Department of Health & Social Care

Department of Health and Social Care

Annual Report and Accounts

2022-23

(For the period ended 31 March 2023)

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

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

Ordered by the House of Commons to be printed on 25 January 2024

HC 33

Department of Health & Social Care

Department of Health and Social Care

Annual Report and Accounts

2022-23

(For the period ended 31 March 2023)

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

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

Ordered by the House of Commons to be printed on 25 January 2024

HC 33

This is part of a series of departmental publications which - along with the Main Estimates 2022-23 and the document Public Expenditure: Statistical Analyses 2023 - present the Government's outturn for 2022-23 and planned expenditure for 2023-24.

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

Any enquiries regarding this publication should be sent to us via our Customer Service Centre using the web contact form at: https://contactus.dhsc.gov.uk/

ISBN: 978-1-5286-4137-1
E02916210 01/24

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

Contents

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 (ALBs), to help people live more independent and healthier lives, for longer, creating a safe and high-quality health and care system.

2022-23 saw the continuation of the Department's focus on returning to business-as-usual work following COVID-19, with the Autumn and Spring COVID-19 Vaccination Booster programmes being managed in addition to other competing demands. This has included health and social care reforms, workforce pressures, urgent and emergency care recovery, and the impact of industrial action, all of which are expanded upon within this report.

Whilst focusing on manifesto commitments, we have published Our Plan for Patients and a Delivery Plan for Recovering Urgent and Emergency Care Services and delivering these is a key element of the Department's current objectives. We also secured funding to speed up discharge out of hospital and support workforce capacity, as well as launching the Better Health Rewards pilot to help people set goals to eat healthier and move more. The Department worked on the Major Conditions strategy following its announcement, and also worked to manage the delay of Adult Social Care charging reform.

Throughout the year, we have managed changes within our structures. The UK Health Security Agency has taken responsibility for planning, preventing, and responding to pandemics and external health threats. For our ALBs, NHSE legally merged with NHS Digital, to collectively ensure that patients receive high-quality care in local health systems that is financially sustainable. In July, Integrated Care Boards replaced Clinical Commissioning groups to help us meet the health needs of the population.

We continue to be acutely aware that the pandemic will have lasting consequences and it is still critical that we, and the wider health and care system, continue to reflect and learn the lessons from the pandemic. With the public hearings of the UK COVID-19 inquiry beginning in the past year, we look to learn lessons for the future from this.

2022-23 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; the impact of the disclaimed UKHSA audit opinion, a regularity qualification in respect of the Elective Recovery Fund 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 progress in lifting qualifications, including inventory where a qualification has been lifted. We will continue to work towards lifting the remaining qualifications.

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

Role, Purpose, Structure and Funding

1. This section introduces the role and purpose of the Department of Health and Social Care ('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. The Department's objectives are crucial as health and social care are constantly in the public eye. We have had many competing demands on us as a department, whether that be COVID-19, health and social care reforms, workforce pressures, urgent and emergency care recovery, the impact of industrial action, or manifesto commitments or our long-term plans. That is why for 2022-23 we worked to fulfil the same set of key priorities as we did in 2021-22, to keep a focus on our vision to enable everyone to live more independent, healthier lives for longer. These priorities are set out in the **Performance Summary** section.

Our Structure

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 (see page 116)** and include:
   - NHS England (NHSE), which leads the NHS in England ensuring patients receive high-quality care in local health systems that are financially sustainable. NHS Digital and Health Education England, which had been separate entities within the NHS, were abolished and legally merged with the NHS on 1 February 2023 and 1 April 2023, respectively.
   - 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 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.
- 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.

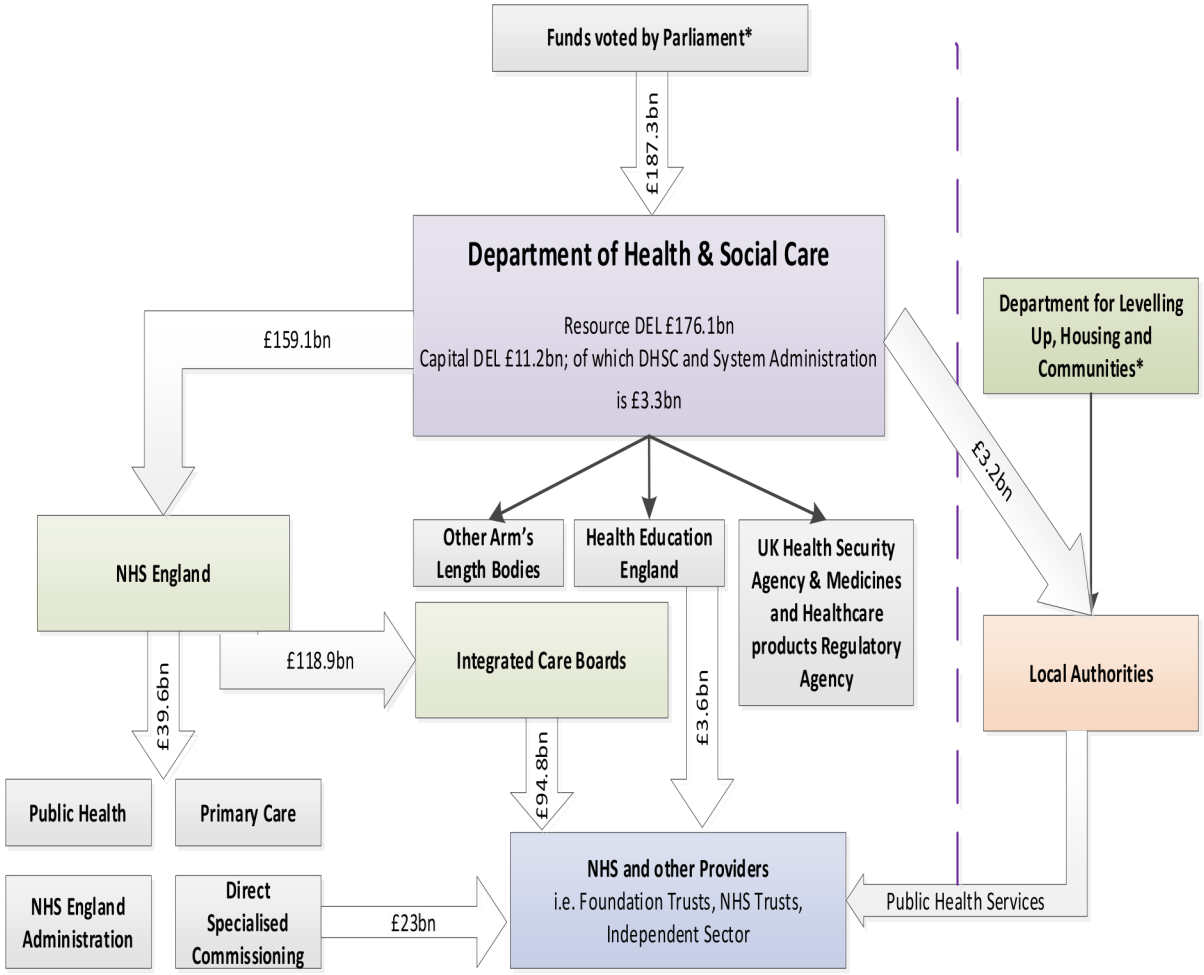
Our Funding

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 2022-23 financial year, the Department had a resource expenditure limit of £176.1 billion and had funding to invest a further £11.2 billion to fund capital items such as new hospitals and equipment, as detailed in **Table 11** on **page 82.**

8. **Figure 1** demonstrates how funding flows round the system, using agreed budget totals for 2022-23 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 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, 2022-23 (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 2022-23 Achievements - At a Glance

A **£50 million capital fund** announced in January to **support discharge**

Publication of **Delivery Plan for Recovering Urgent and Emergent Care Services**

The publication of **A Plan for Digital Health and Social Care**

Publication of **Our Plan for Patients**

Better Health Rewards pilot launched

£500 million discharge funding to speed up discharge out of hospital and support workforce capacity

COVID-19 Autumn and Spring Booster programmes undertaken

44,000 more nurses in March 2023 compared with September 2019

2022-23 - Key Finance Facts

Other than Resource DEL, **DHSC Group Expenditure and cash was contained** within the budgets set by Parliament

The outcome of the **NHS Pay Deal in 2022-23** meant that Resource DEL expenditure was **£0.9bn higher** than the budget set by Parliament

Implementation of the Government's **'Living with COVID'** strategy resulted in 2022-23 COVID spend (£12.6bn) being **66% lower than in 2021-22**

23% spending **growth** in real terms over **2018-19**

£3.2bn COVID-19 funding secured to **procure 110m doses** and **deploy 25m COVID-19 vaccinations**

£9.9bn (net) **investment** in **Capital**

NHSE's £159bn RDEL budget was **the biggest for any ALB** in Government. Underspent by only 0.1% - **maximising almost every penny whilst still keeping within budget**

Over **£500m CDEL invested** on supporting elective recovery

Performance Summary

10. This section provides a high-level performance summary against the Department of Health and Social Care's (the 'Department') strategic priorities during 2022-23.

11. Coronavirus (COVID-19) has been the biggest challenge the country and our public sector have faced in a lifetime. The Department has been central to the Government's response and, as a result, it has continued to adapt in these unprecedented times. The impact of the pandemic has changed since 2020 and therefore the Department has had to change too, with its focus on returning to business-as-usual throughout 2022-23. The Department has put structures in place to contain any new COVID-19 surges and manage legacy work. This will continue into future financial years.

12. During 2022-23, there was a heavy focus on recovering emergency, elective and primary care performance in the NHS. There has also been work on a broad range of other key priorities and policies, including the development of the Major Conditions Strategy and work to manage Adult Social Care reform.

13. The Performance sections within this document provide an overview of performance from areas within the Department's five priority outcomes for 2022-23, along with other topical areas of note from across the year. The five priority outcomes for 2022-23 are outlined in the following paragraph. The Performance Summary is supported by the Performance Analysis section of the Annual Report and Accounts.

Priority Outcomes

14. The Department's Outcome Delivery Plan 2022-23 sets out the Department's five priority outcomes, how success will be measured and how the Department will ensure continuous improvement. The analysis section is structured according to these priority outcomes.

15. As a Department of State our strategic priorities in 2022-23 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.

16. As pandemic-related activities moved to a more business-as-usual status during 2022-23, the Department's role and purpose reverted to that of a more policy-focused Department, while maintaining necessary legacy operational delivery and front-line response to the pandemic.

Detailed Performance Analysis

Introduction

17. The performance analysis section provides an evidence-based, analytical overview of how the Department has performed against its key objectives during 2022-23. The analysis covers the key areas that can be measured within each of the five priority outcomes.

18. Some priority and sub outcomes, such as urgent and emergency care and elective recovery, allow an immediate overview of performance. Other areas, such as cancer outcomes and the reduction of health disparities, have much longer lead times. Where data is not yet available yet, this has been highlighted in the text.

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

19. The response to the Coronavirus pandemic remained one of the key strategic priorities for the Department in 2022-23.

20. With the deployment of vaccines and treatments, and despite the added pressures in winter 2022-23 of COVID-19 and other respiratory illnesses, including flu and respiratory syncytial virus (RSV), the Department managed the situation without further restrictions or significant use of contingencies. The health and social care system therefore moved into a direction of no longer managing COVID-19 as a standalone risk, but towards integrating the response with how it manages other infectious threats.

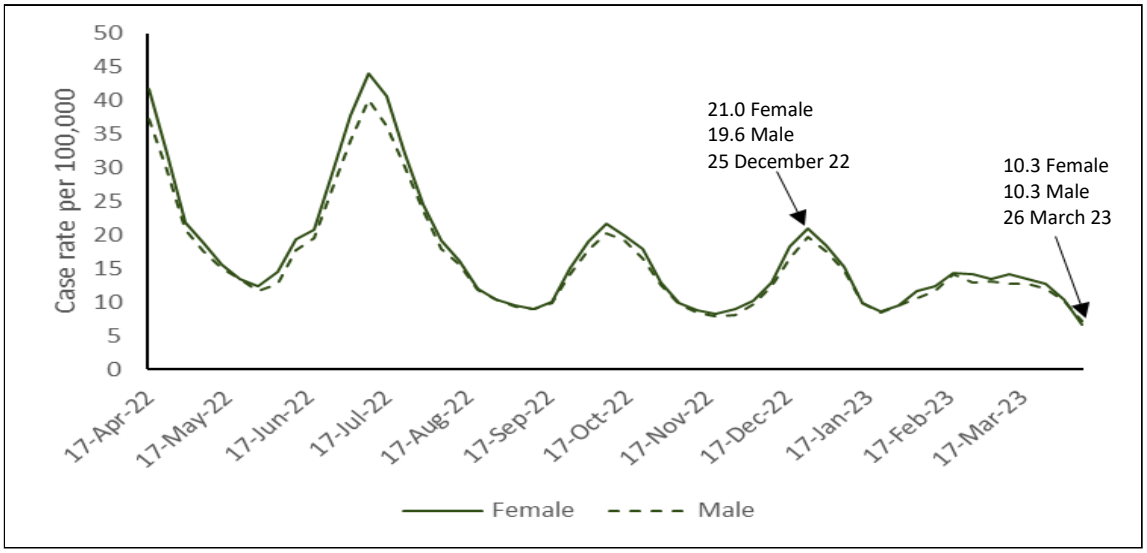
21. The COVID-19 Battle Plan was launched in 2020 as the Department's programme for coordinating and delivering the response to the pandemic. Throughout 2022-23, several Battle Plan workstreams moved towards normalising their COVID-19 response within business-as-usual structures, while others progressed to transitioning or closing specific COVID-19 response areas. Following assurance work with all workstreams on their transition, the Department's Executive Committee (ExCo) approved the recommendation to close the COVID-19 Programme (Battle Plan) and its Oversight Board at the end of March 2023. Normalised areas of response are expected to maintain readiness for surges of COVID-19 and contingency planning within their business-as-usual plans. Some legacy work will also continue across all workstreams, including responding to the independent UK COVID-19 Inquiry.

COVID-19 Prevalence

22. The prevalence of COVID-19 infection amongst the population was measured by the Office for National Statistics (ONS) through the Coronavirus (Coronavirus (COVID-19) Infection Survey (CIS) and the UK Health Security Agency's (UKHSA) national flu and COVID-19 surveillance reports. The CIS was discontinued from 24 March 2023 in line with the reduction in prevalence of the COVID-19 pandemic.

23. The weekly national flu and COVID-19 surveillance reports show the COVID-19 case rates through Pillar 1 testing (in UKHSA labs or in hospitals), the number of Pillar 1 COVID-19 episodes, and polymerase chain reaction (PCR) test positivity. Changes to testing regimes (such as the ending of asymptomatic testing in NHS settings from 31 August 2022) and changes in recording (such as UKHSA's change to episode-based reporting which now includes re-infections as of 31 January 2022) may impact these case rates. As shown in **Figure 2**, as of 25 December 2022, case rates through Pillar 1 were 21.0 and 19.6 per 100,000 for females and males respectively. By 26 March 2023, this had fallen to 10.3 per 100,000 for both females and males respectively. Case rate in this context refers to the number of positive Pillar 1 tests amongst the ONS mid-2020 population estimates.

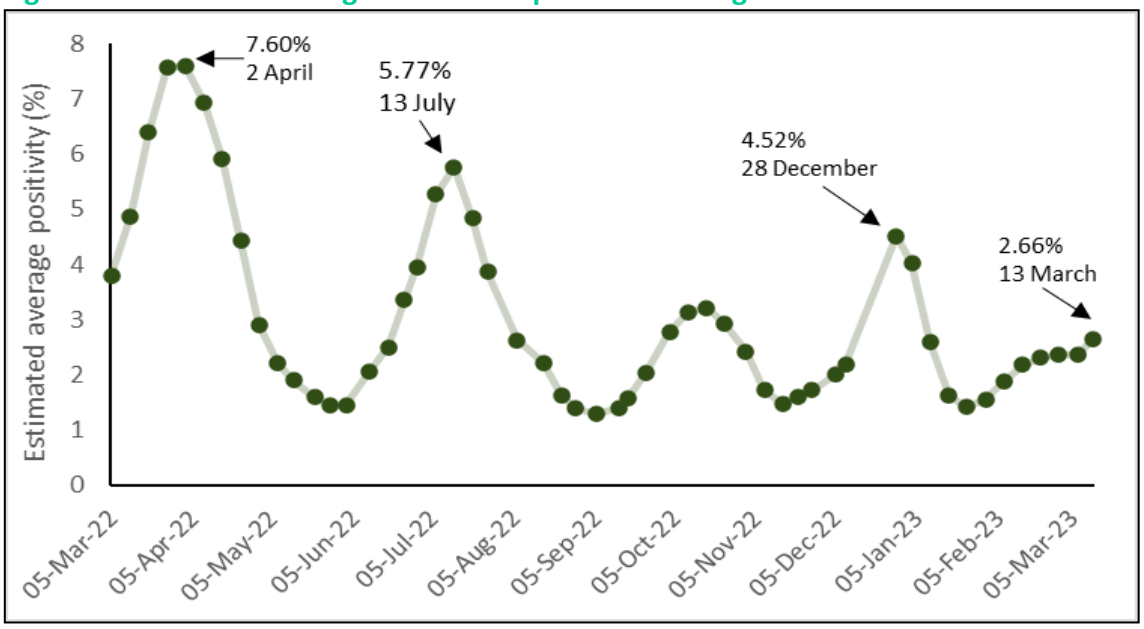
Figure 2: Weekly Confirmed COVID-19 Case Rates per 100,000, by Episode, Tested Under Pillar 1, by sex.



Source: UKHSA National flu and COVID-19 surveillance report

24. Data from the final publication of the Coronavirus (COVID-19) Infection Survey on 24 March 2023 report can be found in **Figure 3**. During the winter period, infection peaked in England. An estimated 4.52% of the population were infected with COVID-19 as of the week ending 28 December 2022, lower than the peaks seen in spring and summer 2022 (7.60% and 5.77% as of the weeks ending 2 April 2022 and 13 July 2022 respectively). The final data recorded as of 13 March 2023 showed an estimated 2.66% of the population were infected with COVID-19.

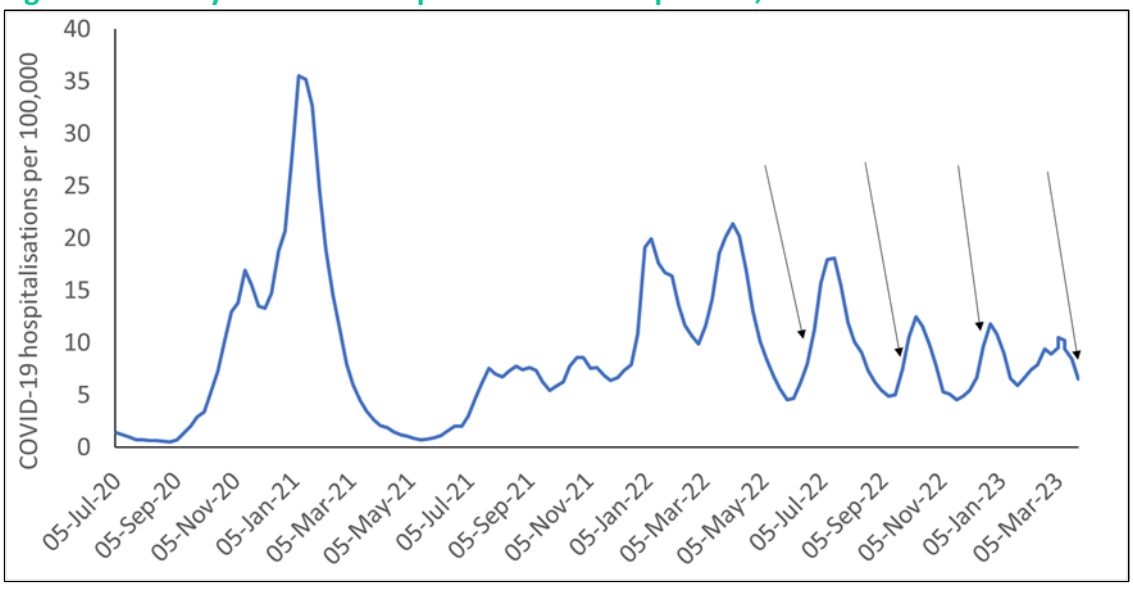
Figure 3: Estimated Average % of the Population Testing Positive for COVID-19



Source: Coronavirus (COVID-19) Infection Survey, UK: 24 March 2023

25. The COVID-19 hospital admission rate (**see Figure 4**) in England remained relatively low in comparison to the peak seven-day average of 35.2 per 100,000 people seen in mid-January 2021. There was a weekly average of 11.2 admissions per 100,000 at the end of Quarter 1 (week ending 26 June 2022). This figure fluctuated in line with COVID-19 infections across the autumn and winter and into the spring of 2023. Admission rates per 100,000 were 7.4 at the end of Quarter 2 (week ending 25 September 2022), 11.8 at the end of Quarter 3 (week ending 25 December 2022) and 6.6 at the end of Quarter 4 (week ending 26 March 2023). The maximum admission rate seen for 2022-23 was 21.4 per 100,000 seen on week ending 03 April 2022, and the minimum was 4.5 per 100,000 seen on week ending 29 May 2022.

Figure 4: Weekly COVID-19 Hospitalisation Rates per 100,000



Source: UKHSA National flu and COVID-19 surveillance report

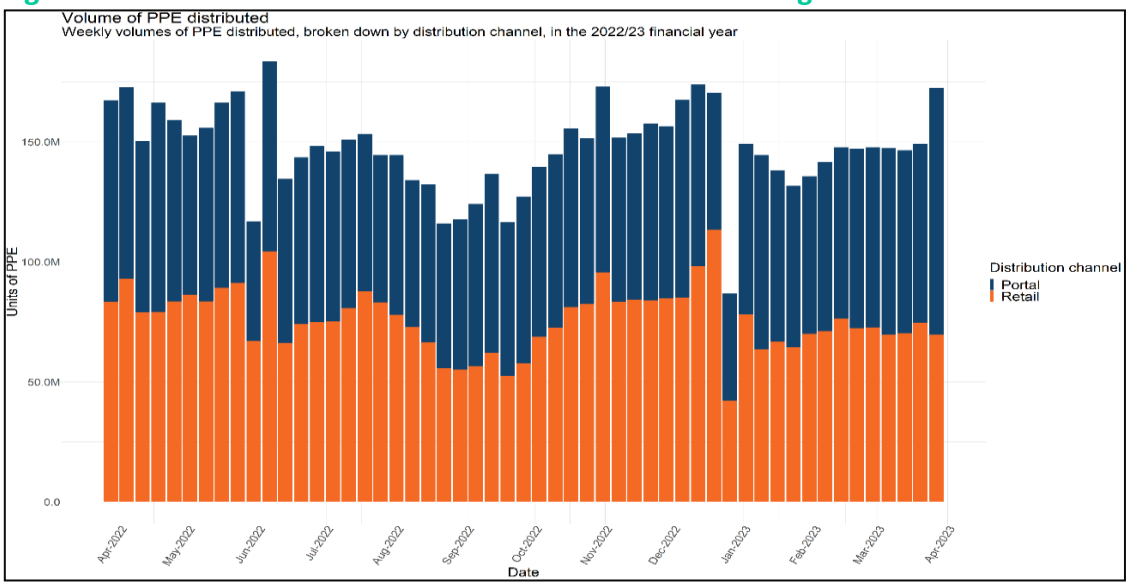
26. The number of death registrations involving COVID-19 per week in England peaked in week ending 29 April 2022, where a total of 1,125 deaths were registered. The fewest deaths were registered in week ending 3 June 2022. COVID-19 death registrations over 2022-23 followed similar trends as seen in the COVID-19 positivity in **Figure 2,** and by the end of 2022-23 33,140 deaths involving COVID-19 had been registered, 56% fewer than the 76,094 registered in the 2021-22 period[1].

Personal Protective Equipment

27. As shown in **Figure 5**, during 2022-23, the Department successfully provided an uninterrupted supply of free COVID-19 Personal Protective Equipment (PPE) to the health and social care sector.

28. Between April 2022 and March 2023, the Department distributed 7.7 billion items. In January 2023, the Department announced that the commitment to provide free PPE would be extended to March 2024 or until stocks are depleted.

Figure 5: Number of PPE Items Distributed Each Week During 2022-23



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

29. Having taken on the responsibility for the supply and distribution of COVID-19 PPE in the pandemic, that responsibility remained with the Department until the end of March 2022.

30. From April 2022, the Department retained responsibility for reducing its excess stock and associated storage, but responsibility for business-as-usual distribution transferred to NHS Supply Chain, which distribute PPE to the wider health and care sector, including primary care (such as general practice, community pharmacies, dentistry and optometry), adult social care (support to adults with physical or learning disabilities, or physical or mental illnesses), and other non-acute settings and contexts such as palliative and end-of-life care providers.

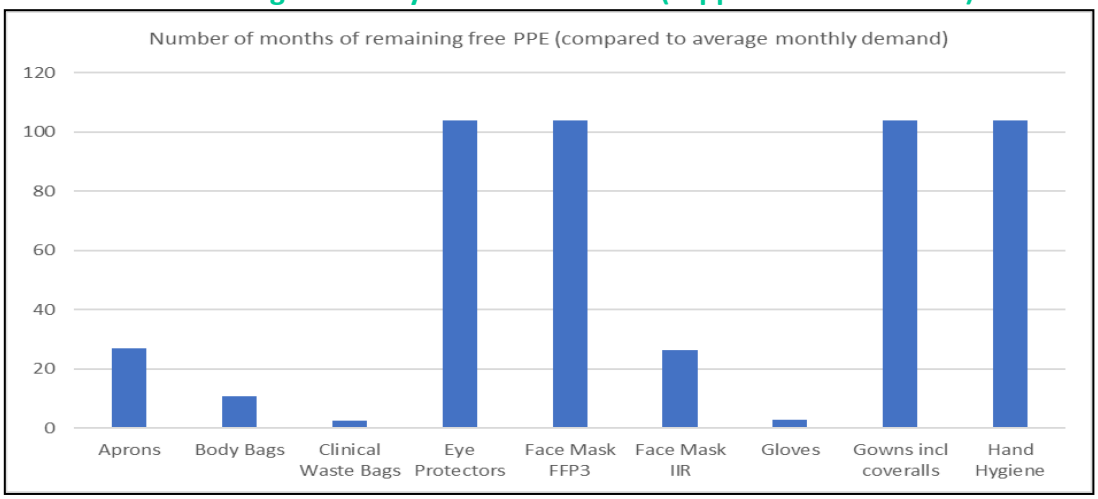
[1] Source: Deaths registered weekly in England and Wales, provisional - Office for National Statistics (ons.gov.uk)

31. NHS Supply Chain has been working to integrate the provision of PPE to acute settings into pre-existing infrastructure, thereby facilitating removal and rationalisation of operational duplications, and to continue providing a PPE ordering portal and associated distribution network for predominantly non-acute settings and contexts (e.g., primary care, social care, and other eligible users).

32. Prior to the pandemic, there was no national database on NHS Trust stock levels of PPE, because it is normally low-cost and easy to secure. Efforts to estimate the reasonable worst-case requirements for PPE began in early March 2020, based on Infection Prevention Control (IPC) guidance, initially considering direct COVID-19 care in acute settings. That early modelling was based on reasonable worst-case scenarios for the virus, from Scientific Advisory Group for Emergencies (SAGE), and our understanding of how much PPE would be required in those scenarios. We planned on a reasonable worst-case scenario, which never fully emerged. In addition, plans were based on the expectation that all categories of 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.

33. **Figure 6** shows the volume of free PPE stock remaining on the 31 March 2023, expressed in terms of the number of months the stock would last at unconstrained average monthly demand. In some categories we continue to have many months of stock remaining. No categories stocked out before the end of March 2023 and the programme is well placed to manage an orderly transition to business-as-usual provision through NHS Supply Chain.

Figure 6: Volumes of Remaining Free PPE Stock, Showing How Many Months the Stock Would Last at Average Monthly Level of Demand (capped at 104 months)



Source: Figures for this chart are calculated by using the year-end stock position as of 31 March 2023 and dividing by average monthly figures for usage. The monthly demand numbers are taken from forward projections of usage, which track recent trends and estimate future levels of demand whilst free PPE continues. Chart is capped at 104 months for usability, further details of the PPE scheme are available here. This also states that "the value of the free PPE scheme for the period 1 April 2021 to 31 March 2023 is around £471,385,725.53. NHS trusts are not included within budgeted costs as they are not subject to subsidy control rules. The value of the scheme for the period 1 April 2021 to 31 March 2024 will be published in 2023 to 2024." The chart includes only those items marked as 'release', so excludes items that are not suitable for use. It includes items stored in UK warehouses or containers only. There is no adjustment for expiry dates, i.e., it includes all 'release' stock regardless of expiry date. The chart is capped at 104 months because the bars for some categories are very large and the chart would not be useable if the full height of the eye protector bar was shown, for example.

34. When it came to managing and reducing our excess PPE and related stock, our priorities were to sell, donate, repurpose, or recycle whatever we can (thereby aligning with the Government's waste hierarchy).

35. Nevertheless, there are some PPE products that cannot be reused or recycled, and which must, for example, be subject to less preferred methods in the waste hierarchy such as 'energy from waste' processes. Most 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 held are not able to be fully recycled and around half are completely non-recyclable.

36. Demand for PPE has fallen as countries move towards their own living with COVID-19 strategies and other countries with surplus stock enter the marketplace for re-sale. As a consequence of the continuing distribution of PPE free of charge, sales, recycling, and contract cost recovery, the exits from the network helped reduce storage costs.

37. In March 2022, an online auction was launched to sell PPE so that individuals and companies may bid for our excess stock. As of 28 February 2023, the Department had sold 11,900 pallets of PPE and associated stock for the PPE Programme through e-auctions, which equated to 161 million items.

38. In March 2022, contracts were awarded to two expert waste service providers. These Lead Waste Partners reviewed the feasibility of recycling each item across the excess and provide detailed options. Since then, the speed of the programme was accelerated. This was particularly the case for stock that was likely to become out-of-date before it was ever used, unsuitable for recycling or particularly complex and costly to recycle.

39. By September 2022, for every pallet of PPE sold, repurposed, donated and recycled, it is estimated the taxpayer avoided on average £2.49 of storage costs per pallet per week.

40. Up to 28 February 2023, 269,500 pallets of PPE had been removed from stock, which equated to 3.14 billion items removed through a mixture of recycling, energy from waste processes, donations, and sales.

41. Several PPE contracts 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.

42. The Department's Contract Dissolution Team (CDT), formed in early 2022, worked through the contracts to minimise loss of public money. The CDT is responsible for resolving issues relating to contracts that are in commercial and legal dispute. The precise nature of each contract dispute differs; however, most are predominantly

focused on elements related to quality control reviews by the Department, i.e., products that were contracted for - but which did not meet - the specified contractual standard.

43. **Table 1** shows the progress made on reducing the number of outstanding contracts. It shows the number of PPE contracts which the team were looking at, the associated value risk (i.e., the value of product at the time it was bought and for which the products had an issue) relating to those contracts and how this was reduced over the quarters.

Table 1: DHSC PPE Contracts in Dissolution - 2022-23

DHSC PPE Contracts in Dissolution	Q1	Q2	Q3
(FY 2022 23)	Apr Jun	Jul Sep	Oct Dec
Number of contracts at the end of each quarter	141	104	60
Associated value at risk (£s billion)	£2.37	£1.95	£1.62

Vaccines and Treatments, Research and Deployment

44. The COVID Vaccine Unit took over the enduring responsibility for COVID-19 vaccine supply from the Vaccine Taskforce on 1 October 2022 as part of its transfer to UKHSA and the Office for Life Sciences (OLS). The innovative approaches, skills, operating models, and team, that were key to the Vaccine Taskforce's success, have continued in the unit as an integrated multidisciplinary directorate within the UKHSA. The Vaccine Taskforce's work in onshoring vaccine manufacturing sits within OLS.

45. The UK was the first country to licence and roll out a bivalent messenger RNA (mRNA) vaccine targeting specific variants as part of its Autumn 2022 COVID-19 vaccine campaign and secured sufficient vaccines to supply the spring booster vaccination campaign, which ran between April and June 2023. In December 2022, the Government signed a 10-year strategic partnership with Moderna, for Moderna to invest in UK-based research and developments, including clinical trials, PhD places and research programmes, and build a state-of-the-art vaccine manufacturing centre.

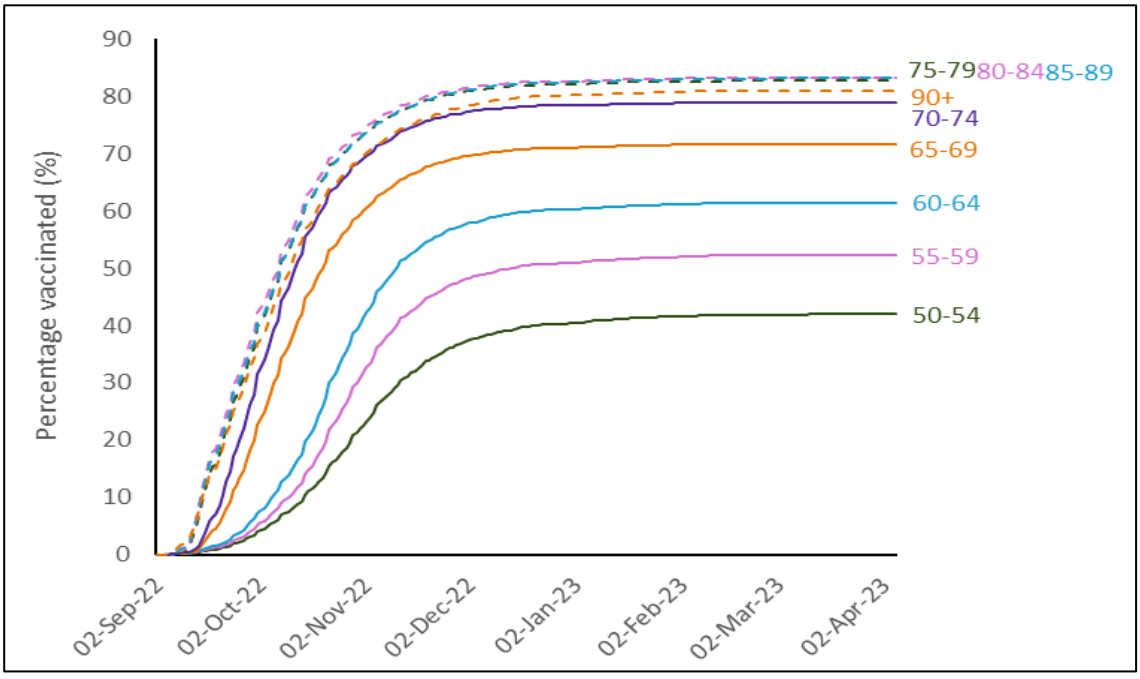
46. The success of the vaccine campaign was key to enabling the COVID-19 Response: Living with COVID-19 (LWC) strategy and significant work continued on COVID-19 vaccine deployment. As of 26 March 2023, 93.9% of the population aged 12 and over had their first dose of the vaccine, 88.8% had their second dose of the vaccine and 70.1% had their booster or third dose of the vaccine (figures calculated using this online tool).

47. The Department also worked to ensure deployment continued to focus 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.

48. As COVID-19 and flu would be circulating at the same time in winter 2022-23, it was vital all those eligible came forward for both jabs to protect our most vulnerable. Everyone aged 50 and over was offered a COVID-19 booster and a flu jab under plans to increase protection against respiratory viruses and keep more people out of hospital. This was supported by a nationwide communications campaign to encourage uptake. Since the Autumn COVID-19 booster programme began on 5 September 2022, over 17.4 million autumn booster doses were administered in England before the offer closed on 12 February 2023. Over 21.2 million flu doses had also been administered in England as of 31 March 2023. **Figure 7** shows the percentage of the English population who had received a COVID-19 Autumn 2022 booster vaccination.

Figure 7: Autumn Booster 2022 Vaccination Uptake by Age, extracted on 1st June 2023



Source: UKHSA COVID-19 dashboard

49. In January 2023, the Joint Committee on Vaccination and Immunisation (JCVI) published interim advice for further booster vaccinations for those at higher risk of severe disease. In March 2023, JCVI published the JCVI statement on spring 2023 COVID-19 vaccinations recommending an extra booster dose in Spring 2023 for a number of high-risks groups.

50. The PANORAMIC national study was launched in 2021 to gather further information on who benefits most from oral antiviral treatments for COVID-19. At the end of March 2023, the trial had recruited over 27,000 patients. In December 2022, the PANORAMIC study reported in the Lancet that early treatment with Molnupiravir in the community did not reduce hospitalisations or deaths in a mostly vaccinated population, when hospital admission was low. The treatment was, however,

associated with a faster recovery time and reduced viral detection and load; participants who received Molnupiravir reported feeling better compared to those who received usual care. These results provided a much clearer picture on how Molnupiravir works against the Omicron variant and who benefited most from receiving Molnupiravir to treat COVID-19 in the UK's mostly vaccinated population. Molnupiravir continues to be available to those at greatest risk from COVID-19.

51. In line with the Government's LWC strategy, the Antivirals and Therapeutics Taskforce closed on 31 March 2023 and the NHS took over oversight of the treatment of COVID-19 patients and will operate in line with evidence-based recommendations from the National Institute for Health and Care Excellence.

52. The Medicines and Healthcare products Regulatory Agency (MHRA) continued to provide support and guidance for industry on flexible regulatory approaches. During the acute phase of the COVID-19 outbreak, MHRA implemented a number of regulatory flexibilities for clinical trials, marketing authorisations, inspections, and drug safety. We have used the lessons learned from these to help shape our regulatory framework, ensuring that MHRA is a proportionate regulator and an enabler of innovation. MHRA has also been building on the successes of cross-organisation working to further enhance expedited pathways such as the Innovative Licensing and Access Pathway and the Innovative Devices Access Pathway.

53. We saw many well-designed clinical trials in response to COVID-19 that saved lives. The Oxford RECOVERY trial identified several treatments for COVID-19, including the first evidence in the world identifying that dexamethasone could reduce mortality for COVID-19 patients. However, the global response also saw poor trials, and these were far more common than those of high quality. To tackle this, the Department spearheaded a new World Health Assembly (WHA) resolution to strengthen clinical trial practice globally, adopted by consensus of all World Health Organization (WHO) Member States at the Seventy-fifth WHA, setting a series of principles for Member States to address these issues as well as a suite of actions for the WHO to support implementation.

54. The MHRA has been working to establish a framework to support more innovative ways of conducting clinical trials in response to proposed regulatory legislative changes. New working groups involving patients and the research community have been developing clear, comprehensive guidance alongside any legislative changes the Department may need to make. New legislation will empower researchers and innovators to take more risk appropriate approaches to trials, including more flexible regulatory requirements and an overarching legal duty to consider proportionate approaches. For trials where the risk is similar to that of standard medical care, a 'notification scheme' will now enable a clinical trial to be approved without the need for regulatory review.

UK Health Security Agency (UKHSA)

55. UKHSA played a lead role in implementing the measures set out in the LWC strategy. It stood down most COVID-19 testing capacity, while continuing to organise testing in high-risk settings such as hospitals and care homes, in August 2022.

56. UKHSA prepared contingency plans in the event that a serious variant of concern required additional testing to be reintroduced, as well as other measures. From January to March 2023, it ran the Heathrow COVID-19 testing surveillance programme, testing a proportion of people arriving from China, in light of concerns that the COVID-19 wave in China may lead to the emergence of new variants.

57. On 30 March 2023, UKHSA announced COVID-19 testing approach plans for 2023-24, including testing to support diagnosis for clinical care and treatment and to protect very high-risk individuals and settings. The approach to COVID-19 surveillance was being reviewed, including discussions with ONS.

Pandemic Preparedness

58. The Department, UKHSA and NHS England (NHSE) have a range of well-tested pandemic and emerging infectious diseases response capabilities. These capabilities allow us to flexibly respond to future outbreaks, protect the health of the UK population, and to contribute to minimising the wider societal disruption that pandemics and infectious disease events can cause.

59. UKHSA also addresses pandemic disease and preparedness through the Centre for Pandemic Preparedness (CPP). This aims to ensure the UK's future pandemic response is faster, more effective, and more efficient to minimise any negative impacts of health threats to the UK.

60. The Department, working closely with UKHSA and NHSE, has been defining a new Pandemic Preparedness Portfolio, in light of the COVID-19 Battle Plan, pre-existing work and the review of pandemic preparedness pre-COVID-19, and the work of the CPP. This will cover the overall objectives and deliverables to maintain and develop new capabilities into a future state of preparedness for a pandemic scenario.

61. UKHSA also employs a permanent Director of Emergency Preparedness, Resilience and Response function (EPRPR), which incorporates preparedness for, and resilience to, all incidents. Since UKHSA's inception in October 2021, there have been 17 preparedness exercises led by the UKHSA EPRPR Exercises Team, including on managing and responding to variants of concern and variants under investigation.

Protecting the UK from Global Threats

62. We have also seen major outbreaks of Ebola and an epidemic of monkeypox in 2022-23. The likelihood of new and emerging threats spreading rapidly is increasing due to rapid global travel and trade, population movement, environmental change, and changes in human behaviour. UKHSA continued to respond to global threats, working collaboratively with the WHO, industry, global counterparts, and other

philanthropic foundations. Scientific, data and policy collaboration with global counterparts provides essential intelligence for protection from global threats.

63. From 1 April 2022, the Government removed guidance on COVID-19 voluntary domestic certification. The COVID-19 pass would still be needed for international travel to countries continuing to require evidence of vaccination status.

64. On 26 June 2022, the Government announced £25 million of UK aid to the World Bank's Pandemic Fund, which finances critical investments to strengthen pandemic prevention, preparedness and response capacities at national, regional and global levels, with a focus on low- and middle-income countries.

Social Care Resilience

65. The Department continued to support adult social care providers to protect people receiving care by providing access to testing and personal protective equipment for free. Eligibility for testing changed throughout the course of 2022-23 to ensure testing was proportionate while continuing to protect those most vulnerable to COVID-19. Free lateral flow device tests remained available throughout 2022 for symptomatic testing of staff and residents, with asymptomatic staff testing ending in August 2022. Guidance was regularly updated to reduce burdens on care staff in line with the reduced level of risk posed by COVID-19.

66. Guidance on infection prevention and control in adult social care settings came into force in April 2022 and included a COVID-19 supplement. This provided the sector with detailed and evidence-based general infection prevention and control information along with COVID-19 specific advice. In December 2022, this guidance was updated to allow more flexibility for care providers and enable them to take more individualised, risk-based approaches. It was further amended on 30 March 2023 to remove much of the testing and isolation burden and to align the COVID-19 approach more closely with that taken for other respiratory infections.

67. The Department worked to improve the experiences of care recipients and to prevent overly onerous restrictions in care homes. Guidance was amended to make clear that care home residents should be able to receive at least one visitor at all times, even during outbreaks or while isolating. Access to visitors has been monitored by the Care Quality Commission (CQC) and through the capacity tracker, which enables care home, in-patient community rehabilitation, substance misuse and hospice providers to share vacancy and other critical information easily and quickly in real time.

Protecting the Most Vulnerable

68. The QCOVID predictive risk model helped clinicians identify other adults with risk factors that make them more vulnerable to COVID-19. At the height of the pandemic, the tool was accessed about 1,000 times per day, whereas figures between January and March 2023 suggested fewer than 30 transactions in total. Low usage and the fact the tool did not consider variants post-July 2021 resulted in QCOVID being closed and put on standby in March 2023.

69. Following the closure of the shielding programme, at the end of 2021 there remained approximately 1.8 million patients whose immune systems meant that they continued to be at higher risk of serious illness from COVID-19 despite vaccination. As a result, a time-limited internal enhanced protection programme was established in January 2022, looking to coordinate the Government's response to these individuals, which included specific COVID-19 treatments, booster vaccinations and advice on protective behaviours. These interventions transitioned to the wider health system and the programme was closed in March 2023.

Key Products Resilience

70. In line with the approach being taken for other non-medicine stockpiles, the requirement to maintain to contingency planning scenario levels as a baseline capability is being reviewed through Ministers.

Non-Pharmaceutical Interventions

71. The success of the COVID-19 vaccination programme facilitated the introduction of LWC on 21 February 2022 to remove remaining legal restrictions and encourage safer behaviours to protect public health, including measures to continue protecting people most vulnerable to COVID-19 and maintaining resilience. Since its publication, there has not been any further requirement to re-introduce non-pharmaceutical interventions.

NHS Resilience

72. The NHS faced challenges from multiple infectious diseases, including COVID-19 and flu, and considerable strain on elective and urgent and emergency care. NHS England set out its winter plan to deliver the annual flu vaccination programme and to offer an autumn booster to provide protection to those most at risk of severe COVID-19, as well as plans to increase bed numbers and staffing, to address backlogs, and to create resilience in services. Details of this work are set out in **Priority Outcome 2**.

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

Elective Care

73. 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. The elective waiting list in England grew from 4.4 million when the pandemic began to a record high of 7.3 million patients in March 2023 (up from over 6.3 million patients in March 2022). The number of patients waiting over a year for treatment increased from approximately 1,600 in February 2020 to approximately 360,000 patients in March 2023.

74. The Government remains committed to ensuring people get the right care at the right time and continues to tackle this elective backlog in the biggest catch-up programme in the NHS's history. In March 2022, the Government announced plans in Build Back Better: Our Plan for Health and Social Care to spend more than £8 billion from 2022-23 to 2024-25.

75. As part of the Autumn Statement 2022, the Government announced an additional £3.3 billion per year for 2023-24 and 2024-25 to support the NHS in England, enabling rapid action to improve emergency, elective, and primary care performance towards pre-pandemic levels.

76. Taken together, this funding could deliver the equivalent of around 9 million more checks and procedures and would mean the NHS in England can aim to deliver around 30% more elective activity by 2024-25 compared to 2019-20.

77. In addition, the Department has also committed to a £5.9 billion investment in capital to support diagnostics, technology, and elective recovery.

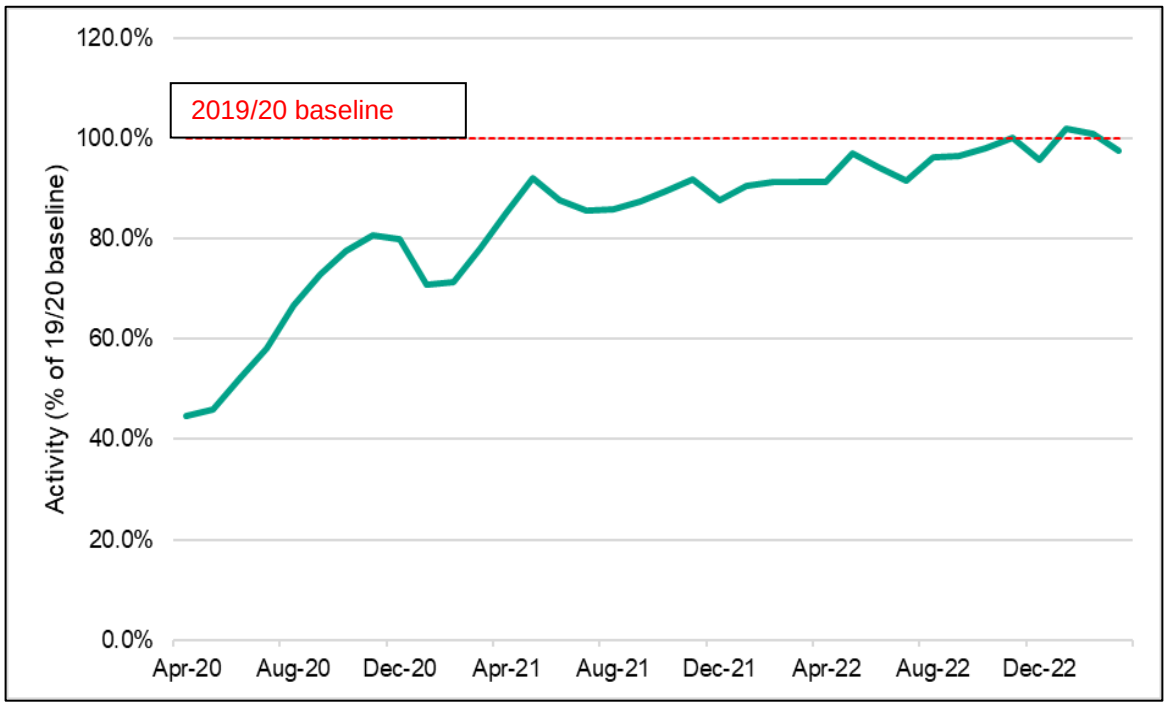
78. In February 2022, the NHS published the Delivery Plan for Tackling the COVID-19 Backlog of Elective Care ('the Elective Care Delivery Plan'). This plan sets out a clear vision for how the NHS will recover and expand elective services until 2025. Thanks to the incredible hard work of NHS staff, waits of 2 years (104 weeks) or more for elective procedures were virtually eliminated in July 2022 (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 was 2,890, down from the peak of 24,424 in January 2022; as of March 2023, there were 559 patients waiting over 104 weeks for treatment in England.

79. The NHS continued to focus on delivering the ambitions set out in the Elective Care Delivery Plan and made significant progress in tackling waits of 78 weeks or more. Since the beginning of February 2022, the NHS had treated more than 2 million people who would otherwise have been waiting 78 weeks by the end of March 2023. The number of patients waiting more than 18 months fell to just 10,737 by April 2023 – down by more than 90% from 124,911 in September 2021 and by more than 80% since the start of January 2023 when there were 54,882.

80. The number of patients waiting more than 1 year for treatment was around 360,000 in March 2023, up from just over 310,000 in March 2022, but down from a peak of almost 411,000 in October 2022.

81. As shown in **Figure 8**, in England, current per working day activity levels (total completed pathways) in March 2023 were over 96.8% of pre-pandemic levels, up from 71% at the peak of pressures in January/February 2021. When adding improved specialist advice and guidance services, which seek to avoid unnecessary referrals for hospital care, this is equivalent to a 101.9% of total activity compared to pre-pandemic.

Figure 8: Per Working Day Activity (excluding the impact of specialist advice and guidance services) as % of 2019-20 Baseline



Source: RTT Waiting Times data

82. NHS Planning Guidance for 2022-23 set out an Elective Activity Target of 104% of pre-pandemic value weighted elective activity nationally. For reasons not anticipated at SR21, this activity target was unachievable within available funding, this was due to factors such as:

- The direct impact of higher levels of COVID and staff absence;

- Lower than expected recovery of pandemic-related productivity drag driven by factors including higher use of bank and agency staff, and disruptions to hospital flow from COVID patients;
- Increased pressure from Urgent and Emergency Care (UEC) and reduced social care capacity leading to higher levels of bed occupancy including delayed discharges, and;
- Hospital cancellations in response to Industrial Action (between December and March).

83. As a result, the decision was taken not to implement clawback during 2022-23 and the NHS retained access to the full Elective Recovery Funding ringfence. This allowed the NHS to maximise elective activity in the given conditions.

84. Efforts to boost elective recovery included increasing capacity – including via Community Diagnostic Centres (CDCs) and surgical hubs, seeking alternate capacity in other trusts or the independent sector, and offering patients more choice over where they receive their NHS treatment after they are referred by their GP.

85. Independent sector providers have played a significant role in supporting the NHS as trusted partners to recover elective services. The Government launched the Elective Recovery Taskforce ('the Taskforce') on 7 December 2022, bringing together academics and healthcare experts to advise the Government on how to unlock capacity in the independent sector to reduce waiting times for things like knee and hip replacements.

86. The last meeting of the Taskforce was on the 28 March 2023 and an Implementation Plan was published on 4 August 2023. The Implementation Plan will summarise the outcome of the Taskforce work into specific themes which can help tackle the backlog and shape proposals for how the healthcare system can make use of all available resources.

Diagnostic Overview

87. In the Autumn Budget and Spending Review 2021, the Department announced £2.3 billion of capital investment, where £900 million of this was ring-fenced in 2022-23 to increase the volume of diagnostic activity and to roll out up to 160 CDCs by March 2025, to help clear the backlog of people waiting for clinical tests, such as magnetic resonance imaging (MRI), ultrasound, and computerised tomography (CT) scans. Public Dividend Capital (PDC) payments relating to diagnostics made in 2022-23 totalled £692 million, of which £352 million was provided for CDCs. CDCs increase diagnostic capacity, supporting faster, earlier diagnosis and reduced waiting times for better patient outcomes.

88. The funding for CDCs is expected to deliver up to 17 million diagnostic tests by March 2025, and will increase annual capacity by up to 9 million tests thereafter – an increase in capacity of a quarter compared with the three years prior to the pandemic.

89. During the 2022-23 financial year, nearly 24.5 million diagnostic tests and over 16 million operations and procedures were delivered by the NHS in England. This compares to nearly 23 million diagnostics tests and over 15 million operations and procedures during the 2021-22 financial year, increases of 6.2% and 7.5% respectively.

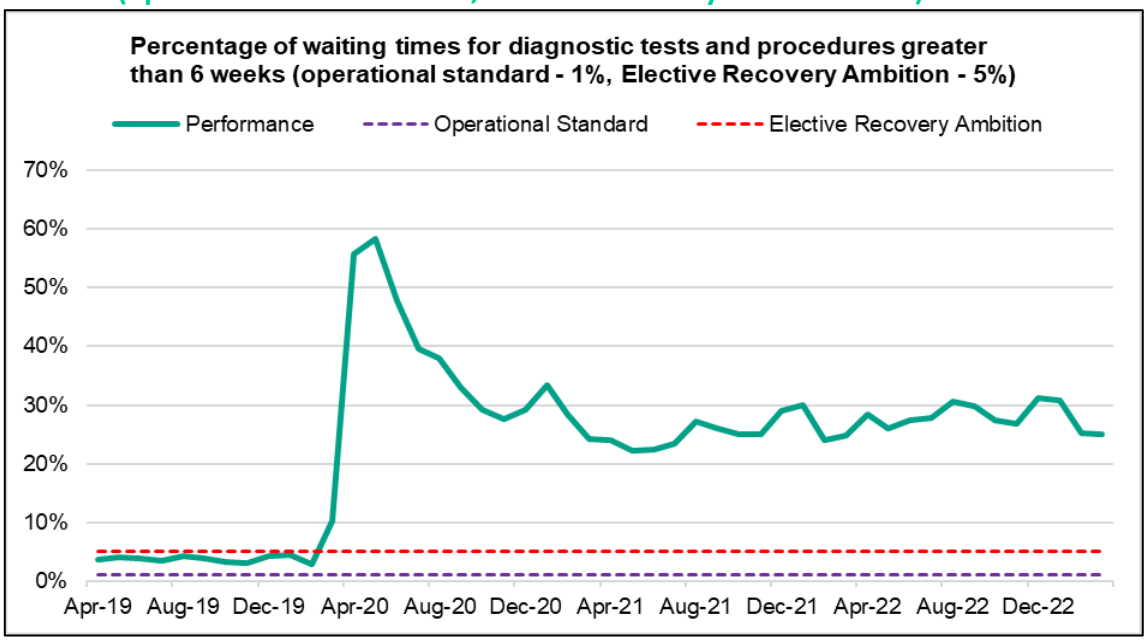
90. NHSE made an assessment of what factors may be driving demand in both planned and unplanned diagnostic activity. These include:
- Clinician behaviour (lower thresholds for requesting tests, testing to reduce the need to admit patients for observation, increased delegation to more junior staff).
- 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 emergency care services instead.
- New therapies, policies, and pathways, such as genomics and cancer, driving increased testing.
- The length of elective waiting lists meaning that more patients are receiving multiple re-tests while waiting for treatment.

Community Diagnostic Centres (CDCs)

91. Throughout 2022-23, local systems (Integrated Care Boards and Trusts), including leads from the sponsoring Trust and the local NHS commissioner, focused on launching the new CDCs with patients who would otherwise have required tests in acute hospitals being diverted to CDCs. This supported the system given the high volumes of urgent and emergency patients requiring diagnostics on acute sites and the need to provide COVID-19-secure facilities for elective diagnostics wherever possible. The expansion in capacity was to support the Department's ambition, set out in the Elective Care Delivery Plan, that 95% of patients needing a diagnostic test receive it within 6 weeks by March 2025. Further detail on performance against this 95% target is shown in **Figure 9**.

92. As of March 2023, there were operational 100 CDCs. These had delivered over 3.67 million tests, checks, and scans, of which over 1.7 million had been imaging tests, and over 100,000 endoscopies. As of 8 April 2022, 81 CDCs were operational (19 large models, 38 standards, and 24 spokes). They had cumulatively delivered 776,163 tests.

Figure 9: Percentage of Waiting Times for Diagnostic Tests and Procedures Greater Than 6 weeks (operational standard - 1%, Elective Recovery Ambition - 5%)



Source: Monthly Diagnostic Waiting Times and Activity

Surgical Hubs

93. One of the commitments set out in the Elective Care Delivery Plan is to transform the way the NHS provides elective care by increasing activity through dedicated and protected surgical hubs, focusing on providing high volume, low complexity surgery, as recommended by the Royal College of Surgeons of England.

94. As at March 2023, there were 87 identified elective surgical hubs operational across England, helping to separate elective care facilities from urgent and emergency care, thus helping improve outcomes for patients and reduce pressures on hospitals. This compares to 93 identified operational surgical hubs one year prior in March 2022. The number of operational surgical hubs was subject to a process of being audited to ensure operational surgical hubs met the definitions agreed by NHSE and were therefore subject to change; several sites previously identified as meeting the definition of a surgical hub were on review, not offering sufficient ring-fenced elective capacity. For surgical hubs delivered and funded via the Targeted Investment Fund 2 (TIF2) funding agreed at SR21, by March 2023, two had opened and were patient ready.

Cancer

95. Cancer performance across the various standards, measured by NHSE, is illustrated in **Figures 10 to 13**. Performance remained negatively impacted by the pandemic and the increased number of referrals coming through the system.

96. The success of the national 'Help Us, Help You' communications campaign resulted in a significant rise in the number of people coming forward with potential cancer symptoms, with referrals seen now consistently above pre-pandemic levels. For example, referrals were at 125% of pre-pandemic (March 2019) levels in March 2023, on a per working day basis.

97. Cancer remains a top priority as services recover. The Elective Care Delivery Plan committed 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.

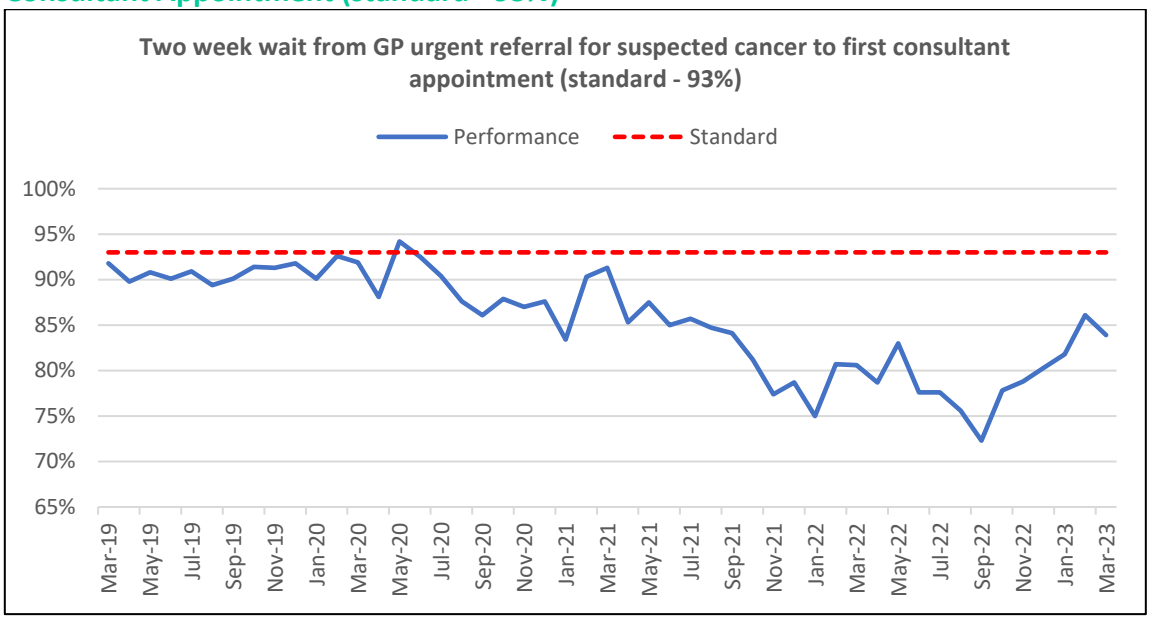
98. On the 62-day backlog, at the end of March 2023 the backlog was 19,248 – a reduction of 43% since peaking at 34,050 in May 2020. However, this figure did not represent a return to pre-pandemic levels (14,123 at week ending 16th February 2020), largely due to the record referral levels, as highlighted above.

99. In February 2023, 75% of patients (see **Figure 13**) were diagnosed with cancer, or had it ruled out, within 28 days of referral, which meant the Faster Diagnosis Standard was reached for the first time since the standard was introduced in April 2021.

100. **Figures 10 to 13** demonstrate performance against some of the key cancer metrics used as measures of success against the Department's stated ambition of improving healthcare outcomes. Not all metrics have been reported for the same length of time, which is why not all graphs are shown over the same time period. Overall, performance against six of the nine cancer waiting times standards was down between April 2022 and March 2023. However, performance did improve against the standard to see a specialist within two-weeks of GP referral, for all cancer patients, and for those with breast cancer symptoms. In some key areas cancer services proved very resilient to the pandemic and continue to perform well, with 91.9% of patients starting their first cancer treatment within one month of a decision to treat in March 2023.

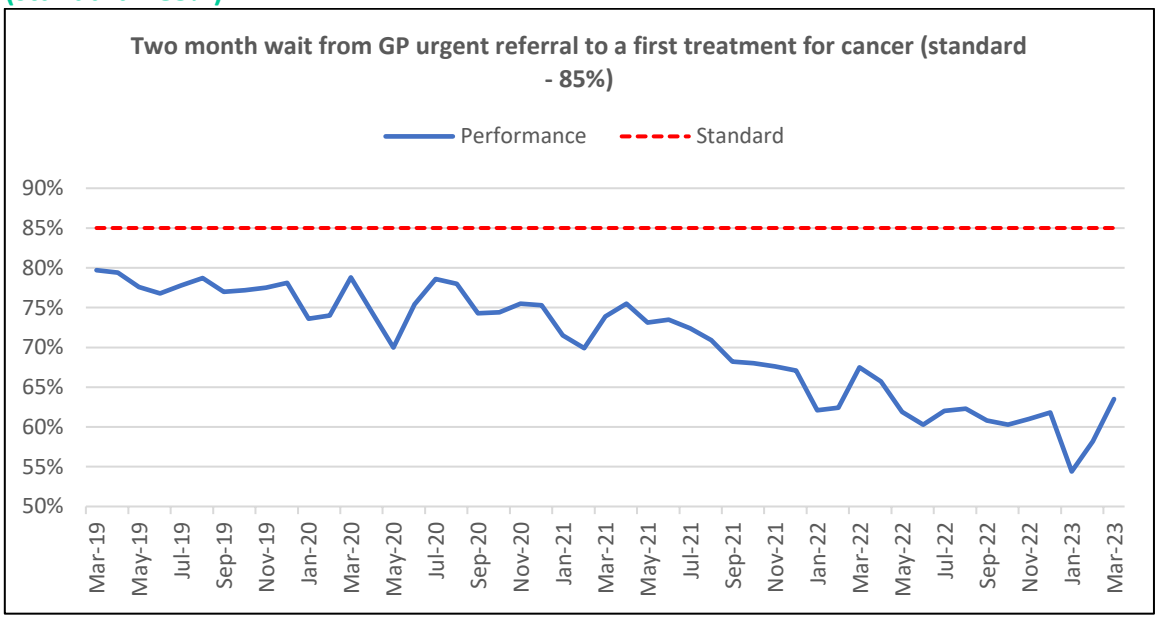
101. For those graphs going back to early 2020, dips in performance associated to the COVID-19 pandemic limiting access to, or otherwise putting pressure on, services can be seen, with some improvement more recently, as services begin to recover from the impact of the pandemic returning to a steadier 'business as usual' state.

Figure 10: Two Week Wait from GP Urgent Referral for Suspected Cancer to First Consultant Appointment (standard - 93%)



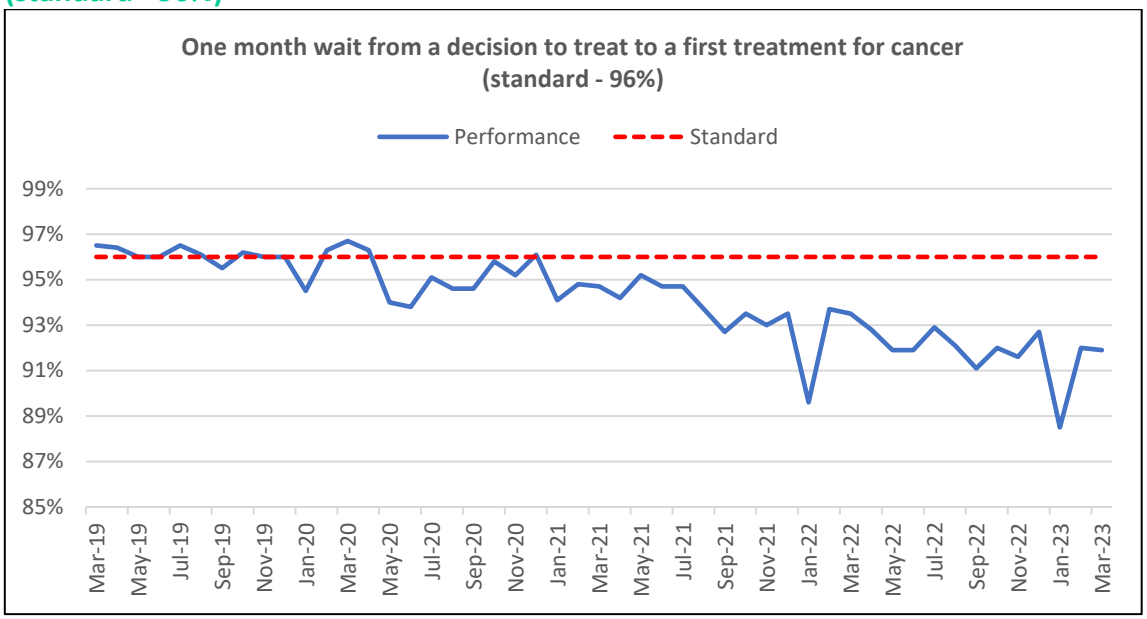
Source: Cancer Waiting Times

Figure 11: Two Month Wait from GP Urgent Referral to a First Treatment for Cancer (standard - 85%)



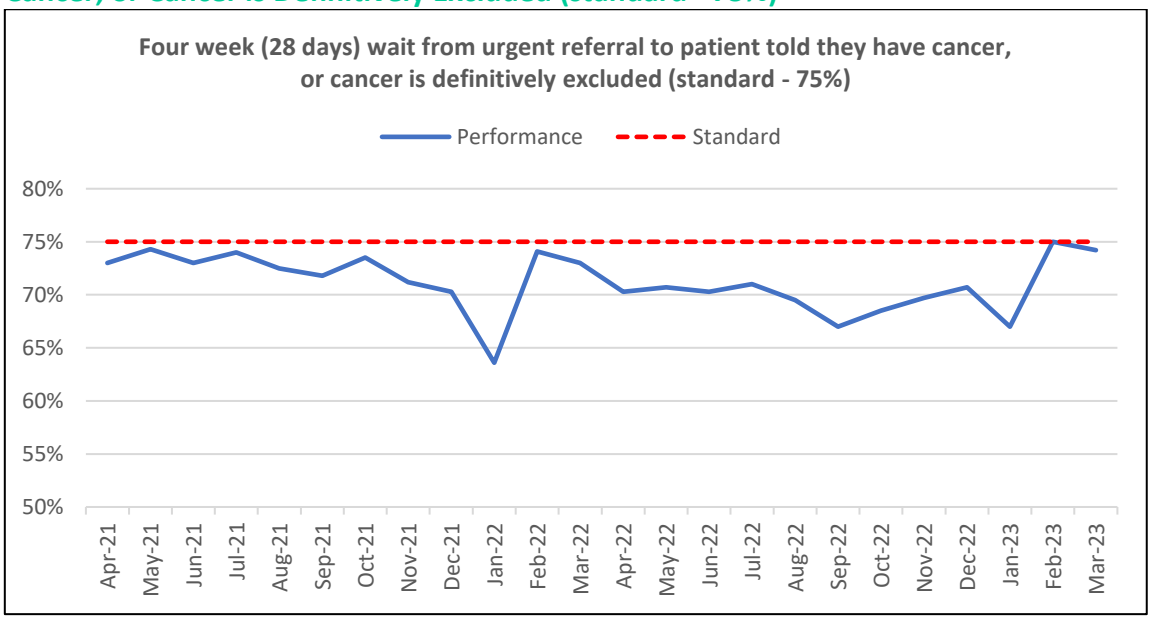
Source: Cancer Waiting Times

Figure 12: One Month Wait from a Decision to Treat to a First Treatment for Cancer (standard - 96%)



Source: Cancer Waiting Times

Figure 13: Four Week (28 days) Wait from Urgent Referral to Patient Told They Have Cancer, or Cancer is Definitively Excluded (standard - 75%)



Source: Cancer Waiting Times

Urgent and Emergency care

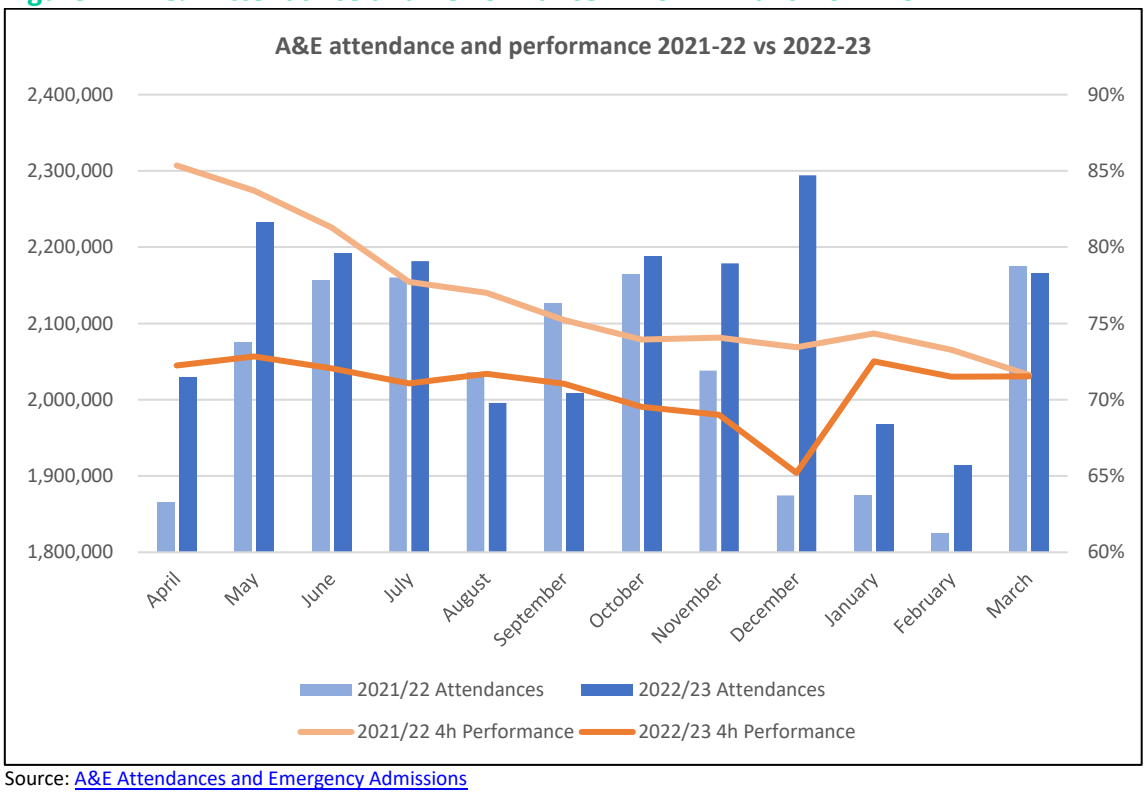
102. Despite a reduction in COVID-19 hospital admissions rates relative to the peaks earlier in the pandemic, the impact of COVID-19 remained evident as the NHS worked to recover the performance of urgent and emergency care in 2022-23. Throughout 2022, there were never fewer than 3,800 people in England in hospital with COVID-19 on any given day, with more than 9,000 on average across the year. This contributed to high bed occupancy rates during 2022-23 and impacted on patient flow and performance.

103. As shown in **Figure 14**, national performance for A&E waiting times in 2022-23 was 70.7%, 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 2020-21 and 2021-22, where performance was 86.8% and 76.7% respectively.

104. Key actions taken by the NHS in 2022-23 to improve A&E performance include increasing bed capacity and rolling out new innovative virtual wards, putting in place System Control Centres to help manage demand, establishing new community falls services and continuing to take action to support safe hospital discharge from hospital.

105. Winter was particularly challenging because for the first time there was a high incidence of both COVID-19 and flu circulating at the same time. In the week up to 1 January 2023, there were over 5,000 patients in hospital with flu, over 130 times more than the same period in 2021. December 2022 was the busiest on record, with nearly 74,000 people attending A&E every day, 4.7% more than December 2019. Ambulance handover delays over 60 minutes also peaked during December 2022, with an average of 2,674 delays per day during the week ending 1 January 2023.

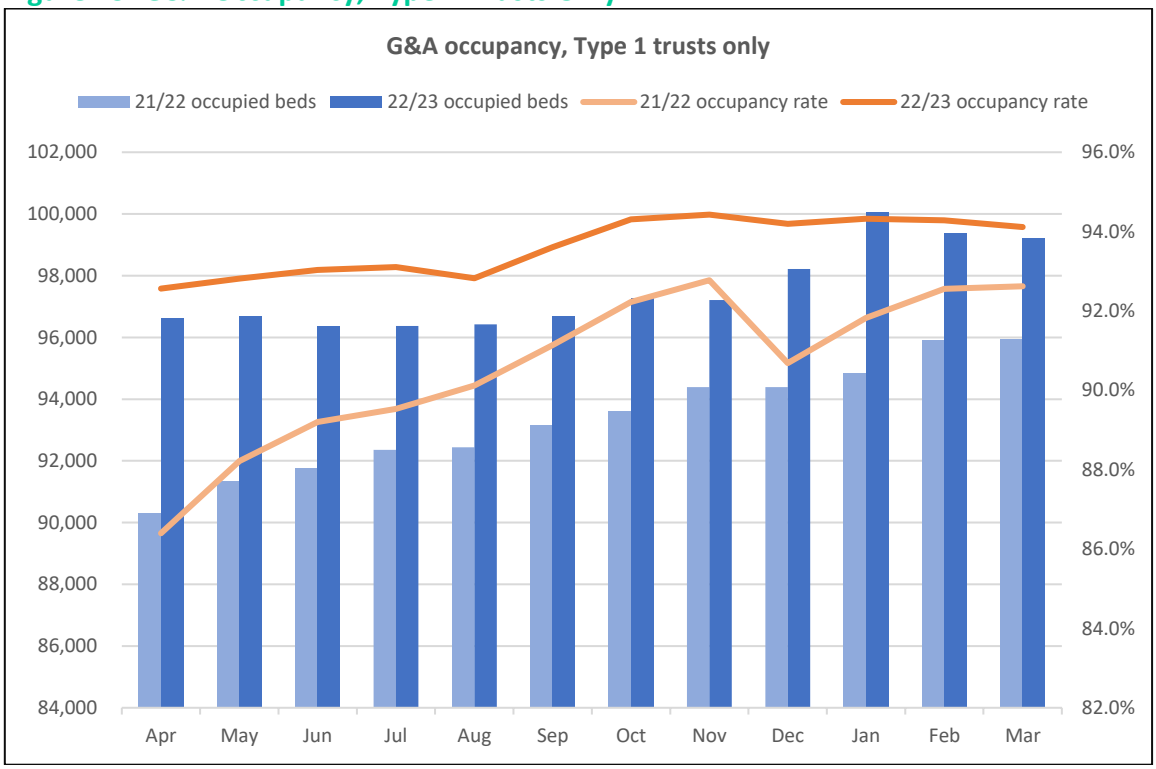
Figure 14: A&E Attendance and Performance in 2021-22 and 2022-23



Source: A&E Attendances and Emergency Admissions

106. As shown in **Figure 15**, General and Acute (G&A) bed occupancy levels remained consistently high throughout 2022-23, reaching a maximum occupancy of 94.4% in November 2022, compared to 2021-22's peak figure of 92.8% (Type 1 Acute Trusts only). Overall, bed occupancy in 2022-23 was higher than 2021-22.

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

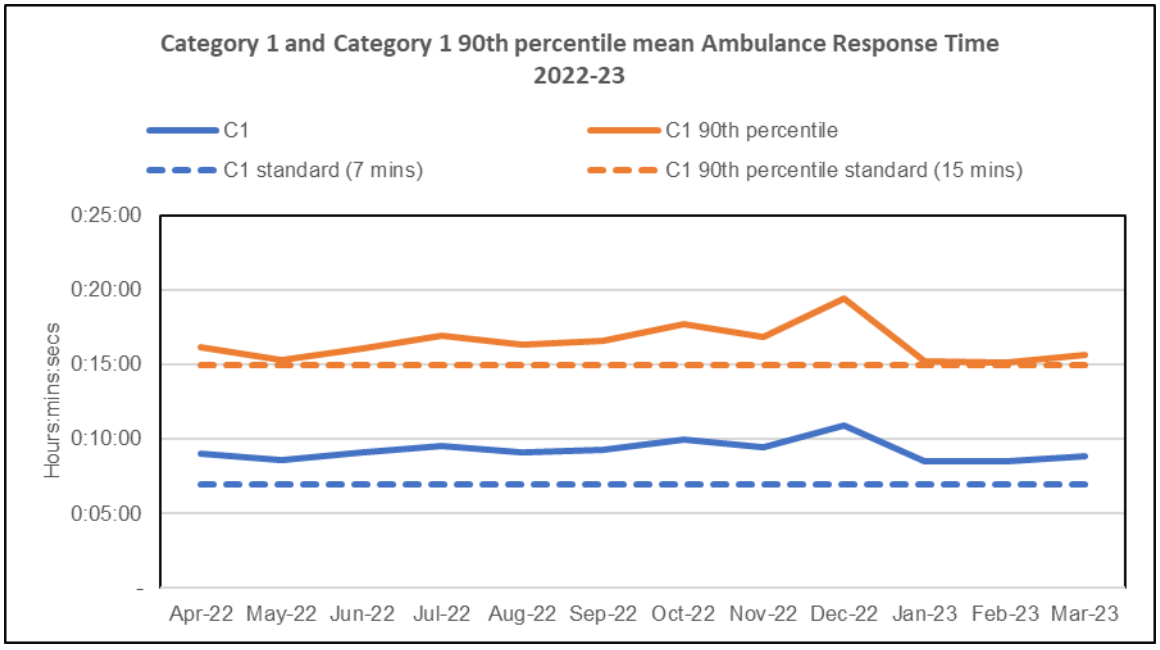


Source: Critical care and General & Acute Beds – Urgent and Emergency Care Daily Situation Reports

107. Ambulance response time performance reflected the wider challenges we saw across the emergency care pathway. December 2022 was the highest month on record for Category 2 response times where the average was 1 hour 32 minutes and 54 seconds (see **Figure 17**). This compares to 27 minutes and 57 seconds for the same period pre-pandemic. A range of factors contributed to this: an increase in higher acuity patients, significant numbers of patients who no longer met the criteria to remain in hospital, and high numbers of flu and COVID-19 admissions. This list of factors reduced patient flow through A&E, driving ambulance handover delays, which in turn increased response time to incoming 999 calls.

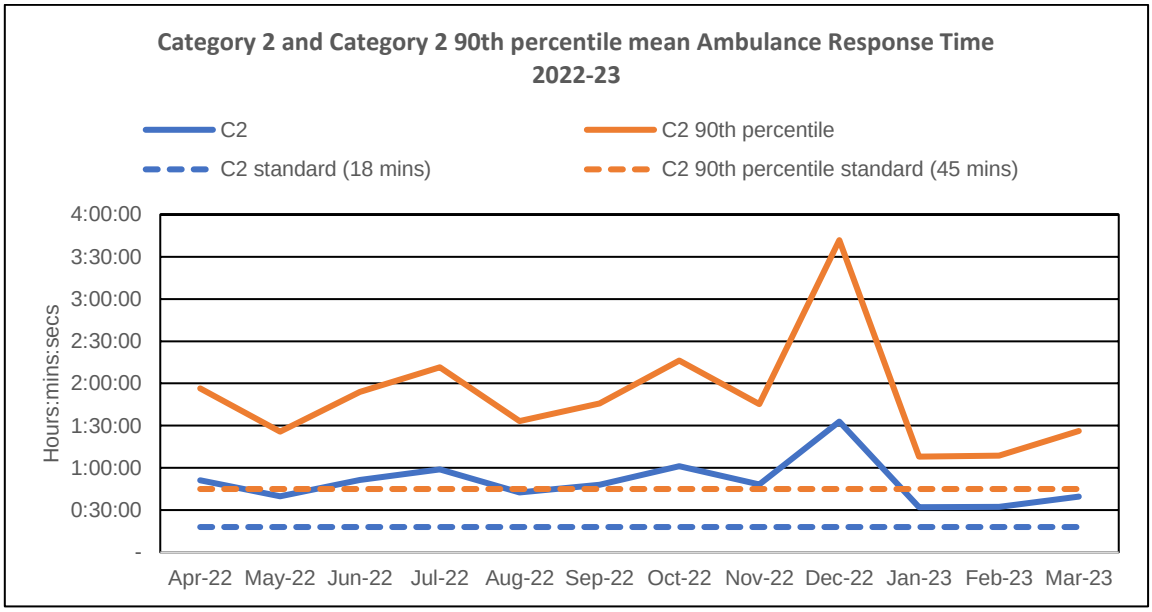
108. None of the 6 national ambulance standards were met over the year 2022-23, with average Category 1 response times at 9 minutes and 14 seconds (against the target of 7 minutes – see **Figure 16**), and Category 2 mean response times at 49 minutes and 52 seconds (against the target of 18 minutes). Also in 2022-23, 9 out of 10 Category 1 incidents were responded to in less than 16 minutes and 31 seconds, whilst the 90th percentile for Category 2 incidents was 1 hour 51 minutes and 25 seconds, against standards of 15 and 40 minutes respectively. In addition, none of the performance standards were met in any single month over the year.

Figure 16: Category 1 and Category 1 90th Percentile Mean Ambulance Response Time 2022-23



Source: Ambulance Quality Indicators

Figure 17: Category 2 and Category 2 90th Percentile Mean Ambulance Response Time 2022-23



Source: Ambulance Quality Indicators

109. A £500 million Adult Social Care Discharge Fund announced in September 2022 was made available between December 2022 and March 2023. The first tranche of funding was received by Integrated Care Boards (ICBs) and local authorities by 9 December 2022. The second tranche was paid on 31 January 2023. The Department is committed to a robust evaluation of hospital discharge funding and will publish findings shortly.

110. Further funding was made available in January 2023 to support services, including an additional £200 million to speed up hospital discharge, freeing up beds for those who need them, and £50 million in capital funding to expand existing discharge lounges and ambulance hubs. Between 24 January and 31 March, sitrep data indicated ICBs used the £200 million to purchase over 7,000 step-down beds (beds providing intermediate rehabilitation care before going home) for short-term step-down care. Six ambulance hubs and 42 new and upgraded discharge lounges were opened at hospitals across the country. Of the £50 million, £47 million was spent in 2022-23.

111. Building on the actions undertaken to support performance last winter, a Delivery Plan for Recovering Urgent and Emergency Care Services (the 'UEC Delivery Plan') was published on 30 January 2023. This aims to deliver one of the fastest and longest sustained improvements in emergency waiting times in the NHS's history, including reducing Category 2 ambulance response times to 30 minutes on average in 2023-24, with further improvements towards pre-pandemic levels the following year. To increase capacity and reduce waits, the UEC Delivery Plan will deliver 5,000 more staffed, permanent beds in 2023-24 compared to 2022-23 plans. The plan is backed by £1 billion of dedicated funding and calls for a scaling up of capacity with an extra 3,000 virtual ward beds to provide over 10,000 in total by Autumn 2023, with a longer-term ambition of enabling more than 50,000 admissions a month. The plan also commits to delivering 800 new ambulances including specialised mental health vehicles.

Urgent Community Response

112. Meeting patients' urgent care needs safely and conveniently at home, where they can recover more comfortably, has been key in improving patient outcomes and preventing deterioration and avoidable hospital admissions, easing pressure on the NHS. Over winter 2022-23, systems were required to roll out the urgent community response services, building on existing capacity, reaching at least 70% of adults referred within 2 hours. In January 2023, more than 4 in 5 (81%) of referrals into urgent community response services were managed by multi-disciplinary teams within two hours.

113. In April 2022, the Department launched a call for evidence on mental health and wellbeing, seeking the public's views on what could be done to improve everyone's mental health and wellbeing. Submissions were received from 5,273 respondents representing a broad range of stakeholders from across England. The responses received were processed and the findings were published on 17 May 2023 in the Mental health and wellbeing paper: discussion paper and call for evidence - results. These findings have informed the development of mental ill health and suicide prevention policies included in the Major Conditions Strategy: case for change and our strategic framework (August 2023) and Suicide prevention strategy for England: 2023 to 2028 (September 2023.)

Mental Health

114. The demand for NHS mental health services remained high as the effects of the COVID-19 pandemic continued to be felt and people have faced greater emotional and financial insecurity due to the rise in the cost of living. The Department has continued to support the delivery of the ambitions set out in the NHS Long Term Plan to expand and transform mental health services in England.

115. In June 2022, the Department published the Draft Mental Health Bill 2022, setting out measures to make the Act work better for people with serious mental illness, address mental health disparities and give individuals much more of a say in their care and treatment.

116. The draft Bill was subject to pre-legislative scrutiny by Parliament and the Joint Committee on the Draft Mental Health Bill published its report on 19 January 2023.

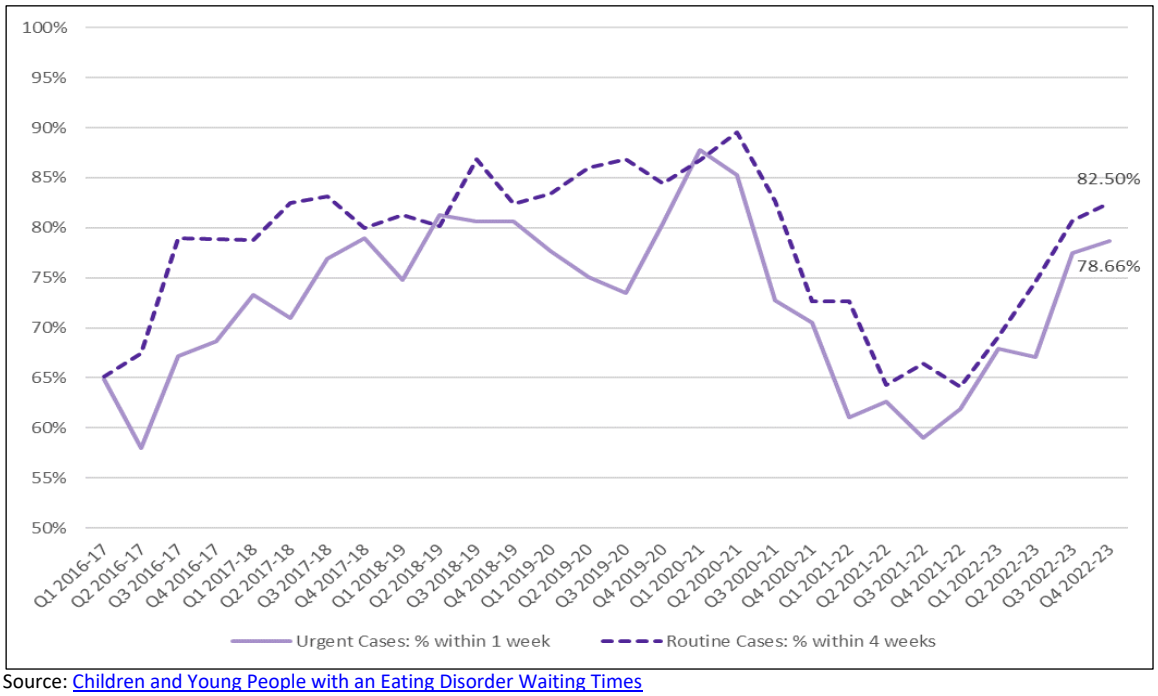
117. The majority of the provisions within the Mental Health Units (Use of Force) Act, also known as Seni's Law, were brought into force on 31 March 2022 and 18 August 2022 and those still outstanding are expected to be brought into force as soon as possible.

118. In response to reports of serious failings in care in a number of mental health providers, the Department announced on 23 January 2023 that it would conduct a rapid review into data on mental health inpatient settings, chaired by Dr Geraldine Strathdee. The Review specifically focused on the use of data and evidence, including complaints, feedback, and whistleblowing alerts, to identify risks to safety.

119. 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 National Institute for Health and Care Excellence (NICE) approved treatment by a designated healthcare professional within one week, for urgent cases, and four weeks, for routine cases.

120. As shown in **Figure 18,** for completed pathways, provisional data show 78.7% of young people (435 out of 553) started treatment for an urgent case within 1 week and 82.5% (2,060 out of 2,497) started treatment for a routine case within 4 weeks, between January and March 2023. This was below the national target of 95%. A number of data providers were affected by the cyber incident in August 2022. NHS England has produced national level estimates for Q2 2022-23, Q3 2022-23 and Q4 2022-23. Therefore, extreme caution should be used when interpreting these statistics.

Figure 18: Children and Young People with an Eating Disorder Waiting Times in England (completed pathways)



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

121. For incomplete pathways, at the end of Quarter 4 (January to March 2023), 132 young people were waiting to start treatment for an urgent case and 1,281 were waiting to start treatment for a routine case.

122. 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 in 2022-23 compared to 2021-22. This impacted how long children and young people were waiting for treatment. The total number of children and young people entering treatment has decreased by 5.2% in 2022-23 to 11,809 on the year before. However, this number is still high, and the Department continues to work closely with the NHS to recover performance.

123. NHS Talking Therapies (previously known as the 'Improving Access to Psychological Therapies (IAPT) programme') continue to expand 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.

124. As shown in **Figure 19**, provisional data shows that in 2022-23, there were 1.74 million referrals to talking therapies in England, with 1.22 million referrals starting a course of treatment. As shown in **Figure 19**, in March 2023, 111,279 referrals entered treatment, which was a 1.9% decrease compared with March 2022 the year before. NHS Digital will publish an annual report on NHS Talking Therapies in Autumn 2024 for 2022-23 data. Data used here is provisional and subject to change. Totals shown are from published monthly data.

Figure 19: Number of Referrals Entering Treatment Per Month Through NHS Talking Therapies (ages 16+) in England

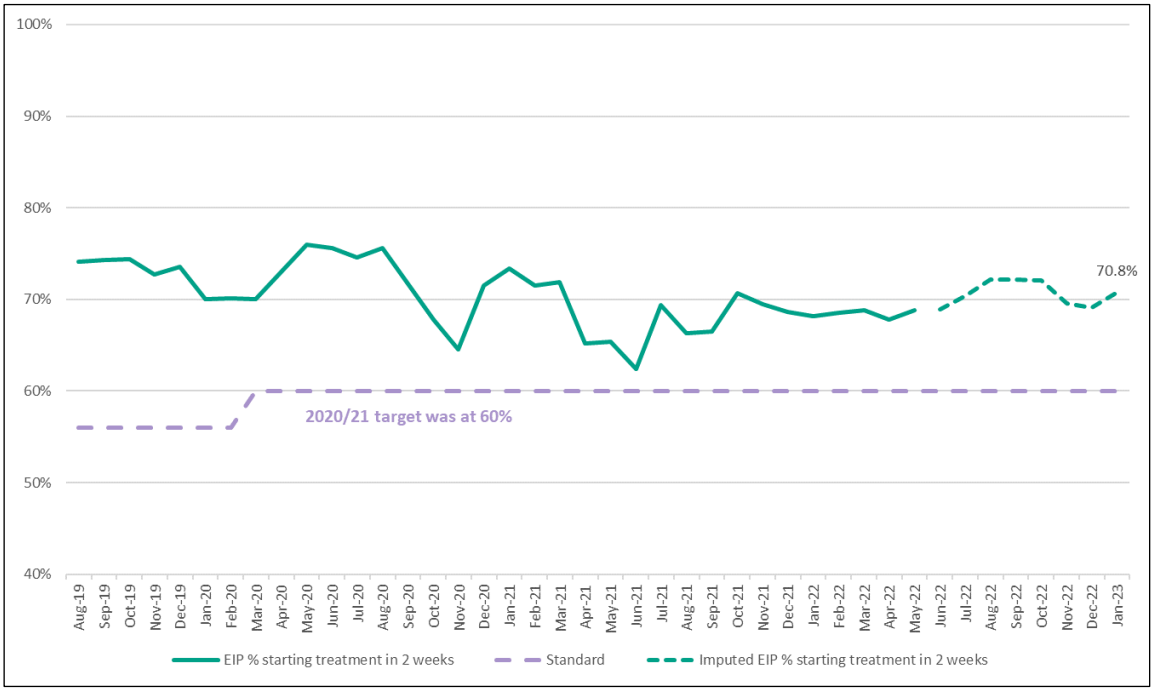
Source: NHS Digital – IAPT Waiting Times

125. The waiting time target for NHS Talking Therapies 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. In March 2023, 90.2% 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%.

126. The recovery target, which states that at least 50% of people who complete treatment should move to recovery, was met in March 2023 where the rate was 51.2%.

127. 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. As seen in **Figure 20**, in the period of January to March 2023, 70.8% of referrals (2,357 out of 3,331) started treatment within two weeks, remaining above the 60% target. This waiting time standard has been met since it was introduced in 2016. A number of data providers were affected by the cyber incident in August 2022 which affected EIP waiting time data. NHS England has produced imputed national level estimates since July 2022 and so extreme caution should be used when interpreting these statistics.

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

Long COVID

128. During 2022-23, an additional £90 million was invested to continue the provision of support for people with long COVID. In publishing the NHS Plan for Improving long COVID services in July 2022, NHSE signalled a continued commitment to improving the identification and management of long COVID in all healthcare settings, expanding clinical education and reducing waiting times to access support.

129. Data available for the COVID-19 Post-COVID Assessment Service covers dates from 11 April 2022 to 12 March 2023. During this period, 42,759 referrals were accepted as clinically appropriate (89.2%) and 41,664 initial specialist assessments and 162,457 follow-up appointments took place.

130. Initial specialist assessment waiting time data for the same period showed that 40% of patients were seen within 6 weeks of referral, 51% were seen within 8 weeks of referral and 26% waited longer than 15 weeks to be seen. Waiting times improved over the course of 2022/2023. Between 13 February 2023 and 12 March 2023, 54% of patients were seen within 6 weeks of referral, compared to 34% of patients in the period of 11 April 2022 to 8 May 2022.

End-of-Life Care

131. NHSE, alongside the independent sector, have continued to provide palliative and end-of-life care. All 42 Integrated Care Systems have palliative and end-of-life care in their strategy, have a clinical and strategic lead for palliative and end-of-life care and are supported by regional Strategic Clinical Networks.

Social Prescribing

132. Social prescribing is a means of enabling health professionals to refer people to a 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. Cumulative numbers of referrals can be seen in **Table 2**.

133. As of March 2022, the number of social prescribing link workers recruited was 2,527 full-time equivalents (FTE), since the beginning of the national roll out in 2019.

Table 2: 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
Q1 2022-23	1,178,274
Q2 2022-23	1,348,779
Q3 2022-23	1,632,191

Source: GPES data provided by NHSE (there may be additional referrals not captured in the GPES system)

Community Pharmacy

134. In 2022-23, the uptake of the clinical services introduced through the Community Pharmacy Contractual Framework (CPCF) 2019 to 2024 5-year deal continued to increase, in accordance with the aims of the NHS Long Term Plan for community pharmacy to be more integrated into the NHS, deliver more clinical services and become the first port of call for minor illnesses.

135. Under the Community Pharmacist Consultation Service (CPCS), NHS111 and GPs can refer patients to community pharmacies for advice and treatment for minor illnesses, and NHS111 can also refer them for urgent medicines supply. In October 2022, referrals were expanded from NHS111 phone to NHS111 online. Between April 2022 and March 2023, there were 1,269,352 completed referrals from NHS111 and GPs for minor illnesses or urgent medicines supply under the CPCS, relieving the burden on GP and A&E services. In the previous year, 2021-22, there were 702,530 completed referrals. This followed a successful six-month pilot across Bristol, North Somerset, South Gloucestershire CCG and the North ICP, and has broadened the existing CPCS service provision.

136. The New Medicine Service (NMS) provides patients with extra support from a community pharmacist with their newly prescribed medication. Between April 2022 and March 2023, 2,841,637 NMS interventions were completed.

137. Every month, around 10,000 patients discharged from hospital were referred to a community pharmacist through the Discharge Medicines Service (DMS) for support with their medicines to prevent rehospitalisation. Between April 2022 and March 2023, 129,247 DMS were carried out in pharmacies (90,367 instances where all 3 stages of the service completed).

138. The Blood Pressure Checks Service (BPCS) enables community pharmacists to identify patients with undiagnosed hypertension. By March 2023, 9,121 community pharmacies had registered to provide the service, of which 2,195 registered in the 2022-23 financial year (the number registered to provide the service is taken from remuneration data DHSC receives directly from NHS BSA and is unpublished). There have been 984,930 cuff checks and 55,042 ABPM delivered between April 2022 and March 2023.

139. Between September 2022 and March 2023, pharmacies delivered 5.01 million flu jabs. Between April 2022 and March 2023, 1,600 pharmacies offered COVID-19 vaccinations.

Maternity

140. The Government has been 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. An additional ambition to reduce the pre-term birth rate from 8% to 6% was also introduced in 2017.

141. The trend towards meeting the ambition has generally been in the right direction, but further improvements for most measures are required to meet the ambition by 2025. Since 2010, the stillbirth rate has reduced by 23%, and the rate of neonatal mortality for babies born over the 24-week gestational age of viability has reduced by 30%. 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 7.7% in 2021. In 2019-2021, the maternal death rate increased by 6% compared with 2018-2020.

142. In 2021 there was an increase in stillbirth, neonatal death, and preterm rates which coincided with the COVID-19 pandemic. The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) annually publishes a detailed analysis of the rates of stillbirth, neonatal mortality and extended perinatal mortality for the UK and for each devolved nation. MBRRACE-UK's Perinatal Mortality Surveillance Report, published in September 2023, analysed data for the period 2013 to 2021. The report indicated that whilst there may have been an impact of COVID-19 on perinatal mortality, calculating the risk of death associated with COVID-19 infection is challenging. Once published, MBRRACE's analysis of data for the 2022 period will allow us to consider the impact of the pandemic on perinatal mortality rates more comprehensively.

143. NHSE has established a Reading the Signals Data Co-ordination Group. This will bring together a series of data projects which aim to make sure the right data will be used in the right way to identify and support trusts which may be vulnerable to risk of unsafe care for patients. This will employ multiple approaches to make sure that all information that may signal concern is captured. This data will provide more timely and sensitive information to inform the data and intelligence to be shared through the perinatal quality surveillance model. Within the NHS Standard Contract there now exists an obligation on providers to comply with the requirements set out in this model.

144. In March 2023, NHS England published the Three-Year Delivery Plan for Maternity and Neonatal Services. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families, intended to improve both their experiences and outcomes.

145. Disparities in maternal and neonatal outcomes are being addressed through NHSE's Equity and Equality guidance which focuses on action to reduce disparities for women and babies from ethnic minorities and those living in the most deprived areas. From 25 October 2022, Local Maternity and Neonatal Systems began to publish Equity and Equality Action Plans to tackle disparities in outcomes and experiences of maternity care at a local level. ICBs will monitor implementation of local Equity and Equality Action Plans, in line with the Hewitt Review and NHSE's operating framework.

146. Further work to better understand and how to remove disparities in outcomes and experiences of care is being overseen by the Maternity Disparities Taskforce (launched in February 2022). The Taskforce has been tackling disparities for mothers and babies and reducing 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.

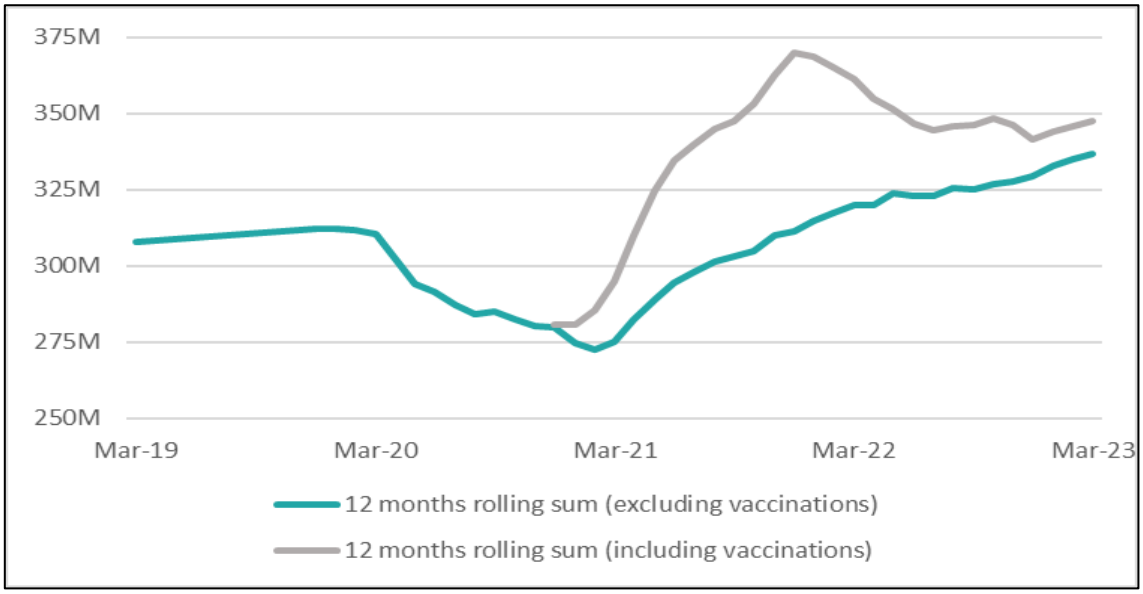
General Practice

147. The Department's aim for 2022-23 was to improve access for patients by supporting general practice to recover services, respond to demand and continue to make progress towards delivering 50 million more appointments a year.

148. General practice appointment numbers first reached pre-pandemic levels in May 2021. Appointment numbers in 2022-23 were consistently higher than 2021-22. As shown in **Figure 21**, in the twelve months up to March 2023 (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 347.4 million appointments were booked across all general practices in England in the twelve months up to March 2023. Compared to the twelve months up to March 2019 (308.0 million as published in April 2019), this is an increase of 39.4 million.

- Excluding COVID-19 vaccination appointments, an estimated 336.8 million appointments were booked across all general practices in England in the twelve months up to March 2023. Compared to the twelve months up to March 2019 (308.0 million as published in April 2019), this is an increase of 28.8 million.

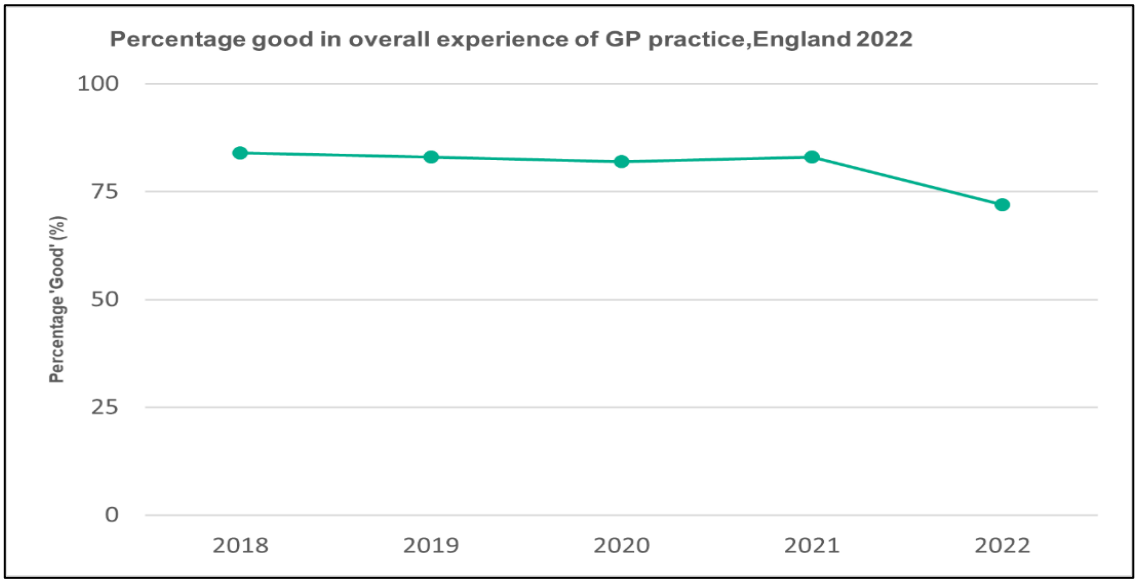
Figure 21: Appointments in General Practice (March 2019 - March 2023)



Source: Appointments in General Practice

149. The General Practice Patient Survey is an annual survey carried out by Ipsos on behalf of NHSE and assesses patients' experience of healthcare services provided by general practices. The 2022 results were published in July 2022 from aggregated data collected by post and online surveys between January 2022 and April 2022. Results showed that 72.4% of patients rated their overall experience of their GP practice as good, a decrease of 10.6% from 2021. This is shown in **Figure 22**.

Figure 22: Percentage 'Good' in Overall Experience of GP Practice, England, 2022



Source: General Practice Patient Survey data

150. On 1 March 2022, NHSE published Letter: General practice contract arrangements in 2022/23, which set out the requirements of general practice and Primary Care Networks (PCNs) from 1 April 2022 to 31 March 2023. The 2022-23 general practice contract provided stability and reassurance to general practice through implementing the changes planned for the fourth year of the Five-Year Framework. In 2022-23, the general practice contractual cycle returned to its standard pattern after a year of shorter-term arrangements to support the delivery of the COVID-19 vaccination programme – providing general practice with the stability of knowing the contract changes to enable them to provide the best support for their patients. These changes included supporting digital patient registration, ensuring that all appointments not requiring triage were available to book online, and standardising the provision of services for patients outside of a General Practitioner's core hours, via the Enhanced Access scheme. This scheme enabled the provision of care patients need at alternative times to those traditionally offered in General Practice. Additional funding of £43 million was also made available in 2022-23 for PCN leadership and management and the weight management enhanced service was continued.

151. On 22 September 2022, the Department published Our Plan for Patients, introducing measures aimed at improving access to general practice, including an expectation that patients are offered an appointment within 2 weeks of booking, with urgent cases seen on the same day. As part of this, NHSE published a procurement framework for cloud-based telephony to ensure that practices switching to new systems would have full functionality, making it easier for patients to contact practices and enabling practices to better manage demand. From November 2022, the Department and NHSE also began publishing, for the first time, appointment data at practice level to make more detailed information available to patients. The Autumn Statement 2022 announced that a recovery plan for the primary care system would be developed.

Dentistry

152. The latest access to NHS dental services indicator showed that 75% of those surveyed in 2023 successfully obtained an NHS dental appointment. The figure decreased significantly over the pandemic – at the start of 2020, the figure was 94%, meaning the rate decreased by 19 percentage points (data taken from the 2022 GP Patient Survey) and has now stabilised. Whilst the 2023 data will still partially reflect the reduced availability of dental appointments during the pandemic, we would have hoped to see a further improvement on the 2022 figure. The survey also showed a more positive experience for existing patients, with 83% reporting being able to get an NHS appointment, up from 79% in 2021. New patients had a less positive experience with only 39% able to get an appointment, down from 51% in 2021 and 70% in 2020.

153. In terms of NHS activity, the sector is now recovering, and from July 2022 NHS dental practices were asked to return to delivering 100% of their NHS contracts. The 2022-23 data shows that 24,151 dentists performed NHS activity in 2022-23, a reduction of 121 on 2021-22, but a higher number than the 23,733 recorded in

2020-21. This equates to 70% of dentists registered with the General Dental Council (34,452 in March 2023) delivering at least 1 Unit of Dental Activity during the year. In addition, 32.5 million courses of treatment were delivered in 2022-23, an increase of 23% compared to the previous year. This suggests that although there are fewer dentists, they are delivering a greater volume of NHS treatment. Whilst the 23% increase in courses of treatment delivered in 2022-23 compared to 2021-22 is positive, this figure remains around 18% lower than the number of courses of treatment that were delivered in a typical pre-pandemic year. The 2022-23 data also shows that patient numbers are increasing steadily with the total proportion of the general adult population being seen increasing to 43%, an increase of 4 percentage points on the previous year, but 9.1 percentage points lower than pre-pandemic.

154. Nevertheless, challenges accessing dental treatment remained in some areas, especially for patients new to the practice. To address this, in September 2022, the Government announced a package of contract reforms detailed in Our Plan for Patients. The changes included:
    - Improvements to the 2006 contract to ensure better remuneration for practices for providing more complex treatment to patients.
    - The issuing of clear guidance on how often patients should expect to attend for check-ups and enabling dentists to make better use of all the staff in their dental teams to deliver NHS treatment.
    - A contractual requirement for practices to update the NHS website with whether they are taking on new NHS patients.
    - The ability to allow practices to deliver up to 110% of their contract value.
    - Legislative changes allowing the General Dental Council more flexibility to expand the registration options open to international dentists.

155. These changes, which were largely welcome by the sector, have started to help improve access, as evidenced by the 2022-23 annual data. But there is more to be done and that is why we have been working with the sector and NHSE to consider further wide-reaching changes to improve the system.

Eye Care

156. On eyecare, NHSE has continued to commission the NHS sight testing service, with over 14.5 million sight test claims processed during 2022-23. Those eligible for free NHS sight tests include children, people aged 60 and over, people on income related benefits, and certain groups at particularly risk of eye disease.

157. In 2022-23, the Department continued to support NHSE in taking forward the long-term plan commitment to bring eyesight checks to children in special residential schools whilst also considering the needs of children in special education day schools.

158. The Department also continued to support NHSE with the transformation of eye care services to increase eye care capacity and ensure sustainable services for the future.

Improving infrastructure

159. The Government has been taking action to improve health infrastructure across the country to ensure high quality health and care for patients. Capital investment is a key factor in ensuring that services are maintained; that new service demands are met; and, to enable service changes and efficiencies. The Autumn Statement 2022 maintained the Department's significant capital settlement of over £36 billion across 2022-23 to 2024-25.

160. The Department's capital spend has increased to £9.2 billion in 2022-23 from £9.1 billion in 2021-22 (further detail is available in Annex B). This increase is before the additional £1.4 billion budget provided for the impact of the new accounting standard for leases (IFRS 16) which the Department implemented from 1st April 2022; further detail of which can be found on page 326.

161. Almost 75% of the above capital funding is being provided to the NHS, via operational capital and various national programmes. This includes capital programmes to build new and upgraded facilities – in particular, the New Hospital Programme and hospital upgrades.

162. The New Hospital Programme forms part of the wider Health Infrastructure Plan, a long-term, rolling programme of strategic investment in health and care buildings, estates, and equipment.

163. The Government confirmed an initial £3.7 billion for the first four years of the programme, including £403 million allocated for 2022-23. Five hospitals are in construction, with one due to complete shortly after the reporting year, and two were completed. A package of support is being provided to all the hospital schemes in the programme to support business case development and streamline approvals.

164. The New Hospital Programme hosted its flagship Industry Day in December 2022, which brought together health and construction sectors to learn about the Programme's transformative approach to designing and building hospitals for the future. It was a significant opportunity for the New Hospital Programme to engage with supply market leaders and build appetite to collaborate with the Programme to support the Government's commitment to build 40 new hospitals and development of enduring national capacity and capability in healthcare infrastructure delivery. We successfully launched the concept of Hospital 2.0, the programme's centralised approach for optimal hospital design, which will drive cost reduction and avoid historic trends of delays and cost overruns common in standalone hospital building projects.

165. The Government also invested in hospital upgrades to modernise and transform NHS's buildings and services, with 17 patient ready upgrades completed during 2022-23. This investment was funded from a £1.7 billion multi-year funding settlement until 2024-25 for over 70 hospital upgrades to improve health infrastructure across the country over the long term. These upgrade investments will modernise and transform the NHS's buildings and services, with the funding

going towards a range of programmes across the country such as new urgent care centres, integrated care hubs that bring together primary and community services and investing in new mental health facilities.

166. We also provided significant capital to the NHS for trusts to prioritise and deliver locally to maintain and refurbish their premises, including to support major objectives such as decarbonisation and sustainability. Operational capital amounting to £4.2 billion was made available in 2022-23 to ICBs to prioritise at a local level and deliver healthcare according to their submitted plans. As part of this, £210 million was provided to manage NHS estates impacted by Reinforced Autoclaved Aerated Concrete (RAAC), providing funding in the short-term to mitigate immediate risks and protect staff and patient safety.

167. The Government has also been making significant investment to improve the mental health estate. More than £400 million has been committed until 2024-25 to eradicate dormitory accommodation from mental health facilities across the country in order to improve the safety, privacy and dignity of patients suffering with mental illness. As of March 2023, 530 mental health dormitory beds were replaced with en-suite rooms. In addition to this, £50 million was provided for mental health urgent and emergency care in 2022-23, which was part of a total funding package of £150 million until 2024-25. This programme is focused on developing better mental health facilities linked to A&E and enhancing patient safety in mental health units, for example, crisis cafes, crisis houses and mental health ambulances.

168. In addition to the wider national programmes, in January 2023 the Government provided £50 million to the NHS for hospital discharge lounges and ambulance hubs to help the discharge of patients. This investment expanded and improved over 50 discharge lounges in NHS trusts and created 6 new ambulance hubs where vehicles can manoeuvre more easily to avoid delays handing over patients. This came in addition to the £47 million provided after September 2022, ahead of winter 2022-23, as part of the NHS's Going further on our winter resilience plans to improve A&E facilities, bring mothballed beds back into use, and convert non-clinical space.

Digital Health and Care Plan

169. The landmark 'A Plan for Digital Health and Social Care' was published in June 2022 and sets out the digital reform agenda and how we plan to digitise, connect and transform health and care.

170. The Plan outlines how the delivery of health and social care will change, taking forward what we have learned from the pandemic, and from tech providers from across the world. The ambition is to deliver a health and social care system that is more responsive and effective and delivers more personalised care.

171. As of March 2023, 16 of these commitments had been completed, including establishing new and continuation of existing digital learning offerings through the NHS Digital Academy, publishing technical requirements for IT suppliers serving pharmacy, optometry, dentistry, ambulance, and community health sectors

alongside an offer of support for ICSs to implement requirements, and publishing a Cyber Security Strategy for Health and Social Care.

Frontline Digitisation

172. In June 2022 the Department agreed £2 billion to digitise the NHS. This investment is focused on secondary care (acute, ambulance, community, and mental health trusts), as the last sector of the NHS requiring digitisation.

173. We have agreed funding allocations with ICBs and trusts to support the implementation of digital capabilities and enabling infrastructure to meet our core standards.

174. We have developed and run a national digital maturity assessment to help ICBs and trusts to understand their current maturity against the What Good Looks Like framework, which will help them to develop their strategic plans.

175. We have developed a comprehensive support offer to help ICBs and trusts to digitise successfully by sharing best practice and expertise across the NHS.

176. As of March 2023, nationwide electronic patient record (EPR) coverage was 88%, so we were on track to meet our target of 90% coverage by December 2023.

NHS App

177. In March 2022 there were 26.6 million recorded sign-ups for the NHS App, which is equivalent to 59.5% of the adult population in England. In March 2023 there were 32.1 million recorded sign-ups for the NHS App, which is equivalent to 71.8% of the adult population. This represents an increase of 5.5 million recorded sign-ups or a 20.6% increase in recorded sign-ups. The target is to have 75% of adults signed-up by March 2024.

178. On 29 June 2022, we published a roadmap for future development across the NHS App as a key digital channel in A Plan for Digital Health and Social Care.

179. Improvements and new functionalities added the NHS App in 2022-23 included:
    - Enabling people to be able to see new information added to their GP health record. The rollout began in November 2022 and as of 31 March 2023 this has been enabled for 6.8 million patients, 23% of online accounts.
    - Enabling people to book and manage their hospital outpatient appointments. A feature available to some 25 million patients across 23 trusts.
    - Managing COVID-19 vaccination appointments via the NHS App was launched on 30 November 2022 and by 28 February 2023 more than 109,000 vaccinations had been booked via the NHS App, c13% of total bookings.
    - From 21 May 2022 to 31 March 2023, 3,635,834 messages were sent through the NHS App for Covid vaccinations.
    - A feature to order repeat prescriptions continued to grow in usage, with 1.9 million prescriptions ordered in February 2023 alone.

- Almost two thirds of GP practices in England offered online consultations through the NHS App, with further third-party integrations planned to extend the number of practices enabled.

NHS 111

180. NHS 111 online can be accessed on a computer, tablet, or mobile phone. The NHS 111 online service is also accessible through the NHS App which has more than 32 million registered users. Contacts through NHS 111 (online or on the phone) are supported by a Clinical Decision Support System called NHS Pathways and the Directory of Services (DoS).

181. Pharmacies are now able to record that they provide palliative care drugs on DoS via Profile Manager. This allows healthcare professions to use Service Finder (and other products) to search the DoS and direct their patients to the appropriate service for these drugs.

182. As well as obvious benefits of ensuring people on end-of-life care get directed to the right service for their needs, this also reduces previous burden on DoS Leads having to update their profiles and increases the likelihood of the information being up to date. It also helps with our understanding of how to support other initiatives such as Pharmacy First and GP referrals into Pharmacy.

183. The Delivery Plan for Recovering Urgent and Emergency Care Services was published on 30 January 2023. The immediate targets are to deliver greater integration of NHS 111 online into the NHS App and a re-platforming of the DoS. Together these will create further connection with other services, helping direct patients to the right place.

Artificial Intelligence (AI)

184. The AI in Health and Care Award competitions launched in 2020 in partnership with the Accelerated Access Collaborative and the National Institute of Health Research. There was £29.2 million of funding available in the FY 2022-2023 for the AI Awards. Round 3 of the Award, the winners of which were announced in March 2023, was the final round, and overall, the Award has made £123 million available for 86 awardees to test and evaluate their innovations which will support areas such as urgent stroke care, home testing for disease and cancer screening. The evaluations from the Awards are intended to generate clinical and economic evidence so that organisations such as NICE can look at recommending AI products for national commissioning.

185. The AI and digital regulations service was launched in full in the summer of 2023. The service, which brings together the key regulators (MHRA, NICE, Health Research Authority and the CQC), will give innovators and health and care providers a one-stop-shop for support, information and guidance on the regulation and evaluation of AI technologies. The vision for the service is that a robust and streamlined regulatory pathway will lead to safer and more effective development

and adoption of data-driven technologies. A public beta of the developer pathway is open for feedback.

186. AI Stroke technologies (NHSE Stroke AI, Pathway to Adoption) were implemented in 80% of stroke units by March 2023. AI algorithms support doctors by providing real-time decision support in the interpretation of brain scans to help guide treatment and transfer decisions for stroke patients, allowing more patients to get the right treatment, in the right place, at the right time. The technology has been shown to reduce the time taken for a patient to be diagnosed and transferred to a specialist stroke unit following a stroke by close to half, from 140 to 79 minutes, and almost triple the chance that survivors can live independently following a stroke.

The Goldacre Review and Data Strategy

187. The findings of the Goldacre Review into the improved use of health data for research and analysis was published on 7 April 2022, and included key recommendations across skills, ethics and data access infrastructure. The government's response to the Review was included as an annex in the Data Saves Lives: Reshaping Health and Social Care With Data strategy.

188. The strategy, published on 13 June 2022, aims to drive transformation in health and care, creating a system which delivers for both patients and professionals now and in the future. The strategy sets out over 100 commitments to achieve our transformation vision.

189. As of 31 March 2023, 50% of these commitments had been completed, including agreeing a target data architecture for health and care, the establishment of an online Analytics Hub, agreeing frameworks, guidelines, and policies to support the analytical community and address the concerns raised in the Goldacre review, and the publication of a data framework for adult social care. Further commitments are on track for completion.

190. Within the strategy, the Department also committed to adopt a system of 'data access as default' for research and external uses of NHS health, a change which will be supported by the implementation of Secure Data Environments (SDEs) across the NHS in England.

191. In September 2022, the Department published our Secure Data Environment Policy Guidelines. The 12 guidelines outline the minimum requirements that organisations and individuals looking to host and use NHS health and social care data will need to adhere to. They are organised around the well-regarded 'Five Safes' framework developed by the ONS.

192. In December 2022, NHSE announced over £13.5 million funding for sub-national SDEs. They will offer near-real time, privacy protecting, access to linked data spanning different types including imaging, pathology, and genomics.

193. We have also established a National Data Advisory Group consisting of expert external stakeholders, to provide advice and challenge, including shaping public and staff engagement approaches, transparency, and emerging policy thinking. The first National Data Advisory Group meeting was held in September 2022, and they are held every six weeks.

194. NHS Digital legally became part of NHSE on 1 February 2023, delivering a key recommendation of the Putting Data, Digital and Tech at the Heart of Transforming the NHS review by Laura Wade-Gery, to create a single statutory body for data, digital and technology to ensure that all expertise and activity in relation to digital transformation are together in a single organisation.

Federated Data Platform (FDP)

195. Procurement for the NHSE FDP and Associated Services launched on 10 January 2023. The FDP will support health and care organisations to make more effective use of the information to improve outcomes for patients. Every hospital trust and ICS will have their own data platform and will be able to connect and share information between organisations.

196. Several pilot programmes are in over 40 trusts:
    - The Improving Elective Care Coordination for Patients (IECCP) Programme supports Trusts to effectively deliver care through the implementation of a Care Coordination Solution (CCS), reducing waits and making better use of operating theatres.
    - The Dynamic Discharges programme simplifies NHS and social care collaboration relating to patient flow at patient level to help multidisciplinary teams effectively plan and track hospital discharges once patients are medically optimised.

197. The contract for the Federated Data Platform was awarded on 21 November 2023 by NHS England to a group led by Palantir Technologies UK, with support from Accenture, PwC, NECS and Carnall Farrar.

198. In addition, NHS England has awarded a contract to a separate provider IQVIA, for Privacy Enhancing Technology, as an additional safeguard to enhance the security of data used in the Federated Data Platform.

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

NHS Workforce

199. The past year has seen record numbers of staff working in the NHS. As of March 2023, there has been an increase of over 5,400 doctors and over 12,900 nurses compared to the same period in 2022. Continuing to grow the workforce remains a priority and there is a substantial amount of work already underway to help support and build the workforce we need for the future. There is more work to be done to further enhance capacity and maintain quality, and the NHS workforce remains under sustained pressure as we work to recover from the impact of the pandemic and deliver on elective recovery and urgent and emergency care ambitions.

200. To support future workforce planning the Department has commissioned NHSE to develop a Long-Term Workforce Plan for the NHS workforce for the next 15 years. The Plan will look at the mix and number of staff required and will set out the actions and reforms across the NHS that will be needed to reduce supply gaps and improve retention. The Plan will also include projections for the number of doctors, nurses and other professionals that will be needed in 5-, 10- and 15-years' time. This Plan will help ensure that we have the right numbers of staff, with the right skills to transform and deliver high quality services fit for the future.

201. As shown in **Table 3**, the data for March 2023, published by NHSE, shows that there are over 1.28 million FTE staff working in the NHS. This is an increase of over 53,600 compared to March 2022.

Table 3: FTE Workforce Numbers Since 2010

	Doctors	Nurses	All Staff
Mar-10	95,496	274,020	1,015,642
Mar-11	97,048	272,670	1,008,281
Mar-12	98,317	267,417	984,181
Mar-13	99,556	266,775	983,721
Mar-14	101,386	271,909	989,319
Mar-15	103,213	272,738	1,006,390
Mar-16	104,048	275,244	1,027,100
Mar-17	106,430	276,806	1,047,679
Mar-18	109,346	277,573	1,064,283
Mar-19	112,031	282,422	1,093,638
Mar-20	118,449	293,684	1,139,422
Mar-21	124,078	304,542	1,197,747
Mar-22	128,392	315,499	1,226,677
Mar-23	133,807	328,455	1,280,350

Source: NHSE workforce statistics

202. As of March 2023, vacancy rates in NHS trusts are similar to pre-pandemic rates. Data published by NHSE shows that there were almost 112,500 vacancies in NHS trusts as of March 2023, equivalent to 8.0% of the workforce. This is an increase from over 105,800 vacancies in March 2022 (7.9% vacancy rate).

Supporting our Existing Workforce

203. The 2022 NHS Staff Survey was published on 9 March 2023 and its results have shown some positive improvements on flexible working, quality of line management and engagement with staff. 69% of staff said their immediate manager takes a positive interest in their health and wellbeing compared to 68.1% in 2021. 72.4% of staff reported that the people that they work with were polite and treat each other with respect.

204. However, there were some areas with worse results than 2021. Staff satisfaction with pay significantly decreased to 25.6% in 2022 from 32.6% in 2021. The 'morale theme' score slightly decreased to 5.74 in 2022 from 5.77 in 2021 (10 being the highest and most positive score). This represented the lowest score of the last 5 years. 32.3% of staff said they often think about leaving their organisation.

205. There is ongoing work across the NHS to improve organisational leadership, culture and staff experience through the NHS People Promise and the forthcoming publication of the NHSE's Long Term Workforce Plan.

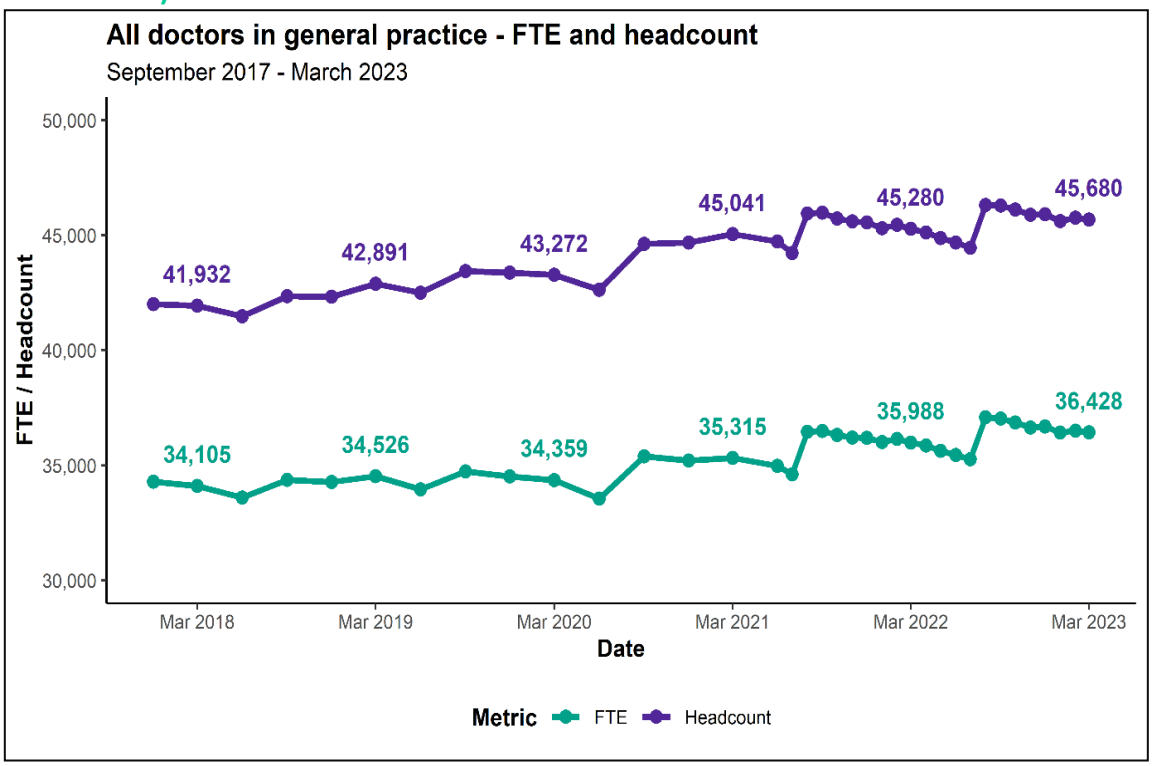
General Practice Workforce

206. The numbers of doctors working in general practice are highly seasonal, affected by new trainees, who typically begin their general practice speciality training in August and September.

207. The number of FTE doctors in general practice has been increasing. As outlined in **Figure 23**, as of March 2023, there were 440 FTE (400 headcount) more doctors working in general practice compared to March 2022 and 1,903 FTE (2,789 headcount) more compared to March 2019.

208. To support practices and to reduce bureaucratic burden on the workforce, as part of the 2020-21 GP contract, the Government committed to a thorough review of levels of bureaucracy in general practice. As part of this work, in August 2022, Bureaucracy busting concordat: principles to reduce unnecessary bureaucracy and administrative burdens on general practice was published agreeing to seven co-designed principles to reduce unnecessary bureaucracy in general practice. The Department has continued to work across government and with the NHS to implement the solutions that have emerged.

Figure 23: All Doctors in General Practice – FTE and Headcount (September 2017 – March 2023)

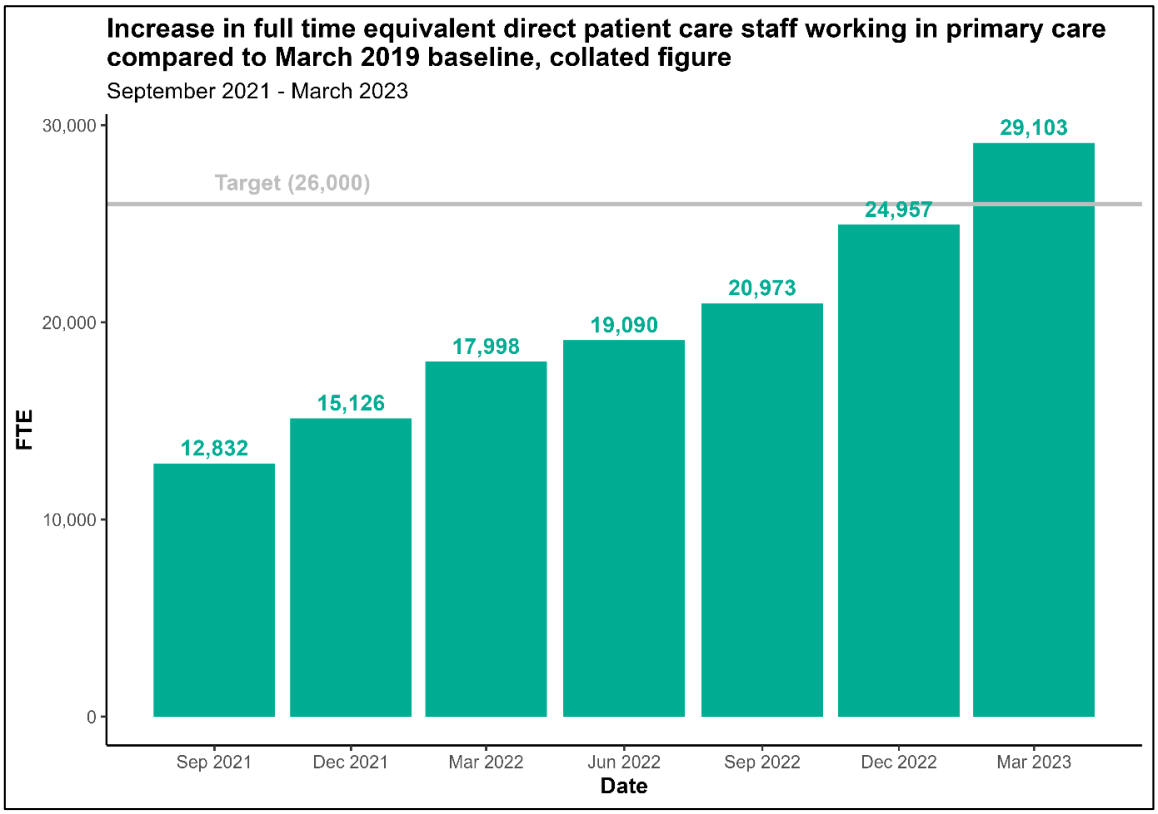


Source: General Practice Workforce, NHS England

209. As shown in **Figure 24**, the numbers of direct patient care staff have consistently increased. As of March 2023, there were 11,105 FTE more primary care professionals working in general practice compared to March 2022 and 29,103 FTE more compared to March 2019, meeting the commitment to recruit 26,000 more primary care staff a year ahead of the March 2024 target.

210. 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 PCNs. As a result, most of the growth in Direct Patient Care (DPC) numbers is in PCNs. As announced in Our Plan for Patients, the ARRS was expanded to fund GP Assistants, who provide clinical and administrative support to GPs, and Digital and Transformation Leads, who support frontline teams and patients to adopt digital solutions. In addition, the cap on hiring Advanced Practitioners was raised from one per PCN to two (double for those with over 100,000 patients). These changes took effect from 1 October 2022.

Figure 24: Direct Patient Care Staff Working in General Practice Compared to March 2019 baseline



Source: Primary Care Workforce Quarterly Update

Leadership Review

211. All seven recommendations in the Health and Social Care Review: Leadership for a Collaborative and Inclusive Future have been accepted by the Government and implementation is being taken forward by NHSE and Skills for Care. Implementation is currently focused on recommendations 1 and 2, looking at improved support around job offer and start of employment, better support on commencing employment, and cross sector support to bring people together across different sectors and employers. NHSE has also been developing an NHS Equality, Diversity, and Inclusion improvement plan to embed inclusive and fair recruitment and promotion practices in organisations, address under-representation and improve talent management across all protected characteristics.

Industrial Action

212. Trade Unions have been in dispute with the Government over the NHS 2022-23 pay award. Last year, some groups of NHS staff on Agenda for Change contracts voted to take strike action at employers in all parts of the UK. As of 31 March 2023, five non-medical unions who represent NHS workers on the Agenda for Change contract had mandates for strike action at employers in England. These are: the Royal College of Nurses (RCN), Unison, Unite, GMB and the Chartered Society of Physiotherapy (CSP). As of 31 March 2023, three medical unions had secured mandates for strike action at employers in England. These are: the British Medical Association (BMA), Junior Doctor's Committee, the Hospital Consultants and Specialists Association (HCSA) and the British Dental Association (BDA).

213. **Table 4** shows strikes that were planned or took place in 2022-23.

Table 4: Industrial Action in 2022-23

Strike Dates	Union	Status
22 March 2023	CSP	Paused due to offer
20 March 2023	GMB/Unite/Unison	Paused due to offer
18-23 March 2023	Unison (action short of a strike except for 20 March where full strike action was planned from 07:00 to 19:00)	Paused due to offer
13-15 March 2023	BMA/BDA/HCSA	Took place
8 March 2023	Unison	Paused due to talks
6 March 2023	GMB/Unite	Paused due to talks
2 March 2023	Christie NHS Foundation Trust only	Took place
1-3 March 2023	RCN	Paused due to talks
22 February	Unite (Northwest only)	Cancelled
20 February 2023	GMB/Unite	Took place
17 February 2023	Unite (West Midlands only)	Took place
13 February 2023	GMB workers at Mersey Care	Took place
10 February 2023	Unison	Took place
09 February 2023	CSP	Took place
07 February 2023	RCN/GMB	Took place
06 February 2023	RCN/GMB/Unite	Took place
26 January 2023	CSP	Took place
24 January 2023	GMB (Northwest only)	Took place
23 January 2023	Unite/GMB/Unison	Took place
19 January 2023	RCN	Took place
18 January 2023	RCN	Took place
11 January 2023	GMB/Unison	Took place
21 December 2022	Unite/GMB/Unison	Took place
20 December 2022	RCN	Took place
15 December 2022	RCN	Took place

Impact of Industrial Action

214. Despite mitigation measures in place, some 330,378 hospital appointments were rescheduled due to strike action in 2022-23, with 43,518 of those being mental health and community appointments.

Legislation on Minimum Service Levels

215. The NHS makes every effort through rigorous contingency planning to minimise disruption and its negative impact on patients and the public during industrial action. NHSE works with providers, professional bodies, trade unions and other bodies to agree safe levels of cover in advance of strike action.

216. Voluntary derogations have not been agreed for all strike action, nor is it guaranteed that voluntary derogations will be agreed for future strike action. The Government believes that setting minimum service levels during strike action in law would help create certainty, better enabling NHS providers to keep patients safe during industrial action.

217. The detail of exact minimum service levels will be set out in secondary legislation. The Department launched a consultation in February 2023 as to whether ambulance services should be covered in regulations as a priority, and if so, the detail regarding the minimum service levels required. Given that increasing strike action is often being taken without voluntary derogations being agreed, the Government is also considering whether to consult on additional minimum service levels covering a wider range of health services to protect the lives and health of the public.

2022-23 Pay Round

218. The Government accepted the Pay Review Bodies' formal recommendations for the 2022-23 pay round. These were implemented in July 2022 and backdated to April 2022.

219. The NHS Pay Review Body (NHSPRB) recommended all Agenda for Change (AfC) staff (around 1 million FTE) receive at least £1,400 (underpinned to 4% for staff at the top pay point of Band 6 and all points in Band 7). The Doctors' and Dentists' Pay Review Body (DDRB) recommended that medical staff (around 130,000 FTE) receive an uplift of 4.5%. The Senior Salaries Review Body (SRRB) recommended an across-the-board increase of 3% for all Very Senior Managers (VSMs) and Executive and Senior Managers (ESMs), with a further 0.5% to ameliorate the erosion of differentials and facilitate the introduction of the new VSM pay framework.

220. Following the implementation of the Pay Review Bodies' recommendations, several health unions balloted their members for strike action and secured a mandate.

221. After constructive talks with AfC unions, the Government put forward a best and final offer for staff on the AfC contract on 16 March 2023. Under the offer, in addition to the pay award that they have already received, staff will receive a non-consolidated award of 2% of an individuals' salary for 2022-23. In addition, they will also receive a one-off 'NHS Backlog Bonus' to recognise the sustained pressure facing the NHS following the pandemic and the extraordinary effort staff has been making to hit backlog recovery targets. The bonus is worth at least £1,250 and is determined by an individual's pay band.

2023-24 Pay Round

222. On 16 November 2022, the Government issued remit letters to the independent pay review bodies – the NHSPRB, the DDRB and the SSRB – formally beginning the 2023-24 pay round. We issued our evidence to the NHSPRB and DDRB on 21 February 2023 and to the SSRB on 23 February 2023, for them to make a recommendation on a pay uplift for NHS workers for the 2023-24 financial year.

223. As part of the formal talks on pay that took place in February and March 2023 with AfC unions, the Government offered AfC staff a 5% consolidated increase in pay for 2023-24, worth at least £1,065, to full-time staff. In addition, this deal includes having the lowest paid staff see their pay matched to the top of AfC band 2, resulting in a pay increase of 10.4%.

NHS Pensions

224. The NHS pension scheme is generous and amongst the best available. For some senior clinicians this means they run out of their allowance for tax-free pension saving and that makes NHS work less attractive. More broadly, a significant proportion of the NHS workforce are aged over 50 and are an important source of skills and expertise for the NHS to retain for longer.

225. In Our Plan for Patients, we announced pension scheme changes to help retain experienced doctors and nurses, whilst making it easier and attractive for retired staff to return.

226. In October 2022, amendments were proposed to the NHS Pension Scheme, to continue the suspension of restrictions on return to work. The Department extended the temporary retire and return easements as follows:
    - The suspension of rules restricting the hours nurses with special retirement rights could work after retirement was extended until 31 March 2025.
    - The 16-hour rule, which limited staff who returned to work from retirement to work 16 hours per week (2 days) or less in the first month after retirement to safekeep their pension benefits, was suspended to 31 March 2023, and permanently removed from 1 April 2023.

227. The Government also amended scheme regulations regarding pension tax, including on timing of inflation proofing that is applied to NHS pension pots, which was changed to protect staff from unintentionally higher annual allowance tax charges driven by inflation. Moreover, the Government announced substantial pension tax reforms in the 2023 Spring Budget which apply to all pension saving across society, not just within the NHS Pension Schemes.

228. Furthermore, the Treasury announced at the Budget that open and closed public service pension schemes for the same workforce will be considered linked for the purposes of calculating annual allowance charges.

229. These measures support staff productivity and retention, ensuring that experienced clinicians are not pushed out of the workforce for tax reasons.

Supply/Growing the Workforce

230. As of March 2023, we were on track to deliver 50,000 more nurses across the NHS by 2024, with over 44,000 more nurses in March 2023 compared with September 2019. A comprehensive delivery programme was established, working across a range of delivery partners to invest in and diversify our training pipeline, ethically recruit internationally, improve retention and support return to practice.

Medical Expansion

231. The Government has funded an additional 1,500 undergraduate medical school places per year for domestic students in England - a 25% increase compared to 2017, taking the total number of medical school places in England to 7,500 each year.

232. The Government temporarily lifted the cap on medical school places for students who completed A-Levels in 2020 and in 2021 and who had an offer from a university in England to study medicine, subject to their grades. As a result of this change, the intakes for 2020-21 and 2021-22 were 8,405 and 8,460 respectively, significantly above the planned cap of 7,500.

233. In January 2023, the Government announced funding for the first 200 medical apprentices to start training as doctors over the next two years. This initiative aims to provide an alternative route into medicine that makes the profession more accessible and helps ensure a diverse workforce that is more representative of local communities.

Clinical Expansion

234. Since September 2020, all eligible nursing, midwifery, and allied health profession degree students have received a non-repayable training grant of a minimum of £5,000 per academic year. Additional funding is also available for studying certain courses – for example, Mental Health Nursing and Learning Disabilities Nursing – with further financial support available to students for childcare, dual accommodation costs and travel. For the third consecutive year we have seen over 26,000 acceptances to undergraduate Nursing and Midwifery programmes. There were 3,700 more acceptances in 2022 than in 2019 – a 16% increase.

International Recruitment

235. We have been growing the domestic workforce to move towards a more sustainable domestic supply in future. However, ethical international recruitment has remained a key element of achieving our workforce commitments.

236. Our Code of Practice for International Recruitment was updated on 23 March 2023, in line with latest advice from the World Health Organisation, to guarantee the most stringent ethical standards when recruiting health and social care staff from overseas. Active recruitment from 'red list' countries with the most vulnerable health systems is prohibited.

237. On 15 December 2022, we published new international candidate guidance. This provided support and information on topics such as how to avoid scams, working rights and standards, and what to consider when deciding whether to take a health or care job in the UK.

238. As of March 2023, there were over 254,000 non-UK nationality staff across NHS trusts and ICBs, an increase of over 38,000 (17.9%) compared to March 2022.

239. In the year to March 2023, over 20,000 non-UK nationality nurses and health visitors joined active service in NHS Trusts and ICBs.

Community Health Services (CHS) Workforce

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

241. Within the NHS, community nursing accounts for 12% of the qualified nursing workforce, of which district nurses account for 11% of community nurses.

242. Data for NHS Trust providers in December 2022 showed:
- 36,500 FTE community health nurses, plus 16,800 FTE support staff.
- 4,100 FTE district nurses.
- 26,000 FTE AHPs (including 5,000 FTE support staff), working primarily in a community setting.

243. Data for the independent sector is incomplete and does not represent the full coverage of the sector. However, as an indication, figures from September 2022 showed an additional 4,400 FTE community health nurses plus an estimated 3,600 FTE support staff.

244. The vacancy rate for registered nurses in community trusts in March 2022 was 10.1%. In March 2023, that rate has increased to 10.8%. Vacancy rates vary regionally, with London having the highest vacancy rate (18.1%) and the East of England having the lowest vacancy rate (2.5%). As well as community trust nursing vacancy rates being higher than for registered nursing staff in acute hospitals, there was additional cause for concern as Community Health Nurses are older on average.

Mental Health Workforce

245. As of March 2023, there were 142,700 FTE people in the mental health workforce. This is an increase of over 9,300 (7.0%) FTE staff since March 2022. This included only those people who work directly on mental health, across NHS hospital trusts and ICBs in England. Data on the staffing of non-NHS provision, which remains a key element of mental health service delivery, is not available.

246. Despite increases in the mental health workforce in recent years and the commitment to increase the wider nursing workforce by 50,000, there is an increasing gap between the demand for mental health nursing and supply. Despite the number of FTE mental health nurses increasing by over 1,100 (3.0%) over the past year, whilst there were over 12,000 FTE vacancies for nurses working in mental health trusts in March 2022, this had increased to over 12,800 FTE vacancies in March 2023. As detailed for nurses working in community trusts, the rate for nurses in mental health trusts is similarly higher than for acute hospitals and varies by region. The rate is as high as 22.2% in the South East in March 2023, down to 14.7% in the North East and Yorkshire.

247. There are approximately 17,000 learning disability nurses on the UK register and approximately 3,000 employed by English NHS Trusts. Data on the staffing of non-NHS provision, which remains a key element of learning disability service delivery, is not available.

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

248. The Office for Health Improvements and Disparities (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.

249. 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.

Health Inequalities and Healthy Life Expectancy

250. A healthy population reduces pressure on the NHS and wider public services and supports a strong economy through increased productivity and labour market participation. As announced in the Levelling Up White Paper, the Department has committed to a levelling up health mission to narrow the gap in Healthy Life Expectancy at birth (HLE) between local areas where it is highest and lowest by 2030, and increase HLE by 5 years by 2035. The gap in the number of years people live in good health is stark and unacceptable. Health disparities exist across a wide variety of conditions from cancer to mental health and contribute to the unacceptable variation in life expectancy and healthy life expectancy. According to the latest available data from ONS, there has been no significant change in healthy life expectancy at birth over the previous decade in England.

251. On 24 January 2023, the Government announced that it will publish a Major Conditions Strategy. The Major Conditions Strategy, due for publication in early 2024, provides us with a potential opportunity to drive some progress on our levelling up health mission to improve HLE by five years by 2035 and reduce the gap between the highest and lowest areas by 2030. It will focus on tackling the 6 groups of conditions that drive around 60% of the overall burden of disease in England, as well as tackling the prevalence of multi-morbidities (the growing number of individuals living with 1 or more groups of condition). The scope will be broad – covering the whole patient pathway from prevention to treatment. The Strategy will apply a geographical lens to each condition to address regional disparities in health outcomes, supporting the levelling up mission to narrow the gap in healthy life expectancy by 2030.

252. An interim review setting out the direction of travel for the Strategy was published earlier this year, and a Call-For-Evidence to help inform both the interim review and fuller report was published on the 17 May 2023.

Cost of Living

253. The Government recognises the need to protect the public, and to support low-income and vulnerable households in the context of increasing cost-of-living. This

is why a £37 billion package of cost-of-living support for 2022-23 was announced, including £15 billion of targeted, direct support for the most vulnerable households. DHSC provided evidence to support this cross-Government package. There is a strong link between cold homes and cardiovascular and respiratory diseases. Around 40% of excess winter deaths (EWDs) are attributable to cardiovascular diseases and around 33% of EWDs are attributable to respiratory diseases. 30% of all excess winter deaths are attributable to cold homes. The rise in cost of living has already had a direct impact on people's mental health: over half of UK adults say they have felt anxious because of higher prices and 1 in 5 have felt unable to cope. Food and drink prices increased by 16.8% in the year to January 2023, putting additional pressure on families who are already struggling to pay their energy bills.

Economic Activity

254. As of 14 March 2023, there were more than 2.5 million people reporting that they are inactive due to long-term sickness, an increase of 26% since 2018. In light of this, the Spring Budget 2023 introduced a £400 million cross-Government suite of measures which will be led in part by the Department to address the leading causes of ill health related inactivity, including tailored employment support in mental health and musculoskeletal health services, and expanding access to digital resources and health checks.

The DHSC and Department for Work and Pensions Joint Work and Health Directorate (JWHD)

255. The JWHD reflects the shared agenda of boosting employment for disabled people and people with health conditions, recognising that good work is an important wider determinant of health. Throughout 2022-23, JWHD continued to provide much needed support to help these groups to start, stay and succeed in work.

256. JWHD has improved alignment of employment and health systems to deliver evidence-based programmes, trials, and tests. Following a positive evaluation, in October 2022 we announced we would expand the Employment Advisers in NHS Talking Therapies programme throughout England, increasing access to combined psychological and employment support from 40% to 100% coverage across services in England. We have continued to improve access to work and health support for people with complex needs and, following this year's competed grant exercise, six areas covering 30 Local Authority areas will deliver Individual Placement and Support in Primary Care (IPSPC) in England from April 2023 until March 2025, supporting up to an estimated 12,400 people with common physical or mental health conditions to secure or retain employment.

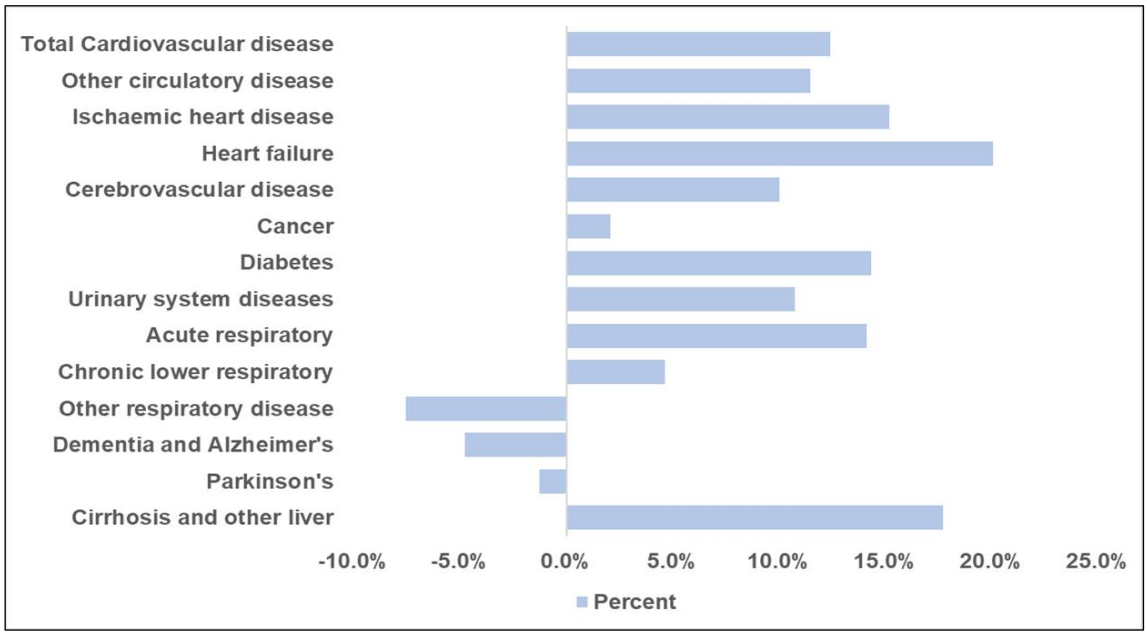
257. We have committed to improving the use of the Fit Note, including, from July 2022, changing the regulations to extend certification of fit notes to a wider range of healthcare professions. Occupational Health (OH) has continued to be a focus in helping disabled people and people with health conditions to remain and thrive in work. Building on existing programmes, we announced a wide-reaching package at the Spring Budget 2023 to tackle rising economic inactivity due to long term

sickness, including providing faster access to joined-up work and health support with a particular focus on mental health and musculoskeletal conditions.

Cardiovascular Disease (CVD)

258. CVD is the second largest cause of death in England, accounting for almost 1 in 4 (24%) of deaths across all ages in 2019. It affects around 6.4 million people, is the largest contributor to disability adjusted life years, and accounts for around a quarter of the life expectancy gap between the richest and poorest in England. It is also a significant contributor to excess deaths. Overall mortality between mid-April 2022 and 31 March 2023 was 10% higher than expected. Cardiovascular disease (CVD) was a substantial contributor with deaths around 12% higher than expected (28,564 excess deaths). Deaths involving heart failure were 20% higher than expected, while deaths involving ischaemic heart disease and cerebrovascular disease, including stroke, were respectively 15% and 109% higher than expected. See **Figure 25**.

Figure 25: Ratio Between Registered and Expected Deaths (expressed as a percentage) by Mentions of Cause of Death in England (Mid-April 2022 to 31st March 2023)



Source: Excess mortality in England and English regions (Multiple causes of death can be mentioned on death certificates, the same death may therefore be counted in more than cause group)

259. To tackle these issues, the Department has made progress through:

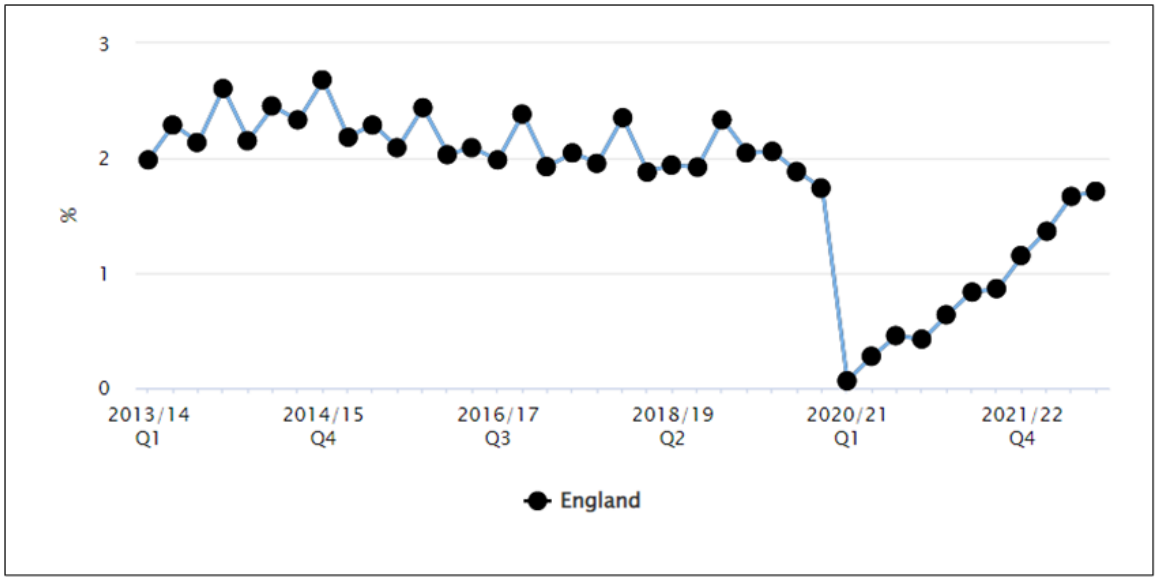
- Developing a national digital NHS Health Check, which will be an innovative service aiming to bolster local authority delivery of the programme. As part of the Spring Budget 2023, £13 million was awarded for digitising the NHS Health Check and we are working towards a live version being available in Spring 2024.
- Appointing Professor John Deanfield as Government Champion for Personalised Prevention, as announced by the Secretary of State in March 2023. In this role, Professor Deanfield will lead an ambitious vision for a modern, personalised cardiovascular disease prevention service that will contribute to the Government's ambition to increase healthy life expectancy and level up.

- Working with stakeholders both internally and externally to see how we can go further to prevent CVD, building on existing NHS activity. CVD will form a part of the Government's Major Conditions Strategy, which will focus on conditions that contribute most to morbidity and mortality across the population in England.

The NHS Health Check Programme

260. The NHS Health Check programme is a core component of England's CVD prevention pathway, aims to prevent heart disease, stroke, diabetes and some cases of dementia and kidney disease among healthy adults aged 40-74 years. Prior to the COVID-19 pandemic, on average 310,000 NHS Health Checks were delivered each quarter. As shown in **Figure 26**, the programme was largely suspended during the pandemic but based on current trend delivery is expected to recover by June 2023.

Figure 26: Percentage of NHS Health Checks Received by the Total Eligible Population in the Quarter



Source: NHS Health Check - Data - OHID (phe.org.uk)

Healthy Start Digitisation

261. Healthy Start is a statutory scheme that helps to encourage a healthy diet by offering support for pregnant women (at least 10 weeks into pregnancy), babies and families with a child under four years old, from low-income households. Pregnant women and children aged under four and over one each receive £4.25 every week, and children under one each receive £8.50 every week. Eligibility is based on claiming certain welfare benefits. All pregnant women aged under 18 are also eligible for the Healthy Start scheme.

262. Healthy Start can be used to buy, or be put towards the cost of, fresh, frozen, or tinned fruit and vegetables, fresh, dried, and tinned pulses, plain cow's milk, and infant formula. Healthy Start beneficiaries are also eligible for free Healthy Start Vitamins for pregnant women and children.

263. The NHS Business Services Authority (NHSBSA) operates the scheme, which also covers Wales and Northern Ireland, on behalf of the Department and the Devolved Administrations.

264. In April 2022, the Scheme began operating as a fully digital service, the most significant development since its inception in 2006. The digitised scheme has delivered an increase in national uptake, from 59.9% in August 2021 to 63.9% in March 2023, supporting more than 365,000 beneficiaries.

An Enhanced Screening Offer for Preventative Health

265. In 2022, the UK National Screening Committee (NSC)'s terms of reference were expanded to include targeted as well as population-wide screening programmes. This will enable the independent advisory committee to make recommendations relating to screening for specific groups within the wider population.
266. An initial recommendation made in June 2022 is that targeted lung cancer screening should be offered to the high-risk group of people aged 55 to 74 years with a history of smoking.

267. In July 2022, DHSC invested £10 million for 28 new breast screening units, which will be targeted at areas with the greatest challenges of uptake and coverage. This will provide extra capacity for services to recover from the impact of the pandemic, boost uptake of screening in areas where attendance is low, tackle health disparities and contribute towards higher early diagnosis rates in line with the NHS Long Term Plan.

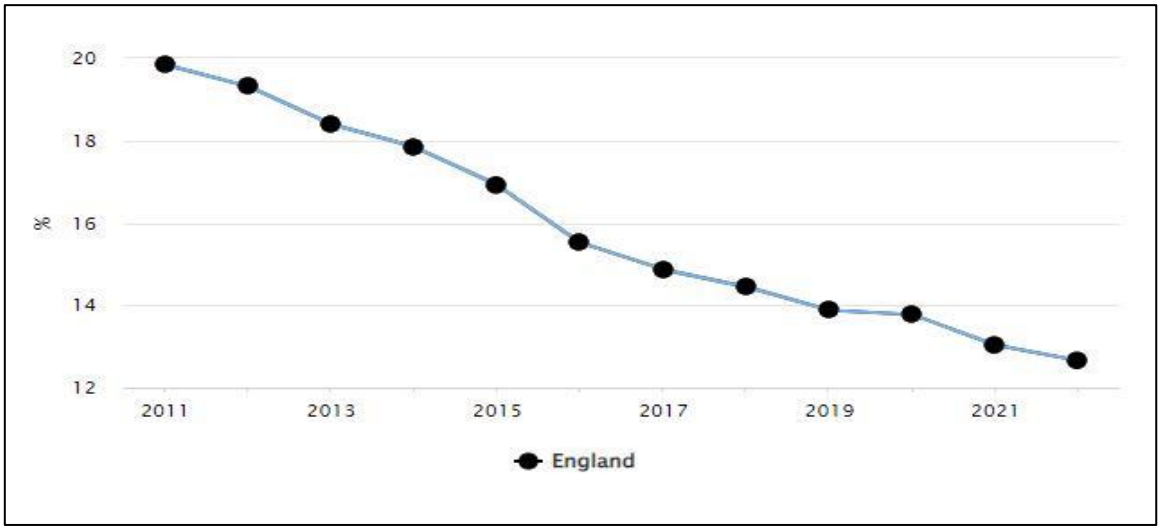
268. At the UK NSC meeting held November 2022, it was recommended to include tyrosinemia screening into the new-born screening programme. If found early, vital treatment can be given to avoid damage to the liver, kidneys and the nervous system. The UKNSC has worked with the Health Technology Assessment to develop prospective research of the use of AI in breast screening.

Smoking Prevalence

269. In 2019, the Government set the bold ambition for England to be Smokefree by 2030 by reducing smoking rates to 5% or less. To support this, the Government commissioned Dr Javed Khan OBE to undertake an Independent Review, which was published in June 2022.

270. Smoking is the single biggest behavioural cause of preventable illness and death in England. In 2019, around 64,000 deaths were attributable to smoking, around 13% of all deaths. Between 2012 and 2022, adult smoking prevalence has decreased by over a third (34.2%) (**Figure 27**). In 2012 19.3% of adults smoked, compared to 12.7% in 2022. In 2022, smoking prevalence was higher in the most deprived decile of local authorities compared to the least (16.4% compared to 10.3% respectively). In 2021, 3.3% of 15-year-olds were regular smokers, and we are on course to meet our target of 3%.

Figure 27: Smoking Prevalence in Adults (18+) – Current Smokers (APS) for England



Source: Smoking Prevalence in adults (18+) - current smokers (APS)

271. Regulations requiring medium and large businesses (50+ employees) to restrict less healthy products from being featured in key locations, such as checkouts, store entrances, aisle ends, and their online equivalents came into force in October 2022. This policy is aimed at improving our food environment and encouraging reformulation of high in fat, salt or sugar food and drink. The policy focuses on the products that are significant contributors to sugar and calorie intakes in children and that are heavily promoted. The location restrictions are the single most impactful obesity policy at reducing children's calorie consumption and are expected to accrue health benefits of nearly £58 billion and provide NHS savings of over £4 billion, over the next 25 years. Social care savings are estimated to be £5 billion and reduced premature mortality is expected to deliver nearly £7 billion of economic output.

272. With around 3.8 million (ONS, 2021) users in England, vapes have become the most popular quitting aid in England. Evidence indicates that they can help smokers to quit, particularly when combined with additional support from local smoking cessation services, and that they contribute to an estimated 50-70,000 additional 'quits' per year in England.

273. The Vaping in England report, published in September 2022, was the final in the current commission of annual independent academic evidence updates.

274. This series of reports has allowed Government to provide smokers and the public with clear, evidence-based, and accurate information on the relative harm of nicotine vapes. In turn, this has provided the scientific underpinning for HMG policy on vaping. For example, the previous (7th) report found that using a vaping product is the most popular aid used by people trying to quit smoking. This report is the most comprehensive to-date, particularly on the science of vaping with 9 systematic reviews, including on harm, behaviours, and attitudes. The report addresses international regulatory developments, nicotine and flavours, potential

exposures and health harms, poisonings, explosions, and perceptions of harm. It also reviews the health effects of heated tobacco.

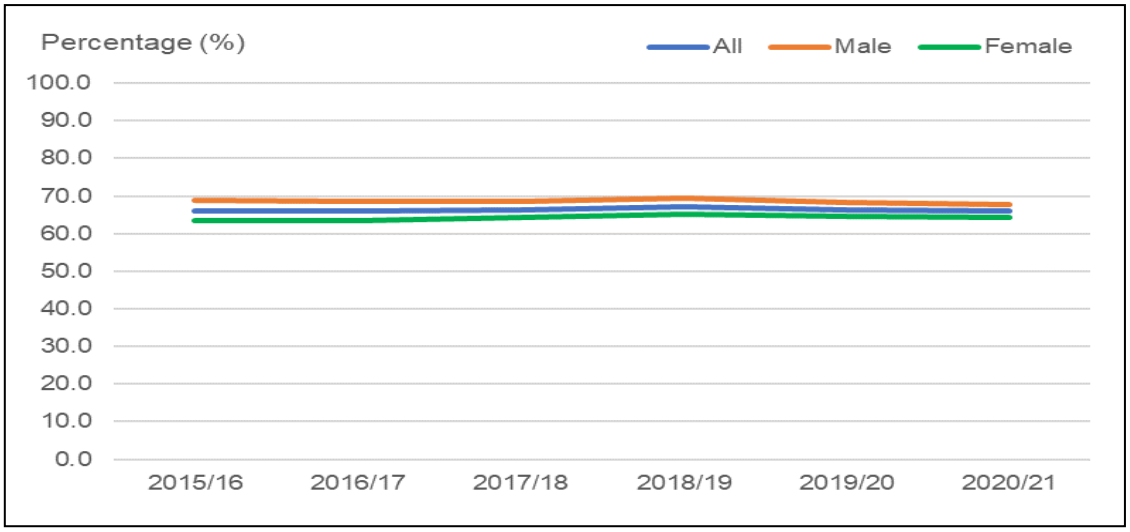
275. Over the past 12 months, there has been an increase in vape use by children and young people. Data collected in NHS Digital's Smoking, Drinking and Drug Use among Young People in England survey showed a doubling of regular vape use for 11-to-15-year-olds to 4% in 2021 compared to 2% in 2018. This was confirmed in the 2023 Action on Smoking and Health (ASH) survey report 'Use of e-cigarettes among young people in Great Britain' showing a significant increase with 16- to-17-year-olds, at 15%, an increase from 5% in 2018.

Physical Activity

276. Physical inactivity and sedentary behaviour are risk factors for conditions such as coronary heart disease, some cancers, MSK conditions and type 2 diabetes. Working towards the UK Chief Medical Officer Guidelines for Physical Activity is safer for most people and can help to reduce the risk of these conditions, help people living with long-term conditions to manage symptoms and promote positive mental health and social connection. Regular physical activity is essential for children and is associated with bone, muscle and cognitive development, cardiovascular fitness, improved mental health and a healthier weight status.

277. In 2020 to 2021, more than six in ten adults (aged 19 +) were physically active, having achieved 150+ minutes of moderate activity, or 75 minutes of vigorous per week. See **Figure 28**.

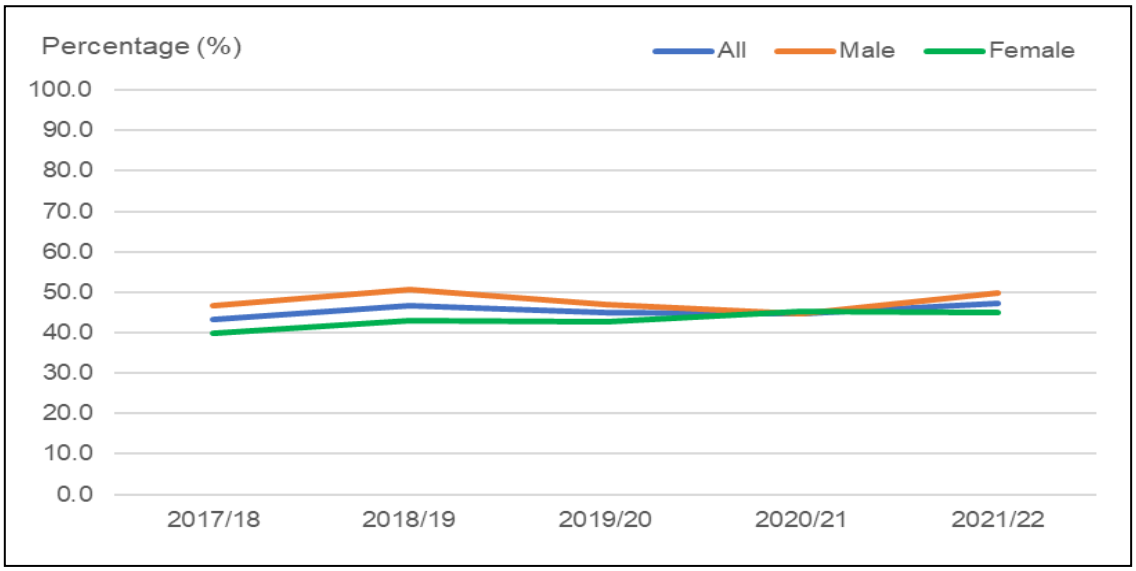
Figure 28: Percentage of Physically Active Adults, 2015-16 to 2020-21



Source: Office for Health Improvement and Disparities (based on the Active Lives Adult Survey, Sport England): Physical Activity - Data - OHID (phe.org.uk)

278. In the 2021-22 academic year, 47.2% of children and young people were meeting the Chief Medical Officers' guidelines of taking part in sport and physical activity for an average of 60 minutes or more every day. Activity levels increased by 2.6 percentage points compared to 2020-21. See **Figure 29**.

Figure 29: Percentage of Physically Active Children and Young People. Period 2015-16 to 2021-22



Source: Active Lives Children and Young People Survey, Sport England: Physical Activity - Data - OHID (phe.org.uk)

279. OHID has continued to collaborate with the Department of Education and Department for Culture, Media, and Sport on a joined-up approach to encourage children to lead more active lives. In 2022-23, OHID provided £67 million to support the Primary School PE and Sport Premium and the School Games Organisers network, both of which provided children, with opportunity to try out different sports, learn new skills and get more physically active.

280. OHID has worked with Sport England and other partners, to deliver and evaluate the Moving Healthcare Professionals Programme. This programme has enabled thousands of healthcare and allied health professionals to access training, which has increased their awareness and knowledge of how physical activity can help support their patients manage their conditions and lead more active lives.

281. In March 2023, OHID, Public Health Scotland, and other UK Health Departments, published a guide on how to communicate the UK Chief Medical Officer's physical activity guidelines to professionals and practitioners within and outside the health sector.

Voluntary Sugar Reduction Programme

282. The voluntary sugar reduction programme was announced in the first chapter of the Childhood Obesity Plan (2016) with guidelines for all sectors of industry, to help them deliver a 20% reduction by 2020, being published in 2017. In 2018, the programme was extended to include juices and milk-based drinks that are excluded from the UK's soft drinks industry levy (SDIL), with businesses expected to reduce the overall sugar content by 5% and 20% by 2021, respectively.

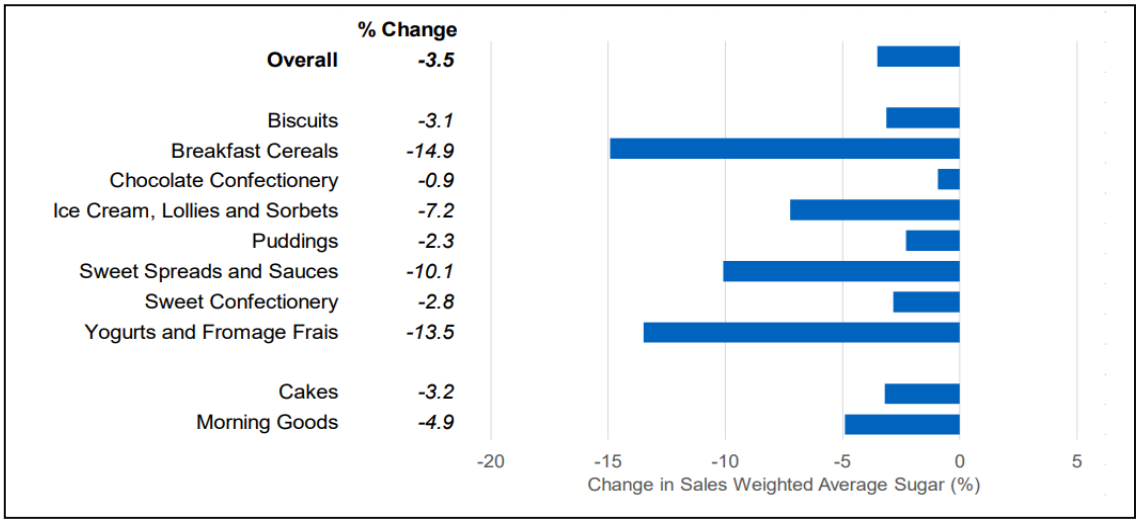
283. In December 2022, OHID published the fourth progress report of the sugar reduction programme. This included reporting for the food categories in the programme and the second assessment of industry progress in reducing the sugar

content of unsweetened juices and sweetened milk-based drinks. The report showed that between 2015 and 2020, retailers and manufactures reduced the sales weighted average (SWA) sugar content per 100g in breakfast cereals (-14.9%) and yogurts and fromage frais (-13.5%); and for the first time, reductions were seen across all food categories. For the programme overall, retailers and manufacturer-branded products achieved a -3.5% reduction in SWA sugar content per 100g. The overall figure was lower than the reductions for some categories due to the continued increase in sales of higher sugar products (e.g., confectionery) where minimal reformulation had been undertaken.

284. The report showed that reductions have been achieved in juices and milk-based drinks between baseline (2017) and year 2 (2020), with reductions in SWA per 100 ml reported in pre-packed milk-based drinks (-29.7% reduction), pre-packed fermented yogurt drinks (-7.1% reduction) and pre-packed flavoured milk substitute drinks (-6.9% reduction). Less progress was seen in the eating out-of-home sector across all food and drink categories included in the sugar reduction programme. See **Figure 30**.

285. The report also includes the fourth assessment of change in drinks subject to the Soft Drinks Industry Levy (SDIL). Between 2015-2020, the average sugar content of SDIL drinks reduced by -46% for retailers and manufacturer-branded products, and -44.3% for the out of home sector, all whilst sales have continued to increase by +21.3%. Data from retailers and manufacturer branded products suggests that the impact of these reductions is similar across all socio-economic groups.

Figure 30: Percentage Change in Sales Weighted Average Total Sugar (g per 100g) by Category Between Baseline (2015) and Year 4 (2020) for Retailers and Manufacturer Branded Products



Source: Office for Health Improvement and Disparities: Sugar reduction programme: industry progress 2015 to 2020 - GOV.UK (www.gov.uk)

286. The next report on industry progress in reducing the levels of sugar in juice and milk-based drinks and those in scope of the SDIL is expected in early 2024.

Weight Management Services (WMS) GP Referrals

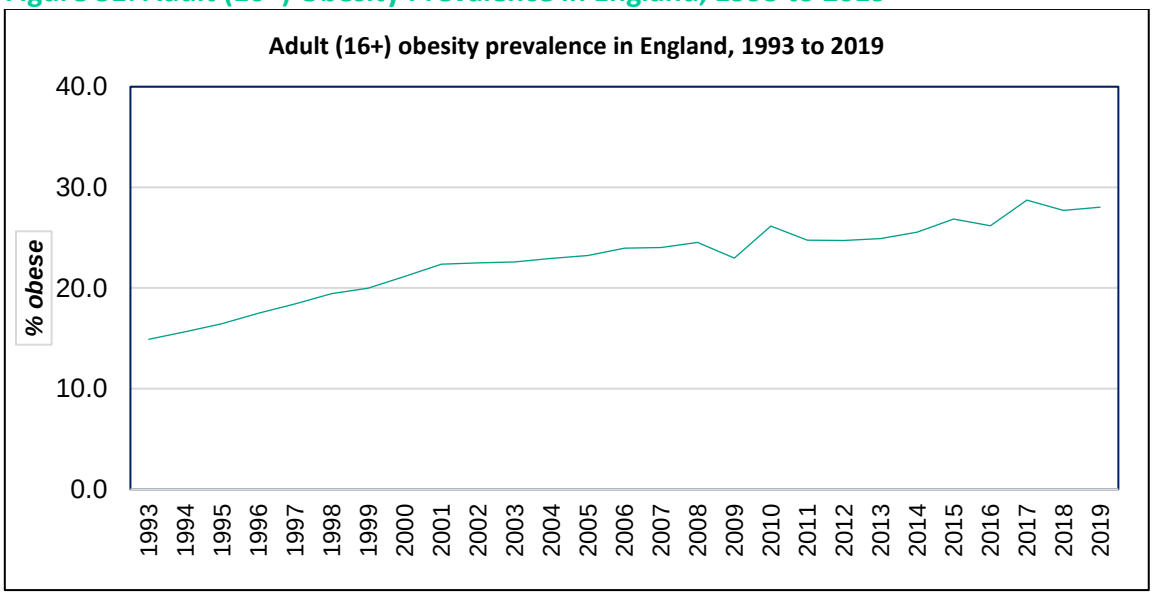
287. A voluntary GP Weight Management Enhanced Service was introduced in the 2021-22 GP contract to incentivise GPs to identify and refer appropriate patients to weight management services (WMS). There is good evidence that WMS are both effective and cost effective at helping people to lose weight. GPs are integral to this process as they are the main referrers to all NHS WMS and provide around a third of referrals to Local Authority-commissioned WMS. GPs also have good reach into at-risk groups where obesity prevalence is likely to be higher, such as people from more deprived areas and some ethnic minority groups, which means that they can be considered for referral to WMS where appropriate. GP practices are provided with a payment of £11.50 each time they identify and refer an eligible adult into a WMS. This Enhanced WMS continued in the 2022-23 contract and will continue in the 2023-24 contract.

Obesity Prevalence – Adults

288. Published in December 2022, the latest data in the Health Survey for England 2021 estimated that 25.9% of adults in England in 2021 were living with obesity. Due to a change in methodology during the pandemic, estimates for 2021 are not directly comparable with previous years.

289. Over time, the proportion of adults in England who are living with obesity has increased from 14.9% in 1993 to 28.0% in 2019. See **Figure 31**.

Figure 31: Adult (16+) Obesity Prevalence in England, 1993 to 2019



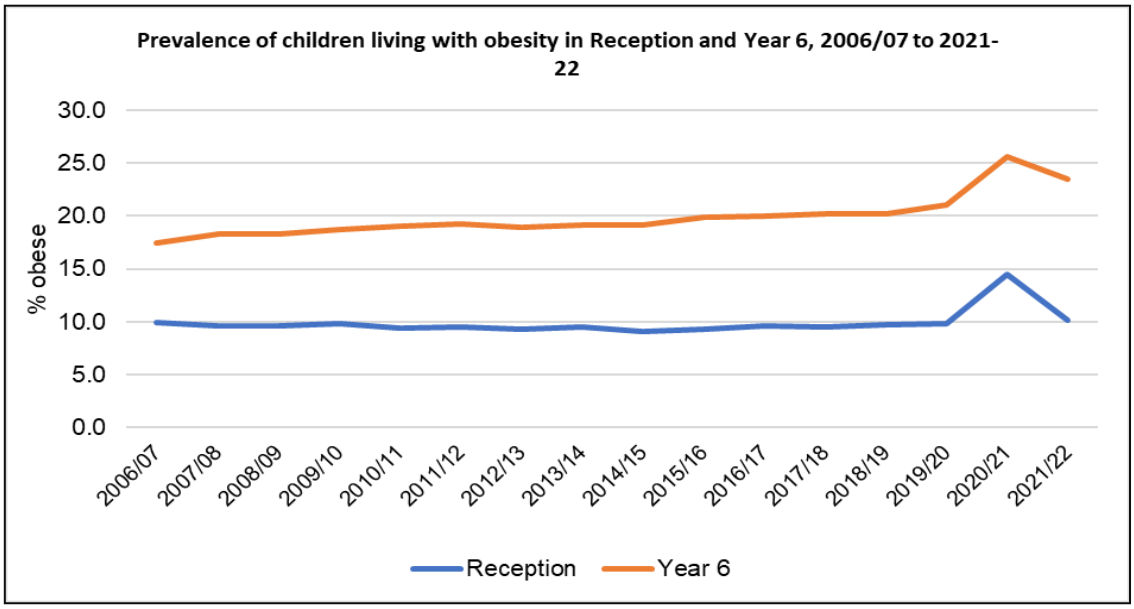
Source: Health Survey for England: Health Survey for England 2019 [NS] - NDRS (digital.nhs.uk)

Obesity Prevalence – Children and Young People

290. The Health Survey for England estimated that obesity prevalence in children and young people aged 2 to 15 increased from 11.7% 1995 to 16.3% in 2019.

291. The National Child Measurement Programme (NCMP) records children's height and weight at the first and last years of primary school. During the 2021-22 school year, 10.1% of children in Reception (aged 4 – 5) and 23.4% in Year 6 (age 10 – 11) were living with obesity. Both age groups saw a decrease compared to 2020-21, but prevalence remained higher than pre-pandemic levels. See **Figure 32.**

Figure 32: Prevalence of Children Living with Obesity in Reception and Year 6, 2006/07 to 2021-22



Source: National Child Measurement Programme: National Child Measurement Programme, England, 2021/22 school year - NDRS (digital.nhs.uk)

Start for Life Programme

292. 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 from conception to age 2, with the aim of ensuring every baby in England is given the best 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 around £300 million to transform Start for Life and family help services, across Government Departments, including DHSC.

293. The Family Hubs and Start for Life programme is overseen jointly by the Department and the Department for Education. Through this programme, we have been working with 75 local authorities in England with high levels of deprivation to ensure that parents and carers can access improved local start for life services during the critical period from conception to age two.

The Health Incentives Pilot - Better Health: Rewards

294. The Health Incentives Pilot - Better Health: Rewards launched in Wolverhampton on 17 February 2023. The pilot is a digital app-based intervention, open for free to all adults in Wolverhampton. It uses financial incentives such as supermarket vouchers and cinema tickets to support people to eat better and move more, helping OHID to deliver on its priority to cut waiting lists. The pilot will be live for 6 months and is set up as a Randomised Control Trial. The evaluation of the pilot is expected to be available in early 2024 and will examine the impact of financial incentive on the health behaviours of different groups.

Drugs

295. Drugs is a major delivery programme for the Department. In December 2021, the Government published a 10-year drug strategy to cut crime and save lives. To support its delivery, a record £532 million was made available to the Department over the three-year Spending Review period to transform the drug and alcohol treatment and recovery system. The Department has been working closely across government, and with local authorities, to ensure the ambitious targets of the drug strategy are met, including preventing nearly 1000 deaths and getting at least 54,500 additional people into treatment by 2025.

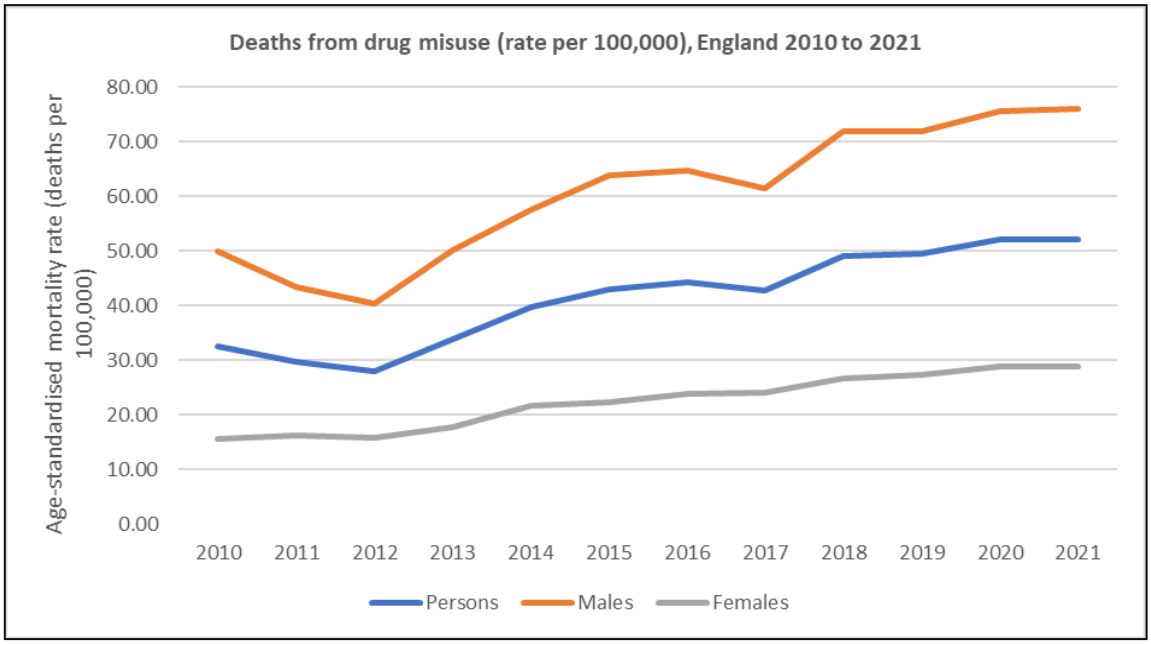
296. The Department made available £95.4 million to Local Authorities in 2022 to 2023, supporting them with planning tools and signing grant agreements. Allocations for 2023 to 2024, and indicative allocations for 2024 to 2025, have been announced and plans are being finalised and grant agreements signed. This is part of the new 10-year drug strategy, to cut crime and save lives by reducing the supply and demand for drugs and delivering a high-quality treatment and recovery system.

Deaths From Drug Misuse (age-standardised mortality rate per 100,000)

297. In 2019, drug use was the 10th leading risk factor attributed to years lived with a disability (YLDs) in England. The rate of deaths from drug misuse registered in 2021 was 1.9 times higher than the rate in 2012 (the year with the lowest rate in the past decade): 52.2 deaths per 100,000 compared to 28.0 respectively. See **Figure 33**.

298. 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.

Figure 33: Deaths from Drug Misuse (rate per 100,000), England 2010 to 2021



Source: ONS Deaths related to drug poisoning in England and Wales - ONS (ons.gov.uk)

Water Fluoridation

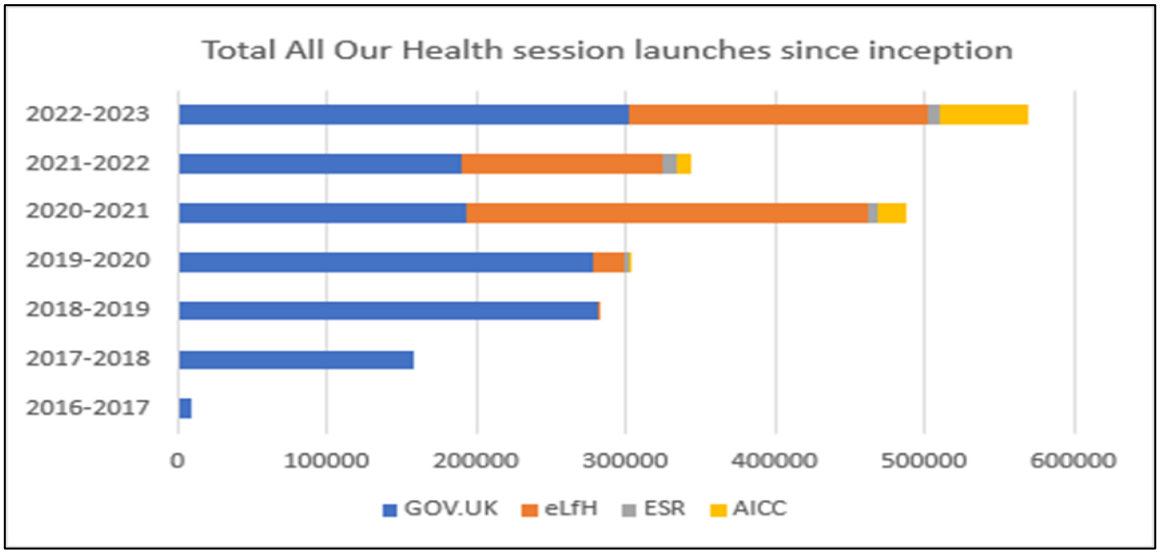
299. We made it possible for more of England's population to benefit from water fluoridation through provisions in the Health and Care Act 2022. We are expanding the scheme to an additional 1.6 million people in the Northeast of England over the Spending Review 21 (SR21) period, subject to consultation.

All Our Health

300. All Our Health is OHID's professional workforce development platform and home to a wide collection of bite-sized eLearning, covering over 33 important public health topics. Each session uses key evidence and data to highlight the importance of addressing each public health issue and signpost learners to other trusted sources of information.

301. During 2022-23, four new All Our Health sessions were developed: Health Disparities; Financial Wellbeing; Healthy Eating; Learning Disability. An evaluation of the Health Disparities session showed statistically significant improvements in knowledge, confidence, and intention to act post learning. During this time, we also saw over 570,000 (see **Figure 34**). All Our Health session launches across the platform, an increase of 40% on the previous year. The most popular topics amongst learners were Childhood Obesity, Adult Obesity and Mental Health and Wellbeing.

Figure 34: Total All Our Health Session Launches Since Inception



Source: Google Analytics and Tableau data analysis tools.

Public Health

302. Public health services commissioned by local authorities in England are mainly funded through a ring-fenced Public Health Grant.

303. In 2022-23, the value of the Public Health Grant increased by 2.81%, taking total funding to £3.417 billion. This is part of a wider package of specific investment (additional c.£120 million) to improve the start for life offer and support improvements in the quality and capacity of drug and alcohol treatment.

304. This investment will enable local authorities to continue to invest in prevention of ill health and essential frontline services like child health visits, drug treatment and sexual health services.

305. 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.

306. Building public health analytical capacity and capability is an important priority. During 2022-23, 84 skills development sessions were delivered to professionals across local public health systems with over 2,400 attendees. Training was delivered on analytical methods as well as the use of public health data to inform local decision-making.

307. The COVID-19 pandemic highlighted the importance of an agile analytical workforce that can readily respond to emerging challenges. In collaboration with UKHSA, OHID delivered an apprentice programme for 42 data scientists employed across the seven regions. The apprentices have gained qualifications while also gaining on the job experience, with the majority progressing to secure jobs in data science in the public sector.

Regional Directorates

308. OHID's 7 regional directorates link OHID to local public health systems at place. Each Regional Director of Public Health is also NHS Regional Director of Public Health for the same geography. They report to the Deputy Chief Medical Officer (DCMO) within OHID and to the NHSE Regional Directors. London's Regional Director has a statutory responsibility as the public health advisor to the Mayor of London.

309. During 2022-23 OHID's Regional Directors of Public Health and their teams strengthened local and regional public health systems of delivery, with a focus on disease prevention. They brought a place-based perspective to a range of policy areas including CVD prevention. They assured and ensured local implementation of OHID's key priorities, such as the local transformation of drug services and family hubs within the start for life programme.

310. OHID's Regional Directors of Public Health and their deputies provided national public health leadership on many topics including HIV prevention, Research and Development and public health workforce development. Through their joint NHS appointments, they supported the development of ICSs, shaping their population health priorities and ensuring ICSs focused on reducing health inequalities and kept the prevention ambitions in the NHS Long Term Plan and Core 20 Plus 5 centre stage.

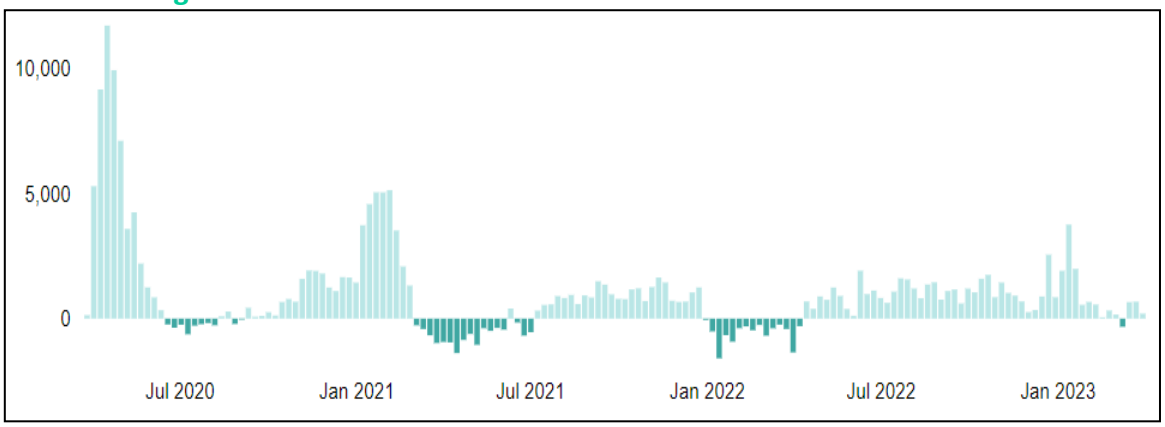
311. On behalf of the Secretary of State, the Regional Directors of Public Health assured the use of the £3.4 billion public health grant that is distributed to 150 upper tier local authorities and (working with LA chief executives) led on the appointment of LA Directors of Public Health.

312. The Regional Directors of Public Health and their teams also focused on influencing the wider determinants of health in place, by making strong links to other Government Departments and relevant sub-national bodies. Examples from 2022-23 include the deep dive work with the Department for Levelling Up, Housing and Communities on Grimsby and Blyth (Northumberland), looking at short- and medium-term interventions to level up their economies, improve infrastructure, improve employment opportunities, improve local health services, and improve the health of their populations.

Excess Mortality and Suicide

313. During the 12 months to March 2023, the tool showed that deaths were higher than expected in almost every week in England (see **Figure 35**). Used extensively to understand potential causes, the tool showed, for example, that deaths involving circulatory diseases made the largest contribution to excess mortality last year. This enabled discussion across the health system about how this could be addressed.

Figure 35: Weekly Excess Deaths by Date of Registration, for All Persons, England, Weeks Ending 27 March 2020 to 31 March 2023



Source: Office for Health Improvement and Disparities, Excess Mortality in England tool

314. Using data provided by the National Police Chief's Council, during 2022-23 OHID has developed a near to real-time suspected suicide surveillance system for England. The term 'suspected suicide' means cause of death and method(s) have not yet been confirmed by Coroner Inquest.

315. Reporting from April 2023, monthly reports will provide an early warning system for patterns of potentially preventable suicides. Overall numbers and rates of suspected suicide will also be analysed by gender, age group, suicide method and location type. Deaths will be reported within 12 weeks providing vital early intelligence to guide national and local work on suicide prevention.

Health Disparities

316. No updates are currently available for the 13 indicators of health disparities for 2022-23. Please refer to last year's report 2021-22 for the latest available data and analysis.

317. 7 out of the 13 indicators are from the NHS Outcomes Framework, which is currently under review following the merger between NHS Digital and NHSE in February 2023. Consequently, their publication has been delayed. The other 6 indicators are dependent on the ONS publication of life expectancy and healthy life expectancy data, and the latest reporting period for which data is available is for 2018-20, which was included in last year's report.

Major Campaigns

318. Over 2022-23, the Better Health programme has supported heathy behaviour change, extending its range of apps, behaviour change tools, support programmes, campaigns, and websites.

319. The Every Mind Matters campaign encouraged people to protect and improve their mental wellbeing and was enhanced with a new anxiety email support programme. 2 in 3 people reported better mental health and wellbeing after completing.

320. ‘Stoptober’ and New Year smoking campaigns channelled smokers to quitting support and new content was designed to dispel commonly held misconceptions around vaping.

321. Start for Life launched a weaning campaign designed to support healthy choices introducing solid food and new ‘chat, play, read’ campaign supporting parents of pre-school children to get them school ready.

322. The 10 Minute Shake Up campaign supported by Disney got an estimated 844,000 children more active with 2.2million games packs distributed.

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

323. **Tables 5 to 10** show areas that are currently measured and publicly reported against, with the most recent available data provided. In **Table 6** and **Table 8**, there is no national data available for 2020-21 as collection was voluntary during COVID-19. In **Table 7**, as opposed to the regular two-year interval, there is a three-year gap in data, which is a result of the pausing of the Survey of Adult Carers in England for one year during COVID-19.

324. **Table 5** details the percentage of all registered locations that have been rated by CQC as either a good or outstanding on the dates shown.

325. **Table 6** shows the social care quality of life score (out of 24, with 24 representing the highest possible social care-related quality of life score), this is a measure which aims to give an overarching view of the quality of life of users of local authority-funded, long-term social care services. It takes into account areas including control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation, identified as important to users in research by the Personal Social Services Research Unit (the Adult Social Care Outcomes Toolkit). This is broadly in line with previous scores although represents a slight fall from 2019-20.

326. **Table 7** shows quality of life scores for carers (out of 12). This gives an overarching view of the quality of life of carers (who are known to their local authority) based on outcomes identified through research by the Personal Social Services Research Unit. This has fallen slightly since the previous survey in 2018-19.

327. **Table 8** shows the proportion of users reporting they feel safe and secure. This has fallen slightly from the pre-pandemic levels.

328. **Tables 9 and 10** show adult social care workforce metrics which are proxies for a wider set of outcomes.

329. **Table 9** shows the staff turnover rate, defined as the proportion of directly employed staff in the formal care workforce leaving their role in the past year. Low staff turnover is a proxy for continuity of care, which care users and carers tell us is an important aspect of high-quality care. It also acts as a proxy for workforce work-related quality of life and an indicator of workforce sustainability, as staff are more likely to stay in their role if supported. Finally, lower staff turnover can help to make care more affordable, as the cost of recruiting and training care workers is reduced when turnover falls. However, it should be noted that the majority of staff leaving their role (approximately two-thirds) do so to another role in the sector rather than leaving adult social care. The increase in turnover between 2020-21 and 2021-22 was a cause for concern and contributed to our decision to provide further funding to Local Authorities to support the ASC workforce, via the

Market Sustainability and Improvement Fund (see below) and other grants. Estimates for 2022-23 for the independent sector indicate a partial recovery.

330. The vacancy rate in **Table 10** reflects staff vacancies and is calculated as the number of posts advertised as vacant by employers in the sector, on average, during the year as a proportion of all posts (filled and vacant). The significant rise in vacancies between 2020-21 and 2021-22 was a cause for concern, indicating a less sustainable service, and 2022-23 data indicates a partial recovery.

Table 5: Percentage of CQC Locations with Overall Rating of Outstanding/Good

Date	Percentage good or outstanding
April 2021	86.4%
April 2022	86.4%
April 2023	85.5%

Source: CQC State of Care / Release Schedule: Annual

Table 6: Social Care-related Quality of Life

Year	Social Care Related Quality of Life (*out of 24)*
2021-22	18.9
2019-20	19.1

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

Table 7: 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 8: Percentage of People Who Use Social Care Services Who Say That Those Services Have Made Them Feel Safe and Secure

Year	Percentage of people who use Social Care Services who say that those services have made them feel safe and secure
2021-22	85.6%
2019-20	86.8%

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

Table 9: Staff Turnover Rate for Directly Employed Staff Working in the Adult Social Care Sector

Year	Staff Turnover Rate (%)
2021-22	29.0%
2020-21	28.5%

Source: Skills for Care / Release Schedule: Annual

Table 10: Vacancy Rate in Adult Social Care Sector

Year	Vacancy Rate (%)
2022-23	9.9%
2021-22	10.6%
2020-21	7.0%

Source: Skills for Care / Release Schedule: Annual

Funding

331. The Government made more than £1 billion of additional funding available for social care in 2022-23, ensuring councils could improve conditions for carers and those in need.

332. Over the course of 2022-23 the Department worked closely with the care sector to make sure we had a clear understanding of the impact increasing energy prices and inflation were having on the sector. To address these new pressures the Autumn Statement in 2022 announced the largest funding uplift for adult social care in history, with up to £7.5 billion of additional funding made available over two years. This package was partly funded by making the difficult decision to delay the national rollout of adult social care charging reforms.

333. These funds are focused on helping people leave hospital on time, improving workforce recruitment and retention, and reducing waiting times for care. Crucially, more funding for adult social care will improve access to care for those who need it. Our investment has already led to tangible improvements. The fee rate paid by local authorities to care providers during the 2023-24 financial year increased between 7.6% and 10.1% year on year, depending on the service type.

Publications

334. The 2022-23 BCF Policy Framework was published in July 2022, setting out details on funding, national conditions and metrics aimed at improving integration between health and social care. In November 2022, an addendum to the 2022-23 BCF Policy Framework and Planning Requirements was published. It incorporated new requirements governing an additional £500 million funding for adult social care discharge, allowing local areas much greater certainty to plan and commission services supporting hospital discharge.

335. In January 2023, the Adult Social Care Winter Statement was published, which provided reassurance to the sector on work the Government has been doing to mitigate seasonal system pressures.

336. In February 2023, the Department published Care data matters: a roadmap for better data for adult social care, which outlined the Government's plan for transforming adult social care data in England and sought views on the data needed to commission, deliver, and oversee care and support.

337. In March 2023, updated Infection Prevention Control (IPC) Guidance for the social care sector was published.

Legislation

338. The Health and Care Act 2022 created a new duty for the CQC to assess Local Authorities' delivery of their Care Act 2014 duties, which went live in April 2023. This was alongside new powers to enable the Secretary of State to intervene where he/she is satisfied that local authorities have failed or are failing to discharge Care Act functions to an acceptable standard.

Consultation and Engagement

339. In July 2022, the consultation on changes to the Mental Capacity Act code of Practice and implementation of Liberty Protection Safeguards closed with over 700 responses received, and 17 successful engagement events.

340. In August 2022, the Department published a consultation on 'adult social care charging reform: distribution of funding 2023 to 2024'. This consultation sought views on proposals for distributing funding to support the first year of delivery of adult social care charging reform, in 2023 to 2024.

341. The Department has continued to work closely with the CQC to gain a more granular and timely understanding of the risk of major provider failure and improve our contingency plans, with particular focus on the risk of multiple major provider failures.

342. The Health and Wellbeing Alliance Social Care subgroup continues to meet monthly, which is attended and co-chaired by member from voluntary, community, and social enterprises with a stake in Adult Social Care.

343. Since Summer 2022, following best practice from the sector, we have established our own reference group of people with lived experience of care and support, including people who draw on and provide unpaid care, to ensure their experiences are heard.

344. In February 2023, the Department established the Adult Social Care Capacity: Expert Group, under the chairmanship of Stephen Chandler, Chief Executive of Oxfordshire County Council. The group provides expert advice on how to achieve sustainable growth in the capacity of adult social care services, with a focus on preparing for winter 2023-24.

Workforce

345. There has been a strong uptake of international recruitment in the care sector since the Department made care workers eligible for the Health and Care Worker visa and added them to the shortage occupation list in February 2022.

346. In December 2022, the Migration Advisory Committee's annual report 2022 stated that there were approximately 29,000 care worker and senior care worker visa applications from the start of 2022 through to September 2022.

Charging Reform

347. Following the consultation on 'adult social care charging reform: distribution of funding 2023 to 2024', delays to charging reform were announced in the Autumn Statement 2022. The funding intended for implementation of the reforms was retained in local authority budgets to help them meet current pressures.

348. Following the decision to delay the reforms, the Department acted to pause the implementation activity, including to end preparatory activity with early implementer 'trailblazer' local authorities.

349. The Department also took steps to learn lessons and ensure effective knowledge management of key documentation and commence replanning for the new implementation timetable.

Digital

350. In December 2021, the adult social care reform white paper, People at the Heart of Care, announced ambitious plans to drive digitisation in the sector, with a target of 80% of CQC-registered providers adopting a digital social care record by March 2024.

351. As of 31 March 2023, more than 50% of care providers had a digital social care record, up from 40% in December 2021.

352. During the 2022-23 financial year, we invested almost £50 million to support digitisation, including making more than £35 million available to ICSs to support care providers to adopt digital social care records and other care technologies that help improve the quality and safety of care, or support people to remain independent at home for longer.

The War in Ukraine

353. The Department has continued to support the wider UK Government's response to the war in Ukraine, which has had devastating health impacts in Ukraine and put additional pressure on health systems in refugee-hosting countries in the region. By June 2022, the Department (with NHSE and the Devolved Administrations) had donated over 11 million items of medicines and medical supplies into Ukraine to meet immediate needs. These included critical supplies such as wound care packages, PPE, bandages, antibiotics, and analgesics. The Department moved away from making direct donations-in-kind as the international response scaled up. Multilateral organisations operating in the region (particularly the WHO) have continued to coordinate the supply of medical resources, with support from the UK Government.

354. After receiving a request from the charities Tabletochki and SAFER Ukraine, the Department and NHSE arranged to evacuate 21 Ukrainian paediatric oncology patients and their families to England to continue life-saving treatment. The Department worked with Local Authorities to support the families as they moved into long-term accommodation.

355. Following the establishment of the Ukraine Family and Homes for Ukraine visa schemes, over 170,000 individuals have arrived in the UK. All arrivals are entitled to full and free access to the NHS, and the Department has worked with NHSE and UKHSA to support arrivals access to healthcare. In 2022, the Department published guidance for Ukrainians, with translations available in Ukrainian and Russian, on how to access health and social care services, including vaccination and emergency healthcare services. The guidance was further updated in January 2023.

356. The Department has also been working with partners to ensure no impacts on domestic health and social care services arose. Initially, this included closely monitoring critical supply chains, encouraging Arm's Length Bodies to diversify their commercial arrangements away from Russian or Belarussian suppliers. Work has continued with Trusts and Adult Social Care providers to bolster their cyber security resilience for a range of threats.

The Department's Financial Performance

Table 11: DHSC Departmental Outturn 2022-23 Against Parliamentary and HM Treasury Controls

	Budget £m	Outturn £m	Under/ (Overspend) £m	Key disclosure notes/further detail
Parliamentary Controls:				
Resource Departmental Expenditure Limit (RDEL)	176,148	177,095	(946)	SOPS 1.1, Annex B
of which: Resource Administration	*3,308*	*2,808*	*499*	*SOPS 1.1, Annex B*
Capital Departmental Expenditure Limit (CDEL)	11,193	9,848	1,345	SOPS 1.2, Annex B
Resource Annually Managed Expenditure (RAME)	(35,957)	(61,972)	26,015	SOPS 1.1
Capital Annually Managed Expenditure (CAME)	106	20	85	SOPS 1.2
Net Cash Requirement	149,492	144,489	5,003	SOPS 3
Further HM Treasury Controls:				
Ringfenced Resource DEL	2,219	1,519	700	Annex B
Non-ringfenced Resource DEL	173,929	175,576	(1,647)	Annex B

Resource Departmental Expenditure Limit (RDEL)

357. As shown in **Table 11**, the Department's 2022-23 budgets were agreed as part of the 2021 Spending Review (SR21), with £176.1 billion resource funding made available, including to support the ambitious plans to tackle the NHS elective backlog, improve social care outcomes through reforms to the Adult Social Care system and implement the first year of the Government's Living with COVID-19 policy.

358. During 2022-23, the Department faced challenges to contain inflationary pressures and increasing costs within agreed SR21 funding. Through careful prioritisation and financial management, the Department managed significant in-year cost pressures, including:
    - Acceptance of the 2022-23 NHS pay deal to support frontline workers;
    - Winter pressures on services which led us to prioritise resources for the NHS and Adult Social Care Winter Plan; and
    - Other in-year pressures including those relating to the Government's response to the Monkey Pox and Polio outbreaks.

359. In March 2023, a further pay deal was offered to and subsequently accepted by NHS unions, resulting in around £2.7 billion of additional expenditure accrued in 2022-23. The pay deal was reached after budgets had been finalised for the year in the Supplementary Supply Estimates, therefore the Department's Accounting Officer obtained a Ministerial Direction relating to the increased NHS pay expenditure, confirming wider public interest outweighed the need to contain spending within formal Parliamentary limits.

360. The £2.7 billion additional funding for the NHS pay deal created a funding pressure. This was partially offset by underspends against the depreciation budget, and further underspends in COVID-19 and other business as usual areas, resulting in

the Department overspending against its RDEL budget by £0.9 billion. Further detail is included in **Annex B**.

Capital Departmental Expenditure Limit (CDEL)

361. The Department's 2022-23 budgets were agreed as part of the 2021 Spending Review (SR21), £9.8 billion of capital funding was spent during the year, including on; investment in modernising and transforming the NHS estate through the new hospital and upgrade programmes, investing in elective recovery, transformation of diagnostic services and innovative use of digital technology. Further detail is included in **Annex B**.

362. The Department underspent the available capital funding by circa £1.3 billion (12.7% of the capital budget), most of which was unavoidable due to uncertainty and complexity, including:
    - IFRS 16: like other government Departments, DHSC implemented IFRS 16, the international accounting standard for leases during 2022-23. Additional capital funding was secured for its impact. However, the associated capital costs were around £0.8 billion lower than expected;
    - COVID-19: around £0.3 billion of the underspend relates to COVID-19 and HM Treasury's CDEL budgeting classification of the movements in test and trace inventory and COVID-19 vaccines pre-payments; and
    - Business-as-usual: the remaining £0.2 billion underspend occurred in COVID-19 and business as usual areas. This is equivalent to 2.3% of the capital budget.

COVID-19 Funding and Expenditure in 2022-23

363. As stated above, during 2022-23, the Department implemented the Government's Living with COVID policy. The 2021 Spending Review made available some funding for enduring COVID-19 programmes, with the balance of funding being allocated from HM Treasury's reserve through the 2022-23 Supplementary Supply Estimate. Further information on material 2022-23 COVID-19 programmes and outturn are detailed in **Annex B**.

Annually Managed Expenditure (AME)

364. Expenditure that HM Treasury has deemed demand-led, and volatile is treated as Annually Managed Expenditure (AME). The Department's AME is additionally subject to many variables outside direct control, such as changes to the discount rates in measuring the value of long-term provisions liabilities.

365. The Department underspent the Resource AME (RAME) Limit by circa £26.0 billion. This mainly comprised lower than planned AME in NHS Resolution (NHSR). Following changes to the discount rates used to value provisions prescribed by HM Treasury, the budget was changed as part of the Supplementary Supply Estimates based on a range of estimates produced by NHSR's actuarial advisors. As a result of favourable reductions, of which more detail can be found in NHSR's ARA, the estimated quantum of future clinical negligence expenditure was £21.7 billion lower than the forecast used to set the final budget. Further detail on the AME outturn is set out in **Annex B**. Both the RAME estimate and outturn for 2022-23 are

negative due to the impact of the HMT prescribed discount rate movements (a £75 billion credit for clinical negligence provisions in 2022-23). Such a large underspend on AME is unprecedented and is driven primarily by changes to the discount rate. Due to the timing of the available information, it was not possible to align the AME budget with the forecast as part of the Supplementary Supply Estimates.

Net Cash Requirement

366. The Department underspent against its cash limit by circa £5.0 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 £2.3 billion of the underspend is explained by the resource non-ringfenced DEL underspend of £1.0 billion (excluding the £2.7 billion NHS pay accrual) and capital DEL underspends of £1.3 billion, respectively. The balance is mainly due to working capital requirements being lower than estimated.

Sustainability

367. The Department recognises that the climate and nature emergency is also one of health, which is inextricably linked to our departmental function and directly threatens our vision 'to enable everyone to live more independent, healthier lives for longer'. Therefore, we recognise our obligation to respond with leadership, by minimising the environmental footprint of our own estate and operations, and by embedding sustainability at the heart of everything that we do, including our policymaking.

DHSC's progress and key activity in 2022-23

Embedding Sustainability

368. We have developed and shared with staff our new internal sustainability strategy, setting out the actions that we will take within the Department itself to help safeguard a healthy environment. This supports and locally builds upon the Greening Government Commitments for 2021 to 2025.

369. We scheduled our first director-led Sustainability Delivery Board, commencing in June 2023, to oversee and monitor progress against this strategy, and to hold relevant business areas accountable for delivery. This group will now report upwards to DHSC's Executive Committee on a regular basis.

370. The Department's Green Network, comprised of over 100 staff members, continues its work to raise awareness of the climate and nature emergency, and to inspire colleagues to adopt more eco-friendly ways of living and working. In November 2022, this included a targeted, two-week internal communications campaign, in line with COP27 and the launch of our internal sustainability strategy.

371. Our staff organised three volunteering days near to our second headquarters, Quarry House in Leeds, to support Leeds City Council in their woodland creation scheme. Between 26 DHSC volunteers, we planted approximately 2,500 trees. To encourage other colleagues to use their allotted volunteering leave similarly, we internally published a list of environmental volunteering opportunities.

372. We have committed to developing a programme whereby all DHSC staff can sign up to Carbon Literacy Training – one day's worth of learning about climate change. We are engaged in discussions with the Carbon Literacy Project, aiming to commence rollout of this training in 2023-24.

373. We continue to actively engage our community of colleagues leading on sustainability work across our ALBs. DHSC hosts a quarterly forum bringing this group together to share knowledge and best practice, identify opportunities for collaboration and monitor progress towards our shared environmental goals.

374. Sustainability considerations are factored into DHSC's programme and project management assurance processes (gateway reviews etc.) where relevant to the

stage that the project/programme has reached. For construction specifically, net zero requirements are considered at the investment appraisal stage.

375. DHSC has prepared for the new statutory duty to have due regard to the Environmental Principles Policy Statement, which applies to all significant policymaking from 1 November 2023. We have worked closely with DEFRA to communicate the duty across DHSC and its ALBs, and to embed this within our departmental processes. This work supports policymakers and ministers to consider the climate and environmental impacts of policies.

Buildings and Energy Use

376. In August 2022, we exited our largest and most energy intensive office premises, Skipton House in London, since the building was underutilised.

377. We have conducted a prioritisation exercise and, from this, identified two of our offices as high priority for decarbonisation initiatives, given our expected lengths of occupancy and degree of control over the buildings etc. These are Seaton House in Nottingham and Wellington House in London.

378. For Seaton House, DHSC has sought support from Government Property Agency (GPA), who have conducted a building survey and provided accompanying recommendations as part of their Net Zero Programme. This proposes new LED lighting, upgraded lighting controls, heat decarbonisation (eliminating our reliance on gas boilers) and a system of solar PV panels. We are awaiting funding approval on this project and exploring our preferred heat decarbonisation method.

379. For Wellington House, we have received GPA funding to install new LED lighting, with works due to be carried out in 2023-24. Our facilities management provider is also leading a project to optimise the use of the building management system, which has significantly reduced gas and electricity use at this site.

380. We recognise that additional home energy demand from hybrid working also contributes to the Department's wider carbon footprint. In November 2022, we held an Energy Advice Café for staff looking to reduce their home energy use, joined by an expert speaker from the Energy Saving Trust.

381. We are currently refurbishing some areas within our second headquarters, Quarry House in Leeds[2]. There are two active contracts for this project, both from public sector procurement frameworks where sustainability and social value are integral to the supplier selection process. Of the waste generated to date, the project is averaging a 98.5% recycling rate. Around 34% of spend has been in the local area.

[2] The scope of this refurbishment project is too small to derive a meaningful BREEAM rating.

Travel

382. We have updated DHSC's travel and expenses policy to stipulate that, where travel is business critical, and there are no reasonable, digital alternatives, staff must select the most environmentally friendly mode of transport wherever possible (typically public transport, including rail). For air travel, this requires staff to consider lower carbon options first; where no alternative is possible, staff must obtain approval from a senior civil servant in order to access the flight booking system.

383. We have developed guidance for staff on how they can make best use of the active travel facilities at our office premises. We have also made some improvements in consultation with DHSC's Active Travel Network, including by increasing locker capacity and improving drying room ventilation.

Waste

384. Upon vacating Skipton House in London, DHSC redistributed some furniture and equipment for internal reuse where practical (including lockers, to expand the active travel facilities at our other offices). For surplus items, we utilised the Office of Government Property's 'Furniture Clearing House' to donate around seven truckloads to other government departments and agencies. This process and lessons learnt have been embedded into a new clearance policy, to reduce waste and increase reuse in future.

385. We have established a new data collection process to identify the consumer single-use plastics (CSUPs) procured by DHSC. In 2022-23, this totalled 332,976 CSUP items – of which 227,617 related to cleaning, 91,260[3] to catering, and 14,099 to stationery. We will now commence proactive work to reduce this figure towards zero, exploring reuse schemes and plastic-free products etc.

386. We have established a new data collection process for food waste, at our two offices with catering facilities (Wellington House and 39 Victoria Street in London). In 2022-23, we estimate to have generated approximately 0.53[4] tonnes of food waste.

Water

387. For 2022-23, we renewed the 'fusion' water monitoring system in place at three of our offices (Wellington House and 39 Victoria Street in London, and Premier House in Reading). Here, individual sensors on each water meter provide 24-hour major leak detection, flow rates and temperature levels.

[3] This figure is an estimate based on a 'typical' month's catering order (November 2022). Going forwards, DHSC's catering provider will provide actual data on a quarterly basis.

[4] This figure is an estimate based on one month's worth of food waste data (April-May 2023). Going forwards, DHSC's catering provider will provide actual data on a quarterly basis.

Sustainable Procurement

388. DHSC has implemented and embedded Procurement Policy Note 06/21 in all commercial practices, stipulating that, for contracts over £5 million per annum, suppliers must provide a carbon reduction plan confirming their commitment to net zero by 2050 in the UK, otherwise they will be excluded from bidding. For new contracts not within scope of PPN 06/21, our standard terms and conditions have also been updated to include obligations on suppliers to provide annual carbon reduction plans. For existing contracts, we have begun to contact suppliers to request carbon reduction plans, in priority order (based on the contract value and level of risk).

389. We continue to maintain full compliance with Procurement Policy Note 06/20, whereby social value must be explicitly evaluated in new procurements, with five priority themes for suppliers, including 'fighting climate change'. Within DHSC's e-procurement system, we have implemented a mechanism by which commercial teams can record social value achievements against their contracts, monitor compliance and report progress directly to Cabinet Office on a quarterly basis.

390. Our working groups, focused on net zero and social value procurement policies, continue to develop relevant processes, training, and support for staff in this area. Guidance has been tailored to different categories of products/services and market capabilities, ensuring that our application of the policies is relevant, appropriate, and proportionate, to generate greater value and more sustainable outcomes.

391. DHSC has implemented Procurement Policy Note 02/23 (tackling modern slavery in government supply chains) in all standard practices. In line with this, we have developed guidance on the circumstances in which procurement colleagues must use the Modern Slavery Assessment Tool. Additional provisions have been included in our standard terms and conditions for high-risk contracts and those with strategic suppliers, with a focus on ensuring supplier cooperation when obtaining supply chain visibility.

392. With regards to DHSC's food and catering services specifically, they 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. In the coming year, we intend to actively engage our catering supplier, to discuss potential sustainability initiatives for DHSC's catering facilities.

Nature Recovery

393. Whilst DHSC does not hold significant natural capital or landholdings[5], with our estate concentrated in major towns and cities, we recognise that we all have a role to play in making space for wildlife. Within our new sustainability strategy, we have committed to maximising our estate's contribution to nature recovery. We intend to commence work on this in the coming financial year, first seeking best practice from other government departments and agencies at a relevant, DEFRA-led workshop in Summer 2023.

Climate Change Adaptation

394. As per the Greening Government Commitments for 2021 to 2025, DHSC is committed to developing its own departmental climate change adaptation strategy. We intend to commence work on this in 2023-24, first seeking examples of best practice from colleagues across government and our ALBs.

395. We have created an information and support pack for colleagues who may be experiencing eco-anxiety (i.e., those who are worried about climate change and the state of the environment), with input from relevant colleagues at several of our ALBs. This resource will be launched internally in the coming year.

396. DHSC is working with partners across government and the health system to develop the third National Adaptation Plan (NAP3), due for publication in Summer 2023. This will set out plans to protect the UK from a changing climate over the coming five years. DHSC and its health system partners are responsible for four NAP3 pathways: the risk to health and care delivery from climate change, opportunities for health and wellbeing from higher temperatures, risks to UK public health from climate change overseas, and risk to health from vector-borne diseases.

ICT and Digital

397. DHSC continues to provide membership to the cross-government Sustainable Technology Advice and Reporting (STAR) Team, and we report to DEFRA annually on our progress against the Greening Government ICT and Digital Services Strategy for 2020 to 2025.

398. In 2022-23, DHSC's data centres and cloud services were responsible for approximately 10 tonnes of carbon dioxide equivalent (tCO2e). We produced 0.4 tonnes of ICT waste, of which 29% was reused via commercial sale and 71% was recycled, with zero to landfill[6]. To promote resource efficiency, we continue to operate a single best-suited device policy for staff (only issuing smartphones upon request, for example) and the Department reuses laptops and smartphones until they are no longer serviceable.

[5] Please note that this relates to the Department itself, and does not include, for example, the NHS estate, which is reported on separately by NHS England.

[6] DHSC is not reporting any expenditure related to ICT waste disposal, as our ICT supplier does not charge us for this service.

399. We have replaced our fleet of printers and, in doing so, streamlined the number of devices in place by 36%, to reflect the Department's reduced reliance on paper. We have also opted for a carbon neutral contract for our new managed print service, achieved through both reducing and offsetting emissions.

400. For the coming year, we have committed to a series of actions to reduce the environmental impacts of DHSC's ICT and digital services. As we are due to complete our transition to a new ICT supplier, this provides a 'clean slate' from which to make improvements, and an opportunity to collaborate on proactive sustainability initiatives going forwards; this will be driven by the monthly Social Value and Sustainability Board that our new ICT supplier now operates with relevant DHSC colleagues.

UN Sustainable Development Goals

401. As a member state committed to the United Nations' 17 Sustainable Development Goals (SDGs) by 2030, the UK presented its first Voluntary National Review in 2019, taking stock of progress to date. DHSC led on coordinating the chapter dedicated to SDG 3 – Good Health and Well-Being.

402. We use our Departmental Outcome Delivery Plans to identify how our work will support delivery of the SDGs – see **Table 12** for the links with DHSC's five priority outcomes. Our latest progress against these priority outcomes can be found in the 'Performance' section of this report.

Table 12: DHSC Priority Outcomes

Priority Outcome	Link to SDGs
Priority Outcome 1 - Protect the public's health through the health and social care system's response to COVID-19	SDG 3 – Good Health and Well-Being (Targets 3.1, 3.2, 3.4)
	SDG 9 – Industry, Innovation, and Infrastructure (Target 9.1)
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	SDG 3 – Good Health and Well-Being (Targets 3.8, 3.b)
Priority Outcome 3 – Improve healthcare outcomes through a well-supported workforce.	SDG 3 – Good Health and Well-Being (Target 3.c)
Priority Outcome 4 - Improve, protect, and level up the nation's health, including through reducing health disparities	SDG 3 – Good Health and Well-Being (Targets 3.4, 3.5, 3.7, 3.a)
Priority Outcome 5 – Improve social care outcomes through an affordable, high-quality, and sustainable adult social care system	SDG 3 – Good Health and Well-Being (Target 3.8)

403. Sustainability is also listed as one of DHSC's key strategic enablers. Our sustainability work completed during 2022-23, reported on above, supports the following goals in particular: SDG 7 – Affordable and Clean Energy, SDG 12 – Responsible Consumption and Production and SDG 13 – Climate Action.

Rural Proofing

404. The Health and Care Act 2022 established Integrated Care Boards and Integrated Care Partnerships, strengthening partnerships between the NHS and local authorities, and improving integration and collaboration across the healthcare system. The Act conferred new duties for Integrated Care Boards to consider inequalities in access to health services, outcomes, and experience. This will help to factor in the inequalities faced by rural populations when accessing health services.

405. In October 2022, DHSC's Minister of State for Health and Secondary Care attended a relevant debate on rural healthcare at Westminster Hall (see the Hansard record for further detail).

406. With rural proofing embedded into DHSC's 'Policy Foundations' programme for staff, we ran four awareness raising sessions on this subject during 2022-23, open to all within the Department, to ensure that we continue to develop and deliver policies that take in to account the effect on rural communities.

Greening Government Commitments

407. **Tables 13 to 18** summarise our performance against the current Greening Government Commitments. This is set against a 2017-18 baseline and our performance last year in 2021-22, which was our first year of reporting against the latest targets. The data provided combines that of both DHSC and its in-scope ALBs[7], demonstrating our collective progress towards these cross-government targets (please note that the targets referenced below are the overall aims for 2024-25, rather than progress that we have left to make).

Table 13: Overall Greenhouse Gas Emissions (tCO_2e)

	2017 18 (baseline)	2021 22	2022 23	Performance	Target by 2024 25
Scope 1	16,699	9,668	6,134	-63%	-20%
Scope 2	23,703	11,870	8,099	-66%	-
Scope 3[8]	5,469	2,271	3,955	-28%	-
Total	45,871	23,809	18,188	-60%	-44%

N.B. DHSC and its ALBs have not purchased any accredited carbon offsets during 2022-23.

Table 14: Energy Use (kWh)

	2017 18 (baseline)	2021 22	2022 23	plus expenditure	Performance
Gas	74,683,131	50,071,329	30,355,246	£3,498,903	-59%
Oil	5,504,907	230,614	1,509,385	£145,567	-73%
Electricity	67,422,670	55,905,390	41,883,125	£23,552,141	-38%
Total	147,610,708	106,207,333	73,747,756	£27,176,611	-50%

[7] This includes CQC, HEE, HRA, HFEA, HTA, MHRA, NHSBSA, NHSCFA, NHSE (now merged to include the former NHSD), NHSR, NICE and UKHSA. Please note that HFEA and HTA have submitted partial returns and so their organisations' data is only reflected in the 2022-23 performance data – they are not included in the 2017-18 baseline, the 2021-22 data or the related expenditure figures for 2022-23. NHSBT are exempt from the Greening Government Commitments, given their dual status as a trading body.

[8] In line with the Greening Government Commitments reporting, this covers emissions related to business travel and transmission/distribution losses from electricity only.

Table 15: Business Travel (tCO2e)

		2017 18 (baseline)	2021 22	2022 23 plus distance travelled and expenditure			Performance	Target by 2024 25
Rail		1,688	370	1,277	35,973,516km	-	-24%	-
Road		1,968	1,064	1,906	11,564,285km	-	-3%	-
Air	Domestic	453	24	134	1,033,199km	-	-70%	-30%
	International	2,304	228	785	9,038,125km	-	-66%	-
Total		6,413	1,686	4,102	57,650,148km	£14,42 2,225	-36%	-

408. Of the distance travelled by international air, 20% is associated with short haul and 80% with long haul. Broken down by flight class, 91% were economy, 4.5% premium economy, 3.5% business and 1% first.

409. With regards to our progress against the Government Fleet Commitment, 91% of our vehicle fleet is made up of ultra-low emissions vehicles (ULEV), meaning that we exceeded the 25% target for 2022. 74% of our vehicles are zero emissions at the tailpipe, putting us in good stead to achieve the 100% target for 2027.

Table 16: Waste (tonnes)

	2017 18 (baseline)	2021 22	2022 23 plus expenditure		Performance	Target by 2024 25
Recycled	1,410	1,210	1,418	£312,465	0.5%	-
Composted/food waste	0	30	32	£14,200	-	-
Incinerated with energy recovery	176	473	551	£371,651	213%	-
Incinerated without energy recovery	189	159	150	£210,761	-20%	-
Landfill	1,738	457	21	£7,339	-99%	-
Total	3,513	2,329	2,172	£916,416	-38%	-15%

410. Waste that is recycled represents 65% of overall waste (against a target of at least 70% by 2024-25), and waste going to landfill represents 1% (against a target of less than 5% by 2024-25).

Table 17: Paper Purchased (A4 reams)

2017 18 (baseline)	2021 22	2022 23	Performance	Target by 2024 25
150,215	28,175	30,145	-80%	-50%

Table 18: Water Consumption (m3)

2017 18 (baseline)	2021 22	2022 23 plus expenditure		Performance	Target by 2024 25
283,469	152,915	161,212	£1,106,328	-43%	-8%

Other Performance Reporting

Parliamentary Questions

411. We are continuing to see progress through the delivery of our PQ Recovery Plan. Between April 2022 and March 2023, we processed 11,215 PQs, volumes which are very similar to the previous year. The average on-time rate for Q4 (January-March 2023) was 75%, a big improvement on Q2 and Q3. The on-time rate for April 2023 was 82.2%, the highest we have recorded since February 2020. We are continuing to drive forward our recovery work in all areas of the system so we can improve performance further.

Freedom of Information (FOI) Requests

412. In 2022, the last full year for which figures are available, the Department responded to 1,633 in the calendar year. Of these, some 952 were 'Resolvable requests', where it was possible to make a substantive decision on whether to release the requested information. Of the 952, 352 were responded to with 'full disclosure', 201 'partial disclosure', while for 342 requests, information was 'fully withheld'. This, and further, information can be seen on Tab 7 of the Freedom of Information statistics: annual 2022 collection. 1,369 or 87% were answered within the statutory 20 working day deadline (or Public Interest extension). This is against a target of 90% as set by the Information Commissioner's Office.

413. We are committed to improving our performance against this target and the published statistics for January 2023 to March 2023 show that we have answered 94% per cent of these within the statutory 20 working day deadline (or Public Interest extension).

Other Correspondence

414. As shown in **Table 19**, we answered 31,323 letters and emails due in 2022, compared to 66,346 in the previous year. While this is clearly a significant drop, volumes nonetheless remain higher than before the pandemic. 53 per cent of cases were answered within our target rate of 20 working days. In line with standard correspondence reporting across Government, the data shown is for the calendar year 2022 and not the financial year 2022-23.

Table 19: Other Classes of Correspondence 2022

Case Type	Due in 2022	Answered On Time	Percentage On Time
Private Office	19,756	8,358	42%
Treat Official	921	555	60%
Departmental Email	10,646	7,793	73%
TOTAL	31,323	16,706	53%

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

415. In 2022-23 the Department received 3 complaints.

416. As shown in **Table 20**, in 2021-22 (the last year for which published results are available), the PHSO received 444 enquiries regarding complaints about the core Department, of which 53 progressed to assessment. Zero cases progressed to investigation.

Table 20: PHSO Complaints 2021-22

Enquiries Received	Assessed	Accepted for Investigation*	Investigation Upheld/Partly Upheld	Investigations not Upheld	Investigations resolved through intervention**	Investigations resolved without a finding***
444	53	0	0	0	0	0

*The 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.
** Complaints where PHSO starts an investigation but can 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.

Prompt Payment of Undisputed Invoices

417. 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.

418. **Table 21** details the percentage and value of undisputed invoices paid by NHS provider organisations within the agreed terms over the last 3 years.

Table 21: Prompt Payment of Undisputed Invoices

	NHS providers invoices paid within target	
Financial Year	Percentage	Value (£m)
2022-23	90	62,847
2021-22	91	58,294
2020-21	87	48,259

Source: NHS Provider Accounts.

419. NHS England monitors 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.

420. NHS England discuss performance with providers with poor or deteriorating working capital position and supports individual providers in seeking ways to improve this position.

Official Development Assistance

421. The Department of Health and Social Care's expenditure on Official Development Assistance (ODA) totalled £465 million in 2022.

422. 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 31 different DAC members including the UK.

423. 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).

424. The DHSC's ODA activities support the UK government's commitment to 'reduce the risk of future global health threats, building stronger health systems, strengthening the World Health Organization (WHO) and improving global health surveillance and response capability' (International Development Strategy), focussing on the areas of global health research, global health, and health security.

425. There are two main portfolios – Global Health Research and Global Health Security (GHS). These are complemented by a project which supports the implementation of the WHO's Framework Convention on Tobacco Control and the Global Health Workforce Programme which builds capacity in the international health workforce.

426. In 2022, the GHS programme's activities in these areas have helped developing countries to reduce preventable deaths and burden of disease; to detect health threats, such as antimicrobial resistance; and to provide rapid and effective response to health threats that emerge.

427. GHS research activities funded innovative research in specific vaccine and vaccine technologies and informed best practice in disease outbreaks interventions and to reduce the threat of antimicrobial resistance.

428. The Global Health Research portfolio supports high-quality, applied health research for the direct and primary benefit of people in low-and middle-income countries (LMICs). This is delivered through the National Institute for Health and Care Research, and by working in partnerships with other global funders. In 2022, the portfolio aims were delivered through a mix of researcher-led and targeted, thematic calls to support equitable partnerships in areas including multiple long-term conditions and health policy and systems research, and through initiatives to develop and advance global health research capability, both in LMICs and in the UK.

429. The Department of Health and Social Care pays an annual subscription to the 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 United Nations Scales of assessment agreed in New York. These scales are negotiated by the Foreign

Commonwealth and Development Office in accordance with the United Nations Charter and UK membership obligations.

430. The Department of Health and Social Care has funded the first twelve months of asylum seekers healthcare costs following their arrival in the UK. In 2022, healthcare support was also provided to refugees under the Afghanistan Resettlement programme and Ukraine Schemes.

Performance Report Accounting Officer Sign-Off

21 January 2024
Sir Chris Wormald KCB
Permanent Secretary

Accountability Report

Lead Non-Executive Board Member's Report

Performance and Priorities

431. The 2022-23 period has seen a shift of focus across the Department, with COVID-19 activity moving into business-as-usual structures as we move out of the height of the pandemic and look to face the challenges left in its wake.

432. The Board met four times in 2022-23 with good attendance from ministers, officials, and non-executive directors. The Board's agenda focused on the Department's performance and the reform taking place within in the NHS.

433. The past year saw three changes of Secretary of State for Health and Social Care and new members of the ministerial team following the changes of Prime Minister in the summer and autumn. Therefore, in addition to discussions on performance, the Board also devoted attention to their priorities for the health and social care system which for our current Secretary of State include maximising efficiency and adopting innovation.

434. In November 2022, Sir Julian Hartley left the non-executive team to take up the position of Chief Executive with NHS Providers. In February 2023 we welcomed Samantha Jones to the non-executive team. Samantha brings extensive NHS expertise and experience both as a nurse and in senior leadership, 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.

435. The Audit and Risk Committee (ARC) continued with Gerry Murphy as chair and held four 'full Committee' 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.

436. 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 Senior Civil Service (SCS) talent and performance as well as non-executive director recruitment and succession planning.

437. 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, objectives, and manifesto

commitments, as well as the Departmental risk register. The PRC met four times over the year.

438. 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, NHS111, New Hospitals Programme, EU trade and assurance and the Covid 19 Inquiry preparation as well as offering advice and support to members of staff on a more ad hoc basis.

439. 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 the dedication, the achievements, and the resilience of everyone in the Department and we look forward to continuing to work with them.

Accountability Report

440. 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 2023

The Rt Hon Steve Barclay MP

Secretary of State for Health & Social Care
Chair of the Departmental Board
Appointed 5 July 2022 to 5 September 2022.
Reappointed as Secretary of State 25 October 2022 to 12 November 2023.

Helen Whately MP

Minister of State for Social Care
Appointed as Minister of State 26 October 2022.

Will Quince MP

Minister of State for Health and Secondary Care.
Appointed as Minister of State 7 September 2022 to 12 November 2023.

Maria Caulfield MP

Women's Minister (GEO) & Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy.
Appointed Parliamentary Under Secretary of State 27 October 2022.
Parliamentary Under Secretary of State (Minister for Patient Safety and Primary Care) 17 September 2021 to 7 July 2022.
Minister of State for Health 7 July 2022 to 7 September 2022

Neil O'Brien MP

Parliamentary Under Secretary of State for Primary Care and Public Health.
Appointed Parliamentary Under Secretary of State 8 September 2022 to 12 November 2023.

Lord Markham CBE

Parliamentary Under Secretary of State (Minister for the Lords)
Appointed Parliamentary Under Secretary 22 September 2022.

Other ministers who served in the Department during 2022-23 were:

- Sajid Javid MP resigned as Secretary of State on 5 July 2022.
- Thérèse Coffey MP was appointed as Secretary of State for Health and Social Care on 6 September 2022 and resigned on 24 October 2022.
- Ed Argar MP resigned as Minister of State on 6 July 2022.
- James Morris MP was appointed as Minister for Primary Care and Patient Safety on 8 July 2022 and resigned on 7 September 2022.
- Gillian Keegan MP resigned as Minister of State on 8 September 2022.
- Robert Jenrick MP was appointed as Minister of State on 7 September 2022 and resigned on 24 October 2022.
- Caroline Johnson MP was appointed as Minister of State on 8th September 2022 and resigned on 26 October 2022.
- Maggie Throup MP resigned as Parliamentary Under Secretary of State (Minister for Vaccines and Public Health) on 7 September 2022.
- Lord Kamall resigned as Parliamentary Under Secretary of State (Minister for Technology, Innovation and Life Sciences) on 19 September 2022.

Changes to The Department's ministers after 31 March 2023 are listed on page 158 to 159.

Our Non-Executive Board Members at 31 March 2023

Kate Lampard
Lead Non-Executive Director
1 October 2017-30 September 2023.

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 several 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.

Samantha Jones
Non-Executive Director
14 February 2023-present.

Samantha was appointed as a non-executive director at the Department on 14 February 2023. She started her career as a general and paediatric nurse. Having completed the NHS Management Training Scheme, she worked in a variety of operational management roles across the NHS including as a chief executive for 2 trusts. She has worked nationally at NHS England leading the New Models of Care programme before moving to run primary care services as chief executive of the largest primary care provider in England. Throughout her career Samantha has worked in both the public and private sector focused on delivering health services.

Samantha was appointed as expert adviser to the Prime Minister for NHS transformation and social care in 2021 where she led on all elements of health and social care policy before taking up post as the interim Permanent Secretary and Chief Operating Officer for 10 Downing Street. Samantha was most recently the expert adviser to the Secretary of State for Health and Social Care.

Other Non-Executive Directors who served in the Department during 2022-23 were:

- Sir Julian Hartley resigned as a Non-Executive Director on 10 November 2022.

Other Non-Executive Directors appointed after 31 March 2023 are:

- Sir Roy Stone
- Will Harris

Our Executive Board Members at 31 March 2023

Sir Chris Wormald KCB
Permanent Secretary

Prof. Sir Chris Whitty
Chief Medical Officer

Shona Dunn CB
Second Permanent Secretary

Andy Brittain
Director General Finance

Other Senior Officials at 31 March 2023

Clara Swinson CB
Director General for Global Health

Jonathan Marron CB
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 DWP and DHSC Joint Work & Health Directorate

Other Senior Officials who served in the Department during 2022-23 were:

- Matthew Gould left the Department in May 2022.
- Steve Oldfield left the Department in October 2022.

Departmental Disclosures

441. 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.

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

Register of Interests

443. 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.

444. 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.

445. Any remunerated outside employments held by a member of the Department's Senior Civil Servants (SCS) are also published online.

446. Further relevant interests of the Department's senior leadership, as identified in the start of the **Accountability Report** 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 2022-23 Financial Year

NED	Held by	Name of Company	Position Held	Type of Interest	Other Information
Doug Gurr	Self	British Heart Foundation	Chair	Volunteer (not remunerated)	Ended Oct 2022
Doug Gurr	Self	Natural History Museum	Director	Salary	
Doug Gurr	Self	Permira Ltd	Advisor	Fees	
Doug Gurr	Self	The Alan Turing Institute	Chair	Fees	From July 2022
Doug Gurr	Self	The Landmark Trust	Trustee	Volunteer (not remunerated)	
Doug Gurr	Self	UK Biobank	Director	Volunteer (not remunerated)	
Gerry Murphy	Self	Currys PLC	Non-Executive Director	Remunerated and Shareholding	
Julian Hartley	Self	Leeds Teaching Hospital NHS Trust	Chief Executive	Salary	Resigned Jan 2023
Julian Hartley	Self	NHS Providers	Chief Executive	Salary	From Feb 2023
Julian Hartley	Self	University of Leeds	Honorary Professor Healthcare Leadership	Not remunerated	
Kate Lampard	Self	Esmee Fairbairn Foundation	Trustee	Not remunerated	
Kate Lampard	Self	GambleAware	Chair	Salary	
Kate Lampard	Self	Royal Horticultural Society	Trustee	Not remunerated	
Kate Lampard	Self	StoneTurn Consultants	Senior Associate	Remuneration for work undertaken	
Kate Lampard	Self	Torry Hill Chestnut Fencing Limited	Shareholder	Shareholding	
Kate Lampard	Self	Torry Hill Farm Partnership	Partner	Partnership drawings	
Kate Lampard	Self	Rochester Cathedral Trust	Trustee	Not Remunerated	
Kate Lampard	Self	Verita Associates	Senior Associate	Remuneration for work undertaken	
Kate Lampard	Self	Yokes Court Consultancy Ltd	Director and shareholder	Shareholding	
Samantha Jones	Husband	Milton Keynes University Hospital NHS Foundation Trust	Chief Executive	Paid	
Samantha Jones	Husband	NHSE	National Director of Digital Channels	Paid	
Samantha Jones	Husband	Oxford Academic Health Science Network	Member	Not remunerated	
Samantha Jones	Husband	NHS Employers Policy Board	Chair	Not remunerated	
Samantha Jones	Husband	Bedfordshire, Luton, and Milton Keynes Integrated Care Board	Member	Not remunerated	
Samantha Jones	Husband	NHS Confederation	Trustee	Not remunerated	

NED	Held by	Name of Company	Position Held	Type of Interest	Other Information
Samantha Jones	Husband	National Associate of Primary Care	Council Member	Not remunerated	
Samantha Jones	Husband	CRN Thames Valley and South Midlands Partnership	Chair	Not remunerated	

Official	Held by	Name of Company	Position Held	Type of interest	Other Information
Professor Sir Chris Whitty KCB	Self	Gresham College	Visiting professor	Stipend	
Professor Sir Chris Whitty KCB	Self	London School of Hygiene & Tropical Medicine	Honorary professor	Not remunerated	
Professor Sir Chris Whitty KCB	Self	Pembroke and Wolfson Colleges, Oxford	Hon. Fellow	Not remunerated	
Professor Sir Chris Whitty KCB	Self	Sightsavers (Royal Commonwealth Society for the Blind)	Trustee	Not remunerated	
Professor Sir Chris Whitty KCB	Brother	Smith Whitty International Consultants Limited	Director		
Professor Sir Chris Whitty KCB	Self	University College London Hospitals and HTD	Consultant physician	Not remunerated	
Sir Chris Wormald KCB	Self	Bennett Institute for Public Policy, University of Cambridge	Member of the Advisory Council	Unpaid	
Sir Chris Wormald KCB	Brother	Corpus Christi College, Oxford	Academic at Corpus Christi College, Oxford	Salary	
Sir Chris Wormald KCB	Self	Economic and Social Research Council	Member	Unpaid	
Sir Chris Wormald KCB	Self	Nuffield College, University of Oxford	Visiting Fellow	Accommodation/dining	
Sir Chris Wormald KCB	Sister-in-Law	Salesforce	Consultant	Salary	
Sir Chris Wormald KCB	Self	Step Up to Serve	Member of the Advisory Council	Unpaid	
Sir Chris Wormald KCB	Self	The Institute for Fiscal Studies	Member of the Advisory Board of the Centre for Microeconomic Analysis of Public Policy	Unpaid	

Official	Held by	Name of Company	Position Held	Type of interest	Other Information
Clara Swinson CB	Partner	Cazoo Ltd	Chief Technology Officer	Salary and shareholding	
Clara Swinson CB	Partner	Unbiased EC1 Ltd	Non-Executive Director	Salary and shareholding	
Jenny Richardson	Partner	Medicines & Healthcare products Regulatory Agency	Chief Operating Officer	Salary	Ended May 2022
Jonathan Marron CB	Self	Institute of Lifecourse Development, University of Greenwich	Non-exec member	Unpaid	
Professor Lucy Chappell	Self	Guy's and St Thomas' NHS Foundation Trust	Honorary Consultant Obstetrician	Part-time paid role	
Professor Lucy Chappell	Self	King's College London	Professor of Obstetrics	Part-time paid role	
Professor Lucy Chappell	Self	Medical Research Council	Member, Council	Unpaid	
Matthew Gould	Brother	11 Alberbrook Road Management Co.LTD	Director		
Matthew Gould	Self	Early Detection of Neurodegenerative Diseases Initiative	Non-Executive Board Member	Unpaid	
Matthew Gould	Self	Endocrine Pharmaceuticals	None	Minor shareholding	
Matthew Gould	Self	F2G Ltd	None	Minor shareholding	
Matthew Gould	Brother	Hoolvale Properties Limited	Director		
Matthew Gould	Brother	Lawrence Gould Consultancy Ltd	Director		
Matthew Gould	Brother	Locum’s Nest	Formerly Interim Chief Financial Officer		
Matthew Gould	Self	Phico Therapeutics Ltd		Minor shareholding	
Matthew Gould	Brother	RCV Engines Limited	Director		
Matthew Gould	Self	Seneca Growth Capital VCT		Minor shareholding	
Matthew Gould	Brother	The One-to-One Children's Fund	Director		
Matthew Gould	Self	The Royal Air Force	Non-Executive Board Member	Unpaid	
Matthew Gould	Self	University of Leeds	Visiting Professor of Cyber Security Policy	Unpaid	
Matthew Style	Partner	Blood Cancer UK	Chief Executive	Salary	To Dec 2022

Official	Held by	Name of Company	Position Held	Type of interest	Other Information
Matthew Style	Partner	Macmillan Cancer Support	Chief Executive	Salary	From Jan 2023
Michelle Dyson	Brother	Advantage Mentoring Community Interest Corporation	Member and Director		
Michelle Dyson	Brother	Candela Medical, Inc	Non-executive Director / Chairman	Indirect shareholding	
Michelle Dyson	Brother	Healthcare team at Apax Partners UK Ltd	Partner	Share of profits	
Michelle Dyson	Brother	Healthium Medtech Limited	Non-Executive Director / Chairman	Indirect shareholding	
Michelle Dyson	Brother	Rodenstock GmbH	Non-Executive Director / Chairman	Indirect shareholding	
Michelle Dyson	Daughter	Royal Free London NHS Foundation Trust	Volunteer		
Michelle Dyson	Brother	Vyaire Holding Company	Non-Executive Director / Chairman	Indirect shareholding	
Michelle Dyson	Self	World Jewish Relief (charity)	Committee Member		
Shona Dunn CB	Partner	Thales UK	Tax Advisor		
Stephen Oldfield	Self	Gosden House School	School Governor	Volunteer	
Stephen Oldfield	Self	Proctor & Gamble		Minor shareholding	
Stephen Oldfield	Self	Safecast		Minor shareholding	
Stephen Oldfield	Self	Total Oil & Gas		Minor shareholding	

Non-Executive Board Members' Interests

447. 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

448. The Department has reviewed its code of conduct policies, processes and guidance and is content that these are up to date and in line with best practice. The Department reviewed its declaration and management of outside interests' policy in line with Cabinet Office guidance recently, and it was published in December 2022.

449. Our policy is clear, in that all declarations of interest should be updated as they cease or arise. All members of the Senior Civil Service (SCS) need to confirm on an annual basis that their declarations of interest are up to date (including a nil return). All SCS employees receive reminders each year to ensure compliance with this policy.

450. A reminder was issued to all staff in the Department on 23 November 2022 through an intranet article, including instructions on how to log declarations of interest on D365, the Department's reporting system. Another reminder was issued to staff on 13 July 2023.

451. 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. 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).

Declaration of Non-Executive Director Interests

452. 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

453. In line with the current Declaration of Interests policy for special advisers, all special advisers have declared any relevant interests or confirmed they do not consider they have any relevant interests. The Permanent Secretary has considered these returns and the following relevant interests are set out in public:

Special Adviser Name (time in post at Department where applicable)	Details of Interest
Caroline Elsom	Caroline's partner is the Director of External Affairs at Waymap and is a Conservative Councillor on Wandsworth Borough Council. Caroline's sister is a General Practice Specialist at Knowle Green Medical Practice. **Mitigation:** Should there be any interactions with the organisations concerned then Caroline would recuse herself from any involvement. Other than declaration no other mitigations are required.
Iain Carter	Iain has a number of shareholdings each below £5,000. Iain is a trustee of the Conservative Party Archive Trust.
Macer Hall	Macer has a FTSE tracker ISA managed by Aegon
Robert Ede	Robert's wife works in a government-facing role at Biogen UK. **Mitigation:** Mitigations have been place including Robert not having any involvement with any dealings, discussion or advice related to Biogen and/or potential future contracts or bids. This will be reassessed if Biogen contracts directly to DHSC. Robert has also recused himself from discussions of any report he authored before joining the Department
Alice Hopkin (until 05/07/22)	Alice held a stocks and shares ISA account managed by St James Place Wealth Management. Alice was a director of Director of Digital Tories Ltd, a trustee of the Glyn Hopkin Charitable Foundation CIO and a governor of Fitzjohn's Primary School, Hampstead.
Clarence Mitchell (between 07/11/22 and 08/02/23)	Clarence was the founder of Clarence Mitchell Communications Ltd, a director of The Enterprise Forum, a governor of The Avenue Special Needs Academy, Reading, a trustee of both The Mitzen Foundation and Sponsorstars, and a councillor for Emmer Green Ward, Reading Borough Council.
Ed Winfield (between 06/09/22 and 25/10/22)	Ed held shares in Accenture PLC and as a former employee of the consultancy firm, maintains contact with former colleagues in the consultancy industry. Ed's partner worked for Deloitte LLP. Ed also held shares in Royal Mail.
Hannah Guerin (between 06/09/22 and 25/10/22)	Hannah was a governor at Haling Park Primary School, Croydon
James Hedgeland (until 05/07/22)	James was a board member of the RAMP Project
John Gardner (between 01/08/22 and 06/09/22)	John had two potential Share Awards from Babcock International Group PLC, one vesting this summer, the second in December 2023. John was a trustee of the Armed Forces Parliamentary Scheme. John's wife was employed by Connect Communications.
Sam Coates (until 05/07/22)	Sam was a director in Coates Events and holds shares in the company. Sam was a Special Constable in the Metropolitan Police and Senior Associate Fellow at the Royal United Services Institute. Sam had previously worked with the CSJ Thinktank and the Kurdistan Regional Government.

Business Appointment Rules

454. 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 2022 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. Further amendments were made in March 2023 to increase compliance.

455. 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.

456. 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 749 (of which 29 were SCS). 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.

457. 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. As seen in **Table 22**, the Department set BAR conditions for 34 individuals in the past year. No BAR applications were found to be unsuitable for the applicant to take up and no enforcement action was taken by the Department with regard to breaches of the Rules in the preceding year.

Table 22: BAR Applications

Grade	Number of BAR Applications Assessed	Number of BAR Conditions Set
AO	0	0
EO	0	0
HEO	0	0
SEO	0	0
Grade 7	3	3
Grade 6	1	1
SCS	25	25
Special Advisor	4	4
Minister	1	1

458. 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.

459. 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.

460. 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

Statement and Scope of Accounting Officer Responsibilities

461. 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 following sections include 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

462. 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, Medicines and Healthcare products Regulatory Agency (MHRA) 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 20** to the accounts).

463. 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.

464. 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.

465. 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.

466. 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.

467. 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.

468. The Department published in July 2018, an Accounting Officer System Statement setting out lines of accountability within the Department and the healthcare system. This includes the responsibilities and relationships between the Accounting Officers in the Department, its Agencies, Arm's Length Bodies, and the NHS.

469. 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.

470. 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

471. 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 2022-2023 and is current up to the date this Annual Report was signed.

472. 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.

473. The Head of Internal Audit's opinion is that they can provide 'Moderate' assurance regarding the overall adequacy and effectiveness of the Core Department's systems of risk management, governance, and internal control for the year. This classification means that 'some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control'. This is an improved position compared to 2021-22 and 2020-21 when a 'Limited' annual audit opinion was provided meaning that significant weaknesses had been identified in respect of control, risk, and governance arrangements. Further detail regarding the audit opinion is provided from **page 203.**

474. 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.

475. 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), Integrated Care Boards (ICBs), 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.

476. 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.

Arm's Length Bodies and Delivery Partners

477. DHSC's 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 for health and care;
    - providing central services to the NHS, and
    - Keeping our communities safe by preparing for, preventing, and responding to health hazards.

478. Our ALBs fall into several distinct types:
    - **Executive Agencies** are legally part of DHSC but with greater operational independence.
    - **Executive Non-Departmental Public Bodies (ENDPBs)** are 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)** are created by order and subject to direction by the Secretary of State for Health and Social Care.
    - **Limited companies** are incorporated under the Companies Act and included in this Annual Report and Accounts.
    - **Other bodies** included in the Departmental Group which therefore fall within our Annual Report and Accounts.

479. The Department currently has two Executive Agencies: UK Health Security Agency (UKHSA) and the Medicines and Healthcare products Regulatory Agency (MHRA).

480. NHS Digital ceased to operate as a separate ENDPB on 31 January 2023, with the legal transfer of its statutory functions (together with assets and staff) to NHS England.

481. Health Education England ceased to operate as a separate ENDPB on 1st April 2023, with the legal transfer of its statutory functions (together with assets and staff) to NHS England.

482. Our Permanent Secretary is the Principal Accounting Officer for the Departmental Group which as of 31 March 2023 consisted of:
    - Seven ENDPBs (including NHS England and its 42 Integrated Care Systems (ICSs)). The seven became six on 1 April 2023 when HEE was merged with NHSE;
    - Three[9] Special Health Authorities (SpHAs);
    - Eight other bodies (including companies);
    - 144 NHS Foundation Trusts (FTs);
    - 68 NHS Trusts (NHSTs);
    - and NHS charities.

483. 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. This process is managed by senior Departmental sponsors.

484. 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.

485. 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 noted changes occurring as a result of a new Ministerial team. The evaluation identified suggestions to be made which will further strengthen the current function of the Board, for example that the Board's visibility across the Department could be improved.

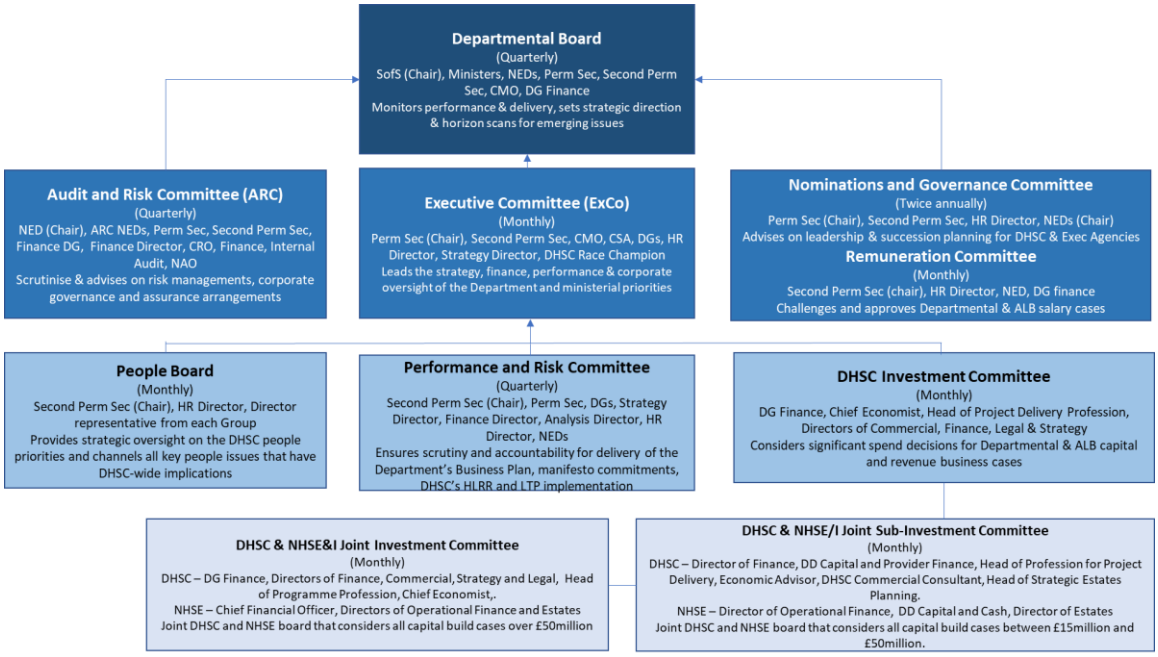
Departmental Governance

486. 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.

487. The Departmental Board meets on a quarterly basis. The Board met on four occasions during the 2022-23 financial year. Full membership and attendance are outlined in the **Directors' Report**. The Departmental Board is supported by the committees shown in the structure chart at **Figure 36.**

[9] in addition, DHSC has a fourth Special Health Authority, NHS Blood & Transplant which falls outwith the DHSC group boundary.

Figure 36: Departmental Board Structure



488. The Committees are responsible for the following:

- The **Executive Committee** is the Department's major decision-making body and 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 2022-23 included: COVID-19 Planning (twice); locations strategy (three times); health impacts of COVID-19; delegated pay award; impact of inflation; diversity and inclusion strategy; COVID-19 Inquiry; Secretary of State's priorities; business continuity; non-NHS Budget; DHSC efficiencies and transformation; people survey; and digital function. The Committee met thirteen times during the reporting year, including a scheduled monthly meeting of the full Committee in each month (except August), an additional full Committee meeting in June (to discuss Civil Service 2025 Workforce Efficiencies) and a restricted discussion of SCS Pay in August.

- 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 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 ten times in the year and reviewed 15 urgent cases by correspondence.

- The **Nominations and Governance Committee** advises on matters relating to senior leadership and succession planning for the Department. The 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.

- 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 full committee meetings which covers papers and updates on Finance, Internal Audit, NAO audits, value-for-money studies, and Departmental risk management. It also regularly discusses PAC reports and recommendations, counter fraud, cyber security, the Department's major projects portfolio and GMPP. In 2022-23, there were deep dive discussions on the bioterrorism, funding and NHS performance high-level risks, NHS workforce, GMPP, anti-fraud, the New Hospitals programme, supply chain disruptions, and NICE. The full Committee met four times during 2022-23.

489. **Table 23** summarises attendance at the Departmental Board and the four next-tier committees.

Table 23: Committee Attendance

Name of Board or Committee member [1,2]	Departmental Board Met 4 times	Executive Committee [3] Met 13 times	Audit and Risk Committee Met 4 times	Nominations and Governance Committee Met 2 times	Remuneration Committee [4] Met 10 times
Ministers					
Rt Hon Sajid Javid MP [5]	1 (out of 1)	-	-	-	-
Edward Argar MP [6]	1 (out of 1)	-	-	-	-
Rt Hon Stephen Barclay MP	3 (out of 3)	-	-	-	-
Maria Caulfield MP	1 (out of 3)	-	-	-	-
Helen Whately MP	1 (out of 3)	-	-	-	-
Will Quince MP	0 (out of 3)	-	-	-	-
Neil O'Brien MP	0 (out of 3)	-	-	-	-
Lord Markham	3	-	-	-	-
Officials					
Sir Chris Wormald	4	13	-	2	-
Professor Sir Chris Whitty	4	11 (out of 13)	-	-	-
Shona Dunn	3 (out of 4)	12 (out of 13)	2 (out of 4)	2	9 (out of 10)
Clara Swinson	-	12 (out of 13)	-	-	-
Jonathan Marron	-	13	-	-	-
Professor Lucy Chappell	-	11 (out of 13)	-	-	-
Michelle Dyson	-	13	-	-	-
Andy Brittain	3 (out of 4)	12 (out of 13)	4	-	9 (out of 10)
Matthew Style	-	11 (out of 13)	-	-	9 (out of 10)
Jenny Richardson [7]	-	10 (out of 12)	-	2	7 (out of 10)
Lorraine Jackson [7]	-	10 (out of 11)	-	-	-
Hugh Harris [7]	-	12 (out of 12)	4	-	-
Non-Executive Directors					
Kate Lampard	4	-	-	1 (out of 2)	1
Doug Gurr	4	-	-	-	-
Sir Julian Hartley [8]	1 (out of 1)	-	-	-	-
Samantha Jones [9]	1 (out of 1)				
Gerry Murphy	4	-	4	1 (out of 2)	8
Independent Members					
Anne Barnard	-	-	4	-	-
Graham Clarke	-	-	4	-	-
Richard Hornby	-	-	3 (out of 4)	-	-

1. Table represents Committee members' attendance only. Attendance of observers or item presenters is not recorded in the above table.
2. Where a number appears in brackets, this is the maximum number of meetings that person could have attended.
3. Where a Director General could not attend an Executive Committee meeting, a deputy attended on their behalf.
4. Attendance of the Remuneration Committee is shared amongst Non-Executive Directors.

5. Sajid Javid was appointed as Secretary of State in June 2021. He resigned this position on 6 July 2022.
6. Edward Argar resigned as Minister of State on 7 July 2022
7. Jenny Richardson, Lorraine Jackson and Hugh Harris are Director level members of the Executive Committee and did not attend a restricted meeting in August 2022 which discussed SCS2 (Director) pay. Lorraine Jackson also did not attend a meeting in December to discuss DHSC Efficiencies and Transformation.
8. Sir Julian Hartley resigned as a Non-Executive Director on 10 November 2022 so was only able to attend the meeting in June 2022 prior to his resignation
9. Samantha Jones was confirmed as a Non-Executive Director on 13 February 2023 and attended the March Departmental Board in this capacity. She also attended December 2022 and January 2023 Board meetings prior to appointment.
10. Jenny Richardson was unable to attend 3 meetings of the Remuneration Committee. Lee O'Sullivan the Deputy Director responsible for Arm's Length Body reward attended in her place.

490. The Department also has the following other major committees:

- 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 focused on achievements and concerns, overall progress towards objectives, manifesto commitments, core metrics and key risks to performance and the performance of key corporate functions.

- 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 considers the pipeline of forward cases and sets approval conditions and expectations on the circumstances for resubmission of previously agreed cases where necessary. As shown in **Figure 36** the Investment Committee is supported by the DHSC and NHS England (NHSE) Joint Investment Committee and Joint Investment sub-Committee, which consider NHS Trust and Foundation Trust business cases over delegated limits, with both committees also meeting at least once a month.

Core Assurance Framework, Risk Management and Control

491. 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.

Three Lines of Defence

492. 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.

- 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. Our Governance Committees continue 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.

- The **third line** of defence comprises the oversight provided by the Audit and Risk Committee (ARC) and the independent oversight and challenge of the Government Internal Audit Agency (GIAA), which both provide independent challenge and assessment of the robustness of arrangements in place. The ARC has considered the way in which the Department manages risk at its four meetings during 2022-23 and reviews and discusses the Department's risk register as a standing agenda item at these meetings.

493. Through this scrutiny the ARC has supported the Departmental Board to ensure effective systems were in place to deliver high-quality internal control, governance, and risk management. The Chair of the ARC also sits as a co-opted non-Executive member of NHS England's Audit and Risk Committee. A quarterly update to members of the Departmental Board is provided on the activities of ARC and all the major Board subcommittees. 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.

Managing Risk

494. The Performance and Risk Committee (PRC) also 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 as part of the Risk Management Framework and discusses major core business issues, concerns

around significant ALB risks, or performance. In doing this, PRC makes decisions on what issues or risks require further investigation or assurances which are then discussed further at ARC. 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.

495. 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.

496. 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.

497. Significant risks actively managed by the Department during 2022-23 have included:

External Risk	• The health and care system's resilience to cyber-attack – see 'Data Issues – Cyber Security Programme' on **page 141;** • 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 15**.
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 19**.
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 132**.

498. Some of the key activities in mitigating these risks are set out in the **Performance Report**. The Executive Committee, ARC, and Departmental Board members have challenged and advised on the controls and actions being taken to further mitigate

them, through regular discussion of risk overall and through regular 'deep-dive' examination of particular risks.

499. The Departmental Board receives the quarterly Performance and Risk packs and 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.

500. In 2022-23, 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 due to scheduling conflicts, full BAM reports have been shared with senior staff.

501. 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.

502. In 2022-23, the Department also introduced a new Assurance Framework. This comprises of two parts – a Central Framework which assures on HR, Finance, Workplace, Information Security, Commercial and Governance policies from a central perspective and a Local Framework, which seeks to confirm that Directors are assured they are meeting core requirements in their own areas including risk management, governance, capacity and capability, counter-fraud, and ALB sponsorship.

Major Projects

503. During 2022-23, the DHSC Major Projects Portfolio (MPP) was reset with the establishment of dedicated supporting governance through a Portfolio Oversight Board (POB). The POB reports into the Performance and Risk Committee and ExCo as part of the Departmental overarching governance and a Ministerial update is now provided after each meeting.

504. The MPP comprises 16 programmes and projects classed either as Tier 1, where responsibility for delivery sits with DHSC, or Tier 2, where delivery sits with ALBs. The criteria for inclusion in the MPP are based on HM Treasury's definition of a 'Major Project' and includes manifesto commitments and programmes or projects which feature in the Government Major Projects Portfolio (GMPP). The MPP team continues to track the delivery of all DHSC's major programmes on the GMPP, working closely with the cross-Government Infrastructure and Projects Authority (IPA).

505. Changes in the reporting year with the reset of the MPP have seen the inclusion of Community Diagnostic Centres (CDC); Targeted Investment Funding (TIF); Antivirals Therapeutics Task Force (ATTF); Data for Research and Development; and Drug Strategy in the Portfolio. The Shared Care Records and Supporting People at Home programmes have been subsumed into other areas of delivery within the NHSE Transformation Portfolio and have been removed from the MPP.

506. In line with other Government departments, DHSC provides an updated delivery confidence assessment for inclusion in the IPA's Annual Report, reflecting the position as at Quarter 4. Details for the 2022-23 return can be found here. It should be noted that the MPP in its entirety is not included in this return, only those programmes and projects that are commissioned on the GMPP.

507. The Project Delivery (PD) Profession within the Department continues to be developed through a re-established steering group and agreed PD strategy. This aligns DHSC and its ALBs to central Government's approach to assessment, using a Government Online Skills Tool and Accreditation. The IPA are rolling this out across departments for the entire PD Profession. The successful re-launch of a DHSC PD Community during the year has been a key component in implementing the PD Strategy.

Better Regulation

508. 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.

509. 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 and Trade (DBT) on qualifying regulatory measures for the annual business impact target report.

510. 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.

511. The Department has been contributing to the ongoing cross-Whitehall regulatory reforms, including the EU exit opportunities being led by Cabinet Office.

512. 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.

Whistleblowing

513. 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 November 2022.

514. The policy offers employees a number of methods by which 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.

515. 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.

516. 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.

517. In 2022-23, fewer than five formal whistleblowing concerns were raised in DHSC. Figures of five or less whistleblowing concerns are not published to protect anonymity, all cases have been investigated and the investigations have concluded.

518. During 2022-23, 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.

519. 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.

520. Over the course of 2022-23, the priority in this area has been to continue the focus on ensuring all staff are aware of the routes in which they can raise concerns and feel supported to do so. This has included a focused 'Speak Up' week in November 2022, communications on reporting routes and support services, and a focus on giving and receiving feedback using events, training, toolkits, and blogs.

521. The results of the 2022 People Survey (October 2022) showed that the percentage of people who felt encouraged to speak up when they identify a serious policy or delivery risk in the Department decreased slightly from 70% to 67% in the last 12 months. Our engagement index score in 2022 was 60%. The recruitment of the new Deputy Champion, whistleblowing health check and further promotion of the Speak Up Service are intended to positively impact the score this year.

522. The 'Safe to Challenge' agenda continues to be an important aspect of DHSC culture and forms part of the 'We Challenge' Department value. The Culture and Engagement Champion network across the Department offer essential insights into Departmental culture that can inform its approach to whistleblowing.

Key Departmental Operational Governance

523. 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 2021-22 ARA or in earlier reports. Where matters have arisen during the reporting year and are not yet resolved, they will feature in future reports.

Coronavirus (COVID-19)

524. The COVID-19 Programme was initiated in March 2020 and played a core role in coordinating DHSC's response to COVID-19. Following the publication of Living with COVID (LWC) in February 2022, the focus of the wider health and care system response to COVID-19 shifted from emergency response to the implementation of the LWC strategy and preparations for any future serious variant of concern, which was also reflected in the structure of the workstreams of the COVID-19 Programme as agreed for 2022-23.

525. Over the last year, workstreams moved towards embedding the response to COVID-19 in their wider response to infectious threats and therefore towards normalisation within normal business as usual structures, while others progressed their plans towards closure or transferring work to other areas in DHSC, UKHSA or NHSE. The Antivirals and Therapeutics Taskforce workstream closed as previously agreed in March 2023.

526. Following our internal transition assurance process, DHSC Executive Committee agreed the COVID-19 Programme would close after March 2023, including the associated Oversight Board and reporting, thereby also completing an action under a previous GIAA recommendation to integrate appropriate governance structures into business-as-usual functions.

UK Health Security Agency (UKHSA) Financial Control and Governance Issues and Resultant Limitation of Scope Group Audit Opinion

527. The Comptroller and Auditor General (C&AG) disclaimed his regularity and true and fair opinions in relation to UKHSA's 2021-22 financial statements. The C&AG concluded that this led to a limitation of scope in the audit opinion for the Departmental Group over the UKHSA transactions and balances included in the 2021-22 Group account (after elimination of intra-group transactions).

528. During 2022-23, significant efforts have been undertaken by the UKHSA to resolve the issues which caused the disclaimed opinion in 2021-22 and these are described in detail in the UKHSA ARA and summarised below.

529. UKHSA implemented an action plan, which looked systematically across a wide variety of areas including systems, business process, central finance processes, HR and payroll processes including workforce, accounts preparation processes and

ways of working. The action plan was delivered through a formal programme, the Finance and Control Improvement Programme (F&CIP) and monitored via an oversight board. This board is chaired by the UKHSA Chief Executive and includes representatives from DHSC, HM Treasury and the Government Internal Audit Agency.

530. The first two phases of the programme prioritised enhancements that would facilitate the production of quality accounts and enable UKHSA to provide sufficient, appropriate evidence for transactions and balances within the financial statements.

531. The audit opinion on UKHSA's accounts in 2021-22 also reflected some concerns about the financial controls and high-level governance arrangements at UKHSA. Whilst some compensating high-level governance arrangements were in place during 2021-22, UKHSA did not have a board or an Audit and Risk Committee. The appointment of the non-executive members of the UKHSA Advisory Board concluded in April 2022, with the appointment of a permanent Chair of the Audit and Risk Committee completed in April 2023. The Advisory Board and the Audit and Risk Committee met formally for the first time in June 2022 and July 2022, respectively, meaning formal high-level governance arrangements were operating as intended for most of 2022-23. The Finance and Control Improvement Board (FCIB) noted above was also established to oversee the F&CIP and address issues with financial control and high-level governance arrangements. We continue to strengthen the governance and oversight of UKHSA. A close working relationship with UKHSA has been formalised further after the balance sheet date with the DHSC Director General of Finance taking on a fuller role in support of the UKHSA Accounting Officer in ensuring effective financial management, governance and controls.

532. As described above, UKHSA has put in place significant improvements in response to the issues that led to the disclaimed audit opinion in 2021-22. This indeed led to a substantially smoother and more assured accounts process. However, a new area of complexity arose in 2022-23 following the transfer of the Covid Vaccine Unit (CVU) from DHSC into UKHSA on 1 October 2022.

533. The audit of CVU balances has taken longer than expected, both as a result of the requirement for increased audit scrutiny (as the transfer of these balances into UKHSA, a much smaller organisation, resulted in a significant increase in the assurance required for audit, to a higher level of precision) and because of post-balance-sheet events that required vaccine usage estimates to be updated, including some as late as December. Those events included: a change to vaccine policy in advance of the Autumn 2023 vaccination campaign to focus vaccination on a smaller age cohort; a new Covid variant, which required an unexpected rephasing of the Autumn vaccination campaign in line with expert clinical advice and a change to some of the underlying forecast modelling (including a change in the modelling tool from Python to Excel); and the completion of the campaign

(with a corresponding update to the estimate to include actual vaccine usage data rather than forecasts).

534. As the work to assure the covid vaccine balances associated with the transferred function remained ongoing in January 2024, UKHSA took the decision to accept a disclaimed audit opinion to ensure its 2022-23 ARA was published by the 31 January 2024 statutory laying deadline.

535. The cause of the 2022-23 disclaimer is very different to the prior year's disclaimer in that it relates to the roll-forward impact of the 2021-22 disclaimer and the specific issue over providing full assurance on the significant CVU balances (inventory, prepayments and onerous contract provisions) in time for the statutory deadline. UKHSA remains committed to providing sufficient appropriate audit evidence over these balances (as part of the 2023-24 audit of opening balances). For existing areas of UKHSA's finances, UKHSA provided sufficient appropriate audit evidence for closing balances, by the statutory deadline.

536. The Comptroller and Auditor General (C&AG) has therefore disclaimed his regularity and true and fair opinions in relation to UKHSA's 2022-23 financial statements. The C&AG concluded that this led to a limitation of scope in the audit opinion for the Departmental Group over the UKHSA transactions and balances included in the 2022-23 Group account (after elimination of intra-group transactions).

537. Full details of the above improvements and audit opinion are given in the UKHSA Annual Report and Account.

Finalisation of Group Entities' Accounts

538. The Department is committed to laying its ARA in as timely a manner as is possible as this is critical for Parliamentary scrutiny.

539. A number of group entities have experienced delays in the finalisation of their audited accounts. This has predominantly occurred in the NHS sector and UKHSA and these delays have prevented an earlier publication of the group accounts.

540. The vast majority of NHS commissioners and their auditors continued to meet the deadline set for submission of audited accounts in 2022-23 and we recognise the significant efforts by commissioners and audit firms made to achieve this. The compliance rate was similar in percentage terms to 2021-22 but the number significantly late in 2022-23 is worse than 2021-22. This small but significant number of CCG and ICB audited accounts that were significantly late has delayed the preparation of these consolidated accounts.

541. There are many reasons why a set of audited accounts may go beyond the deadline: for example, this may reflect illness in the preparer finance team or audit team, or a significant issue may be encountered that takes time to resolve, which may reflect weaknesses in a commissioner's preparation of its accounts. It is

important that auditors can complete their work independently of outside influence and take the necessary time to ensure their audit opinion is the right one and supported by appropriate audit evidence. However, standing back from the level of individual engagements, it is clear that success in enabling commissioners to achieve the audited accounts deadline, to which all firms sign up collaboratively, varies significantly between audit firms. For example, of the sixteen NHS commissioners audited by one audit firm, only three had submitted audited accounts by 31 August, two months after the deadline.

542. There are well-known capacity issues across the local external audit market, which are continuing to affect both local government and NHS audits. A handful of late audits were due to either Local Government Pension Scheme audits awaiting sign off or agreed late deliverable dates as part of NHSE's work to ensure every organisation had an auditor.

543. While a number of firms delivered their audits later than originally planned, one firm in particular repeatedly missed deadlines and, therefore, contributed most significantly to the delay in the Group ARA. The Department worked hard - alongside NHSE, central Government and the Financial Reporting Council (FRC) to keep these audits on track. However, revised plans of audit completion dates were missed. This, in turn, meant that the NHS England (NHSE) Group accounts and the Consolidated Provider Account (CPA) did not have a sufficient level of assurance by 30 November 2023 (the date the Department sought to lay the group ARA) and we have therefore been compelled to lay the Department's ARA later than intended.

544. The Department, alongside NHSE, considered all options to achieve the November laying date. However, given the number of both NHS audits and UKHSA audit outstanding, and the desire to lay with an unqualified audit opinion, the delay in laying to January 2024 was deemed the only and most acceptable course of action whilst still meeting the statutory deadline of 31 January 2024.

545. The Department has received assurances from the particular audit firm where delays have occurred that they will support the timely and professional delivery of future local NHS audits, which should prevent a recurrence of this year's delays. The capacity issues across the local audit market continue to be a concern and the Departmental Group continues to work closely with the Department for Levelling Up, Housing and Communities (DLUHC), HM Treasury and the FRC to determine what can be done to improve the situation in the sector.

546. The Department is committed to bringing the laying timetable forward as far as possible, with an ultimate aim to return to pre-recess laying. However, until capacity constraints in the local audit market are resolved, the ability to achieve this outcome is challenging and to some extent outside the control of the Department.

DHSC Contract Management

547. In April 2022, the transition from separate Procurement and Contract Management functions to the new Commercial Operations Division was implemented. Commercial Operations provides a whole lifecycle commercial offer, ensuring consistent end to end commercial support across 4 key category areas.
    - Professional Services (PS)
    - Digital, Data and Technology (DDaT)
    - Clinical & Corporate Services (CCS)
    - Vaccines and Medical Countermeasures (VCM)

548. Through 2022-23 Commercial Operations has continued to work with Director General Groups to ensure that the DHSC Corporate 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.

549. 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), or **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.

550. Commercial Leads from Commercial Operations 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 DHSC contract portfolio by 31 March 2023. The final one was completed in May 2023.

551. 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.

552. 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, supported with commercial expertise from the Commercial Operations commercial lead.

553. 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 2023, some 2,132 learners across health (DHSC, ALBs and NHS) had registered for the Foundation Training, of which 989 achieved accreditations. We continue to encourage all Foundation learners 'in progress' to complete the learning and achieve accreditation. 94% of OCMs managing DHSC gold contracts have been nominated or completed Expert training as required.

554. As at 31 March 2023, the DHSC contract portfolio stood at 702 contracts with total contract award value of £8 billion; the portfolio consists of 21 Gold contracts, 83 Silver, 306 Bronze and 292 Transactional contracts.

555. Contract management capacity in Commercial Operations has been reviewed as part of the Commercial Directorate reset to ensure that our role in the governance and oversight of the DHSC contract portfolio can be effectively delivered. Capability of the Commercial Operations team has also been strengthened as part of the Directorate reset through additional investment in learning & development to ensure all commercial professionals have the capabilities to operate across the whole commercial lifecycle.

DHSC Information Risk Management and Assurance

556. Launched on 1 April 2021, the Information Risk Management and Assurance Directorate (IRMA) continued to provide valuable expertise in 2022-23 to ensure information is used effectively and lawfully, kept safe and secure, and shared responsibly across the Department to support decision-making and improve services.

557. The Information Governance Committee (IGC) was launched on 1 August 2022. This is a senior governance forum that acts as a supervisory and strategic decision-making body and escalation route for information governance and data protection across DHSC. The Committee holds overall accountability for the management of the Department's information and data protection risks.

558. Work commenced on the implementation of Information Asset Owner (IAO) and Information Asset Manager (IAM) roles across all Director General Groups within the Department. These roles are key to ensuring the identification and effective management of all the information and personal data that is used to support delivery. Since training commenced in March 2023, 142 (~85%) Deputy Directors have been trained in their IAO responsibilities; and 164 staff have been nominated as IAMs, with 116 being trained. One of IAO and IAM key responsibilities is to ensure that an accurate and up to date information asset register exists for their part of

the business. A new DHSC Information Asset Register (IAR) and guidance is being implemented. The IAR will help business areas make more informed decisions about how they use/re-use and share information and to better understand and manage the risks to it. The IAR will help to ensure that the Department creates and maintains an accurate and complete view of the information it holds and uses, and act as a Record of Processing Activity and enable the Department to meet data protection legislative requirements.

559. During 2022 and into 2023, Departmental standards and policies were produced and refreshed, including:
    - Information Risk Management Policy, Framework and Toolkit, which set out the expectation that DHSC and Executive Agencies will ensure that there is an effective information risk management framework in place, so that information risks of significant likelihood, consequence and impact are identified, considered, and pro-actively addressed.
    - Information Security Standard. This standard sets the baseline requirements for information security across the Department.
    - Information Classification & Handling Standard. This standard defines the security classifications that should be used to protectively mark all Departmental information.
    - Information Security Policy. This document sets the overarching requirements for our staff, contracts, third parties and other users of our systems.
    - Acceptable Use Policy. The policy informs staff of the legal and other risks associated with the inappropriate use of DHSC ICT and the extent to which it may be used for personal purposes.

560. The Department has continued to work with the Information Commissioner's Office (ICO), 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). IRMA successfully managed the ICO's investigation into Departmental private-channel communication practices, responding in full to all the ICO's requirements.

561. The Departmental Records Office reviewed 264,723 digital records, with 646 recommended for permanent preservation. 154,372 paper records are now awaiting destruction with 1,524 identified for transfer to the National Archive for permanent preservation.

562. The Department recorded 104 data-related incidents between April 2022 and March 2023, a decrease of 93 on the previous year. Of the 104 reported incidents, none met the criteria to be referred to the Information Commissioner's Office, compared to 4 in the previous year.

DHSC Anti-Fraud Unit

563. The following six sections all cover the work of DHSC's Anti-Fraud Unit (DHSC AFU).

564. Fraudulent activity in the health sector 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 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.

565. Counter fraud work at a national level is led by the DHSC Anti-Fraud Unit (DHSC AFU). Its goal is to prevent, detect and investigate fraud, bribery, and corruption by raising awareness and working in partnership with all parts of DHSC, its arm's-length bodies (ALBs), and companies.

566. The DHSC AFU sets the counter fraud policy and strategy for the Department and the wider health group. We have developed a new counter fraud strategy covering the period 2023-26. The strategy maintains the vision of 'A system-wide approach to tackling fraud which protects taxpayers' money for better patient care' and focuses on four key areas, namely:
    - proactivity and prevention
    - utilising digital and data analytics
    - collaboration and coordination; and
    - response and enforcement.

567. These themes ensure we are aligned with the Public Sector Fraud Authority's (PSFA's) mandate, and this has been developed in consultation with key stakeholders, including our ALBs. The strategy is underpinned by the desire to collaborate and maximise the use of data and analytics.

568. 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.

569. DHSC AFU, through members of the Government Counter Fraud Profession (Fraud Risk Assessment (FRA) discipline), advises colleagues across the Department on how to complete individual Fraud Risk Assessments for specific projects, policies and grants and offers assurance on these assessments, as well as advice on guidance to reduce identified risks where possible.

570. DHSC AFU has worked closely with the PSFA on areas such as the design and development of Initial Fraud Impact Assessments (IFIAs) in line with the Public Accounts Committee (PAC) recommendation. A process has been implemented to embed IFIAs into the Government Major Projects Portfolio process. This means that an assessment of fraud risks and required counter fraud resources will be built in early to high-risk, high-spend and/or contentious projects.

571. DHSC AFU maintains an Enterprise FRA which is being further developed to complement the introduction of Thematic FRAs.

572. 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.

573. We also have a comprehensive programme of engagement and counter fraud improvement work in place with all our health ALBs. This has included a recently completed assessment of ALB compliance with Government Counter Fraud Functional Standards (GCFFS). DHSC continues to work with ALBs to help them achieve compliance with the standards. DHSC, and several ALBs also contributed to the PSFA's counter fraud Workforce and Performance Review (WPR) to provide insight to support levelling up counter fraud capability across Government.

574. The aim of the PSFA's WPR was to map counter fraud investment across the public sector and to identify where this was linked to clear outcomes. Departments were risk rated, (using a Red, Amber, Green (RAG) rating) across three areas – risk, resourcing, and outcomes.

575. Both DHSC and NHS Counter Fraud Authority (NHSCFA) scored green across all three categories. The WPR for DHSC noted that:
- for every £1 that DHSC spent on counter fraud, it detected £3.65, prevented £168.58 and recovered £22.27.
- the returns for 2020-21 are unusually high compared to historical trends, due mainly to COVID-19 related work and are likely to return to pre-COVID-19 levels as we return to business-as-usual.

NHS Counter Fraud Authority (NHSCFA)

576. The NHSCFA spearheads the fight against NHS fraud at a national level. The NHSCFA has 161 full time equivalent staff and 6.75 temporary staff. NHSCFA implements the Department's strategic plan under the sponsorship of DHSC AFU. The NHSCFA will publish its new strategy for 2023-26 following publication of the DHSC Counter Fraud Strategy. We have worked closely with NHSCFA to ensure that the two strategies complement one another and provide for robust counter fraud measures across the health service.

577. NHSCFA publishes an annual Strategic Intelligence Assessment (SIA) which *estimates* the potential vulnerability to fraud in the NHS, in England. The report does not represent actual fraud loss, but estimates based on NHSCFA loss measurement exercises and partner comparative loss assessments. The SIA is broken down into lead thematic risk areas.

578. The SIA Report 2023 (published on 15 September 2023 and based on financial activity data from 2021-22 which is the most recent published report) estimates that the NHS is *vulnerable* to £1.264 billion worth of fraud (not actual fraud losses); compared to £1.198 billion for 2020-21. The increase is primarily linked to increased overall expenditure in the NHS, rather than evidence of increased levels of fraud. The fraud vulnerability estimate is less than 1% of the total NHS budget for 2021-22.

579. There will always be a gap between the level of fraud against the government that is detected and the amount that is estimated, given the use of extrapolation across samples in estimates.

Local Counter Fraud Work

580. The NHS Standard Contract and the NHSCFA published version of the GCFFS (NHS Requirements) require all organisations commissioning and providing NHS services to put in place and maintain appropriate counter fraud arrangements.

581. NHSE has published statutory guidance for Integrated Care Boards (ICBs) on their counter fraud responsibilities and ICBs need to comply with the GCFFS.

582. Local Counter Fraud Specialists (LCFS) support the NHSCFA on national issues, ensure national fraud prevention messages are widely circulated and identify, report, and investigate individual cases. As of March 2023, there were 260 LCFS.

583. Shared intelligence and expert fraud risk assessment helps understand the risks from fraud and the possible responses.

584. Other NHS-facing arm's length bodies with national coverage routinely undertake activity to tackle fraud, for example NHS Business Service Authority undertake fraud awareness, prevention, and detection as part of the range of services that they offer to NHS organisations.

Counter Fraud Oversight

585. The Counter Fraud Board (CFB) maintains oversight and coordination of the response by key national organisations and provides a central function insight and 'critical friend' challenge to the health response. Board members include NHSCFA, NHS England (NHSE), NHS Business Services Authority (NHSBSA), UK Health Security Agency (UKHSA) as well as the PSFA.

586. The NHSCFA chairs a quarterly Control Strategy and Strategic Tasking & Coordination Group consisting of key stakeholders across the health group (DHSC, NHSE, NHSBSA etc) to collectively agree priorities and areas for counter fraud activity for the forthcoming financial year and/or strategic planning cycle.

Post Event Assurance (PEA)

587. During 2022-23, fraud in the supply chain was confirmed for the non-supply of PPE with a value of £45 million but which had already been recovered in 2020-21. This brings the total fraud prevented and/or recovered for COVID-19 procurement to £207 million. Of this, £202 million related to PPE, with £139 million prevented and £63 million recovered. Additionally in 2022-23, the Department detected £825,000 fraud related to a PPE contract following receipt of new information.

588. As previously reported in last year's Annual Report (page 181, para 766), over 28% of PPE procurement contracts which all displayed high risk factors had been through Post Event Assurance. DHSC AFU has determined that further, random sampling would not be the best use of resources and has continued to engage with the DHSC PPE Dissolution team which is responsible for managing contracts through to completion. DHSC AFU advises on any matters on an individual basis.

589. Should intelligence come to light to indicate a fraud risk within PPE procurement, the matter will be assessed for further investigation.

590. 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.

Civil Litigation

591. DHSC AFU also engages in civil litigation cases on behalf of DHSC and the NHS involving the pharmaceutical industry when anti-competitive behaviour is suspected. We continue to develop our approach to these civil litigation cases by engaging with pharmaceutical companies at an early stage and, on a without prejudice basis, seek settlement without lengthy and costly litigation.

Compliance with Equality and Human Rights Legislation (PSED)

592. The overall responsibility for meeting the requirements of equality and human rights legislation in policy and decision-making lies with each team in the Department. The PSED advisor within the Policy Assurance and ALB Oversight team leads the oversight of capability and assurance of PSED in the Department by

supporting and encouraging staff to consider equality from the perspective of improving outcomes for people, rather than as a legal duty or process, and aims to ensure that equality is put at the heart of all policy and decision-making.

593. The team deliver training on PSED, answer queries and provide advice, critically review Equality Impact Assessments, and is responsible for the Department's Equality Objectives and the publication of its PSED annual report. The team also delivers training to staff on equalities and health inequalities alongside the health disparities team. Staff are also encouraged to engage with lawyers during the policy and decision-making process to ensure that legal duties are met.

594. The Department undertakes bi-annual assurance meetings (or 'BAM') with each Director General Group. These are chaired by the Permanent Secretary and attended by the Director General and Directors for that Group. The BAM process ensures that where issues arise during the year, they are appropriately reported and discussed. It also addresses identified weaknesses to drive improvements.

595. Directors General are required to consider compliance with the public sector equality duty and evidence of this is provided in submissions to Ministers. The Department has a template for submissions to ministers where a decision is required on a policy issue. The template includes a checklist that highlights PSED as something that must be considered by the team developing the policy. Information on how the Department complies with the public sector equality duty can be found in the **Staff Report**.

Emergency Preparedness, Resilience and Response (EPRR)

596. The Department works closely with NHSE, UKHSA, other ALBs, and other Government departments to ensure that the health and social care sector can 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.

597. Throughout and following the COVID-19 pandemic, the Department has continued to develop its response capability, including its ability to prepare for and manage concurrent incidents.

598. In 2022-23, the Department contributed to the cross-Government planning for and responses to the UK's first level four Heatwave and industrial action across a range of sectors. The Department played a key role in preparing for and responding to the impacts of health sector industrial action and supported the sector to manage impacts from action in other sectors. The Department also worked across the health and care system to manage the impacts from a number of cyber incidents. The Department also worked with the sector to understand and develop capability against a series of energy disruption scenarios.

599. The Department supported the sector to prepare for and enact Operation London Bridge. This was alongside sector preparations for major events including Birmingham Commonwealth Games and the Diamond Jubilee.

600. 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. As a result of this work the Energy Disruption Programme Board has been established to assess the sector's capability to respond to any disruption of fuel, gas, or electricity supplies. Additionally, work has been undertaken to improve standard operating procedures for risk-agnostic capabilities such as Military Assistance to Civilian Authorities and surge capability. Further risk reviews have been conducted for cyber-attacks, provider failure, fuel supply disruption, resulting in more detailed contingency planning.

601. The Department is the Lead Government Department (LGD) for preparedness for human disease risks, including pathogens with pandemic potential, an emerging infectious disease, including an outbreak of a High Consequence Infectious Disease, and antimicrobial resistance. The plans in place to respond to an influenza pandemic provided the basis for much of the Department's early response to COVID-19.

602. The Department continued the ongoing response to COVID-19 throughout 2022-23, whilst maintaining its preparedness for a future novel pandemic or other emerging infectious disease and is incorporating learning from COVID-19 to further develop our preparedness plans.

603. The Department has and continues to support The UK COVID-19 Inquiry, providing evidence and narrative on the UK's response to and impact of the COVID-19 pandemic, and learning lessons for the future. This includes the lessons applied and capabilities developed from pre-2020 pandemic preparedness.

604. 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.

605. The Department is committed to learning lessons from the COVID-19 pandemic and has sought, and continues to consider, expert advice on products (including PPE) that should be held, or otherwise contracted for, to support the UK's preparedness for future pandemic and emerging infectious disease threats. In April 2023, the Department signed a service level agreement with SCCL (Supply Chain Co-ordination Ltd, an NHS England-owned but autonomous NHS Supply Chain function), which included a schedule on SCCL's role in ensuring supply of PPE in the event of a pandemic. Where appropriate, the Department is agreeing where volumes of PPE procured for COVID-19 are suitable to replenish the previously

depleted pandemic preparedness stockpile and has agreed a model of pandemic preparedness stockpiling that supports rotation of stockpiled product into business as usual wherever possible. Where necessary, the Department is exploring where short-term procurements to further bolster our baseline PPE resilience may be needed, as well as the longer-term approach to PPE stockpiling, which will include consideration of the role of UK-based manufacturing. The Department will continue to refine its approach over time based on the latest information available.

606. The Department completed the expert advisory phase of the Review of Emergency and Clinical Countermeasures, which considered 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. The expert advice is now informing policy and procurement decisions on pandemic preparedness countermeasures.

Data Issues – Cyber Security Programme

607. During 2022-23 DHSC Corporate Cyber Security has worked with the IMS4 IT Delivery programme to enable and ensure the delivery of a more cyber resilient technical estate for the Department. That work has included increasing central monitoring and assurance, improving cyber related protective technologies used, as well as clarifying and improving accountabilities under revised contracts and clearly documented incident response processes. DHSC has over the year increased its cyber security capability with the appointment of a 'Head of Cyber Security' for the Department and will continue to build greater capability and resilience in this team during 2023-24.

608. In February 2023, NHS Digital merged with NHS England bringing the NHS' national data and technology expertise into one organisation. In March 2023 the Cyber Security strategy for health and social care: 2023 to 2030 was published; this provides a unified approach to engage organisations working in or with health and care in meeting its vision for a cyber resilient sector by 2030. It shapes a common purpose and language for tackling the most important cyber risks to the sector and informs our Cyber Futures programme.

609. The cyber security programmes are strengthening cyber resilience across health and care, ensuring organisations comply with relevant standards, protect patient data, and can respond effectively in the event of a cyber-attack. It has taken on increased significance with the swift digital transformation required to support recovery from the pandemic. In total, since 2016 over £338 million has been invested nationally to improve cyber security of the health and care system.

610. In 2022-23, under NHS England's Transformation Directorate, the Joint Cyber Unit (JCU) 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. 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.

611. £12 million of capital funding was allocated to NHS organisations in 2022-23. This has helped to address infrastructure weaknesses and increase overall cyber resilience. Integrated Care Boards worked with local organisations to identify priorities for available capital investment, ensuring the priorities were consistent with local plans for digital transformation.

612. Microsoft Defender for Endpoint™ is now deployed and provides central and local visibility of operating systems and applications across 1.7 million Microsoft desktop devices in the NHS estate. NHS England 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.

613. When critical cyber vulnerabilities are identified, the JCU works with NHS England to issue High Severity Alerts (HSA) to warn and inform NHS organisations what action they need to take. During the reporting year, we had 14 HSAs and have made significant improvements and enhancements to the alert process, improving the overall user experience.

614. 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. 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.

615. 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 2022-23, the number of adult social care providers completing the DSPT to at least Approaching Standards status rose by 14% to 57%.

616. The Cyber Associates Network now has over 2,500 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. Conferences, webinars, and an annual awards ceremony provided key opportunities for collaboration and celebrated innovation and digital expertise within cyber security across the NHS.

617. Incident planning continues to be an essential part of the programme to promote good backup and recovery capabilities so that organisations can plan how to get back online quickly if an attack hits. This year focused on dealing with live incidents

and performing post-incident reviews and launching lessons learned delivery. Exercising will resume in 2023-24.

618. Supply chain cyber security is a challenge across all sectors. In response to a ransomware attack on a third-party software supplier to the health and social care sector in 2022, work is ongoing to identify further critical suppliers in the NHS. This is based on a range of sources including gross commercial value of NHS contracts and broader market share in the system. We are now in the process of establishing a supplier working group to better facilitate ongoing communication and dialogue with industry. This will form part of a wider engagement plan to improve our visibility of supplier risk in the system.

EU, Trade, and the Union

619. During the year, the Department worked across government and with ALB delivery partners to deliver its EU, Trade, and the Union objectives:
    - Implementing the Trade and Cooperation Agreement, Withdrawal Agreement, and other international reciprocal healthcare arrangements, as well as brokering new arrangements to expand the Global Health Insurance Card.
    - Seizing the opportunities opened up by our exit from the EU to make the UK a life sciences superpower within the next ten years and support economic growth.
    - Supporting the Government's commitment to put the UK statute book on a sustainable footing, by considering whether to amend, repeal or replace retained EU Law to encourage growth and protect patient safety and public health.
    - 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.
    - Improving cost recovery for the NHS by providing oversight of, the Immigration Health Surcharge, charging overseas visitors for NHS care (or ensuring exemption from charge as appropriate) and the Injury Cost Recovery scheme.
    - 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.

620. The Department worked closely with the Foreign Commonwealth and Development Office to agree the medicines and medical devices elements of the Windsor Framework with the European Commission. The Framework provides for significant changes to arrangements for the supply of medicines to Northern Ireland, which are anticipated to come into effect in January 2025. These changes ensure that the same medicines in the same packs can be made available across the UK, and removes all EU Falsified Medicines Directive packaging, labelling and barcode requirements for medicines in Northern Ireland. Since the Framework was agreed, the Department has been working with MHRA and stakeholders on its implementation. There are also key changes in the framework that apply to all

medical goods, including medical devices, namely customs changes via the introduction of the new Green Lane model.

COVID-19 Inquiry

621. The UK Covid-19 Inquiry, set up under the Inquiries Act 2005, will examine the UK's preparedness and response to the COVID-19 Pandemic and to learn lessons for the future. In readiness for the opening of the Inquiry, DHSC secured both legal support and Counsel to represent the Department. We identified potential witnesses and set up e-Disclosure services to provide evidence and data to the Inquiry.

622. On 21 July 2022, Baroness Hallett, the Inquiry Chair, made an opening statement and launched the Inquiry's first module into the resilience and preparedness of the UK for a coronavirus pandemic. A further two modules were launched in 2022-2023 covering governance and decision-making by the UK Government and the impact of COVID-19 on healthcare systems.

623. DHSC is committed to responding to the Inquiry with openness and transparency. The Department is a core participant in the first three modules and has begun responding to written requests from the Inquiry for both corporate and individual witness statements to Modules 1 and 2.

Departmental Financial and Audit Governance and Quality Assurance

624. This section includes reviews and disclosures of areas relating to financial and audit governance and quality assurance in the Department.

Role of Internal Audit

625. 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).

626. 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.

627. The team operates in accordance with UK 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.

628. 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.

629. 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 Second Permanent Secretary, and they meet periodically to review lessons arising from Internal Audit.

Internal Audit Opinion

630. In providing an opinion of '**Moderate'** assurance on the adequacy of the framework of governance, risk management and control within the Department of Health and Social Care for 2022-23 the Head of Internal Audit observed that ''overall, there has been a very positive trajectory of travel towards a more robust framework, and I judge that sufficient progress has been made to place the Department on firmer foundations. The significant weaknesses which I have previously reported on have been suitably mitigated. Notwithstanding that, there

is still some work in train to complete the task and further reduce risk to the achievement of business objectives''.

631. On **Risk Management** the Head of Internal Audit considered that the Department has an adequate system and process in place acknowledging that it is developing and embedding its risk management approach. She reported that a recent audit of risk management effectiveness at directorate level, confirmed that there has been investment in developing risk maturity. Notably too the Department has introduced a structured approach to risk appetite. Following this assessment, the audit team judged that the Department had moved to the 'risk-defined' segment within the spectrum of the Institute of Internal Auditors risk maturity level and has demonstrated some elements of the 'risk managed' level which is a step change from the 2020-21 position. In the annual opinion report it was recorded that there is still however more work to do to ensure that the quality of risk management is consistent across the different business areas and in respect of cyber risk. Also, that further action is needed to foster a solid culture of great risk management across the organisation, in particular in terms of regular risk review and proactive horizon scanning.

632. On the **effectiveness of controls and compliance with required controls** the Head of Internal Audit reported that there has been a significant improvement in the control environment across finance, commercial and Human Resources. It was recorded that audits completed in year had generally resulted in a favourable balance of assurance opinions thereby demonstrating that control processes are being applied and that suitable supporting structures are in place (e.g., positive assurance had been given in respect of special payments, spending controls, compliance with the Functional Standards and an improved position regarding the offboarding of staff).

633. The opinion report recorded that considerable progress had been made towards delivering the aims of the Finance Transformation Programme. Key achievements noted included implementation of the Service Delivery Model to strengthen the governance structure within the Finance function, as well as the establishment of a library of financial policies and controls. The audit team acknowledged that, as a result, finance resources are being better utilised with effort focused in the right areas and that the finance teams and the wider organisation have a clearer understanding of the policies and processes to be followed. Overall, it was considered that much groundwork had been put in place, but further work was required in order to achieve all of the planned programme outcomes. The Head of Internal Audit observed that similar improvement work in the Commercial team aligned to the Government Commercial Function Continuous Improvement Framework is proving effective.

634. Internal audit work throughout the year has provided assurance that there are adequate governance structures and processes within the Department. The Head of internal Audit judged that there is a suitable governance framework in place

delivered through a traditional Board and Committee structure. She cited a few elements of governance which could be strengthened in the coming year including:

- Oversight arrangements for Arms' Length Bodies. The audit team had identified occasions where scrutiny could be further increased in order to provide the Principal Accounting Officer with assurance regarding compliance with key government requirements, to deliver greater efficiency or more effective outcomes. One key area was in respect of the UK Health Security Agency.
- The continued development and deployment of the Department's Assurance Framework so that this can be considered fully effective as a tool for the Accounting Officer and senior executives to gain confidence that key controls are in place and are operating effectively.

635. The analysis within the auditor's annual opinion report was based on completion of 25 audits, 17 (68%) of which received a positive assurance opinion (i.e., Substantial or Moderate) and 8 (32%) received a Limited Opinion. Areas for improvement which have not already been referenced include business continuity planning, data management and work to fully integrate staff into the Office for Health Improvement and Disparities.

National Audit Office and Public Accounts Committee

636. As the UK's independent public spending watchdog, the National Audit Office (NAO) both audits the accounts of Departments and their component bodies and, through 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.

637. **Table 24** provides a summary of the key reports published by the NAO in 2022-23, that reflect on activities of the Department.

Table 24: Key NAO reports

Title of significant NAO report	Date of publication
Managing cross-border travel during the COVID-19 pandemic	April 2022
Introducing Integrated Care Systems: joining up local services to improve health outcomes	October 2022
Managing NHS backlogs and waiting times in England	November 2022
Department of Health and Social Care Annual report and accounts 2021-22	January 2023
Progress in improving mental health services in England	February 2023
Alcohol treatment services	February 2023

638. 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.

639. The Department reports on the implementation status of the NAO's recommendations on a bi-annual basis. These are published by the NAO on their Recommendation Tracker

640. 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. In 2022-23, DHSC attended seven 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.

Limitation of Scope Qualification Regarding Inventory

641. The C&AG 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 due to an inadequacy of controls. This limitation of scope opinion also covered the completeness and accuracy of related transactions. The inventory primarily related to the PPE and NHS Test and Trace programmes.

642. The Department has made improvements to the control environment and coupled with the reduction in volumes held is now satisfied that it can meet its requirements to prepare financial statements which are accurate in all material respects.

643. The level of PPE and NHS Test and Trace inventory held by the Departmental Group at 31 March 2023 was £190 million (31 March 2022: £1,160 million). Whilst full stock takes were not able to be performed in all locations, the C&AG has not qualified the closing balance of consumables inventory in 2022-23 as the Department has provided alternative evidence over the valuation, existence and completeness of consumables inventory.

644. We recognise that there remains an immaterial level of uncertainty relating to the exact quantities of inventory held in respect of PPE due to the storage arrangements for this inventory. The vast majority of inventory which cannot be fully counted is earmarked for disposal and appropriately written down.

COVID-19 Impairments and losses

645. 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.

646. 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 2023 suggest that, based on current usage, not all will be used before their expiry dates.

647. 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.

648. In relation to the PPE programme impairments and onerous contract provisions were made in earlier financial periods in respect of inventory already received or included in non-cancellable contracts as at 31 March 2022. As such there has been a relatively small change in the level of impairment recognised in expenditure in 2022-23 for the PPE programme. The amount of expenditure recognised in 2022-23 was £219 million (2021-22: £57 million) as detailed in note 4.3 to the financial statements.

649. The Department also holds impairments and onerous contract provisions in respect of COVID-19 medicines and COVID-19 vaccines which are 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.

650. Further details regarding the various instances for which losses have been recognised in the 2022-23 accounts, can be found in the **Losses Statement** in the **Accountability Report**. Further detail regarding the various instances in which impairments have been recognised can be found in **Notes 4.3 and 12 of the Department's Notes to the Annual Report and Accounts**.

NHS Governance

651. The following narrative explores the Department's relationship with the NHS and key challenges faced during the financial year, followed by specifics regarding NHS Financial and Audit Governance.

The NHS

652. 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.

653. 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. A new NHS Mandate for 2023 was published on 15 June 2023. Other accountability mechanisms include regular reporting, particularly on priority issues and strategies, and regular conversations between the Department and NHS England at all levels to work together on delivering a comprehensive health service.

654. NHS England has responsibility for the commissioning of healthcare in England and, to invest its annual budget (of around £158.5 billion in 2023-24), with a view to bringing about measurable improvements in health outcomes for the population.

655. On 1 July 2022, the functions of NHS Improvement (Monitor and the NHS Trust Development Authority) were transferred to NHS England through the Health and Care Act 2022 and instruments made under it. On 1 February 2023, the functions of NHS Digital (the Health and Social Care Information Centre) were transferred to NHS England under the Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023, giving NHS England the responsibility to develop and operate national IT and data services that support clinicians at work, help patients get the best care, and use data to improve treatment.

656. NHSE reports performance to the Secretary of State against each objective in the mandate. The Secretary of State has a legal duty to, having considered NHS England's annual report for a given financial year, set out in a letter to NHS England their assessment of NHS England's performance of its functions for the financial year in question. The recent annual assessments are expected to be published in Spring 2024.

657. Integrated Care Boards, NHS Trusts and NHS Foundation Trusts are all required to operate risk management procedures. For Integrated Care Boards, 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.

658. For NHS Trusts the processes were previously set by NHS Improvement 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.

659. The current assurance and accountability process provides Ministers with several legislative and non-legislative mechanisms for holding NHSE to account. The Framework Document for NHSE will set out the assurance process, roles, and responsibilities of the Department and NHSE by which accountability will be achieved.

Inquiries and Reviews

660. The Department currently oversees a range of inquiries and investigations, which are discussed further below. As of December 2023, DHSC is sponsoring two independent statutory public inquiries: the Lampard Inquiry (formerly the Essex Mental Health Inquiry) and the Thirlwall Inquiry into the Countess of Chester Hospital. DHSC also sponsors the Fuller Inquiry which published its phase one report in December 2023, the Department will be issuing a response in Spring 2024. NHS England commissions investigations, which can generate recommendations for DHSC as well as the wider health and care system. Of particular note are the East Kent Maternity Investigation which published in October 2022, and the continuing investigation into maternity services at the Nottingham University Hospital Trust.

661. The Department has also responded to requests from the independent public statutory inquiry into infected blood. This inquiry is sponsored by the Cabinet Office and is expected to report in spring 2024.

662. The Health Services Safety Investigations Body (HSSIB) was established in October 2023 under the Health and Care Act 2022, it will be an important focus for future patient safety-related investigations to share learning across the NHS and the Independent Sector. It is launching a series of national investigations into mental health inpatient settings as one of its first priorities. Since October 2023 the CQC hosts the Maternity and Newborn Safety Investigation Programme, under a direction from the Secretary of State.

Lampard Inquiry (formerly the Essex Mental Health Independent Inquiry)

663. 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. This has inquiry has now been converted to a statutory inquiry and is chaired by Baroness Lampard. The inquiry has consulted on its Terms of Reference which will be announced in due course.

Lucy Letby Inquiry (The Thirlwall Inquiry)

664. Following the guilty verdict in the trial of former neonatal nurse Lucy Letby, the Secretary of State announced a statutory inquiry on 4 September 2023.

665. The inquiry, chaired by Lady Justice Thirlwall and known as the Thirlwall inquiry, will investigate the wider circumstances of what happened at the Countess of Chester Hospital, including the handling of concerns and governance. It will also look at what actions were taken by regulators and the NHS and the NHS culture. The Terms of Reference for the Inquiry were published on 19 October 2023. On 22 November 2023, the Chair made an opening statement formally launching the Inquiry.

666. The Inquiry Chair will provide a final report (and if appropriate, interim reports) to the Secretary of State as soon as is practically possible. She will make recommendations as she considers appropriate.

Maidstone & Tunbridge Wells NHS Trust: David Fuller

667. In November 2021, an independent inquiry was established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in mortuaries at the Maidstone and Tunbridge Wells NHS Trust.

668. The Inquiry is split into two phases:
Phase 1 – an initial report on matters relating to Maidstone and Tunbridge Wells NHS Trust.
Phase 2 – a final report looking at the broader national picture and the wider lessons for the NHS and other settings, due at the end of 2024.

669. The phase 1 report, published on 28 November 2023, contains vivid testimony from families of the victims and identifies failures of management, governance, regulation and process and a persistent lack of 'curiosity' which all contributed to an environment in which Fuller could offend unnoticed and unchecked.

670. There will be a full response to the report's recommendations in spring 2024. The NHS is committed to ensuring that lessons are learned across the wider NHS so that no family has to go through this experience again.

East Kent University NHS Foundation Trust Maternity and Neonatal Services

671. Following concerns raised about the quality and outcomes of maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust, in February 2020, NHSE and NHSI commissioned Dr Bill Kirkup to undertake the East Kent Maternity Independent Investigation. The final report of the investigation was published on 19 October 2022 'Maternity and neonatal services in East Kent: 'Reading the signals' report'.

672. The Government published an initial response March on 7 March 2023 and a fuller response in July 2023. This sets out the planned government action around the recommendations. To support the implementation of these recommendations the Government has established the Maternity and Neonatal New Actions Forum Chaired by Bill Kirkup, and the Ministerially Chaired Regional Oversight Forum.

Ockenden Reviews of Maternity Services at Nottingham University Hospitals NHS Trust

673. In May 2022, NHS England appointed Donna Ockenden to lead a further review of NHS maternity units at Nottingham University Hospitals NHS Trust. The terms of reference were published in September 2022 and the review is expected to conclude in 2024.

Infected Blood Inquiry

674. The Infected Blood Inquiry held its final hearings in July 2023 regarding the Government's response to the use of infected blood and blood products and the question of compensation. The Inquiry has since announced a delay to report publication, which is now expected in March 2024. The Cabinet Office remains the sponsor Department for the Inquiry.

675. On 29 July 2022 the Inquiry published its first interim report and in August 2022, the Government accepted the Inquiry's recommendation that interim compensation payments be made to those infected and bereaved partners currently registered on UK infected blood support schemes. Payments of £100,000 were made to eligible beneficiaries by 28 October 2022, meeting the Government's commitment on timing.

676. In 2021, the Cabinet Office commissioned Sir Robert Francis KC to conduct a study looking at the options for a framework for compensation, should the recommendations of the Inquiry lead to this. On 3 February 2023, the Inquiry published a second interim report that agreed these proposals. The Cabinet Office is progressing work in consideration of the Government's future response to these recommendations.

Maternity and Newborn Safety Investigations

677. 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. On 30 March 2023 the Minister for Mental Health and Women's Health Strategy announced that the maternity investigations programme function would be transferred to be hosted by CQC from October 2023. This transfer of function took place on 1st October. The purposes of the maternity investigation programme remain the same: to provide independent, standardised and family focused investigations of maternity cases for families; to provide learning to the health system via reports at local, regional and national level; analyse data to identify key trends and provide system wide learning; be a system expert in standards for maternity investigations; and collaborate with system partners to escalate safety concerns.

Grenfell

678. NHSE has continued to support the implementation of remedial measures to improve the safety of properties where appropriate. 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.

679. Out of eight Trusts identified as needing remedial work, only one Trust (Guy's and St Thomas NHS Foundation Trust) had remediation work ongoing as at 31 March 2023, with remediation work in all the other Trusts completed.

Independent Medicines and Medical Devices Safety Review

680. Last winter, just over a year after our response to the Independent Medicines and Medical Devices Safety (IMMDS) Review the Government published an Implementation Update Report, setting out our commitment to improving patient safety and improving how the health and care system listens to patients.

681. We have made good progress to implement the Government's response to the Review. We have worked with colleagues in MHRA to deliver stronger regulatory measures to reduce the number of pregnancies exposed to sodium valproate. We continue to work alongside NHSE to monitor the effectiveness of the nine specialist mesh centres across England.

682. In January 2023, the Health and Social Care Committee published Follow-up on the IMMDS report and the Government's response, the Government's response was published on 24th April 2023. Overall, we can report good or very good progress across almost all actions.

Reinforced Autoclaved Aerated Concrete (RAAC)

683. The NHS has been surveying sites and undertaking RAAC mitigation work since 2019 and has had an active national remediation programme since 2021 to mitigate and monitor the risks posed by RAAC across the NHS estate.

684. NHSE has issued guidance for trusts nationally on how to establish the presence of RAAC in their estate. There is ongoing engagement with trusts on a national and regional level to ensure RAAC is identified across the NHS estate. If the presence of RAAC is confirmed, trusts join the national RAAC remediation programme.

685. In most identified cases, RAAC has been found in limited parts of a hospital site or an individual building. However, 7 hospitals need a full replacement and will be rebuilt through the New Hospital Programme (NHP) before 2030.

NHS Financial and Audit Governance

Financial Risk and Sustainability in the NHS

686. Returning the NHS to financial stability, alongside the wider ambitions of the LTP remain a government priority. However, with a greater emphasis on supporting recovery, and improving productivity and efficiency in the NHS, previous plans for delivery have been adjusted to account for this shift in focus. These changes have subsequently been reflected in the 2022 Autumn statement.

687. We continue to work with HM Treasury and NHSE to improve our governance and reporting approach to better monitor progress on these priorities as they remain crucial for the delivery of financial sustainability within the NHS.

688. 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 as set out in the NHS mandate.

689. Our monthly Finance sponsorship and accountability Board (FSAB) with NHSE (that supersedes the previous cross system finance board following the merger of 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 the organisations to review financial risks, discuss financial issues and support collective decision making where needed.

690. Furthermore, our monthly ministerial led financial accountability arrangements have been strengthened with improved support arrangements. This has allowed for better ministerial oversight and engagement with NHSE leadership to the scrutinise the overall NHS financial position and monitor progress of systems.

691. Work has also carried on with the Department's financial reset programme, where particular attention has been paid in the development of the governance, assurance, and transparency oversight processes for the NHS to enable the Department to have better information on the NHS financial management and control environment.

692. There has been significant improvement in reporting arrangements and the production of the monthly finance MI pack that informs the discussions throughout our monthly reporting cycle, including the FSAB.

693. Additionally, the development of the more detailed overview of NHS budgets has been used for planning and reprioritisation discussions has increased visibility of the budgetary position.

694. A greater focus on emerging risks and the return to risk adjusted forecasts has also helped provide additional insight into the challenges of the in-year financial position and mitigation strategies being employed to manage these. This has resulted in

greater insight and collaboration in the management of the position at our monthly discussions (that has fed into the gathering of evidence for the supplementary estimates process and reserves requests).

695. Work also continues in strengthening assurance and we have introduced an annual finance assurance assessment that now aligns with HM treasury's annual assessment process and better informs departmental assessments of NHS performance.

696. Ongoing work to revise the spending approval processes with HM Treasury to better support the NHS to deliver continues. We have established approval pipelines with HMT and NHSE to better monitor, manage and track new policy proposals and we are working with HMT and NHSE to review the frameworks of authority to further manage and improve the workflow between the three organisations and support greater compliance.

697. These changes have mainly been possible due to an improvement in collaboration between the organisations, resulting in a clearer understanding of the challenges and goals we collectively face that has helped to better inform decision making.

University Hospitals of Leicester NHS Trust

698. University Hospitals of Leicester NHS Trust has now published all its outstanding ARAs including 2022-23.

699. The 2022-23 audit identified fewer and more isolated misstatements than previously. However, the Trust's external auditors qualified their audit opinion in relation to the existence and valuation of fixed assets under construction.

700. 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.

Overpayments to Medical Practitioners

701. 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.

702. The ARA for 2021-22 referred to overpayments of suspension payments to certain medical practitioners amounting to £964,000, relating to 2 cases. During the 2022-23 reporting period, NHS England identified suspension payments to a further 12 (two of which have been recovered) medical practitioners which resulted in overpayments totalling £1.3 million. Some of these occurred where circumstances had changed, and the practitioner was no longer eligible but continued to receive payments, and also where incorrect amounts were calculated due to incorrect application of the guidance.

703. The NHS England Group Annual Report and Accounts has again received 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 in either year.

704. To ensure the issue was contained, NHS England commissioned a review of all suspension payments by internal audit to ensure that NHS England understood the full scope of any problems.

705. To strengthen the controls on this NHS England is implementing changes to how these payments are administered and suspensions are monitored to ensure a standardised approach. This will avoid variability in judgements around applying the guidance with improved oversight from the Professional Standards national team.

706. NHS England is seeking to recover all overpayments subject to legal advice.

ERF (Elective Recovery Fund) Irregular Spending

707. The NAO has concluded that some of the Department's spend in 2022-23 was irregular on the basis that the spend did not comply with HM Treasury's 'ring-fence' conditions associated with the additional ERF funding provided in that year. Despite there being delegations in place from DHSC to NHSE, the NAO concluded that the framework of authorities in place did not sufficiently pass those conditions onto NHSE and have therefore concluded that this irregularity should apply in DHSC's accounts only, resulting in a regularity qualification.

708. Following this, the Department has now set up a monthly Elective Oversight Board between DHSC, HMT and NHSE that oversees the ERF policy and adherence with that. In addition, the delegations in place with Arm's Length Bodies (ALBs) will be more explicit outlining their requirement to comply with HM Treasury conditions attached to such funding arrangements.

Remuneration and Staff Report

Remuneration Report

709. 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 EPN649 guidance.

710. 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.

711. 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.

712. 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 2022-23

- Sajid Javid MP resigned as Secretary of State for Health and Social Care on 5th July 2022.
- Steve Barclay MP was appointed as Secretary of State for Health and Social Care on 5th July 2022 and resigned on 5th September 2022. He was then reappointed as Secretary of State for Health and Social Care on 25th October 2022 and resigned on 12th November 2023.
- Thérèse Coffey MP was appointed as Secretary of State for Health and Social Care on 6th September 2022 and resigned on 24th October 2022.
- Edward Argar MP resigned as Minister of State on 6th July 2022.
- Gillian Keegan MP resigned as Minister of State on 8th September 2022.
- Robert Jenrick MP was appointed as Minister of State on 7th September 2022 and resigned on 24th October 2022.
- Caroline Johnson MP was appointed as Minister of State on 8th September 2022 and resigned on 26th October 2022.
- William Quince MP was appointed as Minister of State on 7th September 2022 and resigned on 12th November 2023.
- Helen Whately MP was appointed to Minister of State on 26th October 2022.

- Maggie Throup MP resigned as Parliamentary Under Secretary of State (Minister for Vaccines and Public Health) on 7th September 2022.
- Maria Caulfield MP resigned as Minister of State on 7th September 2022 and was reappointed as Parliamentary Under Secretary of State (Minister for Women) on 27th October 2022.
- James Morris MP was appointed as Parliamentary Under Secretary of State (Minister for Primary Care and Patient Safety) on 8th July 2022 and resigned on 7th September 2022.
- Neil O'Brien MP was appointed as Parliamentary Under Secretary of State (Minister for Primary Care and Public Health) from 8th September 2022 and resigned on 12th November 2023.
- Lord Markham CBE was appointed as Parliamentary Under Secretary of State (Minister for the Lords) from 22nd September 2022.
- Lord Kamall resigned as Parliamentary Under Secretary of State (Minister for Technology, Innovation and Life Sciences) on 19th September 2022.
- Victoria Atkins MP was appointed as Secretary of State for Health and Social Care on 13th November 2023.
- Andrew Stephenson MP was appointed as Minister of State on 13th November 2023.
- Andrea Leadsom MP was appointed as Parliamentary Under Secretary of State on 13th November 2023.

Remuneration of Senior Officials and Ministers

713. 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 26**, with Ministers in **Table 25**.

Salary

714. '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.

715. 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.

716. 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 25**.

717. 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.

Non-Consolidated Performance Pay

718. 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.

719. 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.

720. The non-consolidated performance pay included in the 2022-23 figures relates to awards made in respect of the 2021-22 performance year but paid in the 2022-23 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

721. 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 2022-23 by Ministers or Senior Officials of the Department.

722. **Tables 25** and **26** provide details of remuneration interests of the Ministers of the Department and senior officials serving on the Departmental Board for the years 2021-22 and 2022-23 and are subject to audit.

Table 25: Remuneration of Ministers of the Department (subject to audit)

	2022-2023				2021-2022			
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)
Steve Barclay MP *(05/07/2022 - 05/09/2022, 25/10/2022 - 12/11/202*	49,836	-	10,000	60,000	-	-	-	-
Secretary of State								
Full Year Equivalent	67,505							
Thérèse Coffey MP (06/09*/2022 - 24/10/2022)*	5,625	-	3,000	9,000	-	-	-	-
Secretary of State								
Full Year Equivalent	67,505							
Sajid Javid MP *(from 27/06/2021 to 05/07/2022)*	34,660	-	4,000	39,000	51,379	-	13,000	64,000
Secretary of State								
Full Year Equivalent	67,505				67,505			
Edward Argar MP *(to 06/07/2022)*	16,351	-	2,000	18,000	31,680	-	8,000	40,000
Minister of State								
Full Year Equivalent	31,680							
Gillian Keegan MP *(from 16/09/2021 to 08/09/2022)*	15,840	-	3,000	19,000	16,228	-	4,000	20,000
Minister of State								
Full Year Equivalent	31,680				31,680			
Robert Jenrick MP *(07/09/2022 - 24/10/2022)*	5,348	-	1,000	7,000	-	-	-	-
Minister of State								
Full Year Equivalent	31,680							
Caroline Johnson MP *(08/09/2022 - 26/10/2022)*	9,384	-	1,000	10,000	-	-	-	-
Minister of State								
Full Year Equivalent	22,375							
William Quince MP *(from 07/09/2022 - 12/11/2023)*	15,840	-	5,000	21,000	-	-	-	-
Minister of State								
Full Year Equivalent	31,680							
Helen Whately MP *(to 15/09/2021, 26/10/2022 - date)*	13,711	-	3,000	17,000	15,840	-	4,000	20,000
Minister of State								
Full Year Equivalent	31,680				31,680			
Maggie Throup MP *(from 16/09/2021 to 07/09/2022)*	15,351	-	2,000	18,000	11,373	-	3,000	14,000
Parliamentary Under Secretary of State								
Full Year Equivalent	22,375				22,375			
Maria Caulfield MP[2] *(from 17/09/2021 to 06/09/2022, 27/10/2022 - date)*	28,795	-	6,000	35,000	11,361	-	3,000	14,000
Parliamentary Under Secretary of State, Minister of State, Parliamentary Under Secretary of State (current)								
Full Year Equivalent (current)	22,375				22,375			
James Morris MP *(08/07/2022 - 07/09/22)*	8,180	-	1,000	9,000	-	-	-	-
Parliamentary Under Secretary of State								
Full Year Equivalent	22,375							
Neil O'Brien MP (from 08/09/2022 - 12/11/2023)	12,617	-	3,000	16,000	-	-	-	-
Parliamentary Under Secretary of State								
Full Year Equivalent	22,375							
Lord Markham CBE[3] (from 22/09/2022)	-	-	-	-	-	-	-	-
Parliamentary Under Secretary of State								
Full Year Equivalent	-	-	-	-				
Lord Kamall (from 17/09/2021 to 19/09/2022)	35,484		9,000	45,000	38,244	-	9,000	47,000
Parliamentary Under Secretary of State								
Full Year Equivalent	70,969				70,969			
Matt Hancock MP *(from 10/07/2018 - 26/06/2021)*	-	-	-	-	16,126	-	4,000	20,000
Secretary of State								
Full Year Equivalent					67,505			
Nadine Dorries MP *(from 27/07/2019 - 14/09/2021)*	-	-	-	-	15,840	-	3,000	19,000
Minister of State								
Full Year Equivalent					31,680			
Jo Churchill MP *(from 26/07/2019 - 15/09/2021)*	-	-	-	-	11,187	-	3,000	14,000
Parliamentary Under Secretary of State								
Full Year Equivalent					22,375			
Lord Bethell of Romford[4] *(from 09/03/2020 - 15/09/2021)*	-	-	-	-	-	-	-	-
Parliamentary Under Secretary of State (Lords)								
Nadhim Zahawi MP[5] *(from 28/11/2020 - 14/09/2021)*	-	-	-	-	-	-	-	-
Parliamentary Under Secretary of State								
Full Year Equivalent								

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. Figures include any Severance payment/Compensation in lieu of notice payment received by Ministers.
2. Maria Caulfield's salary exceeds the full-year equivalent salary because the figures include a severance payment of £7,920 for the 2022-23 year.
3. Lord Markham's role as parliamentary Under Secretary of State was unpaid.

4. Lord Bethell's roles as Parliamentary Under Secretary of State (Lords) was unpaid.
5. The Parliamentary Under Secretary of State (Minister for COVID-19 Vaccine Deployment) was not paid for this role.

Table 26: Remuneration of Senior Officials of the Department (subject to audit)

	2022-2023					2021-2022				
Officials	Salary (£'000)	Non Consolidated Performance Related Pay (£'000)[1]	Gross Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1000)[2,3]	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	180-185	-	-	6,000	185-190	175-180	15-20	-	46,000	240-245
Shona Dunn *(from 01/04/21)* Second Permanent Secretary	160-165	-	-	(26,000)	130-135	155-160	-	-	36,000	190-195
Professor Sir Chris Whitty[4] Chief Medical Officer for England	205-210	-	-	31,000	240-245	205-210	-	-	30,000	235-240
Clara Swinson CB Director General Global Health	135-140	5-10	-	(11,000)	130-135	130-135	5-10	-	32,000	170-175
Jonathan Marron Director General Office for Health Improvement and Disparities	130-135	-	-	46,000	180 - 185	130-135	5-10	-	54,000	190-195
Matthew Style[5] *(from 01/11/2021)* Director General NHS Policy and Performance	150-155	-	-	304,000	450-455	60-65 140-145	-	-	(27,000)	30-35
Michelle Dyson[6] Director General Adult Social Care	130-135	-	-	17,000	145-150	120-125 125-130	-	-	60,000	180-185
Andy Brittain *(from 05/04/21)* Director General, Finance	130-135	-	-	(28,000)	100-105	125-130 125-130	-	-	34,000	155-160
Steve Oldfield[7] *(to 17/10/22)* **(career break 04/01/22 - 18/07/22)** Chief Commercial Officer Full Year Equivalent	55 - 60 235 - 240	30 - 35	-	5,000	90 - 95	180-185 235-240	40-45	-	5,000	225-230
Matthew Gould[8] *(to 30/09/2022)* Chief Executive Officer, NHSX Full Year Equivalent	60 - 65 125-130	-	-	9,000	70 - 75	25-30 125-130	-	-	5,200	30-35
Lucy Chappell *(from 01/08/2021)*[9] Chief Scientific Adviser	110-115			22,000	130-135	70-75 140-145	-	-	9,100	80-85
Jenny Richardson Director of Human Resources	110-115	5-10	-	9,000	125-130	105-110	5-10	-	27,000	140-145
Hugh Harris[10] Director Ministers, Accountability and Strategy	95-100	5-10	-	9,000	110-115	95-100 105-110	-	-	25,000	120-125
Lorraine Jackson *(from 17/06/2021)* Director of Information Risk Management and Assurance	95-100	0-5	-	(1,000)	95-100	70-75 90-95	-	-	15,000	85-90
David Williams CB *(to 05/04/2021)* Second Permanent Secretary Full Year Equivalent	-	-	-	-	-	0-5 155-160	-	-	-	0-5
Lee McDonough *(to 06/06/2021)* Director General NHS Policy and Performance Full Year Equivalent	-	-	-	-	-	20-25 130-135	-	-	2,000	25-30

1. Non-Consolidated Performance Pay paid in 2022-23 relates to the 2021-22 performance year.
2. The value of pension benefits accrued during the year is calculated as: (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to a transfer of pension rights.
3. Where final salary members have transitioned to the alpha pension scheme, the final salary pension of a person in employment is calculated by reference to their pay and length of service. The pension will increase each year 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 which can result in negative values.
4. Professor Sir Chris Whitty holds a defined contribution pension, so the figures shown represent the Department's contribution to this scheme. No other pension figures are included.
5. Matthew Style has had a retrospective update to service history which has impacted on their pension benefits for this year.
6. Michelle Dyson received pay arrears in January 2023 following an underpayment of salary in 2021-22 due to an administrative error.
7. Steve Oldfield was on career break from 4 January 2022 until 18 July 2022.

8. 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 2021-22 NHSE reimbursed DHSC for 80% of Matthew Gould's costs. As such DHSC show only 20% of pay and pension details with NHSE disclosing the remaining 80% for 2021-22.
9. Professor Lucy Chappell was appointed on 01/08/2021 on secondment from Kings College, London, for 4 days a week. 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.
10. Hugh Harris salary is less than the full-time equivalent figure due to working part-time.

Fair Pay Disclosure (Subject to audit)

723. 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 27**.

Table 27: Pay Ratios for Core Department and Executive Agencies

	Core Department		Department & Executive Agencies	
	2022-2023	2021-2022	2022-2023	2021-2022
25th Percentile Pay Ratio	5.8:1	6.3:1	6.2:1	6.9:1
Median Pay Ratio	4:1	4.5:1	4.8:1	5.2:1
75th Percentile Pay Ratio	3.6:1	3.7:1	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 now consolidated within the Department's ARA and therefore is only included in determining the median earnings calculation for 2022-23.

724. **Table 28** shows the total remuneration and salary element of each of the quartiles.

Table 28: Total Remuneration and Salary Element for Core Department and Executive Agencies

	Core Department 2022-2023	Department & Executive Agencies 2022-2023
25th Percentile Total Remuneration (salary element)	35,899 (34,192)	33,681 (33,681)
Median Total Remuneration (salary element)	51,329 (49,529)	42,846 (41,946)
75th Percentile Total Remuneration (salary element)	58,368 (58,366)	56,389 (54,689)

1. The Medicines and Healthcare Products Regulatory Agency is now consolidated within the Department's ARA and therefore is only included in determining the median earnings calculation for 2022-23.
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.

725. The median earning of the Core Department has increased in 2022-23 by 11.5%, or £5,283, compared to 2021-22 where the increase of median earnings was £4,448. Core Department staff, not including the highest-paid director, had an average 5.3% increase in pay and benefits. See **Table 29**.

726. The increase in median earnings of the core Department can be attributed to changes in the composition of the workforce in 2022-23, such as grade distribution and implementation of the 2022-23 pay award (in line with Civil Service Pay Guidance). This increase is consistent with the pay, reward, and progression policies for the core Department.

Table 29: Percentage Change in Remuneration from 2021-22

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 2021-22	0.0%	5.3%	0.0%	7.8%
Salary and Allowances	0.0%	4.3%	NA	NA
Bonus	0.0%	154.5%	NA	NA

727. The banded remuneration of the highest paid Director also remained the same at £205,000-£210,000 (see **Table 30**). Banded remuneration for the Core Department staff increased, ranging between £20,000-£25,000 and £225,000-£230,000 compared to the 2021-22 range between £15,000-£20,000 and £220,000-£225,000.

Table 30: Banded Remuneration Range for Core Department and Executive Agencies

	Core Department		Department & Executive Agencies	
	2022-2023	2021-2022	2022-2023	2021-2022
Band of Highest Paid Director's Total remuneration (£000)[1]	205-210	205-210	205-210	205-210
Band of Lowest Paid	20-25	15-20	15-20	15-20

1. Salaries for senior management disclosed in bands of £5,000, in accordance with EPN679 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.

728. In 2022-23, similar to 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. This resulted in an increase in the salary, moving to the £225,000-£230,000 range compared to £220,000-£225,000 in 2021-22.

Civil Service Pensions

729. 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.

730. 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).

731. 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 in 2.32%. In all cases members may opt to give up (commute) pension for a lump sum up to the limits set by the Finance Act 2004.

732. 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).

733. 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).

734. Further details about the Civil Service pension arrangements can be found at the website.

Ministerial Pensions

735. 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.

736. 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.

737. 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.

738. The figure shown for pension value includes the total pension payable to the member under both the pre- and post-2015 Ministerial pension schemes.

739. **Tables 31** and **32** provide details of the pension interests for the Department's Officials and Ministers for 2021-22 and 2022-23 and are subject to audit.

Cash Equivalent Transfer Values

740. 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.

741. 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

742. 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.

743. 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 31: Pension Interests of Ministers (subject to audit)

	Accrued pension at age 65 as at 31/03/23	Real increase in pension at age 65	CETV at 31/03/23[2]	CETV at 31/03/22	Real increase in CETV
Steve Barclay MP[4]					
05/07/2022 - 05/09/2022	5-10	0-2.5	69	66	1
25/10/2022 - date	5-10	0-2.5	80	70	3
Thérèse Coffey MP	0-5	0-2.5	60	56	2
Sajid Javid MP	10-15	0-2.5	158	150	2
Edward Argar MP	0-5	0-2.5	19	17	1
Gillian Keegan MP	0-5	0-2.5	17	13	2
Robert Jenrick MP	0-5	0-2.5	35	34	0
Caroline Johnson MP	0-5	0-2.5	1	0	0
William Quince MP	0-5	0-2.5	19	14	1
Helen Whately MP	0-5	0-2.5	22	18	1
Maggie Throup MP	0-5	0-2.5	18	15	2
Maria Caulfield MP[5]					
17/09/2021 - 06/09/2022	0-5	0-2.5	13	10	1
27/10/2022 - date	0-5	0-2.5	16	13	1
James Morris MP	0-5	0-2.5	15	14	1
Neil O'Brien MP	0-5	0-2.5	6	3	1
Lord Markham CBE	-	-	-	-	-
Lord Kamall	0-5	0-2.5	19	9	6

1. The figures given are based solely on the individual benefits as a Minister and will not reflect any pension in respect of their MP salary.
2 The superannuation contributions adjusted for part experience (SCAPE) rate is being changed. This will impact the CETV figures in this table and is expected to result in higher CETV-related values once the revised factors have been produced.
3. 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.
4 The figures provided reflect the two periods within the department during the year.
5 The figures provided reflect the two periods within the department during the year.

Table 32: Pension Information of Senior Officials of the Department (subject to audit)

		Accrued pension at pension age as at 31/03/23 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/03/23	CETV at 31/03/22	Real increase in CETV	Employer contribution to partnership pension account Nearest £100	Employer contribution to external pension scheme Nearest £100
Sir Christopher Wormald KCB	Permanent Secretary	100-105	0-2.5	1,712	1,548	(19)	-	-
Shona Dunn	Second Permanent Secretary	65-70 plus a lump sum of 110-115	(2.5)-0 plus a lump sum of (12.5)-(10)	1,148	1,068	(45)	-	-
Professor Sir Chris Whitty[2]	Chief Medical Officer for England	-	-	-	-	-	30,900	-
Clara Swinson CB	Director General for Global Health	50-55 plus a lump sum of 80-85	0-2.5 with a lump sum of (10) - (7.5)	759	702	(25)	-	-
Jonathan Marron	Director General for Office for Health Improvement and Disparities	25-30	2.5-5	373	319	22	-	-
Matthew Style	Director General NHS Policy and Performance	40-45	15-17.5	582	329	204	-	-
Michelle Dyson	Director General for Adult Social Care	40-45 plus a lump sum of 75-80	0-2.5 plus a lump sum of (5)-(2.5)	746	668	(1)	-	-
Andy Brittain	Director General Finance	50 - 55 plus a lump sum of 100 - 105	(2.5) -0 plus a lump sum of (12.5) - (10)	955	889	(42)	-	-
Steve Oldfield	Chief Commercial Officer	-	-	-	-	-	5,300	-
Matthew Gould	Chief Executive Officer, NHSX	65-70	0-2.5	1,046	975	-	-	-
Lucy Chappell[3]	Chief Scientific Advisor	-	-	-	-	-	-	21,700
Jenny Richardson	Director of Human Resources	40-45	0-2.5	565	511	(7)	-	-
Hugh Harris	Director of Ministers, Accountability and Strategy	40-45	0-2.5	560	508	(5)	-	-
Lorraine Jackson	Director of Information, Risk Management and Assurance	40-45	0-2.5	713	650	(13)	-	-

1. Where the real increase in CETV is disclosed as a negative figure this means that, taking account of inflation, the CETV funder by the employer has decreased in real terms.
2. Professor Sir Chris Whitty holds a defined contribution pension therefore figures shown represent the Department's contribution to this scheme. No other pension figures are included.
3. Lucy Chappell is on secondment and the Department is contributing to her pension scheme with Kings College, London which is include in the figures shown. No other pension figures are included due to the secondment status.

Non-Executive Directors

744. Non-Executive Directors (see **Table 33**) 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.

745. The Departmental Board holds positions for six Non-Executive Directors. The Non-Executive Directors sitting on the Departmental Board during 2022-23 are detailed in the Directors' Report. There are also three independent members of Audit & Risk Committee.

746. 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. NEDs have been able to attend all the Boards we would expect from a governance perspective despite carrying vacancies. The main improvement since filling these roles is the challenge, as even more perspective and areas of expertise now attend the Board.

Table 33: Non-Executive Directors and Members of the Department (subject to audit)

			2022-2023		2021-2022	
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[1]	Non-Executive Board Member & Lead Non-Executive	1 Oct 2017 - 30 Sep 2023	22,000	20,000	20,000	20,000
Julian Hartley	Non-Executive Board Member	1 Nov 2021 - 10 Nov 2022	9,000	15,000	6,000	15,000
Gina Coladangelo	Non-Executive Board Member	1 Sep 2020 - 26 June 2021	-	-	4,000	15,000
Doug Gurr	Non-Executive Board Member	1 Dec 2020 - 30 Nov 2023	15,000	15,000	15,000	15,000
Samantha Jones[2]	Non-Executive Board Member	14 Feb 2023 - 13 Feb 2026	-	15,000	-	-
Anne Barnard	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2025	5,000	5,000	5,000	5,000
Graham Clarke	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2025	5,000	5,000	5,000	5,000
Richard Hornby	Independent Member of Audit & Risk Committee	1 Jan 2020 - 31 Dec 2024		Non-remunerated Civil Servant		Non-remunerated Civil Servant

1. Kate Lampard received additional fees for Covid-19 inquiry unit prep work on top of her NED time commitment.
2. Samantha Jones will receive £15,000 (to nearest £1,000) per annum from 14 Feb 2023, after undergoing pre-employment checks.

Compensation for Loss of Office (subject to audit)

747. 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.

748. The Department paid severance payments to the following Ministers in the 2022-23 financial year[10]:
- Sajid Javid (Secretary of State) received a severance payment of £16,876.
- Steve Barclay (Secretary of State) received a severance payment of £16,876 and returned this in full to the Department.
- Edward Argar (Minister of State) received a severance payment of £7,920 and returned this in full to the Department.
- Maria Caulfield (Minister of State) received a severance payment of £7,920.
- Caroline Johnson (Minister of State) received a severance payment of £5,593.
- Maggie Throup (Parliamentary Under Secretary of State) received a severance payment of £5,593.
- James Morris (Parliamentary Under Secretary of State) received a severance payment of £5,593.

[10] In line with the Constitutional Reform and Governance Act 2010 and the Model Contract for Special Advisers, a Special Adviser's appointment automatically ends when their appointing Minister leaves office. Special Advisers are not entitled to a notice period but receive contractual termination benefits to compensate for this. Termination benefits are based on length of service and capped at six months' salary. If a Special Adviser returns to work for HM Government following the receipt of a severance payment, the payment is required to be repaid, less a deduction in lieu of wages for the period until their return. Termination costs for Special Advisers are reported in the Cabinet Office Annual Report and Accounts

Staff Report

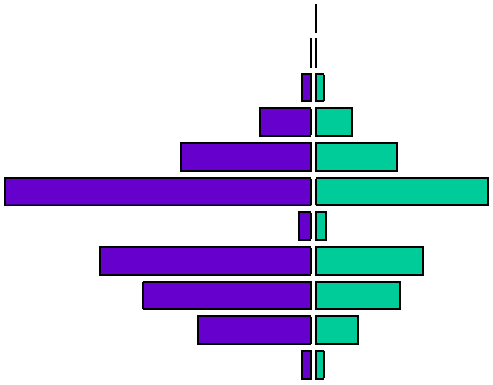
749. This Staff Report summarises the Core Department's key staffing information and policies, with the staff costs, numbers and exit packages disclosures subject to audit.

750. The Core Department employed an average of 3,176 permanent whole time equivalent (WTE) persons during 2022-23 at a total salaries and wages cost of £168.5 million, compared to 3,275 at a cost of £186.3 million in 2021-22. 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 39** and **40**.

DHSC Staff

751. The Department's staff grading structure is as follows; 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 37** outlines the headcount and gender distribution of Core Departmental staff in post at 31 March 2023 and is consistent with Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment with the Department.

Figure 37: Gender Distribution of Core Department Staff (Headcount)



Grade	Female	Male	Total
Perm Sec	1	2	3
SCS 3	2	3	5
SCS 2	25	19	44
SCS 1	121	87	208
GRADE 6	306	191	497
GRADE 7	712	402	1114
FAST ST	30	27	57
SEO	491	252	743
HEO	391	198	589
EO	264	101	365
AO	25	20	45
	2,368	**1,302**	**3,670**

Staff Sickness

752. The Core Department has seen an increase in the number of days lost to short-term sickness, rising from 2,821 in the rolling calendar year up to 31 December 2021 to 5,180 up to 31 December 2022. There has also been a rise in days lost to long-term sickness reported over the same period, from 4,273 to 8,485. This increase can be attributed to part of Public Health England (PHE) merging into the Core Department, an increase in the reporting of sickness absence and an overall increase in employee sickness. Over the same rolling calendar year up to 31 December 2022, the average number of working days lost stands at 3.8, an increase from 2 as at December 2021.

81% of staff with no recorded sickness in the year ending 31 December 2022

Some 81% of our staff have no recorded sickness in the calendar year up to 31 December 2022, down from 89 per cent at the same point the previous year.

Staff Turnover

753. The Core Department has experienced a 14% turnover of staff during the 2022-23 financial year. This has been calculated in line with Cabinet Office guidance. This is an increase over the 2021-22 year in which staff turnover in the Core Department was 11%.

Staff Redeployment

754. During 2022-23 the Department benefited from a number of civil servants loaned from other Government Departments.

755. The number and grade of staff re-deployed is shown in **Table 34**.

Table 34: Staff Redeployment by Grade

Grade	Cost incurred by the Department	Cost not incurred by the Department	Total
	Number	Number	Number
AO & EO	4	0	4
HEO & SEO	39	0	39
G7 & G6	84	2	86
SCS	13	0	13
Totals	**140**	**2**	**142**

756. For those individuals above where the cost was incurred by the Department, the estimated average cost was £55,700.

Health and Safety

757. 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 2022-23, there were eleven reported accidents (four of which resulted in absence) and one near miss.

Staff Diversity

758. 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 (published 23 June 2022). The data shows information relating to DHSC's employees by protected characteristics. The data also includes information on working pattern and caring responsibilities of our employees, as DHSC extends protection from discrimination and disadvantage to these groups, amongst others.

759. The Department's most recent diversity data is available on the Civil Service Diversity and Inclusion Dashboard.

Equal Opportunities Policy

760. The Department is committed to promoting and supporting inclusion in the workplace, in line with DHSC values and legal duties as a public sector body, and is helping to build a diverse and inclusive Civil Service where everyone can realise their potential.

761. The Department's Strategic Commitments to equal opportunities and diversity are set out in the Equality Objectives: 2019-23. The Department's commitment is underpinned by the Civil Service Diversity and Inclusion (D&I) Strategy 2022-2025, delivered in collaboration with our leaders, staff networks and employees across the Department.

762. 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.

763. The Department recognises the important of championing diversity and inclusion more visibly at senior leadership level. To support this, the Department introduced a new D&I Standards Framework for Senior Civil Servants (SCS) for the 2022-23 performance year. These have been created to support members of the SCS identify and set their ambition and goals on the leadership of D&I in the Department and guide them on what to include in their plans for meeting their mandatory D&I objective, required for all SCS across the wider Civil Service.

764. To promote diversity and inclusion at the highest level, the Second Permanent Secretary acts as Department's Senior D&I champion and is supported by D&I champions from the senior leadership team who individually focus on:
- age
- disability and long-term conditions
- domestic abuse
- faith and belief
- gender
- gender identity
- LGBT+
- parents, carers, and flexible working
- race
- social mobility
- speak up
- wellbeing.

765. Diversity and inclusion champions are committed to supporting this by helping to create an environment which is inclusive and where everyone has equal opportunity to achieve their potential and flourish. Diversity and inclusion champions play an important part in ensuring that the Department can do this by helping to embed diversity and inclusion elements into all aspects of working.

766. 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, helping to identify areas for improvement and measure the progress in making DHSC a more inclusive workplace. The Department uses 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).

767. During 2022-23, the Department also:
- Held 3 sessions on Disability and reviewed the Workplace Adjustments process to better support employees with disabilities and long-term conditions.
- Developed and published a Discrimination, bullying and harassment toolkit to supports managers and colleagues identify issues and create an environment that supports speaking up and taking action.
- Had trained volunteers deliver 5 in-house "Let's Talk About Race" sessions on having open and honest conversations about race.
- Organised events for all employees aimed at raising awareness and advancing inclusion in the Department, including Disability Awareness Week, Black History Month, Pride month.

768. The Department has over 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 focus on protected characteristics (as outlined by the Equality Act), grades, professions, or other workplace matters. Representatives of Network form a Diversity Board, which meets regularly to discuss inclusion-related matters at DHSC.

Recruitment and Retention of Under-represented Groups

769. The Department has several 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 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.

770. The Department regularly reviews its processes and practices to attract diverse candidates from within and outside the Department. As a result, the Department strengthened the requirements of selection panels at delegated grades (AA to G6)

to introduce more perspective and lived experiences. Recognising that those comes in many forms, all recruitment selection panels must have at least one panel member from a currently underrepresented group. The aim is to reduce bias from the selection process, ensuring robust decision making when identifying the successful candidate. As importantly, the Department wants candidates applying for roles in the Department to recognise that we strive to best represent and serve the public and that we live 'we are inclusive' value.

771. The Department continues to deliver a range of workshops for internal candidates on how to complete a successful application, interview technique skills and making a personal impact and have made a commitment to deliver these sessions every 3 months.

772. 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 the commitment to providing an inclusive and accessible recruitment process and working environment. As part of this, the Department has a disability at work conversation toolkit to ensure employees receive the support they need.

773. 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, the Department has a dedicated health and safety team and created a new Workplace adjustment advisor role, as well as provide support through our occupational health service for workplace and specialist assessments.

774. Over 2022-23, the Department also continued investment in development programmes focused on inclusion and/or dedicated to those from underrepresented groups, including:
    - Autism Exchange Internship Scheme, a cross-government programme managed by the Cabinet Office
    - Beyond Boundaries programme, cross-government programme for Grade AO to SEO who want to develop an effective career within the Civil Service. DHSC offers at least 50% of the programme slots for employees who have a disability, are from an ethnic minority group, or from a lower socio-economic background.
    - Care leavers Internship Scheme, a cross-government programme managed by the Department for Education
    - Catapult Scheme, a cross-government sponsorship scheme for people from lower socio-economic backgrounds

- DHSC Experience Exchange Mentoring Scheme, a form of 'mutual mentoring' where mentor opportunities are open to staff from underrepresented backgrounds or who have diverse lived experiences at grades AO to grade 6
- Health Policy Fast Track Scheme (HPFTS), a bespoke DHSC graduate scheme, with a focus on promoting the scheme across the diverse talent pool, including candidates from ethnic minorities, disabled candidates, and candidates from a lower socio-economic background
- META (Minority Ethnic Talent Association) and DELTA (Disability Empowers Leadership Talent Association), as part of Future Leadership Scheme, which are cross-government Accelerated Development Schemes.

775. The Department also uses apprenticeship schemes to attract and develop diverse talent, including employees and candidates from lower socio-economic background, who might otherwise not have access to formal education or training.

776. All employees 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 in-house Mental Health First Aiders who are trained in how to give appropriate help and support, as well as internal Speak Up 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.

Trade Union Facility Time

777. Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Department has a statutory requirement to disclose information (see **Tables 35** to **38**) as prescribed by schedule 2 of the above Regulation. The format of these tables is as prescribed by the Regulations.

778. The disclosure has been compiled in line with the Regulations, therefore the information discloses the trade union facility time utilised by the Core Department, MHRA, 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 35: Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
81	80

Table 36: Percentage of Time Spent on Facility Time

Percentage of time	Number of employees
0%	23
1-50%	58
51-99%	0
100%	0

Table 37: Percentage of Pay Bill Spent on Facility Time

Description	Figures
Total cost of facility time	£138,450
Total pay bill	£831,172,793
Percentage of the total pay bill** spent on facility time*	0.02%

* Calculated as: (total cost of facility time ÷ total pay bill) x 100
** UKHSA pay bill figures do not include allowances/overtime.

Table 38: 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

779. With regard to engagement, officials from across the Department 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

780. **Tables 39, 40** and **41** summarise key staff information for the Departmental Group.

Table 39: Staff Costs for the Departmental Group Comprise (subject to audit)[11]

					2022-23 £'000	2021-22 £'000
	Permanently employed staff	Others	Ministers	Special advisors	Total	Total
Salaries and wages	60,206,190	8,251,854	204	-	68,458,248	61,787,878
Social Security costs	6,684,717	173,960	22	-	6,858,699	5,968,471
NHS Pension	9,748,437	188,588	-	-	9,937,025	9,259,894
Other pension costs	143,873	25,616	-	-	169,489	122,602
Sub-total	**76,783,217**	**8,640,018**	**226**	**-**	**85,423,461**	**77,138,845**
Termination benefits	117,469	939	42	-	118,450	13,279
Sub-total	**76,900,686**	**8,640,957**	**268**	**-**	**85,541,911**	**77,152,124**
Less recoveries in respect of outward secondments	(30,147)	(99,830)	-	-	(129,977)	(128,387)
Total Net Costs	**76,870,539**	**8,541,127**	**268**	**-**	**85,411,934**	**77,023,737**

[11] Special Advisers are temporary civil servants. In order to improve efficiency, the administration of staff costs for all Special Advisers costs are reported in the Cabinet Office Annual Report and Accounts. Special Advisers remain employed by the respective Department of their appointing Minister.

Table 40: Average number of whole-time equivalents employed – Departmental Group (subject to audit)

	Permanent staff	Others	Ministers	Special Advisors	2022-23 Number Total	2021-22 Number Total
Core Department						
Core Department	3,176	905	6	4	4,091	6,067
Executive Agencies						
Public Health England	-	-	-	-	-	3,388
UK Health Security Agency	3,585	3,298	-	-	6,883	3,295
Medicines and Healthcare products Regulatory Agency	1,153	93	-	-	1,246	-
Other designated bodies						
NHS Providers	1,242,298	148,710	-	-	1,391,008	1,345,024
Special Health Authorities	4,544	243	-	-	4,787	5,570
NHS England Group	35,383	11,524	-	-	46,907	37,387
Non Departmental Public Bodies	9,925	1,376	-	-	11,301	10,569
Others	8,626	426	-	-	9,052	9,386
Total	**1,308,690**	**166,575**	**6**	**4**	**1,475,275**	**1,420,686**

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.

781. Of the figures shown in **Table 40**, staff engaged on capital projects are shown in **Table 41**.

Table 41: Breakdown of Staff Engaged on Capital Projects (subject to audit)

Of the above, the following staff were engaged on capital projects:	Permanent staff	Others	Ministers	Special Advisors	2022-23 Number	2021-22 Number
Core Dept & Agencies	84	-	-	-	84	57
Other designated bodies	3,931	576	-	-	4,507	4,273
Total	**4,015**	**576**	**-**	**-**	**4,591**	**4,330**

Consultancy, Temporary and Agency Workers

782. **Table 42** 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.

783. The Department utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. In 2022-23 the Core Department spent £4.1 million on consultancy compared to £252.8 million in 2021-22; and £23.1 million on temporary staff compared to £416.4 million in 2021-22. The main reason for the year-on-year decreases on consultancy and temporary staff spend is due to the Test and Trace programme transferring to UKHSA on 1 October 2021.

784. 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 42: Expenditure on Consultancy, Agency and Temporary Workers

	2022-23		2021-22	
	Consultancy	Temporary Agency	Consultancy	Temporary Agency
	£'000	£'000	£'000	£'000
Total DHSC Core	4,092	23,100	252,815	416,383
Executive Agencies	1,163	153,767	-	237,899
Other Designated Bodies	276,638	5,472,934	373,769	4,730,677
Gross Total	**281,893**	**5,649,801**	**626,584**	**5,384,959**
Eliminations	-	-	-	(429)
Total Departmental Group (after eliminations)	**281,893**	**5,649,801**	**626,584**	**5,384,530**

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

Off-Payroll Engagements

785. 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 43** includes all off-payroll engagements (either during 2022-23 in totality or 'as at' 31 March 2023) for a day-rate of more than £245.

786. A regular dialogue has continued between the Department and HMRC throughout the 2022-23 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.

787. 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. For workers to whom the IR35 rules do apply, determinations have been arrived at using the online HMRC 'Check Employment status for tax' tool and reviewed by the tax team.

788. 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.

789. During 2022-23, the Department made a payment on account of £5 million in respect of IR35 tax and NIC liabilities with HM Revenue & Customs (HMRC). This payment followed further dialogue with HMRC in relation to historical IR35 assessments. This is reported as a fruitless payment in the Losses and Special Payment section of the Accountability Report (which can be found on **page 192**).

790. The Department has not paid any penalties for non-compliance.

Table 43: Off-payroll engagements

Table a: For all off-payroll engagements as of 31 March 2023, for more than £245 per day[1]	Core Dept	ALBs	Dept Group
Number of existing engagements as of 31 March 2023	**116**	**1,246**	**1,362**
Of which.....			
Number that have existed for less than one year at time of reporting	58	444	502
Number that have existed for between one and two years at time of reporting	18	491	509
Number that have existed for between two and three years at time of reporting	13	169	182
Number that have existed for between three and four years at time of reporting	27	82	109
Number that have existed for four years or more years at time of reporting	-	60	60

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 2022 and 31 March 2023, for more than £245 per day[1]	Core Dept	ALBs	Dept Group
Number of temporary off-payroll workers engaged between 1 April 2022 and 31 March 2023	**165**	**4,427**	**4,592**
Of which.....			
Number not subject to off-payroll legislation	157	3,315	3,472
Number subject to off-payroll legislation and determined as in scope of IR35[2]	-	1,025	1,025
Number subject to off-payroll legislation and determined as out of scope of IR35	8	87	95
Number of engagements reassessed for compliance or assurance purposes during the year	-	38	38
Of which: number of engagements that saw a change to IR35 status following review	-	10	10

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 2022 and 31 March 2023	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.	-	2	2
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.	403	558	961

1. Across the group, there were 2 off-payroll engagements with significant financial responsibility. Both of these were at Medicines and Healthcare product Regulatory Agency (MHRA). They were engaged for less than 6 months and both engagements were approved by the MHRA accounting officer.

Exit Packages – Civil Service and Other Compensation Schemes

791. **Table 44** 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 44: Exit Packages 2021-22 and 2022-23 (subject to audit)

	2022-23							
	Core Dept & Agencies				Departmental Group			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
≤£10,000	5	8	13	-	187	2,010	2,197	24
£10,001 - £25,000	9	16	25	-	185	483	668	36
£25,001 - £50,000	3	11	14	-	118	446	564	12
£50,001 - £100,000	1	22	23	-	81	440	521	4
£100,001 - £150,000	-	1	1	-	19	255	274	-
£150,001 - £200,000	-	2	2	-	53	128	181	-
>£200,000	-	-	-	-	1	2	3	1
Total Number	**18**	**60**	**78**	**-**	**644**	**3,764**	**4,408**	**77**
Total Cost (£)	**324,012**	**2,732,634**	**3,056,646**	**-**	**24,823,139**	**116,019,558**	**140,842,697**	**1,819,806**

	2021-22							
	Core Dept & Agencies				Departmental Group			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of departures where special payments have been made
≤£10,000	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**

1. No individuals within the Core Department have received over £95,000 as an exit package due to entitlement on voluntary or compulsory redundancy arrangements in 2021-22 or 2022-23.

Other Departures

792. **Table 45** 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 45** will not necessarily match the total number in **Table 44**, which will be the number of individuals.

Table 45: Analysis of Other Departures (subject to audit)

	2022-23	
	Departmental Group	
	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	1,355	96,161
Mutually agreed resignations (MARS) contractual costs	174	5,697
Early retirements in the efficiency of the service contractual costs	1	8
Contractual payments in lieu of notice	2,087	10,974
Exit payments following Employment Tribunals or court orders	95	1,433
Non-contractual payments requiring HMT approval*	71	1,747
Total	**3,783**	**116,020**

*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 £946 million against the Resource DEL budget limit. This is primarily due to the non-consolidated element of the NHS Agenda for Change pay settlement accrued for in 2022-23 after the Supplementary Supply Estimate had been prepared. 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 2022-23

		2022-23			2022-23			2022-23		2021-22
		Outturn			Estimate			Outturn compared with Estimate: saving/ (excess)		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	140,827,808	36,266,858	177,094,666	139,881,363	36,266,858	176,148,221	(946,445)	(946,445)	183,548,237
- Capital	1.2	9,847,950	-	9,847,950	11,192,788	-	11,192,788	1,344,838	1,344,838	9,119,036
Annually Managed Expenditure										
- Resource	1.1	(61,971,916)	-	(61,971,916)	(35,957,397)	-	(35,957,397)	26,014,519	26,014,519	47,970,727
- Capital	1.2	20,329	-	20,329	105,600	-	105,600	85,271	85,271	-
Total Budget										
- Resource	1.1	78,855,892	36,266,858	115,122,750	103,923,966	36,266,858	140,190,824	25,068,074	25,068,074	231,518,964
- Capital	1.2	9,868,279	-	9,868,279	11,298,388	-	11,298,388	1,430,109	1,430,109	9,119,036
Total Budget Expenditure		88,724,171	36,266,858	124,991,029	115,222,354	36,266,858	151,489,212	26,498,183	26,498,183	240,638,000
Non-Budget Expenditure										
- Resource	1.1	-	-	-	-	-	-	-	-	2,457,088
Total		**88,724,171**	**36,266,858**	**124,991,029**	**115,222,354**	**36,266,858**	**151,489,212**	**26,498,183**	**26,498,183**	**243,095,088**
Total Resource		78,855,892	36,266,858	115,122,750	103,923,966	36,266,858	140,190,824	25,068,074	25,068,074	233,976,052
Total Capital		9,868,279	-	9,868,279	11,298,388	-	11,298,388	1,430,109	1,430,109	9,119,036
Total		**88,724,171**	**36,266,858**	**124,991,029**	**115,222,354**	**36,266,858**	**151,489,212**	**26,498,183**	**26,498,183**	**243,095,088**

1. Explanations of variances between Estimates and Outturn are given in tables A to D below.

Net cash requirement 2022-23

		2022-23		2022-23	2022-23	2021-22
		Outturn		Estimate	Outturn compared with Estimate: saving/ (excess)	Outturn
	SoPS Note	£'000		£'000	£'000	£'000
Net cash requirement	3	144,488,919		149,492,047	5,003,128	163,475,997

1. Against the 2022-23 Net Cash Requirement of £149.5 billion, DHSC underspent by 3.3% (£5.0 billion).

Administration Costs 2022-23

	2022-23		2022-23	2022-23	2021-22
	Outturn		Estimate	Outturn compared with Estimate: saving/ (excess)	Outturn
	£'000		£'000	£'000	£'000
Administration Costs	2,808,359		3,307,504	499,145	2,674,612

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

SOPS 1 Net Outturn

SOPS 1.1 Analysis of net resource outturn by section

	2022-23 £'000						2022-23 £'000	2022-23 £'000		2022-23 £'000	2022-23 £'000	2021-22 £'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	1,789,448	-	1,789,448	12,734,585	-	12,734,585	14,524,033	20,612,382	(6,088,349)	14,524,033	-	23,371,789
NHS Providers net expenditure	-	-	-	107,932,134	-	107,932,134	107,932,134	98,511,000	9,421,134	107,932,134	-	99,849,097
DHSC Programme and Administration expenditure	393,010	(2,419)	390,591	6,608,613	(1,933,941)	4,674,672	5,065,263	7,356,160	(3,237,342)	4,118,818	(946,445)	13,268,380
Local Authorities (Public Health)	-	-	-	3,195,761	-	3,195,761	3,195,761	3,201,720	(5,959)	3,195,761	-	4,217,325
Executive Agencies	209,276	(7,615)	201,661	3,955,828	(420,277)	3,535,551	3,737,212	3,593,564	143,648	3,737,212	-	10,181,091
Health Education England net expenditure	60,709	-	60,709	1,728,902	-	1,728,902	1,789,611	1,858,165	(68,554)	1,789,611	-	1,595,487
Special Health Authorities expenditure	205,828	(84,181)	121,647	2,884,582	(36,488)	2,848,094	2,969,741	2,915,312	54,429	2,969,741	-	2,868,350
Non Departmental Public Bodies net expenditure	241,300	-	241,300	528,429	-	528,429	769,729	804,628	(34,899)	769,729	-	875,334
Arm's Length and Other Bodies net expenditure	3,003	-	3,003	841,321	-	841,321	844,324	1,028,432	(184,108)	844,324	-	2,124,627
	2,902,574	**(94,215)**	**2,808,359**	**140,410,155**	**(2,390,706)**	**138,019,449**	**140,827,808**	**139,881,363**	**-**	**139,881,363**	**(946,445)**	**158,351,480**
Non- voted:												
NHS England expenditure financed by NI Contributions	-	-	-	36,266,858	-	36,266,858	36,266,858	36,266,858	-	36,266,858	-	25,196,757
	2,902,574	**(94,215)**	**2,808,359**	**176,677,013**	**(2,390,706)**	**174,286,307**	**177,094,666**	**176,148,221**	**-**	**176,148,221**	**(946,445)**	**183,548,237**
Annually Managed Expenditure (AME)												
Voted:												
NHS England net expenditure	-	-	-	10,693	-	10,693	10,693	250,000	-	250,000	239,307	119,445
NHS Providers net expenditure	-	-	-	962,326	-	962,326	962,326	2,000,000	-	2,000,000	1,037,674	1,100,553
DHSC Programme and Administration expenditure	-	-	-	(3,519,936)	-	(3,519,936)	(3,519,936)	(1,366,231)	-	(1,366,231)	2,153,705	3,115,133
Local Authorities	-	-	-	-	-	-	-	-	-	-	-	-
Executive Agencies	-	-	-	(483,838)	-	(483,838)	(483,838)	300,000	-	300,000	783,838	269,629
Health Education England net expenditure	-	-	-	(856)	-	(856)	(856)	2,000	-	2,000	2,856	596
Special Health Authorities expenditure	-	-	-	(58,933,071)	-	(58,933,071)	(58,933,071)	(37,280,462)	-	(37,280,462)	21,652,609	43,308,197
Non Departmental Public Bodies net expenditure	-	-	-	16,508	-	16,508	16,508	33,196	-	33,196	16,688	25,429
Arm's Length and Other Bodies net expenditure	-	-	-	(23,742)	-	(23,742)	(23,742)	104,100	-	104,100	127,842	31,745
	-	**-**	**-**	**(61,971,916)**	**-**	**(61,971,916)**	**(61,971,916)**	**(35,957,397)**	**-**	**(35,957,397)**	**26,014,519**	**47,970,727**
Non- Budget												
Prior period adjustments	-	-	-	-	-	-	-	-	-	-	-	2,457,088
	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**2,457,088**
Total	**2,902,574**	**(94,215)**	**2,808,359**	**114,705,097**	**(2,390,706)**	**112,314,391**	**115,122,750**	**140,190,824**	**-**	**140,190,824**	**25,068,074**	**233,976,052**

	2022-23 £'000			2022-23 £'000			2022-23 £'000	2021-22 £'000
							Outturn	Outturn
	Administration			Programme			Total	Total
	Gross	Income	Net	Gross	Income	Net		
Total net resource outturn	2,902,574	(94,215)	2,808,359	114,705,097	(2,390,706)	112,314,391	115,122,750	233,976,052
Net gain/(loss) on transfers by absorption	-	182,613	182,613	-	-	-	182,613	-
Capital Grants	18,847	-	18,847	703,953	-	703,953	722,800	810,909
Capital provision movement	-	-	-	(645)	-	(645)	(645)	
Research and Development	-	-	-	1,451,371	-	1,451,371	1,451,371	1,451,440
Income from Consolidated Fund Extra Receipts	-	-	-	-	(672)	(672)	(672)	(14,321)
Utilisation of provisions	(25,102)	-	(25,102)	25,102	-	25,102	-	963,822
IFRIC 12 Adjustment	-	-	-	193,218	(450,061)	(256,843)	(256,843)	(121,674)
Prior period adjustments	-	-	-	-	-	-	-	(2,457,088)
Donated asset/government granted income	-	-	-	-	(482,769)	(482,769)	(482,769)	(381,167)
Expenditure presented on net basis	238,615	(238,615)	-	9,795,110	(9,795,110)	-	-	-
Other adjustments (mainly COVID- 19)	-	(182,614)	(182,614)	590,864	-	590,864	408,250	(815,525)
Net operating cost	**3,134,934**	**(332,831)**	**2,802,103**	**127,464,070**	**(13,119,318)**	**114,344,752**	**117,146,855**	**233,412,448**

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 20 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
4. Other adjustments in 2022-23 mainly relate to COVID-19 adjustments to reflect the agreed budgetary treatment of COVID-19 expenditure. Included within the £408 million adjustment above, £595 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 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.

The outturn vs estimate column is based on the total including virements. The estimate total before virements have been made is included so that users can tie the estimate back to the Estimates laid before Parliament.

SOPS 1.2 Analysis of net capital outturn by section

	2022-23 £'000			2022-23 £'000		2022-23 £'000	2022-23 £'000	2021-22 £'000
			Outturn			Estimate	Outturn vs Estimate	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	238,684	-	238,684	243,575	-	243,575	4,891	291,416
NHS Providers net expenditure	7,537,572	-	7,537,572	8,153,114	-	8,153,114	615,542	6,833,740
DHSC Programme and Administration expenditure	2,006,152	(18,751)	1,987,401	2,265,221	-	2,265,221	277,820	1,795,522
Local Authorities	-	-	-	-	-	-	-	-
Executive Agencies	(216,763)	(57,469)	(274,232)	42,491	-	42,491	316,723	(221,171)
Health Education England net expenditure	1,889	-	1,889	6,248	-	6,248	4,359	1,119
Special Health Authorities expenditure	29,292	(5,577)	23,715	69,987	-	69,987	46,272	30,623
Non Departmental Public Bodies net expenditure	129,542	-	129,542	155,047	-	155,047	25,505	187,746
Arm's Length and Other Bodies net expenditure	203,379	-	203,379	257,105	-	257,105	53,726	200,041
	9,929,747	**(81,797)**	**9,847,950**	**11,192,788**	**-**	**11,192,788**	**1,344,838**	**9,119,036**
Annually Managed Expenditure (AME)								
Voted:								
NHS England net expenditure	-	-	-	-	-	-	-	-
NHS Providers net expenditure	16,807	-	16,807	-	16,807	16,807	-	-
DHSC Programme and Administration expenditure	2,654	-	2,654	105,600	(17,675)	87,925	85,271	-
Local Authorities	-	-	-	-	-	-	-	-
Executive Agencies	-	-	-	-	-	-	-	-
Health Education England net expenditure	-	-	-	-	-	-	-	-
Special Health Authorities expenditure	-	-	-	-	-	-	-	-
Non Departmental Public Bodies net expenditure	-	-	-	-	-	-	-	-
Arm's Length and Other Bodies net expenditure	868	-	868	-	868	868	-	-
	20,329	**-**	**20,329**	**105,600**	**-**	**105,600**	**85,271**	**-**
Total	**9,950,076**	**(81,797)**	**9,868,279**	**11,298,388**	**-**	**11,298,388**	**1,430,109**	**9,119,036**

1. Explanations of variances between Estimate and outturn are given in tables A to D below.
2. Note 20 to the accounts provides details of organisations classified as Special Health Authorities and Non-Departmental Public Bodies.
3. 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.

The outturn vs estimate column is based on the total including virements. The estimate total before virements have been made is included so that users can tie the estimate back to the Estimates laid before Parliament.

Material variances between the Estimate and Outturn

793. HM Treasury designates that Estimates are prepared on a consolidated basis, meaning that all intra-group transactions are removed. Across Government, the Department of Health and Social Care 'Internal Market' of circa £120 billion (mainly transactions between NHS commissioners and NHS providers) is unique to the Department of Health and Social Care Group.

794. 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.

795. 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 of Health and Social Care Group. Due to the size and complexity of our budget, there will inevitably be some variances in our Estimate.

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

797. In line with the guidance published by the Parliamentary Scrutiny Unit for Estimates Memoranda, significant variances over £10m and 10% or over £200 million and 5% have been explained in the tables below.

798. 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	20,612	14,524	6,088	30%	The variance across the NHSE and NHS Providers estimate line is £3.3 billion and mainly relates to the NHS pay deal accrued for in 2022-23 that occurred after the Supplementary Supply Estimate had been prepared.
B	NHS Providers net expenditure	98,511	107,932	(9,421)	-10%	
C	DHSC Programme and Administration expenditure	7,356	5,065	2,291	31%	The £2.3bn variance mainly relates to: 1. £1.5bn - relates to higher than forecast intra group income eliminations; and 2. £0.8bn relates to depreciation and impairments expenditure being lower than forecast.
D	Local Authorities (Public Health)	3,202	3,196	6	0%	
E	Executive Agencies	3,594	3,737	(144)	-4%	
F	Health Education England net expenditure	1,858	1,790	69	4%	
G	Special Health Authorities expenditure	2,915	2,970	(54)	-2%	
H	Non Departmental Public Bodies net expenditure	805	770	35	4%	
I	Arm's Length and Other Bodies (Net)	1,028	844	184	18%	The £0.2bn variance mainly relates to: 1. £0.1bn - relates to lower than forecast intra group expenditure eliminations; and 2. £0.05bn relates to depreciation and impairments expenditure being lower than forecast.
J	NHS England expenditure financed by NI Contributions	36,267	36,267	(0)	0%	
Total RDEL		**176,148**	**177,095**	**-946**		

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	250	11	239	96%	NHSE's provisions expenditure was lower than expected when setting the Supplementary Supply Estimate
L	NHS Providers net expenditure	2,000	962	1,038	52%	NHS providers AME impairments were lower than expected when setting the Supplementary Supply Estimate
M	DHSC Programme and Administration expenditure	(1,366)	(3,520)	2,154	-158%	The variance on this line relates to lower new provisions expenditure and higher than predicted onerous contract provisions release than had been estimated at the time of setting the final budget.
N	Executive Agencies	300	(484)	784	261%	UKHSA's impairments were lower than expected when setting the final budget.
O	Health Education England net expenditure	2	(1)	3	143%	
P	Special Health Authorities expenditure	(37,280)	(58,933)	21,653	-58%	The variance on this line relates to lower than forecast provisions in NHS Resolution - mainly clinical negligence provisions. This was due to favourable changes in assumptions and methodology, including inflationary costs and the estimated quantum of future clinical negligence claims.
Q	Non Departmental Public Bodies net expenditure	33	17	17	50%	NDPB AME impairments and provisions expenditure were lower than expected when setting the Supplementary Supply Estimate
R	Arm's Length and Other Bodies (Net)	104	(24)	128	123%	Arm's Length and Other Bodies AME impairments and provisions expenditure were lower than expected when setting the Supplementary Supply Estimate
Total RAME		**-35,957**	**-61,972**	**26,015**		

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	244	239	5	2%	
B	NHS Providers net expenditure	8,153	7,538	616	8%	The underspend on the NHS Provider and DHSC estimate lines mainly relates to IFRS16 capital, where actual expenditure was lower than the forecast in the Supplementary Supply Estimate
C	DHSC Programme and Administration expenditure	2,265	1,987	278	12%	
D	Local Authorities (Public Health)	0	0	0		
E	Executive Agencies	42	(274)	317	745%	The underspend on this line relates to UK Health Security Agency and their COVID-19 outturn. Test and Trace capital credits were higher than predicted in the Supplementary Supply Estimate because more testing inventory was impaired. Also capital credits arising from the delivery of prepaid vaccines was higher than predicted as more pre-paid inventory was received in-year .
F	Health Education England net expenditure	6	2	4	70%	
G	Special Health Authorities expenditure	70	24	46	66%	Around half of the variance on this estimate line relates to lower than forecast IFRS16 capital expenditure.
H	Non Departmental Public Bodies net expenditure	155	130	26	16%	The majority of the £25m variance on this Estimate line relates to NHS Digital, who merged with NHS England during January 23. The forecast was based on an early assessment of the split of capital between entities.
I	Arm's Length and Other Bodies (Net)	257	203	54	21%	The variance on this estimate line mainly relates to lower than forecast IFRS16 capital expenditure.
Total CDEL		**11,193**	**9,848**	**1,345**		

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		
L	NHS Providers net expenditure	0	17	(17)		NHS Providers lease dilapidations provisions were higher than predicted when setting the Supplementary Supply Estimate.
M	DHSC Programme and Administration expenditure	106	3	103	97%	DHSC lease dilapidations provisions were lower than predicted when setting the Supplementary Supply Estimate.
N	Executive Agencies	0	0	0		
O	Health Education England net expenditure	0	0	0		
P	Special Health Authorities expenditure	0	0	0		
Q	Non Departmental Public Bodies net expenditure	0	0	0		
R	Arm's Length and Other Bodies (Net)	0	1	(1)		
Total CAME		**106**	**20**	**85**		

SOPS 2 Reconciliation of net resource outturn to net operating expenditure

		Note	2022-23 £'000 Outturn	2021-22 £'000 Outturn
Total resource outturn in Statement of Outturn against Parliamentary Supply				
	Budget	SOPS 1.1	115,122,750	231,518,964
	Non-Budget	SOPS 1.1	-	2,457,088
			115,122,750	233,976,052
Add:	Capital Grants		722,800	810,909
	Research and Development		1,451,371	1,451,440
	PFI/LIFT expenditure under IFRS		2,487,476	2,412,124
	PFI/LIFT income under IFRS		(450,061)	(407,410)
	Other - provision utilisation		-	963,822
	Gain on transfers by absorption		182,613	-
	Other[2]		407,605	-
			4,801,804	5,230,885
Less:	Income payable to the Consolidated Fund	SOPS4	(672)	(14,321)
	Donated asset/government granted income[3]		(482,769)	(381,167)
	PFI/LIFT expenditure under UK GAAP		(2,294,258)	(2,126,388)
	Prior period adjustments		-	(2,457,088)
	Loss on transfers by absorption		-	-
	Other		-	(815,525)
			(2,777,699)	(5,794,489)
	Net Operating Cost in Consolidated Statement of Comprehensive Net Expenditure after Financing Activities		**117,146,855**	**233,412,448**

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. Other adjustments in 2022-23 mainly relate to COVID-19 adjustments to reflect the agreed budgetary treatment of COVID-19 expenditure. Of the £408 million adjustment, £595 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.
3. Donated assets/Government granted income does not agree to Note 5.1 as some of this income is included in income received by NHS charities. 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.

SOPS 3 Reconciliation of net resource outturn to net cash requirement

	Note	Estimate	Outturn	2022-23 £'000 Net total outturn compared with Estimate: Savings/(excess)
Resource Outturn	SOPS 1.1	140,190,824	115,122,750	25,068,074
Capital Outturn	SOPS 1.2	11,298,388	9,868,279	1,430,109
Accruals to cash adjustments:				
Adjustments to remove non-cash items:				
Depreciation		(2,230,988)	(361,198)	(1,869,790)
New provisions and adjustments to previous provisions		34,755,393	(18,854,576)	53,609,969
IFRIC12 revenue adjustments			(32,762)	32,762
Adjustment for stockpiled goods			159	(159)
Non-cash investment additions			(9,647)	9,647
Net gain/loss on transfers by absorption			20,484	(20,484)
Other non-cash items[3]		-	75,091,678	(75,091,678)
Adjustments for NDPBs, NHS Trusts, Foundation Trusts, Charities and Other bodies:				
Remove voted resource and capital		(134,018,992)	(134,953,501)	934,509
Add cash grant-in-aid, PDC, loans and share capital from Core Department, and expenditure financed by Parliamentary Funding		131,913,580	125,070,185	6,843,395
Adjustments to reflect movements in working balances:				
Increase/(decrease) in inventory			(1,099,795)	1,099,795
less COVID-19 budgeting impacts on non-cash transactions[2]			932,276	(932,276)
less transfers from non-current assets			(159)	159
Increase/(decrease) in receivables			(92,856)	92,856
less movement in current financial assets			(4,029)	4,029
less movements in finance lease receivables			(103,119)	103,119
capital element of finance lease receivables			(4,382)	4,382
(Increase)/decrease in payables		-	2,915,833	(2,915,833)
less movement in payables to the Consolidated Fund			127,741	(127,741)
less movement in finance lease/PFI payables			354,625	(354,625)
add capital element of finance lease/PFI payables			43,436	(43,436)
Use of provisions		3,850,700	6,634,365	(2,783,665)
		185,758,905	180,665,787	5,093,118
Removal of non-voted budget items:				
National Insurance contributions		(36,266,858)	(36,266,858)	-
Other adjustments				
Net cash transferred under absorption accounting			(18,952)	18,952
Other cashflow adjustments			108,942	(108,942)
Net cash requirement		**149,492,047**	**144,488,919**	**5,003,128**

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 the NCR boundary reflect the non-cash impact of COVID-19 transactions where non-standard budgeting treatments have been agreed with HM Treasury.
3. Other non-cash items includes £75.8 billion relating to change in discount rate on provisions

For explanations of variances between estimate and resource and capital outturn, please see explanations of material variances from **paragraph 793** 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 2022-23 £'000		Outturn 2021-22 £'000	
	Accruals	*Cash Basis*	Accruals	*Cash Basis*
Operating income outside the ambit of the Estimate	672	*672*	284,012	*284,012*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total income payable to the Consolidated Fund	**672**	***672***	**284,012**	***284,012***

Parliamentary Accountability Disclosures (subject to audit)

The following disclosures are all subject to audit.

Regularity of Expenditure (subject to audit)

We are custodian of taxpayers' funds and have a duty to Parliament to ensure the regularity and propriety of our activities and expenditure. We manage public funds in line with HM Treasury's Managing Public Money. The disclosures made within the Parliamentary Accountability and Audit Report are indicative of this.

The importance of operating with regularity and the need for efficiency, economy, effectiveness, and prudence in the administration of public resources to secure value for public money, is the responsibility of our Accounting Officer whose responsibilities are also set out in Managing Public Money. The manner in which the Accounting Officer and the wider Department discharges its responsibilities in the administration of public resources are detailed within the Statement of Accounting Officer Responsibilities and the Governance Statement.

Losses and Special Payments

Table 46: Losses Statement

		2022-23		Restated[1] 2021-22	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	900	350,040	1,499	57,471
	£'000	2,752,606	2,334,314	747,345	899,162
Cases over £300,000					
Cash losses	Cases	-	5	-	7
	£'000	-	1,787	-	22,659
Claims abandoned	Cases	1	4	2	6
	£'000	4,160	8,845	4,811	6,822
Cancellation of Public Dividend Capital (PDC)	Cases	2	-	-	-
	£'000	518,114	-	-	-
Fruitless payments	Cases	115	118	33	36
	£'000	279,397	281,740	293,099	319,247
Constructive Loss	Cases	494	496	34	37
	£'000	1,911,579	1,917,481	366,426	372,425
Store losses	Cases	1	11	-	1
	£'000	2,000	8,085	-	583

1. UKHSA has reviewed losses and special payments disclosed in the prior year and has restated them to ensure the categorisation aligns with Managing Public Money Guidelines. In addition, UKHSA management review has established three additional items which should have been included and disclosed in the 2021-22 losses and special payments note. These have been included in the 2021-22 figures above.

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.

Claims Abandoned

During 2022-23 the Department abandoned VAT claims totalling £4,160k. Delays in processing invoices from suppliers prevented any VAT recovery from HMRC under Section 41 of the Value Added Tax Act 1994.

Cancellation of Public Dividend Capital (PDC)

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

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

PDC with a value in excess of £20 million can only be written off with the agreement of HM Treasury by formal notice to Parliament, known as a Minute. During 2022-23, the Department gained HM Treasury approval to write off £518,341k of PDC. The detail for each PDC write off is summarised below.

- £289,302k related to the dissolution of Brighton and Sussex University Hospitals NHS Trust on 1 April 2021 when acquired by Western Sussex Hospitals NHS Foundation Trust, resulting in creation of University Hospitals Sussex NHS Foundation Trust.
- £227k related to the dissolution of North Western Boroughs Healthcare NHS Foundation Trust on 1 June 2021 when acquired by Mersey Care NHS Foundation Trust.
- £228,812k related to the dissolution of Pennine Acute Hospitals NHS Trust on 1 October 2021 when acquired by Salford Royal NHS Foundation Trust, resulting in the creation of Northern Care Alliance NHS Foundation Trust.

Fruitless Payments

During 2022-23 the Department recorded a fruitless payment of £5,000k (2021-22: £6,138k) in respect of amounts payable to HMRC relating to the incorrect interpretation of IR35 status determinations for certain contractors.

During 2022-23 the Department recorded a fruitless payment of £1,200k in respect of amounts payable to HMRC following an internal VAT review which identified output VAT had not been charged in respect of the supply of staff to other Government entities.

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 £959,157k 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 404 contracts.

The fruitless payments recorded in 2022-23 were £279,754k and are 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 2022-23 of £279,754k can be analysed as follows:

- £43,559k - Inventory which arrived in 2022-23 and has been assessed as not suitable for any use.
- £85,471k - Inventory which arrived in previous financial periods which has now been assessed as not suitable for any use.
- £150,724k - 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 previous financial years. As these items have now been disposed of 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 £40,137k as a result of enhanced data quality.
- Cumulative losses are lower by £100k 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 2022-23	Cumulative loss reported in 2021-22
Total							
Fruitless payments	Cases	404	(158)	(12)	(11)	203	382
	£'000	959,157		(100)	(40,137)	279,754	719,640
Constructive losses	Cases	934	(378)	-	(3)	579	736
	£'000	707,713		-	(831)	476,229	232,315

Constructive Losses

In previous financial years the Core Department paid to reserve capacity for clinical trials in relation to COVID-19. Ultimately, there was no requirement to use this reserved capacity and therefore this resulted in a constructive loss of £9,000k.

During 2022-23 the Core Department recognised constructive losses in relation to four COVID-19 medicines with a cost of £1,073,121k and which was either disposed of during the year or had reached its expiry date. The vast majority of these items were fully impaired in the previous financial year.

During 2022-23 the Core Department has recognised £58,769k of constructive losses relating to COVID-19 vaccine inventories which expired before they could be used.

During 2022-23 the Core Department disposed of equipment and other COVID-19 consumable inventory with a carrying value of £34,125k which had reached, or was expected to reach its expiry date.

The Department has recorded constructive losses of £476,229k 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. Cumulative PPE programme constructive losses are shown in the PPE cumulative loss table above.

The interaction between inventory losses and impairments

As disclosed in **Note 4.3**, the Department recognised a combined reduction in inventory carrying value totalling £219 million in respect of personal protective equipment as a result of impairments and disposals. The cumulative impairments recognised in relation to the programme include the amounts disclosed as a fruitless payments and constructive losses above.

Note 4.3 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.

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 4.3**.

Note 4.3 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 47: Analysis of Losses by Sector

	2022-23	Restated 2021-22	2022-23	Restated 2021-22
	Cases Number		Value £'000	
DHSC Core	863	1,478	2,476,362	579,098
Agencies	37	21	276,244	168,247
NHS England Group	304,534	923	16,030	56,469
NHS Providers	42,408	53,403	82,572	92,279
NDPBs	1,949	1,616	951	2,833
Special Health Authorities	251	30	269	236
Eliminations	(2)	-	(518,114)	-
Departmental Group	**350,040**	**57,471**	**2,334,314**	**899,162**

Table 48: Special Payments

		2022-23		Restated[1] 2021-22	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total	Cases	16	7,995	45	9,208
	£'000	6,794	58,801	4,780	21,236
Cases over £300,000	Cases	4	28	20	20
	£'000	6,396	36,598	4,438	4,438

1. UKHSA has reviewed losses and special payments disclosed in the prior year and has restated them to ensure the categorisation aligns with Managing Public Money Guidelines. In addition, UKHSA management review has established three additional items which should have been included and disclosed in the 2021-22 losses and special payments note. These have been included in the 2021-22 figures above.

Special Payments

Special Payments are transactions that Parliament could not have anticipated when passing legislation or approving Supply Estimates for the Department. Examples include extra contractual payments to contractors, ex-gratia payments to contractors, other ex-gratia payments, compensation payments, and extra statutory and extra regulatory payments.

All Core Department special payments 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 49: Special Payments by Sector

	Cases Number		Value £'000	
	2022-23	Restated 2021-22	2022-23	Restated 2021-22
DHSC Core	6	41	1,797	4,770
Agencies	10	4	4,997	10
NHS England Group	56	1,511	581	1,037
NHS Providers	7,907	7,642	51,167	15,279
NDPBs	15	10	235	140
Other Group entities	1	-	24	-
Departmental Group	**7,995**	**9,208**	**58,801**	**21,236**

Other Payments

There have been no other payments made by the Core Department for 2022-23 or in 2021-22.

Fees and Charges (subject to audit)

Table 50: Fees and Charges

	2022-23 Departmental Group		
	Fees and Charges Income £'000	Full Cost of Service £'000	Surplus/(Deficit) £'000
Dental	746,642	2,899,433	(2,152,791)
Prescription	670,324	11,894,526	(11,224,202)
Other Fees and Charges for which the cost of providing the service is over £1million	537,642	497,565	40,077
Total	**1,954,608**	**15,291,524**	**(13,336,916)**

	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)**

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 2022-23, 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 2022-23, 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 £215.8 million (2021-22: £207.9 million) of fees and charges and £217.7 million (2021-22: £198.1 million) of expenditure relating to regulatory income at the Care Quality Commission. The remaining balance relates to services provided by other NDPBs and other ALBs and to the COVID-19 Managed Quarantine Service in 2021-22. 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 2022		Increase in year	Liabilities crystallised in year	Obligation expired in year	31 March 2023		Of which: Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	£'000	No.	£'000
Guarantees	233	1	-	-	(233)	-	-	-
Indemnities	25,900	4	6,125	-	(1,500)	30,525	5	29,025
Letters of comfort	-	-	-	-	-	-	-	-
Total	**26,133**	**5**	**6,125**	**-**	**(1,733)**	**30,525**	**5**	**29,025**

Quantifiable remote contingent liabilities are as shown below:

Indemnities (£m)		
1[2]	The Department has issued an indemnity in relation to the operations of Human Fertilisation and Embryology Authority (HFEA).	1.5
2	The Department holds an indemnity relating to the two contracts signed between His Majesty's Government (HMG) and the medicine supplier Pfizer for the covid-19 antiviral drug PF-07321332+ritonavir (co-packaged and marketed as Paxlovid).	N/A[1]
3	The Department has issued an indemnity in respect of a Department of Health and Social Care established non-statutory, independent inquiry into the care and treatment pathways and the circumstances and practices surrounding the deaths of mental health inpatients in Essex.	N/A[1]
4	The Department holds an indemnity provided to Oxford University for unexpected tax implication as a result of the National Institute for Health Research (NIHR) National Biosample Centre transfer to the Department.	3.2
5	The Department holds a general indemnity provided to Oxford University in relation to the National Institute for Health Research (NIHR) National Biosample Centre transfer to the Department.	14.9

1. Due to the sensitive nature of these contingent liabilities, the value has not been disclosed.
2. This contingent liability relates to the Core Department only, as the contingent liability is intra group and therefore excluded at the group level.

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.

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.

Unquantifiable contingent liabilities are described below:

Indemnities	
1[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).
2[1]	The Department has indemnified the Medicines and Healthcare products Regulatory Agency (MHRA) and would need to meet the costs of damages awarded in litigation involving the bodies actions or decisions in carrying out its functions and activities.

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 has issued an indemnity in relation to the operations 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	The Department holds an indemnity in relation to the Mpox vaccine.
10	UKHSA 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.
Letters of Comfort	
11	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.
Other Remote Unquantifiable Contingent Liabilities	
12	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.

1 These contingent liabilities relate to the Core Department only, as the contingent liabilities are intra group and therefore excluded at the group level.

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

21 January 2024
Sir Chris Wormald KCB
Permanent Secretary

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 2023 under the Government Resources and Accounts Act 2000. The Department comprises the Core Department and its Agencies. 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 2022. The financial statements comprise the Department's and the Departmental Group's:

- Statement of Financial Position as at 31 March 2023;
- 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 the 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 2023 and their net operating 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.

Qualified opinion on regularity

In my opinion, except for the effects of the matters described in the Basis for qualified opinion on regularity section 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 2023 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 two respects.

1) Basis for qualified opinion on opening balances, in-year transactions, and closing balances of the UK Health Security Agency (UKHSA) as I have been unable to obtain sufficient, appropriate audit evidence

Overview

UKHSA was not able to provide sufficient, appropriate evidence to support transactions and balances recorded in its 2022-23 financial statements and therefore I have disclaimed my opinion on the 2022-23 UKHSA accounts. The impact of my disclaimer on the UKHSA accounts means that I have no assurance over these transactions and balances within the Department's group accounts.

Matter giving rise to qualification

UKHSA was not able to provide sufficient, appropriate evidence to support transactions and balances recorded in its 2021-22 or 2022-23 financial statements and I therefore disclaimed my opinion on the UKHSA 2021-22 and 2022-23 accounts. As a result, I have been unable to obtain sufficient, appropriate audit evidence to support the UKHSA total net expenditure in 2022-23 of £3.1 billion (2021-22 £8.9bn) and UKHSA total assets less liabilities of £1.8 billion (2021-22 £0.9bn) as set out in note 21 to the accounts. I have therefore limited the scope of my audit opinion in respect of these UKHSA transactions and balances recorded in the Core Department & Agencies' and Group's Statements of Comprehensive Net Expenditure and Statements of Financial Position as at 31 March 2023 and 31 March 2022.

Scope of my audit work

I audit the accounts of UKHSA (a component body of DHSC) and give an opinion on. The planned scope of my work for the Department's group accounts was to direct, review and rely on the work of the UKHSA audit team to ensure that the procedures carried out gave sufficient assurance over the transactions and balances within those accounts.

Why I was unable to obtain sufficient appropriate audit evidence

As I disclaimed my audit opinion on UKHSA, I was unable to obtain assurance over the UKHSA transactions and balances included within the Departmental accounts which are set out in note 21 to the accounts.

I have set out in further detail the background to the disclaimer issued on the 2022-23 UKHSA financial statements within my report to the House of Commons on pages 223 to 228.

2) Basis for qualified opinion on opening balance of inventory and associated in-year transactions due to lack of records

Overview

I have been unable to obtain sufficient appropriate evidence to support the existence, valuation or completeness in respect of £1.36 billion of consumables inventory in the Core Department & Agencies' and Group Statements of Financial Position as at 31 March 2022. I was unable to assess the completeness and accuracy of the associated transactions in the Core Department & Agencies' and Group Statements of

Comprehensive Net Expenditure, including impairments and write downs recognised of £0.69 billion and inventory consumption of £0.83 billion recorded in note 12 for 2022-23, and impairments and write downs recognised of £1.56 billion and inventory consumption of £8.0 billion recorded in note 12 for 2021-22.

I have been unable to obtain sufficient appropriate evidence as the Department was unable to perform appropriate stock takes or provide alternative assurance to support the balances and transactions I have listed above.

Matter giving rise to qualification

The Department holds substantial amounts of personal protective equipment ('consumable' PPE) inventory that was purchased and held in response to the COVID-19 pandemic. As at 31 March 2022 there were insufficient stock take procedures in place and the Department was unable to provide alternative evidence to support the existence, completeness and valuation in lieu of a stock take. Therefore, I limited the scope of my audit opinion on this balance and the associated impairments, write downs and consumption in the 2021-22 financial statements and I also limit the scope of my opinion on this balance and those associated impairments, write downs and consumption in this set of financial statements.

The movements of impairment, write down and consumption in the 2022-23 inventory consumables balance are all dependent on the balance as at 31 March 2022 and therefore the lack of assurance on this balance has meant that despite procedures on this area, I cannot obtain sufficient and appropriate assurance over these balances.

Scope of my audit work

The scope of my audit work, which focused on evaluating the impact of the qualification in the prior year, including the availability of any alternative assurance over the opening balances, and considering the evidence to support the valuation of inventory as at 31 March 2023, included the following:

- I reviewed the design and implementation of the controls in respect of inventory, including assessing management's approach to obtaining assurance over the existence, completeness, and valuation of the Core Department's inventory and confirmed the Department was unable to provide alternative assurances over the 31 March 2022 balance.
- As set out on page 148, management did not undertake appropriate stock takes over PPE recorded in the financial statements as consumable inventory as at 31 March 2023. I have therefore performed alternative audit procedures to obtain assurance that the closing balance of consumable inventory is not materially misstated.
- I tested inventory additions by agreeing the purchases to supporting invoices, considered the evidence relating to inventory consumption, and agreed the in-year disposals of PPE to destruction certificates from third parties.
- I reviewed and challenged management on the appropriateness of impairments made against its inventory balance. This included checking progress against management's disposal plan for excess and unusable PPE inventory and comparing the initial disposal plan against the actuals in year. I also reviewed the future plans for disposal, including

in the period after the financial statement reporting date and challenged management on the future disposal assumptions.

- Management's disposal programme shows that it will dispose of nearly all of its current PPE inventory stock due to excess volumes being held compared to demand, or to inventory being unusable in a medical setting, thereby rendering the majority of PPE inventory of insignificant value, as set out on page 148.
- This has therefore provided sufficient assurance that the closing balance of PPE inventory is not materially misstated. I have noted that control deficiencies were identified in respect of this matter and these have been disclosed by the Department on page 148 of its Annual Report. My audit has carried out the alternative procedures set out above as a result of these deficiencies.

Why I was unable to obtain sufficient appropriate audit evidence
My opinion remains qualified in respect of comparative figures for inventory because no assurance has been provided to support the balance at 31 March 2022. In the absence of assurance over this balance I was unable to assess the completeness and accuracy of the associated transactions of consumption, impairments and write downs.

I have however been able to undertake sufficient appropriate procedures to conclude the inventory balance as at 31 March 2023 is not materially misstated and is therefore not subject to qualification.

Basis for qualified opinion on regularity

I have qualified my opinion on regularity in three respects.

1) **Basis for qualified opinion on regularity as I have been 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**

The issues that gave rise to me disclaiming my opinion on the UKHSA financial statements, as explained in the Basis of qualified opinions on the financial statements section, also led me to disclaim my regularity opinion on UKHSA. I have therefore limited the scope of my opinion in respect of transactions incurred by UKHSA included in the Department's financial statements, which are set out in note 21 to the 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 against the Voted Resource Departmental Expenditure Limit**

Parliament authorised a Voted Resource Departmental Expenditure Limit of £139.88 billion for the Department in 2022-23. Against this limit, the Department incurred an outturn of £140.83 billion, exceeding the authorised limit by £0.95 billion. This excess was due to the accruing of £2.48 billion for the Agenda for Change pay award offered by the Government in March 2023 and subsequently accepted by the NHS Staff Council. As a result, the Department has exceeded its Voted Resource Departmental Expenditure Limit control total, as shown in the Statement of Outturn against Parliamentary Supply, causing an Excess Vote and a qualification of my opinion on regularity.

3) Basis for qualified opinion on regularity due to the breach of funding conditions for the Elective Recovery Fund

The Department received £1.4 billion of ringfenced 'Elective Recovery Fund' funding in 2022-23, which was conditional on elective recovery targets being met. Elective recovery targets were not met and HM Treasury deemed this to be irregular. As a result, I have concluded that the £1.0 billion of conditional funding for which the required conditions were not met is irregular under Managing Public Money as HM Treasury consent is a requirement within this framework. Therefore I have qualified my opinion on regularity in respect of £1.0 billion of this funding.

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 and Regularity of Public Sector Bodies in the United Kingdom (2022). 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 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.

The framework of authorities described in the table below has been considered in the context of my opinion on regularity.

Framework of authorities	
Authorising legislation	Government Resources and Accounts Act 2000
Parliamentary authorities	Supply and Appropriations Act
HM Treasury and related authorities	Managing Public Money

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 is anticipated that the services which they provide will continue into the future.

Overview of my audit approach

Key audit matters

Key audit matters are those matters that, in my professional judgment, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditor, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. Alongside the matters set out below, my work relating to UKHSA, and on the existence, completeness and valuation of inventory as described in the Basis of qualified opinion paragraphs were also key audit matters.

These matters were addressed in the context of the audit of the financial statements as a whole, and in forming my opinion thereon. I do not provide a separate opinion on these matters.

This is not a complete list of all risks identified through the course of my audit but only those areas that had the greatest effect on my overall audit strategy, allocation of resources and direction of effort. I have not, for example, included information relating to the work I have performed in response to the presumed audit risks of management override of controls or of fraud in revenue recognition, for which I did not identify any matters to report. I have also not included information relating to the work I have performed in response to other risks identified arising from the preparation of the consolidated annual report and accounts, the valuation, existence and allocation of accruals, the Parliamentary Supply classification of COVID-19 transactions, or the risk of material irregularity due to fraud, for which I did not identify any matters to report.

The key audit matters were discussed with the Audit and Risk Committee; its report on matters that it considered to be significant to the financial statements is set out on pages 122-124.

Key audit matter – Valuation and disclosure of the NHS Resolution clinical negligence provisions

Description of risk

The Departmental Group recognised provisions totalling £69.3 billion at 31 March 2023 in relation to clinical negligence (31 March 2022: £128.2 billion). See note 16 to the financial statements.

There are significant judgements implicit in the valuation of the clinical negligence provisions. The valuation requires the support of actuarial experts and involves the use of actuarial assumptions, models, and data held within the NHS Resolution Claims Management System. The 'incurred but not reported' (IBNR) provision includes a greater level of estimation uncertainty as judgements are required by management in respect of the level of claims that will be received for incidents that occurred prior to the reporting date but have not yet been reported to NHS Resolution.

The highly material value of the provisions and the level of judgement and estimation uncertainty inherent in the calculation could result in material misstatement of the Department's financial statements.

How the scope of my audit responded to the risk

In my capacity as group auditor, I directed the auditors of NHS Resolution and satisfied myself that they had:

- reviewed the design and implementation of the controls in place in respect of management's review of the valuation prepared by the actuarial adviser (Government Actuary's Department).
- assessed the independence, objectivity and expertise of the actuarial adviser used in developing the valuation.
- assessed and tested the completeness and accuracy of the incident data which forms the basis of the input data into the model.
- tested the arithmetic accuracy and the logic of the model.
- engaged an actuarial specialist to review the actuarial valuation report to confirm the appropriateness of the methodology and assumptions utilised by the actuarial adviser. I challenged NHS Resolution management in respect of key assumptions utilised, including the use of relevant indices and COVID-19 impacts.

I have assessed the adequacy of the financial statements disclosure, set out on pages 300 to 304.

Key observations

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 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.

I did not identify any material misstatements in the valuation or disclosure of the NHS Resolution clinical negligence provisions in the course of completing my work.

Key audit matter – Implementation of new accounting standards (IFRS 16)

Description of risk

The Departmental Group reported right-of-use assets of net book value £4.6 billion and associated lease liabilities of £4.4 billion at 31 March 2023. See notes 8 and 15 to the financial statements.

IFRS 16: Leases was implemented by the Department (and across government) with effect from 1 April 2022 as required by the government's Financial Reporting Manual (FReM), impacting on the Department's financial reporting. There are a significant number of intra-group leases requiring elimination in the Group accounts; the gross net book value of right-of-use assets in the Departmental Group is £7.3 billion. £2.7 billion of these assets are leased from other components within the group and therefore their value is eliminated upon consolidation into the Group accounts. This presents a considerable audit risk as lessor and lessee accounting transactions are asymmetrical under IFRS 16. Lease liabilities are unwound through payments and unwinding of discounting and right-of-use assets are depreciated and impaired over the lease term. There is a high level of technical complexity in performing the elimination of balances and transactions related to leases accounted for under IFRS 16 and additional data are required from component bodies to permit these eliminations.

There are some aspects of *IFRS 16: Leases* which are implemented differently between International Financial Reporting Standards (IFRS) and the FReM. One such area is the treatment of 'peppercorn' leases. The FReM requires valuation of these leases at current value in existing use or fair value, whereas IFRS allows the additional option of valuing using depreciated cost. In the case of a 'peppercorn' lease this might result in a £nil or negligible right-of-use asset value. NHS Property Services Ltd follows IFRS and has a significant portfolio of 'peppercorn' leases which are valued using depreciated cost. I therefore need to assess the appropriateness of the consolidation adjustment implemented.

In addition, in 2021-22, the audit opinion on the NHS Property Services Ltd financial statements was qualified due to its inability to demonstrate compliance with *IFRS 16: Leases* in respect of 182 occupational arrangements, including undocumented leases, undocumented lease extensions, and renewal arrangements where there is no specific contractual period. These arrangements are excluded from transactions and balances accounted for under *IFRS 16: Leases*; NHS Property Services Ltd was unable to demonstrate whether the recognition criteria had been met, leading to a potential understatement of right-of-use assets and lease liabilities, with a resulting impact on in-year expenditure. There is a risk that leases of this type are not accounted for in compliance with *IFRS 16: Leases* across the Departmental Group.

	I reviewed the design and implementation of the Department's controls in respect of the implementation of *IFRS 16: Leases* and the scope of the data obtained from component bodies of the group to enable the Group accounts to be compiled. I reviewed the Department's approach to communicating the requirements of the standard, and specific guidance on its implementation, to component bodies of its group. I have reviewed adjustments made between the statutory account figures of component bodies and those consolidated into the Group accounts. I have assessed the qualified opinion on the NHS Property Services Ltd 2022-23 financial statements to be immaterial to the Departmental Group accounts.
How the scope of my audit responded to the risk	I challenged management to refine its initial estimate of the impact of NHS Property Services Ltd's 'peppercorn' leases, as its original assessment did not sufficiently evidence the accuracy and appropriateness of the data provided by NHS Property Services Ltd. I engaged a property valuation expert to assess the Department's revised valuation of these 'peppercorn' leases. I have reviewed the quantitative and qualitative disclosures made in the financial statements to ensure that they are sufficient and accurate. **Key observations** In the course of completing this work, I did not identify any material misstatements in the completeness, valuation, and disclosure of leases accounted for under *IFRS 16: Leases*.

Key audit matter – Property valuations across the Departmental Group

Description of risk

The Departmental Group reported property recognised under IAS 16: Property, Plant and Equipment *of net book value £51.8 billion, property recognised under* IFRS 16: Leases *as right-of-use assets of net book value £3.9 billion, property recognised under* IAS 40: Investment Property *valued at £0.2 billion, and property recognised under* IFRS 5: Non-current Assets Held for Sale and Discontinued Operations *valued at less than £0.1 billion as at 31 March 2023 (31 March 2022: Property recognised under* IAS 16 *£48.3 billion, investment property recognised under* IAS 40 *£0.2 billion, and property held for sale recognised under* IFRS 5 *£0.1 billion). See the Consolidated Statement of Financial Position and notes 6 and 8 to the financial statements.*

The net book value of property is highly material to the Department's financial statements; the majority of the Department's property is owned by individual NHS providers, mainly consisting of hospitals and other healthcare buildings. NHS providers are required by the Department to value their specialised property assets on a depreciated replacement cost (DRC) basis using the modern equivalent asset (MEA) basis. The valuation of these property assets represents

significant accounting estimates in each NHS provider's accounts, which are sensitive to key assumptions made by local NHS provider management. Due to the complexities involved, support is often sought from external valuers, operating in line with guidance issued by the Royal Institution of Chartered Surveyors (RICS). Valuers need to consider external factors such as sustained inflationary pressures when valuing as at 31 March 2023.

There is a high level of judgement involved in the underlying assumptions utilised for estimating the value of these property assets. There is also a risk that estimates may be manipulated by NHS provider management in response to NHS system incentives to achieve a desired valuation outcome.

How the scope of my audit responded to the risk	In my capacity as group auditor, I directed the auditors of NHS providers to obtain specific information on their valuation methodology and approach in respect of properties, in addition to undertaking their planned procedures. I have evaluated this information in aggregate to establish the appropriateness and consistency of the valuation basis. In my capacity as group auditor, I performed year-on-year analytical procedures for total property valuations of NHS providers in aggregate. I reviewed management's assessment of the impact on the reinforced autoclaved aerated concrete (RAAC) on the property valuations. **Key observations** I did not identify any material misstatements in the valuation of property in the course of this work.

Key audit matter – Valuation of the Contaminated Blood Provision (including impact of the inquiry)

Description of risk

The Department recognised provisions totalling £2.2 billion as at 31 March 2023 in relation to the Infected Blood payment scheme, which is for individuals who were infected with HIV and/or hepatitis C following treatment with NHS-supplied blood or blood products, and their bereaved partners (31 March 2022: £2.7 billion). See note 16 to the financial statements.

Provisions are inherently risky as they are estimates determined by management and include judgements and assumptions made by management. Based on my risk assessment procedures, I identified the contaminated blood provision as a significant risk based on its material value and risk profile as it is derived from a complex model.

How the scope of my audit responded to the risk	I reviewed the design and implementation of the controls in place in respect of the valuation of the contaminated blood provision, including obtaining an understanding of the relevant controls in respect of the significant inputs and assumptions in the model.

I tested the arithmetic accuracy and the logic of the model with the support of modelling experts, re-creating the model to ensure the output was appropriate.

I assessed the reasonableness of the key assumptions, the level of estimation uncertainty, and any changes since the prior year. I engaged a medical expert to assess the assumptions relating to the progression of the diseases and their impact on the individual's health and life expectancy resulting from the contaminated blood, which were applied to the model, to review the appropriateness of these. I also performed sensitivity analysis.

I assessed the completeness and accuracy of the claimant data which forms the basis of the input data into the model.

There is an ongoing infected blood inquiry. I have challenged management on the implications of the inquiry, and assessed whether the remedies and impacts of the inquiry to date were appropriately reflected in the provision as at 31 March 2023.

I have assessed the adequacy of the financial statements disclosure, set out on page 304**.**

Key observations

The procedures I performed in response to the risk of material misstatement were satisfactory to provide assurance that the provision was not materially misstated in the financial statements.

Key audit matter – Valuation of financial assets (including valuation and impairment of PDC)

Description of risk

The Core Department held financial assets valued at £48.8 billion as at 31 March 2023 (31 March 2022: £47.1 billion). See note 11 to the financial statements. The Core Department holds four categories of financial assets, three of which had material closing balances for 2022-23:

- *Public Dividend Capital (PDC) with NHS providers of £40.1 billion (31 March 2022: £36.9 billion);*
- *Share capital investments of £5.6 billion (31 March 2022: £5.5 billion);*
- *Loans with NHS providers of £2.2 billion (31 March 2022: £2.3 billion); and*
- *Loans with other bodies of £0.9 billion (31 March 2022: £2.4 billion).*

The Department is required to hold its share capital investments at 'fair value' which results in a level of inherent uncertainty in estimating the value at the 31 March 2023. The majority of these assets are held within the Departmental Group and are eliminated on consolidation.

How the scope of my audit responded to the risk	I reviewed the design and implementation of controls around the valuation of financial investments including PDC, loans with NHS provider trusts, loans with other bodies, and share capital investments. I tested in-year PDC additions and PDC assets as at year end to confirm that the assets exist. I assessed the appropriateness of the Department's impairment policy for all loans and PDC and confirmed this was consistent with prior years. I tested PDC impairment calculations to ensure they had been applied in line with the Department's accounting policy on pages 253 to 254. As part of my testing, I confirmed that after impairment the PDC held by the Core Department was equal to or greater than the net assets held by individual provider trusts. I agreed loans to NHS provider trusts to returns from providers for the Consolidated Provider Account confirming the existence and rights and obligations of the assets held at the year end, and agreed the cash repayments and fees. I tested the repayments of loans issued to other bodies. I reviewed and challenged the valuation methodology applied by the Department for each of the share capital investments held to ensure this was appropriate, and consistently applied compared to prior years. I engaged an expert to assist me in challenging management's assumptions applied in the valuations including the discount rates applied to ensure that these valuations were appropriate. I have assessed the adequacy of disclosures made in respect of the financial assets set out of page 288 to 290.
	Key observations The procedures I performed in response to the risk of material misstatement were satisfactory to provide assurance that the Core Department's financial assets are not materially misstated in the financial statements.

Application of materiality

Materiality

I applied the concept of materiality in both planning and performing my audit, and in evaluating the effect of misstatements on my audit and on the financial statements. This approach recognises that financial statements are rarely absolutely correct, and that an audit is designed to provide reasonable, rather than absolute, assurance that the financial statements are free from material misstatement or irregularity. A matter is material if its omission or misstatement would, in the judgement of the auditor, reasonably influence the decisions of users of the financial statements.

Based on my professional judgement, I determined overall materiality for the Department and its Group's financial statements as a whole as follows:

	Departmental Group	Department (Core)
Materiality	£1,700m	£1,500m
Basis for determining materiality	Approximately 1% of departmental group gross operating expenditure, adjusted to exclude the change in discount rate for provisions.	Approximately 90% of departmental group materiality.
Rationale for the benchmark applied	As a public sector department responsible for the provision of health and social care services, the Departmental Group spends money, primarily drawn down from the Consolidated Fund, to undertake this. Gross expenditure is the primary driver of the Departmental Group financial statements; the provision of health and social care in England is the Department's primary purpose and a focus of both Parliamentary and public interest. In line with Practice Note 10, I have therefore chosen gross expenditure as the appropriate benchmark to apply.	Gross expenditure of the Core Department in 2022-23 was in excess of the Departmental Group's gross expenditure (due to the elimination of £162.6 billion of Core Department funding to group bodies in the Departmental Group Statement of Comprehensive Net Expenditure). As a result, materiality for the Core Department has been capped at 90% of the group materiality.

Performance Materiality

I set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality of the financial statements as a whole. Group performance materiality was set at 75% of Group materiality for the 2022-23 audit. In determining performance materiality, I have considered the uncorrected misstatements identified in the previous period.

Other Materiality Considerations

Apart from matters that are material by value (quantitative materiality), there are certain matters that are material by their very nature and would influence the decisions of users if not corrected. Such an example is any errors reported in the Related Parties note in the financial statements. Assessment of such matters needs to have regard to the nature of the misstatement and the applicable legal and reporting framework, as well as the size of the misstatement.

I applied the same concept of materiality to my audit of regularity. In planning and performing my audit work to support my opinion on regularity and in evaluating the impact of any irregular transactions, I considered both quantitative and qualitative

aspects that would reasonably influence the decisions of users of the financial statements, for example, expenditure in excess of a Parliament voted limit.

Error Reporting Threshold
I agreed with the Audit and Risk Committee that I would report to it all uncorrected misstatements identified through my audit in excess of £300,000, as well as differences below this threshold that in my view warranted reporting on qualitative grounds. I also report to the Audit and Risk Committee on disclosure matters that I identified when assessing the overall presentation of the financial statements.

Total unadjusted audit differences reported to the Audit and Risk Committee would have decreased net expenditure and increased net assets by £516.0 million.

Audit scope

The scope of my Group audit was determined by obtaining an understanding of the Department and its Group and its environment, including Department and Group-wide controls, and assessing the risks of material misstatement at the Group level.

The Department of Health and Social Care Group had total operating expenditure of £129 billion, total assets of £102 billion, and total liabilities of £124 billion, as shown in the Consolidated Statement of Comprehensive Net Expenditure on page 229 and the Consolidated Statement of Financial Position on page 230. The group's largest components in respect of expenditure are the Consolidated NHS Provider Accounts, NHS England, and the Core Department. The group's largest components in respect of assets are Consolidated NHS Provider Accounts and the Core Department. The group's largest components in respect of liabilities are NHS Resolution and the Consolidated NHS Provider Accounts. I classed the Core Department, NHS England, Consolidated NHS Provider Accounts, and NHS Resolution as significant components of the group by size.

I further classed the UK Health Security Agency as a significant component of the group by risk, given the disclaimer I issued in the prior year as set out in the Basis for qualified opinions on the financial statements section above. Two other components were material to the Group but were not classed as significant components: NHS Property Services Ltd, which had assets material to the Group at 31 March 2023; and Community Health Partnerships Ltd, which had assets and liabilities material to the Group at 31 March 2023.

I have audited the full financial information of the Core Department, as well as the group consolidation. The audits of all significant components were complete at the time of my completion of the Group audit. As Group auditor, I have gained assurance from the auditors of the significant and material components and engaged regularly on the Key Audit Matters relevant to the Group.

Through audit work on significant components, I covered:

- 95.4% of the Group's expenditure;
- 89.1% of the Group's income;
- 90.6% of the Group's assets; and
- 96.8% of the Group's liabilities.

The remainder of the transactions and balances in the Core Department & Agencies' and Group's financial statements were covered by analytical procedures performed on non-significant components. The audits of all non-significant components, with the exception of Skipton Fund Ltd (which is below the audit threshold and therefore is not audited), the Care Quality Commission, and the National Institute for Health and Care Excellence, were complete at the time of my completion of the Group audit. Together with my audit work on consolidation adjustments, this work gives me the evidence I require for my opinion on the Core Department & Agencies' and Group's financial statements as a whole.

Other Information

The other information comprises the information included in the Annual Report, but does not include the financial statements and my auditor's certificate and report thereon. 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.

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 opinions 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 as at 31 March 2022, 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 £0.69 billion and inventory consumption of £0.83 billion recorded in note 12 for 2022-23, and impairments and write downs recognised of £1.56 billion and inventory consumption of £8.0 billion recorded in note 12 for 2021-22; and
- the UKHSA total net expenditure of £3.1 billion and UKHSA total assets less liabilities of £1.8 billion recorded in note 21 for 2022-23, and 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 for 2021-22.

I have concluded that where the other information refers to any of these areas or totals that include these transactions or balances 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 and its Group and their environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Reports.

In respect solely of the matters referred to in the Basis for qualified opinions on the financial statements section and the Basis for qualified opinion on regularity section above:

- adequate accounting records have not been kept by the Department and its Group or returns adequate for my audit have not been received from branches not visited by my staff; and
- I have not received all of 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 the parts of the Remuneration and Staff Report to be audited are 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;

- providing the C&AG with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the C&AG with additional information and explanations needed for his audit;
- providing the C&AG with unrestricted access to persons within the Department and its Group from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- ensuring that the financial statements give a true and fair view and are prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000;
- ensuring that the annual report, which includes the Remuneration and Staff Report, is prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000; 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.

As set out on page 148, management did not undertake appropriate stock takes over PPE recorded in the financial statements as consumable inventory. I have therefore not been able to perform the procedures prescribed by ISA (UK) 501: Audit Evidence – Specific considerations for selected items in relation to attendance at physical inventory counting.

I have judged it necessary to depart from the attendance of management inventory counts requirement within ISA (UK) 501 because the requirement is for specific procedures to be performed and, in the specific circumstances of my audit of the financial statements of the Department, that procedure would be ineffective in achieving the aim

of the requirement, which is to obtain sufficient appropriate audit evidence regarding the existence and condition of inventory.

In accordance with the requirements of ISA (UK) 200 Overall objectives of the independent auditor and the conduct of an audit in accordance with International Standards on Auditing (UK), I have therefore performed alternative audit procedures to obtain assurance that the closing balance of consumable inventory is not materially misstated.

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, I:

- considered the nature of the sector, control environment and operational performance including the design of the Department and its Group's accounting policies;
- inquired 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 on:
    - identifying, evaluating and complying with laws and regulations;
    - detecting and responding to the risks of 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, and the Supply and Appropriation (Main Estimates) Act 2022;
- inquired of management, the Department's head of internal audit and those charged with governance whether:
    - they were aware of any instances of non-compliance with laws and regulations; and
    - they had knowledge of any actual, suspected, or alleged fraud;
- discussed with the engagement team including significant component audit teams and the relevant internal and external specialists 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, complex transactions, bias in management estimates and claims that feed into clinical negligence provisions. In common with all audits under ISAs (UK), I am required to perform specific procedures to respond to the risk of management override.

I obtained an understanding of the Department and Group's framework of authority and other legal and regulatory frameworks in which the Department and Group operates. I focused 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 2022, employment law, tax legislation, health & safety legislation, and pensions legislation.

Audit response to identified risk

To respond to the identified risks resulting from the above procedures:

- I reviewed 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;
- I enquired of management and the Audit and Risk Committee concerning actual and potential litigation and claims;
- I reviewed 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, I tested the appropriateness of journal entries and other adjustments; assessed whether the judgements on estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- I reviewed the Department's methodology and assumptions in assessing the level of fraud across the NHS and non-NHS bodies in the Group.

I also communicated relevant identified laws and regulations and potential risks of fraud 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: 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 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 I identify during my audit.

Gareth Davies **22 January 2024**
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) 2022-23 which include:

- COVID-19 inventory management; and
- financial management and oversight of the DHSC group including the NHS.

I also explain why I have qualified my opinion on a number of matters including;

- the limitation of scope qualification due to the continuing lack of assurance over the accounts of the UK Health Security Agency;
- the qualifications of my regularity opinion in respect of the Elective Recovery Fund and a control total breach arising from the implementation of the Agenda for Change workforce pay award; and
- the limitation of scope qualification on the opening balance and associated 2022-23 impairments, write downs and consumption qualification in respect of PPE inventory.

Management of Personal protective equipment inventory

2. **As part of its response to the COVID-19 pandemic, the Department procured £13.6 billion of personal protective equipment (PPE).** The procurement took place in 2020-21 and 2021-22. PPE that had not been used or disposed of remained on the Department's Statement of Financial Position at the 31 March 2023 year-end.

3. **Since 2020-21, of the £13.6 billion it has spent, the Department has written down the value of its PPE inventory by £9.9 billion because it was unusable or its market price had fallen since it was purchased during the pandemic.** Some PPE was not usable by the Department because it was defective or not suitable for use within the health and social care sector. Other PPE was not defective, but the Department will not be able to use it before its expiry date.

4. **In 2021-22, I limited the scope of my audit opinion because I was unable to obtain sufficient, appropriate evidence to support the PPE recorded in the Department's accounts.** This was because 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 PPE inventory it held. 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. In 2022-23, these weaknesses in the prior year stock-counts meant that I was unable to obtain adequate assurance that the 2022-23 impairments and consumption of PPE recorded in the Department's accounts were not materially misstated. I have limited the scope of my opinion in this respect. Further details of the impact of this are provided in my Audit Certificate.

5. **In 2022-23 the Department did not perform full and complete stock counts on its PPE inventory, including that held in containers.** The Department has said that a full stock-count would cost £70 million, which it does not believe to be cost-effective. This is the third year in a row that the Department has not been able to apply the normally expected controls over inventory held at year end.

6. **Despite the ongoing deficiencies in the stock-counts, I have obtained sufficient, appropriate evidence over the value of PPE recorded in the Department's accounts at the 31 March 2023 year-end.** The Department's planned disposal programme shows that it will dispose of nearly all of its current PPE inventory stock held in warehouses and containers as this will not be used by the NHS. I have carried out testing to confirm that the programme is being implemented as planned. This has provided me with assurance that the majority of PPE inventory is of insignificant value and that the value of PPE recorded in the accounts is materially correct.

7. **More than three years after the start of the pandemic, the Department is still investigating and trying to recover value from its COVID-19 PPE contracts.** The Department has identified cases of fraud, and its latest estimate, as set out on page 138 is that total fraud prevented and/or recovered for PPE procurement is £202 million, out of £13.6 billion spent. The Department is still working to investigate and recover money from other potential cases of fraud and also contracts which failed to deliver.

Group Financial Management and Oversight

UK Health Security Agency

8. **In 2021-22 I took the unusual step of disclaiming my opinions over the UK Health Security Agency's accounts and I reported on the lack of governance, oversight and control.** It was possible that the impact of undetected misstatements and irregularities was both material and pervasive to the UK Health Security Agency (UKHSA) financial statements, and I therefore issued a disclaimer on my 'true and fair' and 'regularity' opinions on the UKHSA financial statements. I consequently limited the scope of my true and fair and regularity opinions over UKHSA transactions and balances recorded in the Department's accounts.

9. **In 2022-23 I have again disclaimed my opinions over the UKHSA accounts.** Whilst UKHSA has improved its governance arrangements and was ultimately able to provide transactions listings that agree to its accounts for the first time, the lack of assurance which led to the prior year disclaimer meant that I was unable to obtain assurance over the opening balances and in-year transactions. In addition, I was unable to obtain assurance before the statutory deadline for laying accounts, over the Covid Vaccine Unit model which was transferred from DHSC to UKHSA on 1 October 2022. This model predicts future demand for Covid vaccines and assesses the extent to which vaccines held will be used before they expire. It supports a number of significant balances in the UKHSA accounts. The combination of the

impact of the prior year disclaimer and the lack of assurance over the model led me to issue a disclaimer on my 'true and fair' and 'regularity' opinions on the UKHSA financial statements.

10. **The disclaimer on the UKHSA 2022-23 accounts means that I have been unable to obtain sufficient, appropriate audit evidence to support the UKHSA total net expenditure of £3.1 billion and UKHSA total assets less liabilities of £1.8 billion as set out in Note 21 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 21 to the accounts. Further details of my findings from the UKHSA audit can be found in my Report on Account on UKHSA's 2022-23 accounts.

Delays to accounts and audits process for NHS bodies

11. **Timeliness of financial reporting across the NHS continued to be a challenge in 2022-23, undermining oversight and accountability across the group:** 23% of NHS providers and 20% of NHS commissioners missed NHS England's certification deadline of 30 June 2023, compared with 28% of NHS providers and 20% of NHS commissioners in 2021-22. Before the COVID-19 pandemic, DHSC routinely laid its annual report and accounts in Parliament before the Parliamentary summer recess. The Department has not achieved this since the pandemic.

12. **A significant number of NHS provider and NHS commissioner audits were ongoing at 30 November 2023, the date the Department originally committed to Parliament that its accounts would be certified by.** 3% of NHS providers and 8% of NHS commissioner audits were not completed by 30 November 2023, preventing my certification of the Consolidated NHS Provider Accounts and NHS England financial statements, and consequently delaying the Department's financial statements. This has prevented timely reporting which is a key part of effective management of public money and public trust in how taxpayers' money is spent. NHS England clearly recognises the risks that late auditor reporting can represent and has been proactive in using its influence to support providers, commissioners and local auditors with timely delivery.

13. **I reported on the timeliness of local auditor reporting on local government in 2023, and found that delays to local government audit opinions adversely impacted on NHS bodies.** NHS bodies reported growing concerns about the capacity of their external auditors, resulting in auditors carrying out fewer interim audits and increasing pressure on the audit of the final accounts. They also reported concerns around the attractiveness of the market to audit providers and the capacity of NHS finance staff to meet accounts preparation timetables. A further impact of delays to local government audited accounts is delayed provision of assurance in respect of Local Government Pension Scheme (LGPS) asset valuations to NHS bodies and others.

Financial management and oversight of group bodies

14. **I noted a number of financial and compliance issues in bodies across the Departmental Group.** In addition to the issues on UKHSA and the timeliness of NHS reporting, these have included the following.

- **Irregular suspension payments to suspended medical practitioners.** Under certain qualifying circumstances, NHS England can make suspension payments to medical practitioners who have been suspended as set out in relevant statutory regulations. Twelve medical practitioners were identified in 2022-23 as having received ineligible suspension payments over the 2017-18 to 2022-23 financial years (see para 701 to 706), totalling £1,335,626, including £156,429 paid in 2022-23 to eight medical practitioners. I have qualified my NHS England regularity opinion in relation to these ineligible suspension payments.

- **Compliance with accounting standards and HM Treasury (HMT) Guidance.** A number of bodies across the DHSC group had accounting and governance issues which in some cases led to a qualified audit opinion. There were a number of cases across the DHSC group of potentially novel, contentious or repercussive expenditure, for which HMT or Cabinet Office approval was required. Whilst in most instances these approvals were granted retrospectively, there is a weakness in the timely identification and approving of these transactions.

I do not consider these to be material to the DHSC group, so have not qualified my opinion on the group for these matters.

Qualifications of my audit opinion on the regularity of expenditure

Elective Recovery Fund

15. **The Department received £1.4 billion of ringfenced funding from the Consolidated Fund, termed 'Elective Recovery Funding' (ERF), in 2022-23.** The framework of authorities for this funding was set by HMT through the 2022-23 NHS operational planning guidance exercise.

16. **ERF was required to be 'earned' by Integrated Care Systems (ICSs) hitting elective recovery targets.** Where elective recovery targets were not met, the cash received by the Department should have been returned to the Consolidated Fund.

17. **I received notification from the Department in March 2023 that elective recovery targets had not been met across a number of ICSs, but the associated funding had not been returned to the Consolidated Fund.** The Department had requested from HMT a relaxation of the ringfence; HMT prospectively relaxed the ringfence

for the remainder of 2022-23 but did not approve a retrospective relaxation of the ringfence for the circa £1.0 billion of funding to ICSs up to that point.

18. **I have qualified my regularity opinion on the Department's accounts in respect of the ERF expenditure of £1bn.** The expenditure was not spent in accordance with the framework of authorities because a condition of the funding, meeting elective recovery targets, was not met.

Excess Vote due to a control total breach

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 Department's outturn against Voted Resource Departmental Expenditure Limit (Voted RDEL) was £140.83 billion but Parliament had authorised Voted RDEL of £139.88 billion for the Department in 2022-23.** This means that the authorised limit was breached by £0.95 billion.

21. **The Department has identified the accrual of the 2022-23 Agenda for Change (AfC) workforce pay award, of £2.48 billion, as the reason for the breach.** The Department made a final pay award offer for the AfC workforce to unions on 16 March 2023, following pay negotiations between the government and the NHS Staff Council (comprising NHS employers and unions representing the AfC workforce). This offer included a non-pensionable, non-consolidated pay award for 2022-23, and a consolidated pay award for 2023-24. The Department has accrued for the 2022-23 element of the pay award in its accounts as the award had been agreed between the government and AfC unions. Following balloting by AfC unions, the NHS Staff Council agreed that the pay offer should be implemented on 2 May 2023.

22. **The timing of the pay offer in March 2023 meant that the Department was unable to request additional Resource Departmental Expenditure Limit (RDEL) budget to cover the pay award through the Supplementary Estimate process, which was published in February 2023.** Given the proximity of the Department to its Voted RDEL control total prior to the pay award being agreed, and the value of the pay award (£2.48 billion for 2022-23), the Department has breached its 2022-23 Voted RDEL control total by £0.95 billion. The Department sought, and obtained, a Ministerial Direction to implement the pay award. It sought the Direction because implementation of the pay award was not compliant with Managing Public Money as it would cause an Excess Vote.

23. **Due to this breach of its Voted RDEL control total, I have qualified my regularity opinion on the Department's accounts.**

Future challenges

24. **The Department continues to face significant challenges, both financial and operational, in the immediate future.** The NHS elective care waiting list rose in 2023 to the highest level on record and is forecast by The Health Foundation to peak in August 2024. A number of other key targets, including ambulance response times for all categories, are consistently being missed. I will be reporting on financial management of the NHS in England in summer 2024.

Recommendations

25. The Department should continue to investigate potential cases of fraud in COVID-19 procurement and ensure that it recovers as much money as possible where it has identified fraud and also from contracts that have failed to deliver.

26. I recommended in 2021-22 that the Department implement an action plan to get UKHSA on track to deliver auditable financial statements for 2022-23, restore timely financial reporting across the NHS, and establish more effective oversight of the Departmental Group. My findings within this report highlight that despite some progress further work is still needed to ensure the Department exercises adequate oversight over its group and supports its entities to strengthen financial governance and control. This should include:

- continuing to support and oversee UKHSA in addressing the challenges in its financial control environment to embed strong financial management within the entity to enable the production of fully auditable financial statements for 2023-24;
- working with NHS England and wider Government, the Department must develop a clear plan to work with local NHS bodies and their auditors to produce audited accounts to enable a pre-summer recess sign off of the Departmental Group as soon as possible; and
- strengthening its governance and controls across the group to ensure that bodies produce unqualified accounts and comply with Department, HM Treasury, and Cabinet Office requirements.

Gareth Davies **22 January 2024**
Comptroller and Auditor General

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

Financial Statements

Consolidated Statement of Comprehensive Net Expenditure

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

For the period ended 31 March 2023

		2022-23		2021-22	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Income from contracts	5	(2,260,805)	(11,165,446)	(1,546,108)	(9,169,687)
Other operating income	5	(1,211,298)	(1,788,895)	(1,173,585)	(1,474,643)
Income received by NHS charities		-	(169,781)	-	(162,055)
Total operating income		**(3,472,103)**	**(13,124,122)**	**(2,719,693)**	**(10,806,385)**
Staff costs	3	868,370	85,089,315	1,335,416	76,742,959
Purchase of goods and services	4	4,169,662	82,808,978	17,499,971	94,459,703
Depreciation and impairment charges	4	(92,897)	4,974,148	1,190,467	6,582,161
Provision expense	4	(163,608)	(56,685,146)	4,991,908	51,046,883
Other operating expenditure	4	9,395,974	13,010,995	10,132,565	13,983,635
Grant in Aid to NDPBs		162,007,841	-	156,158,304	-
Funding to Group bodies		606,190	-	642,947	-
Resources expended by NHS charities		-	75,326	-	62,637
Total operating expenditure		**176,791,532**	**129,273,616**	**191,951,578**	**242,877,978**
Net operating expenditure for the year ended 31 March 2023		**173,319,429**	**116,149,494**	**189,231,885**	**232,071,593**
Finance income		(70,418)	(328,027)	(66,828)	(26,565)
Finance expense		18,569	1,325,388	(14,770)	1,367,420
Net (gain)/loss on transfers by absorption		(97,021)	(182,613)	155,672	-
Total Net Expenditure for the year ended 31 March 2023		**173,170,559**	**116,964,242**	**189,305,959**	**233,412,448**
Other Comprehensive Net Expenditure					
Items that will not be reclassified to net operating costs:					
Net (gain)/loss on:					
- revaluation of property, plant and equipment	CSoCTE	(28,828)	(2,850,195)	(1,036)	(1,898,532)
- revaluation of right of use assets	CSoCTE	-	(25,324)	-	-
- revaluation of intangibles	CSoCTE	(30,118)	(31,133)	(9,628)	(11,001)
-revaluation of charitable assets	CSoCTE	-	18,842	-	(21,262)
- impairments and reversals taken to revaluation reserve	CSoCTE	-	575,820	-	172,496
- equity instruments measured at fair value through OCI	CSoCTE	(169,664)	73,959	143,689	219,517
- fair value gains/(losses) on other financial assets mandated at FV through OCI	CSoCTE	-	136	-	265
Actuarial (gains)/losses on defined benefit pension schemes	CSoCTE	-	(113,630)	-	(87,317)
Other pensions remeasurements	CSoCTE	-	44,579	-	6,411
Other (gains) and losses	CSoCTE	-	17,367	72,331	81,873
Total Comprehensive Expenditure for the year ended 31 March 2023		**172,941,949**	**114,674,663**	**189,511,315**	**231,874,898**

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.

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 2023

		2022-23		2021-22	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Non-current assets					
Property, plant and equipment	6	1,181,130	66,872,802	1,056,721	62,267,053
Investment property		44,125	240,813	41,083	235,928
Intangible assets	7	103,033	2,734,969	212,588	2,669,674
Right of use assets	8	234,907	4,632,328	-	-
Charitable non-current assets		-	8,431	-	4,394
Financial assets- Investments	11	48,799,049	651,426	47,088,536	682,182
Charitable investments		-	355,641	-	379,324
Other non-current assets	14	419,088	900,718	483,259	1,005,387
Total non-current assets		**50,781,332**	**76,397,128**	**48,882,187**	**67,243,942**
Current assets					
Assets classified as held for sale		750	45,117	-	55,134
Inventories	12	1,053,480	2,602,442	2,153,275	3,582,839
Trade and other receivables	14	1,312,919	4,459,331	1,209,755	3,994,802
Other current assets	14	392,071	2,291,887	540,110	2,223,473
Charitable other current assets		-	24,015	-	20,550
Other financial assets	14	215,018	2,277	210,989	1,329
Cash and cash equivalents	13	1,016,021	15,561,412	959,885	18,096,779
Charitable cash		-	259,924	-	258,141
Total current assets		**3,990,259**	**25,246,405**	**5,074,014**	**28,233,047**
Total assets		**54,771,591**	**101,643,533**	**53,956,201**	**95,476,989**
Current liabilities					
Trade and other payables	15	(676,542)	(9,165,003)	(2,084,242)	(10,347,270)
Other liabilities	15	(3,497,591)	(24,766,815)	(5,404,965)	(23,250,580)
Charitable liabilities		-	(54,345)	-	(43,113)
Provisions	16	(982,060)	(5,310,129)	(3,865,458)	(7,710,794)
Total current liabilities		**(5,156,193)**	**(39,296,292)**	**(11,354,665)**	**(41,351,757)**
Non-current assets less net current liabilities		**49,615,398**	**62,347,241**	**42,601,536**	**54,125,232**
Non-current liabilities					
Other payables	15	(147,214)	(993,689)	(46,916)	(907,982)
Charitable liabilities		-	(3,634)	-	(626)
Provisions	16	(3,625,023)	(71,053,568)	(4,829,137)	(131,992,133)
Net pension asset/(liability)		-	(12,727)	-	(81,747)
Financial liabilities	15	(297,014)	(12,833,776)	-	(10,008,766)
Total non-current liabilities		**(4,069,251)**	**(84,897,394)**	**(4,876,053)**	**(142,991,254)**
Total assets less liabilities		**45,546,147**	**(22,550,153)**	**37,725,483**	**(88,866,022)**
Taxpayers' equity and other reserves					
General fund		40,565,147	(39,150,679)	33,024,559	(103,219,248)
Revaluation reserve		234,864	15,809,765	89,634	13,446,004
Other Reserves		4,746,136	200,729	4,611,290	288,552
Total Taxpayers' Equity		**45,546,147**	**(23,140,185)**	**37,725,483**	**(89,484,692)**
Charitable funds		-	590,032	-	618,670
Total Reserves		**45,546,147**	**(22,550,153)**	**37,725,483**	**(88,866,022)**

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. Note 21 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 in paragraphs 527 to 537.

21 January 2024
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 2023

		2022-23		2021-22	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
	Notes	£'000	£'000	£'000	£'000
Net cashflow from operating activities					
Net expenditure for the year		(173,170,559)	(116,964,242)	(189,305,959)	(233,412,448)
Adjustments for non-cash transactions	4.2	635,791	(50,668,574)	4,400,481	56,234,347
Adjustments for net finance costs		(66,052)	767,623	(65,684)	979,309
Other non cash movements in Statement of Financial Position items		(13,766)	(109,731)	(381,221)	(504,573)
Less movements arising from absorption transfers		(97,021)	(182,613)	155,672	-
Adjustments for charities		-	3,220	-	(9,661)
(Increase)/decrease in trade and other receivables	14	105,017	(429,222)	179,238	77,963
(Increase)/decrease in inventories	12	1,099,795	980,397	1,932,603	1,971,293
Increase/(decrease) in trade and other payables	15	(2,917,762)	3,244,685	(4,241,529)	731,876
Adjustment for working capital amount arising from absorption transfers		(17,472)	(17,472)	5,924	-
Adjustment for working capital balances in the SoFP not flowing through the SoCNE[1]		(292,959)	(3,226,572)	428,221	622,756
Use of provisions	16	(899,301)	(3,798,409)	(378,745)	(2,997,843)
Transfer of provisions to payables/ inventories	16	(3,041,959)	(3,085,076)	(1,500,654)	(1,523,313)
Cash payments in respect of pensions		-	(6,396)	-	(12,880)
Other operating cashflows		53,903	46,057	9,071	15,326
Net cash outflow from operating activities		**(178,622,345)**	**(173,446,325)**	**(188,762,582)**	**(177,827,848)**
Cash flows from investing activities					
Purchase of property, plant and equipment & investment properties		(256,180)	(7,565,135)	(306,320)	(7,030,281)
Purchase of intangible assets		(109,742)	(847,435)	(117,348)	(957,825)
Proceeds of disposal of property, plant and equipment		16,538	106,396	21,277	109,114
Proceeds of disposal of intangibles		230	4,575	16,864	19,276
Proceeds of disposal of right of use assets		4,171	1,229	-	-
Proceeds of disposal of assets held for sale		-	70,591	357,109	412,176
Purchase of investments		(3,676,102)	(34,133)	(3,603,094)	(58,013)
Proceeds of disposal of investments		1,742,633	8,423	3,678,715	15,653
Receipts in respect of finance leases		4,382	12,396	-	-
Interest Received from group bodies		45,313	-	68,551	-
Interest Received from external bodies		1,379	303,281	125	20,920
Non-cash disposals of financial assets		(104)	-	-	-
Payment of direct costs in respect of obtaining right of use assets		-	(323)	-	-
Other investing cashflows		10,831	11,474	272	748
Net cash outflow from investing activities		**(2,216,651)**	**(7,928,661)**	**116,151**	**(7,468,232)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year	CSoCTE	144,900,000	144,900,000	163,200,000	163,200,000
Net financing from the National Insurance Fund	CSoCTE	36,266,858	36,266,858	25,196,757	25,196,757
Net Movements of Capital element of Loans		-	(7,952)	-	19,254
Payments in respect of leases		(36,400)	(718,782)	-	-
Capital element of payments in respect of PFI contracts		-	(410,909)	-	(488,881)
Interest paid to group bodies		(1,011)	-	(1,517)	-
Interest paid to external bodies		(21)	(983,314)	(100)	(912,887)
Net cash transferred under absorption accounting		51,047	51,047	-	-
Other financing cashflows		(1,329)	(1,731)	-	20
Net financing		**181,179,144**	**179,095,217**	**188,395,140**	**187,014,263**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**340,148**	**(2,279,769)**	**(251,291)**	**1,718,183**
Payment of amounts due to the Consolidated Fund		(284,012)	(284,012)	(365,721)	(365,721)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**56,136**	**(2,563,781)**	**(617,012)**	**1,352,462**
Cash and cash equivalents at the beginning of the period		959,885	18,344,367	1,576,897	16,991,905
Cash and cash equivalents at the end of the period		**1,016,021**	**15,780,586**	**959,885**	**18,344,367**

1. The adjustment for working capital balances in the SoFP not flowing through the SoCNE mainly relates to movements in current and non-current lease liabilities (£3.8 billion) as discussed in Note 15.

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 2023

		Core Dept & Agencies				Departmental Group					
	Note	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Taxpayers' Equity £'000	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Taxpayers' Equity £'000	Charitable Funds £'000	Total Reserves £'000
Balance at 1 April 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)
Prior period adjustments in local accounts		-	-	-	-	(22,400)	56,804	(5,642)	28,762	(567)	28,195
Impact of adoption of IFRS 16		6,578	-		6,578	235,514	-		235,514		235,514
Net parliamentary funding - drawn down		144,900,000			144,900,000	144,900,000			144,900,000		144,900,000
Net parliamentary funding - deemed		1,247,417			1,247,417	1,247,417			1,247,417		1,247,417
National Insurance contributions		36,266,858			36,266,858	36,266,858			36,266,858		36,266,858
Supply (payable)/receivable adjustment	15	(1,658,498)			(1,658,498)	(1,658,498)			(1,658,498)		(1,658,498)
CFERs and other amounts payable to the Consolidated Fund	15	(672)			(672)	(672)			(672)		(672)
PDC investment adjustment		518,337			518,337	-			-		-
Comprehensive Net Expenditure for the Year		(173,170,559)			(173,170,559)	(116,955,190)			(116,955,190)	(9,052)	(116,964,242)
Non-cash adjustments:											
Non-cash charges - auditor's remuneration	4.1	2,350			2,350	2,510			2,510		2,510
Movements in Reserves											
Recognised in Statement of Comprehensive Expenditure											
Net gain/(loss) on revaluation of non-current assets			58,946	-	58,946		2,906,652	-	2,906,652	-	2,906,652
Net gain/(loss) on revaluation of charitable assets					-				-	(18,842)	(18,842)
Fair value gains/(losses) on equity instruments designated at FV through OCI		(56,323)		225,987	169,664	(56,323)		(17,636)	(73,959)		(73,959)
Fair value gains/(losses) on other financial assets mandated at FV through OCI				-	-			(136)	(136)		(136)
Impairments and reversals			-		-		(575,820)		(575,820)	-	(575,820)
Net Actuarial Gain/(Loss) on Defined Benefit Pension Scheme		-		-	-	113,630		-	113,630		113,630
Other pensions remeasurements		-		-	-	(65,873)		21,294	(44,579)		(44,579)
Other gains and losses		-		-	-	(18,147)		780	(17,367)		(17,367)
Transfers between reserves		4,752	86,388	(91,140)	-	80,484	6,071	(86,555)	-	-	-
PDC written off		(518,337)			(518,337)	-			-		-
Other movements		(1,325)	(2)	(1)	(1,328)	(23,692)	(6,903)	72	(30,523)	(177)	(30,700)
Other transfers		10	(102)	-	(92)	22,951	(23,043)	-	(92)	-	(92)
Balance at 31 March 2023		**40,565,147**	**234,864**	**4,746,136**	**45,546,147**	**(39,150,679)**	**15,809,765**	**200,729**	**(23,140,185)**	**590,032**	**(22,550,153)**

1. 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.
2. 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.

For the year ended 31 March 2022

	Note	Core Dept & Agencies				Departmental Group					
		General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	**Taxpayers' Equity £'000**	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	**Taxpayers' Equity £'000**	Charitable Funds £'000	**Total Reserves £'000**
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 Statement of Comprehensive Expenditure											
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)**

Notes to the Department's Annual Report and Accounts

1. Statement of accounting policies

The accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) as adapted and interpreted by the 2022-23 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 2022-23 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 and transfers of assets and liabilities from demising Clinical Commissioning Groups to Integrated Care Boards established on 1 July 2022, occurred via a modified absorption approach, in which the gain/loss on transfer is recognised directly in reserves.

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, right of use assets, stockpiled goods and certain financial assets and financial liabilities.

1.3 Basis of consolidation

The accounts comprise a consolidation for the Core Department of Health and Social Care, its Executive 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 and their successor bodies Integrated Care Boards, 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 20** together with reference to entities controlled but not consolidated by the Department.

1.4 Employee Benefits

1.4.1 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.

1.4.2 Retirement benefit costs:

NHS Pensions

Past and present employees of the NHS are covered by the provisions of the two NHS Pension Schemes. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022,

updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024 to 23.7% of pensionable pay.

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.

Figures relating to NHS pensions cost for the Department can be found in **Note 3**.

1.5 Grants payable and Grant-in-Aid

1.5.1 Grants payable

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

1.5.2 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 either audited by the Comptroller and Auditor General or they appoint an auditor under local audit arrangements as is the case for NHS Trusts, Clinical Commissioning Groups and Integrated Care Boards. 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.

A significant source of revenue for the Core Department relates to the Voluntary scheme for branded medicines pricing and access (VPAS) income. The Department has judged that the scheme's performance obligations are satisfied over a period of time, as the benefit is received and consumed simultaneously. Payments are due within one month of the end of each quarter. Due to the mismatch between the timing of revenue recognition and payment, a contract asset is recognised equal to the revenue expected but not yet received. As the estimate of revenue expected is subject to uncertainty, it is constrained to levels that would not entail a significant reversal of revenue being recognised per the requirements of the Standard. The Department uses historic knowledge and experience, as well as comparison with actual payments received after the reporting date in constraining the estimate. Payments in relation to the final year of the scheme (2023 calendar year) may be subject to a refund at a later date. The Department recognises a contract liability for any amounts which it expects to refund. Further detail is provided in **Note 15.**

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 any Consolidated Fund Extra Receipts (CFERs) which fall outside the Ambit of the Vote must therefore be returned to HM Treasury, as is confirmed in the 2022-23 Main Supply Estimate paragraph 22, page 9.

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 (PPE)

1.9.1 Recognition

PPE 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.

1.9.2 Valuation of property, plant, and equipment

All PPE 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 PPE 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.

1.9.3 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.

1.9.4 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. PPE 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 PPE. 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.

1.10.1 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.

1.11 Depreciation, amortisation, revaluation and impairments of property, plant and equipment and intangible assets

1.11.1 Depreciation and amortisation of property, plant and equipment and intangible assets

Freehold land and investment properties are not depreciated/amortised. PPE 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 PPE, 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 PPE, 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.

1.11.2 Revaluation and impairments of PPE and intangible assets

An increase to an asset's value 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. 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.

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.

At each financial year-end, the Department determines whether there is any indication that its PPE 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.
Gains and losses recognised in the revaluation reserve are reported in the Consolidated Statement of Changes in Taxpayers' Equity.

1.12 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. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

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.

1.13 IFRS 16 – Leases

1.13.1 General approach of IFRS 16

IFRS 16 Leases superseded IAS 17 Leases and is effective for the Departmental Group for periods beginning on or after 1 April 2022. 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.

1.13.2 Transition to IFRS 16

The transition to IFRS 16 has been completed using the Cumulative Catch-Up Method. This retrospectively recognises 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 have not been 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 has applied the practical expedient 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, 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.
- The Department has recognised a lease liability at the date of initial application for leases previously classified as operating leases by 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 has measured the right of use assets for leases previously classified as operating leases at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.
- The Department has relied on its existing assessment of whether leases are onerous rather than carrying out an impairment review on transition in respect of certain leases.

The above transitional provisions have not been applied to operating leases:

- whose terms end within 12 months of the date of initial application
- 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 have been expensed on a straight-line basis.

On transition, hindsight has been used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease and the classification of all of its continuing subleasing arrangements have been reassessed.

1.13.3 Approach to application of IFRS 16

There are further expedients or elections that have been employed in applying IFRS 16. These include;

- The measurement requirements under IFRS 16 have not been applied to leases with a term of 12 months or less.
- The measurement requirements under IFRS 16 have not been 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.
- The Department has chosen not to apply IFRS 16 to any new leases of intangible assets. All intangible assets are accounted for by applying the approaches described in **Notes 1.10** to **1.11** of these accounting policies.

HM Treasury has 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 but may not be enforceable in their legal form. Prior to accounting for such arrangements under IFRS 16 the Department has 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.

1.13.4 Acting as a Lessee

At the commencement date for the leasing arrangement a lessee recognises a right of use asset and corresponding lease liability.

The Department employs 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 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, or appropriately modified or remeasured 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. The incremental borrowing rate increased to 3.51% for leases entered into or appropriately modified or remeasured, from 1 January 2023.

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 change to 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 determines whether the arrangement constitutes a separate lease.

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.

1.13.5 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 the leased 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 value 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.

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.

Further details regarding the nature of the Department's leasing activities and transactions are detailed in **Note 8**.

1.14 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'.

1.14.1 Services received

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

1.14.2 PFI and LIFT assets, liabilities, and finance costs

The PFI assets are recognised as PPE 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.

1.14.3 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.

1.14.4 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 PPE.

1.14.5 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.

1.15 Inventories and stockpiled goods

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.

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. 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. 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.

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.

1.16 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.

1.17 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 1.70% (2021-22: minus 1.30%) 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 short-term rate of 3.27% (2021-22: 0.47%) is applied to expected cash flows in a time boundary of between 0 and up to and including 5 years from the Consolidated Statement of Financial Position date.
- A medium-term rate of 3.20% (2021-22: 0.70%) is applied to the time boundary of after 5 and up to and including 10 years from the Consolidated Statement of Financial Position date.
- A long-term rate of 3.51% (2021-22: 0.95%) 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 very long-term rate of positive 3.00% (2021-22: 0.66%) 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.

In employing the HM Treasury inflation rates provided;

- An inflation rate of 7.4% (2021-22: 4.0%) is applied to all relevant expected cashflows up to and including 1 year from the date of the Consolidated Statement of Financial Position.
- An inflation rate of 0.6% (2021-22: 2.6%) 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 inflation rate of 2.0% (2021-22: 2.0%) is applied to all relevant cashflows exceeding 2 years from the Consolidated Statement of Financial Position date.

1.17.1 Clinical and non-clinical negligence costs

Clinical and non-clinical negligence costs are managed through schemes run by NHS Resolution (NHSR).

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 2022-23 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 contracts actuarial advisers, the Government Actuary's Department (GAD), 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.

A key assumption 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 as 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**.

The schemes NHSR manage are detailed below.

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 responsible 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 scheme covers claims arising in general practice in relation to incidents that occur on or after 1 April 2019.

Existing Liability Scheme for General Practice (ELSGP)

The scheme 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 (MDDUS) from 6 April 2020 and was extended to Medical Protection Society members from 1 April 2021.

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 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.

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.

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 2023 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 GAD to assess the potential value of IBNRs against each of the schemes it operates. The actuaries review existing claims records and, using an appropriate model, calculate values in respect of IBNRs for all schemes. The provisions and contingent liabilities arising are shown in **Notes 16** and **17** respectively. The sums concerned are accounting estimates and, although determined on the basis of information currently available, the ultimate liabilities may vary as a result of subsequent developments.

1.18 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. **Note 17** provides details of the Department's contingent liabilities. 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.

1.19 Public Dividend Capital, Funding, and interaction with 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 and do not generate a financial instrument.

The Department's investment in NHS providers is represented by Public Dividend Capital (PDC) which, being issued under statutory authority, is not classed as a financial instrument under IFRS 9.

PDC is held at historic cost less impairments. PDC is impaired, on an individual NHS provider basis, where the net assets of those NHS providers are 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 Statement of Comprehensive Net Expenditure.

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 are financial instruments under IFRS 9.

1.20 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 in line with IFRS 13.

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.

1.20.1 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.

1.20.2 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 elected to irrevocably designate its equity instruments to be measured at fair value through other comprehensive income. The Department's equity instruments relate to its investment in private limited companies as detailed in **Note 11**.

1.20.3 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.

1.20.4 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 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.

1.21 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**.

1.22 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. 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.

1.23 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.

1.24 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 relates to a programme or policy area of an entity that has an integrated set of activities and associated assets and liabilities capable of being managed to achieve specific objectives.

1.24.1 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 counterparty 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 and assets and liabilities transferred from demising CCGs to newly established ICBs as of 1 July 2022 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.

1.25 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 2022-23.

IFRS 17

Insurance Contracts which replace 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. HM Treasury interpretation and adaptation of the Standard is yet to be finalised stemming from the HM Treasury IFRS 17 implementation consultation and the Department continues to liaise closely with HM Treasury to discuss and further refine the proposed approach to implementing the new Standard. It is therefore too early for the Department to provide an estimate of the impact of adopting IFRS 17.

1.26 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 valuation approach - 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.

- Useful lives of property, plant and equipment - as shown in **Note 6**, 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.

- Share capital valuations are determined by applying the most appropriate methodology, Net Asset Value or Discounted Cash Flow, in line with IFRS 13.

- IAS 36 Impairments - management makes judgement on whether there are any indications of impairments to the carrying amounts of the Department's assets. Further information including an analysis of key sensitivities is included in **Note 4.3**, 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.

- IFRS 15 timing of income recognition - the Department makes judgements 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, 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 and Skipton Fund Ltd.

Net expenditure by operating segment is regularly reported to the Departmental Board. The information provided to the Departmental Board is presented on a budgeting basis and therefore mirrors the Statement of 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

	2022-23									
	DHSC Core £000	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	Eliminations and Adjustments £000	Departmental Group £000
Gross expenditure (2.2)	178,256,548	3,686,078	(55,194,531)	123,019,893	162,825,517	6,426,974	1,635,886	178,833	(290,236,194)	130,599,004
Income (2.3)	(3,022,106)	(930,273)	(3,224,580)	(121,536,282)	(5,138,606)	(366,887)	(1,483,047)	(169,781)	122,419,413	(13,452,149)
Total net expenditure before absorption gains and losses (per CSCNE)	**175,234,442**	**2,755,805**	**(58,419,111)**	**1,483,611**	**157,686,911**	**6,060,087**	**152,839**	**9,052**	**(167,816,781)**	**117,146,855**
Budgeting adjustments per SoPS2										
Capital Grants	(657,934)	(74)	(4,655)	(4,957)	(60,138)	-	-	-	4,958	(722,800)
Capital provision movement	-	-	-	645	-	-	-	-	-	645
Research and Development	(1,451,371)	-	-	-	-	-	-	-	-	(1,451,371)
Provision adjustment	-	-	-	-	-	-	-	-	-	-
Prior period adjustments	-	-	-	-	-	-	-	-	-	-
Other (mainly COVID-19)	(1,010,948)	606,263	(82,463)	637,501	(312,702)	321,171	(6,963)	-	(2,438)	149,421
Total adjustments	**(3,120,253)**	**606,189**	**(87,118)**	**633,189**	**(372,840)**	**321,171**	**(6,963)**	**-**	**2,520**	**(2,024,105)**
Budget outturn per SoPS1, of which:	**172,114,189**	**3,361,994**	**(58,506,229)**	**2,116,800**	**157,314,071**	**6,381,258**	**145,876**	**9,052**	**(167,814,261)**	**115,122,750**
RDEL	175,634,125	3,845,832	426,842	1,018,315	157,303,378	6,365,583	149,755	9,052	(167,658,216)	177,094,666
RAME	(3,519,936)	(483,838)	(58,933,071)	1,098,485	10,693	15,675	(3,879)	-	(156,045)	(61,971,916)
RNB	-	-	-	-	-	-	-	-	-	-

1. Included within other budgeting adjustments above are COVID-19 budget adjustments totalling £609 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.

		2021-22									
		DHSC Core £000	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		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		(2,537,970)	(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 before absorption gains and losses (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)
Capital provision movement		-	-	-	-	-	-	-	-	-	-
Research and Development		(1,451,440)	-	-	-	-	-	-	-	-	(1,451,440)
Provision adjustment		(963,822)	-	-	-	-	-	-	-	-	(963,822)
Prior period adjustments		-	-	2,457,088	-	-	-	-	-	-	2,457,088
Other		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.

2.2 Departmental Group Detail – Expenditure

	2022-23									
	DHSC Core £000	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	Eliminations and Adjustments £000	Departmental Group £000
Material Expenditure Items										
Staff costs	304,118	564,198	234,474	79,596,969	3,255,557	786,009	362,018	-	(14,028)	85,089,315
Purchase of healthcare from non-NHS bodies	-	-	-	3,121,790	16,642,128	-	-	-	-	19,763,918
Goods and Services from other NHS Bodies	-	-	4,866	13,158	105,968,391	-	2,141	-	(105,982,895)	5,661
Utilisation and write down of COVID-19 inventories	-	-	-	200,660	-	-	-	-	-	200,660
Purchase of social care	-	-	-	207,048	1,024,918	-	-	-	-	1,231,966
General Dental Services (GDS) and Personal Dental Services (PDS)	-	-	-	-	3,023,228	-	-	-	(123,795)	2,899,433
Establishment	336,184	-	16,293	1,238,564	596,318	43,824	12,039	-	(105,753)	2,137,469
Premises	25,502	38,826	23,291	4,186,315	302,813	33,477	291,705	-	(434,218)	4,467,711
PFI/Lift and other service concession arrangement charges	-	-	-	1,131,814	-	-	96,380	-	-	1,228,194
Multi Professional Education and Training (MPET)	-	-	-	-	-	5,108,882	-	-	(3,709,855)	1,399,027
Prescribing Costs	(147)	-	-	-	9,780,935	-	-	-	(6,693)	9,774,095
G/PMS, APMS and PCTMS	-	-	-	-	11,506,436	-	-	-	(40,826)	11,465,610
Pharmaceutical Services	-	-	-	-	2,123,252	-	-	-	(2,821)	2,120,431
Supplies and Services - Clinical	-	-	-	18,092,452	1,754,948	98	4,926	-	(2,162,088)	17,690,336
Supplies and Services - General	35,269	1,342,730	83,719	1,844,474	2,265,649	186,482	127,160	-	(985,235)	4,900,248
Dividends Payable on Public Dividend Capital (PDC)	-	-	-	1,040,932	-	-	-	-	(1,040,932)	-
Rentals under operating leases	8,343	-	548	183,356	(5,089)	2,043	63,263	-	(42,114)	210,350
Interest charges	3,994	385	204	1,024,632	31,419	821	146,297	-	(112,079)	1,095,673
Research and development	1,366,811	(527)	8	298,510	16,081	-	4,922	-	(879,016)	806,789
Clinical negligence Costs	346,000	-	-	2,434,892	202	63	-	-	(2,434,267)	346,890
Grant in Aid	162,007,841	-	-	-	-	-	-	-	(162,007,841)	-
General Ophthalmic Services	-	-	-	-	539,053	-	-	-	(2)	539,051
Business Rates Paid to Local Authorities	7,272	-	-	419,289	2,685	1,880	59,378	-	-	490,504
Education, Training and Conferences	3,552	3,820	163	431,918	119,403	5,866	4,830	-	(31,866)	537,686
Consultancy Services	4,092	1,163	55	196,092	50,980	4,446	25,065	-	-	281,893
Legal fees	35,799	(13,941)	1,029	107,903	257,541	11,457	9,173	-	(10,212)	398,749
Funding to Group Bodies	5,328,890	-	-	-	-	-	-	-	(5,328,890)	-
Funding for additional pensions uplift	-	-	-	-	2,892,656	-	-	-	(2,892,656)	-
Audit Fees	1,700	969	1,326	50,887	28,705	1,432	1,458	-	(1,949)	84,528
Other	969,602	131	638,225	1,576,448	64,072	14,104	81,257	-	(417,459)	2,926,380
Material expenditure items	170,784,822	1,937,754	1,004,201	117,398,103	162,242,281	6,200,884	1,292,012	-	(288,767,490)	172,092,567

2.2 Departmental Group Detail – Expenditure (cont.)

	2022-23									
	DHSC Core £000	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	Eliminations and Adjustments £000	Departmental Group £000
Grants to Other Bodies	709,103	-	-	-	51,744	-	-	-	-	760,847
Grants to Local Authorities[4]	3,635,036	(3,767)	-	-	-	-	-	-	-	3,631,269
Capital Grants	657,934	74	-	-	60,138	-	-	-	-	718,146
Total Grants expenditure	5,002,073	(3,693)	-	-	111,882	-	-	-	-	5,110,262
Movement in expected credit loss allowance (non credit impaired)	4,211	575	2,248	98,109	12,917	409	55,284	-	(9,713)	164,040
Depreciation on property, plant and equipment	12,286	76,736	8,031	2,824,410	163,789	8,925	225,025	-	470	3,319,672
Depreciation on right of use assets	18,153	9,541	3,852	812,130	55,220	11,477	82,511	-	(339,964)	652,920
Amortisation on intangible assets	198,239	15,045	19,516	388,528	40,270	88,904	7,728	-	-	758,230
Impairments and reversals	294,471	174,025	200	1,053,592	-	14,977	(1,259)	-	(401,368)	1,134,638
Provisions provided for in year	1,055,571	(312,597)	18,110,217	6,758	281,022	1,281	6,489	-	1	19,148,742
Non-cash expenditure from movement in pension liability	-	-	-	9,066	19	-	2,473	-	-	11,558
Provisions - unwinding of discount	13,288	915	251,419	2,174	4,322	2	(42,405)	-	-	229,715
Provisions - Change in discount rate	(906,582)	-	(74,604,370)	(88,292)	(246,120)	(82)	-	-	-	(75,845,446)
Non-cash expenditure	689,637	(35,760)	(56,208,887)	5,106,475	311,439	125,893	335,846	-	(750,574)	(50,425,931)
Total non-material expenditure	84,853	92,332	10,155	515,315	159,915	100,197	8,028	178,833	(133,770)	1,015,858
Covid-19 expenditure (Core and Agencies)[2]	1,695,163	1,695,445							(584,360)	2,806,248
Total Gross Expenditure	**178,256,548**	**3,686,078**	**(55,194,531)**	**123,019,893**	**162,825,517**	**6,426,974**	**1,635,886**	**178,833**	**(290,236,194)**	**130,599,004**

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 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 impairments and write downs of inventory (£753 million), costs relating to NHS Test and Trace (£589 million) and the supply of COVID-19 vaccines (£1,069 million).
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. In the prior year, grants to local authorities from the Core Department included £2.1 billion of grants relating to NHS Test and Trace and COVID-19 social care which have not been replicated in 2022-23.

	2021-22									
	DHSC Core £000	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	-	-	-	2,686,701	17,031,072	-	-	-	-	19,717,773
Goods and Services from other NHS Bodies	-	-	3,558	11,111	99,244,560	-	2,077	-	(99,255,473)	5,833
Utilisation of COVID-19 inventories	-	-	-	318,323	-	-	-	-	-	318,323
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
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

	2021-22									
	DHSC Core £000	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
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
Depreciation on right of use assets	-	-	-	-	-	-	-	-	-	-
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
Total 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)	9,902,176	7,411,864							(2,837,229)	14,476,811
Total 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**

2.3 Departmental Group Detail - Income

	2022-23									
	DHSC Core £000	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	Eliminations and Adjustments £000	Departmental Group £000
Material Income Items										
Income from Local Authorities	-	-	-	(2,080,422)	-	-	(955)	-	-	(2,081,377)
Income from Private patients	-	-	-	(637,659)	-	-	-	-	-	(637,659)
Income from injury costs recovery	-	-	-	(171,844)	-	-	-	-	-	(171,844)
Income from DHSC/NHS bodies	-	-	-	(105,272,297)	-	-	(81,684)	-	105,231,934	(122,047)
Other non-NHS patient care services	-	-	-	(710,950)	(240,352)	-	(1,980)	-	-	(953,282)
Income for additional pension uplift	-	-	-	(2,890,530)	-	-	(2,126)	-	2,892,656	-
Non patient care services to other bodies	(81,656)	-	(92,197)	(833,683)	(2,964,232)	(28,181)	(346,396)	-	3,518,493	(827,852)
Education, training and research	-	(2,268)	(211)	(4,856,768)	(60,728)	(81,510)	(5,067)	-	4,419,077	(587,475)
Provider Sustainability Fund and Financial Recovery Fund Income	-	-	-	-	-	-	-	-	-	-
Support from DHSC for mergers	-	-	-	-	-	-	-	-	-	-
Voluntary Scheme for Branded Medicines Pricing and Access	(1,664,954)	-	-	-	-	-	-	-	-	(1,664,954)
Fees and Charges	-	(253,893)	(3,130,794)	(231,628)	(1,416,966)	(243,483)	(138,403)	-	3,457,389	(1,957,778)
Additional Funding Streams	-	-	-	(333,720)	-	-	-	-	333,720	-
Other Contract Income	(8,624)	(218,954)	(359)	(1,890,781)	(316,341)	(2,744)	(537)	-	640,423	(1,797,917)
Non-material contract income	(39,461)	-	(235)	(324,314)	(9,150)	(3,977)	(152)	-	14,028	(363,261)
Income from contracts	(1,794,695)	(475,115)	(3,223,796)	(120,234,596)	(5,007,769)	(359,895)	(577,300)	-	120,507,720	(11,165,446)
Non-Contract Income										
Rental revenue from operating leases	(5,650)	(434)	-	(79,519)	(4,050)	(101)	(755,078)	-	481,230	(363,602)
PDC Dividend Received	(1,040,932)	-	-	-	-	-	-	-	1,040,932	-
Charitable and other contributions to expenditure	-	-	-	(92,769)	(1,246)	-	-	-	21,080	(72,935)
Donation of Assets	-	-	-	(212,796)	-	-	-	-	185,922	(26,874)
Other non-contract income	(91,309)	-	(344)	(11,550)	(110,136)	(3,928)	(115,484)	-	(325,075)	(657,826)
Non-material non-contract income	(20,366)	(49,976)	(440)	(601,595)	(15,405)	(2,963)	(20,427)	-	43,514	(667,658)
Non-contract operating income	(1,158,257)	(50,410)	(784)	(998,229)	(130,837)	(6,992)	(890,989)	-	1,447,603	(1,788,895)
COVID-19 Income (Core and Agencies)	-	(403,396)		-					403,396	-
Other non-contract operating income	(1,158,257)	(453,806)	(784)	(998,229)	(130,837)	(6,992)	(890,989)	-	1,850,999	(1,788,895)
Income received by NHS charities	-	-	-	-	-	-	-	(169,781)	-	(169,781)
Finance income	(69,154)	(1,352)	-	(303,457)	-	-	(14,758)	-	60,694	(328,027)
Total income	**(3,022,106)**	**(930,273)**	**(3,224,580)**	**(121,536,282)**	**(5,138,606)**	**(366,887)**	**(1,483,047)**	**(169,781)**	**122,419,413**	**(13,452,149)**

	2021-22									
	DHSC Core £000	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 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	-	-	-	(1,124,441)	-	-	-	-	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)**

3. Staff costs

Staff costs for the Departmental Group comprise:

	2022-23 £'000	2021-22 £'000
	Total	Total
Salaries and wages	68,458,248	61,787,878
Social Security costs	6,858,699	5,968,471
NHS Pension	9,937,025	9,259,894
Other pension costs	169,489	122,602
Termination benefits	118,450	13,279
Sub-total	**85,541,911**	**77,152,124**
Less recoveries in respect of outward secondments	(129,977)	(128,387)
Total Net Costs	**85,411,934**	**77,023,737**

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

Of which:			2022-23 £'000
	Charged to revenue budgets	Charged to capital	Total
Core Dept & Agencies	868,370	5,816	874,186
Other designated bodies	84,235,027	316,803	84,551,830
Less elimination of intra-group expenditure	(14,082)	-	(14,082)
Total	**85,089,315**	**322,619**	**85,411,934**

			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**

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 2020.

For 2022-23, employers' contributions were payable to the NHS Pension Scheme at the rate of 20.68% (2021-22: 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 £9.937 billion (2021-22: £9.260 billion) against NHS pension costs, £385.4 million is attributable to NHS England Group (2021-22: £328.2 million), £9.424 billion is attributable to NHS providers (2021-22: £8.790 billion) with the balance of £127.2 million (2021-22: £142.1 million) to ALBs.

Employer contribution rates payable to the NHS Pension Scheme in 2023-24 remain the same as those payable in 2022-23 therefore we do not expect overall NHS pension costs in 2023-24 to be materially different from 2022-23.

4. Expenditure

4.1 Expenditure

	Note	2022-23 £'000		2021-22 £'000	
		Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
4.1 (a) Purchase of goods and services					
Rentals under leases		8,343	210,350	84,685	798,486
Supplies and services - clinical		-	17,690,336	-	16,835,525
Supplies and services - general		1,377,899	4,900,248	1,783,320	5,050,967
Supply of COVID-19 Ventilators to NHS providers		(2,421)	-	4,479	-
Supply of COVID-19 Ventilators to Devolved Authorities		16,124	16,124	36,519	36,519
Supply of COVID-19 Personal Protective Equipment to NHS providers		183,385	-	251,510	-
Supply of Personal Protective Equipment to external bodies		198,705	198,705	414,723	414,723
Utilisation of COVID-19 specific inventory by NHS providers		-	197,924	-	311,797
Cost of COVID-19 equipment		-	97	-	2,513
Donation of vaccines[2]		1,068,893	1,068,893	2,083,894	2,083,894
Supply of COVID-19 Medicines		181,004	181,004	279,107	279,107
Cost of NHS Test and Trace consumables		401,799	401,799	7,249,263	7,249,263
COVID-19 Statistical Research		-	-	249,180	249,180
NHS Test and Trace Operational Costs		186,921	186,921	2,449,578	2,449,578
Goods and services from other NHS bodies		-	5,661	-	5,833
Multi Professional Education and Training (MPET)		-	1,399,027	-	1,242,110
Purchase of healthcare from non NHS bodies		-	19,763,918	-	19,717,773
Purchase of Social Care		-	1,231,966	-	1,131,315
Expenditure on Drug Action Teams		-	31	-	277
General Dental Services (GDS) and Personal Dental Services (PDS)		-	2,899,433	-	3,056,990
Prescribing Costs		(147)	9,774,095	(6,814)	9,079,790
G/PMS, APMS and PCTMS		-	11,465,610	-	11,317,007
Pharmaceutical Services		-	2,120,431	-	2,339,706
General Ophthalmic Services		-	539,051	-	560,949
Consultancy services		5,255	281,893	252,815	626,584
Establishment		333,392	2,137,469	897,225	2,571,798
Transport (Business Travel)		4,533	338,237	35,215	315,728
Premises		60,965	4,467,711	1,182,266	5,348,353
Education, Training and Conferences (cash)		7,372	537,686	7,383	522,811
Insurance		170	88,092	571	80,664
Legal fees		21,858	398,749	127,923	453,539
NHS Informatics Major Contracts Cost		112,943	222,989	114,454	244,990
Audit fees - statutory audit (cash)		140	53,792	-	39,178
Auditor remuneration - other		179	28,226	-	39,942
Non-cash items					
Audit fees - statutory audit - non-cash		2,350	2,510	2,675	2,814
Purchase of goods and services		**4,169,662**	**82,808,978**	**17,499,971**	**94,459,703**

	Note	2022-23 £'000 Core Dept & Agencies	2022-23 £'000 Departmental Group	2021-22 £'000 Core Dept & Agencies	2021-22 £'000 Departmental Group
4.1 (b) Depreciation and impairment charges					
non-cash items					
Depreciation on property, plant and equipment		89,022	3,319,672	132,525	3,272,200
Depreciation on right of use assets		27,613	652,920	-	-
Amortisation on intangible assets		213,284	758,230	106,937	575,603
Impairments and reversals	4.3	(422,816)	243,326	951,005	2,734,358
Depreciation and impairment charges		**(92,897)**	**4,974,148**	**1,190,467**	**6,582,161**
4.1 (c) Provision expense					
non-cash items					
Non-cash expenditure from movement in pension liability		-	11,558	-	21,007
Provision provided for in year[4]	16	742,974	19,148,742	4,555,881	7,976,038
Provisions change in discount rate	16	(906,582)	(75,845,446)	436,027	43,049,838
Provision expense		**(163,608)**	**(56,685,146)**	**4,991,908**	**51,046,883**
4.1 (d) Other operating expenditure					
PFI/LIFT and other service concession arrangements charges		-	1,228,194	-	1,150,405
Chair and non-executive Directors' costs		-	49,821	-	68,411
Business rates paid to local authorities		7,272	490,504	8,395	509,537
Clinical negligence		346,000	346,890	-	1,030
Research and development		1,354,719	806,789	1,201,605	685,943
Grants to Local Authorities		3,631,269	3,631,269	5,679,902	5,679,902
Grants to Other bodies		709,103	760,847	750,005	888,087
Capital Grants		658,008	718,146	669,790	810,909
DHSC support for mergers		-	-	6,000	-
Prior period adjustments in local accounts		-	2,748	-	(4,235)
Non-cash items					
Loss on disposal of non-current assets and assets held for sale		8,706	47,155	29,496	71,658
Movement of expected credit loss allowance (non-credit impaired)		4,786	164,040	75,282	220,894
Inventories write down (covid specific)		1,644,114	1,644,114	85,899	85,899
Inventories write down		68,631	87,378	82,417	99,188
COVID-19 - Inventories Write Downs (NHS providers)		-	2,639	-	4,013
Loan Write Off		277	277	174	174
Capital grants in kind		-	4,654	-	-
Apprenticeship training grant (non-cash)		363	136,017	277	116,558
Prior period adjustments in local accounts (non-cash)		-	(29,301)	-	1,588
Changes in fair value through SoCNE		-	1,945	1,351	5,438
Other non-cash expenditure		2,357	11,377	2,325	31,884
Foreign Exchange Rate (Gains)/Losses		(20,797)	(20,888)	(1,049)	(1,049)
Other[5,6]		981,166	2,926,380	1,540,696	3,557,401
Other operating expenditure		**9,395,974**	**13,010,995**	**10,132,565**	**13,983,635**

1. Supply of COVID-19 ventilators, personal protective equipment and medicines represents the donation for nil consideration of inventory purchased centrally by DHSC. Utilisation of COVID-19 related inventory represents the usage of donated items by recipient bodies.
2. Donation of vaccines includes £1,069 million (2021-22: £2,078 million) COVID-19 vaccines.
3. The Living with Covid Strategy has resulted in a significant reduction in COVID-19 expenditure and specifically cost of NHS Test & Trace consumables, COVID-19 statistical research and NHS Test & Trace operational costs, as well as those costs in footnotes 1 and 2 above.
4. Provisions provided in the year for the Departmental Group of £19,149 million (2021-22: £7,976 million) is net of provisions not required written back of £5,175 million (2021-22: £3,980 million). This mainly relates to the Clinical Negligence Provision. Further details are provided in Note 16.
5. The Core Department and Agencies 'Other' expenditure figure of £981 million (2021-22: £1,541 million) includes £257 million (2021-22: £108 million) of EEA reciprocal healthcare payments, £243 million of revenue policy payments (2021-22: £148 million), £162 million in respect of outsourcing contracts (2021-22: £541 million) and £172 million of Healthy Start – Welfare Foods payments (2021-22: £159 million).
6. Other expenditure for the Departmental Group also includes £694 million (2021-22: £677 million) of transport costs in the provider sector relating to expenditure such as fuel costs, vehicle parts and other fleet related costs.
7. Core Department and Agencies expenditure figures may be greater than those of the Departmental Group due to the elimination of intercompany trading.

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:

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Expenditure after financing activities - non-cash items (Note 4 & SOCNE)	3,515,974	(47,364,820)	16,764,803	69,007,465
Less non-cash income after financing activities (Note 5 & SOCNE)	(6,475)	(259,223)	(172,581)	(403,155)
Total non-cash transactions	**3,509,499**	**(47,624,043)**	**16,592,222**	**68,604,310**
Movement in expected credit loss allowance	(4,786)	(164,040)	(75,282)	(220,894)
Inventories write down	(1,712,745)	(1,734,131)	(168,316)	(189,100)
Impairment of inventories	891,312	891,312	(1,628,648)	(1,628,648)
Utilisation of Covid-19 related inventory	(2,047,489)	(2,064,546)	(10,319,495)	(10,377,816)
Donation of assets	-	26,874	-	46,495
Less non-cash movements on SoFP balances analysed separately in the Cash Flow statement	**(2,873,708)**	**(3,044,531)**	**(12,191,741)**	**(12,369,963)**
Total non-cash transactions as per Consolidated Statement of Cash Flows	**635,791**	**(50,668,574)**	**4,400,481**	**56,234,347**

4.3 Impairments

	2022-23 £'000		2021-22 £'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	180,671	1,018,573	10,095	670,822
Intangible asset impairments	-	36,868	1	53,262
Right of use assets impairments	6,695	91,367	-	-
Financial asset impairments	281,130	(13,246)	(687,739)	381,039
Non current assets held for sale impairments	-	1,076	-	587
Inventory impairments	(891,312)	(891,312)	1,628,648	1,628,648
Total impairments charged to Consolidated Statement of Comprehensive Net Expenditure	**(422,816)**	**243,326**	**951,005**	**2,734,358**
Impairments charged to Revaluation Reserve				
Property, plant and equipment impairments	-	567,474	-	172,468
Intangible asset impairments	-	-	-	28
Right of use assets impairments	-	8,346	-	-
Financial asset impairments	-	-	-	-
Total impairments charged to Revaluation Reserve	**-**	**575,820**	**-**	**172,496**
Impairments charged to General Fund				
PDC impairments	(518,337)	-	518,338	-
Total impairments charged to General Fund	**(518,337)**	**-**	**518,338**	**-**
Total impairments charged in year	**(941,153)**	**819,146**	**1,469,343**	**2,906,854**

The above table includes both impairments and impairment reversals.

Financial and other asset impairments

Financial and other asset impairments include Public Dividend Capital impairments and advance payment impairments for COVID-19 vaccines.

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 charged in 2022-23 was £294 million (2021-22: credit of £1,069 million).

In addition, as described in Note 1, impairments arising or reversed in relation to demising NHS Trusts or Foundation Trusts are charged to the General Fund. In 2022-23 an impairment reversal of £518 million (2021-22: £518 million charge) was recognised.

Inventory Impairments

Inventory impairments can be broken down as follows:

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Personal protective equipment (PPE)	(320,991)	(320,991)	(24,799)	(24,799)
COVID-19 Medicines	(924,388)	(924,388)	866,710	866,710
COVID-19 Vaccines	(68,238)	(68,238)	249,835	249,835
NHS Test and Trace consumables	297,901	297,901	285,215	285,215
Other COVID-19 related equipment and consumables	124,404	124,404	251,687	251,687
Total inventory impairments	**(891,312)**	**(891,312)**	**1,628,648**	**1,628,648**

The impact on expenditure of impairments and write downs for 2022-23 and 2021-22 can be summarised as follows:

2022-23 £'000	Core Dept & Agencies			Departmental Group		
	Impairments charge/(credit)	Writedown	Total charge/(credit) to expenditure	Impairments credit/(charge)	Writedown	Total charge/(credit) to expenditure
Personal protective equipment (PPE)	(320,991)	536,878	**215,887**	(320,991)	539,517	**218,526**
COVID-19 Medicines	(924,388)	1,073,110	**148,722**	(924,388)	1,073,110	**148,722**
COVID-19 Vaccines	(68,238)	-	**(68,238)**	(68,238)	-	**(68,238)**
NHS Test and Trace consumables	297,901	-	**297,901**	297,901	-	**297,901**
Other COVID-19 related equipment and consumables	124,404	34,126	**158,530**	124,404	34,126	**158,530**
Total	**(891,312)**	**1,644,114**	**752,802**	**(891,312)**	**1,646,753**	**755,441**

2021-22 £'000	Core Dept & Agencies			Departmental Group		
	Impairments credit/(charge)	Writedown	Total charge/(credit) to expenditure	Impairments credit/(charge)	Writedown	Total charge/(credit) to expenditure
Personal protective equipment (PPE)	(24,799)	77,695	**52,896**	(24,799)	81,708	**56,909**
COVID-19 Medicines	866,710	-	**866,710**	866,710	-	**866,710**
COVID-19 Vaccines	249,835	10,708	**260,543**	249,835	10,708	**260,543**
NHS Test and Trace consumables	285,215	-	**285,215**	285,215	-	**285,215**
Other COVID-19 related equipment and consumables	251,687	8,204	**259,891**	251,687	8,204	**259,891**
Total	**1,628,648**	**96,607**	**1,725,255**	**1,628,648**	**100,620**	**1,729,268**

Personal Protective Equipment (PPE)

PPE inventory was increased in carrying value due to a net reversal of impairments of £321 million during 2022-23 (2021-22: £25 million) which was recognised in expenditure and is largely as a result of items being disposed of during the year.

There are also write downs of £540 million (2021-22: £82 million) relating to PPE inventory in 2022-23 as a result of disposal of these items. These are recognised as inventories written down in Note 4.1 and are included within the losses disclosure.

The combined impact on expenditure of PPE impairments and disposals was £219 million in 2022-23 (2021-22: £57 million).

Additionally, £21 million was transferred from the opening onerous contract provision, the expenditure associated with this having already been recognised as a provision expense in previous years.

The net £300 million increase in PPE inventory carrying value (impairment reversal of £321 million less onerous contract provision transfer of £21 million) (2021-22: £939 million decrease in carrying value, being £25 million impairment reversal less onerous contract provision transfer of £964 million) can be further analysed as:

- £6 million **reversal** (2021-22: £67 million **reversal**) in respect of items which have been assessed as not being suitable for any use;
- £136 million **reversal** (2021-22: £427 million **reversal**) 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;
- £411 million **charge** (2021-22: £885 million **charge**) reflects the impairment recognised as a result of fluctuations in the market price of personal protective equipment; and
- £569 million **reversal** (2021-22: £548 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 £2,714 million (2021-22: £3,869 million). Paragraphs 645 to 650 of the Annual Report contains further information in relation to these 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 2023. 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 2023; 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.

COVID-19 Vaccines

The Departmental Group holds inventories 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 not all the vaccines delivered will be used.

- An impairment reversal of £68 million (2021-22: £250 million charge) has been recognised in expenditure which represents the movement in the impairment required for inventories held which are now not expected to be used.
- The carrying value of COVID-19 vaccine inventories has also been reduced in value by £Nil million (2021-22: £11 million) as a result of the inventories written off either as a result of disposal or by having reached their expiry date. These costs are shown in note 4.1.

The combined impact on expenditure of COVID-19 Vaccines impairments and disposals was £68 million credit in 2022-23 (2021-22: £261 million charge).

The carrying value of COVID-19 vaccine inventories has also been reduced in value by £790 million as a result of the utilisation of onerous contract provisions, the expenditure associated with this having already been recognised as a provision expense in a prior year.

COVID-19 Medicines

The Department holds inventories 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 not all the medicines delivered will be used.

- An impairment reversal of £924 million (2021-22: £867 million charge) has been recognised in expenditure which represents the movement in the impairment required for inventories held which are now not expected to be used.
- The carrying value of COVID-19 medicine inventories has also been reduced in value by £1,073 million as a result of the inventories written off either as a result of disposal or by having reached their expiry date. These costs are shown in Note 4.1.

The combined impact on expenditure of COVID-19 Medicines impairments and disposals was £149 million in 2022-23 (2021-22: £867 million).

The carrying value of COVID-19 medicine inventories has also been reduced in value by £1,680 million as a result of the utilisation of onerous contract provisions, the expenditure associated with this having already been recognised as a provision expense in a prior year.

NHS Test and Trace consumables

NHS Test and Trace Consumables have been impaired by £298 million (2021-22: £285 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 £124 million (2021-22: £252 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.

The carrying value of other COVID-19 related equipment and consumables has also been reduced in value by £34 million (2021-22: £8 million) as a result of the inventories written off as a result of disposal. These costs are shown in Note 4.1.

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 2023.

5. Income

5.1 Income

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Income from contracts				
Revenue from Patient Care activities				
Income from Local Authorities	-	2,081,377	-	1,846,414
Income from Private patients	-	637,659	-	540,011
Income from Chargeable Overseas Patients	-	99,622	-	67,021
Income from injury costs recovery	-	171,844	-	147,933
Income in respect of EEA claims	39,461	39,461	69,021	69,021
Income from DHSC/NHS bodies	-	122,047	-	119,792
Other non-NHS patient care services	-	953,282	-	771,943
Other contract income				
Non-patient care services to other bodies	78,583	827,852	68,584	898,211
Education, training and research	2,268	587,475	1,974	460,509
Prescription Fees and Charges	-	670,324	-	651,964
Dental Fees and Charges	-	746,642	-	633,847
Other Fees and Charges	247,907	540,812	663,898	938,022
Income in respect of Staff Costs	54	224,178	-	207,886
Voluntary Scheme for Branded Medicines Pricing and Access	1,664,954	1,664,954	731,488	731,488
Other Contract Income[1]	227,578	1,797,917	11,143	1,085,625
Income from contracts	**2,260,805**	**11,165,446**	**1,546,108**	**9,169,687**
Other non-contract operating income				
Rental revenue from finance leases	5	2,277	-	675
Rental revenue from operating leases	6,948	363,602	24,473	311,075
PDC Dividend Received	1,040,932	-	904,222	-
Charitable and other contributions to expenditure	-	72,935	-	60,749
Donations of Assets	-	26,874	-	46,495
Receipts of donations for capital acquisitions	-	138,892	-	153,569
Receipt of grants for capital acquisitions	49,976	269,117	-	117,841
Profit on disposal	6,112	49,249	169,354	198,441
Dividends	13,894	28,801	23,000	31,756
Other non-cash income	-	41,369	2,950	54,924
Apprenticeship training grant (non-cash)	363	136,017	277	116,558
Funding from other Government departments	-	1,936	-	4,129
Prior period adjustments in local accounts	-	-	-	(1,675)
Other non contract income	93,068	657,826	49,309	380,106
Non-contract income	**1,211,298**	**1,788,895**	**1,173,585**	**1,474,643**

1. Other contract income includes £1,305 million relating to the provider sector. These amounts arise from a significant number of entities and as such are not material individually.

6. Property, plant, and equipment

	Departmental Group 2022-23									
	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 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**
Prior period adjustments in underlying accounts	(1,645)	(21,078)	(187)	(48,237)	(1,728)	(333)	(20,482)	(17)	-	(93,707)
Impact of adoption of IFRS 16	(71,076)	(576,917)	(15,394)	(81,742)	(1,128)	(12,345)	(385,478)	(1,360)	-	(1,145,440)
Additions	50,648	1,285,223	7,913	609,382	4,323,836	32,955	754,024	18,952	23,737	7,106,670
Donations	-	65,984	-	14,035	336,941	1,770	43,470	67	-	462,267
Impairments and reversals	(265,424)	(1,092,142)	(4,094)	(36,641)	(348,574)	(6,274)	(10,003)	-	-	(1,763,152)
Transfers	5,294	114,213	-	9,617	1,514	129	28,529	-	(159)	159,137
Reclassifications	(24,666)	2,500,897	16,136	278,398	(3,353,987)	39,659	354,859	29,227	-	(159,477)
Revaluation and indexation	147,315	1,384,796	27,551	(4,048)	995	15	6,243	(80)	-	1,562,787
Disposals	(25,847)	(96,107)	-	(501,651)	(6,849)	(43,883)	(765,690)	(23,273)	(114)	(1,463,414)
Derecognition due to finance leasing	-	(89,745)	-	-	-	-	-	-	-	(89,745)
At 31 March 2023	**6,212,636**	**46,326,286**	**394,566**	**6,378,483**	**7,146,074**	**727,254**	**11,653,134**	**559,721**	**392,882**	**79,791,036**
Depreciation										
At 1 April 2022	**470**	**1,331,467**	**18,728**	**3,597,019**	**-**	**472,237**	**7,039,177**	**329,054**	**159,905**	**12,948,057**
Prior period adjustments in underlying accounts	62	(60,671)	(309)	(31,833)	-	(76)	(19,655)	(29)	-	(112,511)
Impact of adoption of IFRS 16	(34)	(132,198)	(194)	(44,278)	-	(3,013)	(224,227)	(475)	-	(404,419)
Charged in year	92	1,553,718	11,140	777,289	-	46,987	847,872	59,741	22,833	3,319,672
Impairments and reversals	27,733	(223,726)	(2,797)	(1,211)	-	(1,151)	23,665	382	-	(177,105)
Transfers	-	105	-	7,739	-	103	19,144	-	-	27,091
Reclassifications	(51)	(23,236)	(58)	(1,863)	-	(3,396)	(18,446)	(10,127)	-	(57,177)
Revaluation and indexation	(19,924)	(1,256,286)	(8,948)	(4,173)	-	(1,162)	3,169	(84)	-	(1,287,408)
Disposals	-	(42,263)	-	(492,971)	-	(42,855)	(738,363)	(21,514)	-	(1,337,966)
Derecognition due to finance leasing	-	-	-	-	-	-	-	-	-	-
At 31 March 2023	**8,348**	**1,146,910**	**17,562**	**3,805,718**	**-**	**467,674**	**6,932,336**	**356,948**	**182,738**	**12,918,234**
Net book value at 31 March 2023	**6,204,288**	**45,179,376**	**377,004**	**2,572,765**	**7,146,074**	**259,580**	**4,720,798**	**202,773**	**210,144**	**66,872,802**
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
Asset financing:										
Owned - purchased	5,718,651	31,313,353	297,428	2,556,869	6,697,395	248,639	4,271,152	201,894	210,144	51,515,525
Owned - donated	94,207	1,520,345	14,615	10,948	445,169	10,937	297,503	879	-	2,394,603
On-Statement of Financial Position PFI contracts	391,430	12,345,678	62,194	4,948	3,510	4	152,143	-	-	12,959,907
PFI residual interests	-	-	2,767	-	-	-	-	-	-	2,767
Net book value at 31 March 2023	**6,204,288**	**45,179,376**	**377,004**	**2,572,765**	**7,146,074**	**259,580**	**4,720,798**	**202,773**	**210,144**	**66,872,802**

	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**

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 2023 was £44.725 billion.

Property, plant and equipment disclosed in this note includes assets which are subject to operating leases where group entities grant the use of these assets to third parties. The majority of total property, plant and equipment assets in the departmental group are held in the NHS provider sector. It is not possible to accurately quantify the total value of assets subject to operating leases in this sector due to the impracticability in apportioning whole site valuations to partial assets, which are subject to such leases. Therefore it is not possible to include an analysis of the utilisation of property, plant and equipment in the departmental account.

The ranges of estimated useful lives are currently:

- Buildings and dwellings: 1 – 169 years
- Information technology: 1 – 30 years
- Furniture and fittings: 1 – 40 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, Trademarks and Development Expenditure relating to both the Department and the entities consolidated within these financial statements.

	Departmental Group 2022-23			
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2022	**4,436,198**	**293,439**	**573,069**	**5,302,706**
Prior period adjustments in underlying accounts	(10,592)	(104)	(1,542)	(12,238)
Impact of adoption of IFRS 16	(21,991)	-	-	(21,991)
Additions	411,849	20,638	331,948	764,435
Donations	944	-	4,753	5,697
Impairments and reversals	(38,810)	222	(5,278)	(43,866)
Transfers	29,882	16,907	2,511	49,300
Reclassifications	303,862	10,799	(261,896)	52,765
Revaluation and indexation	(13,921)	2,124	(15)	(11,812)
Disposals	(228,248)	(9,824)	(2,623)	(240,695)
Other movements	58	-	(6)	52
At 31 March 2023	**4,869,231**	**334,201**	**640,921**	**5,844,353**
Amortisation				
At 1 April 2022	**2,453,547**	**148,947**	**30,538**	**2,633,032**
Prior period adjustments in underlying accounts	(17,343)	661	(1)	(16,683)
Impact of adoption of IFRS 16	(18,067)	-	-	(18,067)
Charged in year	713,407	38,517	6,306	758,230
Impairments and reversals	(7,192)	83	111	(6,998)
Transfers	25,962	5,909	-	31,871
Reclassifications	1,300	(2,290)	(38)	(1,028)
Revaluation and indexation	(44,279)	1,309	25	(42,945)
Disposals	(216,491)	(9,820)	(1,761)	(228,072)
Other movements	43	-	1	44
At 31 March 2023	**2,890,887**	**183,316**	**35,181**	**3,109,384**
Net Book Value at 31 March 2023	**1,978,344**	**150,885**	**605,740**	**2,734,969**
Net book value at 31 March 2022	1,982,651	144,492	542,531	2,669,674

				Departmental Group 2021-22
	IT & Software	Development Expenditure	Other	Total
	£'000	£'000	£'000	£'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

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. Right of Use Assets

	Departmental Group 2022-23						
	Property	Information Technology	Furniture & Fittings	Plant and Machinery	Transport Equipment	Intangible Assets	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation							
At 1 April 2022	-	-	-	-	-	-	-
Impact of adoption of IFRS 16	4,054,326	121,067	12,709	818,519	123,062	21,991	5,151,674
Additions	392,445	16,301	14	145,732	39,354	-	593,846
Remeasurements	39,803	-	(1)	8,464	(275)	-	47,991
Disposals and derecognitions	(34,304)	(1,460)	-	(28,026)	(661)	(11,262)	(75,713)
Capital provisions and reversals	20,974	-	-	-	-	-	20,974
Impairments and reversals	(64,696)	(3,418)	-	-	-	-	(68,114)
Revaluation and indexation	8,450	(308)	-	1,366	2	-	9,510
Transfers	-	-	-	-	-	-	-
Reclassifications	17,095	817	-	(2,888)	695	-	15,719
At 31 March 2023	**4,434,093**	**132,999**	**12,722**	**943,167**	**162,177**	**10,729**	**5,695,887**
Depreciation							
At 1 April 2022	-	-	-	-	-	-	-
Impact of adoption of IFRS 16	120,538	43,950	3,013	224,554	475	18,067	410,597
Charged in year	416,886	27,261	1,281	157,564	48,540	1,388	652,920
Disposals and derecognitions	(3,705)	(1,429)	-	(23,479)	(217)	(11,214)	(40,044)
Impairments and reversals	33,757	(2,158)	-	-	-	-	31,599
Revaluation and indexation	(17,030)	-	-	1,215	1	-	(15,814)
Transfers	-	-	-	-	-	-	-
Reclassifications	24,127	1,559	-	(2,080)	695	-	24,301
At 31 March 2023	**574,573**	**69,183**	**4,294**	**357,774**	**49,494**	**8,241**	**1,063,559**
Net book value at 31 March 2023	**3,859,520**	**63,816**	**8,428**	**585,393**	**112,683**	**2,488**	**4,632,328**
Net book value at 31 March 2022	-	-	-	-	-	-	-

Following the adoption of IFRS 16 during the year most assets previously held under operating leases have now been capitalised and included on the Statement of Financial Position. On transition a net £4.7 billion of Right of Use assets have been capitalised. A corresponding lease liability of £4.4 billion has been recognised on transition. Note 15.2 reconciles the opening operating lease commitment to the lease liability recognised on transition.

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.

	2022-23 £'000		2021-22 £'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	10,144	2,396,573	55,815	2,182,348
Intangible non-current assets	8,134	164,453	16,589	211,268
	18,278	**2,561,026**	**72,404**	**2,393,616**

9.2 Operating lease receipts

Total future minimum lease receipts under operating leases are given in the tables below for each of the following periods.

	2022-23 £'000	
	Core Dept & Agencies	Departmental Group
Not later than 1 year	697	151,777
Later than 1 year and not later than 2 years	604	127,681
Later than 2 years and not later than 3 years	156	115,046
Later than 3 years and not later than 4 years	134	109,434
Later than 4 years and not later than 5 years	134	96,347
Later than 5 years	18	948,066
	1,743	**1,548,351**

	2021-22 £'000	
	Core Dept & Agencies	Departmental Group
Not later than 1 year	5,795	159,945
Later than 2 years and not later than 5 years	15,068	407,104
Later than 5 years	21,484	962,315
	42,347	**1,529,364**

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 1 off-Statement of Financial Position LIFT scheme with an estimated capital value of £0.9 million (2021-22: one scheme, £0.9 million). The assets which make up this capital value were not assets of Community Health Partnerships Ltd.

	2022-23 £'000		2021-22 £'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	-	246	-	247
Later than 5 years	-	3,537	-	3,598
	-	**3,845**	-	**3,907**

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. (2021-22: 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 £60.6 million (2021-22: £56.1 million).

NHS providers

In this financial year, 6 NHS providers (2021-22: 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:

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Total obligations under on-Statement of Financial Position LIFT schemes for the following periods comprise:				
Not later than 1 year	-	163,179	-	165,137
Later than 1 year and not later than 5 years	-	641,859	-	642,923
Later than 5 years	-	1,976,159	-	2,136,057
	-	**2,781,197**	-	**2,944,117**
Less interest element	-	(1,149,135)	-	(1,266,487)
Present Value of obligations	-	**1,632,062**	-	**1,677,630**

	2022-23 £'000		2021-22 £'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	-	46,340	-	45,571
Later than 1 year and not later than 5 years	-	205,292	-	194,320
Later than 5 years	-	1,380,430	-	1,437,739
Total Present Value of obligations	-	**1,632,062**	-	**1,677,630**

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 £64.4 million (2021-22: £59.7 million).

Community Health Partnerships Ltd and NHS providers with NHS LIFT contracts are committed to the following total charges:

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	72,261	-	63,682
Later than 1 year and not later than 5 years	-	307,415	-	270,641
Later than 5 years	-	546,490	-	565,116
	-	**926,166**	-	**899,439**

9.3.4 PFI Schemes deemed to be off-Statement of Financial Position

NHS providers

In this financial year 3 NHS providers reported off-Statement of Financial Position PFI schemes (2021-22: 7 NHS providers).

	2022-23 £'000		2021-22 £'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	-	1,650	-	3,940
Later than 1 year and not later than 5 years	-	3,042	-	13,266
Later than 5 years	-	3,991	-	7,878
	-	**8,683**	-	**25,084**

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 29 on-Statement of Financial Position PFI schemes (2021-22: 28 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 £35.8 million (2021-22: £31.3 million).

NHS providers

In this financial year, 143 NHS providers reported on-Statement of Financial Position PFI Schemes (2021-22: 147 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 £1,127.9 million. (2021-22: £1,059.4 million).

Obligations relating to assets included in the on-Statement of Financial Position PFI schemes are shown below:

	2022-23 £'000		2021-22 £'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	-	849,167	-	888,169
Later than 1 year and not later than 5 years	-	3,255,153	-	3,328,633
Later than 5 years	-	9,591,631	-	10,603,568
	-	**13,695,951**	**-**	**14,820,370**
Less interest element	-	(5,842,329)	-	(6,604,375)
Present Value of obligations	**-**	**7,853,622**	**-**	**8,215,995**

	2022-23 £'000		2021-22 £'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	-	352,908	-	356,525
Later than 1 year and not later than 5 years	-	1,426,639	-	1,392,773
Later than 5 years	-	6,074,075	-	6,466,697
Total Present Value of obligations	**-**	**7,853,622**	**-**	**8,215,995**

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 £1,163.8 million (2021-22: £1,090.7 million). Future committed service charges and off-balance sheet costs are set out below:

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	-	1,127,940	-	1,045,567
Later than 1 year and not later than 5 years	-	4,653,012	-	4,296,806
Later than 5 years	-	14,915,641	-	14,769,625
	-	**20,696,593**	**-**	**20,111,998**

9.4 Other Financial Commitments

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Not later than 1 year	1,910,292	3,273,365	6,504,622	7,699,074
Later than 1 year and not later than 5 years	3,980,305	4,998,580	2,664,903	3,652,794
Later than 5 years	1,957,559	2,085,024	70,749	136,861
	7,848,156	**10,356,969**	**9,240,274**	**11,488,729**

This note discloses commitments to future expenditure not otherwise disclosed elsewhere in the financial statements. Included within other financial commitments are non-cancellable contracts and purchase orders which commit the Departmental group to revenue expenditure in a future period. Commitments to expenditure under other forms of agreement such as Memorandums of Understanding may be considered as commitments if they would be reputationally or politically damaging for Departmental group bodies to withdraw from the agreement. Any future funding within the Department's accounting boundary does not represent a financial commitment.

Included within the Core Department & Agencies and Departmental Group figures for 2022-23 are financial commitments of £5,075 million relating to UKHSA. The majority of these commitments relate to anticipated spend under non-cancellable contracts that commit the agency to future expenditure in the procurement of vaccines as well as any milestone payments relating to the Moderna Strategic Partnership. Whilst these contracts are non-cancellable, in some instances the future expenditure is dependent on conditions being met and as such the commitment disclosed is an estimate of likely future expenditure.

In 2021-22, the Core Department held non-cancellable contractual commitments in respect of two COVID-19 vaccine contracts. The total amount due in respect of these two contracts in 2021-22 was £3,799 million.

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 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 the NHS sector is made up principally of domestic organisations with the great majority of transactions, assets and liabilities being in the UK and sterling based, exposure to currency rate fluctuations is 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. The majority of NHS provider income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

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.

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, not least through their powers of intervention.

Analysis of financial assets

As at 31 March 2023, the financial assets of the Departmental Group amounted to £21.1 billion (31 March 2022: £22.8 billion) of which £20.7 billion (31 March 2022: £22.4 billion) was held at amortised cost and £0.4 billion (31 March 2022: £0.4 billion) was designated at fair value through Other Comprehensive Income.

As at 31 March 2023, the financial assets of the Core Department and Agencies amounted to £11.6 billion (31 March 2022: £12.8 billion), of which £5.6 billion (31 March 2022: £5.5 billion) was designated at fair value through Other Comprehensive Income and £6.0 billion (31 March 2022: £7.3 billion) was held at amortised cost.

Analysis of financial liabilities

As at 31 March 2023, the financial liabilities of the Departmental Group amounted to £45.4 billion (31 March 2022: £42.2 billion). At both 31 March 2023 and 31 March 2022, all financial liabilities of the group were held at amortised cost.

As at 31 March 2023, the financial liabilities of the Core Department and Agencies amounted to £4.5 billion (31 March 2022: £7.3 billion). At both 31 March 2023 and 31 March 2022, all financial liabilities of the Core Department and Agencies were held at amortised cost.

11. Financial Assets – Investments

	2022-23 £'000							2022-23 £'000
	Core Dept & Agencies					Departmental Group		
	NHS Healthcare Providers		Other Bodies		Total	Other Bodies		Total
	PDC	Loans	Loans	Share Capital		Loans	Share Capital and Other Investments	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2022	**36,874,712**	**2,341,012**	**2,396,504**	**5,476,308**	**47,088,536**	**6,134**	**676,048**	**682,182**
Issued	3,497,479	93,624	671	93,975	3,685,749	671	33,462	34,133
Disposals	-	-	-	-	-	-	(1,561)	(1,561)
Repaid	(25,079)	(10,688)	(1,456,048)	-	(1,491,815)	(809)	(2,834)	(3,643)
Transfers to and from current receivables	-	(254,132)	(611)	-	(254,743)	(611)	(778)	(1,389)
Written off	(518,337)	-	(277)	-	(518,614)	(277)	-	(277)
Changes in fair value through other comprehensive income	-	-	-	169,664	169,664	-	(74,095)	(74,095)
Changes in fair value through CSCNE	-	-	-	-	-	-	(1,166)	(1,166)
Expected credit loss impairments	-	-	-	-	-	-	(120)	(120)
Other Impairments and reversals	223,841	-	50	-	223,891	50	-	50
Reclassifications	-	-	-	-	-	(1,328)	-	(1,328)
Transfers	-	-	-	(92,788)	(92,788)	-	(788)	(788)
Other movements	-	-	-	(10,831)	(10,831)	-	19,428	19,428
Balance at 31 March 2023	**40,052,616**	**2,169,816**	**940,289**	**5,636,328**	**48,799,049**	**3,830**	**647,596**	**651,426**
Investments held by Core Dept & Agencies								48,799,049
Less elimination of intra-group investments								(48,558,890)
Investments held by other designated bodies								411,267
Total								**651,426**

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).

	2021-22									2021-22
	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 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**

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. six-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.

In 2022-23 the value of impairment charged to the SoCNE was £294 million (2021-22: £1,069 million credit) and the value of impairments credited to reserves was £518 million (2021-22: £518 million charge). For further details see **Note 4.3** above.

Loans to other bodies

During 2022-23 loans totalling £Nil (2021-22: £350 million) were issued to Supply Chain Coordination Ltd in order to provide a working capital facility. Loan repayments were also made in year of £1.5 billion (2021-22: £3.3 billion).

Share capital and other investments

The Department's Share Capital investments are measured at fair value. 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.

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.

					2022-23
					Core Department
Entity	Valuation basis	Level 1	Level 2	Level 3	Total
		£'000	£'000	£'000	£'000
Community Health Partnerships Ltd	Net assets	-	830,000	438,000	1,268,000
NHS Property Services Ltd	Net assets	-	3,632,000	-	3,632,000
Genomics England Ltd	Capital invested	-	500,000	-	500,000
NHS Professionals Ltd	Discounted cash flow	-	-	229,000	229,000
Other share capital investments	Various	-	-	7,328	7,328
		-	**4,962,000**	**674,328**	**5,636,328**

					Core Department
Entity	Valuation basis	Level 1	Level 2	Level 3	Total
		£'000	£'000	£'000	£'000
Community Health Partnerships Ltd	Net assets	-	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
Other share capital investments	Various	-	-	72,958	72,958
		-	**4,681,317**	**776,641**	**5,457,958**

1. The valuation of Community Health Partnerships Ltd is based on net assets. This is adjusted to account for certain 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 2022-23							
	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 2022	**501,250**	**5,884**	**61,752**	**-**	**224,784**	**1,359,605**	**-**	**2,153,275**
Prior period adjustments in underlying accounts	(39,323)	-	-	-	39,323	-	-	-
Inventory additions	548,980	-	2,005,316	-	1,845,617	405,137	1,623	4,806,673
Inventories consumed/disposed of	(516,840)	(14)	(181,004)	-	(1,071,521)	(832,862)	(2,315)	(2,604,556)
Write Downs	(68,340)	(511)	(1,073,110)	-	-	(570,784)	-	(1,712,745)
Impairment of inventory	-	-	924,388	-	68,238	(101,314)	-	891,312
Transfers	-	14	-	-	-	-	10,279	10,293
Transfer from provisions	-	-	(1,679,990)	-	(790,146)	(20,637)	-	(2,490,773)
Other	1	-	-	-	-	-	-	1
Balance at 31 March 2023	**425,728**	**5,373**	**57,352**	**-**	**316,295**	**239,145**	**9,587**	**1,053,480**

1. See Note 4.3 for details of inventory impairments.

Consumables can be further analysed as follows:

	Core Dept & Agencies 2022-23				
	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 2022	**752,414**	**361,119**	**236,627**	**9,445**	**1,359,605**
Inventory additions	44,790	344,965	4,031	11,351	405,137
Inventories consumed/disposed of	(406,448)	(401,799)	(24,615)		(832,862)
Write Downs	(536,878)		(34,126)	220	(570,784)
Impairment of inventory	320,991	(297,901)	(124,184)	(220)	(101,314)
Provisions transferred to inventory	(20,637)				(20,637)
Balance at 31 March 2023	**154,232**	**6,384**	**57,733**	**20,796**	**239,145**

	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**

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**

	Departmental Group 2022-23								
	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 2022	**501,250**	**5,884**	**449,071**	**61,752**	**-**	**224,784**	**2,241,893**	**98,205**	**3,582,839**
Prior period adjustments in underlying accounts	(39,323)	-	(5,620)	-	-	39,323	9,682	(4,062)	-
Inventory additions	548,980	-	8,479,811	2,005,316	-	1,845,617	4,764,540	561,961	18,206,225
Inventories consumed/disposed of	(516,840)	(14)	(8,399,394)	(181,004)	-	(1,071,521)	(5,137,688)	(559,381)	(15,865,842)
Write Downs	(68,340)	(511)	(13,089)	(1,073,110)	-	-	(578,924)	(157)	(1,734,131)
Impairment of inventory	-	-	-	924,388	-	68,238	(101,314)	-	891,312
Transfers	-	14	-	-	-	-	2,518	10,279	12,811
Transfer from provisions	-	-	-	(1,679,990)	-	(790,146)	(20,637)	-	(2,490,773)
Reclassification	-	-	1	-	-	-	6	(7)	-
Other	1	-	-	-	-	-	-	-	1
Balance at 31 March 2023	**425,728**	**5,373**	**510,780**	**57,352**	**-**	**316,295**	**1,180,076**	**106,838**	**2,602,442**

1. See Note 4.3 for details of inventory impairments.

Consumables can be further analysed as follows:

	Departmental Group 2022-23				
	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 2022	**798,738**	**361,119**	**234,661**	**847,375**	**2,241,893**
Prior period adjustments in underlying accounts	-	-	-	9,682	9,682
Inventory additions	44,790	344,965	4,031	4,370,754	4,764,540
Inventories consumed/disposed of	(420,987)	(401,799)	(24,615)	(4,290,287)	(5,137,688)
Write Downs	(539,517)	-	(34,126)	(5,281)	(578,924)
Impairment of inventory	320,991	(297,901)	(124,184)	(220)	(101,314)
Transfers to/from non-current assets	-	-	2,518	-	2,518
Provisions transferred to inventory	(20,637)	-	-	-	(20,637)
Reclassification	-	-	-	6	6
Balance at 31 March 2023	**183,378**	**6,384**	**58,285**	**932,029**	**1,180,076**

	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**

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**

13. Cash and cash equivalents

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Balance at 1 April 2022	**959,885**	**18,096,779**	**1,576,897**	**16,795,536**
Net change in cash	56,136	(2,535,367)	(617,012)	1,301,243
Balance at 31 March 2023	**1,016,021**	**15,561,412**	**959,885**	**18,096,779**
The following balances at 31 March were held at:				
Government Banking Service	1,015,557	15,001,957	959,704	17,742,486
Commercial banks and cash in hand	464	274,607	181	300,555
Short term investments	-	284,848	-	53,738
Balance at 31 March 2023	**1,016,021**	**15,561,412**	**959,885**	**18,096,779**

14. Trade receivables and other current assets

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade receivables	850,000	3,054,017	611,566	2,271,783
Deposits and advances	-	11,048	-	11,478
Capital receivables	-	86,266	-	44,460
Interest receivable	-	18,520	516	5,833
Other receivables	462,919	1,289,480	597,673	1,661,248
Trade and other receivables	**1,312,919**	**4,459,331**	**1,209,755**	**3,994,802**
Contract Assets	5,362	8,429	-	3,247
Other prepayments and accrued income	386,709	2,167,297	540,110	2,099,056
Current part of PFI and other service concession arrangements prepayments	-	25,932	-	24,698
Capital Prepayments	-	85,621	-	92,602
Other current assets	-	4,608	-	3,870
Other current assets	**392,071**	**2,291,887**	**540,110**	**2,223,473**
Current part of loans repayable transferred from investments	215,018	2,277	210,989	1,329
Other financial assets	**215,018**	**2,277**	**210,989**	**1,329**
Total current receivables	**1,920,008**	**6,753,495**	**1,960,854**	**6,219,604**
Amounts falling due after more than one year:				
Trade receivables	-	170,921	-	164,078
Deposits and advances	-	5,547	-	5,486
Capital receivables	-	16,519	-	36,033
Contract Assets	-	4,558	-	4,710
Other receivables	293,945	296,456	303,194	371,655
Interest Receivable	-	-	-	498
Other Prepayments and accrued income	125,143	162,095	180,065	210,906
Non-current part of PFI and other service concession arrangements prepayments	-	54,825	-	51,608
Capital Prepayments	-	189,797	-	160,413
Total non-current receivables	**419,088**	**900,718**	**483,259**	**1,005,387**
Total receivables at 31 March 2023	**2,339,096**	**7,654,213**	**2,444,113**	**7,224,991**

15. Trade payables and other current liabilities

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Amounts falling due within one year:				
Trade payables[1]	640,379	4,272,256	1,963,690	4,592,589
Capital payables	5,317	2,032,511	67,747	2,149,454
Other payables[2]	30,846	2,860,236	52,805	3,605,227
Trade and other payables	**676,542**	**9,165,003**	**2,084,242**	**10,347,270**
Bank Overdraft	-	40,750	-	10,553
VAT	1,012	43,641	65,373	137,916
Other taxation and social security	22,653	1,633,963	5,533	1,485,034
EEA Medical Costs Accrual	711,275	711,275	662,933	662,933
Contract liabilities	14,841	1,531,926	-	1,524,117
Other accruals[3]	956,692	16,668,521	3,027,654	16,814,545
Deferred income	93,050	345,580	112,043	355,920
Current Lease Liabilities	38,898	631,917	-	85,254
Current part of imputed finance lease element of PFI contracts and other service concession arrangements	-	399,248	-	402,096
Amount issued from the Consolidated Fund for supply but not spent at year end	1,658,498	1,658,498	1,247,417	1,247,417
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received	672	672	284,012	284,012
Current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	37,936	-	95,049
Pension liabilities[4]	-	1,032,599	-	130,989
Other current liabilities	-	30,289	-	14,745
Other liabilities	**3,497,591**	**24,766,815**	**5,404,965**	**23,250,580**
Total current payables	**4,174,133**	**33,931,818**	**7,489,207**	**33,597,850**
Amounts falling due after more than one year:				
Non-current Lease Liabilities	297,014	3,747,341	-	517,223
Imputed finance lease element of PFI contracts and other service concession arrangements	-	9,086,435	-	9,491,529
Pension liabilities	-	-	-	14
Financial liabilities	**297,014**	**12,833,776**	**-**	**10,008,766**
Trade payables	-	494	-	9,587
Contract liabilities	116,498	255,142	-	124,617
Other accruals	785	1,486	7,383	11,228
Capital payables	9,649	17,900	10,207	16,565
Other payables	-	326,072	-	296,018
Deferred income	62	96,724	9,106	118,037
Non-current loans payable by NHS Providers (NHS Trusts and Foundation Trusts) to entities outside the accounting boundary	-	295,871	-	331,930
Loans payable by DHSC to group bodies	20,220	-	20,220	-
Other payables	**147,214**	**993,689**	**46,916**	**907,982**
Total non-current payables	**444,228**	**13,827,465**	**46,916**	**10,916,748**
Total payables	**4,618,361**	**47,759,283**	**7,536,123**	**44,514,598**

1. Trade payables falling due within one year for the Core Department includes £554 million (2021-22: £1,452 million) due to Supply Chain Coordination Limited, which eliminates on consolidation.
2. Other payables falling due within one year includes £771 million (2021-22: £1,289 million) relating to the provider sector and £1,255 million (2021-22: £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. Other accruals falling due within one year for the Core Department include £92 million (2021-22: £Nil million) due to Supply Chain Coordination Limited, which eliminates on consolidation. Other accruals falling due within one year for the Group includes £9,493 million (2021-22: £7,581 million) relating to the provider sector and £5,855 million (2021-22: £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.
4. In 2022-23 NHS provider pension contributions payable of £0.9 billion have been reclassified so that they show as pension liabilities. In the prior year these contributions were predominantly included in other payables.

15.1 Lease Liabilities

Total future lease payments under leases are given in the table below:

	2022-23 £'000		2021-22 £'000	
	Core Dept & Agencies	Departmental Group	Core Dept & Agencies	Departmental Group
Current lease liabilities	38,898	631,917	-	85,254
Non-current lease liabilities	297,014	3,747,341	-	517,223
Total lease liabilities	**335,912**	**4,379,258**	**-**	**602,477**

Lease liability maturity analysis

	2022-23 £'000	
	Core Dept & Agencies	Departmental Group
Undiscounted lease payments falling due in:		
Not later than 1 year	41,612	676,792
Later than 1 year and not later than 5 years	114,552	1,874,917
Later than 5 years	203,944	2,388,289
Sub-total	**360,108**	**4,939,998**
Less interest element	(24,196)	(560,740)
Total lease liabilities	**335,912**	**4,379,258**

IFRS 16 was implemented with effect on 1 April 2022 and replaces IAS 17 (Leases). The DHSC group has applied IFRS 16 using the modified retrospective approach and therefore the comparative information has not been restated.

The Departmental Group has a diverse range of leasing arrangements. The vast majority of the Departmental Group's leases relate to property, these include office premises and a range of health sector specialised assets.

The Departmental Group does not have significant exposure to future cash outflows which are not reflected in the measurement of lease liabilities.

Further detail on the nature of the group's leases can be found in the accounts of individual Departmental bodies, in particular NHS Property Services Limited and the Consolidated Provider Account.

15.2 IFRS 16 Transition

The table below reconciles the operating lease commitment disclosed at 31 March 2022 with the finance lease liability recognised on transition to IFRS 16 on 1 April 2022.

	2022-23 £'000
	Departmental Group
Operating lease commitments as at 31 March 2022	4,013,149
Impact of discounting	(366,694)
Finance lease liabilities at 31 March 2022	602,477
Exemptions for:	
- Short-term leases	(112,401)
- Leases of low-value assets	(48,098)
Advance payments	4,850
Irrecoverable VAT not included in the lease liability	(151,622)
Lease costs reassessed as service agreements	1,699
Extension and termination options reasonably certain to be exercised	383,478
Variable lease payments based on an index or a rate	1,334
Other adjustments	118,715
Lease liability recognised at 1 April 2022	**4,446,887**

16. Provisions for liabilities and charges

	2022-23							2021-22						
							Core Dept & Agencies							Core Dept & Agencies
	Early departure costs	Injury Benefits	EEA medical costs	Contaminated Blood	Capital provisions	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Contaminated Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 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**
Provided in the year	-	-	543,928	427,812	1,155	163,855	1,136,750	4,016	57,474	962,223	126,170	3,951,384	5,101,267
Provisions not required written back	(1,217)	(12,423)	-	-	-	(378,981)	(392,621)	(3,584)	(17,117)	-	(220,410)	(304,275)	(545,386)
Transfers	-	-	-	-	-	1,998	1,998	-	-	-	-	-	-
Provisions utilised in the year	(10,659)	(44,371)	(134,151)	(115,196)	-	(594,924)	(899,301)	(10,856)	(45,375)	(183,407)	(77,287)	(61,820)	(378,745)
Transfer to accruals	-	-	(546,544)	-	-	(2,495,415)	(3,041,959)	-	-	(536,815)	-	(963,839)	(1,500,654)
Borrowing costs (unwinding of discount)	(1,028)	(7,836)	3,661	22,066	-	(2,660)	14,203	(11,995)	(48,253)	(126)	46,306	(1,846)	(15,914)
Change in discount rate	(8,157)	(82,751)	(21,375)	(782,084)	-	(12,215)	(906,582)	1,568	36,425	(865)	391,639	7,260	436,027
Balance at 31 March 2023	**69,141**	**467,611**	**1,079,993**	**2,229,082**	**1,155**	**760,101**	**4,607,083**	**90,202**	**614,992**	**1,234,474**	**2,676,484**	**4,078,443**	**8,694,595**

	Early departure costs	Injury Benefits	EEA medical costs	Contaminated blood	Capital provisions	Other	Total	Early departure costs	Injury Benefits	EEA medical costs	Contaminated Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current	10,276	42,941	252,921	140,553	-	535,369	982,060	10,603	44,081	455,529	100,458	3,254,787	3,865,458
Non Current	58,865	424,670	827,072	2,088,529	1,155	224,732	3,625,023	79,599	570,911	778,945	2,576,026	823,656	4,829,137
Expected timing of cash flow													
Not later than 1 year	10,276	42,941	252,921	140,553	-	535,369	982,060	10,603	44,081	455,529	100,458	3,254,787	3,865,458
Later than 1 year, not later than 5 years	37,848	171,392	818,130	470,978	134	174,963	1,673,445	43,031	186,604	778,945	394,608	761,351	2,164,539
Later than 5 Years	21,017	253,278	8,942	1,617,551	1,021	49,769	1,951,578	36,568	384,307	-	2,181,418	62,305	2,664,598
Total	**69,141**	**467,611**	**1,079,993**	**2,229,082**	**1,155**	**760,101**	**4,607,083**	**90,202**	**614,992**	**1,234,474**	**2,676,484**	**4,078,443**	**8,694,595**

	2022-23								2021-22						
	Departmental Group								Departmental Group						
	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Contaminated Blood	Other	Capital Provisions	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Contaminated Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 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**
Prior period adjustments in underlying accounts	-	176	-	-	-	(5,685)	-	(5,509)	(510)	2,157	-	-	-	(13,049)	(11,402)
Impact of IFRS 16 Transition	-	-	-	-	-	(6,219)	-	(6,219)	-	-	-	-	-	-	-
Provided in the year	13,061	15,311	543,928	22,256,184	427,812	1,067,801	20,682	24,344,779	21,755	84,391	962,223	5,856,906	126,170	4,908,175	11,959,620
Provisions not required written back	(8,915)	(19,768)	-	(4,251,055)	-	(894,995)	(622)	(5,175,355)	(8,572)	(21,589)	-	(3,111,800)	(220,410)	(617,347)	(3,979,718)
Transfers	-	(3,146)	-	-	-	5,144	-	1,998	6	(6)	-	-	-	-	-
Provisions utilised in the year	(23,912)	(58,107)	(134,151)	(2,641,701)	(115,196)	(825,342)	-	(3,798,409)	(38,448)	(59,122)	(183,407)	(2,402,863)	(77,287)	(236,716)	(2,997,843)
Transfer to accruals/inventories	(4,033)	(3,282)	(546,544)	-	-	(2,531,217)	-	(3,085,076)	(3,443)	(2,908)	(536,815)	-	-	(980,147)	(1,523,313)
Borrowing costs (unwinding of discount)	(677)	(8,113)	3,661	251,343	22,066	(38,542)	(23)	229,715	(12,647)	(50,416)	(126)	347,586	46,306	30,843	361,546
Change in discount rate	(23,030)	(150,472)	(21,375)	(74,542,722)	(782,084)	(325,763)	292	(75,845,154)	4,230	47,197	(865)	42,614,725	391,639	(7,088)	43,049,838
Balance at 31 March 2023	**198,881**	**701,378**	**1,079,993**	**69,256,238**	**2,229,082**	**2,877,796**	**20,329**	**76,363,697**	**246,387**	**928,779**	**1,234,474**	**128,184,189**	**2,676,484**	**6,432,614**	**139,702,927**

	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Contaminated Blood	Other	Capital Provisions	Total	Early departure costs	Injury Benefits	EEA medical costs	Clinical Negligence	Contaminated Blood	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current	28,250	61,400	252,921	3,333,859	140,553	1,490,858	2,288	5,310,129	29,950	65,149	455,529	2,686,621	100,458	4,373,087	7,710,794
Non Current	170,631	639,978	827,072	65,922,379	2,088,529	1,386,938	18,041	71,053,568	216,437	863,630	778,945	125,497,568	2,576,026	2,059,527	131,992,133
Expected timing of cash flow															
Not later than 1 year	28,250	61,400	252,921	3,333,859	140,553	1,490,858	2,288	5,310,129	29,950	65,149	455,529	2,686,621	100,458	4,373,087	7,710,794
Later than 1 year, not later than 5 years	102,328	246,009	818,130	12,553,042	470,978	675,070	4,870	14,870,427	112,441	266,127	778,945	12,843,937	394,608	1,211,964	15,608,022
Later than 5 Years	68,303	393,969	8,942	53,369,337	1,617,551	711,868	13,171	56,183,141	103,996	597,503	-	112,653,631	2,181,418	847,563	116,384,111
Total	**198,881**	**701,378**	**1,079,993**	**69,256,238**	**2,229,082**	**2,877,796**	**20,329**	**76,363,697**	**246,387**	**928,779**	**1,234,474**	**128,184,189**	**2,676,484**	**6,432,614**	**139,702,927**

1. Included within the Clinical Negligence provision above is £64,405 million (31 March 2022: £120,359 million) relating to the Clinical Negligence Scheme for Trusts (CNST).

Discount Rates

Note 1.17 Provisions provides information on the discount rates applied by the Department to expected future cashflows.

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 Resolution (NHSR) accounts for clinical negligence and non-clinical liabilities under twelve schemes or arrangements. 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 three key elements of NHS Resolution's provisions are:

- Known claims – provisions for claims received by NHS Resolution but not yet settled
- Settled Periodical Payment Orders (PPOs) - where the past settlement of a claim involves ongoing payments to the claimant into the future, generally for their lifetime
- Incurred but not reported (IBNR) - provision for claims that have not yet been received but where it can be reasonably 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

Effect of change in discount rate

One of the key assumptions used in calculating the provisions is the discount rate 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 2022-23, there was a significant increase in the discount rates prescribed by HM Treasury across all durations. This update has decreased the provision across all schemes administered by NHS Resolution by £74.5 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, 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 £74.5 billion decrease in the provisions reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

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 decreased by £58,928 million in 2022-23 from £128,184 million at 31 March 2022 to £69,256 million at 31 March 2023. The key movements in the provision during the year were as follows:

- An increase of £14.4 billion relating to another year's worth of activity for all schemes for all incident years
- A decrease of £3.7 billion due to changes in assumptions affecting the IBNR provision. The main drivers of this decrease relate to the CNST IBNR provision and include a decrease of £2.6 billion in respect of claim number projections, a decrease of £0.7 billion relating to an update to the long-term inflation assumptions, a decrease of £0.6 billion for average cost assumptions and an increase of £0.2 billion in respect of lag and payment patterns, updated mortality assumptions in respect of potential PPO claims and updated probability assumptions in respect of paying damages.
- An increase of £7.7 billion in respect of changes in data (such as reserve values and other data held for individual claims) and assumptions affecting known claims. The known claims provision is impacted by the changes in inflation and Annual Survey of Hours and Earnings (ASHE) assumptions. Of this increase, £4.9 billion relates to the updating of probability percentages for claims that are expected to settle with damages payments.
- A decrease of £2.7 billion relating to amounts paid out during the financial year to settle claims.
- A significant decrease of £74.6 billion due to increases in the 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 2022 and 31 March 2023 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 lower number of potential PPO claims reported over the year which leads to a slight decrease in the assumed number of claims and IBNR provision. The impact of this change is a reduction in the CNST IBNR provision of £2.6 billion.
- All discount rates have been updated. Short- and medium-term rates have increased by 2.80 percentage points and 2.50 percentage points respectively. The long-term and very long-term rates have increased by 2.56 percentage points and 2.34 percentage points respectively. The net impact of these changes is a decrease in the CNST IBNR provision of £35.9 billion.

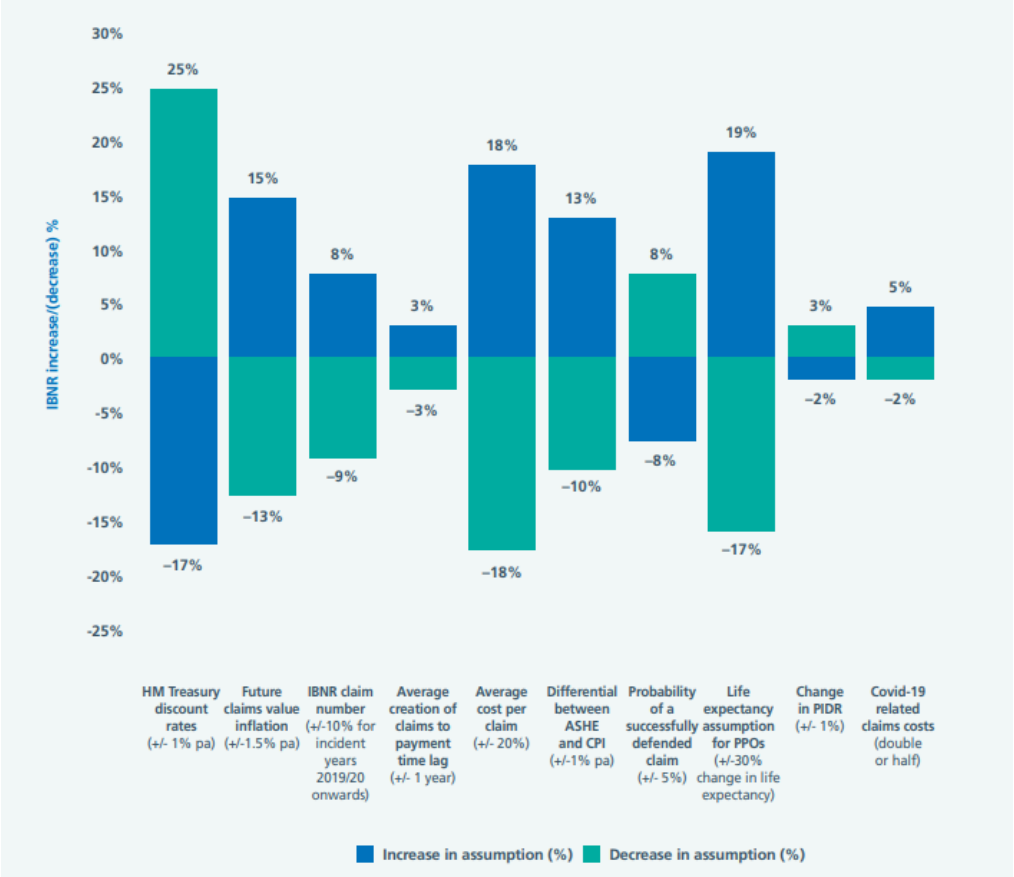
The provisions above are also reported in the accounts of NHSR together with other provisions of £357 million (31 March 2022: £366 million).

Key areas of uncertainty

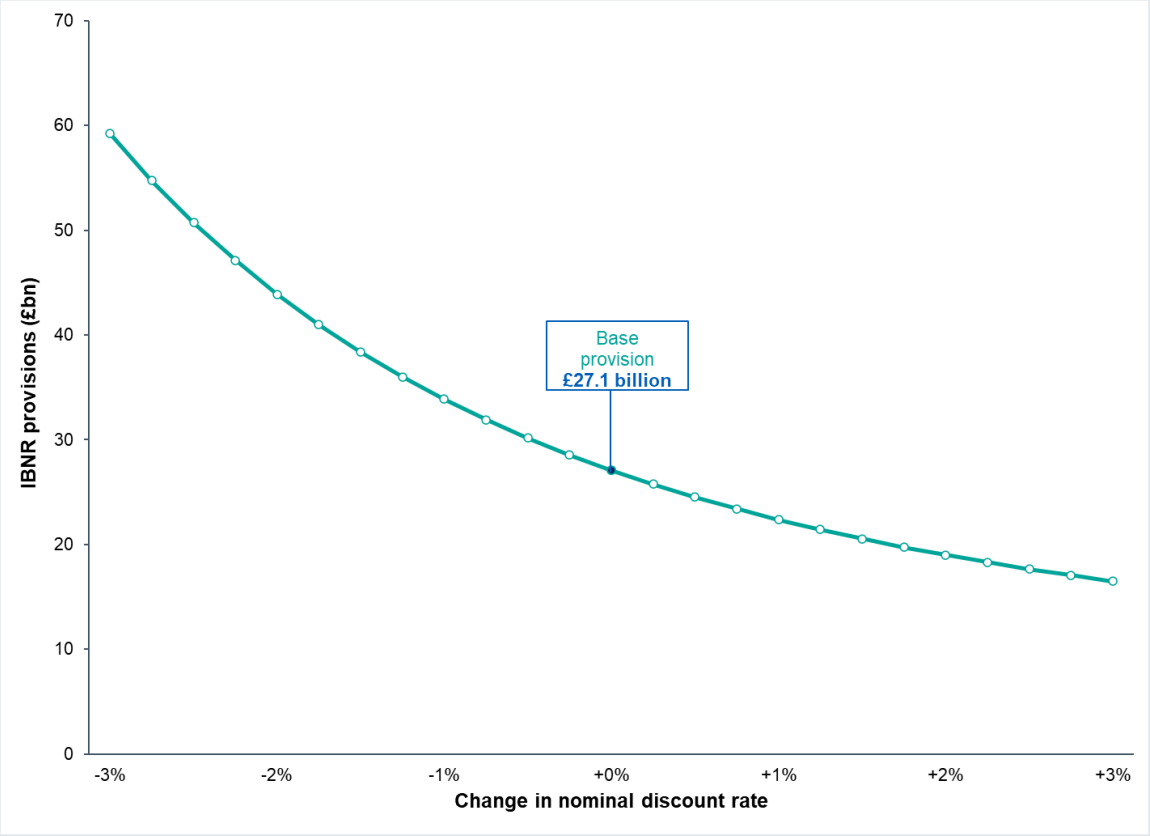
Due to the long-term nature of the liabilities and the assumptions on which the estimate of the provision is based, some uncertainty about the value of the liability remains. This is particularly relevant to the IBNR element of the provision (the largest single element of total provisions, and therefore where uncertainty has the greatest effect).

Claims settling as PPOs also remain a key area of uncertainty, given the high value of PPO settlements and the relatively small number of claims that settle on this basis. 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 graph shows the value and percentage impact of variations in the key assumptions within the CNST IBNR estimate. 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.



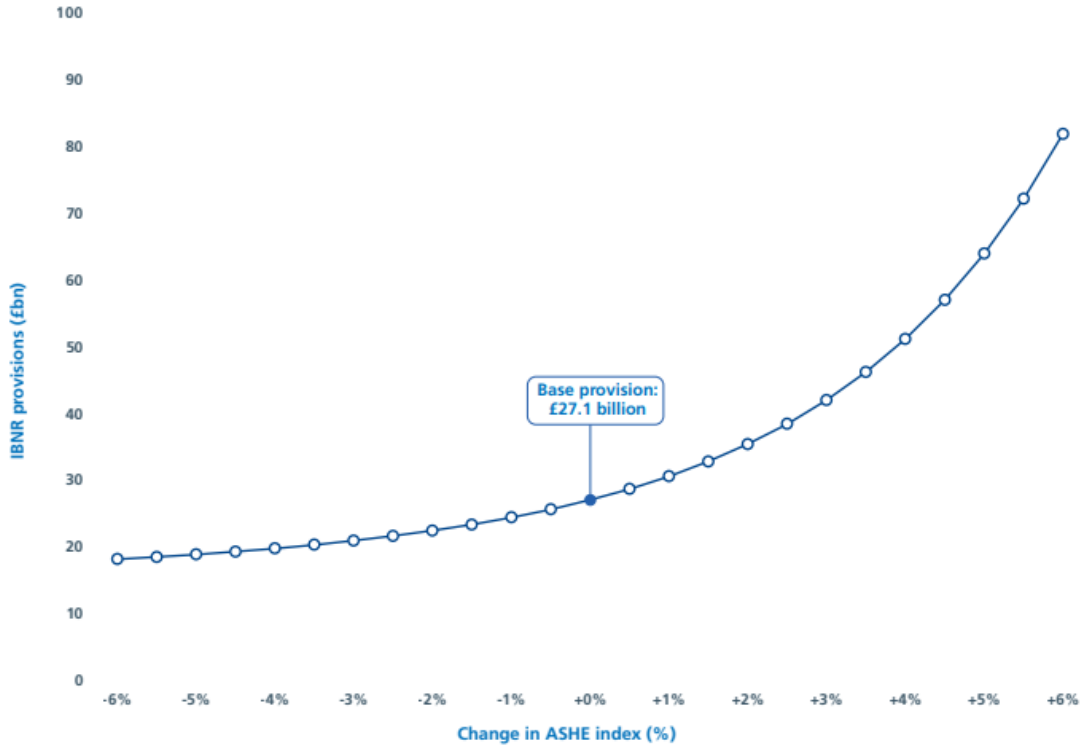
The clinical negligence provision's value is particularly sensitive to changes in the long-term discount rate given its nature. The disclosures above show the impact of percentage changes.

In 2022-23, there was a significant increase in the discount rates prescribed by HM Treasury, which decreased 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 IBNR provision 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.



Clinical negligence claims which may succeed, but are less likely or cannot be reliably estimated, are accounted for as contingent liabilities. (See **Note 17**)

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 their bereaved partners. 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.

From 2022-23 onwards provision is also included for the future cost of payments due to be made under the Infected Blood Interim Compensation Payment Scheme. 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.

Other Provisions

These financial statements disclose other provisions of £760 million (2021-22: £4,078 million) for the Core Department and Agencies and £2,878 million (2021-22: £6,433 million) for the Departmental Group, which can be analysed as follows:

	2022-23 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 2022	**36,799**	**1,773,742**	**1,714,726**	**553,176**	**4,078,443**
Provided in the year	-	29,888	32,335	101,632	163,855
Provisions not required written back	-	-	(333,694)	(45,287)	(378,981)
Transfers under absorption accounting	-	-	-	1,998	1,998
Provisions utilised in the year	-	-	(398,664)	(196,260)	(594,924)
Transfer to accruals/inventories	(20,637)	(1,679,990)	(790,146)	(4,642)	(2,495,415)
Borrowing costs (unwinding of discount)	-	-	2,486	(5,146)	(2,660)
Change in discount rate	-	-	-	(12,215)	(12,215)
Balance at 31 March 2023	**16,162**	**123,640**	**227,043**	**393,256**	**760,101**

	2022-23 Departmental Group				
	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 2022	**36,799**	**1,773,742**	**1,714,726**	**2,907,347**	**6,432,614**
Prior period adjustments in underlying accounts				(5,685)	(5,685)
Impact of IFRS 16 Transition				(6,219)	(6,219)
Provided in the year	-	29,888	32,335	1,005,578	1,067,801
Provisions not required written back	-	-	(333,694)	(561,301)	(894,995)
Transfers under absorption accounting	-	-	-	5,144	5,144
Provisions utilised in the year	-	-	(398,664)	(426,678)	(825,342)
Transfer to accruals/inventories	(20,637)	(1,679,990)	(790,146)	(40,444)	(2,531,217)
Borrowing costs (unwinding of discount)	-	-	2,486	(41,028)	(38,542)
Change in discount rate	-	-	-	(325,763)	(325,763)
Balance at 31 March 2023	**16,162**	**123,640**	**227,043**	**2,510,951**	**2,877,796**

The other balance for the Departmental Group includes £1.2 billion (2021-22: £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 COVID-19 Medicines

The Department holds 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 4.3, 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. The Department has used £1,680 million of the related onerous contract provision in 2022-23 as inventories have been delivered. The residual balance of £124 million is expected to be used in 2023-24.

Onerous Contracts relating to COVID-19 Vaccines

The Departmental Group holds contracts for the delivery of vaccines for COVID-19. 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.

£1,189 million of the related onerous contract provision has been used in the year and a reversal of £334 million has been recognised in the year as a result of fluctuations in the values of future payments and changes in the expected levels of inventory which will be used.

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 2023 this provision totalled £163 million (2021-22: £319 million). 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 rate of disposal.
- The costs to store PPE prior to 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.
- The costs to dispose of PPE - The disposal costs are estimated based on the average disposal costs incurred since the disposals commenced in April 2022 plus the costs of moving stock to its disposal location. 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 assumption driven estimate of future operating losses, there is a degree of uncertainty associated with each of the assumptions, but this is not material.

Increase / (decrease) in provision required based on percentage change in assumptions

	-10% change	+10% change	+50% change
Rate of disposal	£12,259k	(£10,044k)	(£37,162k)
Cost of disposals	(£3,812k)	£3,812k	
Cost of storage	(£10,868k)	£10,868k	

The Department is constantly assessing the feasibility of accelerating disposal in order to minimise the cost to the taxpayer.

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.

17.2 Contingent Liabilities

Unless there are compelling grounds for non-disclosure due to confidentiality considerations, the contingent liabilities required by IAS 37 are detailed below. Further information for all contingent liabilities can be found in the underlying accounts of individual bodies.

Contingent Liabilities under IAS 37 (£million)		
Clinical Negligence		
1	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 £32,179 million (2021-22: £73,370 million).	
Legal Cases		
2	**Employment Tribunal Cases** Not disclosed due to sensitive nature of the contingent liabilities.	N/A[1]
3	**Legal Cases – Department as Claimant** Not disclosed due to sensitive nature of the contingent liabilities.	N/A[1]
4	**Legal Cases – Department as Defendant** Not disclosed due to sensitive nature of the contingent liabilities.	N/A[1]
Liabilities in respect of the COVID-19 Vaccination Programme		
5	**Indemnities for Covid-19 Vaccines Purchases** Not disclosed due to sensitive nature of the contingent liabilities.	N/A[1]

Indemnities		
6	**Indemnities issued to members of the Department's expert advisory committees** There are uncertainties around likelihood and expected costs which have meant the Department is unable to quantify the contingent liability.	-
Letters of Comfort		
7[2]	**Care Quality Commission – Letter of comfort in respect of potential future pension liabilities** 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. There are uncertainties around timing, likelihood and expected costs which have meant the Department is unable to quantify the contingent liability.	-
NHS England Group		
8	Within the NHS England Group account (which incorporates Clinical Commissioning Groups, Integrated Care Boards, Supply Chain Coordination Ltd and NHS England) at 31 March 2023, there were contingent liabilities of £42.2 million (2021-22: £22.4 million). These were mainly in respect of continuing care liabilities which transferred from Primary Care Trusts (PCTs) on 1 April 2013. No contingent liabilities relate to Clinical Commissioning Groups at 31 March 2023 due to their demise during the year.	42.2
9	NHS providers at 31 March 2023 had net contingent liabilities of £35.5 million (2021-22: £29.5 million).	35.5
NHS Resolution		
10	At 31 March 2023, NHS Resolution had other non-clinical contingent liabilities of £263 million (2021-22: £295 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.	263.0
Other IAS 37 Contingent Liabilities		
11	**Contractual liability for redundancy payments** There are uncertainties around timing and likelihood of redundancies covered by the contract, as well as the payments expected as a result.	0.5
12	**Provision of life assurance cover for individuals transferred to the Department** There are uncertainties around timing and likelihood of payments being required, as well as the expected payments.	0.4

13	**Compensation payments due to individuals unable to be traced** There are uncertainties around timing, likelihood and expected costs which have meant the Department is unable to quantify the contingent liability.	-
14	**Sensitive Contingent Liability** Not disclosed due to sensitive nature of the contingent liabilities.	N/A[1]

1. Due to the sensitive nature of these contingent liabilities, the value has not been disclosed.
2. These contingent liabilities relate to the Core Department only, as the contingent liability is intra-group and therefore excluded at the group level.

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 20**, the Department acts as the parent of the group of organisations whose accounts are consolidated within this Annual Report and Accounts. It also acts as the sponsor for NHS Blood and Transplant (a Public Corporation). 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 2022-23.

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	Purchases from related party	Income from related party	Purchases from related party	Income from related party
			2022-23 £'000	2022-23 £'000	2021-22 £'000	2021-22 £'000
Doug Gurr[1]	Non Executive Board Member	UK BioCentre	-	488	16,879	-
Doug Gurr[2]	Non Executive Board Member	The Alan Turing Institute	719	-	-	-
Samantha Jones[3]	Non Executive Board Member	NHS Confederation	7,696	-	-	-

1. UK BioCentre is a 100% owned subsidiary of UK Biobank. Doug Gurr is a Director of UK Biobank on a non-remunerated basis.
2. Doug Gurr holds the position of Chair at the Alan Turing Institute on a remunerated basis.
3. An individual related to Samantha Jones is a Trustee at the NHS Confederation on a non-remunerated basis.

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 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.

Related Party Entity	Relationship with DHSC	Payables with related party	Purchases from related party	Receivables with related party	Income from related party	Share capital issued/repaid to/by related party	Loans issued to/(repaid by) related party
		2022-23 £'000	2022-23 £'000	2022-23 £'000	2022-23 £'000	2022-23 £'000	2022-23 £'000
NHS Shared Business Services Ltd.	DHSC Equity investment (50% shareholding)	531	5,160	2,000	2,021	-	238

Related Party Entity	Relationship with DHSC	Payables with related party	Purchases from related party	Receivables with related party	Income from related party	Share capital issued/repaid to/by related party	Restated[1] Loans issued to/(repaid 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	2,000	2,000	-	514

1. The 2021-22 receivables and income figures for NHS Shared Business Services Ltd have been restated to include an omitted balance.

The Department's share capital of NHS Shared Business Services Limited was transferred to NHS Business Services Authority on 31 March 2023. The value transferred was £92 million.

19. Events after the Reporting Period

On 1 April 2023, the functions of Health Education England were merged into NHS England. This will be accounted for as an absorption transfer in 2023-24.

These financial statements were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller & Auditor General.

20. Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2022-23.

(a) Consolidated in the Department's Annual Report and Accounts	Website
Supply Financed Agencies	
UK Health Security Agency	https://www.gov.uk/government/organisations/uk-health-security-agency
Medicines and Healthcare products Regulatory Agency	Medicines and Healthcare products Regulatory Agency - GOV.UK (www.gov.uk)
Other Bodies	
Clinical Commissioning Groups	Available on the website of the relevant organisation.
Integrated Care Boards	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://www.england.nhs.uk/
NHS Charities	Available on the website of the relevant organisation.
Skipton Fund Limited	http://www.skiptonfund.org/home.php
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	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[3]	https://resolution.nhs.uk
National Health Service Trust Development Authority	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	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 England[4]	https://www.england.nhs.uk/
The Health and Social Care Information Centre[5]	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 or UK Health Security Agency 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
Public Corporation	
NHS Blood and Transplant	http://www.nhsbt.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. The NHS Litigation Authority is known as NHS Resolution.
4. NHS England was previously the NHS Commissioning Board.
5. The Health and Social Care Information Centre is known as NHS Digital.

Changes in group structure in year

The following key changes in the structure of the group occurred during 2022-23:

- Clinical Commissioning Groups ceased to exist on 30 June 2022 with their functions being subsequently adopted by Integrated Care Boards. This has had no impact on the accounts of the Departmental Group.
- National Health Service Trust Development Authority and Monitor ceased to exist on 30 June 2022 and have been merged into NHS England. From that date the transactions of these functions fall into the NHS England results in the segmental analysis and in the Statement of Outturn against Parliamentary Supply.
- The Health and Social Care Information Centre (known as NHS Digital) merged into NHS England on 1 February 2023. From that date the transactions of this function will fall into the NHS England results in the segmental analysis and in the Statement of Outturn against Parliamentary Supply.

The Department of Health & Social Care's registered office is 39 Victoria Street, London, SW1H 0EU.

21. 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 which are subject to the limitation of scope audit opinion as described in the Governance Statement on paragraphs 527 to 537. 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 2022-23 £'000	UKHSA transactions included in the Departmental Group column of the Statement of Comprehensive Net Expenditure 2022-23 £'000	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	(349,601)	(303,661)	(137,473)	(118,894)
Other non-contract operating income	(49,976)	(49,976)	(4,323)	(8,292)
Total operating income	**(399,577)**	**(353,637)**	**(141,796)**	**(127,186)**
Staff costs	482,094	482,094	416,355	416,215
Purchase of goods and services	2,774,436	2,732,902	7,766,877	7,609,057
Depreciation and impairment charges	489,095	488,059	477,769	477,769
Provision expense	(312,597)	(312,597)	72,749	72,749
Other operating expenditure	83,371	83,371	374,391	431,229
Total operating expenditure	**3,516,399**	**3,473,829**	**9,108,141**	**9,007,019**
Net operating expenditure for the year ended 31 March 2023	**3,116,822**	**3,120,192**	**8,966,345**	**8,879,833**
Finance income	-	-	(272)	(272)
Finance expenditure	1,188	1,119	-	-
Net (gain)/loss on transfers by absorption	(6,408)	-	-	-
Total Net Expenditure for the year ended 31 March 2023	**3,111,602**	**3,121,311**	**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	(23,024)	(23,024)	(580)	(580)
- equity instruments measured at fair value through OCI	18,350	18,350	-	-
Other (gains) and losses	-	-	27,000	27,000
Total Comprehensive Expenditure for the year ended 31 March 2023	**3,106,928**	**3,116,637**	**8,992,493**	**8,905,981**

	UKHSA balances included in the Core and Agencies column of the Statement of Financial Position 2022-23 £'000	UKHSA balances included in the Departmental Group column of the Statement of Financial Position 2022-23 £'000	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	907,021	907,021	926,983	926,983
Investment Property	15,236	15,236	15,491	15,491
Intangible assets	31,492	31,492	37,741	37,741
Right of use assets	24,216	16,960	-	-
Financial assets- Investments	-	-	18,350	18,350
Other non-current assets	125,058	125,058	18	18
Total non-current assets	**1,103,023**	**1,095,767**	**998,583**	**998,583**
Current assets				
Inventories	774,576	774,576	1,102,482	1,102,482
Trade and other receivables	292,568	278,868	255,688	244,953
Other current assets	221,856	221,856	69,688	69,688
Cash and cash equivalents	155,624	155,624	215,598	215,598
Total current assets	**1,444,624**	**1,430,924**	**1,643,456**	**1,632,721**
Total assets	**2,547,647**	**2,526,691**	**2,642,039**	**2,631,304**
Current liabilities				
Trade and other payables	(38,672)	(29,091)	(164,649)	(123,448)
Other liabilities	(375,775)	(374,678)	(1,984,313)	(1,509,743)
Provisions	(295,281)	(295,281)	(98,283)	(98,283)
Total current liabilities	**(709,728)**	**(699,050)**	**(2,247,245)**	**(1,731,474)**
Non-current assets less net current liabilities	**1,837,919**	**1,827,641**	**394,794**	**899,830**
Non-current liabilities				
Provisions	(17,701)	(17,701)	(16,682)	(16,682)
Financial liabilities	(20,098)	(13,852)	-	-
Total non-current liabilities	**(37,799)**	**(31,553)**	**(16,682)**	**(16,682)**
Total assets less liabilities	**1,800,120**	**1,796,088**	**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

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 **Outturn**	2023-24 Plan
Resource DEL							
A	NHS England	16,598,249	17,186,308	25,597,500	23,371,789	**14,524,033**	29,683,055
B	NHS Providers	75,607,340	81,526,454	93,119,985	99,849,097	**107,932,134**	108,811,192
C	DHSC Programme and Administration	1,107,488	856,606	26,540,107	13,268,380	**5,065,263**	3,893,798
D	Local Authorities (Public Health)	3,011,064	2,931,555	4,205,920	4,217,325	**3,195,761**	3,370,210
E	Executive Agencies	1,026,301	923,546	1,480,833	10,181,091	**3,737,212**	2,010,366
F	Health Education England (footnote)	1,819,177	1,444,495	1,448,640	1,595,487	**1,789,611**	
G	Special Health Authorities	2,718,887	2,743,281	2,650,888	2,868,350	**2,969,741**	2,992,296
H	Non Departmental Public Bodies	624,829	628,293	723,579	875,334	**769,729**	108,321
I	Arm's Length Bodies [1]	838,583	2,981,221	2,849,887	2,124,627	**844,324**	148,274
J	NHS Commissioning Board financed from National Insurance contributions (non voted)	21,926,343	22,961,639	22,823,176	25,196,757	**36,266,858**	27,560,297
Total Resource DEL		**125,278,261**	**134,183,398**	**181,440,515**	**183,548,237**	**177,094,666**	**178,577,809**

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 **Outturn**	2023-24 Plan
Capital DEL							
A	NHS England	221,233	265,530	330,577	291,416	**238,684**	444,137
B	NHS Providers	3,928,404	4,498,029	7,281,187	6,833,740	**7,537,572**	8,297,926
C	DHSC Programme and Administration	1,658,348	1,811,114	4,677,582	1,795,522	**1,987,401**	2,841,061
D	Local Authorities (Public Health)	-	0	0	0	**0**	0
E	Executive Agencies	(70,475)	140,735	21,022	(221,171)	**(274,232)**	156,600
F	Health Education England	467	1,557	532	1,119	**1,889**	
G	Special Health Authorities	(49,815)	24,172	47,320	30,623	**23,715**	40,312
H	Non Departmental Public Bodies	95,246	118,533	156,325	187,746	**129,542**	20,264
I	Arm's Length Bodies [1]	157,836	155,574	189,762	200,041	**203,379**	287,501
Total Capital DEL		**5,941,244**	**7,015,244**	**12,704,307**	**9,119,036**	**9,847,950**	**12,087,801**

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 **Outturn**	2023-24 Plan
Resource AME							
K	NHS England	(19,733)	294,489	86,125	119,445	**10,693**	250,000
L	NHS Providers	1,134,119	1,070,401	1,978,051	1,100,553	**962,326**	2,000,000
M	DHSC Programme and Administration	(437,113)	785,506	1,997,564	3,115,133	**(3,519,936)**	645,000
N	Executive Agencies	(2,181)	(2,033)	13,831	269,629	**(483,838)**	0
O	Health Education England	(44)	68	159	596	**(856)**	
P	Special Health Authorities	6,405,024	675,203	(1,266,873)	43,308,197	**(58,933,071)**	7,882,000
Q	Non Departmental Public Bodies	6,373	3,536	23,207	25,429	**16,508**	2,000
R	Arm's Length Bodies [1]	(72,480)	20,839	49,696	31,745	**(23,742)**	101,000
Total Resource AME		**7,013,965**	**2,848,009**	**2,881,760**	**47,970,727**	**-61,971,916**	**10,880,000**

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 **Outturn**	2023-24 Plan
Capital AME							
K	NHS England	0	0	0	0	**0**	0
L	NHS Providers	0	0	0	0	**16,807**	13,378
M	DHSC Programme and Administration	(4,801)	(5,563)	(7,355)	0	**2,654**	92,222
N	Executive Agencies	0	0	0	0	**0**	0
O	Health Education England	0	0	0	0	**0**	
P	Special Health Authorities	0	0	0	0	**0**	0
Q	Non Departmental Public Bodies	0	0	0	0	**868**	0
R	Arm's Length Bodies [1]	-	-	0	0	**0**	0
Total Capital AME		(4,801)	(5,563)	(7,355)	0	**20,329**	**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

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 **Outturn**	2023-24 Plan
Administration Budgets							
A	NHS Commissioning Board	1,508,274	1,545,410	1,488,859	1,474,998	**1,789,448**	1,789,448
B	NHS Providers	-	-	-	-	**0**	0
C	DHSC Programme and Administration	230,029	230,249	449,061	522,365	**390,591**	578,434
D	Local Authorities (Public Health)	-	-	-	-	**0**	0
E	Executive Agencies	48,778	49,134	51,140	174,753	**201,591**	27,826
F	Health Education England	59,943	61,296	58,970	60,183	**60,709**	
G	Special Health Authorities	178,184	180,884	192,996	167,127	**121,647**	118,092
H	Non Departmental Public Bodies	248,219	239,886	258,655	280,647	**241,300**	90,387
I	Arm's Length Bodies	(739)	(5,777)	(6,850)	(5,461)	**3,003**	1,000
Total Administration Budget		**2,272,688**	**2,301,082**	**2,492,831**	**2,674,612**	**2,808,289**	**2,605,187**

Supporting narrative for the core tables can be found within performance section and **Annex B.**

Annex B (i) – Financial Performance Detail

27. The Department of 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

28. Spending for all Government Departments is measured against a set of metrics as agreed in HM Treasury's Spending Review. **Figure 38** provides a breakdown of the consolidated budgets for all bodies in the Department of Health and Social Care Group into the main spending metrics.

Figure 38: Department of Health and Social Care Group – Spending Metrics

Total Department Expenditure Limit (TDEL)	Total Annually Managed Expenditure (TAME)
£185.12bn	**-£37.62bn**
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)
£176.15bn	**£11.19bn**	**-£35.96bn**	**£0.11bn**
The control total for which current resource expenditure, net of income, must be contained.	The control for which capital expenditure, e.g. fixed assets additions and capital grants, net of capital disposals must be contained.	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)
£3.31bn
Administration budgets cover the costs of all central government administration, excluding depreciation and the costs of direct frontline service provision.

Total Departmental Expenditure Limit:

29. The Department of 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.

30. TDEL spending continues to grow cumulatively since SR15 and was significantly impacted by COVID-19 spending in 2020-21 and 2021-22. The level of COVID-19 spending in 2022-23 was significantly reduced from the prior two years.

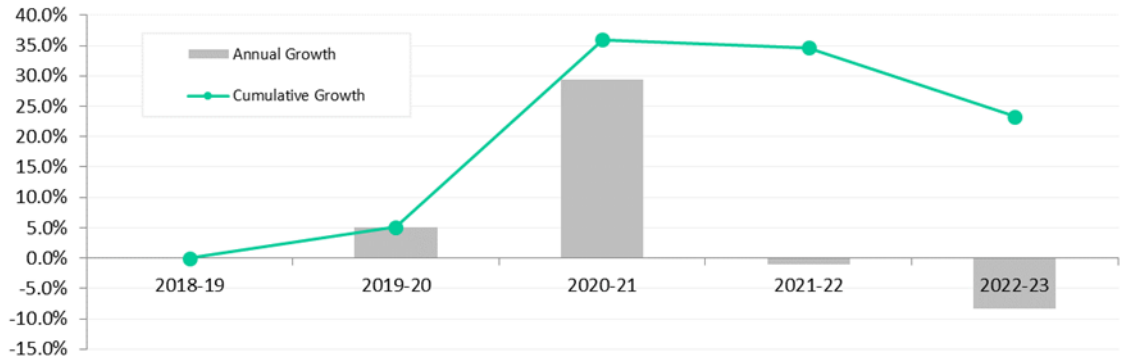
31. **Table 51** details 2022-23 TDEL spending outturn and compares that to previous years.

Table 51: Total Departmental Expenditure Limit Spending

	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
TDEL spending	**130,300**	**140,498**	**193,126**	**189,914**	**185,424**
Growth Nominal (£)	*5,146*	*10,198*	*52,627*	*(3,211)*	*(4,491)*
Growth Nominal (%)	*4.1%*	*7.8%*	*37.5%*	*(1.7%)*	*(2.4%)*

32. As shown in **Figure 39**, in 2022-23, the Departmental real-terms spending was 8.4% lower than in 2021-22 and 23.3% greater than in 2018-19.

Figure 39: Real Terms Spending Growth



1. Cumulative growth figures are from 2017-18
2. GDP Deflators at June 2023 used to calculate real terms growth

33. The TDEL expenditure growth results from:
    - the funding secured in the 2015 Spending Review, 2019 Spending Round and 2021 Spending Review; and,
    - the cumulative real-term increases in 2020-21 to 2022-23 TDEL expenditure, compared to 2018-19 are mainly as a result of the DHSC Group's response to the coronavirus pandemic which increased TDEL expenditure (nominal terms) by £46.2 billion in 2020-21, by £36.9 billion in 2021-22 and by £12.6 billion in 2022-23.

34. The Department of Health and Social Care Group's outturn against the budgets authorised by Parliament is detailed in **Table 52.**

Table 52: Parliamentary DEL and AME control totals

	Budget £m	Outturn £m	Under/ (Overspend) £m
Parliamentary Controls:			
Resource Departmental Expenditure Limit (RDEL)	176,148	177,095	(946)
of which: Resource Administration	*3,308*	*2,808*	*499*
Capital Departmental Expenditure Limit (CDEL)	11,193	9,848	1,345
Resource Annually Managed Expenditure (RAME)	(35,957)	(61,972)	26,015
Capital Annually Managed Expenditure (CAME)	106	20	85
Net Cash Requirement	185,122	144,489	5,003
Further HM Treasury Controls:	*0*	*0*	*0*
Ringfenced Resource DEL	2,219	1,519	700
Non-ringfenced Resource DEL	173,929	175,576	(1,647)

35. 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)

36. The Department's total 2022-23 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).

37. The spending plans for all Government Departments are submitted to Parliament for scrutiny and approval as part of the Parliamentary Supply Estimates process – these budgetary limits are known as voted limits. The Department receives the majority of its resource funding via this process, but also receives an element of funding from National Insurance Contributions, which are not voted on in the Parliamentary Supply Estimates.

38. In 2022-23, National Insurance Contributions receipts were in line with the non-voted funding set out in the Parliamentary Estimate.

39. **Table 53** summarises the RDEL outturn against budget since 2018-19; highlighting the £0.9 billion (0.5%) overspend in 2022-23.

Table 53: Resource DEL

	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
RDEL Budget	125,924	134,628	201,996	186,895	176,148
RDEL Spending Outturn	**125,278**	**134,183**	**181,441**	**183,548**	**177,095**
Underspends / (Overspends) (£m)	*646*	*444*	*20,556*	*3,347*	*(946)*
Underspends / (Overspends) (%)	*0.5%*	*0.3%*	*10.2%*	*1.8%*	*(0.5%)*

RDEL: Funding Flows and Sector Breakdown

40. Of the Department's total £176.1 billion 2022-23 RDEL budget, £158.8 billion was allocated directly to NHS commissioners, with the remaining £17.4 billion funding allocated to ALBs and the Department's central budgets, i.e., the non-NHS sector.

41. 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.

42. 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).

43. Approximately £108.0 billion of resource expenditure in the Department of 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.

44. The RDEL budget is set net of income and in 2022-23 the Department of Health and Social Care Group received around £13.4 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.

RDEL: DHSC Group

45. **Table 54** details the DHSC Group Resource DEL outturn by sector against budgets.

Table 54: DHSC Group Resource DEL

	Budget £m	Outturn £m	Under/ (Overspend) £m
NHS RDEL (excl. depreciation)	158,521	158,347	175
Non-NHS RDEL (excl. depreciation)	18,083	17,229	854
Funding for the March 23 pay award accrual	(2,675)	0	(2,675)
DHSC Group RDEL (excl. depreciation)	**173,929**	**175,576**	**(1,647)**
NHS RDEL (depreciation)	288	283	5
NonNHS (depreciation)	1,931	1,236	695
DHSC Group RDEL (incl. depreciation)	**176,148**	**177,095**	**(946)**

46. As set out in Performance Summary, the Department exceeded the Resource Departmental Expenditure Limit (RDEL) by circa £0.9 billion. This was mainly due to:
    - A funding pressure of circa £2.7 billion for the 2022-23 NHS pay award offered to and subsequently accepted by NHS unions in March 2023, and included in the NHS' final budget, offset by;
        - circa £0.7 billion underspend on the RDEL budget ring-fenced for depreciation; and,
        - circa £1.0 billion underspend on COVID-19 and business as usual programmes - details of which are set out in the following paragraphs.

RDEL NHS: Overall NHS Performance against NHS Financial Directions – resource limits

47. The following section provides detail on the financial performance of the NHS in 2022-23.

48. The Financial Directions to the Government's revised NHS mandate for 2022-23 separately sets out the resource and capital funding limits against spending controls for the NHS. These spending controls stem from the same controls that HM Treasury apply to the Department. NHS England must ensure that spending across Integrated Care Boards, NHS providers and their own centrally managed budgets is contained within these funding limits. **Table 55** summarises the performance against those limits.

Table 55: Financial Performance – NHS England, Integrated Care Boards & NHS providers

	RDEL NRF £m	RDEL RF £m
NHSE Central	38,281	225
Integrated Care Boards	119,088	34
NHS Trusts and Foundation Trusts	978	24
Net NHS Outturn as per Statement of Parliamentary Supply	**158,347**	**283**
Budgets as per 22.23 Financial Directions	**158,521**	**288**
Over / Underspend	175	5

49. The RDEL non-ringfence budget of circa £158.5 billion is used to fund the costs of healthcare services delivered in England. In 2022-23, the NHS underspent by circa £175 million (or less than 0.1%) on that control.

50. The majority of that budget is allocated to Integrated Care Boards (ICB), who together with their partners in Integrated Care Systems (ICS) will use that to fund healthcare services in their respective local areas. In 2022-23, ICS reported a year-end overspend of circa £517 million as impacts of Covid and shortfalls on stretching efficiency ambitions continued to impact on spending. This overspend was offset by underspends on other budgets to ensure that the NHS once again delivered balance within their overall RDEL limit. **Table 56** provides a further breakdown of the NHS' outturn by sector:

Table 56: Further breakdown of NHS spending against RDEL NRF limits

	Plan	Outturn	Over / Under spend
NHSE Central	39,248	38,557	691
Intergrated Care Systems	119,273	119,790	-517
Net NHS Outturn as per SoPS	**158,521**	**158,347**	**175**
Of which:			
Elective Recovery	*1,366*	*1,000*	*366*
COVID-19 Vaccines	*915*	*795*	*120*
COVID-19 Other	*6,096*	*6,096*	*0*
Business as usual	*150,145*	*150,456*	*(311)*
Integrated Care System Breakdown			
Integrated Care Boards/Clinical Commissioning Groups		119,088	
NHS providers SRP		450	
NHS providers Other		252	
Total ICS	**119,273**	**119,790**	**(517)**
Number of ICS in balance	32	2	(30)
Number of ICS in deficit	10	18	8
Number of ICS in surplus	0	22	22

51. Further commentary, together with the consolidated accounts of the NHS England group, is published on NHS England's website.

RDEL Non-NHS: Financial Performance Resource DEL Spending

52. Outside of the NHS sector and the late NHS pay agreement, the Department of Health and Social Care Group's non-NHS sector contained resource expenditure within DEL spending limits.

10%
Of DHSC RDEL expenditure

53. 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 2022-23

	Plan £m	Outturn £m	Under/ (Overspend) £m
RDEL (excl. depreciation) -			
Health Education England	5,355	5,343	11
UKHSA (excl COVID vaccines and Test & Trace)	1,012	844	168
Other ALBs	835	779	56
Public Health Local Authority Grants	3,202	3,196	6
Voluntary scheme for branded medicines pricing and access	(1,800)	(1,665)	(135)
Public dividend capital (PDC) payments and loan interest	(1,114)	(1,100)	(14)
European Economic Area (EEA) medical costs	722	914	(192)
Adult Social Care	413	392	21
COVID - Vaccines Supply and deployment	2,450	2,123	327
COVID - Treatments	2,089	2,072	17
COVID - UKHSA Test & Trace	1,982	1,384	598
COVID - Personal Protective Equipment	376	382	(6)
COVID - Oxygen/Ventilators	186	87	99
Other DHSC Central Budgets	2,376	2,478	(102)
Total RDEL (excl. depreciation)	**18,083**	**17,229**	**854**
Funding for NHSE 2022-23 Pay Award	(2,675)	0	(2,675)
	15,408	**17,229**	**(1,821)**
NonNHS (depreciation)	1,931	1,236	695
DHSC Group RDEL (incl. depreciation)	**17,339**	**18,465**	**(1,126)**

54. Excluding NHS Pay and depreciation, the non-NHS sector's RDEL outturn was around £0.8 billion lower than the allocated funding. Details of the main components of the outturn and resultant underspend are set out below.

UK Health Security Agency

55. Expenditure in UKHSA was circa £0.2 billion lower than budgeted for. Around £60 million of the underspend relates to lower than planned vaccines and countermeasures response expenditure, which is mostly demand led. Further underspends in core UKHSA relate mainly to delays in recruitment.

COVID – 19 Test and Trace (UKHSA TT)

56. The bulk of testing expenditure in the non-NHS was in UKHSA with circa £80 million incurred by NHS Digital for The National Testing Platform. This enables test ordering by individuals for different settings and for the uploading of test results, bulk registration and reporting for care homes and prisons and elective care.

57. UKHSA was allocated £1.9 billion in relation to the COVID-19 Test and Trace programme, with a final outturn against budget of £1.4 billion. As part of this UKHSA was responsible for:
    - Creating and maintaining daily capacity for tests across a peak of 800 testing sites during 2022-23
    - Purchasing and providing both PCR and LFD tests for citizens;
    - Conducting COVID-19 tests in line with government policy; and
    - Contacting people to notify them to self-isolate.

58. The £0.6 billion saving against budget was predominantly driven by changes in government policy including the move to the Living with COVID Strategy which significantly reduced demand for testing services below the original assumptions for the testing programme.

COVID – 19 Vaccine procurement, supply, and deployment

59. In 2022-23, the COVID-19 vaccine procurement, supply and deployment programme, was allocated £2.4 billion of non-NHS funding and spent £2.1 billion. This was in addition to the £0.9 billion of funding allocated directly to the NHS for vaccine deployment of the largest vaccination programme in NHS history.

60. In 2022-23 the programme procured 110 million doses and administered 25 million vaccinations.

61. The £0.3 billion saving against budget was mainly due to the changing trajectory of the pandemic. Vaccines were procured on a worst-case scenario which did not crystallise. This allowed UKHSA to negotiate more suitable future delivery schedules with suppliers to minimise wastage.

62. £0.1 billion of the saving related to vaccine deployment. As requirements and deployment methods changed during the year in response to the latest scientific advice and final uptake numbers, expenditure on associated activities, such as consumables, testing and communications was lower than planned.

COVID-19 Treatments

63. In 2022-23 the COVID-19 treatments programme was allocated £2.1 billion, of which £2.1 billion was spent on therapeutic COVID-19 treatments, mainly comprising £0.2 billion consumption and £1.8 billion impairment.

64. The Department had previously 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.

65. 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 £1.7 billion has been recognised, representing the Department's best estimate of the value of medicines held at 31 March 2023 that will reach expiry prior to the expected usage date. This is in addition to the £0.9 billion recognised in 2021-22 as further contracted medicines have been delivered in the 2022-23 financial year.

European Economic Area medical costs:

66. Expenditure on European Economic Area medical costs was circa £0.2 billion higher than budgeted for. This was largely due to additional liabilities identified in the 2022-23 financial year, and the settlement of outstanding liabilities following historic claims with member states.

Adult Social Care

67. The table above (**Table 52**) includes £0.4 billion Departmental 2022-23 expenditure on Adult Social Care (ASC). This expenditure includes Winter Discharge programme expenditure of £0.2 billion. This was funded via a series of ASC reprioritisations in-year.

RDEL Administration

68. 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 Group) and all the Department's central Government Arm's Length Bodies (ALBs).

69. Against the total Resource Administration limit of £3.31 billion the DHSC Group underspent by £0.50 billion, and this mainly comprised:
    - circa £0.24 billion underspend on depreciation and impairments; and
    - circa £0.26 billion underspend RDEL non-ringfenced, of which £0.14 billion was in NHSE and the balance mainly on COVID-19 administration.

70. **Table 58** shows the Department of Health and Social Care Group administration outturn (excluding depreciation and impairments) between 2018-19 and 2022-23 Spending on administration increased in 2022-23 by circa £90 million compared to 2021-22, this is mainly occurred in NHS England and can be attributed to the 2022-23 NHS pay award.

Table 58: Department of Health and Social Care Group Administration

	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
Administration Outturn	2,189	2,212	2,405	2,575	2,665

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 £2.8 billion.

Capital Departmental Expenditure Limit (CDEL)

£9.8bn CDEL spend

71. The Department of Health and Social Care Group's total 2022-23 CDEL outturn is the consolidated net capital spending of all bodies within the Departmental group.

72. **Table 59** summarises the CDEL outturn against budget since 2018-19, highlighting the £1.3 billion (12.0%) underspend in 2022-23.

Table 59: Capital DEL

	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
CDEL Budget	5,983	7,125	12,918	10,447	11,193
CDEL Spending Outturn, of which:	**5,941**	**7,015**	**12,704**	**9,119**	**9,848**
CDEL Underspend	*42*	*110*	*235*	*1,328*	*1,345*
CDEL Underspend %	*0.7%*	*1.5%*	*1.8%*	*12.7%*	*12.0%*

CDEL: DHSC Group

73. **Table 60** details the DHSC Group Resource DEL outturn by sector against budgets:

Table 60: DHSC Group Capital DEL

	Budget £m	Outturn £m	Under/ (Overspend) £m
NHS capital DEL	7,351	7,174	177
NonNHS capital DEL	2,407	2,070	337
Sub-total (excl IFRS16)	**9,758**	**9,244**	**514**
IFRS16 (NHS)	1,199	701	498
IFRS16 (NonNHS & Group)	236	-97	333
Sub-total (IFRS16)	**1,435**	**604**	**831**
TOTAL CDEL	**11,193**	**9,848**	**1,345**

74. As set out in Performance Summary (paragraph 362), the Department underspent the Capital Departmental Expenditure Limit (CDEL) by circa £1.3 billion. This was mainly due to:
    - IFRS 16: the Department implemented the accounting standard for leases during 2022-23. Additional capital funding was secured for its impact, however the associated capital costs were around £0.8 billion lower than expected; and
    - underspends of circa £0.5 billion in demand-led COVID-19 (£0.3 billion) and business as usual programmes (£0.2 billion).

CDEL NHS: Financial Performance Capital DEL Spending

Summary

75. The summarised CDEL outturn compared to plan for key elements of the NHS sector are shown in **Table 61**.

Table 61: NHS Capital DEL

	Budget £m	Outturn £m	Under/ (Overspend) £m
NHS England business as usual activities	275	223	52
NHS Providers business as usual activities	7,076	6,950	126
NHS Providers IFRS16	1,144	653	490
NHS England IFRS16	55	49	6
TOTAL NHS CDEL, *of which:*	**8,550**	**7,875**	**675**
NHS Providers incl.IFRS 16		7,603	
NHSE incl.IFRS 16		272	

NHS providers

76. The NHS provider Capital DEL (CDEL) expenditure was £7.6 billion in 2022-23 (exclusive of net capital investment of NHS Charities and inclusive of IFRS 16 spend). This is a circa 12% increase on the equivalent net investment in 2021-22 (£6.8 billion). There have been increases in expenditure on National Programmes in 2023-23, along with the budgetary impact of implementing the IFRS 16 accounting standard. The NHS Provider capital outturn is detailed in **Table 62**.

Table 62: NHS provider Capital DEL

	2022-23 £m
Capital DEL Outturn [1]	**7,603**
Of which	
Operational Capital Expenditure [2]	3,894
National Programmes	2,878
IFRS16	653
PFI Residual Interest [3]	178

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 system capital support.
3. HMT's budgeting framework requires PFI residual interest on assets, to score to CDEL.

Operational Capital

77. Operational capital is issued to prioritise the capital needs of the NHS, including renewal and replacement of plant, information technology, equipment, minor building works and investment to deliver core clinical strategies. Operational capital includes system capital support for NHS providers who have insufficient cash levels to fund their operational capital programme, 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 in 2022-23

were allocated at system level to Integrated Care Systems (ICS) to improve the coordinated planning, allocation and delivery of investment, and the join up of services.

78. As part of operational capital, £210 million was provided to manage NHS estates affected by Reinforced Autoclaved Aerated Concrete (RAAC), providing funding in the short-term to mitigate immediate risks and protect staff and patient safety. This includes a programme of fail-safe measures in the worst affected hospitals that have RAAC planks, including those which will be fully replaced through the New Hospital Programme, and removing smaller sections of RAAC completely from specific buildings in Trusts where the overall exposure is lower.

79. NHS providers are required to set their operational budgets within those envelopes and reflect system-wide priorities. In-year system capital support applications and re-prioritisation or rephasing of capital spend are made at a local level through ICS/NHS Provider discussions.

National Programmes

80. Funding for national programmes, such as the New Hospital Programmes and Hospital Upgrades is directly issued by the Department in the form of Public Dividend Capital (PDC) to cover NHS providers' approved capital 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.

81. **Table 63** provides details of National Programmes, the detail of which is described in the following paragraphs.

Table 63: National Programmes Capital DEL

	2022-23 Total £m
New Hospital Programme/Upgrades	929
Elective Recovery	536
NHS Technology and Digital	432
Diagnostics	691
Mental Health Dormitories	141
Mental Health Capacity and safety	57
Demand and Capacity capital (Winter Funding)	36
Discharge Fund	47
Mobile Breast Screening	9
NHS Providers National PDC Total	**2,878**

New Hospital Programme/Hospital Upgrades:

82. The New Hospital Programme forms part of the wider Health Infrastructure Plan, a long-term, rolling programme of strategic investment in health and care buildings, estates, and equipment. The Government has committed to deliver 40 hospitals by 2030, and as announced in October 2020 was backed by an initial £3.7 billion for the first four years of the programme. Five hospitals are in construction, with two having now completed. The programme is standardising the design and delivery of hospitals through a national approach, Hospital 2.0. This will mean the development and construction of hospitals will be quicker, increasing value for taxpayer's money.

83. At Spending Review 2021, the Department received £1.7 billion for over 70 hospital upgrades, continuing a programme of investment which had previously been announced, with 17 patient ready upgrades completed during 2022-23. These investments will modernise and transform the NHS' buildings and services, with the money going towards upgrading facilities, increasing capacity so more people can be treated and shifting the emphasis towards prevention. This is being delivered through a range of programmes across the country including new urgent care centres; integrated care hubs that bring together primary and community services; and investing in new mental health facilities.

Elective Recovery:

84. The £1.5 billion Targeted Investment Fund (TIF) was established after the Spending Review 2020 to support elective recovery. Capital for new capacity and productivity improvements to the NHS estate has been allocated, with regional teams working with systems and trusts to identify the most impactful and deliverable schemes to support elective recovery. The funds' outcomes include supporting the expansion or creation of surgical/elective hubs, the creation of 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 additional diagnostic activity in all regions.

NHS Technology schemes:

85. Successful digital transformation in the NHS delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. National funding issued in 2022-23 for NHS technology programmes totalled £432 million, funding improvements in infrastructure for managing and sharing digital patient records between health care providers across the country, transforming remote monitoring of patients, and raising digital maturity. This has included investment in the NHS frontline digitisation programme, strengthening the implementation of digital capabilities across secondary care, and enabling infrastructure to meet our core standard.

Diagnostics:

86. To enhance the NHS Diagnostic capability, the Government has committed funding to increase the volume of diagnostic activity to help clear the backlog of people waiting for clinical tests, such as magnetic resonance imaging (MRI), ultrasound, and computerised tomography (CT) scans. CDCs increase diagnostic capacity,

supporting faster, earlier diagnosis and reduced waiting times for better patient outcomes. A significant proportion of the Diagnostic funding has enabled the rollout of Community Diagnostic Centres (CDCs). CDCs increase diagnostic capacity, supporting faster, earlier diagnosis and reduced waiting times for better patient outcomes. The programme to date has approved 143 CDC sites in community hospitals, on university campuses, retail, and council sites in deprived community locations across England.

Mental Health:

87. Mental health has been a priority of the government's capital investment strategy. This includes the announcement made by the Secretary of State in October 2020 that more than £400 million will be committed to the end of 2024-25 to eradicate dormitory accommodation from mental health facilities across the country and replace dormitory beds with single en-suite accommodation. The eradication of dormitories will improve safety, privacy and the individual care that can be given to patients, potentially reducing the length of their stay.

88. Funding was also awarded in the 2021 Spending Review for Mental Health Urgent and Emergency Care, with improving mental health services being a priority of the government's capital investment strategy. This investment has been targeted at better supporting people experiencing – or at risk of experiencing – mental health crises to receive care and support in more appropriate settings outside of A&E and helping to ease pressures facing the NHS. 2022-23 was the first in a 3-year capital programme to fund projects supporting the provision of mental health crisis response and urgent mental health care, including crisis cafes, crisis houses, health-based places of safety (a safe space for people detained by the police) and improvements to crisis phone lines.

Winter Demand and Capacity:

89. During 2022-23, NHS systems were asked to identify additional general and acute (G&A) capacity to admit patients to reduce the number of patients waiting in Emergency Departments for a suitable bed, which would also have an impact on ambulance handover delays, and ambulance response times. Schemes ranged from conversions of existing space, modular builds, refurbishments, and modernising of spaces to create additional capacity in increase of beds, trolley spaces and supporting flow through Department.

Discharge Fund:

90. £50 million capital funding was announced in January 2023 to upgrade and expand hospitals with new ambulance hubs and the creation and expansion of discharge lounges in Trusts, along with other facilities to support discharge. These schemes aimed to improve flow through acute settings. Six ambulance hubs and 42 new and upgraded discharge lounges have opened at hospitals across the country. The new ambulance hubs and discharge lounges are an example of our investments to cut waiting times, by freeing up beds and reducing the time for patients waiting to be admitted from A&E. The hubs will allow ambulances to manoeuvre more quickly and cut out unnecessary delays, and the lounges will free up hospital beds, while

offering patients a more comfortable environment to recover in while they are waiting to leave hospital.

CDEL Non-NHS: Financial Performance Capital DEL Spending

91. Outside of the NHS sector, the Department's non-NHS sector capital expenditure was around £0.4 billion lower than the allocated funding.

92. The summarised DEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 64**.

Table 64: Summarised CDEL Financial Position for 2022-23 Non-NHS

	Plan £m	Outturn £m	Under/ (Overspend) £m
CDEL			
UKHSA (excl COVID vaccines and Test & Trace)	165	125	40
Other ALBs	482	373	109
Research & Development	1,330	1,319	11
Disabled Facilities Grant	573	573	0
NHS Technology	59	75	(16)
UKHSA COVID Test & Trace	(140)	(355)	215
COVID vaccines supply and deployment	(123)	(163)	40
DHSC IFRS16	150	(102)	252
Other DHSC Central Budgets	147	127	20
Total Non-NHS CDEL	**2,643**	**1,973**	**671**

93. Details of the main components of the underspend are set out below:

COVID – 19 UK Health Security Test and Trace (UKHSA TT)

94. As per their budgeting guidance for inventory purchases, HM Treasury decided that UKHSA TT inventory purchases should be classified as 'large'. This means that inventory purchases are charged to capital DEL on purchase and are charged to revenue DEL with an equivalent credit to capital DEL on consumption.

95. Given UKHSA TT carried forward inventory £362 million from 2021-22 into 2022-23, UKHSA TT was allocated a capital budget of negative £0.14 billion to reflect the assumption that consumption of inventory would exceed new inventory and other asset purchases. The UKHSA TT CDEL credit relates to consumption of inventory purchased in prior the year and impairment of inventory currently held which will not be required.

96. UKHSA TT's £0.2 billion saving against budget is mainly because more inventory was consumed than had been estimated at the time of setting the final budget.

Vaccine procurement, supply, and deployment

97. In 2022-23, the COVID-19 vaccine procurement and supply programme was allocated 'negative budget' of £0.1 billion and incurred negative capital expenditure of £0.2 billion on the supply of vaccines to facilitate biggest vaccination programme in NHS history. As part of HM Treasury budgeting convention, long-term advance payments more than £20 million made to secure the supply of COVID-19 vaccines, scored as a cost to the capital budget in 2021-22. The £0.04 billion underspend arose because more pre-paid vaccines were delivered in the financial year than had been estimated when setting the final budget, creating a larger credit to the capital budget.

IFRS 16

98. In line with other government departments, during 2022-23, DHSC implemented IFRS 16, the international accounting standard for leases. DHSC Group has a significant number of leasing arrangements which makes establishing funding requirements and implementing IFRS 16 more challenging.

99. Additional capital funding was secured for the impact of IFRS 16; however, the associated capital costs were lower than expected. As detailed in the table above, the core Department's IFRS 16 capital expenditure was around £0.3 billion lower than the funding available. Additionally, around £82 million of the 'other ALBs' £114 million underspend relates to IFRS 16.

Annually Managed Expenditure (AME)

100. Details of the Department of Health and Social Care Group's total 2022-23 AME budget and expenditure are set out in **Table 65**, which shows the group underspent by £26.0 billion (72.3%) against its final Resource AME budget.

(£62.1bn)
AME outturn

Table 65: Annually Managed Expenditure

	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
Resource AME Budget	12,926	11,420	10,002	49,000	(35,957)
RAME Outturn	**7,014**	**2,848**	**2,882**	**47,971**	**(61,972)**
Underspend/(Overspend) £m	*5,912*	*8,572*	*7,120*	*1,029*	*26,015*
Underspend/(Overspend) %	*45.7%*	*75.1%*	*71.2%*	*2.1%*	*(72.3%)*
Capital AME Budget	15	15	15	15	106
Capital AME Outturn	**(5)**	**(6)**	**(7)**	**0**	**20**
Underspend/(Overspend) £m	*20*	*21*	*22*	*15*	*85*
Underspend/(Overspend) %	*132.0%*	*137.1%*	*149.0%*	*100.0%*	*80.7%*

101. The Department of 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 of 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.

102. Additionally, the Department of 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.

103. The final AME budget in 2022-23 was set at negative £36.0 billion and included a £48 billion decrease to budget in the 2022-23 Supplementary Supply Estimate mainly for the change in the 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 a change in the incidence of harm or an increase in the cash required to settle claims.

104. The main elements of Department of Health and Social Care Group's AME negative £62.1 billion outturn and resultant £26.1 billion underspend are mainly due to:
    - NHS Resolution's (NHSR) AME outturn of negative £58.9 billion was £21.7 billion lower than anticipated when setting the budget due to favourable changes in assumptions and methodology, claims inflation and the estimated quantum of future clinical negligence claims was lower than had been forecast;
    - The NHS sector's AME outturn, mainly comprising impairments expenditure, was around £1.2 billion lower than planned for in setting the budget; and
    - The non-NHS sector's AME outturn, comprising net provisions movement; and impairments expenditure was £3.2 billion lower than anticipated when setting the final budget. This was mainly due to less new provisions expenditure than had been predicted and higher than predicted onerous contract provisions release.

Annex B (ii) – Supplementary Time-Series Information

105. In addition to the core tables and financial performance detail, the tables below provide further timeseries breakdowns of key spending numbers of regular interest to parliament and the wider public.

NHS Total Departmental Expenditure Limit

106. The majority of the Department of Health and Social Care Group's budget is allocated to fund the NHS. **Table 66** provides an explanation of the adjustments made to the NHS budget since the 2015 Spending Review (SR).

Table 66: NHS Outturn Versus Budget - Timeseries

	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 (LTS)											
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)	6,691	2,623	
Additional Covid-19 funding [7]							19,988	16,295			
SR21 Funding									8,989	6,085	8,161
Autumn Statement 22 Funding										3,300	3,200
NHS RDEL Budget at per NHSE Mandate					**114,421**	**123,377**	**149,473**	**150,614**	**158,521**	**163,326**	**165,841**
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***	***158,521***	***163,326***	***165,841***
Plus NHS provider sector net RDEL outturn			935	1,038	826	1,009	(732)	(595)	978		
Plus Net commissioner and NHSE underspend			(902)	(970)	(916)	(636)	(5,374)	(697)	(1,152)		
Net NHS RDEL Outturn [3]	**97,098**	**100,572**	**105,735**	**109,605**	**114,331**	***123,750***	***143,367***	***149,322***	***158,347***	***163,326***	***165,841***
NHSE CDEL	189	182	240	228	221	266	331	291	272	444	219
NHS TDEL	**97,287**	**100,754**	**105,975**	**109,833**	**114,552**	**124,016**	**143,698**	**149,613**	**158,618**	**163,770**	**166,060**
Memo item: NHS Provider depreciation was reclassified as RDEL RF from 2023-24 [8]	*(1,844)*	*(1,878)*	*(1,864)*	*(1,987)*	*(1,904)*	*(2,043)*	*(2,341)*	*(2,641)*	*(3,293)*	*(3,321)*	*(3,442)*

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 £16.3 billion in 2021-22.

8. NHS Provider depreciation was reclassified from RDEL NRF to RDEL RF from 2023-24. Future HMT publication will incorporate this change.

NHS Financial Performance – NHS providers (NHS Trusts and Foundations Trusts) and Integrated Care Boards (ICBs)

107. **Table 67** provides a timeseries of the aggregate surplus/deficit position in NHS providers, plus the further adjustments to that surplus/deficit needed to calculate the impact on the Resource DEL.

Table 67: NHS providers (NHS Trusts and Foundation Trusts) RDEL breakdown - Timeseries

NHS Providers Timeseries	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
Gross Deficit	2,433	2,755	1,560	158	126	1,001
Gross Surplus	-1,337	(1,889)	-567	(363)	-442	(299)
Reporting Adjustment	-105	(39)	-323	(450)	-240	(252)
NHS Providers - Sector Reported Performance	**991**	**827**	**670**	**(655)**	**(556)**	**450**
Plus additional RDEL adjust	47	(1)	338	(77)	-39	528
Net NHS providers RDEL NRF	**1,038**	**826**	**1,008**	**(732)**	**(595)**	**978**

108. **Table 68** provides a timeseries of the aggregate surplus/deficit position across Integrated Care Systems (ICS). 2022-23 is the first year that commissioners and providers work together as ICS to manage to an agreed financial plan and therefore prior year comparators are not available.

Table 68: Integrated Care Systems (ICS) Financial Performance – Timeseries

Integrated Care System Timeseries	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
Integrated Care Boards/Clinical Commissioning Groups						119,088
NHS providers Sector Reported Performance						450
NHS providers Reporting Adjsutments						252
Net NHS ICS SRP						**119,790**
ICS Budget						**119,273**
Variance						**(517)**

Purchase of Healthcare from Non-NHS Providers

109. Most healthcare services are purchased from NHS providers (NHS Trusts and Foundation Trusts); however, £16.6 billion of these types of services were purchased from non-NHS healthcare providers in 2022-23. These non-NHS providers include Local Authorities, voluntary sector/not for profit organisations, Devolved Administrations, and private sector providers. **Table 69** provides data between 2017-18 and 2022-23

Table 69: NHS England's Purchase of healthcare from non-NHS Providers

Purchase of healthcare from non-NHS Providers	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
Independent Sector Providers	8,765	9,180	9,692	12,139	10,854	11,454
Voluntary Sector / Not for profit	1,564	1,619	1,705	1,866	1,791	1,264
Local Authorities	2,737	2,899	2,984	4,312	4,318	3,805
Devolved Administrations	43	50	49	36	48	28
Other Group Bodies	0	0	0	31	35	90
Sub-total	**13,109**	**13,748**	**14,430**	**18,384**	**17,046**	**16,641**
Total DHSC RDEL	**120,650**	**125,278**	**134,183**	**181,441**	**183,548**	**176,774**
Spend with private sector as a % of total RDEL	*7%*	*7%*	*7%*	*7%*	*6%*	*6%*
Spend on all non-NHS bodies as a % of total RDEL	*11%*	*11%*	*11%*	*10%*	*9%*	*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.

Financial Information by Arm's-length body (ALB)

110. 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.

111. Each ALB consolidated into the Department's Group Annual Report and Accounts (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 70** provides the necessary information. Notes to the table aide the users' interpretation of the figures presented.

Table 70: Financial information by ALB

	2022-23						
				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	(3,022,106)	178,256,548	174,782,096	3,176	234,314	905	74,622
UK Health Security Agency	(806,929)	3,524,926	3,256,723	3,585	258,996	3,298	228,886
Medicines and Healthcare products Regulatory Agency	(124,256)	162,064	(145,595)	1,153	76,461	93	5,663
NHS England Group	(5,138,606)	162,825,517	157,362,611	35,383	2,590,315	11,524	669,298
National Health Service Trust Development Authority	(2,896)	44,448	51,089	358	33,898	11	164
NHS Providers	(121,531,486)	123,015,097	1,487,423	1,242,298	72,511,523	148,710	7,496,128
Monitor	(284)	4,030	9,120	21	3,142	-	(35)
Care Quality Commission	(218,861)	246,024	27,163	2,883	165,104	151	26,499
National Institute for Health and Care Excellence	(23,448)	81,272	57,824	807	56,692	11	802
NHS Digital	(31,754)	633,887	917,930	3,051	176,511	811	79,636
Human Fertilisation and Embryology Authority	(6,018)	7,300	1,282	68	4,699	4	499
Human Tissue Authority	(4,489)	4,942	453	53	3,624	3	114
Health Research Authority	(451)	22,240	21,789	263	14,822	3	418
Health Education England	(85,321)	5,431,003	5,345,682	2,779	208,835	393	63,818
NHS Counter Fraud Authority	(285)	14,722	14,437	161	9,610	7	763
NHS Business Services Authority	(730,766)	940,243	117,477	3,472	148,203	200	7,691
NHS Resolution	(2,491,070)	(56,193,507)	(58,684,577)	553	39,069	25	1,750
NHS Property Services Ltd	(760,652)	832,417	67,953	5,568	176,208	261	1,442
Community Health Partnerships Ltd	(485,733)	480,318	(5,415)	232	14,377	17	1,478
Genomics England Ltd	(27,345)	114,298	86,953	467	39,217	42	2,319
Skipton Fund Ltd	(74)	124	50	-	-	-	-
Nursing & Midwifery Council	(102,885)	99,956	(2,929)	1,030	53,232	65	2,688
Health & Care Professions Council	(36,141)	38,416	2,275	261	13,337	22	1,793
Wiltshire Health and Care LLP	(68,228)	68,233	5	1,028	47,321	18	4,991
Professional Standards Authority for Health and Social Care	(5,236)	5,405	169	40	3,567	1	48

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, Clinical Commissioning Groups (CCGs) and Integrated Care Boards (ICBs). For completeness, however, the above table includes NHS providers and NHS England.
3. The amounts above do not include any central adjustments the Department has made, the results of NHS Charities or intragroup eliminations.

Annex C - Reconciliation of contingent liabilities included in the Supply Estimate to the accounts (not subject to audit)

Quantifiable Contingent Liabilities				
	Description of Contingent Liability	Supply Estimate £'000	Amount Disclosed in ARA £'000	Variance (Estimate – Amount disclosed in ARA) £'000
1	Within the NHS England Group account (which incorporates Clinical Commissioning Groups, Integrated Care Boards, Supply Chain Coordination Ltd and NHS England) at 31 March 2023, there were contingent liabilities of £42.2 million (2021-22: £22.4 million). These were mainly in respect of continuing care liabilities which transferred from Primary Care Trusts (PCTs) on 1 April 2013. No contingent liabilities relate to Clinical Commissioning Groups at 31 March 2023 due to their demise during the year.	15,584	42,200	(26,816)
2	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.	54,000	-	54,000
3	Legal Cases – Department as Claimant	-	N/A[1]	N/A
4	Contractual liability for redundancy payments	-	522	(522)
5	Provision of life assurance cover for individuals transferred to the Department	-	358	(358)
6	Legal Cases – Department as Defendant	-	N/A[1]	N/A
7	Sensitive Contingent Liability	-	N/A[1]	N/A
8	The department holds an indemnity provided to Oxford University for unexpected tax implication as a result of the National Institute for Health Research (NIHR) National Biosample Centre transfer to the department.	-	3,200	(3,200)
9	The department holds a general indemnity provided to Oxford University in relation to the National Institute for Health Research (NIHR) National Biosample Centre transfer to the department.	-	14,925	(14,925)
10	Indemnities for Covid-19 Vaccines Purchases	-	N/A[1]	N/A
11	Compensation payments due to individuals unable to be traced	-	400	(4,000)
12	NHS providers at 31 March 2023 had net contingent liabilities of £35.5 million (2021-22: £29.5 million)	-	35,500	(35,500)
13	At 31 March 2023, NHS Resolution had other non-clinical contingent liabilities of £263 million (2021-22: £295 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.	-	263,000	(263,000)

1. Due to the sensitive nature of these liabilities, the value has not been disclosed.

1. The Department is required by the Government Financial Reporting Manual (FReM) to provide an explanation for material variances only. The department does not determine any of the variances to be material, however the below comment has been included to provide further context.
2. The value for the items three, six, seven and ten have not been disclosed due to the sensitive nature of the contingent liabilities. The department does not determine the variances for the individual items to be material.

Unquantifiable Contingent Liabilities				
	Description of Contingent Liability	**Included in the Supply Estimate (Yes/No)**	**Disclosed in ARA (Yes/No)**	**Explanation of difference**
1	The Department is bearing an insurable risk for professional indemnity or malpractice on behalf of the Human Fertilisation and Embryology Authority.	Yes	Yes	N/A
2	The Department is bearing an insurable risk for professional indemnity or malpractice on behalf of the Human Tissue Authority.	Yes	Yes	N/A
3	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.	Yes	Yes	N/A
4	The Department has undertaken to cover any damages arising from NHS Blood and Transplant clinical trials activity.	Yes	Yes	N/A
5	The Department has undertaken to indemnify members of its expert advisory committees: a) Advisory Committee on Dangerous Pathogens (ACDP) (and their associated Working Groups); b) New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG); c) Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI); d) The Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO).	Yes	Yes	N/A
6	The Department has undertaken to indemnify members of the: a) Committee for Carcinogenicity; b) Committee for Mutagenesis; c) Committee for Medical Effects of Radiation; d) Committee for Medical Aspects of Air Pollution; e) Administration of Radioactive Substances Advisory Committee. The Department would pay the legal costs and damages of any member who was personally subject to any action arising out of the business of these Committees and sub-committees of them.	Yes	Yes	N/A
7	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.	Yes	Yes	N/A
8	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.	Yes	Yes	N/A
9	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.	Yes	Yes	N/A
10	Where there is a requirement for HMG to aeromedically 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.	Yes	No	Expired
11	The Department is involved in a number of Employment Tribunal cases.	Yes	Yes	N/A
12	The Department holds contractual liabilities in respect of redundancy payments and entitlements, and it also holds liabilities	Yes	Yes	N/A

	in respect of commercial contract obligations. These liabilities include contractual indemnities the Department has entered into as part of its response to COVID-19.			
13	The Department is the actual or potential defendant in a number of actions regarding alleged clinical negligence. There is a large degree of uncertainty as to the Department's liability and the amounts involved.	Yes	Yes	N/A
14	UK Health Security Agency 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.	Yes	Yes	N/A
15	The Department holds a contingent liability relating to contracts signed between Her Majesty's Government and Pfizer/BioNTech for their COVID-19 vaccine.	Yes	Yes	N/A
16	The Department holds a contingent liability relating to the contract signed between Her Majesty's Government and AstraZeneca/Oxford for their COVID-19 vaccine.	Yes	No	See Note 3
17	The Department holds a contingent liability relating to the contracts signed between Her Majesty's Government and Moderna for their COVID-19 vaccine.	Yes	Yes	N/A
18	The Department has further contingent liabilities relating to the COVID-19 vaccine programme.	Yes	No	Expired
19	The Department holds a contingent liability relating to the two contracts signed between Her Majesty's Government and the medicine supplier Pfizer for their COVID-19 antiviral drug PF-07321332+ritonavir, co-packaged and marketed as Paxlovid.	Yes	Yes	N/A
20	UK Health Security Agency 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.	Yes	Yes	N/A
21	The Department has issued a letter of comfort to Supply Chain Coordination Limited to requirements relating to COVID-19.	Yes	No	Expired
22	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.	Yes	Yes	N/A
23	The Department also provides an indemnity in respect of an inquiry and a contingent liability in regard to a case under the Equalities Act.	Yes	No	N/A
24	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.	Yes	Yes	N/A
25	Legal Cases – Department as Defendant	No	Yes	See Note 4
26	Legal Cases – Department as Claimant	No	Yes	See Note 4
27	The Department holds an indemnity in relation to the Mpox vaccine	No	Yes	See Note 5

3. This item is no longer considered a contingent liability and has now been recognised in the Department's provisions.
4. These items are not part of the normal course of business and therefore not subject to parliamentary approval.
5. Contingent liability documented after the submission of the Supply Estimate.

E02916210
ISBN 978-1-5286-4137-1