Department of Health & Social Care

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Annual Report and Accounts 2023-24

For the year ended 31 March 2024

HC 476

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For the year ended 31 March 2024

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

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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/

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Permanent Secretary's overview

The Department of Health and Social Care (DHSC) supports its ministers in leading the nation's health and care system. Our objectives, delivered in conjunction with our arm's length bodies (ALBs), are to help people live more independent and healthier lives, for longer, creating a safe and high-quality health and care system.

The year to 31 March 2024 was another challenging year for the health and care sector. We managed many competing demands, including health and social care reforms, workforce pressures, urgent and emergency care recovery, the impact of industrial action, delivering manifesto commitments under the then government and our long-term plans for the future.

During the year, DHSC continued 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. DHSC is committed to responding to the inquiry with openness and transparency. DHSC had submitted more than 50,000 pieces of evidence to the inquiry, including written witness and corporate statements, and has supported ministers and senior civil servants to give evidence at the hearings to date. DHSC continues to embed the lessons learned from the COVID-19 pandemic, including launching a new UK-wide health and care pandemic preparedness strategic framework.

DHSC also responded to requests from the independent public statutory inquiry into infected blood, which reported on 20 May 2024. The department has continued to make support payments to individuals under the English support scheme. These payments will continue until the scheme is transferred to the newly formed Infected Blood Compensation Authority (IBCA), who will then take on the responsibility for payments. The department is committed to learning from the findings identified in the inquiry to ensure that this does not happen again.

Throughout the year, we have managed changes within our structures. NHS England legally merged with Health Education England on 1 April 2023, which gave NHS England the responsibility to plan, recruit, educate and train the health workforce, ensuring that the healthcare workforce has the right numbers, skills, values and behaviours in place to support the delivery of excellent healthcare and health improvement to patients and the public. The Health Services Safety Investigations Body (HSSIB) was established in October 2023 with powers and independence to conduct investigations into incidents which occur during the provision of healthcare.

The Comptroller and Auditor General (C&AG) has qualified his opinion in two respects, both of which relate to the roll-forward impact of prior year qualifications. These relate to the comparative in-year transactions and 2022-23 opening balances relating to the UK Health Security Agency, and similarly, those relating to consumables inventory held by the core department and its agencies. These matters are discussed in more detail in the Governance Statement and the C&AG's certificate and Report on Account.

DHSC welcomed the report on the state of the NHS in England, the findings of which are outlined in the Independent Investigation of the National Health Service in England ('the Lord Darzi report') which was published in September 2024 under the new government. DHSC is committed to working with NHS England and the new government to address the findings in the report and to support the development of the 10-Year Health Plan, to reset the relationships with the public and our dedicated staff across the health and social care sector, and to set out the reform programme for healthcare.

It has been a great privilege to lead DHSC and I would like to take this opportunity to thank all the staff both within DHSC and across the wider 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

This section introduces the role and purpose of DHSC and sets out how funding flows from Parliament around the health and social care system.

Our role and purpose

For 2023-24, the vision of DHSC was to enable everyone to live more independent, healthier lives for longer. This vision focused around the 4 core roles to:

- provide world-class advice to ministers that is supported by expert research and analysis
- 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 DHSC's agencies and partners to deliver health and care services to improve and protect everyone's health and wellbeing
- work with other government departments, DHSC agencies and partners locally, regionally, nationally, and internationally to contribute to the government's wider health, economic and social goals.

Over 2023-24, DHSC faced many competing demands, including health and social care reforms, workforce pressures, urgent and emergency care recovery, the impact of industrial action, manifesto commitments and long-term plans. For 2023-24 DHSC continued working to fulfil the same set of key priorities as in 2022-23, 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

DHSC works through its arm's length bodies (ALBs), which we support and hold to account in carrying out their responsibilities. These ALBs are listed in Note 20, the largest of which is NHS England, which leads the NHS in England, ensuring patients receive high-quality care in local health systems that are financially sustainable.

DHSC prioritises building strong and effective working relationships with each of its ALBs via departmental sponsorship teams. These teams, in line with the Cabinet Office 'ALB Sponsorship Code of Good Practice', work collaboratively to ensure accountable, efficient and effective health and care services are provided to the public.

The Secretary of State for Health and Social Care and other DHSC 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.

Risk management

DHSC's risk management policy is to:

- identify and understand its risks
- have clear accountabilities in place for the management of risks
- have robust and consistent procedures in place for risk management, and
- have staff at all levels who possess the necessary competencies in risk management.

Risk management enhances strategic planning and prioritisation across the department, assists in achieving objectives and strengthens the ability to be agile in responding to the challenges faced.

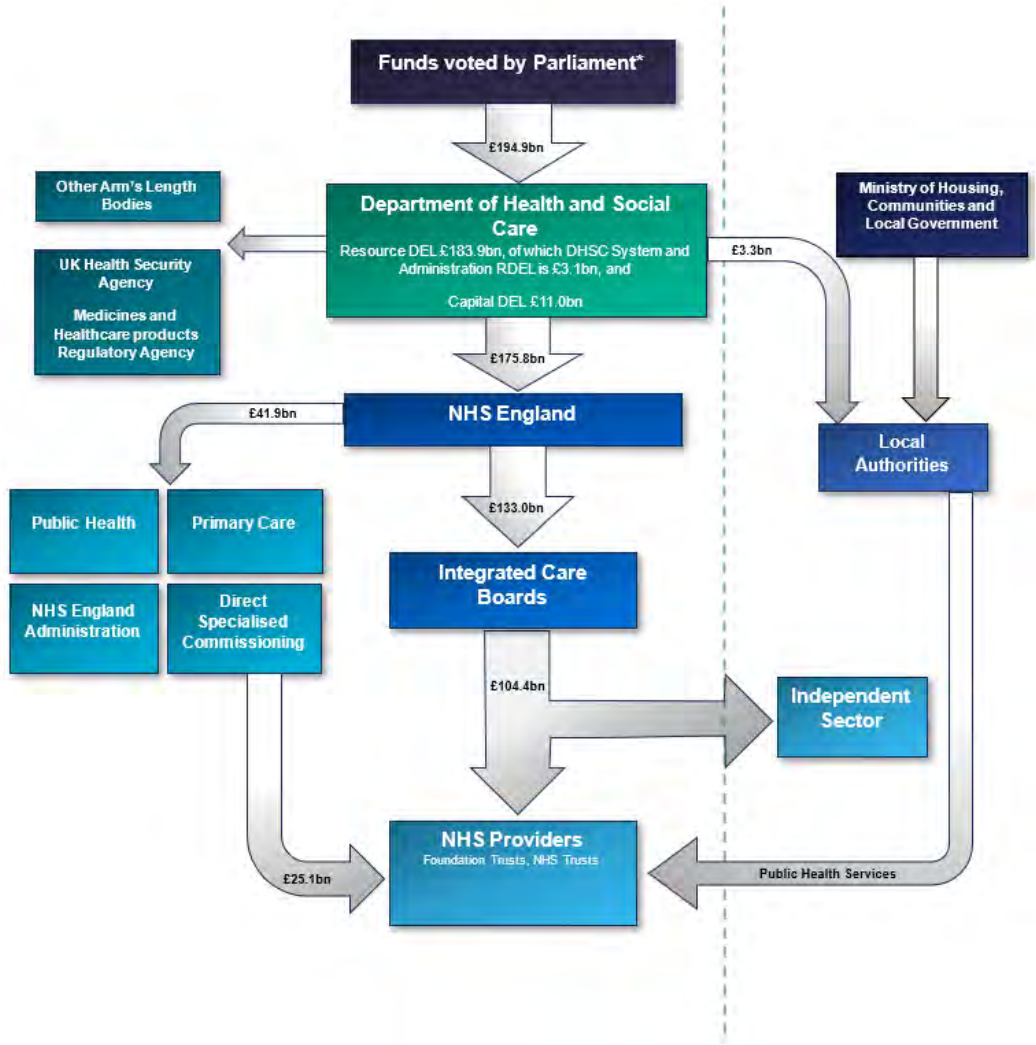
Our funding

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 2023-24 financial year, DHSC had a resource departmental expenditure limit of £183.9 billion and had funding to invest a further £11.0 billion to fund capital items such as new hospitals and equipment, as detailed in **Table 5** on page 84.

Figure 1 demonstrates how funding flows round the system, using agreed budget totals for 2023-24 per the supplementary estimate.

Separately, but not shown in Figure 1, DHSC is responsible, together with the Ministry of Housing, Communities and Local Government (MHCLG), for securing funds for adult social care through the Spending Review settlement. The Ministry of Housing, Communities and Local Government (MHCLG) remains accountable for the overall sufficiency of local government funding, and the allocation of those funds to local authorities.

Figure 1: Funding flows in the health and care system, 2023-24 (per supplementary estimate)



*The reference to 'Funds voted by Parliament' 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.

Achievements at a glance

£40 million Local Authority **Urgent and Emergency Care Support Fund** issued

Publication of **the Primary Care Recovery Plan**

Publication of the **NHS Long Term Workforce Plan**

New reciprocal healthcare agreement with the EEA-EFTA states came into force

The first formal **CQC assessments** of local authorities started in December 2023

Launch of the first **national career structure** for care workers

Hormone replacement therapy **prescription prepayment certificate launched**

Publication of the **dental recovery plan**

Key finance facts

All DHSC group expenditure and cash was contained within the budgets set by Parliament

£10.5bn (net) investment in capital

NHSE's **£171bn RDEL** (excluding depreciation) budget was the biggest of any ALB in government.

14% spending **growth** in real terms since **2019-20**

Over £500m CDEL invested on supporting elective recovery through new capacity and productivity improvements to the NHS estate

DHSC underspent by only 0.6%[1], maximising almost every penny while still keeping within budget

[1]The reference to 0.6% refers to an underspend against its total resource departmental expenditure limit

Performance summary

Priority outcomes

This section provides a high-level summary of the Department of Health and Social Care's (DHSC's) performance against its 5 strategic priorities for 2023-24. It is supported by the performance analysis section of the annual report and accounts, which offers a detailed discussion of performance in key areas related to the priority outcomes, along with discussion of other topical areas of note from across the year.

As a department of state our strategic priorities in 2023-24 were:

- Priority outcome 1: protect the public's health through the health and social care system's response to COVID-19
- 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
- Priority outcome 3: improve healthcare outcomes through a well-supported workforce
- Priority outcome 4: improve, protect, and level up the nation's health, including reducing health disparities
- Priority outcome 5: improve social care outcomes through an affordable, high-quality, and sustainable adult social care system

The summary below provides an at-a-glance overview of how we worked towards delivering DHSC priority outcomes in this financial year (2023-24). Further detail can be found in the 'detailed performance analysis' section.

Priority outcome 1: protect the public's health through the health and social care system's response to COVID-19

The spring 2023 COVID-19 vaccination programme ran in England from April 2023 to June 2023, for everyone living in care homes for older people, all those aged 75 or over, and all those with immunosuppression aged 5 or over. The autumn COVID-19 vaccination and seasonal flu vaccination programmes both started in September 2023 in England allowing co-administration wherever practical for those eligible for both vaccinations.

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

During 2023-24, there was a heavy focus on recovering emergency, elective, and primary care performance in the NHS. Amid widespread industrial action, progress was made on

delivering the actions outlined in the Delivery plan for tackling the COVID-19 backlog of elective care, including an expansion in the number of operational elective surgical hubs across England. Work was also undertaken in collaboration with NHS England to progress the Data saves lives strategy, aimed at reshaping health and social care through improved data use.

Priority outcome 3: improve healthcare outcomes through a well-supported workforce

In June 2023, NHS England published the NHS Long Term Workforce Plan, setting out steps to train, retain and reform the NHS workforce. Industrial action continued throughout 2023-24, affecting the scheduling of appointments and operations across acute NHS trusts. Negotiations progressed throughout the year and, during 2024-25, agreements were reached with the NHS Staff Council (representing the collective of Agenda for Change (AfC) unions), unions representing consultants and speciality and specialist (SAS) doctors, and the BMA junior doctors committee.

Priority outcome 4: improve, protect, and level up the nation's health, including reducing health inequalities

The Major conditions strategy: case for change and our strategic framework was published and set out the approach to health and care delivery to improve outcomes and better meet the needs of our population. In February 2023, the then government published The Best Start for Life: A progress report on delivering the Vision which set out the progress made on delivering the best start for life vision.

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

The reform priorities for 2023-24 and 2024-25 were set out in the Next Steps to put People at the Heart of Care. Progress made against these priorities in 2023-24 included a national career pathway for adult social care, a new assessment framework for local authority assurance, and funding for scaling of innovations in technology and beyond. Care data matters: a roadmap for better adult social care data was published in December 2023, which set out the context for the adult social care data landscape, and the changes required for how adult social care data is collected, shared and used. The adult social care outcomes framework (ASCOF) was updated in December 2023 to ensure that the ASCOF aligned with the Care Act 2014. In December 2023, CQC started assessing how well local authorities deliver their duties under Part 1 of the Care Act 2014.

Detailed performance analysis

Introduction

The detailed performance analysis section provides an evidence-based, analytical overview of how DHSC has performed against its key objectives during 2023-24. The analysis covers the key areas that can be measured within each of the 5 priority outcomes.

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, 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

Vaccines, treatments, research and deployment

For spring 2023, the Joint Committee on Vaccination and Immunisation (JCVI) advised, and the government accepted, that everyone living in care homes for older people, all those aged 75 or over, and all those with immunosuppression aged 5 or over should be offered a further COVID-19 vaccination.

The programme ran in England from April 2023 to June 2023 and had an uptake of 71% for the over 75s and 41% for the immunosuppressed; compared with 79% and 49% respectively for the similar programme in 2022.

For autumn 2023, JCVI advised that those living in care homes for older people as well as everyone aged 65 or over should be offered a vaccination, along with those aged 6 months to 64 years in a clinical risk group, staff in care homes for older people, front line health and social care staff, unpaid carers, and household contacts of the immunosuppressed.

The COVID-19 and seasonal flu programmes started on the same date in England, allowing co-administration wherever practical for those eligible for both vaccinations.

In England, by 4 February 2024, the COVID-19 autumn 2023 vaccination programme had administered over 11.8 million doses, while the 2023 seasonal flu autumn vaccination programme reported on 4 April 2024 that 18.3 million doses had been administered.

By week ending 4 February 2024 uptake for COVID-19 vaccinations was 70% in those over 65 in comparison to 79% by week ending 12 February 2023. Uptake in over 65s flu programme from 1 September 2023 to 29 February 2024 was 78% in comparison to 80% from 1 September 2022 to 28 February 2023.

On 7 February 2024, the JCVI advice to run a further spring campaign for the most vulnerable in the population in 2024 was accepted and the JCVI statement on COVID-19 vaccination in spring 2024 and considerations on future COVID-19 vaccination was published. This programme began in mid-April 2024 in England and covered all those living in care homes for older people, everyone aged 75 or above, and anyone aged 6 months to 74 with immunosuppression.

UK Health Security Agency (UKHSA)

As part of the COVID-19 Response: Living with COVID-19 approach, UKHSA collaborated with DHSC and the wider care sector to implement the new policy approach to reduce testing.

The ownership of NHS staff and patient testing, as well as testing for vulnerable cohorts eligible for therapeutics treatment, was transferred from UKHSA to the NHS in autumn 2023.

In March 2024, UKHSA also transferred large volumes of personal protective equipment, lateral flow devices, and polymerase chain reaction components to the NHS. In total, COVID-19 assets to the value of £2 million were transferred from UKHSA to the NHS.

UKHSA contributed to the COVID-19 vaccination autumn 2023 campaign with approximately 30 million vaccines supplied for the autumn to UKHSA stores for use.

Pandemic preparedness

DHSC has an established pandemic preparedness function that ensures pandemic preparedness is aligned with our refreshed strategic approach across the health and care system, working closely with the UKHSA Centre of Pandemic Preparedness and policy teams across DHSC and NHS England.

This function is also responsible for maintenance of pandemic countermeasures stockpiles and the emergency, preparedness, resilience, and response function for DHSC's role as lead government department for pandemic and infectious diseases risks in the National Strategic Risk Assessment (NSRA). That will include preparedness for any future COVID-19 variants that could threaten a new pandemic.

Learning lessons from the pandemic, the new strategic approach to pandemic preparedness focuses on a flexible, adaptable, and scalable set of capabilities that cover all the tools needed in a pandemic. These include clinical countermeasures such as vaccines and medicines; the core capabilities of UKHSA for surveillance, diagnostics and contact tracing; and case management, and enabling capabilities such as research and development and international collaboration.

DHSC preparedness is expanding to cover all 5 routes of transmission (air, touch, sexual/blood, vector or oral) and continues to take into account the impact of resilience in the wider system.

During 2023-24, DHSC continued to develop its Pandemic Preparedness Portfolio and started work on three key areas for embedding its new strategic approach, working with UKHSA and NHSE. These were:

- developing a health and care pandemic preparedness strategic framework that will set out how DHSC is learning lessons from the pandemic and the principles of the new approach, the capabilities available, and areas for future improvement

- a review of health and care capabilities against readiness for a range of response levels from a large outbreak to a sustained pandemic response

- developing technical content for a health and care respiratory pandemic response plan to outline how DHSC will use capabilities in response to a respiratory pandemic. This plan has been prioritised given experts agree that the respiratory route remains the most likely source of a new pandemic. It will subsequently be adapted to develop response plans for all routes of transmission.

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

The COVID-19 pandemic placed considerable strain on the delivery of elective care and has meant we have more patients waiting for treatment, and many waiting much longer for treatment than before the pandemic.

Agreed funding to tackle the elective backlog so that people get the right care at the right time included:

- plans to spend more than £8 billion from 2022-23 to 2024-25, as announced in Build Back Better: Our Plan for Health and Social Care
- £3.3 billion per year for 2023-24 and 2024-25 to support the NHS in England, enabling action to improve emergency, elective, and primary care performance towards pre-pandemic levels as announced by the then government in the Autumn Statement 2022
- £1.7 billion to mitigate against the direct cost of industrial action in the financial year 2023-24
- £5.9 billion of capital investment across the spending review period to support diagnostics, technology, and elective recovery.

Additional funding for elective care was underpinned by a transformation plan to reduce waiting times. 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 set out how the NHS would recover and expand elective services.

The NHS made progress in delivering many of the actions in this plan, but in some areas, progress was hampered by widespread industrial action. Over 1.4 million hospital appointments were rescheduled up to March 2024 due to strike action which has taken place since December 2022. The effects of industrial action were partly mitigated through funding amounting to £1.7 billion in 2023-24.

Elective activity for 2023-24 remained high, at 15.3% above the 2019/20 baseline value-weighted activity[1] (including advice and guidance) for 31 March 2024.

[1] As a percentage of 2019 value weighted activity which provides a comparison to the pre-pandemic position. Value-weighted activity adjusts for the differing complexity and cost of, for example, an outpatient appointment and a surgical procedure, so that comparisons can be made over time on a consistent basis.

As of March 2024, the elective waiting list was 7.54 million, up from 3.1 million before the pandemic in February 2020.

Most recent headline targets in the Elective Care Delivery Plan were not met by the specified time, but the NHS made progress on reducing the number of patients waiting the longest periods. NHS England reported that, as at March 2024, waits of over 18 months had reduced to 4,800, down by more than 96% from a peak of nearly 125,000 in September 2021.

Waits of over 65 weeks, the focus of the target for March 2024, had reduced by 79% from the peak of over 233,000 in June 2021 to 49,000 at March 2024. The NHS Operational Planning Guidance reset the 65-week target to deliver by the end of September 2024.

Diagnostic overview

In the Autumn Budget and Spending Review 2021, DHSC announced £2.3 billion of capital investment. This included funding for up to 160 Community Diagnostic Centres (CDCs) to be opened 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. CDCs increase diagnostic capacity, supporting faster, earlier diagnosis and reduced waiting times for better patient outcomes.

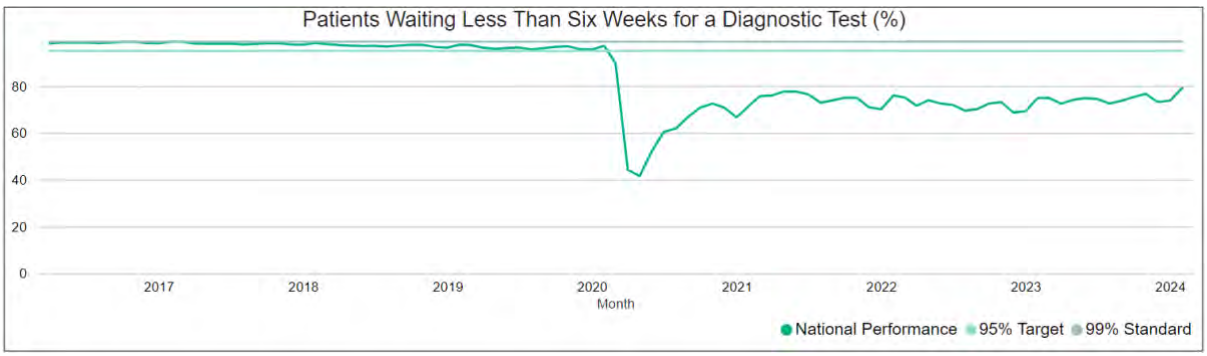
Throughout 2023-24, local systems (integrated care boards (ICBs) and trusts), including leads from the sponsoring trust and the local NHS commissioner, continued to roll out approved CDCs to serve patients who would otherwise have required tests in acute hospitals.

As of the end of March 2024, CDCs were delivering additional tests and checks on 160 sites across the country and had delivered nearly 8 million additional tests since July 2021.

The expansion in capacity was to support the ambition set out in the Elective Care Delivery Plan for 95% of patients needing a diagnostic test to receive it within 6 weeks by March 2025. Further detail on performance against this 95% target is shown in Figure 2.

This target has consistently not been met, with the published position showing that 78.2% of patients received a diagnostic test within 6 weeks and that CDCs delivered approximately 9.1% of all NHS diagnostics in March 2024.

Figure 2: Percentage of waiting times for diagnostic tests and procedures greater than 6 weeks (operational standard - 99%, Elective Recovery Ambition (February 2022) - 95%)



Source: Monthly Diagnostic Waiting Times and Activity (DM01), NHS England

Surgical hubs

One of the commitments set out in the Elective Care Delivery Plan was 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.

As of March 2024, there were 101 identified elective surgical hubs operational across England, helping to separate elective care facilities from urgent and emergency care. This compares to 87 identified operational surgical hubs one year prior in March 2023.

NHS England run a surgical hub accreditation scheme, jointly badged with the Royal College of Surgeons in England. The accreditation scheme ensures hubs are meeting best practice standards, maintains ring-fencing of staff, and improves the profile of the hubs. The expectation is that hubs are or will be operational 6 days a week across 48 weeks per year with 2.5 sessions a day and achieving an 85% theatre utilisation rate.

As of March 2024, 35 surgical hubs had been accredited for clinical and operational excellence.

Independent sector

The independent sector providers play a role in supporting the NHS as partners to recover elective services. In December 2022, the elective recovery taskforce (the 'Taskforce') was launched to identify ways to increase the volume of elective consultations and procedures by both the NHS and the independent sector as far as possible to tackle the backlog.

The Taskforce concluded in March 2023 and, in August 2023, it published an implementation plan that summarised the outcome of its work into specific themes. This included better use of data to help the NHS identify potential opportunities for the independent sector to support patient care, giving patients choice over where they are treated, and expanding training opportunities for staff.

Cancer performance

Cancer survival rates increased across cancer types and demographics. Overall, one-year survival rates were up from 65.6% for adults diagnosed in 2005 to 74.6% for those diagnosed in 2020, and 5-year survival was up from 47.9% for adults diagnosed in 2005 to 55.7% for those diagnosed in 2016.

From April 2023 to March 2024, there was a 5% increase year on year for the number of urgent general practitioner (GP) referrals.

In response to the clinically-led review of standards across the NHS which recommended consolidating cancer waiting times from 10 standards into 3, NHS England changed the cancer waiting times standards to improve early diagnosis of cancer. The new standards came into effect on 1 October 2023.

The NHS 2023-24 priorities and operational planning guidance set the faster diagnosis standard (FDS) ambition that, by March 2024, 75% of patients urgently referred for suspected cancer either receive a cancer diagnosis or have cancer ruled out within 28 days. This was achieved consecutively in February and March 2024, at 78.1% and 77.3% respectively. This showed a similar trend compared to the same time last year.

In March 2024, 90% of patients received a first or subsequent treatment within 31 days of a decision to treat (against national standard of 96%); performance over the last 12 months was 90%. In March 2024, 68.7% (against national standard of 85%) of patients received treatment within 62 days of an urgent suspected cancer or breast symptomatic referral, or consultant upgrade to a first definitive treatment for cancer; performance averaged 64.7% over the last 12 months. The 62-day performance standard showed improvement compared to the same time last year. Figures 3 to 5 demonstrate performance against the 3 standards.

NHS England began publishing management information showing the backlog of patients who are waiting over 62 days for treatment after an urgent referral with suspected cancer. The latest published figures showed that the 62-day backlog for week ending 31 March 2024 stood at 14,916 which had fallen 50% since its peak in the pandemic. The figures were below the end of year target (18,755) to return the backlog to pre-pandemic levels, which was a priority goal for 2023-24.

In December 2023, NHS England extended the starting age to offer people bowel cancer screening kits to those aged 54.

Following the UK National Screening Committee's recommendation, a national targeted lung cancer screening programme was announced in June 2023. This offered lung screening tests to people between the ages of 55 and 74 who were current or former smokers and were at greater risk of lung cancer. Latest data in January 2024 showed that

1,437,177 people were invited to lung health checks, of which 3,504 lung cancers were diagnosed; 75% of which were staged at stage 1 and 2.

Figure 3: Faster diagnosis standard – 28 days wait from urgent referral to patient told they have cancer, or cancer is definitively excluded (standard – 75%)

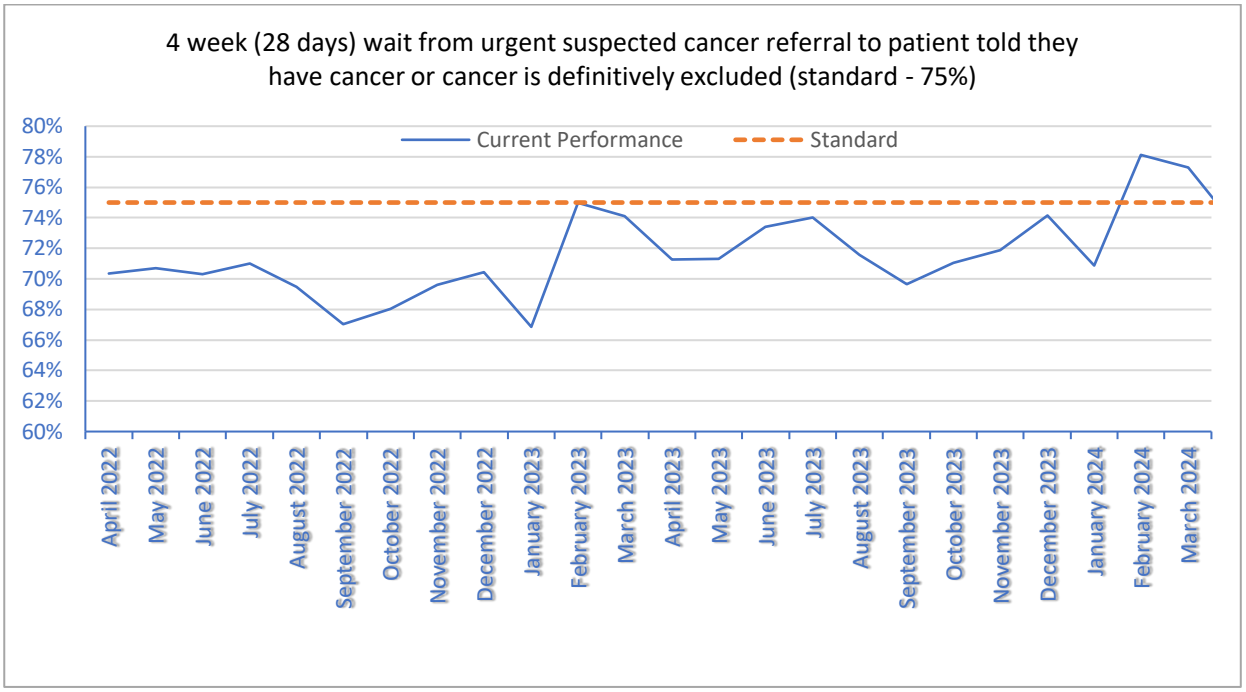


Figure 4: one month wait from a decision to treat to a first treatment for cancer (standard - 96%)

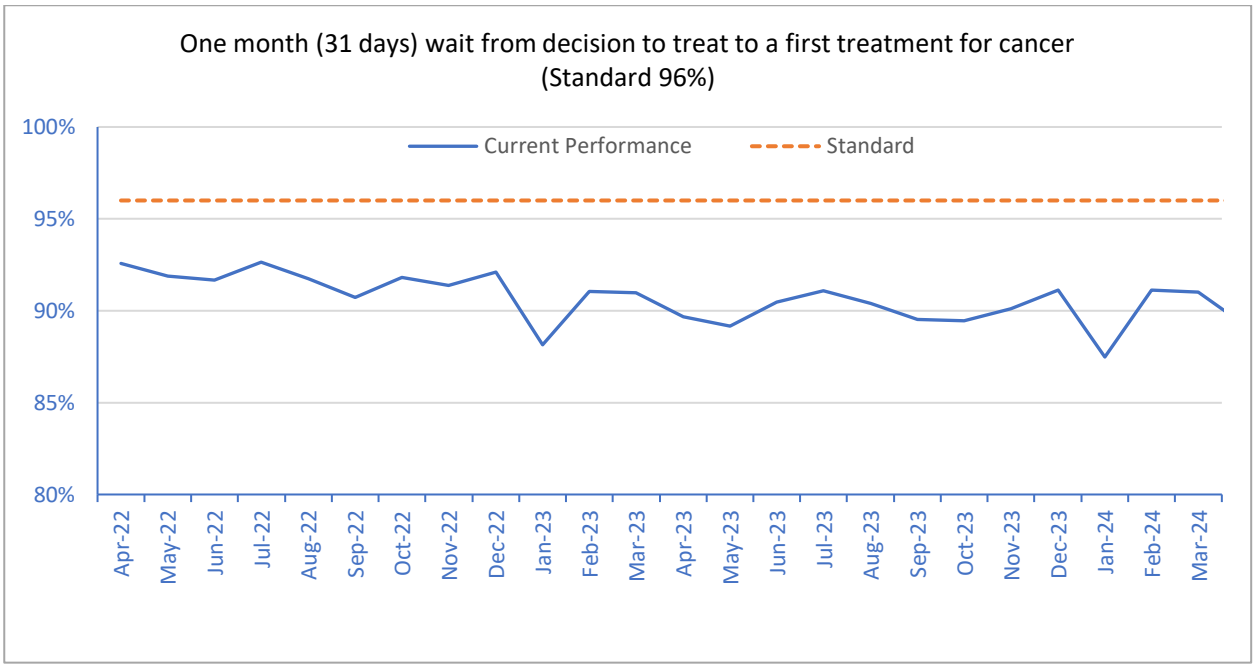
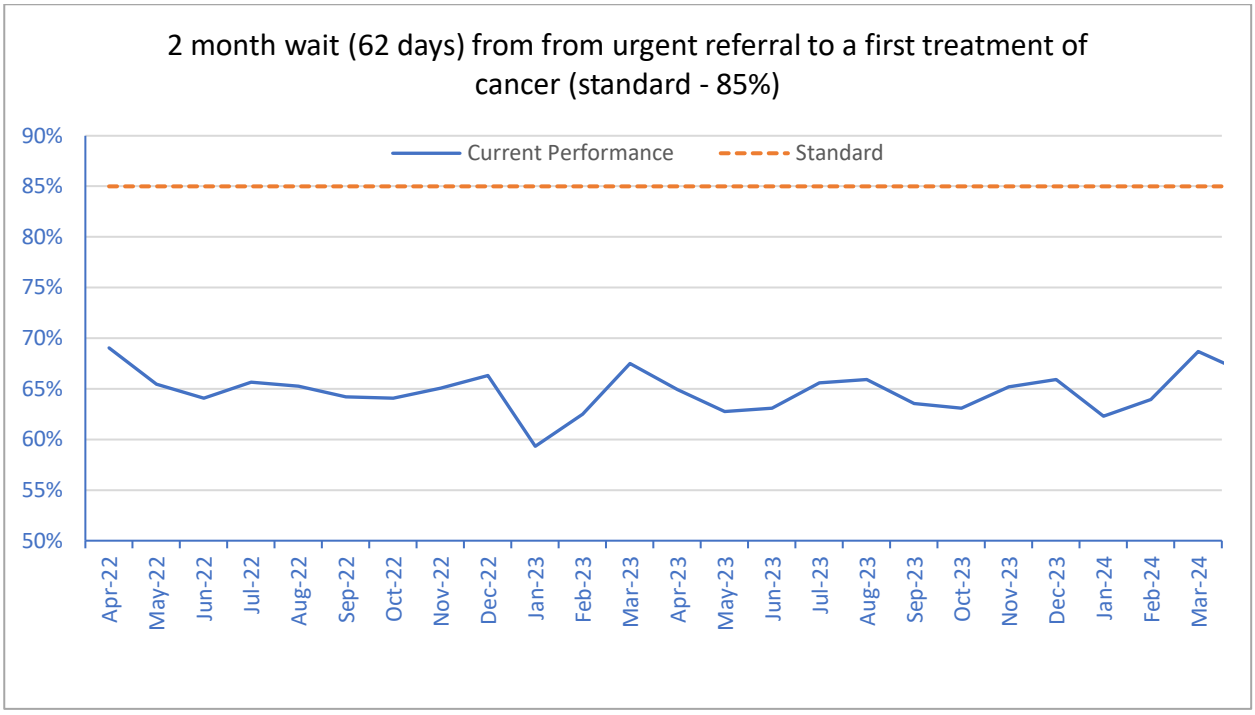


Figure 5: 2 month wait from GP urgent referral to a first treatment for cancer (standard - 85%)



Urgent and emergency care

In January 2023, NHS England published a 2 year delivery plan for recovering urgent and emergency care services with the aim of improving urgent and emergency care waiting times. The 2 main performance ambitions for 2023-24 were:

- to improve A&E wait times to a minimum of 76% of patients being admitted, transferred, or discharged within 4 hours by March 2024
- to reduce Category 2 ambulance response times to 30 minutes on average over 2023-24.

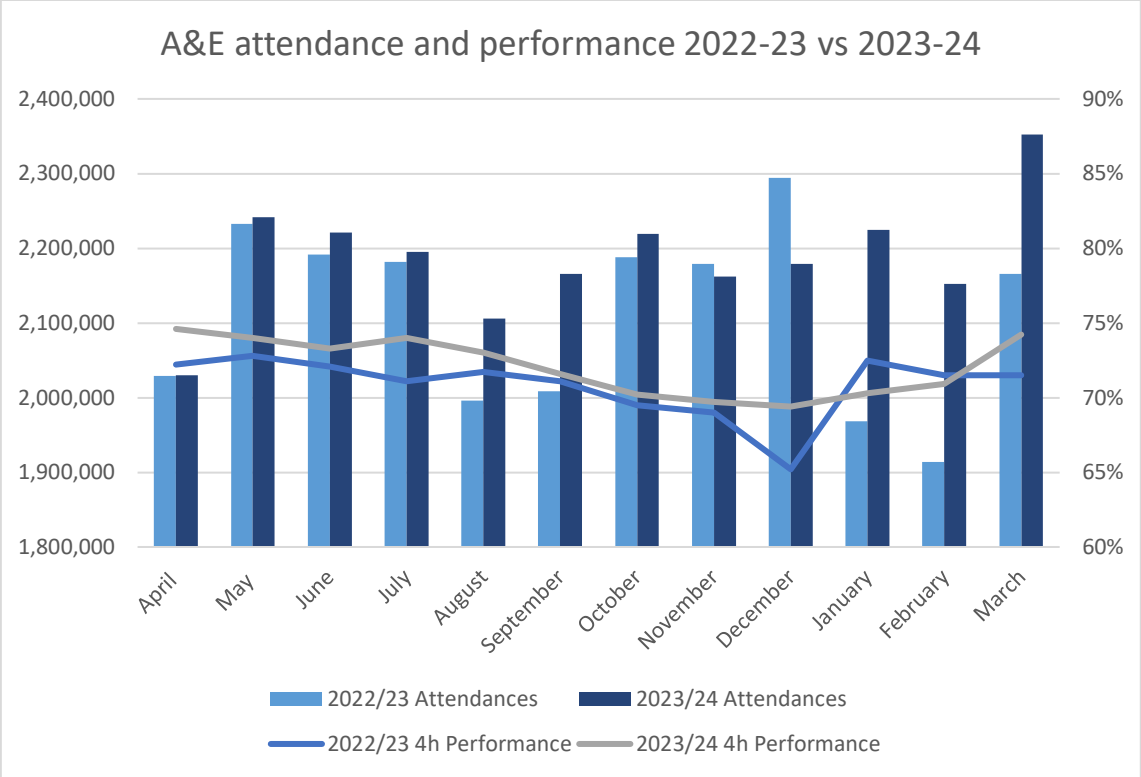
ICBs received £1 billion of funding to increase urgent and emergency care capacity during 2023-24, including:

- delivering 5,000 additional permanent staffed (core) beds
- increasing virtual ward capacity to around 11,800 virtual ward beds
- the roll out of same day emergency care, increasing the number of patients who can be assessed, diagnosed, and treated without having to stay overnight in hospital.

Ambulance trusts received £200 million of additional funding in 2023-24 to increase capacity and deployed ambulance hours.

As shown in Figure 6, despite a general improvement in average monthly A&E performance compared to 2022-23, performance in March 2024 was 74.2%, below the recovery plan performance target of 76% and the national standard of 95%. Average monthly A&E attendances increased by 3.8% from 2,112,404 in 2022-23 to 2,193,422 in 2023-24. Average monthly emergency admissions increased by 6.5% from 501,722 in 2022-23 to 534,219 in 2023-24.

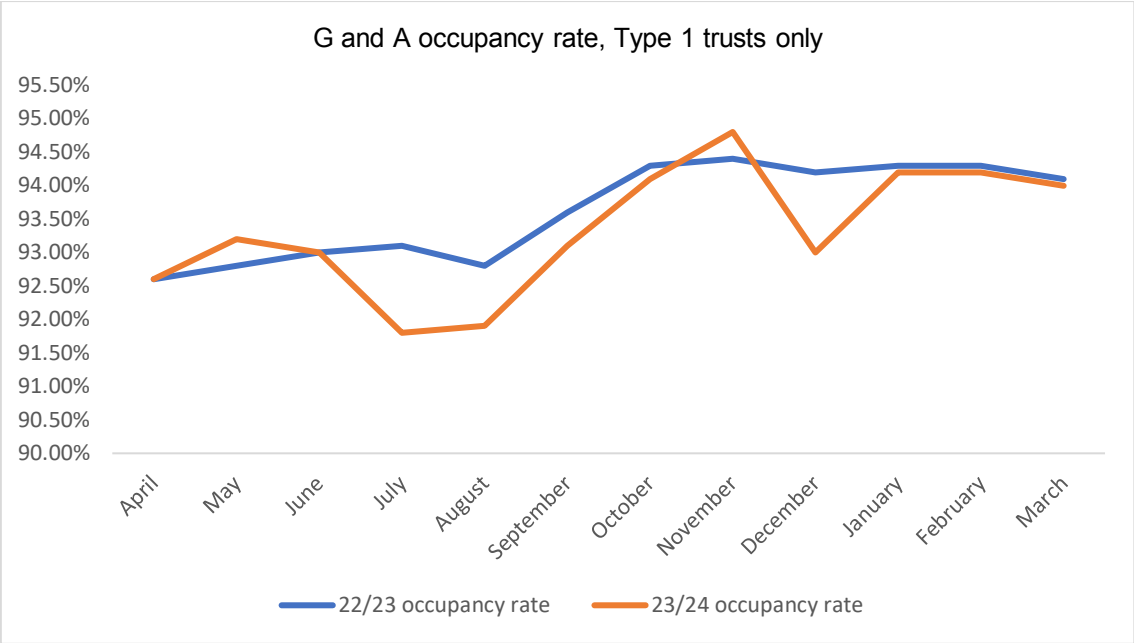
Figure 6: A&E attendance and performance in 2022-23 and 2023-24



Source: A&E Attendances and Emergency Admissions

As shown in Figure 7, general and acute (G and A) bed occupancy levels remained consistently high throughout 2023-24, reaching a maximum occupancy of 94.8% in November 2023, compared to 2022-23's peak figure of 94.3% (Type 1 acute trusts only).

Figure 7: G and A occupancy, Type 1 trusts only

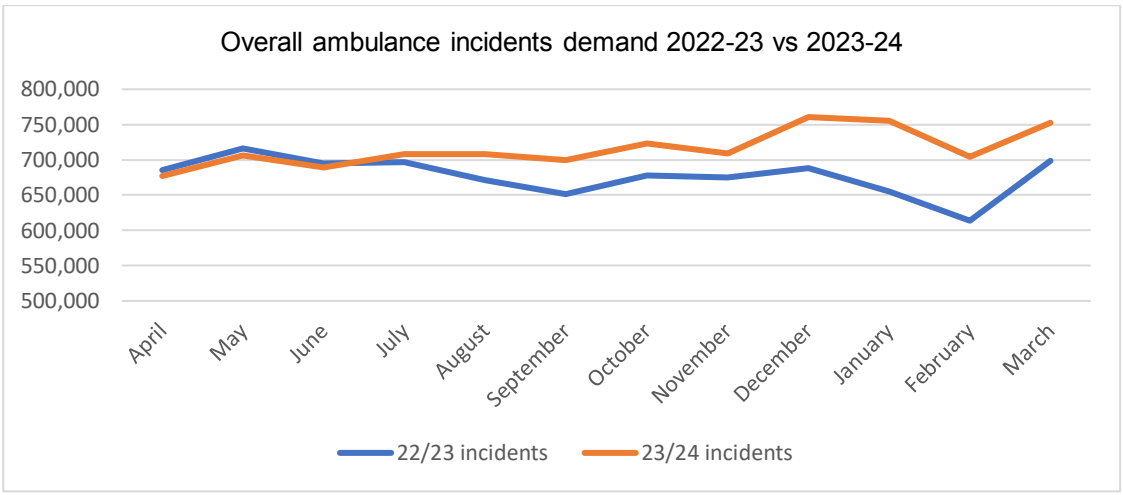


Source: Critical care and General and Acute Beds – Urgent and Emergency Care Daily Situation Reports

None of the 6 national ambulance standards was met during 2023-24 apart from the Category 1 90th percentile standard of 15 minutes, which was achieved during 7 months of the year. The average Category 1 response time during 2023-24 was 8 minutes and 27 seconds. This was an improvement of 50 seconds compared to 2022-23 but above the national standard of 7 minutes.

As set out in Figure 8 there were 24,363 ambulance incidents per day between December 2023 and March 2024, 11.0% higher than in the same period the previous year and 1.5% higher than the pre-pandemic baseline of 24,000 per day (February 2020).

Figure 8: Overall ambulance incidents demand 2022-23 and 2023-24

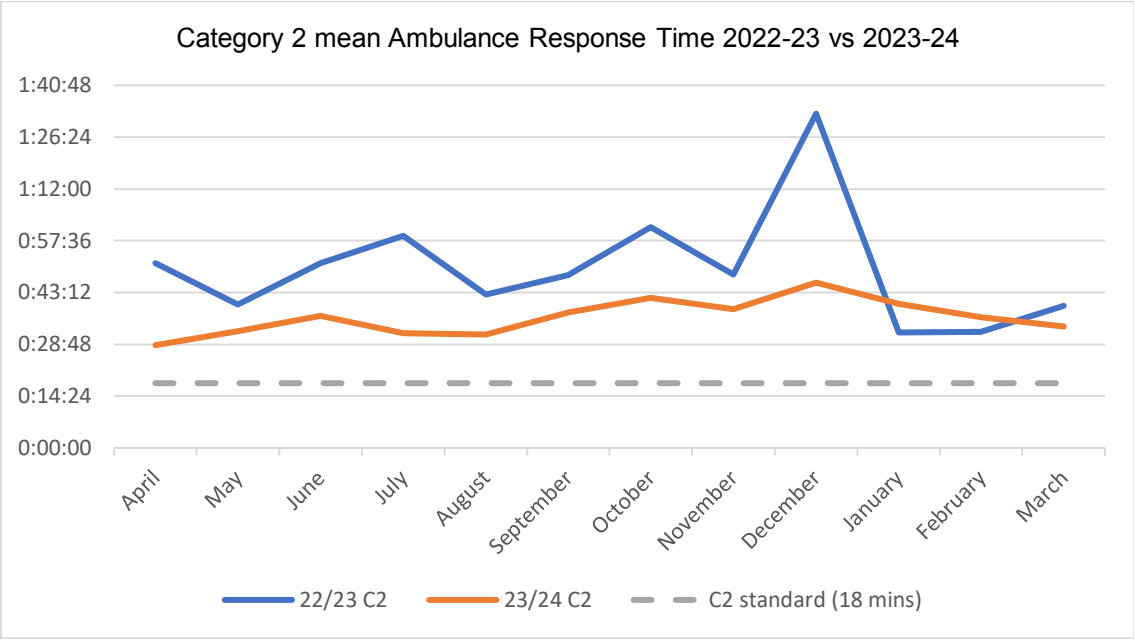


Source: Ambulance Quality Indicator

The average Category 2 response time was 36 minutes and 22 seconds, a 27% improvement compared to 2022-23 but exceeding the recovery plan performance target of

30 minutes and the national standard of 18 minutes. Figure 9 compares Category 2 response times in 2022-23 and 2023-24.

Figure 9: Category 2 Mean Ambulance Response Time 2022-23 and 2023-24



Source: Ambulance Quality Indicator

Discharge

ICBs and local authorities received £600 million in discharge funding during 2023-24 to improve capacity to support discharge. In December 2023, selected local authorities received an additional £40 million to fund additional interventions or services to support urgent and emergency care services over the 2023 to 2024 winter period.

Comparing the year ending March 2024 to the year ending March 2023, there was a 13% increase in the number of supported discharges (discharges involving a new or additional package of health and/or social care support) for acute hospital patients and a 4% reduction in the average daily number of patients in hospital with delayed discharges.

In November 2023, NHS England began publication of a new dataset showing length of discharge delays by trust, with incorporation of local authority data from December 2023.

DHSC published updated statutory guidance on hospital discharge and community support in January 2024.

Mental health

The demand for NHS mental health services remained high. DHSC 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.

In June 2022, DHSC published the Draft Mental Health Bill 2022, setting out measures to make the Mental Health Act 1983 work better for people with serious mental illness, people with a learning disability and autistic people, address mental health inequalities and give individuals much more of a say in their care and treatment.

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. The then government responded to the Committee on 21 March 2024.

The majority of the provisions within the Mental Health Units (Use of Force) Act 2018, 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, alongside statutory guidance.

In response to reports of serious failings in care in a number of mental health providers, DHSC 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. The review's final report, Rapid review into data on mental health inpatient settings: final report and recommendations, was published on 28 June 2023 and DHSC published the Rapid review into data on mental health inpatient settings: government response on 21 March 2024, setting out how DHSC planned to take forward each recommendation and the progress made.

Of the 28 key mental health commitments in the NHS Long Term Plan, 24 commitments were met. However, delivery was significantly affected by the COVID-19 pandemic, with some commitments to be delivered by NHS England in 2024-25. The pandemic impacts include factors such as increased demand (for instance, probable mental health disorders in children and young people aged 8 to 16 increased from 12.5% in 2017 to 20.3% in 2023) and reduced capacity in some mental health services. In addition, other system disruption such as industrial action also impacted on delivery.

Total mental health spend increased from £12.5 billion in 2018-19 to £17.6 billion in 2023-24, an increase of around 40%.

A large proportion of this expenditure was incurred by ICBs, with the Mental Health Investment Standard (MHIS) requiring ICBs to at least increase their investment in mental health services in line with their overall increase in funding for the year. All ICBs met the MHIS in 2023-24.

The NHS has made progress in expanding mental health services. At the end of March 2024, 788,108 children and young people were in contact with NHS mental health services (38% more than in March 2021), 361,210 physical health checks were carried out of

people with severe mental illness (over double the number in 2019-20), and 58,303 people accessed perinatal mental health services (85% more than in March 2021).

In February 2024, DHSC and NHS England published a full definition of what achieving parity of esteem between physical and mental health means in practice. According to this definition, delivering parity of esteem for mental health would mean parity of timely access, evidence-based and therapeutic care, and patient experience for people with mental health needs.

The NHS Long Term Plan included the commitment that, by March 2024, the number of people with a learning disability and autistic people who are inpatients in mental health hospitals should be equivalent to a 50% net reduction compared with March 2015. For people who have a learning disability and who do not have an autism diagnosis, the Assuring Transformation (NHS England) dataset for the end of March 2024 showed that there was a 60% net reduction in the number of such people in hospital since March 2015 (from 1,630 to 655).

During the same period, for people who have both a learning disability and autism diagnosis, there was a 38% net reduction in the number of people in hospital since March 2015 (from 665 to 410). However, the number of people with an autism diagnosis who do not have a learning disability in hospital inpatient settings increased since March 2015.

As of 31 March 2024, the Assuring Transformation dataset reports that there are 2,045 people with a learning disability and autistic people in a mental health inpatient setting, compared to 2,905 in March 2015.

The distinction in trends between the different groups of people means that, overall, there has been a net decrease of 30% against the NHS Long Term Plan objective. This is not a static population, with new admissions each month and over 11,500 people discharged since March 2015.

Detailed progress on mental health targets

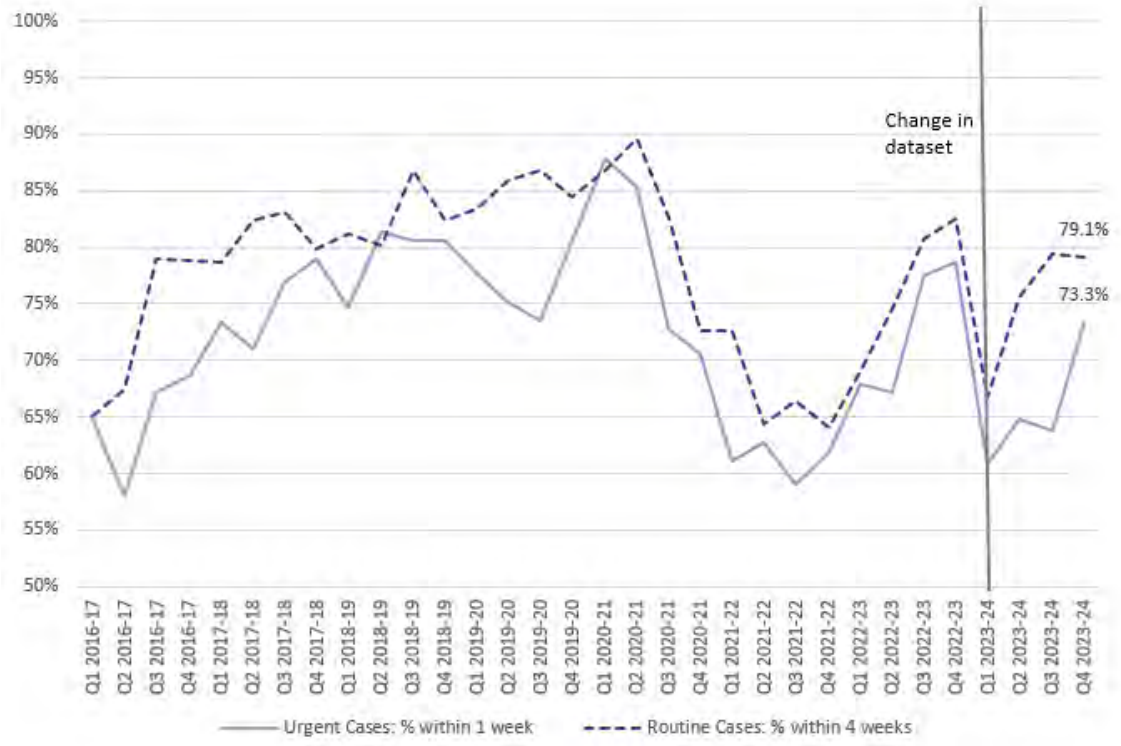
The NHS has waiting times standards in place for children and young people's eating disorder services, NHS Talking Therapies, and Early Intervention in Psychosis.

The children and young people with an eating disorder waiting time standard states that children and young people (up to the age of 19) referred for assessment or treatment for an eating disorder should receive NICE-approved treatment by a designated healthcare professional within one week for urgent cases and 4 weeks for routine cases.

As shown in Figure 10, for completed pathways, provisional data show that, between January and March 2024, 74.9% of young people (265 out of 354) started treatment for an urgent case within one week and 78.9% (1,832 out of 2,321) started treatment for a routine case within 4 weeks. This was below the national target of 95%. The apparent drop in

waiting time performance in quarter 1 2023-24 (April to June 2023) was attributed to data quality issues as providers moved over to a new dataset rather than a decrease in performance. Therefore, caution should be used when interpreting these statistics.

Figure 10: 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 and Mental Health Services Monthly Statistics - NHS England Digital

For incomplete pathways, at the end of quarter 4 2023-24 (January to March 2024), 814 young people were waiting to start treatment for an urgent case and 5,757 were waiting to start treatment for a routine case.

The ability to meet this waiting time standard was affected by the rise in demand as a result of the COVID-19 pandemic, with more children and young people being treated than 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. However, provisional data for 2023-24 shows demand is slowing and the total number of children and young people entering treatment decreased by 14.0% in 2023-24 to 10,156 on the year before (11,809). As that number was still high, DHSC continued to work closely with the NHS to recover performance.

NHS Talking Therapies (previously known as the 'Improving Access to Psychological Therapy' (IAPT) programme) continued to expand with the aim as set out in the NHS Long Term Plan that at least 1.9 million adults could access care each year by 2023-24.

As shown in Figure 11, in the 12 months to March 2024, 1,257,718 referrals entered treatment, which was a 3.5% increase compared with the 12 months to March 2023. Data used here is provisional and subject to change with totals shown taken from published monthly data.

Figure 11: Number of referrals entering treatment through NHS Talking Therapies in England (rolling 12-month period)

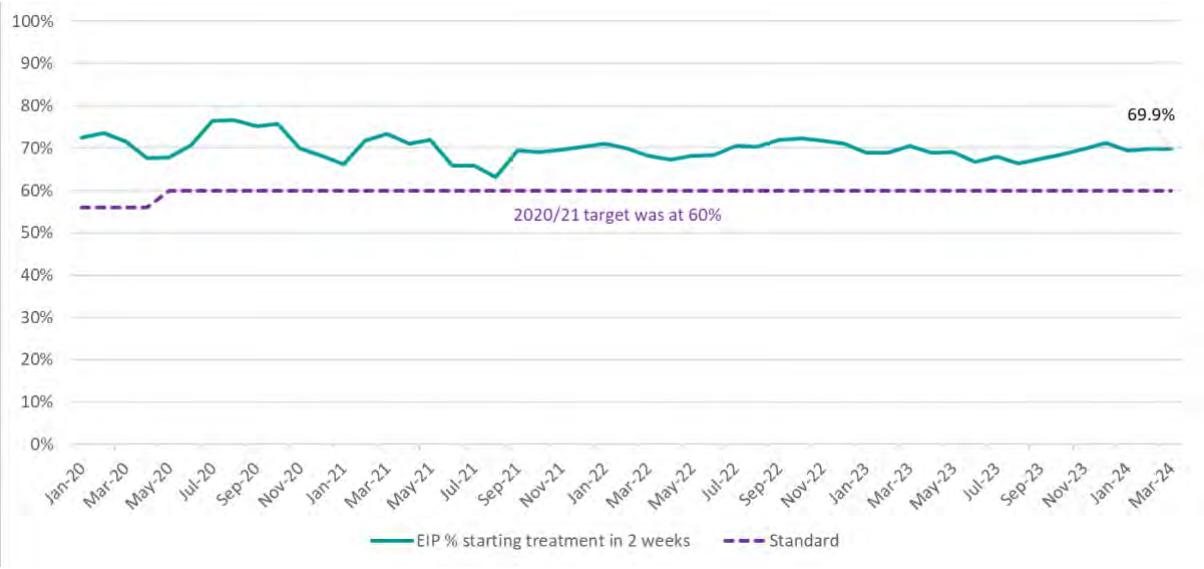
Source: NHS Talking Therapy Statistics

The waiting time standard 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 2024, 92.3% of people completing treatment waited less than 6 weeks against the target of 75%, and 98.7% of people completing treatment waited less than 18 weeks for their treatment to start against a target of 95%.

The recovery standard, which states that at least 50% of people who complete treatment should move to recovery, was met in March 2024 when the rate was 50.9%.

The Early Intervention in Psychosis (EIP) waiting time standard is that at least 60% of people with first episode psychosis start treatment with a NICE-recommended package of care with a specialist service within 2 weeks of referral. As seen in Figure 12, in the period of January to March 2024, 69.9% of referrals (2,438 out of 3,490) started treatment within 2 weeks, remaining above the 60% standard. A number of data providers were affected by the cyber incident between August 2022 and March 2023 which affected EIP waiting time data. NHS England has produced imputed national level estimates during this period and so extreme caution should be used when interpreting these statistics.

Figure 12: EIP proportion of referrals with suspected first episode of psychosis waiting less than 2 weeks to enter treatment in England.



Source: Mental Health Services Monthly Statistics, NHS England Digital

Long COVID

During 2023-24, an additional £90 million was invested to continue the provision of support for people with long COVID. In the commissioning guidance for post-COVID services for adults, children and young people (published December 2023), NHS England presented guidance for the commissioning and oversight of post-COVID services by ICBs in England for adults and children and young people from April 2024.

Data available for the COVID-19 Post-COVID Assessment Service covers the period 5 July 2021 to 29 February 2024. In total, since the data was first published in July 2021, 104,889 patients have received an initial specialist assessment. A further 369,975 follow-up appointments have taken place.

Initial specialist assessment waiting time data for the most recent period, 1 February 2024 to 29 February 2024, showed that 66% of patients were seen within 6 weeks of referral, 77% were seen within 8 weeks of referral and 10% waited longer than 15 weeks to be seen. Waiting times improved over the course of 2023-2024 compared to the same period a year previously, 13 February 2023 to 12 March 2023, when only 54% of patients were seen within 6 weeks of referral.

End-of-life care

NHS England, alongside the independent sector, continued to provide palliative and end-of-life care. All 42 integrated care systems (ICSs) have palliative and end-of-life care in their joint forward strategic plans, and they all have a clinical and strategic lead for palliative and end-of-life care.

Social prescribing

Social prescribing is a key component of the NHS's universal personalised care and is a way for GPs or local agencies to refer people to a social prescribing link worker. Social prescribing link workers give people time, focusing on what matters to them and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support. For some people that may be sports and exercise projects, or arts and nature-based activities.

Social prescribing seeks to address the wider determinants of health (for example, social, economic, and environmental) which impact on an individual's wellbeing.

Social prescribing can work well for those who are socially isolated or whose wellbeing is being impacted by non-medical issues, and routinely present to primary or secondary care as a result. Social prescribing activities are commissioned locally, utilising community assets often in the voluntary, community and social enterprise sector.

As of January 2024, the number of social prescribing link workers recruited was 3,664 full time equivalents (FTE) since the beginning of the national roll out in 2019 with over 2.6 million referrals.

Community pharmacy

In 2023-24, 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.

Under the Community Pharmacist Consultation Service (CPCS), DHSC already enabled NHS 111 and GPs to refer patients to community pharmacies for advice and treatment for minor illnesses, and NHS 111 for urgent medicines supply. In May 2023 DHSC expanded this to referrals from urgent and emergency care (UEC) settings. On 31 January 2024 DHSC launched the NHS Pharmacy First Service, incorporating the existing CPCS and expanding it to include a new service enabling community pharmacists to supply prescription-only medicines for 7 common conditions without a prescription from a GP.

Between April 2023 and March 2024, 2,077,849 CPCS consultations took place in community pharmacy. Between 31 January 2024 and March 2024, 423,310 Pharmacy First Clinical Pathway consultations were claimed for by contractors in England.

In April 2023 DHSC introduced a contraception service in community pharmacy enabling pharmacists to supply women ongoing oral contraception based on an existing prescription from a GP or other prescriber. In December 2023 DHSC expanded this so that

pharmacists can now also initiate women on oral contraception. Between April 2023 and March 2024, 54,672 oral contraception consultations took place in community pharmacy.

The new medicine service (NMS) provides patients with extra support from a community pharmacist with their newly prescribed medication. Between April 2023 and March 2024, 4,038,262 NMS interventions were completed.

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 2023 and March 2024, 173,892 DMS were carried out in pharmacies.

The Blood Pressure Check Service enables community pharmacists to identify patients with undiagnosed hypertension. Between April 2023 and March 2024 the service delivered 1,726,688 cuff checks and 116,306 ambulatory blood pressure monitoring.

Between September 2023 and March 2024, pharmacies delivered 3,773,946 million flu jabs.

Maternity

There is a programme of work underway to improve maternity outcomes and ensure that all maternity services provide safe and compassionate care. This work is underpinned by the three year delivery plan for maternity and neonatal services (2023-2026), which sets out how maternity and neonatal care will be made safer, more personalised, and more equitable for women, babies, and families.

The 3-year plan brings together action being taken at the national, regional and local level as well as work in response to recommendations made by a range of inquiries and investigations into maternity services. In 2023-24 DHSC invested an additional £186 million a year to improve maternity and neonatal care, compared with 2021.

The Maternity and Neonatal Care National Oversight Group was established as a mechanism to bring together key organisations to oversee progress against priorities and identify and resolve barriers to delivery. Alongside this, there are independent forums, including the Maternity and Neonatal New Actions Forum, chaired by Dr Bill Kirkup, and the Independent Maternity Working Group, to improve teamworking and culture in response to the issues identified in the Maternity and neonatal services in East Kent: 'Reading the signals' report.

The Pregnancy Loss Review, published in July 2023, made 73 recommendations on improving the care and support women and families receive when experiencing a pre-24-week gestation baby loss. In response to this review, in February 2024, a voluntary 'Baby Loss Certificate' service was introduced to allow parents to record and receive a certificate

to provide recognition of their loss. Over 45,000 certificates had been issued by 31 March 2024.

The National Maternity Safety Strategy ambition was to halve the 2010 rates of stillbirths, neonatal and maternal deaths and neonatal brain injuries occurring during or soon after birth by 2025, and to reduce the pre-term birth rate from 8% to 6%. Data monitoring progress is lagged, meaning recent efforts to improve outcomes are not yet reflected.

Between 2010 and 2022, the stillbirth rate had reduced by 23%, and the rate of neonatal mortality for babies born over the 24-week gestational age of viability reduced by 30% between 2010 and 2021.

The overall rate of brain injuries is 2% lower than the 2010 baseline, and the proportion of babies born preterm (with gestational age between 24 and 37 weeks) reduced from 8.1% of all births in 2017 to 8.0% in 2022.

In 2020 to 2022, the maternal death rate increased by 26% compared with 2009 to 2011 and there was a statistically significant increase in the overall maternal death rate in the UK from 8.79 per 100,000 in 2017 to 2019 to 13.41 in 2020 to 2022. The leading causes were thrombosis/thromboembolism, COVID-19 and cardiac disease.

NHS England have developed 14 maternal medicine networks across England to ensure all women have access to specialist management and care for chronic and acute medical problems around pregnancy. Additionally, maternal mental health services were also established in nearly all ICS areas to provide psychological therapy for women experiencing mental health difficulties related to their maternity experience.

The Maternity Disparities Taskforce was established to tackle disparities in health outcomes. It focused on improving access to effective pre-conception and maternity care. At a local level, disparities in maternal and neonatal outcomes are being tackled through NHS England's Equity and equality: Guidance for local maternity systems, which focuses on action to reduce disparities for women and babies from ethnic minorities and those living in the most deprived areas. In January 2024, DHSC also announced a £50 million National Institute for Health and Care Research challenge fund, to help address maternity disparities.

General practice

DHSC's aim for 2023-24 was to improve access for patients by supporting general practice to recover services and respond to demand.

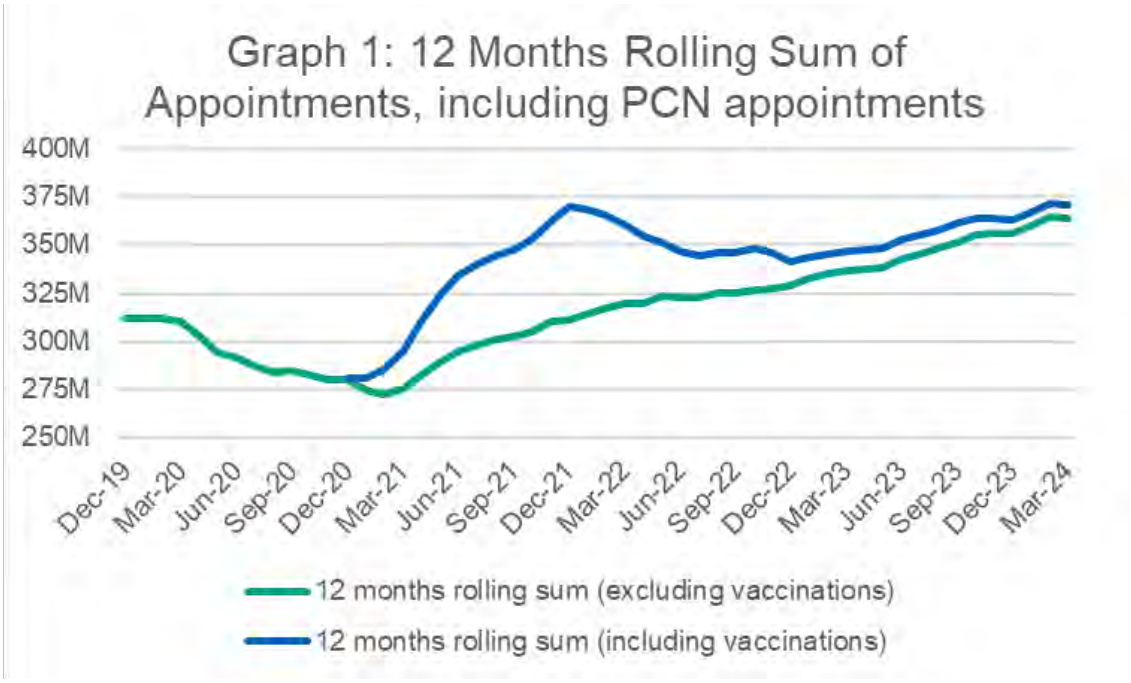
As of March 2024, there were 2,709 more FTE doctors working in general practice compared to March 2019. Additionally, as of March 2024, the collated figure showed that there were 50,992 FTE direct patient care staff working in primary care, such as pharmacists and physiotherapists, an increase of 39,473 FTE compared to March 2019.

Following a decrease during the pandemic, general practice appointment numbers first returned to pre-pandemic levels in May 2021. Appointment numbers in 2023-24 were consistently higher than 2022-23. As shown in Figure 13, in the 12 months up to March 2024:

- including COVID-19 vaccination appointments, an estimated 370.7 million appointments were booked across all general practices in England. Compared to the 12 months up to March 2019 (308.0 million as published in April 2019), this is an increase of 62.7 million.

- excluding COVID-19 vaccination appointments, an estimated 363.6 million appointments were booked across all general practices in England. Compared to the 12 months up to March 2019 (308.0 million as published in April 2019), this is an increase of 55.6 million.

Figure 13: Appointments in general practice (March 2019 - March 2024)



Source: Appointments in General Practice

The General Practice Patient Survey is an annual survey carried out by Ipsos on behalf of NHS England and assesses patients' experience of healthcare services provided by general practices. The 2024 results were published in July 2024 from aggregated data collected by post and online surveys between January 2024 and March 2024. Results showed that 73.9% of patients rated their overall experience of their GP practice as good, with 12.7% rating it as poor. The 2024 results are not comparable with previous years because of changes to the questionnaire and to the survey design.

On 6 March 2023, NHS England published a letter setting out the changes to the GP contract in 2023-24, which set out the requirements of general practice and primary care

networks (PCNs) from 1 April 2023 to 31 March 2024. The 2023-24 contract was the final year of the 5-year framework (investment and evolution). The changes to the 2023-24 contract were focused on improving patient experience and satisfaction and formed part of the delivery plan for recovering access to primary care.

The changes included improving the consistency in access that patients can expect when they contact their practice, by making clear that patients should be offered an assessment of need or signposted to an appropriate service at first contact with the practice.

The contract also mandated the use of cloud-based telephony framework meaning practices were required to procure their telephony solutions (when their existing arrangements expired) from an NHS England framework with recommended suppliers.

Alongside this, changes were made to GP registration requirements, the GP retention scheme cap, incentive schemes, and the Additional Roles Reimbursement Scheme. The weight management service was continued, and further optional changes were made to childhood immunisations and updates to the routine vaccine schedule were made in line with recommendations from the JCVI.

On 9 May 2023, DHSC and NHS England published the Delivery plan for recovering access to primary care. The plan committed up to £645 million for expanded community pharmacy services and £240 million for digital tools and training for practices. The 2024-25 GP contract changes build on and embed the plan.

Dentistry

DHSC's aim for 2023-24 was to continue to recover dental services and improve access to NHS dental care for people who need it. In April 2023 DHSC raised dental patient charges, which had been frozen from December 2020 to April 2023, by 8.5%. Other similar charges such as for NHS prescriptions also increased in that period. The increase in NHS dental charges contributed to NHS budgets.

In June 2023, DHSC announced a 40% increase in dentistry and dental hygiene and therapy training places by 2031 as part of the NHS Long Term Workforce Plan, alongside making legislative changes which give the General Dental Council more flexibility to expand the registration options open to overseas-qualified dentists. DHSC also committed to launching a consultation in spring 2024 on introducing a ‘tie-in’ for graduate dentists, which would ensure that graduates spend at least some of their time delivering NHS care in the years following the completion of undergraduate training.

Alongside these changes, DHSC consulted on proposals to enable dental therapists and hygienists who are fully trained and qualified to deliver some treatments without the need for a prescription from a dentist. This change, which will enable therapists and hygienists to work to their full scope of practice came into force in June 2024.

The 2024 access to NHS dental services indicator showed that of those people who tried to get an appointment in the last two years, 76% were successful. This is similar to the 77% reported in the 2023 and 2022 surveys but is significantly lower than pre-pandemic levels. At the start of 2020, the figure was 94%. Whilst the latest 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 and 2023 figures. The survey also showed that existing patients continue to be much more likely than new patients to be successful in getting an appointment (83% and 39% respectively).

In terms of NHS activity, data from the sector is showing some signs of recovery, and from July 2022 NHS dental practices were asked to return to delivering 100% of their NHS contracts. 24,335 dentists performed NHS activity in 2022-23. This equates to around two thirds of dentists registered with the General Dental Council. In addition, 34.1 million courses of treatment were delivered in 2023-24, an increase of 4% compared to the previous year, although this is still lower than pre-pandemic (39 million in 2019-20). The 2023-24 data also shows that 18.4 million adults were seen by an NHS dentist in the 24 months up to 30 June 2024, an increase of 320,000 (1.8%) when compared to the previous year but 3.5 million (16%) lower than pre-pandemic (2019-20).

On 7 February 2024, DHSC published Faster, simpler and fairer: our plan to recover and reform NHS dentistry which included plans for a New Patient Premium to support dentists to take on new patients, dental vans to bring care to isolated communities and ‘golden hello’ incentives to encourage dentists into underserved areas.

The New Patient Premium was launched on 1 March 2024. At the beginning of April 2024, nearly 500 more dental practices were showing themselves as open to new patients on the NHS website, compared with January 2024.

Eye care

NHS England has continued to commission the NHS sight testing service, with over 12 million sight test claims processed during 2023-24. Those eligible for free NHS sight tests include children, people aged 60 and over, people on income related benefits, and certain groups at particular risk of eye disease.

Improving infrastructure

DHSC has been taking action to improve health infrastructure across the country to secure 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 Spring Budget 2024 maintained DHSC’s significant capital settlement of over £33 billion across 2022-23 to 2024-25.

DHSC’s capital allocation increased to £11 billion in 2023-24 from £9.8 billion in 2022-23 (further detail is available in Annex B).

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

The New Hospital Programme (NHP) was established in October 2020 to deliver the then government's commitment to build 40 new hospitals by 2030. The NHP's programmatic approach set out to deliver hospitals as efficiently and effectively as possible, while recognising the individual needs and circumstances of each hospital scheme. Hospitals in the NHP built wholly or primarily from reinforced autoclaved aerated concrete (RAAC) were prioritised to protect patient and staff safety.

In 2020, the NHP inherited 8 schemes, with a prior commitment to be delivered. These schemes were either close to or already in construction at this time (including 2 schemes directly affected by the collapse of Carillion). Since joining the programme, the NHP has funded and supported these schemes through to delivery and:

- 2 hospitals are now completed and fully open to patients: Greater Manchester Major Trauma Hospital (GMMTH), Northern Centre for Cancer Care

- 3 schemes have completed their main build and are open to patients. However, they all have additional phases and are being supported by the NHP to complete these: Brighton Trauma, Tertiary and Teaching (3T's) redevelopment, Royal Liverpool University Hospital, and the Care, Environment, Development and Re-provision (CEDAR) Programme

- one scheme has completed construction and opened to patients in October 2024: Midland Metropolitan University Hospital

- 2 more schemes are being supported by the NHP to complete construction: Oriel Eye Hospital and National Rehabilitation Centre (NRC).

In addition to the above schemes, the NHP also completed one new hospital which is open to patients (Dyson Cancer Centre) and 3 more hospitals are in construction (St Ann's Hospital, Alumhurst Road Children's Mental Health Unit, and Royal Bournemouth Hospital).

The NHP's approach to standardising design for future hospitals, known as 'Hospital 2.0', is being developed with clinical and operational staff, and will mean hospitals can be built more quickly and will result in facilities for both patients and staff that are at the cutting edge of modern technology, innovation, sustainability, and excellent patient care. Design products for Hospital 2.0 are being developed and refined and are shared with trusts as soon as possible on an ongoing basis.

Since the general election, a review and prioritisation exercise of the NHP has been commissioned by the present government. The review will be completed as soon as possible in autumn 2024. The outcome will be fed into the programme Spending Review 2025 bid and included in the 2024-25 Annual Report and Accounts.

In 2023-24, £209 million was allocated to NHS trusts through NHS England's RAAC programme. This funding delivered mitigation, safety, and eradication works across all 54 NHS sites in England with confirmed RAAC, to keep facilities safe and open. As of 29 February 2024, RAAC had been eradicated at 4 sites, in the national RAAC programme. The government is committed to removing RAAC from across the NHS estate.

DHSC also invested in hospital upgrades to modernise and transform NHS's buildings and services. 13 patient-ready upgrades were completed during 2023-24 as part of a £1.7 billion multi-year funding settlement for over 70 hospital upgrades. These upgrade investments improve health infrastructure across the country and include a range of programmes such as new urgent care centres, integrated care hubs that bring together primary and community services and new mental health facilities.

DHSC continued to invest in the upgrade of the NHS's energy infrastructure, in line with decarbonisation and efficiency goals. A £40 million investment in light-emitting diode (LED) lighting through the National Energy Efficiency Fund saw the installation of 125,000 new lamps, an investment that will pay for itself within 4 years. DHSC also saw a major capital injection into the NHS from the Department for Energy Security and Net Zero (DESNZ) budgets, with £225 million in grant funding awarded to trusts through the Public Sector Decarbonisation Scheme's (PSDS) Phase 3b projects, supported in some cases by trust contributions from operational capital. This brought the total PSDS investment in the NHS to over £800 million since 2020-21, enabling a major step toward the NHS's goal of achieving a net zero estate by 2040.

Funding was provided to improve the mental health estate. More than £400 million was 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 2024, around 650 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 2023-24, 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.

In 2023-24, DHSC provided £250 million as part of the Additional Capacity Targeted Investment Fund. This programme was aimed at identifying and funding local capital investments to support the NHS to increase capacity and improve flow across the urgent and emergency care pathway and thus drive the strategic aims of the Delivery plan for

recovering urgent and emergency care (UEC) services. This is just one part of the wider funding package in support of delivering the plan to recover UEC services.

The elective recovery funding provided at the 2021 spending review (SR21), amounting to more than £5 billion over 2022-23 to 2024-25, delivered both surgical hubs and CDCs. This investment was split as follows:

	Total capital funding available across three years of SR21	**What was delivered in 2023/24?**
Surgical hubs	£1.5 billion	14 new surgical hubs 5 expansions 9 schemes, which have provided additional bed capacity, and equipment to help elective services recover.
Diagnostic programme, including CDCs	£2.3 billion	66 CDCs and investment in diagnostics equipment, digital diagnostics, screening and endoscopy.
Investment in NHS technology supporting our goal of ensuring that frontline leaders have the right information, tools and support to digitally transform services and provide better care, especially by the innovative use of digital technology.	£2.1 billion	An ongoing programme of work and levelling up of the digital maturity of all providers.

DHSC has also invested in programmes outside of the NHS on areas of spend such as social care and research and development. In 2023-24, this included:

- £623 million on the Disabled Facilities Grant which was an increase of £50 million from the previous year. This provides local councils with funding to deliver home adaptations for disabled people

- over £1.3 billion on health and social care research. This is primarily through the National Institute for Health and Care Research, which is the research arm of DHSC and delivers translational, clinical, and applied health and care research. In 2023-24 DHSC published an implementation plan in response to the Lord O'Shaughnessy review into commercial clinical trials to improve the UK's attractiveness as a place to conduct research, and by March 2024 approximately 80% of studies were delivering to time and target

- £84.5 million invested in Genomics England, to deliver a whole genome sequencing (WGS) service in the NHS and other key projects. Investment also continued under the Office for Life Sciences (OLS) Healthcare Missions that bring together industry, academia, the third sector and the NHS to collaborate in advancing early disease prevention, diagnosis, treatment, monitoring, and developing breakthrough products and technologies to save lives.

Digital health and care plan

The DHSC digital strategy was guided by A plan for digital health and social care and Data saves lives: reshaping health and social care with data, both published in June 2022.

As of November 2023, 90% of NHS trusts had electronic patient records (EPRs) in place. As of February 2024, at least 63% of care providers had a digital social care record, up from 40% in December 2021. Shared care records were in place in all ICSs, allowing information from general practice and acute settings to be shared for direct care.

Frontline digitisation

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

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

DHSC developed a support offer to help ICBs and trusts to digitise by sharing best practice and expertise across the NHS.

As of March 2024, nationwide EPR coverage was 90%.

NHS app

In March 2024 there were 34.3 million recorded sign-ups for the NHS app, which is equivalent to 75% of the adult population in England.

Improvements and new functionalities added to the NHS app between April 2023 and March 2024 included:

- introducing the highest level of ID verification: 88% of registered app users had the highest level of ID verification in March 2024, allowing them to access the full range of app features

- allowing app users to view, book, and manage secondary care appointment: this increased by 206% over the past 12 months, with 6.6 million viewed and managed (4.35 million views and 2.26 million managed) in March 2024

- allowing app users to request repeat prescriptions: this increased by 44% over the past 12 months, with 3.7 million requested in March 2024

- allowing app users to view their health record: this increased by 113% over the past 12 months, with 14.9 million views in March 2024, and 84% of patients now able to access their detailed coded record

- allowing app users to access help from general practice via online consultations: this increased 144% over the last 12 months with 1.5 million happening in the NHS app in March 2024

- allowing app users to access messages from hospitals, vaccinations, and GP practices: 97% of practices can now send messages through the NHS app, with 74 million messages sent last year across all NHS care settings which is a rise of over 500% year on year

- allowing app users to book covid and flu vaccinations: 14.4 million invites were sent for winter vaccinations via the app, with 1.4 million starting the booking process there.

A roadmap for future development across the NHS app is published quarterly on the NHS England website. Focus areas include enabling people to see new information added to their health record, modernising the digital prescription service, extending the use of messaging, and improving navigation to appropriate services.

NHS 111

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. 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).

Pharmacies can now record that they provide palliative care drugs on the DoS via Profile Manager. This allows healthcare professionals to use NHS Service Finder (and other products) to search the DoS and direct their patients to the appropriate service for these drugs. This also reduces the previous burden on DoS leads 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. This understanding was key in helping us make the supporting changes for NHS 111 to refer and signpost Pharmacy First services available for patients earlier this year. A range of changes have been implemented, ensuring that we

direct as many patients as possible toward pharmacies for treatment, relieving pressures on GP practices.

The Delivery plan for recovering urgent and emergency care services was published on 30 January 2023. The immediate targets were to deliver greater integration of NHS 111 online into the NHS App and a re-platforming of the DoS, to create further connection with other services and enable patients to be directed to the right place, the first time.

Artificial intelligence

The AI in Health and Care Award competitions launched in 2020 in partnership with the Accelerated Access Collaborative and the National Institute for Health and Care Research. There was £18.4 million of funding available in the financial year 2023-24 for the AI Awards. Winners of the final round of the AI awards were announced in March 2023 and projects starting in July 2023.

Overall, the AI Award has made £113 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 AI Awards aimed to produce clinical and economic evidence so that organisations such as NICE can look at recommending AI products for national commissioning.

The AI and digital regulations service for health and social care launched in June 2023. The service brings together expertise of key regulators (MHRA, NICE, Health Research Authority (HRA), and CQC) to provide innovators and health and care providers with a single point of contact for regulatory support, information, and guidance on AI technologies. The service aims to establish a robust and streamlined regulatory pathway, promoting the safe and effective development and adoption of data-driven technologies. This service also facilitates close collaboration between regulators, enabling them to identify areas within the AI technology pathway where regulatory processes can be streamlined, potentially accelerating the adoption of AI technologies.

The NHS AI Lab has supported the MHRA with a £1 million investment to take the AI Airlock initiative forward. AI Airlock is a regulatory sandbox designed to help developers of AI as a medical device (AIaMD) navigate the complexities of bringing their innovative technologies to the UK market. The AI Airlock provides a safe, controlled environment where developers can test and gather evidence on their AI-powered medical devices before full market release.

By March 2024, AI stroke technologies (NHS England Stroke AI, Pathway to Adoption) were implemented in 95% of stroke units. 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 NHS AI Lab is leading the delivery of a pilot for an AI Deployment Platform (AIDP) for radiology workflows, a centralised cloud-based deployment platform for AI technologies that will inform our understanding of how to safely deploy AI at scale in the NHS. The AIDP pilot will test whether having a centralised platform and deployment processes:

- accelerates the safe and ethical deployment of trusted AI products at multiple hospital sites
- provides a cost and time-effective standard deployment process of AI products for NHS organisations and AI innovators
- provides reasonable access to post-market surveillance resources of AI vendors
- provides the case study for accelerating the broader adoption of AI imaging technologies across NHS organisations.

Over the 6 months to March 2024 DHSC has mobilised and worked with multiple delivery partners and stakeholders to support this project. This includes 2 imaging networks (East Midlands Imaging Network and Thames Valley Radiology Network) that consist of 12 NHS trusts, and DHSC's platform delivery partners who have proceeded with onboarding the trusts onto the platform. DHSC also selected 3 AI technologies from 3 different radiology specialisms (prostate MRI, musculoskeletal (MSK) radiology and chest x-ray) that will be deployed as part of the pilot.

At the end of March 2024, we launched the tender for the independent evaluation of the AI Lab programme, which seeks to understand the lessons learned, impact and value for money of the AI Lab and its sub-programmes. The evaluation outputs will help inform future AI programmes in the healthcare sector as well as the wider public sector.

Data strategy

DHSC worked with NHS England to continue implementation of Data saves lives: reshaping health and social care with data (published in June 2022). The Digital Policy Unit published a Data Saves Lives Implementation Update to report on progress in June 2023.

By 31 March 2024, work delivered included the roll out of a target data architecture for health and social care and the collection of more granular adult social care data from local authorities. DHSC also oversaw publication of supplementary data-related papers including the NHS Cloud strategy, Care data matters: a roadmap for better adult social care data (December 2023), and the Value Sharing Framework for NHS data partnerships (July 2023).

During 2023-24, DHSC oversaw the contract award for the Federated Data Platform (further details are provided below) and began mobilisation and roll-out of the platform. DHSC also expanded the use of the Digital Social Care Record and planned for large-scale public engagement in partnership with Thinks Insight and Strategy.

The Data Strategy Advisory Panel (formerly known as the National Data Advisory Group) continued to play a key role in providing advice and challenge on implementation of Data Saves Lives and on the wider strategic approach to health and care data. The panel consists of expert external stakeholders, such as the National Data Guardian and Chair of the Academy of Medical Royal Colleges. It was established in September 2022 and met every 8 weeks.

DHSC committed to adopt a system of 'data access as default' for research and external uses of NHS health data, a change which will be supported by the implementation of secure data environments (SDEs) across the NHS in England.

In October 2023, DHSC published the Data access policy update, which outlined our policy direction and intent in more detail.

In May 2023, £175m of funding was confirmed to deliver the Data for Research and Development programme, the majority of which will fund the NHS Research SDE Network. Between April 2023 and March 2024, the funding has allowed the programme to establish regional and national delivery teams to lay the foundations for a minimal viable product (MVP) service.

Federated data platform (FDP)

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.

Several pilot programmes have tested this approach in over 40 trusts and:

- 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.

Following an open procurement process, the contract for the FDP 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.

In addition, NHS England 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 FDP.

Priority outcome 3 – improve healthcare outcomes through a well-supported workforce

NHS workforce

In June 2023, NHS England published the NHS Long Term Workforce Plan (LTWP). The plan commits to:

- train more staff
- retain our workforce
- reform and modernise the way staff work and harness new technology and innovations.

Compared to 12 months ago, as of March 2024, there were over 6,900 more doctors and over 21,200 more nurses working in the NHS in hospital and community health service settings.

As shown in **Table 1**, the data for March 2024, published by NHS England, shows that there are over 1.34 million full-time equivalent (FTE) staff working in the NHS. This is an increase of almost 64,700 compared to March 2023.

Table 1: FTE workforce numbers since 2019

	Doctors	Nurses	All Staff
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
Mar-24	140,774	349,675	1,345,047

Source: NHS England workforce statistics

As of March 2024, vacancy rates in NHS trusts were similar to pre-pandemic rates. Data published by NHS England showed that there were over 100,600 vacancies in NHS trusts as of March 2024, equivalent to 6.9% of the workforce. This is a decrease from almost 112,500 vacancies in March 2023 (8.0% vacancy rate).

Supporting our existing workforce

Staff retention is a complex issue that ultimately depends on the personal choices and decisions of 1.4 million people working across the NHS. Many factors can influence this, including, but not limited to, career progression and pay and reward.

To bolster efforts to retain staff and to continue to attract more people to join the NHS workforce, NHS England published an equality, diversity and inclusion plan for the NHS workforce in June 2023. The 6 high impact actions aim to ensure staff work in an

environment where they feel they belong, can safely raise concerns and provide the best possible care to patients. The NHS Workforce Race and Disability Equality Standards continue to provide information and data to assist trusts in their efforts to tackle discrimination and inequalities.

The 2023 NHS Staff Survey was published on 7 March 2024 and its results showed some improvements compared to previous years. Some of the questions saw results heading back to pre-pandemic levels. Staff morale increased to 5.95 (out of 10) in 2023 from 5.74 in 2022. The proportion of staff thinking about leaving their organisation decreased from 32.36% in 2022 to 29.12% in 2023.

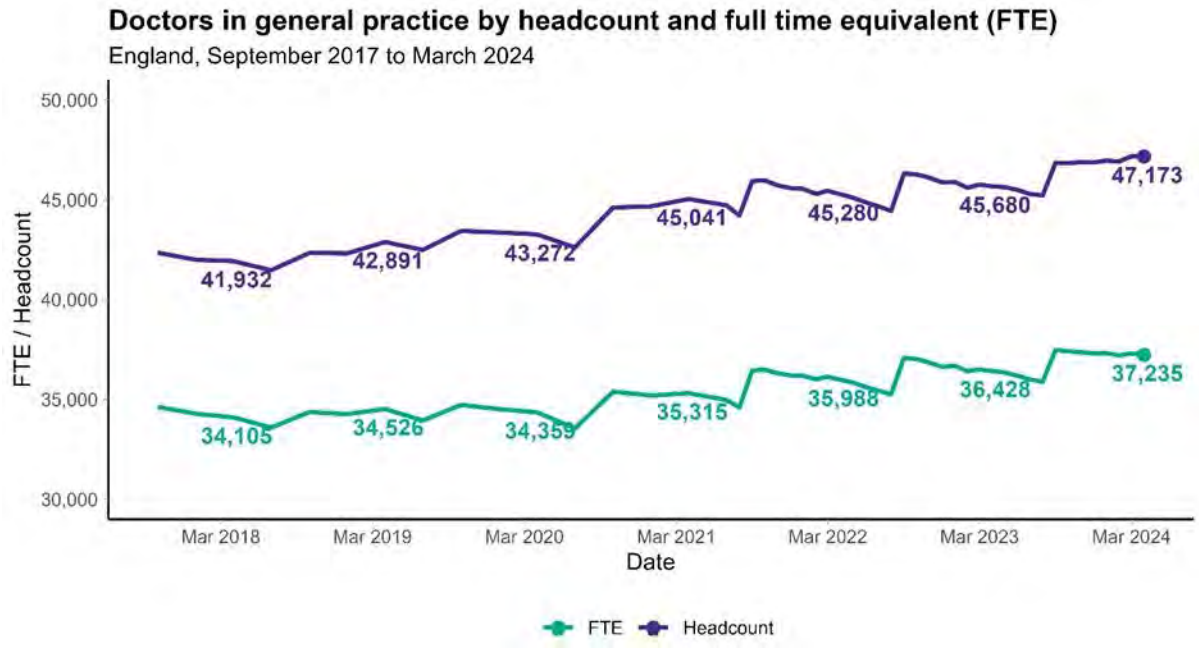
The staff engagement theme score remained at a similar level to previous years measuring 7.04 in 2019 compared to 6.89 in 2023. Although the percentage of staff satisfied with pay increased overall, results specifically for medical and dental staff indicated a decline of 4.58% from 36.6% in 2022 to 32.05% in 2023.

General practice workforce

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.

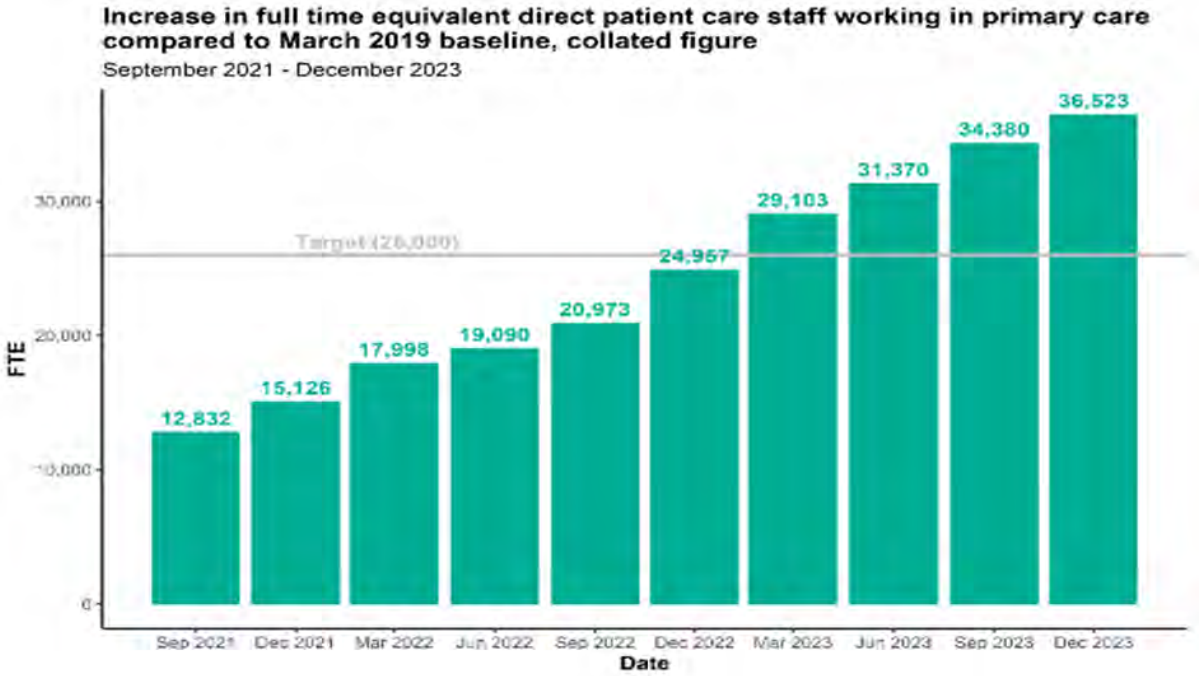
The number of doctors working in general practice has been increasing as outlined by Figure 14. As of March 2024, there was an additional 807 FTE (1,493 headcount) doctors working in general practice compared to March 2023, and an additional 2,709 FTE doctors (4,282 headcount) compared to March 2019.

Figure 14: All doctors in general practice – FTE and headcount (September 2017 – March 2024)



Source: General practice workforce, 31 March 2024, NHS England. Includes estimates for practices that did not provide fully valid staff records.

Figure 15: Direct patient care staff working in general practice compared to March 2019 baseline



Source: Primary Care Workforce Quarterly Update, 31 December 2023, NHS England

As shown in Figure 15, the numbers of direct patient care staff have consistently increased. As of December 2023, there were 11,566 FTE more primary care professionals working in general practice compared to December 2022 and 36,523 FTE more compared to March 2019.

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 numbers is in PCNs. Changes to the ARRS for 2024-25 have increased the flexibility of the scheme and have also increased the number of reimbursable roles.

Leadership review

NHS England is leading on the implementation of the Messenger review, Health and social care review: leadership for a collaborative and inclusive future. They have developed an induction framework for all new staff entering the NHS. In June 2023, the NHS equality, diversity, and inclusion improvement plan for the NHS workforce was published. This will help boards and leaders in tackling bullying and discrimination.

Industrial action

Industrial action continued, with **Table 2** showing strikes that went ahead which had a national impact in 2023-24. Other strikes were called by Unite and Unison throughout this

period but as they concerned local issues, they were managed within the affected areas rather than nationally. National strikes focused on calls for increases to headline pay from all involved staff groups, but local strikes included broader grievances.

Table 2: Strikes in 2023-24 (BMA (British Medical Association), HCSA (Hospital Consultants and Specialists Association), BDA (British Dietetic Association), RCN (Royal College of Nurses), SoR (Society of Radiographers))

Dates	Unions	Staff Group
11-15 April 2023	BMA[1]; HCSA[2]; BDA[3]	Junior doctors; dental trainees
30 April-1 May 2023[1]	RCN[4]	Nurses
14-17 June 2023	BMA; HCSA; BDA	Junior doctors; dental trainees
13-18 July 2023	BMA; HCSA; BDA	Junior doctors; dental trainees
20-21 July 2023	BMA; BDA	Consultants
25-27 July 2023	SoR[5]	Radiographers
11-15 August 2023	BMA	Junior doctors
24-25 August 2023	BMA	Consultants
19-20 Sept 2023	BMA; BDA	Consultants
20-22 Sept 2023	BMA; HCSA; BDA	Junior doctors; dental trainees
2-5 October 2023	BMA; HCSA; BDA	Junior doctors; dental trainees; consultants
3-4 October 2023	SoR	Radiographers
20-23 Dec 2023	BMA; HCSA; BDA	Junior doctors; dental trainees
3-9 January 2024	BMA; HCSA; BDA	Junior doctors; dental trainees
24-29 February 2024	BMA; HCSA	Junior doctors

1. Strike was originally called to last until 2 May 2023, but DHSC successfully challenged this in court as the RCN's strike mandate expired at midnight on 1 May 2023.

A deal was reached with the NHS Staff Council (representing the collective of Agenda for Change (AfC) unions) in May 2023, which ceased the majority of strike action for this workforce. Some unions remained in formal dispute but strike action ended either due to unions no longer receiving a mandate from members (RCN) or ceasing action while remaining in dispute (SoR). Negotiations with unions representing consultants and specialty and specialist (SAS) doctors took place towards the end of the financial year. These resulted in deals being accepted for both groups (Consultants in April 2024 and SAS in June 2024). Negotiations were also held with the BMA junior doctors committee but these came to an end when the union called strikes for December and January. In July 2024, negotiations with the BMA junior doctors committee took place, resulting in the agreement of an offer in principle which was announced on 29 July 2024. The offer was accepted on 16 September 2024 bringing an end to the dispute.

Impact of industrial action

Over 1.1 million appointments and operations were rescheduled by acute NHS trusts due to industrial action in 2023-24 (the number is higher when action taken in 2022-23 and

2024-25 is included). There were 786,638 total workforce absences from all staff groups due to strike action in 2023-24 and the equivalent of 36 days were lost to industrial action by junior doctors and 9 days to industrial action by consultants (the number is higher when action taken in 2022-23 and 2024-25 is included).

Legislation on minimum service levels

In December 2023, following a period of public consultation, the then government introduced minimum service level regulations for ambulance services during periods of strike action. DHSC also consulted between September and November on whether minimum service levels should be introduced for hospital services during strike action. A consultation response has not been published.

On 6 August 2024, the government announced plans to repeal the Strikes (Minimum Service Levels) Act 2023 through the Employment Rights Bill.

2023-24 pay round

The NHS Pay Review Body (NHSPRB) was stood down from providing recommendations when the NHS Staff Council voted by a majority to accept the Agenda for Change (AfC) deal in May 2023. Under the AfC deal, most staff received a 5% pay uplift, whilst the lowest paid received 10.4%. Eligible staff received 2 additional non-consolidated awards worth between 3.5% and 8.2% of 2022/23 basic pay. DHSC also agreed to several non-pay measures.

DHSC accepted the recommendations of the Review Body on Doctors' and Dentists' Remuneration (DDRB) and the Senior Salaries Review Body (SSRB) in full. DHSC increased junior doctors' pay by 8.1%-10.3%, with the greatest uplift going to first-year junior doctors. This was an average increase of 8.8%. Other doctors under the 2023-24 DDRB remit (e.g. consultants, specialist, associate specialist and speciality (SAS) doctors on old contracts, salaried GPs and dentists) received an uplift of 6%. SAS doctors on new contracts were given a 3% pay increase on top of what they had received under their multi-year deal. The deal subsequently negotiated with consultant unions and accepted by members was separate to this. DHSC also agreed the recommended 5% uplift for Very Senior Managers (VSM) and Executive Senior Managers (ESM) in the NHS, and the additional 0.5 per cent of the ESM and VSM pay bill in each employing organisation to address specific pay anomalies.

2024-25 pay round

On 20 December 2023 the then government issued remit letters to the pay review bodies to formally commence the pay setting round for NHS staff for 2024-25. DHSC submitted written evidence on 29 February 2024 with oral evidence sessions taking place throughout March and April.

On 29 July 2024, the government announced public sector pay uplifts for 2024-25. The pay recommendations for NHS staff were accepted in full which means all pay points for AfC staff will be uplifted by 5.5% on a consolidated basis. In addition, for AfC staff, the government has committed to adding intermediate pay points at AfC Bands 8a and above and to working with the NHS Staff Council to take forward the NHSPRB's recommendations on AfC pay structures. Doctors under the 2024-25 DDRB remit (for example consultants, SAS doctors, salaried GPs and dentists) will receive an uplift of 6%. Doctors and dentists in training will receive an uplift of 6% plus £1,000 on a consolidated basis. A 5% increase for VSMs and ESMs was accepted.

NHS pensions

At the 2023 Spring Budget, the former Chancellor, Jeremy Hunt, announced reforms to pension tax, which had previously impacted some senior NHS clinicians. In April 2023, the annual allowance for tax-free pension saving increased from £40,000 to £60,000, and the lifetime allowance was removed.

Alongside the pension tax reforms announced at the 2023 Spring Budget, DHSC implemented new retirement flexibilities. These include a new 'partial retirement' option as an alternative to full retirement, whereby staff can draw down some or all their pension whilst continuing to work and build up further pension. Since October 2023, over 7,000 applications for partial retirement have been received.

Also in October 2023, DHSC launched a public consultation on permanently removing rules which restricted the hours that nurses with special retirement rights could work after retirement. This consultation has now concluded, and these rules were permanently removed from 1 April 2024 to support NHS capacity. Since 1 April 2023, retired staff who return to NHS work can also re-join the scheme and build up more pension if they wish.

Growing the workforce

DHSC met its target of 50,000 more nurses in September 2023. Data shows that, as of March 2024, there were over 366,000 nurses working across the NHS (across Hospital and Community Health Service and General Practice settings) which is over 65,000 more than September 2019.

Medical expansion

DHSC allocated 205 and 350 additional medical school places for the 2024-25 and 2025-26 academic years. The allocation of these places was confirmed by the Office for Students in February 2024 and May 2024 respectively.

Clinical expansion

All eligible nursing, midwifery, and allied health profession degree students continued to receive non-repayable supplementary funding support in addition to the primary student funding available from Student Finance England. This included a training grant of £5,000

per academic year, additional funding for studying certain courses, for example, Mental Health Nursing and Learning Disabilities Nursing, and further financial support available to students with children. Funding to support travel and dual accommodation costs were increased from September 2023 to ensure students are appropriately reimbursed for their placement costs, with eligible students able to claim 50% more for their travel and accommodation. Eligible students can also access a hardship fund of up to £3,000 per academic year.

International recruitment

The Code of practice for international recruitment of health and social care personnel in England guarantees stringent ethical standards when recruiting health and social care staff from overseas. The code follows the latest guidance from the World Health Organisation and active recruitment from 'red list' countries with the most vulnerable health systems is prohibited.

International candidate guidance provides 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.

As of March 2024, 20% (298,487) of staff had a non-UK nationality across NHS trusts and other core organisations. This was an increase from 18% (254,651) in March 2023.

In the year to March 2024, 43% (20,537) of the nurses and health visitors who joined active service in NHS Trusts and other core organisations had a non-UK nationality.

Community health services (CHS) workforce

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.

Within the NHS, community health nursing accounts for 11% of the qualified nursing workforce, of which district nurses account for 11% of community health nurses. This does not include CHS staff employed by independent sector providers, including charities, social enterprises, and independent sector companies.

Data for NHS trust providers in March 2024 showed 40,332 FTE community health nurses, plus 17,487 FTE support staff, including 4,302 FTE district nurses.

The vacancy rate for registered nurses in community trusts in March 2023 was 10.8%. In March 2024, that rate decreased to 10.4%. Vacancy rates varied regionally, with London having the highest vacancy rate (10.0%) and the northeast and Yorkshire having the lowest vacancy rate (5.3%). 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 were older on average.

Mental health workforce

As of March 2024, there were 152,280 FTE people in the mental health workforce. This was an increase of over 9,500 (6.7%) FTE staff since March 2023. This included only those people who work directly on mental health, across NHS hospital trusts and other core organisations in England. Data on the staffing of non-NHS provision, which remains a key element of mental health service delivery, is not available.

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. The number of FTE mental health nurses increased by over 2,700 (6.9%) over the past year and FTE vacancies for nurses working in mental health trusts decreased from over 12,800 vacancies in March 2023 to over 10,600 vacancies in March 2024. However, the vacancy rate for nurses in mental health trusts in March 2024 (14.8%) was still much higher than for acute trusts (5.7%). The rate for nurses in mental health trusts also varied by region, being as high as 20.5% in the South East in March 2024, down to 9.9% in the northeast and Yorkshire.

There were approximately 16,800 learning disability nurses on the UK register and approximately 3,400 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

The Office for Health Improvement and Disparities (OHID) became fully operational on 1 October 2021. It sits in the heart of DHSC and brings together expert advice and evidence to shape policy development and implementation, driving health improvement and reducing health inequalities. OHID is outward facing, and works with the whole of government, the NHS, local government, industry, and wider partners to deliver change.

In February 2024, DHSC carried out a review of our structure to ensure it was properly aligned to post COVID-19 priorities and to achieve a better balance of our Director General (DG) portfolios. As a result, OHID national teams were embedded across 3 DG groups, reflecting the importance of many parts of DHSC in delivering this central part of our mission. OHID will continue to describe DHSC's work on health improvement and inequalities.

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 inequalities so that we break the link between people's background and prospects for a healthy life.

Health inequalities and healthy life expectancy (HLE)

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, DHSC was committed during this period to a levelling up health mission to narrow the gap in HLE between local areas where it was 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. Health inequalities exist across a wide variety of conditions from cancer to mental health and contribute to the variation in life expectancy and HLE. According to the latest available data published by the Office for National Statistics (ONS) on 26 March 2024, both females and males in England lost approximately one year in HLE between the non-overlapping periods 2017 to 2019 and 2020 to 2022. This appears to have been as a result of the COVID-19 pandemic and the high mortality rate observed.

Major conditions strategy: case for change and our strategic framework was published in August 2023 making the case for changing the way care is organised based on a strategic framework for the whole life course. This work was paused following the announcement of the general election and dissolution of parliament.

NHS England continued to develop and implement the Core20PLUS5 approach to support integrated care systems to reduce inequalities. The approach focuses on improving cardiovascular disease, cancer, respiratory, maternity and mental health outcomes in the

poorest 20 percent of the population, along with ethnic minorities and inclusion health groups.

One such important action is the NHS' new Patient and Carer Race Equality Framework (PCREF), its first ever anti-racism framework which is mandatory for all mental health service providers to embed across England from March 2025 as aligned to NHS Standards Contract 2024/25, ensuring they are responsible for implementing concrete actions to reduce racial inequality within their services. It will become part of CQC's and EHRC's inspection processes and 13 pilot trusts have already started to implement targeted changes in areas such as governance, data collection, staff training and community engagement to shift the dial on cultural awareness and ensure transparency.

No updates were available for the 13 health inequality indicators based on the definition of health inequalities set out in the DHSC annual report and accounts: 2021 to 2022 (paragraph 505 on page 112 and Table 23 on page 114). This is because the definition used in the report used the Slope Index of Inequality to measure inequality, which is reliant on Lower Super Output Area level population data. This data had not been updated by the ONS following the 2021 Census at the time this report was drafted.

On 26 March 2024, the ONS published updated national and regional figures for HLE at birth for England covering the periods 2019 to 2021 and 2020 to 2022. HLE at birth for females and males for the period 2020 to 2022 was 62.7 and 62.4 years respectively, a difference of 0.3 years, which was broadly similar to the 0.4 years observed for the nearest non-overlapping period 2017 to 2019. However, due to differences in life expectancy at birth (82.8 years for females and 78.9 years for males), females spent more of their longer lives in poorer health, on average, compared to males.

The levelling up health mission included a commitment to reduce the gap in HLE at local level. However, HLE data at local level was not published by ONS in this release, so it was only possible to comment on regional differences in England. For both females and males, the north east had the lowest HLE at birth estimates and the south east had the highest, for all reporting periods from 2011 to 2013 to the most recent 2020 to 2022.

Since 2017 to 2019, the regional gap in HLE at birth (the difference between the lowest and highest HLE estimates by region of England) for females narrowed from 6.8 years to 5.7 for the period 2020 to 2022, but increased for males from 5.9 years to 7.0 between the same periods. For females, this change was largely as a result of a fall in HLE in the southeast, whereas for males, it was mostly due to a fall in HLE in the northeast.

Drugs

Combatting illicit drug use was a major delivery programme for DHSC. In December 2021, the then government published a 10-year drugs strategy, From harm to hope: A 10-year drugs plan to cut crime and save lives. To support its delivery, £532 million was made available to DHSC over the 3-year spending review period to transform the drug and

alcohol treatment and recovery system. DHSC worked closely across government, and with local authorities, to support the delivery of targets, including preventing nearly 1,000 deaths and getting 54,500 additional people into treatment over the 3 years to March 2025. In 2024-25, DHSC has allocated local authorities an additional £267 million which is on top of the public health grant, to support expansion of the treatment and recovery system and improve the quality of interventions. This is an increase in investment from the previous year (2023-24) in which £154 million was allocated to local authorities. Additional drug and alcohol treatment funding allocations: 2024 to 2025 were announced on 13 November 2023.

In 2023-24, the 2nd year of delivering the drugs strategy, the number of people in treatment grew rapidly, rising by around 2,500 each month from June 2023. As of March 2024, there were 25,090 additional people benefiting from treatment. Over the period, continuity of care performance increased for prison leavers who receive drug and alcohol treatment in prisons and need to continue their treatment in the community. As of March 2024, over half of people who leave prisons (53%) were being seen within 3 weeks of release, a 12 percentage point improvement over the year since March 2023. Local authorities reported that by September 2023 they had recruited over 2,370 additional staff, including 1,780 drug and alcohol workers, to support increased capacity and quality for people who need treatment for drug and alcohol problems.

Many people who need treatment for drug and alcohol problems have other needs or experiences that make delivery of services complex, including poor mental health, rough sleeping and homelessness and engagement with the criminal justice system. In response to issues raised in Dame Carol Black's 2021 independent review of drugs, DHSC commissioned research to better understand drug use in ethnic minority communities, including barriers and facilitators to treatment and prevention; this was published in January 2024. In their delivery planning for 2024-25, local authorities and their partners were encouraged to use additional funding made available for substance misuse services to engage vulnerable and priority groups in their communities including new parents, disabled people and people who are engaged with sex work. We also encouraged local authorities to use some of the additional funding to ensure there is good provision for underserved ethnic groups, women and girls, LGBTQ+ communities, and people engaged in chemsex.

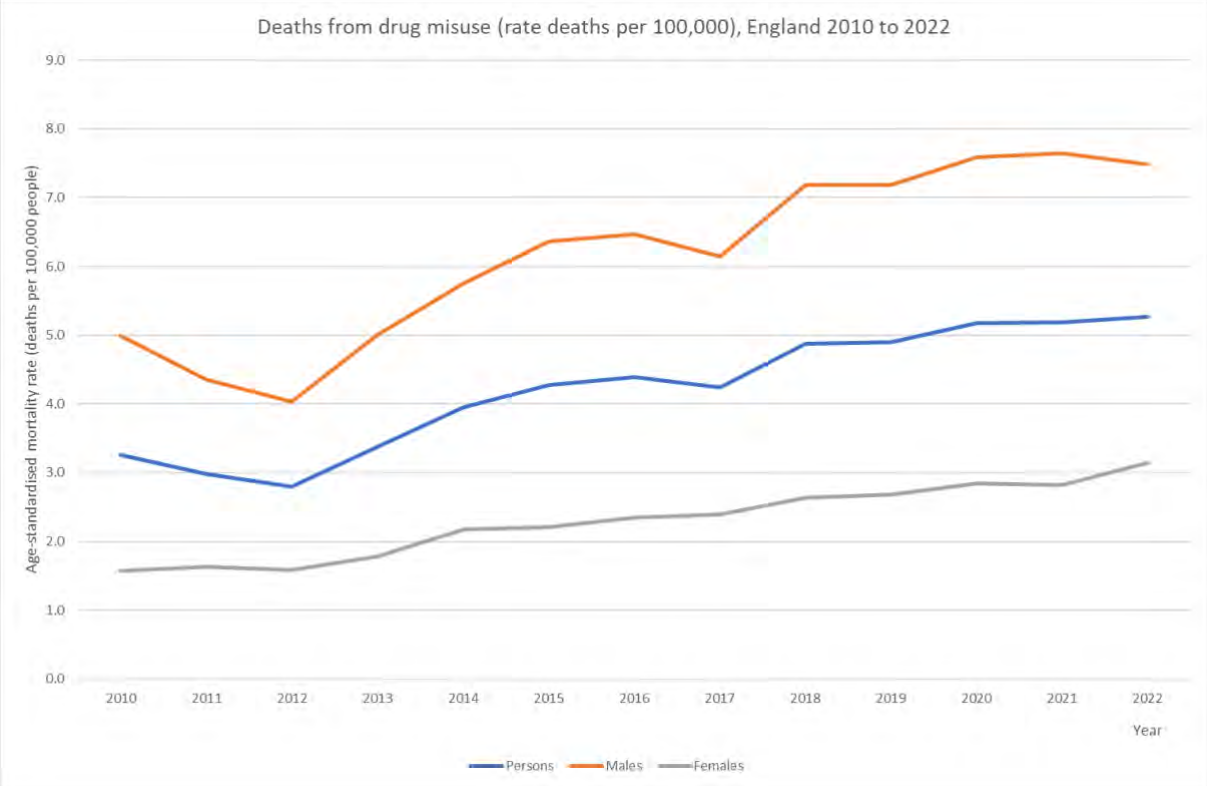
During 2023-24 DHSC, working closely with the Department for Work and Pensions (DWP), managed the continued national roll out of Individual Placement and Support in drug and alcohol treatment services, which provides support to people in treatment to find and retain employment. Working closely with MHCLG, DHSC managed the mobilisation of the Housing Support Grant in 28 local authorities to test the impact of targeted housing support interventions on recovery outcomes, and the Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG), delivered in 83 areas. The RSDATG improves access to, and support from, treatment services for people who sleep rough or are at risk of sleeping rough.

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

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 2022 was 1.9 times higher than the rate in 2012 (the year with the lowest rate in the past decade): 5.3 deaths per 100,000 compared to 2.8 respectively. See Figure 16.

Almost half of drug-related deaths involve opiates, however, there has been an increase in deaths related to other substances, especially cocaine. Across Europe, the number of new heroin users has fallen, while deaths involving heroin and morphine 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. However, this is only one factor in rising deaths.

Figure 16: Deaths from drug misuse (rate per 100,000), England 2010 to 2022



Source: ONS - Deaths related to drug poisoning in England and Wales

Smoking prevalence

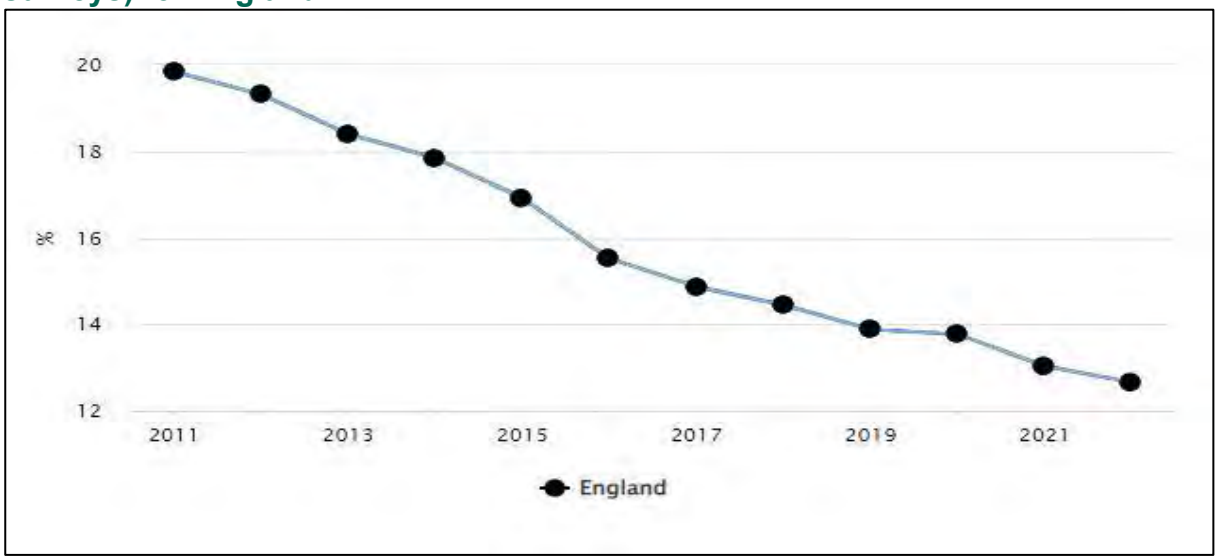
Smoking is the number one preventable cause of death, disability and ill health, causing around 80,000 deaths per year across the UK (sum of separate figures published for England, Scotland, Wales and Northern Ireland). In 2022 in England, 12.7% of adults smoked, compared to 19.3% in 2012, a decrease of over a third (34.2%) (Figure 18). 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). Whilst youth smoking is reducing, rates in older teens remain high. In 2023, Over 12% of 16- to 17-year-olds

smoked in England and in 2018-19 over 30% of under 18-year-old pregnant mothers smoke.

Vapes are the most popular quitting aid for smoking in England with around 3.9 million adult users in England estimated in 2022. Evidence indicates that they can help smokers to quit, particularly when combined with additional support from local smoking cessation services, and that they contributed to an estimated 50-70,000 additional 'quits' per year in England.

The number of children using vapes is increasing, however. Data collected in NHS Digital's Smoking, Drinking and Drug Use among Young People in England survey showed an increase in regular vape use for 11 to 15-year-olds from 2% in 2018 to 5% in 2023. Separately, the 2023 Action on Smoking and Health survey, use of e-cigarettes (vapes) among young people in Great Britain, found that 18% of children (aged 11 to 17) had tried vaping when surveyed in March to April 2024. Selling vapes to under 18s is illegal and the government is clear that vapes should only ever be used as a smoking quit aid.

Figure 17: Smoking prevalence in adults (18+) – current smokers (annual population surveys) for England



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

In October 2023, the then government announced proposals to address smoking and youth vaping through a range of legislative and non-legislative measures, as set out in the Stopping the start: our plan to create a smokefree generation command paper. These proposals built on the recommendations from the independent review led by Dr Javed Khan OBE.

A consultation on plans for new legislation in relation to the proposals was carried out between 12 October and 6 December 2023, and the consultation response was published on 12 February 2024. The majority of responses supported the proposal to create a smokefree generation.

On 20 March 2024, the Tobacco and Vapes Bill was introduced to Parliament. The Bill included measures to create a smokefree generation so that children born on or after 1 January 2009 could never legally be sold tobacco. It would also, amongst other provisions, introduce powers for the government to restrict vapes appealing to children in the future. The Bill extended to all 4 nations of the United Kingdom.

The Tobacco and Vapes Bill did not complete passage in Parliament before the general election was called. However, in the King's Speech on 17 July 2024, the government confirmed it will introduce legislation on tobacco and vaping to progressively increase the age at which people can buy cigarettes and impose limits on the sale and marketing of vapes during this parliamentary session.

Further programmes were delivered in 2023-24 to support current smokers to quit. Plans to roll out a national 'Swap to Stop' scheme were announced in April 2023, seeking to offer up to 1 million smokers across England a free vape starter kit alongside behavioural support to help them to quit. Expressions of interest for approximately 400,000 vape starter kits for delivery in 2023-24 and 2024-25 were received by DHSC by the end of 2023-24.

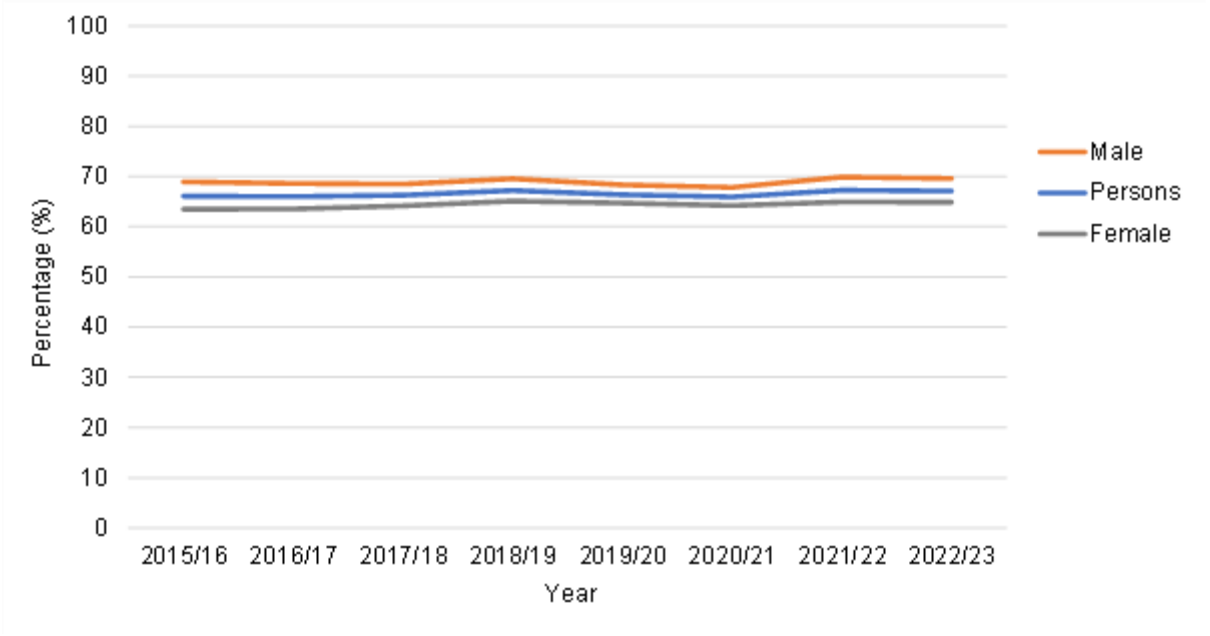
An additional £70 million per annum was also agreed for local authorities to support the expansion of local stop smoking services. Grant agreement letters were issued to all 153 local authorities in late February 2024, for grant funding to be delivered from early 2024-25.

Reducing physical inactivity

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 (CMO) guidelines for physical activity is safe 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.

In 2022 to 2023, more than 6 in 10 adults (aged 19 +) in England were physically active, having achieved 150+ minutes of moderate activity, or 75 minutes of vigorous per week. See Figure 18.

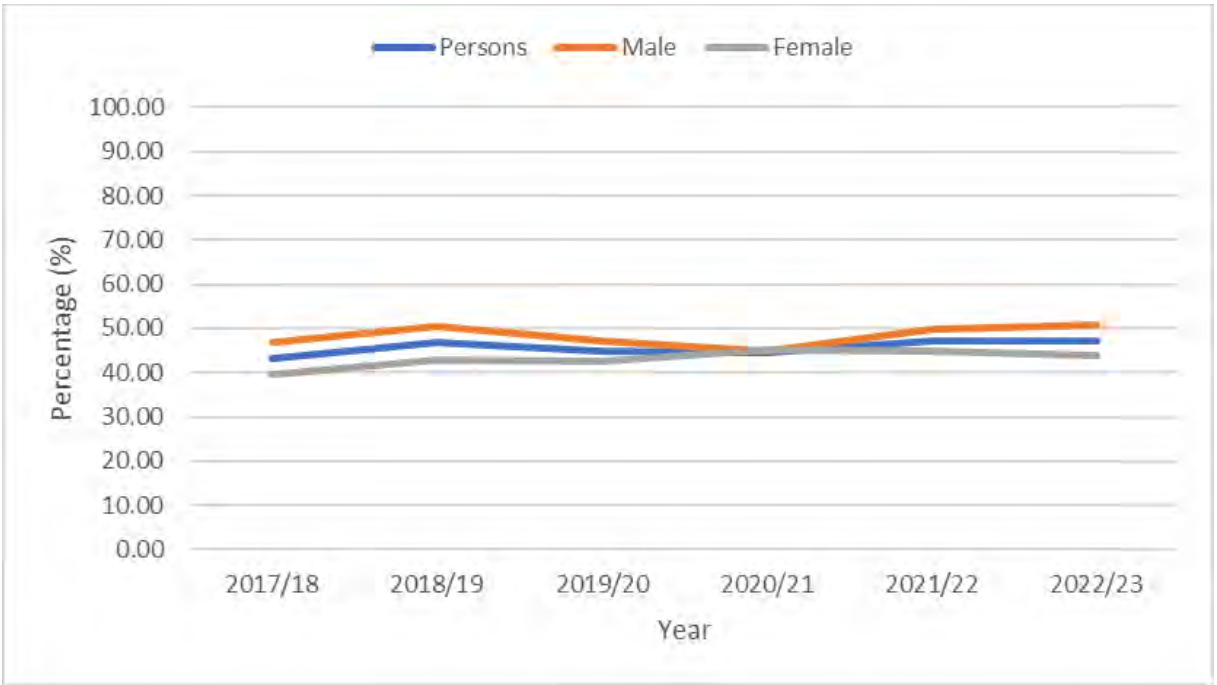
Figure 18: Percentage of physically active adults (Aged 19+) in England, 2015-16 to 2022-23



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

In the 2022-23 academic year, 47% of children and young people in England were meeting the Chief Medical Officers' guidelines of taking part in physical activity for an average of 60 minutes or more every day. Activity levels have remained relatively stable compared to 2021-22. See **Figure 19**.

Figure 19: Percentage of physically active children and young people (Aged 5 – 16) in England. Period 2015-16 to 2022-23



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

OHID collaborated with the Department for Education (DfE) and Department for Culture, Media and Sport (DCMS) 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.

In August 2023, DCMS published the then government's sports strategy Get Active which set out plans to drive up participation in sport and tackle inactivity. A taskforce was announced that would connect relevant organisations across government, including DHSC, and the sport and physical activity sector to deliver the strategy and its targets. These included a focus on demographic groups who are more inactive, lower socio-economic groups, adults with disabilities, older adults, women and ethnic minorities.

Diet and obesity

OHID delivered a programme of work which included a voluntary reformulation programme to reduce levels of salt, sugar and calories in food and drink, reducing the promotion of high fat, salt and sugar (HFSS) products in supermarkets and placing restrictions on the advertising and marketing of HFSS food and drink.

DHSC supported 3 million children through the Healthy Foods Schemes.

Excess weight, poor diet and physical inactivity disproportionately impact the most deprived groups so tackling these risk factors will be critical to address health inequalities.

Obesity prevalence – adults

Published in September 2024, the latest data in the Health Survey for England (HSE) 2022 estimated that 28.9% of adults in England in 2022 were living with obesity. Over time, the proportion of adults in England who are living with obesity has increased from 14.9% in 1993 to 28.9% in 2022 (Figure 20).

Adult obesity prevalence – Ethnicity

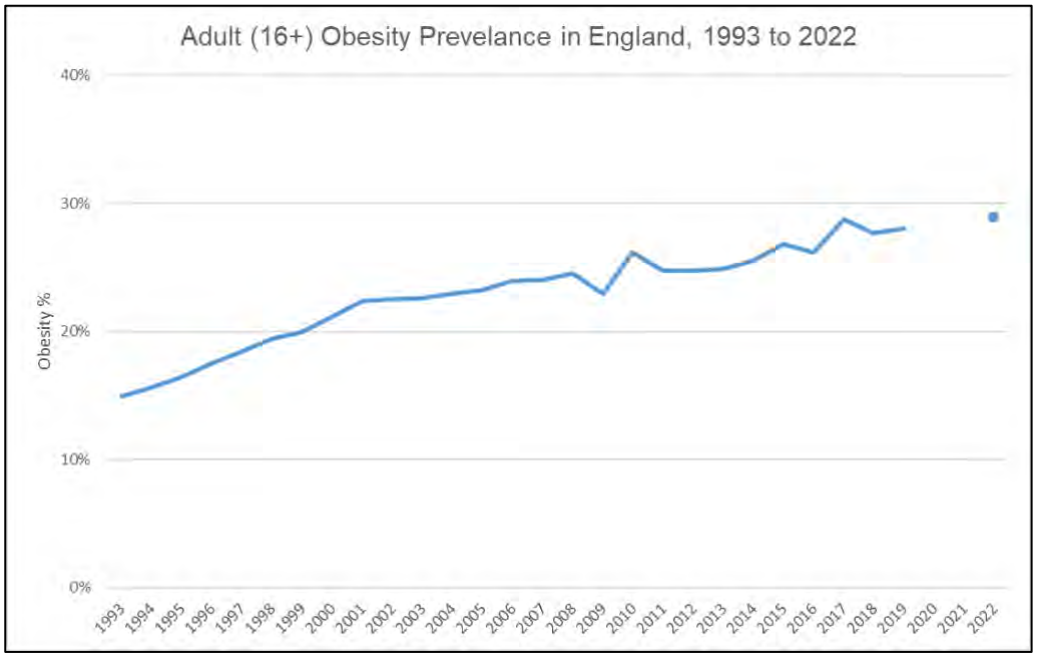
Additional analysis in HSE 2019 which has not yet been repeated in HSE 2022 found that, between 2011 and 2019, the proportions of adults who were either overweight or obese varied across ethnic groups. The proportions were significantly lower among Chinese adults where the age standardised proportion of excess weight was 29% (approximately 26% overweight and 3% obese). The ethnicities with the highest proportion of excess weight were black African and black Caribbean backgrounds; both reported at 69%. For black African adults, approximately 34% were overweight and 34% obese and, for black Caribbean adults, approximately 32% overweight and 37% obese.

Adult obesity prevalence – Deprivation

According to HSE 2022, there are significant disparities in BMI category, with a clear correlation with deprivation. Normal weight and overweight were more prevalent in least

deprived areas whereas underweight and obesity were more prevalent in the most deprived areas. The prevalence of normal weight decreased as deprivation increased with 39.3% in least deprived areas whilst in most deprived areas it was 28.8%. Conversely, the prevalence of obesity increased with deprivation from 22.1% in the least deprived areas to 35.7% in the most deprived areas.

Figure 20: Adult (16+) obesity prevalence in England, 1993 to 2022



Source: Health Survey for England: HSE 2022
Note: Due to the COVID-19 pandemic data collection and publication did not take place in 2020.2021 data is not directly comparable with other years due to changes in survey methodology and response rates and, as such, is excluded from the series above.

Obesity prevalence – children and young people

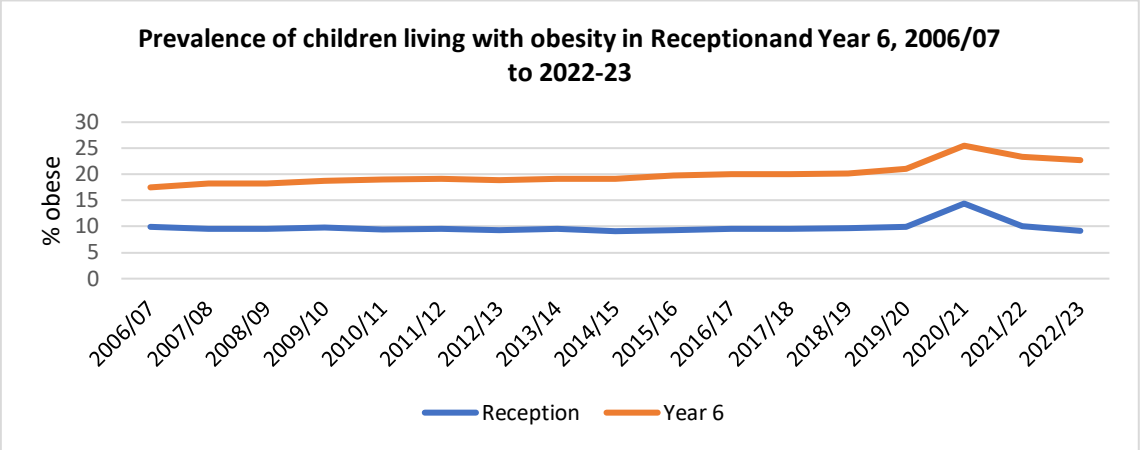
The Health Survey for England estimated that obesity prevalence in children and young people aged 2 to 15 increased from 12.0% in 1995 to 19.0% in 2004-05, before declining to 16.0% in 2008 and remaining at a similar level since that time and most recently 16.3% in 2019.

The National Child Measurement Programme (NCMP) records children's height and weight in the first and last years of primary school. Prevalence of obesity among reception children (aged 4-5 years) increased to 14.4% in 2020-21, then dropped to 9.2% in 2022-23. This decrease is a return to pre-pandemic levels for this age group and is one of the lowest levels since 2006-07. Obesity prevalence among year 6 children (aged 10-11 years) in England in 2022-23 (22.7%) remained above pre-pandemic levels. See Figure 21.

According to (NCMP), obesity prevalence in children varies across ethnic groups, following the same trend as adults. For children in Year 6 Chinese backgrounds have the lowest

prevalence of overweight (11%) and obese (15%) whilst the highest prevalence is seen in black African backgrounds with 15.8% overweight and 31.8% obese.

Figure 21: Prevalence of children living with obesity in reception and year 6, 2006-07 to 2022-23



Source: National Child Measurement Programme: National Child Measurement Programme, England, 2022/23 School Year - NHS England Digital

Voluntary reduction and reformulation programme

The voluntary reduction and reformulation programme required businesses in all sectors of the food industry, such as retailers, manufacturers and all parts of the eating out of home sector including takeaway and delivery, to reduce the levels of salt, sugar and calories in everyday food and drink. These changes mean that people can eat more healthily without having to change their usual diets; and that everyone, irrespective of demographics, will benefit from the changes made. Data shows that reductions made to date on sugar reduction have benefited all socio-economic groups equally.

The calorie reduction programme focused on savoury foods that substantially contribute to children and adults' calorie intake and where reformulation is possible. Retailers and manufacturers were asked to deliver up to a 10% reduction, and the eating out of home sector up to a 20% reduction, by 2024. A larger ambition was applied to the eating out of home sector as the calorie ranges in products are much larger in this sector.

The first progress report for the calorie reduction programme, Calorie reduction programme: industry progress 2017 to 2021, was published on 15 February 2024. This showed generally little change in calorie levels across all sectors and categories between 2017 and 2021, and increased volume sales in some areas. However, the data period covers some of the COVID-19 pandemic when the food supply was disrupted, and more food was purchased for consumption in the home.

In 2018, the sugar reduction 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. The next report on industry progress, covering change in sugar levels in

juices and milk-based drinks between 2017 and 2021, and those in scope of the SDIL between 2015 and 2021, will be published in due course.

Work to develop voluntary industry guidelines to reduce levels of sugar and salt in, and improve the labelling of, commercial baby food and drink aimed at children aged up to 36 months is near completion. The guidelines are due to be delivered in the coming months.

Weight management services GP referrals

A voluntary GP Weight Management Enhanced Service (WM ES) was introduced in the 2021-22 GP contract, to incentivise GPs to identify patients living with obesity and refer them to appropriate weight management services (WMS). There is good evidence that WMS are both effective and cost-effective at helping people to lose weight, benefiting health. GPs 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, enabling referral to WMS where appropriate. GP practices are provided with a payment of £11.50 each time they identify and refer an adult into a WMS. This WM ES has been in place since its introduction and remains in the 2024-25 contract.

Excess mortality and suicide

Excess deaths are normally defined as the difference between the actual number of deaths registered in a particular period and the number of deaths ‘expected’ in that period, based on an historical baseline. Excess deaths can either be expressed in absolute terms (number higher than expected) or relative terms (% higher than expected). Excess deaths are presented as negative values when the registered deaths are lower than expected. Excess deaths is one of a number of indicators we use to monitor mortality and is most useful for monitoring short term changes.

In February 2024, OHID and ONS revised their methods for estimating excess deaths, bringing them into broad alignment. The changes provide greater consistency between their estimates and help ensure continued accuracy for ongoing reporting. The method considers population growth and ageing and provides estimates of excess deaths given that the pandemic has occurred.

Data on excess deaths show that deaths were 2% higher than expected overall in 2023. The conditions with the largest excess in this period were respiratory diseases, cardiovascular disease (CVD) and dementia. However, excess deaths were negative (that is, deaths were lower than expected) in the last 6 months of 2023 and in January to March 2024.

Since November 2023, OHID has published a monthly near to real-time suspected suicide surveillance (nRTSSS) for England. The report uses data provided by the National Police

Chief's Council; the term 'suspected suicide' means cause of death and method(s) have not yet been confirmed by Coroner Inquest.

These monthly reports provide an early warning system for patterns of potentially preventable suicides. Overall numbers and rates of suspected suicide are presented and analysed by gender, age group and suicide method. Deaths are reported within 12 weeks of occurrence providing vital early intelligence to guide national and local work on suicide prevention.

A new Suicide Prevention Strategy for England was published in September 2023. In addition, 79 voluntary, community or social enterprise organisations were allocated £10 million in funding from the two-year (2023-25) Suicide Prevention Grant Fund.

Cardiovascular disease (CVD)

CVD is the second largest cause of death in England, accounting for almost 1 in 4 (24%) of deaths across all ages in 2022. It affects around 6.4 million people, is the second largest contributor to disability adjusted life years (Global Burden of Disease, 2019), and accounts for around a quarter of the life expectancy gap between the richest and poorest in England. Excess deaths from all causes, including CVD, have been declining across 2023-24, with negative excess (fewer deaths than expected) shown in the most recent data.

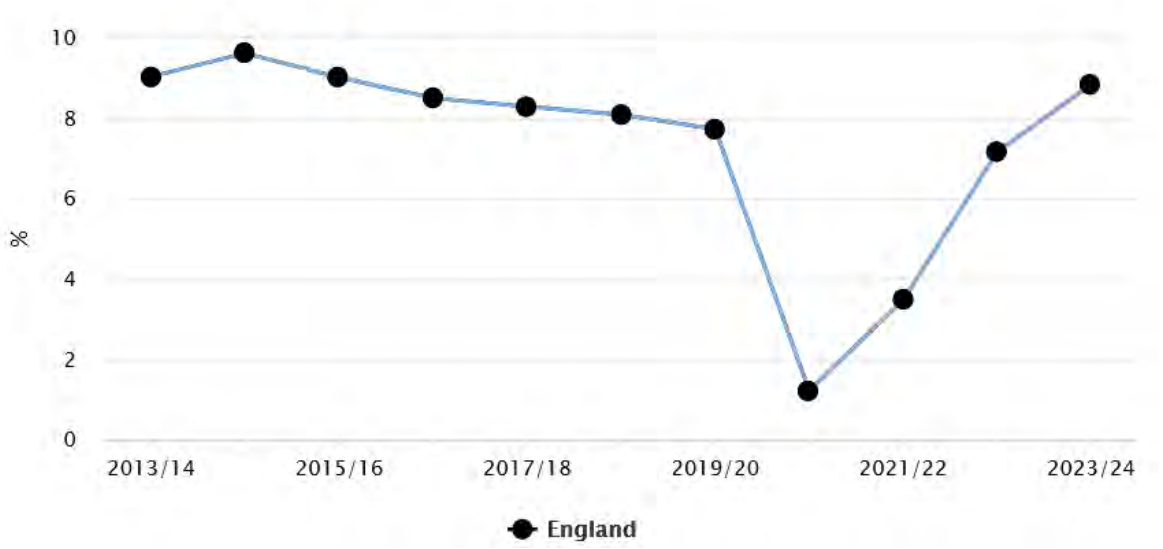
DHSC:

- continued to invest in the NHS Health Check, England's CVD prevention programme (see separate section below)
- invested almost £17 million in the development of a new digital NHS Health Check
- prepared to launch a pilot for workplace CVD health checks, to be rolled out in 2024-25 for up to 130,000 people in their place of work
- provided free, walk-in, blood pressure checks to people over 40 in community pharmacies, helping to detect thousands more people living with high blood pressure earlier, allowing access to treatment that will reduce their risk of death or serious illness from CVD. As part of the service, pharmacies have delivered over 3.2 million blood pressure checks since October 2021. As of April 2024, 7,382 pharmacies were actively delivering the service (performing at least 1 cuff check or ambulatory blood pressure monitoring)
- ran a marketing campaign to motivate and encourage people to get checked for high blood pressure, the largest single known risk factor for CVD. The campaign raised awareness that the only way to really know whether you have high blood pressure is to get a check because it usually presents with no symptoms. It directed people to look for a local pharmacy where they can get a free check without the need for pre-booking.

The NHS Health Check programme

The NHS Health Check programme is a core component of England's CVD prevention pathway; it aims to prevent heart disease, stroke, diabetes and some cases of dementia and kidney disease among healthy adults aged 40-74 years. The programme was largely suspended during the pandemic but recovered to pre-pandemic levels in 2023-24. The year 2023-24 saw the highest number of NHS Health Checks delivered in a year since 2014-15, and the highest level of offers ever reported in a year. In 2023-24, 39.9% of those offered a check had one.

Figure 22: Percentage of the eligible population receiving an NHS Health Check in each year since 2013-14



Source: NHS Health Check - Data - OHID (phe.org.uk). If each eligible person received a check, we would expect 5% of the eligible population to have a check each quarter

A screening offer for preventative health

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 enabled the independent advisory committee to make recommendations relating to screening for specific groups within the wider population.

In the summer of 2023 previous Conservative ministers agreed a UK NSC recommendation 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. A programme of targeted lung health checks was initiated in the most deprived areas of England where people were 4 times more likely to smoke and were therefore at greater risk of lung cancer. Initial data from the NHS England programme showed that 75% of the cancers detected in the programme were found at stage 1 and 2 when they were more treatable, compared to only 29% outside the programme. By February 2024, 1.5 million people had been invited, over 600,000 checks had been carried out and 3,662 cancers had been detected. The

programme used AI to assist the readers in judging the size of lung nodules to determine who should be invited back for further checks.

The UK NSC recommended in November 2023 that the NHS be allowed the use of digital pathology for national screening programmes. Previous Conservative ministers accepted this recommendation in January 2024, and it was implemented in some NHS trusts to assist in the efficiency of reading results. There is also interest in the use of AI to support screening and the UK NSC has worked with the Health Technology Assessment to develop prospective research of the use of AI in breast screening.

The then government agreed the UK NSC's recommendation to include tyrosinaemia screening into the new-born screening programme, with a written ministerial statement laid in March 2024. If found early, vital treatment can be given to babies with tyrosinaemia to avoid damage to the liver, kidneys and the nervous system.

Sexual and reproductive health

The government has committed to ending new human immunodeficiency viruses (HIV) transmissions within England by 2030. In December 2021, the then government published an HIV Action Plan 2022 to 2025, setting out interim targets and actions. The present government has commissioned a new HIV Action Plan which will be published in due course.

In November 2023, DHSC announced an additional £20 million for new research, which will involve an expansion and evaluation of the existing bloodborne virus opt-out testing in 47 additional emergency departments in areas of England with high HIV prevalence.

As part of the previous 2022 to 2025 Action Plan, DHSC committed to extend the delivery of the National HIV prevention Programme for England to 2024-25, including improving information and testing for HIV and other sexually transmitted infections. National HIV Testing Week 2024 delivered more than 25,000 testing kits to key populations, including for those disproportionately affected by HIV such as black African communities for whom uptake of testing kits has tripled since 2021. In February 2024, the HIV Action Plan Implementation Steering Group published a roadmap for meeting the PrEP (pre-exposure prophylaxis) needs of those at significant risk of HIV to help guide efforts in improving uptake and access to HIV prevention drug PrEP.

DHSC continued to meet its statutory duties under the Abortion Act 1967. This includes fulfilling the Secretary of State's powers to approve places for the purpose of treatment for termination of pregnancy. Between April 2023 and March 2024, 30 independent sector clinics were approved. DHSC worked with abortion providers, NHS England and the CQC to ensure women have access to safe, regulated abortion services in accordance with the legal framework laid down by the Abortion Act 1967.

DHSC has continued to work to reduce the numbers of unwanted pregnancies through improved access to contraception. In April 2023, DHSC introduced the NHS Pharmacy Contraception Service. This service offers greater choice in how people can access contraception services. Delivering on a key commitment in the Women's Health Strategy for England, in September 2023 DHSC launched the Women's Reproductive Health Survey to gather vital data on women's menstrual health, contraception, pregnancy planning and menopause. The survey ran for 6 weeks and received over 50,000 responses which will be used to inform future policy development and strategy work to help monitor changes and disparities in women and girls' access to and experience of reproductive health services.

The health incentives pilot - Better Health: Rewards

The health incentives pilot ran in Wolverhampton between 17 February and 13 October 2023. The pilot aimed to test whether offering users monetary incentives via a digital app in exchange for improving their diet and being more active can drive behaviour change. Over 28,000 people signed up, equivalent to 1 in 8 adults in Wolverhampton. During the pilot, participants completed just over 130,000 personalised challenges to improve their diet and activity levels. This equates to over 7.9 billion steps walked, over 24 million minutes of moderate-vigorous physical activity undertaken and over 447,000 portions of fruit and vegetables consumed. The government will consider the results of the independent evaluation, led by the Behavioural Insights Team.

Cost of living

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. There are multiple targeted schemes in place to deliver energy efficiency measures to low income and fuel poor households. These include the Energy Company Obligation (ECO), the Social Housing Decarbonisation Fund and the Home Upgrade Grant (HUG).

We continue to deliver the Warm Home Discount which provides a £150 annual rebate on energy bills for eligible low-income households. There is a strong link between cold homes and cardiovascular and respiratory diseases. Around 40% of excess winter deaths (EWDs) are attributable to cardiovascular disease and around 33% of EWDs are attributable to respiratory diseases.

Working with DESNZ, DHSC continues to provide evidence and input to shape the design of energy efficiency schemes, to ensure health-related vulnerabilities are considered. We are also advising and informing the ongoing refresh of the Fuel Poverty Strategy for England.

Cumulative cost of living pressures have impacted people's physical and mental health. According to the impact of winter pressures on different population groups in Great Britain:

18 October 2023 to 1 January 2024, fewer than half of adults (48%) reported that their mental health had not been affected by cost and other pressures over the winter.

Start for Life

The then government published The best start for life: a vision for the 1,001 critical days in March 2021. This vision set out 6 action areas for improving support for families during the 1,001 critical days from pregnancy to age 2 years to ensure that every baby in England is given the best start in life, regardless of background. A progress report on delivering the vision was published in February 2023.

Through the joint DHSC and DfE Family Hubs and Start for Life programme, an additional £300 million was invested to improve support for families. The programme is implementing elements of the Best Start for Life Vision. Some local authorities without programme funding have also chosen to implement elements of the vision.

All local authorities receiving funding through the Start for Life programme have opened a family hub in their area. These hubs, many of which are located in areas of high deprivation, are part of a network of around 400 family hubs across England all helping to give babies the best start for life.

A number of national initiatives have also been delivered as part of the Family Hubs and Start for Life Programme, including:

- the development of an e-learning programme about the links between breastfeeding and mental health for the early years' workforce

- increasing the opening hours of the National Breastfeeding Helpline to provide breastfeeding support for women and families across the UK.

The DWP and DHSC Joint Work and Health Directorate (JWHD)

The Joint DWP and DHSC Work and Health Directorate (JWHD) was set up in 2015 in recognition of the significant link between work and health and to improve employment opportunities for disabled people and people with health conditions.

Long-term sickness continues to be the most common reason for economic inactivity among the working age population. Between 2019 and 2022 this figure rose by around half a million and continued on an upward trajectory, reaching 2.8 million in August to October 2023. The number remained stable, at around 2.8 million, in the six months to March 2024.

Disabled people and people with health conditions are a diverse group. Access to the right work and health support, in the right place, at the right time is key. JWHD maintained its focus on the significant link between work and health; to improve alignment of employment and health systems to deliver evidence-based programmes, trials, and tests. In addition to programmes being delivered nationally across Great Britain and within England and

Wales, JWHD worked at a local level with local authorities (LA), ICSs, and others to support disabled people and people with health conditions to start and stay in work.

Throughout the current spending period, the business plan for employment advisers (EAs) in NHS Talking Therapies is to increase from 40% coverage across England to 100% coverage. The EAs in NHS Talking Therapies programme is on track to cover 100% of NHS Talking Therapies services by the end of 2024-25, with the potential to support up to 100,000 people per year from 2025 onwards.

DSHC has continued to improve access to work and health support for people with complex needs, including by funding the expansion to 12 lead local authorities to deliver Individual Placement and Support in primary care services across 42 upper tier local authorities in England from April 2023.

A number of new programmes and initiatives were announced by the government during the 2023-24 reporting period, including:

- a £64 million WorkWell pilot to support around 59,000 disabled people through a multidisciplinary approach combining health and work professions to build a personalised action plan. On 30 November 2023, the WorkWell grant competition invited applications from local partnerships led by ICBs in England to become one of approximately 15 organisations running the pilot service

- testing new ways of providing individuals receiving a fit note with tailored support, including referral to support through their local WorkWell pilot.

- funding to increase support for mental health and MSK conditions, as 2 of the main causes of sickness absence and economic inactivity, including introducing EAs into MSK pathways. See other sections for further details

- the digital information and guidance service for employers, Support with employee health and disability, which offers tailored guidance on health and disability. It is now live and available across Great Britain and testing very well with employers. Developed with small and medium-sized enterprise (SME) employers, the service offers a resource which helps employers to feel more confident having conversations about health and disability, understand and fulfil their legal obligations and signposts to sources of expert support.

Employers and workplaces are key enablers for supporting disabled people and those with health conditions in work. The occupational health (OH) reform programme is focused on increasing access and uptake of occupational health. JWHD has undertaken a range of activities this reporting year in support of this aim, including:

- the Occupational Health: Working Better consultation, which was launched by DWP and DHSC on 20 July 2023 and ran for 6 weeks, consulted on ways to increase occupational health coverage

- the Occupational Health: Working Better Response (announced at Autumn Statement 2023) which outlined plans to establish an expert group to support the development of a new occupational health voluntary minimum framework

- work to start addressing shortages within the clinical OH workforce. In July 2023 DHSC launched the OH Workforce Expansion Scheme which provides funding for doctors and nurses to undertake OH training and an option to take exams to gain formal qualifications in OH. The first exams took place in May 2024

- in January 2023, DHSC launched a £1 million fund to stimulate innovation in the OH market, focused on increasing access to and capacity in OH. Phase 1 ended in January 2024 and all 10 projects have researched and developed technologies to improve access to OH for SME's and the self-employed. 5 of the 10 projects successfully secured funding for Phase 2 which will run from 1 April 2024 until 31 March 2025 with a focus on continued development of projects from Phase 1 through prototyping and real-world testing ahead of scaling up and commercialisation

- in February 2024, DHSC launched an initial small-scale digital pilot of the OH financial incentive scheme for SMEs which will inform potential wider rollout and impact evaluation.

Water fluoridation

DHSC made it easier for more of England's population to benefit from water fluoridation schemes through provisions in the Health and Care Act 2022. DHSC consulted on the expansion of water fluoridation to an additional 1.6 million people in the northeast of England. The outcome to the consultation will be published in due course.

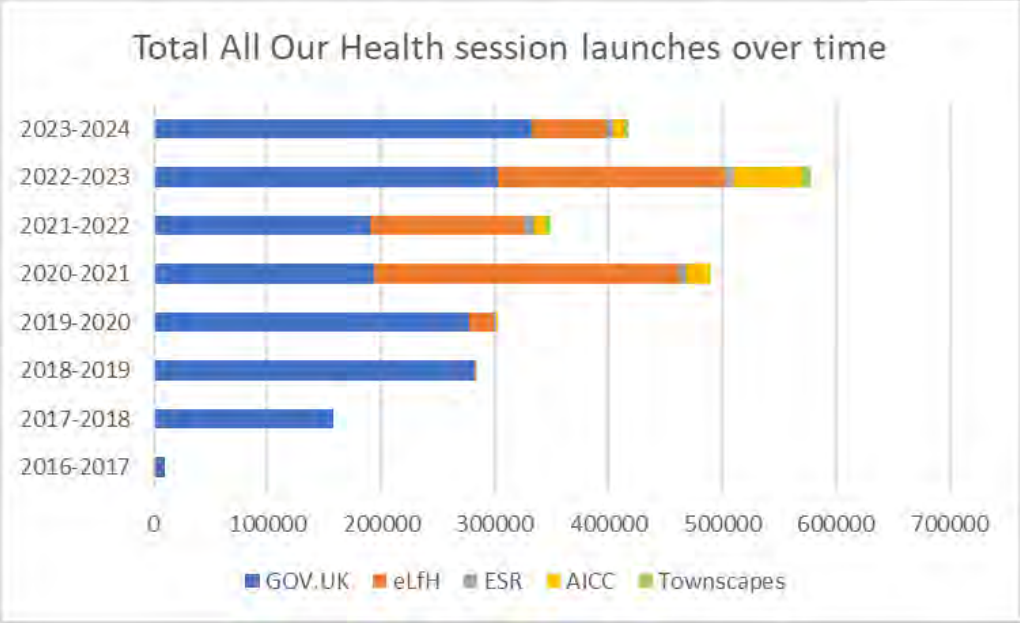
All Our Health

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

During 2023-24, DHSC published an All Our Health implementation toolkit, which aimed to support higher education institutions, provider trusts and other organisations to enhance their existing offer for curricula and/or continuing professional development on public and population health. DHSC also commissioned a new e-learning resource which will be aimed specifically at the social care workforce. The e-learning identified 'ten top tips' for improving public health in social care settings.

During 2023-24 there were over 415,000 sessions launched on the All Our Health platform. Since launching, there were almost 2.6 million launches overall (Figure 23).

Figure 23: Total All Our Health session launches since inception (eLfh – NHS England eLearning for Healthcare platform, ESR – NHS England electronic staff record database, AICC – content accessed via aviation industry computer-based training committee data exchange, Townscapes – All Our Health supporting tools)



Source: Google Analytics and Tableau data analysis tools.

Public health funding and analytical capability

Public health services commissioned by local authorities in England are mainly funded through a ring-fenced public health grant.

In 2023-24, the value of the public health grant increased by 3.3% in cash terms, taking total funding to £3.530 billion (this includes the notional allocations for the 10 Greater Manchester local authorities, which are piloting business rate retention for public health and use this funding in lieu of a grant). In addition to the public health grant, DHSC also provided £213 million of targeted funding to local authorities in England for drug and alcohol treatment and recovery systems and services that support the best start in life.

During 2023-24, provision of training in public health analytical concepts and methods was updated, adopting a blended learning approach, which was piloted via the new online collaborative platform for public health intelligence professionals, Public Health Intelligence Online.

Regional directorates

In 2021, England's 7 Regional Directors of Public Health (RDsPH) and their teams moved from Public Health England into DHSC. The RDsPH and Deputy Regional Directors (DRDs) are joint appointments with NHS England. The 7 RDsPH are senior experts on

public health and, supported by their teams, provide expertise and strategic support regionally and nationally on health improvement and prevention, healthcare public health, and identifying and addressing health inequalities. In partnership with UKHSA teams they support health protection priorities.

RDsPH co-ordinate strategic coherence and oversight across different partners with public health responsibilities. They provide an essential role in bringing together the implementation of national government public health policy with regional mayors, local government, and the NHS at regional, ICS level and locality level. In 2024 the local knowledge and intelligence teams were added to the portfolio of regions.

RDsPH have delegated authority, on behalf of the Secretary of State (NHS Act 2006 Section 73A) to appoint local Directors of Public Health (DsPH), whose responsibilities are to assess local population health.

OHID's 7 RDsPH report to the Primary Care and Prevention DG who links to the OHID Board chaired by the Deputy Chief Medical Officer, alongside DHSC's other 3 DGs.

Regional directorates link DHSC to local public health systems at place. This embeds public health and a local, system view into DHSC and to the NHS England regional directors. London's regional director has a statutory responsibility as the public health advisor to the Mayor of London.

OHID's RDsPH and their teams strengthened local and regional public health systems of delivery, with a focus on delivering ministerial priorities and supportive improvement on evidenced local and regional public health challenges such as infant mortality, work and health and tackling inequalities. The RDsPH brought a place-based perspective to a range of policy areas and ensured local implementation of OHID's key priorities; such as delivery of the Drug Strategy working with a range of stakeholders across health and the criminal justice system; implementation of the Family Hubs and Start for Life programme including workforce pilots; overseeing capacity and capability building with local authorities to help achieve the Smoke Free Generation priority and supporting partners to improve primary and secondary CVD prevention to reduce demand on NHS services.

OHID's Regional Directorates provided public health leadership at a national, regional, and local level on a broad and diverse range of agendas, from advising on healthy places priorities such as housing, planning and licensing, through to improvement support for commissioning of services such as NHS Health Checks, 0-19 services, sexual health and HIV prevention. They provide system leadership, engaging with partners on research and development initiatives alongside building and advising on capacity and capabilities to support the resilience and sustainability of the public health workforce. Through their joint NHS appointments, RDsPH and their teams 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 Core20Plus5 centre stage.

On behalf of the Secretary of State, the RDsPH assured the use of the £3.530 billion public health grant distributed between 152 upper tier local authorities and provided scrutiny which included deep dives and diagnostic plans reporting into ministers and No.10 to ensure dedicated funding for delivery of the Drug Strategy and resources for Smoke Free Generation. Regional teams also worked with local authority chief executives and the Faculty of Public Health leading on behalf of the Secretary of State on the appointment of local authority directors of public health.

The RDsPH and their teams focused on preventing ill health by influencing the wider determinants of health in place, by making strong links to other government departments and relevant sub-national bodies such as devolved combined authorities. Examples from 2023-24 include the deep dive work with MHCLG on 8 levelling-up partnerships across England, looking at short- and medium-term interventions to level up their economies and to improve infrastructure, employment opportunities, local health services, and improve the health of their populations.

Major campaigns

The Press Partnership, a collaboration between DHSC and the newspaper industry, published sponsored content on 12 different health areas (such as mental health, smoking cessation and women's health). Published in over 350 national, regional, local, and multicultural titles in England, the activity reached over 35 million adults (67%), who saw the content on average 11.8 times.

The Better Health behaviour change programme extended its range of apps, behaviour change tools, support programmes, campaigns, and websites. In 2023, 'Couch to 5k' was downloaded 605,300 times and there were 5.13 million runs, with 1.9 million active monthly users.

A CVD campaign was run to promote blood pressure checks to members of the public most at risk of hypertension, directing the audience to the expanded blood pressure testing capacity in pharmacies.

Start for Life launched the 'if they could tell you' campaign, which covered weaning, breastfeeding and parent infant relationships. The campaign emphasised the critical importance of a child's early physical, social, and emotional development through paid advertising, new digital support tools, public relations, and partnership activity. The Start for Life website had over 1 million monthly visits.

Every Mind Matters launched a campaign to encourage people to protect and improve their mental health and wellbeing. The 'Little Big Things' campaign focused on the little actions that people could take to make a big impact on their mental health. A new 6-week

email behaviour change programme to support better sleep was also launched called ‘Put Sleep First’ to work with the existing Mind Plan and anxiety programmes. 2 in 3 programme completers reported better mental health than at the start of the programme.

In addition to Stoptober, further campaigns ‘Good Things Happen when you stop smoking’ launched in January and ‘Smoking Survivors’ in March as part of new funding linked to the Tobacco and Vapes Bill. The campaign was supported with celebrity spokespeople including footballer David James and singer and presenter Coleen Nolan. The Quit Smoking app had 144,100 downloads in 2023 and there were 60,400 Stoptober quit attempts with one in 3 users reaching twenty-eight days smoke free.

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

DHSC maintained a focus on supporting the operational resilience and capacity of the adult social care system and the integration of health and care services and support, working in partnership with the NHS, local authorities, providers, and carers. DHSC also continued to work closely with the CQC and other stakeholders to assess risks in the provider market, and in particular the risk of major provider failure.

In December 2021 the then government set out a 10-year vision for adult social care in the People at the Heart of Care: adult social care reform white paper and set out reform priorities for 2023-24 and 2024-25 in the publication Next Steps to put People at the Heart of Care in April 2023. Progress made against these priorities during 2023-24 included a national career pathway for adult social care, a new assurance framework for local authorities, and funding for scaling of innovations in technology and beyond.

The principal way in which the overall outcomes of the adult social care system can be measured is through the adult social care outcomes framework (ASCOF). This is a set of annual indicators that measure how well care and support services achieve the outcomes that matter most to people. In particular, the adjusted quality of life score for care users estimates the impact that local authority-funded social care has on the outcomes of people who draw on social care.

One of the key data collections used in ASCOF is the Adult Social Care Survey (ASCS), through which care users (or carers on their behalf) report their views on issues including their level of control over daily life, cleanliness and comfort, food and drink, accommodation, personal safety, social participation and involvement, occupation, and dignity, adjusted for their level of need.

The latest ASCOF scores were published in 2023 and include measures for 2022-23. This publication shows the quality of life score to be stable at 0.411 out of a hypothetical maximum of 1.000, from 2021-22 (see Table 3). This score implies that the average user of long-term local authority services is benefitting from an improvement in their living standards with a social value of almost £30,000 a year.

Table 3: Adjusted social care-related quality of life for care users

Year	Adjusted social care-related quality of life (out of 1.000)
2022-23	0.411
2021-22	0.407
2020-21	-
2019-20	0.401

Source: Adult Social Care Outcomes Framework / Release Schedule: Annual. The Adult Social Care Survey was voluntary for LAs in 2020-21 given the impact of the coronavirus pandemic.

CQC quality ratings

National measures of care quality have remained steady in 2023 compared to 2022, with 83.4% of all social care settings regulated by CQC being rated as good or outstanding in August 2023. However, the proportion of social care settings rated good or outstanding is lower than the recent high of 84.7% in July 2021 (see **Table 4**).

Table 4: Percentage of CQC regulated social care settings with overall rating of Good or Outstanding

Year	Proportion of social care settings rated Good or Outstanding
2022/23	83.4%
2021/22	83.3%
2020/21	84.7%

Source: CQC State of Care annual reports

User satisfaction

In 2022-23, 64% of users were extremely or very satisfied with their care and support in England, comparable to 2021-22, as reported in Measures from the Adult Social Care Outcomes Framework.

Adult social care funding

At the Autumn Statement 2022, the then government made available up to £2.8 billion in additional funding for 2023-24 in England to help support adult social care and discharge. This included £1 billion of new grant funding, of which:

- £400m was provided through the new Market Sustainability and Improvement Fund (MSIF) and
- £600m was provided through the Discharge Fund.

Local authorities were also allowed to increase the adult social care precept by up to 2% in 2023-24, which raised a total of £561 million.

The funding made available at the Autumn Statement was supplemented by a further £365 million for 2023-24 through the Market Sustainability and Improvement Fund (MSIF): Workforce Fund, announced in July 2023. The objective of this funding was to support local authorities to buy more care packages, help people leave hospital on time, improve workforce recruitment and retention, and reduce waiting times for care.

Public expenditure on adult social care was £25.88bn in 2023-24, an increase of £2.9bn (12.8%) compared to 2022-23.

Workforce capacity

Since the pandemic the adult social care workforce has faced significant challenges, with workforce levels falling by 4% between 2020-21 and 2021-22. Latest data from Skills for Care shows that in 2023-24 there were 1.705 million filled posts in the adult social care sector, an increase of 4.2% (70,000 posts) from 2022-23. This follows an increase of 20,000 posts in 2022-23.

Skills for Care reported it is likely that this overall growth depended on international recruitment - 105,000 people arrived in the UK in 2023-24 and started roles providing direct care in the independent sector.

Reductions in workforce turnover indicated more workers chose to remain in posts in the sector, delivering greater continuity of care for users. Skills for Care data shows staff turnover rates in local authorities and the independent sector decreased from 29.1% in 2022-23 to 24.8% in 2023-24.

Evidence from Adult Social Care Workforce Data Set (ASC-WDS) collected between 2023 and 2024 suggests that international recruitment may have played a part in this decrease, with the turnover rate for international recruits being around 15 percentage points lower than for those recruited within the UK.

System reform

Following the publication of the People at the Heart of Care: adult social care reform white paper, the then government published Next steps to put People at the Heart of Care which provided detailed delivery plans for the following 2 years. Progress on system reform included the areas of workforce development, data and assurance, digitising social care, housing and innovation which are outlined below.

Workforce development

On 10 January 2024, the then government unveiled a package of measures to reaffirm care work as a career, helping to recruit and retain talent by providing new, accredited qualifications, digital training and funded apprenticeships.

In January 2024, the first national career pathway for care workers was launched, later followed by the Level 2 Care Certificate in June 2024. DHSC provided £8 million to support apprenticeships and added £5 million to the 2023-24 Workforce Development Fund. A further £15 million was provided to support international recruitment alongside the publication of an international recruitment toolkit to enable best practice.

Data, assurance and support

The then government published Care data matters: a roadmap for better adult social care data in December 2023 which set out the government's plan to transform how adult social care data is collected, shared, and used.

In spring 2023, the then government updated the ASCOF. The updates were intended to ensure that ASCOF better aligns with the Care Act 2014 and the whitepaper on system reform. In December 2023, the final updated ASCOF handbook of definitions was published. This update set out changes to the ASCOF metrics, with examples intending to minimise confusion and inconsistency in reporting and interpretation.

Progress on the delivery of this adult social care data strategy included:

- The introduction of the first national person-level social care data collection (Client Level Data - CLD) for all 153 local authorities that provided more timely and granular national information on adult social care activities. Since CLD became mandatory on the 1 April 2023, all 153 local authorities have submitted data describing 9 million interactions with 2.5 million people drawing on care and support (covering activity in the 12 months from 1 April 2023 to 31 March 2024)

- engagement with over 300 adult social care representatives on the development of a new digital product that will provide access to adult social care data for all those who need it, in one place. Procurement for the initial phases of the project was also launched

- exploration of options to streamline the national and local authority data collections from providers and carried out extensive engagement with stakeholders to develop a core long term provider minimum dataset. Making use of the digitisation of the sector to reduce burden on providers and improve flows where possible, working with the NHS to publish a first draft of what we hope could be automatically aggregated from Digital Social Care Records (DSCRs).

In December 2023 CQC started assessing how well local authorities deliver their duties under Part 1 of the Care Act 2014.

In 2023-24, £16 million was provided to sector partners to deliver a programme of support to local authorities and their partners to meet their statutory duties, improve services and tackle operational challenges. This included networks and groups to support the collaboration of Directors of Adult Social Services and their teams; training; best practice resources; and tailored support to help local authorities tackle specific problems.

Intervention powers were introduced in the Health and Care Act 2022 and commenced on 1 April 2023. These powers enable the Secretary of State to intervene where local authorities have failed or are failing to discharge their Care Act 2014 functions. In August 2023, an Operational framework for adult social care intervention in local authorities was published to provide local authorities with information on the new intervention powers and how they are intended to be used.

Digitising social care

During 2023-24, approximately £42 million was invested to support adult social care digitisation, building on almost £50 million spent during 2022-23. This investment was targeted at driving up adoption of DSCRs and other proven care technologies, while improving the foundations for digital working across the sector.

DHSC increased adoption of DSCRs by CQC-registered providers from 40% in December 2021, to at least 63% in February 2024, covering 70% of people in receipt of care. During 2023-24, DHSC provided a central package of financial support to the largest care providers to streamline the offer for organisations that provide care services across multiple ICS footprints.

Several DSCR systems offered GP Connect integration, enabling approved non-clinical staff to access a restricted view of an individual's care record. Data from February 2024 showed that 1,500 providers had implemented GP Connect, supporting almost 80,000 people.

The then government introduced the Adult Social Care Technology Fund to test, evaluate and scale care technologies, building the evidence base for future investment. DHSC announced the first 4 successful projects receiving funding of over £3 million in October 2023, and in March 2024 awarded a total of £4 million to an additional 4 projects.

In May 2023, DHSC published Digital working in adult social care: What Good Looks Like, guidance for digital working in adult social care, alongside an updated Digital Skills Framework to help people working in adult social care understand and develop the digital skills they need.

The new Digitising Social Care website was launched in September 2023, providing a central source of trusted information and guidance to support the digital transformation of adult social care.

DHSC also continued work with our partner programme, Better Security, Better Care, to raise cyber awareness and improve data security in the sector. Compliance with the Data Security and Protection Toolkit increased from 41% in December 2021 to 70% in 2024, helping to ensure digital transformation is safe and secure.

Innovation

In Next steps to put People at the Heart of Care DHSC announced a new innovation and improvement unit to develop and define clear priorities for innovation in adult social care. The Accelerating Reform Fund (ARF) supported these priorities and was launched in October 2023. The ARF provided £20 million of grant funding to local authorities in March 2024 to support innovation and scaling in adult social care, and to kick start a change in services to support unpaid carers.

A significant proportion of the projects that the ARF is designed to fund are aimed at supporting unpaid carers. All ICS areas in the country are using the ARF to scale innovations that will better identify, recognise, and support unpaid carers. Analysis by the Social Care Institute for Excellence found that around 7 in 10 projects have an element supporting unpaid carers.

At the end of 2022-23, DHSC provided £27 million to local authorities through a grant to streamline local authority adult social care assessment processes. During 2023-24 DHSC commissioned Ipsos to evaluate the way that local authorities used this funding which included a survey (approximately 50 local authority respondents and 7 local authority case studies). The evaluation found that 75% of local authorities that responded to the survey had either spent all or some of the grant on intended activities or planned to do so. 66% of local authority respondents agreed that the grant had contributed to the streamlining of assessment activities.

Housing

In May 2023, DHSC and the MHCLG jointly launched an independent taskforce to develop recommendations on how to expand the range, choice, and volume of housing options for older people. This work brought together experts from across the adult social care and housebuilding sectors, local government, and charities. Wide engagement and new research were undertaken. This resulted in a series of recommendations for growing the specialised, private older peoples' housing market, as well as supporting people in mainstream housing.

DHSC also continued to provide funding for home adaptations to support people to remain independent. In addition to the £573 million allocated to local authorities in May 2023 for the Disabled Facilities Grant in 2023-24, a further £50 million was provided in September 2023.

Consultation and engagement

In November 2023, DHSC attended the National Children and Adult Social Care Conference and Exhibition (NCASC). NCASC is the annual opportunity for those with an interest in social care, children's services, education, health, and related fields to network with peers and hear the very latest thinking on key policy and improvement agendas.

Publications

Other publications included an Online Care Needs Self-Assessment Good Practice Guide for local authorities that was published in November 2023. The guide explains how to implement these tools and what good tools should include.

Secretary of State for Health and Social Care Annual Report 2023-24

Additional information to accompany the Department of Health and Social Care (DHSC) Annual Report and Accounts 2023-24

Foreword

The NHS has faced enormous challenges in recent years but there is no escaping the fact that the system has underperformed and now finds itself in a state of crisis. After more than a decade of mismanagement, short-termism, and underinvestment, the NHS is broken.

During 2023-24, despite a focus on recovering emergency and elective performance in the NHS, performance against the 4-hour A&E standard in March 2024 was still below the delivery plan for recovering urgent and emergency care services performance target.

Latest data shows there are significant challenges facing NHS dentistry, with only 40% of adults being seen by an NHS dentist in the 24 months up to June 2024, down from 49% before the pandemic and 52.5% in 2010/11.

There is still much work to do to make a shift towards prevention in the NHS.

During September of this year, NHS waiting lists reached the longest in the history of the NHS, at 7.77 million. Industrial action remained unresolved and cost the NHS more than one million cancelled appointments and operations, and more than £1 billion.

The new government has already begun the difficult work of renewal. The Autumn Budget delivered significant investment to the NHS, but we are clear that investment must be linked to reform and every penny invested must provide value for money.

We need to take a whole system approach to health and social care, which is why alongside our 10-year plan for change and modernisation of the NHS, we will deliver a long-term plan for reform of adult social care.

Building an NHS for the future requires three big shifts – from analogue to digital, from hospital to community, and from sickness to prevention. We clearly have a long road ahead. But while the NHS is broken, it’s not beaten. We will turn the NHS around, so it is there for us when we need it, once again.

Introduction

The Secretary of State is required by section 247D of the National Health Service Act 2006, (the 2006 Act), to publish an annual report (laid before Parliament pursuant to section 247D(3)) on the performance of the health service in England. The report must

include an assessment of the effectiveness of the discharge of the duties under sections 1A and 1C of the 2006 Act.

This report includes an assessment of how effectively the Secretary of State has discharged their duties under sections 1A (duty as to improvement in quality of services) and 1C (duty as to reducing health inequalities) of the 2006 Act, as required under section 247D(2) of the 2006 Act, and is supplementary to the full Department of Health and Social Care (DHSC) Annual Reports and Accounts 2023-24.

The Secretary of State is under a duty in section 1A of the 2006 Act to exercise their functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the matters listed at 1A(1)(a) (the prevention, diagnosis or treatment of illness) and 1A(1)(b) (the protection or improvement of public health). In discharging this duty, the Secretary of State must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services and the Secretary of State must have regard to quality standards prepared by the National Institute for Health and Care Excellence (NICE) as set out in section 234 of the Health and Social Care Act 2012. Under section 1C of the 2006 Act, the Secretary of State is under a duty to have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service.

A full performance analysis for 2023-24 can be found in the 'Detailed performance analysis' section of the Department of Health and Social Care (DHSC) Annual Report and Accounts 2023-24. Assessments of the effectiveness of the discharge of the duties under sections 1A and 1C of the 2006 Act can be found below.

Assessment for section 1A (duty as to improvement in quality of services)

Prevention, diagnosis, or treatment of illness

During 2023-24, there was a focus on recovering emergency and elective performance in the NHS. The NHS made progress on reducing the number of patients waiting the longest periods, with waits of over 18 months in March 2024 down by more than 96% from a peak of nearly 125,000 in September 2021. However, nearly all the targets from the delivery plan for tackling the COVID-19 backlog of elective care were missed. In some areas, progress was hampered by widespread industrial action, thus delaying the target date to treat all patients waiting over 65 weeks for care from March 2024 to September 2024. Despite a stabilisation across the year in accident and emergency (A&E) performance from a very challenged position during 2022-23, performance against the 4 hour A&E standard in March 2024 was below the delivery plan for recovering urgent and emergency care services performance target.

DHSC's aim for general practice in 2023-24 was to improve access for patients and respond to growing demand. Appointment numbers in 2023-24 were consistently higher than 2022-23, and numbers of FTE doctors and other direct patient care staff also increased. Further information can be found under Priority Outcome 2 in the Department of Health and Social Care Annual Report and Accounts 2023/24.

In 2023-2024, more appointments were delivered in general practice in comparison to 2022-2023 and there were slightly fewer patients waiting longer than two weeks for an appointment. However, the overall percentage of appointments completed within 2 weeks has remained mostly constant over the past 2 years. The 2024 GP Patient Survey showed that 73.9% of respondents had a positive overall experience with their GP practice, additionally, when asked about waiting times for appointments, almost two-thirds of patients (65.9%) described the wait as "about right". Despite this, previous reports highlight a steady decline in satisfaction rates, dropping from 83.8% in 2018 to just 71.3% in 2023. Despite some access improvements such as increased appointments and slight decreases in waiting times, improvements have not translated into increased satisfaction, as overall satisfaction has continued to decline.

The expansion and transformation of NHS mental health, learning disabilities and autism services in England continued through 2023/24 despite high levels of demand, meaning that more people were supported. Work also continued to improve women's health outcomes and progress was made in the delivery of the three-year plan to improve maternity and neonatal services and provide safe and compassionate care, although the impact on services and public confidence in them has not yet been felt nationally. Further information can be found under Priority Outcome 2 in the Department of Health and Social Care Annual Report and Accounts 2023/24.

NHS Planning Guidance 2023/24 set out a national objective to consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard. The Urgent Community Response Service aims to reach people within two hours with the aim of, where appropriate, providing care where they live. UCR activity has increased over 2023-24, with total referrals growing nationally by 47% (between April 2023 and March 2024), consistently achieving the standard that over 80% of patients are referred within two hours.

The latest data shows that although activity continues to recover, there are some significant challenges facing NHS dentistry. Only 40% of adults were seen by an NHS dentist in the 24 months up to June 2024. This is down from 49% before the pandemic and 52.5% in 2010/11. 34.1million courses of dental treatment were delivered in England in 2023/24. This rose by 4% last year but is down on the 39.7million delivered in 2018/19.

The Joint DWP and DHSC Work and Health Directorate facilitates the significant link between work and health to improve employment opportunities for disabled people and people with health conditions. During this reporting year, this included a new WorkWell pilot, combining health and work professions in a multidisciplinary approach to create

personalised action plans, which will support approximately 59,000 people through local partnerships led by 15 Integrated Care Boards (ICBs) in England. And, following a successful trial, rollout across England of Employment Advisers in NHS Talking Therapies proceeded well during 23/24 and is now on track to complete by the end of the next reporting period.

Some progress was made in work to prevent and/or delay the onset of disease through secondary prevention (services provided to individuals designed to reduce risks of ill health and/or avoid or delay the onset of disease). Increases in the numbers of NHS Health Checks offered and delivered, and the introduction of targeted lung cancer screening were particularly positive and several new initiatives, including incentivising individuals to improve their health behaviours, were successfully trialled. However, there is evidence that there remains a great deal to do and a need for a greater shift towards prevention in the NHS.

Protection or improvement of public health

The Public Health Outcomes Framework was last updated on 6 August 2024. The Public Health Outcomes Framework examines indicators that help us understand trends in public health and is updated quarterly.

Adult Social Care Outcomes Framework (ASCOF)

The total number of people receiving long-term support in England showed an increase from 630,445 on 30 April 2023 to 660,460 on 31 March 2024.

This trend is driven by the increase in support delivered in community settings (including support in the form of direct payments from the local authority that people can then use to buy their own care and support), where the number of people receiving long-term support increased from 455,370 on 30 April 2023 to 483,255 on 31 March 2024. The reported increase could be partly due to improved reporting by some local authorities. It may also be the result of seasonal patterns in long-term support provision.

We began publishing statistics drawn from Client Level Data (CLD) in our monthly publication, Monthly statistics for adult social care (England) - GOV.UK (www.gov.uk) in March 2024, and will continue to publish these quarterly. We also plan to expand the portfolio of statistics we include in this publication to improve the transparency of reporting on issues and trends in adult social care. In future, some ASCOF metrics will be drawn from CLD as well as from the more traditional data collection sources. Further updates on social care outcomes can be found under Priority Outcome 5 in the Department of Health and Social Care Annual Report and Accounts 2023-24.

Some progress has been made in adult social care in England over 2023/24, especially around the long-term support received. We continue to work hard to ensure everyone acquires the care that they deserve.

Quality and patient safety

When the NHS Patient Safety Strategy was launched by NHS England in 2019, it was estimated that its work could avoid 1,000 deaths and save the system £100m each year from 2024. By April 2024, the Strategy's patient safety improvement programmes showed demonstrable impact with over 1100 neonatal lives saved, over 400 fewer cerebral palsy cases in premature babies, and more than 500 opium-related deaths prevented. The Strategy's major delivery programmes include the Patient Safety Incident Response Framework (PSIRF), the Learn From Patient Safety Events (LFPSE) service, the NHS Patient Safety Syllabus, and the Framework for Involving Patients in Patient Safety. By the end of 2023/24, 83% of Trusts had transitioned to PSIRF, 81% of Trusts had transitioned to LPFSE, over 850,000 staff had completed Level 1 of the patient safety syllabus (the first standardised approach to patient safety training across the NHS) and work continued to embed the Patient Safety Partner role within NHS Trusts.

The Department is sponsoring two statutory inquiries: the Thirlwall Inquiry which is examining the events at the Countess of Chester hospital, where Lucy Letby was a neonatal nurse, and the Lampard Inquiry which is investigating mental health inpatient deaths in Essex from 2000 to 2023. Both inquiries started their public hearings in September 2024 and will be key to ensuring continuous improvement for quality and patient safety. The Department also sponsors the Fuller Inquiry, a non-statutory inquiry 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. The Phase 1 Report was published in November 2023 and identified failures of management, governance, regulation, and lack of curiosity enabling Fuller's repeat offending. Phase 2 will look at the wider national lessons for the NHS and that report is due in Summer 2025.

In February 2024, the then Government and NHS England announced plans to implement Martha's Rule in at least 100 acute or specialist NHS sites in England by March 2025. Martha's rule is an initiative that gives patients and their families who are concerned about deterioration in their physiological condition the right to initiate a rapid review of their case from someone outside of their immediate care team.

In the reporting period 2023/24, the Health Services Safety Investigations Body (HSSIB) published 17 investigation reports (8 reports published under the previous body 'HSIB' and a further 9 reports published when the body transitioned from HSIB to HSSIB and was formally established in October 2023). HSSIB made a total of 22 national safety recommendations and 19 safety observations to organisations across the heath system. It also launched 12 new investigations. HSSIB are on track to publish 20 investigation reports from April 2024 to March 2025. HSSIB also experienced a significant increase in the number of people enrolling onto their education programme, commenced work on developing a new strategy and investigation criteria and published its first Annual Report and Accounts (which was presented to Parliament in July 24).

NICE quality standards

NICE quality standards are concise sets of prioritised statements designed to drive and measure quality improvements within a particular area of health or care. Between 1 April 2023 and 31 March 2024, NICE fully updated 7 quality standards, including standards on skin cancer, alcohol-use disorders and epilepsy. NICE also aligned 35 quality standards with updated guidance.

Overall Assessment (section 1A)

The Secretary of State's assessment is that progress was significantly challenging against the duty under section 1A of the 2006 Act to secure continuous improvement in the quality, effectiveness and safety of services provided to individuals. On 12 September 2024, Lord Darzi's report following his investigation of the state of the NHS, which assessed patient access, quality of care and the overall performance of the health system, was published. The report's findings, which the Department and NHS England will take forward, identified the NHS as broken but not beaten, and that improvements were required across these areas to support the 10-year plan for health that will make the NHS fit for the future.

Assessment for section 1C (duty as to reducing inequalities)

An update on public health and health disparities can be found under Priority Outcome 4 of the Performance Report in the Department of Health and Social Care Annual Report and Accounts 2023-24 and the Public Health Outcomes Framework (last updated on 6 August 2024).

From a clinical perspective, NHS England has a 'Core20PLUS5' approach focused on improving the 5 clinical areas at most need of accelerated improvement (cardiovascular disease, cancer, respiratory, maternity and mental health outcomes) in the poorest 20% of the population, along with other disadvantaged population groups identified at a local level.

To support delivery, NHS England has established initiatives such as 'Core20PLUS5 Connectors', which supports community-based approaches to addressing inequalities by recruiting people with lived experience to help bridge between healthcare services and communities.

Overall Assessment (section 1C)

The Secretary of State's assessment of how well the health inequalities duty has been fulfilled in 2023-24 is that there was limited progress, but as Lord Darzi's report clearly stated, more can and must be done in the years to come. The Government's health mission aims to increase healthy life expectancy by preventing premature mortality and shortening time spent in ill health.

DHSC group financial performance

DHSC is accountable to Parliament for ensuring that total spending by all bodies within the DHSC group is contained within the overall budgets approved by Parliament per table 5 (table may not sum due to roundings).

Table 5: DHSC departmental outturn 2023-24 against parliamentary and HM Treasury controls

	Budget £m	Outturn £m	Underspend/ (overspend) £m	Key disclosure notes/further detail
Parliamentary controls:				
Resource departmental expenditure limit (RDEL)	183,861	182,819	1,043	SOPS 1.1, Annex B
of which: resource administration	*3,119*	*2,571*	*547*	*SOPS 1.1, Annex B*
Capital departmental expenditure limit (CDEL)	10,989	10,519	470	SOPS 1.2, Annex B
Resource annually managed expenditure (RAME)	(2,272)	(9,730)	7,458	SOPS 1.1
Capital annually managed expenditure (CAME)	106	32	74	SOPS 1.2
Net cash requirement	164,270	160,749	3,520	SOPS 3
Further HM treasury controls:				
Ringfenced resource DEL	5,373	4,724	649	Annex B
Non-ringfenced resource DEL	178,488	178,095	394	Annex B

Resource departmental expenditure limit (RDEL)

DHSC's 2023-24 budgets were agreed as part of the 2021 Spending Review (SR21). During 2023-24, DHSC faced challenges to contain inflationary pressures and increasing costs within agreed SR21 funding, however, through careful prioritisation and financial management, expenditure was contained within budgetary limits.

DHSC underspent the available RDEL non-ringfenced funding by circa £0.4 billion (0.2% of the budget), as follows:

- **Funding for NHS pay/ industrial action:** £0.3 billion related to NHS pay and industrial action costs that were lower than those predicted when agreeing the final budget; and

- **Other programmes:** the remaining £0.1 billion underspend occurred across a range of programmes. This is equivalent to 0.1% of the budget.

DHSC underspent the available RDEL budget ringfenced for depreciation and impairments by circa £0.6 billion (12% of the budget). This was because actual expenditure was lower than the forecasts available when agreeing the final budget in the Supplementary Supply Estimate.

Capital departmental expenditure limit (CDEL)

DHSC's 2023-24 budgets were agreed as part of the 2021 Spending Review (SR21). Details of the changes to the capital budget since SR21 are set out on page 7 of the

Department's Supplementary Supply Estimate memorandum. £10.5 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.

DHSC underspent the available capital funding by circa £0.5 billion (4.3% of the capital budget), most of which was unavoidable due to uncertainty and complexity, including:

- **IFRS 16:** like other government departments, since 2022-23 DHSC has followed IFRS 16, the international accounting standard for leases, and additional capital funding was secured for its 2023-24 impact. However, the associated capital costs in 2023-24 were around £0.3 billion lower than expected.

- **Other capital:** the remaining £0.2 billion underspend occurred across a range of capital budgets and is equivalent to 1.9% of the capital budget.

Further detail on the RDEL and CDEL outturns is set out in **Annex B**.

Annually managed expenditure (AME)

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

DHSC underspent the resource AME (RAME) limit by circa £7.5 billion. This mainly comprised lower than planned AME in NHS Resolution (NHSR). Following changes to the discount rate 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, including assumptions around inflationary costs, the estimated quantum of future clinical negligence expenditure was £6.6 billion lower than the forecast used to set the final budget. Further detail on the AME outturn is set out in **Annex B**.

Net cash requirement

DHSC underspent against its cash limit by circa £3.5 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 £0.9 billion of the underspend is explained by the resource non-ringfenced and capital DEL underspends of circa £0.4 billion and circa £0.5 billion respectively. The balance is mainly due to working capital requirements being lower than estimated.

Sustainability

DHSC 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 help everyone to live healthy, independent 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 environmental sustainability at the heart of everything that we do, including our policymaking. This year, DHSC's work in this area has continued to develop and mature, as summarised in the section below.

DHSC's progress and key activity in 2023-24

Embedding sustainability

DHSC's sustainability team, which is focused on our departmental estate and operations, has successfully recruited 2 new staff members, expanding its total headcount and increasing workforce capacity to deliver upon our internal sustainability strategy.

DHSC continues to actively engage with our community of ALB colleagues leading on sustainability and we host regular group forums, including 2 during 2023-24. This acts as a mechanism by which we can exchange best practice, identify opportunities for collaboration and monitor progress towards our shared environmental goals.

We have developed a bespoke carbon literacy training course for DHSC and its ALBs, working closely with the NHS Business Services Authority (NHSBSA) and the Carbon Literacy Project. On Carbon Literacy Action Day (4 December 2023), we worked collaboratively to launch this among sustainability colleagues spanning 7 ALBs, as a catalyst for further rollout within their organisations as desired. We plan to commence our internal DHSC training programme in 2024-25.

A short, introductory pack has been created for presentation to staff groups across DHSC, focused on the importance of sustainability and how all colleagues can support within their various spheres of influence. This was delivered to the adult social care group in November 2023, and we plan to extend this across DHSC in the coming year.

Our staff organised 3 environmental volunteering days this year, joined by 19 colleagues. This included 2 litter picks near DHSC's Leeds and London headquarters, where they collected 50 bags of rubbish. Staff also volunteered with Leeds City Council to support woodland management and the removal of invasive plant species at a public park.

DHSC's green network formed a new committee and refreshed its membership, now comprising 46 colleagues. They continue to raise awareness among staff around the climate and nature emergency and its interaction with health, highlighting relevant work taking place across DHSC. This included producing internal communications and co-organising an expert panel event to reflect upon Health Day at COP28 in December 2023.

We have delivered a comprehensive work programme to implement and embed the Environmental Principles Policy Statement duty across DHSC and its ALBs. This included incorporating the duty within standard departmental policymaking processes and providing accessible materials/training to support policymakers and ministers to effectively consider environmental impacts of their policies. We continue to work closely with the Department for Environment, Food and Rural Affairs (DEFRA) and other government departments to share lessons learnt and improve our related practices.

Sustainability considerations are factored into DHSC's project and programme management assurance processes (e.g. gateway reviews) where relevant to the stage that the project/programme has reached. For construction specifically, net zero requirements are considered at the investment appraisal stage. This year, DHSC engaged with the Infrastructure and Projects Authority (IPA) in their development of sustainability data capture as part of Government Major Projects Portfolio (GMPP) quarterly reporting.

Buildings and energy use

Following an earlier prioritisation exercise, DHSC has continued to focus on its 2 highest priority buildings for sustainability – Seaton House in Nottingham and Wellington House in London (selected due to our expected lengths of occupancy and degree of control).

At Seaton House, we secured funding from Government Property Agency (GPA) for a net zero project. We are now liaising with GPA to prepare for the delivery of LED lighting and solar panels in 2024-25, with heat decarbonisation expected to follow in 2025-26. This is anticipated to generate savings of around 33 tonnes of CO_2 equivalent (tCO_2e) per year.

In tandem, DHSC is embarking on a wider office refurbishment project at Seaton House. We aim to do so in an environmentally conscious way and have sought ideas from staff on potential sustainability initiatives at the site via a survey and workshop. We are currently exploring options for furniture reuse.

At Wellington House, our GPA-funded project to remove incandescent lighting and replace this with less energy intensive LEDs is now complete. Discussions have also begun with GPA around the possibility for further decarbonisation initiatives at the building.

Our facilities management provider has continued its building management system (BMS) optimisation project at Wellington House, which, over a 12-month period, has significantly reduced electricity and gas use with associated cost savings of over £100,000.

We are currently refurbishing some areas within our second headquarters, Quarry House in Leeds. The scope of this refurbishment project is too small to derive a meaningful BREEAM (Building Research Establishment Environmental Assessment Method) rating. 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. This year, 100% of waste generated was diverted from landfill. Around 88% of spend was in the local area (within 40 miles) and 82% of labour was local.

Travel

DHSC's travel and expenses policy currently states that, where travel is business critical, with no reasonable digital alternatives, staff must select the most sustainable 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 to access the flight booking system.

We are now working to implement a strengthened policy around domestic business flights, following recent internal approval. This will clarify that they are not permitted unless under defined exceptional circumstances, given the significant environmental impacts.

Our security team have also commenced a review of DHSC's overseas business travel policy. The sustainability team are providing input via an advisory group, to incorporate environmental considerations and identify any opportunities to support our net zero goal.

DHSC's active travel network relaunched this year, with 35 founding members, including site-specific champions at our Leeds and London headquarters. The network aims to support staff to cycle, run, walk and incorporate other physical activity into their commute. DHSC has an active travel guide for colleagues, outlining the provisions and facilities available, which is updated regularly.

Waste

In 2023-24, DHSC procured approximately 601,884 consumer single-use plastic (CSUP) items, of which 55% related to cleaning (please note that the cleaning data includes some estimates, where actual data was not available from DHSC's supplier), 38% to catering and 7% to stationery. We have begun preparatory work with the aim of removing CSUPs from our estate by 2025. For cleaning and catering, we have considered how the requirement to be CSUP-free could be embedded within our future contracts. For stationery, we are in discussions with our supplier to understand the availability of CSUP-free alternatives to our frequently ordered items, to form part of a new stationery ordering process within DHSC in the coming year.

In 2023-24, we have generated approximately 0.29 tonnes of food waste (incorporating some estimated data within quarter 1 and quarter 4, where actual data was not available from the supplier) at our two offices with catering facilities (Wellington House and 39 Victoria Street in London). Our catering provider now donates any surplus food items to a third party for redistribution.

Water

This year, we renewed the water monitoring system in place at 3 of our offices (Wellington House and 39 Victoria Street in London, and Premier House in Reading), whereby individual sensors on each water meter provide 24-hour major leak detection, flow rates and temperature levels.

Sustainable procurement

DHSC has implemented and embedded Procurement Policy Note (PPN) 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, or otherwise be excluded from bidding. For new contracts not within scope of PPN 06/21, our standard terms and conditions also include obligations on suppliers to provide annual carbon reduction plans. For existing contracts, we have contacted suppliers to request carbon reduction plans, in priority order, based on contract value and level of risk.

This year, we implemented PPN 01/24, which introduces an optional standard carbon reduction contract schedule, by strongly recommending its use as best practice, as early in the procurement process as possible and throughout the commercial lifecycle. To best support net zero, our commercial professionals are encouraged to consider the benefits of applying both PPN 06/21 and PPN 01/24 to any contract, regardless of value, where it has direct environmental impacts or the relevant industry is known to be carbon intensive.

DHSC continues to maintain full compliance with PPN 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 to record social value achievements against our contracts, monitor compliance and report quarterly progress directly to Cabinet Office.

We continue to refine the processes, training and support for our commercial professionals in applying these net zero and social value procurement policies, cascading this to our ALBs to ensure a consistent approach. Guidance is tailored to different categories of products/services and market capabilities, to ensure that our policy application is relevant, appropriate and proportionate, generating greater value and more sustainable outcomes.

DHSC has implemented PPN 02/23, on tackling modern slavery in government supply chains, in all standard practices. We provide guidance on the circumstances under which our commercial professionals must use the Modern Slavery Assessment Tool. Additional provisions are included in our standard terms and conditions for high-risk contracts and those with strategic suppliers, focused on ensuring supplier cooperation when obtaining supply chain visibility. We are collaborating with NHS England to develop and deliver an approach to modern slavery risk assessment that can be standardised across the health group.

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. Our estates team meets with our catering supplier on a monthly basis to monitor performance, and any issues with adherence to government buying standards would be addressed at this forum. In the coming months, we intend to gather staff feedback and engage with our supplier further to explore potential sustainability initiatives at our catering facilities.

Nature recovery

Whilst DHSC does not have significant landholdings (relating to the core department itself, and not including, for example, the NHS estate, which is reported on separately by NHS England), we recognise that everyone has a role to play in making space for wildlife and so, in our internal sustainability strategy, we have committed to maximising our estate's contribution to nature recovery. In line with the biodiversity duty in the Environment Act 2021, DHSC has now taken its first consideration of action to conserve and enhance nature, seeking expert advice from Natural England for our 2 highest priority buildings for sustainability. This will inform our creation of a nature recovery plan during 2024-25, supporting the Greening Government Commitments.

Climate change adaptation

As per the Greening Government Commitments, DHSC is committed to developing its own departmental climate change adaptation strategy. In 2023-24, we have sought supporting resources and examples of best practice from across government and our ALBs, which will assist us as we produce our own strategy in the coming year.

DHSC is working alongside other government departments and health system partners to take action to adapt to the health impacts arising from climate change. This includes those within UK government's third National Adaptation Programme, published in Summer 2023 – that is 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. This work supports government to better prepare and protect the UK health system against the changing climate.

ICT and digital

DHSC continues to provide membership to the cross-government Sustainable Technology Advice and Reporting (STAR) group, and, this year, 2 DHSC representatives attended a related, cross-government summit, enriching our knowledge around digital sustainability. We continue to report to DEFRA annually on our departmental progress against the Greening Government ICT and Digital Services Strategy.

In 2023-24, DHSC's data hosting was responsible for approximately 19 tonnes of carbon dioxide equivalent (tCO_2e). We produced 14 tonnes of ICT waste (this related to, for example, the decommissioning of 2 data centres and some user devices as we

transitioned to a new ICT supplier) – of this, 11% was reused via charity donation and 89% was recycled, with zero to landfill. DHSC is not reporting any expenditure related to ICT waste disposal, as we do not receive an additional charge for this service from our ICT supplier. To promote resource efficiency, we continue to operate a single best-suited device policy for staff (only issuing smartphones upon request, for example) and we reuse laptops and smartphones until they are no longer serviceable.

To reduce the environmental impacts of our ICT and digital services, we have committed to a series of actions for 2024-25, which aim to, for example, minimise the footprint of our data hosting and further embed circular economy principles. As we have transitioned to a new ICT supplier this year, this provides a 'clean slate' from which to make improvements and an opportunity to collaborate on proactive sustainability initiatives going forwards; this will be supported by a monthly social value and sustainability board operated by our supplier.

Task Force on Climate-related Financial Disclosures (TCFD)

DHSC has reported on climate-related financial disclosures consistent with HM Treasury's TCFD-aligned disclosure application guidance, which interprets and adapts the framework for the UK public sector. DHSC has complied with the TCFD recommendations and recommendations disclosures around governance (all recommended disclosures) and metrics and targets (disclosures (b)). This is in line with central government's TCFD-aligned disclosure implementation timetable. DHSC plans to make disclosures for strategy, risk management and metrics and targets disclosures (a) and (c) in future reporting periods, in line with the central government implementation timetable.

TCFD – governance

Disclosures around governance are for the core department only and do not cover ALBs, as there is a varied landscape across our various organisations, which cannot currently be conflated into a singular statement. In-scope ALBs will be required to provide their own TCFD-aligned disclosures within their ARA.

In 2022-23, our sustainability team launched an internal sustainability strategy for DHSC's estate and operations, after receiving endorsement from directors across DHSC and the second permanent secretary at our people board. This work is directly overseen by the director for workspace, information, security and technology and 2 other directors also agreed to support as senior sponsors – the North West regional director for public health and director for the Better Care Fund and hospital discharge.

In 2023-24, we established a sustainability delivery board to monitor progress against this strategy. This brings together various teams responsible for its delivery (including estates, travel, procurement, technology, communications and our green network), providing a holistic view of the relevant work taking place. The board is co-chaired by our 2 director-level sponsors, with the sustainability team acting as secretariat, and it serves as a forum

by which to highlight, track and address any climate-related risks, issues and opportunities for DHSC; in instances where critical matters emerge between meetings, these are also escalated to co-chairs on an ad hoc basis, where senior support is required. The board convened 3 times this year and will continue to do so on a quarterly basis.

Following each quarterly board meeting, the sustainability team produces a report for DHSC's executive committee (ExCo), summarising messages heard, including any key climate-related risks, issues and opportunities. In line with meetings held thus far, ExCo received 3 sustainability reports in 2023-24, with these updates sponsored by their deputy chair, the second permanent secretary. These included details of progress made towards our net zero target, plus the proactive work taking place to reduce DHSC's environmental footprint, to make us more resilient to climate impacts and to embed sustainability into our departmental culture. Reports are reviewed by ExCo members, with an opportunity to discuss at their meeting as needed; this equips them with knowledge that can then inform other decision-making groups of which they are part, with ExCo members having a line of sight across its various sub-committees, including investment committees.

In 2023-24, DHSC also supported the completion of 2 relevant audits by Government Internal Audit Agency (GIAA) and both final reports were shared with the second permanent secretary and finance director general. The first, focused on sustainability reporting, provided assurances that 'there are adequate processes in place within DHSC to capture the required sustainability data in the Department'. However, this audit also considered our ALBs and provided a 'limited' rating overall, highlighting the need for improvements in our group-level assurance processes; a relevant action for DHSC has now been closed, after we issued guidance to ALBs on the recommended process to ensure that their data is accurate and complete prior to submission.

The second audit, part of a cross-government net zero review, found that there were 'adequate overarching governance frameworks and processes in place to deliver the DHSC net zero priorities and to meet the Department's Greening Government Commitment (GGC) reporting requirements'. DHSC were provided with a 'moderate' rating, with some low to medium priority actions that we will work to address by the end of 2024.

For further context on DHSC's broader governance structures, please see the 'governance statement' section of this report.

TCFD – metrics and targets

DHSC calculates its own scope 1, 2 and 3 emissions on a quarterly basis, in line with our Greening Government Commitments reporting requirements, and combines this with counterpart data from our in-scope ALBs. This data is summarised in **Table 7** below.

UN Sustainable Development Goals

DHSC's internal business plan links our departmental objectives with strategic enablers and the UN Sustainable Development Goals (SDGs), as summarised in **Table 6** below. Our latest progress can be found in the performance section of this report.

Table 6: Links between DHSC's objectives and the UN SDGs

SDG	Linked Objectives
SDG 3: Ensure healthy lives and promote well-being for all at all ages.	Opening opportunities to good work, supporting a healthier, more productive and inclusive nation.
SDG 5: Achieve gender equality and empower all women and girls.	Improve the lives and outcomes of people with mental health needs and disabilities, by raising awareness of these conditions, prevention and increasing access to high quality, person-centred care in the most appropriate setting and improve women's health outcomes, including the way the health and care system listens to women.
SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.	Lead on the public health policy, evidence and delivery of services to prevent and reduce the health impact caused by drugs, tobacco, alcohol and gambling, and support the health outcomes of socially excluded groups. Opening opportunities to good work, supporting a healthier, more productive and inclusive nation. Develop our leaders, capability and skills to create an inclusive and great place to work. Provide commercial leadership, oversight and assurance for DHSC and the wider health and care system to deliver value for money and improved outcomes.

SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation.	To ensure that the health and care system has a resilient supply chain of safe and high-quality products, achieve value for money, embeds sustainability, has access to and adoption of innovative products, and has a smooth and managed transition on MedTech issues relating to the UK's exit from the EU and COVID-19 recovery.
SDG 10: Reduce inequality within and among countries.	Lead on the public health policy, evidence and delivery of services to prevent and reduce the health impact caused by drugs, tobacco, alcohol and gambling, and support the health outcomes of socially excluded groups.

Rural proofing

The Health and Care Act 2022 established integrated care boards and integrated care partnerships, which strengthen the partnerships between the NHS and local authorities and improve 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.

Integrated care boards have produced the first iteration of their joint forward plans, setting out their five-year strategies to arrange and provide NHS services to meet their population's physical and mental health needs. NHS England has issued further guidance for integrated care boards to update their joint five-year forward plan, providing the opportunity to reflect 2024-25 priorities and operational guidance.

Greening Government Commitments

Tables 7 to 12 combine data from both DHSC and its in-scope ALBs, demonstrating our collective performance against the Greening Government Commitments, with a 2017-18 baseline year. In-scope ALBs are CQC, HRA, Human Fertilisation and Embryology Authority (HFEA), Human Tissue Authority (HTA), MHRA, NHSBSA, NHS Counter Fraud Authority (NHSCFA), NHS England, NHSR, NICE and UKHSA.

They also allow comparison with our performance in 2021-22 and 2022-23 – the previous reporting years under the current framework. The targets referenced are the overall aims by 2024-25, rather than progress that is left for us to make.

Table 7: Overall greenhouse gas emissions (tCO_2e)

	2017-18 (baseline)	2021-22	2022-23	2023-24	Performance	Target by 2024-25
Scope 1	16,699	9,668	6,134	6,204	−63%	−20%[1]
Scope 2	23,703	11,870	8,099	8,442	−64%	-
Scope 3	5,469	2,271	3,955	4,620	−16%	-
Total	**45,871**	**23,809**	**18,188**	**19,266**	**−58%**	**−44%[2]**

Within the health group, £29,635 was spent on accredited carbon offsets in 2023-24.

1. This target relates to scope 1, defined by the Greenhouse Gas Protocol as comprising direct emissions from sources that our organisations own or control.
2. This overall target covers scope 1, 2 and 3 emissions. Scope 1 emissions are defined in the previous footnote. Scope 2 comprises indirect emissions from the generation of electricity that our organisations purchase. Scope 3 comprises other indirect emissions that occur in our organisations' value chains; for the purposes of the Greening Government Commitments specifically, this includes emissions from business travel (excluding international flights and staff commutes) and electricity transmission/distribution only.

Table 8: Energy use (kWh)

	2017-18 (baseline)	2021-22	2022-23	2023-24		
				kWh	£	Performance
Gas	74,683,131	50,071,329	30,355,246	29,430,465	£1,568,162	−61%
Gas oil	5,504,907	230,614	1,509,385	856,865	£85,283	−84%
Electricity	67,422,670	55,905,390	41,883,125	40,770,048	£9,624,371	−40%
Diesel oil	-	-	-	10,571	£1,533	-
Hydrotreated vegetable oil	-	199,910	-	50,000	£8,975	-
Electricity from renewable sources	-	1,386,917	1,316,825	1,333,778	-	-
Heat from non-renewable sources	584,699	-	-	-	-	−100%
Total	**148,195,407**	**107,794,160**	**75,064,581**	**72,451,727**	**£11,288,324**	**−51%**

Table 9: Business travel (tCO_2e)

		2017-18 (baseline)	2021-22	2022-23	2023-24 plus distance travelled and expenditure			Performance	Target by 2024-25
Rail		1,688	370	1,277	1,717	48,448,201km	-	+2%	-
Road		1,968	1,064	1,906	2,141	13,511,894km	-	+9%	-
Air	Domestic	453	24	134	156	971,772km	-	−66%	−30%
	International	2,304	228	785	1,628	12,595,535km	-	−30%	-
Total		**6,413**	**1,686**	**4,102**	**5,642**	**75,527,402km**	**£17,498,063**	**−12%**	**-**

Of the distance travelled by international air, 11% is associated with short haul journeys and 63% with long haul, with the remaining 26% unknown. Broken down by flight class, 78% were economy, 3% premium economy, 10% business, with the remaining 9% unknown.

With regards to our progress against the Government Fleet Commitment, 92% of our vehicle fleet is made up of ultra-low emissions vehicles (ULEV). 77% of our vehicle fleet are zero emissions at the tailpipe, putting us in good stead to achieve the 100% zero emissions target for 2027.

Table 10: Waste (tonnes)

	2017-18 (baseline)	2021-22	2022-23	2023-24	2023-24 plus expenditure	Performance	Target by 2024-25
Recycled	1,410	1,210	1,418	997	£200,562	−29%	-
Composted/food waste	-	30	32	37	£26,201	-	-
Incinerated with energy recovery	176	473	551	458	£323,125	+160%	-
Incinerated without energy recovery	189	159	150	150	£120,223	−21%	-
Landfill	1,738	457	21	17	£8,459	−99%	-
Total	**3,513**	**2,329**	**2,172**	**1,659**	**£678,570**	**−53%**	**−15%**

Waste that is recycled (including waste composted) represents 62% of overall waste (against a target of at least 70% by 2024-25), and waste to landfill represents 1% (against a target of less than 5% by 2024-25).

Table 11: Paper purchased (A4 reams)

2017-18 (baseline)	2021-22	2022-23	2023-24	Performance	Target by 2024-25
150,215	28,175	30,145	35,265	−77%	−50%

Table 12: Water consumption (m^3)

2017-18 (baseline)	2021-22	2022-23	2023-24	2023-24 plus expenditure	Performance	Target by 2024-25
283,469	170,720[1]	161,212	149,226	£431,572	−47%	−8%

1. This figure has been amended due to a retrospective update to our 2021-22 water consumption data.

Other performance reporting

Parliamentary questions (PQs)

Between April 2023 and March 2024, DHSC processed 8,515 PQs, more than any other government department, although volumes were reduced by 24% compared to the previous year. In the 2023-24 session (November 2023-May 2024), our Ordinary PQ on-time rate was on-target, at 85%. However, our Named Days performance was 74%, which although an improvement on the previous session, was still short of our target.

We have made sustained progress in terms of our PQ performance, and we are now consistently meeting our targets for Commons Ordinary PQs. However, we continue to look at how we can make further improvements in the months ahead. For example, DHSC continues to focus on increasing the on-time rate of Commons Named Day PQs through various initiatives across the breadth of DHSC.

Freedom of information (FOI) requests

In calendar year 2023, we responded to 1,665 FOI requests. DHSC answered 95 per cent of these within the statutory 20 working day deadline (or public interest extension). The overall volume of FOIs received has remained in line with the volumes received in the previous year (1,633). Last year, DHSC's compliance rate was 87 per cent and we maintained our commitment to recovering this to meet the ICO's target of 90 per cent. DHSC's compliance rate was 95 per cent for the year, which was an increase of 8 per cent for the full year, bringing compliance above the ICO's target.

Correspondence and complaints

As shown in **Table 13**, we answered 29,515 letters and emails due in 2023, compared to 31,323 in the previous year. This shows that receipts have now stabilised following the pandemic but continue to remain elevated overall. 60 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 2023 and not the financial year 2023-24. DHSC is committed to improving performance on ministerial correspondence to the cross-government target of 80%.

Table 13: Other classes of correspondence 2023

Case Type	Due in 2023	Answered on time	Percentage on time
Ministerial	15,752	6,710	42.6%
Public	13,763	10,999	79.9%
Total	**29,515**	**17,709**	**60.0%**

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

In 2023-24 DHSC received 9 complaints.

As shown in **Table 14**, in 2022-23 (the last year for which published results are available), the PHSO received 74 enquiries regarding complaints about the core department, of which 22 progressed to assessment. Zero cases progressed to investigation.

Table 14: PHSO complaints 2022-23

Enquiries received	Assessed	Accepted for investigation[1]	Investigation upheld/partly upheld	Investigations not upheld	Investigations resolved through intervention[2]	Investigations resolved without a finding[3]
74	22	0	0	0	0	0

1. 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. For example, the PHSO may have accepted a complaint for investigation in 2017-18 but not completed it until the following year 2018-19. Similarly, it may have completed an investigation in 2017-18 which we originally accepted for investigation in the previous year 2016-17.
2. These are complaints where PHSO starts an investigation but can resolve the complaint without having to formally complete the investigation.
3. 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

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.

Table 15 details the percentage and value of undisputed invoices paid by NHS provider organisations within the agreed terms over the last 3 years.

Table 15: Prompt payment of undisputed invoices

	NHS providers invoices paid within target	
Financial Year	Percentage	Value (£m)
2023-24	91	73,667
2022-23	90	62,847
2021-22	91	58,294

Source: NHS provider accounts

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. The BPPC target is to pay 95% of undisputed invoices within 30 days.

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

DHSC's expenditure on official development assistance (ODA) totalled £394.24 million in the 2023/2024 financial year.

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.

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).

The DHSC's ODA activities support the UK government's commitment to 'strengthen global health security, reform the global health architecture, strengthen health systems in the UK and globally and advance the UK's position as a leader in global health science and technology' (Global Health Framework), focussing mainly on several areas of global health, including global health research and global health security.

There are two main DHSC ODA spending portfolios –managed by the global health research (GHR) and global health security (GHS) teams. These are complemented by a project which supports the implementation of the World Health Organization's (WHO's) Framework Convention on Tobacco Control and the Global Health Workforce Programme, which building the capacity of the global health workforce to implement it.

The GHR portfolio supports high-quality applied health research and research capacity building 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 (NIHR), through partnerships with other global funders. In 2023, 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.

In 2023, the GHS programme has helped developing countries to better prevent and detect health threats, such as antimicrobial resistance (AMR); and to provide rapid and effective response to emerging health threats. GHS research activities funded innovative early-stage research in specific vaccines and new innovative technologies to prevent diseases of epidemic potential, and to improve the pipeline for new therapeutics and diagnostics that tackle AMR in LMICs.

DHSC 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.

DHSC funds the first twelve months of asylum seekers' healthcare costs following their arrival in the UK. In the 2023/2024 financial year, healthcare support was also provided to refugees under the Afghanistan resettlement programme and Ukraine schemes.

Performance Report Accounting Officer Sign-Off

12 December 2024
Sir Chris Wormald KCB
Permanent Secretary

Accountability report

Lead non-executive board member's report

The 2023-24 period has seen some vital recovery plans launched to continue the return to pre-pandemic NHS waiting times as well as ambitious targets for the future such as the smokefree generation programme.

The board met 4 times in 2023-24 with good attendance from ministers, officials, and non-executive directors. The board's agenda focused on DHSC's performance, the adoption of innovation across the health and care services, winter planning and productivity.

The past year saw a change of Secretary of State for Health and Social Care and new members of the ministerial team. So, the board also devoted attention to the progression of their ambitions and plans for the health and social care system.

In April 2023 we welcomed both Sir Roy Stone and Will Harris to the non-executive team. Sir Roy brings extensive experience of the workings of parliament and government, and Will brings knowledge in advertising and digital. In September 2023, Baroness Lampard left the non-executive team to chair the Lampard inquiry and I took up the role of the lead non-executive, initially on an interim basis and am delighted to have since been appointed for the remainder of my term. In March 2024, the Secretary of State announced the appointment of Steve Rowe as a non-executive director. Steve has significant experience of delivery in large organisations. In a further addition, Richard Douglas, the current Chair for NHS South East London Integrated Care Board and former director general of finance in DHSC from 2007-2015 has also been appointed to the DHSC board as a non-executive director. His background in financial management will be invaluable for the board. I am grateful for the continued valuable contributions from all my fellow non-executive directors.

The audit and risk committee (ARC) continued with Gerry Murphy as chair and held four committee meetings over the year. It discussed DHSC's finances, risks, accounts, and internal audit reviews, and provided challenge to DHSC and arm's length bodies (ALBs) on particular areas of performance through regular deep dives on policy and risk areas. The ARC, led by Gerry, were instrumental in assisting in the delivery and sign-off of the annual report and accounts. I thank Gerry for his dedication to his role on the board.

The nominations and governance committee welcomed Sir Roy Stone as a formal member in his capacity as the non-executive leading on talent management. The committee discussed director general talent and performance as well as non-executive director recruitment and succession planning.

Non-executive directors, through their membership on the performance and risk committee (PRC), have provided further external challenge and scrutiny of DHSC's performance on key priorities, objectives, and manifesto commitments, as well as the DHSC risk register. The PRC met 4 times over the year.

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 DHSC's work such as the NHS app, workforce planning, public health, and preparation for the COVID-19 Inquiry as well as offering advice and support to DHSC on an ad hoc basis.

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

Samantha Jones
Lead non-executive director

Accountability report

DHSC 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 2024

Rt Hon Victoria Atkins MP

Secretary of State for Health and Social Care
Chair of the Departmental Board
Appointed 13 November 2023

Helen Whately MP

Minister of State for Social Care
Appointed 26 October 2022

Andrew Stephenson MP

Minister of State
Appointed 13 November 2023

Maria Caulfield MP

Women's Minister (GEO) and Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy
Appointed 27 October 2022

Rt Hon Andrea Leadsom MP

Parliamentary Under Secretary of State
Appointed 13 November 2023

Lord Markham CBE

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

Other ministers who served in DHSC during 2023-24 were:

- Rt Hon Steve Barclay MP - Secretary of State for Health and Social Care to 12 November 2023

- Will Quince MP - Minister of State for Health and Secondary Care to 12 November 2023

- Neil O’Brien MP - Parliamentary Under Secretary of State for Primary Care and Public Health to 12 November 2023

Our non-executive board members at 31 March 2024

Samantha Jones

Non-executive director since 14 February 2023
Lead non-executive director from 1 December 2023 to 7 November 2024

Samantha was appointed as a non-executive director (NED) at DHSC 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.

Gerry Murphy

Non-executive director and chair of audit and risk committee
1 August 2014 to 31 July 2024

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 and 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 to 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 adviser for Permira.

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

Sir Roy Stone

Non-executive director
24 April 2023 to present

Roy has experience as a former senior civil servant. He has been a government affairs and parliamentary consultant having previously been a specialist adviser to the Chancellor of the Duchy of Lancaster and former No.10 Chief of Staff.

Other experience includes being the Director of House of Commons Business Manager where he was the principal adviser to the Leader of the House of Commons, Chief Whip and their respective ministerial teams, Principal Private Secretary to the Government Chief Whip and Private Secretary to the Government Chief Whip. Other career history includes being a parliamentary clerk to Prime Ministers Margaret Thatcher, John Major and Tony Blair and the Duty Clerk for 10 Downing Street. He started his career in the Ministry of Defence working in supply and the Procurement Executive.

Will Harris

Non-executive director
24 April 2023 to 18 September 2024

Will is currently the founding executive at Bridge F61, a marketing consultancy. His prior experience includes being the chief marketing officer for Battersea Power Station, chief strategy and marketing officer for Karhoo, CEO of Mission Media, Business Director at WPP and chief marketing officer at LVMH, chief marketing officer for Nokia, CEO at The Bank, chief marketing officer for The Conservative Party, with other early experience at O2, AMV BBDO and WCRS. He is currently a

non-executive at The London Library and was formerly a NED at Nottingham Trent University.

Steve Rowe

Non-executive director
11 March 2024 to present

Steve is the former CEO of Marks & Spencer plc retiring from the business in July 2022 after nearly 40 years. During that time, he held a wide range of executive positions as a director including operations, e commerce, and running both the food and clothing divisions.

Subsequently, he was an adviser to the former Secretary of State for Health and Social Care Steve Barclay on efficiency and has advised a few small businesses.

Previous non-executive posts include roles on the governance committee as co-chair of the human rights pillar for The Consumer Goods Forum and strategic board member at the New West End Company. Steve is also an independent non-executive of Westfalia Fruit International.

Sir Richard Douglas

Non-Executive Director
11 March 2024 to present

Richard's current roles include chair of the South East London Integrated Care System/Board, advisory role with Incisive Health, trustee for Place2be, a children's mental health charity, as well as a trustee of Demelza Hospice Care for Children. He has previously held NED roles with both NHS England and NHS Improvement. Prior to this he was a Director General at DHSC and has held various roles in the civil service that have had a financial focus. Richard held the role of Acting Permanent Secretary at DHSC for a brief period in 2010.

Other Non-Executive Directors who served in DHSC during 2023-24 were:

- Baroness Kate Lampard resigned as lead non-executive director and as a non-executive director on 30 September 2023

Our Executive Board Members at 31 March 2024

Sir Chris Wormald KCB

Permanent Secretary

Prof. Sir Chris Whitty

Chief Medical Officer

Shona Dunn CB

Second Permanent Secretary (left DHSC on 31 May 2024)

Andy Brittain

Director General Finance

Other senior officials at 31 March 2024

Clara Swinson CB
Director General for Global and Public Health (left DHSC on 23 September 2024)

Jonathan Marron CB
Director General for Primary Care and Prevention

Matthew Style
Director General for Secondary Care and Integration

Professor Lucy Chappell
Chief Scientific Officer

Michelle Dyson
Director General for Adult Social Care

Jenny Richardson
Director of Human Resources (career break 23 October 2023 to 29 March 2024)

Hugh Harris
Director of Ministers, Accountability and Strategy

Lorraine Jackson
Director DWP and DHSC Joint Work and Health Directorate

Other senior officials who served in the Department during 2023-24 were:

- Zoe Bishop – Interim Director of Human Resources (9 October 2023 to 16 April 2024)

Departmental disclosures

DHSC has a code of business conduct, which incorporates the principles set out in the Civil Service code and applies to all staff working in DHSC, including those who have authority or responsibility for directing or controlling DHSC.

Information on personal data-related incidents is reported to the Information Commissioner's Office and, if applicable, are included within the governance statement.

Register of interests

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.

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 is published as part of the quarterly transparency data also held on gov.uk website.

Any remunerated outside employments held by DHSC's senior civil servants (SCS) are also published online.

Further relevant interests of DHSC's senior leadership, as identified in the start of the accountability report section are detailed in the following register of interests table.

Register of interests for the 2023-24 financial year

NED	Held by	Name of company	Position held	Type of Interest	Other information
Doug Gurr	Self	CommentSold	Director	Minority equity interest	
Doug Gurr	Self	Natural History Museum	Director	Salary	
Doug Gurr	Self	Permira Ltd	Adviser	Fees	
Doug Gurr	Self	The Alan Turing Institute	Chair	Fees	
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	
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	NHS England	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	NHS Confederation	Trustee	Not remunerated	

Samantha Jones	Husband	National Association of Primary Care	Council Member	Not remunerated
Samantha Jones	Husband	CRN Thames Valley and South Midlands Partnership	Chair	Not remunerated
Samantha Jones	Self	Alzheimer's Society	Trustee	Not remunerated
Samantha Jones	Self	National Association of Primary Care	Adviser	Remuneration for work undertaken
Samantha Jones	Self	G Square Capital	Adviser	Remuneration for work undertaken
Samantha Jones	Self	Keys Group	Chair	Salaried
Samantha Jones	Self	Bain Consulting Group	Adviser	Remunerated for work undertaken
Samantha Jones	Self	CeraCare	Advisory Board Member	Shareholding
Samantha Jones	Self	Huma	Shareholder	Minor shareholding
Samantha Jones	Self	Accurx	Advisory and Board Member	Remuneration and shareholding
Samantha Jones	Self	HSBUK	Adviser	Remunerated for work undertaken
Samantha Jones	Self	PA Consulting	Adviser	Remunerated for work undertaken
Samantha Jones	Self	Carnall Farrar	Adviser	Remunerated for work undertaken
Samantha Jones	Self	System C	Adviser	Minor shareholding
Samantha Jones	Self	Samantha Jones Limited	Director	Shareholding
Sir Richard Douglas	Self	Inizio Evoke Incisive Health	Senior Counsel	Remunerated
Sir Richard Douglas	Self	South East London Integrated Care Board	Chairman	Remunerated
Sir Richard Douglas	Self	South East Medical Services Ltd	Director	Non-remunerated

Sir Richard Douglas	Self	Place2Be	Trustee	Non-remunerated	
Sir Richard Douglas	Self	Demelza Hospice Care for Children	Trustee	Non-remunerated	
Will Harris	Self	Nichols and Harris LLP	LLP designated member	LLP designated member	
Will Harris	Self	Bridge Consulting London Ltd	Director	Shareholding	
Will Harris	Self	Anglofive Ltd	Director	Shareholding	

Minister	Held by	Name of company	Position held	Type of interest	Other information
Andrea Leadsom	Husband	Hope Enterprises (Northampton) CIC	Director	Non-remunerated	
Andrea Leadsom	Husband	Northampton Hope Centre	Trustee	Non-remunerated	
Andrea Leadsom	Husband	Island Research LLP	LLP member	LLP member	

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 and 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	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	
Clara Swinson CB	Partner	Cazoo Ltd	Chief Technology Officer	Salary and shareholding	Ended May 2023
Clara Swinson CB	Partner	Unbiased EC1 Ltd	Non-Executive Director	Salary and shareholding	
Clara Swinson CB	Partner	EQT Ventures	Advisory role	Consulting role and fee	
Jenny Richardson	Self	The Whitehall and Industry Group	Member of Advisory Group - People	Unpaid	
Jonathan Marron CB	Self	Institute of Lifecourse Development, University of Greenwich	Non-executive member	Unpaid	
Jonathan Marron CB	Partner	University of East London	Research Fellow		
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	Brother	Vyaire Holding Company	Non-Executive Director / Chairman	Indirect shareholding
Michelle Dyson	Self	Norwood Ravenswood (charity)	Committee Member	
Matthew Style	Partner	Macmillan Cancer Support	Chief Executive	Salary
Shona Dunn CB	Partner	Thales UK	Tax Adviser	

Non-executive board members' interests

A register of interests covering non-executive members is maintained by DHSC. 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

DHSC 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. DHSC's declaration and management of outside interests policy was last updated in February 2024 following the audit of the 2022-23 Annual Report and Accounts by the National Audit Office.

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). Delegated grades complete the declaration on appointment and maintain the record.

Annual reminders are sent to employees via our HR system, D365. In addition, a reminder was issued to all staff in DHSC on 28 March 2024 through an intranet article, including instructions on how to log declarations of interest on D365.

DHSC is required to publish the relevant interests of its permanent secretaries, and other SCS who are board members at least annually within its annual report and accounts (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 is published on gov.uk and can be accessed here: register of senior civil servants' secondary paid employment. This does not include voluntary roles.

Declaration of non-executive director interests

DHSC 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 DHSC and they provide in-year updates as necessary.

Declaration of special adviser interests

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 DHSC where applicable)	Details of interest
Caroline Elsom (joined December 2022, left May 2024)	Caroline's partner is the Director of External Affairs at Waymap and is a Conservative councillor on Wandsworth Borough Council. He was the Conservative prospective parliamentary candidate for Tooting constituency during the July 2024 General Election. Caroline's sister is a General Practice Specialist at Broad Lane Surgery **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 (Left November 2023)	Iain is a trustee of the Conservative Party Archive Trust.
Macer Hall (Joined November 2022, left November 2023)	Nothing to declare
Robert Ede (Joined November 2022 and left July 2024)	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
Peter Wilson (Joined December 2023, Left May 2024)	Peter's sister is a consultant paediatrician at St Richard's Hospital. Peter's brother-in-law, is a GP partner at St Paul's surgery, Winchester

	Peter is the owner and sole director of PPW Consulting Limited, through which he conducted communications consulting work on a self-employed basis between November 2022 and December 2023, prior to his appointment as a special adviser. **Mitigation:** Peter's intention is that the PPW Consulting Limited will be rendered dormant once outstanding invoices and any other necessary administrative affairs are settled. Peter will not solicit new business or conduct any business whatsoever through the entity, or on behalf of or in concert with his former clients for the duration of his employment as a special adviser. Should any potential conflicts, or the perception of potential conflicts, arise with respect to his former clients through his work as a special adviser, Peter will declare this to the Permanent Secretary in a timely manner and recuse himself if appropriate.
Fergus Cameron Watt (Joined November 2023, Left May 2024)	Fergus is recused from involvement in discussions or matters relating to Bain & Co
Grace Hanson Eden (Joined April 2023, Left November 2023)	Nothing to declare

Business appointment rules

DHSC 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. DHSC last reviewed and updated its BAR processes and guidance in March 2023 to ensure alignment with Cabinet Office guidance.

In compliance with BAR, DHSC 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 DHSC collection page for BAR advice.

Under the application of BAR to civil servants (including special advisers) leaving Crown Service in DHSC, the number of exits from Crown Service (civil servants and special advisers) in the past year was 830 of which 61 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.

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 16**, DHSC set BAR conditions for 15 individuals in the past year. No BAR applications were found to be unsuitable for the applicant to take up and there were no breaches of the rules in the preceding year.

Table 16: 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	2	1
SCS	10	10
Special adviser	0	0
Minister	0	0

Source: DHSC

DHSC's policy is that employees have the responsibility to submit BAR applications either before or after their departure from DHSC. For delegated grades, the rules apply for one year post departure and for SCS the rules apply for 2 years. Individuals are required to submit BAR applications to their line manager prior to them accepting an outside appointment. Line managers are required to review this information and provide advice on any concerns, issues, or associated risks. They should also confirm that the information provided is accurate, add any further detail they feel is relevant and suggest conditions to be set. HR Operations review the application and confirm that enough detail has been provided for consideration.

For SCS3 applications, the HR Director reviews and sets conditions and these are then forwarded to the Advisory Committee on Business Appointments (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 DHSC writes to individuals confirming the conditions set.

DHSC implements and monitors BAR applications across all grades and increases awareness amongst employees by informing all new starters and leavers of their contractual obligations under the BAR. Full guidance is also published on the departmental intranet. Additionally, leavers letters are issued to all leavers from DHSC. These letters remind individuals of 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, DHSC's published policy and leavers' letters to all employees.

Governance statement

Statement and scope of accounting officer responsibilities

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

Statement of principal accounting officer's responsibilities

Under the Government Resources and Accounts Act 2000 (the GRAA), HM Treasury has directed DHSC 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 DHSC (inclusive of its executive agencies, Medicines and Healthcare products Regulatory Agency (MHRA) and UK Health Security Agency (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 2023 no.1360 (together known as the 'departmental group', consisting of DHSC and sponsored bodies listed at **Note 20** to the accounts).

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of DHSC 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.

In preparing the accounts, the Principal Accounting Officer of the DHSC 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 DHSC 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

- 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.

HM Treasury has appointed the Permanent Secretary of DHSC as Principal Accounting Officer of DHSC. In addition, HM Treasury has appointed a separate Accounting Officer to be accountable for the NHS Pension Scheme (incorporating the NHS Compensation for Premature Retirement Scheme) Resource Account. These are produced and published as a separate account.

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 DHSC is responsible for ensuring that appropriate systems and controls are in place to ensure that any funds that DHSC 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.

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 DHSC 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.

DHSC published in July 2018 an Accounting Officer System Statement setting out lines of accountability within DHSC and the healthcare system. This includes the responsibilities and relationships between the accounting officers in DHSC, its agencies, arm's length bodies, and the NHS.

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 judgements required for determining that it is fair, balanced, and understandable.

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

Scope of responsibility

This governance statement covers the DHSC group and outlines how responsibility for the management and control of DHSC's resources were discharged during the year. This statement covers 2023-24 and is current up to the date this annual report was signed.

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 DHSC complies with the provisions of the corporate governance code for central government departments, published by HM Treasury and the Cabinet Office.

The Head of Internal Audit's opinion is that they can provide 'moderate' assurance regarding the overall adequacy and effectiveness of DHSC'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 opinion is in line with 2022-23 and represents 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 152.

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 DHSC. Consequently, the nature of control in the DHSC group is different from the concept of a group in the commercial sector. As guardian of the system overall, DHSC is responsible for providing oversight and direction, and retains overall accountability for the use of resources and delivery of objectives. DHSC does not however, directly control every aspect of the departmental group.

While I am personally accountable for the resources provided to DHSC 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.

I discharge my responsibility for the governance and control of DHSC through the civil service staff based within DHSC. 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

DHSC’s arm’s length bodies (ALBs) and delivery partner organisations are either accountable to parliament directly or via DHSC. 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 DHSC 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
- keeping our communities safe by preparing for, preventing, and responding to health hazards.

Our delivery partners 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.

DHSC currently has 2 executive agencies: UK Health Security Agency (UKHSA) and the Medicines and Healthcare products Regulatory Agency (MHRA).

Our Permanent Secretary is the Principal Accounting Officer for the departmental group which as of 31 March 2024 consisted of:

- 7 ENDPBs – these include NHS England (consisting of 42 integrated care boards (ICBs), 4 commissioning support units (CSUs), 7 regional offices and a central

specialised commissioning hub), and our newest body, the Health Services Safety Investigation Body (HSSIB)

- 3 special health authorities (SpHAs)
- 8 other bodies (including companies)
- 143 NHS foundation trusts (FTs)
- 67 NHS trusts (NHSTs)
- NHS charities

The objectives and deliverables of DHSC's ALBs are set through their annual business planning process. DHSC uses ALB mandates, remit letters and business plans to hold its ALBs to account. This process is managed by senior departmental sponsors.

Recognising that a number of wider health and care system risks are beyond the direct control of DHSC, the audit and risk committee (ARC) regularly challenges departmental sponsors of ALBs on the risk and accountability of our ALBs. Senior officials from DHSC routinely attend audit and risk meetings across our ALBs in order to identify interdependencies between our risks and issues.

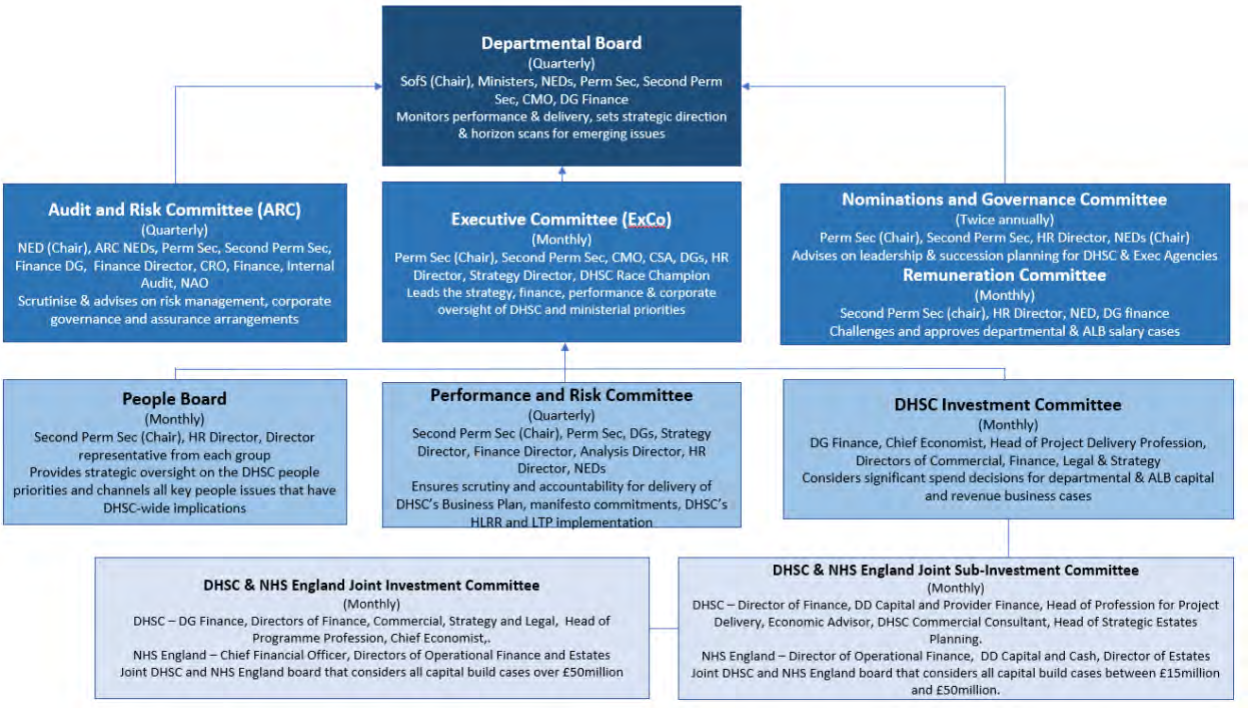
The reporting year's annual board effectiveness evaluation was led by DHSC's lead non-executive board member, Samantha Jones. The evaluation reflected on progress made in the reporting year and noted changes occurring as a result of a new ministerial team. The evaluation identified suggestions to be made which will further strengthen the current function of the board, for example that the board's visibility across DHSC could be improved.

Departmental governance

The departmental board chaired by the Secretary of State for Health and Social Care brings together ministerial and civil service leadership with non-executive directors from outside government who provide independent support and challenge.

The departmental board meets on a quarterly basis. The board met on 4 occasions during the 2023-24 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 24**.

Figure 24: Departmental board structure



The committees are responsible for the following:

- the Executive Committee is DHSC's major decision-making body and oversees strategy, finance, performance, and corporate issues in DHSC. It reports to the departmental board quarterly, including reports from various sub-committees. Issues discussed at the Executive Committee in 2023-24 included: delegated (non-senior civil service) and senior civil service grades pay award; people survey (twice); business planning; SIRO (senior information risk officer) assurance; AI (artificial intelligence); NHS winter resilience; mid-year review of DHSC finance; pandemic preparedness; social care reform; HM Treasury and the next spending review; NHS productivity plan; approach to managing 2024-25 finance across DHSC policy teams; and, a review of delegated grades performance management. The committee met 11 times during the reporting year and in each month except August.

- the DHSC Remuneration Committee acts on behalf of the Secretary of State for Health and Social Care 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 12 times in the year and reviewed 3 urgent cases by correspondence.

- the Nominations and Governance Committee advises on matters relating to senior leadership and succession planning for DHSC. 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 DHSC and its group bodies and reviews the comprehensiveness of assurances and integrity of financial statements. ARC has a standing meeting agenda for its 4 full committee meetings which covers papers and updates on finance, internal audit, NAO audits, value-for-money studies, departmental risk appetite and board assurance framework. It also regularly discusses Public Accounts Committee (PAC) reports and recommendations, counter fraud, cyber security, DHSC's major projects portfolio and the Government Major Projects Portfolio (GMPP). In 2023-24, there were deep dive discussions on the cyber, pandemic preparedness, health inequalities, funding and adult social care high-level risks. The committee also held discussions on antifraud, the new hospitals programme, HTA, HFEA and NHS CFA. The full committee met 4 times during 2023-24.

Table 17 summarises respective committee or board member attendance at the departmental board and the four next-tier committees.

Table 17: Committee attendance

Name of board or committee member [1,2]	Departmental Board	Executive Committee [3]	Audit and Risk Committee	Nominations and Governance Committee	Remuneration Committee [4]
	Met 4 times	Met 11 times	Met 4 times	Met 2 times	Met 12 times
Ministers					
Rt Hon Victoria Atkins MP [5]	2 (out of 2)	-	-	-	-
Rt Hon Stephen Barclay MP [5]	2 (out of 2)	-	-	-	-
Maria Caulfield MP	2	-	-	-	-
Helen Whately MP	2	-	-	-	-
Andrew Stephenson MP [6]	2 (out of 2)	-	-	-	-
Rt Hon Dame Andrea Leadsom MP	2 (out of 2)	-	-	-	-
Will Quince MP [7]	0 (out of 2)	-	-	-	-
Neil O'Brien MP [7]	0 (out of 2)	-	-	-	-
Lord Markham	3	-	-	-	-
Officials					
Sir Chris Wormald	4	11	-	2	-
Professor Sir Chris Whitty	4	6	-	2	-
Shona Dunn	4	9	4	2	11
Clara Swinson	-	11	-	-	-
Jonathan Marron	-	10	-	-	-
Professor Lucy Chappell	-	9	-	-	-
Michelle Dyson	-	10	-	-	-
Andy Brittain	4	10	3	-	10
Matthew Style	-	11	-	-	9
Jenny Richardson [8]	-	5 (out of 6)	-	1 (out of 1)	6 (out of 8)
Lorraine Jackson	-	11	-	-	-
Hugh Harris	-	9	-	-	-
Zoe Bishop [9]	-	5 (out of 5)	-	1 (out of 1)	2 (out of 4)
Non-executive directors					
Kate Lampard [10]	1 (out of 2)	-	-	-	1
Doug Gurr	4	-	-	-	-
Samantha Jones	4	-	-	-	10 (out of 12)
Gerry Murphy	3	-	4	1	11 (out of 12)
Will Harris	4	-	-	-	-
Sir Roy Stone	4	-	-	1	-
Steve Rowe [11]	0 (out of 1)	-	-	-	-
Sir Richard Douglas [11]	0 (out of 1)	-	-	-	-
Independent members					
Anne Barnard	-	-	4	-	-
Graham Clarke	-	-	3	-	-
Richard Hornby	-	-	3	-	-

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. Kate Lampard and Gerry Murphy attended 9 out of 10 meetings combined.

5. Stephen Barclay was succeeded as Secretary of State for Health and Social Care by Victoria Atkins on 13 November 2023. Each attended two Boards.

6. Andrew Stephenson was appointed Minister of State on 13 November 2023.

7. Will Quince was Minister of State for Health and Secondary Care until 12 November 2023. Neil O'Brien was Parliamentary Under Secretary of State for Primary Care and Public Health until 12 November 2023.

8. Jenny Richardson commenced a career break from 23 October 2023 to 29 March 2024. For Executive Committee (ExCo) meetings between November 2023 and March 2024 inclusive she was represented at ExCo by Zoe Bishop.

9. Zoe Bishop was interim HR director from 9 October 2023 to 16 April 2024.

10. Kate Lampard resigned as lead non-executive director and as a non-executive director on 30 September 2023. She was succeeded as lead non-executive director by Samantha Jones.

11. Steve Rowe and Richard Douglas were both appointed as non-executive directors in DHSC on 11 March 2024.

DHSC also has the following other major committees:

- The Performance and Risk Committee (PRC) exists to oversee departmental performance and management of DHSC's high-level risks. By making a regular assessment of DHSC'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 4 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 DHSC'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 24,** the Investment Committee is supported by DHSC and NHS England 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.

- The People Board is a sub-committee of the DHSC Executive Committee (ExCo). The board channels all the key people matters that have DHSC-wide implications into one forum and oversees delivery of people-related initiatives in DHSC, ensuring activity is aligned to DHSC strategy and priorities. Issues discussed at People Board in 2023-24 included skills and professions, people survey results, performance management, the leadership and management offer, diversity and inclusion, the DHSC 'Great Place to Work' programme, and culture and 'safe to challenge'. The board also received updates on the people impacts of DHSC's 'Reform and Efficiency' programme, including the voluntary exit scheme and the 'Our Future Estates' programme. The board met 11 times during the reporting year, once each month with the exception of August.

Core assurance framework, risk management and control

DHSC 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

DHSC applies the 'three lines of defence' principle to its management of risk whereby:

- 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 officers (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 DHSC'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 Government Internal Audit Agency (GIAA), which both provide independent challenge and assessment of the robustness of arrangements in place. ARC has considered the way in which DHSC manages risk at its 4 meetings during 2023-24, and reviews and discusses DHSC's risk register and approaches to risk as a standing agenda item at these meetings.

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 is provided to members of the departmental board 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 ARC meetings.

Managing risk

The Performance and Risk Committee (PRC) also exercises governance of risk management for DHSC 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 DHSC 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 DHSC's business plan.

The systems of internal control for identifying, evaluating, and managing risks have been in place for the full year under review. DHSC'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.

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.

Significant risks actively managed by DHSC during 2023-24 have included:

External risks	• The health and care system's resilience to cyber-attack – see 'Data Issues – Cyber Security Programme' on **page 143** • The global threat of antimicrobial resistance; and the risk relating to pandemics/major infectious disease outbreaks and biological attack • Continuity of supply of medicines and medical products – See 'vaccines, treatments, research and deployment' on **page 10**
System-wide risks	• The risk of demand for NHS services growing beyond that assumed in the long-term plan • Commercial controls and capability • Health disparities • The risk that the system does not recruit and retain the right numbers and skills of staff needed to deliver care, across primary, secondary, and social care • The growth in demand for NHS services compromises the ability of the system to deliver performance standards within our means • The sustainability of the adult social care system
Change-based risks	• The risk that DHSC's workforce has insufficient capacity and/or capability to provide a quality service – see 'DHSC contract management' on **page 138**.

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.

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 DHSC. 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 DHSC that we are asked to assure via the governance statement.

In 2023-24, directors and 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.

The BAM reports are part of DHSC'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.

In 2023-24, DHSC used an assurance framework comprised of 2 parts. This included a central framework which assures on HR, finance, workplace, information security, commercial and governance policies from a central perspective and a local assurance 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

The Major Projects Portfolio (MPP) continues to manage the oversight of the delivery of DHSC's key programmes and projects delivering priorities and manifesto commitments. Scrutiny and challenge are still provided through the Portfolio Oversight Board (POB) which has refined its dataset for reporting over the past year. In the past year the MPP team have established a senior responsible officer (SRO) network to allow the SROs to meet and discuss common issues, areas of challenge to delivery, best practice and learning that can be shared. There has also been a series of SRO forum discussions with the 2nd Permanent Secretary and the Chief Project Delivery Officer established.

The MPP currently comprises 19 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). In the year a further GIAA review was held on the MPP which returned an improved rating of 'Moderate', up from 'Limited' 2 years previously.

Changes in the reporting year have seen the addition of Moderna Strategic Partnership (MSP); Digital Transformation of Screening (DTOS); Federated Data Platform (FDP); the UKHSA health security campus at Harlow; and Cyber Improvement to the portfolio. The

GP IT Futures programme left the programme as it had come to the end of its business case.

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 of the latest 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.

The project delivery (PD) profession within DHSC continues to develop with the ongoing roll out of project delivery accreditation. Our PD community has grown during the year and learning within the community has been enabled through dedicated PD community events that have been well attended. These have been in addition to the centralised learning offer from the IPA through Major Projects Leadership Academy, Project Leadership Programme and more recently the Managing Projects and Leading Workstreams, demand for these courses continues to be high.

Better regulation

DHSC 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.

DHSC 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 the 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 DHSC's wider understanding of how they should approach regulatory policy, highlighting the importance of consideration to alternative options to regulation where appropriate. DHSC monitors its regulatory policies and reports annually to the Department for Business and Trade (DBT) on qualifying regulatory measures.

Where regulation is required DHSC'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.

DHSC has been contributing to the ongoing cross-Whitehall regulatory reforms, including the smarter regulation programme being led by the Department for Business and Trade.

Whistleblowing

DHSC'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 May 2024.

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 DHSC'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.

DHSC also has a board-level 'Whistleblowing and Speak Up Champion'. In the reporting period, this remained the Director General for Finance. A Grade 6 deputy champion also supports this work.

When a report of a whistleblowing concern is received, DHSC conducts initial conversations to establish whether it falls under the whistleblowing policy. If a case of whistleblowing is established, DHSC will investigate following the protocols outlined in the policy.

In 2023-24, fewer than 5 formal whistleblowing concerns were raised in DHSC. Figures of 5 or less whistleblowing concerns are not published to protect anonymity.

During 2023-24, we completed an internal whistleblowing health check in line with Cabinet Office guidance. The process was an additional mechanism for DHSC 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 DHSC is compliant with the guidance from Cabinet Office, we have identified some actions we could take to further improve.

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. DHSC'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 every 6 months by DHSC's People Board.

The results of the 2023 people survey (September 2023) showed that the percentage of people who knew how to raise a concern if they see or experience any form of wrongdoing in DHSC, increased from 76% to 80%.

Over the course of 2023-24, 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 included the following activities:

- ‘Speak Up’ week was held in November 2023
- regular communications on reporting routes and support services to further promote the Speak Up adviser offer
- further training has been given to Speak Up advisers including nominated officer training provided by the Cabinet Office
- ‘Active Bystander’ training provided by Pearn Kandola
- creation of a bullying, harassment and discrimination Toolkit for HR business partners to support SCS conversations.

The 'safe to challenge' agenda continues to be an important aspect of DHSC culture, with 'We challenge' being one of DHSC’s 4 core values. DHSC also has an extensive network of culture and engagement champions, who offer essential insights into departmental culture that continues to inform our approach to raising concerns, speaking up and whistleblowing.

Key departmental operational governance

This section includes areas which relate to DHSC’s key operations during the reporting year. Issues disclosed below may have covered more than one reporting year and, where that is the case, will have been first raised in the 2022-23 ARA or in earlier reports. Where matters have arisen during the reporting year and are not yet resolved, they will continue to feature in future reports.

Core department’s role in group oversight

The core department has a robust framework for financial management and oversight of its group ALBs but recognises the need for continuous improvement in this area, in particular in relation to UKHSA and NHS England.

The department has worked closely with UKHSA to address the disclaimed opinions on UKHSA’s 2021-22 and 2022-23 accounts. As part of this, the core department has provided strong support to and oversight of UKHSA financial management under the leadership of the DHSC Director General Finance, including attendance at quarterly senior governance meetings and monthly assurance meetings, and greater transparency in financial and other reporting.

In 2022-23, the departmental group accounts received a qualified regularity opinion as some of its spend did not comply with HM Treasury’s ‘ring-fence’ conditions associated with the additional elective recovery funding provided. This qualification was one-off in nature and an elective recovery oversight board has since been established to mitigate against recurrence. Oversight boards have been established for other key programmes,

and the monthly finance sponsorship and accountability board with NHS England provides a regular forum for the senior finance leadership in both organisations to review financial risks, discuss financial issues, and monitor progress on the management of in-year challenges, supporting collaborative working with the NHS.

UK Health Security Agency (UKHSA) limitation of scope group audit opinion

The Comptroller and Auditor General (C&AG) disclaimed his regularity and true and fair opinions in relation to UKHSA's 2022-23 financial statements for the second year running. 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).

During 2022-23, significant efforts were undertaken by the UKHSA to resolve the issues which caused the disclaimed opinion in 2021-22. However, the audit of CVU balances took longer than expected as described in the 2022-23 annual report and accounts (ARA), and 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.

Further progress has been made by UKHSA in 2023-24, as described in their annual report and accounts. This included significant assurance work over 2023-24 closing balances in the financial statements. This has resulted in the disclaimer audit opinion in the UKHSA accounts being lifted for the 2023-24 closing balance sheet and replaced with a limitation of scope audit opinion over the 2022-23 CVU-related closing balances and 2023-24 CVU-related transactions, as well as the brought forward disclaimer for the 2022-23 opening balances and 2022-23 in year transactions.

Additionally, the C&AG has concluded that the group ARA is now only subject to a limitation of scope audit opinion in relation to UKHSA 2022-23 transactions and opening 2022-23 balances (net of eliminations). **Note 21** gives details of transactions and balances over which this limitation of scope applies.

Progress has already been made by UKHSA, which has been supported by a third party "review and recommend" assurance piece. This is described in detail in the UKHSA ARA. Also, a finance and control improvement board was established towards the end of 2022-23 and was in place for the full 2023-24 financial year. This board oversees the finance and control improvement programme, holding it to account. The Director General for Finance and Operations for DHSC is a member of this board and further details of additional DHSC oversight is also provided in the UKHSA ARA. Further work is still required to improve systems and processes for 2024-25 and beyond.

Finalisation of group entities' accounts

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

A number of group entities have again experienced delays in the finalisation of their audited accounts. This has predominantly occurred in the NHS sector and UKHSA and the certification of the group accounts is reliant upon the completion of the audits of these bodies.

Regarding the NHS sector, a combination of fewer delayed local audits and the proactive steps NHS England have implemented to significantly bring forward the timetable for accounts and audit completion have facilitated the laying of the NHS England Group account on 15 October 2024 and the Consolidated Provider Account (CPA) on 26 November 2024. This is a significant improvement compared to 2022-23, when the accounts were laid on 25 January 2024. In a change to previous years, the NHS sector has published its ARAs ahead of the departmental group, improving the timeliness and transparency of its financial results.

Additionally, the UKHSA account has been certified considerably earlier than in 2022-23.

For 2023-24 the departmental group ARA has been certified more than one month earlier than last year. The department is committed to further improving the timeliness of publication of the ARA for the departmental group 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

Commercial operations provides a whole lifecycle commercial offer, ensuring consistent end to end commercial support on contractual requirements across 3 key category areas of:

- professional services
- digital, data and technology
- corporate, clinical and medical services.

There is a fourth team within commercial operations that also manages DHSC grants.

Through 2023-24 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 directors general have corporate visibility of the DHSC contract portfolio. Directors general have reported on contracts as part of the bi-annual

assurance process, helping to ensure contracts and associated risks are identified and managed.

The DHSC Contract Management Operating Model is a 3-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 DHSC 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 and so on. DHSC's model of classifying contracts is to differentiate contracts into either gold (high risk by either value or impact), silver (medium risk with a lower value or impact), or bronze (low value or 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 and so on.

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. These attestations are completed on an annual basis for all gold and silver contracts, and at 31 March 2024 all gold contract attestations (17) had been completed or partly completed; of the in-scope silver contracts for attestation purposes (31) approximately two-thirds had been completed or partly completed.

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.

The DHSC contract management (CM) operating model is for operational contract management to be undertaken out in the business. Each contract should have an operational contract manager plus a senior contract owner, supported with commercial expertise from the commercial operations commercial lead.

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 2024, some 2,548 learners across health (DHSC, ALBs and NHS) had registered for the Foundation training, of which 1,291 achieved accreditations. We continue to encourage all Foundation learners 'in progress' to complete the learning and achieve accreditation. 54% of OCMs managing DHSC gold contracts have been nominated or completed Expert training as required.

As at 31 March 2024, the DHSC contract portfolio stood at 587 contracts with total contract award value of £5.1 billion; the portfolio consists of 17 gold contracts, 64 silver, 263 bronze and 243 transactional contracts.

Contract management capacity in commercial operations is regularly reviewed 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 is also ensured through investment in learning and development to ensure all commercial professionals have the capabilities to operate across the whole commercial lifecycle.

DHSC information risk management and assurance

The information governance committee (IGC) acts as a supervisory and strategic decision-making body and escalation route for information governance and data protection across DHSC. The committee meets regularly and holds overall accountability for the management of DHSC's information and data protection risks.

Information risk management and assurance expertise continues to provide DHSC with support throughout 2023-24 to ensure information is used effectively and lawfully, kept safe and secure, and shared responsibly across DHSC to support decision-making and improve services.

DHSC has an established information asset register (IAR) which is kept updated via its information asset owners (IAOs) and information asset managers (IAMs). The IAOs have responsibility for their own information assets being recorded on the register. The register is iterative and is updated as responsibilities and assets are amended. The IAR helps 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 helps to ensure DHSC creates and maintains an accurate and complete view of the information it holds and uses and acts as a record of processing activity and enables DHSC to meet data protection legislative requirements.

Departmental standards and policies for data protection, information risk and assurance were reviewed and updated, including the Acceptable Use Policy, Information Security Standard and the Information Classification and Handling Standard, to keep up to date with technology.

DHSC continues 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).

DHSC recorded 113 data-related incidents between April 2023 and March 2024, an increase of 9 on the previous year. Of the 113 reported incidents, 0 met the criteria to be referred to the Information Commissioner's Office, compared to 0 in the previous year.

Compliance with equality and human rights legislation

The overall responsibility for meeting the requirements of equality and human rights legislation in policy and decision-making lies with each team in DHSC. The public sector equality duty advisor within the policy assurance and ALB oversight team leads on ensuring DHSC is in a position to meet its objectives under the public sector equality duty by overseeing capability and assurance in DHSC. It does this 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.

The team delivers training on the public sector equality duty, answers queries and provides advice, critically reviews equality impact assessments, and is responsible for the publication of DHSC's equality objectives and its annual report setting out how it has met its obligations under the duty. The team also delivers training to staff on equalities. Staff are also encouraged to engage with lawyers during the policy and decision-making process to ensure that legal duties are met.

DHSC undertakes bi-annual assurance meetings ('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.

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

Emergency preparedness, resilience and response (EPRR)

DHSC 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.

DHSC 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.

DHSC is embedding a new strategic approach to pandemic preparedness, implementing lessons learnt from COVID-19. This approach is based on having a range of response

capabilities that are adaptable, flexible, and scalable and can be applied to a pandemic threat regardless of the route of disease transmission (respiratory; oral; sexual/blood; contact; and vector).

The range of capabilities required to respond to a pandemic include equipment (for example stockpiles and countermeasures, such as medicines and vaccines), skilled people (for example research, science, and laboratory staff) and infrastructure (for example laboratory, testing, and treatment facilities). These resources are represented in the core capabilities of UKHSA, such as surveillance and diagnostics, and the response capabilities of the wider health and care system, in particular the NHS and adult social care.

DHSC has assessed current capabilities against the ability to respond to a large outbreak, the resources needed to manage the first 100 days of a pandemic, and the broader resources required to sustain a longer-term pandemic response. DHSC continues to evaluate those capabilities to identify future improvements.

DHSC is also refreshing plans to reflect the new strategic approach and how these capabilities would be deployed. A Tier 1 exercise is being planned for 2025 to test our readiness to respond to a major pandemic.

As part of its pandemic preparedness planning, DHSC seeks to ensure that the appropriate 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 advance purchase agreement for a pandemic specific influenza vaccine. DHSC’s pandemic stockpiles are designed to mitigate a severe pandemic, for example, the reasonable worst-case scenario risk of a pandemic as outlined in the national risk register. DHSC has agreed target volumes for England’s PPE stockpiles, which will be regularly reviewed. A longer-term strategy for PPE pandemic preparedness is in development, taking into account lessons from the COVID-19 pandemic, and will be revisited regularly, including following recommendations made by the COVID-19 inquiry.

DHSC 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, DHSC signed a service level agreement with SCCL (Supply Chain Coordination Ltd, an NHS England-owned but autonomous NHS Supply Chain function), which included a schedule on SCCL’s role in ensuring supply of PPE to health and social care providers in the event of a pandemic.

Pandemic preparedness PPE stockpiles have been replenished where possible and appropriate using excess stock originally procured for the COVID-19 pandemic. In the future, and subject to business-as-usual usage rates, dynamic stockpiling (where stock is rotated into business-as-usual) will be the default for any newly purchased pandemic preparedness PPE, which can reduce storage re-procurement and disposal costs and represent better value-for-money.

DHSC is exploring where short-term procurements to further bolster our baseline PPE resilience may be needed, as well as the longer-term strategy, which will also consider other approaches to the requirement for and supply of PPE, including alternative contractual arrangements and incentivising UK manufacturing.

DHSC completed the expert advisory phase of the review of emergency and clinical countermeasures in 2022, which considered the products (including medicines and vaccines), volumes, supply, storage, management, and governance arrangements required for a broader range of future pandemic and infectious disease risks, in addition to pandemic influenza. The expert advice is now informing policy and planning decisions for pandemic preparedness countermeasures to expand preparedness for a broader range of potential pandemic and emerging infectious disease risks, with funding to support this subject to the outcome of the next spending review.

Data issues – cyber security programme

The UK health and social care sector is considered an attractive target to a range of threat actors because of the quantity and sensitivity of health data available. The future of the NHS and social care relies on using digital technology to provide safer, more efficient, more personalised care. Throughout 2023-24 we have continued to increase cyber resilience across the health and care sector.

Following the March 2023 publication of the Cyber security strategy for health and social care: 2023 to 2030, DHSC received approval for a 2 year cyber improvement programme to 2025. The cyber improvement programme is 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. The scope of the programme is constructed around the 5 strategic themes of the cyber strategy and delivers the aims and outcomes of the strategy to 2025.

In 2023-24 under NHS England’s transformation directorate, DHSC continued to work in partnership with NHS England to reduce exposure to cyber risk in its arm’s length bodies, the NHS and its supply chain 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 procuring services to assist local organisations to improve their cyber security posture and reduce overall risk.

DHSC allocated funding of £14 million capital and £3 million revenue to 105 NHS trusts and 7 arm's length bodies. This addressed issues including backup capability, network infrastructure and cyber management software applications. A further £1.2m revenue was invested in centrally procured, locally delivered services to assess and improve critical infrastructure in selected NHS trusts.

We continued to strengthen cyber security standards through the data security and protection toolkit (DSPT) which all organisations must use if they have access to NHS patient data and systems. As at March 2024, 78% of NHS trusts had met or exceeded the standard, the remainder are approaching standards with an agreed improvement plan in place. For the adult social care sector, the 'Better Security, Better Care' programme provided a range of tailored local and national support further improving their overall data and cyber security. As of March 2024, 69% of adult social care providers had met or exceeded the DSPT standard, up from 57% at the same time last year.

Microsoft Defender for EndpointTM is now deployed and provides central and local visibility of operating systems and applications across 1.9 million Microsoft desktop devices in the NHS estate.

When critical cyber vulnerabilities are identified, the Joint Cyber Unit 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 13 HSAs and have made significant improvements and enhancements to the alert process, improving the overall user experience.

In September 2023 DHSC published an updated guide to the health and care system on the Network and Information Systems Regulations. This reflects changes to the Regulations since this guidance was first published in 2018 and provides further information for operators of essential services on fulfilling the security and incident reporting duties and the department's oversight and enforcement approach.

Since the June 2024 cyber-attack on pathology service provider Synnovis, Synnovis had restored 90% of testing capacity by mid-August and the majority of their core IT systems are now rebuilt. DHSC and NHS England have completed interim lessons identified and DHSC and NHS England's Joint Cyber Unit are leading a structured debrief to ensure a holistic and strategic set of recommendations. We will ensure that recommendations are followed up to ensure continuous improvement to the resilience of the NHS and to our ability to respond to incidents when they do happen.

The Synnovis cyber-attack further highlighted the increasing and changing threat to supply chains. Supply chain resilience is identified as a vulnerability in the Cyber Strategy to 2030 and will be addressed through our Cyber Improvement Programme, including developing a national platform to help map the supply chain, identifying and mitigating concentrated risk.

COVID-19 Inquiry

The UK COVID-19 Inquiry has been set up to examine the UK's response to and impact of the COVID-19 pandemic and learn lessons for the future.

As of October 2024, 10 modules have opened and public hearings have been held on Module 1, resilience and preparedness, and Module 2, core UK decision-making and political governance. Hearings on Module 3, the impact of the pandemic on healthcare systems in the 4 nations of the UK, began on 9 September 2024. Modules on vaccines and therapeutics, procurement, the care sector, test, trace and isolate, children and young people, the economic response and the impact on society are in progress.

The Inquiry published its Module 1 report on 18 July 2024, which focuses on resilience and preparedness for a pandemic. The government's full response is expected to be published by January 2025.

DHSC is committed to responding to the Inquiry with openness and transparency. By the end of August 2024, DHSC had submitted more than 50,000 pieces of evidence to the Inquiry, including written witness and corporate statements, and has supported 8 then serving and former ministers and senior civil servants to give evidence at the hearings.

Clinical negligence

The department spent £2.6 billion on clinical negligence payments in 2023-24. Repeated inquiries and investigations have highlighted significant issues with patient safety, and the department is clear in its ambition to restore public confidence.

Multiple, complex and interrelated factors lead to patient harm during the provision of healthcare. These include:

- organisational factors such as staffing levels, shift patterns and education and training provision
- task factors such as the complexity of medical interventions, processes and procedures
- technological and tools-related factors such as the availability of health information systems, equipment, medication and diagnostics
- environmental factors such as the physical estate, its layout and maintenance
- person-related patient-related factors including fatigue, familiarity, clinical knowledge and experience
- external factors including demand and financial pressures.

Problems normally arise in systems due to the complex interplay of these factors.

The department is committed to prioritising the continuous improvement of patient safety so that the NHS treats people with the high-quality and safe care that they deserve. The NHS Resolution annual report and accounts 2023-24 outline some of the measures being taken to improve patient safety, including sharing data and insights as a catalyst to improve service delivery, identifying emerging patient safety risks and supporting a greater understanding of the causes of incidents. Additionally, collaboration to improve maternity outcomes has been a strategic priority for NHS Resolution and has included an Early Notification scheme and Maternity Incentive scheme, as well as launching an e-learning module designed to support clinicians working in maternity services.

Fraud prevention

DHSC anti-fraud unit

The following sections cover the work of the DHSC anti-fraud unit (DHSC AFU).

Fraudulent activity in the health sector means that taxpayers' 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.

Counter fraud work at a national level is led by the 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.

The DHSC AFU sets the counter fraud policy and strategy for DHSC and the wider health group. We have a counter fraud strategy in place covering the period 2023 to 2026. The strategy sets out our vision of 'A system-wide approach to tackling fraud which protects taxpayers' money for better patient care' and focuses on 4 key areas, namely:

- proactivity and prevention
- utilising digital and data analytics
- collaboration and coordination
- response and enforcement.

These themes ensure we are aligned with the Public Sector Fraud Authority's (PSFA) 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.

Our response to tackling fraud has been, and continues to be, based on the following principles whereby:

- 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 or 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

- it ensures 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 the health group

- it acknowledges that work on fraud and other types of financial loss is critical to maintaining a sustainable and financially balanced NHS.

DHSC AFU, through membership of the Government Counter Fraud Profession (GCFP) (Fraud Risk Assessment (FRA) discipline), advises colleagues across DHSC 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.

DHSC AFU has worked closely with the PSFA on areas such as the design and development of initial fraud impact assessments (IFIAs). A process has also 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.

The DHSC AFU continue to develop an enterprise and thematic fraud risk assessment, to expand the oversight and understanding of fraud risk across departmental activity and groups.

DHSC AFU, through accredited counter fraud specialists and membership of the GCFP (Investigator discipline), 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.

In late 2023 DHSC was assessed for compliance by the PSFA against the Government Counter Fraud Functional Standards (GCFFS). The report was issued in April 2024. DHSC delivered a strong showing in the PSFA compliance check, rating at least good in the majority of areas. Despite this strong showing, DHSC has a programme of work to continue improving on all areas of counter fraud activity.

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 GCFFS. DHSC continues to work with ALBs to help them achieve compliance with the standards. DHSC, and several of its ALBs, also contributed to the PSFA's counter fraud Workforce and Performance Review (WPR) 2024 to provide insight to support levelling up counter fraud capability across government.

NHS Counter Fraud Authority (NHSCFA)

The NHSCFA spearheads the fight against NHS fraud at a national level. The NHSCFA carries out the Secretary of State's counter fraud functions in respect of the health service in England. As a Special Health Authority, established in November 2017, it is tasked to lead the fight against fraud, bribery, and corruption in the NHS, in England. The AFU is the DHSC sponsor for the NHSCFA and provides oversight and holds the NHSCFA to account to deliver against its remit.

The NHSCFA has 165.75 full time equivalent staff and 7.2 full time equivalent fixed term temporary staff. NHSCFA implements DHSC's strategic plan under the sponsorship of DHSC AFU. On the 8 June 2023, the NHSCFA published its new strategy for 2023 to 2026, following publication of the DHSC Counter Fraud Strategy. DHSC worked closely with NHSCFA to ensure that the 2 strategies complement one another and provide for robust counter fraud measures across the health service.

NHSCFA publishes an annual Strategic Intelligence Assessment (SIA) which estimates the potential vulnerability to fraud in the NHS in England. The SIA does not indicate actual fraud losses but rather an estimate of fraud vulnerability based on NHSCFA loss measurement exercises and partner comparative loss assessments. The SIA is broken down into lead thematic risk areas. This informs the NHSCFA and its stakeholders of the priorities for the year ahead by capturing established, emerging and potential future threats. The SIA has, and will continue to, ensure a coordinated response to fraud and protect funding meant for patient care.

The SIA Report 2024 (published on 28 October 2024), based on financial activity data from 2022-23 (which is the most recent published report), estimates that the NHS is vulnerable to £1.361 billion worth of fraud (not actual fraud losses); compared to £1.264

billion for 2021-22. 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 2022- 23.

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.

DHSC has committed to invest £12 million in the NHS Counter Fraud Authority over 2 years. On 21 February 2024, the NHSCFA announced that it will be utilising analytical and data science capability, developing a series of machine learning models to enhance fraud prevention and detection in the NHS in high-risk areas.

Project Athena is a new pilot project aiming to both prevent fraud and deliver a dedicated response by identifying patterns in data on a scale that has never been done before across the NHS for counter fraud purposes. It will give the NHSCFA the expertise to focus on key areas using data analytics. This will mean that more fraud can not only be detected, but also prevented.

Further information regarding measures being taken to combat fraud can be found in the 2024 SIA.

Local counter fraud work

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.

NHS England has published statutory guidance for integrated care boards (ICBs) on their counter fraud responsibilities and ICBs need to comply with the GCFFS.

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 2024, there were 260 LCFSs.

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

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

Counter fraud oversight

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, NHSBSA, UK Health Security Agency (UKHSA) as well as the PSFA.

The NHSCFA chairs a quarterly control strategy and strategic tasking and coordination group consisting of key stakeholders across the health group (DHSC, NHS England, NHSBSA, and UKHSA) to collectively agree priorities and areas for counter fraud activity for the forthcoming financial year and/or strategic planning cycle.

Covid pandemic fraud

Fraud is a hidden crime and therefore it is impossible to give exact amounts. However, the Department's best estimate is that 2.4% (£324m of £13.6bn) of expenditure on PPE was fraudulent and, to date, we have recovered £70m and also assess a further £163m was prevented from being lost in the first place.

PPE procurement, unlike other support schemes, is subject to ongoing contract management controls, active dispute resolution and recovery action. It is not possible to forecast how much fraud might be identified and recovered in the future or how many cases will be the subject of legal action.

Contracts suspected to be fraudulent, on the balance of probabilities, have been referred to law enforcement partners. DHSC also continues to focus on holding companies to account for contracts that have not performed. Actions include pursuing companies through the High Court, mediation, and working with liquidators in cases where companies have ceased trading. This work resolves to secure company assets and hold directors to account and often involves collaboration with statutory agencies.

Civil litigation

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.

Departmental financial and audit governance and quality assurance

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

Role of internal audit

DHSC's internal audit service continues to be provided by a dedicated health and social care team within the Government Internal Audit Agency (GIAA).

The team plays a crucial role in the review of the effectiveness of risk management, controls, and governance within DHSC 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
- providing advice to management on internal control implications of proposed and emerging changes.

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.

The head of internal audit submits regular reports to the ARC relating to the adequacy and effectiveness of DHSC's systems of internal control, and the management of key business risks, together with recommendations for improvement. These recommendations have been discussed and the resulting action plan is agreed by management and includes a timetable for implementation.

The status of internal audit recommendations and the collection of evidence to verify their implementation are reported to the ARC. The head of internal audit also has direct access to DHSC's Second Permanent Secretary, and they met periodically during the year to review lessons arising from internal audit.

Internal audit opinion

The Head of Internal Audit provided an opinion of “moderate” assurance on the adequacy and effectiveness of the risk management, control and governance arrangements within the core department in 2023-24.

A summary of the internal audit engagements reported on in 2023-24 is shown below:

Engagement	Report date
Sustainability Reporting	17/08/2023
Conflicts of Interest	08/11/2023
Office for Health Improvement and Disparities – Regional Delivery Performance Reporting	10/01/2024
New Hospitals Programme – financial focus	14/03/2024
Social Care Data Assurance and Support Programme	22/03/2024
Legacy Information Technology - Office for Health Improvement and Disparities	21/03/2024
Security: Insider Risk	28/03/2024 (draft report)
Cross-government Engagement – Sponsorship of ALBs	24/01/2024
Cross-government Engagement – Supplier Resilience	12/01/2024
Cross-government Engagement – Net Zero	26/03/2024 (draft report)
Cross-government Engagement - Efficiencies	30/04/2024
Anti-Fraud Culture	15/02/2024
Portfolio Office	20/09/2023
Supply Chain Disruption	20/10/2023
Contract Management	29/09/2023
Parliamentary Questions, Freedom of Information requests and Correspondence	10/11/2023
Publication of Statistics	20/11/2023

Investment Committee appraisal	30/01/2024
Data Protection	20/03/2024
Budget management	16/04/2024
Travel and expenses	09/04/2024
National Institute for Health and Care Research - Governance	25/03/2024
Health and safety	25/03/2024
Estates strategy	26/04/2024
Governance: structures and sub-boards	30/04/2024 (draft report)
Payroll	26/04/2024
Grants standards (advisory)	23/06/2023
Prevention of Future Deaths Reports (advisory)	01/12/2023
Information management services 4 post-transition implementation (advisory)	16/04/2024
Information technology strategy (advisory)	30/04/2024 (draft report)

In summary:

- There were 186 recommendations made in relation to the engagements listed above
- Of these, 32 have been cleared, 127 are not yet due, and 27 are overdue
- 26 overdue recommendations related to engagements where “moderate” assurance was provided, and 1 related to an advisory engagement

In forming the opinion of “moderate” assurance, the Head of Internal Audit observed that, overall, the department had an adequate framework in place to ensure the effectiveness of risk management and noted that it had been investing in developing its risk maturity. She noted 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. She observed that improvement in risk management continued to be seen but that there is still more work to do to ensure that the quality of risk management is consistent across the different business areas with regular risk review and proactive horizon scanning.

The Head of Internal Audit also confirmed that the work of her team during 2023-24 provided assurance that there are adequate governance structures and processes within the core department. The internal audit of governance structures and sub-boards provided assurance that the governance structure below board level is adequate and generally in line with best practice outlined in HMT’s Corporate Governance in Central Government Departments: Code of Good Practice.

On the effectiveness of controls and compliance with required controls, the Head of Internal Audit noted further strengthening of the control environment, particularly in the group operations and finance area, with longstanding recommendations relating to control weaknesses having now been implemented.

Since September 2021, functional standards have set expectations for the consistent management of 13 central functions across government departments and their arm’s length bodies, and governance to set expectations for the effective management and use of public funds. DHSC internal audit reviews DHSC compliance with the government functional standards and in 2024-25, DHSC will also complete the Government Finance Function Continuous Improvement Assessment Framework Tool.

National Audit Office and Public Accounts Committee

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.

Table 18 provides a summary of the key reports published by the NAO in 2023-24, that reflect on activities of DHSC.

Table 18: Key NAO reports

Title of significant NAO report	Date of publication
Progress with the New Hospital Programme	July 2023
Reforming adult social care in England	November 2023

NHS Supply Chain and efficiencies in procurement	January 2024
Investigation into the UK Health Security Agency's health security campus programme	February 2024
NHS England's modelling for the Long-Term Workforce Plan	March 2024

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 DHSC is the primary client. Where DHSC is a third-party client, the NAO seeks to confirm the factual accuracy of references to DHSC with the Director General of Finance.

DHSC reports on the implementation status of the NAO's recommendations on a bi-annual basis. These are published by the NAO in their Recommendations Tracker.

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 are government's response to the recommendations the PAC makes in its reports. In 2023-24, DHSC officials attended 6 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.

COVID-19 impairments and losses

During the height of the pandemic response DHSC 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.

At 31 March 2024 the valuation of DHSC's PPE within **Note 12** to the financial statements is £Nil as all inventory has either been transferred to the pandemic preparedness stockpile, utilised, donated, sold, disposed of, or is now held for future disposal following the cessation of the free PPE provision scheme on 1 April 2024.

The pandemic preparedness stockpile is accounted for within property plant and equipment (**Note 6** to the financial statements).

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 2023. As such there has been a relatively small change in the level of impairment recognised in expenditure in 2023-24 for the PPE programme. The amount of expenditure recognised in 2023-24 was £19 million (2022-23: £219 million) as detailed in **Note 4.3** to the financial statements.

All items of PPE that have been disposed of or are surplus to requirements have now been disclosed as losses. In the vast majority of cases, such losses have been recognised as impairments in the financial statements in previous financial years, but the losses are now crystallising as it has been confirmed that the inventory will not be used. This includes losses in respect of items which had previously been assessed as not being suitable for use in the PPE programme, but for which alternative uses were being sought.

DHSC holds impairments in respect of COVID-19 medicines which are expected to be surplus to requirements due to the reduction in prevalence and severity of COVID-19. The onerous contract provision of £124 million held at 31 March 2023 has now been fully utilised as all the relevant inventory has been received. The amount of expenditure recognised in 2023-24 in relation to impairments and write downs of COVID-19 medicines was a net reversal of expenditure of £24 million (2022-23: £149 million charge) as detailed in **Note 4.3** to the financial statements.

DHSC has reported losses in respect of COVID-19 medicines where these have reached their expiry dates in 2023-24.

Further details regarding the various instances for which losses have been recognised in the 2023-24 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 **Note 4.3** and **Note 12** of DHSC's annual report and accounts.

NHS governance

The following narrative explores DHSC's relationship with the NHS and key challenges faced during the financial year, followed by specifics regarding NHS financial and audit governance.

The NHS

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.

In relation to NHS England, the National Health Service Act 2006, as amended, requires DHSC 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 DHSC and NHS England at all levels to work together on delivering a comprehensive health service.

NHS England has responsibility for the commissioning of healthcare in England and to invest its annual budget (of around £164.9billion in 2023-24) with a view to bringing about measurable improvements in health outcomes for the population.

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 and staff 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. On 1 April 2023, the functions and staff of Health Education England were transferred to NHS England under the Health Education England (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023, giving NHS England the responsibility to plan, recruit, educate and train the health workforce, ensuring that the healthcare workforce has the right numbers, skills, values and behaviours in place to support the delivery of excellent healthcare and health improvement to patients and the public.

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 NHS England, and further details are included in NHS England's governance statement and published in their annual report and accounts.

For NHS trusts the processes were previously set by NHS Improvement and are now set by NHS England. 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.

The current assurance and accountability process provides ministers with several legislative and non-legislative mechanisms for holding NHS England to account. The framework document for NHS England will set out the assurance process, roles, and responsibilities of DHSC and NHS England by which accountability will be achieved.

Inquiries and reviews

DHSC currently oversees a range of inquiries and investigations, which are discussed further below. DHSC is sponsoring 2 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 November 2023. NHS England commissions investigations, which can generate recommendations for DHSC as well as the wider health and care system. This includes the continuing investigation into maternity services at the Nottingham University Hospital NHS Trust.

DHSC also responded to requests from the independent public statutory inquiry into infected blood. The Cabinet Office sponsored this inquiry, which reported on 20 May 2024.

Lampard inquiry (formerly the Essex mental health independent inquiry)

In January 2021, Nadine Dorries, the then Minister of State for Patient Safety, Suicide Prevention and Mental Health, announced the establishment of a non-statutory independent inquiry into the circumstances of mental health inpatient deaths in Essex. This inquiry was officially converted to a statutory inquiry in October 2023 and is now chaired by Baroness Lampard. The inquiry consulted on its terms of reference in November 2023. The final terms of reference were laid in Parliament on 10 April 2024.

Lucy Letby inquiry (The Thirlwall inquiry)

Following the guilty verdict in the trial of former neonatal nurse Lucy Letby, the then Secretary of State for Health and Social care announced a statutory inquiry on 4 September 2023.

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. The inquiry held its first preliminary hearing on 16 May 2024 and began its substantive hearings in September 2024.

The inquiry chair will provide a final report (and if appropriate, interim reports) to the Secretary of State for Health and Social Care as soon as is practically possible. She will make recommendations as she considers appropriate.

Maidstone and Tunbridge Wells NHS Trust: David Fuller

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.

The first phase of the inquiry, on matters relating to Maidstone and Tunbridge Wells NHS Trust, concluded in November 2023 with the publication of the phase 1 report. The report identified failures of management governance, regulation and processes and a persistent

lack of curiosity which all contributed to an environment in which Fuller could offend unnoticed and unchecked.

The report set out 16 recommendations for the trust and 1 for the local councils. The recommendations reflect the focus of the inquiry: security, board assurance, offending, employment practices, mortuary management, and the trust's interaction with regulators and coroners. On 15 October 2024, the Government updated the House on the progress made to implement the Fuller Inquiry's Phase 1 recommendations and ongoing compliance monitoring. The Inquiry also published their interim report on the findings from their funeral sector module. This provides recommendations on safeguarding the security and dignity of the deceased in that sector.

Phase 2 of the inquiry will look at the broader national picture, the wider lessons for the NHS and other settings and make recommendations with the aim of preventing anything similar happening again.

East Kent University NHS Foundation Trust maternity and neonatal services

Following concerns raised about the quality and outcomes of maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust, in February 2020, NHS England and NHS Improvement 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.

The then government published an initial response on 7 March 2023 and a fuller response in July 2023. This set out the planned action around the recommendations. To support the implementation of these recommendations, the then government 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

In May 2022, NHS England appointed Donna Ockenden to lead a further review of NHS maternity units at Nottingham University Hospitals NHS Trust. Updated terms of reference were published in September 2023, with the scope of the review expanded in May 2024 to include antenatal care experience.

Infected blood inquiry

Following the publication of the infected blood inquiry's final report on 20 May 2024, the then government announced a proposed compensation scheme for infected and affected victims of infected blood to be delivered through the Infected Blood Compensation Authority (IBCA). Regulations to establish the Infected Blood Compensation Scheme were made on 24 August 2024. The first set of regulations established the core compensation

route for the infected people. Further regulations will be required to extend the scheme to people who are affected (family members), and to establish the supplementary compensation route for people who are both infected and affected. The Minister for the Cabinet Office will update Parliament when we expect the compensation service to go live in due course.

While the ICBA and compensation scheme are being established, DHSC remains responsible for the English Infected Blood Support Scheme, administered by NHS Business Services Authority, and through this scheme, making interim payments to infected people and to the families of deceased people. First interim payments of £100,000 were made to the living infected people and their bereaved partners by October 2022 and further interim payments of £210,000 were made to living infected people in June 2024. Government has further committed to make interim payments of £100,000 to the estates of the deceased infected people, to recognise those that have not yet received compensation, the scheme opened for applications on 24 October 2024.

The government will respond to the inquiry's final report in due course. The Department is committed to learning from the findings identified in the inquiry to ensure that this does not happen again.

Maternity and newborn safety investigations

The Maternity and Newborn Safety Investigation Programme (MNSI) was established in 2018 as part of the Healthcare Safety Investigation Branch. It was originally announced in 2022 that a separate Special Health Authority would be established to continue the programme. However, following further consideration, in 2023, DHSC decided that the most appropriate and streamlined way to continue the delivery of independent maternity investigations was for the MNSI programme to be hosted within the Care Quality Commission (CQC). This transfer of function took place on 1st October 2023.

The MNSI programme investigates early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England, and maternal deaths in England. The purposes of the maternity investigation programme have remained the same since it transitioned to the CQC: 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; to analyse data to identify key trends and provide system wide learning; and to be a system expert in standards for maternity investigations; and collaborate with system partners to escalate safety concerns.

Reinforced Autoclaved Aerated Concrete (RAAC)

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.

NHS England 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.

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). These 7 critical RAAC schemes are out of scope of the current review of the NHP, as confirmed in the terms of reference. These schemes will proceed at pace due to the substantive safety risks associated with them.

NHS Financial and Audit Governance

Financial Risk and Sustainability in the NHS

The financial stability of the NHS has remained a government priority this year as the NHS continues to adapt to the complexities of a post pandemic world.

Efforts have continued with improving productivity and efficiency within the NHS to support the recovery of services and put the NHS back on the path to financial sustainability that align with work the NAO have undertaken as referenced in their recent report on NHS Financial Management and Sustainability (nao.org.uk). However, the impact of industrial action, as well as the ongoing effects of inflation have proven to be significant challenges, limiting the scope of recovery this year.

Regardless, DHSC have continued to work closely with NHS England and HM Treasury to manage the impact of these issues, utilising and improving our governance mechanisms between the organisations to ensure emerging risks are collectively considered, debated and actions agreed.

In support of this approach, our monthly finance sponsorship and accountability board (FSAB) with NHS England, DHSC ministerial accountability meetings with the NHS CFO, and regular HM Treasury engagements have continued to operate during the reporting year with further improvements made to information sharing and reporting.

The FSAB has continued to provide a regular forum for the senior finance leadership across DHSC and NHS to monitor, discuss and manage the in-year financial position, identify and mitigate emerging financial risks, debate and inform financial decisions as necessary, as well as allow the group to review progress on the delivery of agreed financial objectives as set out in the NHS mandate.

Our monthly minister-led financial accountability meeting with the NHS CFO has also continued to support improved ministerial oversight on the delivery of the overall NHS position. Allowing the responsible minister the opportunity to formally engage with the CFO to better understand the overall NHS financial position and raise queries or concerns where appropriate using the latest data and information available.

Furthermore, work also continues in strengthening our annual financial assurance processes to better inform the department's assessment of NHS financial performance. Following the introduction of the annual end of year financial assurance assessment last year, we have continued to develop this exercise to aid improved identification of potential problems and gaps in assurance and ensure the process and outputs better align with HM Treasury's own annual assessment process of the DHSC.

In support of NHS service delivery, ongoing work to review and improve spend planning and the approval processes with HM Treasury also continues. We are working with HMT

and NHS England to review the frameworks of authority to further manage and improve the workflow between the three organisations. Approval pipelines with HMT and NHS England to better monitor, manage and track new policy proposals continue to be refined. Proposed work to look into underlying drivers of significant financial issues in the NHS and links to NHS oversight processes are in development to identify whether any opportunities exist for coordinated action to be taken across the organisations to address these challenges.

These changes have largely been possible due to continued collaborative improvement between the organisations, resulting in a clearer understanding of the challenges that will support better informed decisions. Building on the work by the NAO in their financial management and sustainability report, we will continue to develop these arrangements to better understand the risks and challenges to the wider health system going forward and improve planning to support the longer-term goals.

Overpayments to Medical Practitioners

If a medical practitioner is suspended, they may be entitled to receive payments under the statutory regulations if the qualifying criteria is met.

During the reporting period, NHS England has made changes to the way that these payments are administered to improve national oversight and to reduce variation in interpretation of the statutory regulations. Following review, NHS England has identified one case where the circumstances of the practitioner had changed in November 2023 and the practitioner was no longer eligible but continued to receive payments. This resulted in overpayments equating to £32,662. These payments ceased in June 2024. All other overpayments relating to the reporting period have been disclosed in the 2022-2023 annual report and accounts.

Overpayments to suspended practitioners is an issue that was first identified in 2021-22. Last year, overpayments equating to £1.3 million were identified, as noted in the losses and special payment disclosures to the 2022-23 annual report and accounts. Recoveries are being sought subject to legal advice.

From April 2024, all payments to suspended practitioners are made from the national team following a standardised approach to applying the guidance and improved monthly assurance on changes in circumstances. A full review has been completed of all cases which identified the single case specified above. This is an improvement on previous years where overpayments have been made to several individuals and of much higher values. The additional national oversight has improved the process for making these payments going forwards.

Special severance payments

NHS providers are required to obtain approval in advance of making non-contractual departure payments (termed 'special severance payments') to employees. At the time of finalising the disclosures in the consolidated provider accounts on 1 November 2024, there were five outstanding cases where payments were made without prior authorisation. These have been submitted to HM Treasury retrospectively and HM Treasury's view is awaited. These cases, while currently irregular, have been judged as individually and collectively not material by nature to the consolidated provider accounts. NHS England will continue to reinforce the requirement that such payments be approved by HM Treasury.

Remuneration and staff report

Remuneration report

This remuneration report provides details of the remuneration and pension interests of ministers and the most senior management of DHSC. This includes ministers, non-executive directors and directors general (DGs)/senior officials and is compliant with EPN710.

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
- cash equivalent transfer values (CETV) and increases

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.

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 2023-24

- Steve Barclay MP was Secretary of State for Health and Social Care during 2023-24 until his resignation on 12th November 2023.

- 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.
- 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.
- Will Quince MP was Minister of State during 2023-24 until his resignation on 12th November 2023.

Remuneration of senior officials and ministers

The directors' report outlines the senior officials and ministers of DHSC and their dates of appointment (and departure where appropriate), but their remuneration is detailed in **Table 20**, with ministers in **Table 19**.

Salary

'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 DHSC, and this is recorded in these accounts.

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. DHSC does pay legitimate expenses for ministers which are not a part of the salary or a benefit in kind.

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 DHSC, and is therefore shown in full in **Table 19**.

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 Senior Civil Service (SCS) framework guidance issued by Cabinet Office.

Non-consolidated performance pay

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

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

The non-consolidated performance pay included in the 2023-24 figures relates to awards made in respect of the 2022-23 performance year but paid in the 2023-24 financial year. An award of £7,000 was paid to SCS receiving an 'exceeding' performance rating and an award of £3,500 was paid to SCS receiving a 'high performing' performance rating in each SCS pay band (band 1-3). These awards were not differentiated by grade (SCS pay band 1-3).

Benefits in kind

The monetary value of benefits in kind covers any payments or other benefits provided by DHSC which are treated by His Majesty's Revenue & Customs (HMRC) as a taxable emolument. For its direct employees, DHSC pays the individual a net sum and pays tax directly to HMRC. No benefits in kind were incurred during 2023-24 by ministers or senior officials of DHSC.

Tables 19 and **20** provide details of remuneration interests of the ministers of DHSC and senior officials serving on the departmental board for the years 2022-23 and 2023-24 are subject to audit.

Table 19: Remuneration of ministers of the department (subject to audit)

Ministers	2023-24 Salary (£)[1]	2023-24 Gross benefits in kind (to nearest £100)	2023-24 Pension benefits (to nearest £1000)	2023-24 Total (to nearest £1000)	2022-23 Salary (£)[1]	2022-23 Gross benefits in kind (to nearest £100)	2022-23 Pension benefits (to nearest £1000)	2022-23 Total (to nearest £1000)
Victoria Atkins MP (from 13/11/2023) Secretary of State Full year equivalent	22,502 72,454		8,000	30,000	-	-	-	-
Steve Barclay MP (05/07/2022 to 05/09/2022, 25/10/2022 to 12/11/2023) Secretary of State Full year equivalent	45,003 72,454		10,000	55,000	49,836 67,505	-	10,000	60,000
William Quince MP[4] (from 07/09/2022 to 12/11/2023) Minister of State Full year equivalent	29,040 31,680		4,000	33,000	15,840 31,680	-	5,000	21,000
Helen Whately MP (from 26/10/*2022*) Minister of State Full year equivalent	31,680 31,680		8,000	40,000	13,711 31,680	-	3,000	17,000
Andrew Stephenson MP (from 13/11/2023) Minister of State Full year equivalent	10,560 34,742		4,000	14,000	-	-	-	-
Andrea Leadsom MP (from 13/11/2023) Parliamentary under Secretary of State Full year equivalent	8,577 24,947		2,000	11,000	-	-	-	-
Maria Caulfield MP[2] (from 17/09/2021 to 06/09/2022, then from 27/10/2022) Parliamentary Under Secretary of State, Minister of State, Parliamentary Under Secretary of State (current) Full year equivalent (current)	22,375 22,375		6,000	28,000	28,795 22,375	-	6,000	35,000
Neil O'Brien MP[5] (from 08/09/2022 to 12/11/2023) Parliamentary Under Secretary of State Full year equivalent	20,510 22,375		3,000	24,000	12,617 22,375	-	3,000	16,000
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) Parliamentary Under Secretary of State Full year equivalent	-	-	-	-	35,484 70,969	-	9,000	45,000
Thérèse Coffey MP (from 06/09/2022 to 24/10/2022) Secretary of State Full year equivalent	-	-	-	-	5,625 67,505	-	3,000	9,000
Sajid Javid MP (from 27/06/2021 to 05/07/2022) Secretary of State Full year equivalent	-	-	-	-	34,660 67,505	-	4,000	39,000
Edward Argar MP (to 06/07/2022) Minister of State Full year equivalent	-	-	-	-	16,351 31,680	-	2,000	18,000
Gillian Keegan MP (from 16/09/2021 to 08/09/2022) Minister of State Full year equivalent	-	-	-	-	15,840 31,680	-	3,000	19,000
Robert Jenrick MP (from 07/09/2022 to 24/10/2022) Minister of State Full year equivalent	-	-	-	-	5,348 31,680	-	1,000	7,000
Caroline Johnson MP (from 08/09/2022 to 26/10/2022) Minister of State Full year equivalent	-	-	-	-	9,384 22,375	-	1,000	10,000
Maggie Throup MP (from 16/09/2021 to 07/09/2022) Parliamentary Under Secretary of State Full year equivalent	-	-	-	-	15,351 22,375	-	2,000	18,000
James Morris MP (from 08/07/2022 to 07/09/22) Parliamentary Under Secretary of State Full year equivalent	-	-	-	-	8,180 22,375	-	1,000	9,000

1. Figures include any severance payment/compensation in lieu of notice payment received by ministers.
2. Maria Caulfield's salary exceeded the full-year equivalent salary in 2022-23 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 is unpaid.
4. William Quince's salary includes a severance payment of £7,920
5. Neil O'Brien's salary includes a severance payment of £5,594

Table 20: Remuneration of senior officials of DHSC (subject to audit)

Officials	2023-24 Salary (£'000)	2023-24 Non consolidated performance related pay (£'000)[1]	2023-24 Gross benefits in kind (to nearest £100)	2023-24 Pension benefits (to nearest £1000)[2,3]	2023-24 Total (£'000)	2022-23 Salary (£'000)	2022-23 Non consolidated performance related pay (£'000)[1]	2022-23 Gross benefits in kind (to nearest £100)	2022-23 Pension benefits (to nearest £1000)[2]	2022-23 Total (£'000)
Sir Christopher Wormald KCB Permanent Secretary	200-205	-	-	169,000	370-375	180-185	-	-	6,000	185-190
Shona Dunn Second Permanent Secretary	165-170	-	-	51,000	220-225	160-165	-	-	(26,000)	130-135
Professor Sir Chris Whitty[4] Chief Medical Officer for England	220-225	-	-	51,000	270-275	205-210	-	-	31,000	240-245
Clara Swinson CB Director General Global and Public Health	145-150	5-10	-	54,000	205-210	135-140	5-10		(11,000)	130-135
Jonathan Marron Director General Primary Care and Prevention	140-145	-	-	69,000	210-215	130-135	-	-	46,000	180-185
Matthew Style[5] Director General Secondary Care and Integration	155-160	-	-	51,000	205-210	150-155	-	-	304,000	450-455
Michelle Dyson[6] Director General Adult Social Care	135-140	0-5	-	58,000	200-205	130-135	-	-	17,000	145-150
Andy Brittain Director General, Finance	135-140	-	-	60,000	195-200	130-135	-	-	(28,000)	100-105
Lucy Chappell[7] Chief Scientific Adviser	120-125	-	-	-	120-125	110-115	-	-	22,000	130-135
Jenny Richardson[8] Director of Human Resources Full year equivalent	65-70 115-120	5-10	-	49,000	120-125	110-115	5-10	-	9,000	125-130
Zoe Bishop[9] *(from 9 October 2023 to 19 April 2024)* Director of Human Resources Full year equivalent	35-40 95-100	-	-	19,000	55-60		-	-	-	-
Hugh Harris[10] Director Ministers, Accountability and Strategy Full year equivalent	105-110 115-120	-	-	66,000	170-175	95-100	5-10	-	9,000	110-115
Lorraine Jackson Director of Work and Health Unit	100-105	5-10	-	67,000	175-180	95-100	0-5	-	(1,000)	95-100
Steve Oldfield[11] *(to 17 October 2022)* Chief Commercial Officer Full year equivalent	-	-	-	-	-	55-60 235-240	30-35	-	5,000	90-95
Matthew Gould *(to 30 September 2022)* Chief Executive Officer, NHSX Full year equivalent	-	-	-	-	-	60-65 125-130	-	-	9,000	70-75

1. Non-consolidated performance pay paid in 2023-24 relates to the 2022-23 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 was previously a member of the Partnership pension scheme.
5. Matthew Style has had a retrospective update to service history which has impacted on their pension benefits for 2022-23.
6. Michelle Dyson received pay arrears in January 2023 following an underpayment of salary in 2021-22 due to an administrative error.
7. Professor Lucy Chappell was appointed on 01/08/2021 on secondment from King's College, London, for 4 days a week. The salary figures in the table represent the proportion DHSC paid only, not the full salary. The pension benefits figure for 2022-23 represents the contribution paid by the department to Kings College London as part of the secondment agreement for 80% of Lucy Chappell's time. The disclosure for 2023-24 represents the value of pension benefits accrued during the year.
8. Jenny Richardson was on career break from 23 October 2023 until 29 March 2024.
9. Zoe Bishop was on loan to DHSC from 9 October 2023 - 19 April 2024 from the Ministry of Defence. Zoe Bishop's salary is less than the full time equivalent due to working part-time.
10. Hugh Harris' salary is less than the full-time equivalent figure due to working part-time.
11. Steve Oldfield was on career break from 4 January 2022 until 18 July 2022.

Fair pay disclosure (subject to audit)

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 21**.

Table 21: Pay ratios for core department and executive agencies

	Core department		Core department and executive agencies 2023-2024	Core department and executive agencies 2022-2023
	2023-2024	2022-2023		
25th percentile pay ratio	5.5:1	5.8:1	6.3:1	6.2:1
Median pay ratio	4.1:1	4:1	4.9:1	4.8:1
75th percentile pay ratio	3.6:1	3.6:1	3.8:1	3.7:1

Pay ratio compares the percentile pay benefits to the highest paid director.

Table 22 shows the total remuneration and salary element of each of the quartiles.

Table 22: Total remuneration and salary element for core department and executive agencies

	Core department 2023-2024	Core department and executive agencies 2023-2024
25th percentile total remuneration (salary element)	40,765 (38,628)	35,963 (35,963)
Median total remuneration (salary element)	55,263 (53,463)	46,039 (46,039)
75th percentile total remuneration (salary element)	62,909 (62,909)	59,915 (57,114)

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.

The median earning of the core department has increased in 2023-24 by 7.7%, or £3,936, compared to 2022-23 where the increase of median earnings was £5,283. Core department staff, not including the highest-paid director, had an average 8.1% increase in pay and benefits. See **Table 23**.

The increase in median earnings of the core department can be attributed to changes in the composition of the workforce in 2023-24, such as grade distribution and implementation of the 2023-24 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 23: Percentage change in remuneration from 2022-23

	Core department		Core department and executive agencies	
Percentage change in total remuneration	Highest paid director	Average of total employees	Highest paid director	Average of total employees
Change from 2022-23	7.6%	8.1%	8.1%	6.5%
Salary and allowances	7.6%	6.2%	NA	NA
Bonus	0.0%	109.3%	NA	NA

The banded remuneration of the highest paid director increased in 2023-24 to £220,000-£225,000 (see **Table 24**). Banded remuneration for the core department staff remained the same in 2023-24 for the lowest paid, ranging between £20,000 - £25,000.

Table 24: Banded remuneration range for core department and executive agencies

	Core department		Core department and executive agencies	
	2023-2024	2022-2023	2023-2024	2022-2023
Band of highest paid director's total remuneration (£000)[1]	220-225	205-210	220-225	205-210
Band of lowest paid	20-25	20-25	20-25	15-20

1. Salaries for senior management disclosed in bands of £5,000, in accordance with EPN710 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.

Civil service pensions

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.

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 (CETV) 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).

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

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).

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).

Further details about the civil service pension arrangements can be found at the website.

Changes to civil service pensions under remedy

In 2015 the then government introduced reforms to public service pensions. Most public sector workers were moved into reformed career average pension schemes. For the Civil Service this was alpha. In 2018, the Court of Appeal found that the rules put in place in 2015 to protect older workers by allowing them to remain in their original scheme were discriminatory on the basis of age.

As a result, steps are being taken to remedy those 2015 reforms, making the pension scheme provisions fair to all members. Some active members will have seen changes from April 2022.

The remedy is made up of two parts. The first part was completed last year with all active members now being members of alpha from 1 April 2022, this provides equal treatment for all active pension scheme members. The second part is to put right, 'remedy,' the discrimination that has happened between 2015 and 2022.

Ministerial pensions

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.

Those ministers who are Members of Parliament (MP) 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.

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.

The figure shown for pension value includes the total pension payable to the member under both the pre- and post-2015 ministerial pension schemes.

Tables 25 and **26** provide details of the pension interests for the DHSC's ministers and senior officials for 2022-23 and 2023-24 and are subject to audit.

Cash equivalent transfer values (CETV)

A CETV is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the 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

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.

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 25: Pension interests of ministers (subject to audit)

	Accrued pension at age 65 as at 31/03/24	Real increase in pension at age 65	CETV at 31/03/24[2]	CETV at 31/03/23	Real increase in CETV
	£'000	£'000	£'000	£'000	£'000
Victoria Atkins MP from 13/11/2023	0-5	0-2.5	52	43	5
Steve Barclay MP 05/07/2022 - 05/09/2022 25/10/2022 - 12/11/2023	5-10	0-2.5	111	95	7
William Quince MP 07/09/2022 - 12/11/2023	0-5	0-2.5	29	24	2
Helen Whately MP from 26/11/2022	0-5	0-2.5	37	26	5
Andrew Stephenson MP from 13/11/2023	0-5	0-2.5	46	41	2
Andrea Leadsom MP from 13/11/2023	5-10	0-2.5	99	93	2
Maria Caulfield MP 17/09/2021 - 06/09/2022 from 27/10/2022	0-5	0-2.5	27	19	4
Neil O'Brien MP 08/09/2022 - 12/11/2023	0-5	0-2.5	11	8	2
Lord Markham CBE from 22/09/2022	-	-	-	-	-
Thérèse Coffey MP 06/09/2022 - 24/10/2022	-	-	-	-	-
Sajid Javid MP 27/06/2021 - 05/07/2022	-	-	-	-	-
Edward Argar MP to 06/07/2022	-	-	-	-	-
Gillian Keegan MP to 08/09/2022	-	-	-	-	-
Robert Jenrick MP 07/09/2022 - 24/10/2022	-	-	-	-	-
Caroline Johnson MP 08/09/2022 - 26/10/2022	-	-	-	-	-
Maggie Throup MP to 07/09/2022	-	-	-	-	-
James Morris MP 08/07/2022 - 07/09/22	-	-	-	-	-
Lord Kamall to 19/09/2022	-	-	-	-	-

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 DHSC part way through the year, the figures above are calculated according to the period in-post.

Table 26: Pension information of senior officials of DHSC (subject to audit)

		Accrued pension at pension age as at 31/03/24 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/03/24	CETV at 31/03/23	Real increase in CETV	Employer contribution to external pension scheme Nearest £100
Sir Christopher Wormald KCB	Permanent Secretary	105-110	7.5-10	2,238	1,909	150	-
Shona Dunn	Second Permanent Secretary	60-65 plus lump sum of 165-170	2.5-5 plus lump sum of 0	1,447	1,293	30	-
Professor Sir Chris Whitty[1]	Chief Medical Officer for England	0-5	2.5-5	48	-	38	-
Clara Swinson CB	Director General for Global Health	45-50 plus lump sum of 125-130	2.5-5 plus lump sum of 0	998	880	33	-
Jonathan Marron	Director General for Office for Health Improvement and Disparities	25-30	2.5-5	530	432	50	-
Matthew Style	Director General NHS Policy and Performance	45-50	2.5-5	822	723	24	-
Michelle Dyson	Director General for Adult Social Care	45-50 plus lump sum of 115-120	2.5-5 plus lump sum of 0-2.5	985	861	41	-
Andy Brittain	Director General Finance	55-60 plus lump sum of 150-155	2.5-5 plus lump sum of 0-2.5	1,266	1,118	43	-
Lucy Chappell[2]	Chief Scientific Advisor	100-105 plus lump sum of 100-105	-	1,782	1,785	-	-
Jenny Richardson	Director of Human Resources	45-50	2.5-5	786	686	36	-
Zoe Bishop (9 October 2023 to 19 April 2024)	Director of Human Resources	5-10	0-2.5	93	76	9	-
Hugh Harris	Director of Ministers, Accountability and Strategy	40-45	2.5-5	777	664	49	-
Lorraine Jackson	Director of Information, Risk Management and Assurance	45-50	2.5-5	967	833	56	-
Steve Oldfield (to 17 October 2022)	Chief Commercial Officer	-	-	-	-	-	-
Matthew Gould (to 30 September 2022)	Chief Executive Officer, NHSX	-	-	-	-	-	-

1. Professor Sir Chris Whitty was previously a member of Partnership pension scheme.
2. Professor Lucy Chappell was appointed on 01/08/2021 on secondment from King's College, London (KCL) for 4 days per week. Her pension is with the NHS pension scheme and DHSC contributes 80% of the costs paid in to the scheme by KCL. Her full pension accrual is shown in the table above.

Non-executive directors (NEDs)

NEDs (see **Table 27**) are not employees of DHSC. 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. NEDs also make a significant contribution to departmental business by working through committees and with senior officials.

The departmental board holds positions for 6 NEDs. The NEDs sitting on the departmental board during 2023-24 are detailed in the directors' report. There are also 3 independent members of Audit and Risk Committee (ARC).

One of the non-executive directors chairs DHSC's Audit and Risk Committee (4-5 meetings per year). The lead non-executive director chairs DHSC'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.

Table 27: NEDs and members of DHSC (subject to audit)

Non-Executive	Position	Term	2023-24 Fee received to nearest £1,000	2023-24 Annual fee entitlement to nearest £1,000	2022-23 Fee received to nearest £1,000	2022-23 Annual fee entitlement to nearest £1,000
Gerry Murphy	Non-Executive Board Member & Chair Audit & Risk Committee	1 August 2017 - 31 July 2024	20,000	20,000	20,000	20,000
Doug Gurr	Non-Executive Board Member	1 December 2020 - 30 November 2026	15,000	15,000	15,000	15,000
Samantha Jones[1]	Non-Executive Board Member & Lead Non-Executive	14 February 2023 - 13 February 2026	19,000	20,000	-	15,000
Roy Stone	Non-Executive Board Member	24 April 2023 - 23 April 2026	14,000	15,000	-	-
Will Harris	Non-Executive Board Member	24 April 2023 - 23 April 2026	14,000	15,000	-	-
Anne Barnard	Independent Member of Audit & Risk Committee	1 January 2020 - 31 December 2025	5,000	5,000	5,000	5,000
Graham Clarke	Independent Member of Audit & Risk Committee	1 January 2020 - 31 December 2025	5,000	5,000	5,000	5,000
Steve Rowe	Non-Executive Board Member	7 March 2024 - 6 March 2027	-	15,000	-	-
Richard Douglas[2]	Non-Executive Board Member	7 March 2024 - 6 March 2027	-	15,000	-	-
Richard Hornby	Independent Member of Audit & Risk Committee	1 January 2020 - 31 December 2024	-	Non-remunerated Civil Servant	-	Non-remunerated Civil Servant
Kate Lampard[3]	Non-Executive Board Member & Lead Non-Executive	1 October 2017 - 7 September 2023	10,000	20,000	22,000	20,000
Julian Hartley	Non-Executive Board Member	1 November 2021 - 10 November 2022	-	-	9,000	15,000

1. Samantha Jones became interim lead NED 29 September 2023 and formally appointed to the role in March 2024.
2. Richard Douglas will receive £20,000 from 1 August 2024 when he takes over as ARC chair.
3. Kate Lampard received additional fees for COVID-19 Inquiry Unit preparation work on top of her NED time commitment.

Compensation for loss of office (subject to audit)

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.

DHSC paid severance payments to the following ministers in the 2023-24 financial year[2]:

- William Quince (Minister of State) received a severance payment of £7,920
- Neil O'Brien (Parliamentary Under Secretary of State) received a severance payment of £5,594

[2] 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

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.

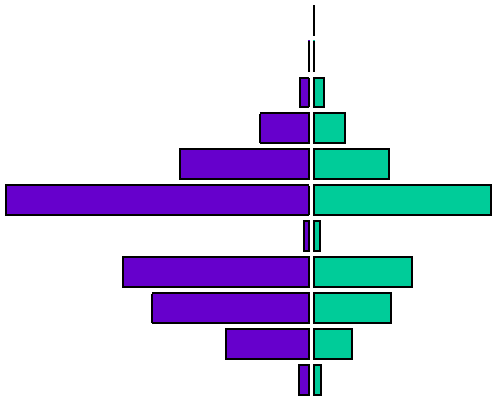
The core department employed an average of 2,897 permanent whole time equivalent (WTE) persons during 2023-24 at a total salaries and wages cost of £165.6 million, compared to 3,176 at a cost of £168.5 million in 2022-23. A breakdown of staff numbers and associated costs for the core department together with its executive agencies and for the overall departmental group are included in **Tables 33** and **34**.

DHSC structure

DHSC's staff grading structure is as follows: administrative (AO); managerial (EO, Fast stream, HEO, SEO); senior management (grade 6 and 7); senior civil service (SCS1 (deputy director), SCS2 (director), SCS3 (director general)). **Figure 25** outlines the headcount and gender distribution of core department staff in post at 31 March 2024 and is consistent with Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment with the core department.

Figure 25: Gender distribution of core department staff (headcount)

Grade	Female	Male	Total
Perm Sec	1	2	3
SCS 3	2	3	5
SCS 2	22	25	47
SCS 1	108	70	178
GRADE 6	286	170	456
GRADE 7	669	393	1062
FAST ST	13	15	28
SEO	413	218	631
HEO	347	171	518
EO	185	86	271
AO	24	18	42
	2,070	**1,171**	**3,241**



Staff sickness

73% of staff with no recorded sickness in the year ending 31 December 2023

The core department has seen an increase in the number of days lost to short-term sickness, rising from 5,180 in the rolling calendar year up to 31 December 2022 to 6,401 up to 31 December 2023. There has also been a rise in days lost to long-term sickness reported over the same period, from 8,485 to 10,471. This increase can be attributed to 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 2023, the average number of working days lost stands at 5.2, an increase from 3.8 as at December 2022. Some 73 per cent of our staff have no recorded sickness in the calendar year up to 31 December 2023, down from 81 per cent at the same point the previous year.

Staff turnover

The core department has experienced a 15% turnover of staff during the 2023-24 financial year. This has been calculated in line with Cabinet Office guidance. This is an increase from the 2022-23 year where staff turnover in the core department was 14%. This increase can be attributed to the voluntary exit leavers from DHSC during 2023-24.

Staff redeployment

During 2023-24 DHSC benefited from a number of civil servants loaned from other government departments.

The number and grade of staff re-deployed is shown in **Table 28**.

Table 28: Staff Redeployment by Grade

Grade	Cost incurred by DHSC Number	Cost not incurred by DHSC Number	Total Number
AO and EO	2	0	2
HEO and SEO	10	0	10
G7 and G6	26	0	26
SCS	8	0	8
Totals	**46**	**0**	**46**

For those individuals above where the cost was incurred by DHSC, the estimated average cost was £62,093.

Health and safety

DHSC 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 2023-24, there were 5 reported accidents (one of which resulted in absence) and one near miss.

Staff engagement

The annual Civil Service People Survey looks at civil servants' attitudes to and experience of working in government departments. Every year a Civil Service benchmark report is published alongside a summary of main department scores.

DHSC's response rate in 2023 was 84%. This maintains the response rate from 2022, which was 12% higher than the response rate in 2021 (72%) and represents the highest response rates since the survey started in 2009.

The Civil Service People Survey engagement score for DHSC reduced slightly this year to 57%. Some themes remained the same, while others increased or decreased by one or two percentage points. The biggest change in score was for 'Leadership and Managing Change', which dropped by 4 percentage points, from 49% to 45%.

A decrease in score was seen in 2 further core themes: 'My Team' at 84% and 'Inclusion and Fair Treatment' at 80%. 2 core themes maintained the same score: 'My Work' at 77% and 'My Manager' at 77%. A rise in score was seen in 4 key themes this year, including 'Organisational Objectives and Purpose' at 70%; 'Learning and Development' at 53%; 'Resources and Workload' at 72% and 'Pay and Benefits' at 31%.

Staff diversity

Information showing how DHSC 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 DHSC's most recent report on our equality objectives. 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.

DHSC's most recent diversity data is available on the Civil Service Diversity and Inclusion Dashboard.

Equal opportunities policy

DHSC 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.

DHSC's strategic commitments to equal opportunities and diversity are set out in the DHSC equality objectives 2023-27. DHSC's commitment is underpinned by the Civil Service Diversity and Inclusion (D AND I) Strategy 2022-2025, delivered in collaboration with our leaders, staff networks and employees across DHSC.

DHSC is committed to treating all staff fairly and responsibly. The aim of DHSC'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.

DHSC recognises the importance of championing diversity and inclusion more visibly at senior leadership level. To support this, DHSC introduced a new D AND I standards framework for senior civil servants (SCS) for the 2022-23 performance year, these have

been embedded further for 2023-24. The framework supports members of the SCS to identify and set their ambition and goals on the leadership of D AND I in DHSC and guide them on what to include in their plans for meeting their mandatory D AND I objective, required for all SCS across the wider civil service.

To promote diversity and inclusion at the highest level, the second permanent secretary acts as DHSC's senior D AND I champion and is supported by D AND 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

The inclusion plan and its actions are stress-tested and supported by DHSC's governance. D AND I is discussed quarterly between the executive board and people board, ensuring that D AND I matters are on the forefront of DHSC's agenda.

DHSC 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. DHSC 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).

During 2023-24, DHSC also:

- refreshed and mainstreamed D AND I governance so that all senior leaders are involved and supporting D AND I priorities across DHSC
- launched DHSC's new inclusion plan for 2023-2027, setting out our strategic intent and direction alongside tangible deliverables
- launched the Experience Exchange Mentoring Programme for senior leaders to learn from the under-represented staff and for those staff to benefit from building senior networks
- strengthened our speak up adviser service, recruiting more advisers and creating an adviser support buddy system
- rolled out active bystander training so that staff could further develop inclusive behaviours
- provided line management support on workplace adjustments and renewed membership of the Disability Confidence Scheme

DHSC 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 networks form a diversity board, which meets regularly to discuss inclusion-related matters at DHSC.

Recruitment and retention of under-represented groups

DHSC 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.

DHSC regularly reviews its processes and practices to attract diverse candidates from within and outside DHSC. As a result, DHSC strengthened the requirements of selection panels at delegated grades (AA to G6) to introduce more perspective and lived experiences. Recognising that those come 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, DHSC wants candidates applying for roles in DHSC to recognise that we strive to best represent and serve the public and that we live the 'we are inclusive' value.

DHSC 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.

DHSC operates 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, DHSC has a disability at work conversation toolkit to ensure employees receive the support they need.

DHSC, 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, DHSC 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, DHSC has a dedicated health and safety team and created a new workplace adjustment adviser role, as well as providing support through our occupational health service for workplace and specialist assessments.

DHSC uses a range of talent and apprenticeship schemes to attract or develop diverse talent, including employees and candidates from lower socio-economic background, who might otherwise not have access to formal education or training.

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' advisers, 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

Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, DHSC has a statutory requirement to disclose information (see **Tables 29** to **32**) as prescribed by schedule 2 of the above regulation. The format of these tables is as prescribed by the regulations.

The disclosure has been compiled in line with the regulations. The information below only discloses the trade union facility time utilised by the core department, MHRA, and UKHSA staff only. All other in-scope entity's annual reports and accounts enable statutory reporting requirements to be met.

Table 29: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
70	64.5

Table 30: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	17
1-50%	53
51-99%	0
100%	0

Table 31: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£143,243
Total pay bill	£723,822,270
Percentage of total pay bill spent on facility time	0.02%

Note: The total pay bill percentage is calculated as: (total cost of facility time ÷ total pay bill)

Table 32: Paid trade union activities

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

Note: the percentage is calculated as total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours)

With regard to engagement, officials from across DHSC 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. DHSC 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

Tables 33, 34 and **35** summarise key staff information for the departmental group.

Table 33: Staff costs for the departmental group (subject to audit)

	2023-24 Permanently employed staff £'000	2023-24 Others £'000	2023-24 Ministers £'000	2023-24 Total £'000	2022-23 Total £'000
Salaries and wages	63,707,242	7,944,471	172	71,651,885	68,458,248
Social security costs	7,400,491	210,771	18	7,611,280	6,858,699
NHS pension	10,691,232	233,722	-	10,924,954	9,937,025
Other pension costs	163,989	12,833	-	176,822	169,489
	81,962,954	**8,401,797**	**190**	**90,364,941**	**85,423,461**
Termination benefits	65,669	9,500	14	75,183	118,450
	82,028,623	**8,411,297**	**204**	**90,440,124**	**85,541,911**
Less income in respect of secondments	(27,641)	(112,342)	-	(139,983)	(129,977)
Total staff costs	**82,000,982**	**8,298,955**	**204**	**90,300,141**	**85,411,934**

Special advisers are temporary civil servants. To improve efficiency, the administration of staff costs for all special advisers across government is managed by the Cabinet Office, with corresponding budget cover transfers. Therefore all special adviser costs are reported in the Cabinet Office annual report and accounts. Special advisers remain employed by the respective department of their appointing minister.

Table 34: Average number of whole-time equivalents employed – departmental group (subject to audit)

	2023-24 Permanent staff	2023-24 Others	2023-24 Ministers	2023-24 Special advisers	2023-24 Total	2022-23 Total
Core department						
Core department	2,897	360	6	4	3,267	4,091
Executive agencies						
UK Health Security Agency	4,564	788	-	-	5,352	6,883
Medicines and Healthcare products Regulatory Agency	1,145	111	-	-	1,256	1,246
Other designated bodies						
NHS providers	1,312,780	144,049	-	-	1,456,829	1,391,008
Special health authorities	4,796	214	-	-	5,010	4,787
NHS England group	38,512	10,325	-	-	48,837	46,907
Non-departmental public bodies	4,209	224	-	-	4,433	11,301
Others	8,736	1,146	-	-	9,882	9,052
Total	**1,377,639**	**157,217**	**6**	**4**	**1,534,866**	**1,475,275**

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.

Several changes in group structure during 2022-23 and 2023-24 have impacted the groupings in the above table. This includes the Health and Social Care Information Centre (known as NHS Digital) and Health Education England merging with NHS England and therefore no longer being included in non-departmental public bodies.

Of the figures shown in **Table 34**, staff engaged on capital projects are shown in **Table 35**.

Table 35: Breakdown of staff engaged on capital projects (subject to audit)

	2023-24 Permanent staff	2023-24 Others	2023-24 Ministers	2023-24 Special advisors	2023-24 Total	2022-23 Total
Core department and agencies	312	-	-	-	312	84
Other designated bodies	3,918	509	-	-	4,427	4,507
Total	**4,230**	**509**	**-**	**-**	**4,739**	**4,591**

Consultancy, Temporary and Agency Workers

Table 36 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.

DHSC utilises off-payroll, temporary and consultancy staff where it is necessary and prudent to do so. In 2023-24 the core department spent £3.9 million on consultancy compared to £4.1 million in 2022-23; and £4.2 million on temporary staff compared to £23.1 million in 2022-23. The main reason for the year-on-year decrease on temporary staff spend is a reduction in COVID-19 related roles that were filled with temporary staff.

Table 36: Expenditure on consultancy, agency and temporary workers

	2023-24 Consultancy £'000	2023-24 Temporary agency £'000	2022-23 Consultancy £'000	2022-23 Temporary agency £'000
DHSC core	3,938	4,174	4,092	23,100
Executive agencies	1,280	33,742	1,163	153,767
Other designated bodies	252,134	5,027,886	276,638	5,472,934
Gross total	**257,352**	**5,065,802**	**281,893**	**5,649,801**
Eliminations	-	-	-	-
Total after eliminations	**257,352**	**5,065,802**	**281,893**	**5,649,801**

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

Off-payroll engagements

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 37** includes all off-payroll engagements (either during 2023-24 in totality or 'as at' 31 March 2024) for a day-rate of more than £245.

A regular dialogue has continued between DHSC and the Tax Centre of Excellence throughout the 2023-24 financial year to ensure ongoing compliance with the IR35 rules. This dialogue ensures that DHSC keeps updated with any policy changes implemented during the year and can therefore amend process accordingly if so required.

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 by the tax team.

DHSC has not paid any penalties for non-compliance.

Table 37: Off-payroll engagements

Table 37a: For all off-payroll engagements as of 31 March 2024, for more than £245 per day

	Core department	ALBs	Total
Number of existing engagements as of 31 March 2024	**21**	**838**	859
Of which:			
Number that have existed for less than one year at time of reporting	1	440	441
Number that have existed for between one and two years at time of reporting	7	131	138
Number that have existed for between two and three years at time of reporting	1	99	100
Number that have existed for between three and four years at time of reporting	7	77	84
Number that have existed for four years or more years at time of reporting	5	91	96

Table 37b: For all off-payroll engagements between 1 April 2023 and 31 March 2024, for more than £245 per day

	Core department	ALBs	Total
Number of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	**47**	**1,677**	**1,724**
Of which:			
Number not subject to off-payroll legislation	45	581	626
Number subject to off-payroll legislation and determined as in scope of IR35	1	1,039	1,040
Number subjected to off payroll legislation and determined as out of scope of IR35	1	57	58
Number of engagements reassessed for compliance or assurance purposes during the year	-	16	16
Of which: number of engagements that saw a change to IR35 status following review	-	1	1

Table 37c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024

	Core department	ALBs	Total
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-	1	1
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.	233	509	742

There was one case of an off-payroll individual board member, and/or, senior official with significant financial responsibility during the financial year. This relates to Wiltshire Health and Care LLP and is a result of the organisation being unable to fill this role permanently during the year.

Exit packages – civil service and other compensation schemes

Table 38 details civil service and other compensation schemes and exit packages. Redundancy and other departure costs for civil servants 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 group.

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.

As part of a wider Reform and Efficiency Programme, a voluntary exit scheme was launched on 18 May 2023. The scheme was used alongside robust recruitment controls to reduce headcount within the Department, as well as creating an opportunity to rebalance and reshape the Department.

The scheme was designed in such a way that although anyone could apply for a voluntary exit, it did not approve the exit of those believed to have the right skills and delivery capability for the future.

147 employees left the core department on voluntary exit terms during the financial year 2023-24.

One individual within the core department received over £95,000 as an exit package due to entitlement on voluntary redundancy arrangements in 2023-24. There was one further individual within the core department who received over £95,000 as an exit package.

Additional disclosure for group entities can be found in the ARA of the individual bodies as set out in **Note 20**.

Table 38a: Exit packages (subject to audit)
Core department and agencies for the year ended 31 March 2024

	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 or less	25	9	34	-
£10,001 to £25,000	31	14	45	-
£25,001 to £50,000	-	35	35	-
£50,001 to £100,000	-	100	100	-
£100,001 to £150,000	1	3	4	-
£150,001 to £200,000	-	-	-	-
More than £200,000	-	-	-	-
Total number	**57**	**161**	**218**	**-**
Total cost (£)	**725,321**	**9,922,471**	**10,647,792**	**-**

1. Within the total above, there were 147 exit packages during 2023-24 relating to the Voluntary Exit Scheme

Table 38b: Exit packages (subject to audit)
Core department and agencies for the year ended 31 March 2023

	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 or less	5	8	13	-
£10,001 to £25,000	9	16	25	-
£25,001 to £50,000	3	11	14	-
£50,001 to £100,000	1	22	23	-
£100,001 to £150,000	-	1	1	-
£150,001 to £200,000	-	2	2	-
More than £200,000	-	-	-	-
Total Number	**18**	**60**	**78**	**-**
Total Cost (£)	**324,012**	**2,732,634**	**3,056,646**	**-**

Table 38c: Exit packages (subject to audit)
Departmental group for the year ended 31 March 2024

	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 or less	254	1,955	2,209	18
£10,001 to £25,000	266	538	804	24
£25,001 to £50,000	169	403	572	9
£50,001 to £100,000	156	403	559	4
£100,001 to £150,000	66	98	164	1
£150,001 to £200,000	48	42	90	-
More than £200,000	1	3	4	-
Total number	**960**	**3,442**	**4,402**	**56**
Total cost (£)	**39,067,020**	**79,377,043**	**118,444,063**	**1,024,465**

Table 38d: Exit packages (subject to audit)
Departmental group for the year ended 31 March 2023

	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 or less	187	2,010	2,197	24
£10,001 to £25,000	185	483	668	36
£25,001 to £50,000	118	446	564	12
£50,001 to £100,000	81	440	521	4
£100,001 to £150,000	19	255	274	-
£150,001 to £200,000	53	128	181	-
More than £200,000	1	2	3	1
Total Number	**644**	**3,764**	**4,408**	**77**
Total Cost (£)	**24,823,139**	**116,019,558**	**140,842,697**	**1,819,806**

Other departures

Table 39 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 39** will not necessarily match the total number in **Table 38**, which represents the number of individuals where exit packages have been agreed.

Table 39: Analysis of other departures (subject to audit)

	2023-24 Departmental group Number	2023-24 Departmental group £'000
Voluntary redundancies including early retirement costs	751	45,373
Mutually agreed resignation schemes (MARS)	491	16,297
Early retirements in the efficiency of the service	4	384
Contractual payments in lieu of notice	2,162	14,859
Exit payments following Employment Tribunals or court orders	96	1,302
Non contractual payments requiring HMT approval	52	1,161
Total	**3,556**	**79,376**

The analysis above may not agree to the cost in **Table 38c** above due to roundings.

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 DHSC'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, the Government Financial Reporting Manual (FReM) requires DHSC to prepare a Statement of Outturn against Parliamentary Supply (SOPS) and supporting notes.

The SOPS and related notes 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**).

Explanations of variances between Estimates and Outturn are given in tables A to D.

The SOPS and Estimates are compiled against the budgeting framework, which is similar to, but different to, IFRS. Further information regarding the fiscal framework can be found in Chapter 1 of the Consolidated Budgeting Guidance. Further information on the Public Spending Framework and the reasons why budgeting rules are different to IFRS can also be found in chapter 1 of the Consolidated Budgeting Guidance, available on gov.uk. **Figure 1** at the front of this report helps show how funds flow around the departmental group.

The SOPS provides a detailed view of financial performance, in a form that is voted on and recognised by Parliament. The financial review, in the Performance Report, provides a summarised discussion of outturn against estimate and functions as an introduction to the SOPS disclosures.

Summary of resource and capital outturn 2023-24

	SOPS note	Outturn			Estimate			Outturn vs estimate: saving / (excess)		Prior year outturn total
		Voted £'000	Non-voted £'000	Total £'000	Voted £'000	Non-voted £'000	Total £'000	Voted £'000	Total £'000	£'000
Departmental expenditure limit										
Resource	1.1	153,763,095	29,055,511	182,818,606	154,805,905	29,055,511	183,861,416	1,042,810	1,042,810	177,094,666
Capital	1.2	10,519,244	-	10,519,244	10,988,845	-	10,988,845	469,601	469,601	9,847,950
Total		**164,282,339**	**29,055,511**	**193,337,850**	**165,794,750**	**29,055,511**	**194,850,261**	**1,512,411**	**1,512,411**	**186,942,616**
Annually managed expenditure										
Resource	1.1	(9,730,033)	-	(9,730,033)	(2,271,625)	-	(2,271,625)	7,458,408	7,458,408	(61,971,916)
Capital	1.2	31,655	-	31,655	105,601	-	105,601	73,946	73,946	20,329
Total		**(9,698,378)**	**-**	**(9,698,378)**	**(2,166,024)**	**-**	**(2,166,024)**	**7,532,354**	**7,532,354**	**(61,951,587)**
Total budget										
Resource	1.1	144,033,062	29,055,511	173,088,573	152,534,280	29,055,511	181,589,791	8,501,218	8,501,218	115,122,750
Capital	1.2	10,550,899	-	10,550,899	11,094,446	-	11,094,446	543,547	543,547	9,868,279
Total budget expenditure		**154,583,961**	**29,055,511**	**183,639,472**	**163,628,726**	**29,055,511**	**192,684,237**	**9,044,765**	**9,044,765**	**124,991,029**

Net cash requirement 2023-24

	SoPS Note	Outturn £'000	Estimate £'000	Outturn vs estimate: saving/ (excess) £'000	Prior year outturn £'000
Net cash requirement	3	160,749,151	164,269,570	3,520,419	144,488,919

Administration costs 2023-24

	Outturn £'000	Estimate £'000	Outturn vs estimate: saving/ (excess) £'000	Prior year outturn £'000
Administration costs	2,571,282	3,118,757	547,475	2,808,359

Figures in the areas outlined in thick line cover the voted control limits voted by Parliament. Refer to the Supply Estimates guidance manual, available on gov.uk, for detail on the control limits voted by Parliament. Although not a separate voted limit, any breach of the administration budget will also result in an excess vote.

SOPS 1 Outturn detail, by estimate line

SOPS 1.1 Analysis of net resource outturn by estimate line

	Resource outturn							Estimate			Outturn vs estimate: saving / (excess)	Prior year outturn total
	Administration			Programme								
	Gross £'000	Income £'000	Net £'000	Gross £'000	Income £'000	Net £'000	Total £'000	Total £'000	Virements £'000	Total incl. Virements £'000	£'000	£'000
Departmental expenditure limit (DEL)												
Voted expenditure												
NHS England net expenditure	1,851,566	-	1,851,566	26,005,541	-	26,005,541	27,857,107	31,722,686	(3,459,279)	28,263,407	406,300	14,524,033
NHS providers net expenditure	-	-	-	114,691,376	-	114,691,376	114,691,376	111,232,097	3,459,279	114,691,376	-	107,932,134
DHSC programme and administration expenditure	358,152	(5,386)	352,766	2,336,819	(2,236,108)	100,711	453,477	2,876,194	(1,817,435)	1,058,759	605,282	5,065,263
Local authorities	-	-	-	3,301,393	-	3,301,393	3,301,393	3,309,210	-	3,309,210	7,817	3,195,761
Executive agencies	180,303	(10,763)	169,540	2,860,150	(400,540)	2,459,610	2,629,150	2,235,605	405,992	2,641,597	12,447	3,737,212
Health Education England net expenditure	-	-	-	-	-	-	-	-	-	-	-	1,789,611
Special health authorities expenditure	211,721	(99,609)	112,112	3,701,293	(42,326)	3,658,967	3,771,079	3,167,691	607,873	3,775,564	4,485	2,969,741
Non-departmental public bodies net expenditure	89,600	-	89,600	114,013	-	114,013	203,613	123,213	81,577	204,790	1,177	769,729
Arm's length and other bodies net expenditure	(4,302)	-	(4,302)	860,202	-	860,202	855,900	139,209	721,993	861,202	5,302	844,324
	2,687,040	**(115,758)**	**2,571,282**	**153,870,787**	**(2,678,974)**	**151,191,813**	**153,763,095**	**154,805,905**	**-**	**154,805,905**	**1,042,810**	**140,827,808**
Non-voted expenditure:												
NHS England expenditure financed by NI contributions	-	-	-	29,055,511	-	29,055,511	29,055,511	29,055,511	-	29,055,511	-	36,266,858
Total spending in DEL	**2,687,040**	**(115,758)**	**2,571,282**	**182,926,298**	**(2,678,974)**	**180,247,324**	**182,818,606**	**183,861,416**	**-**	**183,861,416**	**1,042,810**	**177,094,666**
Annually managed expenditure (AME)												
Voted:												
NHS England net expenditure	-	-	-	(80,093)	-	(80,093)	(80,093)	150,000	-	150,000	230,093	10,693
NHS providers net expenditure	-	-	-	2,158,520	-	2,158,520	2,158,520	2,000,000	158,520	2,158,520	-	962,326
DHSC programme and administration expenditure	-	-	-	(466,781)	-	(466,781)	(466,781)	102,162	(158,520)	(56,358)	410,423	(3,519,936)
Executive agencies	-	-	-	(160,517)	-	(160,517)	(160,517)	728	-	728	161,245	(483,838)
Health Education England net expenditure	-	-	-	-	-	-	-	-	-	-	-	(856)
Special health authorities expenditure	-	-	-	(11,132,970)	-	(11,132,970)	(11,132,970)	(4,551,806)	-	(4,551,806)	6,581,164	(58,933,071)
Non-departmental public bodies net expenditure	-	-	-	(50,717)	-	(50,717)	(50,717)	2,044	-	2,044	52,761	16,508
Arm's length and other bodies net expenditure	-	-	-	2,525	-	2,525	2,525	25,247	-	25,247	22,722	(23,742)
Total spending in AME	**-**	**-**	**-**	**(9,730,033)**	**-**	**(9,730,033)**	**(9,730,033)**	**(2,271,625)**	**-**	**(2,271,625)**	**7,458,408**	**(61,971,916)**
Total resource	**2,687,040**	**(115,758)**	**2,571,282**	**173,196,265**	**(2,678,974)**	**170,517,291**	**173,088,573**	**181,589,791**	**-**	**181,589,791**	**8,501,218**	**115,122,750**

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.

SOPS 1.2 Analysis of net capital outturn by estimate line

	Outturn			Estimate			Outturn vs estimate: savings / (excess) £'000	Prior year outturn total £'000
	Gross £'000	Income £'000	Net total £'000	Net Total £'000	Virements £'000	Total incl. Virements £'000		
Departmental expenditure limits (DEL)								
Voted expenditure								
NHS England net expenditure	376,068	-	376,068	433,307	-	433,307	57,239	238,684
NHS providers net expenditure	7,763,873	(10,072)	7,753,801	7,926,847	-	7,926,847	173,046	7,537,572
DHSC programme and administration expenditure	2,192,069	(48,706)	2,143,363	2,248,983	(1,884)	2,247,099	103,736	1,987,401
Executive agencies	(79,656)	(13,375)	(93,031)	32,277	-	32,277	125,308	(274,232)
Health Education England net expenditure	-	-	-	-	-	-	-	1,889
Special health authorities expenditure	25,317	(1,145)	24,172	34,312	-	34,312	10,140	23,715
Non-departmental public bodies net expenditure	20,804	-	20,804	18,920	1,884	20,804	-	129,542
Arm's length and other bodies net expenditure	294,067	-	294,067	294,199	-	294,199	132	203,379
Total spending in DEL	**10,592,542**	**(73,298)**	**10,519,244**	**10,988,845**	**-**	**10,988,845**	**469,601**	**9,847,950**
Annually managed expenditure (AME)								
Voted expenditure								
NHS England net expenditure	(1,237)	-	(1,237)	13,378	-	13,378	14,615	-
NHS providers net expenditure	16,843	-	16,843	-	16,843	16,843	-	16,807
DHSC programme and administration expenditure	5,060	-	5,060	92,223	(27,832)	64,391	59,331	2,654
Arm's length and other bodies net expenditure	10,989	-	10,989	-	10,989	10,989	-	868
Total spending in AME	**31,655**	**-**	**31,655**	**105,601**	**-**	**105,601**	**73,946**	**20,329**
Total capital	**10,624,197**	**(73,298)**	**10,550,899**	**11,094,446**	**-**	**11,094,446**	**543,547**	**9,868,279**

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

HM Treasury designates that estimates are prepared on a consolidated basis, meaning that all intra-group transactions are removed. Across government, the DHSC 'internal market' of circa £130 billion (mainly transactions between NHS commissioners and NHS providers) is unique to the DHSC group.

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.

At the start of each financial year, we estimate our income and expenditure, including intra-group transactions, for each of the bodies within the DHSC group. Due to the size and complexity of our budget, there will inevitably be some variances in our estimate.

In setting the parliamentary estimate, DHSC takes a pragmatic approach and eliminates only the material transactions between DHSC group bodies.

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.

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	31,723	27,857	3,866	12%	The variance across the NHSE and NHS Providers estimate lines is £0.4 billion and mainly relates to higher than forecast intragroup income and expenditure eliminations.
B	NHS Providers net expenditure	111,232	114,691	(3,459)	-3%	
C	DHSC Programme and Administration expenditure	2,876	453	2,423	84%	The £2.4bn variance mainly relates to: 1. £1.8bn higher than forecast intra group eliminations; and 2. £0.6bn lower than forecast depreciation and impairments expenditure.
D	Local Authorities (Public Health)	3,309	3,301	8	0%	
E	Executive Agencies	2,236	2,629	(393)	-18%	The £0.4bn variance mainly relates to: 1. £0.1bn lower than forecast depreciation and impairments expenditure; and 2. The remaining £0.3bn mainly relates to intra-group budget transfers not wholly completed at the time of finalising the Supplemetary Supply Estimate, for example Vaccines and Countermeasures Response (VCR).
F	Special Health Authorities expenditure	3,168	3,771	(603)	-19%	The £0.6bn variance mainly relates to higher than forecast intragroup income eliminations.
G	Non Departmental Public Bodies net expenditure	123	204	(81)	-66%	The £0.1bn variance mainly relates to higher than forecast intragroup income eliminations.
H	Arm's Length and Other Bodies (Net)	139	856	(717)	-516%	The £0.7bn variance mainly relates to higher than forecast intragroup income eliminations.
I	NHS England expenditure financed by NI Contributions	29,056	29,056	0	0	
Total	**RDEL**	**183,862**	**182,818**	**1,044**		

Annex B includes a more detailed explanation of the DHSC's administrative spend.

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	%	
J	NHS England net expenditure	150	(80)	230	153%	Net provisions expenditure was lower than forecast when setting the final budget.
K	NHS providers net expenditure	2,000	2,159	(159)	-8%	
L	DHSC programme and administration expenditure	102	(467)	569	558%	Net provisions expenditure was lower than forecast when setting the final budget.
M	Executive agencies	1	(161)	162	16200%	UKHSA's net provisions expenditure was lower than forecast when setting the final budget.
N	Special health authorities expenditure	(4,552)	(11,133)	6,581	-145%	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.
O	Non-departmental public bodies net expenditure	2	(51)	53	2650%	Net provisions expenditure was lower than forecast when setting the final budget.
P	Arm's length and other bodies (net)	25	3	22	88%	
Total	**RAME**	**(2,272)**	**(9,730)**	**7,458**		

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.

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	433	376	57	13%	The £0.1bn variance is mainly due to slippage resulting from the NHSE merger, where the scope of work for individual schemes needed to be reassessed to ensure they were fit for the merged organisation.
B	NHS providers net expenditure	7,927	7,754	173	2%	
C	DHSC programme and administration expenditure	2,249	2,143	106	5%	
D	Local authorities (public health)	-	-	-		
E	Executive agencies	32	(93)	125	391%	Capital credits arising from the delivery of prepaid vaccines was higher than predicted as more pre-paid inventory was received in-year.
F	Special health authorities expenditure	34	24	10	29%	Underspend mainly relates to procurement delays of IT systems.
G	Non-departmental public bodies net expenditure	19	21	(2)	-11%	
H	Arm's length and other bodies (net)	294	294	-	0%	
Total	**CDEL**	**10,988**	**10,519**	**469**		

Table D: Comparison of capital AME estimate and outturn

	CAPITAL AME	ESTIMATE	OUTTURN	TOTAL VARIANCE		Explanation of significant variances
		£m	£m	£m	%	
J	NHS England net expenditure	13	(1)	14	108%	IFRS16 dilapidations provisions expenditure was lower than forecast when setting the final budget
K	NHS providers net expenditure	-	17	(17)	0%	IFRS16 dilapidations provisions expenditure was higher than forecast when setting the final budget
L	DHSC programme and administration expenditure	92	5	87	95%	IFRS16 dilapidations provisions expenditure was lower than forecast when setting the final budget
M	Executive agencies	-	-	-	0%	
N	Special health authorities expenditure	-	-	-	0%	
O	Non-departmental public bodies net expenditure	-	-	-	0%	
P	Arm's length and other bodies (net)	-	11	(11)	0%	IFRS16 dilapidations provisions expenditure was higher than forecast when setting the final budget
Total	**CAME**	**105**	**32**	**73**		

SOPS 2 Reconciliation of net resource outturn to net operating expenditure

		SOPS note	2023-24 Outturn £'000	2022-23 Outturn £'000
Total resource outturn		**1.1**	**173,088,573**	**115,122,750**
Add:	Capital Grants		763,964	722,800
	Research and development expenditure		1,506,936	1,451,371
	Service concession arrangement expenditure under IFRS		4,596,438	2,487,476
	Service concession arrangement income under IFRS		(512,331)	(450,061)
	Gain on transfers by absorption		-	182,613
	Other		244,821	407,605
			6,599,828	**4,801,804**
Less:	Income payable to the Consolidated Fund	**4**	(14,034)	(672)
	Donated asset and government grant income		(361,907)	(482,769)
	Service concession arrangement expenditure under UK GAAP		(2,586,324)	(2,294,258)
	Loss on transfers by absorption		(971)	-
			(2,963,236)	**(2,777,699)**
Net operating cost in consolidated statement of comprehensive net expenditure before absorption transfers			**176,725,165**	**117,146,855**

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 capital DEL but accounted for as expenditure in the financial statements, and therefore function as reconciling items between resource and net operating expenditure.

Donated assets and government grant income does not agree to **Note 5** as some of this income is included in income received by NHS charities. This income functions as a reconciling item between resource and net operating expenditure as it is accounted for as income in the financial statements but recognised as capital DEL in outturn.

Other adjustments in 2023-24 mainly relate to COVID-19 adjustments to reflect the agreed budgetary treatment of COVID-19 expenditure. Included within the £245 million adjustment above, £165 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.

SOPS 3 Reconciliation of net resource outturn to net cash requirement

	SOPS note	Outturn £'000	Estimate £'000	Outturn vs estimate: savings / (excess) £'000
Total resource outturn	**1.1**	**173,088,573**	**181,589,791**	**8,501,218**
Total capital outturn	**1.2**	**10,550,899**	**11,094,446**	**543,547**
Adjustments for ALBs:				
Remove voted resource and capital		(154,109,566)	(154,081,147)	28,419
Add cash grant-in-aid, PDC, loans and share capital from core department, and expenditure financed by parliamentary funding		148,856,809	151,472,923	2,616,114
Adjustments to remove non-cash items:				
Depreciation		(221,272)	(1,408,353)	(1,187,081)
New provisions and adjustments to previous provisions		8,469,484	377,421	(8,092,063)
Finance leased asset additions		147	-	(147)
Service concession arrangement revenue adjustments		84,359	-	(84,359)
Adjustment for stockpiled goods		(65,477)	-	65,477
Non-cash investment additions		(9,057)	-	9,057
Net gain/loss on transfers by absorption		3,138	-	(3,138)
Other non-cash items		(1,147,628)	-	1,147,628
Adjustments to reflect movements in working balances:				
Increase / (decrease) in inventories		(361,365)	-	361,365
COVID-19 budgeting impacts on non-cash transactions		179,279	-	(179,279)
Transfers to non-current assets		68,833	-	(68,833)
Increase / (decrease) in receivables		(415,148)	-	415,148
Movement in Consolidated Fund receivables		(13)	-	13
Movement in current financial assets		(119,534)	-	119,534
Movements in finance lease receivables		3,678	-	(3,678)
Capital element of finance lease receivables		(12,759)	-	12,759
(Increase) / decrease in payables		(721,745)	-	721,745
Movement in payables to the Consolidated Fund		1,414,211	-	(1,414,211)
Movement in finance lease/PFI payables		(86,657)	-	86,657
Capital element of finance lease/PFI payables		45,456	-	(45,456)
Use of provisions		4,306,501	4,280,000	(26,501)
		189,801,146	**193,325,081**	**3,523,935**
Removal of non-voted budget items:				
National Insurance contributions		(29,055,511)	(29,055,511)	-
Other adjustments		3,516	-	(3,516)
Net cash requirement		**160,749,151**	**164,269,570**	**3,520,419**

New provisions and adjustments to previous provisions includes the impact of the change in discount rate on provisions of £14.9 billion in 2023-24.

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.

For explanations of variances between estimate and resource and capital outturn, please see explanations of material variances from **page 197** onwards.

SOPS 4 Analysis of income payable to the Consolidated Fund

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

	2023-24 Outturn		2022-23 Outturn	
	Accruals £'000	*Cash basis £'000*	Accruals £'000	*Cash basis £'000*
Income outside the ambit of the Estimate	14,034	*14,021*	672	*672*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total amount payable to the Consolidated Fund	**14,034**	***14,021***	**672**	***672***

Parliamentary accountability disclosures

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 (subject to audit)

Table 40: Losses statement

		2023-24 Core department and agencies	2023-24 Departmental group	2022-23 Core department and agencies	2022-23 Departmental group
Total losses	**Cases**	**1,512**	**467,842**	**900**	**350,040**
	£'000	**8,988,276**	**9,093,885**	**2,752,606**	**2,334,314**
Cases over £300,000					
Cash losses	Cases	-	-	-	5
	£'000	-	-	-	1,787
Claims abandoned	Cases	1	3	1	4
	£'000	7,070	8,933	4,160	8,845
Cancellation of public dividend capital	Cases	-	-	2	-
	£'000	-	-	518,114	-
Fruitless payments	Cases	222	222	115	118
	£'000	2,480,678	2,480,678	279,397	281,740
Constructive losses	Cases	310	311	494	496
	£'000	6,442,148	6,443,314	1,911,579	1,917,481
Store losses	Cases	-	11	1	11
	£'000	-	7,898	2,000	8,085

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.

COVID-19 personal protective equipment (PPE) losses

Introduction

During the height of the pandemic, the demand for PPE far outweighed the supply available globally, driving higher than normal prices which the department was required to meet in order to ensure continuity of supply of these critical safety items. In total, DHSC

purchased approximately 38 billion items of PPE centrally at a total cost of £13.6 billion between 1 April 2020 and 31 March 2024, which were then distributed onwards to the NHS and wider health and social care settings free of charge.

Of this, as noted in the department's ARAs for 2020-21 to 2023-24, £10.0 billion has been recognised in impairment and write-down charges, of which only £19 million has been incurred in 2023-24. The costs of £10.0 billion included:

- Impairments for items that were either not suitable for use at all, or were unsuitable for use in health and care settings
- Impairments for items which were suitable for use, but were not expected to be used in advance of their expiry dates
- Reductions in market value to reflect current prices for items that were suitable for use and expected to be used

In accordance with requirements published by HM Treasury in "Managing Public Money", the department is required to formally report a loss at the point at which items of PPE have been disposed of, or are expected to be disposed of. Between 1 April 2020 and 31 March 2024, the department has reported cumulative losses of £8.1 billion, of which £6.5 billion has been reported in 2023-24. These losses are not in addition to the £10.0 billion costs already reported and as such do not represent additional costs to the taxpayer.

The losses described below relate to items that:

- are unsuitable for any use, or unsuitable for use in health and care settings (classified as fruitless payments)
- are suitable for use but are surplus to requirements and have either been disposed of during 2023-24, or are expected to be disposed of during 2024-25 (classified as constructive losses)

Fruitless payments

Due to the critical nature of the situation during the height of the pandemic, 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 failed to meet the specified criteria due to failing quality or safety standards, a lack of product documentation or insufficient packaging and labelling. These items are therefore unsuitable for use in health and social care settings as intended. Where possible DHSC sought to repurpose these items so they could be safely used in different settings.

DHSC has recorded cumulative losses of £3.3 billion (from the £8.1 billion noted above) for items purchased, which following technical assurance, were deemed unsuitable for any use, or were unsuitable for use in the NHS and could not be repurposed for other uses or sold.

The fruitless payments recorded in 2023-24 were £2.4 billion (from the £6.5 billion noted above) and are included at the weighted average cost price of the relevant functionally interchangeable stock categories. The vast majority of the £2.4 billion loss disclosed in 2023-24 relates to 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 noted above, the vast majority of this inventory has already been impaired in a previous financial year and as such these costs have already been recognised; therefore this loss does not represent an additional cost to the taxpayer.

For fruitless payments in relation to inventory, each group of similar stock keeping units (SKUs) by supplier 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.

The table below shows the cumulative loss position for the PPE programme and details the movement from the prior period's disclosed losses. The cases and amounts below are cumulatively lower than the individual annual reported losses due to enhanced data quality:

		Cumulative Losses	Loss cases reported in more than one year	Data quality adjustments	Losses reported in 2023-24	Cumulative loss reported in 2022-23
Fruitless payments	Cases	700	(149)	(2)	447	404
	£'000	3,311,816		(32,711)	2,385,370	959,157
Constructive losses	Cases	1,286	(670)	2	1,020	934
	£'000	4,782,811		410	4,074,688	707,713

In some cases, recovery action on disputed contracts which may reduce the overall amount of the final loss to the department remains in progress. PPE contracts are also likely to be independently assessed by the COVID-19 Counter-Fraud Commissioner once they are in post.

For further information relating to fraud identified within the PPE programme, please see **page 150**.

Constructive losses

During 2023-24 DHSC has recorded constructive losses of £4.1 billion (of the £6.5 billion noted above) in relation to PPE. These losses arise where inventory which was suitable for use in the NHS was disposed of or because the inventory held was surplus to requirements. As the programme of free PPE donation to the NHS and wider healthcare settings has now ended, all remaining unused inventory has now either been transferred to

the pandemic preparedness stockpile, or has been disclosed as a loss. The vast majority of the items disclosed as losses have already been fully impaired in the financial statements in previous financial years, as they had reached their expiry dates or were expected to do so before they could be used. This loss is stated at the weighted average cost price of the relevant functionally interchangeable stock categories.

For constructive losses in relation to PPE 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.

Other losses

In 2023-24, DHSC also disposed of £112 million of COVID-19 ICU equipment which was not suitable for use in the NHS. This is recorded as a fruitless payment in **Table 40** above.

During 2023-24 DHSC disposed of COVID-19 consumable inventory with a carrying value of £64 million which was surplus to requirements. This is recorded as a constructive loss in **Table 40** above.

During 2023-24 DHSC recognised constructive losses in relation to one COVID-19 medicine with a cost of £343 million which had reached its expiry date. The vast majority of these items were fully impaired in the previous financial year.

The interaction between inventory losses and impairments

As disclosed in **Note 4.3**, DHSC recognised a combined reduction in inventory carrying value totalling £19 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.

The carrying value of PPE held in inventory in the core department is now £Nil. The provision of free PPE to the NHS ceased on 31 March 2024, and consequently all PPE held by the core department has either been transferred to the pandemic preparedness stockpile (and is therefore classified within non-current assets), or is held for future disposal.

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. However, they are disclosed as impairments in the financial statements and are referenced here for clarity.

Note 4.3 describes the other inventory impairments which have been recognised by DHSC. 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 41: Analysis of losses by sector

	2023-24 Number	2022-23 Number	2023-24 £'000	2022-23 £'000
DHSC core	1,494	863	6,978,582	2,476,362
Agencies	18	37	2,009,694	276,244
NHS England group	425,634	304,534	7,611	16,030
NHS providers	39,635	42,408	97,069	82,572
NDPBs	606	1,949	491	951
Special Health Authorities	455	251	438	269
Other group entities	-	-	-	-
Eliminations	-	(2)	-	(518,114)
Departmental group	**467,842**	**350,040**	**9,093,885**	**2,334,314**

Special payments (subject to audit)

Table 42: Special payments

		2023-24 Core department and agencies	2023-24 Departmental group	2022-23 Core department and agencies	2022-23 Departmental group
Total special payments	**Cases**	**28**	**7,411**	**16**	**7,995**
	£'000	**2,341**	**20,755**	**6,794**	**58,801**
Cases over £300,000	Cases	1	4	4	28
	£'000	1,395	4,474	6,396	36,598

Special payments are transactions that Parliament could not have anticipated when passing legislation or approving supply estimates for DHSC. 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) DHSC ensures that any proposal to keep a special payment confidential is carefully justified in line with MPM requirements.

Table 43: Special payments by sector

	2023-24 Number	2022-23 Number	2023-24 £'000	2022-23 £'000
DHSC core	12	6	1,894	1,797
Agencies	16	10	447	4,997
NHS England group	174	56	1,224	581
NHS providers	7,044	7,907	17,106	51,167
NDPBs	4	15	33	235
Special Health Authorities	5	-	1	-
Other group entities	156	1	50	24
Departmental group	**7,411**	**7,995**	**20,755**	**58,801**

Other payments (subject to audit)

There have been no other payments made by the core department for 2023-24 or in 2022-23.

Table 44: Fees and charges (subject to audit)

Fees and charges for the year ended 31 March 2024

	Fees and charges income £'000	Full cost of service £'000	Surplus/(deficit) £'000
Dental	777,479	2,958,044	(2,180,565)
Prescription	693,188	12,485,392	(11,792,204)
Other fees and charges for which the cost of providing the service is over £1million	585,110	565,992	19,118
Total	**2,055,777**	**16,009,428**	**(13,953,651)**

Fees and charges for the year ended 31 March 2023

	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)**

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, as per The National Health Service (Charges for Drugs and Appliances) (Amendment) Regulations 2023, are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2023-24, the NHS prescription charge for each medicine or appliance dispensed was £9.65. However, around 90% of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £31.25 for three months or £111.60 for a year.

Those who are not eligible for exemption are required to pay NHS dental charges, as per The National Health Service (Dental Charges) (Amendment) Regulations 2023, which fall into three bands depending on the level and complexity of care provided. In 2023-24, the charge for Band 1 treatments was £25.80, for Band 2 was £70.70 and for Band 3 was £306.80.

Included in the 'Other fees and charges' (for which the cost of providing the service is over £1.0 million) is £223 million (2022-23: £216 million) of fees and charges and £222 million (2022-23: £218 million) of expenditure relating to regulatory income at the Care Quality Commission.

Remote contingent liabilities (subject to audit)

In addition to IAS 37 contingent liabilities disclosed within the Accounts, DHSC 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 DHSC 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 contingent liabilities

The core 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 2023 £'000	No.	Increase in year £'000	Liabilities crystallised in year £'000	Obligation expired in year £'000	31 March 2024 £'000	31 March 2024 No.	Amount reported to Parliament by departmental minute £'000
Guarantees	-	-	-	-	-	-	-	-
Indemnities	30,525	5	3,817	-	-	34,342	7	32,025
Letters of comfort	-	-	-	-	-	-	-	-
Total	**30,525**	**5**	**3,817**	**-**	**-**	**34,342**	**7**	**32,025**

Quantifiable remote contingent liabilities are as shown below:

Indemnities (£m)		
1[1]	The core department has issued an indemnity in relation to the operations of the Human Fertilisation and Embryology Authority (HFEA).	1.5
2	The core 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[2]
3	The core department has issued an indemnity in respect of a Department of Health and Social Care established statutory, independent inquiry into the care and treatment pathways and the	N/A[2]

	circumstances and practices surrounding the deaths of mental health inpatients in Essex.	
4	The core 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 core 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
6	The core department holds an indemnity relating to use of a monoclonal antibody, Sotrovimab, developed for the treatment of COVID-19 to bring expired stock back into circulation by relabelling the stock.	N/A[2]
7	The core department has issued an indemnity in respect of a DHSC established independent inquiry into the issues raised by the David Fuller case.	N/A[2]

1. This contingent liability relates to the core department only, as the contingent liability is intra group and therefore excluded at the group level.
2. Due to the sensitive nature of these contingent liabilities, the value has not been disclosed.

Unquantifiable contingent liabilities

The core department has entered into a number of unquantifiable or unlimited contingent liabilities with various health bodies and private companies. Where the core 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 core 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 core 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 core 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) • New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) • The Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO)
4	The core 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 core 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 core department has issued an indemnity in relation to the operations of the Human Tissue Authority (HTA).
6	The core 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 core 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 core department has undertaken to cover any damages arising from NHS Blood and Transplant clinical trials activity.
9	The core department holds an indemnity in relation to the Mpox vaccine.
Other Remote Unquantifiable Contingent Liabilities	
10	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.
11	UKHSA holds remote contingent liabilities relating to contract disputes, primarily relating to contracts let in response to the COVID-19 pandemic.
12	UKHSA 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. 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. While this testing has now completed, the limitation of claims relating to these has not yet expired.
13	Legal cases – DHSC as defendant Not disclosed due to sensitive nature of the contingent liabilities.

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 and 2 and accompanying narrative can be found within **Annex C**.

NHS Blood and Transplant (disclosure subject to audit)

In 2023-24, DHSC had lead policy responsibility for NHS Blood and Transplant. As a public corporation the results of NHS Blood and Transplant are not consolidated into the group financial statements.

Accountability Report Sign-Off

12 December 2024
Sir Chris Wormald KCB
Permanent Secretary

THE CERTIFICATE OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSES OF PARLIAMENT

Qualified opinion on financial statements

I certify that I have audited the financial statements of the Department of Health and Social Care (DHSC) and of its Departmental Group for the year ended 31 March 2024 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 2023. The financial statements comprise: the Department's and the Departmental Group's:

- Statement of Financial Position as at 31 March 2024;
- 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 possible effects on the corresponding figures 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's and the Departmental Group's affairs as at 31 March 2024 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.

Opinion on regularity

In my opinion, 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 2024 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

Due to the possible effect of the following matters on the corresponding figures, and the comparability of the current period's figures and the corresponding figures, I have qualified my opinion on the financial statements in two respects.

1) **Basis for qualified opinion on 2022-23 opening balances and 2022-23 in-year transactions of the UK Health Security Agency (UKHSA) as I have been unable to obtain sufficient, appropriate audit evidence**

Overview

I was unable to obtain sufficient, appropriate audit evidence over the transactions and balances in UKHSA's 2022-23 financial statements, and as a result I disclaimed my opinion. The impact of my disclaimer on the 2022-23 UKHSA financial statements means that I have no assurance over these transactions and balances within the Department's and the Departmental Group's accounts. I have been subsequently able to obtain assurance over the 2023-24 opening balances, and therefore the 2022-23 closing balances.

Matter giving rise to qualification

UKHSA was not able to provide sufficient, appropriate evidence to support transactions and balances recorded in its 2022-23 financial statements and I therefore disclaimed my opinion on the UKHSA 2022-23 financial statements. I have undertaken additional procedures in my 2023-24 audit of the UKHSA financial statements, and have been able to obtain assurance that the 2023-24 opening balances, and therefore the 2022-23 closing balances, are not materially misstated in the Core Department & Agencies' and Departmental Group's Statement of Financial Position as at 31 March 2023. As a result of the 2022-23 disclaimed opinion, I have been unable to obtain sufficient, appropriate audit evidence to support the UKHSA net expenditure in 2022-23 of £3.1 billion, and UKHSA total assets less liabilities of £0.4 billion and £0.9 billion as at 1 April 2022 as set out in note 21 to the financial statements, and associated cash flows. I have therefore limited the scope of my audit opinion in respect of these UKHSA transactions recorded in the Core Department & Agencies' and Departmental Group's Statements of Comprehensive Net Expenditure for the year ended 31 March 2023, and in respect of the UKHSA balances as at 1 April 2022 as recorded in the Core Department & Agencies' and Departmental Group's Statement of Changes in Taxpayers' Equity and in the notes to the financial statements.

Scope of my audit work

I audit and give an opinion on the financial statements of UKHSA, an executive agency of the Department. The planned scope of my work for the Department's and the Departmental Group's financial statements 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 financial statements.

Why I was unable to obtain sufficient, appropriate audit evidence

As I disclaimed my audit opinion on the 2022-23 UKHSA financial statements, I have been unable to obtain assurance over these UKHSA transactions included in the Department's and Departmental Group's financial statements, which are set out in note 21 to the financial statements. I was able to obtain sufficient, appropriate audit evidence that the UKHSA opening balances, in-year transactions and closing balances for 2023-24, and therefore the closing balances for 2022-23, were not materially misstated in the Core Department & Agencies' and Departmental Group's financial statements.

I have set out in further detail the background to the 2023-24 UKHSA financial statements within my report to the Houses of Parliament on pages 237 to 242.

2) Basis for qualified opinion on 2022-23 opening balance of inventory and associated 2022-23 in-year transactions due to lack of records

Overview

Whilst I was able to undertake sufficient, appropriate procedures to conclude that the inventory balances as at 31 March 2023 and 31 March 2024 are not materially misstated, I was 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 and Agencies' and Departmental Group's Statements of Financial Position as at 1 April 2022. I was unable to assess the completeness and accuracy of the associated transactions in the Core Department and Agencies' and Departmental Group's Statements of Comprehensive Net Expenditure for the year ended 31 March 2023, including impairments and write downs recognised of £0.69 billion and inventory consumption of £0.83 billion recorded in note 12.

Matter giving rise to qualification

The Department held 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 of this inventory in lieu of stock take procedures. Therefore, I limited the scope of my audit opinion on the opening balance at 1 April 2022 and the associated impairments, write downs and consumption in the 2022-23 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 meant that despite procedures on this area, I was unable to obtain sufficient, appropriate assurance over these figures.

I was able to undertake sufficient, appropriate procedures to conclude that the inventory balance as at 31 March 2023 and 31 March 2024 was not materially misstated and was therefore not subject to qualification.

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.

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**

The framework of authorities described in the table below has been considered in the context of my opinion on regularity.

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. The matters set out in the Basis for qualified opinions on the financial statements section are by their nature key audit matters, as well as those matters set out below.

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 related to the work I have performed in response to other risks identified arising from the preparation of the consolidated annual report and accounts, or in the implementation of IFRS 16 valuation basis for service concession arrangements, for which I did not identify any matters to report.

The key audit matters were discussed with the Audit and Risk Committee; their report on matters that they considered to be significant to the financial statements is set out on pages 131-133.

In this year's report the following changes to the risks identified have been made compared to my prior year report:

- The implementation of new accounting standards (IFRS 16) key audit matter identified in 2022-23 is not considered to be a key audit matter in 2023-24, as the risk I had identified was in respect of the first-time adoption of the new accounting standard. I did not identify any material misstatements in the completeness, valuation or disclosures related to leases accounted for under *IFRS 16: Leases* in 2022-23, and there has not been a material annual change in leasing arrangements. In line with the Government's Financial Reporting Manual, *IFRS 16: Leases* was implemented for the measurement of liabilities arising from service concession arrangements (Private Finance Initiative (PFI) arrangements and Local Improvement Finance Trust (LIFT) arrangements) by the Department and its Group with effect from 1 April 2023, but I do not consider this to be a key audit matter.

- The classification, existence, rights and obligations, presentation, and valuation of the Department's financial assets key audit matter identified in 2022-23 remains a key audit matter in 2023-24. The Department's share capital investments were subject to a full valuation exercise in 2023-24, for which the Department engaged an investments expert. The scope of my audit therefore included additional procedures to respond to this exercise.

Key audit matter – Valuation and disclosure of the NHS Resolution clinical negligence provisions

Description of risk

The Departmental Group recognised provisions totalling £58.2 billion at 31 March 2024 in relation to clinical negligence (31 March 2023: £69.3 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 Departmental Group's financial statements.

This key audit matter has been considered to be one of the most significant assessed risks of material misstatement.

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;
- evaluated whether management had taken appropriate steps to understand and reduce estimation uncertainty; and
- 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 308 to 312.

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 have obtained sufficient assurance over this risk through my testing. I did not identify significant misstatements in the valuation or disclosure of the NHS Resolution clinical negligence provisions as a result of the work I have performed.

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 £52.7 billion, property recognised under IFRS 16: Leases as right-of-use assets of net book value £3.8 billion, property recognised under IAS 40: Investment Property valued at £0.3 billion, and property recognised under IFRS 5: Non-current Assets Held for Sale and Discontinued Operations valued at £0.1 billion as at 31 March 2024 (31 March 2023: Property recognised under IAS 16 £51.8 billion, property recognised as right-of-use assets under IFRS 16 £3.9 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 Departmental Group's financial statements; the majority of the Departmental Group'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 management at each NHS provider. Due to the complexities involved, support is often sought from external valuers, operating in line with guidance issued by the Royal Institute of Chartered Surveyors (RICS). Valuers need to consider the impact of

factors such as the presence (whether known or possible) of reinforced autoclaved aerated concrete (RAAC) and movements in the inflation rate in reaching their valuations as at 31 March 2024.

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.

This key audit matter has been considered to be one of the most significant assessed risks of material misstatement.

How the scope of my audit responded to the risk

In my capacity as group auditor, I directed the auditors of Consolidated NHS Provider Accounts and satisfied myself that they had:

- directed the auditors of NHS providers to obtain specific information on the provider's valuation methodology and approach, and key assumptions in respect of properties, in addition to undertaking their planned procedures;
- evaluated this information in aggregate to establish the appropriateness and consistency of the valuation basis;
- performed year-on-year analytical procedures for total property valuations of NHS providers in aggregate; and
- reviewed management's assessment of the impact of RAAC on property valuations.

Key observations

I have obtained sufficient assurance over this risk through my testing. I did not identify significant misstatements in the valuation of property as a result of the work I have performed.

Key audit matter – Valuation of the infected blood provision (including impact of the Inquiry)

Description of risk

The Department recognised provisions totalling £2.0 billion as at 31 March 2024 (31 March 2023: £2.2 billion) 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. 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 infected blood provision as a significant risk based on its material value and the complexity of the model used to arrive at the estimate.

The final report of the Infected Blood Inquiry was published on 20 May 2024. Its findings, conclusions and recommendations may have resulted in reportable events after the reporting period (see note 19 to the financial statements).

This key audit matter has been considered to be one of the most significant assessed risks of material misstatement.

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 review the appropriateness of the medical assumptions used. We examined the assumptions relating to the progression of the diseases and their impact on the individual's health and life expectancy resulting from the infected blood, which were applied to the

model. I concluded that the assumptions used were appropriate. 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.

I have challenged management on the implications of the final Infected Blood Inquiry report and the government announcements regarding the payment of compensation and the establishment of the Infected Blood Compensation Authority, and assessed whether the remedies and impacts of the Inquiry were appropriately reflected in the valuation of the provision as at 31 March 2024.

I have assessed the adequacy of the financial statements disclosure in relation to the provision, set out on page 312. I have also assessed the adequacy of the financial statements disclosure in respect of the impact of the Infected Blood Inquiry's final report as an event after the reporting period, set out on pages 316 to 317.

Key observations

I have obtained sufficient assurance over this risk through my substantive testing. I did not identify significant misstatements in the valuation of the infected blood provision as a result of the work I have performed.

I have concluded that the publication of the final report of the Infected Blood Inquiry is not an adjusting event after the reporting period.

Key audit matter – Classification, existence, rights and obligations, presentation, and valuation of the Department's financial assets

Description of risk

The Department held financial assets valued at £43.8 billion as at 31 March 2024 (31 March 2023: £48.8 billion). See note 11 to the financial statements. The Department holds four categories of financial assets, three of which had material balances at 31 March 2024:

- *Public Dividend Capital (PDC) to NHS providers of £37.4 billion (31 March 2023: £40.1 billion);*
- *Share capital investments of £4.3 billion (31 March 2023: £5.6 billion);*
- *Loans to NHS providers of £1.9 billion (31 March 2023: £2.2 billion); and*
- *Loans to other bodies of £0.2 billion (31 March 2023: £0.9 billion).*

This key audit matter is in relation to the Department's Public Dividend Capital (PDC) to NHS providers and its share capital investments.

The Department is required to value its share capital investments at 'fair value', which results in a level of inherent uncertainty on estimating the value as at 31 March 2024. The Department undertook a full valuation exercise of its share capital investments as at 31 March 2024 with the assistance of an investments expert.

I identified a risk of misclassification between PDC with and loans to NHS providers, and inherent risks regarding the existence and rights and obligations of financial assets. There is further a risk that the presentation of the Department's financial assets may not be in accordance with the requirements of the reporting framework.

The majority of the Department's financial assets are held within the Departmental Group and are eliminated on consolidation in the Departmental Group financial statements.

This key audit matter has been considered to be one of the most significant assessed risks of material misstatement.

How the scope of my audit	I reviewed the design and implementation of controls around the valuation of financial assets including PDC and share capital investments.

responded to the risk

I tested in-year PDC additions and PDC assets as at 31 March 2024 to confirm that the assets exist and that the rights and obligations of the assets were held by the Department.

I assessed the appropriateness of the Department's impairment policy for PDC and confirmed that this was consistent with prior years. I tested PDC impairment calculations to ensure that they had been applied in line with the Department's accounting policy as set out on page 264. As part of my testing, I confirmed that, after impairment, the PDC recognised by the Department in its financial statements was equal to or less than the net assets held by individual NHS providers, and that there were therefore no indications of further required impairments.

I engaged a valuations expert to assist me in:

- reviewing and challenging the valuation methodology applied by the Department for each of its share capital investments to ensure that these were appropriate, reasonable, and consistently applied;
- reviewing and challenging management's assumptions applied in the valuations, including the discount rate applied, to ensure that these were appropriate; and
- reviewing the relevance and reliability of the data used by the Department in valuing its share capital investments.
- I concluded that the methodology used in the valuation of the Department's share capital investments was appropriate.

I have assessed the adequacy of the disclosures made in respect of the Department's financial assets, including their classification, set out on pages 296 to 298.

Key observations

I have obtained sufficient assurance over this risk through my substantive testing. I did not identify significant misstatements in the classification, existence, rights and obligations,

presentation, and valuation of the Department's financial assets as a result of the work I have performed.

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 (parent)
Materiality	£2.0 billion	£1.8 billion
Basis for determining materiality	Approximately 1% of Departmental Group gross expenditure of £191.3 billion, adjusted to remove the impact of the change in discount rate for provisions of £14.9 billion, giving a total of £206.2 billion. The basis for determining materiality for the 2023-24 financial statements remains the same as that used in 2022-23, when materiality was £1.7 billion.	Approximately 90% of Departmental Group materiality. The basis for determining materiality for the 2023-24 financial statements remains the same as that used in 2022-23, when materiality was £1.5 billion.
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	Use of gross expenditure, adjusted to exclude the impact of the change of discount rate for provisions, of the Department in 2023-24 would have resulted in a materiality approximately the same as

	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. I have adjusted this figure to remove the impact of the change in discount rate for provisions, as this expenditure item is solely a result of macroeconomic conditions resulting in the promulgation of central discount rates set by HM Treasury, can result in significant fluctuations year-on-year, and is not due to the operations of the Departmental Group.	that of the Departmental Group, primarily due to £177.4 billion of Grant in Aid and funding to Departmental Group bodies which is eliminated on consolidation into the Departmental Group financial statements. As a result, to reduce the risk of accumulated misstatements resulting in a material misstatement for the Departmental Group, materiality for the Department has been capped at 90% of the Departmental 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 2023-24 audit (2022-23: 75%). 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.

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 £0.3 billion.

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 Departmental Group had total expenditure of £191 billion, total assets of £102 billion, and total liabilities of £118 billion, as shown in the Consolidated Statement of Comprehensive Net Expenditure on page 243 and the Consolidated Statement of Financial Position on page 244. The Group's largest components in respect of expenditure are the Consolidated NHS Provider Accounts, NHS England, and the Department (parent, excluding executive agencies). The Group's largest components in respect of assets are Consolidated NHS Provider Accounts and the Department (parent, excluding executive agencies). The Group's largest components in respect of liabilities are NHS Resolution and the Consolidated NHS Provider Accounts. I class the Department (parent, excluding executive agencies), 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 2022-23, as set out in the Basis for qualified opinions on the financial statements section above, and in 2021-22. 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 2024; and Community Health Partnerships Ltd, which had assets and liabilities material to the Group at 31 March 2024.

I have audited the full financial information of the Department (parent, excluding executive agencies), as well as directing the auditors of components of the Group, and auditing the Group consolidation. This direction included requiring component auditors to undertake specific procedures to establish compliance of the group as a whole with the Department's framework of authorities. 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:

- 97.9% of the Group's expenditure;
- 91.2% of the Group's income;
- 92.9% of the Group's assets; and
- 95.9% of the Group's liabilities.

The remainder of the transactions and balances in the Department's and the Departmental 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, Community Health Partnerships Ltd, and Wiltshire Health and Care LLP, 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 Department's and Departmental Group's financial statements as a whole.

I have audited the Statement of Outturn against Parliamentary Supply. I have assessed the appropriateness of the Supply classifications of different classes of transaction, and of reconciling items between the Statement of Comprehensive Net Expenditure and the Statement of Outturn Against Parliamentary Supply. I have recalculated the Statement of Outturn against Parliamentary Supply and its supporting notes to ensure that they are accurate.

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 UKHSA total net expenditure of £3.1 billion for 2022-23, and UKHSA total assets less liabilities of £0.4 billion and £0.9 billion as at 1 April 2022, as set out in note 21 to the financial statements, and associated cash flows; and

- the £1.36 billion of consumables inventory represented in the Department's and Departmental Group's Statement of Financial Position as at 1 April 2022, together with the associated transactions in the Department's and Departmental Group's Statement of Comprehensive Net Expenditure for 2022-23, including impairments and write downs recognised of £0.69 billion and inventory consumption of £0.83 billion recorded in note 12 to the financial statements.

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 issued under the Government Resources and Accounts Act 2000.

In my opinion, except for the effects of the matters described below, 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 issued 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.

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 UKHSA total net expenditure of £3.1 billion for 2022-23, and UKHSA total assets less liabilities of £0.4 billion and £0.9 billion as at 1 April 2022, as set out in note 21 to the financial statements, and associated cash flows; and

- the £1.36 billion of consumables inventory represented in the Department's and Departmental Group's Statement of Financial Position as at 31 March 2022, together with the associated transactions in the Department's and Departmental Group's

Statement of Comprehensive Net Expenditure for 2022-23, including impairments and write downs recognised of £0.69 billion and inventory consumption of £0.83 billion recorded in note 12 to the financial statements.

I have concluded that where the Performance Report or Accountability Report refers to transactions or balances covered by my qualification, or where figures include amounts relating to these transactions or balances, it may not be consistent with 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 Report.

In respect solely of the matters referred to in the Basis for qualified opinions on the financial statements section of my certificate:

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

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Principal Accounting Officer's Responsibilities, the Accounting Officer is responsible for:

- maintaining proper accounting records;
- 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;

- preparing financial statements which give a true and fair view and are in accordance with HM Treasury directions issued under the Government Resources and Accounts Act 2000;

- preparing the annual report, which includes the Remuneration and Staff Report, in accordance with HM Treasury directions issued 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.

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 2023;
- 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;
    - 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, including those engaged as valuation experts in respect of share capital investments, and those engaged as modelling experts and medical experts in respect of the infected blood provision, 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 2023, employment law, tax legislation, health and 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, the Audit and Risk Committee, and legal counsel concerning actual and potential litigation and claims;

- I reviewed minutes of meetings of those charged with governance and the Board and internal audit reports;

- I addressed the risk of fraud through management override of controls by testing the appropriateness of journal entries and other adjustments; assessing whether the judgements on estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and

- I reviewed the Department's assessment the level of fraud across the NHS and non-NHS bodies in the Group.

I 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 sufficient appropriate audit evidence 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 **Date 13 December 2024**
Comptroller and Auditor General

National Audit Office
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The Report of the Comptroller and Auditor General to the Houses of Parliament

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) 2023-24 annual report and accounts and explain my qualified 'true and fair' opinion on the prior year comparatives. My report covers:

- an update on the governance, oversight and control issues at the UK Health Security Agency (UKHSA);
- group governance and Departmental oversight; and
- the worsening financial position within NHS providers and the re-emergence of switching capital budgets to cover day-to-day spending.

UK Health Security Agency

2. **In both 2021-22 and 2022-23 (covering the period from UKHSA's operational launch on 1 October 2021 until 31 March 2023) I took the unusual step of disclaiming my opinions over the UKHSA's financial statements.** This was because, in 2021-22, it was possible that the impact of undetected misstatements and irregularities was both material and pervasive to the UKHSA financial statements. Whilst governance arrangements were improved in 2022-23, the lack of assurance from 2021-22 meant that I was unable to obtain assurance over the opening balances and in-year transactions. I was also unable to obtain assurance over the model used to predict future demand for COVID-19 vaccines and therefore estimates of the extent to which vaccines held will be used before they expire; this model supports a number of significant balances in the UKHSA financial statements. These circumstances led me to disclaim my 'true and fair' and 'regularity' opinions on the UKHSA 2021-22 and 2022-23 financial statements, and I consequently limited the scope of my true and fair and regularity opinions over UKHSA transactions and balances recorded in the Department's 2021-22 and 2022-23 group financial statements.

3. **In 2023-24, I modified my audit opinion on the UKHSA financial statements.** I gained sufficient assurance that the UKHSA financial statements give a true and fair view, except for:

- balances as at 31 March 2023, and in-year transactions and cashflows for 2023-24 in relation to the Covid Vaccine Unit (CVU); and

- corresponding figures comprising in-year transactions and cash flows for 2022-23, balances disclosed as at 1 April 2022, and note-only disclosures as at 31 March 2023.

Whilst this is a significant improvement on previous years, further improvements still need to be made.

4. **In my role as DHSC group auditor, I have been able to conclude that UKHSA 2023-24 transactions and balances included in the Core & Agencies' and Departmental Group's financial statements are not materially misstated due to the higher Departmental materialities.** I have not qualified my opinion on the Core & Agencies' and Departmental Group's statements of comprehensive net expenditure for 2023-24 and statements of financial position as at 31 March 2024.

5. **I have welcomed greater rigour in the approach UKHSA has taken to project management in producing its 2023-24 financial statements.** In previous years, I have noted a level of optimism bias in management's approach to preparing the financial statements which has resulted in an underestimation of the scale of the challenge. For UKHSA to continue its progress toward an unqualified audit opinion it is vital that management maintain a realistic approach with appropriate Departmental oversight.

6. **There are still significant weaknesses in UKHSA's control environment, and UKHSA has had to rely upon substantial corrective action to produce a set of auditable accounts.** UKHSA engaged a professional services firm to provide additional support in cleansing listings, quality assuring sample evidence and providing assurance to management over the CVU model. Overall, this has had a positive impact on the audit progress, including UKHSA's ability to provide assurance over the closing CVU balances for the first time. However, my team still identified a high error rate in the account, including a high gross aggregate error in respect of property, plant and equipment and intangible non-current assets. Whilst I was able to conclude that UKHSA's financial statements were materially correct, with the exception of the matters described in paragraph 3 of my report, more needs to be done to improve UKHSA's transaction processing at source and overall control environment. It is imperative that the Department continue to support UKHSA in strengthening their control environment.

Weaknesses in Departmental oversight

Timeliness of reporting

7. **The Department's Annual Report and Accounts for 2023-24 has been presented to Parliament earlier than in recent years (the earliest since before**

the COVID-19 pandemic). The Department laid its Annual Report and Accounts (ARA) in Parliament in the January following the end of the reporting period every reporting period between 2019-20 and 2022-23, having previously laid its ARA before the summer Parliament recess in July in each of the seven years prior to this. The Department has been able to lay its 2023-24 ARA in Parliament in December 2024, a month earlier than for the four preceding years' ARAs.

8. **There has been an overall improvement in the timeliness of NHS providers and Integrated Care Boards (ICBs) reporting their audited financial results.** As I have set out in my reports on the NHS England and Consolidated NHS Provider Accounts 2023-24 ARAs, there has been an improvement in the timeliness of the completion of NHS providers' and ICB's audits in 2023-24 compared to 2022-23. This improvement meant that the NHS England 2023-24 ARA, which consolidates the financial results of ICBs, was laid in Parliament on 10 October 2024, 107 days earlier than for its 2022-23 ARA, and that the Consolidated NHS Provider Accounts 2023-24 ARA was laid in Parliament on 26 November 2024, 60 days earlier than for its 2022-23 ARA.

9. **Significant work remains to enable the Department to meet its target to lay its 2026-27 ARA in Parliament before the Parliamentary summer recess.** In response to recommendations made by the Public Accounts Committee in its report on the Department's 2022-23 ARA, the Department's target is to return to a pre-summer recess sign off for its ARA by the 2026-27 year end. The Department does not currently have an achievable plan to ensure that this will be met. To meet this commitment, the Department's timetable for completion of the NHS provider and ICB audits will need to be significantly advanced. This is dependent on earlier completion of audits at these bodies. In addition, the remaining weaknesses in the UKHSA control environment will need to be addressed to allow an earlier sign off and assurances provided for the Departmental ARA.

Group oversight

10. **My audits identified a number of financial and compliance issues in bodies across the Departmental Group in 2023-24.** In addition to the issues on UKHSA and the timeliness of NHS reporting, these have included the following.

- **A number of entities across the Departmental Group did not seek approval for expenditure that was potentially novel or contentious before the money was spent.** HM Treasury's (HMT's) Managing Public Money (MPM) includes the requirement to obtain prospective approval from HMT for novel, contentious or repercussive expenditure or commitments, and for expenditure outside delegated limits or authorities. In 2023-24, my audit of the Consolidated NHS Provider

Accounts identified a number of instances where retrospective approval was sought for special severance payments. This included a number of exit packages to Chief Executives outside of statutory or contractual agreements. In a number of instances HMT has not yet provided retrospective approval for these items of expenditure. The Department was not aware of these cases until after the expenditure had been incurred.

- **Entities outside the NHS experienced delays in their financial reporting.** A number of audits within the Departmental Group continue to sign off their ARAs late. The Department's process for tracking audit progress is weak and does not always identify issues arising from this process in real time.

Financial challenges in the National Health Service

11. **I issued a report in July 2024 on NHS financial management and sustainability.** NHS resource expenditure grew less in real terms in the decade from 2014-15 than the long-term average calculated over the period 1950-51 to 2013-14, and the NHS's financial position is worsening due to a combination of recent and long-standing issues.

12. **In 2023-24, 61% of NHS providers (2022-23: 43%) recorded operating expenditure greater than their operating income.** As a collective, NHS providers spent £1.7 billion more on operating expenditure than they received in operating income. Deficits at NHS providers could impact on their future financial sustainability.

13. **The worsening of NHS providers' financial positions has led to the Department reducing the value of its Public Dividend Capital (PDC) investments in NHS providers by £7.5 billion in 2023-24.** The Department supports NHS providers by issuing PDC, as described in note 11 to the financial statements. The worsening financial position of NHS providers, exacerbated by the remeasurement of liabilities arising from service concession arrangements as set out in note 1.14.1, means that it is less likely that the Department will be able to recoup its investments. The Department held gross PDC investments in NHS providers of £56.0 billion at the end of 2023-24, including investments made during 2023-24 of £4.9 billion. As described in note 1.19, when an NHS provider's net assets fall below the carrying value of the PDC, the Department impairs its PDC investments. This is to recognise that NHS providers in this position do not have the ability to repay the PDC at the 31 March 2024. The Department has impaired its PDC investments over a number of years: at 31 March 2024, the total level of impairment was £18.6 billion, of which £7.5 billion was impaired in 2023-24.

14. **During 2023-24, the Department switched £892 million of its capital budget to use on day-to-day expenditure.** This reallocation was made,

with HMT approval, in the Supplementary Estimate voted on by Parliament. Such reallocations did not occur during the COVID-19 pandemic, when additional money was made available to the Department for its pandemic response. I have previously reported on the reallocation of capital budgets by the Department in my 2020 Review of Capital Expenditure in the NHS, where the Department transferred £4.3 billion from its capital budgets to its resource budgets between 2014-15 and 2018-19. Continued reallocations of capital budgets increase the risk that healthcare assets deteriorate, costing more to repair and maintain in the long run and potentially impacting patient services.

Qualified 'true and fair' opinion of the prior year comparatives in respect of personal protective equipment inventory

15. **I limited the scope of my audit opinion in 2022-23 in respect of the in-year impairment and consumption of personal protective equipment (PPE) inventory.** Weaknesses in prior year stock-counts meant that I was unable to obtain adequate assurance that the 2022-23 in year impairments and consumption of PPE recorded in the Department's accounts were not materially misstated. The value of remaining PPE inventory was immaterial as at 31 March 2023 and at 31 March 2024 and therefore I have not qualified my true and fair opinion in this respect.

16. **As I reported in 2022-23, the Department has been undertaking a planned disposal programme for PPE it purchased during the COVID-19 pandemic that it has now deemed surplus or unusable.** This programme is due to complete during the 2024-25 financial year and, on the basis that the remaining PPE is surplus or unusable and destined for disposal, I have determined that the value of PPE inventory held in the Department's Core and Agencies, and Departmental Group financial statements is materially correct.

17. **At the end of 2023-24, the Department transferred £73m of PPE from being held as 'inventory' in its accounts to being held as 'stockpile goods'.** Stockpile goods are strategic materials held for us in national emergencies, and are held with property, plant and equipment as non-current assets in the statement of financial position. This stockpile of PPE is held for use in any potential future pandemic. However, although short term arrangements are in place as described by the Department on pages 141 to 143, I remain concerned that the Department does not yet have a longer term strategy for the purchase, maintenance or use of stockpile goods in any future national emergency.

Recommendations

18. **The Department should support UKHSA to continue focusing on improving its accounting at source rather than relying on time-consuming and costly**

corrective controls. This would improve in-year financial control and facilitate the timelier provision of sufficient appropriate audit evidence. For 2023-24 UKHSA has successfully produced a set of auditable financial statements which is a significant achievement from a difficult starting point. The Department should work with UKHSA to build on this to secure effective financial management and reporting.

19. **The Department should better understand and address issues faced by its group bodies to improve compliance with MPM.** To do this, the Department should improve its governance and oversight of the bodies within its group and its understanding of the challenges they face. This will allow the Department to work with its bodies to proactively address issues on a timely basis and ensure they comply with the requirements that public money is spent with the appropriate approvals.

20. **The Department should set out a plan for laying its ARA in Parliament before Parliamentary summer recess in 2027**. The Department does not currently have an achievable plan to ensure that this will be met. The Department will need to consider the internal and external barriers to achieving pre-summer recess laying, and then clearly set out what the next key steps are to removing these.

Gareth Davies **13 December 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 statement summarises the expenditure incurred and income generated on an accruals basis. It also includes other comprehensive income and expenditure, which includes changes to the values of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

For the year ended 31 March 2024

	Note	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Income from contracts	5	(2,666,410)	(12,209,191)	(2,260,805)	(11,165,446)
Non-contract income	5	(1,085,195)	(1,488,107)	(1,211,298)	(1,788,895)
Income received by NHS charities		-	(141,404)	-	(169,781)
Total operating income		**(3,751,605)**	**(13,838,702)**	**(3,472,103)**	**(13,124,122)**
Staff costs	3	752,654	89,948,968	868,370	85,089,315
Purchase of goods and services	4	2,255,036	86,844,204	4,169,662	82,808,978
Depreciation and impairment charges	4	6,336,277	5,879,603	(92,897)	4,974,148
Provision expense	4	672,814	(8,400,110)	(163,608)	(56,685,146)
Other operating expenditure	4	9,333,024	12,888,602	9,395,974	13,010,995
Grant in aid to NDPBs		176,843,451	-	162,007,841	-
Funding to group bodies		547,480	-	606,190	-
Resources expended by NHS charities		-	143,167	-	75,326
Total operating expenditure		**196,740,736**	**187,304,434**	**176,791,532**	**129,273,616**
Net operating expenditure		**192,989,131**	**173,465,732**	**173,319,429**	**116,149,494**
Finance income		(71,259)	(695,692)	(70,418)	(328,027)
Finance expense	4	122,575	3,955,125	18,569	1,325,388
Net (gain)/loss on transfers by absorption		(3,138)	971	(97,021)	(182,613)
Net expenditure for the year		**193,037,309**	**176,726,136**	**173,170,559**	**116,964,242**
Other comprehensive net expenditure					
Items that will not be reclassified to net operating costs:					
Net (gain)/loss on:					
- revaluation of property, plant and equipment	6	(75,612)	(1,663,218)	(28,828)	(2,850,195)
- revaluation of intangibles	7	(737)	(5,857)	(30,118)	(31,133)
- revaluation of right of use assets	8	(232)	(17,103)	-	(25,324)
- revaluation of charitable assets		-	(22,604)	-	18,842
- net impairments taken to revaluation reserve	4.3	200	1,737,084	-	575,820
- equity instruments measured at fair value	11	1,478,601	(101)	(169,664)	73,959
- other financial assets mandated at fair value	11	-	7	-	136
Actuarial (gains)/losses on pension schemes		-	(9,689)	-	(113,630)
Other pension remeasurements		-	12,472	-	44,579
Other (gains) and losses		-	(6,642)	-	17,367
Comprehensive net expenditure for the year		**194,439,529**	**176,750,485**	**172,941,949**	**114,674,663**

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. Public dividend capital 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 2024

	Note	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Non-current assets					
Property, plant and equipment	6	910,665	68,387,445	1,181,130	66,872,802
Investment property		43,341	281,604	44,125	240,813
Intangible assets	7	124,969	2,940,323	103,033	2,734,969
Right of use assets	8	155,034	4,574,893	234,907	4,632,328
Charitable non-current assets		-	1,819	-	8,431
Net pension asset		-	45,142	-	-
Non-current investments	11	43,811,802	638,506	48,799,049	651,426
Charitable investments		-	350,230	-	355,641
Other non-current assets	14	255,143	789,594	419,088	900,718
Total non-current assets		**45,300,954**	**78,009,556**	**50,781,332**	**76,397,128**
Current assets					
Assets held for sale		9,519	64,518	750	45,117
Inventories	12	692,115	2,311,452	1,053,480	2,602,442
Trade and other receivables	14	376,420	3,905,293	1,312,919	4,459,331
Other current assets	14	943,394	2,966,365	392,071	2,291,887
Charitable other current assets		-	23,730	-	24,015
Other financial assets (investments)	14	334,552	104,398	215,018	2,277
Cash and cash equivalents	13	2,369,542	14,591,920	1,016,021	15,561,412
Charitable cash		-	203,605	-	259,924
Total current assets		**4,725,542**	**24,171,281**	**3,990,259**	**25,246,405**
Total assets		**50,026,496**	**102,180,837**	**54,771,591**	**101,643,533**
Current liabilities					
Trade and other payables	15	(63,595)	(8,621,315)	(676,542)	(9,165,003)
Other liabilities	15	(5,051,935)	(23,784,738)	(3,497,591)	(24,766,815)
Charitable liabilities		-	(64,310)	-	(54,345)
Provisions	16	(814,964)	(5,561,675)	(982,060)	(5,310,129)
Total current liabilities		**(5,930,494)**	**(38,032,038)**	**(5,156,193)**	**(39,296,292)**
Total assets less current liabilities		**44,096,002**	**64,148,799**	**49,615,398**	**62,347,241**
Non-current liabilities					
Other payables	15	(36,678)	(954,108)	(147,214)	(993,689)
Charitable liabilities		-	(9)	-	(3,634)
Provisions	16	(3,166,261)	(58,922,323)	(3,625,023)	(71,053,568)
Net pension liability		-	-	-	(12,727)
Financial liabilities	15	(211,881)	(20,326,003)	(297,014)	(12,833,776)
Total non-current liabilities		**(3,414,820)**	**(80,202,443)**	**(4,069,251)**	**(84,897,394)**
Total assets less liabilities		**40,681,182**	**(16,053,644)**	**45,546,147**	**(22,550,153)**
Taxpayers' equity and other reserves					
General fund		36,999,238	(32,285,589)	40,565,147	(39,150,679)
Revaluation reserve		329,575	15,409,618	234,864	15,809,765
Other reserves		3,352,369	307,262	4,746,136	200,729
Total equity		**40,681,182**	**(16,568,709)**	**45,546,147**	**(23,140,185)**
Charitable funds		-	515,065	-	590,032
Total reserves		**40,681,182**	**(16,053,644)**	**45,546,147**	**(22,550,153)**

1. **Note 21** 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.

12 December 2024
Sir Chris Wormald KCB
Permanent Secretary

Consolidated statement of cash flows

The statement 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 by classifying cash flows as operating, investing and financing activities. The amount of net cash flows arising from operating activities is a key indicator of service costs and the extent to which these operations are funded by way of income from the recipients of services provided by the department. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to the department's future public service delivery.

For the year ended 31 March 2024

	Note	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Net cashflow from operating activities					
Net expenditure for the year		(193,037,309)	(176,726,136)	(173,170,559)	(116,964,242)
Adjustments for non-cash transactions	4.2	8,633,776	(135,286)	635,791	(50,668,574)
Adjustments for net finance costs		(65,147)	2,232,288	(66,052)	767,623
Other non cash movements in statement of financial position items		(14,932)	(48,242)	(13,766)	(109,731)
Adjustments for charities		-	35,138	-	3,220
(Increase)/decrease in trade and other receivables	14	429,587	(111,437)	105,017	(429,222)
(Increase)/decrease in inventories	12	361,365	290,990	1,099,795	980,397
Increase/(decrease) in trade and other payables	15	745,728	5,926,881	(2,917,762)	3,244,685
Movements arising from absorption transfers		(3,138)	971	(97,021)	(182,613)
Adjustment for working capital amount arising from absorption transfers		17,394	49	(17,472)	(17,472)
Adjustment for working capital movements not in income or expenditure		(1,267,801)	(9,343,087)	(292,959)	(3,226,572)
Use of provisions	16	(527,927)	(3,591,803)	(899,301)	(3,798,409)
Transfer of provisions to payables/ inventories	16	(905,767)	(954,889)	(3,041,959)	(3,085,076)
Cash payments in respect of pensions		-	(2,980)	-	(6,396)
Other operating cashflows		(10,292)	10,786	53,903	46,057
Net cash outflow from operating activities		**(185,644,463)**	**(182,416,757)**	**(178,622,345)**	**(173,446,325)**
Cash flows from investing activities					
Purchase of property, plant, equipment and investment properties		(101,085)	(7,341,423)	(256,180)	(7,565,135)
Purchase of intangible assets		(77,741)	(835,806)	(109,742)	(847,435)
Purchase of investments		(5,110,000)	(18,956)	(3,676,102)	(34,133)
Proceeds of disposal of property, plant and equipment		8,718	118,500	16,538	106,396
Proceeds of disposal of intangibles		5	1,412	230	4,575
Proceeds of disposal of right of use assets		2,948	587	4,171	1,229
Proceeds of disposal of assets held for sale		689	62,508	-	70,591
Proceeds of disposal of investments		1,034,653	23,759	1,742,633	8,423
Receipts in respect of finance leases		12,759	7,966	4,382	12,396
Interest received from group bodies		65,347	-	45,313	-
Interest received from external bodies		43	671,899	1,379	303,281
Non-cash disposals of financial assets		(656)	(656)	(104)	-
Payment of direct costs in respect of obtaining right of use assets		-	(538)	-	(323)
Other investing cashflows		-	39,856	10,831	11,474
Net cash outflow from investing activities		**(4,164,320)**	**(7,270,892)**	**(2,216,651)**	**(7,928,661)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year	SoCTE	162,150,000	162,150,000	144,900,000	144,900,000
Net financing from the National Insurance Fund	SoCTE	29,055,511	29,055,511	36,266,858	36,266,858
Net movements of capital element of loans		-	(27,212)	-	(7,952)
Payments in respect of leases		(41,405)	(810,527)	(36,400)	(718,782)
Capital payments in respect of PFI contracts		-	(775,010)	-	(410,909)
Interest paid to group bodies		(1,116)	-	(1,011)	-
Interest paid to external bodies		(14)	(907,374)	(21)	(983,314)
Net cash transferred under absorption accounting		-	-	51,047	51,047
Other financing cashflows		-	(10,880)	(1,329)	(1,731)
Net cash outflow from financing activities		**191,162,976**	**188,674,508**	**181,179,144**	**179,095,217**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**1,354,193**	**(1,013,141)**	**340,148**	**(2,279,769)**
Payment of amounts due to the Consolidated Fund		(672)	(672)	(284,012)	(284,012)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**1,353,521**	**(1,013,813)**	**56,136**	**(2,563,781)**
Cash and cash equivalents at the beginning of the period		1,016,021	15,780,586	959,885	18,344,367
Cash and cash equivalents at the end of the period		**2,369,542**	**14,766,773**	**1,016,021**	**15,780,586**

The increase in adjustments for working capital movements not in income or expenditure is mostly due to the application of IFRS 16 principles to service concession liabilities, as required by the FReM. Further detail is provided in **Note 1.14**.

Consolidated statement of changes in taxpayers' equity: core department and agencies

This statement shows the movement in the year on the different reserves held by the department and its agencies, analysed into 'general fund reserves' (that is, those reserves that reflect a contribution from the Consolidated Fund). The revaluation reserve reflects the change in asset values that have not been recognised as income or expenditure. Other reserves represents unrealised gains on financial assets held at fair value through other comprehensive income. The general fund represents the total assets less liabilities of a department, to the extent that the total is not represented by other reserves and financing items.

For the year ended 31 March 2024

	Note	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Taxpayers' equity £'000
Balance at 1 April 2023		**40,565,147**	**234,864**	**4,746,136**	**45,546,147**
Prior period adjustments in local accounts		(25,445)	26,431	-	986
Parliamentary and other funding					
Parliamentary funding - drawn down	SoCF	162,150,000	-	-	162,150,000
Parliamentary funding - deemed		1,658,498	-	-	1,658,498
Parliamentary funding - amounts unspent at period end	15	(3,059,347)	-	-	(3,059,347)
Amounts payable to the Consolidated Fund	15	(14,034)	-	-	(14,034)
National Insurance Fund contributions	SoCF	29,055,511	-	-	29,055,511
Net expenditure for the year	SoCNE	(193,037,309)	-	-	(193,037,309)
Non-cash auditor's remuneration	4.1	2,460	-	-	2,460
Other comprehensive net expenditure					
Net gain/(loss) on revaluation of non-current assets		-	76,581	-	76,581
Net impairments	4.3	-	(200)	-	(200)
Fair value gains/(losses) on equity instruments	11	(85,034)		(1,393,567)	(1,478,601)
Other movements					
Transfers between reserves		8,092	(7,892)	(200)	-
PDC impairments	4.3	(226,725)	-	-	(226,725)
Other movements		7,424	2	-	7,426
Other transfers		-	(211)	-	(211)
Balance at 31 March 2024		**36,999,238**	**329,575**	**3,352,369**	**40,681,182**

For the year ended 31 March 2023

	Note	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Taxpayers' equity £'000
Balance at 1 April 2022		**33,024,559**	**89,634**	**4,611,290**	**37,725,483**
Impact of adoption of IFRS 16		6,578	-	-	6,578
Parliamentary and other funding					
Parliamentary funding - drawn down	SoCF	144,900,000	-	-	144,900,000
Parliamentary funding - deemed		1,247,417	-	-	1,247,417
Parliamentary funding - amounts unspent at period end	15	(1,658,498)	-	-	(1,658,498)
Amounts payable to the Consolidated Fund	15	(672)	-	-	(672)
National Insurance Fund contributions	SoCF	36,266,858	-	-	36,266,858
Net expenditure for the year	SoCNE	(173,170,559)	-	-	(173,170,559)
Non-cash auditor's remuneration	4.1	2,350	-	-	2,350
Other comprehensive net expenditure					
Net gain/(loss) on revaluation of non-current assets		-	58,946	-	58,946
Fair value gains/(losses) on equity instruments	11	(56,323)	-	225,987	169,664
Other movements					
Transfers between reserves		4,752	86,388	(91,140)	-
PDC impairments	4.3	518,337	-	-	518,337
PDC written off		(518,337)	-	-	(518,337)
Other movements		(1,325)	(2)	(1)	(1,328)
Other transfers		10	(102)	-	(92)
Balance at 31 March 2023		**40,565,147**	**234,864**	**4,746,136**	**45,546,147**

Consolidated statement of changes in taxpayers' equity: departmental group

This statement shows the movement in the year on the different reserves held by the department and its agencies, analysed into 'general fund reserves' (that is, those reserves that reflect a contribution from the Consolidated Fund). The revaluation reserve reflects the change in asset values that have not been recognised as income or expenditure. Other reserves represents unrealised gains on financial assets held at fair value through other comprehensive income, the differences between the value of non-current assets taken over by NHS bodies at establishment and the corresponding figure in the opening capital debt and to reflect pension assets/liabilities in respect of staff in non-NHS defined benefit pension schemes. The general fund represents the total assets less liabilities of a department, to the extent that the total is not represented by other reserves and financing items.

For the year ended 31 March 2024

	Note	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Taxpayers' equity £'000	Charitable funds £'000	Total reserves £'000
Balance at 1 April 2023		**(39,150,679)**	**15,809,765**	**200,729**	**(23,140,185)**	**590,032**	**(22,550,153)**
Prior period adjustments in local accounts		(47,162)	(3,993)	88,893	37,738	(937)	36,801
Application of IFRS 16 measurement principles to PFI liability		(6,396,880)	(152,393)	-	(6,549,273)	-	(6,549,273)
Parliamentary and other funding							
Parliamentary funding - drawn down	SoCF	162,150,000	-	-	162,150,000	-	162,150,000
Parliamentary funding - deemed		1,658,498	-	-	1,658,498	-	1,658,498
Parliamentary funding - amounts unspent at period end	15	(3,059,347)	-	-	(3,059,347)	-	(3,059,347)
Amounts payable to the Consolidated Fund	15	(14,034)	-	-	(14,034)	-	(14,034)
National Insurance Fund contributions	SoCF	29,055,511	-	-	29,055,511	-	29,055,511
Net expenditure for the year	SoCNE	(176,629,459)	-	-	(176,629,459)	(96,677)	(176,726,136)
Non-cash auditor's remuneration	4.1	2,633	-	-	2,633	-	2,633
Other comprehensive net expenditure							
Net gain/(loss) on revaluation of non-current assets		-	1,686,178	-	1,686,178	-	1,686,178
Fair value gains/(losses) on equity instruments		(454)	-	555	101	-	101
Net gain/(loss) on revaluation of charitable assets		-	-	-	-	22,604	22,604
Fair value gains/(losses) on other financial assets	11	-	-	(7)	(7)	-	(7)
Net impairments	4.3	-	(1,737,084)	-	(1,737,084)	-	(1,737,084)
Net actuarial gain/(loss) on defined benefit pension scheme		9,689	-	-	9,689	-	9,689
Other pensions remeasurements		(15,687)	-	3,215	(12,472)	-	(12,472)
Other gains and losses		6,706	-	(64)	6,642	-	6,642
Other movements							
Transfers between reserves		151,455	(165,395)	13,940	-	-	-
Other movements		(32,870)	(758)	1	(33,627)	43	(33,584)
Other transfers		26,491	(26,702)	-	(211)	-	(211)
Balance at 31 March 2024		**(32,285,589)**	**15,409,618**	**307,262**	**(16,568,709)**	**515,065**	**(16,053,644)**

For the year ended 31 March 2023

	Note	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Taxpayers' equity £'000	Charitable funds £'000	Total reserves £'000
Balance at 1 April 2022		**(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		235,514	-	-	235,514	-	235,514
Parliamentary and other funding							
Parliamentary funding - drawn down	SoCF	144,900,000	-	-	144,900,000	-	144,900,000
Parliamentary funding - deemed		1,247,417	-	-	1,247,417	-	1,247,417
Parliamentary funding - amounts unspent at period end	15	(1,658,498)	-	-	(1,658,498)	-	(1,658,498)
Amounts payable to the Consolidated Fund	15	(672)	-	-	(672)	-	(672)
National Insurance Fund contributions	SoCF	36,266,858	-	-	36,266,858	-	36,266,858
Net expenditure for the year	SoCNE	(116,955,190)	-	-	(116,955,190)	(9,052)	(116,964,242)
Non-cash auditor's remuneration	4.1	2,510	-	-	2,510	-	2,510
Other comprehensive net expenditure							
Net gain/(loss) on revaluation of non-current assets		-	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	11	(56,323)	-	(17,636)	(73,959)	-	(73,959)
Fair value gains/(losses) on other financial assets	11	-	-	(136)	(136)	-	(136)
Net impairments	4.3	-	(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)
Other movements							
Transfers between reserves		80,484	6,071	(86,555)	-	-	-
Other movements		(23,692)	(6,903)	72	(30,523)	(177)	(30,700)
Other transfers		22,951	(23,043)	-	(92)	-	(92)
Balance at 31 March 2023		**(39,150,679)**	**15,809,765**	**200,729**	**(23,140,185)**	**590,032**	**(22,550,153)**

Notes to the financial statements

1. Statement of accounting policies

The accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) as adapted and interpreted by the 2023-24 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply 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 DHSC for the purpose of giving a true and fair view has been selected. The policies adopted by DHSC are described below and have been applied consistently in dealing with items considered material to the accounts.

The 2023-24 annual report and accounts includes two departures from the FReM, both of which have been agreed with HM Treasury:

- public dividend capital issued by the core department on the creation of new NHS trusts, any subsequent impairment, or that written-off on dissolution, are recognised as movements in the general fund.

- receipts of National Insurance contributions from the National Insurance Fund are recognised on a cash basis.

The FReM requires DHSC's annual report and accounts to be produced on a going concern basis. Parliament has demonstrated its commitment to fund DHSC for the foreseeable future. There is no reason to believe funding will not be available to meet the future liabilities of DHSC. Therefore the use of the going concern basis is appropriate.

1.1 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.

1.2 Basis of consolidation

The accounts comprise a consolidation for the core department, 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, integrated care boards, NHS charities, and certain limited companies.

The departmental group includes all entities designated for inclusion by HM Treasury, which equates to those bodies that are classified by the Office for 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 DHSC.

1.3 Employee benefits

1.3.1 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.

1.3.2 Retirement benefit costs - NHS Pensions

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website.

Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 respect of defined benefit schemes, the FReM requires that the period between formal valuations shall be four years, with approximate assessments in intervening years. An outline of the basis of valuation of the NHS Pension Scheme is as 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 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 and was published in April 2024. The results of this valuation set the employer contribution rate payable from April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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.

Figures relating to NHS pensions cost for the Department can be found in **Note 3**.

1.4 Grants payable and grant-in-aid

1.4.1 Grants payable

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

1.4.2 Grant-in-aid

The provision of grant-in-aid by DHSC 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**.

1.5 Audit costs

A charge reflecting the cost of audit is included in expenditure. DHSC 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 DHSC annual report and accounts.

Other consolidated bodies are either audited by the Comptroller and Auditor General or they appoint an auditor under the relevant statutory provisions. Expenditure in respect of audit fees is included in their individual accounts.

1.6 Value added tax

Most of the activities of DHSC 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, with the exception of leases under IFRS 16 where the FReM requires that irrecoverable VAT is expensed on a straight-line basis over the life of the lease. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.7 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 DHSC relates to the delivery of healthcare. Further detail is provided in **Note 5**. DHSC 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.

A significant source of revenue for the core department relates to the voluntary scheme for branded medicines pricing, access and growth (VPAG). DHSC 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. Payments in relation to the final year of the 2019 scheme are expected to be subject to a refund as part of the end of scheme reconciliation. DHSC recognises a contract liability for these amounts, which is included in **Note 15.**

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 IFRS 15. DHSC uses historic knowledge and experience, as well as comparison with actual payments received after the reporting date in constraining the estimate.

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, such as the issue of a prescription or payment for dental treatment.

There are sources of income that DHSC receives which are outside the scope of IFRS 15 as adapted and interpreted by the FReM. Where this is the case, DHSC recognises the income when it can be measured reliably, and it is probable that economic benefit associated with the transaction will flow to DHSC 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 2023-24 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.

1.8 Property, plant, and equipment (PPE)

1.8.1 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, DHSC
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item costs 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.

1.8.2 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 (DRC), modern equivalent asset basis (MEA)

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.

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.

1.8.3 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 expensed in the period in which it is incurred.

1.9 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 DHSC'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 (MEA basis) and value in use where the asset is income generating.

1.10 Research and development

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

Expenditure on development activity can be capitalised subject to meeting the specific recognition criteria for internally generated intangible assets. The sum of the expenditure incurred from the date when the criteria for recognition are initially met, represents the initial recognition value for such an intangible asset. 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

Freehold land and investment properties are not depreciated.

Assets in the course of construction or development are not depreciated until the asset is brought into use.

Otherwise, depreciation or amortisation, as appropriate, is charged to record the costs or valuation of PPE, right of use assets and intangible non-current assets, less any residual value, in expenditure on a straight-line basis over their estimated remaining useful lives, or lease term, whichever is shorter. The estimated useful life of an asset is the period over which DHSC expects to obtain economic benefits or service potential from the asset.

Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.11.2 Revaluation and impairments

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, DHSC determines whether there is any indication that its PPE, right of use assets 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.

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 Leases

1.13.1 General approach of IFRS 16

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. In applying IFRS 16 DHSC has applied the following expedients and elections:

- Right of use assets and corresponding lease liabilities have not been recognised for leases with a term of 12 months or less, with such short-term arrangements being expensed on a straight-line basis.

- Right of use assets and corresponding lease liabilities have not been recognised for leases where the underlying asset is below £5,000, with such low value assets being expensed on a straight-line basis.

- DHSC has chosen not to apply IFRS 16 to any new leases of intangible assets.

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:

- DHSC 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 DHSC has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

- DHSC 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 the treatment of donated assets.

1.13.2 Acting as a lessee

At the commencement date for the leasing arrangement a lessee recognises a right of use asset and corresponding lease liability.

DHSC employs a revaluation model for the subsequent measurement of its right of use assets, across all categories of right of use assets disclosed in **Note 8**, 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.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the statement of comprehensive net expenditure.

HM Treasury incremental borrowing rates have been applied in accounting for lease liabilities where the lessee cannot readily determine the interest rate implicit in the lease unless another discount rate would more accurately represent the incremental borrowing rate. The incremental borrowing rate was 3.51%, for leases entered into or appropriately modified or remeasured, from 1 January 2023 and 4.72% from 1 January 2024.

Where changes in future lease payments result from a change in an index or rate or rent review, 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, DHSC will apply a revised rate for calculating the remeasured lease liability. Where existing leases are modified DHSC determines whether the arrangement constitutes a separate lease.

1.14 Service concession arrangements

HM Treasury has determined that government bodies shall account for infrastructure PFI and 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. DHSC therefore recognises the PFI or LIFT asset as an item of property, plant and equipment, together with a liability to pay for it, on its 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
- Payment for the replacement of components of the asset during the contract ‘lifecycle replacement’

1.14.1 PFI and LIFT assets, liabilities, and finance costs

PFI and LIFT assets are recognised as PPE when they come into use.

The FReM required that, from 1 April 2023, the service concession assets and related liabilities are initially measured in accordance with the principles of IFRS 16. Prior to 1 April 2023 initial measurement was in accordance with the principles of IAS 17. This change was to be applied prospectively.

Subsequently PFI and LIFT assets are measured at current value in existing use as detailed in **Note 1.8.2**.

IAS 17 and IFRS 16 both require an annual finance cost to be charged to expenditure, calculated by applying the implicit interest rate in the lease to the lease liability for the period. Under IAS 17, an element of the annual unitary payment increase due to cumulative indexation, was treated as contingent rent and expensed as incurred. Under IFRS 16 in contrast, contingent rent is considered a variable lease payment dependent upon an index or rate and factored in to the ongoing remeasurement of the lease liability.

From 1 April 2023, service concession liabilities are remeasured when cashflows change as a result of a change in index or rate. The net change in lease liabilities due to remeasurement is charged to finance costs in expenditure.

On 1 April 2023 service concession liabilities have been remeasured to include all the index linked changes relating to the capital element of the contract which took place since the arrangement commenced. This remeasurement has been completed using a cumulative catch-up approach by which the cumulative effect of the change in measurement of the service concession liability is recognised as an adjustment to the opening balance of taxpayers' equity. Comparative information has not been restated in line with the transitional requirements detailed in the FReM.

Other areas of accounting for PFI and LIFT arrangements are unaffected by this change in the measurement basis of the liability from 1 April 2023.

1.14.2 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.

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

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

1.14.4 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

Inventories are valued at the lower of cost and net realisable value. Expenses are recognised on sale, donation, consumption, impairment or write off of the inventory in the period in which the specific event occurs.

Impairment of inventories result from a fall in their estimated net realisable value. 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.

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 DHSC has a present legal or constructive obligation as a result of a past event, it is probable that DHSC 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. These discount rates are published in the DHSC Group Accounting Manual.

1.17.1 Clinical negligence costs

Clinical negligence costs are managed through schemes run by NHS Resolution.

The accounts for the schemes are prepared by NHS Resolution in accordance with IAS 37. Further detail as to the management of the schemes can be found in NHSR's 2023-24 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.

NHS Resolution 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. NHS Resolution'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.

Some key assumptions used in the production of the estimates reported are outside the formal control of NHS Resolution. For instance, HM Treasury prescribes the discount rates to be used in calculating the provisions. Patients (and their legal representatives) also 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.

The schemes NHS Resolution manage are detailed in NHS Resolution's annual report and accounts. All the schemes relate to the management of claims for clinical negligence.

1.18 Contingent liabilities and contingent assets

A contingent liability is either:

- 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 DHSC

- 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 DHSC's contingent liabilities. Remote contingent liabilities are disclosed elsewhere in the annual report and accounts as part of DHSC'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 DHSC. A contingent asset is disclosed where an inflow of economic benefits is probable.

1.19 Public dividend capital, funding, and interaction with financial instruments

DHSC 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.

DHSC'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 by the core department.

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 the core department.

DHSC 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 when DHSC 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 where the classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and determined at the time of initial recognition.

1.20.1 Financial assets at amortised cost

Financial assets measured at amortised cost includes trade receivables, loans receivable, and other simple debt instruments.

1.20.2 Financial assets at fair value through other comprehensive income

On transition to IFRS 9 DHSC elected to irrevocably designate its equity instruments to be measured at fair value through other comprehensive income. DHSC'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 not otherwise measured at amortised cost or fair value through other comprehensive income fall into this category, such as financial assets acquired principally for the purpose of selling in the short term.

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, DHSC recognises a loss allowance representing expected credit losses on the financial instruments.

DHSC adopts the simplified approach to impairment 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).

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 as an impairment gain or loss in income or expenditure.

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 when DHSC 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. 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 providers, that would be the nominal rate charged on the loan. Such loans are a financial liability measured at amortised cost for NHS providers, 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 DHSC's foreign exchange transactions relate to reciprocal healthcare medical costs. Payments made are valued at prevailing exchange rates. Outstanding balances at year end are converted at the closing exchange rate.

Due to delays in submission of medical cost claims by member states, DHSC 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

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.

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

IFRS 17 Insurance Contracts

IFRS 17 will be implemented across the public sector from 1 April 2025. IFRS 17 details a comprehensive approach to accounting for insurance contracts which IFRS 4 did not provide. However, the definitions contained within IFRS 4 and scope of application of that standard is broadly consistent with the approach taken in IFRS 17. Accordingly, where arrangements have been appropriately identified as out of scope of IFRS 4 and those scope exemptions are carried forward to IFRS 17, such as in relation to NHS Resolution's

portfolio of indemnity schemes, and where arrangements have not been identified as insurance contracts historically, there is limited risk of those arrangements being reclassified as insurance contracts on transition to IFRS 17.

In adopting IFRS 17, a full retrospective approach will be applied where practicable on transition. As such prior year comparatives will be restated where relevant. 1 April 2024 is therefore identified as the transition date for IFRS 17.

The financial statement impact of implementing IFRS 17 is not yet known or reasonably estimable, but DHSC does not expect the impact to be material.

IFRS 18 Presentation and Disclosure in Financial Statements

Application is required for accounting periods beginning on or after 1 January 2027. The standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures

Application is required for accounting periods beginning on or after 1 January 2027. The standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.

1.25 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 (PPE) - DHSC's judgements as to the useful economic lives of PPE impacts the amount of annual depreciation charged to expenditure. Useful economic lives are reviewed regularly to ensure that they are appropriate. **Note 6** discloses for each category of PPE, the lowest minimum, and the highest maximum in the ranges of useful lives.

Share capital valuations are determined by applying the most appropriate methodology in line with IFRS 13. DHSC uses experts to assist with determining the fair value of its investments. Further details are given in **Note 11.**

Impairments of non-current assets - 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 of financial assets – the core 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 core 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.

Clinical negligence provision- DHSC's most significant provision is for clinical negligence, and significant estimation is required to calculate the amounts provided. 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. Further detail on the sensitivities of the various assumptions is outlined in **Note 16** and in the NHS Resolution annual report and accounts.

Other 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**.

Timing of income recognition - DHSC has made the judgement that the income recognised from the delivery of healthcare is over time (see **Note 1.7**).

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. DHSC coordinates extensive agreement of balances exercises across the 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 DHSC 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 DHSC departmental board for financial management purposes. They cover the core department, 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, The 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 'group 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.

On 1 April 2023, Health Education England (HEE) merged with NHS England. Previously, the operations of HEE were included within the non-departmental public bodies segment but are included in the NHS England group this year. The relevant net expenditure for HEE, before group eliminations, was £5.3 billion in 2022-23.

2.1 Departmental group summary

For the year ending 31 March 2024

	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	Group eliminations and adjustments £'000	Departmental group £'000
Gross expenditure (2.2)	195,960,664	2,899,459	(7,219,776)	134,125,229	179,958,832	337,801	2,087,322	238,081	(317,128,053)	191,259,559
Income (2.3)	(3,361,031)	(465,852)	(3,458,158)	(129,611,871)	(5,836,677)	(260,642)	(1,627,737)	(141,404)	130,228,978	(14,534,394)
Net expenditure before absorption gains and losses	**192,599,633**	**2,433,607**	**(10,677,934)**	**4,513,358**	**174,122,155**	**77,159**	**459,585**	**96,677**	**(186,899,075)**	**176,725,165**
Capital grants	(676,889)	-	-	-	(87,075)	-	-	-	-	(763,964)
Service concession arrangement adjustments	(84,359)	-	-	(1,101,853)	-	-	(311,571)	-	-	(1,497,783)
Capital provision movement	(39)	-	-	198	(20)	-	-	-	56	195
Research and development	(1,506,936)	-	-	-	-	-	-	-	-	(1,506,936)
Other budgeting adjustments	(149,342)	-	-	324,822	95,812	(95,373)	26,638	(69,754)	(907)	131,896
Budgeting adjustments	**(2,417,565)**	**-**	**-**	**(776,833)**	**8,717**	**(95,373)**	**(284,933)**	**(69,754)**	**(851)**	**(3,636,592)**
Budget outturn, of which:	**190,182,068**	**2,433,607**	**(10,677,934)**	**3,736,525**	**174,130,872**	**(18,214)**	**174,652**	**26,923**	**(186,899,926)**	**173,088,573**
Resource DEL	190,648,849	2,594,047	455,036	1,351,439	174,210,965	32,477	192,604	26,923	(186,693,734)	182,818,606
Resource AME	(466,781)	(160,440)	(11,132,970)	2,385,086	(80,093)	(50,691)	(17,952)	-	(206,192)	(9,730,033)

For the year ending 31 March 2023

	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	Group 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)
Net expenditure before absorption gains and losses	**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**
Capital grants	(657,934)	(74)	(4,655)	(4,957)	(60,138)	-	-	-	4,958	(722,800)
Service concession arrangement adjustments	32,762	-	-	229,716	-	-	(5,635)	-	-	256,843
Capital provision movement	-	-	-	645	-	-	-	-	-	645
Research and development	(1,451,371)	-	-	-	-	-	-	-	-	(1,451,371)
Other budgeting adjustments	(1,043,710)	606,263	(82,463)	407,785	(312,702)	321,171	(1,328)	-	(2,438)	(107,422)
Budgeting adjustments	**(3,120,253)**	**606,189**	**(87,118)**	**633,189**	**(372,840)**	**321,171**	**(6,963)**	**-**	**2,520**	**(2,024,105)**
Budget outturn, 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**
Resource DEL	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
Resource AME	(3,519,936)	(483,838)	(58,933,071)	1,098,485	10,693	15,675	(3,879)	-	(156,045)	(61,971,916)

2.2 Departmental group detail – expenditure

For the year ended 31 March 2024

	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	Group eliminations and adjustments £'000	Departmental group £'000
Staff costs	269,349	483,305	227,427	84,696,269	3,634,446	291,822	391,920	-	(45,570)	89,948,968
Purchase of healthcare from non-NHS bodies	-	-	-	3,534,900	18,108,889	-	-	-	-	21,643,789
Goods and services from other NHS bodies	-	-	-	3,496	112,693,867	111	5,856	-	(112,697,109)	6,221
Utilisation and write down of COVID-19 inventories	-	-	-	42,230	-	-	-	-	-	42,230
Purchase of social care	-	-	-	239,872	1,196,487	-	-	-	-	1,436,359
Dental services	-	-	-	-	3,108,156	-	-	-	(150,112)	2,958,044
Establishment	236,151	-	17,100	1,291,282	920,758	28,790	11,832	-	(147,328)	2,358,585
Premises	29,487	44,768	26,599	4,604,213	347,235	9,375	346,924	-	(512,395)	4,896,206
Service concession arrangements	-	-	-	1,200,891	-	-	108,796	-	-	1,309,687
Multi professional education and training	-	-	-	-	5,361,316	-	-	-	(3,996,398)	1,364,918
Prescribing costs	(1,415)	-	-	-	10,345,592	-	-	-	(5,400)	10,338,777
Primary care services	-	-	-	-	12,507,273	-	-	-	(32,757)	12,474,516
Pharmaceutical services	-	-	-	-	2,146,218	-	-	-	397	2,146,615
Supplies and services - clinical	-	-	-	19,710,064	2,470,441	-	5,172	-	(2,643,053)	19,542,624
Supplies and services - general	30,650	990,615	104,863	1,947,316	2,096,394	5,753	118,071	-	(1,178,202)	4,115,460
Dividends payable on public dividend capital	-	-	-	1,026,980	-	-	-	-	(1,026,980)	-
Rentals under operating leases	(433)	-	447	187,423	484	149	40,490	-	(42,454)	186,106
Interest charges	5,400	995	305	2,446,432	7,818	145	558,940	-	(92,055)	2,927,980
Research and development	1,430,238	2,606	-	287,469	21,525	-	5,125	-	(892,142)	854,821
Clinical negligence	-	-	-	2,641,202	223	-	-	-	(2,641,299)	126
Grant in aid	176,843,451	-	-	-	-	-	-	-	(176,843,451)	-
Ophthalmic services	-	-	-	-	614,432	-	-	-	2	614,434
Business rates	1,630	-	-	488,083	2,201	1,388	63,871	-	-	557,173
Education, training and conferences	3,596	6,466	382	415,867	84,214	1,645	5,334	-	(17,692)	499,812
Consultancy	3,938	1,280	-	167,353	56,457	849	27,475	-	-	257,352
Legal fees	37,975	(4,003)	1,109	106,547	252,289	12,564	10,814	-	(11,586)	405,709
Funding to group bodies	2,540,180	-	-	-	-	-	-	-	(2,540,180)	-
Funding for additional pensions uplift	-	-	-	-	3,195,283	-	-	-	(3,195,283)	-
Auditor remuneration including fees	1,500	1,343	1,387	59,188	21,530	764	1,582	-	(1,565)	85,729
Other	855,962	860	1,810	1,594,803	47,743	12,238	317	-	161,413	2,675,146
Material expenditure items	**182,287,659**	**1,528,235**	**381,429**	**126,691,880**	**179,241,271**	**365,593**	**1,702,519**	**-**	**(308,551,199)**	**183,647,387**

For the year ended 31 March 2024 (continued)

	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	Group eliminations and adjustments £'000	Departmental group £'000
Grants to other bodies	692,154	-	621,260	-	35,628	2	-	-	(621,260)	727,784
Grants to local authorities	4,030,916	(155)	-	-	-	-	-	-	-	4,030,761
Capital grants	676,889	-	-	-	87,075	-	-	-	-	763,964
Total grants expenditure	**5,399,959**	**(155)**	**621,260**	**-**	**122,703**	**2**	**-**	**-**	**(621,260)**	**5,522,509**
Movement in expected credit loss allowances	141	(709)	2,445	106,412	19,930	154	34,948	-	(2,968)	160,353
Depreciation on property, plant and equipment	13,661	108,655	7,923	3,067,374	154,989	2,651	236,627	-	477	3,592,357
Depreciation on right of use assets	17,725	6,792	4,247	845,305	58,884	3,439	82,621	-	(330,281)	688,732
Amortisation on intangible assets	12,841	28,776	20,493	410,367	134,600	9,039	7,243	-	-	623,359
Net impairments (excluding COVID-19 inventory impairment)	7,270,305	296,538	499	2,188,225	592	(163)	39,291	-	(7,400,826)	2,394,461
Net provisions arising	895,092	84,634	5,405,075	169,755	(26,095)	3,277	(5,013)	-	(1,428)	6,525,297
Movement in pension liability	-	-	-	1,543	-	-	2,797	-	-	4,340
Provisions - unwinding of discount	116,463	-	884,985	11,259	14,484	10	-	-	(56)	1,027,145
Provisions - change in discount rate	(306,912)	-	(14,552,776)	(16,069)	(47,570)	(45)	(6,375)	-	-	(14,929,747)
Non-cash expenditure	**8,019,316**	**524,686**	**(8,227,109)**	**6,784,171**	**309,814**	**18,362**	**392,139**	**-**	**(7,735,082)**	**86,297**
Non-material expenditure categories	**106,683**	**130,547**	**4,644**	**649,178**	**285,044**	**(46,156)**	**(7,336)**	**238,081**	**(191,219)**	**1,169,466**
Covid-19 expenditure (core and agencies)	**147,047**	**716,146**	**-**	**-**	**-**	**-**	**-**	**-**	**(29,293)**	**833,900**
Total expenditure	**195,960,664**	**2,899,459**	**(7,219,776)**	**134,125,229**	**179,958,832**	**337,801**	**2,087,322**	**238,081**	**(317,128,053)**	**191,259,559**

For the year ended 31 March 2023

	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	Group eliminations and adjustments £'000	Departmental group £'000
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
Dental services	-	-	-	-	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
Service concession arrangements	-	-	-	1,131,814	-	-	96,380	-	-	1,228,194
Multi professional education and training	-	-	-	-	-	5,108,882	-	-	(3,709,855)	1,399,027
Prescribing costs	(147)	-	-	-	9,780,935	-	-	-	(6,693)	9,774,095
Primary care services	-	-	-	-	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	-	-	-	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	346,000	-	-	2,434,892	202	63	-	-	(2,434,267)	346,890
Grant in aid	162,007,841	-	-	-	-	-	-	-	(162,007,841)	-
Ophthalmic services	-	-	-	-	539,053	-	-	-	(2)	539,051
Business rates	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	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)	-
Auditor remuneration including 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**

For the year ended 31 March 2023 (continued)

	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	Group eliminations and adjustments £'000	Departmental group £'000
Grants to other bodies	709,103	-	-	-	51,744	-	-	-	-	760,847
Grants to local authorities	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	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
Net impairments (excluding COVID-19 inventory impairment)	294,471	174,025	200	1,053,592	-	14,977	(1,259)	-	(401,368)	1,134,638
Net provisions arising	1,055,571	(312,597)	18,110,217	6,758	281,022	1,281	6,489	-	1	19,148,742
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)**
Non-material expenditure categories	**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)	**1,695,163**	**1,695,445**	**-**	**-**	**-**	**-**	**-**	**-**	**(584,360)**	**2,806,248**
Total 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**

2.3 Departmental group detail - income

For the year ended 31 March 2024

	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	Group eliminations and adjustments £'000	Departmental group £'000
Income from local authorities	-	-	-	(2,214,407)	-	-	(867)	-	-	(2,215,274)
Income from private patients	-	-	-	(749,750)	-	-	-	-	-	(749,750)
Income from injury costs recovery	-	-	-	(195,285)	-	-	-	-	-	(195,285)
Income from DHSC/NHS bodies	-	-	-	(112,174,071)	-	-	(96,082)	-	112,133,031	(137,122)
Other non-NHS patient care services	-	-	-	(758,511)	(171,447)	-	(150)	-	-	(930,108)
Income for additional pension uplift	-	-	-	(3,192,943)	-	-	(2,340)	-	3,195,283	-
Non patient care services to other bodies	(23,125)	-	(111,316)	(990,094)	(3,719,662)	-	(395,688)	-	4,335,617	(904,268)
Education, training and research	-	(2,930)	-	(5,146,662)	(17,748)	(967)	(1,171)	-	4,517,993	(651,485)
Branded medicines income	(2,139,445)	-	-	-	-	-	-	-	-	(2,139,445)
Fees and charges	-	(292,499)	(3,346,700)	(259,501)	(1,470,667)	(246,685)	(148,732)	-	3,715,357	(2,049,427)
Other contract income	(23,387)	(169,330)	(19)	(2,097,280)	(326,818)	(9,077)	(286)	-	706,454	(1,919,743)
Non-material contract income categories	(21,594)	-	-	(335,110)	(4,924)	(556)	(670)	-	45,570	(317,284)
Income from contracts	**(2,207,551)**	**(464,759)**	**(3,458,035)**	**(128,113,614)**	**(5,711,266)**	**(257,285)**	**(645,986)**	**-**	**128,649,305**	**(12,209,191)**
Rental revenue from operating leases	(4,910)	(400)	-	(104,169)	(405)	(1)	(805,094)	-	532,985	(381,994)
PDC dividend income	(1,026,980)	-	-	-	-	-	-	-	1,026,980	-
Charitable and other contributions to expenditure	-	-	-	(98,975)	(796)	-	-	-	15,098	(84,673)
Donation of assets	-	-	-	(29,293)	-	-	-	-	29,293	-
Other non-contract income	(44,406)	(675)	(123)	(15,464)	(124,200)	(1,035)	(138,516)	-	(145,783)	(470,202)
Non-material non-contract income categories	(5,551)	-	-	(586,360)	9	(2,321)	(20,039)	-	63,024	(551,238)
Non-contract income	**(1,081,847)**	**(1,075)**	**(123)**	**(834,261)**	**(125,392)**	**(3,357)**	**(963,649)**	**-**	**1,521,597**	**(1,488,107)**
Income received by NHS charities	-	-	-	-	-	-	-	(141,404)	-	(141,404)
Finance income	(71,633)	(18)	-	(663,996)	(19)	-	(18,102)	-	58,076	(695,692)
Total income	**(3,361,031)**	**(465,852)**	**(3,458,158)**	**(129,611,871)**	**(5,836,677)**	**(260,642)**	**(1,627,737)**	**(141,404)**	**130,228,978**	**(14,534,394)**

For the year ended 31 March 2023

	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	Group eliminations and adjustments £'000	Departmental group £'000
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)
Branded Medicines income	(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 categories	(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)**
Rental revenue from operating leases	(5,650)	(434)	-	(79,519)	(4,050)	(101)	(755,078)	-	481,230	(363,602)
PDC dividend income	(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 categories	(20,366)	(49,976)	(440)	(601,595)	(15,405)	(2,963)	(20,427)	-	43,514	(667,658)
Non-contract 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 agency only)	-	(403,396)	-	-	-	-	-	-	403,396	-
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)**

3. Staff costs

Staff costs for the Departmental Group comprise:

	2023-24 £'000	2022-23 £'000
Salaries and wages	71,651,885	68,458,248
Social security costs	7,611,280	6,858,699
NHS pension	10,924,954	9,937,025
Other pension costs	176,822	169,489
Termination benefits	75,183	118,450
	90,440,124	**85,541,911**
Less income in respect of secondments	(139,983)	(129,977)
Total staff costs	**90,300,141**	**85,411,934**
Less: amounts charged to capital	(351,173)	(322,619)
Total staff costs recognised in expenditure	**89,948,968**	**85,089,315**

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 liabilities. The FReM interpretation of IAS 19 states that the NHS pension scheme should be accounted for as a defined contribution scheme.

4. Expenditure

4.1 Analysis of expenditure

	Notes	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
4.1 (a) Purchase of goods and services					
Rentals under leases		(462)	186,106	8,343	210,350
Supplies and services - clinical		-	19,542,624	-	17,690,336
Supplies and services - general		1,018,522	4,115,460	1,377,899	4,900,248
COVID-19 ventilators and other equipment		-	-	13,703	16,221
COVID-19 personal protective equipment		59,825	71,624	382,090	396,629
COVID-19 vaccines		595,517	595,517	1,068,893	1,068,893
COVID-19 medicines		65,696	65,696	181,004	181,004
Cost of NHS Test and Trace consumables		32,936	32,936	401,799	401,799
NHS Test and Trace operational costs		-	-	186,921	186,921
Goods and services from other NHS bodies		-	6,221	-	5,661
Multi professional education and training		-	1,364,918	-	1,399,027
Purchase of healthcare from non NHS bodies		-	21,643,789	-	19,763,918
Purchase of social care		-	1,436,359	-	1,231,966
Expenditure on drug action teams		-	(1)	-	31
Dental services		-	2,958,044	-	2,899,433
Prescribing costs		(1,415)	10,338,777	(147)	9,774,095
Primary care services		-	12,474,516	-	11,465,610
Pharmaceutical services		-	2,146,615	-	2,120,431
Ophthalmic services		-	614,434	-	539,051
Consultancy		5,218	257,352	5,255	281,893
Establishment		235,590	2,358,585	333,392	2,137,469
Transport (business travel)		8,958	352,111	4,533	338,237
Premises		75,025	4,896,206	60,965	4,467,711
Education, training and conferences		10,068	499,812	7,372	537,686
Insurance		310	120,375	170	88,092
Legal fees		33,972	405,709	21,858	398,749
NHS informatics		112,433	274,690	112,943	222,989
Audit fees - statutory audit (cash)		153	54,162	140	53,792
Auditor remuneration - other		230	28,934	179	28,226
Non-cash items					
Audit fees - statutory audit - non-cash		2,460	2,633	2,350	2,510
Purchase of goods and services		**2,255,036**	**86,844,204**	**4,169,662**	**82,808,978**

Analysis of expenditure (continued)

	Notes	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
4.1 (b) Depreciation and impairment charges					
Non-cash items					
Depreciation on property, plant and equipment	6	122,316	3,592,357	89,022	3,319,672
Amortisation on intangible assets	7	41,617	623,359	213,284	758,230
Depreciation on right of use assets	8	24,820	688,732	27,613	652,920
Impairments and reversals	4.3	6,147,524	975,155	(422,816)	243,326
Depreciation and impairment charges		**6,336,277**	**5,879,603**	**(92,897)**	**4,974,148**
4.1 (c) Provision expense					
non-cash items					
Movement in pension lability		-	4,340	-	11,558
Net provisions arising	16	979,726	6,525,297	742,974	19,148,742
Provisions - change in discount rate	16	(306,912)	(14,929,747)	(906,582)	(75,845,446)
Provision expense		**672,814**	**(8,400,110)**	**(163,608)**	**(56,685,146)**
4.1 (d) Other operating expenditure					
Service concession arrangements		-	1,309,687	-	1,228,194
Chair and non-executive directors' costs		-	44,871	-	49,821
Business rates paid to local authorities		1,630	557,173	7,272	490,504
Clinical negligence		-	126	346,000	346,890
Research and development		1,430,764	854,821	1,354,719	806,789
Grants to local authorities		4,030,761	4,030,761	3,631,269	3,631,269
Grants to other bodies		692,154	727,784	709,103	760,847
Capital grants		676,889	763,964	658,008	718,146
Prior period adjustments in local accounts		-	(12,040)	-	2,748
Realised foreign exchange rate (gains)/losses		(9,375)	(9,375)	-	-
Other cash expenditure		857,340	2,675,146	981,166	2,926,380
Non-cash items					
Loss on disposal of assets		5,620	33,548	8,706	47,155
Movement in expected credit loss allowances		(568)	160,353	4,786	164,040
Inventories write down (covid specific)		1,528,525	1,528,525	1,644,114	1,644,114
Inventories write down		32,903	54,160	68,631	87,378
COVID-19 inventories write downs (NHS providers)		-	1,138	-	2,639
Loan write offs		-	-	277	277
Capital grants in kind		-	-	-	4,654
Apprenticeship training grant		345	157,018	363	136,017
Prior period adjustments in local accounts		95,137	80,940	-	(29,301)
Changes in fair value		784	(23,442)	-	1,945
Other non-cash expenditure		(14,300)	(50,953)	2,357	11,377
Unrealised foreign exchange rate (gains)/losses		4,415	4,397	(20,797)	(20,888)
Other operating expenditure		**9,333,024**	**12,888,602**	**9,395,974**	**13,010,995**
4.1 (e) Finance expense					
Interest on obligations under PFI and LIFT contracts		-	956,658	-	1,005,673
Interest on obligations under leases		4,979	81,492	3,311	67,212
Remeasurement of service concession labilities		-	1,859,938	-	-
Interest on late payment of commercial debt		-	1,376	-	220
Other interest expense		1,133	19,419	1,055	15,096
Interest on loans and overdrafts		-	9,097	-	7,472
Provisions - unwinding of discount		116,463	1,027,145	14,203	229,715
Finance expense		**122,575**	**3,955,125**	**18,569**	**1,325,388**

1. Other expenditure for the departmental group includes £742 million (2022-23: £694 million) of transport costs in the provider sector relating to expenditure such as fuel costs, vehicle parts and other fleet related costs.
2. Remeasurement of service concession liabilities represents an increase in service concession liabilities recognising the impact of index/rates changes as at the end of the year. There is no comparative as the change in measurement was adopted from 1 April 2023. The increase on transition is accounted for in the consolidated statement of changes in taxpayers' equity.

4.2 Non-cash transactions

The total of non-cash transactions included in the reconciliation of operating costs to operating cashflow in the consolidated statement of cash flows comprises:

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Non-cash expenditure after financing activities	9,534,849	1,220,728	3,515,974	(47,364,820)
Non-cash income after financing activities	(5,545)	(265,371)	(6,475)	(259,223)
Total non-cash transactions	**9,529,304**	**955,357**	**3,509,499**	**(47,624,043)**
Movement in expected credit loss allowances	568	(160,353)	(4,786)	(164,040)
Inventories write down	(1,561,428)	(1,583,823)	(1,712,745)	(1,734,131)
Impairment of inventories	1,419,306	1,419,306	891,312	891,312
Utilisation of COVID-19 related inventory	(753,974)	(765,773)	(2,047,489)	(2,064,546)
Donation of assets	-	-	-	26,874
Less non-cash movements analysed separately in the cash flow statement	**(895,528)**	**(1,090,643)**	**(2,873,708)**	**(3,044,531)**
Total non-cash transactions as per consolidated statement of cash flows	**8,633,776**	**(135,286)**	**635,791**	**(50,668,574)**

4.3 Impairments

	Notes	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Impairments charged to consolidated statement of comprehensive net expenditure					
Property, plant and equipment impairments	6	313,506	2,246,914	180,671	1,018,573
Intangible asset impairments	7	1,055	77,790	-	36,868
Right of use asset impairments	8	5,405	51,290	6,695	91,367
Non-current investments impairments	11	7,246,864	(1,657)	281,130	(13,246)
Assets held for sale impairments		-	20,124	-	1,076
Inventory impairments	12	(1,419,306)	(1,419,306)	(891,312)	(891,312)
		6,147,524	**975,155**	**(422,816)**	**243,326**
Impairments charged to revaluation reserve					
Property, plant and equipment impairments	6	200	1,726,767	-	567,474
Intangible asset impairments	7	-	1,563	-	-
Right of use asset impairments	8	-	8,754	-	8,346
		200	**1,737,084**	**-**	**575,820**
Impairments charged to general fund					
Non-current investments impairments	11	226,725	-	(518,337)	-
		226,725	**-**	**(518,337)**	**-**
Total impairments charged in year		**6,374,449**	**2,712,239**	**(941,153)**	**819,146**

The above table includes both impairments and impairment reversals.

Financial asset impairments

Financial 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 2023-24 was £7,247 million (2022-23: £294 million).

As part of an agreed departure from the FReM, as detailed in **Note 1**, impairments arising or reversed in relation to demising NHS trusts or foundation trusts are charged to the general fund. In 2023-24 an impairment charge of £227 million (2022-23: £518 million reversal) was recognised.

Inventory impairments

The impact on expenditure of impairments and write downs for 2023-24 and 2022-23 can be summarised as follows:

	2023-24					
	Core department and agencies			Departmental group		
	Impairment charge / (credit) £'000	Write down £'000	Total charge / (credit) to expenditure £'000	Impairment charge / (credit) £'000	Write down £'000	Total charge / (credit) to expenditure £'000
Personal protective equipment	(800,288)	817,798	17,510	(800,288)	818,936	18,648
COVID-19 medicines	(367,474)	343,212	(24,262)	(367,474)	343,212	(24,262)
COVID-19 vaccines	-	92,908	92,908	-	92,908	92,908
NHS Test and Trace consumables	(5,215)	-	(5,215)	(5,215)	-	(5,215)
Other COVID-19 related equipment and consumables	(246,329)	274,607	28,278	(246,329)	274,607	28,278
Total	**(1,419,306)**	**1,528,525**	**109,219**	**(1,419,306)**	**1,529,663**	**110,357**

	2022-23					
	Core department and agencies			Departmental group		
	Impairment charge / (credit) £'000	Write down £'000	Total charge / (credit) to expenditure £'000	Impairment charge / (credit) £'000	Write down £'000	Total charge / (credit) to expenditure £'000
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**

Personal Protective Equipment (PPE)

PPE inventory was increased in carrying value due to a net reversal of impairments of £800 million during 2023-24 (2022-23: £321 million reversal) 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 £819 million (2022-23: £540 million) relating to PPE inventory in 2023-24 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 £19 million in 2023-24 (2022-23: £219 million). This represents minimal movement in the assumptions underpinning the PPE impairments alongside the ongoing PPE disposal programme.

Additionally, £2 million (2022-23: £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 provision of free PPE to the NHS ceased on 31 March 2024. At 31 March 2024 the valuation of DHSC's PPE within **Note 12** is £Nil as all inventory has either been transferred to the pandemic preparedness stockpile, utilised, donated, sold, disposed of, or is now held for future disposal following the cessation of the free PPE provision scheme.

The pandemic preparedness stockpile is accounted for within property plant and equipment (Note 6 to the financial statements).

Consequently, all PPE held by the core department was held for future disposal and accordingly valued to £Nil. The annual report contains further information in relation to the PPE programme.

COVID-19 Vaccines

DHSC 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 £Nil million (2022-23: £68 million reversal) 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 £93 million (2022-23: £Nil 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 £93 million charge in 2023-24 (2022-23: £68 million credit).

The carrying value of COVID-19 vaccine inventories has also been reduced in value by £224 million (2022-23: £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.

The combined impact on expenditure of COVID-19 medicines impairments and disposals was £24 million credit in 2023-24 (2022-23: £149 million charge).

The carrying value of COVID-19 medicine inventories has also been reduced in value by £124 million (2022-23: £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.

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 2024.

5. Income

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Revenue from patient care activities				
Income from local authorities	-	2,215,274	-	2,081,377
Income from private patients	-	749,750	-	637,659
Income from overseas patients	-	122,909	-	99,622
Income from injury costs recovery	-	195,285	-	171,844
Income in respect of reciprocal healthcare claims	21,594	21,594	39,461	39,461
Income from DHSC/NHS bodies	-	137,122	-	122,047
Other non-NHS patient care services	-	930,108	-	953,282
Other contract income				
Non-patient care services to other bodies	23,125	904,268	78,583	827,852
Education, training and research	2,930	651,485	2,268	587,475
Prescription fees and charges	-	693,188	-	670,324
Dental fees and charges	-	777,479	-	746,642
Other fees and charges	286,599	578,760	247,907	540,812
Income in respect of staff costs	-	172,781	54	224,178
Branded medicines income	2,139,445	2,139,445	1,664,954	1,664,954
Other contract income	192,717	1,919,743	227,578	1,797,917
Income from contracts	**2,666,410**	**12,209,191**	**2,260,805**	**11,165,446**
Rental revenue from finance leases	6	310	5	2,277
Rental revenue from operating leases	5,308	381,994	6,948	363,602
PDC dividend received	1,026,980	-	1,040,932	-
Charitable and other contributions to expenditure	-	84,673	-	72,935
Donations of assets	-	-	-	26,874
Receipts of donations for capital acquisitions	-	164,628	-	138,892
Receipt of grants for capital acquisitions	-	139,508	49,976	269,117
Profit on disposal	5,200	41,081	6,112	49,249
Dividends	-	13,211	13,894	28,801
Other non-cash income	-	30,397	-	41,369
Apprenticeship training grant (non-cash)	345	157,018	363	136,017
Funding from other government departments	-	2,018	-	1,936
Prior period adjustments in local accounts	-	3,067	-	-
Other non contract income	47,356	470,202	93,068	657,826
Non-contract income	**1,085,195**	**1,488,107**	**1,211,298**	**1,788,895**

Other contract income includes £1,422 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 for the year ended 31 March 2024

	Land £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Information technology £'000	Payments on account & assets under construction £'000	Furniture and fittings £'000	Plant and machinery £'000	Transport equipment £'000	Stockpiled goods £'000	Total £'000
Cost or valuation										
At 1 April 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**
Prior period adjustments in underlying accounts	5,565	(149,346)	(1,997)	(3,034)	(148,560)	19,845	(12,121)	-	(35,512)	(325,160)
Additions	20,825	1,453,252	10,665	513,670	4,560,917	34,997	731,926	23,974	30,409	7,380,635
Donations	879	50,027	136	2,738	223,737	501	70,891	256	-	349,165
Impairments and reversals	(458,062)	(3,064,415)	(6,642)	(7,609)	(349,969)	(1,240)	(9,713)	(6)	(3,356)	(3,901,012)
Transfers	75	676	-	2,006	(40,747)	8,511	23,967	-	68,833	63,321
Reclassifications	(8,978)	3,043,577	987	271,165	(4,025,378)	34,523	389,747	30,227	-	(264,130)
Revaluation and indexation	109,468	(116,035)	11,505	(2,685)	1,365	(722)	(10,919)	(228)	20,803	12,552
Disposals	(18,307)	(54,202)	(680)	(558,868)	(35,057)	(70,432)	(1,008,280)	(23,637)	(35,775)	(1,805,238)
At 31 March 2024	**5,864,101**	**47,489,820**	**408,540**	**6,595,866**	**7,332,382**	**753,237**	**11,828,632**	**590,307**	**438,284**	**81,301,169**
Depreciation										
At 1 April 2023	**8,348**	**1,146,910**	**17,562**	**3,805,718**	**-**	**467,674**	**6,932,336**	**356,948**	**182,738**	**12,918,234**
Prior period adjustments in underlying accounts	(69)	(177,475)	(2,157)	(8,021)	-	6,337	(34,867)	-	2,393	(213,859)
Charged in year	80	1,719,691	12,205	810,800	-	47,595	901,105	60,631	40,250	3,592,357
Impairments and reversals	25,818	40,477	3,316	958	-	(195)	2,108	187	-	72,669
Transfers	-	(942)	-	(5)	-	1	(227)	-	-	(1,173)
Reclassifications	66	(57,875)	(246)	(29,678)	-	240	(3,442)	(10,347)	-	(101,282)
Revaluation and indexation	(25,239)	(1,588,432)	(14,143)	(3,892)	-	(933)	(17,804)	(223)	-	(1,650,666)
Disposals	-	(47,082)	(570)	(551,840)	-	(70,053)	(984,275)	(21,106)	(27,630)	(1,702,556)
At 31 March 2024	**9,004**	**1,035,272**	**15,967**	**4,024,040**	**-**	**450,666**	**6,794,934**	**386,090**	**197,751**	**12,913,724**
Net book value at 31 March 2024	**5,855,097**	**46,454,548**	**392,573**	**2,571,826**	**7,332,382**	**302,571**	**5,033,698**	**204,217**	**240,533**	**68,387,445**
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
Asset financing										
Owned - purchased	5,388,968	32,437,657	303,892	2,543,880	6,868,195	285,499	4,456,494	203,588	240,533	52,728,706
Owned - donated	87,699	1,659,028	16,936	23,269	448,420	17,069	419,175	629	-	2,672,225
PFI contracts	378,430	12,357,863	68,771	4,677	15,767	3	158,029	-	-	12,983,540
PFI residual interests	-	-	2,974	-	-	-	-	-	-	2,974
Net book value at 31 March 2024	**5,855,097**	**46,454,548**	**392,573**	**2,571,826**	**7,332,382**	**302,571**	**5,033,698**	**204,217**	**240,533**	**68,387,445**

Departmental group for the year ended 31 March 2023

	Land £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Information technology £'000	Payments on account & assets under construction £'000	Furniture and fittings £'000	Plant and machinery £'000	Transport equipment £'000	Stockpiled goods £'000	Total £'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)
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
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**

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 2024 was £45.9 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 – 45 years
- Plant and machinery 1 – 36 years
- Transport equipment 1 – 20 years

7. Intangible assets

Departmental group for the year ended 31 March 2024

	IT & software £'000	Development expenditure £'000	Other £'000	Total £'000
Cost or valuation				
At 1 April 2023	**4,869,231**	**334,201**	**640,921**	**5,844,353**
Prior period adjustments in underlying accounts	22,879	4,590	17,953	45,422
Additions	241,272	181,230	401,111	823,613
Donations	986	69	1,615	2,670
Impairments and reversals	(65,942)	(5,543)	(11,950)	(83,435)
Transfers	36,664	14,121	(50,956)	(171)
Reclassifications	435,085	(15,309)	(387,216)	32,560
Revaluation and indexation	8,716	9,208	865	18,789
Disposals	(455,073)	(49,909)	(2,470)	(507,452)
Other movements	(10)	-	16	6
At 31 March 2024	**5,093,808**	**472,658**	**609,889**	**6,176,355**
Amortisation				
At 1 April 2023	**2,890,887**	**183,316**	**35,181**	**3,109,384**
Prior period adjustments in underlying accounts	(1,854)	-	(23)	(1,877)
Charged in year	470,091	147,538	5,730	623,359
Impairments and reversals	(3,547)	(541)	6	(4,082)
Transfers	-	(72)	61	(11)
Reclassifications	4,665	(10,841)	3,010	(3,166)
Revaluation and indexation	6,872	5,284	776	12,932
Disposals	(449,211)	(49,703)	(1,613)	(500,527)
Other movements	(4)	-	24	20
At 31 March 2024	**2,917,899**	**274,981**	**43,152**	**3,236,032**
Net book value at 31 March 2024	**2,175,909**	**197,677**	**566,737**	**2,940,323**
Net book value at 31 March 2023	1,978,344	150,885	605,740	2,734,969

Departmental group for the year ended 31 March 2023

	IT & software £'000	Development expenditure £'000	Other £'000	Total £'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

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 – 30 years
- Development expenditure 1 – 12 years
- Other 1 – 20 years

8. Right of use assets

Departmental group for the year ended 31 March 2024

	Property £'000	Information technology £'000	Furniture and fittings £'000	Plant and machinery £'000	Transport equipment £'000	Intangible assets £'000	Total £'000
Cost or valuation							
At 1 April 2023	**4,434,093**	**132,999**	**12,722**	**943,167**	**162,177**	**10,729**	**5,695,887**
Prior period adjustments in underlying accounts	(9,934)	-	-	2,815	(21)	-	(7,140)
Additions	443,882	24,468	-	128,224	43,625	-	640,199
Remeasurements	83,004	1,070	(1)	7,954	1,126	-	93,153
Disposals and derecognitions	(138,608)	(11,241)	(47)	(52,343)	(9,952)	-	(212,191)
Capital provisions and reversals	33,092	-	-	3	-	-	33,095
Impairments and reversals	(47,689)	(1,336)	-	(78)	(5)	-	(49,108)
Revaluation and indexation	(12,942)	308	-	788	33	-	(11,813)
Transfers	4,497	-	-	-	-	-	4,497
Reclassifications	(13,551)	1,733	-	27,120	(44)	-	15,258
At 31 March 2024	**4,775,844**	**148,001**	**12,674**	**1,057,650**	**196,939**	**10,729**	**6,201,837**
Depreciation							
At 1 April 2023	**574,573**	**69,183**	**4,294**	**357,774**	**49,494**	**8,241**	**1,063,559**
Prior period adjustments in underlying accounts	(1,708)	-	-	664	(13)	-	(1,057)
Charged in year	443,170	22,016	2,070	165,921	55,204	351	688,732
Disposals and derecognitions	(37,848)	(9,178)	(32)	(45,467)	(8,549)	-	(101,074)
Impairments and reversals	10,936	-	-	-	-	-	10,936
Revaluation and indexation	(28,915)	-	-	6	(7)	-	(28,916)
Transfers	1	-	-	-	-	-	1
Reclassifications	(4,425)	(886)	-	(607)	681	-	(5,237)
At 31 March 2024	**955,784**	**81,135**	**6,332**	**478,291**	**96,810**	**8,592**	**1,626,944**
Net book value at 31 March 2024	**3,820,060**	**66,866**	**6,342**	**579,359**	**100,129**	**2,137**	**4,574,893**
Net book value at 31 March 2023	3,859,520	63,816	8,428	585,393	112,683	2,488	4,632,328

Departmental group for the year ended 31 March 2023

	Property £'000	Information technology £'000	Furniture and fittings £'000	Plant and machinery £'000	Transport equipment £'000	Intangible assets £'000	Total £'000
Cost or valuation							
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
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							
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)
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**

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 DHSC to the expenditure as it would be reputationally or politically damaging for DHSC to withdraw from the agreement.

Any future capital funding within the DHSC's accounting boundary does not represent a capital commitment.

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Property, plant and equipment	10,215	2,510,326	10,144	2,396,573
Intangible non-current assets	4,792	135,747	8,134	164,453
	15,007	**2,646,073**	**18,278**	**2,561,026**

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.

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Not later than 1 year	1,141	173,691	697	151,777
Later than 1 year and not later than 2 years	719	136,863	604	127,681
Later than 2 years and not later than 3 years	587	126,185	156	115,046
Later than 3 years and not later than 4 years	587	115,021	134	109,434
Later than 4 years and not later than 5 years	552	107,318	134	96,347
Later than 5 years	-	896,025	18	948,066
	3,586	**1,555,103**	**1,743**	**1,548,351**

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 the relevant group body.

9.3.1 LIFT schemes deemed to be on-Statement of Financial Position

In this financial period there were 304 on-Statement of Financial Position LIFT schemes (2022-23: 304). The substance of each contract is that the department has a finance lease, and payments comprise an imputed finance lease charge and a service charge.

Total future obligations in respect of LIFT contracts are given in the table below:

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Not later than 1 year	-	272,892	-	163,179
Later than 1 year and not later than 5 years	-	1,099,569	-	641,859
Later than 5 years	-	3,708,493	-	1,976,159
	-	**5,080,954**	**-**	**2,781,197**
Less interest element	-	(2,040,994)	-	(1,149,135)
Present value of obligations	**-**	**3,039,960**	**-**	**1,632,062**

9.3.2 Charges to the Consolidated Statement of Comprehensive Net Expenditure in respect of LIFT Contracts

The total charges in the period to expenditure in respect of off-Statement of Financial Position LIFT contracts and the service element of on-Statement of Financial Position LIFT contracts was £72 million (2022-23: £64 million).

Total future obligations in respect of these charges are given in the table below:

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Not later than 1 year	-	75,211	-	72,261
Later than 1 year and not later than 5 years	-	318,239	-	307,415
Later than 5 years	-	461,459	-	546,490
	-	**854,909**	**-**	**926,166**

9.3.3 PFI schemes deemed to be on-Statement of Financial Position

In this financial period there were 167 on-Statement of Financial Position PFI Schemes (2022-23: 172). The substance of each contract is that the department has a finance lease, and payments comprise an imputed finance lease charge and a service charge.

Total future obligations in respect of PFI finance leases are given in the table below:

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Not later than 1 year	-	1,386,628	-	849,167
Later than 1 year and not later than 5 years	-	5,420,192	-	3,255,153
Later than 5 years	-	15,446,983	-	9,591,631
	-	**22,253,803**	**-**	**13,695,951**
Less interest element	-	(7,964,315)	-	(5,842,329)
Present Value of obligations	**-**	**14,289,488**	**-**	**7,853,622**

The significant increase in the present value of obligations is due to the implementation of IFRS 16 measurement principles in relation to PFI contracts.

9.3.4 Charges to the Consolidated Statement of Comprehensive Net Expenditure in respect of PFI contracts

The total charges in the period to expenditure in respect of off-Statement of Financial Position PFI schemes and the service element of on-Statement of Financial Position PFI schemes was £1,237 million (2022-23: £1,164 million).

Total future obligations in respect of these charges are given in the table below:

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Not later than 1 year	-	1,182,676	-	1,127,940
Later than 1 year and not later than 5 years	-	4,784,737	-	4,653,012
Later than 5 years	-	13,317,846	-	14,915,641
	-	**19,285,259**	**-**	**20,696,593**

9.4 Other Financial Commitments

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 DHSC 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 DHSC's accounting boundary does not represent a financial commitment.

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Not later than 1 year	2,241,587	4,233,397	1,910,292	3,273,365
Later than 1 year and not later than 5 years	3,587,155	4,972,370	3,980,305	4,998,580
Later than 5 years	2,192,205	2,370,026	1,957,559	2,085,024
	8,020,947	**11,575,793**	**7,848,156**	**10,356,969**

Included within the core department and agencies and departmental group figures for 2023-24 are financial commitments of £4,197 million relating to UKHSA (2022-23: £5,075 million). The majority of these commitments relate to 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.

10. Financial instruments

10.1 Risk profile

As the cash requirements of DHSC 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 majority of financial instruments relate to contracts for non-financial items in line with DHSC's expected purchase and usage requirements and DHSC is therefore usually exposed to little credit, liquidity or market risk.

The core department's investments in NHS providers are represented by public dividend capital which, being issued under statutory authority, are not classed as being a financial instrument.

Currency risk

DHSC undertakes certain transactions denominated in foreign currencies, the vast majority of which are transactions relating to reciprocal healthcare medical costs. Due to the lead time in the submission of medical cost claims by member states DHSC estimates annual medical costs and adjusts future years' expenditure when actual costs are claimed. DHSC is therefore exposed to a limited amount of currency risk in relation to these expected claims before they can be settled.

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 group mostly originates from central government. 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.

Interest rate risk

DHSC has limited exposure to interest rate risk.

Credit risk

The vast majority of the group's income is generated from public sector bodies and as such is exposed to low credit risk.

10.2 Analysis of financial assets

	Departmental group		Core department and agencies	
	31 March 2024 £ billion	Restated 31 March 2023 £ billion	31 March 2024 £ billion	31 March 2023 £ billion
Financial assets	20.8	21.7	10.4	11.6
of which:				
held at amortised cost	20.1	21.0	6.1	6.0
held at fair value through other comprehensive expenditure	0.7	0.7	4.3	5.6

The departmental group amounts have been restated at 31 March 2023 to include charitable financial assets for comparability purposes.

10.3 Analysis of financial liabilities

	Departmental group		Core department and agencies	
	31 March 2024 £billion	31 March 2023 £ billion	31 March 2024 £ billion	31 March 2023 £ billion
Financial liabilities	51.0	45.4	5.2	4.5

At both 31 March 2024 and 31 March 2023, all financial liabilities were held at amortised cost.

11. Non-current investments

Core department and agencies for the year ended 31 March 2024

	Public dividend capital issued to NHS providers £'000	Loans issued to NHS providers £'000	Loans issued to other bodies £'000	Share capital issued to other bodies £'000	Total £'000
Balance at 1 April 2023	**40,052,616**	**2,169,816**	**940,289**	**5,636,328**	**48,799,049**
Issued	4,879,167	50,120	80,000	109,770	5,119,057
Repaid	(53,560)	(13,551)	(762,932)	-	(830,043)
Net transfer to current receivables	-	(263,488)	(60,000)	-	(323,488)
Changes in fair value through other comprehensive income	-	-	-	(1,478,601)	(1,478,601)
Other impairments and reversals	(7,474,213)	-	41	-	(7,474,172)
Balance at 31 March 2024	**37,404,010**	**1,942,897**	**197,398**	**4,267,497**	**43,811,802**

Core department and agencies for the year ended 31 March 2023

	Public dividend capital issued to NHS providers £'000	Loans issued to NHS providers £'000	Loans issued to other bodies £'000	Share capital issued to other bodies £'000	Total £'000
Balance at 1 April 2022	**36,874,712**	**2,341,012**	**2,396,504**	**5,476,308**	**47,088,536**
Issued	3,497,479	93,624	671	93,975	3,685,749
Repaid	(25,079)	(10,688)	(1,456,048)	-	(1,491,815)
Net transfer to current receivables	-	(254,132)	(611)	-	(254,743)
Written off	(518,337)	-	(277)	-	(518,614)
Changes in fair value through other comprehensive income	-	-	-	169,664	169,664
Other impairments and reversals	223,841	-	50	-	223,891
Transfers	-	-	-	(92,788)	(92,788)
Other movements	-	-	-	(10,831)	(10,831)
Balance at 31 March 2023	**40,052,616**	**2,169,816**	**940,289**	**5,636,328**	**48,799,049**

Departmental group for the year ended 31 March 2024

	Loans £'000	Share capital and other investments £'000	Total £'000
Balance at 1 April 2023	**3,830**	**647,596**	**651,426**
Prior period adjustments in underlying accounts	-	(377)	(377)
Issued	-	18,956	18,956
Disposals	-	(17,135)	(17,135)
Repaid	(912)	(2,177)	(3,089)
Net transfer to current receivables	-	(807)	(807)
Changes in fair value through other comprehensive income	-	94	94
Changes in fair value through net expenditure	-	3,728	3,728
Other impairments and reversals	41	1,033	1,074
Other movements	-	(15,364)	(15,364)
Balance at 31 March 2024	**2,959**	**635,547**	**638,506**
Investments held by core department and agencies			43,811,802
Less elimination of intra-group investments			(43,578,836)
Investments held by other group bodies			405,540
Total			**638,506**

Departmental group for the year ended 31 March 2023

	Loans £'000	Share capital and other investments £'000	Total £'000
Balance at 1 April 2022	**6,134**	**676,048**	**682,182**
Issued	671	33,462	34,133
Disposals	-	(1,561)	(1,561)
Repaid	(809)	(2,834)	(3,643)
Net transfer to current receivables	(611)	(778)	(1,389)
Written off	(277)	-	(277)
Changes in fair value through other comprehensive income	-	(74,095)	(74,095)
Changes in fair value through net expenditure	-	(1,166)	(1,166)
Expected credit loss impairments	-	(120)	(120)
Other impairments and reversals	50	-	50
Reclassifications	(1,328)	-	(1,328)
Transfers	-	(788)	(788)
Other movements	-	19,428	19,428
Balance at 31 March 2023	**3,830**	**647,596**	**651,426**
Investments held by core department and agencies			48,799,049
Less elimination of intra-group investments			(48,558,890)
Investments held by other group bodies			411,267
Total			**651,426**

Financing of NHS providers

DHSC finances NHS providers by issuing public dividend capital and loans.

Public dividend capital (PDC) is issued when DHSC needs to provide additional financing to NHS providers for either capital or revenue requirements. PDC is a form of government financing provided to public sector organisations. PDC issued by DHSC is recorded as equity on the statement of financial position of providers and as an investment asset for the core department. The rules governing PDC for NHS trust and NHS foundation trusts are provided in the NHS Act 2006. This allows for the use of PDC as originating capital for NHS trusts, and initial PDC for NHS foundation trusts. Providers pay dividends to the core department based on the provider's average relevant net assets. The current dividend rate for PDC is 3.5% of average relevant net assets. PDC is repayable to the core department but does not have a set repayment schedule.

In 2023-24 the value of impairment in respect of public dividend capital charged to the expenditure was £7,247 million (2022-23: £294 million charge) and the value of impairments charged to reserves was £227 million (2022-23: £518 million credit). For further details see **Note 4.3**.

Loans are normally made under standard government loan terms, that is 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.

Share capital and other investments

The core department's share capital investments are measured at fair value. DHSC 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 2024.

Valuation classification

The classification of the inputs used to value the core department's share capital 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.

For the year ended 31 March 2024

Entity	Valuation basis	Level 1 £'000	Level 2 £'000	Level 3 £'000	Total £'000
Community Health Partnerships Ltd	Net assets	-	-	-	-
NHS Property Services Ltd	Net assets	-	3,449,791	-	3,449,791
Genomics England Ltd	Capital invested	-	587,700	-	587,700
NHS Professionals Ltd	Discounted cash flow	-	-	222,000	222,000
Other share capital investments	Various	-	-	8,006	8,006
		-	**4,037,491**	**230,006**	**4,267,497**

For the year ended 31 March 2023

Entity	Valuation basis	Level 1 £'000	Level 2 £'000	Level 3 £'000	Total £'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**

Following the application of IFRS 16 to PFI and LIFT contracts in 2023-24, the valuation of Community Health Partnerships Ltd (CHP) has fallen as a result of the recognition of revised liabilities in relation to these contracts.

12. Inventories

Core department and agencies for the year ended 31 March 2024

	Notes	Adult and childhood vaccines £'000	Pandemic flu and pre pandemic flu £'000	COVID-19 medicines £'000	COVID-19 vaccines £'000	Consumables £'000	Other £'000	Total £'000
Balance at 1 April 2023		**425,728**	**5,373**	**57,352**	**316,295**	**239,145**	**9,587**	**1,053,480**
Prior period adjustments in underlying accounts		631	-	-	(44,737)	6,233	-	(37,873)
Inventory additions		596,137	492	153,305	813,304	16,315	2,695	1,582,248
Inventory consumed/disposed of		(556,720)	(3,462)	(65,696)	(595,517)	(135,792)	(2,193)	(1,359,380)
Write downs		(32,859)	-	(343,212)	(92,908)	(1,092,449)	-	(1,561,428)
Impairment of inventory	4.3	-	-	367,474	-	1,051,832	-	1,419,306
Transfers		-	3,462	-	-	(73,177)	882	(68,833)
Transfers from provisions		-	-	(123,641)	(224,227)	(2,267)	-	(350,135)
Other		-	-	-	-	(604)	15,334	14,730
Balance at 31 March 2024		**432,917**	**5,865**	**45,582**	**172,210**	**9,236**	**26,305**	**692,115**

Core department and agencies for the year ended 31 March 2023

	Notes	Adult and childhood vaccines £'000	Pandemic flu and pre pandemic flu £'000	COVID-19 medicines £'000	COVID-19 vaccines £'000	Consumables £'000	Other £'000	Total £'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
Inventory 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	4.3	-	-	924,388	68,238	(101,314)	-	891,312
Transfers		-	14	-	-	-	10,279	10,293
Transfers 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**

Departmental group for the year ended 31 March 2024

	Notes	Adult and childhood vaccines £'000	Pandemic flu and pre pandemic flu £'000	Drugs £'000	COVID-19 medicines £'000	COVID-19 vaccines £'000	Consumables £'000	Other £'000	Total £'000
Balance at 1 April 2023		**425,728**	**5,373**	**510,780**	**57,352**	**316,295**	**1,180,076**	**106,838**	**2,602,442**
Prior period adjustments in underlying accounts		631	-	512	-	(44,737)	5,721	-	(37,873)
Inventory additions		596,137	492	9,325,128	153,305	813,304	4,829,111	553,151	16,270,628
Inventory consumed/disposed of		(556,720)	(3,462)	(9,288,389)	(65,696)	(595,517)	(4,887,215)	(557,990)	(15,954,989)
Write downs		(32,859)	-	(14,500)	(343,212)	(92,908)	(1,099,450)	(894)	(1,583,823)
Impairment of inventory	4.3	-	-	-	367,474	-	1,051,832	-	1,419,306
Transfers		-	3,462	-	-	-	(73,177)	882	(68,833)
Transfers from provisions		-	-	-	(123,641)	(224,227)	(2,267)	-	(350,135)
Reclassification		-	-	-	-	-	5,227	(5,227)	-
Other		-	-	-	-	-	(604)	15,333	14,729
Balance at 31 March 2024		**432,917**	**5,865**	**533,531**	**45,582**	**172,210**	**1,009,254**	**112,093**	**2,311,452**

Departmental group for the year ended 31 March 2023

	Notes	Adult and childhood vaccines £'000	Pandemic flu and pre pandemic flu £'000	Drugs £'000	COVID-19 medicines £'000	COVID-19 vaccines £'000	Consumables £'000	Other £'000	Total £'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
Inventory 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	4.3	-	-	-	924,388	68,238	(101,314)	-	891,312
Transfers		-	14	-	-	-	2,518	10,279	12,811
Transfers 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**

13. Cash and cash equivalents

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Balance at 1 April 2023	**1,016,021**	**15,561,412**	**959,885**	**18,096,779**
Net change in cash	1,353,521	(969,492)	56,136	(2,535,367)
Balance at 31 March 2024	**2,369,542**	**14,591,920**	**1,016,021**	**15,561,412**
The following balances at 31 March were held at:				
Government Banking Service	2,368,996	13,915,029	1,015,557	15,001,957
Commercial banks and cash in hand	546	281,276	464	274,607
Short term investments	-	395,615	-	284,848
Balance at 31 March 2024	**2,369,542**	**14,591,920**	**1,016,021**	**15,561,412**

14. Trade receivables and other assets

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Amounts falling due within one year:				
Trade receivables	71,356	2,630,129	850,000	3,054,017
Deposits and advances	-	4,675	-	11,048
Capital receivables	-	55,127	-	86,266
Interest receivable	-	22,750	-	18,520
Other receivables	305,064	1,192,612	462,919	1,289,480
Trade and other receivables	**376,420**	**3,905,293**	**1,312,919**	**4,459,331**
Consolidated Fund Extra Receipts receivable	13	13	-	-
Contract assets	6,145	8,722	5,362	8,429
Other prepayments and accrued income	937,236	2,813,961	386,709	2,167,297
Service concession arrangement prepayments	-	29,220	-	25,932
Capital prepayments	-	111,195	-	85,621
Other current assets	-	3,254	-	4,608
Other current assets	**943,394**	**2,966,365**	**392,071**	**2,291,887**
Loans receivable	334,552	2,398	215,018	2,277
Other current financial assets	-	102,000	-	-
Other financial assets	**334,552**	**104,398**	**215,018**	**2,277**
Total current receivables	**1,654,366**	**6,976,056**	**1,920,008**	**6,753,495**
Amounts falling due after more than one year:				
Trade receivables	-	178,900	-	170,921
Deposits and advances	-	6,798	-	5,547
Capital receivables	-	24,881	-	16,519
Contract assets	-	5,283	-	4,558
Other receivables	254,784	273,182	293,945	296,456
Other prepayments and accrued income	359	29,183	125,143	162,095
Service concession arrangement prepayments	-	59,430	-	54,825
Capital prepayments	-	211,937	-	189,797
Total non-current receivables	**255,143**	**789,594**	**419,088**	**900,718**
Total receivables	**1,909,509**	**7,765,650**	**2,339,096**	**7,654,213**

15. Trade payables and other liabilities

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Amounts falling due within one year:				
Trade payables	36,475	4,180,074	640,379	4,272,256
Capital payables	1,428	2,172,597	5,317	2,032,511
Other payables	25,692	2,268,644	30,846	2,860,236
Trade and other payables	**63,595**	**8,621,315**	**676,542**	**9,165,003**
Bank overdrafts	-	28,752	-	40,750
VAT	-	53,726	1,012	43,641
Other taxation and social security	24,181	1,876,179	22,653	1,633,963
Reciprocal healthcare payables	730,225	730,225	711,275	711,275
Contract liabilities	526,360	1,921,659	14,841	1,531,926
Other accruals	512,331	13,316,745	956,692	16,668,521
Deferred income	147,269	306,554	93,050	345,580
Lease liabilities	38,188	640,776	38,898	631,917
Service concession arrangements	-	660,577	-	399,248
Amount issued from the Consolidated Fund for supply but not spent at year end	3,059,347	3,059,347	1,658,498	1,658,498
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received	14,021	14,021	672	672
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Receivable	13	13	-	-
Loans payable to entities outside the group	-	46,740	-	37,936
Pension liabilities	-	1,112,252	-	1,032,599
Other current liabilities	-	17,172	-	30,289
Other liabilities	**5,051,935**	**23,784,738**	**3,497,591**	**24,766,815**
Total current payables	**5,115,530**	**32,406,053**	**4,174,133**	**33,931,818**
Amounts falling due after more than one year:				
Lease liabilities	211,881	3,657,145	297,014	3,747,341
Service concession arrangements	-	16,668,871	-	9,086,435
Pension liabilities	-	(13)	-	-
Financial liabilities	**211,881**	**20,326,003**	**297,014**	**12,833,776**
Trade payables	-	1,697	-	494
Contract liabilities	11,104	186,280	116,498	255,142
Other accruals	-	2,710	785	1,486
Capital payables	214	22,005	9,649	17,900
Other payables	-	381,779	-	326,072
Deferred income	5,140	100,971	62	96,724
Loans payable to entities outside the group	-	258,666	-	295,871
Loans payable by DHSC to group bodies	20,220	-	20,220	-
Other payables	**36,678**	**954,108**	**147,214**	**993,689**
Total non-current payables	**248,559**	**21,280,111**	**444,228**	**13,827,465**
Total payables	**5,364,089**	**53,686,164**	**4,618,361**	**47,759,283**

Other payables and other accruals for the departmental group consist of a large number of individual balances from bodies across the group. None of these balances is individually material.

Service concession arrangement payables have increased significantly in 2023-24 due to the impact of the implementation of IFRS 16.

15.1 Lease liabilities

Total expected future lease payments under leases (excluding service concession arrangements which are disclosed in **Note 9.3**) are given in the table below:

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Current lease liabilities	38,188	640,776	38,898	631,917
Non-current lease liabilities	211,881	3,657,145	297,014	3,747,341
Total lease liabilities	**250,069**	**4,297,921**	**335,912**	**4,379,258**

Maturity analysis

	2023-24 Core department and agencies £'000	2023-24 Departmental group £'000	2022-23 Core department and agencies £'000	2022-23 Departmental group £'000
Undiscounted lease payments falling due in:				
Not later than 1 year	43,393	690,257	41,612	676,792
Later than 1 year and not later than 5 years	116,599	1,856,731	114,552	1,874,917
Later than 5 years	123,031	2,342,019	203,944	2,388,289
Sub-total	**283,023**	**4,889,007**	**360,108**	**4,939,998**
Less interest element	(32,954)	(591,086)	(24,196)	(560,740)
Total lease liabilities	**250,069**	**4,297,921**	**335,912**	**4,379,258**

DHSC has a diverse range of leasing arrangements. The vast majority of DHSC's leases relate to property, these include office premises and a range of health sector specialised assets.

DHSC 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 Accounts.

16. Provisions for liabilities and charges

Core department and agencies for the year ended 31 March 2024

	Early departure costs £'000	Injury benefits £'000	Reciprocal healthcare costs £'000	Infected blood £'000	Capital provisions £'000	Other £'000	Total £'000
Balance at 1 April 2023	**69,141**	**467,611**	**1,079,993**	**2,229,082**	**1,155**	**760,101**	**4,607,083**
Prior period adjustments in underlying accounts	-	-	-	-	-	12,866	12,866
Provided in the year	11,706	38,936	808,473	82,751	5,900	134,189	1,081,955
Provisions not required written back	(4,362)	(17,654)	-	(5,305)	(126)	(69,008)	(96,455)
Provisions utilised in the year	(10,659)	(45,875)	(186,447)	(143,466)	-	(141,480)	(527,927)
Transfers to accruals and inventories	-	-	(555,631)	-	-	(350,136)	(905,767)
Borrowing costs (unwinding of discount)	993	13,991	27,045	71,099	39	3,296	116,463
Change in discount rate	(1,324)	(23,333)	(9,412)	(265,467)	(81)	(7,376)	(306,993)
Balance at 31 March 2024	**65,495**	**433,676**	**1,164,021**	**1,968,694**	**6,887**	**342,452**	**3,981,225**
Included in							
Current provisions	10,353	44,591	393,294	143,383	-	223,343	814,964
Non current provisions	55,142	389,085	770,727	1,825,311	6,887	119,109	3,166,261
Total	**65,495**	**433,676**	**1,164,021**	**1,968,694**	**6,887**	**342,452**	**3,981,225**
Expected timing of cash flow							
not later than 1 year	10,353	44,591	393,294	143,383	-	223,343	814,964
later than 1 year, not later than 5 years	37,599	168,596	770,727	457,952	2,471	76,714	1,514,059
later than 5 years	17,543	220,489	-	1,367,359	4,416	42,395	1,652,202
Total	**65,495**	**433,676**	**1,164,021**	**1,968,694**	**6,887**	**342,452**	**3,981,225**

Core department and agencies for the year ended 31 March 2023

	Early departure costs £'000	Injury benefits £'000	Reciprocal healthcare costs £'000	Infected blood £'000	Capital provisions £'000	Other £'000	Total £'000
Balance at 1 April 2022	**90,202**	**614,992**	**1,234,474**	**2,676,484**	**-**	**4,078,443**	**8,694,595**
Provided in the year	-	-	543,928	427,812	1,155	163,855	1,136,750
Provisions not required written back	(1,217)	(12,423)	-	-	-	(378,981)	(392,621)
Transfers	-	-	-	-	-	1,998	1,998
Provisions utilised in the year	(10,659)	(44,371)	(134,151)	(115,196)	-	(594,924)	(899,301)
Transfers to accruals and inventories	-	-	(546,544)	-	-	(2,495,415)	(3,041,959)
Borrowing costs (unwinding of discount)	(1,028)	(7,836)	3,661	22,066	-	(2,660)	14,203
Change in discount rate	(8,157)	(82,751)	(21,375)	(782,084)	-	(12,215)	(906,582)
Balance at 31 March 2023	**69,141**	**467,611**	**1,079,993**	**2,229,082**	**1,155**	**760,101**	**4,607,083**
Included in							
Current provisions	10,276	42,941	252,921	140,553	-	535,369	982,060
Non current provisions	58,865	424,670	827,072	2,088,529	1,155	224,732	3,625,023
Total	**69,141**	**467,611**	**1,079,993**	**2,229,082**	**1,155**	**760,101**	**4,607,083**
Expected timing of cash flow							
not later than 1 year	10,276	42,941	252,921	140,553	-	535,369	982,060
later than 1 year, not later than 5 years	37,848	171,392	818,130	470,978	134	174,963	1,673,445
later than 5 years	21,017	253,278	8,942	1,617,551	1,021	49,769	1,951,578
Total	**69,141**	**467,611**	**1,079,993**	**2,229,082**	**1,155**	**760,101**	**4,607,083**

Departmental group for the year ended 31 March 2024

	Early departure costs £'000	Injury benefits £'000	Reciprocal healthcare costs £'000	Clinical negligence £'000	Infected blood £'000	Capital provisions £'000	Other £'000	Total £'000
Balance at 1 April 2023	**198,881**	**701,378**	**1,079,993**	**69,256,238**	**2,229,082**	**20,329**	**2,877,796**	**76,363,697**
Prior period adjustments in underlying accounts	-	-	-	-	-	1,783	9,420	11,203
Provided in the year	26,077	60,812	808,473	9,316,692	82,751	37,575	794,842	11,127,222
Provisions not required written back	(9,122)	(23,903)	-	(3,939,775)	(5,305)	(4,739)	(585,926)	(4,568,770)
Provisions utilised in the year	(25,253)	(60,491)	(186,447)	(2,821,167)	(143,466)	(1,245)	(353,734)	(3,591,803)
Transfers to accruals and inventories	(4,369)	(3,902)	(555,631)	-	-	-	(390,987)	(954,889)
Borrowing costs (unwinding of discount)	4,032	18,395	27,045	881,547	71,099	124	24,903	1,027,145
Change in discount rate	(4,814)	(35,410)	(9,412)	(14,537,295)	(265,467)	(60)	(77,349)	(14,929,807)
Balance at 31 March 2024	**185,432**	**656,879**	**1,164,021**	**58,156,240**	**1,968,694**	**53,767**	**2,298,965**	**64,483,998**
Included in								
Current provisions	28,865	63,457	393,294	3,666,241	143,383	7,622	1,258,813	5,561,675
Non current provisions	156,567	593,422	770,727	54,489,999	1,825,311	46,145	1,040,152	58,922,323
Total	**185,432**	**656,879**	**1,164,021**	**58,156,240**	**1,968,694**	**53,767**	**2,298,965**	**64,483,998**
Expected timing of cash flow								
not later than 1 year	28,865	63,457	393,294	3,666,241	143,383	7,622	1,258,813	5,561,675
later than 1 year, not later than 5 years	100,636	242,399	770,727	12,368,086	457,952	15,883	433,995	14,389,678
later than 5 years	55,931	351,023	-	42,121,913	1,367,359	30,262	606,157	44,532,645
Total	**185,432**	**656,879**	**1,164,021**	**58,156,240**	**1,968,694**	**53,767**	**2,298,965**	**64,483,998**

Departmental group for the year ended 31 March 2023

	Early departure costs £'000	Injury benefits £'000	Reciprocal healthcare costs £'000	Clinical negligence £'000	Infected blood £'000	Capital provisions £'000	Other £'000	Total £'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**
Prior period adjustments in underlying accounts	-	176	-	-	-	-	(5,685)	(5,509)
Impact of adoption of IFRS 16	-	-	-	-	-	-	(6,219)	(6,219)
Provided in the year	13,061	15,311	543,928	22,256,184	427,812	20,682	1,067,801	24,344,779
Provisions not required written back	(8,915)	(19,768)	-	(4,251,055)	-	(622)	(894,995)	(5,175,355)
Transfers	-	(3,146)	-	-	-	-	5,144	1,998
Provisions utilised in the year	(23,912)	(58,107)	(134,151)	(2,641,701)	(115,196)	-	(825,342)	(3,798,409)
Transfers to accruals and inventories	(4,033)	(3,282)	(546,544)	-	-	-	(2,531,217)	(3,085,076)
Borrowing costs (unwinding of discount)	(677)	(8,113)	3,661	251,343	22,066	(23)	(38,542)	229,715
Change in discount rate	(23,030)	(150,472)	(21,375)	(74,542,722)	(782,084)	292	(325,763)	(75,845,154)
Balance at 31 March 2023	**198,881**	**701,378**	**1,079,993**	**69,256,238**	**2,229,082**	**20,329**	**2,877,796**	**76,363,697**
Included in								
Current provisions	28,250	61,400	252,921	3,333,859	140,553	2,288	1,490,858	5,310,129
Non current provisions	170,631	639,978	827,072	65,922,379	2,088,529	18,041	1,386,938	71,053,568
Total	**198,881**	**701,378**	**1,079,993**	**69,256,238**	**2,229,082**	**20,329**	**2,877,796**	**76,363,697**
Expected timing of cash flow								
not later than 1 year	28,250	61,400	252,921	3,333,859	140,553	2,288	1,490,858	5,310,129
later than 1 year, not later than 5 years	102,328	246,009	818,130	12,553,042	470,978	4,870	675,070	14,870,427
later than 5 years	68,303	393,969	8,942	53,369,337	1,617,551	13,171	711,868	56,183,141
Total	**198,881**	**701,378**	**1,079,993**	**69,256,238**	**2,229,082**	**20,329**	**2,877,796**	**76,363,697**

Clinical negligence

The departmental group, through the operations of several schemes under NHS Resolution, recognises a clinical negligence provision. Most of the estimate relates to the clinical negligence scheme for trusts (CNST), representing £54 billion of the total provision (2022-23: £64 billion).

The provision represents DHSC's best estimate of its future obligations from clinical negligence as a result of incidents up to 31 March 2024. The best estimate is split between three categories:

- Known claims – where a claim has been received by NHS Resolution
- Settled claims – where the past settlement of a claim involves ongoing future payments
- Incurred but not reported claims (IBNR) – claims that may be brought in the future 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 (PPOs) 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 decreased the clinical negligence provision by £75 billion. In 2023-24, there has been a further, but lesser, increase in the discount rates which has led to a decrease of £15 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 (for example, the personal injury discount rate). As such, the decreases in the

provisions, both in this year and last year, reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

The table below details the movements in the provision if the same discount rates as 2022-23 had been applied.

At 1 April 2023 £ billion	Provided in year £ billion	Provisions not required written back £ billion	Provisions utilised in year £ billion	Borrowing costs £ billion	At 31 March 2024 £ billion
69.3	9.3	(4.0)	(2.8)	0.9	**72.7**

Key movements in provision

Known 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 IBNR claims are valued using actuarial models to predict likely values. The value of the provision decreased by £11 billion in 2023-24 from £69 billion at 31 March 2023 to £58 billion at 31 March 2024.

The key movements in 2023-24 were:

- an increase of £5.7 billion from clinical activity in 2023-24
- a decrease of £0.2 billion due to changes in assumptions affecting the IBNR provision. The main drivers of the decrease relate to the CNST IBNR provision and include decreases of £0.7 billion for average cost assumptions, £0.6 billion for COVID-19 related provisions, £0.3 billion for updates to the long-term inflation assumptions. These decreases are offset by increases of £1.1 billion in respect of claim number projections, £0.2 billion following updates to the probability assumptions for paying damages, and £0.1 billion in respect of lag and payment patterns and updated mortality assumptions in respect of potential PPO claims
- an increase of £0.9 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
- a decrease of £2.9 billion relating to amounts paid out during the financial year to settle claims
- a decrease of £14.6 billion due to increases in the discount rates specified for use by HM Treasury under the Public Expenditure System (PES).

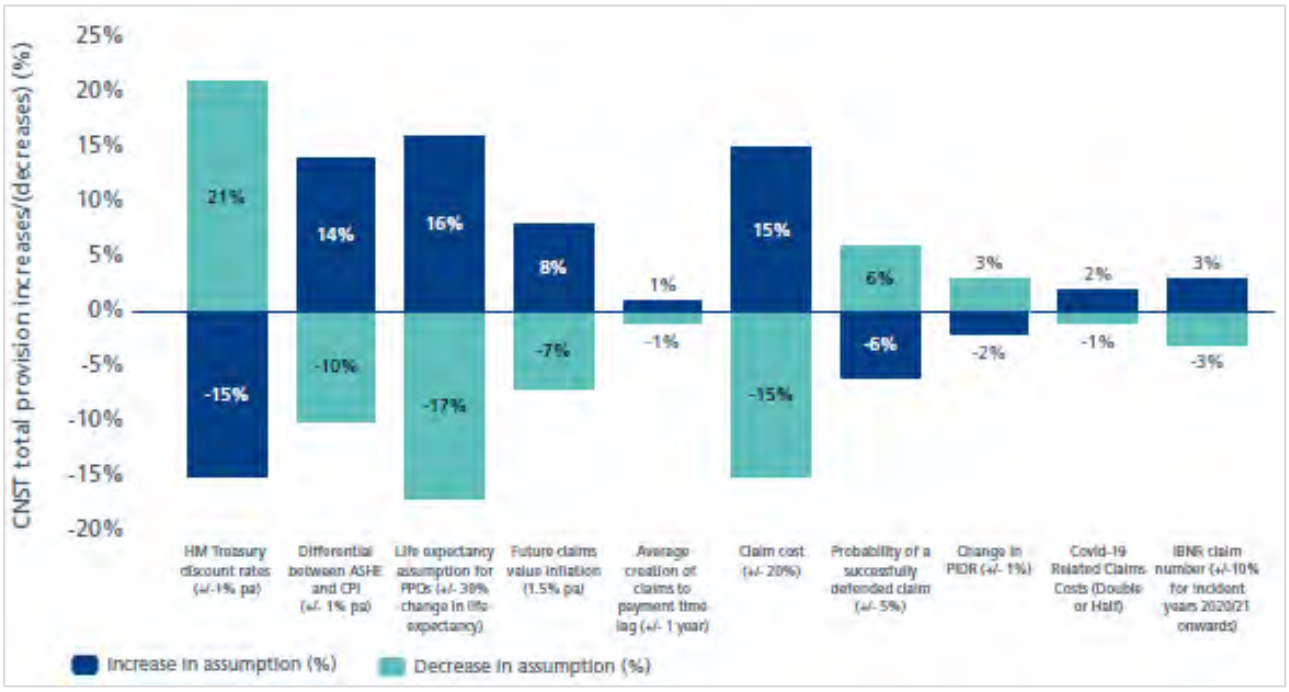
Full details of the changes above can be found in the Annual Report and Accounts of NHS Resolution.

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).

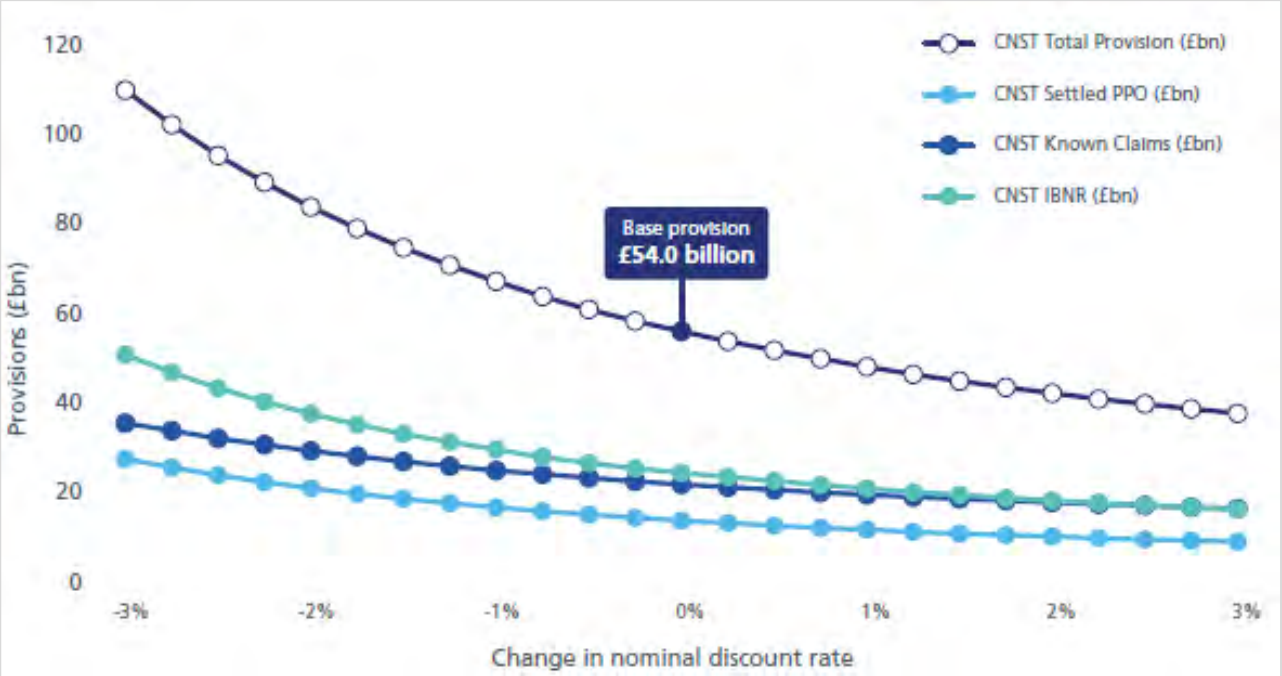
Claims settling as PPOs also remain a key area of uncertainty, given the high value of PPO settlements and the relatively small number of claims that settle on this basis. PPO claim settlements are paid over the lifetime of the claimant, and consequently, there are additional inflation and longevity 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.



Note: PIDR is the personal injury discount rate. It is a percentage figure used to help calculate how much defendants have to pay in damages to claimants in serious, life-changing personal injury cases, when the damages are paid in the form of a lump sum. It is the duty of the Lord Chancellor under the Damages Act 1996 (the Act) to set the PIDR.

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.

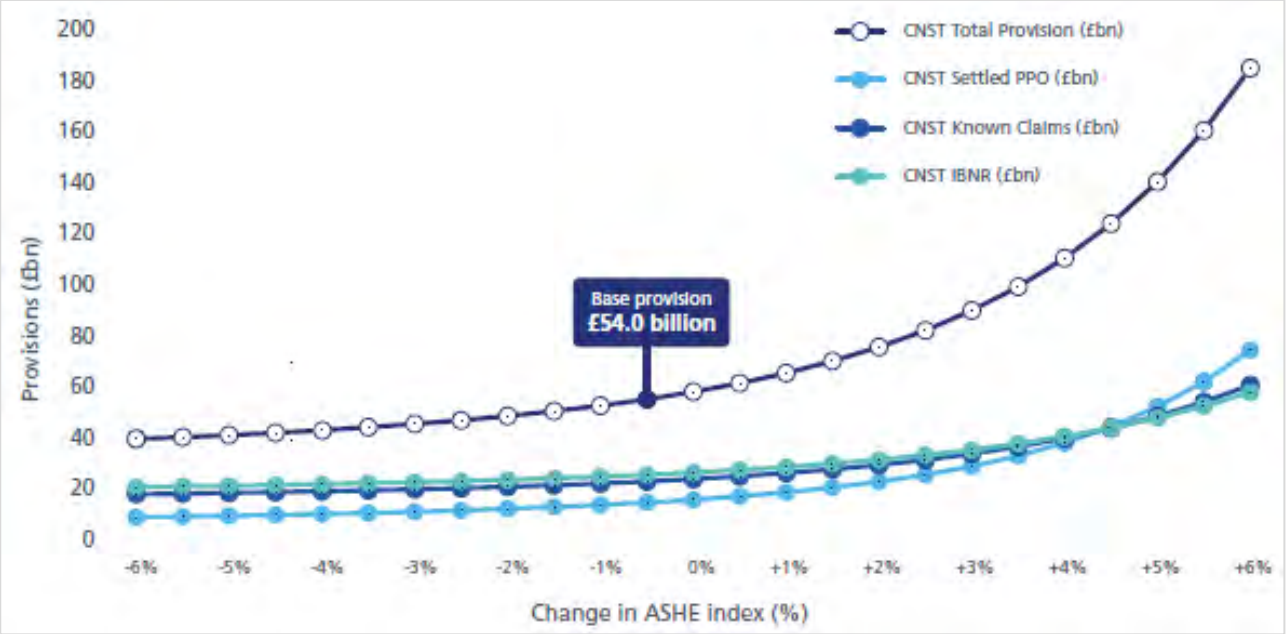
This year, there was a significant increase to discount rates across all durations, as prescribed by HMT, which has decreased the provision significantly.

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 support 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 expected 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 CPI.

Provision is included for the expected future cost of payments as at 31 March 2024 due to be made under the Infected Blood Interim Compensation Payment Scheme. This does not include amounts which were committed to by government after the end of the financial year. See **Note 19** for details of events after the reporting period.

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

Other provisions are made up of a number of small provisions from a number of bodies within the departmental group. None of the provisions within the other provisions amount is individually material.

17. Contingent assets and liabilities disclosed under IAS 37

17.1 Contingent assets

DHSC has lodged several civil litigation claims seeking damages linked to civil actions around a breach of competition regulations. DHSC 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	DHSC is the actual or potential defendant in a number of actions regarding alleged clinical negligence, liabilities relating to 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 DHSC's liability and the amounts involved. This contingent liability discloses possible total expenditure, assuming that damage payments were awarded on all claims, rather than taking into account the probability of damages being paid.	24,553.8 (2022-23: 32,179)
Legal Cases		
2	Employment tribunal cases Not disclosed due to sensitive nature of the contingent liabilities.	n/a
3	Legal cases – DHSC as claimant Not disclosed due to sensitive nature of the contingent liabilities.	n/a
4	Legal cases – DHSC as defendant Not disclosed due to sensitive nature of the contingent liabilities.	n/a
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
Letters of Comfort		
6	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.	n/a

	There are uncertainties around timing, likelihood and expected costs which have meant the core department is unable to quantify the contingent liability. This liability exists within the core department financial statements only, as it is eliminated within the group.	
NHS England Group		
7	There were contingent liabilities within the NHS England Group account (which incorporates ICBs, Supply Chain Coordination Ltd, Health Education England and NHS England). These were mainly in respect of continuing care liabilities which transferred from primary care trusts on 1 April 2013.	29.8 (2022-23: 42.2)
8	There were contingent liabilities of NHS providers at 31 March 2024.	113.1 (2022-23: 35.5)
NHS Resolution		
9	At 31 March 2024, NHS Resolution had other non-clinical contingent liabilities. 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.	226.9 (2022-23: 263)
Other IAS 37 Contingent Liabilities		
10	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 (2022-23: 0.5)
11	Provision of life assurance cover for individuals transferred to DHSC There are uncertainties around timing and likelihood of payments being required, as well as the expected payments.	0.4 (2022-23: 0.4)
12	Compensation payments due to individuals unable to be traced There are uncertainties around timing, likelihood and expected costs.	0.4 (2022-23: nil)
13	Sensitive Contingent Liability Not disclosed due to sensitive nature of the contingent liabilities.	n/a
14	NHS Property Services has an unquantifiable contingent liability regarding its ability to claim capital allowances on inherited assets. There is uncertainty with regards to timing and any potential tax liability.	n/a

15	UKHSA is involved in a variety of material contract disputes, four over £300,000 which UKHSA believe constitute contingent liabilities, primarily relating to contracts let in response to the COVID-19 Pandemic. These have associated financial risks, which constitute a contingent liability for the organisation. Not disclosed due to sensitive nature of the contingent liabilities.	n/a

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.

The core department is the parent of the group of organisations and sponsor of the non-departmental public bodies shown in **Note 20**. These bodies are regarded as related parties with which the core department has had various material transactions during the year.

In addition, the core department had a small number of transactions with other government departments and other central government bodies in 2023-24.

A small number of Ministers, Non-Executive Directors, and senior officials 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:

Connected individual	DHSC role	Organisation	Payables with related party 2023-24 £'000	Purchases from related party 2023-24 £'000	Receivables with related party 2023-24 £'000	Sales to related party 2023-24 £'000	Payables with related party 2022-23 £'000	Purchases from related party 2022-23 £'000	Receivables with related party 2022-23 £'000	Sales to related party 2022-23 £'000
Doug Gurr[1]	Non Executive Board Member	UK BioCentre	n/a	n/a	n/a	n/a	-	-	-	488
Doug Gurr[2]	Non Executive Board Member	The Alan Turing Institute	-	1,221	-	-	-	719	-	-
Samantha Jones[3]	Non Executive Board Member	NHS Confederation	-	9,718	-	-	-	7,696	-	-
Samantha Jones[4]	Non Executive Board Member	Accurx Ltd	-	1,331	-	-	-	1,128	-	-
Samantha Jones[5]	Non Executive Board Member	Alzheimer's Society	-	-	898	1,197	-	14	-	-
Steve Barclay[6]	Former Secretary of State	Anglian Water	-	524	-	-	44	523	-	-

1. UK BioCentre was a 100% owned subsidiary of UK Biobank. Doug Gurr is a Director of UK Biobank on a non-remunerated basis. UK BioCentre ceased to be a related party in 2023-24.
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.
4. Samantha Jones holds the position of board member at Accurx Ltd.
5. Samantha Jones holds the position of Trustee at Alzheimer's Society.

6. An individual related to Steve Barclay holds the position of Head of Infrastructure at Anglian Water. The 2022-23 information in the table above was omitted from the related parties note in the 2022-23 annual report and accounts and is therefore included here in accordance with IAS 8.

The accountability report identifies 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 core 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 remuneration report.

NHS Shared Business Services Limited was regarded as a related party of the core department by virtue of a 50% shareholding. The investment in NHS Shared Business Services Limited was transferred to the NHS Business Services Authority on 31 March 2023. The value transferred was £92 million.

In 2022-23, prior to this transfer, the core department had the following transactions with NHS Shared Business Services Limited.

Payables	Purchases	Receivables	Income	Loans issued
£'000	£'000	£'000	£'000	£'000
531	5,160	2,000	2,021	238

19. Events after the reporting period

On 21 May 2024 the then government made a number of announcements and commitments in relation to those affected by infected blood products. These announcements represent new commitments and are therefore not reflected in these financial statements.

The then government announced further interim payments of £210,000 for existing eligible beneficiaries of the England Infected Blood Support Scheme.

In addition, the then government announced a final compensation scheme and a widening of eligibility criteria for compensation. These costs will be met by the newly established Infected Blood Compensation Authority which was established on 24 May 2024.

Further information relating to the Infected Blood Inquiry can be found on **pages 159 to 160** of the annual report.

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

The entities within the boundary comprise supply financed agencies and those entities listed in the designation and amendment orders presented to Parliament. They are:

Supply financed agencies

Entity	Website
Medicines and Healthcare products Regulation Agency	Medicines and Healthcare products Regulatory Agency - GOV.UK (www.gov.uk)
UK Health Security Agency	UK Health Security Agency - GOV.UK (www.gov.uk)

Special health authorities

Entity	Website
NHS Business Services Authority	Welcome | NHSBSA
NHS Counter Fraud Authority	Welcome to the NHS Counter Fraud Authority (NHSCFA) public website | NHS Fraud? See it. Stop it. Report it.
NHS Litigation Authority (known as NHS Resolution)	Home - NHS Resolution

Executive non-departmental public bodies

Entity	Website
Care Quality Commission	Care Quality Commission (cqc.org.uk)
Human Fertilisation and Embryology Authority	HFEA: UK fertility regulator
Health Research Authority	Health Research Authority (hra.nhs.uk)
Health Services Safety Investigations Body	Health Services Safety Investigations Body (HSSIB)
Human Tissue Authority	Home | Human Tissue Authority (hta.gov.uk)
National Institute for Health and Care Excellence	NICE | The National Institute for Health and Care Excellence
NHS England	NHS England

Other bodies

Entity	Website
Integrated care boards	Accounts for integrated care boards are available on the websites of the individual bodies
NHS trusts and NHS foundation trusts (collectively referred to as NHS providers)	Accounts for NHS providers are available on the websites of the individual bodies
NHS charities (see note below)	Accounts for NHS charities are available on the websites of the individual bodies
Community Health Partnerships Limited	Community Health Partnerships - Helping to build healthier communities
Genomics England Limited	Homepage | Genomics England
Health and Care Professions Council	The Health and Care Professions Council (HCPC) | (hcpc-uk.org)
NHS Property Services Limited	NHS Property Services | Home | NHS Property Services
Professional Standards Authority for Health and Social Care	Healthcare Regulation | Professional Standards Authority
Skipton Fund Limited	Welcome to The Skipton Fund - The Skipton Fund
The Nursing and Midwifery Council	The Nursing and Midwifery Council - The Nursing and Midwifery Council (nmc.org.uk)
Wiltshire Health and Care LLP	Wiltshire Health and Care | Enabling people to live independent and fulfilling lives

NHS charities are charitable trusts where the trustees are an NHS foundation trust (as established under section 30 of the National Health Service Act 2006) and English NHS charities as defined by section 149(7) of the Charities Act 2011, excluding those with full independent status which are not subject to consolidation.

Non-executive non-departmental public bodies

These non-executive NDPBs are not separate legal entities, rather they are part of the core department or UK Health Security Agency accounts. As such they do not prepare separate 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 Impact Awards
- Advisory Committee on Dangerous Pathogens
- Advisory Committee on the Safety of Blood, Tissues and Organs
- Advisory Group on Hepatitis
- British Pharmacopoeia Commission
- Commission on Human Medicines
- 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 Medical Effects of Air Pollutants
- Committee on Mutagenicity of Chemicals in Food, Consumer Products and the Environment
- Expert Advisory Group on AIDS
- Healthwatch England
- Independent Reconfiguration Panel
- Joint Committee on Vaccination and Immunisation
- The NHS Pay Review Body
- Office of the Commissioner for Patient Safety
- Office of the National Data Guardian for Health and Social Care
- Review Body on Doctors' and Dentists' Remuneration
- Scientific Advisory Committee on Nutrition
- UK Nutrition and Health Claims Committee

In addition to the bodies listed above DHSC is the sponsoring department for NHS Blood and Transplant. As a Public Corporation the results of NHS Blood and Transplant are not consolidated into the group financial statements.

Changes in group structure in year

The following key change in the structure of the group occurred during 2023-24:

- On 1 April 2023 the functions of Health Education England merged into NHS England. From that date the transactions of this function are shown in the NHS England results in the segmental analysis and in the statement of outturn against parliamentary supply.

- The Health Services Safety Investigations Body (HSSIB) was created on 1 October 2023.

DHSC'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 2023-24 DHSC group ARA is subject to a limitation of scope audit opinion relating to the UKHSA opening balances for 2022-23 (2021-22 closing balances) and 2022-23 in year transactions included in the group ARA. UKHSA closing 2022-23 balances and 2023-24 transactions and closing balances included in the group ARA are not subject to the limitation of scope audit opinion. The following tables provide an analysis of the transactions and balances which are subject to the limitation of scope audit opinion. The circumstances around these comparative audit scope limitations are described in the Governance Statement on page 137.

These amounts will not agree to the local annual report and accounts of UKHSA due to the impact of intra group eliminations and also local prior period account adjustments in UKHSA's accounts.

The table below shows the balances subject to the limitation of scope audit opinion. These represent the balances as at 1 April 2022 for the group ARA (that is the 2021-22 closing balances):

	UKHSA balances included in the core and agencies column of the statement of financial position at 1 April 2022 £'000	UKHSA balances included in the departmental group column of the statement of financial position at 1 April 2022 £'000
Non-current assets		
Property plant and equipment	926,983	926,983
Investment property	15,491	15,491
Intangible assets	37,741	37,741
Non-current investments	18,350	18,350
Other non-current assets	18	18
Total non-current assets	**998,583**	**998,583**
Current assets		
Inventories	1,102,482	1,102,482
Trade and other receivables	255,688	244,953
Other current assets	69,688	69,688
Cash and cash equivalents	215,598	215,598
Total current assets	**1,643,456**	**1,632,721**
Total assets	**2,642,039**	**2,631,304**
Current liabilities		
Trade and other payables	(164,649)	(123,448)
Other liabilities	(1,984,313)	(1,509,743)
Provisions	(98,283)	(98,283)
Total current liabilities	**(2,247,245)**	**(1,731,474)**
Non-current assets less net current liabilities	**394,794**	**899,830**
Non-current liabilities		
Provisions	(16,682)	(16,682)
Total non-current liabilities	**(16,682)**	**(16,682)**
Total assets less liabilities	**378,112**	**883,148**

The table below shows the UKHSA transactions in the DHSC group account which are subject to the audit limitation of scope opinion in 2023-24. These are the comparatives for 2023-24 which were subject to the limitation of scope opinion in 2022-23:

	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
Income from contracts	(349,601)	(303,661)
Other non-contract operating income	(49,976)	(49,976)
Total operating income	**(399,577)**	**(353,637)**
Staff costs	482,094	482,094
Purchase of goods and services	2,774,436	2,732,902
Depreciation and impairment charges	489,095	488,059
Provision expense	(312,597)	(312,597)
Other operating expenditure	83,371	83,371
Total operating expenditure	**3,516,399**	**3,473,829**
Net operating expenditure for the year ended 31 March 2023	**3,116,822**	**3,120,192**
Finance income	-	-
Finance expenditure	1,188	1,119
Net gain/(loss) on transfer by absorption	(6,408)	-
Total net expenditure for the year ended 31 March 2023	**3,111,602**	**3,121,311**
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)
- equity instruments measured at fair value through OCI	18,350	18,350
Total comprehensive expenditure for the year ended 31 March 2023	**3,106,928**	**3,116,637**

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

		2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Plan
Resource DEL							
A	NHS England	17,186,308	25,597,500	23,371,789	14,524,033	27,857,107	34,279,537
B	NHS providers	81,526,454	93,119,985	99,849,097	107,932,134	114,691,376	114,022,013
C	DHSC programme and administration	856,606	26,540,107	13,268,380	5,065,263	453,464	862,536
D	Local authorities (public health)	2,931,555	4,205,920	4,217,325	3,195,761	3,301,393	3,368,797
E	Executive agencies	923,546	1,480,833	10,181,091	3,737,212	2,629,150	1,369,173
F	Health Education England [1]	1,444,495	1,448,640	1,595,487	1,789,611	-	-
G	Special health authorities	2,743,281	2,650,888	2,868,350	2,969,741	3,771,079	3,397,616
H	Non departmental public bodies	628,293	723,579	875,334	769,729	203,613	141,968
I	Arm's length bodies	2,981,221	2,849,887	2,124,627	844,324	855,900	829,261
J	NHS Commissioning Board financed from National Insurance contributions (non voted)	22,961,639	22,823,176	25,196,757	36,266,858	29,055,511	29,365,285
Total Resource DEL		**134,183,398**	**181,440,515**	**183,548,237**	**177,094,666**	**182,818,593**	**187,636,186**

		2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Plan
Capital DEL							
A	NHS England	265,530	330,577	291,416	238,684	376,068	431,442
B	NHS providers	4,498,029	7,281,187	6,833,740	7,537,572	7,753,801	8,058,237
C	DHSC programme and administration	1,811,114	4,677,582	1,795,522	1,987,401	2,143,363	3,680,108
D	Local authorities (public health)	-	-	-	-	-	-
E	Executive agencies	140,735	21,022	(221,171)	(274,232)	(93,031)	103,060
F	Health Education England [1]	1,557	532	1,119	1,889	-	-
G	Special health authorities	24,172	47,320	30,623	23,715	24,172	25,900
H	Non departmental public bodies	118,533	156,325	187,746	129,542	20,804	13,660
I	Arm's length bodies	155,574	189,762	200,041	203,379	294,067	343,300
Total Capital DEL		**7,015,244**	**12,704,307**	**9,119,036**	**9,847,950**	**10,519,244**	**12,655,707**

		2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Plan
Resource AME							
K	NHS England	294,489	86,125	119,445	10,693	(80,093)	250,000
L	NHS providers	1,070,401	1,978,051	1,100,553	962,326	2,158,520	2,000,000
M	DHSC programme and administration	785,506	1,997,564	3,115,133	(3,519,936)	(466,781)	3,561,017
N	Executive agencies	(2,033)	13,831	269,629	(483,838)	(160,517)	-
O	Health Education England [1]	68	159	596	(856)	-	-
P	Special health authorities	675,203	(1,266,873)	43,308,197	(58,933,071)	(11,132,970)	5,003,000
Q	Non departmental public bodies	3,536	23,207	25,429	16,508	(50,717)	2,000
R	Arm's length bodies	20,839	49,696	31,745	(23,742)	2,525	63,983
Total Resource AME		**2,848,009**	**2,881,760**	**47,970,727**	**(61,971,916)**	**(9,730,033)**	**10,880,000**

		2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Plan
Capital AME							
K	NHS England	-	-	-	-	(1,237)	13,378
L	NHS providers	-	-	-	16,807	16,843	-
M	DHSC programme and administration	(5,563)	(7,355)	-	2,654	5,060	929,222
N	Executive agencies	-	-	-	-	-	-
O	Health Education England [1]	-	-	-	-	-	-
P	Special health authorities	-	-	-	-	-	-
Q	Non departmental public bodies	-	-	-	-	-	-
R	Arm's length bodies	-	-	-	868	10,989	-
Total Capital AME		**(5,563)**	**(7,355)**	**-**	**20,329**	**31,655**	**942,600**

1. In April 2023 NHS England and Health Education England legally merged to create a new, single organisation to lead the NHS in England.

Core table 2: administration budgets

		2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Plan
Administration Budgets							
A	NHS Commissioning Board	1,545,410	1,488,859	1,474,998	1,789,448	1,851,566	2,125,509
B	NHS providers	-	-	-	-	-	-
C	DHSC programme and administration	230,249	449,061	522,365	390,591	352,766	631,153
D	Local authorities (public health)	-	-	-	-	-	-
E	Executive agencies	49,134	51,140	174,753	201,661	169,540	139,074
F	Health Education England (1)	61,296	58,970	60,183	60,709	-	-
G	Special health authorities	180,884	192,996	167,127	121,647	112,112	130,376
H	Non-departmental public bodies	239,886	258,655	280,647	241,300	89,600	100,200
I	Arm's length bodies	(5,777)	(6,850)	(5,461)	3,003	(4,302)	-
Total Administration Budget		**2,301,082**	**2,492,831**	**2,674,612**	**2,808,359**	**2,571,282**	**3,126,312**

1. In April 2023 NHS England and Health Education England legally merged to create a new, single organisation to lead the NHS in England.

Supporting narrative for the core tables can be found within performance section and **Annex B.**

Annex B (i) – Financial performance detail

Largest DEL Budget in Government

The DHSC group has the largest departmental expenditure limit (DEL) in government. We consolidate the spending of around 300 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.

Spending for all government departments is measured against a set of metrics as agreed in HM Treasury's spending review. **Figure 26** provides a breakdown of the consolidated budgets for all bodies in the DHSC group into the main spending metrics.

Figure 26: DHSC group – spending metrics

Total department expenditure limit (TDEL)	Total annually managed expenditure (TAME)
£189.5bn	**(£3.9)bn**
Total funding for DHSC, excluding AME and DEL depreciation & impairments.	Total AME funding for DHSC, excluding depreciation & impairments.

Resource departmental expenditure limit (RDEL)	Capital departmental expenditure limit (CDEL)	Annually managed expenditure - resource (RAME)	Annually managed expenditure - capital (CAME)
£183.9bn	**£11.0bn**	**(£2.3)bn**	**£0.1bn**
The control total for which current resource expenditure, net of income, must be contained.	The control total for which capital expenditure, e.g. fixed assets additions and capital grants, net of capital disposals must be contained.	The control total 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. This mainly comprises net provisions and impairments expenditure.	The control total for items that HM Treasury have deemed to be classified as CAME. This includes net IFRS16 lease dilapidation provisions expenditure.

Administration (Admin)
£3.1bn
Administration budgets cover the costs of all central government administration, excluding depreciation and the costs of direct frontline service provision.

Total departmental expenditure limit

The DHSC group's total DEL (TDEL); a spending measure, not formally managed, consistent with the presentation of spending in HM Treasury publications, is calculated as the sum of resource departmental expenditure limit (RDEL) plus capital departmental expenditure limit (CDEL) less depreciation.

TDEL spending continues to grow cumulatively since the 2015 spending review (SR15) and was significantly impacted by COVID-19 spending in 2020-21 and 2021-22. The level of COVID-19 spending in 2022-23 and 2023-24 was significantly reduced from the prior 2 years.

Table 45 details 2023-24 TDEL spending outturn and compares that to previous years.

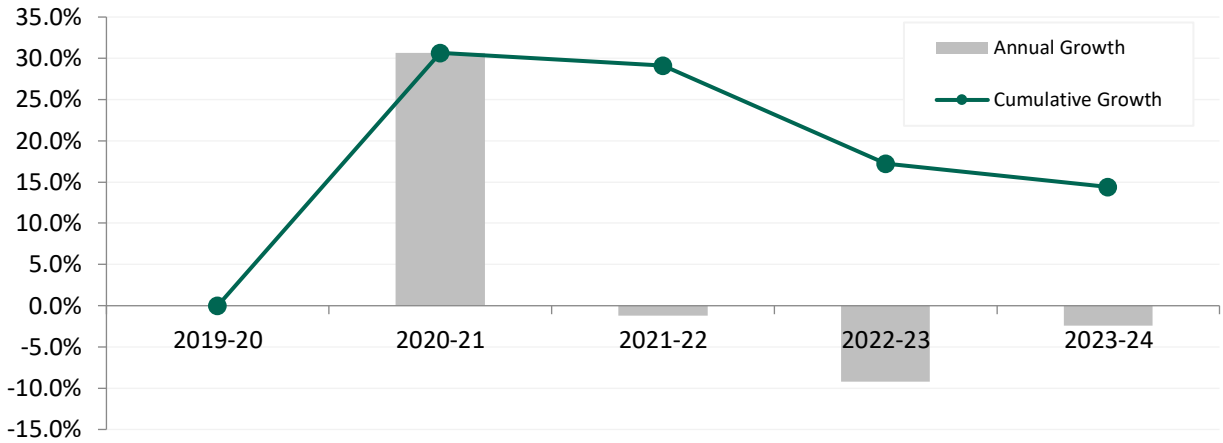
Table 45: Total departmental expenditure limit spending

	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
TDEL spending	**138,455**	**190,610**	**187,274**	**182,131**	**188,614**
Growth Nominal (£)		*52,155*	*(3,336)*	*(5,143)*	*6,483*
Growth Nominal (%)		*37.7%*	*(1.8%)*	*(2.7%)*	*3.6%*

1. This table has been adjusted to reflect the reclassification of NHS provider depreciation to RDEL RF.

As shown in **Figure 27**, in 2023-24, DHSC real-terms spending was 2.4% lower than in 2022-23 and 14.4% greater than in 2019-20.

Figure 27: Real terms spending growth



1. Cumulative growth figures are from 2019-20. GDP deflators at October 2024 used to calculate real terms growth.

The TDEL expenditure change results from the funding secured in the 2015 spending review, 2019 spending round and 2021 spending review.

The cumulative real term increases in 2020-21 to 2022-23 TDEL expenditure compared to 2019-20 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, £36.9 billion in 2021-22 and £12.6 billion in 2022-23.

The TDEL real terms reduction in 2023-24 expenditure is mainly because of the reduced levels of COVID expenditure in 2023-24 compared to the prior years.

DHSC group's outturn against the budgets authorised by Parliament is detailed in **Table 46** below:

Table 46: Parliamentary DEL and AME control totals

	Budget £m	Outturn £m	Under/ (Overspend) £m
Parliamentary Controls:			
Resource departmental expenditure limit (RDEL)	183,861	182,819	1,043
of which: resource administration	*3,119*	*2,571*	*547*
Capital departmental expenditure limit (CDEL)	10,989	10,519	470
Resource annually managed expenditure (RAME)	(2,272)	(9,730)	7,458
Capital annually managed expenditure (CAME)	106	32	74
Net cash requirement	189,477	160,749	3,520
Further HM Treasury controls:			
Ringfenced resource DEL	5,373	4,724	649
Non-ringfenced resource DEL	178,488	178,095	394

The following narrative, with commentary and supporting tables, provides an explanation of the financial performance of the system, including financial outturn against DHSC's own spending controls.

Resource departmental expenditure limit (RDEL)

DHSC's total 2023-24 resource DEL (RDEL) represents the consolidated resource spending of all bodies within the NHS and non-NHS sectors of the departmental group, that is, NHS healthcare providers and commissioners and the department plus its arm's length bodies (ALBs).

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. DHSC 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.

In 2023-24, National Insurance contributions receipts of £29.1 billion were in line with the non-voted funding set out in the parliamentary estimate.

Table 47 summarises the RDEL outturn against budget since 2019-20; highlighting the £1.0 billion, 0.6% underspend in 2023-24:

Table 47: Resource DEL

	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
RDEL budget	134,628	201,996	186,895	176,148	183,861
RDEL spending outturn	**134,183**	**181,441**	**183,548**	**177,095**	**182,819**
Underspends / (overspends) (£m)	*444*	*20,556*	*3,347*	*(946)*	*1,043*
Underspends / (overspends) (%)	*0.3%*	*10.2%*	*1.8%*	*(0.5%)*	*0.6%*

RDEL: Funding flows and sector breakdown

Of the department's total £183.9 billion 2023-24 RDEL budget, £175.5 billion was allocated directly to NHS commissioners, with the remaining £8.4 billion funding allocated to ALBs and the department's central budgets, that is, the non-NHS sector.

NHS healthcare providers are not directly funded, instead they generate income to cover their spending via trading activity with commissioners, for example, 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.

Across government, this 'internal market' is unique to the DHSC 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).

Approximately £114.7 billion of resource expenditure in the DHSC 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.

The RDEL budget is set net of income and in 2023-24 the DHSC group received around £13.8 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

Table 48 details the DHSC group resource DEL outturn by sector against budgets.

Table 48: DHSC group resource DEL

	Budget £m	Outturn £m	Underspend/ (overspend) £m
NHS RDEL (excl. depreciation)	171,036	171,271	(235)
Non-NHS RDEL (excl. depreciation)	7,177	6,824	353
NHS pay/ industrial action funding	276		276
DHSC group RDEL (excl. depreciation)	**178,488**	**178,095**	**394**
NHS RDEL (depreciation)	4,474	4,223	251
Non-NHS (depreciation)	899	500	399
DHSC group RDEL (incl. depreciation)	**183,861**	**182,819**	**1,043**

As set out in the performance summary (page 84), the department underspent against the resource departmental expenditure limit (RDEL) by circa £1.0 billion. The net underspend mainly comprised:

- RDEL non-ringfence: DHSC underspent the available RDEL non-ringfenced funding by circa £0.4 billion (0.2% of the budget). Further details of the NHS and non-NHS performance are set out in the following paragraphs

- RDEL ringfence: DHSC underspent the available RDEL budget ringfenced for depreciation and impairments by circa £0.6 billion because actual expenditure was lower than the forecasts available when agreeing the final budget in the supplementary supply estimate

RDEL NHS: Overall NHS performance against NHS financial directions – resource limits

The following section provides detail on the financial performance of the NHS in 2023-24.

The Financial Directions to the Government's revised NHS mandate for 2023-24 separately set 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 DHSC. NHS England must exercise its duties with a view to ensuring that spending across integrated care boards, NHS providers and their own centrally managed budgets is contained within the funding limits set out in annex 1 of those directions. **Table 49** below summarises the performance against those limits.

Table 49: Financial performance – NHS England, integrated care boards and NHS providers

	RDEL NRF £m	RDEL RF £m
NHSE central	40,132	349
Integrated care boards	133,632	
Net NHSE group outturn	**173,763**	**349**
NHS trusts and foundation trusts	(2,492)	3,874
Net NHS outturn as per statement of parliamentary supply	**171,271**	**4,223**
Budgets as per 2023-24 financial directions	**171,036**	**4,474**
Under/ (overspend)	**(235)**	**250**

The RDEL non-ringfence budget of circa £171.0 billion is used to fund the costs of healthcare services delivered in England. In 2023-24, the NHS' costs were £0.2 billion higher than budget (being 0.1% of the budget). This was due to decisions on NHS pay that could not have been anticipated and planned for during the course of the financial year.

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 2023-24, ICBs and NHS providers, collectively "NHS systems", reported a year-end overspend of circa £1.4 billion as inflationary pressures and disruptions to plans affected by industrial action impacted on spending. This overspend was offset by underspends on other NHS England managed budgets. **Table 50** provides a further breakdown of the NHS' outturn by sector:

Table 50: Further breakdown of NHS spending against RDEL NRF limits

	Plan	Outturn	Under/ (Overspend)
NHSE central	41,451	40,132	1,319
NHS systems (ICBs+NHS providers)	133,566	134,944	(1,378)
Classification adjustments	(3,981)	(3,805)	(176)
Net NHS outturn as per SoPS	**171,036**	**171,271**	**(235)**

1. As per 2023-24 financial directions to NHS England Annex A1: Directions Under Section 223D of the 2006 Act

Table 51: Breakdown of NHS England spending outturn against revenue DEL budget

	Plan	Outturn	Under/ (Overspend)
Revenue departmental expenditure limit (excluding depreciation and impairments)	**175,016**	**173,763**	**1,253**
Of which:			
Industrial action	*1,743*	*1,743*	*-*
Individual placement support	*6*	*6*	*-*
NHSE administration limit	*1,945*	*1,806*	*139*
Revenue departmental expenditure limit (depreciation and impairments)	**393**	**349**	**44**

1. As per 2023-24 financial directions to NHS England Annex A2: Directions under section 223E(1) and (3) of the 2006 Act

Table 52: NHS systems breakdown

	Plan	Outturn	Under/ (Overspend)
Integrated care boards		133,632	
NHS providers' adjusted financial performance		1,312	
Total adjusted financial performance	**133,566**	**134,944**	**(1,378)**

	Plan	Outturn	*Diff*
Number of NHS systems in balance	*41*	*3*	*(38)*
Number of NHS systems in surplus	*0*	*12*	*12*
Number of NHS systems in deficit	*1*	*27*	*(26)*

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

4%
Of DHSC RDEL expenditure

The DHSC group's non-NHS sector contained resource expenditure within DEL spending limits.

The summarised RDEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 53**:

Table 53: Summarised financial position for the non-NHS in 2023-24

	Plan £m	Outturn £m	Under/ (Overspend) £m
RDEL (excl. depreciation) -			
UK Health Security Agency	2,303	2,105	197
Other ALBs	495	383	112
Public health local authority grants	3,309	3,301	8
Voluntary scheme for branded medicines pricing and access	(2,239)	(2,142)	(97)
Public dividend capital (PDC) payments and loan interest	(1,000)	(1,166)	166
European Economic Area (EEA) medical costs	735	944	(209)
Adult social care	799	619	180
Other DHSC central budgets	2,775	2,752	23
NHS Charities	-	27	(27)
Total RDEL (excl. depreciation, NHS pay and industrial action excess funding)	**7,177**	**6,824**	**353**
Excess funding for NHS pay and industrial action	276	-	276
Total RDEL (excl. depreciation)	**7,453**	**6,824**	**629**
NonNHS (depreciation)	899	500	399
NonNHS RDEL (incl. depreciation)	**8,352**	**7,324**	**1,028**

Excluding other funding for NHS industrial action/ pay and depreciation, the non-NHS sector's RDEL outturn was around £0.4 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

Expenditure in UKHSA was circa £0.2 billion lower than budgeted mainly due to:

- COVID-19 vaccines: lower than planned expenditure due to a reduced NHS England stock build up in quarter 4 for the Spring vaccination campaign and slippage into 2024-25

- COVID-19 testing: lower demand than planned as UKHSA exited the existing testing infrastructure during 2023-24.

Voluntary scheme for branded medicines pricing, access and growth (VPAG):

VPAG income is based on the NHS' spend on branded medicines throughout the year and this was circa £0.1 billion lower than had been budgeted for. While the forecasts are updated throughout the year, data on the final quarter of spend is not available until the end of the financial year and therefore final income can differ to the estimated income.

Public dividend capital (PDC) payments and loan interest:

Income received in the core department was around £0.2 billion higher than estimated when agreeing opening budgets.

European Economic Area (EEA) medical costs

Expenditure on European Economic Area medical costs is demand led and the £0.2 billion overspend was largely due to the settlement of outstanding liabilities being higher than anticipated when setting the budget.

Adult social care

The circa £0.2 billion underspend was mainly due to planned reform activity delayed into 2024-25.

Other ALBs

The £0.1 billion underspend is mainly driven by underspends in NHS Resolution and Community Health Partnerships Ltd, alongside other changes across the ALB sector.

RDEL administration

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).

Against the total resource administration limit of £3.1 billion the DHSC group underspent by £0.5 billion, and this mainly comprised:

- circa £0.2 billion underspend on depreciation and impairments
- circa £0.3 billion underspend in RDEL NRF, of which £0.1 billion was in the NHS and £0.2 billion in the non-NHS.

Table 54 shows the DHSC group administration outturn (excluding depreciation and impairments) between 2019-20 and 2023-24:

Table 54: DHSC administration

	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
Administration outturn	2,212	2,405	2,575	2,665	2,428

Figures do not include depreciation and as a result will not directly reconcile to the administration outturn in the statement of outturn against parliamentary supply of £2.6 billion.

Spending on administration reduced in 2023-24 by circa £0.2 billion compared to 2022-23. This reduction mainly occurred in NHS England and can be attributed to efficiencies delivered through the successful mergers of NHS Improvement, NHS Digital and Health Education England into NHS England.

Capital departmental expenditure limit (CDEL)

£10.5bn CDEL spend

The DHSC group's total 2023-24 CDEL outturn is the consolidated net capital spending of all bodies within the departmental group.

Table 55 summarises the CDEL outturn against budget since 2019-20, highlighting the £0.5 billion (4.3%) underspend in 2023-24:

Table 55: Capital DEL

	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
CDEL Budget	7,125	12,918	10,447	11,193	10,989
CDEL Spending Outturn, of which:	**7,015**	**12,704**	**9,119**	**9,848**	**10,519**
CDEL Underspend	*110*	*214*	*1,328*	*1,345*	*470*
CDEL Underspend %	*1.5%*	*1.7%*	*12.7%*	*12.0%*	*4.3%*

CDEL: DHSC group

Table 56 details the DHSC group capital DEL outturn by sector against budgets:

Table 56: DHSC group capital DEL

	Budget £m	Outturn £m	Under/ (Overspend) £m
NHS capital DEL	7,679	7,550	129
NonNHS capital DEL	2,408	2,332	76
Sub-total (excl IFRS16)	**10,088**	**9,882**	**205**
IFRS16 (NHS)	866	792	74
IFRS16 (NonNHS & Group)	35	(155)	190
Sub-total (IFRS16)	**901**	**637**	**264**
TOTAL CDEL	**10,989**	**10,519**	**470**

As set out in the performance summary, the department underspent the capital departmental expenditure limit (CDEL) by circa £0.5 billion. This was mainly due to:

- **IFRS 16:** the department has followed the accounting standard for leases since 2022-23. Additional capital funding was secured for its impact, however the associated capital costs in 2023-24 were around £0.3 billion lower than expected

- **other capital:** underspends of circa £0.2 billion occurred across a range of capital budgets, the details of which are on **pages 334 and 339**.

CDEL NHS: financial performance capital DEL spending

Summary

The summarised CDEL outturn compared to plan for key elements of the NHS sector are shown in **Table 57**.

Table 57: NHS capital DEL

	Budget £m	Outturn £m	Under/ (overspend) £m
NHS providers business as usual activities	7,268	7,188	81
NHS England business as usual activities	410	363	48
NHS providers IFRS16	837	766	71
NHS England IFRS16	29	26	3
TOTAL NHS CDEL, of which:	**8,545**	**8,342**	**203**
NHS providers		*7,953*	
NHSE		*388*	

NHS providers

NHS provider capital DEL (CDEL) expenditure was £8.0 billion in 2023-24 (exclusive of net capital investment of NHS charities and inclusive of IFRS 16 spend). This is a circa 4.6% increase on the equivalent net investment in 2022-23 (£7.6 billion). Capital budgets are allocated to NHS providers via operational capital and various national programmes. There have been increases in expenditure on national programmes overall in 2023-24, along with continued budgetary impact of implementing the IFRS 16 accounting standard. The NHS provider capital outturn is detailed in **Table 58** below.

Table 58: NHS provider capital DEL

	2023-24 £m
Capital DEL Outturn[1]	**7,953**
Of which	
Operational capital expenditure[2]	3,915
National programmes	3,091
IFRS16	766
PFI residual interest[3]	182

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

Operational capital is issued to cover regular business as usual capital needs of the NHS, including renewal and replacement of plant, information technology, equipment, minor building works and investment to deliver core clinical strategies. The majority of the NHS operational capital budget in 2023-24 was allocated at system level to the 42 integrated care systems (ICS). NHS providers are required to set their operational budgets within those envelopes and reflect system-wide priorities.

System capital support is available for NHS providers who have insufficient cash levels to fund their operational capital programme, and self-financed CDEL expenditure, such as where NHS providers use the income they receive for depreciation, their own cash reserves, and loans. 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.

£209 million is allocated within operational capital to manage those 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.

As in 2022-23, funding was again allocated to systems to provide CDEL cover for right-of-use leases that now present a capital impact, following DHSC's adoption of the IFRS 16 accounting standard in 2022-23.

National programmes

Funding for national programmes, such as the new hospital programmes and hospital upgrades is directly issued by DHSC 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.

Table 59 lists national programmes funding, the details of which are described in the following paragraphs.

Table 59: National Programmes Capital DEL

	2023-24 £m
New hospital programme/upgrades	829
Elective recovery	509
NHS technology and digital	417
Diagnostics	834
Mental health dormitories	160
Mental health capacity and safety	46
UEC additional capacity targeted investment	257
Decarbonisation scheme	39
NHS providers national PDC total	**3,091**

Diagnostics

Funding has been committed 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. 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. As of April 2024, 160 CDCs sites are operational across the country and have delivered nearly 8 million additional tests since July 2021. The other programmes within the scope of this funding included purchasing of diagnostic equipment for endoscopy, imaging, additional scanning capacity for the targeted lung health check programme and screening.

New hospital programme/hospital upgrades

The new hospital programme was set up to meet the challenge of the then government's commitment to build 40 hospitals by 2030. On 25th May 2023, the then government announced that five hospitals constructed mostly using reinforced autoclaved aerated concrete (RAAC) will be rebuilt by 2030 as part of the new hospital programme, along with two already in the programme, protecting patient and staff safety. The new hospital programme is working alongside NHS England and NHS providers using a national programmatic approach that will deliver hospitals as efficiently and effectively as possible, recognising the individual needs and circumstances of each hospital scheme. The programme is standardising the design and delivery of hospitals through a national approach, 'hospital 2.0', which will result in facilities for both patients and staff that are at the cutting edge of modern technology. By the end of the financial year 2023-24, four hospitals were open.

Investment has continued on hospital upgrades to modernise and transform the NHS' buildings and services, with 13 patient-ready upgrades completed during 2023-24. At Spending Review 2020, the department received £1.7 billion for over 70 hospital upgrades, continuing a programme of investment which had previously been announced.

These investments are helping to modernise and transform the NHS' buildings and services, with the money going towards 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. The funding was spent on upgrading facilities, increasing capacity so more people can be treated and shifting the emphasis towards prevention – with more money for mental health and integrated care services in the community.

Elective recovery

The £1.5 billion targeted investment fund (TIF) was set up after the spending review 2021 to support elective recovery. Capital for new capacity and productivity improvements to the NHS estate was allocated at regional level with NHS England working with systems and trusts to identify the most impactful and most deliverable schemes to support the elective recovery challenge. The proposals focused on increasing elective capacity and the resilience and separation of activity, to support restoring activity to pre-pandemic levels. 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 or additional diagnostic activity in all regions.

NHS technology schemes

Successful digital transformation in the NHS delivers multiple benefits, from improved clinical outcomes and patient/service user experience, through to financial savings. Funding issued to NHS providers in 2023-24 for NHS technology programmes totalled £417 million – including funding made available through operational capital. The funds have ensured 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 core standards.

Urgent and emergency care (UEC) additional capacity targeted investment

In 2023-24, DHSC provided £250 million as part of the additional capacity targeted investment fund. This programme aimed at identifying and funding local capital investments to support the NHS to increase capacity and improve flow across the urgent and emergency care pathway and thus drive the strategic aims of the delivery plan to recover UEC services. Funding was awarded to schemes generating additional general and acute beds through conversions, modular builds and refurbishments and included other types of beds such as intermediate care beds. The funding also supported improvements in processes and productivity through same day emergency care and urgent treatment centre schemes.

Mental health

More than £400 million has been committed up to the end of 2024-25 to eradicate dormitory accommodation from mental health facilities across the country and replace dormitory beds with single ensuite 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.

£150 million of capital has also been invested in NHS mental health crisis response and urgent and emergency care services across the Spending Review 2021 period up to March 2025. This includes funding for procuring specialised mental health ambulances and to provide new, and improve existing, mental health crisis response infrastructure, covering over 200 schemes such as crisis cafes, crisis houses and crisis hubs. Step-down services, mental health urgent assessment and care centres, crisis line upgrades and improvements to health-based places of safety and emergency department spaces are also being funded.

Decarbonisation scheme

Funding has continued to be invested in the upgrade of NHS's energy infrastructure, in line with decarbonisation and efficiency goals. In 2023-24 £40 million of funding was awarded to NHS providers, which included £20 million from the Department for Energy Security and Net Zero, for investment in light emitting diodes (LED) lighting schemes and solar panel installations.

CDEL non-NHS: financial performance capital DEL spending

Outside of the NHS sector, DHSC's non-NHS sector capital expenditure was around £0.3 billion lower than the allocated funding.

The summarised DEL outturn compared to plan for key elements of the non-NHS sector are shown in **Table 60**.

Table 60: summarised CDEL financial position for 2023-24 non-NHS

Non NHS capital DEL	Plan	Outturn	Under/ (Overspend)
	£m	£m	£m
CDEL			
UK Health Security Agency	7	(104)	111
Other ALBs	383	320	63
Research & development	1,362	1,379	(17)
Disabled Facilities Grant	623	623	-
Core IFRS16	(47)	(130)	83
Other DHSC central budgets	116	115	1
NHS charities	-	(26)	26
Total non-NHS CDEL	**2,444**	**2,178**	**266**

Details of the main components of the underspend are set out below:

UK Health Security Agency (UKHSA)

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. A large proportion of UKHSA's circa £0.1 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

As detailed in the table above, the core department's IFRS 16 capital expenditure was around £0.1 billion lower than the funding available. Additionally, around £40 million of the 'other ALBs' underspend relates to IFRS 16.

Annually managed expenditure (AME)

(£9.7bn) AME

Details of the DHSC group's total 2023-24 AME budget and expenditure are set out in **Table 61**, which shows the group underspent by £7.5 billion against its final resource AME budget, and £0.1 billion against its capital AME budget.

Table 61: annually managed expenditure

	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
Resource AME budget	11,420	10,002	49,000	(35,957)	(2,272)
RAME outturn	**2,848**	**2,882**	**47,971**	**(61,972)**	**(9,730)**
Underspend/(overspend) £m	*8,572*	*7,120*	*1,029*	*26,015*	*7,458*
Underspend/(overspend) %	*75.1%*	*71.2%*	*2.1%*	*(72.3%)*	*(328.3%)*
Capital AME budget	15	15	15	106	106
Capital AME outturn	**(6)**	**(7)**	**-**	**20**	**32**
Underspend/(overspend) £m	*21*	*22*	*15*	*85*	*74*
Underspend/(overspend) %	*137.1%*	*149.0%*	*100.0%*	*80.7%*	*70.0%*

The DHSC group's AME provision (resource and capital) is set annually outside of 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 DHSC group's AME spending is not typical to most government departments' AME spending, which normally will impact on the fiscal framework in the same way as DEL spending.

Additionally, the DHSC group's AME is demand-led and volatile, being subject to many variables outside DHSC's direct control, such as changes to the discount rates used to measure the value of long-term provisions liabilities. **Note 16** within the financial statements provides further detail and analysis of variables.

The final AME budget in 2023-24 was set at negative £2.3 billion and included a £13.2 billion decrease to budget in the 2023-24 supplementary supply estimate. The reduction was mainly driven by the change in the discount rates. Discount rates are prescribed by HM Treasury and are 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.

The main elements of the DHSC group's AME negative £9.7 billion outturn and resultant £7.5 billion underspend are due to:

- NHS Resolution's (NHSR) AME outturn of negative £11.1 billion was £6.6 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 non-NHS sector's AME outturn, comprising net provisions movement and impairments expenditure, was around £1.0 billion lower than anticipated when setting the final budget.

Annex B (ii) – Supplementary time-series information

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

The majority of the DHSC group's budget is allocated to fund the NHS. **Table 62** provides an explanation of the adjustments made to the NHS budget since the 2015 spending review (SR).

Table 62: 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
Adjustment for NHS pensions [5]											1,965
NHS mandate adjustments [6]					(182)	(281)	(373)	(1,815)	6,691	7,429	4,698
Additional Covid-19 funding [7]							19,988	16,295			
SR21 funding									8,989	6,085	8,161
Autumn statement 22 funding										3,300	3,300
Autumn statement 23 funding										1,114	
Spring budget 24 funding											2,450
NHS RDEL budget as per NHSE mandate	**97,098**	**100,572**	**105,702**	**109,536**	**114,421**	**123,377**	**149,473**	**150,614**	**158,521**	**169,246**	**175,054**
Adjustment for provider depreciation [8]	(1,844)	(1,878)	(1,864)	(1,987)	(1,904)	(2,043)	(2,341)	(2,641)	(3,293)	(3,321)	(3,442)
Adjustment for bodies merged with NHSE [9]	5,203	5,105	5,380	5,292	4,998	4,735	4,992	5,636	5,886	5,110	5,303
NHS RDEL budget as per NHSE mandate (adjusted)	**100,457**	**103,798**	**109,218**	**112,841**	**117,514**	**126,069**	**152,124**	**153,609**	**161,114**	**171,036**	**176,915**
4. Latest reported outturn (exc depreciation)	Actual										Plan
NHS RDEL budget	***100,457***	***103,798***	***109,218***	***112,841***	***117,514***	***126,069***	***152,124***	***153,609***	***161,114***	***171,036***	***176,915***
Plus NHS provider sector net RDEL outturn			935	1,038	826	1,009	(732)	(595)	978	*828*	
Plus net commissioner and NHSE underspend			(902)	(970)	(916)	(636)	(5,374)	(697)	(1,152)	*(593)*	
Net NHS RDEL outturn [3]	***100,457***	***103,798***	***109,250***	***112,909***	***117,424***	***126,442***	***146,018***	***152,317***	***160,939***	***171,271***	***176,915***
NHSE CDEL	189	182	240	228	221	266	331	291	272	388	431
Adjustment for bodies merged with NHSE [9]	16	19	24	71	85	105	80	102	112		
NHS TDEL	**100,662**	**103,999**	**109,515**	**113,208**	**117,731**	**126,813**	**146,429**	**152,711**	**161,323**	**171,659**	**177,347**

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 (namely, 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 NHS England 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 England.
7. COVID-19 funding of £20.0 billion was added to NHS England'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 publications will incorporate this change.
9. The NHS' spending outturn has been adjusted to reflect spending in entities that were merged with NHS England during 2022-23 and from 2023-24, to allow for consistency across all years

NHS financial performance – NHS providers (NHS trusts and foundation trusts) and integrated care boards (ICBs)

Table 63 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 63: NHS providers (NHS Trusts and Foundation Trusts) RDEL breakdown - timeseries

NHS providers' financial performance - timeseries	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
Gross deficit	2,755	1,560	158	126	1,001	1,606
Gross surplus	(1,889)	(567)	(363)	(442)	(299)	(305)
Reporting adjustment	(39)	(323)	(450)	(240)	(252)	12
NHS providers - adjusted financial performance	**827**	**670**	**(655)**	**(556)**	**450**	**1,312**
Plus additional RDEL adjustment	(1)	338	(77)	(39)	528	69
Depreciation classification adjustment	(1,904)	(2,043)	(2,341)	(2,641)	(3,293)	(3,874)
Net NHS providers RDEL NRF	**(1,078)**	**(1,035)**	**(3,073)**	**(3,236)**	**(2,315)**	**(2,492)**

Table 64 provides a timeseries of the aggregate surplus/deficit position across NHS systems (ICBs and NHS providers). 2022-23 is the first year that commissioners and providers work together as integrated care systems (ICS) to manage to an agreed financial plan and therefore prior year comparators are not available.

Table 64: ICS financial performance – timeseries

NHS systems financial performance - timeseries	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
Integrated care boards/ clinical commissioning groups					119,088	133,632
NHS providers adjusted financial performance					450	1,312
NHS providers reporting adjustments					252	0
Net outturn					**119,790**	**134,944**
Plan					**119,273**	**133,566**
Under / (over) Spend					***(517)***	***(1,378)***

Purchase of healthcare from non-NHS providers

Most healthcare services are purchased from NHS providers (NHS trusts and foundation trusts); however, £18.1 billion of these types of services were purchased from non-NHS

healthcare providers in 2023-24. These non-NHS providers include local authorities, voluntary sector/not for profit organisations, devolved administrations and private sector providers. **Table 65** provides data between 2018-19 and 2023-24.

Table 65: NHS England's purchase of healthcare from non-NHS providers

Purchase of healthcare from non-NHS providers	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
Independent sector providers	9,180	9,692	12,139	10,854	11,015	12,357
Voluntary sector / not for profit	1,619	1,705	1,866	1,791	1,734	1,841
Local authorities	2,899	2,984	4,312	4,318	3,805	3,825
Devolved administrations	50	49	36	48	59	56
Other group bodies	-	-	31	35	28	27
Sub-total	**13,748**	**14,430**	**18,384**	**17,046**	**16,640**	**18,108**
Total DHSC RDEL	**125,278**	**134,183**	**181,441**	**183,548**	**177,095**	**182,819**
Spend with private sector as a % of total RDEL	*7%*	*7%*	*7%*	*6%*	*6%*	*7%*
Spend on all non-NHS bodies as a % of total RDEL	*11%*	*11%*	*10%*	*9%*	*9%*	*10%*

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)

As part 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. Each ALB consolidated into DHSC'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, DHSC consolidates the ALB information to produce its group ARA. **Table 66** provides the necessary information. Notes to the table aide the users' interpretation of the figures presented.

Table 66: Financial information by ALB

	Total operating income	Total operating expenditure	Net expenditure for the year (including financing)	Permanently employed staff Employees	Permanently employed staff Staff costs	Other staff Employees	Other staff Staff costs
	£'000	£'000	£'000	Number	£'000	Number	£'000
DHSC core	(3,361,031)	195,960,664	192,596,495	2,897	238,642	360	31,807
UK Health Security Agency	(315,973)	2,710,762	2,394,789	4,564	315,279	788	78,541
Medicines and Healthcare products Regulatory Agency	(149,850)	188,668	38,818	1,145	91,072	111	3,388
NHS England group	(5,836,677)	179,958,832	174,220,666	38,512	2,962,837	10,325	682,881
NHS providers	(129,605,360)	134,118,718	4,488,100	1,312,780	77,532,652	144,049	7,614,035
Care Quality Commission	(226,534)	220,922	(5,866)	2,989	177,559	211	37,460
National Institute for Health and Care Excellence	(22,917)	83,191	60,274	803	58,847	7	535
Human Fertilisation and Embryology Authority	(6,044)	7,197	1,153	79	5,011	3	208
Human Tissue Authority	(4,654)	5,015	361	54	4,025	-	-
Health Research Authority	(453)	18,463	18,010	241	13,951	1	91
Health Services Safety Investigations Body	(101)	3,083	2,868	43	2,183	2	64
NHS Counter Fraud Authority	(285)	16,571	16,286	165	10,374	10	751
NHS Business Services Authority	(732,765)	967,707	234,942	3,964	167,205	191	6,119
NHS Resolution	(2,725,562)	(8,203,600)	(10,929,162)	667	46,807	13	1,018
NHS Property Services Ltd	(819,532)	960,698	167,395	5,565	178,848	889	3,900
Community Health Partnerships Ltd	(554,044)	792,059	238,015	237	15,498	21	1,973
Genomics England Ltd	(29,763)	113,791	84,028	517	48,022	16	1,235
Skipton Fund Ltd	(76)	76	-	-	-	-	-
Nursing & Midwifery Council	(107,215)	107,926	711	1,076	60,379	73	3,242
Health & Care Professions Council	(40,598)	36,273	(4,325)	274	14,331	26	1,787
Wiltshire Health and Care LLP	(75,660)	75,645	(15)	1,021	53,584	121	5,317
Professional Standards Authority for Health and Social Care	(5,643)	5,687	44	46	3,794	-	10

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. The amounts above do not include any central adjustments, 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 £'000
1	NHS England group contingent liabilities	40,080	29,751	10,329
2	The core 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).	0	-[1]	0
3	The Clinical Negligence Scheme for Coronavirus	21,547	16,460	5,087
4	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.	0	-[1]	0

5	DHSC holds a contingent liability for the provision of life assurance cover for individuals transferred to the Department.	400	358	(42)
6	The core 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	-
7	The core 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	-
8	The core department holds a contingent liability for compensation payments due to individuals unable to be traced.	0	400	(400)
9	The core department holds a contractual liability for redundancy payments.	500	519	(19)
10	NHS Resolution non-clinical contingent liabilities	236,000	226,930	9,070
11	Legal cases – DHSC as defendant	-	N/A[2]	N/A
12	The core department has issued an indemnity in respect of a Department of Health and Social Care established independent inquiry into the issues raised by the David Fuller case.	-	N/A[2]	N/A
13	Legal cases – DHSC as claimant	-	N/A[2]	N/A

14	NHS Providers at 31 March 2024 had net contingent liabilities	-	113,054	(113,054)
15	DHSC is the actual or potential defendant in a number of actions regarding alleged clinical negligence. There is a large degree of uncertainty as to DHSC's liability and the amounts involved	Unquantifiable at time of estimate	24,537,389	N/A
16	The core department has issued an indemnity in relation to the operations of the Human Fertilisation and Embryology Authority (HFEA).	1.5	1.5	-

1. This contingent liability is included as an unquantifiable contingent liability.
2. Due to the sensitive nature of these liabilities, the value has not been disclosed.

DHSC is required by the Government Financial Reporting Manual (FReM) to provide an explanation for material variances only. The only material variance relates to item 15. At the time of agreement of the supplementary supply estimate, this liability is not quantifiable and subject to a significant degree of uncertainty due to changes in the discount rate.

The value for the items 11, 12, and 13 have not been disclosed due to the sensitive nature of the contingent liabilities. The DHSC does not determine the variances for the individual items to be material.

Unquantifiable contingent liabilities

	Description of contingent liability	Included in the Supply Estimate	Disclosed in ARA	Explanation of difference
1	The core department is bearing an insurable risk for professional indemnity or malpractice on behalf of the Human Tissue Authority.	Yes	Yes	N/A
2	The core 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

3	The core department has undertaken to cover any damages arising from NHS Blood and Transplant clinical trials activity.	Yes	Yes	N/A
4	The core 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.	Yes	Yes	N/A
5	The core 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
6	The core 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
7	The core 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

8	The core department is involved in a number of Employment Tribunal cases.	Yes	Yes	N/A
9	The core department holds contractual liabilities in respect of redundancy payments and entitlements, and it also holds liabilities in respect of commercial contract obligations. These liabilities include contractual indemnities the Department has entered into as part of its response to COVID-19.	Yes	Yes	N/A
11	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
12	The core 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
13	The core 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
14	The core 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

15	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
16	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
17	The core department holds a contingent liability relating to the interim compensation payments of the Infected Blood Inquiry.	Yes	No	See below
18	The core department holds an indemnity in relation to the Mpox vaccine.	Yes	Yes	N/A
19	Indemnity related to the relabelling of the monoclonal antibody sotrovimab as a result of a shelf-life extension, which will permit the continued use of the stock.	Yes	Yes	N/A
20	The core department entered into contracts for the supply of PPE during the COVID-19 pandemic, which were found to be not suitable. Legal proceedings have been initiated against the Department for the balance of the contract and damages.	Yes	Yes	N/A
21	Legal cases – DHSC as defendant.	No	Yes	See below
22	NHS Property Services has an unquantifiable contingent liability regarding its ability to claim capital allowances on inherited assets.	No	Yes	See below
23	UKHSA also holds contingent liabilities relating to contract disputes, primarily relating to contracts let in response to the COVID-19 pandemic.	No	Yes	See below

Item 17 is not deemed to be a contingent liability. Please see **Note 19** Events after the reporting period for further details.

Items 21, 22 and 23 are part of the normal course of business and therefore not subject to parliamentary approval.

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