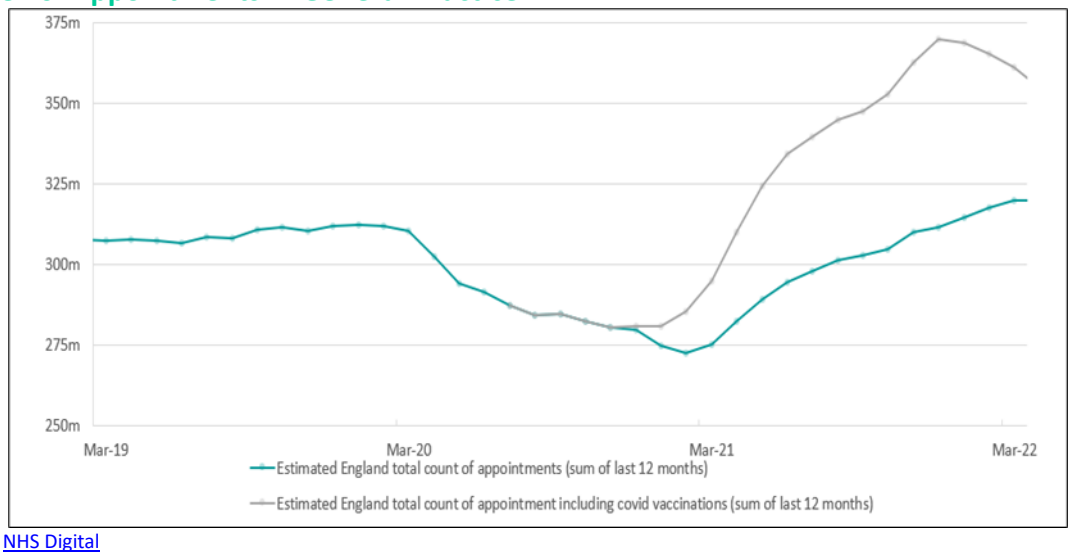
89. During 2021-22, general practice devoted significant resources to rolling out the COVID-19 vaccine programme and, in response to the Omicron variant, general practices and their teams continued their incredible contribution to help deliver the booster programme while still providing care for their patients. As of March 2022, a total of 61.2 million COVID-19 vaccinations had been delivered by general practice and Primary Care Networks (PCNs) since December 2020 when the vaccine programme began.

90. In both the initial vaccine roll-out and the booster programme, practices were asked to prioritise vaccinations. To support this, in response to Joint Committee on Vaccination and Immunisation (JCVI) advice following the emergence of the Omicron variant, NHSE and NHSI announced a set of time-limited measures to release GP practice capacity in December 2021.

91. These measures aimed to support practices to deliver an accelerated COVID-19 vaccination programme, while ensuring they continued to provide services to patients who needed them and proactively target their most vulnerable patients. These included part-income protecting the Quality and Outcomes Framework (QOF) and Investment and Impact Fund (IIF) until 31 March 2022, as well as several time limited easements around requirements for the provision of medical evidence. Examples include suspension of requests for medical evidence for DVLA licensing decisions and (in cooperation with DWP) extending the self-certification period for sickness from 7 to 28 days for statutory sick pay (to reduce the volume of fit note requests that practices needed to respond to during this period).

92. As shown in **Figure 16**, in the twelve months up to March 2022 (and comparing to March 2019 because March 2020 data was impacted by the first lockdown and March 2021 was heavily affected by the vaccination campaign):
    - Including COVID-19 vaccination appointments, an estimated 361.1 million appointments were booked across all general practices in England in the twelve months up to March 2022. Compared to the twelve months up to March 2019 (307.3 million as published in April 2019), this is an increase of 53.8 million.
    - Excluding COVID-19 vaccination appointments, an estimated 319.8 million appointments were booked across all general practices in England in the twelve months up to March 2022. Compared to the twelve months up to March 2019 (307.3 million as published in April 2019), this is an increase of 12.5 million.

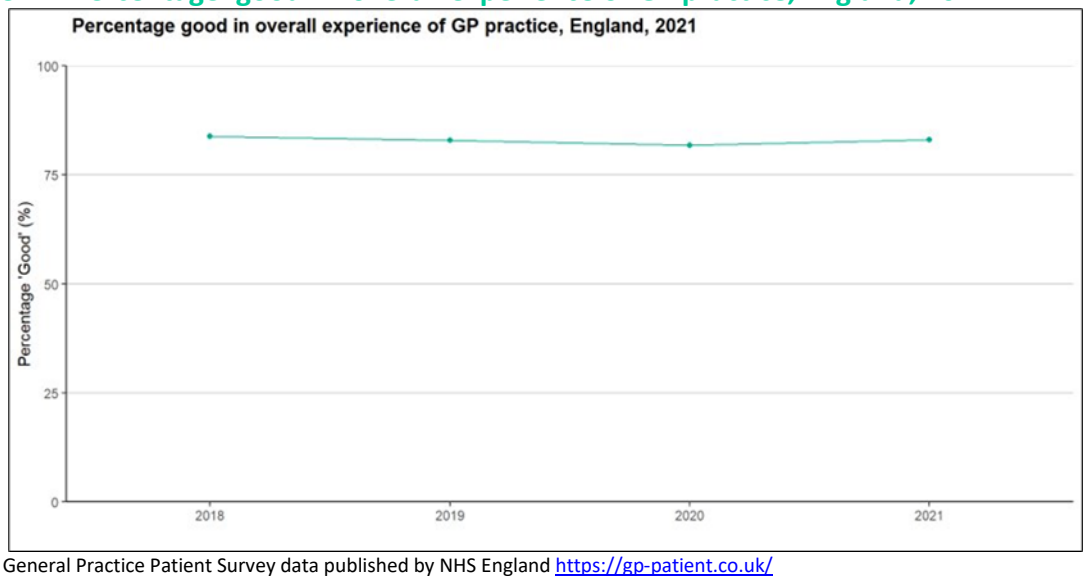
Figure 16: Appointments in General Practice



Source: NHS Digital

93. Results from the General Practice Patient Survey showed that the percentage of people reporting a 'good' overall experience of general practice have remained relatively consistent since 2018, with 83% of patients reporting a 'good' overall experience in 2021. This is shown in **Figure 17**.

Figure 17: Percentage 'good' in overall experience of GP practice, England, 2021.



Source: General Practice Patient Survey data published by NHS England https://gp-patient.co.uk/

Mental Health

94. In March 2021, the Department published the COVID-19 Mental Health and Wellbeing Recovery Action Plan, backed by additional funding of £500 million for 2021-22. This funding was targeted at those groups whose mental health and wellbeing was most affected by the COVID-19 pandemic, including those with a severe mental illness, young people, and frontline staff. It was used to provide additional capacity for mental health services, following the rise in referrals and longer waiting times as COVID-19 restrictions eased, and give more people the mental health support they need.

95. Amongst other things, this funding delivered:
- more adults and children and young people being able to access community mental health services as a result of an additional £110 million for adult services and £79 million for children and young people's services. This included urgent mental health helplines for people in crisis being established and maintained in all areas of the country, around 22,500 more children and young people accessing community health services, 2,000 more accessing children and young people's eating disorder services and mental health support teams operating in schools and colleges covering 26% of pupils (achieving the NHS Long Term Plan target of 20-25% a year early).
- an increased provision of physical health checks to people with serious mental illness with 227,000 health checks delivered with the support of the additional £14 million invested.

- an improved inpatient environment covering 941 beds in 40 sensory-friendly ward projects as part of the £31 million invested in improvements for people with learning disabilities and autistic people.
- strengthening resilience among 113 voluntary, community and social enterprise organisations offering help to people struggling with their mental health or thoughts of suicide through the £5.4 million Suicide Prevention Grant Fund. 97% of recipients reported that the Fund had helped them cope with increased demand and provide services such as signposting, crisis lines, outreach, and treatment.
- funding over 250 local projects promoting better mental health and wellbeing in 40 of the most deprived local authority areas in England through the £15 million Prevention and Promotion for Better Mental Health Fund.

96. We also invested a further £15 million in the Prevention and Promotion for Better Mental Health Fund to help level up mental health and wellbeing across the country. This saw funding provided to over 250 local projects promoting better mental health and wellbeing in 40 of the most deprived local authority areas in England.

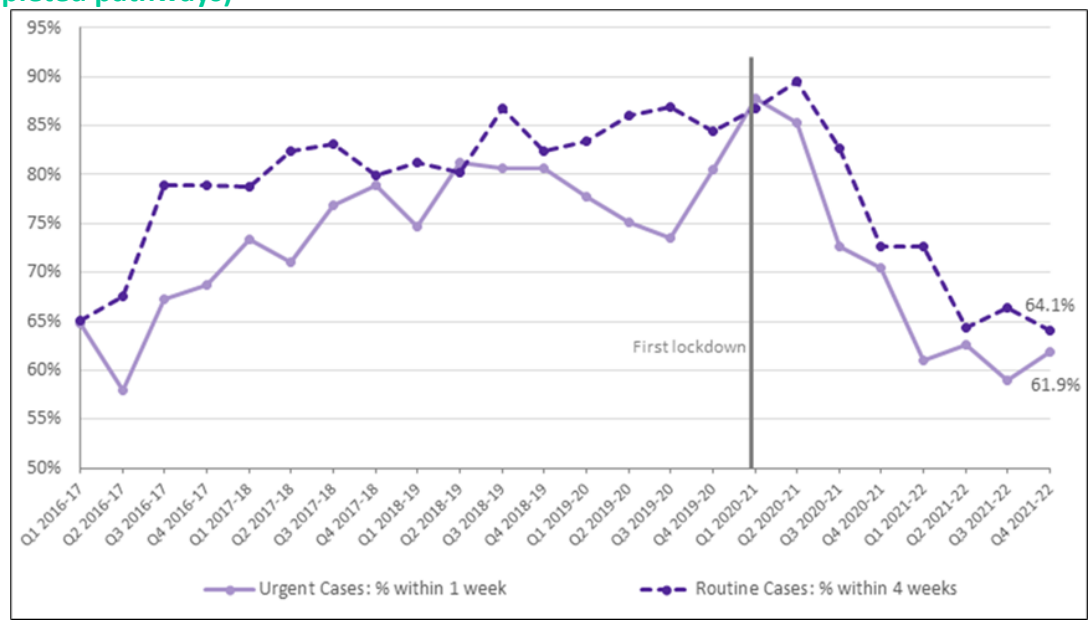
97. As well as continuing to bring all parts of Government together to support people's mental health, the Department continues to support the delivery of the NHS's ambitious plans set out in the NHS Long Term Plan to expand and transform mental health services in England. This is despite the challenges and increased demand placed on services during the pandemic and as we have moved towards living with COVID-19. This includes, for example, the establishment of 33 new maternal mental health services, bringing together psychological therapy, maternity services and reproductive health for women who have mental health needs following trauma or loss related to their maternity experience. These services will be available across the whole of England by March 2024.

98. In addition, the Department has published its response to the public consultation on Reforming the Mental Health Act in July 2021 as part of the development of the draft Mental Health Bill which was published on 27 June 2022.

99. The Mental Health Units (Use of Force) Act, also known as Seni's Law, commenced in December 2021 and was accompanied by publication of the statutory guidance on the use of force in mental health settings and the Government's response to the consultation on the guidance. The majority of the provisions within the Act were brought into force on 31 March 2022 and 18 August 2022, with the rest expected to be brought into force as soon as possible.

100. The children and young people with an eating disorder waiting time standard states that children and young people (up to the age of 19) referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week, for urgent cases, and four weeks, for routine cases.

Figure 18: Children and young people with an eating disorder waiting times in England (completed pathways)



Source: NHS Digital - Children and Young People with an Eating Disorder Waiting Times

101. As shown in **Figure 18**, for completed pathways, 61.9% of young people (365 out of 590) started treatment for an urgent case within 1 week and 64.1% (1,536 out of 2,396) started treatment for a routine case within 4 weeks, between January and March 2022.

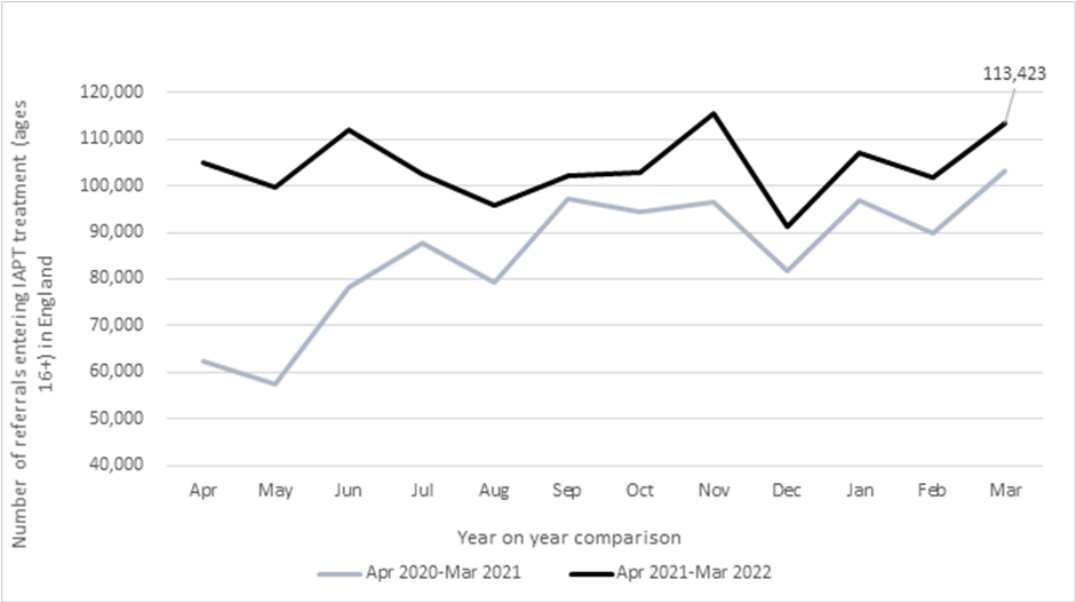
102. For incomplete pathways, at the end of Quarter 4 (January to March 2022), 249 young people were waiting to start treatment for an urgent case and 1,697 were waiting to start treatment for a routine case.

103. The ability to meet this waiting time standard was affected by the rise in demand as a result of the pandemic with more children and young people being treated than ever before. Those entering urgent treatment for an eating disorder increased by 11% in 2021-22 compared to 2020-21. This was on top of a rise of 73% in 2020-21 compared to 2019-20. This impacted how long children and young people were waiting for treatment. The Department continues to work closely with the NHS to recover performance.

104. NHS talking and psychological therapies delivered through the Improving Access to Psychological Therapies (IAPT) programme are expanding with the aim as set out in the NHS Long Term Plan that at least 1.9 million adults can access care each year by 2023-24.

105. Quarterly data shows that in 2021-22, there were 1.81 million referrals to talking therapies in England, with 1.25 million referrals starting a course of treatment. As shown in **Figure 19**, in March 2022, 113,423 referrals entered treatment, which was a 20.3% increase compared with pre-pandemic levels.

Figure 19: Number of referrals entering IAPT treatment (ages 16+) in England



Source: NHS Digital – IAPT Waiting Times

106. The waiting time target of the IAPT programme is that for referrals completing a course of treatment in the month, 75% enter treatment within 6 weeks, and 95% within 18 weeks. This is based on the waiting time between the referral date and the first attended treatment appointment.

107. In March 2022, 88.8% of people completing treatment waited less than 6 weeks against the target of 75% and 98.4% of people completing treatment waited less than 18 weeks for their treatment to start against a target of 95%.

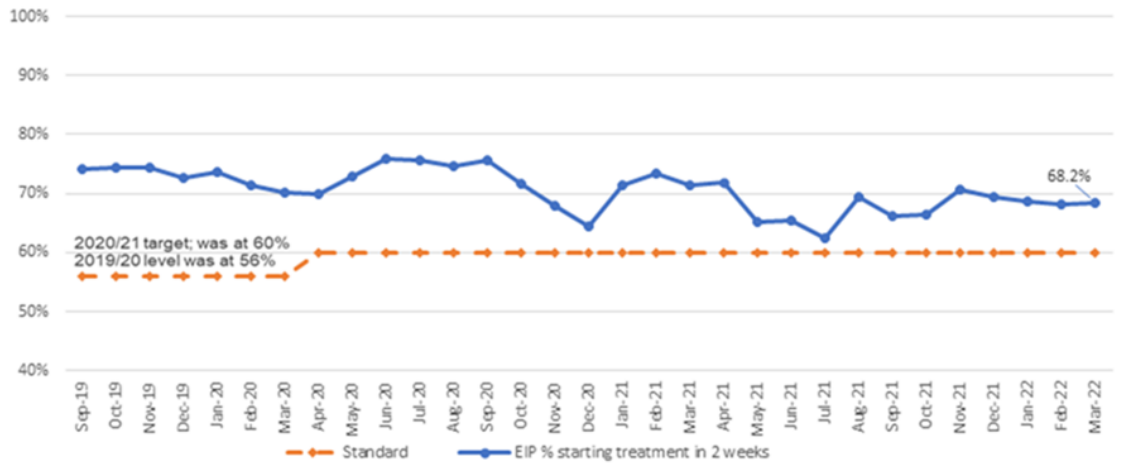
108. The recovery target stating that at least 50% of people who complete treatment should move to recovery, was met in March 2022 where the rate was 51%. In August 2021, it fell below 50% for six months but recovered in February 2022.

109. The Early Intervention in Psychosis waiting time standard is that at least 60% of people with first episode psychosis to have started treatment with a NICE-recommended package of care with a specialist service within two weeks of referral.[3]

110. As seen in **Figure 20**, in the period January to March 2022, 68.2% of referrals (2,354 out of 3,452) started treatment within two weeks, remaining above the 60% target. This waiting time standard has been met since it was introduced.

[3] NHS England. Implementing the Five Year Forward View for Mental Health. Accessed here.

Figure 20: Early intervention in Psychosis (EIP) proportion of referrals with suspected First Episode of Psychosis waiting less than two weeks to enter treatment in England.



Source: NHS Digital - *https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics*

Maternity

111. The government is committed to making the NHS the best place in the world to give birth through the provision of personalised, safe, high-quality care. The National Maternity Safety Ambition is to halve the 2010 rates of stillbirths, neonatal and maternal deaths and neonatal brain injuries occurring during or soon after birth by 2025, with an interim ambition of a 20% reduction in these rates by 2020 (between 2010 and 2020, there was a 25% reduction in the stillbirth rate). An additional ambition to reduce the pre-term birth rate from 8% to 6% was also introduced in 2017.

112. Good progress has been made against several elements of the ambition. Since 2010, stillbirth rate has reduced by 19.3%, rate of neonatal mortality has reduced by 36%, and maternal mortality has reduced by 17%. The overall rate of brain injuries occurring during or soon after birth has fallen to 4.2 per 1,000 births in 2019, 2% lower than the 2010 baseline, and the proportion of babies born preterm (with gestational age under 37 weeks) has reduced from around 8% of all births in 2017, to 7.5% in 2020.

113. Investment of £95.6 million, announced in 2021, has been made in maternity services to fund an additional 1,200 midwives and 100 consultant obstetricians backed up international recruitment. An additional £127 million, announced in March 2022, will further boost the workforce and help improve the culture in maternity units. To help hospitals plan their workforce needs almost £450,000 has been provided to the Royal College of Obstetricians and Gynaecologists (RCOG) to develop a new workforce planning tool.

114. In addition, a new NHSE perinatal clinical quality surveillance model was introduced to structure the oversight of perinatal clinical quality, governance,

training and workforce. As a result, trusts where there are safety concerns can be identified and supported early. The model is integrated into the integrated care system (ICS) structures that were established across England on a statutory basis on 1 July 2022. ICSs will have clear lines of accountability for addressing quality concerns at each level of the system early and thus avoid deaths and injuries caused by insufficiencies in care.

115. Disparities in maternal and neonatal outcomes are being addressed through use of Continuity of Carer, where a pregnant person has one team of midwives from booking to postnatal care.

116. Work to understand and how to remove disparities in outcomes and experiences of care is being overseen by the newly established Maternity Disparities Taskforce. The taskforce will tackle disparities for mothers and babies and reduce maternal and neonatal deaths by improving access to effective preconception and maternity care for women from ethnic minorities and those living in the most deprived areas. The Taskforce is seeking to improve timely monitoring data, research, and delivery of existing interventions, support the spread of 'what works well', identify new challenges, and influence system partners to continuously improve and holding them to account for agreed actions. All of this supports the actions that form the work of the Maternity Transformation Programme.

117. The Department provided £5 million to the 'Avoiding Brain Injury in Childbirth' (ABC) collaboration in 2021-22 for a programme focused on improving the identification, escalation, and action on fetal deterioration in labour; as well as the management of an impacted fetal head during caesarean section. The Programme has developed protocols, clinical tools and training approaches targeting these clinical areas. Planning for the introduction of these across all maternity services is in progress. These two areas for improvement were identified through the NHS Resolution Early Notification Scheme.

118. The final report of the Independent Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden, was published on 30 March 2022. It contains 84 actions. Of these 66 are for the local trust, 15 for the wider NHS and 3 for the Secretary of State. All of these have been accepted. Details of a further, separate Review can be found in the Accountability Report at **paragraph 892**.

119. The Department will also receive the findings and recommendations from a further independent review into failings in maternity services at East Kent Hospitals University NHS Foundation Trust. The final Report 'Maternity and neonatal services in East Kent: 'Reading the signals' report' was published on 19 October 2022, and the Department will consider the report and respond in due course. Separately, NHSE confirmed that Donna Ockenden has been appointed as Chair of the new independent review into maternity services at Nottingham University Hospitals Trust, with the review expected to conclude in 2024. The

Department and NHSE are committed to ensuring that necessary changes highlighted by these reports, are implemented as soon as possible, and has established a working group to take forward the actions arising from the Ockenden and East Kent Reports.

Dental and Eye Care

120. The impact of the COVID-19 pandemic on NHS dentistry continued in the 2021-22 financial year, with the activity of dentists supressed because of the Infection Prevention and Control measures needed to keep patients, dentists, and their teams safe.

121. The Government continued to provide unprecedented support to the sector through reduced threshold requirements for activity, meaning NHS dentists would be paid in full provided they reached the threshold. Dentists were encouraged to undertake as much activity as they safely could to assist access for patients.

122. NHSE and NHSI and the Office of the Chief Dental Officer led work, with support from the Department, on setting contractual arrangements for the first half of the 2021-22 financial year. The Department, the then Parliamentary Under-Secretary of State for Primary Care (Jo Churchill), NHSE and NHSI and the Chief Dental Officer jointly issued a letter to NHS dental practices on 29 March 2021 setting revised thresholds for delivery of NHS dental services for Q1 and Q2 of 2021-22. These thresholds were reviewed and revised, increasing throughout 2021-22, informed by increasing knowledge about COVID-19 transmission and practice delivery levels.

123. An exemptions process remained in place to support practices with extenuating circumstances such as staff self-isolation. These arrangements were put in place for 6 months to provide increased stability for practices.

124. The IPC dental appendix was updated in late 2021, in line with the revision of the IPC guidance for health and social care, and removed the need for post-aerosol generating procedures (AGP) 'fallow time' for the majority of patients, with fallow time needed only for higher risk patients and procedures.

125. At the beginning of 2022, the Government and NHSE&I secured agreement to make available an additional £50 million to help address the backlog in dental care which arose as a result of the impact of the pandemic, recognising that in some areas of the country, some people were finding it difficult to access dental care. From later in January, regions were given access to this additional funding, to secure extra activity outside of core contracted hours for the remainder of 2021-22 and provide additional care to patients. NHSE regional teams worked with commissioning dental teams to understand where additional activity was possible, and this was delivered up to the end of March 2022. As a result, an additional 64,456 people received care, 67% of which were for urgent care. Of the 4,138

additional patients who received care from community dental services (CDS), 55% were children.

126. Government announced a package of improvements to the NHS dental system in July 2022, detailed in Our Plan for Patients, published on 22 September 2022. These changes will improve dental access for patients, better target care to patients with higher oral health needs and make NHS work more attractive to dentists and the wider dental team.

127. More information on access to dental services can be found at **paragraph 370** within the Secretary of State's Report section.

128. On eyecare, NHS England has continued to commission the NHS sight testing services. This service provided over 12 million NHS sight tests during 2021-22 to eligible groups including children, people aged 60 and over, people on income related benefits, and certain groups at particularly risk of eye disease.

129. The Department continues to support NHSE in taking forward the long term plan commitment to bring eyesight checks to children with a learning disability, autism, or both in special residential schools; and transforming hospital eye services to support the NHS to meet future predicted demand for services.

130. For the final quarter of the 2021-22 financial year practices were required to deliver 85% of contracted dental activity and 90% orthodontic activity. NHSE&I's performance data indicated that performance against the Q4 threshold of 85% was lower than expected, probably due to the Omicron variant wave. NHSE and NHSI subsequently proposed a retrospective lower dental activity threshold of 75% for Q4 and a minimum threshold level of 95% was determined for Q1 and communicated by NHSEI on 5 April 2022, to ensure the sustainability by limiting penalties on dental practices.

Long COVID

131. Throughout 2021-22, provision for Long COVID was expanded and the one-year GP Enhanced Service was established to improve the identification and management of long COVID in primary care. An additional £100 million was invested in these services during 2021-22.

132. Data available for the COVID-19 Post-COVID Assessment Service covers dates from 5 July 2021 to 10 April 2022. During this period:
    - 49,159 referrals were accepted, 88% of referrals were accepted as clinically appropriate, and
    - 41,589 initial specialist assessments and 77,054 follow-up appointments took place.

133. Initial specialist assessment waiting time data is available for the period 25 October 2021 to 10 April 2022, during which time 37% seen within 6 weeks of

referral, 47% seen within 8 weeks of referral and 35% waited longer than 15 weeks to be seen.

End-of-Life Care

134. The number of deaths registered in England in the financial year 2020-21 was 607,098. Of these, 28% were at home, 23% in a care home, 43% in hospital, 4% in a hospice and 3% elsewhere (including communal establishments). In the financial year 2021-22 there were 527,795 deaths, a decrease of 13% from the previous 12 months. The proportion of deaths at home increased by 2 percentage points (pp) from 28% to 30%, deaths in a care home decreased by 3pp from 23% to 20%, deaths in hospital remained stable at 43%, deaths in hospices increased by 1pp from 4% to 5% and deaths elsewhere (including communal establishments) remained stable at 3%. (Source: Office for National Statistics (ONS).

135. The national hospice grant fund was reinstated in December 2021, with £148 million made available to hospices to increase discharge capacity and alleviate pressure on the acute sector. The grant provided 178,571 inpatient bed days and 435,997 hospice at home bed days, equating to 614,568 total bed days. It also provided 4.5 million community contacts which enabled hospices to adapt their resource to meet the shift in numbers of people dying at home.

Social Prescribing

136. Social prescribing is a means of enabling health professionals to refer people to range of non-clinical, local services. These are voluntary and community resources and statutory services that can provide practical and emotional support, taking a holistic approach to people's health and wellbeing. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses.[4]

137. NHSE and NHSI social prescribing leads provided the following quarterly data (See **Table 1**) on social prescribing referrals from NHS Digital's General Practice Extraction Service (GPES) data. There may be further social prescribing referrals not captured in the GPES system.

138. In addition, as of March 2022 the number of social prescribing link workers recruited was 2,526 FTE, since the beginning of the national roll out in 2019.

[4] https://www.kingsfund.org.uk/publications/social-prescribing#:~:text=Social%20prescribing%2C%20also%20sometimes%20known,example%2C%20GPs%20or%20practice%20nurses.

Table 1: Cumulative number of social prescribing referrals.

Cumulative number of social prescribing referrals	
Q1 2021-22	532,429
Q2 2021-22	660,218
Q3 2021-22	826,636
Q4 2021-22	993,231

Community Pharmacy

139. In line with the strategic direction set out in the Community Pharmacy Contractual Framework (CPCF) 2019 to 2024, 5-year deal, further new clinical services have been commissioned to relieve pressure on general practice and other parts of the NHS and to make better use of the skill set in community pharmacies.

140. Under the Community Pharmacist Consultation Service (CPCS), NHS111 and GPs can refer patients to community pharmacies for advice and treatment for minor illnesses. NHS111 can also refer for urgent medicines supply. In 2020-21 NHSE have commissioned support for general practices to implement the CPCS referral pathway and the use of CPCS is being incentivised through the GP contract. CPCS referrals divert patients with minor illnesses to a community pharmacist and free up time for GPs to deal with more serious cases, ensuring patients get help quicker.

141. NHSE and NHSI also signalled that it would continue to incentivise referrals to community pharmacy from other parts of the NHS by announcing in Autumn 2021 that, from April 2022, referrals from general practice to the CPCS would be incentivised through an Investment and Impact Fund (IIF) target. In January 2022, NHSE announced that the Commissioning for Quality and Innovation (CQUIN) scheme would also include an indicator incentivising referrals into the community pharmacy NHS discharge medicines service (DMS) from acute trusts. The DMS aims to reduce avoidable patient harm and readmissions caused by medicines by supporting medicines reconciliation for patients discharged from hospital.

142. In September 2021, the New Medicine Service (NMS) was expanded to more therapeutic areas resulting in more patients benefitting from extra support from a community pharmacist with their newly prescribed medication. Additionally, a catch-up NMS was introduced between 1 September 2021 and 31 March 2022 for patients who were prescribed a new medicine during the COVID-19 pandemic, but who did not receive the NMS at that time. As a result, between April 2021 and March 2022 community pharmacies provided over 2 million NMS consultations.

143. In October 2021, the Blood Pressure Checks Service (BPCS) was introduced, enabling community pharmacist to identify patients with undiagnosed hypertension. By March 2022, 6,900 community pharmacies had registered to provide the service.

144. In March 2022, the Smoking Cessation Service was introduced, enabling NHS trusts to refer patients discharged from hospital to a community pharmacy of their choice to continue their smoking cessation treatment. By March 2022, some 1,313 pharmacies had registered to deliver this advanced service.

145. In 2021-22 a record number of flu vaccinations were delivered in community pharmacy - 4.85 million flu vaccines were administered in a pharmacy rather than their GP practice. At the height of the COVID-19 vaccination programme, there were over 1,500 community pharmacist-led COVID-19 vaccination sites.

New Hospitals Programme

146. We continue to make progress on the Government's priority commitment to health infrastructure through the delivery of 40 new hospitals. This is in addition to the 8 previously announced; this will mean 48 hospitals delivered by the end of the decade. These hospitals are part of our wider plans to invest in buildings and equipment across the NHS to ensure our world-class healthcare system and staff have the facilities they need for the future.

147. A national programme across DHSC and NHSE has been established to support this Government Commitment, as a central team to collaborate with the Trusts to deliver. We recognise that Trusts will always be best placed to understand and define local clinical requirements, however individual scheme-level delivery cannot utilise economies of scale and exert the required level of influence to build a market capable of delivering 48 hospitals by 2030. This approach enables delivery that demonstrates improved value for money, reduced whole of lifecycle costs through a consistent national delivery approach, and builds capability for modern, rapid hospital design and construction.

148. We are embedding expertise from specialists in all areas of hospital design, build and operation into the programme, working closely to develop revised national policies and standards to deliver new facilities for both staff and patients that will be at the cutting edge of modern technology, innovation, sustainability, and will drive excellent patient care. We also continue to consult key local and regional stakeholders on key aspects of the New Hospital Programme such as for a clinical strategy and creating a supplier guide for the construction industry.

149. A package of support is being provided to all the hospital schemes in the programme to support business case development and streamline approvals. We are working closely with all trusts within the programme to plan how and when new hospitals will be built across the decade. The NHP has a large portfolio of enabling works on-going throughout the programme which will support the construction of the Trust's main schemes, including demolition works and car park construction.

150. As of October 2022, two of the forty-eight hospitals have now opened for patients:
    - Northern Centre for Cancer Care – North Cumbria Integrated Care NHS Foundation Trust.
    - Royal Liverpool Hospital – Liverpool University Hospitals NHS Foundation Trust.

151. Five further hospitals are under currently under construction:
    - Midlands Metropolitan Hospital – Sandwell and West Birmingham Hospitals NHS Trust.
    - Northgate Hospital – Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.
    - Greater Manchester Major Trauma Hospital – Northern Care Alliance NHS Foundation Trust.
    - 3Ts Hospital – Brighton & Sussex University Hospitals NHS Trust.
    - Bath Cancer Hospital - Royal United Hospital Bath NHS Foundation Trust.

152. Under the national programme, a new hospital is defined as:
    - A whole new hospital site on a new site or current NHS land (either a single service or consolidation of services on a new site)
    - A major new clinical building on an existing site or a new wing of an existing hospital (provided it contains a whole clinical service, such as maternity or children's services)
    - A major refurbishment and alternation of all but the building frame or main structure delivering a significant extension to useful life which includes major or visible changes to the external structure.

153. All schemes that are part of the programme will be consistent with at least one of these criteria.

154. The process to select the final eight hospitals to conclude the 40 was launched in the summer of 2021. The selection process is ongoing, and the government aims to make an announcement as soon as possible.

Health and Care Bill

155. The Health and Care Bill was introduced in July 2021 and promoted local collaboration through the creation of statutory bodies for Integrated Care Systems, bringing together NHS, local government, and wider system partners to put collaboration and partnership at the heart of healthcare planning. The Bill also included measures to reduce bureaucracy by improving the arrangement of healthcare services and to improve accountability and enhance public confidence in the health and care system. This was alongside a range of targeted measures to support people at all stages of life, including through improvements to the social care system, enhanced patient safety and measures to address health inequalities - from improving oral health to tackling obesity.

156. During the passage of the Bill, the government worked closely with parliamentarians and external stakeholders. Over 500 amendments were tabled during Lords' Committee, to which the Government responded. Amendments made during the passage of the Bill saw important new provisions introduced, for example banning virginity testing and hymenoplasty, allowing longer storage of embryos, and emphasising the importance of addressing health inequalities. The final Health and Care Act 2022, which received Royal Assent in April 2022, marked a landmark for the health and care system.

Priority Outcome 3: Improve healthcare outcomes through a well-supported workforce

NHS Workforce

157. As stated in the Long-Term Plan, there is a need to tackle pressures on staff, increasing inequalities and pressures from a growing and ageing population. DHSC's ambition was also to ensure that the NHS has the capacity, capability, and flexibility to deliver the services required during the pandemic and beyond, supporting the recovery towards previous levels of elective activity, and then going further and faster as we move into the future.

158. NHS Staff Survey results have indicated that some staff are struggling with burnout following the challenges of the pandemic. As we work to re-establish services, we are mindful of protecting the workforce, recognising the challenges staff have faced over the last two years.

159. A central priority set out in the NHS People Plan, published in 2020, is staff health and wellbeing, which has been taken forward through the NHS national planning guidance in 2021-22 and 2022-23. Trust boards, leaders, and managers across the NHS have been asked to consider the health and wellbeing of all staff as a strategic priority, so that it is a consideration in every decision and organisation.

160. This commitment was further bolstered in October 2021 when the then Secretary of State commissioned the Health and Social Care Leadership Review. The review was published in June 2022 with seven recommendations aimed at fostering and replicating the best examples of leadership and management and improving workforce culture in health and care. All recommendations have been accepted in full by the Government, and publication of the report will be followed by a plan committing to implementing the recommendations.

161. Through the 50,000 nurse manifesto commitment, we are addressing nurse vacancies via retention of the existing workforce, boosting training and education routes into nursing, and using international recruitment to supply the NHS with a long-term sustainable nursing workforce.

162. As of April 2022, there are over 29,000 more full time equivalent (FTE) nurses working in the NHS than in September 2019, giving a total of 329,975. This places the programme well on the way to meeting the target.

163. NHSE and NHSI vacancy data shows that, as at March 2022, the overall number of full-time equivalent (FTE) vacancies had increased over the previous year. The increase is in part a return to pre-covid levels, COVID-19 artificially suppressed vacancy numbers in 2020 and early 2021.

164. As outlined in the following bullets, and in the subsequent table at **Table 2**, as at March 2022, there were:
    - Over 105,800 vacancies overall (7.9% of the workforce) – an increase of over 29,700 since the previous year but a smaller increase of over 9,400 compared to March 2019 (pre-pandemic) when the vacancy rate was 8.1%
    - Over 38,900 nursing and midwifery vacancies (10.0% of the workforce). There are almost 4,300 more nursing and midwifery vacancies, but the rate of vacancies is still lower than pre-pandemic (11.1%)
    - Over 8,000 doctor vacancies (5.6% of the workforce). There are almost 1,400 more doctor vacancies than the previous year. The rate of vacancies remains below that seen pre-pandemic (7.2%).

Table 2: Q4 NHSE and NHSI vacancy data

		2018-19 Q4 (Mar-19)	2019-20 Q4 (Mar-20)	2020-21 Q4 (Mar-21)	2021-22 Q4 (Mar-22)
Nursing	Vacancy rate	11.1%	9.9%	9.2%	10.0%
	WTE Vacancies	39,524	36,083	34,678	38,972
Medical	Vacancy rate	7.2%	6.3%	4.8%	5.6%
	WTE Vacancies	9,181	8,338	6,634	8,016
Total workforce	**Vacancy rate**	**8.1%**	**7.2%**	**5.9%**	**7.9%**
	WTE Vacancies	**96,361**	**88,347**	**76,082**	**105,855**

Source: NHS Vacancy Statistics England April 2015 – September 2022 Experimental Statistics

165. There are also record numbers of medical students in training and in response to the pandemic, we temporarily lifted the cap on medical and dental school places for students who completed A levels in 2020 and 2021 and who had an offer from a university in England to study medicine or dentistry, subject to grades. There were 8,460 entrants to undergraduate medical courses in England in 2021.

166. Health Education England (HEE) has invested in courses and continuing professional development initiatives for all staff directly employed to support in their learning and development goals and to improve their skillset to deliver the best possible patient care. In September 2019, the Government announced a £210 million funding boost for frontline NHS staff which included a £1,000 personal development budget for every nurse, midwife, and allied health

professional working in the NHS to support their continuing professional development.

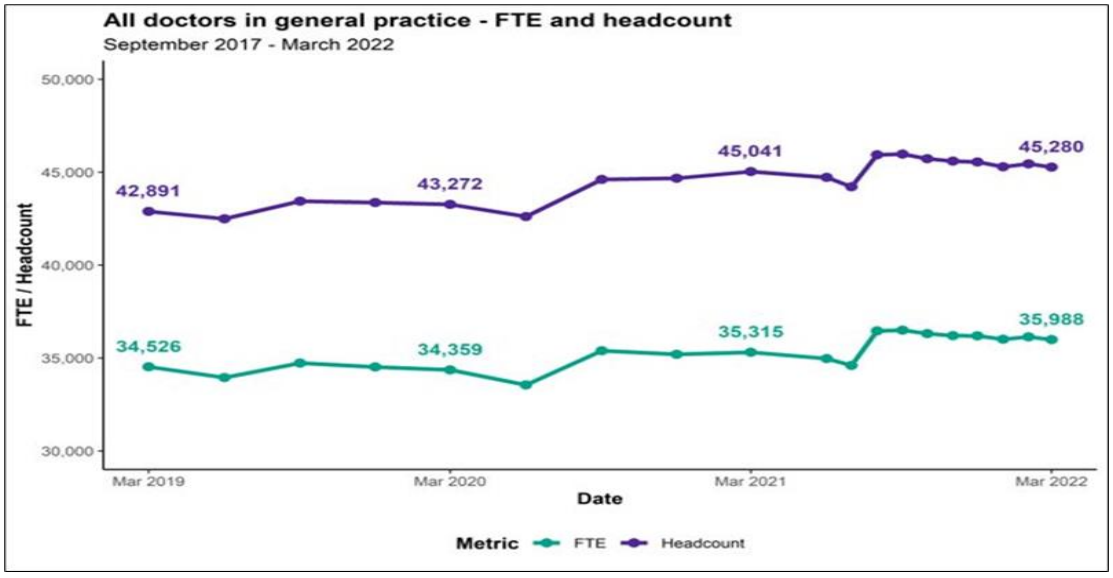
167. In July 2021, the Department commissioned HEE to work with partners and review the long-term strategic trends for the health and regulated social care workforce. This work has looked at the key drivers of workforce demand and supply over the longer term and sets out the impact upon the required shape of the future workforce. It will set out a series of planning assumptions and actions. This work is nearing its final stages.

168. The Department has also recently commissioned NHS England to develop a Long-term Workforce Plan.

General Practice Workforce

169. The numbers of doctors working in general practice are highly seasonal, affected in particular by the new trainees who typically begin their general practice speciality training in August and September. The number of FTE doctors in general practice is increasing. As outlined in **Figure 21**, as of March 2022, there were over 1,400 FTE more doctors working in general practice compared to March 2019.

Figure 21: All doctors in general practice – FTE and headcount (September 2017 – March 2022).

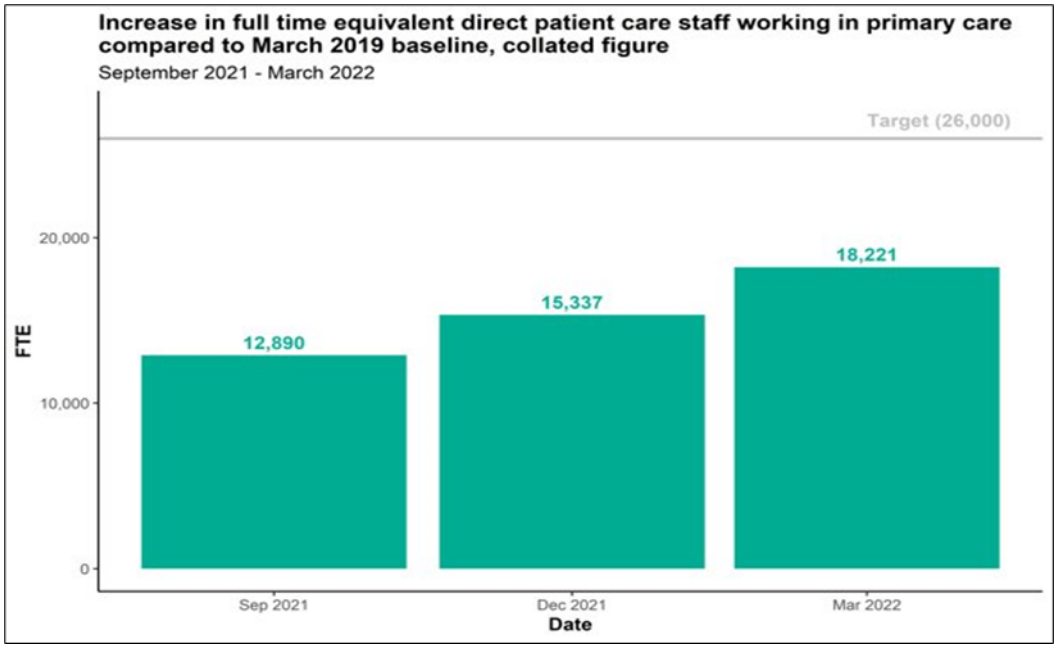


Source: Primary Care Workforce Quarterly Update, 31st March 2022, Experimental Statistics - NHS Digital

170. As shown in **Figure 22**, the numbers of direct patient care staff are consistently increasing with 18,221 FTE more staff having been recruited as of March 2022, compared to March 2019. We are ahead of schedule to deliver the 26,000 more primary care professionals manifesto commitment by March 2024.

171. Direct patient care staff can be employed directly by practices, though the roles are only eligible for Additional Roles Reimbursement Scheme (ARRS) funding if recruited through Primary Care Networks (PCNs). As a result, most of the growth in Direct Patient Care (DPC) numbers is in PCNs.

Figure 22: Patient care staff working in primary care compared to March 2019 baseline.



Source: General Practice Workforce, 31 March 2022 - NHS Digital

Community Health Services (CHS) Workforce

172. It is difficult to estimate CHS workforce due to data gaps for the independent sector. However, it is estimated that the CHS clinical workforce across both NHS and non-NHS organisations is around 100,000 FTE - including Community Health Nurses, community-based Allied Health Professionals (AHPs) and support staff.

173. Within the NHS, Community nursing accounts for 12% of the qualified nursing workforce, of which district nurses account for 13% of community nurses.

174. Data for NHS Trust providers in March 2022 shows:
- 36,000 FTE Community Health Nurses plus 17,000 FTE support staff.
- 4,100 FTE District Nurses
- 24,800 FTE AHP's (inc. 4,700 FTE support staff), working primarily in a community setting.

175. Data for the independent sector is incomplete, so do not represent the full coverage of the sector, but as an indication, figures from Sept 2020 showed an additional 4,600 FTE community health nurses plus 3,000 FTE support staff
- Community nursing vacancy rates in March 2022 were at 10.1%. Vacancy rates vary regionally, with London having the highest vacancy rate (15.2%) and the East of England having the lowest vacancy rate (4.8%).

- As well as community nursing rates being higher than in adult hospital nursing, there is additional cause for concern as Community Health Nurses are older on average. According to ESR in 2021 55% of community health nurses could choose to retire in the next decade once they reach 55 years.

Mental Health Workforce

176. As of March 2022, there were 133,391 full time equivalent (FTE) people in the mental health workforce. This includes only those people who work directly on mental health, across NHS hospital trusts and commissioning bodies. There was an increase of almost 6,500 (5.1% increase) FTE staff in the mental health workforce in March 2022 compared to March 2021.

177. As part of our £500 million additional funding to support the delivery of our COVID-19 Mental Health and Wellbeing Recovery Action Plan, we provided an additional £111 million in 2021-22 to support the NHS mental health workforce. This funding has helped grow the workforce by training and upskilling 202 clinical psychologists, 17 child and adolescent psychotherapists, 667 children's wellbeing practitioner trainees and 1,241 peer support workers (exceeding the original target).

Priority Outcome 4: Improve, protect and level up the nation's health, including through reducing health disparities

Office for Health Improvements and Disparities (OHID)

178. OHID became fully operational on 1 October 2021. It sits in the heart of the Department and brings together expert advice and evidence to shape policy development and implementation, driving health improvement and reducing health disparities. OHID is outward facing, and works with the whole of Government, the NHS, local government, industry, and wider partners to deliver change.

179. OHID's mission is to minimise preventable ill health so that everyone can expect to live more of life in good health; and to level up health disparities so that we break the link between people's background and prospects for a healthy life. Further narrative covering health disparities can be found from **paragraph 470** in the Secretary of State's Report section of this report.

180. Recognising the importance of cross-Government action to tackle the causes of ill health, health disparities and to address the biggest risk factors, the Health Promotion Taskforce (HPTF) Cabinet Committee was established to drive a cross-government effort to improve the nation's health. The Committee is chaired by the Secretary of State for Health and Social Care and attended by Secretaries of State from across Government who hold responsibility for areas that underpin good health. Its terms of reference are to improve the nation's health, supporting

economic recovery and levelling up, and it takes collective decisions that are binding across Government.

181. To effect a long-term change, the Levelling Up White Paper (LUWP) set out 12 missions to 2030. The Department's mission for health is to narrow the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest by 2030, and to increase HLE overall by reaffirming the Government's existing commitment for 5 extra years of healthy life by 2035.

182. The Department has committed to improve the nation's health and tackle disparities in the LUWP, through action on prevention and improving health service provision. This includes commitments to the 'Smokefree 2030' ambition, tackle obesity, invest in treatment and recovery services to tackle substance misuse (as set out in the 10 Year Drug Strategy), transform 'Start for Life' services for parents and babies, and establish new Community Diagnostic Centres.

183. Funding for local government's health responsibilities is an essential element of our commitment to invest in preventing ill health, promoting healthier lives, and addressing health disparities and an important complement to our plans to invest strongly in both the NHS and social care.

184. As part of the 2021 Spending Review, the Government confirmed that the Public Health Grant for local authorities will increase in each of the next three years. In 2022-23 each local authority will receive a 2.81% increase, taking total funding to £3.417 billion. The SR21 settlement increases the value of the public health grant from £3.324 billion in 2021-22 to £3.553 billion in 2024-25, investing £489 million cash growth over the SR period.

185. In addition to the Public Health Grant, the Department is funding a wider package of investment in improving the public's health. This includes additional targeted DHSC investment over the Spending Review period of £170 million to improve the Start for Life offer available to families, including breastfeeding support and infant and parent mental health, and £560 million over the same period to support improvements in the quality and capacity of drug and alcohol treatment announced with the Government's Drugs Strategy.

186. The Start for Life Unit was established in April 2021 after 'The Best Start for Life: A Vision for the 1,001 Critical Days' review was published in March 2021. The review looked at ways to reduce inequalities and improve health and development outcomes in young children from conception to age two, with the aim of ensuring every baby in England is given the best possible start in life, regardless of background. The Start for Life Unit works across Government and with the wider sector to implement this vision and transform the support for families during the 1,001 critical days. In the 2021 Spending Review, the Chancellor of the Exchequer announced £500 million investment over the next three years to transform Start

for Life and family help services. This includes £200 million for the Supporting Families programme.

187. Progress has been made in implementing the Department's Obesity Strategy. We invested £100 million in 2021-22 financial year in healthy weight programmes, including the expansion of weight management services and incentives to help people to eat better and move more. Regulations on out-of-home calorie labelling in large businesses, including restaurants, cafes, and takeaways, were made on 13 May 2021 and came into force on 6 April 2022. The location restrictions which require medium and large business to restrict less healthy products from being featured in key locations such as checkouts, store entrances, aisle ends, and their online equivalent were made on 2 December 2021 and came into effect on 1 October 2022. The volume price promotions restrictions have been delayed by 12 months due to the unprecedented global economic situation and will come into force on 1 October 2023. We have also announced a 12 month delay to the introduction of further restrictions of advertising HFSS products on TV and online.

188. The Department has also begun work to give local authorities their allocations, planning tools and grant agreements under the new 10 year Drugs Strategy, to cut crime and save lives by reducing the supply and demand for drugs and delivering a high-quality treatment and recovery system.

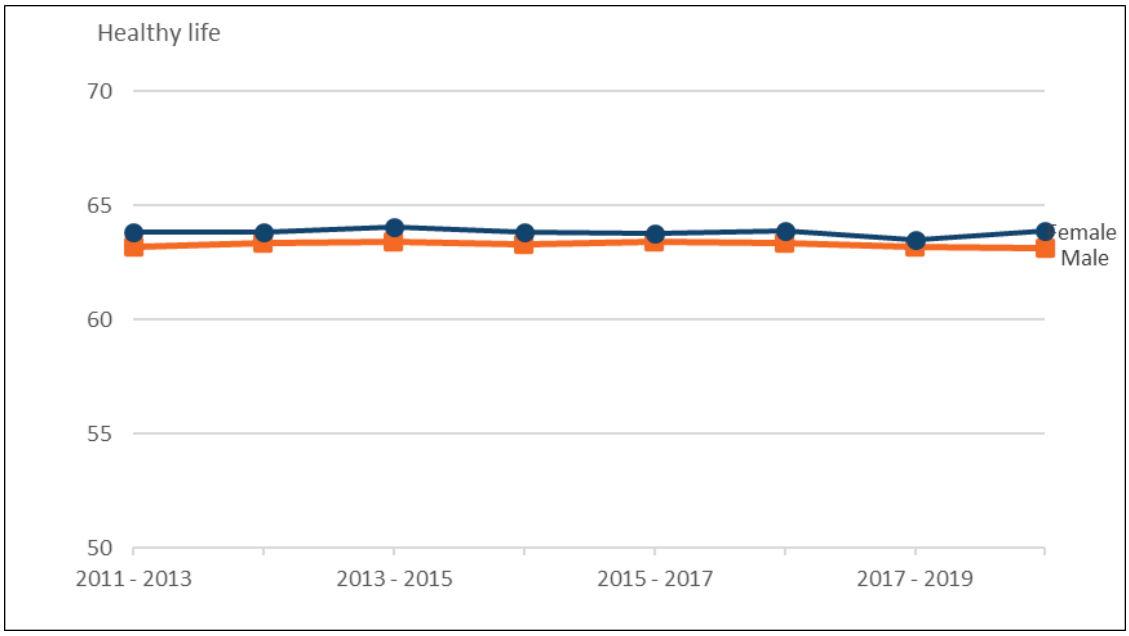
189. In December 2021, we published Towards Zero: the HIV Action Plan for England - 2022 to 2025. The plan sets out how we will achieve the 2030 goal of no new HIV transmission and the 2025 target of an 80% reduction in new HIV infections.

190. Since OHID was established, the Department launched four national Better Health campaigns, Every Mind Matters in October 2021, to help people with their mental wellbeing. A campaign on Smoking in December 2021 which is a new film to discuss how adult smokers can influence younger people. Adult Weight loss campaign which encourages adults across the nation to lose excess weight, eat more healthily and get active during the summer. The Food Scanner Families Campaign in January 2022 was launched to help parents improve children's diet.

Healthy life expectancy (HLE) at birth

191. In 2018-20, HLE at birth for England was 63.9 years for females and 63.1 years for males. Between 2011-13 and 2018-19, there was no significant change in HLE at birth for either males or females in England – See **Figure 23**. Comparing 2018-20 to 2015-17 (the most recent non-overlapping time period), there were no statistically significant changes in HLE at birth for males and females. The 2018-20 data is inclusive of mortality and health state prevalence data collected in 2020 during the COVID-19 pandemic.

Figure 23: Healthy life expectancy at birth, England, for males and females, from 2011-13 to 2018-20.



Source: ONS, Health State Life Expectancies, Health state life expectancy, all ages, UK - Office for National Statistics (ons.gov.uk)

Smoking prevalence

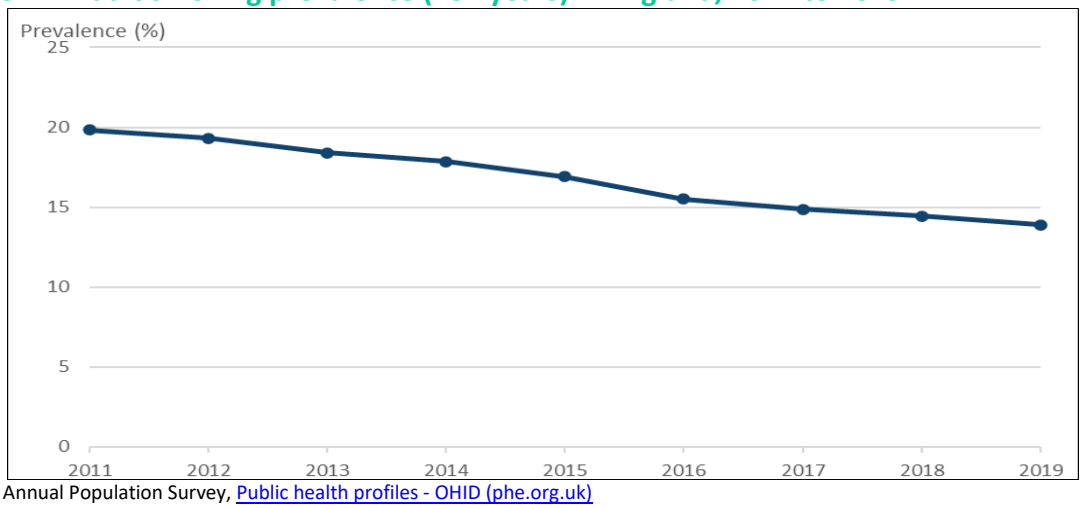
192. In 2019, smoking was the risk factor accounting for the greatest attributable burden of death, and the third leading risk factor attributable to Years Lived with Disability (YLD) in England[5]. Between 2011 and 2019, adult smoking prevalence in England has decreased by almost a third (28.4%) (**Figure 24**). In 2011, 19.4% of adults smoked, compared to 13.9% in 2019. In 2019, smoking prevalence was almost twice as high in the most deprived decile of local authorities[6] compared to the least (16.9% compared to 9.1% respectively).

193. Due to a change in data collection methods during the COVID-19 pandemic, smoking prevalence data from 2020 Q2-Q4 is not currently comparable with previous years however there is ongoing work at ONS to adjust the data to make it comparable.

5 Global Burden of Disease (2019).

6 Deprivation deciles defined by grouping lower-tier local authorities according to their 2019 Index of Multiple Deprivation score.

Figure 24: Adult smoking prevalence (18+ years) in England, 2011 to 2019.



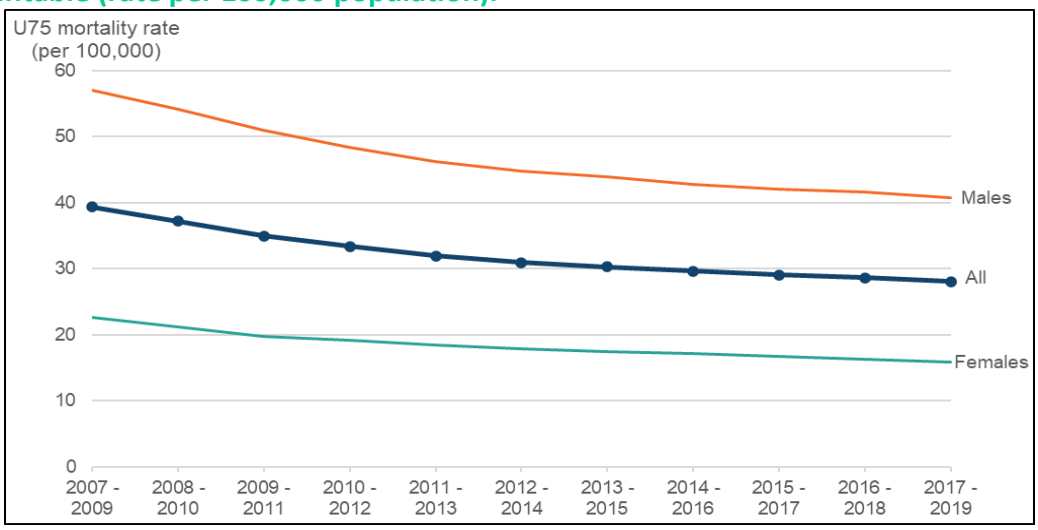
Source: Annual Population Survey, Public health profiles - OHID (phe.org.uk)

Under-75 mortality rate from cardiovascular diseases considered preventable

194. In 2019, cardiovascular disease was the health condition accounting for the second greatest number of deaths in England (after cancer)[7]. Between 2007-09 and 2017-19, the under-75 mortality rate from cardiovascular diseases considered preventable in England decreased from 39.3 to 28.0 per 100,000 **(Figure 25**). The rate has remained higher for males than females (40.8 compared to 15.9 in 2017-19 respectively), however both males and females have also observed a decrease in rates over the course of the time-series.

7 Global Burden of Disease (2019).

Figure 25: Under-75 mortality rate from cardiovascular disease considered preventable (rate per 100,000 population).

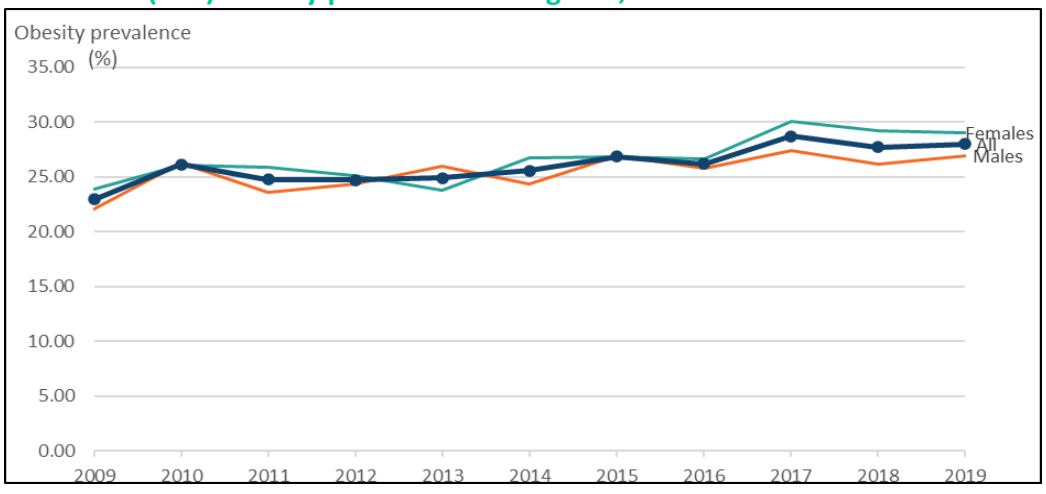


Source: OHID. Fingertips (2022). Public health profiles - OHID (phe.org.uk)

Obesity prevalence (adults)

195. In 2019, a high body mass index (BMI) was the leading risk factor attributed to Years of healthy life lost due to disability (YLDs) in England[8]. Between 2009 and 2019, adult obesity prevalence increased from 23.0% to 28.0%; a 21% increase (**Figure 26**). In 2019, prevalence was higher among females (29.0%) compared to males (27.0%), however this difference is not statistically significant[9].

Figure 26: Adult (16+) obesity prevalence in England, 2009 to 2019.



Source: NHS Digital, Health Survey for England (2019). Health Survey for England 2019 [NS] - NHS Digital

8 Global Burden of Disease (2019).

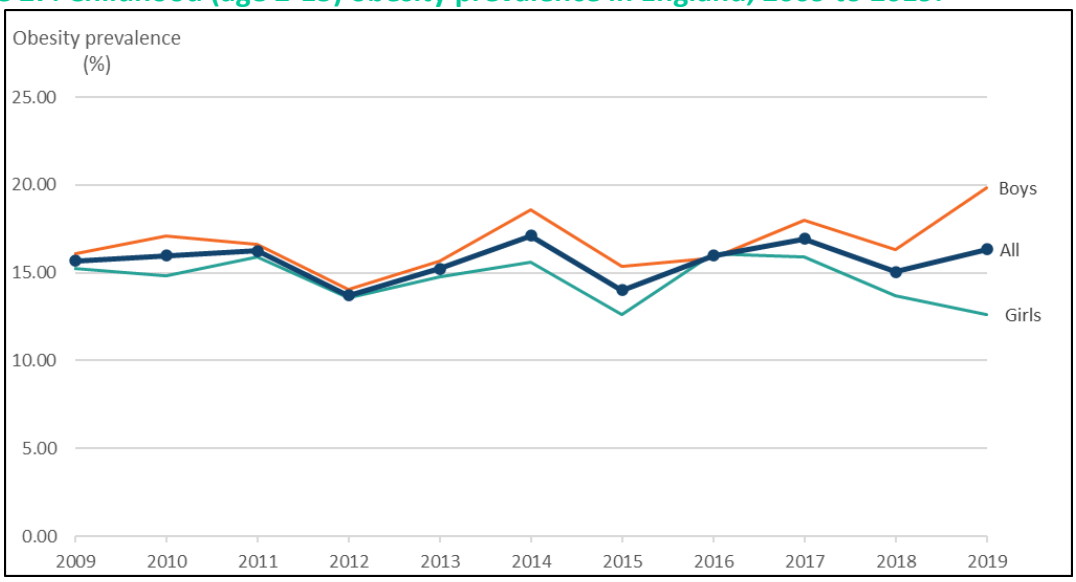
9 HSE 2019 Overweight and obesity in adult and child (digital.nhs.uk)

Obesity prevalence (Children – aged 2 to 15)

196. Between 2009 and 2019, childhood obesity prevalence increased from 15.7% to 16.3% (**Figure 27**). In 2019, an estimated 1.6 million children aged between 2 and 15 were obese[10]. Prevalence in 2019 was statistically significantly higher among males (19.9%) compared to females (12.6%).

197. The National child Measurement Programme (NCMP) records children's height and weight at the first and last years of primary school. During the 2020-21[11] school year, obesity prevalence in Reception increased by 4.5 percentage points (from 9.9% to 14.4%), and 4.5 percentage points (from 21.0% to 25.5%) in Year 6 when compared to the 2018-19 school year[12].

Figure 27: Childhood (age 2-15) obesity prevalence in England, 2009 to 2019.



Source: NHS Digital, Health Survey for England (2019). Health Survey for England 2019 [NS] - NHS Digital

Physical activity

198. Regular physical activity[13] among adults acts as a protective factor for conditions such as coronary heart disease, obesity and type 2 diabetes, and mental health problems, as well as social isolation[14 15]. Regular physical activity among children is

10 HSE 2019 Overweight and obesity in adult and child (digital.nhs.uk)

11 NCMP data collection was impacted due to the COVID-19 pandemic. Data is inclusive of upper-tier local authorities who submitted 75+% of child measurements compared to previous years; 25 UTLAs in total. The sampling approach enables estimates of prevalence at national level.

12 National Child Measurement Programme, England 2020/21 School Year - NHS Digital

13 'Active levels' of physical activity are defined in the Chief Medical Officer's guidelines for physical activity, as achieving an average of 150+ minutes a week of physical activity for adults, and an average of 60 minutes per day for children and young people.

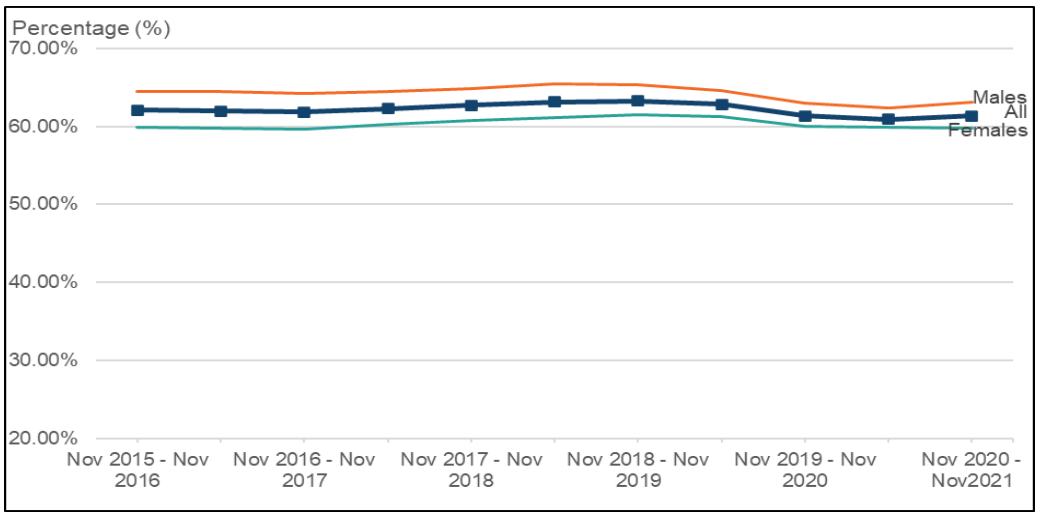
14 PHE. Health matters: physical activity - prevention and management of long-term conditions (2020). Health matters: physical activity - prevention and management of long-term conditions - GOV.UK (www.gov.uk)

15 DHSC. UK Chief Medical Officers' physical activity guidelines (2020). Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK (www.gov.uk)

associated with improved mental health and cardiovascular fitness and contributes to a healthy weight status[16] [17].

199. Adult physical activity levels have decreased since a peak of 63.27% in the period November 2018 to November 2020, with males remaining more likely to be physically active than women (**Figure 28**). Disruption due to the COVID-19 pandemic has likely impacted activity levels between 2019-20 and 2020-21[18].

Figure 28: Physically active adults in England (%), 2015-16 to 2020-21.



Source: Active Lives Survey, Sport England Active Lives | Sport England

200. Levels of physical activity among children and young people have increased from 43.3% in 2017-18 to 44.6% in 2020-21, peaking at 46.8% in 2018-19 (**Figure 29**). Activity levels have fallen among boys since 2017-18, and for the first time in 2020-21, boys and girls were equally likely to be active. School closures and disruption to sporting activities due to the COVID-19 pandemic are likely to have impacted physical activity levels in 2019-20 and 2020-21[19] [20].

16 PHE. Health matters: physical activity - prevention and management of long-term conditions (2020). Health matters: physical activity - prevention and management of long-term conditions - GOV.UK (www.gov.uk)

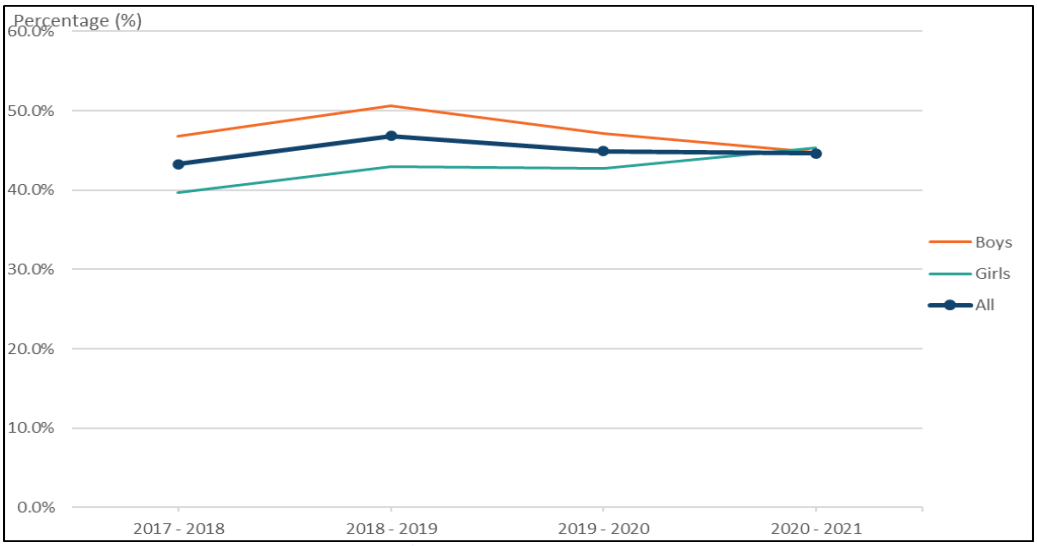
17 DHSC. UK Chief Medical Officers' physical activity guidelines (2020). Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK (www.gov.uk)

18 Sport England. Active Lives Adult Survey: November 2020-21 report. Active Lives | Sport England

19 Sport England. Active Lives Children and Young People Survey: Academic year 2020-21. Active Lives | Sport England

20 Sport England. Active Lives Children and Young People Survey: Academic year 2019-20. Active Lives | Sport England

Figure 29: Physical activity in children (%), England, 2017-18 to 2020-21.



Source: Active Lives Survey, Sport England. Active Lives | Sport England

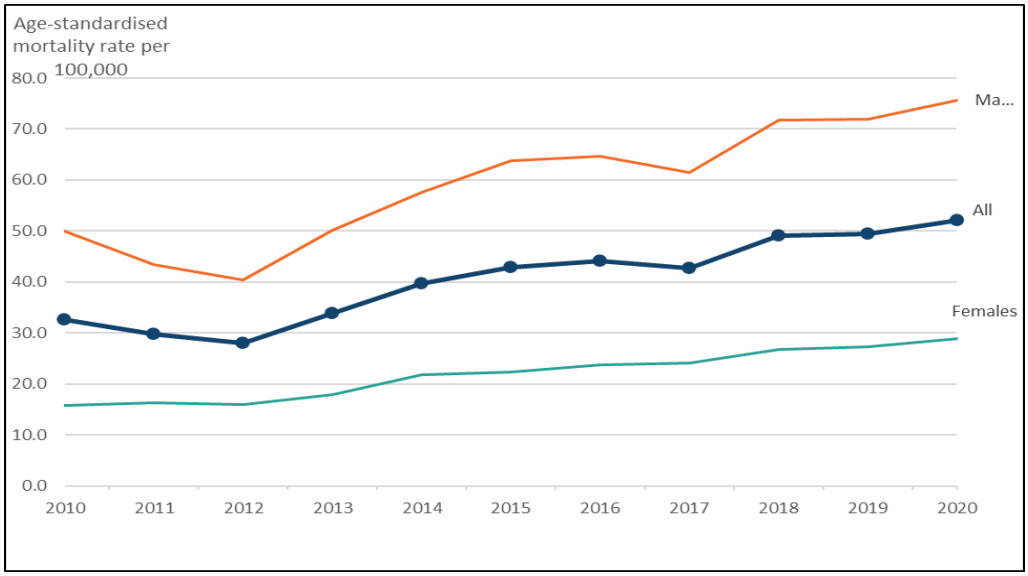
Deaths from drug misuse (age-standardised mortality rate per 100,000)

201. See **Figure 30**. In 2019, drug use was the 10th leading risk factor attributed to YLDs in England[21]. The rate of deaths from drug misuse in 2020 was 1.9 times higher the rate is 2012 (the year with the lowest rate in the time series); 52.1 deaths per 100,000 compared to 28.0 respectively. Drug-related deaths are driven by deaths related to opiates however, there has been an increase in deaths related to other substances. Across Europe, the number of new heroin and morphine users has fallen, whilst deaths involving the same substances have increased; this suggests that there is an ageing cohort of drug users who are more vulnerable to overdosing and the health impact of long-term usage[22].

21 Global Burden of Disease (2019).

22 ONS. Deaths related to drug poisoning in England and Wales: 2020 registrations. Deaths related to drug poisoning in England and Wales - Office for National Statistics (ons.gov.uk)

Figure 30: Deaths from drug misuse (rate per 100,000), England 2010 to 2020.



Source: ONS, Deaths related to drug poisoning, England and Wales. Deaths related to drug poisoning, England and Wales - Office for National Statistics (ons.gov.uk)

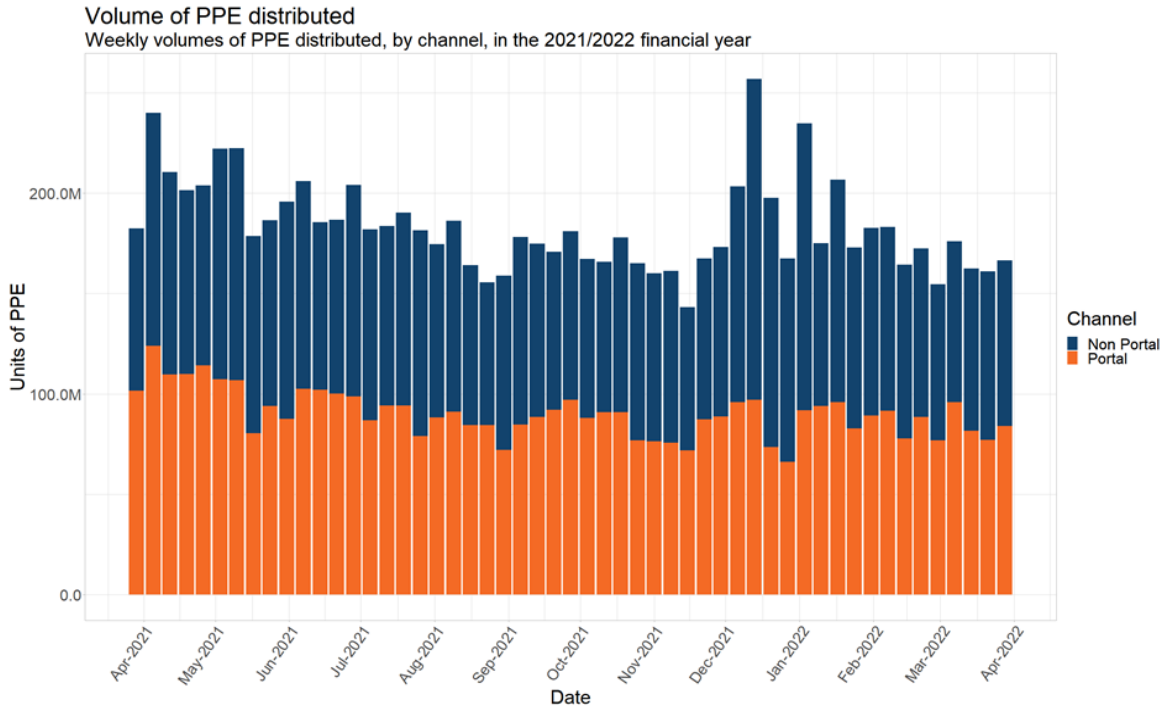
Personal Protective Equipment (PPE)

202. To note, PPE is covered in several areas of this Report, most notably: 'Funding' from **paragraph 283**; Stock issues (from **paragraph 206**), Contracts (from **paragraph 677** and Fraud (from **paragraph 746**) in the Accountability Report sections; and, within the Notes to the Accounts section.

203. As shown in **Figure 31**, during 2021-22, the Department successfully provided an uninterrupted supply of free COVID-19 PPE to the health and social care sector; between April 2021 and March 2022 we distributed 9.9 billion items. In January 2022, the Department announced that the commitment to provide free PPE would be extended to March 2023.

204. Having taken on the responsibility for the supply and distribution of COVID-19 PPE in the crisis, that responsibility remained with the Department throughout the reporting year. The Department retained responsibility during the financial year, but responsibility for distribution transferred to NHS Supply Chain from April 2022. The NHS Supply Chain is working to integrate the provision of PPE to acute settings through the existing infrastructure to remove any duplication from the operation and operate the PPE portal and associated distribution network for other settings.

Figure 31: Number of PPE items distributed each week during the 2021-22



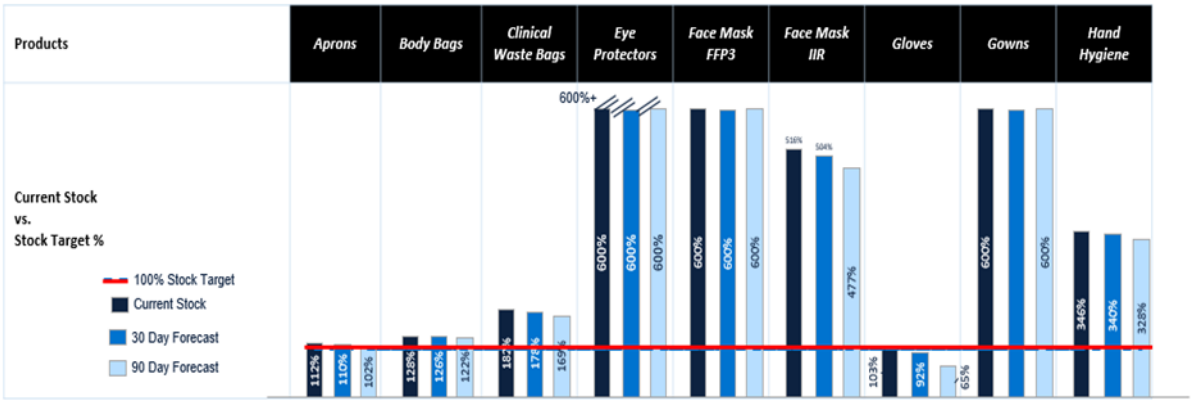
Source: PPE distribution statistics (England) - GOV.UK (www.gov.uk)

205. The Department will continue to work with NHS Supply Chain to deliver a PPE supply chain for the NHS which the wider health and care sector can access, including primary care (general practice, community pharmacy, dental and optometry); adult social care (support to adults with physical or learning disabilities, or physical or mental illnesses); and non-acute settings such as palliative and end-of-life care providers.

206. Prior to the pandemic, we did not hold national data on trust stock levels of PPE as in normal times it is a low-cost, easily available item. Efforts to estimate the reasonable-worst case requirement for PPE began in early March 2020, based on Infection Prevention Control (IPC) guidance, at first covering direct COVID care in acute settings. That early modelling was based on reasonable worst-case scenarios for the virus, from SAGE, and our understanding of how much PPE would be required in those scenarios. We planned on a reasonable worst-case scenario, which never emerged. In addition, plans were based on the expectation that all PPE would be single use, when in practice items such as goggles and visors were used for sessions and also reused, resulting in materially lower actual demand.

207. **Figure 32** shows the percentage level of stock for each category of PPE at the time the chart was produced. This is broken down by current stock, the expected stock levels in 30 days and the expected stock levels in 90 days.

Figure 32: Critical PPE volume levels for March 2022 (all critical PPE products were above their target volume level throughout 2021-22)



Source: [Stockpile of personal protective equipment (PPE) on 30 November 2020 - GOV.UK (www.gov.uk)]

208. Demand for PPE is now waning as countries move towards a living with COVID strategy, and other countries with surplus stock enter the marketplace for re-sale. This has nevertheless contributed to a reduction in our forecast cost of storage, by £1.5 million per year, with storage costs currently approximately £24m per month.

209. The priority has been, and continues to be, to sell, donate, repurpose, or recycle whatever we can. Nevertheless, there are some PPE products that cannot be reused or recycled. The majority of PPE items are designed to be single use and disposed of as medical waste, so are often made up of complex chains of polymers. These items cannot be broken down for recycling. As a result, many of the products that we hold are not able to be fully recycled and around half are completely non-recyclable.

210. In March 2022, an online auction was launched to sell PPE so that individuals and companies may bid for our excess stock. Details are available on Gov.UK. The first round of the auction went on to successfully sell 240 pallets for £46,270.

211. In March 2022, contracts were awarded to two expert waste service providers. These Lead Waste Providers will review the feasibility of recycling each item across our excess and provide detailed options. Going forward, in order to reduce storage costs, the speed of the programme will be accelerated. This is particularly the case for stock that is likely to become out-of-date before it is ever used and is unsuitable for recycling. As at September 2022, for every pallet of PPE that is sold, repurposed, donated and recycled, it is estimated that taxpayers save on average £2.64 of storage costs per pallet of PPE per week.

212. The Department has retained ownership of all stock into the 2022-23 financial year, including continuing to progress the work on sales, donations, and disposals. We will work with our Lead Waste Providers to examine wider disposal options including through 'energy from waste' processes. Environmental concerns will be key, and we will be taking into consideration the Government's waste hierarchy,

prioritising recycling, and then energy from waste for the proportion of stock which we hold that cannot be recycled.

213. The PPE contracts themselves represent a significant commercial challenge: a series of high value contracts let at the height of the pandemic and in the context of a global shortage of PPE has resulted in a suite of quality issues, aligned with complex contractual relationships, in a high profile and high scrutiny environment.

214. The Department's PPE Procurement Team worked through the contracts to maximise the value obtained from taxpayer's money by reducing incoming PPE contracts. By February 2022, the Department had negotiated the cancellation or variation of contracts to reduce the original supply of PPE by 1.21 billion items with an associated reduction in value of £572 million.

215. The Department formed a Dissolution Team in early 2022 of commercial specialists that will continue to work through 2022-23, with quarterly targets to achieve resolution of contracts that have not performed to the standards the Department expects or would want.

Priority outcome 5: Improve social care outcomes through an affordable, high-quality and sustainable adult social care system

216. The Department is in the process of developing an overarching evaluation framework for our Adult Social Care reforms, including engaging with a diverse range of voices across the sector and those who draw on care and support, to identify measures of success for the three-year objectives in our 10-year vision.

217. The evaluation framework will allow us to articulate the interaction between the intended impacts of individual policies and identify appropriate and proportionate approaches to evaluation.

218. **Tables 3** to **8** show areas that are currently measured and publicly reported against, with the most recent available data provided.

Table 3: Percentage of Care Quality Commission locations with overall rating of outstanding/good

Date	Percentage good or outstanding
31 July 2022	79% Good 5% Outstanding
31 July 2021	80% Good 5% Outstanding
31 March 2020	80% Good 5% Outstanding

Source: CQC State of Care / Release Schedule: Annual

Table 4: Social care-related quality of life

Year	Social Care Related Quality of Life (*out of 24)*
2020-21	19.0
2019-20	19.1

Source: Adult Social Care Outcomes Framework Release Schedule: Annual

Table 5: Carer reported quality of life

Year	Carer reported quality of life (*Score out of 12)*
2021-22	7.3
2018-19	7.5

Source: Personal Social Services Survey of Adult Carers in England / Release Schedule: Every 2 years

Table 6: Percentage of people who use social care services who say that those services have made them feel safe

Year	Percentage of people who use Social Care Services who say that those services have made them feel safe
2020-21	88.0%
2019-20	86.8%

Source: Adult Social Care Outcomes Framework / Release Schedule: Annual

Table 7: Staff turnover rate for directly employed staff working in the adult social care sector

Year	Staff Turnover Rate (%)
2020-21	28.5%
2019-20	30.4%

Source: Skills for Care / Release Schedule: Annual

Table 8: Vacancy rate in adult social care sector

Year	Vacancy Rate (%)
2020-21	6.8%
2019-20	7.3%

Source: Skills for Care / Release Schedule: Annual

219. Throughout 2021-22, the Department has taken steps to protect the adult social care (ASC) sector from COVID-19 and mitigate other risks to the system. Alongside responding to COVID-19, the Department has focused on other measures to build the system sustainability.

Overview of support to the ASC sector to meet the challenges of COVID-19

220. In 2021-22, the Department continued to work closely with the adult social care (ASC) sector and public health experts to put in place guidance to keep safe people who used care and support services during COVID-19. This included ensuring they had access to COVID-19 testing, vaccines, PPE, as well as providing

funding to local authorities and adult social care providers for enhanced infection prevention and control (IPC).

221. Throughout the year, the Department worked closely with UKHSA to update guidance in line with the latest clinical evidence. The Department produced guidance across all the key elements of the COVID-19 response in adult social care, and for all types of settings. The Department also provided further support with implementing policy changes through communications and events.

222. The Department worked closely with partners to understand the challenges facing the sector and to shape and deliver support. Alongside ad hoc engagement, officials worked through several stakeholder groups to enable data and intelligence to reach the Department as well as two-way feedback on response planning. This was in addition to working with partners on specific issues and support.

223. The Department also continued to maintain a strong regional presence through the Regional Assurance Team, made up of staff with front-line delivery experience. The team worked very closely with partners at a regional level, including the Association of Directors of Adult Social Services (ADASS) and CQC.

224. Throughout the year, ASC Group worked with UKHSA to strengthen and expand the COVID-19 testing regime in adult social care and NHSE to deliver doses of the COVID-19 vaccine. This included establishing and monitoring the operational and logistics arrangements around testing provision, delivery, processing, and reporting.

225. To drive take-up of the COVID-19 vaccine in the ASC sector, the Department worked with NHSE on monitoring, data-collection, communications and removing practical barriers to ASC staff and care recipients accessing the vaccine.

COVID-19 funding

226. In April 2021, the existing Infection Control Fund and Rapid Testing Fund were amalgamated into the Infection Control and Testing Fund. This provided £341 million to support the adult social care sector to reduce transmission of COVID-19 within and between care settings until 30 June 2021. This was extended again in June, with £251.3 million between 1 July and 30 September. At this point, the total ring-fenced funding provided over the course of the pandemic was £1,490 million for infection prevention and control and £396 million to support testing (£345 million for IPC and £247 million for testing in 2021-22).

227. The Department extended funding for designated settings as part of the £478 million made available to support hospital discharge over the winter and support Designated Settings Indemnities from September, until 31 March 2022. Designated settings provided a CQC-assured setting for those who were

discharged from hospital whilst positive for COVID-19, to ensure they were isolated from the wider care home population.

Roadmap out of lockdown

228. The Department held a weekly visiting stakeholder working group throughout the first part of the year. The group provided views from the sector on how current guidance was being implemented, what the challenges were, and recommendations for changes at each step of the national Roadmap out of Lockdown (February 2021). These recommendations were considered alongside clinical advice to develop guidance at each step.

229. Restrictions on visits into and out of care homes, and care home admissions were gradually relaxed as we moved along the 'Roadmap'. Between 8 March and 19 July 2021, the Department made five updates to visiting guidance to ensure that the restrictions in place were proportionate to the risk to health and wellbeing of care home residents.

230. PPE for all COVID-19 needs of the ASC sector has been provided for free since 18 September 2020. During the period 1 April 2021 to 31 March 2022 the Government provided PPE guidance which was specifically tailored to the ASC sector; for example the 'How to work safely guidance' with documents for the care homes and domiciliary care (applicable to other care settings) respectively. This was updated in line with the latest available clinical evidence.

231. Following a significant update in May 2021, the Department held webinars for the sector hosted by the Chief Nurse for ASC, Deborah Sturdy, to answer FAQs and support implementation of the guidance.

232. In September 2021, the Department conducted a review of all ASC guidance related to COVID-19. This was to ensure that the guidance remained clear, proportionate, up to date, and useful to the sector. The review drew on the recommendations of Sir David Pearson's review of the 2020-21 Adult Social Care Winter Plan and contributions from UKHSA, and other partners, including: Carers UK, The National Care Forum, Care England, ARCO (PPE suppliers), Alzheimer's UK and care providers.

The second dose of the vaccine

233. Having coproduced standard operating procedures (SOP) with NHSE and NHSI for delivering COVID-19 vaccines, the Department and its partners continued to deliver a programme of work to drive vaccine uptake in adult social care.

234. The Department also conducted a targeted year-long communication campaign, providing bespoke materials for providers including a stakeholder toolkit, Q&A, leaflets for staff, posters, guidance, and an employer toolkit. The Department communicated directly with frontline workers and providers via webinars, letters, paid advertising, online social media content, blogs, and case studies. Since the

beginning of the vaccines rollout in December 2020, the Department has hosted 7 webinars in support of vaccines deployment, tackling hesitancy and driving uptake in the sector.

COVID-19 related activity during October-March

235. In November 2021, the Department published Adult social care: COVID-19 winter plan 2021 to 2022. The plan built on Sir David Pearson's review of the Winter Plan 2020 to 2021 and included a response to his recommendations. It set out the Government's planned national support for the ASC Sector over the winter, as well as the principal actions to be taken by local authorities, NHS organisations and ASC providers across all settings.

Funding

236. In August 2021, the Department announced a further 6-month extension to the Infection Control and Testing Fund – providing a further £388.3 million until 31 March 2022. This included £25 million specifically to support social care staff with the costs of travelling to receive COVID-19 or flu vaccinations and ensuring that they were paid their usual wages to do so. By the time the Infection Control and Testing Fund concluded in March 2022, it had provided £1.81 billion for infection prevention and control (including the £60 million un-ringfenced Omicron Support Fund, which was provided in January 2022 to help the ASC sector deal with additional pressures caused by the Omicron variant), as well as £523 million for testing.

237. In October 2021, the Department established the £162.5 million Workforce Recruitment and Retention Fund (WRRF) to support recruitment and retention of adult social care staff, including helping to meet the cost to cover absence due to self-isolation or illness. The Department announced a second round of the WRRF (totalling £300 million) in December 2021 to enable local authorities and providers to address adult social care workforce capacity pressures through recruitment and retention activity in their geographical area. The fund came to an end at the end of March 2022.

238. In January 2022, the Department announced that it would continue to provide free PPE for the COVID-19 needs of the adult social care sector until the end of March 2023. Also in January, the Department provided an extra £60 million to local authorities to help them support the adult social care response to the COVID-19 Omicron variant through the Omicron Support Fund.

Omicron response and Living with COVID-19

239. As evidence emerged of the increased transmissibility of the Omicron variant, the Department enacted its contingency plan for new variants of concern in adult social care to rapidly put in place additional measures to protect care homes, residents, and staff.

240. From 25 November 2021 to 31 March 2022, the Department regularly updated guidance to reflect the changing situation and clinical advice. Through guidance on 14 December, the Department reintroduced some restrictions in relation to visiting and admissions in care homes, in response to the Omicron variant. The Department then eased some restrictions on 31 January, with isolation periods for care home residents reduced in line with new clinical advice on 22 March.

241. In December 2021, the Department set-up the Winter Steering Group (WSG). The group brought together policy teams within the Department with clinical experts in UKHSA, representatives of local authorities and local government, directors of public health, NHS England and the CQC to review planning and response and ensure any intelligence and data from the front-line was reaching the Department.

242. The Department also established the Senior Stakeholder Group to communicate with national organisations representing care providers about our planning and allow them a chance to input and provide feedback directly. These groups ran alongside the COVID-19 ASC working group of stakeholders (CAWGS), a diverse group of sector stakeholders set up in September 2021 to support ongoing delivery of work in response to COVID-19.

243. The Department also established the Vaccine Booster Taskforce to coordinate and drive uptake of boosters and flu vaccinations among social care workers during a period of increased response over Winter 2021. The taskforce, chaired by Sir David Pearson, regularly met to coordinate and accelerate vaccination within care homes and other care settings, and published a good practice guide 'Protecting the Adult Social Care: Good Practice for Local Booster Vaccination' on 4 February 2022, aimed at integrated care systems, local authorities, and adult social care providers.

244. The Department continued to work with UKHSA health protection teams, local authorities, NHS Regional Teams, and care home providers to monitor and address risks, including COVID-19 outbreaks. In February 2022, the Department reduced the normal length of an outbreak to 10 days following the last positive case. This followed a report from the SAGE Social Care Working Group that considered outbreak arrangements.

245. Following the publication of the Living with COVID-19 Strategy, the Department conducted a further review of guidance. This resulted in most COVID-19 guidance for Adult Social Care being removed and replaced with 'Infection prevention control: resource for adult social care', supported by a COVID-19 supplement (March 2022). All remaining COVID-19 visiting restrictions were removed on 4 April 2022, although outbreak management procedures for care homes remain in place.

Sustainable Adult Social Care (ASC) system

246. A key component of the Department's work is to ensure a sustainable adult social care system, including identifying approaches that help to maintain and build capacity and capability across all care settings. This included its interactions with partners at regional and local levels who continued to provide local intelligence and insight to support the Department's oversight of the ASC system. It covered a range of risks, including system capacity, provider viability, workforce, and cost pressures such as inflation.

247. In relation to provider viability, the Department continued to develop and carry out monitoring through regular assessment of the market to determine whether further intervention might be required. The Department maintained its well-established and well tested contingency plan to ensure readiness to respond in the event of major provider failure, under which the Department would coordinate a system-wide response to support local authorities in discharging their duty to secure continuity of care for people with care and support needs.

248. In December 2021, the Department confirmed the details of its £1,360 million Market Sustainability and Fair Cost of Care Fund of which £160 million is being made available in 2022-23, and £600 million in both 2023-24 and 2024-25. The Fund will support local authorities to prepare their markets for reform and move towards paying providers a fair cost of care.

249. The Workforce Recruitment and Retention Fund (WRRF), national recruitment campaign and existing systems in place for rapid DBS-checks and induction for new recruits bolstered staffing to enhance overall workforce capacity. In addition, the Department, worked with key partners - UKHSA, the Operational Resource Centre and sector stakeholders - to monitor the ongoing picture and respond to emerging local workforce pressures.

250. Additionally, in February 2022, the Government changed the immigration rules to enable overseas recruitment of care workers and added the roles to the shortage occupation list (SOL) which reduced the salary threshold down from £25,600 to £20,480. Early indications – such as several oversubscribed training seminars and stakeholder feedback – suggest this new recruitment route has been welcomed by the sector.

251. On 24 March 2022, the Department published the Adult Social Care Infection and Testing fund guidance and grant conditions to set out how the Department expect funding to be used and to drive best practice, and consistency, in understanding and reporting local provider costs and risks to local markets. Alongside this, intelligence from internal data sources, other Government Departments and funded partners helped identify where local authority support had been most needed. The Department's Regional Team provided local intelligence and

expertise to provide intensive and targeted support. The Department continue to fund improvement activity at a local and regional level.

NHSX[23]

252. NHSX continued to build on the NHS App; a complex 'tech' project that has enabled millions of people to travel and go to events more safely. Adding the NHS Covid Pass to the NHS App led it to become the most downloaded free iPhone™ app in 2021-22, downloads were seen to have increased from 2 million users to over 24 million.

253. In partnership with the seven NHS England Regions, NHSX supported the scale up of remote monitoring services for care home residents and patients with key long-term conditions, enabling over 200,000 people with long-term conditions into programmes that let their clinicians monitor how they're doing remotely.

254. Improving digital maturity remained a key component of NHSX's work. On 31 August 2021, NHSX published the What Good Looks Like framework outlining the vision for what a good digital NHS or social care organisation should look like and clarifying how tech funding should be made available to the system through the Who Pays For What publication.

The war in Ukraine

255. By the end of the reporting year, supporting the wider UK Government response to the war in Ukraine became a key focus for the Department. By the end of March 2022, the Department (with NHSE and the Devolved Administrations) had donated over 5.2 million items of donated medicines and medical supplies into Ukraine. These included critical supplies such as wound care packages, PPE, bandages, antibiotics, and analgesics.

256. After receiving a request from a charity operating out of Poland, the Department and NHSE arranged to evacuate 21 Ukrainian paediatric oncology patients and their families to England to continue life-saving treatment. The Department continues to work with Local Authorities to support the families as they move into long-term accommodation.

257. Following the establishment of the Ukraine Family and Homes for Ukraine visa schemes, the Department has been working with NHS England and UKHSA to ensure that those arriving into England can access the healthcare they need and has worked across Government to develop welcome packs and hubs to support on arrival to the UK. On 17 March 2022, the Department amended charging regulations to guarantee free access to healthcare for any Ukrainian in the UK with a visa.

[23] To note – as of 2022 NHSX is now referred to as the Digital Transformation Directorate.

258. The Department has also been working with partners to ensure no impacts on domestic health and social care services arose. This included closely monitoring critical supply chains, encouraging ALBs to diversify their commercial arrangements away from Russian or Belarussian suppliers, and working with Trusts and Adult Social Care providers to bolster their cyber security resilience.

259. The Department has followed cross government requirements relating to assessing and managing the exposure of the Group to entities and individuals subject to the Russian financial sanctions regime. This included following the guidance in Procurement Policy Notice 01/22: Contracts with Suppliers from Russia and Belarus, which instructs that contracting authorities should consider how they can further cut ties with companies backed by the states of Russia and Belarus. The risk of exposure of the Departmental Group to such suppliers has been assessed as low.

Inflation

260. The current economic environment and general global instability has contributed to inflationary pressures that will affect the financial position of the departmental group going forwards.

261. A full assessment of the impact of the current rates of inflation is ongoing and may fluctuate over time in response to changing economic conditions. The Department is monitoring the situation and working with HM Treasury to fully assess the impact of current inflationary pressures. This analysis includes the potential impact on health and social care, capital, and workforce.

NHS Financial performance

262. The majority of the DHSC Group budget is spent in the NHS, for which the Government agreed a Long-Term Settlement in 2018. This committed funding increases of £12.4 billion by 2020-21, rising to £33.9 billion by 2023-24, and fully funded the NHS's own Long-Term Plan. On top of this, the government provided a further £16.3 billion in 2021-22.

263. The additional £16.3 billion increases the NHS's total Revenue Departmental Expenditure Limit (RDEL) total to £150.6 billion, which includes £1.1 billion to reduce NHS waiting lists through tackling the elective backlog, £2.4 billion for the deployment of COVID-19 vaccinations in NHS settings, £1.1 billion for enhanced discharge programmes, £0.4 billion to expand mental health services and additional funding for the costs of testing in NHS settings, enhanced flu programme and dental recovery.

264. This approach to supporting the NHS through the pandemic has seen a significant improvement in the financial position of frontline NHS organisations, with the NHS provider sector ending the financial year with a healthy aggregate surplus.

265. Against this total budget, the NHS has ended the year with a net underspend of £1.2 billion, mainly driven by capacity pressures in hospitals and other healthcare settings due to the Covid-19 Omicron variant, which slowed down spending on normal NHS commissioning activity and service transformation.

266. Funding was agreed at prudent levels and has fully funded the direct and indirect costs to the NHS in 2021-22. In addition, savings have arisen in business as usual (BAU) budgets i.e., non-COVID-19 related core NHS services, as the NHS rightly focussed more on the COVID-19 operational response.

DHSC Group Financial performance

267. The Department is accountable to Parliament for ensuring that total spending by all bodies within the Department for Health and Social Care Group is contained within the overall budgets approved by Parliament per **Table 9**.

Table 9: DHSC Departmental Outturn 2021-22 against Parliamentary & HM Treasury Controls

	Budget £m	Outturn £m	Under/ (Overspend) £m	Key disclosure notes/further detail
Parliamentary Controls:				
Resource Departmental Expenditure Limit (RDEL)	186,895	183,548	3,347	SOPS 1.1, Annex B
of which: Resource Administration	*3,398*	*2,675*	*724*	*SOPS 1.1, Annex B*
Capital Departmental Expenditure Limit (CDEL)	10,447	9,119	1,328	SOPS 1.2, Annex B
Resource Annually Managed Expenditure (RAME)	49,000	47,971	1,029	SOPS 1.1
Capital Annually Managed Expenditure (CAME)	15	0	15	SOPS 1.2
Non-budget - Prior Period Adjustment	0	2,547	(2,547)	SOPS 1.1, Annex B
Net Cash Requirement	170,581	163,476	7,105	SOPS 3
Further HM Treasury Controls:				
Ringfenced Resource DEL	1,580	2,753	(1,173)	Annex B
Non-ringfenced Resource DEL	185,315	180,795	4,520	Annex B

Note: some figures in above table may not cast due to rounding.

268. As referenced in the key finance facts earlier in the Performance Report and in **Table 9**, the Department for Health and Social Care Group had underspends of £3.3 billion on its Resource Departmental Expenditure Limit (RDEL) £1.3 billion on its Capital Departmental Expenditure limit total, £7.1 billion on its Net Cash Requirement (NCR) control total and £1.0 billion on its Resource Annually Managed Expenditure (AME) control total.

Annually Managed Expenditure (AME)

269. Expenditure that HM Treasury has determined is treated as Annually Managed Expenditure 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.

Non-budget

270. As part of producing their accounts for 2021-22, NHS Resolution undertook a review on the timing of their settlement payments, which identified the need to increase their 2020-21 provisions expenditure by £2.5 billion. HM Treasury budgeting convention requires that Parliament is notified of this expenditure from the prior year through the Statement of Parliamentary Supply. As the change wasn't known about at the time of setting budget requirements in Supplementary Estimates, it will result in a breach of a Parliamentary control known as 'non-budget expenditure'.

Net Cash Requirement

271. The Department for Health and Social Care Group underspent against its cash limit by £7.1 billion. The cash limit was set as part of the Supplementary Supply Estimates and included cash to support the resource and capital budgets as well as an estimate of working capital required. Around £5.8 billion of the underspend can be explained by the resource non-ringfenced DEL and capital DEL underspends of £4.5 billion and £1.3 billion respectively. The balance is due to actual working capital being lower than estimated.

272. The 2021-22 outturn against the Department for Health and Social Care Group's spending controls, is shown in **Table 9**. The following paragraphs, supported by **Table 10** and **Table 11,** provide further information about the nature of the spend and underspends incurred by the Department for Health and Social Care Group during 2021-22 in relation to RDEL and CDEL.

COVID-19 funding and expenditure in 2021-22

273. As part of Government's response to the Coronavirus pandemic the Department for Health and Social Care Group received:
    - £39.2 billion additional RDEL funding - including; £16.0 billion for the Test and Trace programme, £13.7 billion for the NHS to support the frontline response to the pandemic, £5.1 billion for the procurement, supply and deployment of the COVID-19 vaccine, £2.4 billion for the procurement and supply of personal protective equipment, £1.1 billion for infection control fund and other COVID-19 grants, £0.4 billion for COVID-19 treatments, £0.3 billion for the Managed Quarantine Service and £0.1 billion for Ventilators and the Critical Care National Stockpile.
    - £1.2 billion additional CDEL funding - mainly including £0.6 billion for the NHS, negative £0.2 billion for the Test and Trace programme and £0.9 billion for the procurement, supply, and deployment of the COVID-19 vaccine.

Revenue funding and expenditure analysis

Table 10: Resource DEL

Resource DEL Non ring-fenced (RDEL NRF)	RDEL NRF Budget £m	RDEL NRF Outturn £m	Under/ (Overspend) £m	RDEL (ringfenced) outturn £m	AME outturn £m
NHS business as usual activities	134,315	133,670	645	197	1,220
Non-NHS business as usual activities	11,812	10,323	1,489	650	43,957
NHS Test & Trace	16,045	15,154	891	114	181
NHS COVID-19	13,698	13,329	369		
Vaccines supply and deployment [1]	5,036	4,629	407	631	1,715
Personal Protective Equipment	2,361	1,918	443	6	(875)
Infection Control and other grants	1,130	1,110	20		
COVID -19 treatments	440	362	79	895	1,774
Managed Quarantine Service	329	268	60		
Ventilators and Critical Care Stockpile	150	32	118	260	
Total	**185,315**	**180,795**	**4,520**	**2,753**	**47,971**

Note: some figures in above table may not cast due to rounding.

NHS Response

274. The NHS was allocated COVID-19 revenue funding of £16.3 billion to support the frontline response to the pandemic (comprising the £13.7 billion shown in the table above, and the NHS' allocation of vaccine deployment and test and trace funding). The funding supported specific initiatives such as the recovery of elective services, enhanced patient discharge scheme, expansion of the flu programme and mental health service recovery.

NHS Test and Trace (NHSTT)

275. NHS Test and Trace (NHSTT) was allocated revenue funding of £16.0 billion and spent £15.2 billion on:
    - Creating and maintaining daily capacity for tests, establishing over 880 testing sites
    - Providing rapid LFD tests for citizens
    - Conducting COVID-19 tests since March 2020,
    - Contacting people to notify them to self-isolate,
    - Operating the NHS COVID-19 app which has been downloaded over 20 million times in England and Wales.

276. £7.3 billion of NHSTT's expenditure relates to inventory, which scores to RDEL on consumption.

277. The NHSTT £0.9 billion saving against budget was mainly because; the final budget for the year was agreed during the peak of the Omicron wave which was assumed to endure into 2022. The change in policy to the Living with COVID strategy resulted in less than anticipated demand for tests and related activities.

Vaccine procurement, supply, and deployment

278. In 2021-22, the COVID-19 vaccine procurement, supply and deployment programme was allocated £5.0 billion and spent £4.6 billion on the biggest vaccination programme in NHS history. This included:
    - 88,869,941 vaccinations given
    - 179.2 million doses procured

279. The £0.4 billion saving against budget was predominantly due to the final budget being agreed during the Omicron wave and when the deployment programme was delivering surge requirements. The cost of the surge was also less than anticipated at the time.

280. The 179.2 million doses were procured to ensure sufficient supply of COVID-19 vaccines to meet the reasonable worst-case scenario and ensure sufficient supply in the event of a surge scenario.

281. The Department has non-cancellable contracts for the delivery of COVID-19 vaccines and the onerous contract provision disclosed in **Note 16** in the financial statements confirms the Department estimates a £1.7 billion diminution in vaccines inventory value in future years. This expenditure scores to the Department's Resource Annually Managed Expenditure budget. Safeguarding public health in this way is likely to result in a proportion of the doses purchased being surplus to requirements – as set out in the following paragraph.

282. The £1.7 billion figure above is based on COVID-19 vaccine usage under the most likely scenario, i.e., based on the latest Joint Committee for Vaccination and Immunisation (JCVI) advice for 2022-23. However, this does not necessarily mean all of this stock is excess to requirements as the Vaccine Task Force is working to ensure there is sufficient supply for more wide-ranging scenarios, including if it is necessary to rapidly respond to an expansion of eligible vaccination cohorts or a surge to the whole population (as seen in December 2021 with Omicron). Given the trajectory of the pandemic is uncertain, the actual write-off of vaccines could vary significantly.

Personal Protective Equipment

283. The PPE programme was allocated revenue funding of £2.4 billion and spent £1.9 billion predominantly on storage and transportation of PPE. Purchases of PPE related to nitrile gloves, which continue to be bought to meet demand. By the year end the PPE programme distributed approximately 20 billion items since the beginning of the pandemic of the 37.5 billion items purchased. The £0.4 billion saving against budget is primarily due to PPE unit price decreases in comparison to prevailing market rates at budget setting and lower than forecast PPE purchases.

284. The £0.9 billion Resource Annually Managed Expenditure (RAME) credit shown in the table above comprises:

- A credit of £1.2 billion for the reversal of the onerous contract provision raised in 2020-21. The provision is utilised when the goods arrive and this RAME credit ordinarily would give rise to an RDEL cost. However, as we agreed with HM Treasury to score PPE goods to RDEL on purchase, a further RDEL charge isn't required; and
- A RAME cost of £0.3 billion relating to a provision for the estimated future storage and disposal costs associated with personal protective equipment inventory that has been impaired to nil value.

COVID-19 Grants

285. Grants programmes in relation to COVID-19 were allocated and spent revenue funding of £1.1 billion which was mainly distributed to adult social care providers in England for infection control, prevention and assisting with workforce pressures in adult social care.

COVID-19 Treatments

286. Department for Health and Social Care Group was allocated and spent revenue funding of £0.4 billion on therapeutic COVID-19 treatments.

287. The Department procured sufficient supply of COVID-19 antiviral treatments to meet the reasonable worst-case scenario and ensure sufficient supply in the event of a surge scenario.

288. The Department has non-cancellable contracts for the delivery of COVID-19 antiviral treatments and the onerous contract provision disclosed in **Note 16** in the financial statements confirms the Department estimates a £1.8 billion diminution in antiviral treatment inventory value in future years. This expenditure scores to the Department's Resource Annually Managed Expenditure budget.

289. As reported in **Note 8** in the financial statements, the Department estimates the value of its investment in antiviral treatment inventory reduced by £0.9 billion in 2021-22 for excess inventory which has an expiry date prior to the expected usage date.

Other COVID-19 expenditure

290. The Department was allocated and spent revenue funding of £0.3 billion on the Managed Quarantine Service.

291. The Ventilators and critical care stockpile programme was allocated revenue funding of £0.2 billion to cover storage costs and inventory items that score to RDEL on consumption. The saving against budget is due to consumption being lower than assumed when setting the budget.

292. Further detail on Non-NHS and NHS business as usual financial performance is covered in **Annex B.**

EU Exit expenditure

293. In 2021-22 work was still required to minimise disruptions in the early stages of the UK's Departure from the European Union (EU), and to begin to capitalise on the benefits that can be realised outside of it. To support this work, the Department received £20 million in 2021-22 and spent £43 million. Further detail on Non-NHS and NHS 'business as usual' financial performance is covered in **Annex B.**

Capital funding and expenditure analysis

294. The Department's capital funding and outturn, broken down by activity, is shown in **Table 11.**

Table 11: Capital DEL Spending Breakdown by Activity

	Budget £m	Outturn £m	Under/ (Overspend) £m
NHS business as usual activities	6,512	6,422	90
Non-NHS business as usual activities	2,714	2,586	128
NHS COVID-19	580	602	(22)
Vaccine supply and deployment	870	997	(127)
NHS Test and Trace	(239)	(1,499)	1,259
Personal Protective Equipment	5	8	(3)
COVID-19 medicines, treatments and R&D	6	3	3
TOTAL CDEL	**10,447**	**9,119**	**1,328**

Note: some figures in above table may not cast due to rounding.

295. NHS capital is discussed in detail in **Annex B**.

Vaccine procurement, supply, and deployment

296. In 2021-22, the COVID-19 vaccine procurement, supply, and deployment programme was allocated £0.9 billion and spent £1.0 billion capital on the supply of vaccines to facilitate biggest vaccination programme in NHS history. As part of HM Treasury budgeting convention, long-term advance payments in excess of £20 million made to secure the supply of vaccines, score to the capital budget. The £0.1 billion overspend was as a result of long-term advance payments being £0.1 billion higher than estimated when agreeing the final budget.

NHS Test and Trace (NHSTT)

297. As per their budgeting guidance of inventory purchases, HM Treasury decided that NHSTT inventory purchases should be classified as 'large'. This means that NHSTT inventory purchases gave rise to a charge to capital DEL on purchase and a charge to revenue DEL with an equivalent credit to capital DEL on consumption.

298. Given NHSTT carried forward inventory from 2020-21 into 2021-22, NHSTT was allocated a capital budget of negative £0.2 billion to reflect the assumption that consumption of inventory would exceed new inventory and other asset purchases.

299. NHSTT's capital outturn was negative £1.5 billion and comprised:
    - Net inventory of negative £1.8 billion comprising of c£5.8 billion inventory purchases, such as swabs, chemicals, and lateral flow devices, of which c£7.3 billion was consumed and c£0.3 billion impaired.

300. NHSTT's £1.3 billion saving against budget is mainly because; the final budget for the year was agreed during the peak of the Omicron wave which was assumed to endure into 2022. The swift decline of infections, coupled with changes in policy due to the Living with Covid strategy, resulted in lower the anticipated demand for tests and related activities. Purchasing of inventory was lower than anticipated and inventory was impaired and written off due to damage and due to the impairment of the inventories market price.

Personal Protective Equipment

301. The PPE programme was allocated capital funding of £5 million and spent £8 million predominantly on storage costs of PPE. HM Treasury were made aware that PPE capital costs would be higher than the £5 million capital budget agreed in the Supplementary Supply Estimate.

302. Further detail regarding financial performance across the DHSC Group can be found in **Annex B** of this Report.

Our performance against other required reporting

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

Overall performance

303. The latest Greening Government Commitments (GGCs) set targets for Government Departments and their partner organisations to reduce their impacts on the environment in the period 2021 to 2025. This includes reducing our greenhouse gas emissions, waste and water use, as well as procuring more sustainable products and services, supporting nature recovery, adapting to climate change and reducing environmental impacts from ICT and digital services. To support our achievement of these goals, we are currently developing a sustainability strategy, outlining our specific ambitions for DHSC's estate and operations. We have also worked to link this strategy with the UN Sustainable Development Goals (SDGs), contributing to as many as possible, including, but not limited to, SDG 3 (good health and wellbeing), SDG 12 (responsible consumption and production) and SDG 13 (climate action).

304. In terms of our progress against the GGCs, in 2021-22, the Department reduced its overall greenhouse gas emissions (including scopes 1, 2 and 3[24]) by 55.7%, compared to a 2017-18 baseline, exceeding our target reduction of 44% and supporting Government's 2050 net zero emissions target for the UK. There was a significant 89% decrease in emissions related to domestic business flights, from 231.9 tonnes of CO_2 equivalent in 2017-18 to 23.9 in 2021-22, against a target reduction of 30%. 71% of our fleet are now ultra-low emission vehicles (ULEV) and 54% are zero emissions; as such, we have successfully met the Government Fleet Commitment for 2022, requiring 25% to be ULEV. This also puts us in good stead to achieve the target for a 100% zero emissions fleet by the end of 2027.

305. Our overall waste tonnage has decreased by 20% compared to 2017-18, exceeding our target reduction of 15%. 19% of our waste went to landfill, and improvements will be required here to reach our target of less than 5% to landfill by 2025. We reduced our amount of paper purchased by 68% (from 88,592 reams of A4 equivalent in 2017-18 to 28,175 in 2021-22), surpassing our target reduction of 50%. Within DHSC, we have taken steps to reduce the number of consumer single-use plastics (CSUP) present across our estate, but these have not yet been entirely removed; we will continue to identify and work towards eliminating CSUP, largely

[24] Scope 1 (direct) emissions occur from sources owned or controlled by the organisations e.g. emissions from gas combustion in boilers, fugitive emissions from equipment such as air conditioning units, or emissions from fleet vehicles, including those on lease. Scope 2 (indirect) emissions result from energy consumed that is supplied by another party (e.g. electricity supply in buildings) and purchased heat, steam and cooling. The scope 3 (indirect) emissions included within this dataset are from official business travel (both domestic and international), which is paid for by the organisations.

those relating to catering, cleaning, and stationery. At this stage, we have not yet introduced reuse schemes at DHSC. However, in summer 2022, we are planning to use the Office of Government Property's 'Furniture Clearing House' scheme, to offer out and redistribute surplus office furniture to other government departments and agencies as we vacate one of our London office premises.

306. These figures, however, should be caveated, as they have been impacted significantly by the pandemic; measures to tackle COVID-19 have triggered large reductions in business travel and waste and water consumption as many of our employees have been working remotely. Therefore, we may expect to see a decline in some of these measures where increased numbers of staff return to the office, and further targeted interventions will be required if we are to continue to build on our successes here. More detail on our performance to date is available at **Annex E**.

Sustainable procurement

307. We have continued to promote sustainable procurement through the Department's commercial activities, ensuring that spend is leveraged to achieve additional social and environmental benefits. We have implemented and embedded Procurement Policy Notes 06/20 (Social Value Model) and 06/21 (Carbon Reduction Plan) into commercial practices, and have established working groups to further develop policies, processes and training in these areas. Our Standard Contract terms and conditions have been updated to include obligations on suppliers to provide annual carbon reduction plans and to set contract specific Key Performance Indicators for social value. A large percentage of our expenditure is contracted through pan-Government frameworks and contracts managed by the Crown Commercial Service (CCS), and the Department supports the use of sustainable procurement within these frameworks. Our food and catering services are procured through a call off contract from an NHS Shared Business Services framework, which clearly embeds Government Buying Standards for Food within the service requirements.

Nature recovery and biodiversity

308. The Department does not hold significant natural capital or landholdings, and our building estate is concentrated in major towns and cities, with limited space. Nonetheless, we recognise that we all have a role to play in making space for wildlife, and so we have incorporated relevant commitments into our upcoming sustainability strategy, which is currently in development. Through delivery of this strategy, we aim to maximise our estate's contribution to nature recovery where possible, exploring any opportunities to improve biodiversity at our urban office locations.

Climate change adaptation

309. As well as helping to mitigate climate change, we must better understand the risks that changing environments and climate pose to the Department, and build resilience against these projected impacts, to protect staff, estate, and operations.

In line with the GGCs, we are now committed to developing a departmental climate change adaptation strategy (including a risk assessment and action plan) by 2025. We will strive to complete this as soon as possible within that timeframe. We have also included relevant commitments in our upcoming sustainability strategy, which is under development, around incorporating climate hazards into the Department's existing risk management and business continuity systems.

310. More broadly, DHSC worked closely with UK Government partners and other stakeholders to deliver the COP26 Health Programme in November 2021, and we continue to support the UK's international efforts to encourage other countries to sign up to and implement the commitments within this. One commitment made by the UK was to build a climate resilient health system. A key part of delivering this is through contributing to the development of the third National Adaptation Programme (NAP), which will be published in 2023. The NAP sets out actions that Government and others will take in response to identified climate risks. This includes efforts to increase the resilience of health and social care services against extreme weather and to protect UK public health from climate risks overseas, particularly from changes in the prevalence of vector-borne diseases. Work is ongoing across DHSC and with our ALBs to develop specific health actions in these areas. We are also working with other Government Departments to address risks to public health in their climate policy initiatives.

311. Air pollution is also an area of particular significance for the Department, as poor air quality poses the largest environmental risk to public health in the UK. DHSC is working with DEFRA and UKHSA to undertake a comprehensive review of how we communicate air quality information, to ensure that members of the public understand their impacts on air quality, and that vulnerable groups in particular are equipped to protect themselves. This review process will be guided by a steering group, comprising specialists in the fields of air quality science, public health, behavioural science and digital communications, as well as representatives from vulnerable communities, the general public and national and local Government. Members of the steering group will be reaching out to the communities that they represent, and there will be opportunities for attendees to share their own learning and best practice as part of the review.

312. In addition, once the Environmental Principles, set out in the Environment Act 2021, come into effect, DHSC will ensure that due regard is given to these in all policymaking, to further ensure that the Department takes advantage of opportunities to prevent environmental damage and enhance the environment.

Reducing environmental impacts from ICT and digital

313. We have continued to work closely with our incumbent information and communications technology (ICT) supplier to reduce the environmental impacts of the Department's ICT and digital services. Whilst our mobile devices and laptops have a minimum commercial lifespan of 3 and 5 years respectively, we reuse

these until they are no longer serviceable, to prevent waste. Our supplier securely disposes of any redundant ICT kit via a third party, which operates a zero-landfill policy; they recycle items where possible and provide social value via a prison recycling initiative. In 2021-22, a total of 87 items were prepared for reuse and 318 were recycled. In terms of the footprint of our data centres and cloud services, these were responsible for an estimated 1,494 tonnes of CO_2 equivalent during this period. During 2022, the Department is transitioning to a new ICT service provider; this supplier has committed to appoint a designated sustainability lead, who will work with DHSC to implement new reporting and monitoring capabilities for energy consumption, carbon emissions and waste.

Sustainable construction

314. The Department is currently undertaking works to refurbish some areas within its second headquarters at Quarry House, Leeds. There are two active contracts for this project, both from public sector procurement frameworks where environmental sustainability and social value are integral to the supplier selection process. Whilst the scope of this refurbishment is too small to derive a meaningful BREEAM rating, there has been significant sustainability activity here. Of the 46.76m^3 of waste generated to date, the project is averaging a 96% recycling rate, with some furnishings having been donated for reuse, including to the local prison service. Around 34% of the total project spend has been in the local area and 68% of labour has been locally sourced (within 20 miles of the site). Contractors at Quarry House also attended a nearby primary school to partake in a tree planting event in December 2021.

Rural proofing

315. As announced in the Levelling Up White Paper, the Department has committed to a health mission to narrow the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest, by 2030, and to increase HLE by 5 years by 2035.

Parliamentary Questions

316. We remain one of the busiest Departments for Parliamentary Questions (PQs) across Government. In 2021-22, we received 11,312 PQs, which was a slight reduction on the number received in 2020-21 but still significantly more than the numbers received each year before the COVID-19 pandemic.

317. Through continued delivery of our PQ Recovery Plan, we achieved a significant improvement in our 'on time rate' from 28.9% to 57.5% PQs on time and returning 1,453 PQs in March 2022 alone. We are still facing parliamentary pressures in the aftermath of the pandemic; however, we are continuing to see month-by-month improvements in performance across the Department.

Freedom of Information (FOI) requests

318. DHSC received 2,638 FOI requests between 1 April 2021 and 31 March 2022. The overall volume of FOIs received has decreased by 1 per cent compared to the

previous year (2,655) but were an increase of 183 per cent compared to 2019-2020 (933).

319. DHSC answered 74 per cent within the statutory 20 working day deadline (or Public Interest Test extension). The ICO target requires departments to reach a minimum of 90 per cent performance. DHSC recognises that we have not achieved the targeted performance but are committed to recovering this in 2022-23.

Other correspondence

320. As shown in **Table 12**, in 2021 we answered 66,346 letters and emails, compared to the previous year (52,502).

321. Much like PQs, the large increase in volumes caused by the pandemic has impacted on performance, resulting in 55 per cent of cases answered within our target rate of 18 working days. In line with standard correspondence reporting across Government, the data shown is for the calendar year 2021 and not the financial year 2021-22.

Table 12: Other classes of correspondence 2021

Case Type	Due in 2021	Answered On Time	Percentage On Time
Private Office	33,959	9,734	29%
Treat Official	1,459	715	49%
Departmental Email	30,928	25,957	84%
TOTAL	66,346	36,406	55%

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

322. In 2021-22 the Department received 10 complaints.

323. As shown in **Table 13**, in 2020-21 (the last year for which published results are available), the PHSO received 176 enquiries regarding complaints about the Core Department, of which 21 progressed to assessment. No cases progressed to investigation.

Table 13: PHSO Complaints 2020-21

Received	Assessed	Accepted for Investigations*	Investigation Upheld / Partly Upheld	Investigation not Upheld	Investigations resolved through intervention **	Investigation resolved without a finding ***	Ombudsman recommendations complied with ****	Ombudsman recommendations not complied with ****
176	21	0	1	1	1	n/a	n/a	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 2019-20 but not completed it until the following year 2020-21. Similarly, it may have completed an investigation in 2020-21 which we originally accepted for investigation in the previous year 2019-20.
** 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.
**** We have had no recommendations from the Ombudsman over the last two years.

324. The Department's complaints process follows the PHSO's Principles of Good Complaint Handling.

325. We have a three-tier process, the first stage of which involves an investigation of the complaint by the manager of the person/team about which the complaint has been made. If the complainant is dissatisfied with the reply, they may ask for the complaint to be escalated to stage 2 of the complaints process, where the matter is considered by a senior manager in that area. If there is no resolution at this stage, the complainant may ask for the complaint to be escalated to stage 3, which involves consideration of the matter by a senior manager who is independent of the person team concerned. 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

326. The Public Contracts Regulations 2015 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.

327. **Table 14** details the percentage and value of undisputed invoices paid by NHS provider organisations within the agreed terms over the last 3 years.

Table 14: Prompt Payment of undisputed invoices

	NHS providers invoices paid within target	
Financial Year	Percentage	Value (£m)
2021-22	91	58,294
2020-21	87	48,259
2019-20	81	40,776[1]

1. 2019-20 figure revised from £40,941 million due to delayed changes to University Hospitals of Leicester NHS Trust's accounts.

328. 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 monthly, to assess and compare provider performance in this area.

329. 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

330. The Department of Health and Social Care's summary of expenditure on Official Development Assistance (ODA) is included at **Annex D**. This amounted to £223 million in 2021, providing assistance on global health research, global health and health security.

Secretary of State for Health and Social Care Annual Report 2021-22

Introduction

331. The Secretary of State is required by section 247D of the National Health Service Act 2006, (the 2006 Act), to publish an annual report (laid before Parliament pursuant to section 247D(3)) 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.

332. This report comments on services commissioned by the National Health Service Commissioning Board (known as NHS England or NHSE) and clinical commissioning groups (CCGs), (now replaced by Integrated Care Boards (ICBs)), as well as those public health services for which the Secretary of State and local authorities are responsible. Social care is not a health service but is covered for completeness.

333. 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, as required under section 247D(2) of the 2006 Act.

334. The Secretary of State is under a duty in section 1A of the 2006 Act for or in connection with the matters listed at 1A(1)(a) (the prevention, diagnosis or treatment of illness) and 1A(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). 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.

335. 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 disparities.

336. This annual report covers the period before the Health and Care Act 2022 received royal assent, so some of the responsible bodies have since changed / been restructured. This report adds references to the new structure of the health system where appropriate.

Performance of the NHS against key access standards

337. There are several operational and legal 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).

Departmental Business Plan

338. On 15 July 2021, the Department published its Outcome Delivery Plan (ODP) for the 2021-22 financial year. This set out the Department's five Priority Outcomes, agreed as part of the 2021 Spending Review, with clear objectives and key performance measures that the Department worked to as we continued our response to the COVID-19 pandemic. These were linked to the previous Departmental Plan and were used to assess progress for the Department during the 2021-22 financial year.

Outcomes Frameworks

339. 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.

340. 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.

341. 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.

342. As part of the Government and the 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). A short 'overall assessment' can be found starting at **paragraph 468**.

343. As in previous years the data published relates to the previous financial year, so for the 2020-21 report most indicators report the 2019-20 position. Therefore, the impact of COVID-19 will be more widely reported in relation to these indicators in the 2021-22 Annual Report and Accounts.

Alignment

344. 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.

345. 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

346. The NHS Outcomes Framework (NHSOF) was developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The Framework is published annually.

347. The NHSOF currently comprises of 70 indicators or measures which are grouped into the following 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.

348. The full list of all the domains and indicators can be found on NHS Digital's website.

349. Not all the 70 NHSOF indicators were (statistically) tested. **Table 15** provides an overview of the number of indicators that were (i) tested; (ii) not tested but where data was available; and (iii) where there was no data available, over the last year and over the last five years.

Table 15: Number of NHSOF indicators (statistically) tested, not tested or there was no data available over the last year and over five years

	Over the last year	Over the last five years
Tested	21	18
Not tested	24	21
No data	25	31

Source: NHS Outcomes Framework 2020/21 Indicator and Domain Summary Tables

350. For this publication, the focus has been placed on those twenty NHSOF indictors which have shown statistically significant improvement or deterioration (the significance threshold was set at 0.05) over time – either for one year and/or five years previously. Statistical significance indicates that the observed change or difference is unlikely to be due to chance.

Please note: (1) The data originates from various sources, such as NHS Digital and Office of National Statistics; (2) All differences reported in this section are statistically significant unless otherwise stated; (3) the indictor values for 2019-20 and 2020-21 should be interpreted with care given the impact the coronavirus (COVID-19) pandemic

may have had on Hospital Episode Statistics (HES) data. This means we are seeing different patterns in the submitted data than what might be expected. For example, fewer patients being admitted to hospital. However, we cannot be sure though that COVID-19 is the definitive reason for these different patterns and therefore we make no direct assertions between these results and COVID-19. Further information is available in the annual HES publication; and (4) The calculations are based on the rounded indicator values unless otherwise stated.

Preventing people from dying prematurely

351. This domain captures how successful the NHS is in reducing the number of avoidable deaths.

352. There were seven indicators under this domain that showed statistically significant improvement or deterioration over time. The overall results can be seen in **Table 16**.

Table 16: Preventing people from dying prematurely domain – indicators which have significantly improved and/or significantly deteriorated in the last year or over five years

Indicator	Significantly Improved		Significantly deteriorated	
	1 Year	5 Years	1 Year	5 years
Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare – Adult Males		✓		
Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare – Adult Females		✓		
Children and young people - Females		✓		
Under-75 mortality rate from cardiovascular disease			✓	
Under-75 mortality rate from respiratory disease	✓	✓		
Under-75 mortality rate from liver disease			✓	✓
Under-75 mortality rate from cancer		✓		

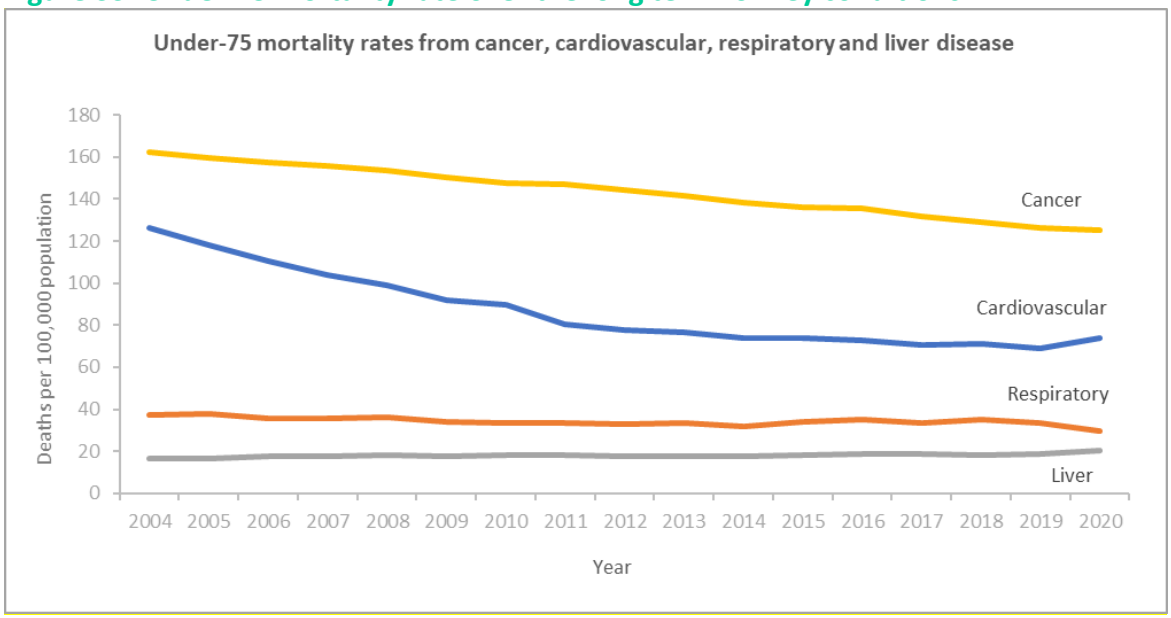
Source: NHS Outcomes Framework: England, March 2022 Annual Publication

353. The 'Under-75 mortality rate' indicators for all four diseases and conditions were examined in detail:

- Cardiovascular disease - In 2020, there were 73.8 deaths per 100,000 population. This is an increase of 7.3% on 2019 when there were 68.8 deaths per 100,000 population.
- Respiratory – there were 29.4 deaths per 100,000 population in 2020. This compares to 33.7 deaths per 100,000 population in 2019 - a decrease of 12.8%.
- Liver disease – There were 20.6 deaths per 100,000 population in 2020. This is an increase of 11.4% or 2.1 deaths per 100,000 population when compared to 2019.
- Cancer – There were 125.1 deaths per 100,000 population in 2020. The indicator value shows no significant change (a 1% decrease) from 2019 when it stood at 126.3 deaths per 100,000 population.

354. Looking at the mortality indicators further back in time (i.e., since 2004) a favourable trend emerges as highlighted by **Figure 33**.

Figure 33: Under-75 mortality rate over the long term for key conditions



Source: NHS Outcomes Framework Indicators - March 2022 release

355. **Figure 33** shows the under-75 mortality rate for cardiovascular disease, respiratory disease, cancer, and liver disease between 2004 and 2020. The following observations can be made from it:

- For cardiovascular disease, there has been a decrease of 41.7%, from 126.5 deaths per 100,000 population in 2004 to 73.8 per 100,000 population in 2020.
- Respiratory disease also shows a decrease of 21.2%, from 37.3 deaths per 100,000 population in 2004 to 29.4 deaths per 100,000 population in 2020.
- Cancer has shown a decrease of 23.0% from 162.5 per 100,000 population in 2004 to 125.1 per 100,000 population in 2020.

- Liver disease has risen by 23.4%, from 16.7 per 100,000 population in 2004 to 20.6 per 100,000 population in 2020.

Enhancing quality of life for people with long-term conditions

356. This domain captures how successful the NHS is in supporting people with long-term conditions to live as normal a life as possible.

357. There were two indicators which were tested under this domain and showed either a statistically significant improvement or deterioration over time. The overall results can be seen in **Table 17**.

Table 17: Enhancing quality of life for people with long-term conditions domain – indicators which have significantly improved and/or significantly deteriorated in the last year or over five years

Indicator	Significantly Improved		Significantly deteriorated	
	1 Year	5 Years	1 Year	5 years
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)	✓	✓		
Unplanned hospitalisation for asthma, diabetes, and epilepsy in under 19s	✓	✓		

Source: NHS Outcomes Framework: England, March 2022 Annual Publication

358. The 'unplanned hospitalisation for asthma, diabetes and epilepsy in under-19s' indicator was examined in more detail. The results can be seen in **Table 18**.

Table 18: Number of unplanned asthma, diabetes and epilepsy hospital admissions for under 19s' in 2020-21 and 2019-20 per 100,000 population.

	2019-20	2020-21	Change from 2019-20 to 2020-21
Asthma	148.3	70.0	- 52.8%
Diabetes	49.3	45.0	- 8.7%
Epilepsy	72.6	61.1	- 15.8%

Source: NHS Outcomes Framework: England, March 2022 Annual Publication

359. All the figures above show a decrease from the previous year. This trend is a continuation of improvements seen in unplanned hospitalisations for all three conditions witnessed since 2016-17.

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

360. This domain captures how people recover from ill health or injury and wherever possible how it can be prevented.

361. There were six indicators which were statistically tested under this domain and showed either a statistically significant improved or deterioration over time. The overall results can be seen in **Table 19**.

Table 19: Helping people to recover from episodes of ill health or following injury domain – indicators which have significantly improved and/or significantly deteriorated in the last year or over five years

Indicator	Significantly Improved		Significantly deteriorated	
	1 Year	5 Years	1 Year	5 years
Emergency admissions for acute conditions that should not usually require hospital admission	✓	✓		
Emergency readmissions within 30 days of discharge from hospital			✓	✓
Emergency admissions for children with lower respiratory tract infections	✓	✓		
Hip fracture: Proportion of patients recovering to their previous levels of mobility at 30 days	✓	✓		
Hip fracture: Proportion of patients recovering to their previous levels of mobility at 120 days		✓		
Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under	✓	✓		

Source: NHS Outcomes Framework: England, March 2022 Annual Publication

362. The following indictors were focussed upon for this domain to provide a flavour of the more detailed findings.

363. Firstly, the 'emergency admissions for acute conditions (e.g., ear/nose/throat infections, kidney/urinary tract infections and angina) that should not usually require hospital admission' indicator was 849.9 per 100,000 population in 2020-21. This indicator has improved on the previous year (2019-20) when it stood at 1,409.4 per 100,000 population. This is a decrease of 39.7% but follows a deterioration in this indicator between 2016-17 and 2019-20.

364. Secondly, the indicator 'where children, aged 10 years or under, have been admitted as inpatients to hospital for tooth extractions due to decay' was 161.3 per 100,000 population in 2020-21. This value has fallen by 58.4% since 2019-20 when the extraction rate was 388.0 per 100,000. This is a large reduction following smaller year-on-year reductions which started several years earlier when the peak rate of 473.0 extractions per 100,000 children was seen in 2014-15.

365. When this indicator was segmented by gender it showed that admissions have been consistently higher among males than females. In 2020-21, the rate for males was 169.9 per 100,000 while for females it was 152.3 per 100,000 population. Both genders have experienced similar reductions in the admission rate when compared to 2019-20 - males seeing a 57.7% reduction (from 401.2) and females a 59.3% reduction (from 374.1).

Ensuring that people have a positive experience of care

366. This domain looks at the importance of providing a positive experience of care for patients, service users and carers. Therefore, indicators under this domain are an important bell-weather to judge the performance of the health service from a patient's perspective.

367. There were five indicators which were statistically tested and showed either a statistically significant improved or deterioration over time. The overall results can be seen in **Table 20**.

Table 20: Ensuring that people have a positive experience of care domain – indicators which have significantly improved and/or significantly deteriorated in the last year or over five years

Indicator	Significantly Improved		Significantly deteriorated	
	1 Year	5 Years	1 Year	5 years
Patient experience of primary care - GP services	✓			
GP out-of-hours services	✓			
NHS dental services			✓	✓
Access to GP services	✓			
Access to NHS dental services			✓	✓

Source: NHS Outcomes Framework: England, March 2022 Annual Publication

368. Two indicators were examined in more detail. One indicator which showed an improvement and another indicator which showed a deterioration.

369. The 'patient experience of primary care, specifically GP services' indicator showed that in 2020-21, 83.1% of patients rated their overall experience of GP services as either 'fairly good' or 'very good'. The indicator had increased (i.e., improved) by 1.3 percentage points since 2019-20. However, this is a lower level of satisfaction than in 2017-18. Data prior to 2017-18 are not comparable due to methodological changes.

370. Meanwhile, the 'Access to NHS dental services' indicator showed that 77% of people in 2020-21 successfully obtained an NHS dental appointment out of those who tried in the last two years. That was a deterioration since 2019-20 when 93.7% were successful - a decrease of 16.7 percentage points. This data reflects the reduced availability of dental appointments during 2020-21 which was necessary in order to protect patients and professionals from transmission of COVID through adherence to new infection prevention and control guidance. The sector is now recovering, but challenges accessing dental treatment remain in some areas, especially for patients new to the practice. Prior to 2020-21, the percentage of those successfully obtaining an NHS dental appointment remained stable, with almost 95% of people being successful in each year, although there was some regional variation. NHS dental practices were asked to return to delivering 100% of their NHS contracts in July 2022, with many already doing so and increasing numbers of dentists undertaking NHS activity. In July, Government also announced changes to the NHS dental contract to increase access for patients and make NHS work more attractive to dentists and their teams.

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

371. This domain explores patients' safety and its importance in terms of quality of care to deliver better health outcomes.

372. None of the indicators in this domain were statistically tested. However, to ensure completeness, an indicator was randomly selected and examined in more detail.

373. In 2020-21 there were 99.4 deaths per 100,000 admissions from 'venous thromboembolism related events within 90 days post discharge from hospital'. This is a deterioration of 37.8 deaths per 100,000 admissions when compared to 61.6 deaths per 100,000 admissions in 2019-20. However, up until the 2020-21, the indicator had shown a gradual improvement since 2007-08.

The Public Health Outcomes Framework

374. The Public Health Outcomes Framework (PHOF) focuses on the two high-level outcomes:
    - Increased healthy life expectancy (a measure not only of how long we live, our life expectancy, but also whether we are living in good health), and
    - Reduced differences in life expectancy and healthy life expectancy between communities.

375. These outcomes reflect the focus we wish to take, not only on how long we live – our life expectancy, but on how well we live – our healthy life expectancy. Our focus is also on reducing differences between people and communities from different backgrounds.

376. The PHOF comprises a variety of indicators that help track progress toward those two outcomes. These indicators are grouped into overarching indicators and four supporting domains: improving the wider determinants of health, health improvement, health protection and healthcare, public health and preventing premature mortality.

377. Throughout this section, an assessment of progress on a selection of these indicators is made by comparing the most recent value of an indicator to the value it had in 2014. As there is variation in the baseline year for the indicators, this baseline year has been set at 2014 to ensure that a high number of indicators could be included in this analysis. Depending on the indicator, the values for 2014 refer to the 2014 calendar year itself, or to the 2013-14 financial year or to a 3-year period that ends in 2014. For brevity, these are all referred to as the position in 2014.

378. Most of the indicators updated within the PHOF cover part of the period since 31 March 2020 and may include the effects of the COVID-19 global pandemic.

379. A small number of indicators are based on programmes delivered in academic settings where data collections and programme delivery have been impacted due to school closures. Several other indicators are being updated later than expected because of other delays in reporting related to the pandemic. Details of these can be found in the 'Indicator updates delayed due to the COVID-19 pandemic', published on 4 May 2022. For these indicators, the latest available data are used in this analysis.

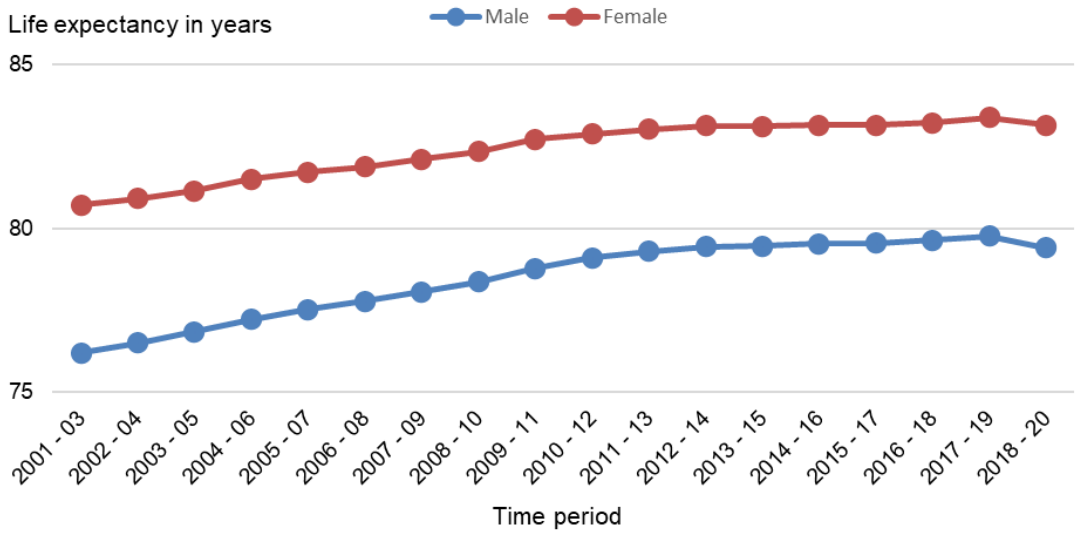
380. Of the 107 indicators included in this analysis from the PHOF, 66 (62%) have either improved since 2014 or remained broadly the same, and 41 (38%) have worsened in comparison with 2014. For most of the indicators, there remains considerable variation across local areas. For details on indicators please refer to the Fingertips website.

Overarching indicators

381. Although there has been a general improvement in life expectancy over the longer term, the rate of improvement slowed down from 2011. Prior to the pandemic, life expectancy had improved slightly since 2014 (latest data for 2017-2019). Life expectancy decreased in the period 2018-2020 and was also lower than it was in 2014 (as shown in **Figure 34**). Healthy life expectancy has remained relatively stable since 2014.

382. Inequalities in life expectancy have been increasing over time, largely due to low or negative growth in life expectancy in the most deprived areas. This is further discussed in the health disparities section of this report.

Figure 34: Life Expectancy at birth, Males, and females 2001-03 to 2018-20



Note: The scale on y-axis starts at 75 years. For each of the subsequent domains, this report highlights those indicators where the percentage changes from the 2014 baseline were greatest.

Wider determinants of health indicators

383. Most of the indicators in this domain have improved or remained constant since 2014.

384. We have seen a decrease in the gap in employment rate between those with a long-term health condition and the overall employment rate (latest data for the financial year 2019-20). The percentage of working days lost due sickness absence (latest data for 2018-20) has also decreased, showing an improvement in this indicator. These data pre-date the pandemic.

385. Indicators for the proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation (latest data for the financial year 2019-20), and also for the gap in employment rate between those with a learning disability and the overall employment rate, have worsened (latest data for the financial year 2019-20).

386. All areas across the country are now transforming their community mental health services to deliver a more person-centred, holistic approach, in line with the Community Mental Health Framework. This framework supports closer working between local authorities and NHS services, to ensure that people with severe mental illnesses receive the help they need to live well in the community. This should include employment support, welfare, and housing advice, as well as personalised care and treatment.

387. The Government is taking action to support more learning-disabled people into the workforce. This includes making up to £18 million available over the next three years to build capacity and strengthen the Supported Internships programme, investing over £7 million in Local Supported Employment services working with 20 Local Authorities, and delivering and improving Access to Work to support workplace adjustments.

Health Improvement Indicators

388. Most of the indicators in this domain have improved or remained constant since 2014.

389. Smoking prevalence in adults (18+ years) has decreased since 2014 (latest data for 2020; note that due to a method change in data collection, the precise reduction from 2014 may be overstated). Teenage pregnancies (<18 years) have also fallen (latest data for 2020). These indicators had also been improving prior to the pandemic.

390. Worsening indicators include deaths from drug misuse (latest data for the period 2018-20) and the number of successful completions of drug treatment for both opiate and non-opiate users (latest data for 2020). These indicators had also been worsening prior to the pandemic.

391. Dame Carol Black's independent review of drugs: part one was published on 27 February 2020. Part two of the review was published 8 July 2021 and focused on prevention, treatment, and recovery.

392. In response, the Government has published a new 10-year drugs strategy, which sets out an ambitious long-term vision to reduce overall drug use towards a historic 30-year low and reduce drug deaths. To support delivery of the strategy, DHSC received an additional £785 million. Of this, £780 million - the largest ever single increase in treatment and recovery funding - will be invested over three years to create a world-class treatment and recovery system, and £5 million will be invested in an innovation fund to test what works to reduce demand for recreational drugs.

393. Work is also ongoing to expand access to naloxone, a drug that reverses the effects of an opioid overdose, which can help to prevent overdose deaths. The Government has consulted on proposals and over 700 responses were received. The responses have been analysed and the Government published a summary of consultation responses on 15 March 2022. A full Government response will be published in 2023.

Health Protection Indicators

394. In contrast to the other three domains, most of the indicators in this domain have worsened since 2014.

395. Indicators that have worsened since 2014 include the coverage rates for some children's vaccination programmes – for example the Hib/MenC booster (Haemophilus influenzae type b/meningococcal group C) at 2 years, and the HPV vaccination (human papillomavirus) for 12-13-year-old girls (latest data for the financial year 2020-21).

396. Following the first wave of the pandemic, plans were put in place for the systematic restart and recovery of immunisation programmes, including the Hib/Men C booster and school-based programmes such as the HPV vaccination. To further increase uptake, the prioritisation of routine immunisations was emphasised in NHS England and NHS Improvement's (NHS and NHSI) letter to the system regarding next steps for general practice. NHSE commenced a 'call and recall' campaign in Spring 2022 aimed at catching up any child under 6 years who has missed one or both doses of the MMR (mumps, measles, and rubella) vaccine and there is long term work underway to improve data capture and reporting. This will support understanding of the variation in uptake of vaccinations and associated actions.

397. Population vaccination coverage for flu in at risk individuals improved, as it also did in 65+ individuals. This improvement was driven by the successful delivery of the largest flu vaccination programme ever in the Winter of 2020-21.

398. PPV (pneumococcal vaccine) and MMR one dose at 2 years indicators also improved (latest data for the financial year 2020-21).

399. The incidence of Tuberculosis also improved since 2014 (latest data for 2018-20).

Healthcare, public health and preventing premature mortality indicators

400. Most of the indicators in this domain have improved or remained unchanged since 2014.

401. The indicators for emergency hospital admissions due to hip fractures (latest data is for the financial year 2020-21) have both shown an improvement.

402. Indicators for under-75 mortality rates from liver disease (latest data is for 2020) worsened. Most of the increase in mortality is driven by deaths from alcohol liver disease.

403. The Department has a strong programme aimed at tackling the health impacts of alcohol. From April 2022, NHSE (previously NHS England and NHS Improvement) have introduced a Commissioning for Quality and Innovation (CQUIN) measure to incentivise providers to improve earlier detection of liver disease for alcohol dependent in-patients. As part of the NHS Long Term Plan, NHSE is investing national funding for an ambitious programme to establish specialist Alcohol Care

Teams (ACTs) in hospitals with the highest rates of alcohol-dependence-related admissions.

The Adult Social Care Outcomes Framework (ASCOF)

404. The Adult Social Care Outcomes Framework (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 21**.

405. Several of the collections which feed into ASCOF have been paused or changed in the reporting year due to the impact of COVID-19. The Adult Social Care Survey (ASCS) feeds into three of the four domains of ASCOF. It is usually mandatory for all local authorities, however, due to COVID-19 restrictions, it was voluntary, with only 18 of the 152 Councils with Adult Social Services Responsibilities (CASSRs) taking part. Therefore, results will not provide a comprehensive national picture of people's experiences or provide a comparison to previous years. The biennial carer survey and the Delayed Transfer of Care collection were also paused in 2020-21 due to the pressures of the pandemic.

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

406. 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 the views of unpaid carers where appropriate.

407. The overall social care quality of life score for England is generally considered to be ASCOF's key indicator. However, as this indicator is calculated from ASCS data, most local authorities will not have a calculated social care quality of life score for 2020-21. Of the 18 authorities who completed the ASCS the average outcome was a score of 19.0 out of 24. This is in line with the national average for 2019-20, where the overall social care quality of life score was 19.1.

408. As the biennial carer survey was not carried out in 2020-21, the most recent measure of carer-reported quality of life is from 2018-19, when it was rated at 7.5 (out of a possible maximum of 12), compared to 8.1 in 2012-13.

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

409. 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 2020-21, 79.1% of such people were still at home after 91 days which is a slight fall from 2019-20 where the rate was 82.0%. The proportion of new clients who received short-term services where no further request was made for ongoing support was 74.9%, falling from 79.5% in 2019-20.

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

410. 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. These measures in ASCOF are derived from the ASCS and the carers surveys. In participating authorities, 67.7% of service users reported that they were extremely satisfied or very satisfied with the care they received. When last collected in 2018-19, 38.6% of carers were satisfied with services.

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

411. 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. Based on the local authorities who participated in the ASCS in 2020-21, 73.6% of respondents reported feeling as safe as they would like.

412. **Table 21** summarises each ASCOF indicator from 2017-18 to 2021-22. To note that where collections were paused or changed due to the impact of COVID-19 a full time series is unable to be shown. Further detail on the ASCOF and all the indicator data can be found at NHS Digital's website.

Refresh of the ASCOF

413. The Department is working with the sector to review the framework such that it is more reflective of the duties of local authorities set out in the Care Act 2014. The review will also make best use of revised social care data collections, including planned updates to the user and carer surveys (ASCS and SACE) and ensure that the framework informs, supports, and reflects upcoming ASC system reform.

Table 21: ASCOF Indicators

ASCOF Indicator	2017/18	2018/19	2019/20	2020/21	2021/22
Enhancing quality of life for people with care and support needs					
1A: Social care-related quality of life (score out of 24)	19.1	19.1	19.1	19.0	18.9
1B: The proportion of people who use services who have control over their daily life	77.7	77.6	77.3	79.8	76.9
1C(1A): The proportion of people who use services who receive self-directed support	89.7	89.0	91.9	92.2	94.5
1C(1B): The proportion of carers who receive self-directed support	83.4	83.3	86.9	87.1	89.3
1C(2A): The proportion of people who use services who receive direct payments	28.5	28.3	27.9	26.6	26.7
1C(2B): The proportion of carers who receive direct payments	74.1	73.4	77.1	75.3	77.6
1D: Carer-reported quality of life (score out of 12)	-	7.5	-	-	7.3
1E: The proportion of adults with learning disabilities in paid employment	6.0	5.9	5.6	5.1	4.8
1F: The proportion of adults in contact with secondary mental health services in paid employment	7.0	8.0	9.0	9.0	6.0
1G: The proportion of adults with learning disabilities who live in their own home or with their family	77.2	77.4	77.3	78.3	78.8
1H: The proportion of adults in contact with secondary mental health services who live independently, with or without support	57.0	58.0	58.0	58.0	26.0
1I(1): The proportion of people who use services who reported that they had as much social contact as they would like.	46.0	45.9	45.9	34.4	40.6
1I(2): The proportion of carers who reported that they had as much social contact as they would like	-	32.5	-	-	28.0
1J: Adjusted Social care-related quality of life – impact of Adult Social Care services	0.4	0.4	0.4	0.4	0.4
Delaying and reducing the needs 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	14.0	13.9	14.6	13.3	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	585.6	577.6	584.0	498.2	538.5
2B(1): Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	82.9	82.4	82.0	79.1	81.8
2B(2): The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	2.9	2.8	2.6	3.1	2.8
2C(1): Delayed transfers of care from hospital, per 100,000	12.3	10.3	10.8	-	-
2C(2): Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population	4.3	3.1	3.2	-	-
2C(3): Delayed transfers of care from hospital that are jointly attributable to NHS and Social Care, per 100,000 population	0.9	0.8	1.0	-	-
2D: The outcome of short-term services: sequel to service (proportion of new clients who received short-term services, where no further request was made for ongoing support)	77.8	79.6	79.5	74.9	77.6
Ensuring that people have a positive experiene of care and support					
3A: Overall satisfaction of people who use services with their care and support	65.0	64.3	64.2	67.7	63.9
3B: Overall satisfaction of carers with social services	-	38.6	-	-	36.3
3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for	-	69.7	-	-	64.7
3D(1): The proportion of people who use services who find it easy to find information about support	73.3	69.7	68.4	70.7	64.6
3D(2): The proportion of carers who find it easy to find information about support	-	62.5	-	-	57.7
Safeguarding adults whose circumstance make them vulnerable and protecting from avoidable harm					
4A: The proportion of people who use services who feel safe	69.9	70.0	70.2	73.6	69.2
4B: The proportion of people who use services who say that those services have made them feel safe and secure	86.3	86.9	86.8	88.0	85.6

1. All indicators are based on 2021-22 data.
2. Correct as at October 2022 (latest available at time of publication).
3. Where proportions are presented, these figures are percentages.

NICE Quality Standards

414. 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.

415. Between 1 April 2021 and 31 March 2022, NICE published quality standards on 5 new topics, including: workplace health, long-term sickness absence and capability to work, fetal alcohol spectrum disorder, and neonatal parenteral nutrition. NICE also fully updated its quality standards on end-of-life care in adults, colorectal cancer, and venous thromboembolism.

416. NICE's 5-year strategy outlines its commitment to develop integrated, living guidelines on priority topics across the health, social care, and public health interface. These will focus on topic areas that represent key system priorities, where NICE is uniquely and best placed to use its skills to add value, ensuring it

maintains a portfolio with the greatest impact on system priorities and on reducing health inequalities.

417. The Secretary of State for Health and Social Care has to have regard to NICE quality standards when discharging his Section 1A functions. See section 1A(4) of the 2006 Act.

Quality and Patient Safety

Patient Safety

418. 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.

419. The NHS Patient Safety Strategy was launched in 2019 and significant progress was made on delivering its objectives during 2021-22 including:
    - Publication of the NHS Patient Safety Syllabus in May 2021 and launch of e-learning training in Levels 1 and 2 of the Syllabus in October 2021. Level 1 'Essentials for patient safety' is intended for all NHS staff and Level 2 'Access to practice' for those who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training.
    - Identification of over 800 patient safety specialists from over 340 organisations to lead safety for their organisations.
    - The creation of the new cross-ALB, multi-professional National Patient Safety Committee (successor to the National Patient Safety Alerting Committee). Its main functions include:
        - focusing efforts on the most significant patient safety challenges in terms of scale of harm, and the potential benefits of collaborative cross organisational approach to improvement;
        - the Healthcare Safety Investigations Branch (HSIB) Recommendation oversight pilot, which is now complete with recommendations made to DHSC;
        - development of a nationally agreed operational process to improve cross ALB responses to urgent patient safety special circumstances; and
        - oversight of the credentialing and approval of issuers of national patient safety alerts, with the following issuers now accredited to issue National Patient Safety Alerts:
            - NHS England Patient Safety Team
            - Medicines and Healthcare products Regulatory Agency (MHRA)
            - UK Health Security Agency (UKHSA) (formerly PHE)
            - NHS England Screening (formerly PHE)
            - Office of Health Improvement & Disparity (OHID) Drugs & Alcohol (formerly PHE)
            - DHSC & NHS England Medicine Supply Disruption
            - NHS Digital

- The publication of the Framework for Involving Patients in Patient Safety in June 2021 which asked organisations to include two patient safety partners on their safety related committees. NHS England are supporting implementation of the framework by sharing learning from a small number of organisations working collaboratively.
- Completion of an initial clinical review to understand how we may take action to reduce health inequalities associated with patient safety (Wade et al., 2022).

420. The Patient Safety Incident Response Framework (PSIRF), an integral part of the Patient Safety Strategy, was piloted with 24 early adopters and independently evaluated. The Framework, published in August 2022, sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

421. The programme to develop a new Learn From Patient Safety Events (LFPSE) service to replace the current NRLS, made significant headway in 2021-22 leading to the major milestone of the online service being launched for smaller providers in July 2021, with the first Trust connecting in November 2021.

422. During 2021-22, the national patient safety team within NHSE (then NHSE and NHSI) continued 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;
- delivering the COVID-19 oximetry @home programme to implement pulse-oximetry in community settings such as care homes;
- 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.

423. Throughout 2021-22, incidents in relation to COVID-19 and the systems, treatments, and equipment the NHS used to respond to the pandemic were reviewed via the National Reporting and Leaning System (NRLS), alongside regular clinical review of all serious patient safety incidents, to identify those with potential for national action.

424. During 2021-2022, the HSIB launched 32 investigations, of which 20 progressed to full investigation. The HSIB completed 22 reports which included two investigations that were launched during the previous financial year and made a total of 73 safety recommendations to 28 system partners.

425. HSIB investigation reports have continued to make an impact on the wider health and care system.

426. In May 2021, the HSIB published the report on 'Management of chronic asthma in children aged 16 years and under'. The report highlighted missed opportunities to recognise asthma as a chronic and life-threatening condition in children. The investigation made seven safety recommendations to improve patient care. This led to NHSE (then NHSE and NHSI) and the British Paediatric Society ensuring health systems are provided with standardised templates to support the delivery of high standards of care for children and young people with asthma. NHS Digital also made changes to information in the NHS Pathways system relating to breathlessness in children.

427. In September 2021, the HSIB published the 'thematic analysis of HSIB's first 22 national investigations.' In this report, they reviewed their first 22 national investigations and identified similar issues were arising, even when investigations were focused on different clinical fields. Three recurring patient safety themes were identified; access to care and transitions of care (when patients move between care providers or care settings), communication and decision making and checking at the point of care. The HSIB recommended that it may be beneficial for the NHS to explore how the application of safety management principles could build on the foundations developed by the NHS Patient Safety Strategy.

428. In October 2021, the HSIB published the report titled, 'Surgical care of NHS patients in independent hospitals.' The investigation explored safety issues with the establishment of surgical services in independent hospitals to support the NHS and the specialist services that are in place to deliver patient care. It also considered the assessment of patients prior to surgery to identify their risk and suitability for an operation.

429. The impacts of this investigation so far, have included NHSX expanding its work programme to improve transfer of information between the NHS and independent sector in support of safe care delivery, and the CQC is updating its inspection framework documentation to ensure patient transfer between NHS and independent providers is inspected.

430. During 2021-22, the HSIB has also undertaken 4 investigations relating to COVID-19, building on the eight completed in 2020-2021. The HSIB continued to focus much of their investigations on responding to the pandemic and highlighting risks associated with COVID-19. A key report was the 'Oxygen issues during the COVID-19 pandemic' (report published June 2021) where the HSIB identified a safety risk arising from an increased demand for oxygen gas in hospital wards during the COVID-19 pandemic. Since the report was published, healthcare technical memorandum guidance has been updated to ensure all appropriate members of hospital staff attend medical gas committees and the CQC are updating their inspection guidance to ensure the estates function is reviewed with respect to oxygen delivery.

431. The HSIB also marked World Patient Safety Day in September 2021 by hosting their first international conference on healthcare safety investigations. More than 1,200 took part, with people dialling in globally.

432. The Health and Care Act 2022 will allow the HSIB to become an independent investigations body known as the Health Services Safety Investigations Body (HSSIB). The HSSIB will investigate incidents that occur in England during the provision of health care services in the NHS and independent sector that have, or may have, implications for the safety of patients.

433. The HSIB will conduct investigations using 'safe space' which prohibits the unauthorised disclosure of protected material. These investigations take a 'no-blame' approach which encourages patients, families, and staff to share information in confidence.

434. The legislation aims to encourage a culture of learning within the NHS through promoting better standards for local investigations and improving their quality and effectiveness. The HSSIB will also provide advice, guidance, and training to NHS bodies, upon request.

435. 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 in their annual Quality Accounts.

436. 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.

437. Medical Examiners are currently being introduced in the NHS in a non-statutory capacity to scrutinise all non-coronial deaths. This will enable the NHS to prepare for the forthcoming statutory system. DHSC is working closely with the National Medical Examiner to achieve full roll out for non-coronial deaths in all healthcare settings. The required amendment to the Coroners and Justice Act 2009 has been made through the Health and Care Act 2022, to host medical examiners in England in NHS bodies rather than local authorities.

438. As stated in the National Medical Examiners report for 2021 (latest published figures), as of 31 December 2021, some 1,427 senior doctors had completed medical examiner training, and 330 staff had completed medical examiner officer training, with further training of both elements planned for 2022-23. The National Medical Examiner has added to guidance through several topical good practice papers published by the Royal College of Pathologists.

439. The National Medical Examiner continued to contribute to the COVID-19 response, responding to technical queries arising during the COVID-19 response. The National Medical Examiner's team published information for all doctors, summarising cause of death and cremation form requirements following expiry of the Coronavirus Act 2020.

440. The Maternity Transformation Programme (MTP) provides the infrastructure for delivering the recommendations from 'Better Births'; the Neonatal Critical Care Review (NCCR) and the Government's National Maternity Safety Ambition. The MTP has made measurable improvements in safety outcomes for women, their babies, and families in maternity and neonatal services, with safety as the golden thread running through the programme.

441. In March 2021, the MTP transitioned into a new governance arrangement, which aimed to simplify the programme and ensure that it is driven by the core aims of delivering safer, more personalised care, alongside improving equity.

442. The MTP leads the delivery of the Government's national ambition to halve the 2010 rates of stillbirths, neonatal and maternal deaths, and intrapartum brain injuries in babies by 2025, with a 20% reduction by 2020, and to reduce the preterm birth rate from 8% to 6% by 2025. Available data shows that since 2010, the rates of stillbirths and neonatal deaths for babies born over 24 weeks gestation has reduced by 19.3% and 36% respectively. The overall rate of brain injuries occurring during or soon after birth in 2019 was 2% lower than the 2010 baseline and the proportion of babies born preterm has reduced from around 8% in 2017, to 7.5% in 2020. Following a period of decreasing rates, the maternal mortality rate in 2018-2020 was 2.5% higher than the 2009-2011 baseline.

443. Considerable progress has been made in improving maternity safety and many key achievements have been recognised.

444. Since 2010, the rate of stillbirths reduced by 19.3% by 2021, the rate of neonatal mortality for babies born over 24 weeks gestational age of viability reduced by 36% by 2020 and maternal mortality has reduced by 17% in the 2017-2019 cohort. The proportion of babies born preterm (with gestational age under 37 weeks) has reduced from around 8% of all births in 2017, to 7.5% in 2020. The overall rate of brain injuries occurring during or soon after birth has fallen to 4.2 per 1,000 births in 2019, 2% lower than the 2010 baseline.

445. Further focus is now on addressing disparity in outcomes for women from a black or minority ethnic background and those living in the most deprived areas who are being disproportionally affected. The former Minister for Patient Safety and Primary care announced the establishment of a Maternity Disparities Taskforce, whose aims are to tackle disparities by improving access to effective pre-conception and maternity care. Furthermore, Equity and Equality guidance,

attached with an investment of £6.8 million for implementation, has been published for Local Maternity Systems, which focuses on specific actions to reduce disparities.

446. Whilst good progress has been made in improving maternity safety, Donna Ockenden's review of maternity services at Shrewsbury and Telford Hospitals Trust shone a light on further improvements that need to be made both nationally and regionally. The Department is now working with the NHS to take forward a working group, as recommended in the Report, to help guide implementation/ next steps of the Immediate and Essential Actions and other national review reports being prepared.

447. To support further improvement in maternity services, a £127 million investment into the maternity system was made in March 2022, additional to the £95 million that was invested in 2021 to support the recruitment of 1,200 more midwives and 100 more consultant obstetricians.

448. And as endorsed in the Ockenden Report, the Department continues its work to establish a Special Health Authority to ensure the continuation of independent, family centred maternity investigations, which will enable learning for the system and contribute to the Government's maternity safety ambition.

449. 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. The UK Government continues to proactively mark World Patient Safety Day on 17 September each year. WHO's Global Patient Safety Action Plan 2021-2030 is also supporting implementation of a UK Government-led Resolution on Global Action on Patient Safety adopted by the World Health Assembly in 2019. The Action Plan is providing strategic direction for concrete actions to be taken by all countries to implement the resolution and so advance patient safety.

Supporting Patients, Families and Staff to raise concerns

450. The Department is working with stakeholders, including the Parliamentary and Health Service Ombudsman to improve how the NHS responds to complaints and concerns. We are focusing on culture within the NHS to help drive improvements in how feedback and concerns from patients, their families, and carers, are dealt with so that the NHS listens, learns and acts.

451. The former Secretary of State described his desire for us to continually listen to patients, users, and their families so that we become more than the sum of our parts when it comes to the voice of patients are care users and we are considering carefully how to take this forward.

452. In October 2020, the then Minister for Primary Care and Patient Safety supported the National Guardian's Office's Speak Up month which saw people across the country make a pledge to improve Speaking Up in the health system. The National Guardian's Office have reported that the speaking up culture through Freedom to Speak Up Guardians continues to improve. The Freedom to Speak Up Index 2021 – the overall measure of the freedom to speak up in the NHS – has improved by 3.7% since 2015.

453. The Government have legislated for a new Patient Safety Commissioner position through the Medicines and Medical Devices Act 2021. The Commissioner will add to existing work that has been done to improve patient safety by acting as a champion for patients.

454. The core role of the Commissioner will be to promote the safety of patients in the context of the use of medicines and medical devices, and to promote the importance of the views of patients and other members of the public in relation to the safety of medicines and medical devices. Regulations will be made setting out further details of the appointment and operation of the Commissioner and a campaign launched in line with the public appointments process to fill the position.

Infected Blood Inquiry

455. The Infected Blood Inquiry continues to hear evidence, most recently from current and former Ministers and civil servants. The Cabinet Office, as the sponsor Department for the inquiry, continues to coordinate work between DHSC and the devolved administrations.

456. The Department is providing the documents that the Inquiry is asking for and has waived its usual right to legal privilege.

457. The Department is committed to working with the support schemes in the Devolved Nations to improve parity of support across the UK. In March 2021, the Paymaster General announced changes across the four schemes which will bring them into broader parity. In August 2022, the Government accepted the Inquiry recommendation to make an interim compensation payment to all those infected and bereaved partners currently registered on UK infected blood support schemes. Further information can be found in the Accountability Report section at **paragraph 808** of the **Accountability Report** section.

Monitoring and Regulation of Quality of Care

458. The Care Quality Commission (CQC) monitors, inspects and regulates registered health and social care providers in England. In 2020-21, the CQC continued work to roll out a transformation programme, to improve its digital infrastructure and enable it to make improvements in how it registers, monitors and inspects services. In January 2021, the Regulator consulted on a new strategy that will

enable it to be more flexible to manage risk and uncertainty. The CQC has said that it learnt from its response to the pandemic and will build on that learning to support services and keep people safe.

459. The CQC's annual State of Care Report for 2021-22, published in October 2022, provides an assessment of health and care services. In this report, the CQC found that generally people are still getting good quality care when they are able to access it. Many patients are unable to leave hospitals when ready to be discharged due to lack of care packages. There are record breaking waits in emergency departments and dangerous ambulance handover delays. Capacity in adult social care has reduced and unmet need has increased. In maternity, the CQC continue to find issues with culture, leadership, and lack of genuine engagement with service users. Service providers are struggling to recruit and retain staff in all sectors. Inequalities in care continue to pervade and persist for many different groups of people.

460. During the pandemic, the CQC stopped its routine programme of inspections and introduced regulating health and social care providers on a risk-based approach. It did not stop rating providers but rated where it was required (i.e., where there was a change in quality). **Table 22** shows CQC ratings by type of provider.

Table 22: Percentage of core services rated by CQC as Good or outstanding by service provider

	Rating							
Location Type/Sector	Outstanding		Good		Requires improvement		Inadequate	
Year	2021	**2022**	2021	**2022**	2021	**2022**	2021	**2022**
Independent Ambulance	2.8%	**2.7%**	58.9%	**60.4%**	32.7%	**32.4%**	5.6%	**4.5%**
Independent Healthcare Organisation	9.1%	**8.5%**	78.8%	**80.2%**	10.2%	**8.7%**	1.8%	**2.7%**
NHS Healthcare Organisation	8.6%	**8.1%**	59.6%	**59.8%**	30.4%	**30.5%**	1.4%	**1.6%**
Primary Medical Services	4.9%	**4.9%**	90.0%	**91.9%**	4.7%	**2.6%**	0.4%	**0.6%**
Social Care Organisation	4.7%	**4.6%**	79.6%	**79.2%**	14.5%	**14.8%**	1.1%	**1.3%**

Inquiries and Reviews

461. The report of the Independent Medicines and Medical Devices Safety Review, chaired by Baroness Julia Cumberlege was published on 8 July 2020 and the report of the Independent Investigation into the life and death of baby Elizabeth Dixon was published on 26 November 2020 and provided system-wide learning.

462. The emerging findings and recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (The Ockenden Review), was published on 10 December 2020. This is the first interim report, following 250 clinical reviews.

463. The Ockenden Review is assessing the quality of investigations relating to new-born, infant and maternal harm at Shrewsbury and Telford Hospitals NHS Trust

(SaTH). The original terms of reference for the Review covered the handling of 23 cases.

464. Following the launch of the review in 2017, additional cases were identified, and the final total of cases being considered increased to 1,862. The second and final report, published on 30 March 2022, contained 64 local actions to the Trust, 15 Immediate and Essential Actions for the maternity system and 3 key asks for the Secretary of State for Health and Social Care. Shortly after publication, The then Secretary of State for Health and Social Care issued an oral statement in the House of Commons, where he apologised to the families for their suffering and accepted all recommendations made in the report.

465. In June 2019, Ministers had announced a new independent investigation to review fresh evidence of substandard care at Liverpool Community Health NHS Trust between 2010 and 2014 and its terms of reference were announced in Parliament on 16 July 2020.

466. Following concerns raised about the quality and outcomes of East Kent Hospitals University NHS Foundation Trust maternity and neonatal care, in February 2020, NHSE (formerly NHSE and NHSI) commissioned Dr Bill Kirkup to undertake the East Kent Maternity Independent Investigation. The terms of reference were agreed and announced in Parliament by the then Minister of State for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries on the 11 March 2021. The final Report 'Maternity and neonatal services in East Kent: 'Reading the signals' report' was published on 19 October 2022.

467. On 21 January 2021 the then Minister of State for Patient Safety, Suicide Prevention and Mental Health announced the establishment of the Essex Mental Health Independent Inquiry into the circumstances of mental health inpatient deaths at the former North Essex Partnership University NHS Foundation Trust, the former South Essex Partnership University Trust and the Essex Partnership University NHS Foundation Trust which took over responsibility for mental health services in Essex from 2017.

Overall Assessment (section 1A)

468. The Secretary of State's assessment is that 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. This assessment is made in the context of the NHS responding to the impact of the COVID-19 health emergency from the final quarter of 2019-20 which greatly added to the already significant challenges: an ageing population, with increasing complexity of medical conditions and more patients with long-term conditions. As part of its successful response, the NHS managed to deliver significant reductions in unplanned hospitalisation for chronic ambulatory sensitive conditions, and for asthma,

diabetes, and epilepsy in the under 19s by better management outside hospital of these conditions.

469. Across the frameworks, whilst we can see the dip in life expectancy caused by COVID-19, and other areas of concern, there are areas where tangible progress has been made. For example, significant progress has been made in maintaining the improving trend on under-75 mortality rates for Cancer and respiratory diseases, and in maintaining the reducing trend in smoking prevalence. However, there has been deterioration in under-75 mortality for cardiovascular and liver disease. Also, many indicators within the domain of health protection have deteriorated; plans are in place for the systematic restart and recovery of immunisation programmes as the waves of COVID-19 recede.

Health Disparities

470. The Secretary of State's legal duty to have regard for the need to reduce health inequalities includes assessment and reporting requirements. For 2021-22, 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. 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.

471. This section of the report contains information on a selection of policies, programmes and priorities demonstrating the breadth and scale of the work in tackling health disparities but is not intended to be an exhaustive list.

472. Over the reporting period, much of the work on reducing health disparities has concentrated on ensuring proportionate efforts continue in relation to disparities in outcomes related to COVID-19, whilst refocusing on pre-existing and long-standing disparities in people's access to, experience of and outcomes from health services. In particular, the Department has contributed to wider Government priorities on Levelling Up, focusing on UK-wide improvements, as well as establishing the Office for Health Improvement and Disparities (OHID) within DHSC to galvanise efforts nationally, regionally, and locally and to shift the focus from treating ill health to preventing it. Further information on OHID is set out in the Performance Report from **paragraph 178 onwards.** The then Secretary of State was clear that tackling disparities is a priority and to do that there must be a focus on the people and places facing the worst health outcomes.

Levelling Up

473. The Government's Levelling Up White Paper (LUWP) outlined policies to improve livelihoods and opportunities in all parts of the UK by driving productivity, strengthening communities and improving public services. There are already commitments to several actions to improve the nation's health and tackle disparities in the LUWP - set out in the Mission for Health - through actions on

prevention and improving health service provision. This includes commitments on smoking, obesity, substance misuse, early years, and Community Diagnostic Centres.

474. The mission for health is to narrow the gap in 'healthy life expectancy' (HLE) between local areas where it is highest and lowest by 2030, and to increase HLE by 5 years by 2035. HLE provides a holistic measure of experiences of ill health during people's lifetimes, and our mission sets out our ambition to compress the period that everyone, in particular those in places experiencing the worst HLE, spends in ill health.

475. Work is underway to produce a delivery plan for this mission. It provides DHSC with an opportunity to:
- understand the drivers of healthy life expectancy and which issues the evidence suggests will have the most impact to improve it;
- work proactively with Other Government Departments (OGDs) on both the issues that influence health as well as on those issues that are driven in turn by ill health; and,
- set out a proactive agenda for the future, working with OGDs, with places, the NHS, the private and voluntary sectors and beyond to address the significant lifetime impacts of ill health on the economy, on individuals and on the sustainability of the NHS.

476. This will build on prevention activity that is already underway with a continued focus to act on the biggest preventable risk factors for ill health and premature death including tobacco, obesity, and harmful use of alcohol and drugs (see examples in the Prevention section beginning at **paragraph 479**). We will also continue to work with the NHS and local government to improve access to the services which detect and act on health risks and conditions, as early as possible.

477. The Minister for Equalities' (MfE) COVID-19 Race Disparity reports set out evidence for the drivers of ethnic minority health disparities, including socio-economic factors, such as type of employment and quality of housing. The final report was published in December 2021 and DHSC and the Race Disparities Unit are now considering how to implement the final recommendations made.

478. The Commission on Race and Ethnic Disparities (CRED) was established in July 2020 in the wake of the Black Lives Matter protests. The then Prime Minister asked the Commission to investigate race and ethnic disparities in the UK. The Inclusive Britain Action Plan (17 March 2022) was developed across Government in response to the CRED report and recommendations. The Action Plan provides a comprehensive plan of how DHSC will tackle the ethnic health disparities highlighted in the report, committing to a number of actions including:
- Commission a new Ethnicity Pay Gap research project;

- implement the recommendations in the MfE report on COVID-19 Race Disparities, including drawing upon learnings of this work for future strategies; and,
- consider and support evidence-based interventions to address disparities in outcomes through the Maternity Disparities Taskforce (announced in February 2022).

Prevention

479. Health conditions such as cardiovascular disease, cancers and respiratory conditions are among the biggest drivers of mortality in England. However, in many cases these conditions can be prevented. Tackling the root causes of these conditions, including through action on obesity, poor diet, smoking and physical inactivity, and identifying and treating these conditions earlier, is critical to improving our nation's health and tackling health disparities.

480. Preventing ill-health and tackling health disparities (both physical and mental) must be at the core of vaccination and screening programmes, mental health services, NHS Health Checks, and identifying and managing key risk factors for cardiovascular disease.

481. There has been good long-term progress in reducing smoking rates, currently at around 13.5%, the lowest on record, although stark inequalities remain. In 2020 20.8% of people in Manchester smoked compared with 5.5% of people in Wokingham (figures based on data from the Annual Population Survey). There are still around 6 million smokers, and tobacco use is still the single largest cause of preventable mortality. The Government has set the bold ambition for England to be Smoke free by 2030.

482. In February 2022 the Government announced that Javed Khan OBE would lead a review into tobacco control, the findings of which were published on 9 June 2022. The Government is currently considering the independent recommendations set out in the Khan Review and how best to take this forward. NHS England will continue to roll out the NHS Long Term Plan commitment to deliver NHS-funded tobacco treatment services to all inpatients, pregnant women and people accessing long term mental health and learning disability services by 2024.

483. In 2021-22, £100 million was invested to support people to achieve a healthy weight. This included the expansion of weight management services, and £6 million for health incentives to encourage people to eat better and move more. Funding allocations for the Adult Weight Management Services Grant to local authorities was weighted according to local authority population size, obesity prevalence and deprivation levels to enable the money to go to where the need is greatest.

484. OHID has also been working to target and support those in underserved communities who experience health disparities to become, and remain, active including the development of UK Chief Medical Officer physical activity guidelines for disabled children and disabled young people. Coproduced with disabled children, disabled young people, their families and wider support systems, this resource is not only vital in fostering a more inclusive approach to promoting sports and physical activity, but also sets the standard for how research and the development of guidance, particularly those that are relevant to underserved groups, should be actively shaped by their insights, experiences, and knowledge.

Inclusion Health

485. The following are examples of work done to support some of the most excluded members of society with the poorest health outcomes.

486. DHSC secured £16 million through the Shared Outcomes Fund to test the Out of Hospital Care Models (OOHCM) Project in 17 areas, across 2020-21 and 2021-22. OOHCM provides interim accommodation, care, and support while full assessments of need are carried out – ensuring people experiencing homelessness receive continuity of care and are not discharged to homelessness or rough sleeping.

487. The Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) currently provides 63 local authorities and 5 pan-London projects with funding to support people at risk of, or currently experiencing, rough sleeping to improve access to and engagement with drug and alcohol treatment services. At the start of 2022 the RSDATG had supported over 2,000 people into structured drug and alcohol treatment.

488. OHID produces the Migrant Health Guide (updated July 2021), a free-to-use, online resource designed to support primary care practitioners in caring for patients who have come to the UK from overseas. The guide was updated to include advice specific to the Afghanistan and the Ukraine schemes. £3 million of funding was provided to the NHS to support an enhanced healthcare offer for people and their families arriving through Afghan resettlement schemes.

COVID-19 and Health Protection

489. The COVID-19 vaccination programme continued to ensure disparities were identified and addressed including through the Antivirals and Therapeutics programme which supported treatment of people with severe symptoms including some ethnic minority communities and people from lower socio-economic groups. In addition, the COVID-19 vaccination — and other immunisation programmes such as MMR and child flu — were rolled out using a range of delivery models (mobile, pop-up, and roving sites) and using targeted communications and using trusted sources of communication such as community and faith leaders.

490. Other examples of consideration of inequalities in health protection and security work include COP26 in November 2021, where, for the first time health had its own presidency programme; consideration of changes to blood donor selection criteria to ensure it was as effective and inclusive as possible, without compromising the safety of our blood supply; and UKHSA's work in other areas including HIV, tuberculosis and hepatitis C also directly and indirectly addresses health disparities.

NHS

491. In February 2022 DHSC announced plans to establish a Maternity Disparities Taskforce to tackle disparities for mothers and babies and reduce maternal and neonatal deaths by improving access to effective pre-conception and maternity care for women from ethnic minorities and those living in the most deprived areas.

492. The Health and Care Act 2022 received Royal Assent in April 2022 and will contribute to tackling health inequalities in a number of important ways particularly through establishing Integrated Care Systems and Integrated Care Partnerships (ICPs). ICPs will bring together the NHS and local government on an equal partnership footing to prepare an integrated care strategy, which will set out how ICPs will address disparities in outcomes, access, and experience.

493. The Act also establishes a new triple aim duty that will oblige those that commission health and care services to consider the effects of their decisions on:
- the health and wellbeing of the people of England (including inequalities in that health and wellbeing)
- the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services)

494. DHSC has also announced an independent review into potential ethnic and other unfair biases in the design and use of medical devices, which themselves could exacerbate health disparities.

495. The NHS is one of the most diverse organisations in this country and we hugely value the contribution that all staff make to delivering care and supporting patients. Communities are better served when the NHS workforce, at all levels, is representative of the communities themselves. Implementing new programmes of action to promote equality, diversity and inclusion within the NHS workforce impacts positively on patient health outcomes. Examples of initiatives to ensure there is a diverse workforce:
- apprenticeships are vital to improving social mobility, widening participation, and providing an important route into the modern NHS. We have a successful NHS apprentice programme training about 25,000 NHS apprentices 2021-22 academic year;

- the Nursing Associate role acts as a bridge between healthcare support and a qualified nurse. Creating such new 'bridging roles' in the NHS enables people to enter the NHS workforce at a lower than degree level providing more accessible roles for people from different backgrounds;
- the Government has reformed the National Clinical Excellence Awards scheme, now named the National Clinical Impact Awards (NCIAs) for NHS consultants. The reforms aim to broaden access to the scheme, make the application process fairer and more inclusive, and ensure the scheme rewards and incentivises excellence across a broader range of activity and behaviours. The NHS consultant workforce is diverse, and the Government wants to ensure that the NCIA scheme fully reflects this. Through these reforms, the Government hopes to encourage applications from more female and ethnic minority consultants.

496. DHSC is working closely with NHS England and Health Education England on workforce initiatives to tackle health disparities.

497. More effective and equitable prevention and treatment of mental illness has the potential to reduce broader economic and social inequalities in deprived areas and regions. The NHS Long Term Plan is expanding access to services to allow an additional 2 million to access NHS-funded care by 2023-24, in all local areas across the country. As part of that, the Improving Access to Psychological Therapies (IAPT) programme aims to increase access to evidence-based psychological therapies, so that 1.9 million people can access support for common mental health disorders by 2023-24. A notable achievement has been that for the first time, IAPT services have met the Recovery Standard for Black and British people accessing the service as well as White people (that 50% of all patients completing treatment move to recovery).

498. DHSC worked with NHS England (then NHSE and NHSI) to ensure that understanding and addressing health disparities were part of the Elective Recovery Plan (published in February 2022). The NHS has recognised that as services are restored it is essential that they are opened up to all, and resources are distributed fairly according to clinical need. DHSC will work with NHS England in this area to ensure it delivers on the commitments made as part of ongoing oversight of elective recovery.

Data and Intelligence

499. During 2021-22, Public Health England and OHID continued to produce a wide range of outputs and intelligence on health disparities:
    - the latest Health Profile for England (updated November 2021) provides a comprehensive picture of the health of the population, including the wider impact of the COVID-19 pandemic on many aspects of health and health disparities.

- data on the direct impacts of the pandemic have been made available via the interactive COVID-19 Health Inequalities Monitoring for England (CHIME) tool (published May 2021; last updated May 2022).
- the Wider Impacts of COVID-19 on Health (WICH) tool (published July 2020; last updated May 2022) has also continued to provide inequality data, for example on access to health care.
- the Vision Atlas (launched August 2021) continues the series of atlases of variation which have helped to identify unwarranted variation in disease risk factors and healthcare interventions.

500. In addition to the development of these tools, important progress has been made in improving access to more detailed, better-quality data on health disparities. For example, primary care data covering diagnosis and management of high-risk conditions that cause stroke, heart attack and other cardiovascular outcomes, are being extracted by CVDPREVENT, a primary care audit set up in support of the broader strategic objective outlined in the NHS Long Term Plan to prevent strokes, heart attacks and cases of dementia over the next ten years.

Analysis of supporting indicators

501. Fifteen indicators of how health outcomes differ by area deprivation are drawn from the Public Health Outcomes Framework (PHOF) and the NHS Outcomes Framework (NHSOF). Breakdowns by other dimensions of inequality are unavailable for all the indicators. Two of the indicators are no longer updated by NHS Digital ('Potential Years of Life Lost from causes considered amendable to healthcare – adults' and 'Health-related quality of life for people with long-term conditions). The indicators are used in this assessment which seeks to identify both recent change and change since the legal duties were introduced through the Health and Social Care Act 2012. This analysis uses PHOF and NHSOF indicator values that have been calculated for each national deprivation decile (IMD 2019).

502. This report features data collected both before and during the COVID-19 pandemic. A number of individual indicators include both pre- and post-COVID-19 data and therefore only partially capture impacts of the pandemic. For example, health state life expectancy indicators include health and mortality data collected between 2018 and 2020.

503. Different patterns have been observed in GP Patient Survey (GPPS) data, mortality data and Hospital Episode Statistics from 2019-20 through to 2020-21 which are likely to have been affected by the pandemic; for example fewer patients being admitted to hospital. Statistics which contain data from this period should be interpreted with this in mind.

Area Deprivation

504. This analysis uses the English Index of Multiple Deprivation (IMD) to define deprivation deciles using the IMD that most closely aligns with the most recent indicator data.

Measuring Disparity

505. Disparity is measured using the Slope Index of Inequality (SII). The SII represents the absolute inequality between the most and least deprived deciles when taking into account inequality across all adjacent deciles. It is calculated, using indicator data from the NHS Outcomes Framework and the Public Health Outcomes Framework, by regressing the indicator values against a measure of deprivation rank, weighted by the population in each decile. The SII is the differences between the most and least disadvantaged ends of the least-squares regression line. The significance of a change in SII values is determined using 95% confidence intervals where non-overlapping confidence intervals between SIIs indicates a significant difference. For comparison to previous years, figures can be found in the Department's previous Annual Report and Accounts.

506. Of the thirteen indicators analysed, five have shown a statistically significant widening of the SII since the previous reporting period and two have significantly narrowed (see **Table 23**). Compared to the baseline period, four have shown a significant widening of the SII and two have shown a significant narrowing.

507. 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.

508. The overarching indicators in the PHOF show that the disparities between people living in the most deprived areas remain:
    - in 2018-20, the disparity in life expectancy at birth between the most and least deprived areas was 9.7 years for males and 7.9 years for females, a statistically significant increase from 2017-2019 for both males and females (9.4 and 7.6 years respectively).
    - in 2018-20 the disparity in healthy life expectancy at birth between the most and least deprived areas was 18.6 years for males and 19.3 years for females, representing a slight, but not significant, decrease from 2017-19 for males and no change for females.
    - disparities in healthy life expectancy at birth have remained stable since the baseline period; however, disparities in life expectancy at birth for males and females significantly widened between the baseline period (2010-12) and 2018-20.

509. The NHSOF covers a wider range of indicators including; health outcomes, access to services and patient experience. These indicators provide a mixed picture:
    - disparity between the most and least deprived areas significantly widened for life expectancy at 75 for males and females since the previous time period (2017-19) and since the baseline period (2011-13).
    - disparity in under 75 mortality rates from cardiovascular diseases has remained broadly stable between the baseline year (2013) but has statistically significantly increased since the last reporting period (2019).
    - disparity in under 75 mortality rates from cancer has not significantly changed from the baseline (2013) or the previous time period (2020).
    - disparity in emergency admissions for acute conditions that should not usually require hospital admission has significantly narrowed since the baseline (2013-14) and since the previous time period (2020-21).
    - disparity in unplanned hospital admission for chronic ambulatory care sensitive conditions has also significantly narrowed from the baseline (2013-14) and the previous time period (2020-21) - calculated using indirectly standardised admission rates. SII estimates may be influenced by the differences in population structures across deprivation deciles.
    - disparity in infant mortality has increased slightly from baseline year (2013) and the previous period 2018, but neither increase is statistically significant.
    - disparities in both patient experience of primary care - GP services and access to GP services have increased since the baseline period (2013-14) but decreased since the most recent previous reporting period (2017-18). Confidence Intervals are not calculated for these indicators, so it is not possible to determine whether changes have been statistically significant.

Table 23: Breakdown of SIIs, upper and lower confidence intervals of NHSOF and PHOF indicators for most recent, previous and baseline periods

NHS Outcomes Framework Indicator	Year	SII	LCL	UCL
1b.i: Life expectancy at 75 - Males				
Baseline	2011-13	2.74	2.68	2.81
Previous time period	2017-19	2.99	2.93	3.06
Latest time period (IMD 2019)	2018-20	3.17*	3.12	3.23
1b.ii: Life expectancy at 75 - Females				
Baseline	2011-13	2.60	2.54	2.67
Previous time period	2017-19	3.13	3.07	3.19
Latest time period (IMD 2019)	2017-19	3.30*	3.25	3.36
1.1: Under 75 mortality rate from cardiovascular disease				
Baseline	2013	-106.49	-109.75	-103.23
Previous time period	2019	-102.49	-105.50	-99.49
Latest time period (IMD 2019)	2019	-110.19*	-113.27	-107.1
1.4: Under 75 mortality rate from cancer				
Baseline	2013	-103.93	-107.81	-99.30
Previous time period	2019	-96.48	-100.34	-92.62
Latest time period (IMD 2019)	2019	-97.69	-101.51	-93.86
1.6.i: Infant mortality				
Baseline	2013	-3.03	-3.57	-2.48
Previous time period	2018	-2.63	-3.18	-2.07
Latest time period (IMD 2019)	2020	-3.31	-3.88	-2.75
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)				
Baseline	2013-14	-978.12	-988.22	-968.87
Previous time period	2019-20	-1047.71	-1056.97	-1038.46
Latest time period (IMD 2019)	2019-20	-751.56**	-759.63	-743.54
3a: Emergency admissions for acute conditions that should not usually require hospital admission (all ages)				
Baseline	2013-14	-931.53	-941.82	-921.33
Previous time period	2018-19	-1062.70	-1073.87	-1051.45
Latest time period (IMD 2019)	2018-19	-630.82**	-639.47	-622.12
4a.i: Patient experience of primary care - GP services				
Baseline	2013-14	5.15	4.89	5.40
Previous time period (IMD 2015)	2018-19	8.74		
Latest time period (IMD 2019)	2020-21	8.06		
4.4.i Access to GP services				
Baseline	2013-14	5.19	4.87	5.51
Previous time period (IMD 2015)	2018-19	7.57	7.19	7.96
Latest time period (IMD 2019)	2020-21	7.47		
Public Health Outcomes Framework Indicator	**Year**	**SII**	**LCL**	**UCL**
Life expectancy at birth - Males				
Baseline	2010-12	9.1	9.0	9.2
Previous time period	2017-19	9.4	9.3	9.5
Latest time period (IMD 2019)	2018-20	9.7*	9.6	9.8
Life expectancy at birth - Females				
Baseline	2010-12	6.8	6.7	6.9
Previous time period	2017-19	7.6	7.5	7.7
Latest time period (IMD 2019)	2018-20	7.9*	7.8	8.0
Healthy life expectancy at birth - Males				
Baseline	2011-13	18.6	18.1	19.1
Previous time period	2017-19	19.0	18.4	19.6
Latest time period (IMD 2019)	2018-20	18.6	17.9	19.3
Healthy life expectancy at birth - Females				
Baseline	2011-13	19.1	18.5	19.7
Previous time period	2017-19	19.3	18.7	20.0
Latest time period (IMD 2019)	2018-20	19.3	18.6	20.0

*Statistically significant widening of disparity

** Statistically significant narrowing of disparity

510. The Secretary of State's assessment of how well his health inequalities duty has been fulfilled in 2021-22 is that whilst there has been welcome progress, a range of actions and initiatives have been put in train and a renewed commitment and determination have been set out across the whole health and care system, more can and must be done in the years to come.

Forward look to 2022-23

511. 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 2022-23.

Performance Report Accounting Officer Sign-off

23rd January 2023
Sir Chris Wormald KCB
Permanent Secretary

Accountability Report

Lead Non-Executive Board Member's Report

Performance and priorities

512. Throughout 2021, the COVID-19 pandemic continued to dominate the health landscape, placing increasing demands on our health and care system. I commend the Department of Health and Social Care for the role it has continued to play in managing the national response and would like to pay tribute to the staff for their extraordinary efforts over the past year.

513. The Board met four times in 2021-2022 with good attendance from ministers, officials, and non-executive directors. The Board's agenda focussed on the Department's performance, the continued response to the COVID-19 pandemic and winter preparedness.

514. The reporting year saw the appointment of a new Secretary of State for Health and Social Care and new members of the ministerial team. So, the Board also devoted attention to the progression of their ambitions and plans for post pandemic recovery, and their vision for the reform of the health and social care system.

515. In November 2021, we welcomed Julian Hartley to the non-executive team. He brings extensive NHS expertise and experience, which has had an immediate impact in how we are able to provide support and challenge to the Department. I am grateful for the continued valuable contributions from all my fellow non-executive directors.

516. The Audit and Risk Committee (ARC) continued with Gerry Murphy as chair and held four full meetings over the year. It discussed the Department's finances, risks, accounts, and internal audit reviews, challenging the Department to improve performance where this was necessary. The ARC, led by Gerry, were instrumental in ensuring the delivery and sign off of the Annual Reports and Accounts. I thank Gerry for his continuing dedication to his role on the Board.

517. The Nominations and Governance Committee continued to include Gerry Murphy as a formal member in his capacity as the non-executive leading on talent management. The Committee discussed SCS talent and performance as well as non-executive director recruitment and succession planning. The committee also discussed governance arrangements for UKHSA, following the formation of the agency in April 2021.

518. Non-executive directors, through their membership on the Performance and Risk Committee (PRC), have provided further external challenge and scrutiny of the

Department's performance on key priorities, the Long-Term Plan, and manifesto commitments, as well as the departmental risk register. The PRC met four times over the year.

519. Outside the formal governance committees, the support and challenge provided by non-executive directors to individual teams continues to be an important part of the role. Individually and collectively, we have participated in deep-dive sessions on various aspects of the Department's work such as Adult Social Care, Personal Protective Equipment (PPE), the COVID-19 vaccine programme, as well as offering advice and support to members of staff on a more ad hoc basis.

520. As the Department's lead non-executive director, it has been an honour to support the work of the Department over the past year and I am grateful to my non-executive team for all their support. I and the rest of the non-executive team are proud of dedication, the achievements, and the resilience of everyone in the Department and we look forward to continuing to work with them.

Kate Lampard

Accountability Report

521. 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

522. 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

523. 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

524. 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 2022

The Rt Hon Sajid Javid MP
Secretary of State for Health & Social Care
Chair of the Departmental Board
Appointed 26 June 2021 to 5 July 2022

Gillian Keegan MP
Minister of State for Care and Mental Health
Appointed 16 September 2021 to 8 September 2022

Edward Argar MP
Minister of State for Health and
Deputy Chair of the Departmental Board
Appointed 10 September 2019 to 6 July 2022

Maria Caulfield MP
Minister of State for Primary Care and Patient Safety
Appointed 17 September 2021 to 6 September 2022

Maggie Throup MP
Parliamentary Under Secretary of State for Vaccines and Public Health
Appointed 16 September 2021 to 7 September 2022

Lord Kamall
Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences (Lords)
Appointed 17 September 2021 to 19 September 2022

Other ministers who served in the Department during 2021-22 were:

- Matt Hancock resigned as Secretary of State in June 2021.
- Helen Whately, Nadine Dorries, Jo Churchill, Nadhim Zahawi and Lord Bethell left roles with the Department in September 2021.

Other Ministerial changes after 31 March 2022 were:

- Sajid Javid resigned as Secretary of State on 5 July 2022.
- Ed Argar resigned as Minister of State on 6 July 2022.
- Steve Barclay joined the Department as Secretary of State on 5 July 2022. He left the Department on 5 September 2022. He was reappointed as Secretary of State for Health and Social Care on 25 October 2022.
- Maria Caulfield was promoted from Parliamentary Under Secretary of State to Minister of State on 6 July 2022. She left the Department on 7 September 2022. She returned to the Department as Parliamentary Under Secretary of State on 27 October 2022.
- James Morris was appointed as Minister for Primary Care and Patient Safety on 8 July 2022. He left the Department on 7 September 2022.
- Gillian Keegan, Minister of State for Care, left the Department on 8 September 2022.
- Lord Kamall, Parliamentary Under Secretary of State, left the Department on 19 September 2022.
- Maggie Throup, Parliamentary Under Secretary of State (Minister for Vaccines and Public Health), left the Department on 7 September 2022.
- Thérèse Coffey was appointed Secretary of State and Deputy Prime Minister on 6 September 2022, and left the Department on 24 October 2022.
- Robert Jenrick was appointed Minister of State on 7 September 2022, and left the Department on 24 October 2022.
- Will Quince was appointed Minister of State on 7 September 2022.
- Dr Caroline Johnson was appointed Parliamentary Under Secretary of State on 8 September 2022, and left the Department on 26 October 2022.
- Neil O'Brien was appointed Parliamentary Under Secretary of State on 8 September 2022.
- Nick Markham was appointed Parliamentary Under Secretary of State (Lords) on 22 September 2022.
- Helen Whately was appointed as a Minister of State on 26 October 2022.

Our Non-Executive Board Members at 31 March 2022

Kate Lampard

Lead Non-Executive Director
1 October 2017-present

Kate Lampard CBE is chair of GambleAware and works as an independent consultant undertaking investigations and advising organisations on management and service effectiveness and development. Kate is a trustee of the Esmée Fairbairn Foundation and the Royal Horticultural Society.

Previously, Kate Lampard led the NHS investigations into Jimmy Savile and produced a report for the then Secretary of State for Health setting out the lessons for today's health service. She was commissioned by the board of Serco Plc to investigate the treatment of residents at Yarl's Wood Immigration Removal Centre and by G4S Plc to undertake an independent investigation into Brook House immigration removal centre. In 2019 to 2020 Kate led a review and produced a report for the Home Office on the Borders, Immigration and Citizenship System.

Kate spent 13 years as a practising barrister before moving into the public sector where she held a number of non-executive appointments. Kate has been the chair of the South East Coast Strategic Health Authority, vice chair of the South of England Strategic Health Authority and a non-executive director and vice chair of the Financial Ombudsman Service Limited. She acted as interim chair of the Independent Advisory Panel on Deaths in Custody. Kate's daughter is a civil servant at the Foreign, Commonwealth and Development Office.

Gerry Murphy

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

Gerry is a co-opted member of the NHS England audit and risk assurance committee. He is also a non-executive director of Currys PLC.

Until 2020, Gerry was Senior Independent Director of Capital & Counties Properties PLC. He is a former Deloitte LLP partner and was leader of its Professional Practices Group with direct industry experience in consumer business, retail and technology, media and telecommunications. He was a member of the Deloitte board and chairman of its audit committee for a number of years and also chairman of the Audit and Assurance Faculty of the Institute of Chartered Accountants in England and Wales.

Doug Gurr

Non-Executive Director with responsibility for the Union
1 December 2020-present

Doug is Director of the Natural History Museum. He is Chair of the Board of Trustees at The British Heart Foundation and Trustee of the Landmark Trust and UK Biobank. He is an advisor for Permira.

Until November 2020, Doug was Country Manager of Amazon UK. He joined Amazon in December 2011 and was President of Amazon China from 2014 to 2016. Previous roles include teaching mathematics and computing at the University of Aarhus in Denmark, working for the UK Government, partner at consultancy firm McKinsey, founder and CEO of internet start-up Blueheath and 5 years on the Board of Asda-Walmart.

Sir Julian Hartley

Non-Executive Director
1 November 2021-10th November 2022

Julian is the Chief Executive of Leeds Teaching Hospitals NHS Trust, one of the largest teaching hospitals in England. He began in the NHS as a general management trainee, before working in a number of NHS management posts at hospital, health authority, regional and national level. His previous roles included:

- Chief Executive at Tameside and Glossop Primary Care Trust
- Chief Executive at Blackpool, Fylde and Wyre Hospitals, and
- Chief Executive at University Hospital of South Manchester NHS Foundation Trust.

Julian also led the development of the NHS People Plan in 2019.

Other non-executive directors who served in the Department during 2021-22 were:

- Gina Coladangelo 1 September 2020 – 26 June 2021.

Our Executive Board Members at 31 March 2022

Sir Chris Wormald KCB
Permanent Secretary

Prof. Chris Whitty
Chief Medical Officer

Shona Dunn
Second Permanent Secretary

Matthew Gould
CEO of NHSX
Left the Department in May 2022

Andy Brittain
Director General Finance

Other Senior Officials at 31 March 2022

Clara Swinson CB
Director General for Global Health

Jonathan Marron
Director General for Public Health

Matthew Style
Director General for NHS Policy and Performance

Professor Lucy Chappell
Chief Scientific Officer

Michelle Dyson
Director General for Adult Social Care

Jenny Richardson
Director of Human Resources

Hugh Harris
Director of Ministers, Accountability and Strategy

Lorraine Jackson
Director for Information Risk Management & Assurance

Other Senior Officials who served in the Department during 2021-22 were:

- David Williams CB left the Department in April 2021.
- Lee McDonough left the Department in June 2021.
- Steve Oldfield began a career break in January 2022 and left the Department on 17 October 2022.

Senior Official role changes after 31 March 2022 were:

- Thomas Waite was appointed as Deputy Chief Medical Officer on 14 April 2022.

Departmental Disclosures

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

526. 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

527. 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.

528. Our Ministers' interests are published on gov.uk website by the Cabinet Office. A Register of Members' Financial Interests also provides information regarding their financial interests, 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.

529. Further, relevant interests of the Department's senior leadership, as identified in the **'who we are' section**, including any interests they have with the current sanctions against Russia, are detailed in the following **Register of Interests** table.

Register of Interests for the 2021-22 Financial Year

Individual Minister	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Edward Argar	Fiance	Marie Curie Foundation	Member of fundraising committee London Area	Volunteer (not remunerated)	
Edward Argar	Sister	Duke of Edinburgh's award	Director and Director of major projects	Salary	
Gillian Keegan	Self	Fisher Investment Fund		Investment	
Gillian Keegan	Self	Sussex Venture Capital Fund		Investment	
Gillian Keegan	Husband				Crown rep, Cabinet Office/MoD
Gillian Keegan	Husband	TechUK Ltd	Vice Chair		
Gillian Keegan	Husband	Centerprise International Ltd	Non-Executive		
Gillian Keegan	Husband	schoolexams.co.uk	Advisor		
Gillian Keegan	Husband	Veritas Technologies	Advisor		
Gillian Keegan	Husband	28 CORNWALL GARDENS LIMITED (04843248)	Director		
Gillian Keegan	Husband	THE TPK PARTNERSHIP LIMITED (11640975)	Director		
Helen Whately	Cousin	Herne Hill Group Practice	GP	Salary	
Jo Churchill	Self	St. Edmundsbury Cathedral	Patron	Unpaid	
Jo Churchill	Self	Suffolk Philharmonic Orchestra	Member, Council of reference	Unpaid	
Jo Churchill	Self	Royal British Legion Women's section - Bury St. Edmunds and District branch	President	Unpaid	
Jo Churchill	Self	Royal Naval Association Stowmarket branch	President	Unpaid	
Jo Churchill	Self	Bury St. Edmunds Town Trust	Trustee	Unpaid	

Individual Minister	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Jo Churchill	Self	Suffolk Association of Local councils	Vice President	Unpaid	
Jo Churchill	Self	South Lincolnshire scaffolding LTD (Company number 03520516)	Shareholding over 15%	Dividend	Transferred shares to husband 5/5/21
Jo Churchill	Self	SLS Pension fund	Trustee		Left scheme, no longer trustee
Jo Churchill	Self	SLS scaffolding LTD (Company number 07493438)	Directorship and shareholding over 50%	Nil, dormant company	
Maggie Throup	Self	Erewash Partnership Ltd	Non-Executive Director	Ex-officio as MP for Erewash	This is a local development agency
Maggie Throup	Self	THE DERBY & SANDIACRE CANAL TRUST LIMITED	Non-Executive Director		
Maggie Throup	Self	Court of the University of Derby	Member as MP for Erewash		
Maggie Throup	Self	Long Eaton Town Deal Board	Member as MP for Erewash		
Maria Caulfield	Self	Royal Marsden Hospital NHS Trust	Bank Nurse	Salary	
Syed Kamall	Self	St Mary's University, Twickenham	Professor of Politics and International Relations	Salary	Currently on unpaid leave of absence
Syed Kamall	Self	Leeds University Business School	Visiting Fellow	Unpaid	
Syed Kamall	Self	Guangdong University of Finance and Economics	Visiting Professorship	Funding offered	Declined April 2022
Syed Kamall	Self	Coalition for a Digital Economy (COADEC)	Steering Board	Fees	Ceased 25 October 2021
Syed Kamall	Self	Tech UK	Brexit Advisory Panel	Unpaid	Ceased 17 September 2021 (but had not met for some time).
Syed Kamall	Self	Smart Startup Token (SMRT)	Adviser on Government and regulation	Unpaid	

Individual Minister	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Syed Kamall	Self	Institute of Economic Affairs	Academic and Research Consultant	Fees	Ceased 17 September 2021
Syed Kamall	Self	Freedom Association	Council Member	Unpaid	Ceased 4 November 2021
Syed Kamall	Self	Islam & Liberty Network	Co-founder and member of Advisory Board	Unpaid	
Syed Kamall	Self	Kitchen Table Charities Trust	Trustee	Unpaid	
Syed Kamall	Self	Conservative Party Kiva Lending Team	Captain	Unpaid	
Syed Kamall	Self	Free Market Forum	Advisory Council member	Unpaid	Ceased 17 September 2021
Nadine Dorries	Self			Ms Dorries is a novelist and before her appointment had delivered (under contract) three book manuscripts for publication from 2019 to 2021	
Nadine Dorries	Daughter		Senior Parliamentary Assistant		
Nadine Dorries	Self	Averbrook Limited (Company number 02928407)	Director and shareholder	Director and shareholder	
Nadhim Zahawi	Self	BT PLC	Shareholdings		
Nadhim Zahawi	Self	SThree PLC (Company number 03805979)	Shareholdings		
Nadhim Zahawi	Self	Kissing It Better	Patron	Unpaid	The charity work with NHS Trusts in hospitals.
Nadhim Zahawi	Partner	Zahawi & Zahawi LTD (Co' number' 07285998)	Director	Salary	
Nadhim Zahawi	Son	Zahawi & Zahawi LTD (Co' number 07285998)	Director	Salary	

Individual Minister	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Nadhim Zahawi	Son	Zahawi & Zahawi LTD (Co' number 07285998)	Director	Salary	
Nadhim Zahawi	Partner	WARREN MEDICAL LIMITED (Co' number 12659013)	Director		
Nadhim Zahawi	Son	WARREN MEDICAL LIMITED (Co' number 12659013)	Director		
Nadhim Zahawi	Son	WARREN MEDICAL LIMITED (Co' number 12659013)	Director		
Nadhim Zahawi	Partner	ZAHAWI WANTAGE LIMITED (Co' number 11305206)	Director	Salary	
Nadhim Zahawi	Partner	ZAHAWI BRIERLEY HILL LIMITED (Co' number 11639945)	Director	Salary	
Nadhim Zahawi	Partner	ZAHAWI PROPERTIES LIMITED (Co' number 12659412)	Director	Salary	
Nadhim Zahawi	Son	ZAHAWI PROPERTIES LIMITED (Co' number 12659412)	Director	Salary	
Nadhim Zahawi	Son	ZAHAWI PROPERTIES LIMITED (Co' number 12659412)	Director	Salary	
Nadhim Zahawi	Self	Royal Shakespeare Company	N/A		Based in constituency
Nadhim Zahawi	Self	Shakespeare Birthplace Trust	N/A		Based in constituency
James Bethell	Self	Hall School Charitable Trust	Governor	Unpaid	Ceased 23 June 2021
James Bethell	Partner	Atairos Management UK	Managing Partner		

Individual Minister	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
		LLP (OC421342)			
James Bethell	Partner	SADLER'S WELLS TRUST LIMITED (Company number 01488786)	Director		
James Bethell	Partner	SADLER'S WELLS LIMITED (Company number 02907116)	Director		
James Bethell	Partner	SADLER'S WELLS DEVELOPMENT TRUST (Company number 01031348)	Director		
James Bethell	Partner	Tesco PLC (Company number (00445790))	Non-Executive Director		
James Bethell	Partner	Exor N.V	Non-Executive Director		
James Bethell	Partner	Diageo PLC (Company number (00023307)	Non-Executive Director		
James Bethell	Self	International Centre for the Study of Radicalisation and Political Violence	Director and Trustee	Unpaid	
James Bethell	Self	Jo Cox Foundation	Director and Trustee	Unpaid	Ceased June 2021
Matthew Hancock	Self	Topwood Ltd (Company number 04398739)	None	Shareholding	
Sajid Javid	Self	Primrose Hospice	Patron		
Sajid Javid	Self	J.P. Morgan	Advisor	Paid role	
Sajid Javid	Self	C3.ai	Advisor	Paid role	

Individual Non-Exec' Director	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Doug Gurr	Self	Natural History Museum	Director	Salary	
Doug Gurr	Self	British Heart Foundation	Chair	Volunteer (not remunerated)	
Doug Gurr	Self	Landmark Trust	Trustee	Volunteer (not remunerated)	
Doug Gurr	Self	UK Biobank (Company number 04978912)	Director	Volunteer (not remunerated)	
Doug Gurr	Self	Permira	Advisor	Fees	
Gerry Murphy	Self	Currys plc	Non-Executive Director	Remunerated and shares held	Ongoing position
Gina Coladangelo	Self	Lither Pendragon	Minor Shareholding	No salary, no dividends	Ceased to be an employee in 2014 and resigned as a Director in 2017
Gina Coladangelo	Self	Oliver Bonas	Marketing & Communications Director	Salary	Role ended in June 2021
Gina Coladangelo	Ex-Partner	Oliver Bonas Limited (Company number 03799350)	Shareholder and Director	Shareholder	Separated in June 2021
Gina Coladangelo	Ex-Partner	Oliver Bonas (Property) Limited (Company number 08944177)	Shareholder		Separated in June 2021
Gina Coladangelo	Self	Beyond Autism	Governor	Not paid	
Gina Coladangelo	Brother	Partnering Health Holdings Ltd (Company number 1320818)	Director		
Gina Coladangelo	Brother	PHY Youla Limited (Company number 12274169)	Director		
Gina Coladangelo	Brother	Partnering Health Limited (Company number 06563486)	Director		

Individual Non-Exec' Director	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Gina Coladangelo	Brother	Youla Ltd (Company number 03898770)	Director		
Gina Coladangelo	Father	Harrison Life Sciences Group (Company number 08488903)	Director		
Gina Coladangelo	Father	MediciSearch (Company number 09743483)	Director		
Gina Coladangelo	Father	IX Group Ltd (Company number 03936262)	Director		
Gina Coladangelo	Father	Youla Ltd (Company number 03898770)	Director		
Gina Coladangelo	Father	Rephine Limited (Company number 04223857)	Director		
Gina Coladangelo	Father	Medix Uk Ltd (Company number 03900651)	Director		
Gina Coladangelo	Father	Rephine Sourcing Ltd (Company number 04394962)	Director		
Gina Coladangelo	Father	PHL Youla Ltd (Company number 12274169)	Director		
Julian Hartley	Self	Leeds Teaching Hospitals NHS Trust	Chief Executive	Salary	
Julian Hartley	Self	University of Leeds	Honorary Professor of Health Leadership in the Faculty of Medicine and Health	No salary/fee	
Kate Lampard	Self	Gambleaware (Company number 04384279)	Chair	Salary	

Individual Non-Exec' Director	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Kate Lampard	Self	Esmee Fairbairn Foundation	Trustee	Not renumerated	
Kate Lampard	Self	The Royal Horticultural Society	Trustee	Not renumerated	
Kate Lampard	Self	StoneTurn Consultants	Senior Associate	Consultancy fee for any work undertaken	
Kate Lampard	Self	Verita Consultants	Senior Associate	Consultancy fee for any work undertaken	
Kate Lampard	Self	Yokes Court Consultancy Limited (Company number 10677778)	Director and shareholder	Shareholding	
Kate Lampard	Self	Torry Hill chestnut fencing limited (Company number 07625860)	Shareholder	Shareholding	
Kate Lampard	Self	Torry Hill farm partnership	Partner	Partnership Drawings	
Kate Lampard	Self	The Trinity Challenge (Company number 12756885)	Trustee	Not renumerated	Ceased to be a trustee in Nov 2021

Individual Official	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Andrew Brittain	Self	Britannia Care Homes (Sussex) Ltd (Company number 03136449)	Company Secretary	Shareholding	Company Secretary of family company renting three rental houses (previously a rest home business which ceased trading in 2015). No dealings with DHSC. Exited this role on 1 Aug 2022.
Chris Whitty	Self	Gresham College	Professor of Physics	Stipend	
Chris Whitty	Self	London School of Hygiene & Tropical Medicine	Honorary Professor	No remuneration	
Chris Whitty	Self	Pembroke College, Oxford	Honorary Fellow	No remuneration	
Chris Whitty	Self	Sightsavers (Royal Commonwealth Society for the Blind)	Trustee	No remuneration	
Chris Whitty	Self	University College London Hospitals	Hon. Consultant Physician	No remuneration	
Chris Whitty	Self	Wellcome Malawi Unit	International Advisory Board	No remuneration	
Chris Whitty	Self	UKHSA	Hon Consultant National Fever Service	No remuneration	
Chris Whitty	Brother	SMITH WHITTY INTERNATIONAL CONSULTANTS LIMITED (Company number 06299058)	Director	Director	
Jenny Richardson	Partner	Medicines & Healthcare products Regulatory Agency	Chief Operating Officer	Salary	
Jenny Richardson	Partner	JUNGLE CROWS FOUNDATION UK (09446137)	Trustee		

Individual Official	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Jonathan Marron	Self	Institute of Lifecourse Development, University of Greenwich	Advisory Board Member	Non-Exec member, Unpaid	
Lucy Chappell	Self	King's College London	Professor of Obstetrics (part-time)	Paid role	
Lucy Chappell	Self	Guy's and St Thomas' NHS Foundation Trust	Honorary consultant obstetrician (part-time)	Paid role	
Matthew Style	Partner	Blood Cancer UK	Chief Executive	Employment	
Michelle Dyson	Self	World Jewish Relief (charity)	Sits on the committee which allocates funds	N/A as a Charity	Most of its £6m pa funding is donor raised but some from FCDO/HO
Michelle Dyson	Brother	Healthcare team at Apax Partners.	Partner	Share of profits	All 4 companies sell medical products or services globally and the NHS is, in some cases, a customer. He is a Partner at the private equity firm Apax Partners. Funds advised by Apax Partners LLP own majority control of all 4 companies listed. He has a small financial interest in the Funds, and therefore an indirect interest in each of the companies listed.
Michelle Dyson	Brother	Vyaire Holding Company	Non-executive Director/ Chairman	Indirect shareholding in each company	
Michelle Dyson	Brother	Rodenstock GmbH	Non-executive Director/ Chairman	Indirect shareholding in each company	
Michelle Dyson	Brother	Healthium Medtech Limited	Non-executive Director/ Chairman	Indirect shareholding in each company	
Michelle Dyson	Brother	Candela Medical, Inc.	Non-executive Director/ Chairman	Indirect shareholding in each company	

Individual Official	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Michelle Dyson	Brother	Advantage Programme – a programme part of West Ham Foundation - (WEST HAM UNITED FOUNDATION)	Chairman	No interest beyond position	Advantage is a mental health charitable programme which partners with the NHS and football clubs (CCOs) to deliver mental health mentoring for young people. West Ham Foundation received a grant of £125k for 2022/23 from NHS NE London to deliver services.
Shona Dunn	Partner	Thales UK	Tax Advisor		
Shona Dunn	Self	Alderbrook Primary school Wandsworth	School Governor		
Shona Dunn	Brother in Law	Repvit UK LTD (Company Number 13369246)	Director		
Chris Wormald	Self	Bennett Institute for Public Policy, University of Cambridge	Member of the Advisory Council	Unpaid	
Chris Wormald	Self	Economic and Social Research Council	Member	Unpaid	
Chris Wormald	Self	Step Up to Serve	Member of the Advisory Council	Unpaid	
Chris Wormald	Self	Nuffield College, University of Oxford	Visiting Fellow	Accomm' and dining	
Chris Wormald	Brother	Corpus Christi College, Oxford	Academic and member of the Medical Sciences Division Undergraduate Studies Committee and Education Policy and Standards Committee.	Salary	
Chris Wormald	Sister in Law	Salesforce	Consultant	Salary	

Individual Official	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Clara Swinson	Partner	Cazoo ltd	Chief Technology Officer	Salary and Shareholding	
Clara Swinson	Partner	Unbiased EC1 ltd (Company number 07504263)	Non-Executive Director	Salary and Shareholding	
Clara Swinson	Partner	Brandlehow Primary School	Governor	Unpaid	
David Williams	Partner	East Sussex Healthcare NHS Trust	AfC NHS employee	Salary	
Lorraine Jackson	Brother	Lincolnshire Partnership NHS Foundation Trust	Non-Executive Director		Ceased 31 July 2021
Matthew Gould	Self	Phico Therapeutics Ltd, (Company number 04062313)	None	Shareholding	Hold 3,151 ordinary 0.1p shares
Matthew Gould	Self	F2G Ltd (company number 03578625)	None	Shareholding	Hold 19,170 ordinary 0.1p shares
Matthew Gould	Self	Endocrine Pharmaceuticals (Company number 03005721)	None	Shareholding	Hold 400 ordinary 0.1p shares
Matthew Gould	Self	Seneca Growth Capital VCT (Company number 04221489)	None	Shareholding	Hold 5,000 ordinary 0.50p shares Hygea VCT was formerly known as BioScience VCT
Matthew Gould	Self	University of Leeds	Visiting Professor of Cyber Security Policy	Unpaid	
Matthew Gould	Self	OncoProbe (Company number 03733856)	None	Shareholding	Hold 74 ordinary 1p shares
Matthew Gould	Brother	Locum's Nest (company number 09976456)	Formerly interim Chief Financial Officer		He is interim CFO of Locum's Nest, a company providing technology services to the NHS, in a consultancy capacity.

Individual Official	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Matthew Gould	Self	Early Detection of Neurodegenerative Diseases (EDON) Initiative, led by Alzheimer's Research UK, charity no 1077089	Non-Executive Board Member	Unpaid	
Matthew Gould	Self	The Royal Air Force	Non-Executive Board Member	Unpaid	
Matthew Gould	Brother	LAWRENCE GOULD CONSULTANCY LTD (Company number 08277071)	Director		
Matthew Gould	Brother	11 ALDERBROOK ROAD MANAGEMENT CO. LTD (Company number 03859637)	Director		
Matthew Gould	Brother	RCV ENGINES LIMITED (Company number 03338081)	Director		
Matthew Gould	Brother	THE ONE TO ONE CHILDREN'S FUND (Company number 04145357)	Director		
Matthew Gould	Brother	HOOLVALE PROPERTIES LIMITED (Company number 04112214)	Director		
Matthew Gould	Brother	OPINIONPANEL LIMITED (Company number 05013113)	Director		Ceased Directorship in April 2021
Lee McDonough	Nil Return				

Individual Official	Interest held by	Name and Number of Company	Position held within the company	Type of interest (salary, fees or shareholding for example)	Any other relevant information
Hugh Harris	Nil Return				
Steve Oldfield	Self	Gosden House School	Member of Board of Governors	Unpaid	
Steve Oldfield	Self	Healthcare UK	Member of AdvisoryBoard	Unpaid	Joint initiative with NHSE and DIT. Membership of the Advisory Board expired in March 2021
Steve Oldfield	Self	Sanofi	Shareholder	Shares granted as part of previous employment	All remaining shares were disposed of in May 2021
Steve Oldfield	Self	Total Oil & Gas		Minor Shareholding	
Steve Oldfield	Self	Proctor & Gamble		Minor Shareholding	
Steve Oldfield	Self	Safecast		Minor Shareholding	

Non-Executive Board Members' Interests

530. A register of interests is maintained by the Department which covers non-executive members. This ensures that any perceived or real conflicts of interest can be identified. This register is updated annually and when relevant changes occur.

Declaration of Interests

531. The Department has reviewed its code of conduct policies, processes and guidance in light of new Cabinet Office guidance in this area shared with departments in Summer 2022, and on 23 November 2022 it published a new Declaration and Management of Outside Interests policy on its intranet, ensuring its guidance remains in line with best practice and the requirements of the Civil Service Management Code (section 4.3). This policy also reflects the new Cabinet Office requirement that asks departments to disclose the outside employment/work/appointment held by all members of the SCS in their Annual Reports and Accounts (ARA), in addition to providing staff with more comprehensive guidance on how to identify a potential conflict of interest.

532. A note was issued to all staff to accompany the launch of the new policy in the form of an intranet article and staff bulletin, reminding staff that it is a mandatory

requirement for all civil servants (including SCS) to declare any potential conflicts of interest as and when they arise (including any nil returns), and providing details of how staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication, and instructions on how to log declarations of interest on D365 (the Department's reporting system).

533. All DHSC staff are reminded of the policy and its requirements every six months and are asked to review whether any circumstances have changed in that time.

534. The Department is required to publish the relevant interests of its Permanent Secretaries, and other SCS who are Board members at least annually within its ARA alongside all Board member interests. As part of the new requirement from Cabinet Office set in Summer 2022, moving forward any outside employment, work, or appointment (paid or otherwise remunerated) held by a member of the SCS that has been agreed through the process for the declaration and management of outside interests should also be published in the ARA (this does not include voluntary roles). This will take effect after the publication of updated policy guidance in November 2022.

535. Applications made under the Business Appointment Rules are discussed on a quarterly basis at the Department's Audit and Risk Committee, with advice published on gov.uk.

Declaration of Non-Executive Director Interests

536. The Department ensures that all Non-Executive Director (NED) interests are reviewed and recorded at least annually. The NEDs have been reminded of the importance of declaring any perceived or real conflicts of interest to the Department and they provide in-year updates as necessary.

Declaration of Special Advisor Interests

537. Special advisers in the Department declare interests to the Permanent Secretary, in line with the Declaration of Interests policy. The personal information which special advisers disclose to the Permanent Secretary is treated in confidence.

538. All special advisers in DHSC have submitted a completed declaration of interests form, including nil returns in instances where there was no actual, potential, or perceived conflict of interest. The Permanent Secretary has considered these returns and there are no relevant interests to be published.

539. Where relevant to the role, and to help manage a perception of conflict or to explain how a conflict is being managed, interests will be published on an annual basis in the relevant Annual Report and Accounts. This provides a balance between transparency and privacy.

Business Appointment Rules

540. The Department continuously reviews business appointment rules (BAR) processes and guidance and is content that these are up to date and in line with best practice. We updated guidance, communications, and documents in 2020-21 to ensure that individuals have the information required to comply with the process. This has included expanding the stakeholders who are informed of any restrictions applied to individuals. The Department undertook a BAR review in June 2022 following new guidance issued by the Propriety and Ethics team in the Cabinet Office to all Government Departments. Managers are now required to discuss BAR with leavers before departure and, before new appointments are made, BAR is referenced in onboarding offer letters to prompt questions and increase understanding from the outset. For existing staff, the Department is publishing 'reminder' information which draws attention to Business Appointment Rules and is available to all staff on the intranet.

541. Individuals are informed of their responsibilities under BAR. Information is included in individual offer letters, contracts and leavers letters. The policy is available for Department employees to view on the intranet and SCS staff are also reminded of BAR rules 6 and 12 months after leaving the Department.

542. In compliance with BAR, the Department is transparent in the advice given to individual applications for senior staff, including special advisers. Advice provided regarding business appointments can be found on gov.uk on the Department's collection page for business appointment rules advice.

543. Under the application of Business Appointment Rules (BAR) to civil servants (including special advisors) leaving Crown Service in the Department, the number of exits from Crown Service (civil servants and special advisers) in the past year was 641. This figure excludes individuals who have transferred to other government departments, returned to other government departments after loan periods or returned to private organisations after secondment periods.

544. BAR rules apply to all civil servants who leave the Civil Service. However, it is an individual's responsibility to follow BAR policy and procedures. The Department set BAR conditions for 8 individuals in the past year. No enforcement action was taken by the Department with regard to breaches of the Rules in the preceding year. The Department's policy is that employees have the responsibility to submit BAR applications either before or after their departure from the Department. For delegated grades, the rules apply for one year post departure and for SCS the rules apply for two years. Individuals are required to submit BAR applications to their line manager prior to them accepting an outside appointment. Line managers are required to review this information and provide advice on any concerns, issues or associated risks. They should also confirm that the information provided is accurate, add any further detail they feel is relevant and suggest conditions to be set. HR Operations review the application and confirm that enough detail has been provided for consideration. For SCS3 applications, the HR

Director reviews and sets conditions and these are then forwarded to ACOBA to confirm the conditions. For SCS1 and SCS2 applications, the HR Director reviews the application and applies conditions. For delegated grades, HR Deputy Directors review the applications and set conditions. To ensure consistency is applied to each application submitted, previous applications and decisions are taken into account and for staff below SCS3 level the Department writes to individuals confirming the conditions set.

545. The Department implements and monitors BARs applications across all grades and increases BAR awareness amongst employees by informing all new starters and leavers of their obligations under the BAR within employment contracts. Full guidance is also published on the Departmental intranet. Additionally, leavers letters are issued to all leavers from the Department. These letters include information on their obligations under the BAR after they leave the Crown Service. The Line Manager's checklist for leavers includes a request for managers to discuss BAR on departure. DHSC also sends notifications to any SCS leavers at both 6 and 12 months after their leaving date, reminding them of their duty under the BAR in addition to information provided in their employment contracts, the Departments published policy and leavers' letters to all employees.

Governance Statement

General Governance

546. This section includes areas of the Department's core governance where decisions are made about the key risks and challenges faced by the Department. The below includes an overview of the major boards and committees within the Department, the nature of their operations, and key decisions on risk assurance made throughout the year.

Statement of Principal Accounting Officer's Responsibilities

547. Under the Government Resources and Accounts Act 2000 (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 of, and the use of resources during the year by the Department (inclusive of its executive agencies, Public Health England and UKHSA) 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 2021 no.1441 (together known as the 'Departmental Group', consisting of the Department and sponsored bodies listed at **Note 21** to the accounts).

548. 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.

549. 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.

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

551. As of March 2020, the Department has had a Second Permanent Secretary as an additional Accounting Officer. The Second Permanent Secretary will assume responsibilities of the Principal Accounting Officer should they be unavailable. The role was initially created to address the operational pressures that have arisen through the Department's COVID-19 pandemic response. The appointment does not detract from the Permanent Secretary's overall responsibility as Principal Accounting Officer for the Department's accounts.

552. 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.

553. 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 published by HM Treasury.

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

555. 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.

556. 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.

Scope of Responsibility

557. 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 2021-2022 and is current up to the date this Annual Report was signed.

558. 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 for central government departments, published by HM Treasury and the Cabinet Office.

559. The Head of Internal Audit's opinion is that they can give limited assurance to the Department's Principal Accounting Officer in relation to the 2021-22 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. Further detail regarding the audit opinion is provided from **page 251.** No concerns have been raised about the quality of information received by the Board or its sub-committees.

560. 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.

561. 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.

562. 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

563. The Departmental Board chaired by the Secretary of State brings together Ministerial and Civil Service leadership with Non-Executive Directors from outside Government who provide independent support and challenge.

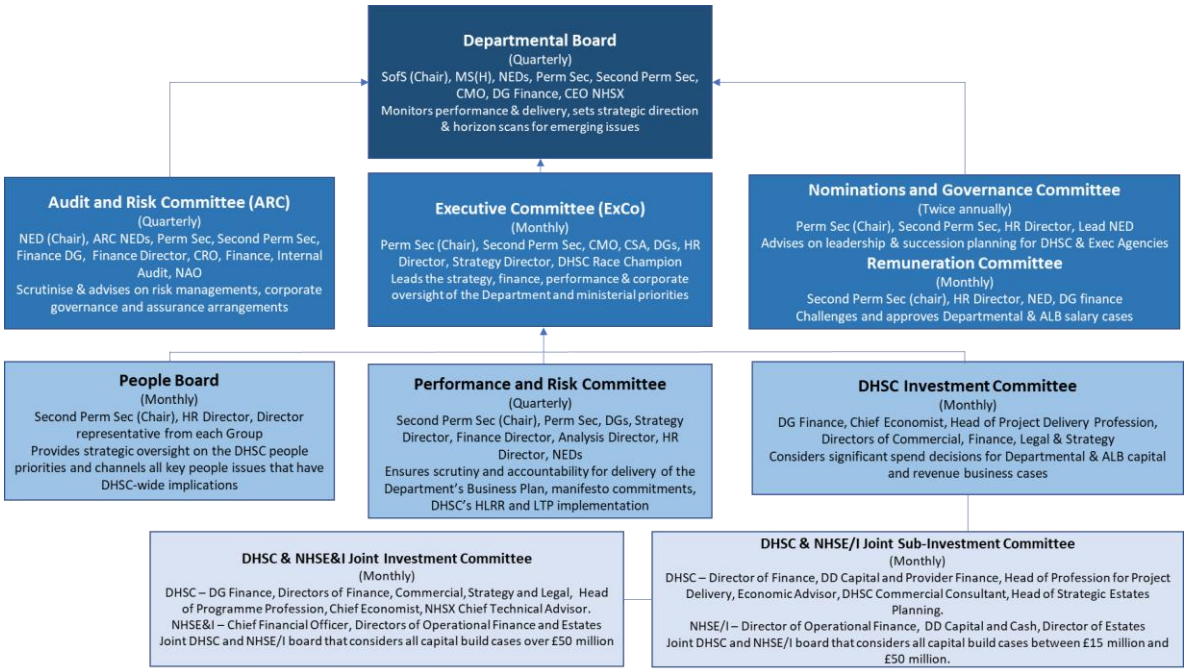
564. The Departmental Board meets on a quarterly basis. The Board met on four occasions during the 2021-22 financial year. Full membership and attendance are outlined in the **Directors' Report**.

565. The Board provides the collective strategic and operational leadership of the Department of Health and Social Care, and 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;
- 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.

566. The Board has responsibility for monitoring performance against objectives and key metrics, including corporate metrics and risks. Discussions have also focused on finance and performance. Board meetings focused on the Department's performance, the continued response to the COVID-19 pandemic and winter preparedness. The past year also saw the appointment of a new Secretary of State for Health and Social Care and new Departmental ministers. The Board devoted attention to the progression of their ambitions and plans for post pandemic recovery, and their vision for the reform of the health and social care system. Individually and collectively, Non-Executive Directors have also participated in deep-dive sessions on various aspects of the Department's work including Adult Social Care, Personal Protective Equipment (PPE) and the COVID-19 vaccine programme.

567. The Departmental Board is supported by the committees shown in the structure chart at **Figure 35.**

Figure 35: Departmental Board Structure



568. The Executive Committee oversees strategy, finance, performance and corporate issues in the Department. It reports to the Departmental Board quarterly, including reports from various sub-committees. Issues discussed at the Executive Committee in 2021-22 included: COVID-19, Supporting the Union, Cyber Risks in the Health and Care System, UK as a Science Superpower, Pandemic Inquiry Preparations, Public Health Reform, Locations Strategy, Spending Review 2021 (preparations, implications, outcomes), Diversity and Inclusion and Omicron. The Committee met eleven times during the reporting year.

569. 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 are 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 twelve times in the year.

570. 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 UKHSA and MHRA, and a

discussion on their talent management and development. The Committee met twice in the reporting year.

571. 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 group bodies and reviews the comprehensiveness of assurances and integrity of financial statements. 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. In 2021-22 there were deep dive discussions on NHSX transition governance, NHS BSA, Social Care, the response to COVID-19 and the COVID-19 Inquiry led by Baroness Hallett; personal protective equipment (PPE) finance and the New Hospitals Programme (NHP). The Committee met four times during 2021-22.

572. The Performance and Risk Committee (PRC) exists to oversee departmental performance and management of the Department's high-level risks. By making a regular assessment of the Department's performance and risks to delivery, the PRC ensures that the Departmental Board and the Executive Committee are supported and held to account for the delivery of the business plan/Outcome Delivery Plan (ODP). The PRC met four times during the year and discussions focussed on achievements and concerns; overall progress towards objectives, milestones and manifesto commitments; and key risks to performance.

573. **Table 24** summarises attendance at the Departmental Board and the four next-tier committees.

Table 24: Committee Attendance

Name of Board or Committee member [1,2]	Departmental Board Met 4 times	Executive Committee [3] Met 11 times	Audit and Risk Committee Met 4 times	Nominations and Governance Committee Met 2 times	Remuneration Committee [4] Met 12 times
Ministers					
Rt Hon Matt Hancock MP [5]	1 (out of 1)	-	-	-	-
Rt Hon Sajid Javid MP [6]	3 (out of 3)	-	-	-	-
Edward Argar MP [7]	3 (out of 4)	-	-	-	-
Officials					
Sir Chris Wormald	4	10	-	2	-
Professor Sir Chris Whitty	3	11	-	-	-
David Williams [8]	-	-	-	-	-
Shona Dunn	4	10	4	2	12
Clara Swinson	-	11	-	-	-
Jonathan Marron	-	11	-	-	-
Lee McDonough [9]	-	2 (out of 2)	-	-	2 (out of 2)
Steve Oldfield [10]	-	5 (out of 8)	-	-	-
Professor Lucy Chappell [11]	-	6 (out of 7)	-	-	-
Matthew Gould	4	9	-	-	-
Michelle Dyson	-	11	-	-	-
Andy Brittain	3 (out of 3)	10	4	-	11
Matthew Style [12]	-	6 (out of 6)	-	-	5 (out of 5)
Jenny Richardson	-	9	-	2	8
Lorraine Jackson [13]	-	9 (out of 9)	-	-	-
Hugh Harris	-	10	-	-	-
Dame June Raine [14]	-	1 (out of 2)	-	-	-
Dame Jenny Harries [14]	-	2 (out of 2)	-	-	-
Non-Executive Directors					
Kate Lampard	4	-	-	2	-
Gina Coladangelo [15]	1 (out of 1)	-	-	-	-
Doug Gurr	2 (out of 4)	-	-	-	3
Sir Julian Hartley [16]	2 (out of 2)	1 (out of 1)	-	-	-
Gerry Murphy	4	-	4	2	9
Independent Members					
Anne Barnard	-	-	4	-	-
Graham Clarke	-	-	4	-	-
Richard Hornby	-	-	4	-	-

1. Table represents Committee members attendance only. To note, other officers' attendance is not recorded within the table.
2. Where a number appears in brackets, this is the maximum number of meetings a member could have attended.
3. Where a Director General could not attend, a deputy attended on their behalf.
4. Attendance of the Remuneration Committee is shared amongst our Non-Executive Directors.
5. Matthew Hancock resigned as Secretary of State in June 2021.
6. Sajid Javid was appointed as Secretary of State in June 2021. He resigned this position on 6 July 2022.
7. Edward Argar resigned as Minister of State on 6 July 2022.

8. David Williams left the Department on 1 April 2021 upon his appointment as Permanent Secretary in the Ministry of Defence. He did not attend any Departmental meetings in 2021-22.
9. Lee McDonough left the Department in May 2021.
10. Steve Oldfield commenced a career break in January 2022 and left the Department on 17 October 2022.
11. Professor Lucy Chappell joined the Department in August 2021.
12. Matthew Style joined the Department in November 2021 but attended Executive Committee meetings since October 2021.
13. Lorraine Jackson was appointed to the Executive Committee in June 2021.
14. Dame June Raine and Dame Jenny Harries both attended two Executive Committee meetings (September and November 2021).
15. Gina Coladangelo resigned as a non-executive director in June 2021.
16. Julian Hartley was appointed as a non-executive director on 1 November 2021. He attended the Executive Committee meeting in March 2022.

Core Assurance Framework, Risk Management and Control

574. 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.

Major Projects

575. The Portfolio Management Office tracks the delivery of all DHSC's major programmes on the Government Major Projects Portfolio (GMPP), working closely with the Infrastructure and Projects Authority (IPA). The Department's Audit and Risk Committee has a standing agenda item on major project delivery, with quarterly delivery reports through the GMPP process.

576. New additions in the reporting year have been the Frontline Digitisation, Supporting People at Home and (Electronic Staff Record) ESR Transformation Programmes, with one programme on National Proton Beam Therapy being removed from the portfolio as it has delivered. Over the year there has been a reset in the Major Projects Portfolio in the Department, with a discussion at the Executive Committee on the delivery of the portfolio function and Project Delivery more broadly in Health and Care including establishment of a dedicated governance forum. The Head of Project Delivery Profession has re-established the Steering Group with Profession Heads across our Arm's Length Bodies with the IPA playing a key part.

577. The DHSC Investment Committee meets at least once a month to consider capital and revenue business cases from within DHSC and its ALBs that are 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 35** 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, which consider NHS Trust and Foundation Trust business cases over delegated limits, with both committee's meeting on a monthly basis also.

Three lines of defence

578. 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.

579. At the second line, our Governance includes the Performance and Risk 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 Departmental business plan objectives with its most recent assessment of the top risks it faces.

580. The third line of defence comprises the oversight provided by the Departmental Board, which includes independent Non-Executive Directors and 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 2021-22 and reviews and discusses the Department's risk register as a standing agenda item at these meetings.

581. Through this scrutiny the ARC 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.

Arm's Length Bodies and Delivery Partners

582. Our Arm's Length Bodies (ALBs) and delivery partner organisations 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 public value most;
- regulating the health and care system and workforce;
- establishing national standards and protecting patients and the public;
- providing central services to the NHS; and
- responding to COVID-19 by providing essential services and/or health guidance.

583. Our ALBs, listed in **Annex F**, fall into several distinct types:
    - Executive Agencies. Legally part of DHSC but with greater operational independence.
    - 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.
    - Special Health Authorities (SpHAs). These are 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.

584. The Department (DHSC) currently has two Executive Agencies: UK Health Security Agency (UKHSA) and the Medicines and Healthcare products Regulatory Agency (MHRA), which are legally part of the Department but have greater operational independence.

585. UKHSA was formed on 1 April 2021. It brought together functions from Public Health England (PHE), NHS Test and Trace and the Joint Biosecurity Centre. PHE continued to deliver its existing functions until UKHSA took full operational responsibility from October 2021.

586. The Office for National Statistics has now re-categorised MHRA as falling within the Departmental Group, therefore it was incorporated into the Department's accounting boundary from 1 April 2022.

587. Our Permanent Secretary is the Principal Accounting Officer for the Departmental Group which as of 31 March 2022 consisted of:
    - Nine ENDPBs (including NHS England and its 106 Clinical Commissioning Groups (CCGs);
    - Four SpHAs;
    - Eight other bodies (including companies);
    - 144 NHS Foundation Trusts (FTs);
    - 69 NHS Trusts (NHSTs);
    - and NHS charities.

588. 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.

589. 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.

590. The objectives and deliverables of the Department's ALBs are set through their annual business planning process. The Department uses ALB mandates, remit letters and business plans to hold its ALBs to account.

591. 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.

592. The reporting year's annual Board Effectiveness Evaluation was led by the Department's lead Non-Executive Board member, Kate Lampard. The evaluation reflected on progress made in the reporting year and the evaluation identified the Board as 'functioning well'.

593. Going forward, there is an opportunity to increase the visibility of the Board across the Department and to continue build on progress to increase the oversight that the Board has of Departmental ALBs.

Managing Risk

594. The Performance and Risk Committee (PRC) exercises governance of risk management for the Department by making a regular assessment of performance and risk to help ensure that ministers, the Departmental Board, and Executive Committee (ExCo) are supported in driving delivery of their objectives. PRC helps ensure the Department takes a joined-up view of its performance and risks so that issues which adversely affect our activities may be identified and tackled. It discusses issues which present significant and/or increasing risks following its Risk Management Framework and discusses major core business issues, concerns around significant ALB risks or performance, and SRO requests for strategic guidance in supporting a major change project. In doing this, PRC makes decisions on what issues or risks require further investigation or assurances. The PRC Chair provides a continuous line of sight between PRC and ExCo, which has delegated responsibility to PRC to ensure scrutiny and accountability for delivering the Department's Business Plan.

595. The systems of internal control for identifying, evaluating and managing risks have been in place for the full year under review. The Department's Director of Strategy undertakes the role of Chief Risk Officer (CRO). 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 has supported our understanding of our risk exposure and the cross-cutting nature of risks across the system.

596. The Department also has a risk escalation process in place to monitor emerging interdependent risks from other parts of the health system and the risk team engages with ALBs in regular forums where risk is discussed in the round.

597. DHSC manages a wide portfolio of risks. Our most severe risks are monitored by our Performance and Risk Committee and Audit and Risk Committee. Below these committees, risks are managed locally by senior civil servants at programme or project level. Risks from the wider DHSC family of arm's length bodies are also managed by DHSC sponsor teams and escalated as required.

598. At strategic level DHSC manages a number of different risks across the health and social care landscape. Significant risks actively managed by the Department during 2021-22 have included:

External risks

- the health and care system's resilience to cyber-attack – see 'Data Issues – Cyber Security Programme'on **page 185**;
- 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; and,
- continuity of supply of medicines and medical products – See 'Vaccines and Treatments, Research and Deployment' on **Page 12**.

System-wide risks

- the risk of demand for NHS services growing beyond that assumed in the Long Term Plan;
- financial and commercial controls and capability;
- 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;
- failure to hold partners' organisations to account to deliver our key objectives; and,
- the sustainability of the adult social care system – See 'Social Care Resilience' on **page 12**.

Change-based risks

- the risk that the Department's workforce has insufficient capacity and/or capability to provide a quality service – see 'DHSC Contract Management' on **page 175**.

599. Some of the key activities in mitigating these risks are set out in the **Performance Report** as shown above. 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.

600. 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.

601. In 2021-22 the Directors General (DGs) participated in the quarterly Performance and Risk Reporting and Bi-annual Assurance Meeting (BAM) process. For DG groups where meetings have not taken place, full BAM reports have been shared with senior staff.

602. The BAM reports are part of the Department's system of control and have contributed to ensuring that where issues have arisen during the year that these are appropriately reported and discussed. The process also contributes to the oversight of the arrangements in place to address identified weaknesses and drive improvement. The internal audit opinion detailed below along with the recommendations made, confirms that improvements can be made to this process to enhance its effectiveness.

Better Regulation

603. The Department is committed to the use of better regulation principles 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.

604. The Department continues to promote the use of alternative approaches to regulation where appropriate. We measure our progress in achieving the aims and objectives as set out in Better Regulation framework and its core principles through our regular interaction with policy teams and our key stakeholders such as the Regulatory Policy Committee (RPC). We also promote learning and

development opportunities to staff to further build on the Department's wider understanding of how they should approach regulatory policy, highlighting the importance of consideration to alternative options to regulation where appropriate. The Department monitors its regulatory policies and reports annually to The Department for Business, Energy and Industrial Strategy (BEIS) on qualifying regulatory measures for the annual business impact target report.

605. Where regulation is required the Department's Better Regulation Unit (BRU) works closely with teams to consider how best to develop proportionate and targeted, regulatory solutions through the development of policy.

606. The Department has been contributing to the ongoing cross-Whitehall regulatory reforms, including the EU exit opportunities being led by Cabinet Office.

607. We also continue to work closely with our key regulators to ensure their activity contributes to the provision of safe, effective, and compassionate care while, at the same time, minimising the burden of bureaucracy on the front line.

Climate Change Strategy

608. DHSC recognises that we must better understand and build resilience to the risks that climate change poses to the Department and, in line with the Greening Government Commitments, we are committed to developing a departmental climate change adaptation strategy (including a risk assessment and action plan) by 2025, and we will strive to complete this as soon as possible within that timeframe – more detail on this, and climate change adaptation work relating to health and social care itself, can be found in the Climate change adaptation section of the **Performance Report**, and in **Annex E 'Sustainable development'**.

Whistleblowing

609. The Department's whistleblowing policy has been in place since August 2015 and includes reporting biannually to the Cabinet Office on all whistleblowing concerns received. The policy is regularly reviewed, with the latest version revised and updated for April 2022.

610. 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 utilise if they have a whistleblowing concern and are uncertain how to address it.

611. The Department also has a Board-level Whistleblowing and Speak Out Champion. In the reporting period, this remained the Director General for Finance. A Grade 6 Deputy Champion was also appointed during the reporting year to support the Champion.

612. When a report of a whistleblowing concern is received, the Department conducts initial conversations to establish whether it falls under the whistleblowing policy. If a case of whistleblowing is established, the Department will investigate following the protocols outlined in the policy.

613. In 2021-22, fewer than five formal whistleblowing concerns were raised in DHSC. Figures of five or less whistleblowing concerns are not published to protect anonymity, but we can say that all cases have been investigated and the investigations have concluded.

614. During 2021-22, we completed an internal whistleblowing health check in line with Cabinet Office guidance. The process was an additional mechanism for the Department to assess whether it has effective processes in place to allow for whistleblowing concerns to be raised safely and a strong culture in place where its staff feel confident to speak-up. Whilst the Department is compliant with the guidance from Cabinet Office, we have identified some actions we could take to further improve.

615. DHSC has a programme of work and action plan on 'Safe to Challenge' which aims to develop a culture where staff feel safe to give and receive feedback and challenge at all levels. The Department's HR team continues to use a 'Safe to Challenge' scorecard to measure progress against the aims of the programme and identify hotspots and trends through data and insights. The scorecard is reviewed quarterly at the Department's People Board.

616. Over the course of 2021-22, the priority in this area has been to continue the focus on ensuring all staff are aware of the routes to raise concerns and feel supported to do so, including PHE staff joining OHID. This has included a focused 'Speak Up' week in September 2021, communications on reporting routes and support services, and a focus on giving and receiving feedback, through the use of events, training, toolkits and blogs.

617. The results of the 2021 People Survey in October 2021 showed that the percentage of people who felt able to speak up in the Department decreased slightly from 73% to 70% in the last 12 months. We have undertaken analysis to understand the reasons behind this and developed a plan of activity to improve in these areas.

618. The 'Safe to Challenge' agenda has also been incorporated into the Department's work on culture and values. In 2021-22, DHSC agreed a new set of Departmental values. Following extensive staff engagement, 'We Challenge' was agreed as one of the four new values, demonstrating our strong commitment to this agenda. This work is part of the Department's Shaping Our Future programme, which is governed by a board chaired by the Second Permanent Secretary.

619. A programme of work is being developed for 2022-23 to bring the values to life within the Department, including the development of a network of Culture and Engagement Champions across the Department, who will provide essential insights into departmental culture that can inform its approach to whistleblowing.

Financial and Audit Governance and Quality Assurance

620. This section includes a review of areas relating to financial and audit governance and quality assurance in the Department. Risk management, controls. and governance in the sections below are carried out by specialist professions and may be reviewed by the Government Internal Audit Agency (GIAA). This section includes a further update of the finance reset programme, which was established in 2020-21, to improve the controls and assurance framework and enable strong and sustainable financial management across the Department.

Role of Internal Audit

621. 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).

622. 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;
- evaluating the design and effectiveness of Departmental processes in achieving business objectives;
- 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.

623. 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.

624. 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.

625. 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

626. In considering the overall adequacy and effectiveness of the Department's framework of governance, risk management and control in 2021-22, the Head of Internal Audit has provided a 'Limited' audit opinion. This rating is consistent with the previous year when significant weaknesses in the framework were identified such that it could be, or could become, inadequate and ineffective. In the reporting year, it was observed that 'there is a positive direction of travel towards a more robust framework'.

627. It was noted that the senior management team have demonstrated real commitment to delivery of actions to strengthen the framework of risk control and governance in what has still been a challenging, fast paced, and changing operating environment. The Head of Internal Audit reported that 'the Department's Shaping Our Future Programme and other related improvement activity is beginning to address weaknesses previously identified' and that 'Further planned action over the coming year should ensure controls over core systems and processes are in place and properly assured and that improved and embedded risk management arrangements are operating across the Department'.

628. In her opinion report, the Head of Internal Audit acknowledged that some key Shaping our Future milestones have been met in year:
    - She cited the fact that the organisation's vision has been reset, and that refreshed strategic objectives have been agreed and appropriately communicated. It was confirmed that this activity goes a long way to address one of the improvements points made in her 2020-21 opinion report i.e., to take action so that there is a more balanced focus regarding responding to the pandemic whilst also delivering agreed objectives per government priorities;
    - She reported that a second improvement point regarding strengthening of governance arrangements by bringing together battle plan and business as usual governance and having a stronger focus on performance metrics had been initiated towards the end of 2020-21, and activity has continued, partly within the Organisational Design Work Strand within the Shaping our Future Programme. She noted the incremental changes and improvements being made e.g., reshaping of the information presented to the Performance and Risk Committee;
    - Regarding getting the basics right through improving compliance with key controls by having better guidance and training and solid lines of defence, the Head of Audit advised that two elements: the 'Ways of working – How we Work' strand, and the 'Capability, Systems and Processes - improving corporate services and governance' strand, are particularly key. These are focused on resetting controls and disciplines in all key areas (including HR, finance and procurement) and refreshing staff understanding of their responsibilities. She stated that she could see that progress is being made here, particularly in

respect of the commercial reset work. Also, that discovery phases for the workstreams have been completed and groundwork has been put in but many of the key milestones fall into 2022-23.

629. The Head of Internal Audit observed that some of the planned improvement activity did take place over a longer timeframe than originally anticipated due, in part, to the pressure on the Department to respond to the impact of the Omicron variant in December 2021 and into the final quarter of the year. She advised that because of the timing of some of the improvement activity, a number of the issues contributing to her opinion of the previous year have remained, by example:

- Lack of key controls, ineffective controls or non-compliance with required controls is something that the audit team has seen within a number of audits in year particularly those within Finance and HR. It was recognised that activity to strengthen the control environment continues through e.g., the production of guidance; delivery of training as well as conducting 1st and 2nd line checks to gain comfort that processes are working as intended. She reported that she can see that concerted effort in some areas is paying off e.g., the improvement in the process for the publication of contract awards but that the team noted other areas where non-compliance is still occurring e.g., offboarding, IR35 and per the audit of the new enterprise resource planning system D365 (focused on finance, HR and procurement);
- There has been greater emphasis on risk management during the reporting year particularly at strategic level, and she judged that the Department has moved from being 'risk aware' to 'risk defined'. This is a very positive direction of travel, but the Head of Audit view was that the Department does not have a strong organisational risk management culture and has work to do before it can be assessed as 'risk enabled'. The 'bottom up' view of organisational risk still lacks rigour and is inconsistent in its insight. Practises and processes have not been embraced by all and are not mature and embedded. The audit team are still finding areas in the business where there is limited formal consideration of risks faced. Ineffective application of risk management was also identified across a number of reviews in year;
- The Department lacks an effective assurance framework and map. The Head of Audit advised that development of this would provide a mechanism for objectively evaluating and linking assurances from various sources to the risks that threaten the achievement of the Department's outcomes and objectives. This should give clarity to where lines of defence checks should operate and who is undertaking them. Audit work in year highlighted two areas in particular where review and refresh of defence lines is needed, namely in respect of people (HR) and finance processes;
- The number of overdue actions has been decreasing but attention is still needed to clear those remaining in order to limit risk exposure.

630. The Head of Internal Audit drew two emerging themes to management attention in her opinion report:

- Programme and Portfolio Management is an area which requires better oversight and maturity of operation. She acknowledged that this has been recognised by the Department and the PPM Team is being strengthened to address governance, risk and control weaknesses and that some improvements are starting to come to fruition;
- Governance arrangements over certain Departmental initiatives could be strengthened so that Boards deliver effectively per business objectives. On occasion she also observed that they could deliver much more effectively if a culture of true collaborative working was fostered with key stakeholders.

Finance Reset Transformation Programme

631. We reported in the Department's 2020-21 Annual Report and Accounts that a finance reset programme had been initiated to improve the controls and assurance framework and enable strong and sustainable financial management. A core part of the programme has been putting in place a proportionate, risk-based framework that ensures the Department has a robust internal control environment and one which provides assurance over areas of spend subject to external controls and other spending proposals to maximise value for money.

632. A Programme Board was set up to have oversight of the transformation programme and meets regularly to monitor progress towards the objectives. Independent members of the Board include representatives from HM Treasury and a DHSC non-executive board member as well as senior membership from the Department.

633. The programme has five key work packages: process and controls to optimise financial and business planning and performance; forecasting, management information and data to improve the ways in which information is managed and reported to support effective strategic decision-making; finance operating systems to establish better systems to govern and manage processes ensuring high-quality data; capability building within the organisation to enable our people to have the right skills strengthening the performance of the finance function; and developing a new finance structure that better meets the needs of the organisation.

634. The programme is progressing well and over the reporting year made significant improvements to the financial management and control framework through these work packages. New standard processes to improve efficiency and controls within our purchase to pay processes have been introduced in addition to implementing updated financial delegations across the Department and our arm's length bodies. The business case approvals framework has been redeveloped supported by new guidance for business case owners. New reporting tools have been introduced to enable greater scrutiny by budget holders along with new mandatory training aimed at increasing awareness and understanding of their responsibilities as budget holders to safeguard financial management and value for money.

635. The finance reset transformation continues and during 2022-23 will transition to focus as a programme of continual improvement to drive further enhancement and embed the new developments and progress made since its inception. Key performance indicators are being established under each work package to monitor and evaluate performance and identify areas that are falling short. More is being done to consolidate transactional roles within Finance Operations to build additional value added.

636. A key feature going forward is implementing a new finance directorate system delivery model which will restructure the function to increase resources focused on governance, control, and risk management. The Department has seen considerable change in the way it operates and need to deliver since the pandemic and a new finance structure will better meet the new demands on the organisation.

Quality Assurance of analysis and models

637. 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. The Department operates in line with HM Treasury guidance in the Aqua book and the recommendations of the Review of quality assurance of Government analytical models published in 2013.

638. During 2021-22, the Department has continued to raise awareness of, and improve, the training and materials available to officials engaged in analytical work. This helps maintain systematic processes to regularly update our list of business-critical models and to ensure that risks are identified, managed, and escalated as necessary.

639. The Department has strengthened its participation in cross-departmental quality assurance (QA) activities including the QA Working Group. During Q3, we participated in a pilot of the Analytical Quality Stamp (AQS) with the 10 Downing Street Data Science Unit (10DS) and Cabinet Office. Developed in consultation with the Analysis Function and the Office of National Statistics (ONS), the Stamp is intended to increase the transparency and accountability of the analyses which support decision making within Government.

640. There have been significant changes to the structure of the analytical community in the Department during 2021-22, most notably the creation of the Office for Health Improvement and Disparities (OHID). We are working across the organisation to ensure that our QA framework is embedded consistently within new units to maintain and promote high standards of quality assurance and analytical rigour.

National Audit Office and Public Accounts Committee

641. As the UK's independent public spending Watchdog, the National Audit Office (NAO) does much more than audit the accounts of Departments and their

component bodies. The Comptroller and Auditor General (C&AG) has the statutory authority to examine and report to Parliament on whether Departments and the bodies they fund have used their resources efficiently, effectively and with economy.

642. Given the scale of the response to the pandemic across the public sector, the NAO have carried out a substantial programme of audit work in relation to COVID-19 activities. This work provides expert insight to help ensure that appropriate lessons are learned for the future. Given the centrality of the Department to the Government's response to COVID-19, a number of significant reports have been published covering the Department's activities through the pandemic. These have been invaluable in providing external scrutiny and recommendations to guide the Department's ongoing response to the pandemic.

643. **Table 25** provides a summary of the key reports published by the NAO in 2021-22, that reflect on activities of the Department

Table 25: Key NAO reports

Title of significant NAO report	Date of publication
Initial learning from the government's response to the COVID-19 pandemic	May 2021
Test and trace in England – progress update	June 2021
Investigation into supply chain finance in the NHS	October 2021
The government's preparedness for the COVID-19 pandemic: lessons for government on risk management	November 2021
NHS backlogs and waiting times in England	December 2021
The rollout of the COVID-19 vaccination programme in England	February 2022
Investigation into the government's contracts with Randox Laboratories Ltd	March 2022
Investigation into the management of PPE contracts	March 2022

644. The NAO seeks to confirm the factual accuracy and provide formal clearance of their reports with the Departmental Director General of Finance, Additional Accounting Officer (Second Permanent Secretary) and the Principal Accounting Officer (Permanent Secretary) where the Department is the primary client. Where the Department is a third-party client, the NAO seeks to confirm the factual accuracy of references to the Department with the Director General of Finance.

645. The Permanent Secretaries, Director General of Finance, and other senior officials give evidence to the Public Accounts Committee (PAC) by appearing at hearings in Parliament. They also have responsibility for approving the subsequent Treasury Minutes which is Government's response to the recommendations the PAC makes in its reports.

646. In 2021-22, DHSC attended eight PAC hearings, details of which can be found via the Committee's website. Updates on NAO and PAC activity are provided at DHSC's Audit and Risk Committee meetings.

Grant Payments to Non-Public Sector Bodies

647. 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.

648. 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.

Limitation of scope qualification regarding inventory

649. The C&AG has qualified his opinion in relation to existence, valuation, and completeness of consumables inventory held by the Core Department and Departmental Group at both 31 March 2021 and 31 March 2022. This limitation of scope opinion also covers the completeness and accuracy of related transactions. The inventory primarily relates to the PPE and NHS Test and Trace programmes.

650. The Department has physically observed the vast majority of its PPE inventory at some point in time, such as at the point inventory is transferred between shipping containers and storage facilities. However, logistical challenges and physical access limitations have again prevented full stock takes being carried out to support the current year-end inventory valuations which reduces the level of existence and completeness assurance available.

651. The Department intends to capitalise on the reduction in the PPE storage footprint which should allow greater levels of inventory to be subject to stock count, and the Department is committed to lifting the current qualification at the earliest opportunity.

652. NHS Test and Trace inventory at 31 March 2022 is held by UK Health and Security Agency and as such is subject to the disclaimed audit opinion in UKHSA's local Annual Report and Accounts and limitation of scope opinion in the Departmental ARA as described in paragraphs 719 to 726. The NHS Test and Trace programme spend has been significantly ramped down as a result of the Living with Covid strategy as announced in February 2022. This will lead to a natural reduction in the NHS Test and Trace inventory held. UKHSA are also committed to improving the control environment over inventory as part of the action plan referred to in paragraph 725. Some control environment improvements have already been made, such as controls over the recording of inventory consumption quantities have already been strengthened.

2020-21 limitation of scope in relation to accruals

653. In 2020-21, the C&AG limited the scope of his audit opinion in respect of the Other Accruals line of **Note 15** Trade Payables and other current liabilities for the Departmental Group.

654. This limitation of scope resulted from the aggregation of identified misstatements, projected most likely misstatements and areas of uncertainty where the NAO were unable to conclude on certain balances, and were a combination of classification issues and those affecting the bottom line. None of these factors were individually material to the Departmental Group but became material in aggregation.

655. No component entity accounts within the DHSC Group attracted similar limitations of scope, however a Group qualification was still possible as the DHSC Group materiality threshold is significantly below the sum of those of its Group components.

656. The limitation of scope was driven by a combination of factors. Some of these are control weaknesses and were therefore addressed in the 2020-21 Governance Statement. There were also other factors which were not control weaknesses, predominately that the Department was unable to conclude its accounts preparation process in sufficient time to allow it to provide sufficient evidence in all areas which led to assurance gaps and uncertainties.

657. As discussed in the Governance Statement in the Department's 2020-21 ARA, the Department, and specifically NHS England and the Core Department, put in place measures to improve related processes. These improvements and the lower balances relating to COVID-19 expenditure at 31 March 2022 have contributed to the lifting of the limitation of scope audit opinion in relation to accruals.

658. Whilst the audit qualification has been lifted over these balances in 2021-22, the Department will continue to improve processes and scrutiny, particularly over differences when intra-group transactions and balances between group bodies are eliminated upon consolidation (as described in Note 1.29).

2020-21 limitation of scope in relation to regularity due to fraud

659. In 2020-21, the Comptroller and Auditor General limited the scope of his audit opinion over the regularity of expenditure in respect of the risk of fraud losses. In combination with the NHS facing fraud estimate communicated in the Strategic Intelligence Assessment (which the Department considers below the materiality threshold), this was principally a direct consequence of the Department being unable to access, at any given point in time, personal protective equipment (PPE) inventory that was stored in sealed containers, this also being the cause of the related limitation of scope in respect of inventory existence.

660. In addition, due to the pace at which PPE inventory purchasing was stood up, the Department did not have a single integrated inventory management system that provided automated linkage between its purchasing records and the inventory present in the storage network on an order by order basis.

661. It is important to note that this accounts qualification conveyed a limitation to the scope of audit work that is possible. The limitation of scope from the regularity of expenditure qualification resulted from gaps in assurance management could provide. We do not believe there was actual material irregularity arising from fraud.

662. In relation to PPE purchasing, as more than two years have now passed since the majority of the PPE arrived, the Department has had the opportunity to conduct extensive checks to ensure it has not been the victim of fraud. These included reconciling overall purchasing records to inventory in the storage network to a high degree of accuracy, demonstrating that virtually all the inventory the Department ordered had arrived, and contract management activity and/or legal action is ongoing where this is not the case.

663. The Department has also quality checked a sample of all the PPE inventory received covering each distinct product. This includes those items stored in sealed containers, and whilst quality issues were identified in 2020-21, as reported in **Note 8** Impairments, these have been assessed and with minimal exception, are not considered indicative of fraud.

664. The vast majority of the inventory held in sealed containers has been physically observed at some point, mainly during the process of transferring the content of shipping containers into owned and rental containers, this process did not raise any fraud concerns. Robust physical security controls were also in operation throughout the transportation and storage processes to safeguard against theft.

665. In the Department's view, these factors give assurance that the possibility of significant levels of fraud existing in respect of PPE inventory purchasing is remote.

666. The Department's other COVID purchasing, for example that associated with NHS Test and Trace, is considered lower risk (more akin to the fraud risk associated with standard procurement), as products were either: generally purchased in areas with which the Department was familiar, from suppliers with considerable experience of supplying the goods and services purchased or from less complex supply chain arrangements. The Department now also has long standing relationships with many of its COVID suppliers, meaning there is a more established history of appropriate delivery under these contracts.

667. Additionally, in 2021-22, the level of COVID-19 purchasing in relation to PPE was significantly lower than the previous year. For 2021-22, the C&AG has removed the limitation of scope opinion in relation to regularity due to fraud.

COVID-19 Impairments and losses

668. During the height of the pandemic response the Department purchased large volumes of COVID-19 related inventory at pace and with a heightened risk appetite; most notably personal protective equipment (PPE), test and trace consumables, ventilators and other capital equipment, COVID-19 Medicines and COVID-19 Vaccines.

669. In preparing the Department's Annual Report and Accounts the Department is required to value its inventory at the lower of cost and net realisable value (NRV). The assessment of NRV for the Department's COVID-19 inventory is complex because most inventory is either used by the NHS or donated to entities outside the Departmental group rather than sold, and because the volume of some inventories held on 31 March 2022 suggest that, based on current usage, not all will be used before their expiry dates.

670. In addition, some inventory received has failed quality testing and/or technical assurance and is either categorised as not fit for any use or not fit for use within the PPE programme. The latter may be suitable for use in other settings but is not suitable for its original intended purpose. As such, from an accounting perspective, this inventory is deemed as being held for sale, donation, or disposal rather than use and must be valued accordingly.

671. In relation to the PPE programme impairments and provisions for impairment were made in 2020-21 in respect of inventory already received or included in non-cancellable contracts at 31 March 2021. As such there has been minimal change in the level of impairment recognised in expenditure in 2021-22 for the PPE programme.

672. During 2021-22 the Department has recognised additional impairments and onerous contract provisions in respect of:
- COVID-19 medicines and COVID-19 vaccines which are now expected to be surplus to requirements due to the reduction in prevalence and severity of COVID-19 and the development of new and improved vaccines used in preference to previous versions.
- Test and Trace impairments have increased due to the winding down of mass testing regimes towards the end of 2021-22 which has resulted in some testing materials now expected to be surplus to requirements.

673. Further details regarding the various instances for which losses have been recognised in the 2021-22 accounts, can be found in the **Losses Statement** in the **Parliamentary and Accountability Report**. Further detail regarding the various

instances in which impairments have been recognised can be found in **Notes 8 and 12 of the Department's Notes to the Annual Report and Accounts**.

Settlement of historical tax liabilities

674. During 2021-22, the Department settled IR35 tax and NIC liabilities with HM Revenue & Customs (HMRC). This payment followed a successful challenge by HMRC of a number of IR35 assessments completed by the Department. The challenge related to a subjective point which, on reflection, the Department conceded HMRC's stance was correct.

675. This is reported as a fruitless payment of £6.1 million in the Losses and Special Payment section of the Accountability Report. This payment relates to the tax years 2017-18 and 2018-19.

676. The Department has not paid any penalties for non-compliance.

High Court ruling into the awarding of PPE contracts

677. At the start of the COVID-19 pandemic in March 2020 DHSC introduced a new approach to the procurement of PPE to ensure that adequate supplies were made available to the NHS and other care providers amidst a global shortage. The new approach involved the procurement of 37.5 billion items of PPE, purchased through more than one thousand directly negotiated and awarded contracts using Regulation 32(2)(c) of the Public Contract Regulations 2015 (PCR).

678. In January 2022, the High Court published its judgement on a Judicial Review into the awarding of PPE contracts to three suppliers. The claimants, the Good Law Project Limited and Everydoctor, challenged DHSC's decision to award contracts to Crisp Websites Limited (trading as Pestfix), Clandeboye Agencies Limited and Ayanda Capital Limited pursuant to Regulation 32(2)(c) of the PCR. There were five grounds brought by the claimants.

679. The court rejected two of these grounds and of the three tested in court found in favour of DHSC on two. On the remaining ground, the court found that the 'open source' approach to contracting met fairness and transparency rules, but that the operation of the High Priority Lane (HPL) did not. However, the court declined to grant the claimants declaratory relief, and acknowledged it was highly unlikely that the outcome would have been substantially different if a different assessment process had been followed.

680. The court also found that DHSC did not rely on the referral to the HPL when awarding contracts and concluded that sufficient financial due diligence and technical verification was carried out on contracts processed through this channel.

London weighting payments for home workers

681. During the early stage of the COVID-19 pandemic, the Department reacted swiftly to respond to the unprecedented challenges that the pandemic posed. This included, but was not limited to, the recruitment of staff and consultants. When

recruitment was undertaken, the effect of lockdowns meant that the individuals recruited by the Department were located in a wider range of areas than before. In addition, permanent 'home working' contracts were not an option. This was in line with Civil Service HR advice, as the Department does not have any roles that require permanent homeworking and only offers homeworking contracts where this is required as a reasonable adjustment. Therefore, when joining the Department, staff were allocated to one of the two main DHSC offices; Leeds or London.

682. One of the Government's, and public's, top priorities was to contain the virus and, whilst some staff visited their allocated office location, the vast majority of DHSC staff continued to work from home. As a result, the Department incurred some cost relating to payment of the London weighting to 52 staff that were, in substance, working from home.

683. Once this issue was identified legal advice was sought and HMT were contacted to ascertain its view on the spend and to seek approval. HMT confirmed that the spend was contentious and that it did not approve the spend, rendering it irregular.

684. Staff affected were in DHSC's employment up until 1 October 2021, at which point they were transferred to UKHSA; splitting the irregular spend (with all irregular spend showing in the DHSC group account). The total costs of the irregular spend as a result of this issue were:
- DHSC Core irregular spend up to 1 October 2021: £159,000
- UKHSA irregular spend from 1 October 2021: £131,000

685. The issue was fully resolved in July 2022 and the Department has reflected on this issue and now has robust procedures in place that would prevent it from reoccurring, even in the event of a similar situation of necessary, rapid recruitment.

Irregular expenditure

686. The C&AG qualified his audit opinion in 2020-21 due to the level of expenditure which HM Treasury determined was irregular. As a result of the work of the finance reset programme within the Department this situation has not recurred to any significant degree in 2021-22.

687. The Department has identified an area of irregular spend in 2021-22 of £290,000 relating to individuals employed by the Department and UKHSA who were paid at the inner London pay rate when they were paid as per contracts which were not in accordance with DHSC policy. This was an isolated COVID related incident, which is not expected to recur.

688. In 2020-21 the NHS England group account was qualified on regularity grounds as a result of unapproved special severance payments made in a CCG.

689. In 2021-22, six special severance payments were made across the NHS England group without HM Treasury approval. Five of these occurred within CCGs and one within the NHS England parent and details can be found in the NHS England account. For three CCGs the NHS England group account has been prepared using unaudited information due to delays in finalising their audits in relation to an irregular exit package.

690. During 2021-22, the Department strengthened its controls and monitoring in this area.

691. Special severance payments which occur in CCGs are submitted via the relevant region to the NHS England Executive Human Resources Sub Group (EHRSG). The EHRSG is chaired by a National Director and reviews and scrutinises the appropriateness of such payments. CCG cases which are approved are then submitted by NHS England to Treasury via the Department.

692. All the above cases are reported quarterly to the NHS England Board via the People, Remuneration and Nominations Committees to provide additional governance at very senior level.

693. Despite the clear processes and improvements set out above, it is important to note that ensuring full compliance across such a diverse and sizeable group is inherently challenging. As such, whilst the Department believes the processes and controls in place represent a proportionate and robust risk mitigation, they cannot guarantee full compliance from all bodies.

694. The Department continues to consider how group controls can be further enhanced in this area.

Key Departmental Operational Governance

695. This section includes areas which relate to the Department's key operations during the reporting year, including COVID-19. Issues disclosed in the below may have covered more than one reporting year and, where that is that case, will have been first raised in the 2020-21 ARA or in earlier reports. Where matters have arisen during the reporting year and are not yet resolved, they will feature in future reports.

Other Governance Disclosures

696. Further matters detailed in the following paragraphs relate to the Department's response to COVID-19 where it was necessary to adopt an increased risk appetite in the initial stage to ensure that sufficient supplies were procured for a reasonable worst-case scenario, e.g., PPE, and resources were allocated swiftly where they were needed. Consequently, matters have arisen requiring disclosure in the ARA regarding the regularity of spend in a specific number of areas, the

extent of approvals regarding indemnities entered into, the value of impairments and losses, and a recent high court ruling.

697. In response, the Department is undertaking a programme of work to reset governance and controls across the operating environment including in relation to special payments where delegated authorities have been clarified and the Department has commenced a review of the control environment across the Group to establish whether further improvements are required.

Coronavirus (COVID-19)

698. Huge progress has been made during the reporting year, and the procurement of vaccines by the Vaccine Taskforce and the deployment of vaccines by the NHS has put the country in a strong position. Steadily, over the course of the year, life returned closer to normal, however COVID-19 continued to have an impact on public health with peaks of infections through 2021-22. DHSC has continued to lead the Government's health and social care system's ongoing response to COVID-19, remaining vigilant, taking action to protect the NHS and supporting the NHS and social care in managing pressures and recovering services.

699. The Department has played a key role in a number of the Government's key announcements and publications on COVID-19 including the COVID-19 Response: Summer 2021; the COVID-19 Response: Autumn and Winter; and the COVID-19 Response: Living With COVID and has continued to work to implement Government strategy.

700. Work on the response to COVID-19 remained a key priority of the whole Department and wider health and care systems. This included vaccine deployment to priority cohorts, continued development and deployment of antivirals and therapeutics, international cooperation on surveillance and guidance to protect care homes. Informed by the best available scientific evidence, the Department's programme of work has helped suppress the virus and protect the NHS in order to save lives and provide a route back to normality.

701. The Department has been agile and dynamic 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 governance controls.

702. Substantial additional resources and expertise remained in the department 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 prioritisation of COVID-19 work at Director General and Director levels. The Department has contributed to ongoing central Government response plans including the response to Omicron.

703. The Government published its Living with Covid Strategy on 21 February 2022, which set out the Government's plan for removing the remaining legal restrictions while protecting people most vulnerable to COVID-19 and maintaining resilience. The Department's objective in the next phase of the COVID-19 response is to enable the country to manage COVID-19 like other respiratory illnesses, while minimising mortality and responding during periods that could again threaten to place the NHS under unsustainable pressure.

704. The Coronavirus Act 2020 ('the Act'), received Royal Assent on 25 March 2020. It helped form the foundation of the Government's approach to maintaining public services, including the NHS, and providing financial support to individuals and businesses throughout the pandemic.

705. Many provisions in the Act were temporary and were set to automatically expire after two years from when the Act was passed by Parliament. The Government removed powers throughout the pandemic as and when they were no longer needed. Thanks to the progress made in the fight against the virus, the Government was able to expire 20 non-devolved, temporary provisions in the Act early and suspended a total of four provisions, which have since expired. The majority of the remaining temporary provisions expired at the end of 24 March 2022. The Government extended five temporary provisions within the Act for up to six months beyond 24 March 2022.

706. There are a number of permanent provisions within the Act, which do not expire automatically, and which would require new primary legislation to repeal. Some of these provisions are still necessary to support the recovery from the pandemic. The Government committed in the 'COVID-19 Response: Living with COVID-19' plan to remove unnecessary provisions from the statute book as soon as possible, and to look for opportunities to do so as the Government's legislative programme proceeds.

707. The COVID-19 Programme was established to coordinate the strategic health and care response across the Department and our ALBs. This included ensuring effective governance arrangements were in place, reporting of performance to the COVID-19 Oversight Board and ensuring that guidance for the public and professionals relating to COVID-19 is timely and accurate.

708. The COVID-19 Oversight Board coordinates and assures the Department's COVID-19 response, supporting and aligning with the cross-government response and assurance. Comprised of senior reporting officers and programme director, it scrutinises programme and risk management to assure the deliverables of the Department's response and, ensures the health and social care system's response to COVID-19 is based on robust scenario planning.

709. The portfolio of programmes within the Department's COVID-19 response sits within a governance framework with clear governance structures in place across

the workstreams, and assurance is provided through these structures. Senior Reporting Officers provide regular (weekly/fortnightly) returns to the Oversight Board to allow scrutiny of programme and risk management and to assure the deliverables of the workstreams.

710. We will continue to review governance in response to the changed focus on implementing the living with covid strategy, including maintaining resilience, as well as reviewing governance in line with DHSC and GIAA standards and recommendations.

711. Escalation routes exist within each of the workstreams and they are able to escalate risks and issues through the COVID-19 Oversight Board, Executive Committee, Performance Committee and Audit & Risk Committee, as relevant and necessary.

712. The UK Health Security Agency (UKHSA) established in April 2021 is the Government agency responsible for UK-wide public health protection and infectious disease capability, and replaced Public Health England (PHE). The Chief Executive is accountable to the Secretary of State for Health and Social Care, through the Permanent Secretary.

713. Ministers are responsible and accountable for policy decisions. They will set public health policy and in doing so will agree the Government's priorities for UKHSA and will hold it to account for delivery.

714. PHE's health protection functions transferred to UKHSA, which will be the UK leader for health protection and ensure the nation can respond quickly and at greater scale to deal with pandemics and future threats. UKHSA has been fully operational from October 2021. From October 2021, the Office for Health Improvement and Disparities (OHID) incorporated most of Public Health England (PHE)'s functions that directly support development and delivery of national health improvement policy.

715. 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.

UK Health Security Agency (UKHSA) Governance

716. In 2021-22 UKHSA was heavily focused on the operational response to COVID-19 and, in particular, the Omicron variant. As such, recruitment and appointment of non-executive members of the Board was concluded later than planned. In April 2022, five non-executive members of the Board were appointed by DHSC ministers, and three associate non-executive members were appointed by the chair. The first informal meeting of the Board was held in June 2022 and, subsequently, the first formal meeting in September 2022.

717. Following the appointment of non-executive members of the Advisory Board, from whom membership of the Audit and Risk Committee (ARC) is drawn, the ARC was established. To date, UKHSA ARC has met in July 2022 and October 2022. The recruitment of a permanent ARC Chair is ongoing and in the interim the committee is being chaired by the UKHSA Chair. Prior to the formation of ARC, and by agreement with DHSC, updates on core issue that would otherwise have been reported to the UKHSA ARC were provided to the ARC of DHSC primarily by correspondence. Whilst a helpful interim arrangement, the DHSC ARC was not intended as a substitute for a UKHSA ARC and the absence of these formal governance arrangements throughout the 2021-22 accounting period means that UKHSA did not fully comply with the principles outlined in government's Corporate Governance in Central Government Departments: Code of Good Practice during the period.

718. During this time, UKHSA's Executive Committee (ExCo) was also established; in shadow form on the 13th of August 2021 and in full establishment on the 1st of October 2021. The ExCo has met formally each week since its full establishment, with daily stand-up meetings on other days of the week to ensure visibility on key strategic and operational issues. This ensured that UKHSA's Chief Executive was supported as Accounting Officer and could focus on UKHSA's governance including; approving and monitoring UKHSA revenue and capital budgets; agreement of priorities; and the design and structure of the organisation.

UK Health Security Agency (UKHSA) Financial Control and Governance Issues and Resultant Limitation of Scope Group Audit Opinion

719. The C&AG has chosen to disclaim his opinion on UKHSA's 2021-22 local Annual Report and Accounts. The disclaimer opinion relates to both the true and fair and regularity aspects of the C&AG's opinion. The C&AG has also concluded that at Departmental Group level, this leads to a limitation of scope opinion over the UKHSA transactions and balances, which are incorporated into the Department's Annual Report and Accounts (ARA). Note 22 of this ARA gives details of the impact of these UKHSA transactions and balances on the Group account (after elimination of intragroup transactions).

720. The following paragraphs summarise the factors which have led to this disclaimer audit opinion at local level and provides insight into the steps being taken to improve the position going forward. Further details can be found in the Annual Report and Accounts of UKHSA.

721. The local audit opinion reflects concerns about the financial controls and high-level governance arrangements, particularly the fact that non-executive members had not been appointed and an Advisory Board and audit committee were not yet in place, within UKHSA in 2021-22 as well as the adequacy of supporting evidence provided.

722. As noted above in **paragraphs 716** to **718**, progress has now been made in terms of improvements to the UKHSA Governance structure, with the establishment of both the Advisory Board and Audit and Risk Committee.

723. However, several factors, many outside UKHSA's control, meant producing UKHSA's 2021-22 Annual Report and Accounts and evidencing those accounts were free from material misstatement was challenging. These included:

- UKHSA inheriting pre-existing assurance gaps relating to NHS Test and Trace inventory and Public Health England (PHE) stockpile goods from predecessor organisations. These broadly arose due to the impact of the scale and pace of the pandemic response on those organisations, and the resultant challenges relating to operational inventory management and control. The financial statement impacts meant some form of UKHSA accounts qualification was both expected and unavoidable;

- a complex organisational merger of NHS Test and Trace, the Joint Biosecurity Centre, and the health protection functions from PHE meant that common financial governance and controls had to be established at pace, mid-way through the financial year;

- transferring NHS Test and Trace from DHSC into UKHSA (a significantly smaller organisation) meant the materiality threshold for audit was significantly lower;

- the implementation of a new finance IT system in October 2021 (a decision UKHSA inherited), at the same time as UKHSA took on its functions, where certain system issues hindered the accounts preparation and audit process;

- considerable levels of temporary workforce and workforce churn both in finance and the wider agency during the period creating challenges when providing supporting evidence for transactions and balances and producing the Remuneration Report;

- competing organisation-wide demands of responding to the pandemic; particularly the surge response to the Omicron wave from December 2021; and

- the decision in February 2022 to reduce UKHSA's Test and Trace funding by £12bn from April 2022. As a result, over the critical weeks before and after the financial year-end the Finance team's attention was prioritised and focused on ramping down spending and contracts. These factors contributed to a set of problems with financial control and the accuracy of the accounts.

724. As a result of the above factors, certain financial controls and disciplines slipped, including completion of timely effective bank reconciliations. Addressing the consequences of these issues, including undertaking significant year-end review and testing to ensure the accuracy of ledger data, significantly slowed down the

2021-22 year-end close and accounts preparation processes, limiting the time and therefore opportunity to gather and present appropriate accounting records. While many of these problems did not result in financial statement errors, some did. It has not been possible to conclude whether or not these control issues result in material errors or assurance gaps in the UKHSA account.

725. UKHSA are fully committed to addressing these issues and the 2021-22 accounts preparation process has assisted in identifying areas of control weakness requiring attention. A draft action plan has been formulated and the plan has been submitted to HMT and DHSC, receiving positive feedback.

726. Whilst the action plan will not guarantee full resolution of all control issues in 2022-23, UKHSA are prioritising delivery of the plan and are confident significant improvements can, and indeed already have in some instances, been made within a relatively short timescale. The delivery of the action plan will be governed and monitored by an oversight board meeting. This board will include representatives from DHSC and HMT and, additionally, UKHSA will formally report into the Department through the existing Finance Reset Programme.

Finalisation of Group Entities' Accounts

727. There has been a deterioration in the timescales for the finalisation of audited accounts of group entities. This has occurred in both the NHS and other entities in the Departmental Group. Indeed, the Annual Report and Accounts of Public Health England (a former Executive Agency) will now not be laid within the statutory deadline of 31 January 2023.

728. Alternative procedures have been required to reduce assurance gaps in the Group and these have enabled the Departmental Group ARA to be finalised and audited.

729. The Department is committed to working with its Group entities, local audit firms and the NAO to improve the situation as far as possible going forwards.

DHSC Contract Management

730. During 2021-22, the Commercial Capability and Supplier Management (CCSM) Team has maintained work with Director General Groups to ensure that the DHSC Corporate Contracts register of contracts (via Atamis system) is comprehensive and Directors and Director Generals have corporate visibility of the DHSC contract portfolio. Director Generals have reported on contracts as part of the Bi-annual Assurance process, helping to ensure contracts and associated risks are identified and managed. The Contract Management Assurance consists of a review of the established contractual arrangements and activities to provide confidence that key commercial requirements are complied with. Contract Management Assurance is an ongoing process which starts during the pre-procurement stage and continues throughout the life of the contract, and is evidenced by:
    - Performance Scorecards (submitted Monthly for Gold Contracts and Quarterly for Silver)

- Contract Management toolkit (min standards including Risk & Issue management, Business Continuity and Disaster Recover Planning, Contingency Planning, Performance Management, Exit Management etc.)
- Assurance Checklist (Contract Attestation).

731. Contract Attestation refers to an Assurance Framework, developed to accompany the Scorecards and the Contract Management toolkit to support the assurance of each Business area's portfolio of contracts and focuses on four key areas:
    - Leadership; including Planning, Resources, Governance and Disputes.
    - Capability; including People, Learning/Training, Skills and Competencies.
    - Contract Management; including Relationships and Delivery, Performance, Risks and Payment.
    - Contract Administration; including Audit and Records, Changes and Variations, Exit Management.

732. The DHSC Contract Management Operating Model is a three-tiered approach based on the proportionate application of resource, governance, and process determined by the strategic importance of each contract. Classifying a contract involves reviewing factors that would have an impact on the Department should the Contract, for any reason, fail. These factors include the total value of the Contract, how many other suppliers are in the market, if the Supplier handles sensitive information, etc. The Department's model of classifying contracts is to differentiate contracts into either a Gold (high risk by either value or impact), Silver (medium risk with a lower value or impact), Bronze (low value/impact). There is a further category titled Transactional and this relates to the lowest value/minimal impact contracts – these are often one-off payments, licences, subscriptions etc.

733. The CCSM team engage with Senior Contract Owners of the highest risk contracts to reinforce the importance of contract management and their respective roles and responsibilities through the annual Assurance Framework Attestation process. In ensuring the Contract Management Operating Model was followed and by agreeing revised timescales where needed, this enabled all but one assurance process to be completed for gold and silver contracts in the 'business as usual' (BAU) contract portfolio by 31 March 2022. The final one was completed in April 2022. Due to the churn in personnel and contract owners in the PPE category, these contracts were not included in the BAU attestation process described previously.

734. Work continues to enrol our Operational Contract Managers (OCMs) and our Senior Contract Owners (SCOs) on to the Contract Management Capability Programme Training and the Senior Responsible Owner training respectively. These Programmes are provided by the Cabinet Office and are part of the Government's commitment to invest in training, to help anyone involved in managing contracts understand all elements of the contract life cycle and effectively manage contracts and relationships with suppliers.

735. The DHSC CM operating model is for operational contract management to be undertaken out in the business. Each contract should have an OCM plus a Senior Contract Owner. The contract management of the contracts awarded for COVID-19 are managed by the respective teams, such as PPE and Test and Trace, and the CCSM team works with the OCMs and SCOs to support them in the management of their contract portfolio.

736. Training is based on the Contract Management Professional Standards and accreditation in contract management is offered at three levels: Foundation, Practitioner, and Expert. By the end of March 2022, some 1,572 learners across health (DHSC, ALBs and NHS) had registered for the Foundation Training, of which 815 achieved accreditation. We continue to encourage all Foundation learners 'in progress' to complete the learning and achieve accreditation. All OCMs managing DHSC gold and silver contracts have been nominated for Practitioner and Expert training as required.

737. Throughout 2021-22 a significant number of new contracts have continued to be awarded across the business portfolio within DHSC, including COVID-19 workstreams.

738. As at 31 March 2022, the DHSC contract portfolio stood at 1,152 contracts, with total contract award value of £12.1 billion; the portfolio consists of 27 Gold contracts; 95 Silver; 445 Bronze and 585 Transactional contracts.

739. Increased contract management capacity in the Commercial Capability and Supplier Management team has been established to allow us to begin to 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.

740. From 1 April 2022, COVID-19 contracts were governed as part of the ongoing BAU portfolio and the distinction made previously between the two portfolios is no longer relevant.

DHSC Information Risk Management and Assurance

741. In 2021-22, continued information governance support has been provided for activities undertaken by DHSC, NHS Test and Trace and the Joint Biosecurity Centre (which are now part of the UK Health Security Agency (UKHSA)) within DHSC's 'Department of State' functions, in response to the pandemic. Launched on 1 April 2021, the Information Risk Management and Assurance Directorate (IRMA) has been established as a permanent function within DHSC and has continued to grow over the previous year.

742. IRMA provides valuable expertise to support an increased need for information governance activity, assisting data focused teams and functions in the Department with matters relating to the use of information and operational data as we move

from the emergency response to the pandemic to a new phase of managing and living with COVID-19. This has included:

- Policies, guidance and tools: building on a comprehensive suite of data protection policies, guidance and tools, IRMA has developed and implemented new policies for DHSC covering Information Management, Information Security, Information Risk and Information Assurance. Together, these policies provide the foundation for the processes, standards and frameworks required to enable safe, secure data sharing across Departments to support decision making and improve services.
- Supporting the transition of NHS Test and Trace and the Joint Biosecurity Centre to UKHSA and specifically in relation to the management of information risk. This has included the development and implementation of a Framework agreement with UKHSA which includes the management of data.
- Supporting transformation of some teams and functions from Public Health England (PHE) to the Office for Health Improvement and Disparities (OHID), specifically on matters relating to information risk and compliance.
- Supporting the conclusion of the consensual audit of NHS Test and Trace by the Information Commissioner (ICO).

743. The Department has continued to work with the Information Commissioner's Office, to ensure that data protection implications and obligations continue to be considered and met and to ensure it is fully compliant with all relevant legislation, including the UK General Data Protection Regulation (UK GDPR).

744. The Department recorded 193 data-related incidents between April 2021 and March 2022, an increase of 71 on the previous year. This increase should be considered in the context of, and as a result of, DHSC's expanded operational focus at national scale and stronger awareness amongst staff on reporting data incidents.

745. It should be noted, that of the 193 reported incidents, only 4 met the criteria to be referred to the Information Commissioner's Office, a reduction of 6 on the previous year. This highlights that increased awareness and training is having a marked improvement on staff understanding of data and its use. The 4 reported incidents have been closed by the ICO and require no further action.

DHSC Anti-Fraud Unit

746. Fraudulent activity in the health sector, especially the NHS, means that taxpayer's money intended for patient care can end up in the hands of criminals. This leads to fewer resources being available for frontline health and social care services such as health and social care facilities, doctors, nurses, and other staff. It can lead to a reduced ability to invest in new and improved equipment and technology, fewer clinical interventions, and a general reduction in the sustainability of an NHS which remains free at the point of delivery.

747. Our counter fraud work at a national level is led by the DHSC Anti-Fraud Unit (DHSC AFU). Its goal is to prevent and deter fraud, bribery, and corruption by raising awareness and working in partnership with all parts of DHSC, its ALBs, and companies.

748. The DHSC AFU sets the counter fraud policy and strategy for the Department and the wider health group, the latest strategy covers the period 2020-23. In the next financial year, we will commence a refresh of that strategy for 2023-26.

749. Our response to tackling fraud has been, and continues to be, based on the following principles:
- It is centrally driven and managed, with clear lines of accountability, whether that be in individual NHS bodies themselves or with the Director General Finance or NHS and the Counter Fraud Board.
- It is reliant on a collaborative approach between organisations, as well as a clear commitment by senior management to developing a consistent and organised mechanism for sharing information about risks and best practice.
- Recognising that reducing fraud/financial loss is the responsibility of all staff. It 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.
- By ensuring fraud risks are assessed and fraud prevention and detection are supported by effective monitoring. Work to continually minimise risk is built in to DHSC policy development at the earliest possible stage and promotes awareness of fraud risks across health group.
- Acknowledging that work on fraud and other types of financial loss is critical to maintaining a sustainable and financially balanced NHS.

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

751. Following COVID-19, in Autumn 2020 we resumed our criminal case investigations but on a reduced basis. The scale of investigations was further extended in Autumn 2021 as we continued to transition back to business as usual.

752. We also have a comprehensive programme of engagement and counter fraud improvement work in place with all our health arm's length bodies, including a recently completed health arm's length bodies' assessment of compliance with Government Counter Fraud Functional Standards. We and a number of ALBs have also contributed to the CO/HMT led CF Workforce and Performance review to provide insight to support levelling up counter fraud capability across Government.

753. Also operating at a national level, the NHS Counter Fraud Authority (NHSCFA) spearheads the fight against NHS fraud and implements the Department's strategic plan under the sponsorship of DHSC AFU. They also launched their own Strategy for 2020 to 2023. NHSCFA has a resource of 163 full time staff.

754. The NHSCFA Strategic Intelligence Assessments (SIA) showed that, between 2017 and 2021, there was a year-on-year reduction in fraud loss estimates.

755. The SIA 2022 (encompassing the intelligence that was collated in 2021-22 and financial vulnerability estimates based on activity data from 2020-21), published on 14 July 2022, showed an increase in the estimate. This increase was primarily due to an increase in NHS funding caused by COVID-19, rather than evidence of increased levels of fraud.

756. As the SIA 2022 is based on 2020-21 financial data, it includes the impact of COVID-19 and additional funding has been captured in this assessment. Vulnerability to fraud, bribery and corruption in relation to the NHS led to an estimated potential loss of £1.198 billion in 2020-21, up from £1.14 billion in 2019-20.

757. Local counter fraud work is guided by the NHS Standard Contract, and the NHSCFA published version of the Government Counter Fraud Functional Standard (NHS Requirements) which require all organisations commissioning and providing NHS services to put in place and maintain appropriate counter fraud arrangements.

758. Integrated Care Boards (ICBs) were established as statutory bodies in July 2022. NHSE have published statutory guidance for ICBs on their counter fraud responsibilities. As with CCGs before them, ICBs will need to comply with the Government Counter Fraud Functional Standards.

759. Local Counter Fraud Specialists (LCFS) support NHSCFA on national issues, ensure national fraud prevention messages are widely circulated and identify, report and investigate individual cases (e.g., payroll and procurement and commissioning fraud). As of May 2022, there were 231 LCFS.

760. Shared intelligence and expert fraud risk assessment of the stimulus spend helps understand the risks from fraud and the possible responses. DHSC AFU and NHSCFA are closely involved with this work.

761. COVID-19 presented an unprecedented set of circumstances and challenges. The Government's COVID-19 stimulus and financial support packages are recognised as being at an increased risk of fraud, from those who would seek to take advantage in these circumstances.

762. Other NHS arm's length bodies with national coverage routinely undertake activity to tackle fraud. The Counter Fraud Board maintains oversight and coordination of the response by key national organisations. Board members include NHSCFA, NHSEI, NHSBSA as well as CO to provide a central function insight and 'critical friend' challenge to the health response. This is supported by regular contact at working level between the NHSCFA, NHSBSA and NHSEI together with an established Counter Fraud Liaison Group network ensuring engagement and influence over all Health ALBs. 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.

763. In response to this, the Department has and is acting to both understand the extent of loss and to find and recover, where practicable, through Post Event Assurance (PEA) activity. In line with this cross-government approach, DHSC continues to undertake PEA activity across high-risk areas of COVID-19 spend.

764. In 2020-21, the Department recovered and/or prevented c£162 million in high-risk procurement payments, through additional examination and checks on contracts identified as heightened risk and contract management to prevent loss and where appropriate seek recovery. Of this, £157 million (£139 million prevented which includes preventing some opportunities reaching contract stage and £18 million recovered) related to PPE.

765. PEA for PPE is ongoing and DHSC has participated in the Government Counter Fraud Function (which became the Public Sector Fraud Authority in August 2022) Fraud Measurement and Assurance (FMA) exercise for PPE Procurement, to provide an independent assessment against the Fraud Measurement Standards, of the risk-based approach and methodology the Department has taken.

766. Given that PEA was taking place at the same time as the procurement programme and risk was evolving, DHSC AFU deliberately focused on a subset of the overall population that had certain high-risk factors about them. However, as the subset focused specifically on high-risk contracts, it was not a completely random sample and therefore did not meet the fraud measurement and assurance standard. The subset made up over 28% of the overall population of PPE contracts, leaving a remaining 72% that did not show the high-risk factors. The exercise was recognised in feedback from the Public Sector Fraud Authority as a high-quality, thorough and robust piece of work on a high-risk subset of the total PPE orderbook. Of the subset:
    - 4.8% is identified fraud and error risk (not loss) with a value of £111,749,490. These contracts were identified as higher risk at an early stage we were able to identify and mitigate risks, therefore, no actual loss occurred.
    - 1.7% is risk of loss from fraud and error with a value of £38,392,922. It is estimated that a fraud or error loss may be occurring because we were unable to identify and mitigate risks at an early stage.

767. In terms of context, the Government Counter Fraud Profession estimate that public bodies lose 0.5% – 5% of their spending to fraud and error, and the amount DHSC have identified as a result of FMA is within this range.

768. DHSC AFU is undertaking a small amount of further sampling for fraud detection, rather than measurement, purposes to provide additional insight into the non-high risk segment of the orderbook.

769. It is acknowledged across Government that there will be a lead time for frauds around COVID-19 to be identified, including in PPE procurement which, unlike other support schemes, is subject to ongoing contract management controls; active dispute resolution and recovery action. While there has been little fraud identified to date, the DHSC AFU is actively engaged with dispute resolution teams to monitor and assess the evolving picture.

770. The Department has also tested a sample of ventilator contracts to identify potential fraud. The programme reports full delivery. Seven contracts (12% of the orderbook) were tested, with no evidence of fraud discovered. The only potential fraud identified within the programme was detected in the early stages, when changes in supply chain companies post contract raised concerns. The contract was terminated with full recovery of initial payments of £5 million, and as such, through design, some items may not be needed.

771. Before the NHS Test and Trace (NHST&T) Counter Fraud Team was established, DHSC AFU sought to undertake PEA work focused on pro-active validation checks on the end to end process of a sample of individual contracts from across the 8 pillars and continued the exercise to completion. The sample was made up of 22 suppliers (5.8% of all suppliers) and detected no instances of fraud. However, some documentation was unavailable to DHSC AFU which may have impacted the final assurance.

772. The NHST&T Counter Fraud Team was recruited shortly before the reporting period. The team worked with the National Cyber Security Centre to stop scam emails and texts purporting to be from NHST&T. Fraudulent texts and emails sent to citizens erode the credibility of legitimate messaging from the testing programme, resulting in a negative impact on public health as citizens do not know what to trust.

773. The team also improved protection of free Lateral Flow Devices (LFDs) that were provided under the Universal Offer being sold online for profit and built fraud prevention measures into the Managed Quarantine Service (MQS). As a result of the fraud prevention control measures implemented by the team, the rate of fraud against MQS reduced from 4% to 0.13%.

774. LFD and MQS schemes were the focus of the NHST&T Counter Fraud Team until the establishment of UK Health Security Agency (UKHSA) in October 2021. UKHSA

took on responsibility for NHST&T schemes from DHSC, including PEA work. To date, this has not included further PEA on procurement activity.

775. DHSC takes fraud seriously and explores every available option, including working with law enforcement partners, where appropriate. The Department will continue to bring those who commit fraud to account and seek to recover fraud losses, where they occur, to ensure public funds are directed to where they are needed most.

Compliance with Equality and Human Rights Legislation (PSED)

776. 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 Policy Assurance and ALB Oversight team who are responsible for raising awareness and capability among staff on equality issues.

777. The Department considers equality issues in its work and policies, including during the pandemic. This has been informed by evidence such as Public Health England's report on disparities in COVID-19 risks and outcomes as well as quarterly reports by the Minister for Equalities and the Government Equalities Office on progress to address COVID-19 health inequalities.

778. The Policy Assurance and ALB Oversight team has supported this by delivering more training sessions and updating guidance on the Department's intranet to support staff to understand their responsibilities. There is also a network of Senior Civil Servants who promote good practice and give visibility to equality issues.

779. Directors General are required to consider compliance with the public sector equality duty and evidence of this is provided in submissions to Ministers. The Policy Assurance and ALB Oversight team offer support in how to comply with the duty.

780. The Department has published summary equality information relating to its policies and workforce, including for the pandemic. Previous reports and our current equality objectives can be found under the equality information section of the Department's website.

Emergency Preparedness, Resilience and Response (EPRR)

781. The Department works closely with NHSE and NHSI, UKHSA, other ALBs, and other Government Departments to ensure that the health and social care sector is able to respond to threats and hazards set out in the Government's National Risk Register of Civil Emergencies (NRR) and other significant disruptions where they arise.

782. Throughout the COVID-19 pandemic, the Department continued to develop its response capability, including its ability to prepare for and manage concurrent incidents.

783. In 2021-22, the Department contributed to the cross-Government response to the evacuation of Afghan nationals, the Autumn fuel supply disruption, Storms Eunice and Dudley, and the crisis in Ukraine.

784. Governance is provided through the Strategic Emergency Preparedness Board, which brings together senior representatives from the EPRR community across DHSC and its delivery partners. Horizon scanning continues to be used to identify where there are gaps in response capability and bespoke risk reviews established to address these.

785. The Department is the Lead Government Department (LGD) for preparedness for human disease risks, including pathogens with pandemic potential, an emerging infectious disease, or an outbreak of a High Consequence Infectious Disease (HCID). The plans in place to respond to an influenza pandemic provided the basis for much of the Department's early response to COVID-19.

786. The Department remained focused on the ongoing response to COVID-19 throughout 2021-22, whilst maintaining its preparedness for a future novel pandemic or other HCID and is incorporating learning from COVID-19 to further develop our preparedness plans.

787. As part of its pandemic preparedness planning, the Department ensures that the right clinical countermeasures are stockpiled or otherwise readily available through other routes. These countermeasures include stockpiles of Personal Protective Equipment (PPE), medicines (including antivirals and antibiotics), clinical consumables, and an Advanced Purchase Agreement for a pandemic specific influenza vaccine. The Department's pandemic stockpiles are designed to mitigate the Reasonable Worst-Case Scenario risk of a pandemic as outlined in the National Risk Register.

788. Elements of these stockpiles were utilised in our response to COVID-19, where our Pandemic Influenza PPE stockpiles, including aprons, eyewear, facemasks, gloves, and gowns, were released to dentists, trusts, and primary and social care in February and March 2020. This has depleted certain products in the specific pandemic influenza stockpiles, but the Department continues to work with the COVID-19 PPE workstream to assure that there is enough PPE available in the system to cover these shortfalls.

789. In the meantime, the Department is finalising its comprehensive review of its requirements for countermeasures for disease outbreaks and pandemics, in light of the experience of responding to COVID-19. This review, informed by expert scientific advice, is considering the products, volumes, supply, storage, and governance arrangements required for a broader set of future pandemic and infectious disease risks, in addition to pandemic influenza. It is also addressing some of the relevant findings and recommendations contained in the Boardman

Review of Government COVID-19 Procurement (December 2020) and the NAO report on The Supply of PPE During the COVID-19 Pandemic (November 2020). The outputs of this review will inform procurement decisions on pandemic preparedness countermeasures.

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

Data Issues – Cyber Security Programme

791. The cyber security programme is strengthening cyber resilience across health and care, ensuring organisations comply with relevant standards, protect patient data and are able to respond effectively in the event of a cyber-attack. It has taken on increased significance with the swift digital transformation required to respond to the pandemic. In total, since 2016 over £300 million has been invested nationally to improve cyber security of the health and care system.

792. In 2021-22 under NHSX, the Joint Cyber Security Unit worked in partnership with NHS Digital (NHSD) and the National Cyber Security Centre (NCSC) to reduce exposure to cyber risk in the NHS and across adult social care. In February 2022, NHSX became part of NHS England's Transformation Directorate. That work included increasing central monitoring and assurance and using regulatory powers to hold organisations to account, as well as centrally procuring services to assist local organisations to improve their cyber security posture and reduce overall risk.

793. Through the Unified Tech Fund, some £26.9 million of capital and £5.7 million of revenue funding was allocated to NHS organisations in 2021-22. This has helped to address infrastructure weaknesses and increase overall cyber resilience. NHSE and NHSI regional digital transformation teams worked with local organisations to identify priorities for available capital investment, ensuring the priorities were consistent with local plans for digital transformation.

794. Microsoft Defender for Endpoint™ is now deployed and provides central and local visibility of operating systems and applications across all 1.6 million Microsoft desktop devices in the NHS estate. NHSD continues to develop its Cyber Security Operations Centre (CSOC) 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.

795. When critical cyber vulnerabilities are identified, the Joint Cyber Unit works with NHSD to issue High Severity Alerts (HSA) to warn NHS organisations and inform them of action they need to take. During the reporting year, significant improvements and enhancements have been made to the alert process, improving the overall user experience; thirteen HSAs have been issued, with the most complex being the Log4Shell vulnerability in December 2021.

796. The programme has continued to strengthen standards through the Data Security and Protection Toolkit (DSPT) which all organisations must use if they have access to NHS patient data and systems. 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.

797. Where mandated standards have not been met, DHSC has used the Network and Information Systems (NIS) Regulations to increase compliance in the NHS, specifically around managing unsupported systems, and to improve responses to high severity cyber alerts.

798. For the adult social care sector, the Better Security, Better Care Programme provides a range of tailored local and national support to help providers complete the DSPT, improving their overall data and cyber security. In 2021-22 the number of adult social care providers completing the DSPT to at least Approaching Standards status almost tripled from 15% of providers to 43% of providers.

799. As part of our COVID-19 recovery, the Joint Cyber Unit has worked with NHS Regional Directors to reset an understanding of the cyber security risk across senior leaders. In July and August 2021, the former CEO of NHSX and the CEO of NHS Digital held a series of regional events at which NHS Trust CEOs were briefed on the cyber threat, known vulnerabilities and key actions which they should be taking. In the context of the war in Ukraine, operational advice and instructions on improving cyber security resilience were issued to NHS organisations, outlining priority actions to take to ensure that the NHS is prepared and ready to deal with any new or emerging threats.

800. The Joint Cyber Unit has also expanded the Cyber Associates Network which now has 2,000 members. This was established in partnership with NHS Digital and continues to be the leading network for cyber security professionals working in the health and care sector. Virtual conference events held in October 2021 were attended by more than 1,200 members of the network, providing key opportunities for collaboration and knowledge sharing.

801. Incident planning continues to be an essential part of the programme and during the reporting year it delivered three national level tabletop incident-planning exercises, promoting good backup and recovery capabilities so that organisations can plan how to get back online quickly if an attack hits.

802. Supply chain cyber security is a challenge across all sectors. The Joint Cyber Unit has accelerated plans to improve the cyber assurance of suppliers to the NHS, and we are exploring with NHS Digital, Cabinet Office, DCMS, and NCSC how government can collectively improve the cyber resilience of suppliers to the public sector.

803. This acceleration is in response to a ransomware attack on Advanced, a third-party software supplier to the health and social care sector, in August 2022. A number of Advanced systems were impacted. The greatest operational impacts were to NHS 111 operators and Mental Health Trusts. The Joint Cyber Unit, NHS England, and NHS Digital have been working closely with Advanced to restore services.

804. The Joint Cyber Unit has provided Ministers with a supply chain action plan, containing a number of short and medium term workstreams. Current priority work includes working to build a picture of the most critical suppliers to the health and social care sector, piloting a programme to assure suppliers and map critical dependencies, and establishing a suppliers' network to distribute threat intelligence and resilience tools and advice.

EU, Trade and the Union

805. During the year, the Department worked across Government and with ALB delivery partners to deliver its EU, Trade and the Union objectives:
- Managing the transition for the health and care system following EU Exit.
- Implementing the Trade and Cooperation Agreement and other international agreements.
- Seizing the opportunities opened up by our exit from the EU to make the UK a life sciences superpower within the next ten years.
- Delivering the commitment to keep the NHS off the table in trade negotiations, whilst promoting new opportunities for health and care and supporting public health.
- Delivering on key priority areas and activities which strengthen UK-wide collaboration on health and social care, and which will provide benefits to citizens in Scotland, Wales, Northern Ireland and England.

806. In terms of the Northern Ireland (NI) Protocol, in April 2022, the European Council adopted a Directive and Regulation for human medicines, bringing into EU law their proposals to address key medicines supply issues. On 13 June 2022, the former Foreign Secretary introduced a Bill to address issues with the Northern Ireland Protocol. The Bill will provide for a 'dual regulatory regime' for goods destined for the NI market - allowing manufacturers to follow EU or UK regulations, or both.

807. DHSC is engaging with businesses and stakeholders in scope; we anticipate that bespoke regimes may be needed for some highly regulated goods. For human medicines, the EU's legislation addresses many of the challenges the UK government and industry have identified; the Bill will enable the UK Government to address outstanding gaps in the EU's legislation if needed in the future. Whilst the Bill progresses, the UK Government's preference continues to be for a negotiated solution.

Infected Blood Inquiry

808. The Infected Blood Inquiry has received evidence from people infected and affected by contaminated blood and has heard from expert groups and from senior clinicians. In 2021-22, the Inquiry took evidence from those working in Transfusion Centres and Haemophilia Centres and about blood transfusion policy and practice. The Cabinet Office, as the sponsor Department for the inquiry, continues to coordinate work between DHSC and the devolved administrations.

809. DHSC is providing full disclosure to the inquiry and has waived its usual right to legal privilege. Forthcoming hearings will consider Government decision-making and actions and issues relating to candour and openness, with a number of former Health Ministers and former Departmental civil servants giving evidence.

810. The Department is committed to working with the support schemes in the Devolved Nations to improve parity of support across the UK. During 2021-22, changes to the four UK schemes have been implemented which have brought them into broader parity.

811. The changes in England included introduction of annual payments for bereaved partners which have replaced the previous income top-up payments, changes to lump sum bereavement payments, and increases to lump sum payments for beneficiaries with Hepatitis C Stage 1 and for those with HIV.

812. On 17 August 2022, the Government announced it had accepted the recommendation in the Inquiry's interim report to make an interim compensation payment of £100,000 to all those infected and all bereaved partners currently registered on UK infected blood support schemes. The Department led on the arrangements for payments to eligible beneficiaries of the England Infected Blood Support Scheme, which were made by 28 October 2022, meeting the Government's commitment on timing.

Independent Medicines and Medical Devices Safety Review

813. The Independent Medicines and Medical Devices Safety Review (IMMDS) looked at what happened when patients raised safety concerns in the cases of Primodos, Sodium Valproate and surgical mesh, and whether the processes pursued had been sufficient and satisfactory. The Baroness Cumberlege Report – First do no harm (Published 8 July 2020) made recommendations and identified actions for improvement in the Review.

814. The Government published its response to the IMMDS Review on 21 July 2021. We accepted the vast majority of the IMMDS Review's 9 strategic recommendations and 50 actions for improvement, setting out an ambitious programme for change that is focussed on improving patient safety.

815. The Government has committed to making rapid progress in all areas set in its response and committed to publishing an update 12 months after its response

was published. Work on the implementation update is underway and we aim to publish this as soon as possible.

COVID-19 Inquiry

816. The UK COVID-19 Inquiry has been set up to examine the UK's preparedness and response to the COVID-19 pandemic, and to learn lessons for the future.

817. The Inquiry has been established under the Inquiries Act 2005. This means that the Chair, Baroness Heather Hallett, will have the power to compel the production of documents and call witnesses to give evidence on oath.

818. Baroness Hallett was appointed Chair in December 2021 and in Spring 2022 consulted the public on the draft Terms of Reference for the Inquiry.

819. The Inquiry consulted on its draft Terms of Reference until 7 April 2022 and the feedback from this consultation has shaped Inquiry Chair Baroness Hallett's recommendations to the Prime Minister on the final Terms of Reference, which will set the topics for the Inquiry's investigations into the UK's pandemic response.

Immensa Laboratory Wolverhampton

820. From 2 September 2021, the Immensa Laboratory in Wolverhampton was commissioned to provide additional COVID-19 PCR testing capacity for NHS Test and Trace. UKHSA suspended testing at the laboratory on 12 October 2021 following reports of inaccurate results. The cause was the incorrect setting of the threshold levels for reporting positive and negative results of by staff at the laboratory. This means that some PCR tests were reported by the lab as negative for COVID-19 which would have been assessed as positive if the threshold had been correctly set.

821. Based on background infection rates in different population groups at the time, UKHSA estimated that this error could have led to around 39,000 results being incorrectly reported as negative when they should have been positive. This represents around 10% of samples tested at the laboratory between 2 September and 12 October 2021 and 0.3% of all samples tested for NHS Test and Trace during this period. In addition, UKHSA researchers have also published an analysis to estimate the impact of the Immensa lab error on transmission in the most affected areas.

822. UKHSA's serious incident investigation has concluded that no singular action or process implemented by NHS Test and Trace could have prevented the errors within the Immensa laboratory arising, but it has also identified a range of ways to enable earlier detection of any similar laboratory errors wherever possible.

823. NHS Test and Trace acted immediately to strengthen its contract and data processes when the issue first emerged and a summary of these actions has also been published alongside the serious incident investigation. These include

enhanced surveillance of laboratory positivity rates so that discrepancies can be identified and investigated as soon as possible.

Independent Inquiry into Ian Paterson

824. The independent inquiry into the issues raised by Ian Paterson reviewed the circumstances surrounding Ian Paterson's malpractice and considered other past and current practices in the NHS and the independent sector. The Right Reverend Graham James made fifteen recommendations in the report of the independent inquiry, which was published during the 2019-20 financial year on 4 February 2020.

825. The Government published its response to the independent inquiry report into the issues raised by former surgeon Ian Paterson on 16 December 2021. We accepted the vast majority of recommendations made by the inquiry and have been working with bodies across the health system to implement these vital improvements.

826. The Government has committed to publishing an update 12 months after the Government response was published. Work on the implementation update is underway and we aim to publish this by the end of the year.

NHS Governance

The NHS

827. 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 of the people of England, and in the prevention, diagnosis and treatment of physical and mental illness.

828. In relation to NHS England, the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022, requires the Department to formally set out its objectives for the health service in a mandate to NHS England, and any requirements considered necessary to achieve those objectives. This is one of the formal accountability mechanisms for holding NHS England to account for the money it spends and the outcomes it achieves.

829. NHS England has responsibility for the commissioning of healthcare in England and, to invest its annual budget (of around £154 billion in 2022-23), with a view to bringing about measurable improvements in health outcomes for the population.

830. On 1 July 2022, NHS Improvement merged with NHS England through the Health and Care Act 2022 and instruments made under it. NHS Improvement (NHSI) was the operational name for an organisation that brought together: Monitor, the NHS Trust Development Authority (TDA), the Patient Safety function from NHS England, the Advancing Change team from NHS Improving Quality, the Intensive

Support Teams from NHS Interim Management and Support (IMAS) and the NHS Leadership Academy, to make a single integrated enterprise.

831. Since April 2019, NHSE and NHSI had adopted a single leadership model under the Chief Executive Officer (CEO) of NHSE and single Chief Operating Officer (COO) of NHSI, with a single COO post covering NHSE and NHSI and reporting directly to the CEO of NHSE and NHSI.

832. Both organisations working as one integrated organisation had been reflected in the mandate, which since 2019-20 has included joint objectives for both NHSE and NHSI. The NHS mandate for 2022-23 set five objectives on managing the impact of COVID-19 on health and care; recovering and maintaining delivery of wider NHS services and functions; renewing focus on delivering against the NHS Long Term Plan; embedding a population health management approach within local systems, stepping up action to prevent ill health and tackle health disparities; and ensuring effective NHS leadership, culture, and use of organisational resource to realise the benefits from structural changes within health and care.

833. NHSE and NHSI have reported performance to the Secretary of State against each objective in the 2020-21 and 2021-22 mandates. The Secretary of State has a legal duty to lay in Parliament each year an assessment of NHSE's performance. Both the 2020-21 annual assessment and 2021-22 annual assessment will be published in due course.

834. 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 NHSE, and further details are included in NHSE's Governance Statement and published in their annual report and accounts.

835. For NHS Trusts the processes were previously set by NHSI and are now set by NHSE. 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.

836. The current assurance and accountability process provides Ministers with several legislative and non-legislative mechanisms for holding NHSE to account. The Framework Agreement for NHSE sets out the assurance process, roles, and responsibilities of the Department and NHSE by which accountability will be achieved.

837. NHSE has been reporting to the Department against the headline metrics that underpin the priority commitments set out in the 2021-22 mandate on a quarterly basis since the start of 2021-22. These metrics were repeated in the 2022-23 mandate, and NHSE will continue to report on them on a quarterly basis going forwards, providing efficient and effective levels of oversight, scrutiny, and transparency.

NHS Financial and Audit Governance

Financial Risk and Sustainability in the NHS

838. Putting the NHS back onto a sustainable financial path is a key priority in the Long Term Plan (LTP) and is essential to allowing the NHS to deliver the service improvements it sets out. The Government previously announced that the NHS would 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 and the five financial tests that underpin it.

839. The budget increases were enshrined in law in March 2020 in the NHS funding Act 2020 and the funding and the NHS budget is entrusted to NHSE and NHSI to deliver the LTP.

840. To support more effective oversight of delivery of the overall LTP and the five financial tests, the Government had been working with NHSE and NHSI to determine a set of metrics that reflect the fundamentals and ambitions of the plan.

841. The intention originally was for these metrics to be used to monitor progress against intended outcomes on a regular basis. However, following the onset of COVID-19 pandemic, this process was paused to allow the system to concentrate on the response to the outbreak. Despite the pause, the Department has continued to work with the NHS to focus on achieving financial balance throughout the pandemic, agreeing additional resources to cover COVID-19 costs where necessary and minimise pressure on the system.

842. Although the successful rollout of the vaccine programme in 2021-22 allowed the NHS to begin addressing some of back log created by the pandemic, the intention to return to the LTP and financial tests was delayed. Subsequent waves of COVID-19 and the disruption to plans they caused meant there was limited capacity to fully return to the evaluation of the LTP and assess the consequences.

843. Furthermore, following the 2021 Spending Review and the Government's stated commitment to focus on elective recovery and efficiency to tackle the backlog, further detailed work has been needed to consider how the additional agreed funding interacts with these objectives in line with the LTP.

844. With the announcement of the LTP update, work is underway to align the priorities of the original LTP against these revised objectives identified alongside the delivery of the Government's living with COVID-19 strategy. As part of this, the interim metrics previously agreed for the five tests are being realigned to ensure they are still fit for purpose to measure delivery of the updated priorities for which the funding has been provided.

845. As we return to business-as-usual financial controls, we continue to work with HM Treasury and the NHS to draw upon any lessons learned from the last few years that can improve our governance framework and future approach to financial forecasting. As part of the Department's financial reset programme, we have agreed a new set of delegations for the NHS and continue work on revising spending approval processes with HM Treasury to better support the NHS to deliver.

846. In addition, the implementation of the new NHS System Oversight Framework, that seeks to monitor the progress of NHS systems and their ability to meet their required standards, including financial and use of resources, has begun and work to address and support challenged systems underway.

847. The Department continues to carry out (and regularly review) its governance and oversight process to ensure funding is used in the most efficient and effective way; and to hold the NHS to account for delivery of agreed financial objectives.

848. Our monthly Cross System Efficiency & Finance Board with NHSE and NHSI, and regular ministerial and HM Treasury engagements have continued to operate during the reporting year, providing a regular forum for the senior finance leadership in both organisations to discuss financial issues and support decision making where needed.

849. With the formal merger of NHSE and NHSI in the Summer of 2022 and the announcement of further mergers, work is also underway to review the impact of these changes and what further governance arrangements need to be put in place.

IFRS 16

850. The implementation of the new leasing standard, IFRS 16 Leases, for the 2022-23 financial year, creates a number of risks for the Department and its group bodies to manage, given the complexity of the leasing arrangements entered into across the group, the materiality of the changes to both accounting and budgeting treatments, and the fact that delays in completing the 2021-22 accounts cycle directly impacts the ability for entities to resource the preparations to adopt IFRS 16 for both group entities and the Department.

851. The level of intra-group lease arrangements, of which there are several thousand, coupled with the size and complexity of the group, means that it is not possible to fully determine the financial impact of IFRS 16 until all group bodies have completed their local implementation of IFRS 16 and the required consolidation adjustments and eliminations have been actioned. The methodology for ascertaining the adjustments required has been determined and components material to the consolidation exercise, as well as the NAO, have been consulted on the approach and necessary collection requirements, to enable the appropriate elimination of intragroup arrangements. However, the delays in finalising the

2021-22 accounts has impacted the ability to resource developing the approach to implementation and consolidation for IFRS 16, meaning the first time a consolidated position will be developed by the Department will be as part of the interim 2022-23 accounts cycle, giving the Department very little time to rectify issues identified in the run up to 2022-23 year end accounts process.

852. The nature of the accounting policy changes in adoption of IFRS 16 creates issues for the Department. Accounting treatment changes for the lessee are more significant than for the lessor under IFRS 16. Whereas IFRS 16 introduces a predominantly singular lessee approach to measurement and classification in which a right of use asset and corresponding lease liability are recognised on the Statement of Financial Position (SoFP), for the lessor, leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee and when this transfer does not occur, leases are classified as operating leases. IFRS 16 can therefore generate asymmetries between the accounting treatments of lessors and lessees. This leads to instances in which assets can be on both the lessee and lessor SoFP and instances in which a relatively small value of assets needs to be reintroduced into the group financial statements despite not being recognised on the Statement of Financial Position of any group entity. Whilst, as noted above, the methodology for dealing with this asymmetry has been determined, there remains inherent challenges and associated risks around collecting and assuring the underlying data of group entities to drive the appropriate intra-group eliminations.

853. The implementation of IFRS 16 will have a material impact on the Departmental Group accounts, with the financial statements disclosing future commitments under operating leases of £4.0 billion (Core and Agency £222 million), which will be recognised on the Statement of Financial Position going forwards. The budgetary currencies through which leasing arrangements will score has also changed for the implementation of IFRS 16. The vast majority of leases entered into from 1 April 2022 and those existing leases transitioned to IFRS 16 accounting that have lease liability remeasurement events such as annual retail price index uplifts, will incur upfront CDEL charges, rather than being charged to non-ringfenced RDEL as they were under the previous leasing standard. Whilst the Department has completed a budgeting exercise for HMT to ensure its budgets are appropriately recast for the adoption of IFRS 16, a level of risk remains with the Department's position, given the issues referenced above regarding both local body and group implementation. The Department continues to engage with HMT as to how it assesses it is performing against its budgetary forecasts for IFRS 16.

854. To further mitigate against the key risks associated with implementing IFRS 16 detailed above, the Department has already conducted an agreement of leases exercise for entities within the Departmental Group, to assist with completeness of records in group bodies as to who engages as a lessee and lessor with other entities in the group and to also assist with the consistency of treatment and or judgements as to whether an arrangement does or doesn't constitute a lease.

Additionally, the Department, with NHS England have published extensive guidance, worked examples and tools to assist local entities with implementing IFRS 16, which have been continually refined based on concerns raised by group entities in consultation with DHSC and NHSE and on reflection of the output from such exercises as the agreement of leases.

Core NHS Performance Standards

855. 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 2021-22. More detail is available in the Performance Summary and Annex C.

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

Other NHS Governance Disclosures

857. A number of other matters are set out in the following paragraphs, including matters initially raised in the 2020-21 accounts which remain issues impacting the 2021-22 ARA. This includes the impairments of the Department's Loans with NHS Providers and the recovery programme being undertaken with regards to the University Hospitals of Leicester NHS Trust.

Impairment of the Department's Loans with NHS Providers

858. As described in the 2019-20 and 2020-21 Annual Reports and Accounts, the Department considered the loans it held with NHS providers to be fully recoverable and not credit impaired. During 2020-21, all loans were fully repaid, through the issuance of new Public Dividend Capital and so do not appear in the Department's 2020-21 comparative Statement of Financial Position.

859. As the National Audit Office's Comptroller and Auditor-General (C&AG) did not agree with the Department's impairment approach he chose to qualify his audit opinion on the 2019-20 Financial Statements. As these loans appear in the 2020-21 comparative information, he has qualified his opinion on this basis.

860. While the qualification of the C&AG's opinion remains, no new disagreement has arisen during 2020-21 or 2021-22.

University Hospitals of Leicester NHS Trust

861. The ARA for one NHS provider, University Hospitals of Leicester NHS Trust, have not been adopted by the Trust's Board or certified by the Trust's auditor for 2021-22. This also means that the Trust has not published its annual governance statement, which forms part of the annual report.

862. 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.

863. During 2020 the work of the Trust and its external auditor identified significant weaknesses in internal control. Findings included deficiencies in financial systems and control, governance, and financial reporting, in particular the use and authorisation of journals in the accounting ledger. Action has now been taken to resolve these matters, including detailed plans for improvement.

864. The Trust's external auditor did not express an audit opinion on the financial statements of the Trust for the year ended 31 March 2020, as they were unable to obtain sufficient appropriate audit evidence in a number of key areas.

865. The 2020-21 audit identified fewer and more isolated misstatements than in 2019-20. However, the Trust's external auditors continued to identify system and control weaknesses resulting in material misstatements during 2020-21 and therefore issued an adverse audit opinion.

866. The Trust recognises that, through the actions being taken and controls being put in place, it still remains on a journey towards sustainable financial improvement and ultimately to an exit from Financial Special Measures and to an unqualified audit opinion.

867. Work remains ongoing to publish the ARA for 2021-22 as soon as possible. The ARA is expected to be finalised in February 2023.

Overpayments to Medical Practitioners

868. If a medical practitioner is suspended, they may be entitled to receive suspension payments for a limited time as set out in relevant statutory regulations.

869. During the reporting period, NHS England identified suspension payments to two medical practitioners which in one case was paid beyond the entitlement period and in the other case where there was never an entitlement to suspension payments. This resulted in two overpayments totalling £964,000. The NHS England Group Annual Report and Accounts has a qualified regularity opinion as a result of these payments as the C&AG considers them to be material by their nature. This does not affect the Department's Annual Report and Accounts.

870. NHS England improved the relevant controls over how suspension payments are managed and as a result found these payments.

871. NHS England improved controls include implementing new procedural guidance that ensures that payments are not made to medical practitioners until entitlement to suspension payment is validated by a named responsible individual in the region. All regional leads now complete monthly monitoring of suspensions, their status and payments being made. There is further improvement to controls

by reporting all current suspension payments monthly via a Professional Standards Oversight Group, which contains national medical representation, which allows for peer review and improves visibility of all current cases. A training process for regional leads has also been carried out with emphasis on the policy and its application.

Excess Vote in relation to clinical negligence provision

872. 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.

873. NHS England, NHS Foundation Trusts and NHS Trusts retain legal responsibility for all liabilities covered by 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 NHS Resolution Annual Report and Accounts 2021-22.

874. 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.

875. The known claims provision calculation uses the expected settlement date (ESD) from individual claims recorded in the Claims Management System (CMS) to apply inflation and discounting to reach a valuation. However, for the disclosure of the expected timing of cashflows, this has historically been based on an actuarial view of settlement patterns.

876. An adjustment to the 2021-22 known claims provision has been applied to the estimate technique as there has been a significant divergence between the two views, most likely as a result of the impact of the COVID-19 pandemic.

877. As part of this reassessment, it has been concluded that this approach should have been applied to prior periods, drawing on the information that was available at the time, as it results in a better estimate of the known claims provision.

878. The prior period financial statements have therefore been restated as required by IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors. Further details of the adjustments to the financial statements are provided at Note 16 to the accounts.

879. This restatement is wholly due to changes in the estimated timing of future payments rather than changes in the underlying expected payment amounts.

Because of the changes in expected settlement dates this impacts the present value of these future payments.

880. The Department is required to record the budgetary impact of this restatement as non-budget voted expenditure. This prior period adjustment was not identified in time to enable the Department to seek parliamentary approval through the supplementary estimate process. As a result, the Department has incurred a technical breach of this Parliamentary control total and requires an Excess Vote. This has consequently led the C&AG to qualify his audit opinion in this regard.

881. Potential changes to the process are being identified to improve the estimate of the expected timing of cash-flows.

Key NHS Operational Governance

882. Further matters covered below relate to inquiries, reviews and issues that have arisen during 2021-22 up to the time of signing these accounts, for which further information will be provided in the 2022-23 accounts as well as commentary on significant ongoing matters such as cyber security, EU Exit, screening programmes and Grenfell.

Screening Programmes

883. Significant progress has been made in addressing the recommendations made in Professor Sir Mike Richards's report on adult screening in England. UK Health Ministers have agreed an expanded remit and revised Terms of Reference for the UK National Screening Committee (UK NSC), so that targeted screening programmes can be reviewed and implemented with the same rigour as population screening programmes.

884. As part of the transition of Public Health England's functions, the Screening Quality Assurance Service and the Clinical and Research Advisory Committees are now embedded within NHS England. This has strengthened the operational delivery and commissioning of screening programmes. NHS England is responsible for designing and implementing new IT systems for screening.

885. Throughout the COVID-19 pandemic, cancer screening services continued where it was clinically safe to do so. However, some aspects of these services were paused locally because of the impact of the pandemic. Restoration of cancer screening services has been a priority for the Department and NHS England. Recovery was overseen by the National Cancer Delivery Taskforce. This enabled a more integrated approach to planning screening services and diagnostic services for people with cancer symptoms and better planning of capacity linked to availability of treatment services.

886. On 1 October 2021, Public Health England's functions and accountabilities for screening services moved in part to the Office for Health Improvement and Disparities (OHID) within DHSC and in part to NHS England. OHID is now responsible for supporting system leadership on screening across DHSC and NHS England, providing the secretariat for the UK NSC and providing expert advice and information to ensure consistency in efficacy and safety across the country. NHS England is responsible for the delivery of screening programmes in line with national pathway requirements and standards.

Grenfell

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

888. 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.

889. Out of eight Trusts identified as needing remedial work, only one Trust had remediation work ongoing at 31 March 2022 with remediation work in all the other Trusts completed, as shown in **Table 26**.

Table 26: Grenfell Remedial Work

Organisation Name	Status
Bradford Teaching Hospital NHS Foundation Trust	Remediation Completed
Gateshead Health NHS Foundation Trust	Remediation Completed
The Royal Wolverhampton NHS Trust	Remediation Completed
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Remediation Completed
Kings College NHS Foundation Trust	Remediation Completed
Oxford University Hospitals NHS Foundation Trust	Remediation Completed
Sheffield Children's NHS Foundation Trust	Remediation Completed
Guy's and St Thomas NHS Foundation Trust	Remediation Ongoing

Source: Ministry for Housing, Communities and Local Government (now called the Department for Levelling Up, Housing and Communities) and NHSE and NHSI.

East Kent University NHS Foundation Trust Maternity and Neonatal Services

890. Following concerns raised about the quality and outcomes of East Kent Hospitals University NHS Foundation Trust maternity and neonatal care, in February 2020, NHSE and NHSI commissioned Dr Bill Kirkup to undertake the East Kent Maternity Independent Investigation.

891. The terms of reference were agreed and announced in Parliament by the then Minister of State for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries on the 11 March 2021. The inquiry has now concluded and the final Report 'Maternity and neonatal services in East Kent: 'Reading the signals' report' was published on 19 October 2022.

Ockenden Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust

892. The Ockenden Review is assessing the quality of investigations relating to new-born, infant and maternal harm at Shrewsbury and Telford Hospitals NHS Trust (SaTH). The original terms of reference for the Review covered the handling of 23 cases.

893. Following the launch of the review in 2017, additional cases were identified, and the final total of cases being considered increased to 1,862. An interim report, published in December 2020, reviewed 250 cases, and contained 7 Immediate and Essential Actions for the NHS.

894. The second and final report, published on 30 March 2022, included detailed and in-depth analysis of all remaining cases and detailed discussion on the themes identified. It contained 64 local actions to the Trust, 15 Immediate and Essential Actions for the maternity system and 3 key asks for the Secretary of State for Health and Social Care.

895. On 30 March 2022, The then Secretary of State for Health and Social Care issued an oral statement in the House of Commons. He apologised to the families for their suffering and accepted all the recommendations made in the report.

896. In May 2022, NHS England appointed Donna Ockenden to lead a further review of NHS maternity units at Nottingham University Hospitals NHS Trust. This review formally launched in September 2022.

Maidstone & Tunbridge Wells NHS Trust: David Fuller

897. In November 2021, David Fuller pleaded guilty to the murder of two young women in 1987 and to a number of sexual offences in a hospital setting. An independent inquiry has been announced into the circumstances surrounding the offences committed in hospital settings, and their national implications.

898. The Inquiry will publish its initial report on matters relating to David Fuller's activities at Maidstone and Tunbridge Wells NHS Trust during 2023 and its final report, looking at the broader national picture and the wider lessons for the NHS and other settings in 2023.

Special Health Authority for Maternity Investigations

899. On 26 January 2022, the then Secretary of State for Health and Social Care announced plans to establish a special health authority to continue the maternity investigation programme, currently a function of the Healthcare Safety Investigation Branch. This Authority will continue independent, standardised, family-centred investigations once the new Health Services Safety Investigations Body is established in April 2023.

Essex Mental Health Independent Inquiry

900. In January 2021, Nadine Dorries, the then Minister of State for Patient Safety, Suicide Prevention and Mental Health announced the establishment of non-statutory Independent Inquiry into the circumstances of mental health inpatient deaths in Essex. The Inquiry intends to publish a report in 2023.

Remuneration and Staff Report

Remuneration Report

901. 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 EPN647 guidance.

902. 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.

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

904. 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.

Ministerial changes during 2021-22

- Matt Hancock resigned as Secretary of State for Health and Social Care on 26th June 2021.
- Sajid Javid was appointed as Secretary of State for Health and Social Care on 27th June 2021.
- Gillian Keegan was appointed as Minister of State (Minister for Care and Mental Health) on 16th September 2021.
- Maggie Throup was appointed as Parliamentary Under Secretary of State (Minister for Vaccines and Public Health) on 16th September 2021.
- Maria Caulfield was appointed as Parliamentary Under Secretary of State (Minister for Patient Safety and Primary Care) on 17th September 2021.
- Lord Kamall was appointed as Parliamentary Under Secretary of State (Minister for Technology, Innovation and Life Sciences) on 17th September 2021.

Remuneration of Senior Officials and Ministers

905. The Directors' Report outlines the senior officials and Ministers of the Department and their dates of appointment (and departure where appropriate), but their remuneration is detailed in **Table 28**, with Ministers in **Table 27**.

Salary

906. '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.

907. 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.

908. 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 27**.

909. The remuneration of Senior Civil Servants is determined in accordance with the rules set out in the Civil Service Management Code and in line with the annual SCS framework guidance issued by Cabinet Office.

910. As a result of the one-year public sector pay freeze, there were no increases in base pay offered to Senior Civil Servants in 2021-22.

Non-Consolidated Performance Pay

911. 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.

912. 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.

913. The non-consolidated performance pay included in the 2021-22 figures relates to awards made in respect of the 2020-21 performance year but paid in the 2021-22 financial year. It was agreed that awards would not be differentiated by grade SCS Pay (Band 1-3). An award of £7,000 was paid to the top performers in each SCS Pay Band (Band 1-3).

Benefits in Kind

914. The monetary value of benefits in kind covers any payments or other benefits provided by the Department which are treated by HM Revenue & Customs as a taxable emolument. For its direct employees, the Department pays the individual

a net sum and pays tax directly to His Majesty's Revenue & Customs (HMRC). No benefits in kind were incurred during 2021-22 by Ministers or Senior Officials of the Department.

915. **Tables 27** and **28** provide details of remuneration interests of the Ministers of the Department and senior officials serving on the Departmental Board for the years 2020-21 and 2021-22 and are subject to audit.

Table 27: Remuneration of Ministers of the Department (subject to audit)

	2021-2022				2020-2021			
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)
Sajid Javid MP *(from 27/06/2021)* Secretary of State	51,379	-	13,000	64,000	-	-	-	-
Full Year Equivalent	67,505							
Edward Argar MP *(to 06/07/2022)* Minister of State	31,680	-	8,000	40,000	31,680	-	8,000	39,000
Full Year Equivalent								
Gillian Keegan MP *(from 16/09/2021)* Minister of State	16,228	-	4,000	20,000	-	-	-	-
Full Year Equivalent	31,680							
Maggie Throup MP *(from 16/09/2021)* Parliamentary Under Secretary of State	11,373	-	3,000	14,000	-	-	-	-
Full Year Equivalent	22,375							
Maria Caulfield MP *(from 17/09/2021)* Parliamentary Under Secretary of State	11,361	-	3,000	14,000	-	-	-	-
Full Year Equivalent	22,375							
Lord Kamall (from 17/09/2021) Parliamentary Under Secretary of State	38,244	-	9,000	47,000	-	-	-	-
Full Year Equivalent	70,969							
Rt Hon Matt Hancock MP *(from 10/07/2018 - 26/06/2021)* Secretary of State	16,126	-	4,000	20,000	67,505	-	17,000	84,000
Full Year Equivalent	67,505							
Helen Whately MP *(from 14/02/2020 - 15/09/2021)* Minister of State	15,840	-	4,000	20,000	31,680	-	8,000	39,000
Full Year Equivalent	31,680							
Nadine Dorries MP *(from 27/07/2019 - 14/09/2021)* Minister of State	15,840	-	3,000	19,000	30,780	-	8,000	38,000
Full Year Equivalent	31,680				31,860			
Jo Churchill MP *(from 26/07/2019 - 15/09/2021)* Parliamentary Under Secretary of State	11,187	-	3,000	14,000	22,375	-	5,000	28,000
Full Year Equivalent	22,375							
Lord Bethell of Romford *(from 09/03/2020 - 15/09/2021)*[2] Parliamentary Under Secretary of State (Lords)	-	-	-	-	-	-	-	-
Nadhim Zahawi MP *(from 28/11/2020 - 14/09/2021)*[3] Parliamentary Under Secretary of State	-	-	-	-	-	-	-	-

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 waive any ministerial increases in their salary for the duration of this Parliament.
2. Lord Bethell's roles as Parliamentary Under Secretary of State (Lords) was unpaid.
3. The Parliamentary Under Secretary of State (Minister for COVID-19 Vaccine Deployment) was not paid for this role.

Table 28: Remuneration of Senior Officials of the Department (subject to audit)

	2021-2022					2020-2021				
Officials	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1000)[2]	Total (£'000)	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1000)[2]	Total (£'000)
Sir Christopher Wormald KCB Permanent Secretary	175-180	15-20	-	46,000	240-245	175-180	-	-	94,000	270-275
Shona Dunn *(from 01/04/21)* [9] Second Permanent Secretary	155-160	-	-	36,000	190-195	-	-	-	-	-
Professor Sir Chris Whitty Chief Medical Officer for England	205-210	-	-	30,000	235-240	205-210	-	-	30,000	235-240
Clara Swinson CB Director General Global Health	130-135	5-10	-	32,000	170-175	130-135	5-10	-	68,000	205-210
Jonathan Marron[3] Director General Office for Health Improvement and Disparities	130-135	5-10	-	54,000	190-195	135-140	-	-	51,000	185-190
Matthew Style *(from 01/11/2021)* [8] Director General NHS Policy and Performance Full Year Equivalent	60-65 140-145	-	-	(27,000)	30-35	-	-	-	-	-
Michelle Dyson *(from 17/09/2020)* Director General Adult Social Care Full year equivalent	120-125 125-130	-	-	60,000	180-185	60-65 120 - 125	-	-	88,000	150-155
Andy Brittain *(from 05/04/21)* Director General, Finance Full Year Equivalent	125-130 125-130	-	-	34,000	155-160	-	-	-	-	-
Steve Oldfield [4] *(to 17/10/22)* **(career break 03/01/22 - 17/10/22)** Chief Commercial Officer Full year equivalent	180-185 235-240	40-45	-	5,000	225-230	235-240	40-45	-	7,000	285-290
Matthew Gould[5] Chief Executive Officer, NHSX Full Year Equivalent	25-30 125-130	-	-	5,200	30-35	25-30 125-130	-	-	10,000	35-40
Lucy Chappell *(from 01/08/2021)* [6] Chief Scientific Adviser Full Year Equivalent	70-75 140-145	-	-	9,100	80-85	-	-	-	-	-
Jenny Richardson[7] Director of Human Resources	105-110	5-10	-	27,000	140-145	105-110	5-10	-	44,000	160-165
Hugh Harris[7] Director Ministers, Accountability and Strategy Full Time Equivalent	95-100 105-110	-	-	25,000	120-125	100-105 105-110	-	-	41,000	140-145
Lorraine Jackson *(from 17/06/2021)* [7,10] Director of Information Risk Management and Assurance Full Time Equivalent	70-75 90-95	-	-	15,000	85-90	-	-	-	-	-
David Williams CB *(to 05/04/2021)* [8] Second Permanent Secretary Full Year Equivalent	0-5 155-160	-	-	-	0-5	155-160	5-10	-	159,000	325-330
Lee McDonough *(to 06/06/2021)* [8] Director General NHS Policy and Performance Full Year Equivalent	20-25 130-135	-	-	2,000	25-30	130-135	-	-	45,000	175-180
Paul Kissack *(from 06/04/2020 to 08/08/2020)* Director General	-	-	-	-	-	-	-	-	-	-
Ros Roughton *(27/04/2020 to 01/09/2020)* Director General	-	-	-	-	-	40-45 120-125	-	-	20,000	60-65

1. Non-Consolidated Performance Pay paid in 2021-22 relates to the 2020-21 performance year.
2. Steve Oldfield (left DHSC on 17 October 2022) and Professor Chris Whitty hold a defined contribution pension therefore figures shown represent the Department's contribution to this scheme. No other pension figures are included.
3. Salary amount disclosed includes backdated pay increase from 01/01/2020.
4. Steve Oldfield (see note 2) was appointed on 07/10/2017 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.
5. 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 was fully remunerated by DHSC as his primary employer, who established his terms of employment on joining the Department on 20/05/2019. For 2020-21 and for 2021-22 NHSE and NHSI reimbursed DHSC for 80% of Matthew's costs and as such DHSC show only 20% of pay and pension details with NHSE and NHSI disclosing the remaining 80%.

6. Professor Lucy Chappell was appointed on 01/08/2021 on secondment from Kings College, London, in 2021-22 she was seconded for 4 days a week between 01/08/2021 and 31/03/2022. The figures in the table represent the proportion the Department paid only, not the full salary. The Department contributes to her pension scheme with Kings College, London.
7. Per the detail in the Accountability Report it has been determined that all members of the Department's Board and Executive Committee should be disclosed as senior officials of the Department in accordance with the FReM.
8. The final salary pension of a person in employment is calculated by reference to their pay and length of service. The pension will increase from one year to the next by virtue of any pay rise during the year. Where there is no, or a small, pay rise the increase in pension due to extra service may not be sufficient to offset the inflation increase. In real terms, the pension value can reduce resulting in negative values.
9. Shona Dunn, SRO of the Community Testing Programme became a member of ExCo in 2020 and was subsequently appointed as Second Permanent Secretary in April 2021. Shona was fully remunerated in her role as Second Permanent Secretary at the Home Office during 2020-21 and as DHSC did not reimburse the Home Office for Shona's work as a workstream SRO during 2020-21, no pay is disclosed.
10. Lorraine Jackson was appointed as a Director from 15/06/2020, subsequently Lorraine became a member of ExCo committee from 17/06/21.

Fair Pay Disclosure (Subject to audit)

916. Departments are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median, and upper quartile remuneration of the organisation's workforce. See **Table 29**.

Table 29: Pay Ratios for Core Department and Executive Agencies

	Core Department		Department & Executive Agencies	
	2021-2022	2020-2021	2021-2022	2020-2021
25th Percentile Pay Ratio	6.3:1	-	6.9:1	-
Median Pay Ratio	4.5:1	6.8:1	5.2:1	7.0:1
75th Percentile Pay Ratio	3.7:1	-	3.9:1	-

1. Pay ratio compares the percentile pay benefits to the highest paid Director.
2. 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.

917. **Table 30** shows the total remuneration and salary element of each of the quartiles.

Table 30: Total Remuneration and Salary Element for Core Department and Executive Agencies

	Core Department 2021-2022	Department & Executive Agencies 2021-2022
25th Percentile Total Remuneration (salary element)	33,092 (32,792)	30,168 (30,168)
Median Total Remuneration (salary element)	46,046 (40,646)	40,074 (40,074)
75th Percentile Total Remuneration (salary element)	55,700 (55,300)	53,655 (53,355)

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. Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind for each employee on the percentile. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.
3. The salary element is the total remuneration of the employee, at the 25th percentile, median, and 75th percentile, further broken down to the salary component.

918. The median earning of the Core Department has increased in 2021-22 by 10.7%, compared to 2020-21. This equated to £4,448. This is a significantly larger increase of median earnings compared to 2020-21, in which the increase of median earnings was £729.

919. A key contributing factor to this movement is the merging of Public Health England (PHE) into the Core Department, to form part of the Office for Health Improvement and Disparities (OHID), parallel with the movement of Test and Trace colleagues out of the Department, to the UK Health Security Agency (UKHSA) Executive Agency, changing the Core Department's composition.

920. In addition, there was a change in the remuneration of the highest paid Director due to a SCS member of staff leaving the Department in 2021-22. This is shown further in **Table 31** which shows the banded remuneration range for the Core Department and Executive Agencies. The remuneration band has been lowered to reflect the new highest paid Director.

Table 31: Banded Remuneration Range for Core Department and Executive Agencies

	Core Department		Department & Executive Agencies	
	2021-2022	2020-2021	2021-2022	2020-2021
Band of Highest Paid Director's Total remuneration (£000)[1]	205-210	280-285	205-210	280-285
Band of Lowest Paid	15-20	15-20	15-20	15-20

1. Salaries for senior management disclosed in bands of £5,000, in accordance with EPN597 guidance.
2. 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.

921. The banded remuneration of the highest paid Core Department Director in 2021-22 was £205,000-£210,000 (2020-21 was £280,000-£285,000). This was 4.5 times the median remuneration of the workforce of £46,046 (2020-21 was £41,598).

922. In 2021-22, one DHSC core employee received remuneration in excess of the highest paid Director. This employee's base salary range was supplemented with allowances, including a Clinical Excellence Award, resulting in a salary in the £220,000-£225,000 range.

923. Banded remuneration ranged from £15,000 to £20,000 and £220,000 to £225,000 (2020-21 was £15,000 to £20,000 and £280,000 - £285,000).

924. On average, core department employees, not including the highest-paid director, had a pay and benefits increase of 2%. The highest paid director decreased by 26.5% between the two years (see **Table 32**).

Table 32: Percentage Change in Remuneration from 2020-21

Percentage Change in Total Remuneration	Core Department		Department & Executive Agencies	
	Highest Paid Director	Average of total employees	Highest Paid Director	Average of total employees
Change from 2020-21	-26.5%	2.0%	-26.5%	-0.8%

Civil Service Pensions

925. Pension benefits are provided through the Civil Service pension arrangements. From 1 April 2015 a new pension scheme for civil servants was introduced – the Civil Servants and Others Pension Scheme or alpha, which provides benefits on a career average basis with a normal pension age equal to the member's State Pension Age (or 65 if higher). From that date all newly appointed civil servants and the majority of those already in service joined alpha. Prior to that date, civil servants participated in the Principal Civil Service Pension Scheme (PCSPS). The PCSPS has four sections: 3 providing benefits on a final salary basis (classic, premium or classic plus) with a normal pension age of 60; and one providing benefits on a whole career basis (nuvos) with a normal pension age of 65.

926. These statutory arrangements are unfunded with the cost of benefits met by monies voted by Parliament each year. Pensions payable under classic, premium, classic plus, nuvos and alpha are increased annually in line with Pensions Increase legislation. Existing members of the PCSPS who were within 10 years of their normal pension age on 1 April 2012 remained in the PCSPS after 1 April 2015. Those who were between 10 years and 13 years and 5 months from their normal pension age on 1 April 2012 switch into alpha sometime between 1 June 2015 and 1 February 2022. Because the Government plans to remove discrimination identified by the courts in the way that the 2015 pension reforms were introduced for some members, it is expected that, in due course, eligible members with relevant service between 1 April 2015 and 31 March 2022 may be entitled to different pension benefits in relation to that period (and this may affect the Cash Equivalent Transfer Values shown in this report – see below). All members who switch to alpha have their PCSPS benefits 'banked', with those with earlier benefits in one of the final salary sections of the PCSPS having those benefits based on their final salary when they leave alpha. (The pension figures quoted for officials show pension earned in PCSPS or alpha – as appropriate. Where the official has benefits in both the PCSPS and alpha the figure quoted is the combined value of their benefits in the two schemes). Members joining from October 2002 may opt for either the appropriate defined benefit arrangement or a defined contribution (money purchase) pension with an employer contribution (partnership pension account).

927. Employee contributions are salary-related and range between 4.6% and 8.05% for members of classic, premium, 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.

928. The partnership pension account is an occupational defined contribution pension arrangement which is part of the Legal & General Mastertrust. The employer makes a basic contribution of between 8% and 14.75% (depending on the age of the member). The employee does not have to contribute, but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.5% of pensionable salary to cover the cost of centrally provided risk benefit cover (death in service and ill health retirement).

929. The accrued pension quoted is the pension the member is entitled to receive when they reach pension age, or immediately on ceasing to be an active member of the scheme if they are already at or over pension age. Pension age is 60 for members of classic, premium and classic plus, 65 for members of nuvos, and the higher of 65 or State Pension Age for members of alpha. (The pension figures quoted for officials show pension earned in PCSPS or alpha – as appropriate. Where the official has benefits in both the PCSPS and alpha the figure quoted is the combined value of their benefits in the two schemes but note that part of that pension may be payable from different ages.)

930. Further details about the Civil Service pension arrangements can be found at the website www.civilservicepensionscheme.org.uk

Ministerial Pensions

931. 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.

932. 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 MPs and aged 55 or older on 1 April 2013 have transitional protection to remain in the previous MP's final salary pension scheme.

933. 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.

934. The figure shown for pension value includes the total pension payable to the member under both the pre- and post-2015 Ministerial pension schemes.

935. **Tables 34** and **33** provide details of the pension interests for the Department's Officials and Ministers for 2020-21 and 2021-22 and are subject to audit.

Cash Equivalent Transfer Values

936. 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.

937. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the pension benefits they have accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total Ministerial service, not just their current appointment as a Minister. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

Real Increase in CETV

938. 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.

939. 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 33: Pension Interests of Ministers (subject to audit)

	Accrued pension at age 65 as at 31/03/22 £'000	Real increase in pension at age 65 £'000	CETV at 31/03/22 £'000	CETV at 31/03/21 £'000	Real increase in CETV £'000
Sajid Javid	10-15	0-2.5	150	132	7
Edward Argar	0-5	0-2.5	22	15	3
Gillian Keegan	0-5	0-2.5	13	9	2
Maggie Throup	0-5	0-2.5	15	10	2
Maria Caulfield	0-5	0-2.5	10	7	1
Lord Kamall	0-5	0-2.5	9	0	5
Matt Hancock	5-10	0-2.5	61	58	1
Helen Whately	0-5	0-2.5	13	9	2
Nadine Dorries	0-5	0-2.5	66	60	3
Jo Churchill	0-5	0-2.5	21	18	2
Lord Bethell[2]	-	-	-	-	-
Nadhim Zahawi[3]	-	-	-	-	-

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. Lord Bethell's role as Parliamentary Under Secretary of State (Lords) was unpaid.

3. Nadhim Zahawi's role as Parliamentary Under Secretary of State (Minister for COVID-19 Vaccine Deployment) was unpaid.

4. Where an individual has left or joined the department part way through the year, the figures above are calculated according to the period in-post.

Table 34: Pension Information of Senior Officials of the Department (subject to audit)

		Accrued pension at pension age as at 31/03/22 and related lump sum £'000	Real increase in pension and related lump sum at pension age £ '000	CETV at 31/03/22 £ '000	CETV at 31/03/21 £ '000	Real increase in CETV £'000	Employer contribution to partnership pension account Nearest £100	Employer contribution to external pension scheme Nearest £'000
Sir Christopher Wormald KCB	Permanent Secretary	90-95	2.5-5.0	1,548	1,446	19	-	-
Shona Dunn	Second Permanent Secretary	60-65 plus a lump sum of 110-115	2.5-5.0 plus a lump sum of 0 (zero)	1,068	993	11	-	-
Professor Sir Chris Whitty[1]	Chief Medical Officer for England	-	-	-	-	-	30,300	-
Clara Swinson CB	Director General for Global Health	45-50 plus a lump sum of 80-85	0-2.5 plus a lump sum of 0 (zero)	702	653	9	-	-
Jonathan Marron	Director General for Office for Health Improvement and Disparities	25-30	2.5-5.0	319	274	27	-	-
Matthew Style	Director General NHS Policy and Performance	20-25	0 (Zero)	328	338	(27)	-	-
Michelle Dyson	Director General for Adult Social Care	35-40 plus a lump sum of 70-75	2.5-5.0 plus a lump sum of 2.5-5.0	651	576	38	-	-
Andy Brittain	Director General Finance	50-55 plus a lump sum of 100-105	0-2.5 plus a lump sum of 2.5-5.0	889	813	25	-	-
Steve Oldfield[1]	Chief Commercial Officer	-	-	-	-	-	5,300	-
Matthew Gould[3]	Chief Executive Officer, NHSX	10-15	0-2.5	195	183	1	-	-
Lucy Chappell[4]	Chief Scientific Advisor	-	-	-	-	-	-	9,100
Jenny Richardson[2]	Director of Human Resources	35-40	0-2.5	511	474	6	-	-
Hugh Harris[2]	Director of Ministers, Accountability and Strategy	35-40	0-2.5	508	471	8	-	-
Lorraine Jackson[2]	Director of Information Risk Management and Assurance	40-45	0-2.5	650	629	4	-	-
David Williams CB	Second Permanent Secretary, Director General for Finance & Group Operations	65-70 plus a lump sum of 140-145	0-2.5 plus a lump sum of 0 (zero)	1,238	1,242	0	-	-
Lee McDonough	Director General for NHS Policy and Performance Group	50-55 plus a lump sum of 145-150	0-2.5 plus a lump sum of 0	1,186	1,180	(1)	-	-
Paul Kissack	Director General	-	-	-	-	-	-	-
Ros Roughton	Director General for Adult Social Care	-	-	-	-	-	-	-

1. Steve Oldfield (left DHSC on 17 October 2022) and Professor Sir Chris Whitty hold a defined contribution pension therefore figures shown represent the Department's contribution to this scheme. No other pension figures are included. Steve Oldfield was appointed on 07/10/2017 on loan from the Government Commercial Office (GCO).
2.Jenny Richardson, Hugh Harris and Lorraine Jackson were members of ExCo during 2019-20 and 2020-21.
3.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 was fully remunerated by DHSC as his primary employer, who established his terms of employment on joining the Department on 20 May 2019. For 2020-21 and for 2021-22, NHSE and NHSI reimbursed DHSC for 80% of Matthew's costs and as such DHSC show only 20% of pay and pension details with NHSE and NHSI disclosing the remaining 80%.
4.Lucy Chappell is on secondment and the department is contributing to her pension scheme with Kings College, London.
5.Where an individual has left or joined the department part way through the year, the figures above are calculated according to the period in-post.

Non-Executive Directors

940. Non-Executive Directors (see **Table 35**) 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. Non-Executive Directors also make a significant contribution to Departmental business by working through Committees and with senior officials.

941. The Departmental Board holds positions for six Non-Executive Directors. The Non-Executive Directors sitting on the Departmental Board during 2021-22 are detailed in the Directors' Report. There are also three Independent members of Audit & Risk Committee.

942. 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 35: Non-Executive Directors and Members of the Department (subject to audit)

			2021-2022		2020-2021	
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 July 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
Julian Hartley	Non-Executive Board Member	1 Nov 2021 - 31 Oct 2024	6,000	15,000	-	-
Michael Mire	Non-Executive Board Member & Member of Audit & Risk Committee	1 Nov 2017 - 31 Oct 2020	-	-	9,000	15,000
Prof Sir Mike Richards	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	-	-	9,000	15,000
Prof Dame Sue Bailey	Non-Executive Board Member	1 Nov 2017 - 31 Oct 2020	-	-	9,000	15,000
Gina Coladangelo[1]	Non-Executive Board Member	1 Sep 2020 - 31 Aug 2023	4,000	15,000	9,000	15,000
Doug Gurr	Non-Executive Board Member	1 Dec 2020 - 30 Nov 2023	15,000	15,000	5,000	15,000
Anne Barnard	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2022	5,000	5,000	5,000	5,000
Graham Clarke	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2022	5,000	5,000	5,000	5,000
Richard Hornby	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2022		Non-remunerated Civil Servant		Non-remunerated Civil Servant

1. Gina Coladangelo resigned from Non Executive Director role on 26 June 2021.

Compensation for Loss of Office (subject to audit)

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

944. There were no severance payments in the 2021-22 financial year.

Staff Report

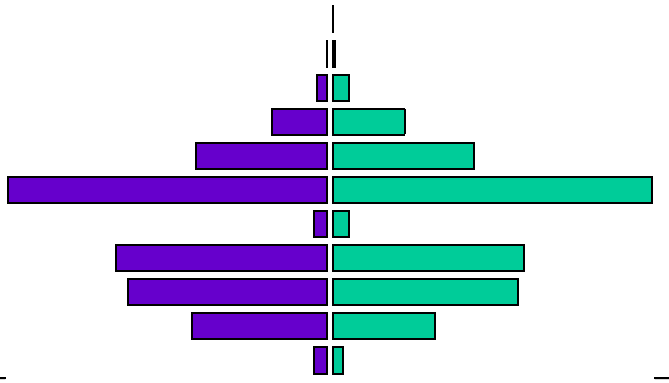
945. This Staff Report summarises the Core Department's key staffing information and policies, with the staff costs, numbers and exit packages disclosures subject to audit.

946. The Core Department employed an average of 3,275 permanent whole time equivalent (WTE) persons during 2021-22 at a total salaries and wages cost of £186.3 million, compared to 2,015 at a cost of £118.9 million in 2020-21. 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 41** and **42**.

DHSC Staff

947. 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 36** outlines the headcount and gender distribution of Core Departmental staff in post as at 31 March 2022 and is consistent with Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment with the Department.

Figure 36: Gender Distribution of Core Department Staff (Headcount)



Grade	Female	Male	Total
Perm Sec	1	2	3
SCS 3	2	4	6
SCS 2	28	24	52
SCS 1	138	98	236
GRADE 6	322	193	515
GRADE 7	773	433	1206
FAST ST	36	25	61
SEO	512	261	773
HEO	486	251	737
EO	329	139	468
AO	36	16	52
	2,663	**1,446**	**4,109**

Staff Sickness

948. The Core Department has seen an increase in the number of days lost to short-term sickness, rising from 1,043 in the rolling calendar year up to 31 December 2020 to 2,821 up to 31 December 2021. There has also been a rise in days lost to long-term sickness reported over the same period, from 3,377 to 4,273. This largely explained by the increase in staff numbers over the previous year. Over the same rolling calendar year up to 31 December 2021, the average number of working days lost stands at

89% of staff with no recorded sickness in the year ending 31 December 2021

2, down from 2.2 as at December 2020. Some 89 per cent of our staff have no recorded sickness in the calendar year up to 31 December 2021, down from 92 per cent at the same point the previous year.

Staff Turnover

949. The Core Department has experienced an 11% turnover of staff during the 2021-22 financial year. This is an increase over the 2020-21 year in which staff turnover in the Core Department was 8%.

Staff Redeployment

950. During 2021-22 the Department benefited from a significant number of civil servants loaned from other Government Departments.

951. The number and grade of staff re-deployed is shown in **Table 36**.

Table 36: Staff redeployment by grade

Grade	Cost incurred by the Department	Cost not incurred by the Department	Total
	Number	Number	Number
AO & EO	8	26	34
HEO & SEO	57	83	140
G7 & G6	109	81	190
SCS	30	20	50
Totals	**204**	**210**	**414**

952. For those individuals above where the cost was not incurred by the Department, the estimated cost at average cost for the relevant grade is £14 million.

953. Of the above 210 individuals for which the cost was not incurred by the Department, 119 individuals were loaned for 6 months or less and 91 were loaned for more than 6 months.

Health and Safety

954. The Department of Health and Social Care recognises its responsibilities, under the Health and Safety at Work Act 1974, for ensuring, so far as is reasonably practicable, the health, safety and welfare of its employees, temporary staff, and visitors to its premises and to others who may be affected by its operations and/or activities. In 2021-22, there was one reported accident (which did not result in absence) and no near misses.

Staff Diversity

955. Information showing how the Department complies with the public sector equality duty as set out in The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, can be found in Section 2 of the report Equality in 2021: how DHSC met the public sector equality duty (23 June 2022). The Report

covers the period up to 30 September 2021, the most recent available data. The data presented shows information relating to DHSC's employees by protected characteristic. Information is presented on age, disability, ethnicity, gender, religion or belief and sexual orientation. We have also provided information on working pattern and caring responsibilities of our employees, as we extend protection from discrimination and disadvantage to these groups, amongst others.

Equal Opportunities Policy

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

957. The Department's Strategic Commitments to equal opportunities and diversity are set out in the Department's Equality Objectives: 2019-23.

958. 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 integral to the Department's culture and values. Our D&I ambition focuses on the 3 overarching themes:
    - Empowered and Accountable Leadership – Ensuring inclusion is everyone's responsibility and should be embedded as part of the normal leadership process.
    - Inclusive by Default – Creating a sense of belonging in our workforce reiterating our goal of inclusion for all.
    - Attract, Develop and Retain Diverse Talent – Allowing us to better reflect the communities we serve.

959. The Department recognises the importance of creating an environment where everyone feels included and motivated to deliver their best. This includes leading from the top on diversity and inclusion and the Second Permanent Secretary has been appointed as the Department's D&I champion. The Second Permanent Secretary is supported by D&I champions from the senior leadership team who individually focus on:
    - disability
    - domestic abuse
    - faith and belief
    - gender identity/trans identity
    - health and wellbeing
    - parents, carers and flexible working
    - race

- sexual orientation
- social mobility
- speak out and safe to challenge.

960. The Department strives to embed an evidence-based and outcome-focused approach in all that we do to progress equality and inclusion. Diversity data is regularly monitored, enabling us to identify areas for improvement and measure our progress in making the Department a more inclusive workplace. We use a range of measures to track progress – including self-declaration data in the HR management system, recruitment data and trends in staff survey data (Civil Service People Survey).

961. The Engagement Index Score for 'Inclusion' in the 2021 People Survey was 83 per cent. Whilst a positive score it does represent a slight decrease from our 2020 position (85 per cent).

962. Throughout the year we have carried out targeted activities to encourage staff to share their diversity data, including blog posts from senior leaders, demonstration sessions and tutorials. This resulted in a 7 per cent increase in data declaration rates and provided actionable insights to the Department to progress equality and inclusion.

963. In line with its commitment to be a fully diverse and inclusive employer, the Department has launched a number of projects as part of our Race Equality Action Plan. Examples of the targeted work the Department has undertaken include: the launch of a reverse mentoring scheme, recruitment workshops aimed at underrepresented groups and the launch of a pilot sponsorship scheme. Upcoming initiatives include running another cohort of the reverse mentoring scheme and rolling out the sponsorship scheme to the rest of the Department.

964. The Department also launched its Enabling Staff Action Plan in December 2021, which seeks to address the unique health and wellbeing concerns of staff with disabilities and long-term conditions by attracting the right people to the Department, ensuring there are no barriers to them bringing their whole selves to work and promoting a culture of equity. One of the key actions in the plan is improving line manager capability to support staff with disabilities through training.

965. The Department's Staff Network Groups host a range of events throughout the year. The events celebrate events such as Black History Month and 'National Inclusion Week 2021', with the latter including sessions focused on race, social mobility, disability, caring, neurodiversity, mental health, and women's health.

966. The Department has around 30 staff networks which provide support to employees, increase knowledge and awareness, provide insight to aid the development of HR policy and initiatives and contribute to creating an inclusive

environment in which individuals can thrive, these networks include protected characteristics (as outlined by the Equality Act), Grades, Professions and Workplace.

967. Over the course of the past year, staff network engagement has significantly increased and has seen the creation of networks that focus on autism, social mobility, dyslexia/dyspraxia, eating disorder support, the Jewish network, and the relaunch of the Flexible Working Network.

Recruitment and Retention of Under-represented Groups

968. The Department has a number of policies and activities in place to aid the recruitment and retention of under-represented groups. 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', occupational health support and mental health first aiders; and accessible IT systems, information, accommodation and facilities.

969. The Department, under the Equality Act 2010, 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 a disability or health condition including physical, mental and learning disabilities or conditions. This could be a physical feature or a change in working arrangements depending on individual needs. Under the Equality Act, the Department recognises that bringing about equality for disabled people may mean changing the way in which employment is structured, the removal of physical barriers and/or providing extra support. To support this commitment, we have an in-house workplace adjustment team, as well as provide support through our occupational health service for workplace and specialist assessments.

970. The Department continues to operate as a Disability Confident Leader under the Disability Confident Scheme, guaranteeing an interview for disabled candidates who demonstrate the minimum requirement at sift. This recognises our commitment to providing an inclusive and accessible recruitment process and working environment. As part of this, the Department developed a disability at work conversation toolkit to ensure employees receive the support they need. We have also worked with the Business Disability Forum to ensure our recruitment process implements the recommendations made through the Disability Confident Leadership accreditation process.

971. The Department works with Youth Employment UK (YEUK) to encourage more successful Health Policy Fast Track Scheme (HPFTS) and DHSC 'entry level' role applications from candidates from ethnic minorities, disabled candidates and

candidates from a lower socio-economic background. YEUK have been providing the Department with help and assistance in reaching out to our target audience. Their research has assisted us with marketing specifically for individuals from ethnic minorities and those with mental health issues.

972. In 2021, we worked with Youth Employment UK to advertise 2022's HPFTS campaign. We provided them with content such as images and quotes to create blogs, articles, newsletters, social media posts and evergreen content. We also used Evenbreak for the 2022 campaign - Evenbreak is a job board that helps talented disabled candidates and inclusive employers find each other.

973. 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 100 in-house Mental Health First Aiders who are trained in how to give appropriate help and support. We also have 12 internal Speak Out Advisors, who are DHSC members of staff that are impartial and independent from line management. These individuals act as a source of guidance for those wanting to raise a challenge or concern in work, such as a concern relating to bullying, harassment or discrimination in the workplace.

974. The Department runs specific targeted information sessions with members of its staff network groups to encourage applicants to apply for Civil Service-wide talent schemes including the Future Leaders Scheme (FLS) and Senior Leaders Scheme (SLS). We also offer additional information sessions with alumni and current participants to candidates who are eligible for the Disability Empowers Leadership Talent (DELTA) scheme or the Minority Ethnic Talent Association (META) scheme, which are integrated into FLS to support minority ethnic participants or those with a disability. The central Accelerated Development Scheme team are currently working on a wider offer for SLS participants who identify in these underrepresented groups.

975. We promote broader leadership schemes to staff networks and underrepresented groups. For example, in Summer 2021 we launched selection for the Beyond Boundaries programme which was a new 12-month cross-Government programme for Grade AO to SEO who want to develop their career within the Civil Service. The Department funded 40 places on the programme, 50% of which were ringfenced for employees who have a disability, are from an ethnic minority group, or from a lower socio-economic background.

Trade Union Facility Time

976. Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Department has a statutory requirement to disclose information (see **Tables 37** to **40**) as prescribed by schedule 2 of the above Regulation. The format of these tables is as prescribed by the Regulations.

977. The disclosure has been compiled in line with the Regulations, therefore the information discloses the trade union facility time utilised by the Core Department, PHE, and UKHSA 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 37: Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
76	76

Table 38: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	76
51-99%	0
100%	0

Table 39: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£93,409.95
Total pay bill	£580,414,375
Percentage of the total pay bill** spent on facility time*	0.016%

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

** UKHSA pay bill figures do not include allowances/overtime.

Table 40: 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

978. With regard to engagement, officials from across the Department's meet formally with Departmental Trade Unions Side (DTUS) regularly where 'people matters' are discussed. The trade Unions represented are: British Dental Association (BDA), British Medical Association (BMA), Chartered Society of Physiotherapy (CSP), First Division Association (FDA), Public and Commercial Services Union (PCS), Prospect, Royal College of Midwives (RCM), Royal College of Nursing (RCN), Unison and Unite. The Department also engages with DTUS on specific areas such as pay and reward, policy changes and re-structures and holds formal pay negotiations on an annual basis.

Staff Data

979. **Tables 41, 42** and **43** summarise key staff information for the Departmental Group.

Table 41: Staff costs for the Departmental Group comprise (subject to audit)

				2021-22 £'000	Restated[1] 2020-21 £'000
	Permanently employed staff	Others	Ministers	Total	Total
Salaries and wages	54,059,866	7,727,793	219	61,787,878	58,135,332
Social Security costs	5,816,703	151,745	23	5,968,471	5,466,312
NHS Pension	9,067,112	192,782	-	9,259,894	8,684,958
Other pension costs	119,421	3,181	-	122,602	118,488
Sub-total	**69,063,102**	**8,075,501**	**242**	**77,138,845**	**72,405,090**
Termination benefits	10,765	2,514	-	13,279	21,850
Sub-total	**69,073,867**	**8,078,015**	**242**	**77,152,124**	**72,426,940**
Less recoveries in respect of outward secondments	(27,105)	(101,282)	-	(128,387)	(120,704)
Total Net Costs	**69,046,762**	**7,976,733**	**242**	**77,023,737**	**72,306,236**

1. As described in Note 1.27 the comparative financial information has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method.

Table 42: Average number of whole-time equivalents employed – Departmental Group (subject to audit)

				2021-22 Number	Restated[2] 2020-21 Number
	Permanent staff	Others	Ministers	Total	Total
Core Department					
Core Department	3,275	2,785	7	6,067	6,030
Executive Agencies					
Public Health (Executive Agencies)	5,047	1,636	-	6,683	6,049
Other designated bodies					
NHS providers	1,210,916	134,108	-	1,345,024	1,293,044
Special Health Authorities	5,346	224	-	5,570	5,397
NHS England Group	27,339	10,048	-	37,387	34,518
Non Departmental Public Bodies	9,275	1,294	-	10,569	9,571
Others	8,890	496	-	9,386	8,896
Total	**1,270,088**	**150,591**	**7**	**1,420,686**	**1,363,505**

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. As described in Note 1.27 the comparative information has been restated to include the average number of whole-time equivalents employed by the Vaccine Taskforce which transferred to the Department on 1 August 2021.
3. Responsibility for special advisors transferred to the Cabinet Office in 2019 and therefore have not been included in this table.

4. Staff numbers for Executive Agencies includes Public Health England and UK Health Security Agency.

980. Of the figures shown in **Table 42**, staff engaged on capital projects are shown in **Table 43**.

Table 43: Breakdown of staff engaged on capital projects (subject to audit)

				2021-22 Number	2020-21 Number
	Permanent staff	Others	Ministers	Total	Total
Core Dept & Agencies	47	10	-	57	85
Other designated bodies	3,663	610	-	4,273	3,571
Total	**3,710**	**620**	**-**	**4,330**	**3,656**

981. Staff employed in the NHS has increased in 2021-22. This is mainly due to increased healthcare assistants and support staff and nursing, midwifery and health visiting staff.

982. Further details of staff employed within NHS organisations is available via NHS Digital, 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

983. **Table 44** 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.

984. The Department utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. In 2021-22 the Core Department spent £252.8 million on consultancy compared to £189.0 million[25] in 2020-21; and £416.4 million on temporary staff compared to £542.0 million in 2020-21. The increase on consultancy spend relates to specific COVID-19 workstreams and the New Hospital programme that required specialist support not available within the Department.

[25] The comparative financial information has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method.

The decrease on temporary staff spend is due to the Test and Trace programme transferring to UKHSA on 1 October 2021.

985. 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 44: Expenditure on Consultancy, Agency and Temporary Workers

	2021-22		Restated[2] 2020-21	
	Consultancy £'000	Temporary Agency £'000	Consultancy £'000	Temporary Agency £'000
DHSC Core	252,815	416,383	188,978	542,021
Executive Agencies	-	237,899	-	28,242
Other Designated Bodies	373,769	4,730,677	314,384	4,074,931
Gross Total	**626,584**	**5,384,959**	**503,362**	**4,645,194**
Eliminations	-	(429)	-	-
Total Departmental Group (after eliminations)	**626,584**	**5,384,530**	**503,362**	**4,645,194**

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.
2. As described in Note 1.27 the comparative financial information has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method.

Off-Payroll Engagements

986. In line with HM Treasury requirements, Departments must publish information regarding their highly paid and/or senior off-payroll engagements. This information, contained in **Table 45 (a-c)** includes all off-payroll engagements (either during 2021-22 in totality or as at 31 March 2022) for a day-rate of more than £245.

987. A regular dialogue has continued between the Department and HMRC throughout the 2021-22 financial year to ensure ongoing compliance with the IR35 rules - this dialogue ensures that the Department keeps updated with any policy changes implemented during the year and can therefore amend process accordingly if so required. A lot of preparatory work has also gone into ensuring the Department is compliant with the delayed HMRC reporting requirements which came into force on 6 April 2021.

988. The figures for the Core Department show most contractors are either on the payroll of their agency or an umbrella company, and so the IR35 rules are not a consideration. Of those who are genuine 'off-payroll' workers, around 77% have been determined as 'inside' IR35 and 23% determined as 'outside' IR35. These determinations have been arrived at using the online HMRC 'Check Employment status for tax' tool and reviewed by the tax team.

989. 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 IR35 regulations.

990. The reduction in the number of off payroll workers engaged at 31 March 2022 compared to 31 March 2021 is due mainly to the transfer of the NHS Test and Trace team out of DHSC on 30 September 2021.

991. During 2021-22, the Department settled IR35 tax and NIC liabilities with HM Revenue & Customs (HMRC). This payment followed a successful challenge by HMRC of a number of IR35 assessments completed by the Department. The challenge related to a subjective point which, on reflection, the Department conceded HMRC's stance was correct.

992. This is reported as a fruitless payment of £6.1 million in the Losses and Special Payment section of the Accountability Report. This payment relates to the tax years 2017-18 and 2018-19.

993. The Department has not paid any penalties for non-compliance.

994. Across the group, there are five individuals who are senior 'off-payroll' engagements (see **Table 45(c)**), four of whom are at NHS Digital (NHSD), one is at the Health Research Authority (HRA). Details are as follows:
    - In NHS Digital
        - the Digital Product Development Director was engaged during the period of recruitment for a permanent replacement;
        - the Chief Technology Officer Director was engaged during the period of recruitment for a permanent replacement. Due to a change is requirements, this permanent role was merged with an existing post;
        - the Head of Platforms was engaged during the period of recruitment for a permanent replacement; and
        - the Chief Information Security Officer was engaged during the period of recruitment for a permanent replacement.
    - In HRA, during 2021-22, an Interim Chief Digital Transformation Officer was engaged during the period of recruitment for a permanent replacement.

Table 45: Off-payroll engagements

Table a: For all off-payroll engagements as of 31 March 2022, for more than £245 per day[1]	Core Dept	ALBs	Dept Group
Number of existing engagements as of 31 March 2022	**243**	**963**	**1,206**
Of which.....			
Number that have existed for less than one year at time of reporting	214	529	743
Number that have existed for between one and two years at time of reporting	28	245	273
Number that have existed for between two and three years at time of reporting	1	123	124
Number that have existed for between three and four years at time of reporting	-	48	48
Number that have existed for four years or more years at time of reporting	-	18	18

1. The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table b: For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day[1]	Core Dept[3]	ALBs	Dept Group
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	**2,608**	**1,787**	**4,395**
Of which.....			
Number not subject to off-payroll legislation[2]	2518	229	2,747
Number subject to off-payroll legislation and determined as in scope of IR35[2]	70	1,433	1,503
Number subject to off-payroll legislation and determined as out of scope of IR35[2]	20	125	145
Number of engagements reassessed for compliance or assurance purposes during the year	-	98	98
Of which: number of engagements that saw a change to IR35 status following review	-	-	-

1. The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

2. A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	Core Dept	ALBs	Dept Group
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-	5	5
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements.	408	577	985

Exit Packages – Civil Service and Other Compensation Schemes

995. **Table 46** 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, a statutory scheme made under the Superannuation Act 1972. 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 46: Exit Packages 2020-21 and 2021-22 (subject to audit)

				Core Dept & Agencies				2021-22 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	3	5	8	-	143	1,682	1,825	13
£10,001 - £25,000	3	1	4	-	137	289	426	23
£25,001 - £50,000	-	1	1	-	104	121	225	16
£50,001 - £100,000	3	-	3	-	57	84	141	7
£100,001 - £150,000	-	-	-	-	35	15	50	1
£150,001 - £200,000	-	-	-	-	16	15	31	2
>£200,000	-	-	-	-	3	2	5	1
Total Number	**9**	**7**	**16**	**-**	**495**	**2,208**	**2,703**	**63**
Total Cost (£)	**269,161**	**68,359**	**337,520**	**-**	**18,362,895**	**24,099,901**	**42,462,796**	**2,221,585**

				Core Dept & Agencies				2020-21 Departmental Group
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
≤£10,000	1	6	7	-	164	1,482	1,646	4
£10,001 - £25,000	1	3	4	-	154	230	384	5
£25,001 - 50,000	-	1	1	-	138	105	243	6
£50,001 - £100,000	-	4	4	-	95	81	176	2
£100,001 - £150,000	-	-	-	-	40	22	62	-
£150,001 - £200,000	-	-	-	-	32	8	40	-
>£200,000	-	1	1	-	5	1	6	-
Total Number	**2**	**15**	**17**	**-**	**628**	**1,929**	**2,557**	**17**
Total Cost (£)	**13,067**	**670,735**	**683,802**	**-**	**26,310,856**	**21,458,214**	**47,769,070**	**449,065**

1. 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 2020-21 or 2021-22.

Other Departures

996. **Table 47** 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 47** will not necessarily match the total number in **Table 46**, which will be the number of individuals.

Table 47: Analysis of Other Departures (subject to audit)

	2021-22 Departmental Group	
	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	155	7,107
Mutually agreed resignations (MARS) contractual costs	118	4,104
Early retirements in the efficiency of the service contractual costs	7	662
Contractual payments in lieu of notice	1,810	8,885
Exit payments following Employment Tribunals or court orders	72	1,151
Non-contractual payments requiring HMT approval*	56	2,191
Total	**2,218**	**24,100**

*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 Outturn against 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 Outturn against 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 as detailed in the Certificate and Report of the Comptroller and Auditor General to the House of Commons.

The SOPS is a key accountability statement that shows, in detail, how an entity has spent against their Supply Estimate. Supply is the monetary provision (for resource and capital purposes) and cash (drawn primarily from the Consolidated fund), that Parliament gives statutory authority for entities to utilise. The Estimate details supply and is voted on by Parliament at the start of the financial year.

Should an entity exceed the limits set by their Supply Estimate, called control limits, their accounts will receive a qualified opinion.

The format of the SOPS mirrors the Supply Estimates, published on gov.uk, to enable comparability between what Parliament approves and the final outturn. The SOPS contain a summary table, detailing performance against the control limits that Parliament have voted on, cash spent (budgets are compiled on an accruals basis and so outturn won't exactly tie to cash spent) and administration.

The supporting notes detail the following: Outturn by Estimate line, providing a more detailed breakdown (note 1); a reconciliation of outturn to net operating expenditure in the SOCNE, to tie the SOPS to the financial statements (note 2); a reconciliation of outturn to net cash requirement (note 3); and an analysis of income payable to the Consolidated Fund (note 4).

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. Further information regarding the fiscal framework can be found in Chapter 1 of the Consolidated Budgeting Guidance. **Figure 1** at the front of this report helps show how funds flow around the Departmental Group.

The Department has incurred an Excess of £2,457 million because of the prior period restatement of the clinical negligence provision, as described in Note 16. The Department will seek parliamentary approval by way of an Excess Vote in the next Supply and Appropriation Act.

Summary of Resource and Capital Outturn 2021-22

		2021-22 Outturn			2021-22 Estimate			2021-22 Outturn compared with Estimate: saving/ (excess)		Restated[2] 2020-21 Outturn
	SoPS Note	Voted £'000	Non-Voted £'000	Total £'000	Voted £'000	Non-Voted £'000	Total £'000	Voted £'000	Total £'000	Total £'000
Departmental Expenditure Limit										
- Resource	1.1	158,351,480	25,196,757	183,548,237	161,698,408	25,196,757	186,895,165	3,346,928	3,346,928	181,438,611
- Capital	1.2	9,119,036	-	9,119,036	10,447,382	-	10,447,382	1,328,346	1,328,346	12,704,307
Annually Managed Expenditure										
- Resource	1.1	47,970,727	-	47,970,727	49,000,000	-	49,000,000	1,029,273	1,029,273	2,881,760
- Capital	1.2	-	-	-	15,000	-	15,000	15,000	15,000	(7,355)
Total Budget										
- Resource	1.1	206,322,207	25,196,757	231,518,964	210,698,408	25,196,757	235,895,165	4,376,201	4,376,201	184,320,371
- Capital	1.2	9,119,036	-	9,119,036	10,462,382	-	10,462,382	1,343,346	1,343,346	12,696,952
Total Budget Expenditure		215,441,243	25,196,757	240,638,000	221,160,790	25,196,757	246,357,547	5,719,547	5,719,547	197,017,323
Non-Budget Expenditure										
- Resource	1.1	2,457,088	-	2,457,088	-	-	-	(2,457,088)	(2,457,088)	-
Total		**217,898,331**	**25,196,757**	**243,095,088**	**221,160,790**	**25,196,757**	**246,357,547**	**3,262,459**	**3,262,459**	**197,017,323**
Total Resource		208,779,295	25,196,757	233,976,052	210,698,408	25,196,757	235,895,165	1,919,113	1,919,113	184,320,371
Total Capital		9,119,036	-	9,119,036	10,462,382	-	10,462,382	1,343,346	1,343,346	12,696,952
Total		**217,898,331**	**25,196,757**	**243,095,088**	**221,160,790**	**25,196,757**	**246,357,547**	**3,262,459**	**3,262,459**	**197,017,323**

1. Explanations of variances between Estimates and Outturn are given in tables a to d below.
2. Prior year comparatives have been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. The outturn for the prior financial period has been increased by £1.26 billion as a result.
3. The department has a prior period adjustment resulting from the increase in the clinical negligence provision for known claims, as described in note 16. It is proper for the department to seek parliamentary authority for the provision that should have been sought previously. In 2020-21, the following prior period adjustment has been made, which has been included within voted Supply in the outturn for 2021-22:

PPA description	Resource/ capital	DEL/ AME	Amount £'000
Increase in clinical negligence provision for known claims	Resource	AME	2,457,088

Net cash requirement 2021-22

	SoPS Note	2021-22 Outturn £'000	2021-22 Estimate £'000	2021-22 Outturn compared with Estimate: saving/ (excess) £'000	Restated[2] 2020-21 Outturn £'000
Net cash requirement	3	163,475,997	170,580,791	7,104,794	167,393,673

1. Against the 2021-22 Net Cash Requirement of £170.6 billion, DHSC underspent by 4% (£7.1 billion).
2. The prior year net cash requirement has been restated to reflect the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. The net cash requirement for the prior financial period has increased by £1.67 billion as a result.

Administration Costs 2021-22

	2021-22 Outturn £'000	2021-22 Estimate £'000	2021-22 Outturn compared with Estimate: saving/ (excess) £'000	Restated[2] 2020-21 Outturn £'000
Administration Costs	2,674,612	3,398,140	723,528	2,492,831

1. Sections outlined in bold are voted totals and/or totals subject to Parliamentary control.
2. Prior year comparatives have been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. The outturn for the prior financial period has been increased by £23 million as a result.

SOPS 1 Net Outturn

SOPS 1.1 Analysis of net resource outturn by section

	2021-22 £'000			2021-22 £'000			2021-22 £'000	2021-22 £'000	2021-22 £'000	2021-22 £'000	2021-22 £'000	Restated[6] 2020-21 £'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	1,474,998	-	1,474,998	21,896,791	-	21,896,791	23,371,789	28,604,620	(3,773,797)	24,830,823	1,459,034	25,597,500
NHS Providers net expenditure	-	-	-	99,849,097	-	99,849,097	99,849,097	96,075,300	3,773,797	99,849,097	-	93,119,985
DHSC Programme and Administration expenditure	530,556	(8,191)	522,365	14,203,543	(1,457,528)	12,746,015	13,268,380	13,074,184	685,152	13,759,336	490,956	25,944,237
Local Authorities (Public Health)	-	-	-	4,217,325	-	4,217,325	4,217,325	3,852,917	364,408	4,217,325	-	4,205,920
Public Health (Executive Agencies)	181,751	(6,998)	174,753	10,212,545	(206,207)	10,006,338	10,181,091	12,725,265	(1,465,478)	11,259,787	1,078,696	2,074,799
Health Education England net expenditure	60,183	-	60,183	1,535,304	-	1,535,304	1,595,487	1,858,780	-	1,858,780	263,293	1,448,640
Special Health Authorities expenditure[3]	238,227	(71,100)	167,127	2,746,243	(45,020)	2,701,223	2,868,350	2,923,299	-	2,923,299	54,949	2,650,888
Non Departmental Public Bodies net expenditure[3]	280,647	-	280,647	594,687	-	594,687	875,334	861,497	13,837	875,334	-	723,579
Arm's Length and Other Bodies net expenditure	(5,461)	-	(5,461)	2,130,088	-	2,130,088	2,124,627	1,722,546	402,081	2,124,627	-	2,849,887
	2,760,901	**(86,289)**	**2,674,612**	**157,385,623**	**(1,708,755)**	**155,676,868**	**158,351,480**	**161,698,408**	**-**	**161,698,408**	**3,346,928**	**158,615,435**
Non-voted:												
NHS England expenditure financed by NI Contributions	-	-	-	25,196,757	-	25,196,757	25,196,757	25,196,757	-	25,196,757	-	22,823,176
	2,760,901	**(86,289)**	**2,674,612**	**182,582,380**	**(1,708,755)**	**180,873,625**	**183,548,237**	**186,895,165**	**-**	**186,895,165**	**3,346,928**	**181,438,611**
Annually Managed Expenditure (AME)												
Voted:												
NHS England net expenditure	-	-	-	119,445	-	119,445	119,445	150,000	-	150,000	30,555	86,125
NHS Providers net expenditure	-	-	-	1,100,553	-	1,100,553	1,100,553	2,020,000	-	2,020,000	919,447	1,978,051
DHSC Programme and Administration expenditure	-	-	-	3,115,133	-	3,115,133	3,115,133	350,000	2,765,133	3,115,133	-	1,997,564
Public Health (Executive Agencies)	-	-	-	269,629	-	269,629	269,629	300,000	-	300,000	30,371	13,831
Health Education England net expenditure	-	-	-	596	-	596	596	5,000	-	5,000	4,404	159
Special Health Authorities expenditure[3]	-	-	-	43,308,197	-	43,308,197	43,308,197	45,940,000	(2,631,803)	43,308,197	-	(1,266,873)
Non Departmental Public Bodies net expenditure[3]	-	-	-	25,429	-	25,429	25,429	30,000	-	30,000	4,571	23,207
Arm's Length and Other Bodies net expenditure	-	-	-	31,745	-	31,745	31,745	205,000	(133,330)	71,670	39,925	49,696
	-	**-**	**-**	**47,970,727**	**-**	**47,970,727**	**47,970,727**	**49,000,000**	**-**	**49,000,000**	**1,029,273**	**2,881,760**
Non-Budget												
Prior period adjustments	-	-	-	2,457,088	-	2,457,088	2,457,088	-	-	-	(2,457,088)	-
	-	**-**	**-**	**2,457,088**	**-**	**2,457,088**	**2,457,088**	**-**	**-**	**-**	**(2,457,088)**	**-**
Total	**2,760,901**	**(86,289)**	**2,674,612**	**233,010,195**	**(1,708,755)**	**231,301,440**	**233,976,052**	**235,895,165**	**-**	**235,895,165**	**1,919,113**	**184,320,371**
Reconciliation to Statement of Comprehensive Net Expenditure												
Net gain/(loss) on transfers by absorption	-	-	-	-	-	-	-					(232)
Capital Grants	32,645	-	32,645	778,264	-	778,264	810,909					938,762
Research and Development	-	-	-	1,451,440	-	1,451,440	1,451,440					1,351,173
Income from Consolidated Fund Extra Receipts	-	-	-	-	(14,321)	(14,321)	(14,321)					(365,721)
Utilisation of provisions[5]	(24,969)	-	(24,969)	988,791	-	988,791	963,822					(333,269)
IFRIC 12 Adjustment	-	-	-	285,736	(407,410)	(121,674)	(121,674)					210,183
Prior period adjustments	-	-	-	(2,457,088)	-	(2,457,088)	(2,457,088)					-
Donated asset/government granted income	-	-	-	-	(381,167)	(381,167)	(381,167)					(162,792)
Expenditure presented on net basis[1]	223,708	(223,708)	-	7,939,300	(7,939,300)	-	-					-
Other adjustments (mainly COVID-19)[4]	-	-	-	(743,525)	(72,000)	(815,525)	(815,525)					(1,173,768)
Net operating cost	**2,992,285**	**(309,997)**	**2,682,288**	**241,253,113**	**(10,522,953)**	**230,730,160**	**233,412,448**					**184,784,707**

1. Under Parliamentary reporting requirements, expenditure for the NHS England Group, NDPBs (including Health Education England), NHS providers and Arm's Length and Other Bodies is shown net

of income. This differs from the treatment in the Consolidated Statement of Comprehensive Net Expenditure, where income and expenditure are reported separately on a gross basis.

2. Explanations of variances between Estimates and Outturn are given in tables a to d below.
3. Note 21 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
4. Other adjustments in 2021-22 mainly relate to COVID-19 adjustments to reflect the agreed budgetary treatment of COVID-19 expenditure. Included within the £816 million adjustment above, £698 million relates to the personal protective equipment (PPE) programme. The budgetary adjustment for personal protective equipment arises from the HM Treasury agreed budgeting treatment to record this expenditure as RDEL on purchase. The SoCNE reflects utilisation, write downs and impairment of PPE inventory and therefore the budgetary adjustment above reflects the difference between these amounts and the cost of inventory purchased in the year.
5. The adjustment for the utilisation of provisions of £964 million relates to onerous contract provisions recorded in 2020-21 which have been utilised against PPE inventory as it has arrived in 2021-22.
6. Prior year comparatives have been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. The outturn for the prior financial period on the DHSC programme and administration expenditure line has increased by £645 million, and the public health line by £594 million.
7. The non-budget resource outturn relates to the prior period adjustment for known claims associated with the clinical negligence provision, as described in Note 16.
8. The total Estimate columns include virements. Virements are the reallocation of provision in the Estimates that do not require parliamentary authority (because Parliament does not vote to that level of detail and delegates to HM Treasury). Further information on virements is provided in the Supply Estimated Manual, available on gov.uk.

SOPS 1.2 Analysis of net capital outturn by section

	2021-22 £'000 Outturn			2021-22 £'000		2021-22 £'000 Estimate	2021-22 £'000 Outturn vs Estimate	Restated[3] 2020-21 £'000 Outturn
	Gross	Income	Net	Net Total	Virements	Total incl. Virements	Savings (Excess)	Net Total
Spending in Departmental Expenditure Limits (DEL)								
Voted:								
NHS England net expenditure	291,416	-	291,416	279,121	12,295	291,416	-	330,577
NHS Providers net expenditure	6,833,740	-	6,833,740	6,729,018	104,722	6,833,740	-	7,281,187
DHSC Programme and Administration expenditure	1,844,687	(49,165)	1,795,522	2,912,432	(117,017)	2,795,415	999,893	4,677,582
Local Authorities (Public Health)	-	-	-	-	-	-	-	-
Public Health (Executive Agencies)	(201,935)	(19,236)	(221,171)	48,104	-	48,104	269,275	21,022
Health Education England net expenditure	1,119	-	1,119	2,000	-	2,000	881	532
Special Health Authorities expenditure[2]	30,623	-	30,623	59,312	-	59,312	28,689	47,320
Non Departmental Public Bodies net expenditure[2]	187,746	-	187,746	193,010	-	193,010	5,264	156,325
Arm's Length and Other Bodies net expenditure	200,041	-	200,041	224,385	-	224,385	24,344	189,762
	9,187,437	**(68,401)**	**9,119,036**	**10,447,382**	**-**	**10,447,382**	**1,328,346**	**12,704,307**
Annually Managed Expenditure (AME)								
Voted:								
NHS England net expenditure	-	-	-	-	-	-	-	-
NHS Providers net expenditure	-	-	-	-	-	-	-	-
DHSC Programme and Administration expenditure	-	-	-	15,000	-	15,000	15,000	(7,355)
Public Health (Executive Agencies)	-	-	-	-	-	-	-	-
Health Education England net expenditure	-	-	-	-	-	-	-	-
Special Health Authorities expenditure[2]	-	-	-	-	-	-	-	-
Non Departmental Public Bodies net expenditure[2]	-	-	-	-	-	-	-	-
Arm's Length and Other Bodies net expenditure	-	-	-	-	-	-	-	-
	-	**-**	**-**	**15,000**	**-**	**15,000**	**15,000**	**(7,355)**
Total	**9,187,437**	**(68,401)**	**9,119,036**	**10,462,382**	**-**	**10,462,382**	**1,343,346**	**12,696,952**

1. Explanations of variances between Estimate and outturn are given in tables a to d below.
2. Note 21 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
3. Prior year comparatives have been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. The outturn for the prior financial period on the DHSC programme and administration expenditure line has been increased by £21 million.
4. The total Estimate columns include virements. Virements are the reallocation of provision in the Estimates that do not require parliamentary authority (because Parliament does not vote to that level of detail and delegates to HM Treasury). Further information on virements is provided in the Supply Estimates Manual, available on gov.uk.

Material variances between the Estimate and Outturn

997. HM Treasury designates that Estimates are prepared on a consolidated basis, meaning that all intra-group transactions are removed. Across Government, the Department for Health and Social Care 'Internal Market' of circa £110 billion (mainly transactions between NHS Commissioners and NHS Providers) is unique to the Department for Health and Social Care Group.

998. To give an example, if NHS England purchase a service from an NHS provider to the value of £20 million, on consolidation, the expenditure of NHS England would be reduced by £20 million and the income of the NHS provider would be equally reduced by £20 million.

999. At the start of each financial year, we estimate our income and expenditure, including intra-group transactions, for each of the bodies within the Department for Health and Social Care Group. Due to the size and complexity of our budget, which increased significantly in 2020-21 as a result of the COVID-19 pandemic, there will inevitably be some variances in our Estimate.

1000. In setting the Parliamentary Estimate, the Department takes a pragmatic approach and eliminates only the material transactions between Departmental group bodies.

1001. In line with the guidance published by the Parliamentary Scrutiny Unit for Estimates Memoranda, significant variances over £10 million and 10% or over £200 million and 5% have been explained in the tables below.

1002. Further detail regarding the variances in the following tables can be found in **Annex B.**

Further Explanation of SOPS 1.1 and 1.2

Table A: Comparison of Resource DEL Estimate and Outturn

RESOURCE DEL		ESTIMATE	OUTTURN	TOTAL VARIANCE		Explanation of significant variances
		£m	£m	£m	%	
A	NHS England net expenditure	28,605	23,372	5,233	18%	The total variance across the NHS England and NHS Provider lines is circa £1.5 billion. This is in line with the NHS' net underspend of £1.2 billion, which was mainly driven by capacity pressures in hospitals and other healthcare settings due to the Covid-19 Omicron variant, which slowed down spending on normal NHS commissioning activity and service transformation. The small difference is explained by the timing of some budget transfers that occurred after the Supplementary Supply Estimate had been finalised
B	NHS Providers net expenditure	96,075	99,849	(3,774)	-4%	
C	DHSC Programme and Administration expenditure	13,074	13,268	(194)	-1%	The net overspend on this estimate line can mainly be explained by: 1. the split of NHS Test and Trace's budget cover applied in Supplementary Supply Estimates (between this estimate line and the estimate line for Public Health) being c£1.5bn lower than the DHSC Core element of the NHS Test and Trace outturn; and 2. impairments of COVID-19 inventory being c£800m higher than estimated at the time of agreeing to funding in the Supplementary Supply Estimate; 3. Covid underspends of c£700m; 4. Funding for Local Authorities Grants (c£360m) held on the DHSC estimate line - see the explanation below on line D; and 5 Other expenditure was c£1bn lower on this estimate line than planned in the Supplementary Supply Estimate
D	Local Authorities	3,853	4,217	(364)	-9%	The main reason for the overspend on this estimate line is that an element the funding for Local Authorities COVID-19 grants was held on the DHSC estimate line in Supplementary Supply Estimates, pending confirmation of the grants
E	Public Health	12,725	10,181	2,544	20%	The majority of this circa £2.5 billion variance relates to NHS Test and Trace. £1.5bn of the difference is due to the split of NHS Test and Trace's budget cover applied in Supplementary Supply Estimates (between this estimate line for UK Health Security Agency (UKHSA) and the estimate line for DHSC Core) being higher than the UKHSA element of the NHS Test and Trace outturn.
F	Health Education England net expenditure	1,859	1,595	263	14%	HEE's' outturn was lower than forecast when setting the estimate line in Supplementary Supply Estimates- mainly due to intra-group transaction eliminations being lower than predicted.
G	Special Health Authorities expenditure	2,923	2,868	55	2%	The Special Health Authorities' outturn was higher than forecast when setting the estimate line in Supplementary Supply Estimates- mainly due to intra-group transaction eliminations being higher than predicted.
H	Non Departmental Public Bodies net expenditure	861	875	(14)	-2%	
I	Arm's Length and Other Bodies (Net)	1,723	2,125	(402)	-23%	ALBs and Other Bodies' outturn was higher than forecast when setting the estimate line in Supplementary Supply Estimates- mainly due to intra-group transaction eliminations being higher than predicted.
J	NHS England expenditure financed by NI Contributions	25,197	25,197	0	0%	
Total RDEL		**186,895**	**183,548**	**3,347**		

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.
3. For elimination variances please see the explanation provided in **Annex B**.

Table B: Comparison of Resource AME Estimate and Outturn

RESOURCE AME		ESTIMATE	OUTTURN	TOTAL VARIANCE		Explanation of significant variances
		£m	£m	£m	%	
K	NHS England net expenditure	150	119	31	20%	NHSE's provisions expenditure was lower than expected when setting the Supplementary Supply Estimate
L	NHS Providers net expenditure	2,020	1,101	919	46%	NHS providers AME impairments were lower than expected when setting the Supplementary Supply Estimate
M	DHSC Programme and Administration expenditure	350	3,115	(2,765)	-790%	The variance on this line mainly relates to: 1. £3.4bn onerous contract provisions - relating to non-cancellable contracts for antivirals and vaccines - where the Department estimates a diminution in antivirals and vaccines inventory value in future years 2. -£1.2bn provisions credit elating to the delivery of PPE items where an onerous contract provision was raised in 2021-21
N	Public Health	300	270	30	10%	PHE and UKHSA's AME impairments were lower than expected when setting the Supplementary Supply Estimate
O	Health Education England net expenditure	5	1	4	88%	
P	Special Health Authorities expenditure	45,940	43,308	2,632	6%	The variance on this line relates to lower than forecast provisions in NHS Resolution - mainly clinical negligence provisions
Q	Non Departmental Public Bodies net expenditure	30	25	5	15%	
R	Arm's Length and Other Bodies (Net)	205	32	173	85%	Arm's Length and Other Bodies AME impairments and provisions expenditure were lower than expected when setting the Supplementary Supply Estimate
Total RAME		**49,000**	**47,971**	**1,029**		

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	279	291	(12)	-4%	The main reason for the variance on these lines is because funding was transferred to the NHS after the Supplementary Supply Estimate had been finalised
B	NHS Providers net expenditure	6,729	6,834	(105)	-2%	
C	DHSC Programme and Administration expenditure	2,912	1,796	1,117	38%	The majority of the variance on this line is due to COVID-19 underspends, of which the largest component is NHS Test and Trace of c£1.0 billion
D	Local Authorities	0	0	0	0%	
E	Public Health	48	(221)	269	560%	The majority of the variance on this line is due to COVID-19 underspends, of which the largest component is NHS Test and Trace of c£0.3 billion
F	Health Education England net expenditure	2	1	1	44%	
G	Special Health Authorities expenditure	59	31	29	48%	The variance occurred across a number of Special Health Authorities, the largest being in NHS Business Services Authorities (c£20 million) - caused by delays in digital projects
H	Non Departmental Public Bodies net expenditure	193	188	5	3%	
I	Arm's Length and Other Bodies (Net)	224	200	24	11%	The variance occurred across a number of bodies, the largest being in Supply Chain Coordination Ltd where c£13 million of funding transferred to the NHS after the Supplementary Supply Estimate had been finalised.
Total CDEL		**10,447**	**9,119**	**1,328**		

1. The Estimate reflects the best estimate of COVID-19 CDEL expenditure for the DHSC Group at a point in time. The distribution of COVID-19 capital across the DHSC Group was revised in Quarter 4 after the Supplementary Supply Estimate had been set.
2. 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	%	
K	NHS England net expenditure	0	0	0	0%	
L	NHS Providers net expenditure	0	0	0	0%	
M	DHSC Programme and Administration expenditure	15	0	15	100%	In the 2021-22 Supplementary Supply Estimate, the CAME budget included cover for Credit Guarantee Finance (CGF) transactions. However the sale of the CGF financial asset completed during the year and this budget cover was not needed.
N	Public Health	0	0	0	0%	
O	Health Education England net expenditure	0	0	0	0%	
P	Special Health Authorities expenditure	0	0	0	0%	
Q	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**	**0**	**15**		

SOPS 2 Reconciliation of net resource outturn to net operating expenditure

		Note	2021-22 £'000 Outturn	Restated[6,7] 2020-21 £'000 Outturn
Total resource outturn in Statement of Outturn against Parliamentary Supply				
	Budget	SOPS 1.1	231,518,964	184,320,371
	Non-Budget	SOPS 1.1	2,457,088	-
			233,976,052	184,320,371
Add:	Capital Grants		810,909	938,762
	Research and Development		1,451,440	1,351,173
	PFI/LIFT expenditure under IFRS		2,412,124	2,713,451
	PFI/LIFT income under IFRS		(407,410)	(408,831)
	Other - provision utilisation[4]		963,822	(333,269)
			5,230,885	4,261,286
Less:	Income payable to the Consolidated Fund	SOPS4	(14,321)	(365,721)
	Donated asset/government granted income[5]		(381,167)	(162,792)
	PFI/LIFT expenditure under UK GAAP		(2,126,388)	(2,094,437)
	Prior period adjustments[6]		(2,457,088)	-
	Loss on transfers by absorption		-	(232)
	Other[3]		(815,525)	(1,173,768)
			(5,794,489)	(3,796,950)
Net Operating Cost in Consolidated Statement of Comprehensive Net Expenditure after Financing Activities			**233,412,448**	**184,784,707**

1. As noted in the introduction to the SOPS above, outturn and Estimates are compiled against the budgeting framework, which is similar to, but different from, IFRS. Therefore, this reconciliation bridges the resource outturn to net operating expenditure, linking the SOPS to the financial statements. Capital Grants and Research and Development expenditure are budgeted for as CDEL, but accounted for as spend on the face of the SoCNE, and therefore function as reconciling items between resource and net operating expenditure.
2. From 2016-17 Government departments were required to capitalise costs that do not meet the criteria to be capitalised in departmental account but meet the ESA10 definition of research and development.

3. Other adjustments in 2021-22 mainly relate to COVID-19 adjustments to reflect the agreed budgetary treatment of COVID-19 expenditure. Of the £816 million adjustment, £698 million relates to the personal protective equipment programme. The budgetary adjustment for personal protective equipment arises from the HM Treasury agreed budgeting treatment (which is a deviation to standard budgetary treatment) to record this expenditure as RDEL on purchase. For further detail please see SOPS 1.1.
4. The adjustment for the utilisation of provisions of £964 million relates to onerous contract provisions recorded in 2020-21 which have been utilised against PPE inventory as it has arrived in 2021-22.
5. 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. The income functions as a reconciling item between resource and net operating expenditure as it is accounted for as spend on the face of the SoCNE, but recognised as CDEL in outturn.
6. The prior period adjustment relates to the prior period adjustment for known claims associated with the clinical negligence provision, as described in Note 16. This creates a reconciling item between resource and net operating expenditure as the effect on outturn has been recognised in 2021-22 but the SoCNE has been restated for 2020-21.
7. The prior period has been restated as described in SOPS 1.1 footnote 6.

SOPS 3 Reconciliation of net resource outturn to net cash requirement

	Note	2021-22 £'000 Estimate	Outturn	Net total outturn compared with Estimate: Savings/(excess)
Resource Outturn	SOPS 1.1	235,895,165	233,976,052	1,919,113
Capital Outturn	SOPS 1.2	10,462,382	9,119,036	1,343,346
Accruals to cash adjustments:				
Adjustments to remove non-cash items:				
Depreciation		(1,415,813)	(267,825)	(1,147,988)
New provisions and adjustments to previous provisions		(50,207,982)	(50,405,612)	197,630
Prior period adjustments			(2,457,088)	2,457,088
IFRIC12 revenue adjustments			(1,134)	1,134
Adjustment for stockpiled goods			158	(158)
Non-cash investment additions			(10,689)	10,689
Net gain/loss on transfers by absorption			3,328	(3,328)
Other non-cash items		-	(1,736,666)	1,736,666
Adjustments for NDPBs, NHS Trusts, Foundation Trusts, Charities and Other bodies:				
Remove voted resource and capital		(138,960,277)	(136,608,164)	(2,352,113)
Add cash grant-in-aid, PDC, loans and share capital from Core Department, and expenditure financed by Parliamentary Funding		136,036,404	128,619,650	7,416,754
Adjustments to reflect movements in working balances:				
Increase/(decrease) in inventory			(1,932,603)	1,932,603
less COVID-19 budgeting impacts on non-cash transactions[2]			2,040,177	(2,040,177)
less transfers from non-current assets			(5,738)	5,738
Increase/(decrease) in receivables			(168,968)	168,968
less movement in current financial assets			19,484	(19,484)
(Increase)/decrease in payables		-	4,244,773	(4,244,773)
less movement in payables to the Consolidated Fund			(357,706)	357,706
Use of provisions		3,967,669	4,344,093	(376,424)
		195,777,548	188,414,558	7,362,990
Removal of non-voted budget items:				
National Insurance contributions		(25,196,757)	(25,196,757)	-
Other adjustments				
Other cashflow adjustments			258,196	(258,196)
Net cash requirement		**170,580,791**	**163,475,997**	**7,104,794**

1. As noted in the introduction to the SOPS above, outturn and the Estimates are compiled against the budgeting framework, not on a cash basis. Therefore, this reconciliation bridges the resource and capital outturn to the net cash requirement.
2. COVID-19 adjustments for NCR boundary reflect the non-cash impact of COVID-19 transactions where non-standard budgeting treatments have been agreed with HM Treasury.

For explanations of variances between estimate and resource and capital outturn, please see explanations of material variances from **paragraph 997** onwards.

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 2021-22 £'000		Outturn 2020-21 £'000	
	Accruals	*Cash Basis*	Accruals	*Cash Basis*
Operating income outside the ambit of the Estimate	284,012	*284,012*	365,721	*365,721*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total income payable to the Consolidated Fund	**284,012**	***284,012***	**365,721**	***365,721***

During 2021-22 the Core Department received proceeds from sale of the Credit Guarantee Finance asset. HM Treasury determined that £284 million of these proceeds were surrenderable to the Consolidated Fund.

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 33: Losses Statement

		2021-22		2020-21	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	1,492	57,464	326	60,363
	£'000	622,769	774,586	1,587,099	1,094,364
Cases over £300,000					
Cash losses	Cases	-	7	3	8
	£'000	-	22,659	1,529	32,197
Claims abandoned	Cases	2	6	-	3
	£'000	4,811	6,822	-	2,049
Cancellation of Public Dividend Capital (PDC)	Cases	-	-	10	-
	£'000	-	-	669,229	-
Administrative write-offs	Cases	-	-	-	1
	£'000	-	-	-	1,600
Fruitless payments	Cases	30	33	101	105
	£'000	227,873	254,021	674,967	690,855
Constructive Loss	Cases	27	30	44	50
	£'000	264,356	270,355	168,441	185,729
Store losses	Cases	3	4	-	4
	£'000	42,787	43,370	-	1,515
Bookkeeping losses	Cases	-	-	-	-
	£'000	-	-	-	-

The narrative disclosures below 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.

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 £70,874k 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. His 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.

Claims Abandoned

During 2021-22 the Department waived a claim in relation to an ongoing supplier mediation totalling £2,428k. The total amount owed by the supplier was £5,868k and during 2021-22 a settlement was reached which resulted in £3,440k being returned to the Department with the balance being waived.

During 2021-22 the Department waived historical rents totalling £2,383k which the Department became entitled to following the purchase of property during the year.

Constructive Losses

During the year, the Department wrote off testing consumables, valued at £1,195k, following the closure of Testing Sites, there being no alternative options for repurposing or storing these assets in advance of their expiry dates.

In 2021-22 the Core Department purchased a central stockpile of the seasonal flu vaccine. These vaccines are specific to the year of purchase and cannot be used for future vaccination campaigns. The Department disposed of flu vaccines costing £28,055k during 2021-22.

During 2021-22 the Core Department disposed of equipment and other COVID-19 consumable inventory with a carrying value of £8,206k which had reached, or was expected to reach its expiry date.

As part of the Department's response to the COVID-19 pandemic, the combination of an accelerated inbound supply of PPE products, with a lower than expected outbound demand, resulted in a sharp increase of PPE inventory in the UK. The PPE Programme Team secured sufficient storage capacity to hold the increased volume of PPE containers, but it was not possible to move all shipping containers from the port to the storage facility before the grace period, which was typically between 5 and 7 days, before demurrage charges were made. As a consequence, the Department incurred demurrage charges of £933k during the early part of 2021-22.

The Department has recorded constructive losses of £232,315k in relation to Personal Protective Equipment. These losses arise where inventory which was suitable for use in the NHS has been disposed of because the inventory held was surplus to requirements. This loss is stated at the weighted average cost price of the relevant functionally interchangeable stock categories.

For constructive losses in relation to inventory, each individual stock holding unit is counted as a loss case.

Fruitless Payments

During 2021-22 the Department recorded a fruitless payment of £6,138k in respect of amounts payable to HMRC relating to the incorrect interpretation of IR35 status determinations for certain contractors between 2017 and 2019.

On 23 March 2021 the container ship Ever Given ran aground in the Suez Canal. This accident caused the closure of the canal for eight days. As a number of containers on the Evergreen held the Department's goods, the Department was required to pay £422k towards the costs and damages incurred.

During the height of the pandemic the demand for Personal Protective Equipment (PPE) far outweighed the supply available globally. As a result, the Department placed contracts for the purchase of 37.5 billion items of Personal Protective Equipment (PPE) centrally to ensure continuity of supply of these critical safety items. These were then distributed onwards to the NHS and wider health and social care settings free of charge.

Due to the critical nature of the situation there was limited time to fully assess the standard and quality of PPE being purchased (for example, by testing a sample product in advance of contract award). Therefore, before distribution, products not previously purchased were rigorously tested to ensure they conformed to the COVID-19 pandemic essential technical specifications as issued by the market surveillance authorities, the Health and Safety Executive and the Medicines and Healthcare products Regulatory Agency.

Some products unfortunately failed to meet the specified criteria due to failing quality or safety standards, a lack of product documentation or insufficient packaging & labelling. These items are therefore unsuitable for use in health and social care settings as intended. Where possible the Department has sought to repurpose these items so they can be safely used in different settings. The Department has recorded cumulative losses of £719,640k for items purchased, which following technical assurance, were deemed unsuitable for use in the NHS and could not be repurposed for other uses or sold, this was across 399 contracts.

The fruitless payments recorded in 2021-22 were £225,451k and is included at the weighted average cost price of the relevant functionally interchangeable stock categories. This ensures consistency between the impairments disclosed in the financial statements and this losses disclosure. The loss disclosure in 2021-22 of £225,451k can be analysed as follows:

- £120,155k - Inventory which arrived in 2021-22 and has been assessed as not suitable for any use.
- £80,406k - Inventory which arrived in previous financial periods which has been assessed during 2021-22 as not suitable for any use.
- £24,890k - Inventory which was not suitable for use in the NHS and which had not previously been disclosed as a loss as efforts to find alternative uses were ongoing in 2020-21. As these items have been disposed of in 2021-22 the loss has crystalised.

For fruitless payments in relation to inventory, each contract where loss occurs is counted as a loss case. Where losses occur in more than one financial year, a loss case is disclosed in each period.

In the interests of transparency, the Department discloses losses at the earliest possible opportunity once a loss is deemed to have crystallised. This is usually when inventory is classified as not suitable for any use or has been disposed of. In some circumstances, new information becomes available which indicates that a previously disclosed loss has no longer crystallised. For example, this might occur when essential technical documentation is obtained which changes the assessment of the usability of the inventory. This is more likely to happen in the periods immediately following receipt of inventory, whilst the programme is actively managing contracts to maximise usable inventory.

Where such a change occurs the Department does not restate the previously disclosed loss. The information shown below details where this has taken place in relation to PPE:

- Cumulative losses are lower by £51 million as a result of enhanced data quality.
- Cumulative losses are lower by £129 million as result of revised technical and quality information which has indicates that stock is no longer not suitable for any use.

The table below shows the cumulative loss position for the PPE programme and details the movement from the prior periods disclosed losses. The cases and amounts below are cumulatively lower than the individual annual reported losses due to the factors described above:

		Cumulative Losses	Loss cases reported in more than one year	Changes in assessment	Data Quality Adjustments	Losses reported in 2021-22	Losses reported in 2020-21
Total							
Fruitless payments	Cases	382	(33)	(13)	(21)	327	122
	£'000	719,640		(128,705)	(50,549)	225,451	673,443
Constructive losses	Cases	736	-	-	-	736	-
	£'000	232,315		-	-	232,315	-
Cases over £300,000							
Fruitless payments	Cases	61	(7)	(10)	(47)	27	98
	£'000	713,487		(125,710)	(53,912)	220,760	672,349
Constructive losses	Cases	18	-	-	-	18	-
	£'000	228,808		-	-	228,808	-

The interaction between inventory losses and impairments

As disclosed in **Note 8**, the Department recognised a reduction in inventory carrying value totalling £939 million in respect of personal protective equipment. The cumulative impairments recognised in relation to the programme include the £225 million disclosed as a fruitless payment above and the £232 million disclosed as a constructive loss.

Note 8 includes further detail as to the carrying value of impairments relating to the PPE programme. These amounts represent the Department's best estimate of the likely loss which may crystalise and therefore become reportable as losses in future accounting

periods. Work is ongoing to ensure that the maximum possible value is recovered in respect of these inventory items.

Changes in inventory value due to fluctuation in market price do not meet the definition of losses and are therefore not recorded as losses in the table above, but are disclosed as impairments in the financial statements and are referenced here for clarity. The valuation method used to calculate each of the inventory impairments mentioned above is disclosed in **Note 8**.

Note 8 describes the other inventory impairments which have been recognised by the Department. Consistent with the above, as these amounts reflect estimates of future diminution of value no loss has yet crystalised and therefore these amounts have not been reported as losses.

Table 34: Analysis of Losses by Sector

	2021-22	2020-21	2021-22	2020-21
	Cases Number		Value £'000	
DHSC Core	1,478	283	579,098	1,585,406
Agencies	14	43	43,671	1,693
NHS England Group	923	1,979	56,469	63,713
NHS Providers	53,403	53,986	92,279	109,109
NDPBs	1,616	3,751	2,833	3,599
Special Health Authorities	30	331	236	73
Other Group entities	-	-	-	-
Eliminations	-	(10)	-	(669,229)
Departmental Group	**57,464**	**60,363**	**774,586**	**1,094,364**

Table 35: Special Payments

		2021-22		2020-21	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	48	9,211	69	7,097
	£'000	70,006	86,462	4,725	26,191
Cases over £300,000	Cases	23	23	4	11
	£'000	69,664	69,664	2,898	8,625

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.

During 2021-22 the Core Department renegotiated a contract for the supply of goods to reduce the total volume purchased. As part of this renegotiation the Department agreed to compensate the supplier £2,080k for costs relating to goods already manufactured but not yet delivered. As the goods in the curtailed element of the

contract would have been otherwise surplus to requirement on receipt, this payment resulted in an overall saving to the taxpayer compared to the original contractual position.

All other 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.

Table 36: Special Payments by Sector

	2021-22	2020-21	2021-22	2020-21
	Cases Number		Value £'000	
DHSC Core	41	69	4,770	4,725
Agencies	7	-	65,236	-
NHS England Group	1,511	111	1,037	3,703
NHS Providers	7,642	6,903	15,279	17,686
NDPBs	10	1	140	1
Special Health Authorities	-	7	-	3
Other Group entities	-	6	-	73
Departmental Group	**9,211**	**7,097**	**86,462**	**26,191**

Other Payments

There have been no other payments made by the Core Department for 2021-22 or in 2020-21.

Fees and Charges (subject to audit)

Table 37: Fees and Charges

	2021-22 Departmental Group		
	Fees and Charges Income £'000	Full Cost of Service £'000	Surplus/(Deficit) £'000
Dental	633,847	3,056,990	(2,423,143)
Prescription	651,964	11,419,496	(10,767,532)
Other Fees and Charges for which the cost of providing the service is over £1million	746,600	1,088,849	(342,249)
Total	**2,032,411**	**15,565,335**	**(13,532,924)**

	2020-21 Departmental Group		
	Fees and Charges Income £'000	Full Cost of Service £'000	Surplus/(Deficit) £'000
Dental	277,665	3,031,109	(2,753,444)
Prescription	615,251	11,451,653	(10,836,402)
Other Fees and Charges for which the cost of providing the service is over £1million	409,847	267,774	142,073
Total	**1,302,763**	**14,750,536**	**(13,447,773)**

The fees and charges information in this note is provided in accordance with the HM Treasury Financial Reporting Manual. 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 2021-22, the NHS prescription charge for each medicine or appliance dispensed was £9.35. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £30.25 for three months or £108.10 for a year.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into three bands depending on the level and complexity of care provided. In 2021-22, the charge for Band 1 treatments was £23.80, for Band 2 was £65.20 and for Band 3 was £282.80.

Included in the 'Other fees and charges' (for which the cost of providing the service is over £1.0 million) is £207.9 million (2020-21: £205.2 million) of fees and charges and £198.1 million (2020-21: £196.6 million) of expenditure relating to regulatory income at the Care Quality Commission. The remaining balance relates to the COVID-19 Managed Quarantine Service and services provided by other NDPBs and other ALBs. Further information relating to fees and charges can be obtained from the financial statements of underlying bodies.

Remote Contingent Liabilities (subject to audit)

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

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

Quantifiable

The Department 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 2021		Increase in year	Liabilities crystallised in year	Obligation expired in year	31 March 2022		Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	£'000	No.	£'000
Guarantees	233	1	-	-	-	233	1	-
Indemnities	3,120	3	22,900	-	(120)	25,900	4	22,900
Letters of comfort	-	-	-	-	-	-	-	-
Total	**3,353**	**4**	**22,900**	**-**	**(120)**	**26,133**	**5**	**22,900**

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 22 remote, 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.

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 would need to meet the costs of damages awarded in litigation involving MHRA actions or decisions in carrying out its functions and activities on behalf of the Secretary of State for Health and Social Care.

3. The Department has undertaken to indemnify members of its expert advisory committees:
   - Advisory Committee on Dangerous Pathogens (ACDP) and their associated Working Groups;
   - Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI).

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.

9. UKHSA holds liabilities in respect of commercial contract obligations. These liabilities include 14 contractual indemnities the Department has entered into as part of its response to Covid-19.

There were two unquantifiable remote contingent liabilities.

1. The Department holds a contingent liability in regard to an ICO investigation.

2. UKHSA maintains a stockpile of medical countermeasures for responding to Chemical, Biological, Radiological and Nuclear (CBRN) incidents. Some of these products are unlicensed because no licensed alternatives are available in the UK. Similarly, UKHSA also holds stocks of unlicensed anti-venoms and anti-toxins. If any recipients were to suffer an adverse reaction to using these products UKHSA would be liable. The associated contingent liability is unquantifiable.

There were two unquantifiable letters of comfort.

1. The Department provided a letter of comfort to SCCL for requirements relating to the pandemic.

2. UKHSA has provided a letter of comfort to local authorities participating in the Covid-19 Community Testing Programme, offering a route to manage potential clinical negligence claims should they arise in the course of testing conducted by local authorities.

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**.

Accountability Report Sign-off

23rd January 2023
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 2022 under the Government Resources and Accounts Act 2000. 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 2021. The financial statements comprise: the Department's and the Departmental Group's

- Statement of Financial Position as at 31 March 2022;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in their preparation of the Group financial statements is applicable law and UK adopted international accounting standards.

In my opinion, except for the effects of the matters described in the basis for qualified opinions on the financial statements section below, the financial statements:

- give a true and fair view of the state of the Department and the Departmental Group's affairs as at 31 March 2022 and its total net expenditure for the year then ended; and
- 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

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 the Department. Significant changes to the liability could occur as a result of subsequent information and events that are different from the current assumptions adopted by the Department. My opinion is not modified in respect of this matter.

Qualified opinion on regularity

In my opinion, except for the effects of the matters described in the basis for qualified opinions on regularity sections below, in all material respects:

- the Statement of Outturn Against Parliamentary Supply properly presents the outturn against voted Parliamentary control totals for the year ended 31 March 2022 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 for qualified opinions on the financial statements

I have qualified my opinion on the financial statements in four respects.

1) Basis for qualified opinion arising from the lack of records in respect of inventory, the onerous contract provision balance and associated transactions

Firstly, in respect of the inventory held by the Department and the Group and related transactions recorded in the financial statements, the evidence available to me was limited as the Department was unable to perform stock takes or provide alternative evidence of the existence, valuation or completeness of inventory held at 31 March 2022 or 31 March 2021.

Consequently, I was unable to obtain sufficient, appropriate audit evidence to support £1.36 billion of consumables inventory represented in the Core Department & Agencies' and Group's Statement of Financial Position at 31 March 2022 and £3.6 billion at 31 March 2021. In the absence of evidence to support the existence or condition of inventory held, I am unable to assess the completeness and accuracy of the associated transactions in the Core Department & Agencies' and Group's Statement of Comprehensive Net Expenditure including impairments and write downs recognised of £1.56 billion and inventory consumption of £8.0 billion recorded in note 12 for 2021-22, and impairments and write downs recognised of £9.0 billion and inventory consumption of £6.1 billion recorded in note 12 for 2020-21.

In addition, at 31 March 2021, I was unable to obtain sufficient, appropriate audit evidence to support the valuation of the Core Department & Agencies' and Group's onerous contract provisions of £1.2 billion recorded in note 16, or the accuracy of related expenditure, which are based on assumptions of the level of excess inventory holdings at year end.

2) Basis of qualified opinion due to been unable to obtain sufficient, appropriate audit evidence to support the UK Health Security Agency transactions and balances included in these accounts

The UK Health Security Agency was not able to provide sufficient, appropriate evidence to support transactions and balances recorded in its 2021-22 financial statements and I have issued a disclaimer on the UK Health Security Agency 2021-22 accounts. As a

result, I have been unable to obtain sufficient, appropriate audit evidence to support the UKHSA total net expenditure of £9 billion and UKHSA total assets less liabilities of £0.4 billion and £0.9 billion as set out in Note 22 to the accounts. Consequently, I have limited the scope of my opinion in respect of these UKHSA transactions and balances recorded in the Core Department & Agencies' and Group's Statement of Comprehensive Net Expenditure and Statement of Financial Position.

3) Basis of qualified opinion on opening balance of accruals due to the insufficient evidence available to demonstrate this area is free from material misstatement

Thirdly, while able to support the 31 March 2022 other accruals balance, I was unable to obtain sufficient assurance in respect of the existence and valuation of the Group's Other accruals at 31 March 2021 of £17.3 billion reported in note 15. Cumulatively across the Group, there had been a significant increase in Other liabilities reported, including accruals, compared to 31 March 2020. Through my audit I identified significant but immaterial levels of overstatement of accruals and related expenditure. In addition, I identified significant populations of accruals where the Department were unable to provide and has been unable to obtain adequate records to support the balance included in the financial statements in the timescale required to meet the statutory deadline for reporting of 31 January 2022. The combination of these factors led me to limit the scope of my opinion in respect of the Group's Other accruals reported at 31 March 2021, and the associated transactions, including those related to accruals.

4) Basis of qualified opinion on opening balance of other financial assets due to disagreement on the application of IFRS 9

While able to support the 31 March 2022 and 31 March 2021 other financial assets balances, I disagreed with the accounting treatment of the loans issued by the Core Department to NHS Trusts and Foundation Trusts, recognised within the Core Department & Agencies Statement of Financial Position as at 31 March 2020, as the requirements of IFRS 9 'Financial Instruments' were not applied. 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. I consider this would have resulted in the opening carrying value being approximately £2.2 billion lower than presented.

Basis for qualified opinions on regularity

I have qualified my opinion on regularity in two respects.

1) Basis for qualified opinion on regularity due to being unable to obtain sufficient appropriate audit evidence to demonstrate that the spend incurred by the UK Health Security Agency was regular under the framework of authorities

As explained in *the Basis for qualified opinions on the financial statements section* in respect of the UKHSA the conclusions reached this audit mean, I have limited the scope of my opinion on the regularity of income and expenditure in respect of the transactions incurred by the UK Health Security Agency that are included in these accounts as I have been unable to obtain sufficient appropriate audit evidence to demonstrate that the spend incurred was regular under the framework of authorities.

2) Basis for qualified opinion on regularity due to the excess of outturn of Resource Non-Budget Expenditure

Parliament authorised a Resource Non-Budget Expenditure limit of £Nil for the Department in 2021-22. Against this limit, the Department incurred an outturn of £2.457 billion, exceeding the authorised limit by £2.457 billion due to the impact of the recognition of a prior period adjustment affecting the clinical negligence provision. As a result, the Department has exceeded its Resource Non-Budget Expenditure control total, as shown in the Statement of Outturn against Parliamentary Supply, causing an Excess Vote and a qualification of my opinion on regularity.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law 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 2019*. I have also elected to apply the ethical standards relevant to listed entities. I am independent of the Department and its Group in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the Department and its Group's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Department or its Group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for the Department and its Group is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which requires entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report, but does not include the financial statements nor my auditor's certificate and report. The Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, 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 I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. 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.

As described in the basis for qualified opinion on the financial statements section of my certificate, I was unable to obtain sufficient, appropriate audit evidence over:

- the £1.36 billion of consumables inventory represented in the Core Department & Agencies' and Group's Statement of Financial Position at 31 March 2022 and £3.6 billion at 31 March 2021, together with the associated transactions in the Core Department & Agencies' and Group's Statement of Comprehensive Net Expenditure including impairments and write downs recognised of £1.56 billion and inventory consumption of £8.0 billion recorded in note 12 for 2021-22, and impairments and write downs recognised of £9.0 billion and inventory consumption of £6.1 billion recorded in note 12 for 2020-21. In addition, at 31 March 2021, the Core Department & Agencies' and Group's onerous contract provisions of £1.2 billion recorded in note 16;

- the UKHSA total net expenditure of £9 billion and UKHSA total assets less liabilities of £0.4 billion and £0.9 billion as set out in Note 22 to the accounts; and

- the Group's Other accruals at 31 March 2021 of £17.3 billion reported in note 15.

In addition, I disagreed with the accounting treatment in respect of the other financial assets balances recognised within the Core Department & Agencies Statement of Financial Position as at 31 March 2020.

I have concluded that where the other information refers to any of these areas it may be materially misstated for the same reason.

I have no other matters to report in this regard.

Opinion on other matters

In my opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000;
- 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 and is in accordance with the applicable legal requirements

Matters on which I report by exception

In the light of the knowledge and understanding of the Department of Health and Social Care and its Group and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Report.

In respect solely of the matters referred to in my basis for qualified opinions on the financial statements section and my basis for my qualified opinion on regularity section above:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; and
- I have not received all the information and explanations I require for my audit.

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

- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

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:

- maintaining proper accounting records
- the preparation of the financial statements and Annual Report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the Annual Report and accounts as a whole is fair, balanced and understandable;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error; and
- assessing the Department and its Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the Department and its Group will not continue to be provided in the future.

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.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. 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

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, we considered the following:

- the nature of the sector, control environment and operational performance including the design of the Department and its Group's accounting policies.
- Inquiring of management, the Department's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Department and its Group's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Department and its Group's controls relating to the Department's compliance with the Government Resources and Accounts Act 2000, Managing Public Money, Supply and Appropriation (Main Estimates) Act 2021 and the Coronavirus Act 2020.
- discussing among the engagement team including significant component audit teams and involving relevant internal and external specialists, including actuarial support to audit the clinical negligence provisions IBNR, in modelling and statistics and valuation of liabilities regarding how and where fraud might occur in the financial statements and any potential indicators of fraud;

As a result of these procedures, I considered the opportunities and incentives that may exist within the Department and its Group for fraud and identified the greatest potential for fraud in the following areas: revenue recognition, posting of unusual journals, bias in management estimates and claims that feed into clinical negligence provisions. In common with all audits under ISAs (UK), I am also required to perform specific procedures to respond to the risk of management override.

I also obtained an understanding of the Department and Group's framework of authority as well as other legal and regulatory frameworks in which the Department and Group operates, focusing on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of the Department and its Group. The key laws and regulations I considered in this context included Government Resources and Accounts Act 2000, Managing Public Money, Supply and Appropriation (Main Estimates) Act 2021, employment law, tax legislation, health & safety and pensions legislation and the Coronavirus Act 2020.

In addition, I considered the Department's assessment of the level of fraud in COVID-19 expenditure incurred in response to the pandemic.

Audit Response to Identified Risk

As a result of performing the above, the procedures I implemented to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements
- enquiring of management, the Audit and Risk Committee concerning actual and potential litigation and claims;
- reading and reviewing minutes of meetings of those charged with governance and the Board and internal audit reports;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- reviewing the Department's methodology and assumptions in assessing the level of fraud in COVID-19 expenditure incurred in response to the pandemic.

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and significant component audit teams and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: http://www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

Other Auditor's Responsibilities

I am required to obtain appropriate evidence sufficient to give reasonable assurance that the Statement of Outturn against 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.

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.

Gareth Davies **25th January 2023**

Comptroller and Auditor General

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

1. In this report, I set out my findings from my audit of the Department of Health and Social Care's (the Department's) 2021-22 accounts and explain why I have qualified my opinion on a number of matters. The issues covered in this report are:

    - COVID-19 procurement and inventory management;
    - Lack of governance, oversight and control at UK Health Security Agency;
    - Financial management and oversight of NHS bodies; and
    - An Excess Vote due to a control total breach.

COVID-19 procurement and inventory management

2. **In 2021-22 the Department continued to procure very significant amounts of inventory as part of its ongoing response to the COVID-19 pandemic.** It purchased:

    - £1.5 billion of Personal Protective Equipment (PPE);
    - £5.8 billion of Test and Trace Consumables (TTC). This includes items such as Lateral Flow tests and PCR tests;
    - £2.7 billion of COVID-19 vaccines; and
    - £1.2 billion of COVID-19 medicines.

3. **In addition to the £8.9 billion impairment in respect of the PPE and other inventory the Department reported in its 2020-21 accounts, the Department estimates that there has been a further £6 billion impairment in 2021-22.** This is made up of:

    - £2.5 billion write-down of items procured in 2021-22, as set out in paragraph 2, the majority of which relates to items the Department no longer expects to use. The remainder of the write-down is due to falling market prices; and

    - £3.5 billion for onerous costs relating to PPE, vaccines and medicines for items it had agreed to purchase before 31 March 2022, but which it now does not expect to use.

In total, the Department has reported £14.9 billion of impairment over the two years.

4. **The Department estimates that the ongoing storage and disposal costs for the excess and unusable PPE will be £319 million.** The Department's estimate is based on disposing of a significant proportion of the unusable and excess PPE. By the end

of March 2022, the Department estimated it was spending £24 million a month on storing PPE.

5. **The Department was unable to complete effective physical stock-counts at the 31 March 2022 year-end to verify the quantity and quality of the consumables inventory (which includes PPE and TTC) it held, despite this being two years after the start of the pandemic.** The Department's records show that it held 17.9 billion items of PPE at 31 March 2022 with a purchase price of £8.1 billion, of which 5 billion items (with a purchase price of £2.9 billion) were still stored in containers. It was not able to access the significant levels of inventory stored in containers and did not implement adequate stock taking controls and processes for 'accessible' inventory in warehouses.

6. **Consequently, I have been unable to obtain sufficient, appropriate audit evidence to support the £1.36 billion of consumables inventory recorded in the Core Department & Agencies' and Group's Statement of Financial Position, including the impairments and consumption in the Core Department & Agencies' and Group's Statement of Comprehensive Net Expenditure.** I have limited the scope of my opinion in this respect.

Group Financial Management and Oversight

Lack of governance, oversight and control at UK Health Security Agency

7. **On 18 August 2020, between the first and second waves of the COVID-19 pandemic, the then-Secretary of State announced a machinery of government change to reorganise public health in England.** The proposed new organisation would bring together the health protection functions of Public Health England (PHE) with the NHS Test and Trace programme from the Department and the Joint Biosecurity Centre.

8. **The Department and PHE worked quickly, in the challenging circumstances of the pandemic, to set up the new organisation whilst also playing a key role in the Government's response to further waves of COVID-19.** Seven months after the Secretary of State's announcement, on 1 April 2021, the new organisation was established as UKHSA, becoming fully operational on 1 October 2021.

9. **During my audit of the UKHSA 2021-22 accounts, I was not able to obtain sufficient, appropriate evidence upon which to form an opinion.** It is possible that the impact of undetected misstatements and irregularities is both material and pervasive to the UKHSA financial statements. Accordingly, I have issued a disclaimer on my 'true and fair' and 'regularity' opinions on the UKHSA financial statements.

10. **UKHSA did not comply with HM Treasury and Cabinet Office guidance on governance arrangements, meaning there was no clear oversight structure or mechanism for identifying and addressing significant control deficiencies.** During the year ended 31 March 2022, UKHSA did not have a Board or an Audit and Risk

Assurance Committee. Although a non-executive Chair was appointed before UKHSA was established on 1 April 2021, no further UKHSA non-executive directors were appointed until 28 April 2022, almost 13 months after UKHSA was established and seven months after it became fully operational. UKHSA's Board and its Audit and Risk Assurance Committee did not meet formally for the first time until June 2022 and July 2022 respectively and the absence of formal governance arrangements exposed UKHSA to a high level of risk.

11. **The Department did not sufficiently support or oversee UKHSA as it established its administrative functions to enable the new organisation to resolve the issues that it inherited from its predecessor organisations, or to equip it to succeed to embedding best practice in financial management.** UKHSA was established at pace while the UK was responding to the COVID-19 pandemic, bringing together the health protection functions of PHE with NHS Test and Trace. The delay in establishing appropriate formal governance arrangements also reflects a deeper fragility in UKHSA's staffing which has been heavily reliant on a temporary workforce.

12. **There was insufficient evidence to support the balances transferred to UKHSA by the Department and PHE on 1 October 2021.** The Department transferred £794 million of NHS Test and Trace inventory to UKHSA but did not perform period-end stock counts over these assets. The Department also transferred £1.5 billion of NHS Test and Trace accruals and UKHSA has not been able to evidence the validity of the balances transferred due to weaknesses in the accruals controls and record keeping. Public Health England ("PHE") transferred £957 million of inventory and stockpiled goods to UKHSA. Although PHE performed period-end stock counts over its vaccine inventories of £761 million before transfer on 1 October 2021, it did not perform such stock counts over stockpiled goods of £254 million transferred at the same date.

13. **Some critical elements of the system of internal control were not operating at UKHSA during the period ended 31 March 2022.** During my audit, I identified that UKHSA had not performed effective bank reconciliations during the period ended 31 March 2022. UKHSA had not previously identified this issue and subsequently performed retrospective reconciliations to cover the period to 31 March 2022.

14. **UKHSA was not able to provide sufficient, appropriate evidence to support transactions and balances recorded in the financial statements.** I encountered large uncertainties where UKHSA was not able to provide sufficient, appropriate evidence to support transactions and balances recorded in the financial statements. I encountered such uncertainties in almost all areas which were within the scope of my audit testing during the year. This includes expenditure, in-year accruals and also manual journals posted to the accounting records. Weaknesses in UKHSA's implementation of its new accounting system contributed to the difficulties it experienced in providing evidence.

15. **The disclaimer on the UKHSA 2021-22 accounts mean that I have been unable to obtain sufficient, appropriate audit evidence to support the UKHSA total net expenditure of £9 billion and UKHSA total assets less liabilities of £0.4 billion and £0.9 billion as set out in Note 22 in these accounts. Consequently, I have limited the scope of my true & fair and regularity opinions over these UKHSA transactions and balances recorded in the Core Department & Agencies' and Group's Statement of Comprehensive Net Expenditure and Statement of Financial Position as set out in Note 22 to the accounts.** Further details of my findings from the UKHSA audit can be found in my Report on Account on UKHSA.

Financial management and oversight of NHS bodies

16. **There has been a continued deterioration in the timely finalisation of NHS bodies' accounts and completion of local audits, undermining accountability and oversight across the group.** In 2021-22, a quarter of providers and a fifth of commissioning bodies failed to meet the deadline of 22 June set by the Department. This is twice as many bodies as missed the deadline in 2020-21. Six bodies (three CCGs and three providers) have still to finalise their accounts seven months after the Department's deadline. Taking account of alternative procedures that NHS England has been able to perform I have concluded that the assurance gaps resulting from the failure of the six bodies to finalise their accounts are not material to the Departmental Group, but it is important to restore timely audited accounts for all NHS bodies.

17. **One of the bodies that has not yet published its 2021-22 accounts is the University Hospitals of Leicester NHS Trust ('UHL').** I reported on the financial management and governance issues at UHL in my report on the Department's 2020-21 accounts. Since my previous report, UHL has signed and published its accounts for 2019-20 and 2020-21. UHL's auditor was not able to obtain sufficient, appropriate evidence upon which to form an opinion for 2019-20 and issued an adverse audit opinion for 2020-21, due to system and control weaknesses resulting in material misstatements.

18. **2022-23 will see a number of complex structural changes in the Departmental Group, which will cause additional risks to achieving timely financial reporting.** In particular, 106 Clinical Commissioning Groups ("CCGs") demised in July 2022, and 42 Integrated Care Boards ("ICBs") were created. This change part way through a financial year will add further pressures to the timely preparation of accounts and the delivery of external audit at a local level with part-year accounts for both the demised CCGs and the new ICBs and external audits required for all of these entities. On 1 July 2022 the NHS Trust Development Authority and Monitor (which were separate arms-length bodies and had previously worked jointly together as NHS Improvement) also ceased to exist when NHS Improvement became part of NHS England. In addition, the Health and Social Care Information Centre (known as NHS Digital) and Health Education England are due to merge into NHS England by 1 April 2023.

Control total breach – Excess Vote

19. **The net expenditure of government departments is authorised by the annual Supply and Appropriation Acts of Parliament and their associated Supply Estimates.** These Acts set a series of expenditure limits on each department's spending, and net cash requirement. Expenditure beyond any of these limits is considered a breach of a control total and results in an 'Excess Vote'. Such expenditure potentially undermines parliamentary control over public spending. Where these limits are breached, I qualify my regularity opinion on the financial statements.

20. **The outturn against Resource Non-Budget Expenditure was £2.457 billion but Parliament had authorised a Resource Non-Budget Expenditure limit of £Nil for the Department in 2021-22.** This means that the authorised limit was breached by £2.457 billion.

21. **The £2.457 billion is the impact of a prior period adjustment in the NHS Resolution 2021-22 accounts**, which is consolidated into the Departmental Group accounts. NHS Resolution provides for future costs in cases where the Department is the defendant in legal proceedings brought by claimants seeking damages for the effects of alleged clinical negligence accounts. One of the key inputs in the valuation of the provision is the Expected Settlement Date for individual claims, which affects the inflation and discounting that are applied. In previous years, Expected Settlement Dates were calculated based on the judgment and experience of individual claims handlers. In 2021-22, NHS Resolution identified that, while these judgments may be reasonable at an individual claims level, collectively they may be optimistic compared with the number and value of schemes that the legal and health systems have the capacity to settle. To address this, it adjusted the claims provision to reflect an actuarial view of a slower settlement pattern than the Expected Settlement Dates suggest. NHS Resolution concluded that this approach should have been applied to prior periods, drawing on the information that was available at the time. This resulted in the prior period adjustment.

22. **The £2.457 billion prior period adjustment was not identified in time to enable the Department to seek parliamentary approval through the Supplementary Estimate process.** Government departments prepare and agree two Supply Estimates during the year, the Main Estimate in or around May each year and the Supplementary Estimate before the year-end in or around February each year. As a result, the recognition of this prior period adjustment has resulted in the Department exceeding its Resource Non-Budget Expenditure control total, as detailed on page 197 of the Annual Report. This breach causes an Excess Vote and a qualification of my opinion on regularity.

Opening balance limitation in scope over accruals

23. **I set out in my report on the 2020-21 accounts that I qualified my audit opinion as the Department had not been able to provide sufficient evidence that the accruals balance recognised in the Departmental Group's Consolidated Statement of Financial Position as at 31 March 2021 was not materially misstated.** This was due to significant levels of error and uncertainty arising from weaknesses in financial control and difficulties in obtaining adequate accounting records and supporting evidence in the Department and across the group. While these issues were not material to individual elements of the Departmental Group, their aggregate impact could be material to the consolidated financial statements.

24. **This qualification does not affect the 31 March 2022 balances.** While there remained errors and uncertainty in accruals balances in the NHS and other group bodies at 31 March 2022, the levels of error and uncertainty were not material.

Opening balance qualification on valuation of loans issued by Core Department to NHS providers

25. **As reported within my report on the 2019-20 accounts, I qualified my opinion on the 'Core Department & Agencies' Statement of Financial Position ("SoFP") due 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 Trusts.** I reported my view that Trusts having negative net assets and, in some cases, agreeing new repayment plans, was a clear indicator of increased credit risk. I concluded that a £2.2 billion impairment was necessary at 31 March 2020 to avoid these loans being recorded at a value that was materially misstated.

26. **This qualification does not affect the 31 March 2021 or 31 March 2022 balances.** In September 2020, the Department issued new Public Dividend Capital (PDC) to enable Trusts to repay their loans. Where the value of net assets of a Trust fell below the value of the PDC issued to it, the Department appropriately impaired the PDC in its accounts

Recommendations

27. The Department should put in place adequate controls over its remaining COVID-19 inventory. This should include processes to physically verify the amount and condition of inventory held in containers and the warehouse system. It should also review its plan for the disposal of excess inventory to ensure this is carried out in the most appropriate and cost-effective way.

28. The Department should work with UKHSA and HM Treasury to agree and implement an action plan to get UKHSA on track to deliver auditable financial statements for 2022-23. We understand that work on an action plan has begun. Resolution of the issues, for example those arising from the implementation of the new ERP system, will require additional investment and support for UKHSA's

finance team to ensure it is properly equipped to succeed with this challenge.

29. NHS England should work with NHS bodies and their auditors to agree and implement an action plan to restore timely financial reporting across the NHS.

30. The Department should establish more effective oversight of the Departmental Group to proactively manage emerging or developing issues, including the significant structural changes to the Group.

31. The Department should develop a plan to return to pre-recess delivery of its Departmental accounts as soon as possible.

Gareth Davies
Comptroller and Auditor General

25th January 2023

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

Financial Statements

Consolidated Statement of Comprehensive Net Expenditure

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

For the period ended 31 March 2022

		2021-22		Restated[3,4] 2020-21	
	Notes	Core Dept & Agencies £'000	Departmental Group £'000	Core Dept & Agencies £'000	Departmental Group £'000
Income from contracts	5	(1,546,108)	(9,169,687)	(1,283,342)	(7,629,690)
Other non-contract operating income	5	(1,173,585)	(1,474,643)	(1,034,918)	(1,135,733)
Income received by NHS charities	19	-	(162,055)	-	(174,031)
Total operating income		**(2,719,693)**	**(10,806,385)**	**(2,318,260)**	**(8,939,454)**
Staff costs	3	1,335,416	76,742,959	1,132,431	72,081,562
Purchase of goods and services	4	17,499,971	94,459,703	13,076,190	86,512,172
Depreciation and impairment charges	4	1,190,467	6,582,161	11,908,893	14,032,469
Provision expense	4	4,991,908	51,046,883	2,787,560	3,578,930
Other operating expenditure	4	10,132,565	13,983,635	11,485,136	15,986,204
Grant in Aid to NDPBs		156,158,304	-	149,814,029	-
Funding to Group bodies		642,947	-	574,327	-
Resources expended by NHS charities	19	-	62,637	-	59,524
Total operating expenditure		**191,951,578**	**242,877,978**	**190,778,566**	**192,250,861**
Net operating expenditure for the year ended 31 March 2022		**189,231,885**	**232,071,593**	**188,460,306**	**183,311,407**
Finance income		(66,828)	(26,565)	(87,093)	(29,764)
Finance expense		(14,770)	1,367,420	(27,976)	1,503,064
Net (gain)/loss on transfers by absorption		155,672	-	6,041	232
Total Net Expenditure for the year ended 31 March 2022		**189,305,959**	**233,412,448**	**188,351,278**	**184,784,939**
Other Comprehensive Net Expenditure					
Items that will not be reclassified to net operating costs:					
Net (gain)/loss on:					
- revaluation of property, plant and equipment		(1,036)	(1,898,532)	(26,876)	(871,516)
- revaluation of intangibles		(9,628)	(11,001)	(48,056)	(54,388)
- revaluation of charitable assets		-	(21,262)	-	(54,865)
- impairments and reversals taken to revaluation reserve		-	172,496	781	920,647
- equity instruments measured at fair value through OCI		143,689	219,517	(53,808)	(305,802)
- fair value gains/(losses) on other financial assets mandated at FV through OCI		-	265	-	(1,496)
Actuarial (gains)/losses on defined benefit pension schemes		-	(87,317)	-	36,922
Other pensions remeasurements		-	6,411	-	(18,079)
Other (gains) and losses		72,331	81,873	-	714
Total Comprehensive Expenditure for the year ended 31 March 2022		**189,511,315**	**231,874,898**	**188,223,319**	**184,437,076**

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 8.2 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. As described in Note 1.27 the comparative financial information has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. The net expenditure for the prior financial period has been increased by £1.26 billion as a result.
4. Provision expense has been restated in 2020-21 to reflect the prior period adjustment relating to known claims in the clinical negligence provision as described in Note 16. This has resulted in a reduction of £333 million.
5. Note 22 of the Annual Report and Accounts contains details of the transactions relating to UK Health Security Agency which are subject to the limitation of scope audit opinion as described in the Governance Statement on pages 173 to 175.

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 2022

		2021-22		Restated[2,3] 2020-21		As at 1 April 2020	
		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	1,056,721	62,267,053	934,133	57,447,621	1,019,606	54,640,754
Investment Property		41,083	235,928	38,468	230,900	92,820	232,854
Intangible assets	7	212,588	2,669,674	228,927	2,248,466	162,111	1,812,382
Charitable non-current assets	19.2	-	4,394	-	4,415	-	7,080
Financial assets- Investments	11	47,088,536	682,182	46,960,282	914,505	27,344,395	815,533
Charitable investments	19.3	-	379,324	-	361,533	-	299,160
Other non-current assets	14	483,259	1,005,387	256,127	761,262	251,452	868,583
Total non-current assets		**48,882,187**	**67,243,942**	**48,417,937**	**61,968,702**	**28,870,384**	**58,676,346**
Current assets							
Assets classified as held for sale		-	55,134	269,693	327,380	-	53,146
Inventories	12	2,153,275	3,582,839	4,085,878	5,554,132	251,503	1,651,737
Trade and other receivables	14	1,209,755	3,994,802	797,777	3,655,723	316,068	2,797,324
Other current assets	14	540,110	2,223,473	1,338,974	2,885,116	304,264	1,887,509
Charitable other current assets	19.2	-	20,550	-	17,909	-	22,028
Other financial assets	14	210,989	1,329	230,473	853	13,724,360	17,870
Cash and cash equivalents	13	959,885	18,096,779	1,576,897	16,795,536	1,460,785	9,111,920
Charitable cash	19.2	-	258,141	-	256,020	-	238,966
Total current assets		**5,074,014**	**28,233,047**	**8,299,692**	**29,492,669**	**16,056,980**	**15,780,500**
Total assets		**53,956,201**	**95,476,989**	**56,717,629**	**91,461,371**	**44,927,364**	**74,456,846**
Current liabilities							
Trade and other payables	15	(2,084,242)	(10,347,270)	(878,792)	(9,085,071)	(87,679)	(6,527,633)
Other liabilities	15	(5,404,965)	(23,250,580)	(10,731,679)	(23,349,944)	(3,316,237)	(15,018,838)
Charitable liabilities	19.2	-	(43,113)	-	(47,271)	-	(47,078)
Provisions	16	(3,865,458)	(7,710,794)	(1,873,407)	(5,548,478)	(494,657)	(3,848,461)
Total current liabilities		**(11,354,665)**	**(41,351,757)**	**(13,483,878)**	**(38,030,764)**	**(3,898,573)**	**(25,442,010)**
Non-current assets less net current liabilities		**42,601,536**	**54,125,232**	**43,233,751**	**53,430,607**	**41,028,791**	**49,014,836**
Non-current liabilities							
Other payables	15	(46,916)	(907,982)	(167,181)	(920,180)	(180,135)	(826,931)
Charitable liabilities	19.2	-	(626)	-	(357)	-	(212)
Provisions	16	(4,829,137)	(131,992,133)	(3,724,593)	(87,295,721)	(3,135,645)	(88,133,413)
Net pension asset/(liability)	16.1	-	(81,747)	-	(158,954)	-	(144,153)
Financial liabilities	15	-	(10,008,766)	-	(10,427,527)	-	(10,739,278)
Total non-current liabilities		**(4,876,053)**	**(142,991,254)**	**(3,891,774)**	**(98,802,739)**	**(3,315,780)**	**(99,843,987)**
Total assets less liabilities		**37,725,483**	**(88,866,022)**	**39,341,977**	**(45,372,132)**	**37,713,011**	**(50,829,151)**
Taxpayers' equity and other reserves							
General fund		33,024,559	(103,219,248)	33,736,464	(59,134,216)	32,192,105	(64,349,268)
Revaluation reserve		89,634	13,446,004	712,734	12,516,825	681,935	12,641,317
Other Reserves		4,611,290	288,552	4,892,779	653,010	4,838,971	358,856
Total Taxpayers' Equity		**37,725,483**	**(89,484,692)**	**39,341,977**	**(45,964,381)**	**37,713,011**	**(51,349,095)**
Charitable funds	19.2	-	618,670	-	592,249	-	519,944
Total Reserves		**37,725,483**	**(88,866,022)**	**39,341,977**	**(45,372,132)**	**37,713,011**	**(50,829,151)**

1. 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.
2. The comparative financial information for 2020-21 has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. This adjustment has increased other current assets by £577 million and increased total current liabilities by £169 million, in the Core Department & Agencies column and in the Departmental Group column.
3. In addition to the restatement described in footnote 2 above, the Departmental Group non-current provisions have been increased by £2.457 billion in 2020-21 and by £2.790 billion in 2019-20 to reflect the prior period adjustment relating to the known claims in the clinical negligence provision as described in Note 16.
4. Note 22 of the Annual Report and Accounts contains details of the balances relating to UK Health Security Agency which are subject to the limitation of scope audit opinion as described in the Governance Statement on pages 173 to 175.

23rd January 2023
Sir Chris Wormald KCB
Permanent Secretary

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 year ended 31 March 2022

		2021-22		Restated[2] 2020-21	
	Notes	Core Dept & Agencies £'000	Departmental Group £'000	Core Dept & Agencies £'000	Departmental Group £'000
Net cashflow from operating activities					
Net expenditure for the year		(189,305,959)	(233,412,448)	(188,351,278)	(184,784,939)
Adjustments for non-cash transactions		4,400,481	56,234,347	5,847,661	9,203,478
Adjustments for net finance costs		(65,684)	979,309	(84,332)	981,991
Other non cash movements in Statement of Financial Position items		(381,221)	(504,573)	-	234,506
Movements arising from absorption transfers		155,672	-	6,041	232
Adjustments for charities		-	(9,661)	-	(15,456)
(Increase)/decrease in trade and other receivables		179,238	77,963	11,972,793	(1,731,668)
(Increase)/decrease in inventories		1,932,603	1,971,293	(3,834,375)	(3,902,395)
Increase/(decrease) in trade and other payables		(4,241,529)	731,876	8,193,601	10,670,042
Adjustment for working capital amount arising from absorption transfers		5,924	-	-	-
Adjustment for working capital balances in the SoFP not flowing through the SoCNE		428,221	622,756	(13,713,584)	(1,265,069)
Use of provisions		(378,745)	(2,997,843)	(282,031)	(2,648,281)
Transfer of provisions to payables and inventories		(1,500,654)	(1,523,313)	(507,094)	(540,285)
Cash payments in respect of pensions		-	(12,880)	-	(18,799)
Other operating cashflows		9,071	15,326	(13,614)	(10,752)
Net cash outflow from operating activities		**(188,762,582)**	**(177,827,848)**	**(180,766,212)**	**(173,827,395)**
Cash flows from investing activities					
Purchase of property, plant and equipment & investment properties		(306,320)	(7,030,281)	(344,100)	(6,705,875)
Purchase of intangible assets		(117,348)	(957,825)	(165,976)	(921,048)
Proceeds of disposal of property, plant and equipment		21,277	109,114	120,596	194,389
Proceeds of disposal of intangibles		16,864	19,276	(726)	1,376
Proceeds of disposal of assets held for sale		357,109	412,176	-	56,744
Purchase of investments		(3,603,094)	(58,013)	(22,994,976)	(77,514)
Proceeds of disposal of investments		3,678,715	15,653	14,071,885	55,630
Interest Received from group bodies		68,551	-	72,172	-
Interest Received from external bodies		125	20,920	170	3,814
Other investing cashflows		272	748	-	264
Net cash outflow from investing activities		**116,151**	**(7,468,232)**	**(9,240,955)**	**(7,392,220)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year		163,200,000	163,200,000	167,871,741	167,871,741
Financing from the National Insurance Fund		25,196,757	25,196,757	22,823,176	22,823,176
Net Movements of Capital element of Loans		-	19,254	-	59,159
Capital element of payments in respect of finance leases and on-balance sheet PFI contracts		-	(488,881)	-	(463,914)
Interest paid to group bodies		(1,517)	-	(505)	-
Interest paid to external bodies		(100)	(912,887)	-	(913,856)
Advances from the Contingencies Fund[1]		-	-	59,000,000	59,000,000
Repayments to the Contingencies Fund[1]		-	-	(59,000,000)	(59,000,000)
Other financing cashflows		-	20	-	85,365
Net cash inflow from financing activities		**188,395,140**	**187,014,263**	**190,694,412**	**189,461,671**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**(251,291)**	**1,718,183**	**687,245**	**8,242,056**
Payment of amounts due to the Consolidated Fund		(365,721)	(365,721)	(571,133)	(571,133)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**(617,012)**	**1,352,462**	**116,112**	**7,670,923**
Cash and cash equivalents at the beginning of the period		1,576,897	16,991,905	1,460,785	9,320,982
Cash and cash equivalents at the end of the period		**959,885**	**18,344,367**	**1,576,897**	**16,991,905**

1. In 2020-21, the Department received advances of £59 billion. This was due to substantially increased spending resulting from the Department's response to COVID-19 and where this occurred prior to expenditure being approved by Parliament through the Estimates process. Following approval, the full amount was repaid to the Contingencies Fund.
2. The cash flow for 2020-21 has been restated to reflect the impact of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. This has increased both net cash outflow from operating activities and net cash inflow from financing activities by £1.67 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 year ended 31 March 2022

		Core Dept & Agencies				Departmental Group					
	Note	General Fund £'000	Revaluation Reserve £'000	Other Reserves	Taxpayers' Equity £'000	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Taxpayers' Equity £'000	Charitable Funds £'000	Total Reserves £'000
Restated Balance at 1 April 2021		33,736,464	712,734	4,892,779	39,341,977	(59,134,216)	12,516,825	653,010	(45,964,381)	592,249	(45,372,132)
Prior period adjustments in local accounts		26,710	(4,572)	-	22,138	36,914	37,799	(159)	74,554	44	74,598
Net parliamentary funding - drawn down		163,200,000			163,200,000	163,200,000			163,200,000		163,200,000
Net parliamentary funding - deemed		1,523,414			1,523,414	1,523,414			1,523,414		1,523,414
National Insurance contributions		25,196,757			25,196,757	25,196,757			25,196,757		25,196,757
Supply (payable)/receivable adjustment	15	(1,247,417)			(1,247,417)	(1,247,417)			(1,247,417)		(1,247,417)
CFERs and other amounts payable to the Consolidated Fund	15	(284,012)			(284,012)	(284,012)			(284,012)		(284,012)
PDC investment adjustment		(518,338)			(518,338)	-			-		-
Comprehensive Net Expenditure for the Year		(189,305,959)			(189,305,959)	(233,418,364)			(233,418,364)	5,916	(233,412,448)
Non-cash adjustments:											
non-cash charges - auditor's remuneration	4.1	2,675			2,675	2,814			2,814		2,814
Movements in Reserves											
Recognised in CSCNE:											
Net gain/(loss) on revaluation of non-current assets			10,664	-	10,664		1,909,533	-	1,909,533	-	1,909,533
Net gain/(loss) on revaluation of charitable assets					-				-	21,262	21,262
Fair value gains/(losses) on equity instruments designated at FV through OCI				(143,689)	(143,689)			(219,517)	(219,517)		(219,517)
Fair value gains/(losses) on other financial assets mandated at FV through OCI				-	-			(265)	(265)		(265)
Impairments and reversals			-		-		(172,496)		(172,496)	-	(172,496)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme		-		-	-	83,145		4,172	87,317		87,317
Other pensions remeasurements		-		-	-	(15,240)		8,829	(6,411)		(6,411)
Other gains and losses		(72,331)		-	(72,331)	(81,971)		98	(81,873)		(81,873)
Transfers between reserves		766,997	(629,197)	(137,800)	-	917,438	(760,787)	(156,651)	-	-	-
Other movements		(401)	5	-	(396)	1,378	(84,870)	(853)	(84,345)	(801)	(85,146)
Other transfers		-	-	-	-	112	-	(112)	-	-	-
Balance at 31 March 2022		**33,024,559**	**89,634**	**4,611,290**	**37,725,483**	**(103,219,248)**	**13,446,004**	**288,552**	**(89,484,692)**	**618,670**	**(88,866,022)**

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 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.
3. 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.
4. Charitable Funds are the reserves associated with NHS Charities consolidated into the Departmental Annual Report and Accounts. They include both restricted, £221 million and unrestricted, £398 million funds.

For the period ended 31 March 2021

	Note	Core Department & Agencies			Restated[1]	Departmental Group					Restated[1]
		General Fund	Revaluation Reserve	Other Reserves	Taxpayers' Equity	General Fund	Revaluation Reserve	Other Reserves	Taxpayers' Equity	Charitable Funds	Total Reserves
		£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as published at 31 March 2020		32,192,105	681,935	4,838,971	37,713,011	(61,558,911)	12,641,317	358,856	(48,558,738)	519,944	(48,038,794)
Effect of prior period adjustment		-	-	-	-	(2,790,357)	-	-	(2,790,357)	-	(2,790,357)
Restated Balance at 31 March 2020		32,192,105	681,935	4,838,971	37,713,011	(64,349,268)	12,641,317	358,856	(51,349,095)	519,944	(50,829,151)
Prior period adjustments in local accounts		-	-	-	-	7,425	23,340	(578)	30,187	(3,008)	27,179
Net parliamentary funding - drawn down		167,871,741			167,871,741	167,871,741			167,871,741		167,871,741
Net parliamentary funding - deemed		1,045,346			1,045,346	1,045,346			1,045,346		1,045,346
National Insurance contributions		22,823,176			22,823,176	22,823,176			22,823,176		22,823,176
Supply (payable)/receivable adjustment	15	(1,523,414)			(1,523,414)	(1,523,414)			(1,523,414)		(1,523,414)
CFERs and other amounts payable to the Consolidated Fund	15	(365,721)			(365,721)	(365,721)			(365,721)		(365,721)
PDC investment adjustment		-			-	-			-		-
Comprehensive Net Expenditure for the Year		(188,351,278)			(188,351,278)	(184,803,914)			(184,803,914)	18,975	(184,784,939)
Non-cash adjustments:											
non-cash charges - auditor's remuneration	4.1	2,270			2,270	2,388			2,388		2,388
Movements in Reserves											
Recognised in CSCNE:											
Net gain/(loss) on revaluation of non-current assets			74,932	-	74,932		925,904	-	925,904	-	925,904
Net gain/(loss) on revaluation of charitable assets					-				-	54,865	54,865
Recycling gains/(losses) on disposal of financial assets mandated at FV through OCI			-	-	-		-	-			-
Fair value gains/(losses) on equity instruments designated at FV through OCI				53,808	53,808			305,802	305,802		305,802
Fair value gains/(losses) on other financial assets mandated at FV through OCI				-	-			1,496	1,496		1,496
Impairments and reversals			(781)		(781)		(920,647)		(920,647)		(920,647)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme					-	(33,414)		(3,508)	(36,922)	-	(36,922)
Net gain/(loss) on transfers by modified absorption		-			-	-			-		-
Other pensions remeasurements		-			-	25,319		(7,240)	18,079		18,079
Other gains and losses		-		-	-	(397)		(317)	(714)		(714)
Transfers between reserves		42,239	(42,239)	-	-	162,998	(163,066)	68	-	-	-
Other movements		-	(1,113)	-	(1,113)	1,675	9,977	275	11,927	1,473	13,400
Other transfers		-	-	-	-	1,844	-	(1,844)	-	-	-
Restated Balance at 31 March 2021		**33,736,464**	**712,734**	**4,892,779**	**39,341,977**	**(59,134,216)**	**12,516,825**	**653,010**	**(45,964,381)**	**592,249**	**(45,372,132)**

1. The balances as at 31 March 2020 and 31 March 2021 have been restated to reflect the impact of the transfer of the Vaccine Taskforce and the prior period adjustment relating to the clinical negligence provision described under the Statement of Financial Position.

Notes to the Department's Annual Report and Accounts

1. Statement of accounting policies

The financial statements have been prepared in accordance with the 2021-22 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.

The 2021-22 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.

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 Agencies 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.

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, as is confirmed in the 2021-22 Main Supply Estimate paragaph 22, page 9.

The value of the benefit received when the Department accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Department;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- 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 at 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.

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, intangible non-current assets and stockpiled goods, 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. Impairment losses are detailed in **Note 8.**

Inventory is measured at the lower of cost and realisable value per the requirements of IAS 2. Any impairment of inventories as a result of a change in the net realisable value is recognised as an expense in the period in which it occurs. Further detail around the derivation of cost and net realisable value is detailed in **Note 1.17** below.

Estimating a net realisable value takes into consideration not only the amount that may be expected to be realised from a sale of the inventory, so factoring in such matters as fluctuations of price or market value, but also the purpose for which inventory is held. Consequently **Note 8** breaks down the nature of the impairments incurred in relation to the Department's inventory purchased as part of the pandemic response.

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.

Where assets donated do not qualify for capitalisation an amount equivalent to the value of the items is taken to expenses on receipt, unless items are held as inventory, such as personal protective equipment, for which a credit to income is recorded on receipt and the donated inventory will be expensed per the treatment of purchased inventories consumed under IAS 2.

Donated assets are valued, depreciated and impaired in the same way as purchased assets. Gains and losses on revaluations, impairments and sales are also 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.

Donations of centrally procured items for use in the pandemic response follows the accounting for donated assets detailed above for the receiving DHSC group body, rather than being treated as financing from a controlling body. This approach has been agreed by the Department as relevant authority as permitted by the FReM.

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

Significant volumes of inventories were purchased by the Department as part of the pandemic response.

Inventories are valued at the lower of cost and net realisable value. Cost includes the direct cost of purchase and other costs incurred in bringing the inventories to their present location and condition, such as freight costs. Expenses are recognised on sale, donation, consumption, impairment or write off of the inventory in the period in which the specific event occurs.

Per the application of IAS 2 and given the extent of inventory procured that is able to be identified as ordinarily interchangeable i.e. similar items with a similar use such that a product can be reasonably substituted for another, the Department has employed the weighted average cost (WAC) basis for deriving the cost of its inventory in conjunction with its stock models in place. A WAC was calculated each month for each functionally interchangeable stock (FIS) category.

In determining the appropriate net realisable value, market values were identified for each FIS category. The purpose of holding the inventory was also considered per the requirements of IAS 2. Exercises such as identifying damaged stock, stock that is not suitable, excess stock or stock close to expiry, have all impacted on the level of impairment of inventory detailed in **Note 8**.

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 depreciated over their useful life. The remaining categories of stockpiled goods are held at current value in existing use and depreciated over their useful life.

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 1.30% (2020-21: 0.95%) 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 0.47% (2020-21 minus 0.02%) 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 0.70% (2020-21 positive 0.18%) is applied to the time boundary of after 5 and up to and including 10 years. A nominal long-term rate of positive 0.95% (2020-21 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 0.66% (2020-21 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 4.0% (2020-21 1.2%) 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 2.6% (2020-21 1.6%) 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 2.0% (2020-21 2.0%) 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.

From 6 April 2020 indemnity for liabilities relating to incidents prior to 1 April 2019 of members of the Medical and Dental Defence Union of Scotland (MDDUS) was provided by Government and administered by NHS Resolution under the Existing Liabilities Scheme for General Practice (ELSGP).

In 2020-21 the interim arrangements continued with the Medical Protection Society (MPS). This is where the legal and operational responsibility of handling claims within scope of those interim arrangements remains with the MDO and NHS Resolution carries out the Secretary of State's oversight and governance responsibilities. This arrangement is known as Existing Liabilities for General Practice (ELGP). From 1 April 2021 indemnity for these claims was provided by Government and administered by NHSR under the Existing Liabilities Scheme for General Practice (ELSGP).

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 2021-22 Annual Report and Accounts. 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. NHSR does not consider that any of the indemnity schemes or management and oversight of General Practice claims fall under the definition of an insurance contract as per IFRS 4 Insurance Contracts. This is because significant insurance risk is passed back to the members of risk-pooling schemes through annual contributions, to the GP Contract funding held by NHS England transferred via DHSC as provision of financing, or directly to DHSC through the provision of financing.

NHSR contracts actuarial advisers, the Government Actuary's Department, to assist with the preparation of financial statements through analysis and modelling of claims data. This is combined with information provided by management on the current economic and claims environment in order to provide estimates in relation to determining the valuation of the liabilities for the accounts. NHSR's Reserving and Pricing Committee is responsible for making decisions on the key judgements and estimates, drawing on advice of the Government Actuary's Department.

One of the key assumptions used in the production of the estimates reported is outside the formal control of NHSR, as HM Treasury prescribes the discount rates to be used in calculating the provisions. There are other factors that influence the provision that are also outside NHSR's control; for example, patients (and their legal representatives) have an element of control over the timing of the reporting of claims.

The Reserving and Pricing Committee keeps all of the factors affecting the calculation of provisions under review to ensure that the final provisions reflect the experience of the organisation and are adjusted in a timely manner.

The difference between the gross value of claims and the amount of the provision calculated above is also discounted, taking into account the likely time to settlement, and is included in contingent liabilities as set out in **Note 17**.

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

Claims are included in the ELS provision on the basis that the incident occurred on or before 31 March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to NHS Resolution with effect from 1 April 1996. Claims against DHSC clinical and non-clinical liabilities relate to claims against dissolved bodies where there is no successor body and a number of other claims NHSR 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 future liability scheme for general practice, established 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 16** 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.

Clinical Negligence Scheme for Coronavirus (CNSC)

Using powers under the Coronavirus Act 2020 and launched on 3 April 2020, the Clinical Negligence Scheme for Coronavirus (CNSC) provides cover for the NHS response to COVID-19 where no other indemnity exists. It constitutes a flexible arrangement to address the fast-paced changes which had to be put in place and extends, for example, to private sector facilities which stepped in to provide overflow capacity for procedures which NHS hospitals were unable to perform owing to the need to give priority to patients with COVID-19.

On the other hand, many new arrangements were picked up by one of our existing schemes, such as retired general practitioners who volunteered to return to give vaccinations being covered by either CNSGP or CNST, depending upon the contractual arrangement in question.

The Coronavirus Temporary Indemnity Scheme (CTIS)

The scheme provides state cover for employer's liability and public liability to fill gaps where COVID-19 positive patients have been discharged from the NHS into designated care home settings which have been unable to secure sufficient private insurance cover.

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 2022 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.

Infected Blood

The Infected 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. On 25 March 2021, a Written Ministerial Statement by Penny Mordaunt, Paymaster General, announced changes across the four separate schemes of the four nations of the United Kingdom to improve their parity. The main change for England to affect the provision, is that bereaved partners will receive the beneficiary's full annual payment for the first year following their death, and subsequently 75% of the payment for the rest of their lifetime, uplifted annually. Infected blood payments are linked to increases in the consumer price index.

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 a review stemming from the transfer of debt to PDC in September 2020 the Department revised its approach to the recognition of impairment against PDC in 2019-20.

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.

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, implicitly (so not legally formed), 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 and COVID-19 purchases. 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.

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.

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. Therefore the FReM directs entities on the appropriate accounting to apply where functions transfer across the public sector. A function is defined as an identifiable business operation with an integrated set of activities and recognised assets and or liabilities that are capable of being conducted and managed to achieve the objectives of that business operation. A function can be an entity, but equally the

definition of a function can relate to a programme or policy area of an entity that has a integrated set of activities and associated assets and liabilities capable of being managed to achieve specific objectives.

Transfer by absorption

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.

Whether eliminating or non eliminating, symmetrical entries between the transferring and receiving entity are required. Post transfer, where adjustments are required to align accounting policies, the corresponding accounting entry in making any adjustments is to the General Fund.

Assets transferred under the Asset Transfer Policy 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 Expenditure. This treatment represents an HM Treasury agreed FReM departure, with all other transfers being accounted for in line with the FReM.

Transfer by merger

For transfers between departments the FReM requires the application of merger accounting. In merger accounting asset and liabilities of the function are brought into the receiving department's Financial Statements from the beginning of the financial year in which the transfer occurred. Restatement of comparative periods is completed so as to account for the function as if the function had always been part of the receiving entity. The opposite is shown by the transferring entity so that the Financial Statements are presented as if the function had never been within the transferring entity accounts. Whilst symmetrical entries are again required for such transfers, appropriate adjustments can be made post transition to align accounting policies within the receiving organisation.

The Department has applied merger accounting in its 2021-22 Financial Statements in receiving the function relating to the Vaccine Taskforce that was transferred from the Department for Business, Energy and Industrial Strategy (BEIS) on 1 August 2021. The Vaccine Taskforce (VTF) was set up by the Government in May 2020 in response to the

COVID-19 pandemic, to drive forward the development and production of a coronavirus vaccine for deployment in the UK and internationally.

Advance payments made to support the manufacturing and clinical development of potential vaccine candidates have been initially recognised as “at risk” payments (i.e., there is a risk that vaccine development and clinical trials may not result in a vaccine candidate approved by the UK Medicines and Healthcare products Regulatory Agency), and so have been expensed in the Statement of Comprehensive Net Expenditure. These expenses are reversed and classified as a prepayment if regulatory approval is subsequently achieved. The prepayment is released when vaccines have been delivered in accordance with the contractual terms.

As assets and liabilities held by BEIS in relation to VTF have transferred to the Department; the **Financial Statements**, associated **Notes to the Department’s Annual Report and Accounts** and **Parliamentary Accountability and Audit Report**, contain the relevant information, in accordance with the relevant standards and reporting requirements detailed in the FReM, in relation to the assets and liabilities arising from the work undertaken by the VTF both in 2021-22 and in 2020-21.

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 2021-22.

IFRS 16 – Leases

General approach of transition to and adoption of, IFRS 16

IFRS 16 Leases supersedes IAS 17 Leases and was effective for periods beginning on or after 1 January 2019. Implementation of IFRS 16 in the public sector has been delayed with government departments not meeting the early adoption criteria described in the FReM, required to adopt IFRS 16 from 1 April 2022.

IFRS 16 represents a significant change in lessee accounting by introducing a predominantly singular lessee accounting model by removing the distinction between operating leases and finance leases that was present under IAS 17. IFRS 16 effectively requires the recognition of all leases as finance leases, from the perspective of the lessee, with exemption given to low value leases and short-term leases, i.e. those with lease terms of less than 12 months. This will result in the recognition of a right of use asset, measured at the present value of future lease payments, and a corresponding liability in the Statement of Financial Position (SoFP).

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

The transition to IFRS 16 will be completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative

effects of applying the Standard, at the date of initial application, as an adjustment to the opening balance of the General Fund. Prior periods will not be restated.

In the transition to IFRS 16 a number of elections and practical expedients offered in the Standard have been employed. These are as follows;

The Department will apply the practical expedient offered in the Standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 Leases and IFRIC 4 Determining whether an Arrangement contains a Lease. Consequently it will not apply IFRS 16 to those arrangements that were identified as not containing a lease under previous leasing standards.

On transition the Department will recognise a lease liability at the date of initial application for leases previously classified as operating leases, per IFRS 16 C8 (a), measuring the liability at the present value of the remaining lease payments discounted at the HM treasury prescribed incremental borrowing rate of 0.95%.

The Department will measure the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

The above transitional provisions will not be applied to operating leases whose terms end within 12 months of the date of initial application per paragraph C10 (c) of IFRS 16 and to those leases for which the underlying asset is of low value, less than £5,000 in alignment with the Department's capitalisation threshold for owned assets. Instead these arrangements will be expensed on a straight line basis in accordance with paragraph 6 of IFRS 16.

Hindsight will be used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to the transitional provisions that will be employed on transition to IFRS 16 the specific criteria for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1 April 2022 will be fully assessed under the requirements of IFRS 16.

There are further expedients or elections that will be employed in applying IFRS 16. These include;

The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.

The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

The Department will not apply IFRS 16 to any new leases of intangible assets applying the requirements described in section 1.10 instead.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16. The Department is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the Department will have assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

The Department is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. Whereas IFRS 16 introduces a predominantly singular lessee approach to measurement and classification, for the lessor, leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

Acting as a Lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability.

The Department will employ a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure. Irrecoverable VAT is expensed in the period to which it relates and

therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The HM Treasury promulgated incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16 and for leases entered into during the 2022 calendar year, after 1 April 2022, where the lessee cannot readily determine the interest rate implicit in the lease and cannot demonstrate another discount rate would more accurately represent the incremental borrowing rate.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate. Where there is a change in a lease term or an option to purchase the underlying asset the Department will apply a revised rate to the remaining lease liability. Where existing leases are modified the Department must determine whether the arrangement constitutes a separate lease and apply the Standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset.

Acting as a lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Department's net investment in the lease. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Department's net investment outstanding in respect of the lease. Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the Department is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the classification of all of its continuing subleasing arrangements need to be reassessed

Impact of the Standard on the Department and its group

The Departmental Group contains limited companies who report under UK adopted IFRS following the Companies Act 2006. As the Standard is UK adopted those entities implemented IFRS 16 in the 2019-20 financial year. HM Treasury 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 did not meet this criterion and has not adopted IFRS 16 for the consolidated Annual Report and Accounts in 2021-22. The necessary adjustments have been made, in respect of these limited companies, to disapply IFRS 16 for 2021-22 in the consolidated financial statements.

As the Department engages in a number of sub leasing arrangements, it is expected that the finance lease receivable will increase under IFRS 16. As referenced above, on application of IFRS 16 entities are required to reassess subleasing arrangements based on the right of use asset generated by the head lease rather 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.

These financial statements disclose future commitments under operating leases of £4.0 billion (Core and Agency £222 million). IFRS 16 requires these lease arrangements 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.

Whilst the value of commitments under operating leases may be an indicator of the approximate value of lease liabilities to be recognised under IFRS 16 there are a number of possible adjustments required on transition which will impact the value ultimately recognised as a liability. For example, on transition entities must recognise liabilities where they assess it is likely that extension or termination options will be exercised. The operating lease disclosure requires that only future minimum lease payments are disclosed, and a difference between the two measures is therefore possible on a lease by lease basis.

Additionally, there are other balances and transactions to be recognised under IFRS 16 for which no clear pre implementation measures provide an accurate estimate. For example, the valuation of right of use assets, particularly those associated with peppercorn leases or leases substantially below market value.

IAS 8 requires the Department to disclose, in respect of IFRS which have been issued but are not yet effective, either a discussion of the impact that initial application of the IFRS is expected to have on the entity's financial statements or if that impact is not known or reasonably estimable, a statement to that effect.

The information provided above gives useful context to the impact of IFRS 16 for the Departmental Group. However, at the date of approving these financial statements it is not yet possible to reasonably estimate the full financial impact of IFRS 16.

The level of intra-group lease arrangements, coupled with the size and complexity of the group, means that it is not possible to determine an estimate of likely financial impact until all group bodies have completed their local implementation of IFRS 16 and the required consolidation adjustments and eliminations have been determined. This is because the consolidation adjustments required are expected to have a significant impact on the balances and transactions reported and therefore a reliable estimate cannot be made until this exercise has been completed in full. Whilst the methodology for ascertaining the adjustments required has been determined, the consolidation exercise cannot be concluded to fully determine the financial impact until local body implementation has been completed in full.

Additionally, it is expected that the implementation of IFRS 16 will require a relatively immaterial value of owned assets to be reintroduced into the group financial statements. This would include owned assets subject to intra-group finance leases which would require reinstatement of the underlying asset as a consolidation adjustment in the group financial statements, which may be valued differently to any related right of use assets in lessee financial statements.

There are several thousand intra-group lease arrangements within the DHSC Group which increases the complexity of calculating the required consolidation adjustments. The Department has already conducted an agreement of leases exercise for entities within the Departmental Group to assist with completeness and consistency of disclosure between group bodies. Additionally, the Department, with NHS England have published extensive guidance, worked examples and tools to assist local entities with implementing IFRS 16.

Group entities are implementing IFRS 16 from 1 April 2022. The Department will calculate and disclose the full impact of transition to IFRS 16 within its Annual Report and Accounts for 2022-23.

The impact of implementing IFRS 16 for the Core Department and its Executive Agencies is not expected to be material to the financial statements.

IFRS 17

Insurance Contracts which replaces IFRS 4 Insurance Contracts. The Standard is expected to be effective in the public sector for accounting periods beginning on or after 1 January 2025, following a recommendation made to the Financial Reporting Advisory Board by HM Treasury, that was agreed by the Board per the minutes for FRAB 146 in March 2022. 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.

- Share capital valuations are determined by applying the most appropriate methodology, Net Asset Value or Discounted Cash Flow, in line with IFRS 13.

- 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. During the year management has made significant judgements in relation to the impairment of inventories. Further information including an analysis of key sensitivities is included in **Note 8**, Impairments.

- 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. Resolution of claims is difficult to predict as many factors can lead to delay during the settlement and/ or resolution process, and emerging evidence can alter valuation. 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. These adjustments may result in classification errors, for example between different types of expenditure. However, these differences are not material both on a net and gross basis and therefore cannot constitute a material misstatement in the group financial statements. The department coordinates extensive 'agreement of balances exercises' across the departmental group, where counterparties to intra-group transactions and balances are required to discuss and agree those amounts, with the aim of minimising residual mismatches. It is not feasible to further resolve these differences due to the significant number of individual entities which contribute to the difference identified.

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 and the UK Health Security Agency (the Department's executive agencies), 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 Outturn against 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

	DHSC Core £000	Public Health (Executive Agencies) £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations and Adjustments £000	Departmental Group £000
										2021-22
Gross expenditure (2.2)	191,417,112	12,262,635	46,910,229	112,802,706	153,619,886	6,008,017	2,872,940	156,139	(281,804,266)	244,245,398
Income (2.3)	(2,537,970)	(2,829,791)	(3,234,806)	(112,640,463)	(3,243,417)	(387,762)	(2,723,942)	(162,055)	116,927,256	(10,832,950)
Total net expenditure (per CSCNE)	**188,879,142**	**9,432,844**	**43,675,423**	**162,243**	**150,376,469**	**5,620,255**	**148,998**	**(5,916)**	**(164,877,010)**	**233,412,448**
Budgeting adjustments per SoPS2										
Capital Grants	(664,626)	(5,164)	-	(22,859)	(141,119)	-	-	-	22,859	(810,909)
Research and Development	(1,451,440)	-	-	-	-	-	-	-	-	(1,451,440)
Utilisation of provisions	(963,822)	-	-	-	-	-	-	-	-	(963,822)
Prior period adjustments	-	-	2,457,088	-	-	-	-	-	-	2,457,088
Other (mainly COVID-19)[1]	447,210	603,740	-	465,822	(139,840)	(1,108)	140,688	-	(183,825)	1,332,687
Total adjustments	**(2,632,678)**	**598,576**	**2,457,088**	**442,963**	**(280,959)**	**(1,108)**	**140,688**	**-**	**(160,966)**	**563,604**
Budget outturn per SoPS1, of which:	**186,246,464**	**10,031,420**	**46,132,511**	**605,206**	**150,095,510**	**5,619,147**	**289,686**	**(5,916)**	**(165,037,976)**	**233,976,052**
RDEL	183,131,331	9,761,791	367,226	(518,943)	149,973,758	5,593,122	274,238	(5,916)	(165,028,370)	183,548,237
RAME	3,115,133	269,629	43,308,197	1,124,149	121,752	26,025	15,448	-	(9,606)	47,970,727
RNB	-	-	2,457,088	-	-	-	-	-	-	2,457,088

1. Included within other budgeting adjustments above are COVID-19 budget adjustments totalling £698 million relating to specific budgetary treatments agreed with HM Treasury for certain inventory purchases in the year. Further information can be found in the Statement of Outturn against Parliamentary Supply.
2. The prior period adjustment relates to the restatement of the clinical negligence provision as described in Note 16.

		Restated								Restated	Restated[2]
											2020-21
		DHSC Core £000	Public Health (Executive Agencies) £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations and Adjustments £000	Departmental Group £000
Gross expenditure		190,574,010	5,373,147	1,602,642	106,140,601	145,968,752	5,383,299	4,093,738	155,056	(265,537,320)	193,753,925
Income		(2,235,247)	(798,630)	(2,825,212)	(105,283,720)	(1,476,832)	(424,982)	(3,679,713)	(174,031)	107,929,149	(8,969,218)
Total net expenditure (per CSCNE)		**188,338,763**	**4,574,517**	**(1,222,570)**	**856,881**	**144,491,920**	**4,958,317**	**414,025**	**(18,975)**	**(157,608,171)**	**184,784,707**
Budgeting adjustments per SoPS2											
Capital Grants		(856,105)	(2,612)	(4,291)	-	(75,804)	(1,775)	-	-	1,825	(938,762)
Research and Development		(1,351,173)	-	-	-	-	-	-	-	-	(1,351,173)
Provision adjustment		-	-	333,269	-	-	-	-	-	-	333,269
Prior period adjustments		-	-	-	-	-	-	-	-	-	-
Other		1,424,018	318	-	448,157	-	(5,723)	(177,940)	-	(196,500)	1,492,330
Total adjustments		**(783,260)**	**(2,294)**	**328,978**	**448,157**	**(75,804)**	**(7,498)**	**(177,940)**	**-**	**(194,675)**	**(464,336)**
Budget outturn per SoPS1, of which:		**187,555,503**	**4,572,223**	**(893,592)**	**1,305,038**	**144,416,116**	**4,950,819**	**236,085**	**(18,975)**	**(157,802,846)**	**184,320,371**
	RDEL	185,557,939	4,558,392	373,281	(679,926)	144,328,892	4,927,407	207,202	(18,975)	(157,815,601)	181,438,611
	RAME	1,997,564	13,831	(1,266,873)	1,984,964	87,224	23,412	28,883	-	12,755	2,881,760
	RNB	-	-	-	-	-	-	-	-	-	-

1. Included within other budgeting adjustments above are COVID-19 budget adjustments totalling £1.19 billion relating to specific budgetary treatments agreed with HM Treasury for certain inventory purchases in the year. Further information can be found in the Statement of Outturn against Parliamentary Supply.
2. The prior period has been restated to reflect the transfer of the Vaccine Taskforce in August 2021 and the restatement of the clinical negligence provision described in Note 16. The transfer of the Vaccine Taskforce increased the total net expenditure of the Core Department and the Departmental Group by £1.26 billion. The restatement of the clinical negligence provision reduced the total net expenditure of Special Health Authorities and the Departmental Group by £333 million.

2.2 Departmental Group Detail – Expenditure

	2021-22									
	DHSC Core £000	Public Health (Executive Agencies) £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations and Adjustments £000	Departmental Group £000
Material Expenditure Items										
Staff costs	700,907	634,509	307,557	71,500,285	2,549,296	731,837	333,037	-	(14,469)	76,742,959
Purchase of healthcare from non-NHS bodies[4]	-	-	-	2,686,701	17,031,072	-	-	-	-	19,717,773
Goods and Services from other NHS Bodies[5]	-	-	3,558	11,111	99,244,560	-	2,077	-	(99,255,473)	5,833
Utilisation and write down of COVID-19 inventories	-	-	-	318,323	-	-	-	-	-	318,323
Provider Sustainability Fund	-	-	-	-	-	-	-	-	-	-
Purchase of social care	-	-	-	199,891	931,424	-	-	-	-	1,131,315
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	3,099,805	-	-	-	(42,815)	3,056,990
Establishment	897,225	-	17,850	1,189,332	614,792	44,002	27,229	-	(218,632)	2,571,798
Premises	994,520	189,336	24,009	3,989,942	245,313	36,542	283,337	-	(414,646)	5,348,353
PFI/Lift and other service concession arrangement charges	-	-	-	1,063,086	-	-	87,319	-	-	1,150,405
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,629,454	-	-	(3,387,344)	1,242,110
Prescribing Costs	(6,814)	-	-	-	9,089,310	-	-	-	(2,706)	9,079,790
G/PMS, APMS and PCTMS	-	-	-	-	11,365,278	-	-	-	(48,271)	11,317,007
Pharmaceutical Services	-	-	-	-	2,341,120	-	-	-	(1,414)	2,339,706
Supplies and Services - Clinical	-	-	-	17,019,343	820,852	49	825,208	-	(1,829,927)	16,835,525
Supplies and Services - General	57,889	1,734,376	90,241	1,692,790	1,590,767	242,170	540,465	-	(897,731)	5,050,967
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	904,222	-	-	-	-	(904,222)	-
Rentals under operating leases	74,072	14,139	7,392	880,221	127,429	12,172	134,733	-	(451,672)	798,486
Interest charges	1,144	-	-	914,590	306	-	153,648	-	(63,814)	1,005,874
Research and development	1,200,526	1,079	77	313,946	17,122	-	4,707	-	(851,514)	685,943
Clinical negligence Costs	-	-	-	2,455,595	336	99	-	-	(2,455,000)	1,030
Grant in Aid	156,158,304	-	-	-	-	-	-	-	(156,158,304)	-
General Ophthalmic Services	-	-	-	-	561,006	-	-	-	(57)	560,949
Business Rates Paid to Local Authorities	8,395	-	-	422,944	1,638	3,946	68,148	-	4,466	509,537
Education, Training and Conferences	3,292	4,091	15,945	412,647	91,082	5,617	4,452	-	(14,315)	522,811
Consultancy Services	252,815	-	458	260,385	75,764	2,769	34,393	-	-	626,584
Legal fees	37,482	90,441	1,752	98,272	235,350	10,433	6,332	-	(26,523)	453,539
Funding to Group Bodies	9,804,646	-	-	-	-	-	-	-	(9,804,646)	-
Funding for additional pensions uplift	-	-	-	-	2,700,677	-	-	-	(2,700,677)	-
Audit Fees	2,000	675	1,504	45,401	30,957	1,566	1,323	-	(1,492)	81,934
Other	1,526,648	(13)	636,723	1,621,399	62,642	18,054	62,747	-	(370,799)	3,557,401
Additional support for delivery of healthcare services	-	-	-	-	-	-	-	-	-	-
Material expenditure items	171,713,051	2,668,633	1,107,066	108,000,426	152,827,898	5,738,710	2,569,155	-	(279,911,997)	164,712,942
Grants to Other Bodies	695,358	54,647	-	-	150,294	-	-	-	(12,212)	888,087
Grants to Local Authorities	3,836,295	1,843,607	-	-	-	-	-	-	-	5,679,902
Capital Grants	664,626	5,164	-	-	141,119	-	-	-	-	810,909
Total Grants expenditure	5,196,279	1,903,418	-	-	291,413	-	-	-	(12,212)	7,378,898
Movement in expected credit loss allowance (non credit impaired)	53,758	21,524	2,170	78,771	1,344	201	43,871	-	19,255	220,894
Depreciation on property, plant and equipment	14,883	117,642	6,578	2,706,169	181,605	9,762	235,091	-	470	3,272,200
Amortisation on intangible assets	103,991	2,946	21,785	339,136	14,795	86,680	6,270	-	-	575,603
Impairments and reversals	(685,514)	7,871	36	700,366	742	27,852	(14,421)	-	1,068,778	1,105,710
Provisions provided for in year	4,483,016	72,865	2,799,893	442,787	173,852	1,314	2,311	-	-	7,976,038
Non-cash expenditure from movement in pension liability	-	-	-	10,816	166	7,549	2,476	-	-	21,007
Provisions - unwinding of discount	(15,914)	-	347,620	(2,718)	3,118	(14)	29,454	-	-	361,546
Provisions - Change in discount rate	436,027	-	42,623,208	13,605	(23,040)	39	-	-	(1)	43,049,838
Non-cash expenditure	4,390,247	222,848	45,801,290	4,288,932	352,582	133,383	305,052	-	1,088,502	56,582,836
Total non-material expenditure	215,359	55,872	1,873	513,348	147,993	135,924	(1,267)	156,139	(131,330)	1,093,911
Covid-19 expenditure (Core and Agencies)[2]	9,902,176	7,411,864							(2,837,229)	14,476,811
Total Gross Expenditure	**191,417,112**	**12,262,635**	**46,910,229**	**112,802,706**	**153,619,886**	**6,008,017**	**2,872,940**	**156,139**	**(281,804,266)**	**244,245,398**

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. COVID-19 expenditure for Core and Agencies includes the operational costs of the NHS Test and Trace, personal protective equipment and other equipment and consumables procured by the Core Department. The most significant elements of these costs are impairment of inventory (£1.6 billion), costs relating to NHS Test and Trace (£9.7 billion) and the supply of COVID-19 vaccines (£2.1 billion).
3. In addition to the above costs relating to COVID-19 other costs have been incurred across the Departmental Group as a result of the COVID-19 pandemic. These costs are not separately identifiable from the existing operations of those Group bodies.
4. Purchase of Healthcare from Non-NHS bodies within the NHS England Group includes expenditure associated with the COVID-19 pandemic in 2021-22.
5. Goods and Services from other NHS Bodies within the NHS England Group include the national block payments arrangement in place to fund NHS Providers for additional costs associated with the COVID-19 pandemic. The associated income in NHS providers is included in Income from DHSC/ NHS Bodies and Additional Funding Streams within Note 2.3.

	Restated								Restated	Restated[1]
										2020-21
	DHSC Core £000	Public Health (Executive Agencies) £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations and Adjustments £000	Departmental Group £000
Material Expenditure Items										
Staff costs	728,737	403,694	285,869	67,433,176	2,270,582	642,296	327,331	-	(10,123)	72,081,562
Purchase of healthcare from non-NHS bodies	-	-	-	1,688,925	18,379,296	-	-	-	-	20,068,221
Goods and Services from other NHS Bodies	-	-	131	75,962	91,952,855	12	6,247	-	(92,007,832)	27,375
Utilisation of COVID-19 inventories	-	-	-	1,145,697	-	-	-	-	-	1,145,697
Provider Sustainability Fund	-	-	-	-	(10,921)	-	-	-	10,921	-
Purchase of social care	-	-	-	203,427	851,720	-	-	-	-	1,055,147
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	3,061,746	-	-	-	(30,637)	3,031,109
Establishment	1,075,139	38,113	16,676	1,056,402	597,629	47,209	14,150	-	(78,491)	2,766,827
Premises	449,531	28,319	26,357	3,824,093	263,278	37,015	289,851	-	(388,888)	4,529,556
PFI/Lift and other service concession arrangement charges	-	-	-	1,054,528	-	-	88,364	-	-	1,142,892
Multi Professional Education and Training (MPET)	-	-	-	-	-	4,196,173	-	-	(3,102,673)	1,093,500
Prescribing Costs	269,717	-	-	-	9,059,707	-	-	-	(2,055)	9,327,369
G/PMS, APMS and PCTMS	-	-	-	-	10,399,491	-	-	-	(97,146)	10,302,345
Pharmaceutical Services	-	-	-	-	2,124,486	-	-	-	(202)	2,124,284
Supplies and Services - Clinical	-	-	-	14,707,579	759,132	97	1,311,117	-	(2,095,221)	14,682,704
Supplies and Services - General	-	872,370	105,557	1,857,107	1,703,756	168,104	1,037,273	-	(1,074,284)	4,669,883
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	736,261	-	-	-	-	(736,261)	-
Rentals under operating leases	75,989	3,423	7,410	816,233	185,414	14,657	138,396	-	(467,314)	774,208
Interest charges	2,761	-	-	920,240	33	-	159,627	-	(70,906)	1,011,755
Research and development	1,989,371	1,997	53	256,665	13,080	-	4,477	-	(759,589)	1,506,054
Clinical negligence Costs	-	-	-	2,253,879	220	137	-	-	(2,253,366)	870
Grant in Aid	149,814,029	-	-	-	-	-	-	-	(149,814,029)	-
General Ophthalmic Services	-	-	-	-	590,306	-	-	-	(26)	590,280
Business Rates Paid to Local Authorities	5,079	2,166	-	484,399	962	3,350	64,528	-	3,869	564,353
Education, Training and Conferences	5,223	1,355	14,521	308,725	86,952	4,519	5,628	-	(12,667)	414,256
Consultancy Services	188,978	-	4,793	232,258	51,552	2,338	23,443	-	-	503,362
Legal fees	39,694	721	792	93,140	180,894	7,066	5,017	-	(7,098)	320,226
Funding to Group Bodies	5,142,370	-	-	-	-	-	-	-	(5,142,370)	-
Funding for additional pensions uplift	-	-	-	-	2,549,567	-	-	-	(2,549,567)	-
Audit Fees	2,000	472	1,515	40,900	31,774	1,444	2,049	-	(1,522)	78,632
Other	1,223,438	854	448,404	1,612,543	84,360	18,938	60,207	-	(42,718)	3,406,026
Additional support for delivery of healthcare services	(1,164)	-	-	-	-	-	-	-	-	(1,164)
Material expenditure items	161,010,892	1,353,484	912,078	100,802,139	145,187,871	5,143,355	3,537,705	-	(260,730,195)	157,217,329
Grants to Other Bodies	663,756	26,713	-	-	292,772	-	-	-	(9,558)	973,683
Grants to Local Authorities	3,354,394	3,076,887	-	-	-	-	-	-	-	6,431,281
Capital Grants	856,105	2,612	-	-	75,804	-	-	-	(1,825)	932,696
Total Grants expenditure	4,874,255	3,106,212	-	-	368,576	-	-	-	(11,383)	8,337,660
Movement in expected credit loss allowance (non credit impaired)	27,261	8	114	178,368	16,752	236	40,912	-	22,527	286,178
Depreciation on property, plant and equipment	7,569	44,496	7,279	2,434,537	168,300	14,442	238,369	-	470	2,915,462
Amortisation on intangible assets	92,467	2,696	14,818	285,731	4,014	67,627	4,422	-	-	471,775
Impairments and reversals	2,616,851	171,039	3,659	1,464,236	322	20,301	8,613	-	(2,613,564)	1,671,457
Provisions provided for in year	2,777,913	1,864	(69,388)	510,185	46,884	5,186	(5,012)	-	-	3,267,632
Non-cash expenditure from movement in pension liability	-	-	-	8,098	67	6,947	3,502	-	-	18,614
Provisions - unwinding of discount	(30,737)	-	503,375	(1,010)	5,137	7	14,537	-	-	491,309
Provisions - Change in discount rate	7,783	-	228,701	15,986	40,216	(2)	-	-	-	292,684
Total non-cash expenditure	5,499,107	220,103	688,558	4,896,131	281,692	114,744	305,343	-	(2,590,567)	9,415,111
Total non-material expenditure	238,867	136,456	2,006	442,331	130,613	125,200	250,690	155,056	(190,226)	1,290,993
Covid-19 Expenditure (Core and Agencies)	18,950,889	556,892							(2,014,949)	17,492,832
Total Expenditure	**190,574,010**	**5,373,147**	**1,602,642**	**106,140,601**	**145,968,752**	**5,383,299**	**4,093,738**	**155,056**	**(265,537,320)**	**193,753,925**

1. Expenditure in 2020-21 has been restated to reflect the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and the restatement of the clinical negligence provision for known claims as described in Note 16.

2.3 Departmental Group Detail - Income

	2021-22									
	DHSC Core £000	Public Health (Executive Agencies) £000	Special Health Authorities £000	NHS Providers £000	NHS England £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations and Adjustments £000	Departmental Group £000
Material Income Items										
Income from Local Authorities	-	-	-	(1,845,539)	-	-	(875)	-	-	(1,846,414)
Income from Private patients	-	-	-	(540,011)	-	-	-	-	-	(540,011)
Income from injury costs recovery	-	-	-	(147,933)	-	-	-	-	-	(147,933)
Income from DHSC/NHS bodies	-	-	-	(97,365,953)	-	-	(75,256)	-	97,321,417	(119,792)
Other non-NHS patient care services	-	-	-	(586,554)	(94,034)	-	(91,355)	-	-	(771,943)
Income for additional pension uplift	-	-	-	(2,698,648)	-	-	(2,029)	-	2,700,677	-
Non patient care services to other bodies	(68,584)	-	(85,116)	(840,282)	(1,519,142)	(40,733)	(1,560,247)	-	3,215,893	(898,211)
Education, training and research	-	(1,974)	(407)	(4,396,989)	(12,270)	(94,502)	(9,952)	-	4,055,585	(460,509)
Provider Sustainability Fund and Financial Recovery Fund Income	-	-	-	-	-	-	-	-	-	-
Support from DHSC for mergers	-	-	-	(6,000)	-	-	-	-	6,000	-
Voluntary Scheme for Branded Medicines Pricing and Access	(731,488)	-	-	-	-	-	-	-	-	(731,488)
Fees and Charges	(424,418)	(244,619)	(3,145,423)	(228,557)	(1,285,811)	(234,956)	(130,723)	-	3,470,674	(2,223,833)
Additional Funding Streams[1]	-	-	-	(1,124,441)	-	-	-	-	1,124,441	-
Other Contract Income	(11,143)	-	(1,721)	(1,594,756)	(235,213)	(9,211)	-	-	766,419	(1,085,625)
Non-material contract income	(69,021)	-	(2,004)	(269,781)	(11,841)	(4,344)	(1,406)	-	14,469	(343,928)
Income from contracts	(1,304,654)	(246,593)	(3,234,671)	(111,645,444)	(3,158,311)	(383,746)	(1,871,843)	-	112,675,575	(9,169,687)
Non-Contract Income										
Rental revenue from operating leases	(24,049)	(424)	-	(78,069)	(4,019)	(95)	(716,364)	-	511,945	(311,075)
PDC Dividend Received	(904,222)	-	-	-	-	-	-	-	904,222	-
Charitable and other contributions to expenditure	-	-	(2)	(77,378)	(684)	-	-	-	17,315	(60,749)
Donation of Assets	-	-	-	(325,343)	-	-	-	-	278,848	(46,495)
Other non-contract income	(44,170)	-	(117)	(17,864)	(80,968)	(1,186)	(101,633)	-	(134,168)	(380,106)
Non-material non-contract income	(194,455)	(1,126)	(16)	(485,008)	565	(2,735)	(21,823)	-	28,380	(676,218)
Non-contract operating income	(1,166,896)	(1,550)	(135)	(983,662)	(85,106)	(4,016)	(839,820)	-	1,606,542	(1,474,643)
COVID-19 Income (Core and Agencies)	-	(2,581,240)							2,581,240	-
Other non-contract operating income	(1,166,896)	(2,582,790)	(135)	(983,662)	(85,106)	(4,016)	(839,820)	-	4,187,782	(1,474,643)
Income received by NHS charities	-	-	-	-	-	-	-	(162,055)	-	(162,055)
Finance income	(66,420)	(408)	-	(11,357)	-	-	(12,279)	-	63,899	(26,565)
Total income	**(2,537,970)**	**(2,829,791)**	**(3,234,806)**	**(112,640,463)**	**(3,243,417)**	**(387,762)**	**(2,723,942)**	**(162,055)**	**116,927,256**	**(10,832,950)**

1. Income from DHSC/NHS Bodies and Additional Funding Streams in the NHS provider sector includes income from NHS England in relation to the national block payments arrangement in place to fund additional costs associated with the COVID-19 pandemic. The associated expenditure in the NHS England Group is included in Goods and Services from other NHS Bodies within Note 2.2.

	DHSC Core £000	Public Health (Executive Agencies) £000	Special Health Authorities £000	NHS Providers £000	NHS England Group £000	Non-Departmental Public Bodies £000	Other Group Bodies £000	NHS Charities £000	Inter company Eliminations and Adjustments £000	Restated 2020-21 Departmental Group £000
Material Income Items										
Income from Local Authorities	-	-	-	(1,804,768)	-	-	(841)	-	-	(1,805,609)
Income from Private patients	-	-	-	(375,926)	-	-	-	-	-	(375,926)
Income from injury costs recovery	-	-	-	(129,959)	-	-	-	-	-	(129,959)
Income from DHSC/NHS bodies	-	-	-	(85,048,091)	-	-	(62,852)	-	85,000,890	(110,053)
Other non-NHS patient care services	-	-	-	(526,247)	-	-	(186,739)	-	-	(712,986)
Income for additional pension uplift	-	-	-	(2,547,728)	-	-	(1,839)	-	2,549,567	-
Non patient care services to other bodies[1]	(68,357)	-	(74,218)	(596,610)	(262,623)	(38,153)	(2,470,953)	-	2,804,370	(706,544)
Education, training and research	-	(495)	(208)	(3,898,083)	(12,075)	(139,067)	(2,868)	-	3,697,726	(355,070)
Provider Sustainability Fund and Financial Recovery Fund Income	-	-	-	10,921	-	-	-	-	(10,921)	-
Support from DHSC for mergers	-	-	-	(8,374)	-	-	-	-	8,374	-
Voluntary Scheme for Branded Medicines Pricing and Access	(490,643)	-	-	-	-	-	-	-	-	(490,643)
Fees and Charges	(97,612)	(197,496)	(2,737,608)	(210,109)	(892,916)	(230,086)	(120,270)	-	3,043,643	(1,442,454)
Additional Funding Streams	-	-	-	(6,865,143)	-	-	-	-	6,865,143	-
Other Contract Income	(364,894)	-	(11,575)	(1,148,639)	(213,974)	(7,503)	-	-	556,865	(1,189,720)
Non-material contract income	(67,813)	-	(779)	(238,275)	(7,765)	(3,526)	(2,691)	-	10,123	(310,726)
Income from contracts	(1,089,319)	(197,991)	(2,824,388)	(103,387,031)	(1,389,353)	(418,335)	(2,849,053)	-	104,525,780	(7,629,690)
Non-Contract Income										
Rental revenue from operating leases	(14,134)	(5,648)	-	(71,211)	(24)	(452)	(706,329)	-	523,509	(274,289)
PDC Dividend Received	(736,262)	-	-	-	-	-	-	-	736,262	-
Charitable and other contributions to expenditure	-	-	-	(69,201)	(11,038)	-	-	-	16,653	(63,586)
Donation of Assets	-	-	-	(1,404,952)	(1)	-	-	-	1,404,953	-
Other non-contract income	(28,487)	-	(863)	10,768	(75,675)	(3,582)	(99,090)	-	(26,728)	(223,657)
Non-material non-contract income	(29,366)	(753)	39	(359,975)	(689)	(2,612)	(13,835)	-	49,290	(357,901)
Non-contract operating income	(808,249)	(6,401)	(824)	(1,894,571)	(87,427)	(6,646)	(819,254)	-	2,703,939	(919,433)
COVID-19 Income (Core and Agencies)	(250,858)	(593,966)							628,524	(216,300)
Other non-contract operating income	(1,059,107)	(600,367)	(824)	(1,894,571)	(87,427)	(6,646)	(819,254)	-	3,332,463	(1,135,733)
Income received by NHS charities	-	-	-	-	-	-	-	(174,031)	-	(174,031)
Finance income	(86,821)	(272)	-	(2,118)	(52)	(1)	(11,406)	-	70,906	(29,764)
Total income	**(2,235,247)**	**(798,630)**	**(2,825,212)**	**(105,283,720)**	**(1,476,832)**	**(424,982)**	**(3,679,713)**	**(174,031)**	**107,929,149**	**(8,969,218)**

1. Income in 2020-21 has been restated to reflect the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method. This has reduced the income of the Departmental Group by £594 million.

3. Staff costs

Staff costs for the Departmental Group comprise:

				2021-22 £'000	Restated[2] 2020-21 £'000
	Permanently employed staff	Others	Ministers	Total	Total
Salaries and wages	54,059,866	7,727,793	219	61,787,878	58,135,332
Social Security costs	5,816,703	151,745	23	5,968,471	5,466,312
NHS Pension	9,067,112	192,782	-	9,259,894	8,684,958
Other pension costs	119,421	3,181	-	122,602	118,488
Sub-total	**69,063,102**	**8,075,501**	**242**	**77,138,845**	**72,405,090**
Termination benefits	10,765	2,514	-	13,279	21,850
Sub-total	**69,073,867**	**8,078,015**	**242**	**77,152,124**	**72,426,940**
Less recoveries in respect of outward secondments	(27,105)	(101,282)	-	(128,387)	(120,704)
Total Net Costs	**69,046,762**	**7,976,733**	**242**	**77,023,737**	**72,306,236**

1. A more detailed analysis of staff costs can be found in the Accountability Report.
2. As described in Note 1.27 the comparative financial information has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method.

			2021-22 £'000
	Charged to revenue budgets	Charged to capital	Total
Core Dept & Agencies	1,335,416	5,667	1,341,083
Other designated bodies	75,422,012	275,111	75,697,123
Less elimination of intra-group expenditure	(14,469)	-	(14,469)
Total	**76,742,959**	**280,778**	**77,023,737**

			2020-21 £'000
	Charged to revenue budgets	Charged to capital	Total
Core Dept & Agencies	1,132,431	4,936	1,137,367
Other designated bodies	70,959,325	219,738	71,179,063
Less elimination of intra-group expenditure	(10,194)	-	(10,194)
Total	**72,081,562**	**224,674**	**72,306,236**

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.

For 2021-22, employers' contributions of £37,704,686 were payable to the PCSPS at one of four rates in the range 26.6% to 30.3% (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 2021-22, 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 £227,691 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 £5,081, 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.

For 2021-22, employers' contributions were payable to the NHS Pension Scheme at the rate of 20.68% (2020-21: 20.68%) 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 £9.260 billion (2020-21: £8.685 billion) against NHS pension costs, £328.2 million is attributable to NHS England Group (2020-21: £287.7 million), £8.790 billion is attributable to NHS providers (2020-21: £8.266 billion) with the balance of £142.1 million (2020-21: £131.3 million) to ALBs.

Employer contribution rates payable to the NHS Pension Scheme in 2022-23 remain the same as those payable in 2021-22 therefore we do not expect overall NHS pension costs in 2022-23 to be materially different from 2021-22.

4. Expenditure

4.1 Expenditure

	Note	2021-22 £'000 Core Dept & Agencies	2021-22 £'000 Departmental Group	Restated[10,11] 2020-21 £'000 Core Dept & Agencies	Restated[10,11] 2020-21 £'000 Departmental Group
4.1 (a) Purchase of goods and services					
Rentals Under Operating Leases		84,685	798,486	78,038	774,208
Supplies and services - clinical		-	16,835,525	-	14,682,704
Supplies and services - general		1,783,320	5,050,967	834,126	4,669,883
Supply of COVID-19 Ventilators to NHS providers		4,479	-	161,538	-
Supply of COVID-19 Ventilators to Devolved Authorities		36,519	36,519	53,989	53,989
Supply of COVID-19 Personal Protective Equipment to NHS providers		251,510	-	1,243,415	-
Supply of Personal Protective Equipment to external bodies		414,723	414,723	1,208,435	1,208,435
Utilisation of COVID-19 specific inventory by NHS providers		-	311,797	-	1,092,007
Cost of COVID-19 equipment		-	2,513	-	12,906
Donation of vaccines[2]		2,083,894	2,083,894	672,899	672,899
Supply of COVID-19 Medicines		279,107	279,107	99,276	99,276
Cost of NHS Test and Trace consumables		7,249,263	7,249,263	3,208,911	3,208,911
COVID-19 Statistical Research		249,180	249,180	519,888	519,888
NHS Test and Trace Operational Costs		2,449,578	2,449,578	2,771,656	2,755,626
Goods and services from other NHS bodies		-	5,833	-	27,375
Multi Professional Education and Training (MPET)		-	1,242,110	-	1,093,500
Additional support for delivery of healthcare services		-	-	(1,164)	(1,164)
Purchase of healthcare from non NHS bodies		-	19,717,773	-	20,068,221
Purchase of Social Care		-	1,131,315	-	1,055,147
Expenditure on Drug Action Teams		-	277	-	805
General Dental Services (GDS) and Personal Dental Services (PDS)[3]		-	3,056,990	-	3,031,109
Prescribing Costs		(6,814)	9,079,790	269,717	9,327,369
G/PMS, APMS and PCTMS[4]		-	11,317,007	-	10,302,345
Pharmaceutical Services		-	2,339,706	-	2,124,284
General Ophthalmic Services		-	560,949	-	590,280
Consultancy services		252,815	626,584	188,978	503,362
Establishment		897,225	2,571,798	1,113,252	2,766,827
Transport (Business Travel)		35,215	315,728	11,222	241,542
Premises		1,182,266	5,348,353	477,850	4,529,556
Education, Training and Conferences (cash)		7,383	522,811	6,572	414,256
Insurance		571	80,664	178	55,083
Legal fees		127,923	453,539	40,415	320,226
NHS Informatics Major Contracts Cost		114,454	244,990	114,527	232,685
Audit fees - statutory audit (cash)		-	39,178	-	35,659
Auditor remuneration - other		-	39,942	202	40,585
Non-cash items					
Audit fees - statutory audit - non-cash		2,675	2,814	2,270	2,388
Purchase of goods and services		**17,499,971**	**94,459,703**	**13,076,190**	**86,512,172**

		2021-22 £'000		Restated 2020-21 £'000	
	Note	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
4.1 (b) Depreciation and impairment charges					
non-cash items					
Depreciation on property, plant and equipment		132,525	3,272,200	52,065	2,915,462
Amortisation on intangible assets		106,937	575,603	95,163	471,775
Impairments and reversals	8	951,005	2,734,358	11,761,665	10,645,232
Depreciation and impairment charges		**1,190,467**	**6,582,161**	**11,908,893**	**14,032,469**
4.1 (c) Provision expense					
non-cash items					
Non-cash expenditure from movement in pension liability		-	21,007	-	18,614
Provision provided for in year	16	4,555,881	7,976,038	2,779,777	3,267,632
Provisions change in discount rate	16	436,027	43,049,838	7,783	292,684
Provision expense		**4,991,908**	**51,046,883**	**2,787,560**	**3,578,930**
4.1 (d) Other operating expenditure					
PFI/LIFT and other service concession arrangements charges		-	1,150,405	-	1,142,892
Chair and non-executive Directors' costs		-	68,411	-	72,841
Business rates paid to local authorities		8,395	509,537	7,245	564,353
Clinical negligence		-	1,030	-	870
Research and development		1,201,605	685,943	1,991,368	1,506,054
Grants to Local Authorities		5,679,902	5,679,902	6,431,281	6,431,281
Grants to Other bodies		750,005	888,087	690,469	973,683
Capital Grants		669,790	810,909	858,717	932,696
DHSC support for mergers		6,000	-	8,374	-
Prior period adjustments in local accounts		-	(4,235)	-	209,368
Non-cash items					
Loss on disposal of non-current assets and assets held for sale		29,496	71,658	21,873	57,617
Movement of expected credit loss allowance (non-credit impaired)[5]		75,282	220,894	27,269	286,178
Inventories write down (covid specific)		85,899	85,899	33	33
Inventories write down		82,417	99,188	64,171	92,214
COVID-19 - Inventories Write Downs (NHS providers)		-	4,013	-	40,784
Loan Write Off		174	174	-	-
Capital grants in kind		-	-	-	6,066
Apprenticeship training grant (non-cash)		277	116,558	929	83,392
Prior period adjustments in local accounts (non-cash)		-	1,588	87,801	165,099
Changes in fair value through SoCNE		1,351	5,438	60,924	6,706
Other non-cash expenditure		2,325	31,884	10,593	13,376
Unrealised Foreign Exchange Rate (Gains)/Losses		(1,049)	(1,049)	(5,269)	(5,325)
Other[6,7]		1,540,696	3,557,401	1,229,358	3,406,026
Other operating expenditure		**10,132,565**	**13,983,635**	**11,485,136**	**15,986,204**

1. Supply of COVID-19 ventilators, personal protective equipment and medicines represents the donation for nil consideration of inventory purchased centrally by DHSC. Personal protective equipment supplied to external bodies has been donated to health and care sector settings and public bodies outside the DHSC Group. Utilisation of COVID-19 related inventory represents the usage of donated items by recipient bodies.
2. Donation of vaccines includes £2.078 billion COVID-19 vaccines and £5 million of child flu vaccines procured centrally by the Core Department.
3. General Dental Services (GDS) and Personal Dental Services (PDS) are alternative models for dental care.
4. 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.
5. 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 forthcoming 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. Please see Note 1.23.4 for details of the Department's accounting policy in respect of Expected Credit Losses.
6. The Core Department and Agencies 'Other' expenditure figure of £1.541 billion (£1.229 billion in 2020-21 (restated)) includes £148 million of revenue policy payments (£480 million in 2020-21), £541 million in respect of outsourcing contracts (£343 million in 2020-21) and £159 million of Healthy Start – Welfare Foods payments (£74 million in 2020-21). Revenue policy payments were higher in 2020-21 as a result of one-off increased awards relating to infected blood payments.
7. Other expenditure also includes £677 million of transport costs in the provider sector relating to expenditure such as fuel costs, vehicle parts and other fleet related costs.
8. A breakdown of the Departmental Group Other figure by sector is provided in Note 2.2 Departmental Group Detail – Expenditure.
9. Core Department and Agencies expenditure figures may be greater than those of the Departmental Group due to the elimination of intercompany trading.
10. As described in Note 1.27 the comparative financial information has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method.
11. Comparative financial information has also been restated to reflect the restatement of the clinical negligence provision for known claims as described in Note 16.

Note 4.2 Non-cash transactions

The total of non-cash transactions included in the Reconciliation of Operating Costs to Operating Cash flow in the Consolidated Statement of Cash Flows comprises:

	2021-22 £'000		Restated[1,2] 2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Expenditure after financing activities - non-cash items (Note 4 & SOCNE)	16,764,803	69,007,465	21,584,773	25,199,659
Less non-cash income after financing activities (Note 5 & SOCNE)	(172,581)	(403,155)	(239,701)	(471,074)
Total non-cash transactions	**16,592,222**	**68,604,310**	**21,345,072**	**24,728,585**
Movement in expected credit loss allowance	(75,282)	(220,894)	(27,269)	(286,178)
Inventories write down	(168,316)	(189,100)	(64,204)	(133,031)
Impairment of inventories	(1,628,648)	(1,628,648)	(8,973,775)	(8,973,775)
Utilisation of Covid-19 related inventory	(10,319,495)	(10,377,816)	(6,648,463)	(6,348,423)
Donations received of Covid-19 related inventory	-	-	216,300	216,300
Donation of assets	-	46,495	-	-
Less non-cash movements on SoFP balances analysed separately in the Cash Flow Statement	**(12,191,741)**	**(12,369,963)**	**(15,497,411)**	**(15,525,107)**
Total non-cash transactions as per Consolidated Statement of Cash Flows	**4,400,481**	**56,234,347**	**5,847,661**	**9,203,478**

1. As described in Note 1.27 the comparative financial information has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method.
2. Comparative financial information has also been restated to reflect the restatement of the clinical negligence provision for known claims as described in Note 16.

5. Income

5.1 Income

	2021-22 £'000		Restated[3] 2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Income from contracts				
Revenue from Patient Care activities				
Income from Local Authorities	-	1,846,414	-	1,805,609
Income from Private patients	-	540,011	-	375,926
Income from Chargeable Overseas Patients	-	67,021	-	61,328
Income from injury costs recovery	-	147,933	-	129,959
Income in respect of EEA claims	69,021	69,021	67,813	67,813
Income from DHSC/NHS bodies	-	119,792	-	110,053
Other non-NHS patient care services	-	771,943	-	712,986
Other contract income				
Non-patient care services to other bodies	68,584	898,211	68,357	706,544
Education, training and research	1,974	460,509	495	355,070
Prescription Fees and Charges	-	651,964	-	615,251
Dental Fees and Charges	-	633,847	-	277,665
Other Fees and Charges	663,898	938,022	291,140	549,538
Additional funding streams	-	-	-	-
Income in respect of Staff Costs	-	207,886	-	181,585
Voluntary Scheme for Branded Medicines Pricing and Access	731,488	731,488	490,643	490,643
Other Contract Income[1,2]	11,143	1,085,625	364,894	1,189,720
Income from contracts	**1,546,108**	**9,169,687**	**1,283,342**	**7,629,690**
Other non-contract operating income				
Rental revenue from finance leases	-	675	-	393
Rental revenue from operating leases	24,473	311,075	19,782	274,289
PDC Dividend Received	904,222	-	736,262	-
Charitable and other contributions to expenditure	-	60,749	-	63,586
Donations of Assets	-	46,495	-	-
Donation of mechanical ventilators	-	-	126,827	126,827
Other donations recognised as inventory	-	-	89,473	89,473
Receipt of donations for capital acquisitions	-	153,569	-	81,854
Receipt of grants for capital acquisitions	-	117,841	-	18,089
Profit on disposal	169,354	198,441	11,878	53,023
Dividends	23,000	31,756	6,718	14,565
Other non-cash income	2,950	54,924	10,594	98,737
Apprenticeship training grant (non-cash)	277	116,558	929	83,392
Funding from other Government departments	-	4,129	-	3,231
Prior period adjustments in local accounts	-	(1,675)	-	4,617
Other non contract income	49,309	380,106	32,455	223,657
Non-contract income	**1,173,585**	**1,474,643**	**1,034,918**	**1,135,733**

1. Other Contract Income includes £330 million in the provider sector, which represents a proportion of the incidental non-clinical sales and services.
2. During 2020-21 the Department received cash that HM Treasury has determined was surrenderable to the Consolidated fund. The income associated with the transfer of this cash was 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 2020-21 was £364 million and is included within other contract income.
3. As described in Note 1.27 the comparative financial information has been restated to include the results of the Vaccine Taskforce which transferred to the Department on 1 August 2021 and has been accounted for using the merger accounting method.

6. Property, plant and equipment

Departmental Group 2021-22

	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 2021	**6,040,256**	**40,336,810**	**351,798**	**5,740,382**	**5,265,602**	**687,774**	**11,062,883**	**529,066**	**396,166**	**70,410,737**
Prior period adjustments in underlying accounts	7,136	4,897	(80)	(35,442)	(2,677)	(929)	(83,382)	(190)	-	(110,667)
Additions	37,565	1,212,543	1,995	677,729	4,016,357	49,112	842,657	27,017	8,311	6,873,286
Donations	500	74,895	-	5,448	224,499	6,036	60,364	198	-	371,940
Impairments and reversals	30,541	(783,299)	(2,081)	(17,355)	(299,188)	(7,628)	(14,816)	-	-	(1,093,826)
Transfers	1	130	-	(169)	(4,922)	(1)	1,790	-	107	(3,064)
Reclassifications	(27,970)	2,089,944	7,502	282,990	(2,985,351)	42,790	408,694	22,332	-	(159,069)
Revaluation and indexation	316,974	(62,714)	5,585	(4,324)	292	767	3,945	90	-	260,615
Disposals	(6,966)	(22,044)	(2,078)	(509,889)	(19,558)	(62,360)	(634,473)	(42,308)	(35,166)	(1,334,842)
At 31 March 2022	**6,398,037**	**42,851,162**	**362,641**	**6,139,370**	**6,195,054**	**715,561**	**11,647,662**	**536,205**	**369,418**	**75,215,110**
Depreciation										
At 1 April 2021	**6,895**	**1,743,545**	**23,813**	**3,375,820**	**-**	**482,305**	**6,902,805**	**319,390**	**108,543**	**12,963,116**
Prior period adjustments in underlying accounts	-	(14,695)	(81)	(34,859)	-	(1,672)	(87,009)	(109)	-	(138,425)
Charged in year	88	1,484,597	12,783	760,513	-	51,919	815,153	60,619	86,528	3,272,200
Impairments and reversals	(4,478)	(240,843)	294	(2,208)	-	(934)	(3,057)	690	-	(250,536)
Transfers	-	131	-	934	-	-	(1,041)	-	-	24
Reclassifications	-	(12,597)	-	(13,143)	-	885	(2,100)	(10,409)	-	(37,364)
Revaluation and indexation	(2,035)	(1,617,548)	(16,737)	(4,246)	-	357	2,159	133	-	(1,637,917)
Disposals	-	(11,123)	(1,344)	(485,792)	-	(60,623)	(587,733)	(41,260)	(35,166)	(1,223,041)
At 31 March 2022	**470**	**1,331,467**	**18,728**	**3,597,019**	**-**	**472,237**	**7,039,177**	**329,054**	**159,905**	**12,948,057**
Net book value at 31 March 2022	**6,397,567**	**41,519,695**	**343,913**	**2,542,351**	**6,195,054**	**243,324**	**4,608,485**	**207,151**	**209,513**	**62,267,053**
Net book value at 31 March 2021	6,033,361	38,593,265	327,985	2,364,562	5,265,602	205,469	4,160,078	209,676	287,623	57,447,621
Asset financing:										
Owned - purchased	5,829,239	28,154,004	262,929	2,488,052	5,862,326	222,671	3,990,678	205,276	209,513	47,224,688
Owned - donated	100,538	1,311,548	12,732	16,785	322,252	11,793	304,072	996	-	2,080,716
Finance leased	57,144	440,157	15,200	31,767	4,388	8,854	161,169	879	-	719,558
On-Statement of Financial Position PFI contracts	410,646	11,613,986	50,485	5,747	6,088	6	152,566	-	-	12,239,524
PFI residual interests	-	-	2,567	-	-	-	-	-	-	2,567
Net book value at 31 March 2022	**6,397,567**	**41,519,695**	**343,913**	**2,542,351**	**6,195,054**	**243,324**	**4,608,485**	**207,151**	**209,513**	**62,267,053**
Analysis of property, plant and equipment										
Core Dept & Agencies	53,141	211,140	-	15,599	497,634	17,303	52,391	-	209,513	1,056,721
Other designated bodies	6,344,426	41,308,555	343,913	2,526,752	5,697,420	226,021	4,556,094	207,151	-	61,210,332
Net book value at 31 March 2022	**6,397,567**	**41,519,695**	**343,913**	**2,542,351**	**6,195,054**	**243,324**	**4,608,485**	**207,151**	**209,513**	**62,267,053**

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 now depreciated over their useful life.

	Departmental Group 2020-21									
	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 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**
Prior period adjustments in underlying accounts	4,800	(25,673)	(88)	(53,360)	(17,599)	(4,116)	(91,819)	(715)	-	(188,570)
Additions	27,400	1,393,590	2,952	824,565	3,897,708	28,827	1,272,875	25,227	81,755	7,554,899
Donations	115	20,143	-	5,222	81,368	737	52,812	225	-	160,622
Impairments and reversals	(1,820)	(2,262,890)	(7,389)	(19,645)	(140,628)	(1,272)	(16,420)	6	(156,880)	(2,606,938)
Transfers	(1,455)	(3,395)	-	(10,324)	-	(15)	-	-	(41,498)	(56,687)
Reclassifications	(26,689)	1,507,930	(4,402)	239,076	(2,213,239)	26,596	288,761	24,642	-	(157,325)
Revaluation and indexation	148,326	(436,502)	7,394	(1,695)	(474)	(4,931)	(8,173)	(34)	-	(296,089)
Disposals	(33,473)	(104,121)	(540)	(460,969)	(8,120)	(38,001)	(490,251)	(20,116)	(24,746)	(1,180,337)
At 31 March 2021	**6,040,256**	**40,336,810**	**351,798**	**5,740,382**	**5,265,602**	**687,774**	**11,062,883**	**529,066**	**396,166**	**70,410,737**
Depreciation										
At 1 April 2020	**8,471**	**1,691,072**	**27,545**	**3,258,088**	**-**	**478,020**	**6,792,955**	**284,257**	**-**	**12,540,408**
Prior period adjustments in underlying accounts	-	(71,578)	(432)	(63,384)	-	(4,104)	(90,733)	(717)	87,801	(143,147)
Charged in year	89	1,432,299	10,986	657,257	-	45,095	690,713	58,281	20,742	2,915,462
Impairments and reversals	(3,567)	(91,783)	(187)	(7,638)	-	(193)	(7,147)	227	-	(110,288)
Transfers	-	-	-	(10,324)	-	(15)	-	-	-	(10,339)
Reclassifications	(218)	(16,622)	(1,591)	(5,793)	-	329	4,651	(3,049)	-	(22,293)
Revaluation and indexation	2,120	(1,147,321)	(12,445)	(1,602)	-	(566)	(7,748)	(43)	-	(1,167,605)
Disposals	-	(52,522)	(63)	(450,784)	-	(36,261)	(479,886)	(19,566)	-	(1,039,082)
At 31 March 2021	**6,895**	**1,743,545**	**23,813**	**3,375,820**	**-**	**482,305**	**6,902,805**	**319,390**	**108,543**	**12,963,116**
Net book value at 31 March 2021	**6,033,361**	**38,593,265**	**327,985**	**2,364,562**	**5,265,602**	**205,469**	**4,160,078**	**209,676**	**287,623**	**57,447,621**
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
Asset financing:										
Owned - purchased	5,508,236	25,855,229	250,648	2,309,343	4,930,217	186,826	3,574,373	208,081	287,623	43,110,576
Owned - donated	87,766	1,223,389	12,152	14,928	308,024	13,743	273,335	1,211	-	1,934,548
Finance leased	54,415	410,683	14,656	33,948	19,322	4,893	160,747	384	-	699,048
On-Statement of Financial Position PFI contracts	382,944	11,103,964	48,156	6,343	8,039	7	151,623	-	-	11,701,076
PFI residual interests	-	-	2,373	-	-	-	-	-	-	2,373
Net book value at 31 March 2021	**6,033,361**	**38,593,265**	**327,985**	**2,364,562**	**5,265,602**	**205,469**	**4,160,078**	**209,676**	**287,623**	**57,447,621**
Analysis of property, plant and equipment										
Core Dept & Agencies	54,812	215,214	-	19,679	307,671	5,263	43,871	-	287,623	934,133
Other designated bodies	5,978,549	38,378,051	327,985	2,344,883	4,957,931	200,206	4,116,207	209,676	-	56,513,488
Net book value at 31 March 2021	**6,033,361**	**38,593,265**	**327,985**	**2,364,562**	**5,265,602**	**205,469**	**4,160,078**	**209,676**	**287,623**	**57,447,621**

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 per the FReM, details of which can be found in the individual body accounts. The value of land and buildings held by NHS providers at 31 March 2022 was £41.330 billion.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 – 169 years
- Information technology: 1 – 25 years
- Furniture and fittings: 1 – 35 years
- Plant and machinery: 1 – 35 years
- Transport equipment: 1 – 20 years

7. Intangible Non-Current Assets

Intangible non-current assets comprise Purchased Software Licences and Internally Developed Software, Trade Marks and Development Expenditure relating to both the Department and the entities consolidated within these financial statements.

	Departmental Group 2021-22			
	IT & Software £'000	Development Expenditure £'000	Other £'000	Total £'000
Cost or valuation				
At 1 April 2021	**4,362,683**	**337,842**	**374,400**	**5,074,925**
Prior period adjustments in underlying accounts	(159,853)	(9,610)	13,088	(156,375)
Additions	509,297	47,705	359,173	916,175
Donations	2,646	-	6,581	9,227
Impairments and reversals	(36,691)	(7,987)	(20,871)	(65,549)
Transfers	1,743	1,186	1,710	4,639
Reclassifications	278,846	(53,575)	(160,019)	65,252
Revaluation and indexation	1,350	(874)	234	710
Disposals	(523,853)	(21,248)	(1,227)	(546,328)
Other movements	30	-	-	30
At 31 March 2022	**4,436,198**	**293,439**	**573,069**	**5,302,706**
Amortisation				
At 1 April 2021	**2,620,430**	**178,352**	**27,677**	**2,826,459**
Prior period adjustments in underlying accounts	(167,270)	(59)	59	(167,270)
Charged in year	532,708	38,272	4,623	575,603
Impairments and reversals	(8,348)	(3,391)	(520)	(12,259)
Transfers	3,455	-	-	3,455
Reclassifications	49,211	(48,956)	(888)	(633)
Revaluation and indexation	(9,378)	(907)	(6)	(10,291)
Disposals	(567,266)	(14,364)	(407)	(582,037)
Other movements	5	-	-	5
At 31 March 2022	**2,453,547**	**148,947**	**30,538**	**2,633,032**
Net Book Value at 31 March 2022	**1,982,651**	**144,492**	**542,531**	**2,669,674**
Net book value at 31 March 2021	1,742,253	159,490	346,723	2,248,466

Analysis of intangible assets	IT & Software £'000	Development Expenditure £'000	Other £'000	Total £'000
Of the total:				
Core Dept & Agencies	180,129	6,895	25,564	212,588
Other designated bodies	1,802,522	137,597	516,967	2,457,086
Net Book Value at 31 March 2022	**1,982,651**	**144,492**	**542,531**	**2,669,674**

	Departmental Group 2020-21			
	IT & Software £'000	Development Expenditure £'000	Other £'000	Total £'000
Cost or valuation				
At 1 April 2020	**3,985,460**	**323,627**	**314,242**	**4,623,329**
Prior period adjustments in underlying accounts	(15,370)	(8,821)	7,920	(16,271)
Additions	593,244	48,039	255,411	896,694
Donations	631	-	1,539	2,170
Impairments and reversals	(47,561)	(4,856)	(34,492)	(86,909)
Transfers	(719)	-	-	(719)
Reclassifications	249,914	(5,569)	(165,179)	79,166
Revaluation and indexation	57,982	(43)	781	58,720
Disposals	(460,835)	(14,535)	(5,822)	(481,192)
Other movements	(63)	-	-	(63)
At 31 March 2021	**4,362,683**	**337,842**	**374,400**	**5,074,925**
Amortisation				
At 1 April 2020	**2,621,799**	**161,026**	**28,122**	**2,810,947**
Prior period adjustments in underlying accounts	(9,280)	-	(1,157)	(10,437)
Charged in year	436,173	30,711	4,891	471,775
Impairments and reversals	5,575	(580)	(961)	4,034
Transfers	(719)	-	-	(719)
Reclassifications	(3,148)	748	(681)	(3,081)
Revaluation and indexation	4,357	(59)	34	4,332
Disposals	(434,255)	(13,494)	(2,571)	(450,320)
Other movements	(72)	-	-	(72)
At 31 March 2021	**2,620,430**	**178,352**	**27,677**	**2,826,459**
Net Book Value at 31 March 2021	**1,742,253**	**159,490**	**346,723**	**2,248,466**
Net Book Value at 31 March 2020	1,363,661	162,601	286,120	1,812,382

Analysis of intangible assets				
	IT & Software £'000	Development Expenditure £'000	Other £'000	Total £'000
Of the total:				
Core Dept & Agencies	195,849	13,252	19,826	228,927
Other designated bodies	1,546,404	146,238	326,897	2,019,539
Net Book Value at 31 March 2021	**1,742,253**	**159,490**	**346,723**	**2,248,466**

Further details of the valuation methods relating to intangible non-current assets can be found in the individual body accounts.

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 – 20 years

8. Impairments

	2021-22 £'000		2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Impairments charged to Consolidated Statement of Comprehensive Net Expenditure				
Property Plant and Equipment impairments	10,095	670,822	169,442	1,576,045
Intangible asset impairments	1	53,262	1,597	90,901
Financial and other asset impairments	(687,739)	381,039	2,616,851	3,537
Non Current Assets Held for Sale impairments	-	587	-	974
Inventory impairments	1,628,648	1,628,648	8,973,775	8,973,775
Total impairments charged to Consolidated Statement of Comprehensive Net Expenditure	**951,005**	**2,734,358**	**11,761,665**	**10,645,232**
Impairments charged to Revaluation Reserve				
Property Plant and Equipment impairments	-	172,468	781	920,605
Intangible asset impairments	-	28	-	42
Financial asset impairments	-	-	-	-
Total impairments charged to Revaluation Reserve	**-**	**172,496**	**781**	**920,647**
Impairments charged to General Fund				
PDC impairments	518,338	-	(669,229)	-
Total impairments charged to General Fund	**518,338**	**-**	**(669,229)**	**-**
Total impairments charged in year	**1,469,343**	**2,906,854**	**11,093,217**	**11,565,879**

The above table includes both impairments and impairment reversals.

Financial and other asset impairments

Vaccine advance payments

As part of the programme to purchase COVID-19 vaccines, the Department made advance payments to pharmaceutical companies at the inception of certain contracts. These prepayments represent a proportion of the cost of future vaccine deliveries and are released as vaccines are delivered and recorded as inventory additions.

Based on the best available expert medical advice, contracts have been entered into on a reasonable worst case basis to ensure all adults would be able to receive a booster dose should this be required.

As a result of the reduction in the prevalence and severity of COVID-19 it is not now expected that all of the doses the Department is committed to purchasing will now be used.

As a result, the Department has impaired the carrying value of its prepayments for future deliveries of vaccine doses by £381 million (2020-21: £Nil) which represents the

Department's best estimate of the value of non-refundable prepayments which will no longer provide future economic benefit at 31 March 2022.

Changes to vaccination guidance and uptake rates in future vaccination campaigns could change the level of impairment required. A 25% increase in expected usage of vaccines would reduce the impairment required by £72 million and a 25% decrease in expected usage of vaccines would increase the impairment required by £76 million.

Public Dividend Capital (PDC)

Financial asset impairments for the Core Department include impairments of PDC issued to providers, where the net assets of the individual provider are below the carrying value of the investment. The impairment credited in 2021-22 was £1.069 billion (2020-21: charge of £2.617 billion) was a credit due to improvements in the net asset position of some NHS providers.

Inventory Impairments

Inventory impairments can be broken down as follows:

	2021-22 £'000		2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Personal protective equipment (PPE)	(24,799)	(24,799)	8,705,057	8,705,057
COVID-19 Medicines	866,710	866,710	-	-
COVID-19 Vaccines	249,835	249,835	-	-
NHS Test and Trace consumables	285,215	285,215	194,714	194,714
Other COVID-19 related equipment and consumables	251,687	251,687	74,004	74,004
Total inventory impairments	**1,628,648**	**1,628,648**	**8,973,775**	**8,973,775**

Personal Protective Equipment (PPE)

PPE inventory was reduced in carrying value by £939 million during 2021-22, £964 million of this reduction was transferred from the opening onerous contract provision, the expenditure associated with this having already been recognised as a provision expense in the prior year. This leaves a net impairment **reversal** of £25 million (2020-21: £8.705 billion **charge**) in 2021-22 which was recognised in expenditure.

The numbers below detail the net movement in the impairment required and include reversals recognised as a result of inventory disposals, which totalled £78 million in 2021-22 and are recognised as inventories written down in Note 4.1 and included within the losses disclosure.

The £939 million reduction in PPE inventory carrying value can be further analysed as:

- £67 million **reversal** (2020-21: £673 million **charge**) in respect items which have been assessed as not being suitable for any use;

- £427 million **reversal** (2020-21: £2,581 million **charge**) for items not suitable for use within the health and social care sector but which may be suitable for other uses and are therefore held for future sale or donation;
- £885 million **charge** (2020-21: £4,701 million **charge**) reflects the impairment recognised as a result of fluctuations in the market price of personal protective equipment; and
- £548 million **charge** (2020-21: £750 million **charge**) relates to inventory which has an expiry date prior to the expected usage date and is therefore held for resale or donation.

The purchase price of the items which have an expiry date prior to the expected usage date at weighted average cost was £3,869 million (2020-21: £3,322 million). Paragraphs 668 to 673 of the Annual Report contains further information in relation to these impairments.

During 2021-22 impairments in respect of items not suitable for use reduced as a result of further successful work to confirm the suitability of items for use. This, coupled with new inventory arriving in 2021-22 increased the level of market value adjustments and excess stock impairments.

Personal protective equipment impairments have been calculated in the order described above as follows: Inventory that cannot be used for its original intended purpose, because it has either been assessed as not suitable for any use or use within the health and social care sector, is impaired upon receipt reflecting the characteristics of the inventory immediately reducing its value. Usable inventory is then subject to an adjustment to its net realisable value where this has dropped below weighted average cost by financial year-end. This impairment reflects a reduction in the market price of these items between the point of purchase and 31 March 2022. A further impairment is subsequently made to the proportion of the usable inventory where the department estimates the items have an expiry date prior to their expected usage date. This impairment reflects a reduction in valuation resulting from the inventory being held for future sale or donation rather than use.

The impairment ordering also presents the most transparent view of the individual factors driving the diminution in inventory value. For example, the impairment for items assessed as not being suitable either for any use or for their original intended purpose is expressed at weighted average cost, with the impairment for fluctuations in market value being a year-end valuation adjustment calculated subsequent to this. The impairment of inventory with an expiry date prior to the expected usage date is an estimate, based on estimates of future demand, of losses that will crystalise in future accounting periods and is based on the net realisable value of the inventory at 31 March 2022; i.e. after the impairment for the fluctuations in market value. However, regardless of the order of calculation, the total impairment would remain as calculated above.

The assessment of the level of impairment recognised is subject to a degree of uncertainty predominantly in the following areas:

- Items held for use in the NHS have been impaired to reflect the best estimate of market value using agreed framework prices. If market values used increase by 10%, the total impairment required would reduce by £196 million. If market values used reduce by 10%, the total impairment required would increase by £202 million.

- The assessment of impairment for inventory which is held for sale or donation would change by £345 million if estimated recoverable value changed by 10% of cost price.

- In assessing the value of impairments required in respect of personal protective equipment which may become surplus to requirements there is inherent uncertainty in the level of future demand. In order to assess the level of impairment required, the Department has considered the latest available demand led modelling and compared this to inventory held at the year end. A 10% increase in the level of estimated demand across all product lines would reduce the total impairment required by £55 million. A 10% decrease would increase the total impairment required by £51 million.

- The value of impairments in respect of personal protective equipment which may become surplus to requirements is calculated by reference to the shelf life of the relevant functionally interchangeable stock category. Due to the volume of stock held, this has necessitated use of an average calculated based on products which are held in palletised storage. The impact of a 6 month increase in average shelf lives would reduce the total impairment required by £137 million and a 6 month reduction would increase the total impairment by £149 million.

COVID-19 Vaccines

During the year the Department entered into contracts for the delivery of COVID-19 vaccines.

As a result of the reduction in the prevalence and severity of COVID-19 and the development of new and improved vaccines it is now expected that not all the vaccines delivered will be used.

An impairment charge of £250 million has been recognised which represents the Department's best estimate of the value of vaccines held at 31 March 2022 that will be surplus to requirements.

COVID-19 Medicines

During the year the Department entered into contracts for the delivery of medicines used to treat the symptoms of COVID-19 with the aim of reducing the rate of death and hospitalisation.
As a result of the reduction in the prevalence and severity of COVID-19 it is now expected that not all the medicines delivered will be used.

An impairment charge of £867 million has been recognised which represents the Department's best estimate of the value of medicines held at 31 March 2022 that will reach expiry prior to the expected usage date.

Should the most up to date reasonable worst case scenario that the Department is planning for be realised, wider deployment of these medicines could reduce the impairment required by approximately £217 million. Conversely, if usage was 50% lower than the most likely assumptions used to calculate this impairment, the impairment charge would need to increase by £10 million.

NHS Test and Trace consumables

NHS Test and Trace Consumables have been impaired by £285 million (2020-21: £195 million) relating to items which are damaged or for which the Departmental Group has not currently identified a suitable use.

Other COVID-19 related equipment and consumables

Other COVID-19 related equipment and consumables have been impaired by £252 million (2020-21: £74 million). The impairment charge in the current year reflects items which are no longer planned to be used for the intended purpose as they are excess to requirements.

Note 12 provides detail relating to the movement of inventory balances between the start and the end of the financial year due to such activity as additions to and consumption of inventory as well as detailing the impact that impairment has on residual balances of inventory at 31 March 2022.

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.

	2021-22 £'000		2020-21 £'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	55,815	2,182,348	201,628	2,318,342
Intangible non-current assets	16,589	211,268	40,176	255,039
	72,404	**2,393,616**	**241,804**	**2,573,381**

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.

	2021-22 £'000		2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	7,546	1,189	6,123
Later than 1 year and not later than 5 years	-	24,507	-	15,171
Later than 5 years	-	57,458	-	29,630
	-	**89,511**	**1,189**	**50,924**
Buildings:				
Not later than 1 year	32,050	397,749	51,764	392,451
Later than 1 year and not later than 5 years	94,652	1,153,596	104,723	1,049,900
Later than 5 years	95,182	1,595,079	93,611	1,385,806
	221,884	**3,146,424**	**250,098**	**2,828,157**
Other:				
Not later than 1 year	118	232,025	123	199,728
Later than 1 year and not later than 5 years	36	435,405	21	345,280
Later than 5 years	-	109,784	-	65,435
	154	**777,214**	**144**	**610,443**

1. Operating lease commitments between bodies within 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.

	2021-22 £'000		2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Land:				
Not later than 1 year	-	6,945	-	6,546
Later than 1 year and not later than 5 years	-	20,713	-	16,842
Later than 5 years	-	338,742	-	186,583
	-	**366,400**	**-**	**209,971**
Buildings:				
Not later than 1 year	5,795	142,290	16,408	139,067
Later than 1 year and not later than 5 years	15,068	363,859	29,335	455,515
Later than 5 years	21,484	608,221	28,947	876,038
	42,347	**1,114,370**	**74,690**	**1,470,620**
Other:				
Not later than 1 year	-	10,710	-	10,431
Later than 1 year and not later than 5 years	-	22,532	-	26,887
Later than 5 years	-	15,352	-	13,080
	-	**48,594**	**-**	**50,398**

1. Future minimum lease receipts under operating leases between bodies within 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.

	2021-22 £'000		2020-21 £'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	-	688	-	1,401
Later than 1 year and not later than 5 years	-	2,555	-	5,565
Later than 5 years	-	8,949	-	21,444
	-	**12,192**	**-**	**28,410**
Less interest element	-	(4,850)	-	(14,898)
Present Value of obligations	**-**	**7,342**	**-**	**13,512**
Buildings:				
Not later than 1 year	-	48,960	-	48,627
Later than 1 year and not later than 5 years	-	182,629	-	179,848
Later than 5 years	-	389,782	-	429,761
	-	**621,371**	**-**	**658,236**
Less interest element	-	(250,673)	-	(267,938)
Present Value of obligations	**-**	**370,698**	**-**	**390,298**
Other:				
Not later than 1 year	-	64,586	-	64,957
Later than 1 year and not later than 5 years	-	139,396	-	143,886
Later than 5 years	-	56,952	-	62,876
	-	**260,934**	**-**	**271,719**
Less interest element	-	(36,497)	-	(40,146)
Present Value of obligations	**-**	**224,437**	**-**	**231,573**

	2021-22 £'000		2020-21 £'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	-	404	-	578
Later than 1 year and not later than 5 years	-	1,644	-	2,752
Later than 5 years	-	5,294	-	10,182
Total Present Value of obligations	**-**	**7,342**	**-**	**13,512**
Buildings:				
Not later than 1 year	-	25,546	-	23,198
Later than 1 year and not later than 5 years	-	104,941	-	99,924
Later than 5 years	-	240,211	-	267,176
Total Present Value of obligations	**-**	**370,698**	**-**	**390,298**
Other:				
Not later than 1 year	-	59,304	-	57,319
Later than 1 year and not later than 5 years	-	118,959	-	122,869
Later than 5 years	-	46,174	-	51,385
Total Present Value of obligations	**-**	**224,437**	**-**	**231,573**

1. Finance lease commitments between bodies within the Departmental Group are eliminated upon consolidation.

9.2.4 Finance lease receivables

Total future minimum lease payments receivable under finance leases are given in the table below for each of the following periods.

	2021-22 £'000		2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Gross investments in leases:				
Not later than 1 year	265	1,782	545	2,119
Later than 1 year and not later than 5 years	-	4,398	182	5,852
Later than 5 years	-	16,647	-	18,473
Less future finance income	(31)	(6,830)	(43)	(7,948)
Present Value of minimum lease payments	**234**	**15,997**	**684**	**18,496**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**234**	**15,997**	**684**	**18,496**
Present Value of minimum lease payments:				
Not later than 1 year	234	1,228	505	1,517
Later than 1 year and not later than 5 years	-	2,369	179	3,672
Later than 5 years	-	12,400	-	13,307
Total Present Value of minimum lease payments	**234**	**15,997**	**684**	**18,496**
Less cumulative provision for uncollectable payments:	-	-	-	-
Total finance lease receivables recognised in the Consolidated Statement of Financial Position	**234**	**15,997**	**684**	**18,496**
included in:				
Current finance lease receivables	234	1,228	505	1,517
Non-current finance lease receivables	-	14,769	179	16,979
Sub total	**234**	**15,997**	**684**	**18,496**

1. Future minimum lease receipts between bodies within 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 (2020-21: one scheme, £0.9 million). The assets which make up this capital value were not assets of Community Health Partnerships Ltd.

	2021-22 £'000		2020-21 £'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	-	62
Later than 1 year and not later than 5 years	-	247	-	248
Later than 5 years	-	3,598	-	3,659
	-	**3,907**	**-**	**3,969**

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 298 on-Statement of Financial Position LIFT schemes. (2020-21: 298). 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 £56.1 million (2020-21: £55.2 million).

NHS Providers

In this financial year, 6 NHS providers (2020-21: 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:

	2021-22 £'000		2020-21 £'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	-	165,137	-	165,650
Later than 1 year and not later than 5 years	-	642,923	-	649,289
Later than 5 years	-	2,136,057	-	2,295,152
	-	**2,944,117**	**-**	**3,110,091**
Less interest element	-	(1,266,487)	-	(1,389,067)
Present Value of obligations	**-**	**1,677,630**	**-**	**1,721,024**

	2021-22 £'000		2020-21 £'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	-	45,571	-	43,395
Later than 1 year and not later than 5 years	-	194,320	-	188,382
Later than 5 years	-	1,437,739	-	1,489,247
Total Present Value of obligations	**-**	**1,677,630**	**-**	**1,721,024**

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 £59.7 million (2020-21: £58.8 million).

Community Health Partnerships Ltd and NHS providers with NHS LIFT contracts are committed to the following total charges:

	2021-22 £'000		2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	63,682	-	59,001
Later than 1 year and not later than 5 years	-	270,641	-	250,857
Later than 5 years	-	565,116	-	603,290
	-	**899,439**	**-**	**913,148**

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 (2020-21: 7 NHS providers).

	2021-22 £'000		2020-21 £'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	-	3,940	-	4,647
Later than 1 year and not later than 5 years	-	13,266	-	17,183
Later than 5 years	-	7,878	-	12,780
	-	**25,084**	**-**	**34,610**

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 28 on-Statement of Financial Position PFI schemes (2020-21: 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 £31.3 million (2020-21: £33.2 million).

NHS Providers

In this financial year, 147 NHS providers reported on-Statement of Financial Position PFI Schemes (2020-21: 148 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 £1,059.4 million. (2020-21: £1,050.9 million).

	2021-22 £'000		2020-21 £'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	-	888,169	-	868,865
Later than 1 year and not later than 5 years	-	3,328,633	-	3,415,109
Later than 5 years	-	10,603,568	-	11,349,754
	-	**14,820,370**	-	**15,633,728**
Less interest element	-	(6,604,375)	-	(7,110,457)
Present Value of obligations	-	**8,215,995**	-	**8,523,271**

	2021-22 £'000		2020-21 £'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	-	356,525	-	327,692
Later than 1 year and not later than 5 years	-	1,392,773	-	1,391,907
Later than 5 years	-	6,466,697	-	6,803,672
Total Present Value of obligations	-	**8,215,995**	-	**8,523,271**

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 £1,090.7 million (2020-21: £1,084.1 million).

	2021-22 £'000		2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	1,045,567	-	971,309
Later than 1 year and not later than 5 years	-	4,296,806	-	4,132,750
Later than 5 years	-	14,769,625	-	15,174,357
	-	**20,111,998**	-	**20,278,416**

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.

As a result of COVID-19 purchasing, a higher number of foreign currency transactions took place in 2021-22 and 2020-21 compared to previous years, although remaining a small proportion of overall expenditure. However, as 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 remains 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. These funding arrangements were replaced in 2020-21 by a system of block contract payments, which continued into 2021-22, to enable NHS organisations to respond to COVID-19 without worrying about funding or contract negotiations.

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, subject to affordability. These can take the form of either term loans or maturity loans. The borrowings are for 1 – 25 years. Interest is charged at the National Loans rate prevailing on the date of signing the loan agreement, and the rate is fixed for the life of the loan. NHS Foundation Trusts have the power to enter into loans and working capital facilities with commercial lenders should they wish but this is governed by NHS England and NHS Improvement.

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 England and Improvement (umbrella organisation of the NHS Trust Development Authority and the independent regulator Monitor), not least through their respective powers of intervention.

Analysis of financial assets

As at 31 March 2022, the financial assets of the Departmental Group amounted to £22,820 million (31 March 2021: £21,421 million) of which £22,369 million (31 March 2021: £20,741 million) was held at amortised cost, £450 million (31 March 2021: £679 million) was designated at fair value through Other Comprehensive Income, and £1 million (31 March 2021: £1 million) was mandated to fair value through profit or loss.

As at 31 March 2022, the financial assets of the Core Department and Agencies amounted to £12,825 million (31 March 2021: £16,495 million), of which £5,476 million (31 March 2021: £5,728 million) was designated at fair value through Other Comprehensive Income and £7,349 million (31 March 2021: £10,767 million) was held at amortised cost.

Analysis of financial liabilities

As at 31 March 2022, the financial liabilities of the Departmental Group amounted to £42,164 million (31 March 2021 restated: £41,925 million). At both 31 March 2022 and 31 March 2021, all financial liabilities of the group were held at amortised cost.

As at 31 March 2022, the financial liabilities of the Core Department and Agencies amounted to £7,344 million (31 March 2021 restated: £11,595 million). At both 31 March 2022 and 31 March 2021, all financial liabilities of the Core Department and Agencies were held at amortised cost.

11. Financial Assets – Investments

	2021-22 £'000						2021-22 £'000			
	Core Dept & Agencies						Departmental Group			
	NHS Healthcare Providers		Other Bodies			Total	Other Bodies			Total
	PDC	Loans	PDC	Loans	Share Capital		PDC	Loans	Share Capital and Other Investments	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Restated Balance at 1 April 2021	**33,285,337**	**2,461,491**	**1,328**	**5,483,876**	**5,728,250**	**46,960,282**	**1,328**	**43,368**	**869,809**	**914,505**
Issued	3,058,021	108,983	-	350,514	96,265	3,613,783	-	514	57,499	58,013
Disposals	-	-	-	-	(1,336)	(1,336)	-	-	(3,132)	(3,132)
Repaid	(19,086)	(20,081)	(1,328)	(3,408,796)	-	(3,449,291)	(1,328)	(8,658)	(2,946)	(12,932)
Transfers to and from current receivables	-	(209,381)	-	777	-	(208,604)	-	777	(757)	20
Written off	-	-	-	(174)	-	(174)	-	(174)	-	(174)
Changes in fair value through other comprehensive income	-	-	-	-	(216,020)	(216,020)	-	-	(292,113)	(292,113)
Changes in fair value through CSCNE	-	-	-	-	(1,351)	(1,351)	-	-	(1,141)	(1,141)
Other Impairments and reversals	550,440	-	-	307	-	550,747	-	307	-	307
Reclassifications	-	-	-	(30,000)	30,000	-	-	(30,000)	29,935	(65)
Transfers	-	-	-	-	(159,000)	(159,000)	-	-	-	-
Other movements	-	-	-	-	(500)	(500)	-	-	18,894	18,894
Balance at 31 March 2022	**36,874,712**	**2,341,012**	**-**	**2,396,504**	**5,476,308**	**47,088,536**	**-**	**6,134**	**676,048**	**682,182**

Investments held by Core Dept & Agencies	47,088,536
Less elimination of intra-group investments	(46,671,093)
Investments held by other designated bodies	264,739
Total	**682,182**

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).

	2020-21 £'000						2020-21 £'000			
	Core Dept & Agencies						Departmental Group			
	NHS Healthcare Providers		Other Bodies			Total	Other Bodies			Total
	PDC	Loans	PDC	Loans	Share Capital		PDC	Loans	Share Capital and Other Investments	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2020	**18,154,873**	**2,766,373**	**1,328**	**818,605**	**5,603,216**	**27,344,395**	**1,328**	**295,057**	**519,148**	**815,533**
Prior period adjustments in underlying accounts	-	-	-	-	-	-	-	-	-	-
Issued	17,847,127	80,200	-	5,017,426	74,513	23,019,266	-	33,255	56,980	90,235
Disposals	-	-	-	-	-	-	-	-	(12,158)	(12,158)
Repaid	(103,099)	(159,218)	-	(88,990)	-	(351,307)	-	(21,779)	(2,410)	(24,189)
Transfers to and from current receivables	-	(225,864)	-	(827)	-	(226,691)	-	(827)	-	(827)
Written off	(669,229)	-	-	-	-	(669,229)	-	-	-	-
Changes in fair value through other comprehensive income	-	-	-	-	53,808	53,808	-	-	307,298	307,298
Changes in fair value through CSCNE	-	-	-	-	-	-	-	-	1,481	1,481
Other Impairments and reversals	(1,944,335)	-	-	-	(3,287)	(1,947,622)	-	-	(3,537)	(3,537)
Reclassifications	-	-	-	(262,338)	-	(262,338)	-	(262,338)	-	(262,338)
Other Movements	-	-	-	-	-	-	-	-	3,007	3,007
Restated Balance at 31 March 2021	**33,285,337**	**2,461,491**	**1,328**	**5,483,876**	**5,728,250**	**46,960,282**	**1,328**	**43,368**	**869,809**	**914,505**

Investments held by Core Dept & Agencies	46,960,282
Less elimination of intra-group investments	(46,296,335)
Investments held by other designated bodies	250,558
Total	**914,505**

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 for either capital or revenue requirements; 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 loans.

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.

PDC is 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 a 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 2021-22 the value of impairment credited to the SoCNE was £1,069 million and the value of impairments charged to reserves was £518 million. For further details see **Note 8** above.

The Department's PDC investment in, and loans to, 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.

Loans to other bodies

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 did not undertake any further CGF loans. The Department's pilot CGF loan was repaid in 2021-22.

During 2021-22 loans totalling £350 million were issued to Supply Chain Coordination Ltd in order to provide a working capital facility. Loan repayments were also made in year to the value of £3.3 billion.

Share capital and other investments

The Department's Share Capital investments are measured at fair value.

Community Health Partnerships Ltd, NHS Property Services Ltd and Genomics England Ltd are consolidated into the Departmental accounts; therefore the investments by the Core Department in these companies are eliminated from the Departmental Group figures.

The Core Department's investment in Supply Chain Coordination Ltd of £159 million was transferred to NHS England on 1 October 2021 as an absorption transfer.

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 last such external valuation was undertaken on 31 March 2021. An internal valuation exercise was carried out as at 31 March 2022 and the value of investments increased by £20.1 million.

Valuation classification

The classification of the inputs used to value the Core Department's equity investments as level 1, level 2 or level 3 within the fair value hierarchy as required by IFRS 13 is shown below, these are all recurring valuations. Valuation input classifications for other entities in the Departmental Group can be found in the accounts of underlying bodies where appropriate.

		2021-22			
		Core Department			
Entity	Valuation basis	Level 1 £'000	Level 2 £'000	Level 3 £'000	Total £'000
Community Health Partnerships Ltd	Net assets[1]	-	776,317	383,683	1,160,000
NHS Property Services Ltd	Net assets	-	3,495,000	-	3,495,000
Genomics England Ltd	Capital invested	-	410,000	-	410,000
NHS Shared Business Services Ltd	Discounted cash flow	-	-	92,000	92,000
NHS Professionals Ltd	Discounted cash flow	-	-	228,000	228,000
Porton Biopharma Ltd	Capital invested	-	-	55,000	55,000
Other share capital investments	Various	-	-	17,958	17,958
		-	**4,681,317**	**776,641**	**5,457,958**

		2020-21			
		Core Department			
Entity	Valuation basis	Level 1 £'000	Level 2 £'000	Level 3 £'000	Total £'000
Community Health Partnerships Ltd	Net assets[1]	-	826,000	374,000	1,200,000
NHS Property Services Ltd	Net assets	-	3,400,000	-	3,400,000
Genomics England Ltd	Capital invested	-	350,000	-	350,000
Supply Chain Coordination Ltd	Net assets	-	159,000	-	159,000
NHS Shared Business Services Ltd	Discounted cash flow	-	-	83,000	83,000
NHS Professionals Ltd	Discounted cash flow	-	-	266,000	266,000
Other share capital investments	Various	-	-	18,400	18,400
		-	**4,735,000**	**741,400**	**5,476,400**

1. The valuation of Community Health Partnerships Ltd is based on net assets. This is adjusted to account for equity investments held by Community Health Partnerships Ltd which are held at cost. This valuation is based on discounted cash flow and this adjustment is therefore classified as level 3.

12. Inventories and work in progress

	Core Dept & Agencies 2021-22							
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Covid-19 Medicines	Raw materials	COVID-19 Vaccines	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2021	**398,655**	**6,371**	**-**	**3,382**	**37,074**	**3,640,396**	**-**	**4,085,878**
Prior period adjustments in underlying accounts	(548)	-	-	-	22,810	-	-	22,262
Inventory additions	638,068	-	1,206,838	(367)	2,704,198	7,288,028	-	11,836,765
Inventories consumed/disposed of	(463,227)	(588)	(279,110)	(1,031)	(2,278,755)	(8,013,826)	(46)	(11,036,583)
Write Downs	(71,698)	(11)	-	-	(10,708)	(85,899)	-	(168,316)
Impairment of inventory	-	-	(866,710)	-	(249,835)	(512,102)	-	(1,628,647)
Transfers	-	112	-	-	-	5,580	46	5,738
Transfer from provisions	-	-	-	-	-	(963,822)	-	(963,822)
Reclassification	-	-	734	(1,984)	-	1,250	-	-
Balance at 31 March 2022	**501,250**	**5,884**	**61,752**	**-**	**224,784**	**1,359,605**	**-**	**2,153,275**

1. See Note 8 for details of inventory impairments.

Consumables can be further analysed as follows:

	Core Dept & Agencies 2021-22				
	Personal Protective Equipment	NHS Test and Trace Consumables	Equipment and other COVID-19 consumables	Other consumables	Total
	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2021	**951,545**	**2,091,362**	**588,166**	**9,323**	**3,640,396**
Inventory additions	1,481,431	5,787,364	7,239	11,994	7,288,028
Inventories consumed/disposed of	(665,828)	(7,237,973)	(98,887)	(11,138)	(8,013,826)
Write Downs	(77,695)		(8,204)	-	(85,899)
Impairment of inventory	24,799	(285,214)	(251,687)	-	(512,102)
Transfers to/from non-current assets	-	5,580	-	-	5,580
Provisions transferred to inventory	(963,822)	-	-	-	(963,822)
Reclassification	1,984	-	-	(734)	1,250
Balance at 31 March 2022	**752,414**	**361,119**	**236,627**	**9,445**	**1,359,605**

	Restated[1] Core Dept & Agencies 2020-21							
	Adult and Childhood Vaccines £'000	Pandemic Flu and Pre Pandemic Flu £'000	Covid-19 Medicines £'000	Raw materials £'000	COVID-19 Vaccines £'000	Consumables £'000	Other £'000	Total £'000
Balance at 1 April 2020	**244,876**	**-**	**-**	**-**	**-**	**6,627**	**-**	**251,503**
Inventory additions	703,614	17,657	-	12,698	617,916	18,649,245	-	20,001,130
Inventories consumed/disposed of	(485,664)	(17,787)	-	-	(580,809)	(6,085,576)	(174)	(7,170,010)
Write Downs	(64,171)	-	-	-	(33)	-	-	(64,204)
Impairment of inventory	-	-	-	-	-	(8,973,775)	-	(8,973,775)
Transfers	-	41,059	-	-	-	-	174	41,233
Reclassification	-	(34,558)	-	(9,316)	-	43,874	-	-
Other	-	-	-	-	-	1	-	1
Balance at 31 March 2021	**398,655**	**6,371**	**-**	**3,382**	**37,074**	**3,640,396**	**-**	**4,085,878**

1. Additions and consumption of Covid-19 vaccines have been restated to reflect the transfer of the Vaccine Taskforce to the Department on 1 August 2021. This has been accounted for using the merger accounting method.

Consumables can be further analysed as follows:

	Core Dept & Agencies 2020-21				
	Personal Protective Equipment £'000	NHS Test and Trace Consumables £'000	Equipment and other COVID-19 consumables £'000	Other consumables £'000	Total £'000
Balance at 1 April 2020	**-**	**-**	**-**	**6,627**	**6,627**
Inventory additions	12,064,577	5,597,537	877,697	109,434	18,649,245
Inventories consumed/disposed of	(2,451,849)	(3,311,461)	(215,527)	(106,739)	(6,085,576)
Impairment of inventory	(8,705,057)	(194,714)	(74,004)	-	(8,973,775)
Reclassification	43,874	-	-	-	43,874
Other	-	-	-	1	1
Balance at 31 March 2021	**951,545**	**2,091,362**	**588,166**	**9,323**	**3,640,396**

	Departmental Group 2021-22								
	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Covid-19 Medicines	Raw materials	COVID-19 Vaccines	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2021	**398,655**	**6,371**	**411,912**	**-**	**3,382**	**37,074**	**4,584,456**	**112,282**	**5,554,132**
Prior period adjustments in underlying accounts	(548)	-	813	-	-	22,810	(15,165)	(133)	7,777
Inventory additions	638,068	-	7,747,004	1,206,838	(367)	2,704,198	11,420,220	538,150	24,254,111
Inventories consumed/disposed of	(463,227)	(588)	(7,699,975)	(279,110)	(1,031)	(2,278,755)	(12,180,840)	(551,858)	(23,455,384)
Write Downs	(71,698)	(11)	(10,683)	-	-	(10,708)	(95,725)	(275)	(189,100)
Impairment of inventory	-	-	-	(866,710)	-	(249,835)	(512,102)	-	(1,628,647)
Transfers	-	112	-	-	-	-	3,614	46	3,772
Transfer from provisions	-	-	-	-	-	-	(963,822)	-	(963,822)
Reclassification	-	-	-	734	(1,984)	-	1,257	(7)	-
Balance at 31 March 2022	**501,250**	**5,884**	**449,071**	**61,752**	**-**	**224,784**	**2,241,893**	**98,205**	**3,582,839**

1. See Note 8 for details of inventory impairments.

Consumables can be further analysed as follows:

	Departmental Group 2021-22				
	Personal Protective Equipment	NHS Test and Trace Consumables	Equipment and other COVID-19 consumables	Other consumables	Total
	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2021	**1,062,169**	**2,091,362**	**588,166**	**842,759**	**4,584,456**
Prior period adjustments in underlying accounts	-	-	-	(15,165)	(15,165)
Inventory additions	1,481,431	5,787,364	7,239	4,144,186	11,420,220
Inventories consumed/disposed of	(726,115)	(7,237,973)	(98,887)	(4,117,865)	(12,180,840)
Write Downs	(81,708)	-	(8,204)	(5,813)	(95,725)
Impairment of inventory	24,799	(285,214)	(251,687)	-	(512,102)
Transfers	-	5,580	(1,966)	-	3,614
Provisions transferred to inventory	(963,822)	-	-	-	(963,822)
Reclassification	1,984	-	-	(727)	1,257
Balance at 31 March 2022	**798,738**	**361,119**	**234,661**	**847,375**	**2,241,893**

	Adult and Childhood Vaccines	Pandemic Flu and Pre Pandemic Flu	Drugs	Covid-19 Medicines	Raw materials	COVID-19 Vaccines	Consumables	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
								Restated[1]	
								Departmental Group	
								2020-21	
Balance at 1 April 2020	**244,876**	**-**	**432,520**	**-**	**-**	**-**	**827,871**	**146,470**	**1,651,737**
Prior period adjustments in underlying accounts	-	-	(763)	-	-	-	(1,915)	13,814	11,136
Inventory additions	703,614	17,657	6,690,982	-	12,698	617,916	22,157,643	703,911	30,904,421
Inventories consumed/disposed of	(485,664)	(17,787)	(6,698,814)	-	-	(580,809)	(9,272,576)	(695,445)	(17,751,095)
Write Downs	(64,171)	-	(12,013)	-	-	(33)	(55,936)	(878)	(133,031)
Impairment of inventory	-	-	-	-	-	-	(8,973,775)	-	(8,973,775)
Transfers	-	41,059	-	-	-	-	(140,731)	(55,590)	(155,262)
Reclassification	-	(34,558)	-	-	(9,316)	-	43,874	-	-
Other	-	-	-	-	-	-	1	-	1
Balance at 31 March 2021	**398,655**	**6,371**	**411,912**	**-**	**3,382**	**37,074**	**4,584,456**	**112,282**	**5,554,132**

1. Additions and consumption of Covid-19 vaccines have been restated to reflect the transfer of the Vaccine Taskforce to the Department on 1 August 2021. This has been accounted for using the merger accounting method.

Consumables can be further analysed as follows:

	Personal Protective Equipment	NHS Test and Trace Consumables	Equipment and other COVID-19 consumables	Other consumables	Total
	£'000	£'000	£'000	£'000	£'000
				Departmental Group	
				2020-21	
Balance at 1 April 2020	**-**	**-**	**-**	**827,871**	**827,871**
Prior period adjustments in underlying accounts	-	-	-	(1,915)	(1,915)
Inventory additions	12,064,577	5,597,537	877,697	3,617,832	22,157,643
Inventories consumed/disposed of	(2,300,441)	(3,311,461)	(75,388)	(3,585,286)	(9,272,576)
Write Downs	(40,784)	-	-	(15,152)	(55,936)
Impairment of inventory	(8,705,057)	(194,714)	(74,004)	-	(8,973,775)
Transfers	-	-	(140,139)	(592)	(140,731)
Reclassification	43,874	-	-	-	43,874
Other	-	-	-	1	1
Balance at 31 March 2021	**1,062,169**	**2,091,362**	**588,166**	**842,759**	**4,584,456**

13. Cash and cash equivalents

	2021-22 £'000		2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Balance at 1 April 2021	**1,576,897**	**16,795,536**	**1,460,785**	**9,111,920**
Net change in cash	(617,012)	1,301,243	116,112	7,683,616
Balance at 31 March 2022	**959,885**	**18,096,779**	**1,576,897**	**16,795,536**
The following balances at 31 March were held at:				
Government Banking Service	959,704	17,742,486	1,576,783	16,463,897
Commercial banks and cash in hand	181	300,555	112	266,937
Short term investments	-	53,738	2	64,702
Balance at 31 March 2022	**959,885**	**18,096,779**	**1,576,897**	**16,795,536**

14. Trade receivables and other current assets

	2021-22 £'000		Restated[4] 2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade receivables	611,566	2,271,783	233,883	1,678,196
Deposits and advances	-	11,478	-	374,147
Capital receivables	-	44,460	-	38,417
Interest receivable	516	5,833	-	4,644
Other receivables	597,673	1,661,248	563,894	1,560,319
Trade and other receivables	**1,209,755**	**3,994,802**	**797,777**	**3,655,723**
Contract Assets	-	3,247	33,033	91,298
Other prepayments and accrued income[2,3]	540,110	2,099,056	1,305,941	2,655,252
Current part of PFI and other service concession arrangements prepayments	-	24,698	-	24,751
Capital Prepayments	-	92,602	-	96,288
Other current assets	-	3,870	-	17,527
Other current assets	**540,110**	**2,223,473**	**1,338,974**	**2,885,116**
Current part of loans repayable transferred from investments	210,989	1,329	230,473	853
Other financial assets	**210,989**	**1,329**	**230,473**	**853**
Total current receivables	**1,960,854**	**6,219,604**	**2,367,224**	**6,541,692**
Amounts falling due after more than one year:				
Trade receivables	-	164,078	-	157,620
Deposits and advances	-	5,486	-	5,571
Capital receivables	-	36,033	-	42,672
Contract Assets	-	4,710	-	4,263
Other receivables	303,194	371,655	255,978	310,444
Interest Receivable	-	498	-	-
Other Prepayments and accrued income[3]	180,065	210,906	149	25,179
Non-current part of PFI and other service concession arrangements prepayments	-	51,608	-	48,772
Capital Prepayments	-	160,413	-	166,741
Total non-current receivables	**483,259**	**1,005,387**	**256,127**	**761,262**
Total receivables at 31 March 2022	**2,444,113**	**7,224,991**	**2,623,351**	**7,302,954**

1. Trade receivables are shown net of the expected credit loss on receivables under the IFRS 9 expected credit loss model.
2. Other prepayments and accrued income for the Core Department and Agencies includes £120 million (2020-21: £604 million) in respect of COVID-19 for ventilators, personal protective equipment and testing.
3. Non-current prepayments totalling £180 million (2020-21: £nil) and current prepayments totalling £227 million (2020-21: £nil) are subject to impairment, their gross unimpaired values are £309 million and £479 million respectively. See Note 8 for further details.
4. Comparative financial information has been restated to reflect the transfer of the Vaccine Taskforce to the Department on 1 August 2021. This has been accounted for using the merger accounting method and has increased other prepayments and accrued income of both the Core Department and the Departmental Group by £577 million.

15. Trade payables and other current liabilities

	2021-22 £'000		Restated[6] 2020-21 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade payables[3]	1,963,690	4,592,589	816,446	3,699,363
Capital payables	67,747	2,149,454	42,962	1,980,582
Other payables[2]	52,805	3,605,227	19,384	3,405,126
Trade and other payables	**2,084,242**	**10,347,270**	**878,792**	**9,085,071**
Bank Overdraft	-	10,553	-	59,651
VAT	65,373	137,916	-	11,958
Other taxation and social security	5,533	1,485,034	13,863	1,364,906
EEA Medical Costs Accrual	662,933	662,933	645,623	645,623
Contract liabilities	-	1,524,117	28,677	1,192,396
Other accruals[4]	3,027,654	16,814,545	8,006,628	17,340,665
Deferred income	112,043	355,920	147,753	212,386
Current part of finance lease	-	85,254	-	81,095
Current part of imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	402,096	-	371,087
Amount issued from the Consolidated Fund for supply but not spent at year end	1,247,417	1,247,417	1,523,414	1,523,414
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received[5]	284,012	284,012	365,721	365,721
Current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	95,049	-	46,030
Pension liabilities	-	130,989	-	114,456
Other current liabilities	-	14,745	-	20,556
Other liabilities	**5,404,965**	**23,250,580**	**10,731,679**	**23,349,944**
Total current payables	**7,489,207**	**33,597,850**	**11,610,471**	**32,435,015**
Amounts falling due after more than one year:				
Finance leases	-	517,223	-	554,288
Imputed finance lease element of on Statement of Financial Position PFI contracts and other service concession arrangements	-	9,491,529	-	9,873,208
Pension liabilities	-	14	-	31
Financial liabilities	**-**	**10,008,766**	**-**	**10,427,527**
Trade payables	-	9,587	-	6,504
Contract liabilities	-	124,617	-	98,909
Other accruals	7,383	11,228	6,976	13,565
Capital payables	10,207	16,565	118,737	128,751
Other payables	-	296,018	-	212,563
Deferred income	9,106	118,037	21,248	100,544
Non-current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	331,930	-	359,344
Loans payable by DHSC to group bodies	20,220	-	20,220	-
Other payables	**46,916**	**907,982**	**167,181**	**920,180**
Total non-current payables	**46,916**	**10,916,748**	**167,181**	**11,347,707**
Total payables	**7,536,123**	**44,514,598**	**11,777,652**	**43,782,722**

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 £1,289 million relating to the provider sector and £1,238 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.
3. Trade payables includes £1,452 million (2020-21 £541 million) and Other accruals falling due within one year for the Core Department include £nil million (2020-21 £3,915 million) due to Supply Chain Coordination Limited, which eliminates on consolidation.
4. Other accruals falling due within one year for the Group includes £7,581 million relating to the provider sector and £6,203 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. The balances include amounts accrued in relation to the COVID-19 pandemic.
5. Further details are given in Note 5, Income.
6. Comparative financial information has been restated to reflect the transfer of the Vaccine Taskforce to the Department on 1 August 2021. This has been accounted for using the merger

accounting method and has increased other accruals of both the Core Department and the Departmental Group by £169 million.

16. Provisions for liabilities and charges

	2021-22						2020-21					
	Core Dept & Agencies						Core Dept & Agencies					
	Early departure costs	Injury Benefits	EEA medical costs	Infected Blood	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Infected Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2021	**111,053**	**631,838**	**993,464**	**2,410,066**	**1,451,579**	**5,598,000**	**104,244**	**676,835**	**808,110**	**1,864,269**	**176,844**	**3,630,302**
Provided in the year	4,016	57,474	962,223	126,170	3,951,384	5,101,267	32,192	78,295	826,882	584,398	1,344,944	2,866,711
Provisions not required written back	(3,584)	(17,117)	-	(220,410)	(304,275)	(545,386)	(3,344)	(25,196)	-	-	(58,394)	(86,934)
Transfers	-	-	-	-	-	-	-	-	-	-	-	-
Provisions utilised in the year	(10,856)	(45,375)	(183,407)	(77,287)	(61,820)	(378,745)	(11,384)	(47,146)	(139,123)	(75,911)	(8,467)	(282,031)
Transfer to accruals/inventories	-	-	(536,815)	-	(963,839)	(1,500,654)	-	-	(507,094)	-	-	(507,094)
Borrowing costs (unwinding of discount)	(11,995)	(48,253)	(126)	46,306	(1,846)	(15,914)	(12,360)	(52,252)	4,121	33,374	(3,620)	(30,737)
Change in discount rate	1,568	36,425	(865)	391,639	7,260	436,027	1,705	1,302	568	3,936	272	7,783
Balance at 31 March 2022	**90,202**	**614,992**	**1,234,474**	**2,676,484**	**4,078,443**	**8,694,595**	**111,053**	**631,838**	**993,464**	**2,410,066**	**1,451,579**	**5,598,000**

	Early departure costs	Injury Benefits	EEA medical costs	Infected Blood	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Infected Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current	10,603	44,081	455,529	100,458	3,254,787	3,865,458	11,107	45,979	364,310	81,916	1,370,095	1,873,407
Non Current	79,599	570,911	778,945	2,576,026	823,656	4,829,137	99,946	585,859	629,154	2,328,150	81,484	3,724,593
Expected timing of cash flow												
Not later than 1 year	10,603	44,081	455,529	100,458	3,254,787	3,865,458	11,107	45,979	364,310	81,916	1,370,095	1,873,407
Later than 1 year, not later than 5 years	43,031	186,604	778,945	394,608	761,351	2,164,539	45,383	190,626	629,154	323,281	20,364	1,208,808
Later than 5 Years	36,568	384,307	-	2,181,418	62,305	2,664,598	54,563	395,233	-	2,004,869	61,120	2,515,785
Total	**90,202**	**614,992**	**1,234,474**	**2,676,484**	**4,078,443**	**8,694,595**	**111,053**	**631,838**	**993,464**	**2,410,066**	**1,451,579**	**5,598,000**

1. The modelling of the future cash flows for infected blood 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.

	2021-22							Restated[3] 2020-21						
	Departmental Group							Departmental Group						
	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Infected Blood	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Infected Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2021	**284,016**	**929,075**	**993,464**	**84,879,635**	**2,410,066**	**3,347,943**	**92,844,199**	**279,043**	**950,148**	**808,110**	**86,557,212**	**1,864,269**	**1,523,092**	**91,981,874**
Prior period adjustments in underlying accounts	(510)	2,157	-	-	-	(13,049)	(11,402)	(1,585)	5,441	-	-	-	(4,590)	(734)
Provided in the year	21,755	84,391	962,223	5,856,906	126,170	4,908,175	11,959,620	57,288	106,186	826,882	4,459,412	584,398	2,266,318	8,300,484
Provisions not required written back	(8,572)	(21,589)	-	(3,111,800)	(220,410)	(617,347)	(3,979,718)	(7,255)	(28,276)	-	(4,657,620)	-	(339,701)	(5,032,852)
Transfers	6	(6)	-	-	-	-	-	-	-	-	-	-	-	-
Provisions utilised in the year	(38,448)	(59,122)	(183,407)	(2,402,863)	(77,287)	(236,716)	(2,997,843)	(27,137)	(60,051)	(139,123)	(2,209,346)	(75,911)	(136,713)	(2,648,281)
Transfer to accruals/inventories	(3,443)	(2,908)	(536,815)	-	-	(980,147)	(1,523,313)	(10,294)	(3,527)	(507,094)	-	-	(19,370)	(540,285)
Borrowing costs (unwinding of discount)	(12,647)	(50,416)	(126)	347,586	46,306	30,843	361,546	(12,564)	(53,106)	4,121	503,307	33,374	16,177	491,309
Change in discount rate	4,230	47,197	(865)	42,614,725	391,639	(7,088)	43,049,838	6,520	12,260	568	226,670	3,936	42,730	292,684
Balance at 31 March 2022	**246,387**	**928,779**	**1,234,474**	**128,184,189**	**2,676,484**	**6,432,614**	**139,702,927**	**284,016**	**929,075**	**993,464**	**84,879,635**	**2,410,066**	**3,347,943**	**92,844,199**

	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Infected Blood	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Infected Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current	29,950	65,149	455,529	2,686,621	100,458	4,373,087	7,710,794	31,961	63,762	364,310	2,682,695	81,916	2,323,834	5,548,478
Non Current	216,437	863,630	778,945	125,497,568	2,576,026	2,059,527	131,992,133	252,055	865,313	629,154	82,196,940	2,328,150	1,024,109	87,295,721
Expected timing of cash flow														
Not later than 1 year	29,950	65,149	455,529	2,686,621	100,458	4,373,087	7,710,794	31,961	63,762	364,310	2,682,695	81,916	2,323,834	5,548,478
Later than 1 year, not later than 5 years	112,441	266,127	778,945	12,843,937	394,608	1,211,964	15,608,022	121,637	264,517	629,154	12,715,195	323,281	460,731	14,514,515
Later than 5 Years	103,996	597,503	-	112,653,631	2,181,418	847,563	116,384,111	130,418	600,796	-	69,481,745	2,004,869	563,378	72,781,206
Total	**246,387**	**928,779**	**1,234,474**	**128,184,189**	**2,676,484**	**6,432,614**	**139,702,927**	**284,016**	**929,075**	**993,464**	**84,879,635**	**2,410,066**	**3,347,943**	**92,844,199**

1. The modelling of the future cash flows for infected blood 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.
2. Included within the Clinical Negligence provision above is £120,359 million (31 March 2021: £78,886 million (restated)) relating to the Clinical Negligence Scheme for Trusts (CNST).
3. Comparative financial information has been restated to reflect the restatement of the clinical negligence provision for known claims as described below. The opening balance as at 1 April 2020 has increased by £2,790 million, the amount provided in the year has reduced by £216 million and the change in the discount rate has reduced by £118 million. The closing balance at 31 March 2021 and the opening balance at 1 April 2021 have increased by £2,457 million.

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 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 NHS Resolution Annual Report and Accounts.

The provision also includes the following liabilities relating to General Practice:

- Clinical Negligence Scheme for General Practice (CNSGP) which covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019.
- Existing Liabilities for General Practice (ELGP), which reflects the interim arrangements under which NHS Resolution carry out the Secretary of State's oversight and governance responsibilities relating to existing liabilities agreed with the Medical Protection Society (MPS), a medical defence organisation.
- Existing Liabilities Scheme for General Practice (ELSGP) which covers claims for historical NHS clinical negligence and other tortious incidents of GP members of participating medical defence organisations occurring at any time before 1 April 2019. This scheme covered members of the Medical and Dental Defence Union of Scotland from 6 April 2020 and was extended to Medical Protection Society members from 1 April 2021.

The three key elements of NHS Resolution's provisions are:

- Claims received by NHS Resolution (known claims)
- Settled Periodical Payment Orders (PPOs) where the settlement of a claim involves payments to the claimant into the future, generally for their lifetime
- Incurred but not reported (IBNR) provision where claims have not yet been received but where it can reasonably be predicted that:
    - an adverse incident has occurred, and
    - a transfer of economic benefits will occur, and
    - a reasonable estimate of the likely value can be made

Prior period adjustment – known claims

The known claims provision calculation uses the expected settlement date (ESD) from individual claims recorded in NHS Resolution's Claims Management System (CMS) to apply inflation and discounting to reach a valuation. However, for the disclosure of the expected timing of cashflows, this has historically been based on an actuarial view of settlement patterns.

The ESD for individual known claims is based on the judgement and experience of individual claims handlers informed by advice and regular review by panel lawyers (where instructed). It is dynamic as it responds to developments on the individual claim, which will not follow a prescribed timetable. Claims handlers are required to keep this field under review and as part of their reporting requirements, panel law firms revise and recommend any changes to the ESD. This judgement is based on a range of factors pertinent to the individual claim such as whether liability issues are clear or complex, or whether the claimant's condition can be assessed easily or requires further examination and expert evidence.

While these judgements may be reasonable at individual claim level, collectively they may be optimistic compared to the number and value of claims that the legal and health systems have the capacity to settle. The appropriateness of the ESD on individual cases is audited as part of the rolling audit programme internally and also when a claims handlers' financial authority limit is considered for review or approval. The audit considers the reasonableness of the claims handlers' judgement, based on the evidence available at that point in time.

A difference between reasonable granular judgements taken together and likely cashflows is not unexpected. NHS Resolution has had in place an actuarial view of the timing of cashflows (derived from historical settlement patterns) for the provisions disclosures in the accounts.

However, the difference between these two views has diverged in 2021-22, most likely due to the impact of the COVID-19 pandemic on the legal and health operating environments. There has been an increase in the volume and value of claims with a settlement date within a shorter timeframe. An adjustment to the known claims provision (£4.6 billion across all schemes at 2021-22 HM Treasury discount rates) has been made to reflect an actuarial view of a slower settlement pattern than the claims ESDs suggest.

As a result of this review, NHS Resolution have concluded that this approach should have been applied to prior periods, drawing on the information that was available at the time, as it results in a better estimate of the known claims provision. The prior period financial statements both for NHS Resolution and for the Departmental group have therefore been restated as required by IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors.

The closing position for the provision at 31 March 2021 has therefore been increased by £2.5 billion, and a corresponding change to the provision expense has been made. The prior year restatement has been confined to the CNST scheme on the basis the impact on the other schemes is not material (based on the work done for the 2021-22 adjustment).

The opening position for the provision at 1 April 2020 for CNST only has also been restated, resulting in an increase of £2.8 billion. Taken together with the restatement at 31 March 2021, there was a net reduction in the provision expense for the restated 2020-21 financial year of £0.3 billion. The following table sets out the changes made to the financial statements and notes to the accounts as a result of this prior year restatement:

	Balance in 2020-21 accounts	Restatement	Revised balance in 2020-21 accounts[1]
	£000	£000	£000
Statement of comprehensive net expenditure			
Provision expense	3,912,199	(333,269)	3,578,930
Total operating expenditure	**191,917,434**	**(333,269)**	**191,584,165**
Total net expenditure for the year ended 31 March 2021	183,857,546	(333,269)	183,524,277
Total comprehensive expenditure for the year ended 31 March 2021	**183,509,683**	**(333,269)**	**183,176,414**
Statement of Financial Position			
Non-current liabilities - Provisions	(84,838,633)	2,457,088	(87,295,721)
Total non-current liabilities	**(96,345,651)**	**2,457,088**	**(98,802,739)**
Total assets less liabilities	(43,322,931)	2,457,088	(45,780,019)
Total taxpayers' equity	**(43,915,180)**	**2,457,088**	**(46,372,268)**
Total reserves	**(43,322,931)**	**2,457,088**	**(45,780,019)**
Statement of cash flows			
Net expenditure for the year	(183,857,546)	333,269	(183,524,277)
Adjustments for non-cash transactions	9,536,747	(333,269)	9,203,478
Statement of changes in taxpayers' equity			
Balance at 1 April 2020	(48,038,794)	(2,790,357)	(50,829,151)
Comprehensive net expenditure for the year	(183,857,546)	333,269	(183,524,277)
Balance at 31 March 2021	**(43,322,931)**	**(2,457,088)**	**(45,780,019)**
Expenditure			
Provision provided for in year	3,483,267	(215,635)	3,267,632
Provisions change in discount rate	410,318	(117,634)	292,684
Total other operating expenditure	**15,366,736**	(333,269)	**15,033,467**

1. The revised balance column does not agree to the primary statement comparatives for 2020-21 due to the impact of the transfer of the Vaccine Task Force into the Core department, which is not reflected in the above table.

Effect of change in discount rate

One of the key assumptions used in calculating the provision is the discount rates used to place a present value on projected future cashflows. Since the discount rates are prescribed by HM Treasury, the rates are outside the formal control of NHS Resolution.

The clinical negligence provision is particularly sensitive to the long term and very long term discount rates. This reflects the long term nature of the liabilities which is driven by the reporting and settlement delays as well as the fact that many high value claims are settled as a Periodical Payment Order (PPO) with payments provided over the remaining lifetime of the claimant.

In 2021-22, there was a significant reduction in the long term and very long term discount rates prescribed by HM Treasury, which increased the provision by £42.6 billion. Although the change in discount rates prescribed by HM Treasury has a material effect on the value of the provisions, it does not alter the cost of settling claims in the short-term – which is driven by the frequency and severity of claims and the legal environment in which the claims are settled (e.g. the personal injury discount rate). As such the £42.6 billion increase in the provisions reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

Indemnity arrangements for coronavirus

The coronavirus pandemic has had a significant impact on the NHS over the last two years, which has the potential to affect the value of the liabilities covered by NHS Resolution. In addition to the two new schemes that have been established (CNSC and CTIS), there are also potential impacts on the liabilities covered under the arrangements that were already in place (i.e. through CNST, CNSGP and LTPS) owing to changes in healthcare provision.

As was the case previously, the estimated effect on the clinical negligence provision is fairly limited (£1.3 billion) at this stage because:

- the success of the vaccination programme meant that clinical activity was not as severely disrupted in 2021-22
- a large share of the total provision is in relation to incidents that occurred prior to 2020-21. While these claims might still be affected by any potential disruption in the reporting and settlement of claims, this is not expected to significantly alter the liabilities due.
- A large proportion of the CNST provision is as a result of claims arising from maternity activity. Although there have been some changes to maternity activities, overall these activities have continued during the pandemic and it is assumed that there will be a similar level of claims as in previous years.

While a small number of claims related to COVID-19 have been received, it will take several years for the impacts of COVID-19 to fully materialise, due to the time lags between incidents, claims and ultimately their settlement. As a result, there is limited experience from which to quantify the impacts of COVID-19 on the provisions and our estimates are subject to uncertainty.

Key movements in provision

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 £43,305 million in 2021-22 from £84,880 million at 31 March 2021 (as restated) to £128,184 million at 31 March 2022. The key movements in the provision during the year were as follows:

- An increase of £8.5 billion relating to another year's worth of activity for all schemes for all incident years
- A decrease of £6.9 billion due to changes in assumptions affecting the IBNR provision. The main drivers of this decrease relate to the CNST IBNR provision, and comprise a decrease of £5.7 billion for inflation and average cost assumptions, a decrease of £2.3 billion as a result of removing the risk and uncertainty margin (addressed through discussion of sensitivities and reasonable range below), a decrease of £0.2 billion for the change in assumption for the projected number of successful claims, and an increase of £2.0 billion in respect of lag and payment patterns and updated mortality assumptions in respect of potential PPO claims. There has been an overall increase of £0.5 billion for the assessed impact of COVID-19 on the provisions, reflecting slightly higher NHS activity than was estimated previously and an increase in the number of claims relating to delays, cancellations and misdiagnosis reflecting longer waiting lists. The remaining decrease of £1.2 billion relates to the effects of assumptions changes on IBNR for the other indemnity scheme.
- An increase of £1.6 billion in respect of changes in assumptions affecting known claims. This comprises a net increase of £2.8 billion due to reserve values, estimated settlement year and probability of success of individual claims being revised as more information becomes available, a decrease of £1.6 billion due to claims closed during the year, either at a lower value than expected or where the claim was repudiated, and an increase of £0.4 billion due to the application of the actuarial view of the timing of cashflows to the known claims provision.
- A decrease of £2.5 billion relating to amounts paid out during the financial year to settle claims.
- A significant increase of £42.6 billion due to the reductions in the long term and very long term discount rates specified for use by HM Treasury under the Public Expenditure System (PES).

Full details of the changes above can be found in the Annual Report and Accounts of NHSR. However, the key changes in assumptions affecting the value of the CNST IBNR provision between 31 March 2021 and 31 March 2022 have been noted below:

- NHS Resolution's Early Notification (EN) scheme has accelerated the reporting of potential PPO claims. This has been allowed for by specifying separate assumptions for claims that are expected to be reported under the EN scheme. There has been a slightly higher number of potential PPO claims reported over the year which leads to

a slight increase in the assumed number of claims and IBNR provision. The impact of this change is an increase in the CNST IBNR provision of £1.6 billion.

- The average costs per claim assumptions have increased slightly but haven't kept pace with the expected level of claims inflation. The impact of this change is a reduction in the CNST IBNR provision of £4.5 billion.
- The inflation assumption for PPO damages has decreased by 0.5% pa from the previous year. This has reduced the value of the CNST IBNR provision by £4.0 billion. However, this has been offset by an assumption that the higher short-term inflationary environment will feed through to higher claims inflation, and this has increased the CNST IBNR provision by £2.8 billion.
- The risk and uncertainty margin has been removed during the reporting year. Previously it was included in the claims inflation assumption. This change has reduced the value of the CNST IBNR provision by £2.3 billion.
- The probability of paying damages has reduced by 2% for PPO damages. This has reduced the value of the CNST IBNR provision by £1.8 billion.
- The life expectancy assumptions for PPO payments have been split between EN claims (42 years) and non-EN claims (37 years). This has increased the value of the CNST IBNR provision by £1.3 billion.
- The long-term and very long-term HM Treasury-prescribed discount rates have decreased by 1.04% and 1.33% respectively. Short- and medium-term rates have increased by 0.49% and 0.52% respectively. The net impact of these changes is an increase in the CNST IBNR provision of £24.5 billion.

The provisions above are also reported in the accounts of NHSR together with other provisions of £366 million. These represent the English element of the clinical negligence provision as shown in Whole of Government Accounts.

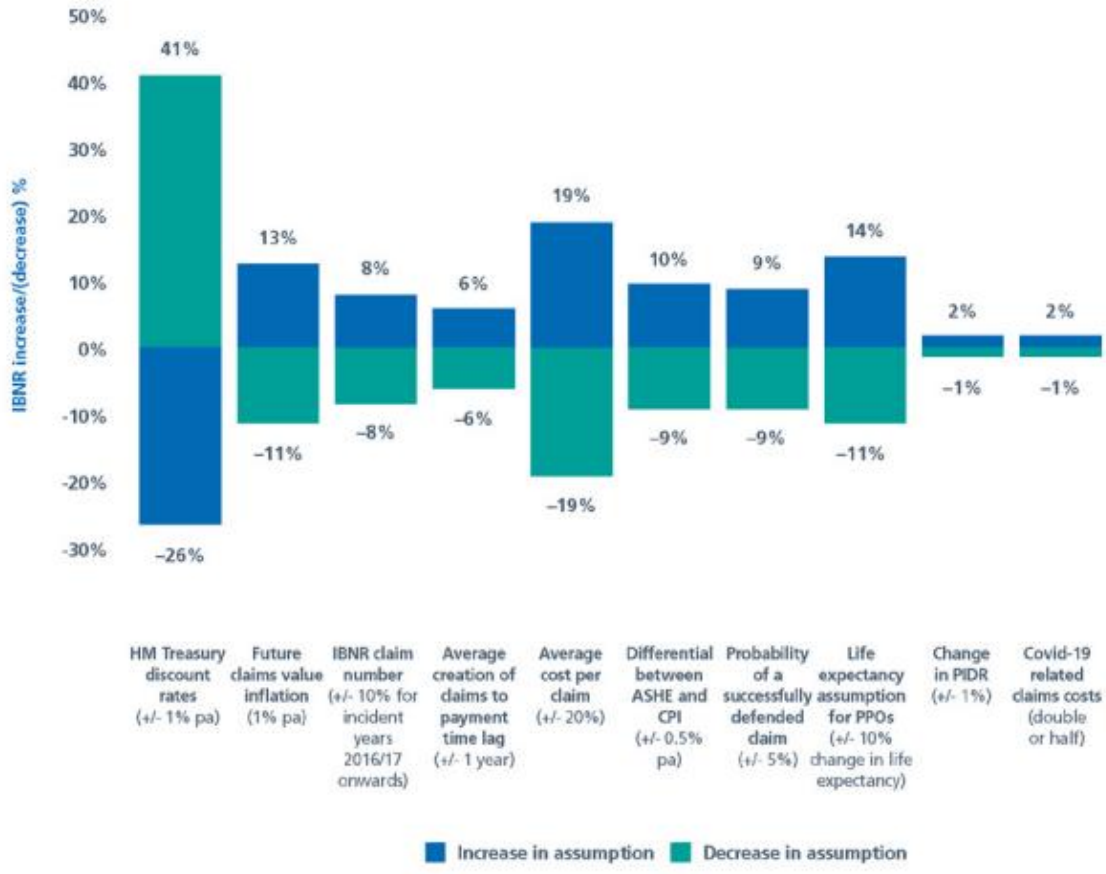
Due to the long-term nature of the liabilities and the assumptions on which the estimate of the provision is based, some uncertainty about the value of the liability remains. This is particularly relevant to the IBNR element of the provision (the largest single element of total provisions, and therefore where uncertainty has the greatest effect).

Claims settling as PPOs also remain a key area of uncertainty, given the high value of PPO settlements, the limited stable past data to base future claim number projections upon and the changing propensity to award PPOs to claimants. PPO claim settlements are paid over the lifetime of the claimant, and consequently there are additional inflation and longevity uncertainties, compared to equivalent lump sum settlements.

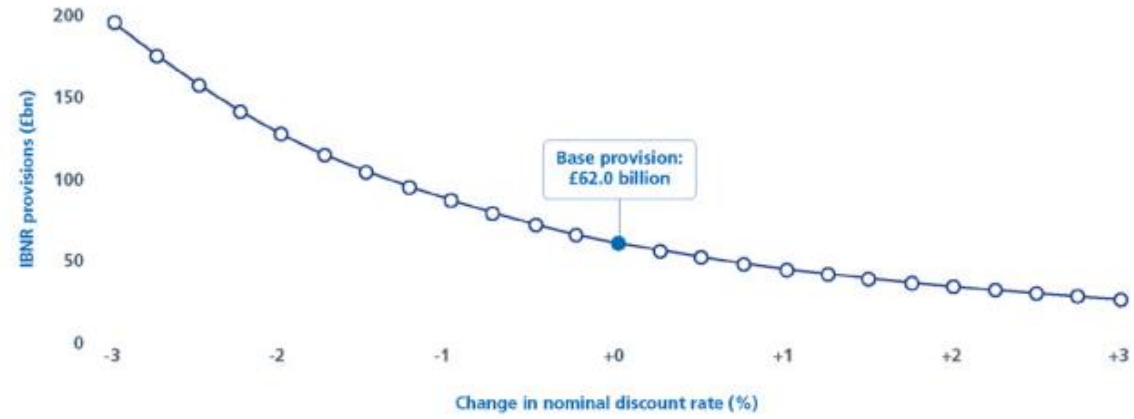
The following tables show the impacts of adjusting some of the key assumptions used for the IBNR estimate for CNST.

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.



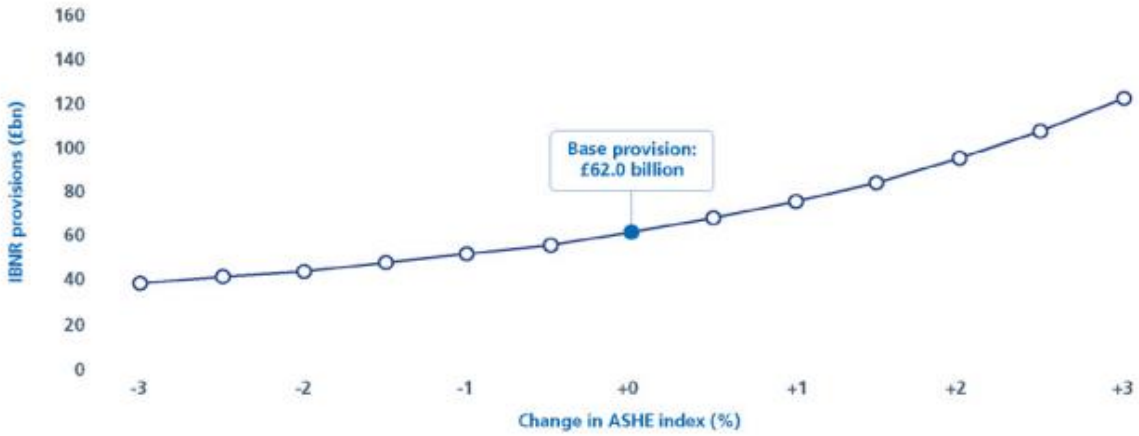
The clinical negligence provision's value is particularly sensitive to changes in the long-term discount rate given its nature. The disclosures above show the impact of percentage changes.

In 2021-22, there was a significant reduction in the long term and very long term discount rates prescribed by HM Treasury, which increased the provision substantially.

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, and the differential between the Consumer Price Index (CPI) and Annual Hourly Earnings index over the long-term and life expectancy.

The following graph shows the sensitivity of the CNST 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 2021 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

This budget refers to the Pension Scheme employer funded element of historic redundancy costs recharged to employers (also referred to as Compensation or Premature Retirement Benefit (PRB) cases). Previously, NHS Pension Scheme staff who met certain criteria on redundancy could receive an enhancement to their pension to compensate them for redundancy in lieu of a payment. The cost of this enhancement to NHS Pension Scheme benefits was then recharged to the employer. This budget is specific to liabilities in cases which were previously the responsibility of PCTs, and have passed to DHSC following the abolition of PCTs in 2013.

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.

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 United Kingdom's departure from the European Union. Reciprocal healthcare arrangements between the UK and the EU have been agreed within the Protocol on Social Security Coordination of the EU – UK Trade and Cooperation Agreement, in addition to the lifelong reciprocal healthcare entitlements afforded to those in scope of the Withdrawal Agreement.

Infected Blood

The Infected Blood payment scheme is for individuals who were infected with HIV and/or hepatitis C following treatment with NHS-supplied blood or blood products, and now their bereaved partners following a Written Ministerial Statement in 2021. 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. Infected blood payments are linked to increases in the consumer price index. On 7 June 2022 the Government published a report by Sir Robert Francis QC which makes recommendations for a framework for compensation for those infected and affected by infected blood, should the recommendations of the Infected Blood Inquiry lead to this. There are a number of complex issues to be considered before Government can respond in detail to Sir Robert's recommendations, therefore this is not reflected in the current provision.

Other Provisions

These financial statements disclose other provisions of £4,078 million for the Core Department and Agencies and £6,433 million for the Departmental Group, which can be analysed as follows:

	2021-22				
	Core Dept & Agencies				
	Onerous Contract provision - Personal Protective Equipment £'000	Onerous Contract provision - Medicines £'000	Onerous Contract provision - Vaccines £'000	Other £'000	Total Other Provisions £'000
Balance at 1 April 2021	**1,231,014**	**-**	**-**	**220,565**	**1,451,579**
Provided in the year	36,799	1,773,742	1,714,726	426,117	3,951,384
Provisions not required written back	(267,192)	-	-	(37,083)	(304,275)
Provisions utilised in the year	-	-	-	(61,820)	(61,820)
Transfer to accruals/inventories	(963,822)	-	-	(17)	(963,839)
Borrowing costs (unwinding of discount)	-	-	-	(1,846)	(1,846)
Change in discount rate	-	-	-	7,260	7,260
Balance at 31 March 2022	**36,799**	**1,773,742**	**1,714,726**	**553,176**	**4,078,443**

	2021-22				
	Departmental Group				
	Onerous Contract provision - Personal Protective Equipment	Onerous Contract provision - Medicines	Onerous Contract provision - Vaccines	Other	Total Other Provisions
	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2021	**1,231,014**	**-**	**-**	**2,116,929**	**3,347,943**
Prior period adjustments in underlying accounts				(13,049)	(13,049)
Provided in the year	36,799	1,773,742	1,714,726	1,382,908	4,908,175
Provisions not required written back	(267,192)	-	-	(350,155)	(617,347)
Provisions utilised in the year	-	-	-	(236,716)	(236,716)
Transfer to accruals/inventories	(963,822)	-	-	(16,325)	(980,147)
Borrowing costs (unwinding of discount)	-	-	-	30,843	30,843
Change in discount rate	-	-	-	(7,088)	(7,088)
Balance at 31 March 2022	**36,799**	**1,773,742**	**1,714,726**	**2,907,347**	**6,432,614**

The other balance for the Departmental Group includes £1.2 billion of other provisions relating to NHS providers. This amount arises from a significant number of entities and as such does not contain items which are material individually.

IAS 37 requires the recognition of an onerous contract provision where the unavoidable costs of meeting the obligations under a contract exceed the economic benefits expected to be received under it.

Onerous Contracts relating to Personal Protective Equipment (PPE)

As part of the response to the COVID-19 pandemic the Core Department entered into contracts for the delivery of 37.5 billion items of PPE. As described in Note 8, an impairment was required to reduce the carrying value of PPE delivered during the year to net realisable value (NRV). Where the Department holds non-cancellable contracts for the future delivery of PPE it assesses these using the inventory impairment methodology described in Note 8.

£964 million of the opening provision as at 1 April 2021 was applied to inventories which arrived during 2021-22 using the principals of the NRV assessment conducted at 31 March 2021. In some cases it was possible to negotiate reduced deliveries, curtail or rearrange contracts with suppliers which meant £267 million of the provision was no longer required and was written back.

Following the assessment of NRV at 31 March 2022, a provision of £37 million is required in respect of future deliveries of PPE which will require impairment on arrival. This is expected to be utilised within one year.

Onerous Contracts relating to COVID-19 Medicines

During the year the Department entered into contracts for the delivery of medicines used to treat the symptoms of COVID-19 with the aim of reducing the rate of death and hospitalisation.

As described in Note 8, it is now expected that not all of the medicines provided will be required as a result of the reduction in the prevalence and severity of COVID-19 since these contracts were entered into.

An onerous contract provision of £1,774 million is therefore required, which represents the Department's best estimate of the value of medicines that the Department is committed to purchasing under non-cancellable contracts at 31 March 2022, which will reach expiry prior to the expected usage date. This provision is expected to be utilised within one year.

Should the most up to date reasonable worst case scenario that the Department plans against be realised, wider deployment of these medicines could reduce the provision required by approximately £505 million. Conversely, if usage was 50% lower than the most likely assumptions used to calculate this provision, the provision would need to increase by £16 million.

Onerous Contracts relating to COVID-19 Vaccines

During the year the Department entered into contracts for the delivery of vaccines for COVID-19. Based on the best available expert medical advice, enough vaccine has been procured on a reasonable worst case basis to ensure all adults would be able to receive a booster dose should this be required.

As a result of the reduction in the prevalence and severity of COVID-19 and the development of new and improved vaccines it is now expected that not all of the doses the Department is committed to purchasing will be used.

An onerous contract provision of £1,715 million is therefore required, which represents the Department's best estimate of the value of vaccines that the Department is committed to purchasing under non-cancellable contracts at 31 March 2022 which will be surplus to requirements.

£1,186 million of this provision is expected to be used within one year and £529 million is expected to be used between one and five years.

Changes to vaccination guidance and uptake rates in future vaccination campaigns could change the level of provision required. A 25% increase in expected usage of vaccines would reduce the provision required by £295 million and a 25% decrease in expected usage of vaccines would increase the provision required by £296 million.

Storage and disposal costs relating to fully impaired Personal Protective Equipment (PPE)

The department has provided for the estimated future storage and disposal costs associated with PPE that has been impaired to nil value. At 31 March 2022 this provision totalled £319m. The existence of this provision does not confirm the inventory will be disposed of, rather that this is a likely outcome. Efforts continue to sell and donate inventory that is not suitable for use within the health and social care sectors but which may be suitable for other uses, and that which has an expiry date prior to the expected date of usage.

The key assumptions used to calculate the provision are the costs to store, move and then finally dispose of the PPE, as well as the rate of disposal.

The storage costs component of the provision is influenced by the rate at which the department is able to dispose of the PPE. The storage costs are calculated using the average cost per pallet from all storage sites in both the UK and abroad.

Movement costs represent the best estimate of operational logistics experts to move the PPE from each location to the identified facility for processing.

The disposal costs are estimated based on the average disposal costs incurred since the disposals commenced in April 2022. The individual per pallet cost changes depending on the type of disposal and the facility used, varying between High Temperature Incineration (HTI) to recycling.

Given the provision is an assumptions driven estimate of future operating costs, there is a degree of uncertainty associated with each of the assumptions. The below table illustrates how changes in the assumptions would impact the estimated provision value.

Storage Costs

Plus 10% (£'m)	Current estimate (£'m)	Minus 10% (£'m)
16.8	319.1	-16.8

*A 10% increase or decrease in future storage costs changes the provision estimate by +/- £16.8m.

Cost of Movement

Plus 10% (£'m)	Current estimate (£'m)	Minus 10% (£'m)
2.0	319.1	-2.0

*A 10% increase or decrease in the future costs of moving the PPE from its storage location to the identified disposal facility changes the provision estimate by +/- £2.0m.

Rate of Disposal

Plus 50% (£'m)	Plus 10% (£'m)	Current estimate (£'m)	Minus 10% (£'m)
-58.2	-15.9	319.1	19.5

*A 10% increase in the future rate of disposal would reduce the provision by £15.9m. Conversely, a 10% decrease would increase the provision by £19.5m. A 50% increase would reduce the provision estimate by £58.2m, this larger increase being shown given te department is seeking to increase the rate of disposal.

Cost of Final Disposal

Plus 10% (£'m)	Current estimate (£'m)	Minus 10% (£'m)
4.8	319.1	4.8

*A 10% increase or decrease in the future costs of final disposal changes the provision estimate by +/- £4.8m.

The department is constantly assessing the feasibility of accelerating disposal in order to minimise the cost to the taxpayer.

Clinicians' Pensions

Other provisions include £290 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 was 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. None of this provision is expected to be utilised in the next five years.

The commitment to make these payments is made by the employing Trust, with an equivalent commitment from NHS England to fund this obligation.

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 £118 million. Of the total, £86 million was expected to be paid within one year, and £32 million between one and 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:

	2021-22 £'000	2020-21 £'000
Present value of the defined benefit obligation at 1 April 2021	**(977,182)**	**(820,628)**
Prior period adjustments in underlying accounts	-	16
Current Service Costs	(15,804)	(13,810)
Past Service Costs	(294)	(85)
Interest Costs	(19,733)	(18,696)
Settlements and curtailments	2,495	8,135
Contribution from scheme members	(2,541)	(2,886)
Actuarial Gains and (Losses)	32,134	(160,169)
Benefits paid	19,780	20,182
Scheme transfers	-	-
Transfers to/from other bodies	-	7,108
Other	10,213	3,651
As at 31 March 2022	**(950,932)**	**(977,182)**
Plan assets at fair value at 1 April 2021	**818,228**	**676,475**
Prior period adjustments in underlying accounts	90	(16)
Interest income	14,824	13,978
Settlements	(5)	(5,783)
Adjustments by the employer	12,880	18,799
Contributions by the plan participants	2,541	2,886
Expected Return on Assets	8,971	22,018
Actuarial Gains and (Losses)	55,183	123,247
Changes in the effect of limiting defined benefit asset to the asset ceiling	(13,534)	(2,203)
Benefits paid	(19,780)	(20,182)
Transfers to/from other bodies	-	(7,340)
Other	(10,213)	(3,651)
As at 31 March 2022	**869,185**	**818,228**
Plan surplus/(deficit) at 31 March 2022	**(81,747)**	**(158,954)**

17. Contingent Assets and Liabilities disclosed under IAS 37

17.1 Contingent Assets

The Core Department has lodged several civil litigation claims seeking damages linked to civil actions around a breach of competition regulations. The Department has also lodged claims linked to commercial regulation breaches. 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 £14.0 million (2020-21: £17.2 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 £73,370 million (2020-21: £47,160 million (restated)), although £70,798 million (2020-21: £44,302 million (restated)) relating to the Clinical Negligence Scheme for Trusts (CNST) would be expected to be met by payments from NHS providers.

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. Contingent liabilities of £54 million are disclosed in the 2021-22 accounts for additional liabilities arising under these indemnity arrangements.

Employment Tribunal Cases

The Department is involved in a number of Employment Tribunal cases.

Liabilities in respect of the COVID-19 Vaccination Programme

The Department holds an indemnity relating to the contract signed between His Majesty's Government and Pfizer/BioNTech for their COVID-19 vaccine.

The Department holds an indemnity relating to the contract signed between His Majesty's Government and AstraZeneca/Oxford for their COVID-19 vaccine.

The Department holds an indemnity as part of a contract between His Majesty's Government and Moderna regarding the COVID-19 vaccination programme.

The Department has further contingent liabilities relating to the COVID-19 vaccine programme.

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

Aeromedical evacuations of patients

Where there is a requirement for HMG to aero-medically evacuate (MEDEVAC) patients with confirmed or suspected High Consequence Infectious Diseases to the UK for treatment, liability for the costs of these MEDEVAC flights may sit with DHSC. A Memorandum of Understanding exists for the RAF Air Transportable Isolator service between DHSC and MOD. DHSC would be expected to cover the cost of the MEDEVAC in cases where a civilian is involved; where we have initiated the flight; and/or, have a clear duty of care to the patient.

Expert Advisory Committees

The Department has undertaken to indemnify members of its expert advisory committees:

- New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG);
- The Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO).

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.

Other Contingent Liabilities

Within the NHS England Group account (which incorporates Clinical Commissioning Groups and NHS England) at 31 March 2022, there were contingent liabilities of £22.4 million (2020-21: £32.9 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 2022 had net contingent liabilities of £29.5 million (2020-21: £23.8 million).

A designated setting scheme exists for people who are medically fit for discharge from hospital (i.e. they do not require to be in an acute NHS bed) but whose ongoing care and support needs are such that they require full-time residential or nursing care. The Department holds a contingent liability which offers targeted and time-limited state-backed indemnity arrangements to care homes registered, or intending to register, as "designated settings", and which are unable to obtain sufficient insurance cover.

At 31 March 2022, NHS Resolution had other non-clinical contingent liabilities of £295 million (2020-21: £312 million). These related to non-clinical claims such as public and employers' liability for incidents on or after 1 April 1999, and non-clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies.

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.

An indemnity has been issued for the Essex Mental Health Enquiry covering the chair and all other members of the enquiry team for the entire duration of the inquiry's work.

The Department also provides an indemnity in respect of an inquiry and a contingent liability in regard to a case under the Equalities Act.

Care Quality Commission has a contingent liability for backdated VAT charges for £313k. It also has contingent liabilities of £916k relating to employment tribunals and legal advice.

NHS Property Services Ltd has unquantifiable contingent liabilities due to ongoing litigation relating to service charge claims. This litigation is still in preliminary stages and therefore the financial impact cannot be determined.

NHS Property Services Ltd also has unquantifiable contingent liabilities in relation to ongoing reviews of capital allowance claims made in corporation tax returns submitted in the years since its inception. No timeline for resolution has been agreed.

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, UK Health Security Agency, 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 NHS Blood and Transplant trading funds and the Medicines and Healthcare products Regulatory Agency 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 2021-22.

When assessing potential related parties for the purpose of their own underlying financial statement Group bodies are required to consider this from the perspective of both the reporting entity and the parent of the reporting entity (the Core Department). For this reason, on an annual basis, the Department circulates a list of relevant parent interests to Group bodies for their consideration should they have transactions with those interests.

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 2021-22 £'000	Purchases from related party 2021-22 £'000	Receivables with related party 2021-22 £'000	Sales to related party 2021-22 £'000	Payables with related party 2020-21 £'000	Purchases from related party 2020-21 £'000	Receivables with related party 2020-21 £'000	Sales to related party 2020-21 £'000
Sir Chris Wormald KCB	Permanent Secretary	Economic and Social Research Council[1]	1,006	3,777	-	-	-	3,194	-	-
Prof. Sir Mike Richards	Non Executive Board Member	Cancer Research UK[2]	-	-	-	-	-	461	-	166
Doug Gurr	Non Executive Board Member	UK BioBank	-	-	-	-	-	2,860	-	-
Doug Gurr	Non Executive Board Member	UK BioCentre (a subsidiary of UK BioBank)[3]	-	16,879	-	-	-	8,292	-	-

1. Chris Wormald is a member of Economic and Social Research Council.
2. Prof. Sir Mike Richards was a trustee at Cancer Research UK in 2020-21. Prof. Sir Mike Richards was not a departmental Non Executive Board Member in 2021-22. Therefore transactions in 2021-22 with Cancer Research UK have not been disclosed.
3. Doug Gurr, Non Executive Director at DHSC, is also a Director at UK BioBank on a non-remunerated basis. UK Biobank has 100% owned subsidary, UK BioCentre, with whom the Department had transactions totalling £16.9 million 2021-22.

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 who have not benefited from those transactions.

Apart from where disclosed in this note, no other Minister, Board member, member of the key management personnel or other related party has undertaken any material transactions with the Department during the year. Compensation paid to management, expense allowances and similar items paid in the normal course of business are disclosed in the notes to the accounts and in the Remuneration Report.

The Department is the parent of NHS Blood and Transplant Agency and the Medicines and Healthcare Products Regulatory Agency. These bodies are regarded as related parties with which the Department has had various material transactions during the year.

The NHS Shared Business Services Limited, an equity investment, is regarded as a related party of the Department with which the Department has had the following transactions (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
		2021-22 £'000	2021-22 £'000	2021-22 £'000	2021-22 £'000	2021-22 £'000	2021-22 £'000
NHS Shared Business Services Ltd.	DHSC Equity investment (50% shareholding)	7	4,438	-	-	-	514

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
		2020-21 £'000	2020-21 £'000	2020-21 £'000	2020-21 £'000	2020-21 £'000	2020-21 £'000
NHS Shared Business Services Ltd.	DHSC Equity investment (50% shareholding)	-	1,223	-	2,326	-	271

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 2022

	NHS Charities 2021-22 £'000	2020-21 £'000
Total resources expended	156,139	155,056
Total incoming resources	(162,055)	(174,031)
Net outgoing / (incoming) resources for the year ended 31 March 2022	**(5,916)**	**(18,975)**
Other Comprehensive Net Expenditure		
Net gain/loss on revaluation of charitable assets	(21,262)	(54,865)
Total Comprehensive Expenditure for the year ended 31 March 2022	**(27,178)**	**(73,840)**

19.2 Summary Charitable Statement of Financial Position as at 31 March 2022

	2021-22 £'000	2020-21 £'000
Non-current assets		
Charitable investments	379,324	361,533
Other charitable non-current assets	4,394	4,415
Total non-current assets	**383,718**	**365,948**
Current assets		
Charitable cash	258,141	256,020
Other charitable current assets	20,550	17,909
Total current assets	**278,691**	**273,929**
Total assets	**662,409**	**639,877**
Current charitable liabilities	(43,113)	(47,271)
Non-current assets plus/less net current assets/liabilities	**619,296**	**592,606**
Non-current charitable liabilities	(626)	(357)
Assets less liabilities	**618,670**	**592,249**
Total charitable reserves	**618,670**	**592,249**

19.3 Charitable Financial Assets - Investments

	2021-22 £'000	2020-21 £'000
Balance as at 1 April	**361,533**	**299,160**
Prior period adjustments in underlying accounts	(324)	(1,065)
Acquisitions	26,460	41,300
Disposals	(27,927)	(35,697)
Net gain/loss on revaluation	20,937	54,735
Transfers	-	-
Other movements	(1,355)	3,100
Balance as at 31 March	**379,324**	**361,533**

19.4 Other Charitable Non-Current Assets

	2021-22 £'000	2020-21 £'000
Balance as at 1 April	4,415	7,080
Prior period adjustments in underlying accounts	(377)	(1,943)
Acquisitions	319	-
Disposals	(196)	-
Net gain/loss on revaluation	325	130
Other movements	(92)	(852)
Balance as at 31 March	**4,394**	**4,415**

20. Events after the Reporting Period

On 1 April 2022 the Medicines and Healthcare Products Regulatory Agency was designated within the scope of the Departmental Group. This will be accounted for as an absorption transfer in 2022-23.

The Health and Care Act 2022 received Royal assent on 28 April 2022. Consequently, on 1 July 2022, the functions of Clinical Commissioning Groups (CCGs) transferred to 42 newly established Integrated Care Boards (ICBs). This transfer will be accounted for as an absorption transfer in 2022-23. This transfer will have no impact on the DHSC group account as the movement is wholly within the NHS England Group.

On 1 July 2022 NHS Improvement merged into NHS England. Commencement orders issued under the Health and Care Act 2022 abolished NHS Trust Development Authority and Monitor and transferred its functions to the expanded NHS England on 1 July 2022.

On 17 August 2022 the Government announced an interim compensation payment of £100,000 for victims of the infected blood scandal. The resultant expenditure of approximately £400 million will be included in the Department's ARA for 2022-23.

The Department applied discount rates as notified by HM treasury to estimated cash flows to calculate the Clinical Negligence provision as at 31 March 2022. In December 2022, HM Treasury published new discount rates to be applied to estimated cash flows to calculate general provisions as at 31 March 2023. If the revised rates had been applied to estimated cash flows at 31 March 2022, it is estimated that the Clinical Negligence provision would have reduced by an amount in the region of £63 billion. The change is a non-adjusting event as HM Treasury prescribe the rates to be applied at each year end.

These financial statements were authorised for issue by Sir Chris Wormald KCB on 26th January 2023

21. Entities within the Departmental boundary (subject to audit)

Ministers had some degree of responsibility for the following bodies during the year 2021-22.

(a) Consolidated in the Department's Annual Report and Accounts	Website
Supply Financed Agencies	
Public Health England[3]	https://www.gov.uk/government/organisations/public-health-england
UK Health Security Agency[3]	https://www.gov.uk/government/organisations/uk-health-security-agency
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	https://www.hcpc-uk.org
Wiltshire Health and Care LLP[2]	http://wiltshirehealthandcare.nhs.uk/
Community Health Partnerships Limited	https://www.communityhealthpartnerships.co.uk
The Nursing and Midwifery Council	http://www.nmc.org.uk/
NHS Property Services Limited	http://www.property.nhs.uk/
Genomics England Limited	http://www.genomicsengland.co.uk/
Professional Standards Authority for Health and Social Care (formerly included as an Executive Non-Departmental Public Body)	https://www.professionalstandards.org.uk/home
Supply Chain Coordination Limited	https://www.sccl.nhs.uk
Special Health Authorities	
NHS Business Services Authority	https://www.nhsbsa.nhs.uk
NHS Counter Fraud Authority	https://cfa.nhs.uk/
NHS Litigation Authority[4]	https://resolution.nhs.uk
National Health Service Trust Development Authority[5]	https://www.england.nhs.uk/
Executive Non-Departmental Public Bodies	
Human Fertilisation and Embryology Authority	https://www.hfea.gov.uk
Care Quality Commission	http://www.cqc.org.uk/
Monitor[5]	https://www.gov.uk/government/organisations/monitor
National Institute for Health and Care Excellence	https://www.nice.org.uk/
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]	https://digital.nhs.uk/
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, UK Health Security Agency or Public Health England accounts. 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
- The NHS Pay Review Body
- Review Body on Doctors' and Dentists' Remuneration
- Scientific Advisory Committee on Nutrition
- UK Nutrition & Health Claims Committee

(b) Non-Consolidated	Website
Trading Funds	
Medicines & Healthcare Products Regulatory Agency	https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agenc
Public Corporation	
NHS Blood and Transplant	http://www.nhsbt.nhs.uk/
DH 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. Public Health England ceased to operate on 1 October 2021, with functions transferring to the Department of Health & Social Care and the newly formed UK Health Security Agency.
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.

The Department of Health & Social Care's registered office is 39 Victoria Street, London, SW1H 0EU.

22. Analysis of UK Health and Security Agency (UKHSA) transactions and balances (subject to limitation of scope audit opinion)

The following tables provide an analysis of the transactions and balances relating to UKHSA (net of intra Group eliminations) included in the Core and Agencies column and the Departmental Group column of the Consolidated Statement of Comprehensive Net Expenditure on page 268 and the Core and Agencies column and the Departmental Group column of the Consolidated Statement of Financial Position on page 269, which are subject to the limitation of scope audit opinion as described in the Governance Statement on pages 173 to 175. These amounts will not agree to the local Annual Report and Accounts of UKHSA due to the impact of intra Group eliminations, which are required here to show the impact on the Departmental Group Account.

	UKHSA transactions included in the Core and Agencies column of the Statement of Comprehensive Net Expenditure 2021-22 £'000	UKHSA transactions included in the Departmental Group column of the Statement of Comprehensive Net Expenditure 2021-22 £'000
Income from contracts	(137,473)	(118,894)
Other non-contract operating income	(4,323)	(8,292)
Total operating income	**(141,796)**	**(127,186)**
Staff costs	416,355	416,215
Purchase of goods and services	7,766,877	7,609,057
Depreciation and impairment charges	477,769	477,769
Provision expense	72,749	72,749
Other operating expenditure	374,391	431,229
Total operating expenditure	**9,108,141**	**9,007,019**
Net operating expenditure for the year ended 31 March 2022	**8,966,345**	**8,879,833**
Finance income	(272)	(272)
Total Net Expenditure for the year ended 31 March 2022	**8,966,073**	**8,879,561**
Other Comprehensive Net Expenditure		
Items that will not be reclassified to net operating costs:		
Net (gain)/loss on:		
- revaluation of property, plant and equipment	(580)	(580)
Other (gains) and losses	27,000	27,000
Total Comprehensive Expenditure for the year ended 31 March 2022	**8,992,493**	**8,905,981**

	UKHSA balances included in the Core and Agencies column of the Statement of Financial Position 2021-22 £'000	UKHSA balances included in the Departmental Group column of the Statement of Financial Position 2021-22 £'000
Non-current assets		
Property plant and equipment	926,983	926,983
Investment Property	15,491	15,491
Intangible assets	37,741	37,741
Financial assets- Investments	18,350	18,350
Other non-current assets	18	18
Total non-current assets	**998,583**	**998,583**
Current assets		
Inventories	1,102,482	1,102,482
Trade and other receivables	255,688	244,953
Other current assets	69,688	69,688
Cash and cash equivalents	215,598	215,598
Total current assets	**1,643,456**	**1,632,721**
Total assets	**2,642,039**	**2,631,304**
Current liabilities		
Trade and other payables	(164,649)	(123,448)
Other liabilities	(1,984,313)	(1,509,743)
Provisions	(98,283)	(98,283)
Total current liabilities	**(2,247,245)**	**(1,731,474)**
Non-current assets less net current liabilities	**394,794**	**899,830**
Non-current liabilities		
Provisions	(16,682)	(16,682)
Total non-current liabilities	**(16,682)**	**(16,682)**
Total assets less liabilities	**378,112**	**883,148**

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

		2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Plan
Resource DEL								
A	NHS Commissioning Board	16,449,871	16,232,918	16,598,249	17,186,308	25,597,500	23,530,155	13,571,325
B	NHS Providers	68,492,416	70,750,505	75,607,340	81,526,454	93,119,985	99,870,372	97,285,300
C	DHSC Programme and Administration	1,579,373	1,747,178	1,107,488	856,606	26,540,107	12,687,729	3,554,882
D	Local Authorities (Public Health)	3,433,394	3,090,533	3,011,064	2,931,555	4,205,920	4,217,325	3,201,720
E	Public Health	877,056	822,586	1,026,301	923,546	1,480,833	10,339,864	4,149,485
F	Health Education England	2,153,292	2,056,903	1,819,177	1,444,495	1,448,640	1,642,502	1,941,809
G	Special Health Authorities	3,489,248	4,034,160	2,718,887	2,743,281	2,650,888	3,464,350	3,026,059
H	Non Departmental Public Bodies	530,669	576,362	624,829	628,293	723,579	867,424	494,561
I	Arm's Length Bodies [1]	-	-	838,583	2,981,221	2,849,887	1,847,161	987,800
J	NHS Commissioning Board financed from National Insurance contributions (non voted)	20,025,641	21,338,869	21,926,343	22,961,639	22,823,176	25,196,757	41,734,710
Total Resource DEL		**117,030,960**	**120,650,014**	**125,278,261**	**134,183,398**	**181,440,515**	**183,663,639**	**169,947,651**
	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.							
Total Resource DEL (adjusted for classification changes)		**117,030,960**	**120,650,014**	**125,278,261**	**134,183,398**	**181,440,515**	**183,663,639**	**169,947,651**

£'000

		2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2021-22 Plan
Capital DEL								
A	NHS Commissioning Board	227,416	227,820	221,233	265,530	330,577	291,416	219,000
B	NHS Providers	2,865,338	3,045,549	3,928,404	4,498,029	7,281,187	6,852,584	7,077,000
C	DHSC Programme and Administration	1,355,172	1,782,811	1,658,348	1,811,114	4,677,582	1,600,644	4,302,252
D	Local Authorities (Public Health)	9,325	15,456	-	0	0	0	0
E	Public Health	51,679	70,695	(70,475)	140,735	21,022	(207,112)	152,500
F	Health Education England	476	628	467	1,557	532	1,119	2,185
G	Special Health Authorities	14,726	16,738	(49,815)	24,172	47,320	30,339	45,924
H	Non Departmental Public Bodies	31,947	78,155	95,246	118,533	156,325	187,519	51,248
I	Arm's Length Bodies [1]	-	-	157,836	155,574	189,762	198,797	197,805
Total Capital DEL		**4,556,079**	**5,237,852**	**5,941,244**	**7,015,244**	**12,704,307**	**8,955,306**	**12,047,914**
	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.							
Total Capital DEL (adjusted for classification changes)		**4,556,079**	**5,237,852**	**5,941,244**	**7,015,244**	**12,704,307**	**8,955,306**	**12,047,914**

£'000

		2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2021-22 Plan
Resource AME								
K	NHS Commissioning Board	(307,784)	17,784	(19,733)	294,489	86,125	114,692	250,000
L	NHS Providers	1,025,251	662,491	1,134,119	1,070,401	1,978,051	820,766	2,000,000
M	DHSC Programme and Administration	223,184	491,136	(437,113)	785,506	1,997,564	2,690,292	310,000
N	Public Health	2,223	4,623	(2,181)	(2,033)	13,831	197,113	300,000
O	Health Education England	4,817	(17,647)	(44)	68	159	596	2,000
P	Special Health Authorities	8,557,599	11,990,518	6,405,024	675,203	(1,266,873)	43,298,724	7,881,000
Q	Non Departmental Public Bodies	2,628	3,406	6,373	3,536	23,207	23,731	36,000
R	Arm's Length Bodies [1]	-	-	(72,480)	20,839	49,696	30,199	101,000
Total Resource AME		**9,507,918**	**13,152,311**	**7,013,965**	**2,848,009**	**2,881,760**	**47,176,113**	**10,880,000**

								£'000
		2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Plan
Capital AME								
K	NHS Commissioning Board	0	0	0	0	0	0	0
L	NHS Providers	0	0	0	0	0	0	0
M	DHSC Programme and Administration	13,349	0	(4,801)	(5,563)	(7,355)	0	105,600
N	Public Health	0	0	0	0	0	0	0
O	Health Education England	0	0	0	0	0	0	0
P	Special Health Authorities	0	0	0	0	0	0	0
Q	Non Departmental Public Bodies	0	0	0	0	0	0	0
R	Arm's Length Bodies [1]	-	-	-	-	0	0	0
Total Capital AME		13,349	0	(4,801)	(5,563)	(7,355)	0	105,600

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
		2016-17 Outturn	2017-18 Outturn	2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Plan
Administration Budgets								
A	NHS Commissioning Board	1,497,776	1,560,979	1,508,274	1,545,410	1,488,859	1,473,688	1,778,100
B	NHS Providers	-	-	-	-	-	-	-
C	DHSC Programme and Administration	353,927	208,067	230,029	230,249	449,061	522,365	568,189
D	Local Authorities (Public Health)	-	-	-	-	-	-	-
E	Public Health	58,925	50,661	48,778	49,134	51,140	174,526	327,663
F	Health Education England	70,783	65,304	59,943	61,296	58,970	60,057	62,977
G	Special Health Authorities	153,922	159,191	178,184	180,884	192,996	159,653	185,866
H	Non Departmental Public Bodies	259,119	259,311	248,219	239,886	258,655	280,490	224,802
I	Arm's Length Bodies	-	-	(739)	(5,777)	(6,850)	(5,701)	1,100
Total Administration Budget		**2,394,452**	**2,303,513**	**2,272,688**	**2,301,082**	**2,492,831**	**2,665,078**	**3,148,697**

Supporting narrative for the core tables can be found within performance section and **Annex B.**

Annex B – Financial Performance Detail

1003. The Department for Health and Social Care Group has the largest Departmental Expenditure Limit (DEL) in Government. We consolidate the spending of around 400 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

1004. Spending for all Government Departments is measured against a set of metrics as agreed in HM Treasury's Spending Review. **Figure 37** provides a breakdown of the consolidated budgets for all bodies in the Department for Health and Social Care Group into the main spending metrics.

Figure 37: Department for Health and Social Care Group – Spending Metrics

Total Department Expenditure Limit (TDEL)	Total Annually Managed Expenditure (TAME)
£195.76bn	**£47.25bn**
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)
£186.90bn	**£10.45bn**	**£49.00bn**	**£0.02bn**
The control total for which current resource expenditure, net of income, must be contained. Of which COVID-19: £39.2 bn	The control for which capital expenditure, e.g. fixed assets additions and capital grants, net of capital disposals must be contained. Of which COVID-19: £1.2 bn	The 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.	The 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)
£3.06bn
Administration budgets cover the costs of all central government administration, excluding depreciation and the costs of direct frontline service provision.

Total Departmental Expenditure Limit

1005. The Department for Health and Social Care Group'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.

1006. TDEL spending continues to grow cumulatively since SR15 and was significantly impacted by COVID-19 spending in 2020-21 and 2021-22.

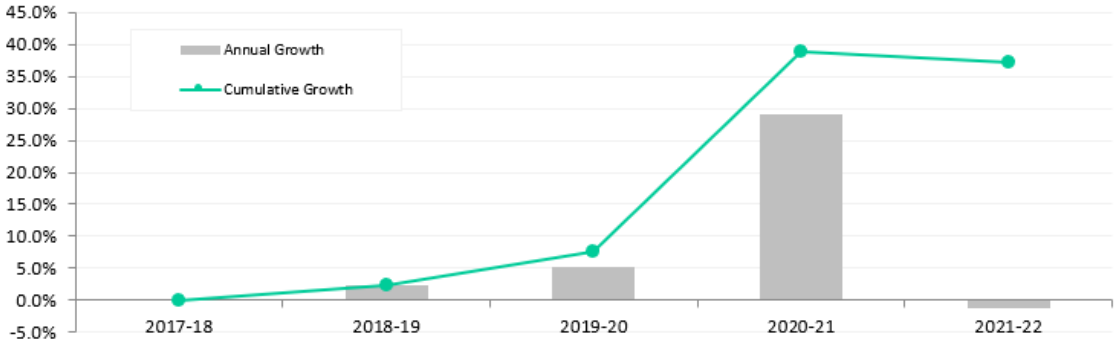
1007. **Table 48** details 2021-22 TDEL spending outturn and compares that to previous years.

Table 48: Total Departmental Expenditure Limit Spending

	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m
TDEL spending	**125,154**	**130,300**	**140,498**	**193,126**	**189,914**
Growth Nominal (£)	*4,570*	*5,146*	*10,198*	*52,627*	*(3,211)*
Growth Nominal (%)	*3.8%*	*4.1%*	*7.8%*	*37.5%*	*(1.7%)*

1008. As shown in **Figure 38**, in 2021-22, the Departmental real-terms spending was 1.2% lower than in 2020-21 and 37.2% greater than in 2017-18.

Figure 38: Real Terms Spending Growth



1. Cumulative growth figures are from 2017-18
2. GDP Deflators at 30th June 2022 used to calculate real terms growth

1009. 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: and
- the cumulative real term increases in 2020-21 and 2021-22 TDEL expenditure, compared to 2017-18, is a result of the Department for Health and Social Care Group's response to the coronavirus pandemic which increased TDEL expenditure by £46.2 billion in 2020-21 and by £36.9 billion in 2021-22.

1010. The Department for Health and Social Care Group contained its resources within all budgets authorised by Parliament as shown in **Table 49**.

Table 49: Parliamentary DEL and AME control totals

	Budget £m	Outturn £m	Under/ (Overspend) £m
Parliamentary Controls:			
Resource Departmental Expenditure Limit (RDEL)	186,895	183,548	3,347
of which: Resource Administration	*3,398*	*2,675*	*724*
Capital Departmental Expenditure Limit (CDEL)	10,447	9,119	1,328
Resource Annually Managed Expenditure (RAME)	49,000	47,971	1,029
Capital Annually Managed Expenditure (CAME)	15	0	15
Non-budget - Prior Period Adjustment	0	2,547	(2,547)
Net Cash Requirement	170,581	163,476	7,105
Further HM Treasury Controls:			
Ringfenced Resource DEL	1,580	2,753	(1,173)
Non-ringfenced Resource DEL	185,315	180,795	4,520

1011. 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.

Resource Departmental Expenditure Limit (RDEL)

1012. The Department for Health and Social Care Group's total 2021-22 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).

1013. The spending plans for all Government Departments are submitted to Parliament for scrutiny and approval as part of the Estimates process. The Department for Health and Social Care Group 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.

1014. In 2021-22, National Insurance Contributions receipts were in line with the funding set out in the Parliamentary Estimate.

1015. **Table 50** summarises the RDEL outturn against budget since 2017-18; highlighting the £3.3 billion underspend in 2021-22.

Table 50: Resource DEL

	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m
RDEL Budget	121,342	125,924	134,628	201,996	186,895
RDEL Spending Outturn	**120,650**	**125,278**	**134,183**	**181,441**	**183,548**
Underspends / (Overspends) (£m)	*692*	*646*	*444*	*20,556*	*3,347*
Underspends / (Overspends) (%)	*0.6%*	*0.5%*	*0.3%*	*10.2%*	*1.8%*

RDEL: Funding Flows and Sector Breakdown

1016. Of the Department for Health and Social Care Group's total £186.9 billion 2021-22 RDEL budget, £151.1 billion was allocated directly to NHS commissioners, with the remaining £35.8 billion funding allocated to ALBs and the Department's central budgets, i.e. the non-NHS sector.

1017. 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.

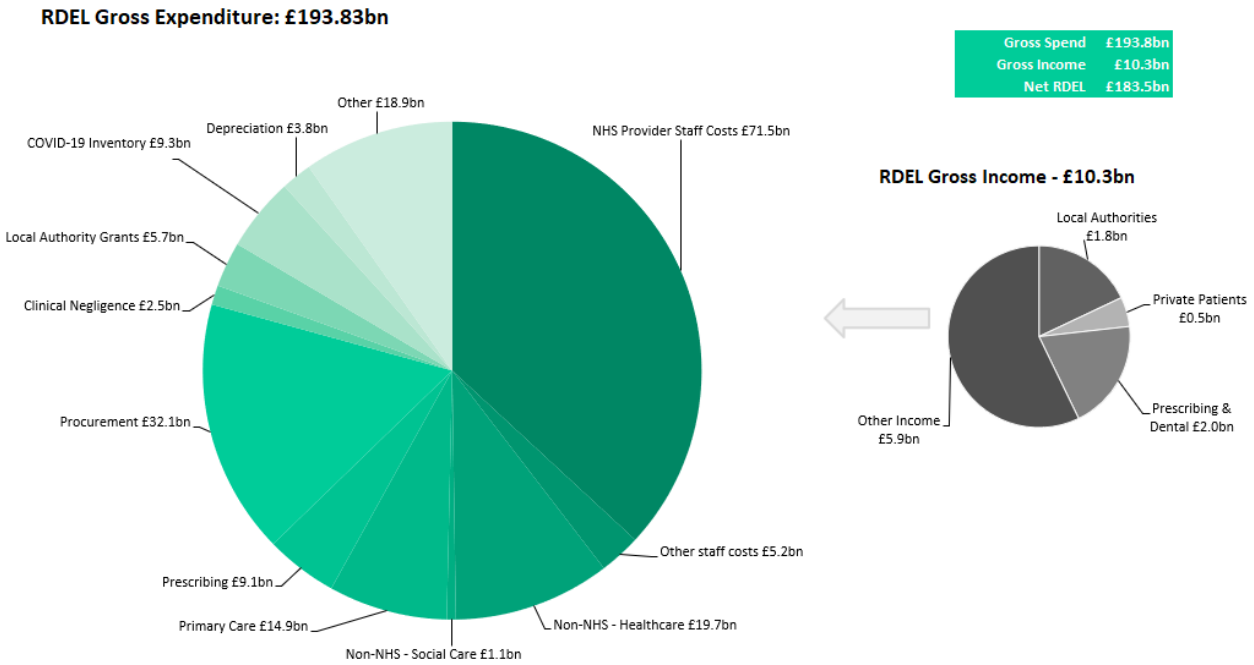
1018. Across Government, this 'Internal Market' is unique to the Department of Health and Social Care Group and adds an additional layer of complexity as all inter-group trading needs to be eliminated on consolidation when preparing the Departmental Group account (via an 'Agreement of Balances' exercise).

1019. Approximately £97.3 billion of resource expenditure in the Department for Health and Social Care Group is 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.

1020. The RDEL budget is set net of income and in 2021-22 the Department for Health and Social Care Group received around £10.4 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.

1021. A breakdown of RDEL expenditure can be found in **Figure 39**.

Figure 39: Resource DEL – spending breakdown (also see SOPS 1.1)



1. The figures in the illustrations above detail the gross RDEL expenditure and RDEL income for the Department for Health and Social Care Group. This differs from the presentation in the Statement of outturn against Parliamentary Supply (SOPS) note 1.1 as not all Department for Health and Social Care Group bodies are detailed on a gross expenditure and income basis.
2. COVID-19 inventory is detailed in the chart above as a 'type' of expenditure, however further detail is provided in the Performance Overview regarding the treatment of inventory in budgets.

NHS Bodies - Financial Performance Revenue DEL (RDEL) Spending

1022. The following section provides detail on the financial performance of the NHS in 2021-22. The NHS ended the financial year with an overall underspend of £1.2 billion, of which £0.6 billion related to COVID-19 ringfences.

1023. **Table 51** provides a summary of the spending position against the total agreed NHS budget of £150.6 billion.

Table 51: Financial Performance – NHS Commissioners & NHS Providers

	£m
Net Outturn against NHS Budget	
NHS England group	149,917
NHS providers net Sector Reported Position Surplus	(556)
Net Outturn	**149,360**
Of which Covid-19	*15,690*
NHS Budget	**150,614**
Under / (over) spend	***1,254***
Additional NHS provider technical RDEL adjustment	(39)
Net RDEL position as per SoPS	**149,322**

Financial Performance – NHS Commissioners

1024. The Financial Directions to the Government's revised NHS mandate for 2021-22 separately 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. NHS England must ensure that spending is contained within each of these funding limits. In addition, a further £16.3 billion was provided to fund the costs of COVID-19 of which £6 billion was separately ringfenced by HM Treasury. **Table 52** provides a breakdown of that spending.

Table 52: Financial Performance – NHS Commissioners

£m

	RDEL NRF (excluding depreciation & impairments)	RDEL RF (depreciation & impairments)	AME	Technical
NHS England budget	150,614	197	150	200
Total NHS England spending outturn	149,917	197	122	1
Net Variance against Resource Limits	***697***	***0***	***28***	***199***
Of which Covid-19				
Budget	*16,295*			
Outturn	*15,690*			
Variance [1]	*604*			

1. Variance relates to underspend on agreed COVID-19 ringfences of £16.3 billion as per the Financial Directions to the 2021-22 NHS Mandate.

1025. The vast majority of healthcare services are purchased from NHS providers (NHS Trusts and Foundation Trusts); however, £17 billion of these types of services were purchased from non-NHS healthcare providers in 2021-22. These non-NHS providers include Local Authorities, voluntary sector/not for profit organisations, Devolved Administrations and private sector providers. **Table 53** provides a breakdown of this spending and compares to 2020-21.

Table 53: NHS England's Purchase of healthcare from non-NHS Providers

	2020-21 £m	2021-22 £m
Independent Sector Providers *(Note 1)*	12,139	10,854
Voluntary sector/Not for profit	1,866	1,791
Local authorities	4,312	4,318
Devolved Administrations	36	48
Other Group Bodies	31	35
Total NHSE spend on all non-NHS bodies	18,384	17,046
Total RDEL	180,199	183,774
Spend with private sector as a % of total RDEL	7%	6%
Spend on all non-NHS bodies as a % of total RDEL	10%	9%

1. In 2020-21 the total for Independent Sector Providers included £31m of expenditure with other group bodies. From 2021-22 onwards this expenditure will be presented in a separate row in the table. The figure in the table above for 2020-21 has been adjusted accordingly.
2. The numbers above have been collected separately from audited accounts data and may include estimates.
3. Totals in the table may not sum due to roundings.

1026. Further commentary, together with the consolidated accounts of the NHS England group, is published on NHS England's website.

NHS Financial Performance – NHS Providers

1027. At the 2021-22 financial year-end, there were 215 provider organisations producing accounts during the year. Together these providers ended 2021-22 with a net financial surplus of circa £0.6 billion. **Table 54** details the reported net position, plus Resource DEL scoring adjustments relating to the categorisation of provisions, PFI, donated assets and prior period adjustments.

Table 54: NHS Providers RDEL Breakdown

£m

	2017-18	2018-19	2019-20	2020-21	2021-22
NHS providers' RDEL Outturn as per SoPS11	**1,038**	**826**	**1,008**	**(732)**	**(595)**
Provisions Adjustment	(39)	23	50	418	320
Other Adjustments2	(8)	(22)	(159)	(341)	(281)
Aggregate Net Deficit (impact on RDEL)	**991**	**827**	**899**	**(655)**	**(556)**
Unallocated sustainability funding	(25)	0	(144)	0	0
Adj for Covid-19 impact on providers' deficit	0	0	(85)	0	0
Reported Net Deficit / (Surplus) (impact on RDEL)	***966***	***827***	***669***	***(655)***	***(556)***

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. All expenditure incurred by providers relating to COVID-19 was fully funded from NHS England central budgets.

1028. Throughout 2021-22, NHS providers have been supported with funding cover to support their operational response to the COVID-19 pandemic. This has resulted in a healthy year-end surplus position across the sector.

1029. The majority of providers, 191 (89%) continue to report a year-end position that is in surplus or in financial balance.

1030. **Table 55** provides a breakdown of the reported deficit and position against control totals.

Table 55: Summary of NHS Provider's surplus / (deficit)

£m

	2017-18	2018-19	2019-20	2020-21	2021-22
Gross Deficit	(2,433)	(2,755)	(1,560)	(158)	(126)
Gross Surplus	1,337	1,889	567	363	442
Adjustments [1]	105	39	323	450	240
Net (Deficit) / Surplus	***(991)***	***(827)***	***(670)***	***655***	***556***
Number of trusts in deficit	101	107	53	42	24
Number of trusts in surplus / balance	133	123	173	177	191

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.

NHS Total Departmental Expenditure Limit

1031. The majority of the Department of Health and Social Care Group's budget is allocated to fund the NHS. **Table 56** provides an explanation of the adjustments made to the NHS budget since the 2015 Spending Review (SR).

Table 56: 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	2024-25 £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**	**151,629**
Adjustment for NHS Pensions [5]					0	2,851	2,851	2,851	2,851	2,851	2,851
NHS Mandate Adjustments [6]					(182)	(281)	(373)	(1,815)	765		
Additional Covid-19 funding [7]							19,988	16,295			
SR21 Funding									8,989	6,085	8,161
NHS RDEL Budget at per NHSE Mandate					**114,421**	**123,377**	**149,473**	**150,614**	**152,595**	**157,403**	**162,641**
4. Latest reported outturn (exc Depreciation)	Actual								Plan		
NHS RDEL Budget	**97,098**	**100,572**	**105,702**	**109,536**	**114,421**	***123,377***	***149,473***	***150,614***	***152,595***	***157,403***	***162,641***
Plus NHS provider sector net RDEL outturn			935	1,038	826	1,009	(732)	(595)			
Plus Net commissioner and NHSE underspend			(902)	(970)	(916)	(636)	(5,374)	(697)			
Net NHS RDEL Outturn [3]	**97,098**	**100,572**	**105,735**	**109,605**	**114,331**	***123,750***	***143,367***	***149,322***	***152,595***	***157,403***	***162,641***
NHSE CDEL	189	182	240	228	221	266	331	291	223	219	219
NHS TDEL	**97,287**	**100,754**	**105,975**	**109,833**	**114,552**	**124,016**	**143,698**	**149,613**	**152,818**	**157,622**	**162,860**

Notes to table:

1. Paragraph 11.6 of the Spending Review and Autumn Statement 2015 publication – https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015
2. Paragraph 7.2 of the Autumn Budget 2017 publication: https://www.gov.uk/government/publications/autumn-budget-2017-documents/autumn-budget-2017
3. In order to be comparable with SR15 (i.e. 2016-17 to 2020-21), NHS RDEL NRF outturns for 2013-14 to 2015-16 have been adjusted to apply a transfer of function from NHSE to Local Authorities for 0-5 years commissioning that occurred halfway through 2015-16, across all years; and net NHS overspends have been removed as these did not form part of the SR baseline.
4. Mandate adjustments are as published in the annual Financial Directions to NHS England.

5. NHS Long Term Settlement and pensions funding details are set out in the 2019-20 Financial Directions to NHS England - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803055/financial-directions-to-nhs-england-2019-to-2020.pdf
6. Details of 2018-19 changes are set out in the 2018-19, 2019-20 and 2020-21 Financial Directions to NHS.
7. COVID-19 funding of £20.0 billion was added to NHSE's financial directions in 2020-21 and £16.3billion in 2021-22.

Non-NHS Bodies - Financial Performance Resource DEL Spending

1032. Outside of the NHS sector, the Department for Health and Social Care Group's non-NHS sector contained resource expenditure within DEL spending limits. The non-NHS's activities, particularly the core department's, changed significantly during 2020-21 and 2021-22 in response to the Coronavirus Pandemic.

19%
Of DHSC RDEL expenditure

1033. The summarised RDEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 57**.

Table 57: Summarised Financial Position for the Non-NHS in 2021-22

	Plan £m	Outturn £m	Under/ (Overspend) £m
RDEL Non Ring-fenced Spending -			
Public Health England / UK Health Security Agency	841	770	71
Public Health Local Authority Grants	3,108	3,108	0
Health Education England	4,791	4,680	111
NHS Resolution	214	(24)	238
NHS Property Services	(64)	(86)	22
NHS Digital	430	417	13
Other ALBs	542	433	109
European Economic Area (EEA) medical costs	720	761	(41)
Pharmaceutical Price Regulation Scheme (PPRS)	(710)	(732)	22
Other DHSC Central Budgets	2,565	2,008	557
Public dividend capital (PDC) payments and loan interest	(913)	(967)	54
NHS Charities	0	(6)	6
Non-NHS Business as usual	**11,524**	**10,362**	**1,162**
NHS Provider technical budget	**290**	**(39)**	**329**
DHSC COVID-19:			
Personal Protective Equipment	2,360	1,918	442
Test & Trace	15,641	14,773	868
Medicines	517	362	155
Vaccine deployment	334	230	104
Vaccines Taskforce	2,294	2,309	(15)
Ventilators & related products	150	32	118
Managed Quarantine Service	341	268	72
Covid grants	1,131	1,110	21
Other COVID-19	120	111	9
DHSC - COVID-19	**22,887**	**21,112**	**1,775**
Total Non-NHS Non Ring-fence	**34,701**	**31,435**	**3,266**
Business as usual	1,383	650	733
COVID-19 treatments	0	895	(895)
Test & Trace	0	114	(114)
Personal Protective Equipment	0	6	(6)
COVID-19 Vaccines		631	(631)
Ventilators & related products	0	260	(260)
Total Non-NHS Ring-fence	**1,383**	**2,556**	**(1,173)**
Total RDEL	**36,084**	**33,991**	**2,093**

1034. The non-NHS sector's outturn was around £2.1 billion lower than the allocated funding, and comprises:
- £1.8 billion relates to Non-NHS COVID-19 savings, explanations on Department for Health and Social Care Group COVID-19 savings are detailed in the Performance Summary;
- £1.2 billion relates to an overspend on the budget ring-fenced for depreciation and impairments, which is due to higher than forecast impairments on COVID-19 inventory (Test and Trace, vaccines and COVID-19 treatments) – details of these are discussed in the **Performance Summary.** HMT budgeting convention permits non ring-fenced RDEL underspends to be used to offset the overspend;
- £0.3 billion relates to funding retained centrally to the cover NHS Provider technical outturn.
- The remaining £1.2 billion relates to business as usual activities as follows:
- NHS Resolution's outturn was £0.2 billion lower than planned primarily driven by a lower than anticipated clinical negligence scheme settlements due to slow down of court activity due to the pandemic;
- Health Education England's outturn was £0.1 billion lower than planned because of the disruption of the pandemic which resulted in decreased placement activity; and
- Other budgets were around £0.6 billion lower than planned, of which around £0.2 billion related to lower than planned workforce expenditure including slippage in recruitment timelines and £0.2 billion underspend due to technical recognition point of expenditure.

RDEL Administration

1035. 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 the Department's central Government Arm's Length Bodies (ALBs).

1036. In 2021-22, Department for Health and Social Care Group underspent by £0.7 billion against the total Resource Administration limit of £3.24 billion. This underspend mainly comprised:
- c£0.2 billion underspend on depreciation and impairments; and
- c£0.5 billion underspend RDEL NRF, of which £0.2 billion was in NHSE and the balance mainly on COVID-19 administration.

1037. **Table 58** shows the Department for Health and Social Care Group administration outturn (excluding depreciation and impairments) between 2017-18 and 2021-22. Spending on administration increased in 2021-22 by c£170 million compared to 2020-21, this is mainly explained by increases in COVID-19, i.e. in NHS Test and Trace, Managed Quarantine Service and vaccine supply and deployment.

Table 58: Department for Health and Social Care Group Administration

	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m
Administration Outturn	2,222	2,189	2,212	2,405	2,575

1. Figures do not include depreciation and as a result will not directly reconcile to the admin outturn in the Statement of Outturn against Parliamentary Supply £2.7bn.

Capital Departmental Expenditure Limit (CDEL)

£9.1bn CDEL spend

1038. The Department for Health and Social Care Group's total 2021-22 CDEL outturn is the consolidated net capital spending of all bodies within the departmental group.

1039. **Table 59** summarises the CDEL outturn against budget since 2017-18; highlighting the £1.3 billion (12.7%) underspend in 2021-22.

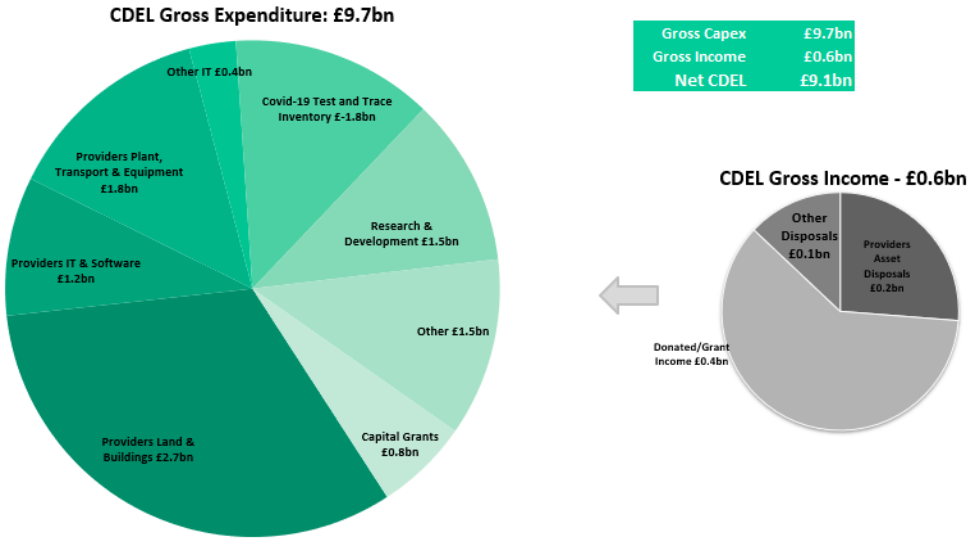
Table 59: Capital DEL Outturn[1]

	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m
CDEL Budget	5,598	5,983	7,125	12,918	10,447
CDEL Spending Outturn, of which:	**5,238**	**5,941**	**7,015**	**12,704**	**9,119**
COVID-19				*3,621*	*111*
Business as usual				*9,084*	*9,008*
CDEL Underspend	*360*	*42*	*110*	*214*	*1,328*
CDEL Underspend %	*6.4%*	*0.7%*	*1.5%*	*1.7%*	*12.7%*

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

1040. **Figure 40** provides a breakdown of 2021-22 capital spend (CDEL) by expenditure type.

Figure 40: Capital DEL - spending breakdown (also see SOPS 1.2)



NHS Bodies - Financial Performance Capital DEL (CDEL) Spending

1041. The summarised DEL outturn compared to plan for key elements of the NHS sector are shown in **Table 60**.

Table 60: NHS Capital DEL Spending Breakdown by Activity

	Budget £m	Outturn £m	Under/(over) £m
NHS England business as usual activities	337	291	46
NHS Providers business as usual activities	6,175	6,130	45
NHS COVID-19 (Elective Recovery)	580	602	(22)
NHS Test and Trace (LIMS)	122	102	20
TOTAL NHS CDEL, of which:	**7,213**	**7,126**	**88**
NHS Providers		*6,834*	
NHSE		*291*	

NHS Providers Capital Expenditure:

1042. **Table 61** provides a breakdown of NHS Provider capital expenditure.

Table 61: NHS Provider Capital DEL Spending Breakdown by Activity

	2020-21 £m	2021-22 £m
Capital DEL Outturn [1]	**7,131**	**6,834**
Of which		
Operational Capital Expenditure [2]	3,867	4,089
National Programmes	2,479	1,856
COVID-19 (2021-22 Elective Recovery & LIMS)[3]	614	704
PFI Residual Interest [4]	171	186

1. NHS CDEL in the table above does not include the net capital investment of NHS Charities
2. Operational Capital Expenditure is self-financed spending by Trusts, loans, and emergency capital
3. LIMS is Laboratory Information Management System
4. HMT's budgeting framework requires PFI residual interest on assets, to score to CDEL.

1043. The NHS Provider Capital DEL (CDEL) expenditure was £6.8 billion in 2021-22 (exclusive of net capital investment of NHS Charities). This is a 4% decrease on the equivalent net investment in 2020-21 (£7.1 billion), shown in **Table 52**. Whilst there have been increases in expenditure against New Hospital/Upgrades programmes and Diagnostics in 2021-22, other programmes such as Critical Infrastructure Risk and the A&E fund were only for 2020-21 resulting in a net reduction.

1044. Funding for national programmes, such as Health Infrastructure Plan (HIP) and Sustainability and Transformation Partnerships (STP) infrastructure, is provided as direct funding issued by the Department in the form of Public Dividend Capital (PDC) to cover Trusts' expenditure. 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 this Annual Report.

Operational Capital

1045. Operational capital covers the day to day capital needs of the NHS, including renewal and replacement of plant, IT, equipment, minor building works and investment to deliver core clinical strategies. Operational capital includes emergency capital issued to NHS Providers, and self-financed CDEL expenditure, i.e. where NHS Providers use the income they receive for depreciation, their own cash reserves, and loans. The majority of operational capital budgets are allocated at system level to the Integrated Care Systems (ICS) to improve the coordinated planning, allocation and delivery of investment, and the join up of services.

1046. NHS Providers are required to set their operational budgets within those envelopes and reflect system-wide priorities. In-year emergency applications and re-prioritisation or rephasing of capital spend are made at a local level through ICS/Provider discussions.

COVID-19

1047. NHS Providers received national capital funding for elective recovery (£602m) and Laboratory Information Management System (£102m) (covered separately in **Table 53**). These funding streams were established to meet the demands of COVID-19 and predominantly included activities to stabilise the NHS such as protected elective in-patient beds, help to scale digital solutions making a real difference to waiting list reduction and allowed free flow of diagnostics data to better manage capacity and demand.

National Programmes

1048. **Table 62** provides details of National Programmes, the detail of which is described in the following paragraphs.

Table 62: NHS Provider National Programmes

	2021-22 £m
New Hospital Programme/Upgrades	1,070
Elective Recovery	602
NHS Technology Schemes	306
Diagnostics	273
Eradicating Mental Health Dormitories	142
Laboratory Information Management System (LIMS)	102
Mental Health Crisis Schemes	30
Other schemes	35
NHS Providers National PDC Total	**2,560**

1049. **New Hospital Programme:** The Government committed to deliver 48 hospitals by 2030, backed by an initial £3.7 billion for the first 4 years of the 10-year programme starting in 2021-22. The majority of the investment in 2021-22 has been spent on build costs on Cohort 1 inflight schemes (those already in construction), the largest of which are Liverpool Phase 1, Brighton 3T's Phase 1 & Midland Metropolitan.

1050. **Hospital Upgrades:** As part of Spending Review 2020 settlement we secured £1.7 billion multi-year funding until 2024-25 for over 70 hospital upgrades to improve health infrastructure across the country over the long term. In 2021-22, 25 schemes were completed, and 29 schemes commenced construction. As at 31 March 2022, 41 schemes were in construction.

1051. **Elective Care Recovery fund** was announced to support investments that would have a material impact on elective activity or demand management, either in 2021-22 or in future years. In 2021-22, the programmes investment of £602m focused on resilience in elective services, enabling delivery of additional elective activity and support in restoring activity to pre-pandemic levels. The funding's benefit includes creating additional protected elective In-patient beds, day case and outpatient procedures, outpatient clinics, additional theatre lists, increased numbers of critical care beds as well as digitally supported virtual wards and additional diagnostic activity in all regions.

1052. **NHS Technology Schemes:** Successful digital transformation in the NHS delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. In 2021-22 the £306 million expenditure improvement in infrastructure for managing and sharing digital patient records between health care providers across the country transformed remote monitoring of patients, raised digital maturity by moving away from a policy of helping the best get better and switched funding efforts to support those who needed extra help to level up across the country.

1053. **Diagnostics:** To enhance NHS diagnostic capability, the Government has committed funding that covers procuring equipment such as CT scanners, MRI machines and digital mammography units. A significant proportion of the diagnostic funding (£146 million) was to support setting up Community Diagnostic Centres (CDCs). CDCs are one-stop-shops that deliver additional diagnostic capacity in England and provide patients with a coordinated set of diagnostic tests in the community, enabling an accurate and fast diagnosis on a range of a clinical pathways. By the end of 2021-22 84 CDCs have been established.

1054. **Improving Mental Health Services** has been a priority of the Government's capital investment strategy. To improve mental health facilities, the Government has committed more than £400 million over 4 years (starting in 2020-21) to eradicate dormitory accommodation across the country. This will improve the safety, privacy and dignity of patients suffering with mental illness. As of 31 March 2022,

22 schemes had been completed and 16 were under construction, with over £220 million invested. In addition, £30 million targeted investment was committed to ensure that service critical and urgent infrastructure projects can be delivered at pace to improve mental health provision.

Non-NHS Bodies - Financial Performance Capital DEL Spending

1055. Outside of the NHS sector, the Department's non-NHS sector contained capital expenditure within DEL spending limits.

1056. The non-NHS's activities, particularly the core department's, changed during 2020-21 and 2021-22 in response to the Coronavirus Pandemic.

1057. Detail regarding the Department for Health and Social Care Group's utilisation of CDEL in its pandemic response is given in the **Performance Summary.**

1058. The non-NHS sector's outturn was around £1.2 billion lower than the allocated funding, of which £1.1 billion relates to COVID-19. The non-NHS sector's business as usual capital outturn was around £130 million lower than planned.

1059. The summarised DEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 63**.

Table 63: Summarised Financial Position for 2021-22 Non-NHS

	Plan £m	Outturn £m	Under/ (Overspend) £m
CDEL			
NHS Digital	97	97	(1)
NHS Property Services	110	107	3
Genomics England Ltd	77	75	2
NHS Business Services Authority	43	24	19
Other ALBs	238	202	35
Research & Development	1,296	1,290	7
Disabled Facilities Grant	573	573	0
NHSX	116	98	18
NHS Charities	0	(1)	1
Other DHSC Central Budgets	164	121	44
DHSC - business as usual	**2,714**	**2,586**	**128**
DHSC Covid-19:			
Personal Protective Equipment	5	8	(3)
Test & Trace	(361)	(1,601)	1,240
Medicines	6	3	3
Vaccine deployment	12	3	9
Vaccines Taskforce	858	994	(136)
DHSC - Covid-19	**520**	**(593)**	**1,113**
Total Non-NHS CDEL	**3,234**	**1,993**	**1,241**

Annually Managed Expenditure (AME)

£48.0bn
AME spend

1060. Details of the Department for Health and Social Care Group's total 2021-22 AME budget and expenditure are set out in **Table 64**, which shows the group underspent by £1.0 billion (2.1%) against its final Resource AME budget.

Table 64: Annually Managed Expenditure plans, outturns and under/ (over) spends

	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m
Resource AME Budget	27,940	12,926	11,420	10,002	49,000
RAME Outturn	**13,152**	**7,014**	**2,848**	**2,882**	**47,971**
Underspend/(Overspend) £m	*14,788*	*5,912*	*8,572*	*7,120*	*1,029*
Underspend/(Overspend) %	*52.9%*	*45.7%*	*75.1%*	*71.2%*	*2.1%*
Capital AME Budget	15	15	15	15	15
Capital AME Outturn	**0**	**(5)**	**(6)**	**(7)**	**0**
Underspend/(Overspend) £m	*15*	*20*	*21*	*22*	*15*
Underspend/(Overspend) %	*100.0%*	*132.0%*	*137.1%*	*149.0%*	*100.0%*

1061. The Department for Health and Social Care Group'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 for Health and Social Care Group's AME spending is not typical to most Government Department's AME spending, which normally will impact on the fiscal framework in the same way as DEL spending.

1062. Additionally, the Department for Health and Social Care Group'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.

1063. The final AME budget in 2021-22 was set at £49 billion and included a £39 billion increase in the 2021-22 Supplementary Supply Estimate mainly for the change in the discount rate discount rates, prescribed by HM Treasury, used to measure the value of long-term provisions liabilities, the largest impact being on clinical negligence scheme provisions. The discount rate change does not reflect an increase in the incidence of harm or an increase in the cash required to settle claims.

1064. The main elements of Department for Health and Social Care Group's AME outturn relate to:

- clinical negligence expenditure in NHS Resolution (NHSR) of £43.3 billion. Expenditure was around £2.6 billion lower than had been anticipated when setting the budget due to favourable reductions, including assumptions around

inflationary costs and the estimated quantum of future clinical negligence expenditure was lower than had been forecast; and

- onerous contract provisions of c£3.5 billion for COVID-19 vaccines (£1.7 billion) and COVID-19 treatments (£1.8 billion). More details are included in the **Performance Summary** and Note 16.

Financial Information by Arm's-length body (ALB)

1065. As of the 2020-21 reporting cycle, HM Treasury require the presentation of ALB income and expenditure figures alongside detail pertaining to staff costs and numbers to aide users of the accounts of Government Departments.

1066. Each ALB consolidated into the Department's Group ARA, produces its own set of ARA which provide information on income, expenditure, staff numbers and staff costs as required by HM treasury. Equally, the Department consolidates the ALB information to produce its Group ARA. **Table 65** provides the necessary information. Notes to the table aide the users' interpretation of the figures presented.

1067. The websites for each of our ALBs (excluding individual NHS provider and Commissioners) can be found in **Annex F**.

Table 65: Financial information by ALB

				2021-22			
				Permanently employed staff		Other Staff	
	Total Operating Income	Total Operating Expenditure	Net Expenditure for the year (including financing)	Number of employees	Staff costs	Number of employees	Staff costs
	£'000	£'000	£'000	Number	£'000	Number	£'000
DHSC Core	(2,537,970)	191,417,112	188,503,405	3,275	257,693	2,785	446,309
Public Health England	(1,259,189)	3,154,494	3,471,785	3,265	209,004	123	13,793
UK Health Security Agency	(1,570,602)	9,108,141	6,492,468	1,782	195,523	1,513	224,106
NHS England Group	(3,243,417)	153,619,886	150,236,629	27,339	1,936,518	10,048	612,778
National Health Service Trust Development Authority	(11,216)	236,172	224,956	1,490	134,181	108	7,462
NHS Providers	(112,606,542)	112,768,785	167,361	1,210,916	65,221,483	134,108	6,612,754
Monitor	(3,722)	30,140	26,418	96	13,224	2	85
Care Quality Commission	(210,821)	233,878	23,057	2,944	164,321	137	11,545
National Institute for Health and Care Excellence	(20,972)	75,149	54,177	717	46,640	6	850
NHS Digital	(44,864)	747,786	701,812	2,662	181,585	841	97,895
Human Fertilisation and Embryology Authority	(5,694)	6,759	1,065	68	4,249	4	559
Human Tissue Authority	(4,263)	4,894	631	46	3,106	4	394
Health Research Authority	(386)	19,676	19,290	254	12,978	7	1,061
Health Education England	(100,991)	4,893,686	4,792,695	2,488	160,922	293	53,622
NHS Counter Fraud Authority	(465)	14,724	14,259	156	9,143	5	480
NHS Business Services Authority	(698,386)	849,782	151,396	3,228	121,800	83	5,793
NHS Resolution	(2,525,620)	45,810,432	43,284,812	472	31,791	28	2,313
NHS Property Services Ltd	(753,701)	846,048	87,207	5,560	155,198	264	1,602
Community Health Partnerships Ltd	(431,470)	428,211	(3,259)	224	12,779	-	-
Supply Chain Coordination Ltd	(1,313,548)	1,305,119	135,871	426	13,204	86	5,151
Genomics England Ltd	(24,267)	100,423	76,156	368	24,846	29	5,494
Skipton Fund Ltd	-	149	149	-	-	-	-
Nursing & Midwifery Council	(100,398)	91,907	(8,491)	1,007	47,791	69	2,548
Health & Care Professions Council	(31,679)	32,660	981	227	10,135	26	2,928
Wiltshire Health and Care LLP	(66,206)	66,037	(169)	1,035	44,374	22	3,518
Professional Standards Authority for Health and Social Care	(5,239)	4,952	(287)	43	3,447	-	22

1. Net expenditure for the year is net operating expenditure after financing, and therefore comprises total operating income, less total operating expenditure, plus finance income less finance expenditure.

2. The requirement to report disaggregated information does not apply to public corporations that are not trading funds, NHS Trusts, NHS Foundation Trusts and Clinical Commissioning Groups (CCGs). For completeness, however, the above table includes NHS providers and CCGs.
3. The amounts above do not include any central adjustments the Department has made, the results of NHS Charities (as these are disclosed separately within the Annual Report and Accounts in Note 19) or intragroup eliminations.

Annex C – NHS Operational Performance

NHS Operational Performance against waiting time standards

1068. The COVID-19 pandemic added additional and unprecedented pressure on the NHS, and stopping non-urgent elective care was essential to prevent the NHS becoming overwhelmed and release capacity to treat COVID-19 patients.

1069. On 31 July 2020, guidance was issued to local NHS providers and commissioners to focus was on accelerating the return of non-COVID-19 health services, fully restoring cancer services, and making full use of available capacity between publication of the guidance and winter, whilst preparing for winter demand pressures. The guidance advised that clinically urgent patients would continue to be treated first, with priority then given to the longest waiting patients.

1070. On 25 March 2021, NHS England and NHS Improvement (NHSE and NHSI) published operational planning guidance for 2021-22 which set the priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.

1071. Integrated Care Systems (ICSs) and their constituent organisations were asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialized services) for April 2021 to September 2021.

1072. Published on 30 September 2021, the updated priorities and planning guidance set out its ambition to maximise elective activity and eliminate waits of over 104 weeks, taking full advantage of opportunities to transform the delivery of services.

1073. On 13 December 2021, NHSE and NHSI issued a letter of guidance to the NHS on the potential impact of Omicron and other winter pressures, directing systems to work in partnership, and to prepare elective contingency plans against different COVID-19 scenarios.

1074. ICSs were asked to continue to deliver elective care and ensure that the highest clinical priority patients including patients on cancer pathways and those with the longest waits continue to be prioritised.

1075. Pressures on beds, staff, and equipment, combined with enhanced infection prevention and control measures necessary to keep people safe, significantly disrupted non-urgent care. This led to the waiting list to grow to a record high of 6.1 million people in January 2022, from 4.4 million people before the pandemic.

1076. On 8 February 2022, NHS England and NHS Improvement published the Delivery Plan for Tackling the COVID-19 Backlog of Elective Care. This plan sets out a clear

vision for how the NHS will recover and expand elective services over the next three years. The Department will continue to work closely with NHS England to deliver this Plan, providing the necessary support and challenge to make sure it benefits patients and delivers value for money.

1077. The Plan commits the NHS to deliver 9 million additional treatments and diagnostic procedures over the next three years and around 30 per cent more elective activity than it was doing before the pandemic by 2024-25.

1078. Announced at the Autumn Budget and Spending Review 2021, the Government plans to spend more than £8 billion from 2022-23 to 2024-25 to support elective recovery, in addition to the £2 billion Elective Recovery Fund and £700 million Targeted Investment Fund already made available to systems in 2021-2022 to help drive up and protect elective activity.

1079. The Government has also committed to a £5.9 billion capital investment for new beds, equipment, and technology. This includes £1.5 billion towards new surgical hubs, increased bed capacity and equipment to help elective services recover, including surgeries and other medical procedures, £2.1 billion to modernise digital technology on the frontline, improve cyber security and the NHS's use of data and redesign care pathways, and £2.3 billion to help increase the volume of diagnostic activity and reduce patient waiting times with ambitions to roll out up to 100 more community diagnostic centres over the next three years to help clear backlogs of people waiting for tests, such as MRI, ultrasound and CT scans.

1080. A new Joint Delivery Unit, bringing together NHS England and NHS Improvement and the Department, will report to the Secretary of State for Health and Social Care and NHS Chief Executive Officer to oversee implementation of this plan.

A&E Waiting Times

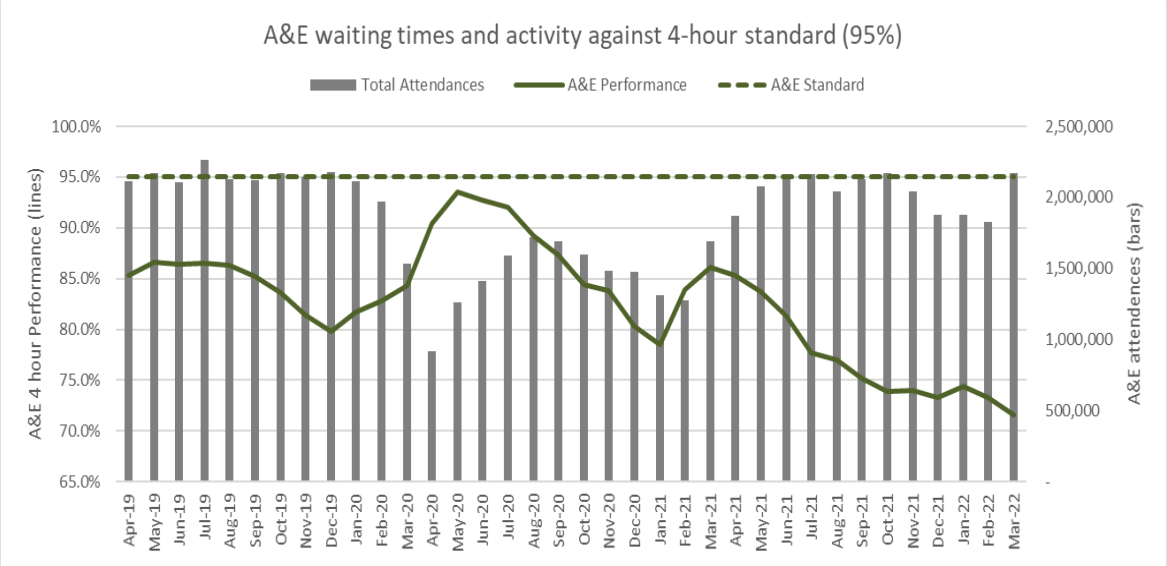
1081. National performance for A&E waiting times in 2021-22 was disrupted during the pandemic, at 76.7% against the standard that 95.0% of patients should be admitted, transferred, or discharged within four hours of arrival in an A&E department.

1082. The average performance was lower than 2019-20 and 2020-21, which was 84.2% and 86.8% respectively. The standard has not been met since July 2015.

1083. The decline in performance as shown in **Figure 41** should be seen in the context of an increase in demand for non-elective services and attendances returning to nearly pre-pandemic levels. A&E attendances in 2021-22 were 2.5% lower than in 2019-20, decreasing to 24.4 million from 25 million in 2019-20. Over the same period, the total number of emergency admissions from A&E decreased by 4.5% from 6.4 million in 2019-20 to 6.1 million in 2020-21.

1084. 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 41: A&E waiting times and activity against the 4-Hour standard (95% threshold) April 2019 – March 2022



Standard - 95% patients admitted, transferred, or discharged within 4 hours of arrival
Source: *A&E Attendances and Emergency Admissions*

Ambulance Response Times

1085. **Figure 42** shows data against ambulance response time categories 1a and 1b for the 11 ambulance trusts. In July 2021, £55 million was invested in ambulance services for Winter 2021-22 to increase call handling and operational response capacity. In March 2022, none of the six national response time standards were met and ambulance services received 30,996 daily 999 calls. The year started in April 2021 with 402,582 incidents where a patient was transported to an emergency department. Alternatives to A&E have been used to avoid taking patients to hospitals facing increased pressures due to the COVID-19 pandemic. By March 2022 the number of incidents where a patient was transported to an emergency department had further reduced to 361,268.

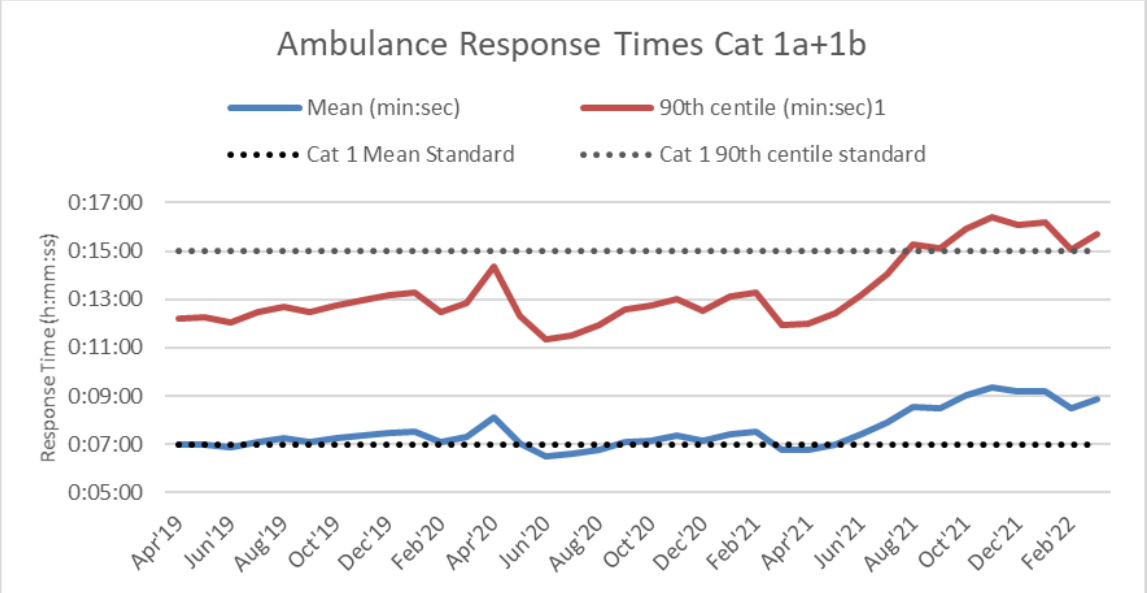
1086. In the year 2021-22, performance against national response time standards has varied. The Category 1 mean standard has been met only once (April 2021), whilst category 1 90th centile was met 3 times. The Category 2 mean, and category 2, 3 and 4 90th centile standards were never met.

1087. The NHS operational priorities for 2022-23 set out in NHS England and Improvement's planning guidance were published on 22 February 2022. This included guidance to improve the responsiveness of urgent and emergency care

and build community care capacity – keeping patients safe and offering the right care, at the right time, in the right setting.

1088. The NHS Long Term Plan focuses on safely reducing conveyance to A&E 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 providing enhanced monitoring and support to the most challenged acute hospital sites.

Figure 42: Ambulance Response Times (mins) for category 1a and 1b – April 2019 to February 2022



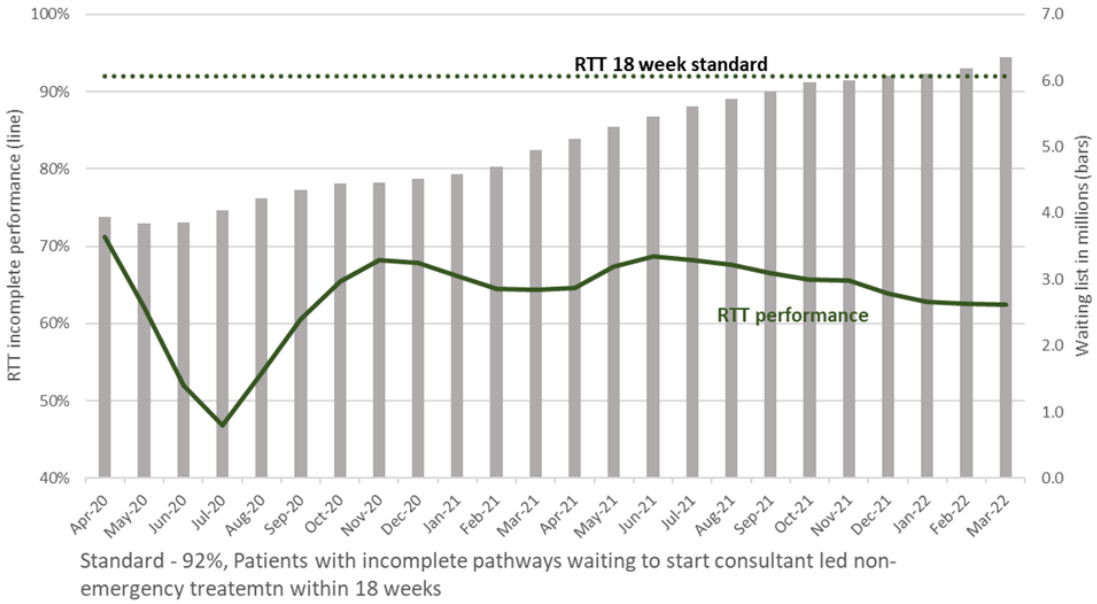
Standard - Category 1 incidents are the most urgent ambulance incidents and have the shortest response time standards, with category 4 being the least urgent. Category 1a is the mean response time for category 1 incidents and this has a standard of 7 minutes or less, Category 1b is the 90th percentile response time and this has a standard of 15 minutes or less.

Source: *Ambulance Quality Indicators*

Referral to Treatment Waiting Times

1089. Elective waiting times are monitored against the referral to treatment (RTT) incomplete pathway standard, in that a minimum of 92% of patients still waiting to start consultant-led treatment for non-urgent conditions at the end of the month, should have been waiting less than 18 weeks from referral. As shown in **Figure 43,** published performance was 62.4% in March 2022, compared to 64.4% in March 2021 and 79.7% in March 2020. The standard was last met in February 2016.

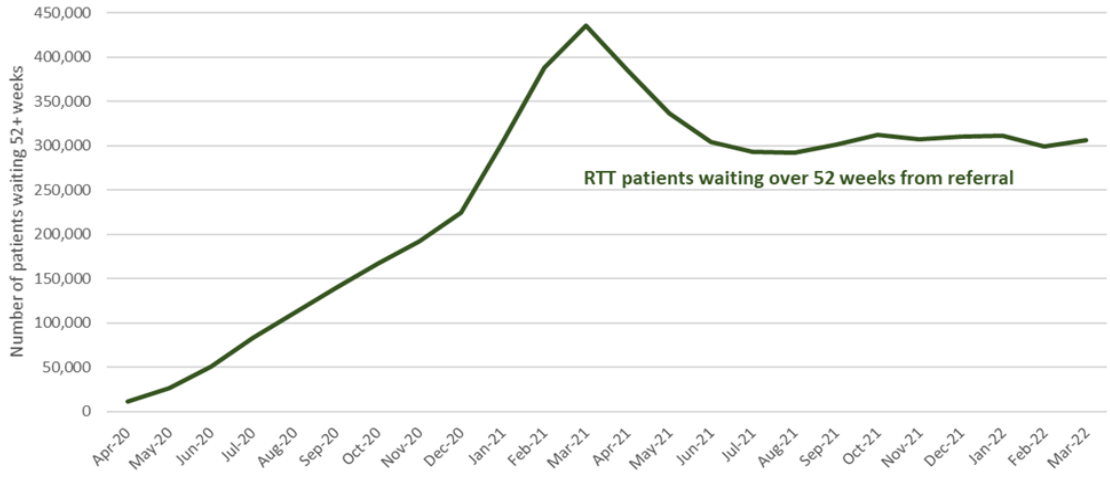
Figure 43: Percentage of patients on RTT incomplete pathways waiting within 18 weeks from referral and waiting list, 2020-21 and 2021-2022



Source: *Consultant-led Referral to Treatment Waiting Times*

1090. Deteriorating performance against the standard is a result of a continued mismatch between demand and activity, which has been amplified by COVID-19 and the measures taken by the NHS to respond to COVID-19 during the first wave. As shown in **Figure 44**, this is more evident from the growth in the number of patients waiting for more than 18 weeks which, by March 2022, had increased by over 626,000 over March 2021. The number of patients waiting for more than 52 weeks has decreased by nearly 130,000 compared to March 2021. Addressing the elective waiting list has become a government priority.

Figure 44: Number of patients waiting over 52 weeks from referral, April 2020 to March 2022



Source: *Consultant-led Referral to Treatment Waiting Times*

Missed demand

1091. The overall size of the waiting list is likely to increase, at least in the short term. It is estimated, in NHS England's Delivery plan for tackling the COVID-19 backlog of elective care, that over 10 million patients who might otherwise have come forward for treatment did not, including a small proportion of these for cancer diagnosis and treatment. If around half the 'missing demand' from the COVID-19 pandemic returns over the next three years, particularly if this is earlier in the period, then we would expect the waiting list will be reducing by around March 2024.

Cancer Waiting Times

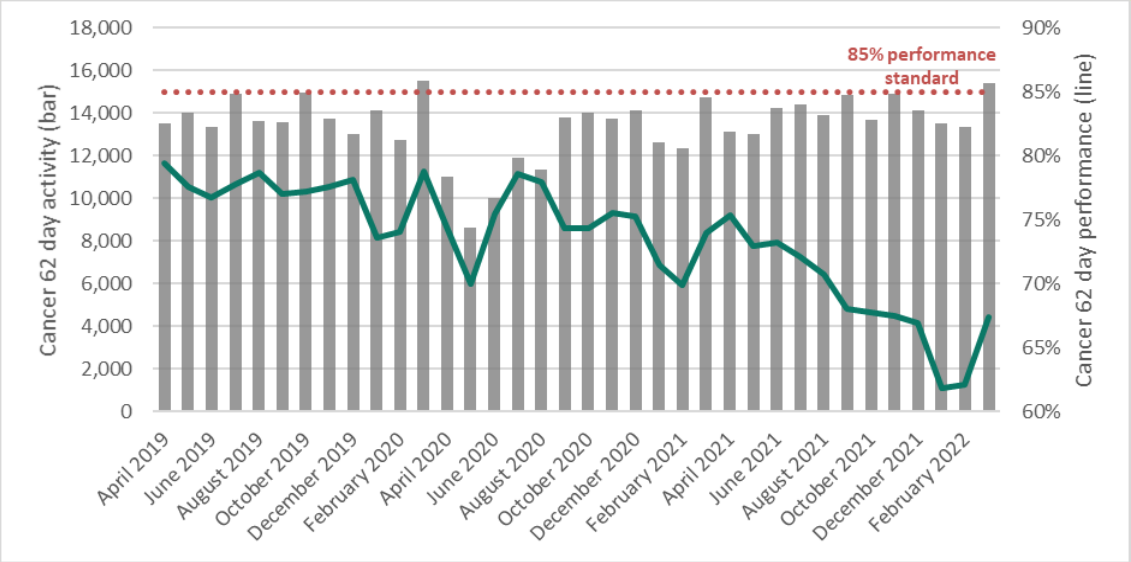
1092. Early diagnosis and treatment are crucial to improving survival rates for cancer. The key cancer waiting time standards cover different elements of the pathway, to ensure patients benefit from better access to cancer services. Increasing the number of people coming forward with cancer symptoms has been highlighted as part of the 'Help Us Help You' campaign. Consequently, following a dip in cancer referrals during the early stages of the pandemic, urgent GP referrals for cancer were the highest ever recorded in November 2021 with over 240,000 referrals on average, over 10,000 patients each working day. This is 22.25% higher than November 2019.

1093. NHS England's Delivery plan for tackling the COVID-19 backlog of elective care was published in February 2022. On cancer, the plan sets out two key ambitions - by March 2023, there will be a reduction in the number of people waiting more than 62 days from an urgent GP referral to start their first cancer treatment back to pre-pandemic levels and by March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer will be diagnosed or have cancer ruled out within 28 days. This delivery plan sets alongside the cancer-focussed Cancer Recovery Plan. The NHS Long Term Plan remains the detailed strategy for cancer services and will continue to apply after the pandemic. The NHS Long Term Plan

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.

1094. As shown in **Figure 45**, 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 2020-21 or 2021-2022, and was last met in December 2015.

Figure 45: 62-day GP Referral to First Treatment of Cancer Performance, April 2019 to March 2022



Standard – 85% of patients receiving a first treatment for cancer following a GP urgent referral.
Source: *Cancer Waiting Times*

Diagnostic Tests

1095. Diagnostic test activity and waiting times have been impacted by the COVID19 pandemic, which continues to affect the current reporting period and comparisons with the previous year.

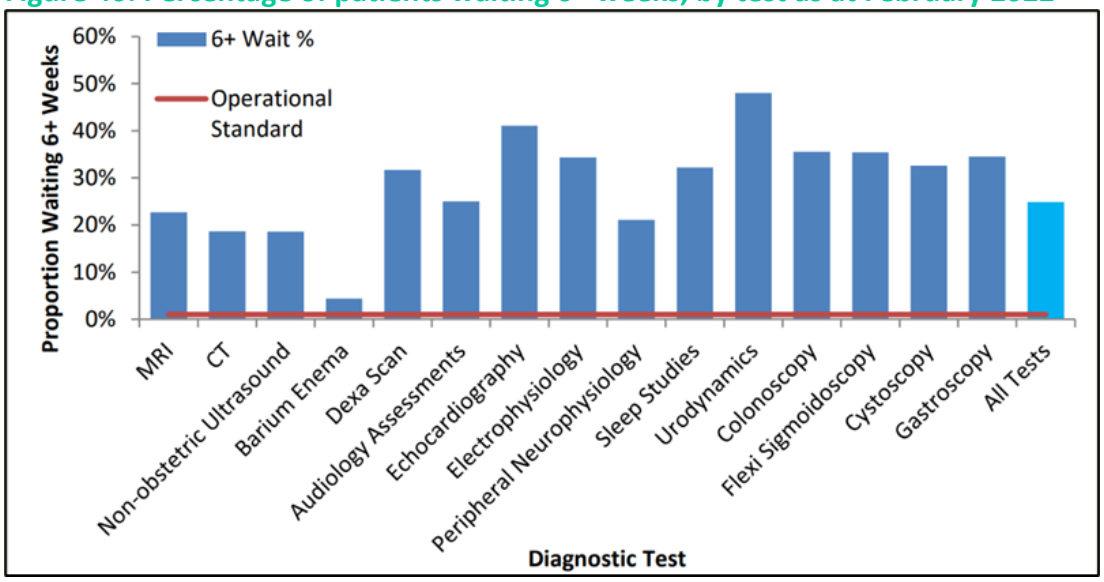
1096. Monthly activity decreased markedly following the start of the COVID-19 pandemic. Total activity in April 2020 fell by 68% compared to April 2019 but subsequently started to recover with some further setbacks. A total of 2,079,300 diagnostic tests were undertaken in March 2022. This is an increase of 145,700 from March 2021.

1097. Compared with March 2021 the total number of patients waiting six weeks or more increased by 84,800 while the proportion of patients waiting six weeks or more increased by 0.6 percentage points.

1098. Waiting times for diagnostic tests are an important contributor to all NHS (including cancer) treatment, because most patients require a diagnostic test to determine whether and what treatment is necessary. As shown in **Figure 46**, 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 in 2021-2022 for the 15 diagnostic tests measured.

Figure 46: Percentage of patients waiting 6+ weeks, by test as at February 2022



Source: *Diagnostics Waiting Times and Activity*

1099. The continued roll out of up to 160 Community Diagnostic Centres by March 2025 will increase the capacity for additional diagnostics activity. These centres are projected to deliver 1 million additional tests before the end of May 2022 and 17 million additional tests by March 2025.

Annex D – Department of Health and Social Care Official Development Assistance

1100. 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.

1101. 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).

1102. **Table 66** shows how the Department spent ODA funding in the 2021 calendar year.

Table 66: Official Development Assistance

The Department of Health and Social Care provided £223 million of Official Development Assistance (ODA) in 2021. (Statistics on International Development: Provisional UK Aid Spend 2021)
In support of the 2015 UK Aid Strategy, Department of Health and Social Care's (DHSC's) ODA activities focused on the areas of global health research, global health and health security. The **National Institute for Health Research (NIHR) 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 applied global health research. Throughout 2021 the **COVID-19 pandemic** continued to impact the existing portfolio and a number of ongoing NIHR funded research teams adapted their timelines and workplans in line with new local and international circumstances. Some award holders provided research evidence for the local, national and international COVID-19 response. DHSC co-created the UK Collaborative on Development Research COVID CIRCLE initiative with other UK funders, which mapped research funding to address COVID-19, co-ordinated funding efforts, connected networks of researchers, and collated learning from research including inform future epidemic and pandemic responses, with a focus on COVID-19 in lower-resource settings. DHSC also joined the network of international funders of research into infectious disease outbreaks (Global Research Collaboration for infectious Disease Preparedness, GloPID-R) to engage directly in clinical trials capacity strengthening aligned with the G7 Clinical Trials Charter.

We provided new contributions to funding schemes to address COVID-19 research:

- We developed and delivered a new rapid response research programme, the Global Effort on COVID-19 (GECO) Health Research jointly with the Medical Research Council (MRC) and UK Research and Innovation (UKRI), aimed at supporting applied health research to address COVID-19 knowledge gaps identified by the WHO Coordinated Global Research Roadmap, understanding the pandemic and mitigating health impacts in LMIC contexts.

The **NIHR GHR funding portfolio** continued to expand in 2021, with the following highlights:

The NIHR continued to support 13 Global Health Research Units and 40 Global Health Research Groups to generate high-quality global health research focusing on health issues that affect the poorest people in LMICs, through equitable partnerships between UK and LMIC researchers. A second call for Units and a third call for Groups was launched in June 2020, with eight and four new research contracts initially awarded, respectively, which started between July and October 2021.

The **NIHR Global Health Policy and Systems Research (Global HPSR) programme** was launched in 2019 with the aim to support research into health systems directly and primarily of benefit to people in LMICs. In 2021, NIHR continued to support five projects with a focus on improving access to appropriate and affordable health services across the lifespan.

The **NIHR Research and Innovation for Global Health Transformation (RIGHT)** 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. In 2021, the programme's third call awarded four new research contracts for applied research on the development and evaluation of interventions to improve outcomes for people living with multiple long-term conditions (multimorbidity). The NIHR also continued to support two applied health research projects on epilepsy, four on severe and stigmatising skin diseases, one on infection-related cancers, as well as six projects on mental health issues.

In 2021, DHSC Global Health Research through NIHR continued to work in partnership with other global funders to address health challenges relevant to people in LMIC settings in areas of unmet need.

Key highlights include:

- With the European and Developing Country Clinical Trials Partnerships (EDCTP), NIHR provided funding for up to 32 female PhD fellowships to address clinical research in sub-Saharan Africa on infectious diseases and contributing to gender and diversity gaps.
- As an Associate Member of the Global Alliance for Chronic Diseases (GACD), NIHR supports annual research calls and the GACD Secretariat. In collaboration with MRC/UKRI, a portfolio of UK-funded awards are ongoing, focused on implementation research to improve mental health and scaling up interventions tackling prevention of diabetes, hypertension and heart disease.
- With the World Bank, NIHR continued to fund the Global Road Safety Facility (GSRF) to address road traffic deaths and injuries in LMICs through supporting the scale-up of scientific, technological and managerial capacities to effectively manage road safety.
- With Grand Challenges Canada (GCC), NIHR supported two new Transition to Scale (TTS) mental health projects in Pakistan and South Africa which aim to support bold solutions

that provide evidence-based, person-centred mental health services in community-based settings. The NIHR also supported three more seed funding awards bringing the total to 15 under the programmes aiming to provide proof-of-concept grants focused on new ideas that have the potential to transform mental health services available for youth in LMICs.
- With MRC, NIHR continued to support research in maternal and neonatal mortality and morbidity, and adolescent health in LMICs and funded a further nine projects as part of the Global Effort on COVID-19 (GECO) Health Research.

Supporting research capacity building and training in LMICs:
- NIHR Global Research Professorships – This programme funds research leaders of the future to promote effective translation of research and to strengthen research leadership at the highest academic levels. Awards provide support for developing a research team as the building blocks of an independent academic research career in global health. In 2021, three Professorships continued, and four additional were contracted. All are affiliated to UK universities.
- With the Royal Society of Tropical Medicine and Hygiene (RSTMH), 161 small grants were awarded to very early career researchers. All were LMIC nationals, covering 31 different countries across sub-Saharan Africa, Latin America and southeast Asia and researching topics such as climate change, drug resistant infections and the interaction between neglected tropical diseases and non-communicable diseases.
- With the WHO Special Programme for Research and Training in Tropical Diseases (TDR), the Antimicrobial Resistance Structured Operational Research Training Initiative (AMR SORT IT) programme aims to build sustainable operational research capacity to generate and utilise evidence on the emergence, spread and health impact of antimicrobial resistance, as a public health problem.
- The NIHR-Wellcome Global Health Research partnership jointly funded 12 new International Fellowships directly to LMIC applicants in areas of global health research priority including women and child health, multimorbidity and non-communicable diseases.

These strategic investments contribute to the portfolio of high-quality global health research focused on health issues of people living in LMICs and pandemic response supported through the Global Health Research ODA budget in 2021.

The **Global Health Security** programme contributes to the 2015 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.

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 Fleming Fund improves laboratory capacity and diagnosis and building sustainable surveillance systems at a country level through a One Health approach, covering human and animal health and agriculture sectors, in places where drug resistant infections have a disproportionate effect. In 2021, the most significant areas of ODA spend were:

- **Surveillance and data:** 11 regional grants and country grants in 21 priority countries were active in supporting the collection of AMR data. 236 labs were supported (covering human,

animal and environmental sectors); 17 Fleming Fund countries submitted data into the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS). GLASS promotes and supports a standardised approach to the collection, analysis and sharing of AMR data at a global level by encouraging and facilitating the establishment of national AMR surveillance systems that are capable of monitoring AMR trends and producing reliable and comparable data.

- **Global guidance, protocols and governance:** support to the key tripartite multilateral organisations – the World Health Organization (WHO), the World Organisation for Animal Health (OIE) and the Food and Agriculture Organization (FAO). Three Fleming Fund countries are now implementing the newly published One Health Tricycle protocol, developed by FAO, WHO and OIE.
- **Awareness and advocacy:** in 2021 the Global Research on Antimicrobial Resistance (GRAM) project submitted three articles to peer reviewed journals including a significant paper on the global burden of bacterial infection, which found that in 2019 at least 1.27 million deaths per year were directly attributable to AMR. This shows that AMR is a leading cause of death globally, higher than HIV/AIDs and Malaria.
- **Partnerships, capacity building and technical assistance:** by the end of 2021 a total of 178 professional and policy fellows have been selected. Within 2021 the Commonwealth Partnerships for Antimicrobial Stewardship scheme trained 501 healthcare workers in four countries in infection prevention and control or antimicrobial stewardship (AMS) principles; those tested were able to demonstrate how to practice their new knowledge after the training.
- **Adaptive management, learning and evaluation:** the third formative evaluation report (March 2021) was produced by the independent evaluation supplier supporting DHSC and the Management Agent to adapt and improve programme delivery based on learning to date. This will help to inform the design of the second phase of the Fleming Fund.

The **UK Vaccine Network** – This project focusses on targeted investments to support the development of new vaccines and vaccine technologies for diseases of epidemic potential in LMICs. It provides DHSC ODA funding to support a portfolio of research projects, with investments guided by a multi-disciplinary advisory group. In 2021, the most significant areas of spend were:

- Ongoing funding of pre-clinical and clinical stage vaccine development projects, through three Small Business Research Initiative (SBRI) competitions managed by Innovate UK. An additional one-year SBRI competition was also developed and launched (awards to begin in 2022).
- Ongoing funding of 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 Evaluation, Trials and Studies Coordinating Centre)
- Ongoing funding of vaccine manufacturing research hubs via a competition managed by the Engineering and Physical Sciences Research Council (EPSRC).
- A £16 million financial commitment to the Coalition for Epidemic Preparedness Innovations (CEPI).
- Ongoing funding of awards managed by BBSRC to support One Health approaches to accelerate vaccine development.
- Ongoing funding of awards made through an Epidemiology for Vaccinology competition run by NIHR (Central Commissioning Facility); projects seek to develop epidemiological models, tools, and technologies to assist with development and clinical trialling of vaccines in

outbreak situations in LMICs.
- Re-orienting existing UKVN-funded research projects to support the COVID-19 response, while ensuring these new research aims were ODA eligible.

A key success of the UKVN was highlighted in 2021, as the UKVN's 2016 investment in development of a vaccine against Middle East respiratory syndrome (MERS) at Oxford University supported the development of the Oxford-Astra Zeneca COVID-19 vaccine using the same platform technology. Using domestic NIHR funding, our partner institution, Oxford University, was able to rapidly pivot vaccine development from MERS to work on COVID-19. This vaccine has been distributed globally with over 2.5 billion doses deployed. Most of these doses have been delivered at cost price.

The **UK Public Health Rapid Support Team (UK-PHRST)** – UK-PHRST is funded by DHSC and delivered as a partnership between the UK Health Security Agency (formerly Public Health England) and the London School of Hygiene and Tropical Medicine. It works to address the threat posed by outbreaks of infectious disease within ODA-eligible countries through an integrated triple remit, incorporating outbreak response, innovative research to inform best practice in disease interventions, and capacity development to help improve countries' preparedness and response.

Under the response element of its remit, the UK-PHRST identifies situations where deployment of specialist expertise can mitigate threats and can rapidly deploy a team of multidisciplinary public health professionals and researchers to an ODA-eligible country. It aims to be ready to deploy a team in as little as 48 hours of a requirement being identified.

The team responded to four calls for in-person assistance in 2021, deploying to Guinea, Tunisia, Bangladesh, and Cambodia. The deployment to Guinea was to provide a rapid assessment of the Ebola outbreak and the others were to support COVID-19 response efforts. Epidemiologists, Infection Prevention and Control experts and microbiologists were deployed from both the core team and reserve cadre. Deployments were through a range of mechanisms including via the Global Outbreak Alert and Response Network to WHO, bilaterally and through the UK Emergency Medical Team. There was also a remote deployment to WHO HQ to review and update the COVID-19 contact tracing guidelines

Research and capacity development activities have continued throughout 2021. Research projects have included those focused on:

- COVID-19 surveillance in Cox's Bazar Rohingya Camps, Bangladesh
- strengthening public mental health capacity in Africa in response to the COVID-19 outbreak
- how MOOCs can be used to support outbreak response
- COVID-19 interventions for public health and healthcare workers
- vaccine strategy implementation for COVID-19 vaccines in low resource settings
- serosurveillance (the monitoring of the presence or absence of specific substances in the blood serum of a population) of healthcare workers in Uganda
- telephone hotlines and outbreak response
- online and offline COVID-19 rumours in Sierra Leone and Tanzania
- research and capacity development for mental health and psychosocial support in outbreak preparedness and response in the Africa Union

- COVID-19 excess mortality in the Gambia
- innovating approaches for monitoring SARS-CoV-2 variants using high-resolution melt curve analysis (HRM) methodology

UK-PHRST research in 2021 also focused on other infectious diseases that continue to threaten ODA-eligible countries including viral haemorrhagic fevers, Ebola, Lassa fever and Crimean-Congo haemorrhagic fever, and outbreak response and preparedness more generally.

Capacity development activities included:

- training local public health staff on physical deployment and within active research studies
- developing training materials, technical resources and a range of courses relating to pandemics and outbreak response
- partnering with Africa Centres for Disease Control and Prevention (Africa CDC) to augment the African Union's operational capacity to respond to public health emergencies

The **International Health Regulations (IHR) Strengthening Project** – The IHR Strengthening Project is an ODA funded project delivered by UKHSA. The project improves IHR capability in partner countries and regions with medium- and long-term activities taking place through partnerships with National Public Health Institutes (NPHIs) in several countries in Africa and Asia. The project has a triple mandate **to build technical capability**, **strengthen leadership**, and **develop sustainable public health systems**. It does this through working at national level in partnerships with NPHIs and Health Ministries, and at a regional level with regional bodies such as Africa CDC and the Eastern Mediterranean Public Health Network (EMPHNET) as well as WHO regional offices.

In 2021, despite the challenges of COVID-19, the project provided significant public health support, training and mentoring across Ethiopia, Nigeria, Zambia, Pakistan and through Africa CDC and EMPHNET.

Specific successes included significantly strengthening laboratory diagnostics and quality management in Nigeria and Zambia, supporting the first cohort of the Kofi Annan Global Leadership Programme, developing laboratory leaders across Africa and rolling out Integrated Disease Surveillance and Response (IDSR) at subnational level in Pakistan. The project increased its international footprint by expanding locally recruited technical teams, strengthening peer to peer partnerships with NPHIs. In addition, the project continued to provide support to both partner NPHIs and UK Missions to respond to the evolving COVID-19 pandemic.

The **Global AMR Innovation Fund (GAMRIF)** – This project develops international partnerships to support early-stage research and development that will advance novel One Health AMR solutions for the benefit of people in LMICs.

In 2021, GAMRIF's spend included 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 research on AMR and the environment. 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 14 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 on vaccines and alternatives for animals, and finally, 10 bacterial vaccinology projects with the BactiVac Network.
- Two **product development partnerships**, namely the Foundation for Innovative New Diagnostics (FIND) and the Global Antimicrobial Research and Development Partnership (GARDP).

Research successes from GAMRIF during 2021 include: supporting an ambitious study on the care of newborns with neonatal sepsis. The study (enrolling over 3,200 newborns) generated comprehensive and high-quality data, helping to explain which antibiotic resistance makes current treatments ineffective.

ODA admin – This budget funds all DHSC staff supporting ODA funded activities and their associated costs, and legal support costs as required.

The Building the Future International Workforce Programme

The health workforce is at the centre of every health system and is key to achieving universal health coverage. However, many countries are grappling with major health workforce challenges such as critical shortages in the supply of workers, an inadequate mix of skills in the workforce, inequitable geographical distribution of health workers, and gaps in their competencies, motivation, and performance.

In addition, the COVID-19 pandemic has resulted in global workforce retention pressures, whilst the demand for health workforce has increased globally. This is threatening the worldwide pandemic recovery and is leading to worldwide health inequalities. WHO projections estimate a shortage of 18 million health workers by 2030, if we are to achieve universal health coverage and to meet Sustainable Development Goal 3, "Ensure healthy lives and promote well-being for all at all ages".

In 2021, the Building the Future International Workforce programme funded healthcare workforce development projects in Ghana, Somaliland, and Uganda to improve health workforce capacity and management, and provide opportunities for refugees/displaced people to use their skills to find safe and sustainable employment. It brought together UK institutions and local partners to address locally identified health workforce priorities.

- The programme in Ghana included work with WHO to support health sector governance, and work with the Tropical Health and Education Trust (THET) and the Liverpool School of Tropical Medicine to evaluate attraction and retention policies, nursing and midwifery training and regulation alongside strengthening post-graduate medical education. It also included work with the Christian Healthcare Association of Ghana to fund 38 refugee/displaced person and host community scholarships to develop foundational skills and train as healthcare professionals.
- The programme in Uganda included working with THET and their partners to strengthen mental health care by reviewing mental health standards, building the skills of 450 health workers, and providing 400 health workers and community leaders training in suicide awareness and prevention.
- The programme in Somaliland included working with THET and their partners to deliver new

and improved national curricula for nursing and midwifery and strengthening the health systems of seven health communities.

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. The FCTC 2030 project has been directly supporting LMICs implement the WHO Framework Convention on Tobacco Control.

The FCTC 2030 project was originally a five-year project due to end in March 2021. Due to the impact of the COVID-19 pandemic in year 5 delivery, the project was extended at no-cost for a further year until March 2022.

Additional funding from the Governments of Australia and Norway has enabled expansion of the FCTC 2030 project to new countries. During year 6 of the project, a further nine countries joined (in July 2021) as Phase 3.

Over the course of the six years, the project has supported 33 countries to improve their tobacco control policy and regulation. The project has helped to reduce the burden of death and disease from tobacco, and enabled countries to make better use of health system resources to improve health and well-being of their populations. This was backed by an independent evaluation by the University of York.

The project has received praise from the countries participating and 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. DHSC was awarded a 2020 United Nations Inter-Agency Task Force Award recognizing the UK's role in the global prevention and control of noncommunicable diseases through supporting the FCTC 2030 project.

The Elton John AIDS Foundation - Promoting HIV Self-testing for Young Men in Kenya project

Kenya has the joint fourth largest HIV/AIDS epidemic in the world. Evidence has shown that men of 18 to 24 years are an important target group when tackling the epidemic.

Funded through one-year ODA spend, this Elton John AIDS Foundation project started in March 2020 and aims to close the HIV testing gap among men in Kenya by promoting HIV self-testing. Its objectives are to:

- innovate service delivery models linking public and private sectors through design of HIV self-testing promotion tools targeting young people
- increase uptake of HIV self-testing through awareness raising on self-testing services for at-risk men ages 20-34
- create a sustainable supply of HIV self-testing kits that are conveniently available and accessible for men in need of HIV self-testing
- create an enabling environment for HIV self-testing scale up and sustainability by adapting and running the intervention through existing health system and structures

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 FCDO 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 seekers 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.

Annex E - Sustainable Development

Sustainability data

1103. **Tables 67** to **69** and **Figures 47** to **49** show our progress in reducing greenhouse gas emissions, waste, and water consumption between 2017-18 and 2021-22.

1104. The data combines that of the Department and our partner organisations that are in scope for reporting against the Greening Government Commitments, including CQC, HEE, HRA, MHRA, NHSBSA, NHSCFA, NHSD, NHSE and NHSI, NHSR, NICE and UKHSA. It does not include HFEA or HTA, who did not submit data. NHSBT are not in scope for this reporting. For more detail on the sustainability performance of individual organisations, please see their own Annual Report and Accounts.

1105. Please note that data shown for 2017-18 to 2020-21 in the tables and figures is based on the previous scope for Greening Government Commitments reporting, for presentational purposes. In 2021-22, additional partner organisations have been included in the data as per the expanded scope. Data is not included relating to DHSC's occupancy at Quarry House, Leeds, as this building is owned and reported on by the Department for Work and Pensions (DWP).

Table 67: Greenhouse gas emissions from 2017-18 to 2021-22

		2017-18	2018-19	2019-20	2020-21	2021-22
Greenhouse gas emissions (tonnes of CO_2 equivalent)	Scope 1	6,361	7,922	7,124	6,686	9,667
	Scope 2	13,720	10,756	9,340	8,117	11,871
	Scope 3 (business travel only)	6,738	5,306	4,236	1,172	2,270
	Total	**26,819**	**23,984**	**20,700**	**15,975**	**23,808**
Related energy consumption (mWh)	Electricity renewable	71	15	12,315	16,475	27,797
	Electricity non-renewable	38,954	37,981	24,225	18,342	28,108
	Gas	31,080	36,788	32,020	33,512	50,071
	Total (including other sources)	**72,039**	**78,216**	**74,024**	**71,126**	**107,614**
Related expenditure (£k)	Energy	5,618	5,922	6,035	6,252	7,628
	Carbon offsetting	168	153	31	0	0
	Business travel	19,584	20,861	11,027	537	4,704

Figure 47: Greenhouse gas emissions from 2017-18 to 2021-22

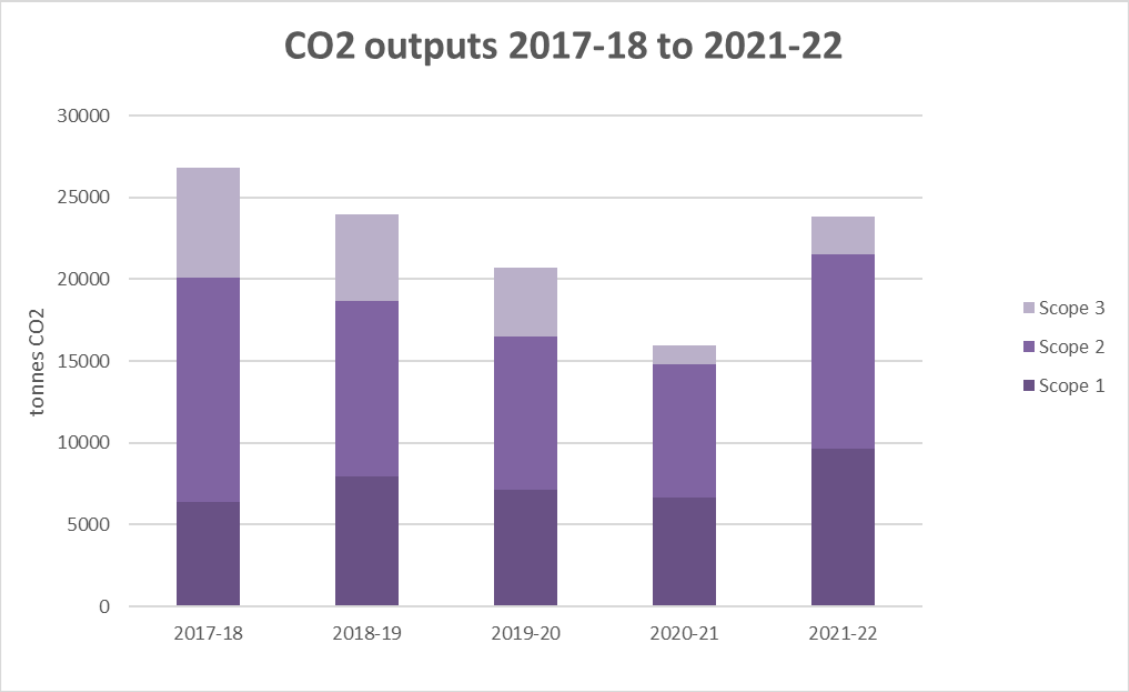


Table 68: Waste from 2017-18 to 2021-22

		2017-18	2018-19	2019-20	2020-21	2021-22
Waste (tonnes)	Recycled (excluding ICT waste)	1,899	1,741	1,498	780	1,030
	Reused (excluding ICT waste)	39	36	39	5	168
	ICT waste recycled	7	8	12	10	88
	ICT waste reused	7	14	5	5	8
	ICT waste recovered	0	0	0	0	3
	Composted/anaerobic digestion [1]	40	28	39	28	30
	Incinerated with energy recovery	312	337	411	433	594
	Incinerated without energy recovery	163	158	77	48	159
	Preparation for reuse	0	20	0	0	0
	Landfill	111	114	50	14	454
	Total (excluding reused)	**2,532**	**2,386**	**2,087**	**1,315**	**2,358**
Related expenditure [2] (£k)	Recycled (excluding ICT waste)	-	-	-	-	221.7
	Reused (excluding ICT waste)	-	-	-	-	57.8
	Composted/anaerobic digestion*	-	-	-	-	10.1
	Incinerated with energy recovery	-	-	-	-	395.0
	Incinerated without energy recover	-	-	-	-	180.0
	Preparation for reuse	-	-	-	-	0.0
	Landfill	-	-	-	-	49.8
	Total (excluding reused)	-	-	-	-	**856.6**

(1) The Department itself does not yet measure composted/food waste, but are planning to do so before the end of 2022, as required by the Greening Government Commitments. The data listed here is for those partner organisations who have reported against this category.
(2) Expenditure information has been included where the information is available.

Figure 48: Waste from 2017-18 to 2021-22

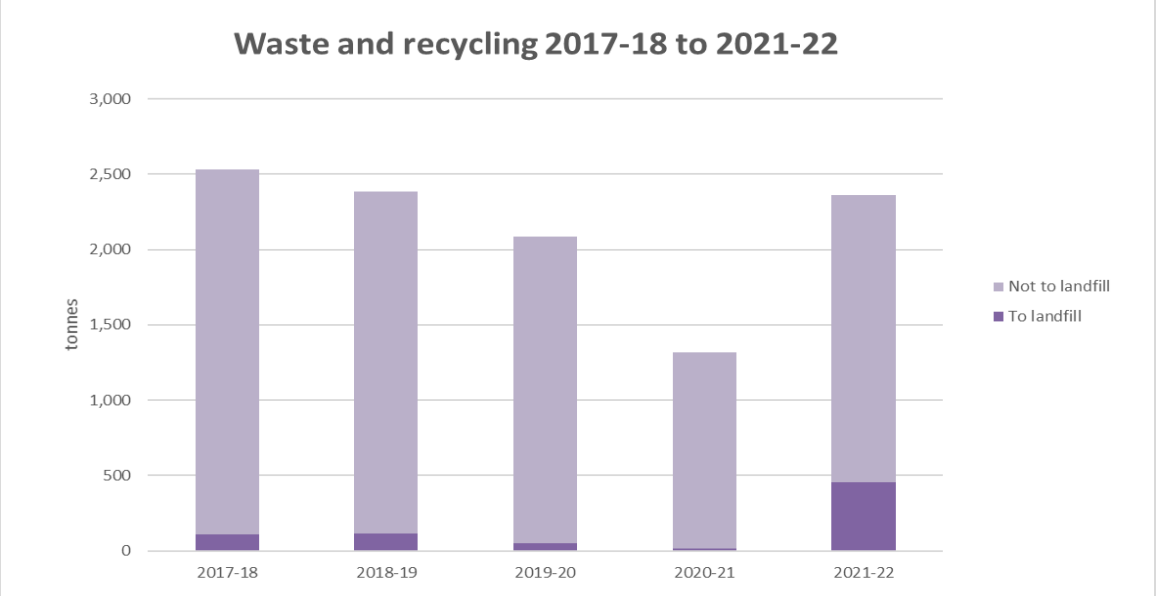
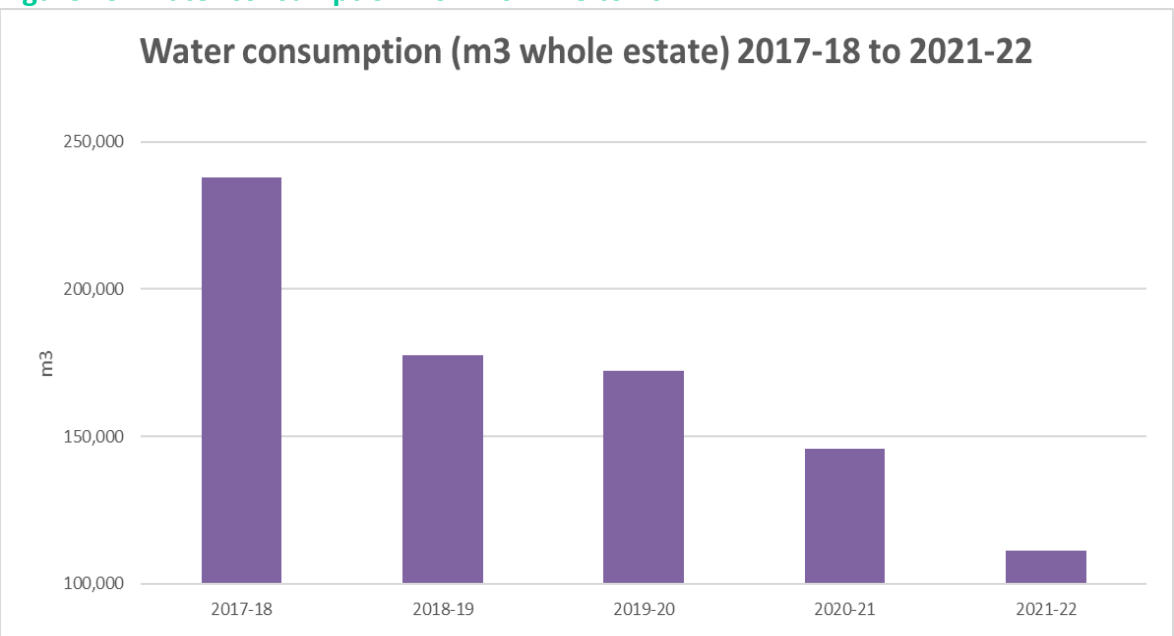


Table 69: Water consumption from 2017-18 to 2021-22

		2017-18	2018-19	2019-20	2020-21	2021-22
Water consumption (m^3)	Per FTE	6.0	6.0	5.9	6.8	3.5
	Total (whole estate)	**237,757**	**177,382**	**172,316**	**145,642**	**111,178**
Related expenditure (£)	Water supply	410	369	520	477	327

Figure 49: Water consumption from 2017-18 to 2021-22



Annex F – Our Arm's Length Bodies and Delivery Partners

Organisation	Status	Website
Our Executive Agencies		
UK Health Security Agency	Executive Agency	https://www.gov.uk/government/organisations/uk-health-security-agency
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 [(4)]	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.

4. Ownership was officially transferred to NHS England and NHS Improvement as of 1 October 2021.

Annex G - Commonly used Acronyms

Acronym	Term
A&E	Accident and Emergency
ALB(s)	Arm's Length Body/Bodies
AME	Annually Managed Expenditure
AQS	Analytical Quality Stamp
ARA	Annual Report and Accounts
ARC	Audit and Risk Committee
ARRS	Additional Roles Reimbursement Scheme
ASCOF	Adult Social Care Outcomes Framework
BAM	Bi-annual Assurance Meeting
BAR	Business Appointment Rules
BAU	Business as usual
BEIS	Department for Business, Energy and Industrial Strategy
BPPC	Better Payments Practice Code
C&AG	Comptroller and Auditor-General
CAS	Clinical assessment Service
CAWGS	COVID-19 ASC Working Group of Stakeholders
CCG	Clinical Commissioning Group
CCS	Crown Commercial Service
CCSM	Commercial Capability and Supplier Management
CDC	Community Diagnostic Centre
CDEL	Capital Departmental Expenditure Limit
CETV	Cash Equivalent Transfer Value
CFERs	Consolidated Fund Extra Receipts
CGF	Credit Guarantee Finance
CIR	Critical Infrastructure Risk
CMDU	COVID-19 Medicines Delivery Unit
CNSC	Clinical Negligence Scheme for Coronavirus
CNSGP	Clinical Negligence Scheme for General Practice
CNST	Clinical Negligence Scheme for Trusts
COO	Chief Operating Officer
CPA	Consolidated Provider Accounts
CPI	Consumer Price Index
CPCF	Community Pharmacy Contractual Framework
CPCS	Community Pharmacist Consultation Service
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRED	Commission on Race and Ethnic Disparities
CRO	Chief Risk Officer
CRS	Clinical Review of Standards
CSCNE	Consolidated Statement of Comprehensive Net Expenditure
CSOC	Cyber Security Operations Centre
CSOPS	Civil Servant and Other Pension Scheme
CSUP	Consumer Single-Use Plastics

CTIS	Coronavirus Temporary Indemnity Scheme
D&I	Diversity and Inclusion
DAC	Development Assistance Committee
DEFRA	Department for Environment, Food and Rural Affairs
DEL	Departmental Expenditure Limit
DELTA	Disability Empowers Leadership Talent scheme
DG	Director General
DHSC	Department of Health and Social Care
DHSC AFU	DHSC Anti-Fraud Unit
DPC	Direct Patient Care
DRC	Depreciated Replacement Cost
DSPT	Data Security and Protection Toolkit
DTA	Decision to Admit
DTOC	Delayed Transfer of Care
DTUS	Departmental Trade Union Side
ED	Emergency Department
EEA	European Economic Area
ELS	Existing Liabilities Scheme
ENDPB	Executive Non-Departmental Public Body
EPRR	Emergency Preparedness, Resilience and Response
EU	European Union
EXCO	Executive Committee
EX RHA	Ex-Regional Health Authority
FIS	Functionally Interchangeable Stock
FLS	Future Leaders Scheme
FMA	Fraud Measurement and Assurance
FOI	Freedom of Information
FReM	Financial Reporting Manual
FT	Foundation Trust
GAD	Government Actuary's Department
GCFF	Government Counter Fraud Function
GCO	Government Commercial Organisation
GGC	Greening Government Commitment
GIAA	Government Internal Audit Agency
GMPP	Government Major Projects Portfolio
GPA	Government Property Agency
GPPS	GP Patient Survey
GRAA	Government Resources and Accounts Act 2000
HCHS	NHS Hospital and Community Health Service
HCID	High Consequence Infectious Disease
HEE	Health Education England
HES	Hospital Episode Statistics
HFSS	High in Fat, Sugar and Salt
HGIAS	Health Group Internal Audit Service
HIP	Health Infrastructure Plan
HLE	Healthy Life Expectancy

HMRC	HM Revenue & Customs
HMT	HM Treasury
HPFTS	Health Policy Fast Track Scheme
HPL	High Priority Lane
HRA	Health Research Authority
HSIB	Healthcare Safety Investigation Branch
HSSIB	Health Services Safety Investigations Body
HTA	Human Tissue Authority
IBNR	Incidents Incurred but Not Reported
IAPT	Improving Access to Psychological Therapies
ICO	Information Commissioner
ICP	Integrated Care Partnership
ICS	Integrated Care Systems
ICT	Information and Communications Technology
IFRS	International Financial Reporting Standards
IIF	Investment and Impact Fund
IMAS	Interim Management and Support
IMD	Index of Multiple Deprivation
IMMDS	Independent Medicines and Medical Devices Safety Review
IPA	Infrastructure and Projects Authority
IPC	Infection Protection Control
IRMA	Information Risk Management and Assurance
ISAs	International Standards on Auditing
ITP	Interdepartmental Talent Partnership
JCVI	Joint Committee on Vaccination and Immunisation
LCFS	Local Counter Fraud Specialists
LFD	Lateral Flow Device
LGD	Lead Government Department
LIFT	Local Improvement Finance Trust
LTPS	Liability to Third Parties Scheme
LUWP	Levelling Up White Paper
MEA	Modern Equivalent Asset
MHCLG	Ministry of Housing, Communities and Local Government
MHRA	Medicines and Healthcare products Regulatory Agency
MPM	Managing Public Money
MTP	Maternity Transformation Programme
NAO	National Audit Office
NAP	National Adaptation Programme
NCIA	National Clinical Impact Awards
NCMP	National Child Measurement Programme
NCR	Net Cash Requirement
NCSC	National Cyber Security Centre
NDPBs	Non-Departmental Public Bodies
NED	Non-Executive Director
NERVTAG	New and Emerging Respiratory Virus Threats Advisory Group
NGO	National Guardian's Office

NHP	New Hospitals Programme
NHS	National Health Service
NHSBSA	NHS Business Services Authority
NHSBT	NHS Blood and Transplant
NHSCFA	NHS Counter Fraud Authority
NHSD	NHS Digital
NHSE and NHSI	NHS England and NHS Improvement
NHSOF	NHS Outcomes Framework
NHSR	NHS Resolution
NHSTT	NHS Test and Trace
NIBSC	National Institute of Biological Standards and Control
NICE	National Institute for Health and Care Excellence
NICs	National Insurance Contributions
NIHR	National Institute for Health Research
NMS	New Medicines Service
NRR	National Risk Register of Civil Emergencies
NRV	Net Realisable Value
OBR	Office of Budget Responsibility
OCM	Operational Contract Managers
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OHID	Office for Health Improvement and Disparities
OHP	Office for Health Promotion
ONS	Office for National Statistics
OOHCM	Out of Hospital Care Models
OSCAR	Online System for Central Accounting and Reporting
PAC	Public Accounts Committee
PCPF	Parliamentary Contributory Pension Fund
PCSPS	Principal Civil Service Pension Scheme
PCN	Primary Care Network
PCR	Public Contract Regulations
PCT	Primary Care Trust
PDC	Public Dividend Capital
PEA	Post Event Assurance
PES	Property Expenses Scheme
PFI	Private Finance Initiative
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PHSO	Parliamentary and Health Service Ombudsman
PPE	Personal Protective Equipment
PQ	Parliamentary Question
PRC	Performance and Risk Committee
PYLL	Potential years of life lost
QOF	Quality and Outcomes Framework
RAME	Resource Annually Managed Expenditure
R&D	Research and Development

RDEL	Resource Departmental Expenditure Limit
RSDATG	Rough Sleeping Drug and Alcohol Treatment Grant
RTT	Referral to Treatment
SAGE	Scientific Advisory Group for Emergencies
SCCL	Supply Chain Coordination Limited
SCS	Senior Civil Servant
SDP	Single Departmental Plan
SIA	Strategic Intelligence Assessment
SLS	Senior Leaders Scheme
SoCNE	Statement of Comprehensive Net Expenditure
SoFP	Statement of Financial Position
SOL	Shortage Occupation List
SOPS	Statement of Outturn against Parliamentary Supply
SpHA	Special Health Authorities
SR	Spending Review
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Partnership
TDA	NHS Trust Development Authority
TDEL	Total Departmental Expenditure Limit
UKHSA	UK Health Security Agency
UK NSC	UK National Screening Committee
UKRI	UK Research and Innovation
ULEV	Ultra-Low Emission Vehicles
WAC	Weighted Average Cost
WHO	World Health Organisation
WRRF	Workforce Recruitment and Retention Fund
WTE	Whole Time Equivalent
YEUK	Youth Employment UK

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