Department of Health & Social Care

Department of Health and Social Care

Annual Report and Accounts 2024-25

For the year ended 31 March 2025

HC 1446

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Secretary of State for Health and Social Care 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

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Performance report

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.

I was honoured and delighted to be appointed as the department's Permanent Secretary in June 2025 at a crucial time for the health and social care sector, just before the publication of the government's 10 Year Health Plan. The Plan sets out the reforms the department and wider government will implement to address the challenges facing the NHS, the key drivers of ill-health and persistent inequalities in health and social care.

I would like to thank my predecessor as Permanent Secretary, Sir Chris Wormald, who left DHSC to take up the post of Cabinet Secretary and Head of the Civil Service in December 2024. Sir Chris made a significant contribution to health and social care during his eight years as Permanent Secretary, I am very grateful, too, to Professor Sir Chris Whitty for leading DHSC as interim Permanent Secretary between December 2024 and June 2025.

The 2024-25 DHSC Annual Report and Accounts focuses on the department's financial and delivery performance between 1 April 2024 and 31 March 2025, so it was under my predecessors' stewardship that the achievements set out in this publication were made. Throughout the year, DHSC focused on delivering three strategic outcomes:

1. An NHS that is there when people need it: provide timely access to high-quality health and care
2. Fewer lives lost to the biggest killers: reduce premature mortality, and
3. A fairer Britain, where everyone lives well for longer: reduce the number of years people spend in ill-health (compressed morbidity).

As the Performance Report sets out, DHSC made significant progress across the health and social care agenda over the course of the year. I would like to pay particular tribute to staff within DHSC for supporting a smooth change in administration after the General Election on 4 July 2024 and to staff both within DHSC and across the wider health and

care system for delivering the new government's health and social care priorities with great professionalism, commitment and passion.

Building on the Independent Investigation of the National Health Service in England ('the Lord Darzi report') published in September 2024, DHSC is now firmly focused on delivering the vital programme of transformation set out in the 10 Year Health Plan. Supported by the additional investment announced in the government's Spending Review 2025, the plan aims to deliver on both the public and staff priorities identified in the major 'Change NHS' consultation exercise last autumn and winter, underpinned by the government's three shifts:

1. From hospital to community – the Neighbourhood Health Service
2. From analogue to digital, and
3. From sickness to prevention.

The aim is to create a truly modern health service designed to meet the changing needs of our communities in the future. To realise the ambition of this plan, the department is developing and implementing a new NHS operating model, to deliver a more diverse and devolved health service. The programme to bring together DHSC and NHS England to form a new joint centre, reducing duplication and focusing on the delivery of the 10 Year Health Plan, is integral to these operating model reforms. The departmental and NHS England leadership team are working hard to ensure an orderly transition and I am very grateful to all our staff for their continuing dedication and hard work as we progress through this period of major change.

Samantha Jones OBE
Permanent Secretary of the Department of Health and Social Care

Lead Non-Executive Board Member's Report 2024-25

The 2024-25 period saw a change of government, resulting in a new ministerial team for DHSC. The new government is focused on delivering the three big shifts that will underpin the 10-Year Plan for Health: from hospital to community; from analogue to digital; and from sickness to prevention.

In January 2025, we welcomed Naomi Eisenstadt CB, Phil Jordan, and Baroness Camilla Cavendish as new Non-Executive Board Members (NEBMs). I was appointed to the Board in November 2024 as the new Lead NEBM, joining Sam Jones OBE and Sir Richard Douglas who continued to serve on the Board for 2024-25. Sam Jones continues to sit on the Board in her new role as Permanent Secretary, which she began on 15 June 2025.

Our new NEBMs bring a wealth of experience from the Civil Service and private sector. Naomi also sits on the Department for Education's Board and brings extensive knowledge of child development and health inequalities as the previous Director of the Sure Start programme. Phil is a former Chief Information Officer with extensive experience of leading organisations through technology transformation. Camilla is currently a crossbench peer in the House of Lords and has experience as the former head of the Downing Street Policy Unit and as a journalist.

In July 2024, Gerry Murphy stepped down from the Board having reached the end of his term. Will Harris, Steve Rowe and Doug Gurr stepped down as new Board appointments arrived. The departing NEBMs contributed a great deal to the Board and DHSC more broadly, and I would like to thank them for their service.

Sir Roy Stone also stepped down as new Board appointments were made. Sadly Sir Roy died on 12 May 2025. He had extensive experience as a former senior civil servant, including having previously been a specialist adviser to the Chancellor of the Duchy of Lancaster, Number 10 Chief of Staff and Private Secretary to the Government Chief Whip. Roy served as a non-executive director at DHSC from April 2023 to January 2025 and was widely respected. I pay tribute to his service to DHSC and across government and offer my condolences to his family.

Aside from meeting formally, the new members of the Departmental Board were active in supporting and challenging senior leadership and policy teams around DHSC. Individually and collectively, we have assisted with various aspects of DHSC's work such as Adult

Social Care, technology transformation, children's health, the 10 Year Health Plan and more. This is in addition to advice and support offered to DHSC on an ad hoc basis.

In addition, I was asked by the Secretary of State to co-chair with Dr Penny Dash, the Chair of NHS England, the oversight of merging DHSC with NHS England. This is a major transformation and will be executed over the next two years.

The Audit and Risk Committee (ARC) continued with Sir Richard Douglas taking over as chair upon Gerry Murphy's departure, with four committee meetings held over the year. ARC discussed the DHSC's finances, risks, accounts, and internal audit reviews. It provided challenge to DHSC and its Arm's Length Bodies through deep dives on policy and risk areas. ARC has also had a key role in ensuring the delivery and sign-off of the Annual Report and Accounts.

As DHSC's Lead NEBM, it has been an honour to support the work of DHSC, and I am grateful to my non-executive team for their continued work. The non-executive team is proud of DHSC's achievements in 2024-25, and we look forward to our continued work over the coming year.

Alan Milburn
Lead Non-Executive Director

Role, purpose, structure and funding

This section introduces the role and purpose of DHSC and sets out how funding flows from Parliament through the health and social care system. It also sets out our key achievements at a glance and key finance facts.

Our role and purpose

Our role and purpose are to:

- support and advise our ministers. We provide world class advice that is supported by expert research and analysis. We are accountable to Parliament and to the public and we strive to achieve the highest standards of good governance in everything we do

- deliver services. We play a major role in people's day to day lives and work with our agencies and partners to deliver health and wellbeing. We think ahead to ensure that services can respond to changing needs

- drive transformation of the health and care system. We are at the heart of the health and care system. We set the strategy, shape policy, secure the funding and develop the legislation that supports it, and

- help others to deliver. We work with other government departments, our agencies and partners locally, regionally, nationally and internationally to contribute to the government's wider health, economic and social goals.

The Independent Report of Lord Darzi published in September 2024 presented findings on the scale of the challenges facing the NHS and set out the need to address the main underlying drivers of ill-health and tackle persistent inequalities in health. This is the way to put the NHS on a sustainable footing.

DHSC is leading the mission to build an NHS fit for the future which starts with tackling waiting lists. We will make progress towards returning to NHS performance standards and improve access to services. We want to see fewer lives being lost to the biggest killers, including cancer, cardiovascular disease and stroke, and suicide. This means diagnosing and treating patients earlier and enabling people to better manage their health and care. People deserve to live in a fairer Britain, where everyone lives well for longer. A healthy society and functioning health system should also ensure people can live their life to the fullest without major health issues holding them back. We set out our performance against our Strategic Outcomes in the Performance Summary and Detailed Analysis of this Annual Report and Accounts.

Delivering the mission requires three big reform shifts, which are central to the Government's 10 Year Health Plan, published in July 2025. These are fundamental and necessary reforms in the way our health services deliver care and address the challenges that Lord Darzi identified in his report:

- from 'hospital to community', bringing care closer to where people live, including through a new neighbourhood health service to deliver more proactive and personalised care
- from 'analogue to digital', by rolling out new technologies and digital approaches to modernise the NHS, including bringing together a single patient record, owned by the patient, shared across their care teams, putting people in control of their own health, and
- from 'sickness to prevention', shortening the amount of time people spend in ill-health by preventing illnesses before they happen, as well as earlier identification and management of chronic conditions.

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.

In April 2025, the Chancellor of the Duchy of Lancaster commissioned a review of ALBs across all government departments as part of the Prime Minister's Plan for Change with a view to close, merge or bring functions back into departments. On 3 July 2025 it was announced that Health Service Safety Investigations Body would transition to become a discrete unit within the Care Quality Commission over the next few years.

This followed the announcement of 13 March 2025 that NHS England will be brought back into DHSC in order to build a new organisation which can build on the Health Mission and 10 Year Plan through enabling and supporting the health and care system and those who lead it locally. Further detail of the governance and oversight arrangements of the

transition programme is included at pages 167 to 168 of the Governance Statement to this Annual Report and Accounts.

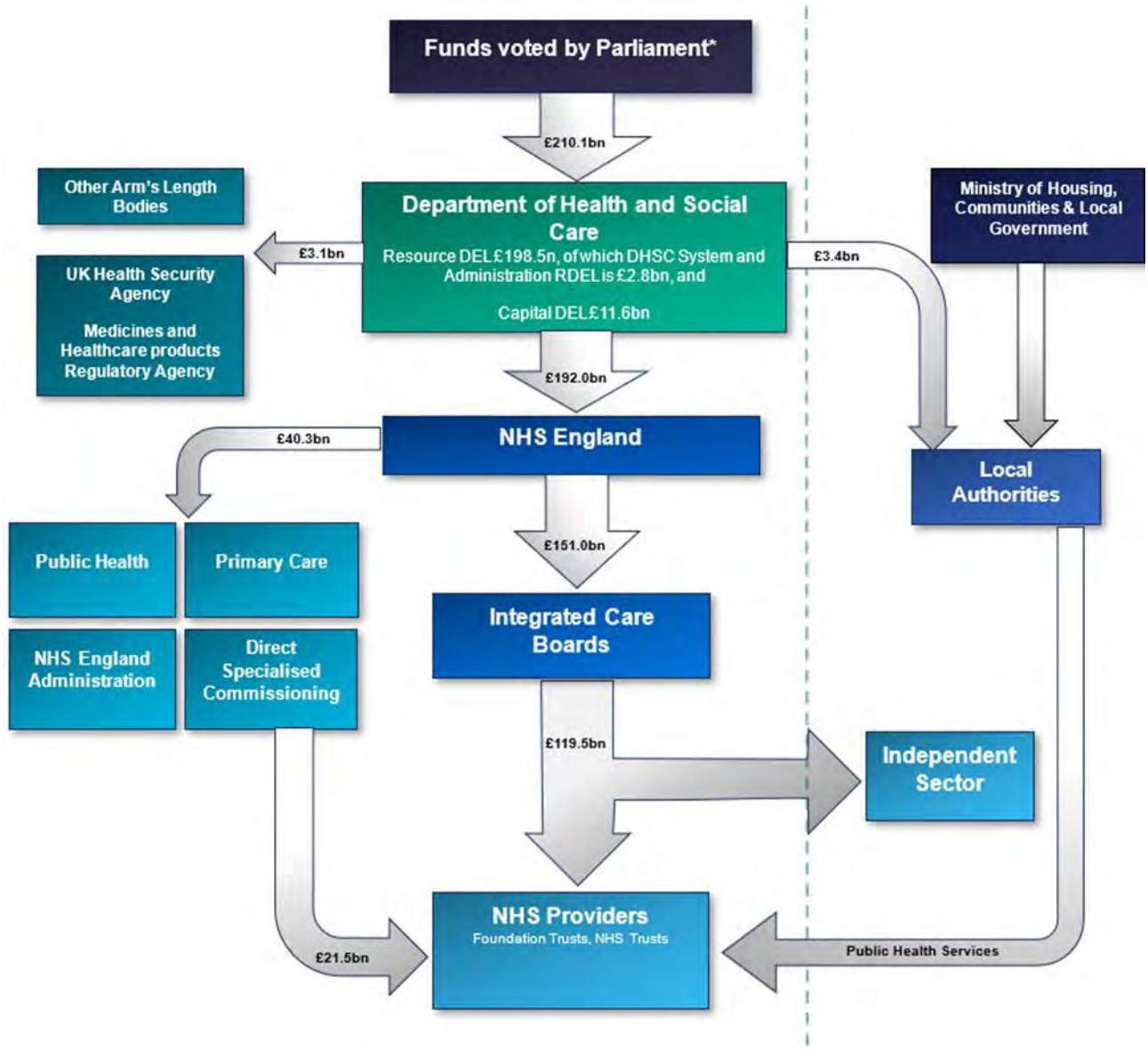
Our funding

DHSC secures funds for health and care services and remains accountable for this funding, which is allocated to the most appropriate local level. For the 2024-25 financial year, DHSC had a resource departmental expenditure limit of £198.5 billion and had funding to invest a further £11.6 billion to fund capital items such as new hospitals and equipment, as detailed in **Table 6** at page 93.

Figure 1 demonstrates how funding flows round the system, using agreed budget totals for 2024-25 per the supplementary estimate.

Separately, but not shown in **Figure 1**, DHSC is responsible for securing funds for adult social care through the spending review settlement, albeit the Ministry of Housing, Communities and Local Government remains accountable for the allocation of those funds to local authorities.

Figure 1: Funding flows in the health and care system, 2024-25 (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 the diagram above with actual figures used by exception where allocations are not included in budgets.

The dashed line indicates boundary of consolidation for DHSC and shows local authority funding to health.

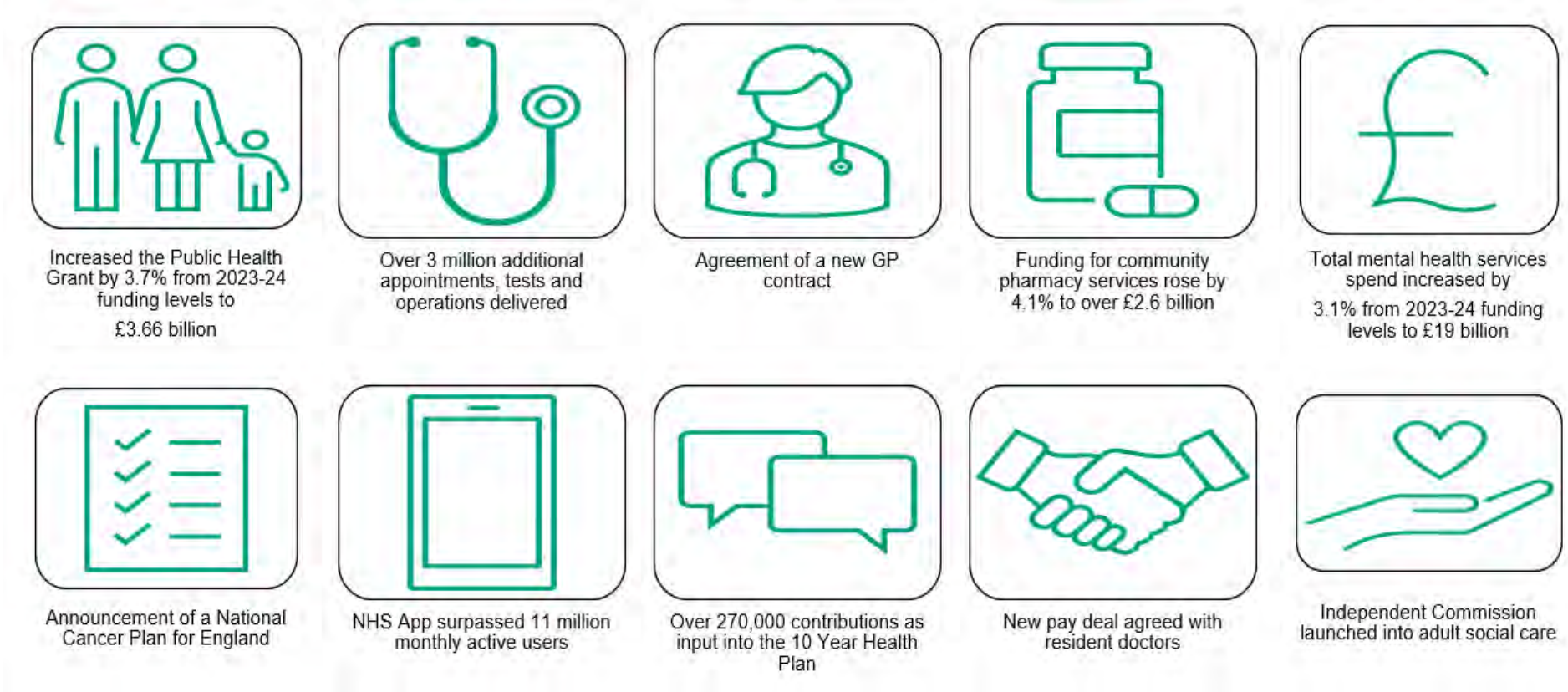
Risk management

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

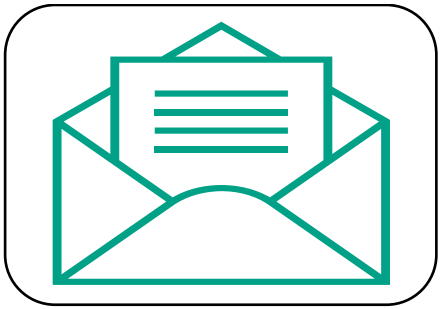
DHSC's risk management policy is to:

- 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.

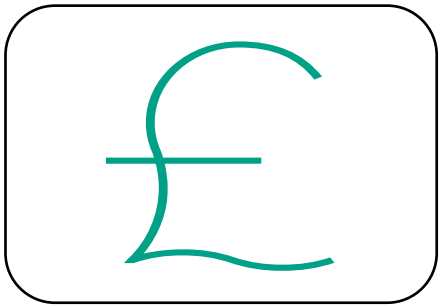
Achievements at a glance



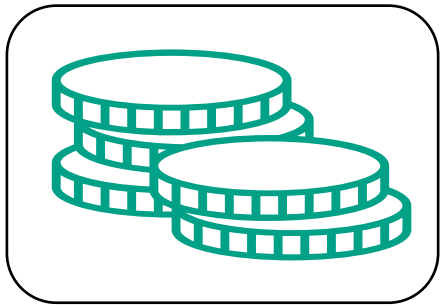
Key finance facts



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



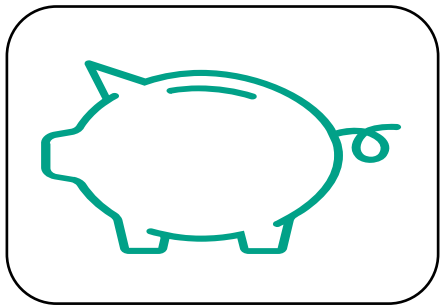
£11.5 billion (net) investment in capital



NHS England's £187 billion RDEL (excluding depreciation) budget was the biggest of any ALB in goverment

20% spending growth in real terms since 2019-20

Over £470 million CDEL invested in addressing critical infrastructure risks and removing reinforced autoclaved aerated concrete across the NHS estate



DHSC underspent by only 0.03%, maximising almost every penny whilst keeping within budget[1]

1. Against its total resource departmental expenditure limit, excluding depreciation and impairments

Performance summary

10 Year Health Plan

In summer 2025, DHSC published a 10 Year Health Plan for England. The plan outlines the changes that the government will deliver to make the NHS fit for the future. To inform the development of this plan, the government launched Change NHS in October 2024. This was the biggest ever conversation about the future of the NHS, with over 270,000 contributions. A film of the Change NHS engagement activities summarises the activity.

Secretary of State with the Prime Minister at the launch of Change NHS – October 2024

Change NHS website

The engagement included the Change NHS website and engagement events across the country to hear from the public, health and care staff, seldom heard audiences, and children and young people.

We made the Change NHS website interactive with blogs, videos, email updates, and a further survey to play back and test what we heard as the engagement progressed. Anyone over the age of 16 could share their experiences, ideas and respond to surveys, and we collected demographics to ensure that we heard from a wide range of people. We widely promoted the site through partner organisations, in NHS staff payslips, and the NHS app. We made content as accessible as possible with British Sign Language, non-English language, easy read, and screen readable formats.

We ran events across the country; this included deliberative events in every NHS region, with over 4,000 health and care staff and members of the public taking part, including children and young people. These events followed a ‘deliberative methodology’ which is a way to involve the public in decision-making and ensure we genuinely heard from a wide variety of people. These events culminated in a National Summit in April 2025 where

almost 300 people who had taken part in previous events came together from across the country to discuss and test proposals before the plan was finalised.

In tandem, over 700 people joined engagement led by NHS system leaders in each NHS region, and we developed ‘workshop in a box’ materials to give partner organisations everything they needed to run their own sessions tailored to local communities and with seldom-heard groups. In total over 17,000 people took part in over 650 events across the country, helping us to reach people in communities across the country and leave a legacy for engaging local populations.

Ministers and senior officials also hosted 17 thematic roundtables to gather first-hand insights from a broad range of voices from across the health system. We heard directly from service users such as children and young people, armed forces veterans, carers, and those living with long-term conditions and disabilities.

Children and young persons’ deliberative event – February 2025

Staff deliberative – February 2025

Partner engagement

As part of the process, we set-up dedicated routes for partner organisations to help us develop the plan. We did this through the Change NHS website where we received over 1,600 partner submissions, and by bringing together 240 partner organisations with health and care expertise into a Partners Council. The Partners Council met four times throughout the plan's development to test key elements of the plan.

Secretary of State at the National Summit – February 2025

Strategic outcomes

The summary table overleaf provides an at a glance overview of how we worked towards delivering DHSC strategic outcomes in the financial year 2024-25. Further details can be found in the Detailed Performance Analysis section of this Annual Report.

These strategic outcomes follow on from the priority outcomes which were in place under the previous government until July 2024. These were:

- protect the public's health through the health and social care system's response to COVID-19
- improve health outcomes by providing high quality and sustainable care at the right time in the right place by improving infrastructure and transforming technology
- improve healthcare outcomes through a well-supported workforce
- improve, protect and level up the nation's health by reducing health inequalities, and
- improve social care outcomes through an affordable, high quality and sustainable social care system.

Strategic outcomes

1: An NHS that is there when people need it: provide timely access to high-quality health and care

In July 2024, the government confirmed its commitment to reduce elective waiting lists by delivering an extra 2 million appointments, tests, and operations within a year, a target that was met by the end of March 2025. The Autumn Budget saw £1.8 billion allocated to support elective performance and reform. A new pay deal was agreed with resident doctors in September 2024.

2: Fewer lives lost to the biggest killers: reduce premature mortality

In February 2025, a call for evidence was launched to support the announcement of a National Cancer Plan, which is set to be published later in 2025. Quarter 1 of 2024-25 also saw the highest number of NHS health checks offered and completed at Q1 since the current programme began in 2013, whilst in November 2024, the government introduced the landmark Tobacco and Vapes Bill to Parliament.

3: Fairer Britain, where everyone lives well for longer: reduce the number of years people spend in ill-health (compressed morbidity)

In 2024-25 the Prime Minister asked Baroness Casey to lead an independent commission into adult social care. This was to sit alongside the government's short-term reforms announced in January 2025. In November 2024, the Mental Health Bill was introduced to the House of Lords, while funding was prioritised in the Autumn Budget for the expansion of NHS Talking Therapies. The rollout of at least one women's health hub pilot in every local system continued, and work to make maternity and neonatal care safer continued through NHS England's three-year delivery plan.

Cross-cutting work area

Workforce

Technology and data

Improving infrastructure

Medicines supply

Research

Pandemic preparedness

Detailed performance analysis

Structure of the performance analysis section

This performance analysis provides a detailed narrative of our performance and includes the following sections:

- Performance on priority outcome and cross cutting areas
- Financial performance across the group
- Secretary of State's Annual Report
- Sustainability report and performance in other areas including correspondence, PQs and fraud and error.

Introduction

The detailed performance analysis section provides an evidence-based, analytical overview of how DHSC has performed against its strategic outcomes during 2024-25. The analysis covers the key areas that can be measured within each of the three outcomes. We also set out the approach taken to delivering productivity and efficiency commitments across the NHS which is vital to the achievement of both high performance for patients and financial sustainability.

Productivity and efficiency improvements

Productivity improvements

The impact of the Covid pandemic on NHS productivity was severe, with an estimated decline of between 22% and 25% in 2020-21, according to Office for National Statistics (ONS) and NHS England data. Since 2020-21, NHS productivity has been recovering each year, but NHS England's latest analysis suggests that acute sector productivity remains around 7% to 8% below pre-Covid levels. As Lord Darzi's independent investigation of the NHS in England concluded, driving up productivity through better operational management, capital investment in buildings and equipment, re-engaging and empowering staff and exploiting technology is essential to reducing waiting lists, improving patient care and the sustainability of the NHS. Therefore, improving NHS productivity is a cornerstone of the 10 Year Health Plan (10YHP), which will enable delivery of the three shifts, as set out in Chapter 9 of the 10YHP; Chapter 9 sets out the DHSC's plans for driving up NHS productivity and providing a new financial foundation for the NHS in detail.

Acute sector productivity has grown by an average of just over 2% per year over the last three financial years (2021-22 to 2023-24). Activity grew across all points of delivery in the acute sector in the first half of 2024-25 with 2.7% overall growth for 2024-25.

These improvements have been supported by interventions across five key areas:

- operational and clinical excellence: including better patient flow, reduced discharge delays, and minimising clinical variation
- workforce: improving planning, retention, and culture, while reducing reliance on agency staffing—with a commitment to eliminate agency staffing by the end of this Parliament
- health rather than illness: shifting care upstream through prevention, screening, and investment in primary, community, and mental health services
- technology: modernising IT infrastructure, including the NHS App and digital tools that free up staff time and improve patient experience, and
- reducing waste: through efficiencies in medicines, procurement, and automation of corporate services.

Productivity has been improved through a focus on efficiencies in elective care, outpatient reform and urgent and emergency care as well as on technology and artificial intelligence (AI). AI technology, tested across nine NHS sites, has freed up clinicians to spend more time with patients. Accident & Emergency (A&E) departments participating in the trial saw a 13.4% increase in patients treated per shift and a 51.7% reduction in time spent completing documentation. This in turn will end the need for staff to carry out tasks like clinical note-taking, letter drafting and manual data entry. When rolled out across the NHS, it could free up the equivalent of over 2,000 full-time GPs' capacity.

Additional surgical hubs have also opened across the country, which provide the space to run surgeries back-to-back, so surgeons can treat more patients each shift. Support for the NHS workforce has improved retention, reduced sickness absence, and lowered reliance on agency staff. Agency spending was cut by almost £1 billion in the past year, 31% of the previous year's spend.

The rollout of electronic prescribing and medicines administration (EPMA) systems has halved discharge medicine preparation times by using mobile devices rather than traditional paper-based systems to record medicine use. These systems will be in use in 98% of areas by March 2026.

Major investment in IT infrastructure such as the electronic referral service and the NHS App is saving clinical time by allowing more care to be delivered more efficiently, remotely

and in new care settings, as well as reducing missed appointments. With more patients able to access correspondence digitally through the app, almost 12 million fewer paper letters were sent by hospitals between July 2024 and April 2025 than would otherwise have been the case.

Further coverage of the impact of productivity and efficiency improvements is set out elsewhere in this performance report, for example increases in planned appointments and improvements in discharges, workforce retention, the NHS App, the Electronic Patient Record, and adoption of the Federated Data Platform.

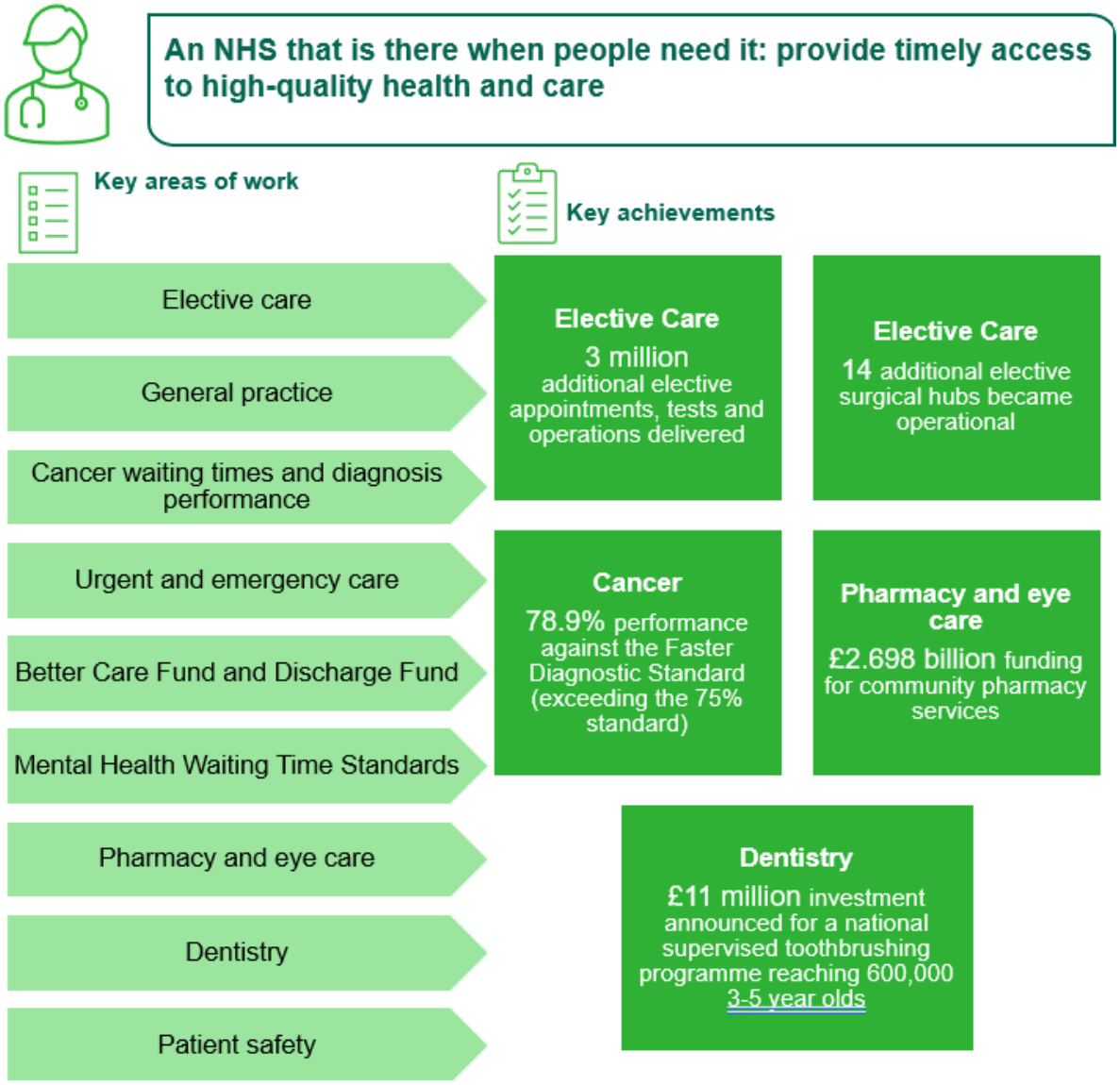
Following the outcome of Spending Review 25, and in conjunction with the implementation of the 10 Year Health Plan, DHSC has committed to delivering 2% productivity growth each year of the Spending Review period out to 2028-29.

Under current plans, trust productivity estimates will be published regularly as an official statistic in development from January 2026.

Efficiency

In 2024-25, the 42 Integrated Care Systems (ICS) and their provider organisations planned the most ambitious efficiency programme of savings measures yet seen across the NHS, targeting £9.3 billion or 6.1% of their total budgets. This includes a wide range of actions to reduce waste and drive greater value for money, such as reducing temporary staffing, improving procurement, delivering service redesign and making improvements in clinical and operational services. Ultimately, ICSs and providers delivered £8.7 billion of efficiencies and savings in 2024-25, compared to £7.3 billion delivered in 2023-24.

Strategic outcome one



Elective care

Elective performance and delivery

Under the previous government, the approach taken to reduce the elective backlog was through a focus on tackling long waits, as set out in the Elective Recovery Plan (February 2022). The Planning Guidance 2023-24 target was to virtually eliminate 65 week waits by March 2024, and the previous government subsequently recommitted in Planning Guidance for 2024-25 to deliver this by September 2024. Waits of more than 65 weeks stood at 48,967 patient pathways in March 2024, and increased to 58,024 in June 2024, later falling to 22,884 in September 2024. The number of waits longer than 52 weeks decreased from 309,299 in March 2024 to 302,693 in June 2024.

In the same period, interventions set out in the Elective Recovery Plan were progressed, including the expansion of Community Diagnostic Centres (CDCs) and surgical hubs.

From July 2024, the current government confirmed its commitment to address the elective waiting list and in 2024-25 delivered on key electives initiatives, including its pledge to deliver an additional 2 million appointments, tests and operations in its first year, with more than 3 million additional appointments having been delivered by the end of March 2025. It also met the milestone set out in the Elective Reform Plan to widen access for patients to view appointment information via the NHS app to 85% of acute trusts by the end of March 2025.

£1.8 billion of funding was announced at the Autumn Budget 2024 to support elective performance and reform as part of the £25.7 billion additional funding provided for the NHS. The government also agreed a new pay deal with resident doctors in September 2024; however two rounds of industrial action by resident doctors took place from 27 June to 2 July 2024 and most recently in November 2025.

In December 2024 the government's Plan for Change committed to restore the NHS constitutional standard on electives – that 92% of patients should wait no longer than 18 weeks from referral to treatment – by March 2029. The publication of the Elective Reform Plan in January 2025 set out the reform and productivity efforts needed to support this commitment. The plan also outlined NHS England and DHSC's wider ambitions: to empower patients, reform delivery, deliver care in the right place, and to align finance, performance oversight and delivery standards.

To support delivery of the 18-week standard by March 2029, key interventions in the Elective Reform Plan include expanding the operating hours of CDCs, increasing the number of surgical hubs, preventing unnecessary referrals, and offering capital incentives to top and improving performers against the standard.

On 30 January 2025, NHS England published the NHS England 2025-26 priorities and operational planning guidance which set streamlined targets for the system to support progress towards the 18-week standard, including that 65% of patients should wait no longer than 18 weeks for treatment by March 2026, with each trust expected to deliver at least a five percentage point improvement.

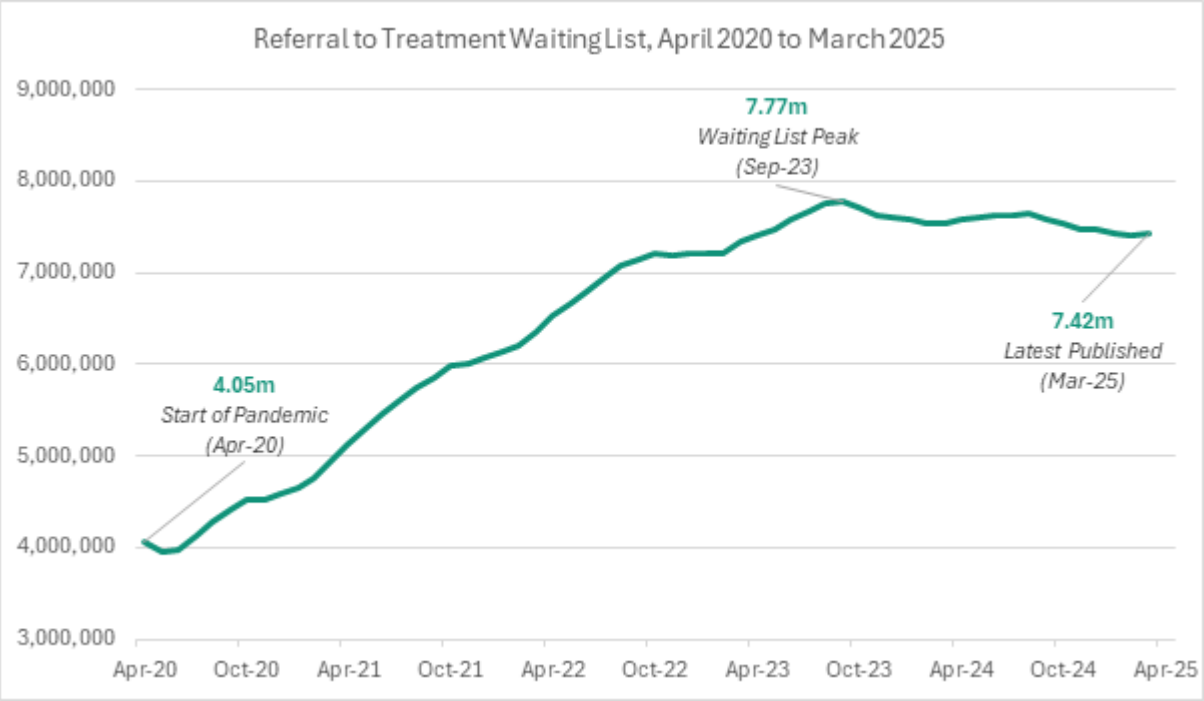
Performance against the 18-week standard increased from 57.2% in March 2024 to 59.8% in March 2025, marking the start of the 2025-26 Planning Guidance period. Elective activity for 2024-25 was high, with value-weighted activity (including advice and guidance) 20% above the 2019-20 baseline (April 2024 to February 2025). As of March 2025, the elective waiting list was 7.42 million, having fallen by almost 118,000 over the previous year.

Significant progress was made against the waiting times target set out in Planning Guidance for 2024-25 – to virtually eliminate waits of over 65 weeks by September 2024 – with 7,381 patient pathways with waits over 65 weeks by March 2025. This represented

only 0.1% of the waiting list in that month and was a reduction from the 48,967 patient pathways with waits over 65 weeks in March 2024.

Additionally, between July 2024 and March 2025 the number of waits over a year reduced from 290,000 to 180,000, a decrease of 110,000. This means that waits of over 52 weeks reduced from 3.8% of the total waiting list to 2.4%, a decrease of 1.4 percentage points.

Figure 2: Referral to Treatment Waiting List



Diagnostic overview

In the Elective Recovery Plan (February 2022), the NHS committed to 95% of patients being seen within six weeks of a referral for a diagnostic test. Planning Guidance for 2024-25 required systems to make progress towards the 95% ambition. While progress was made against this ambition, it was not achieved by the March 2025 ambition date.

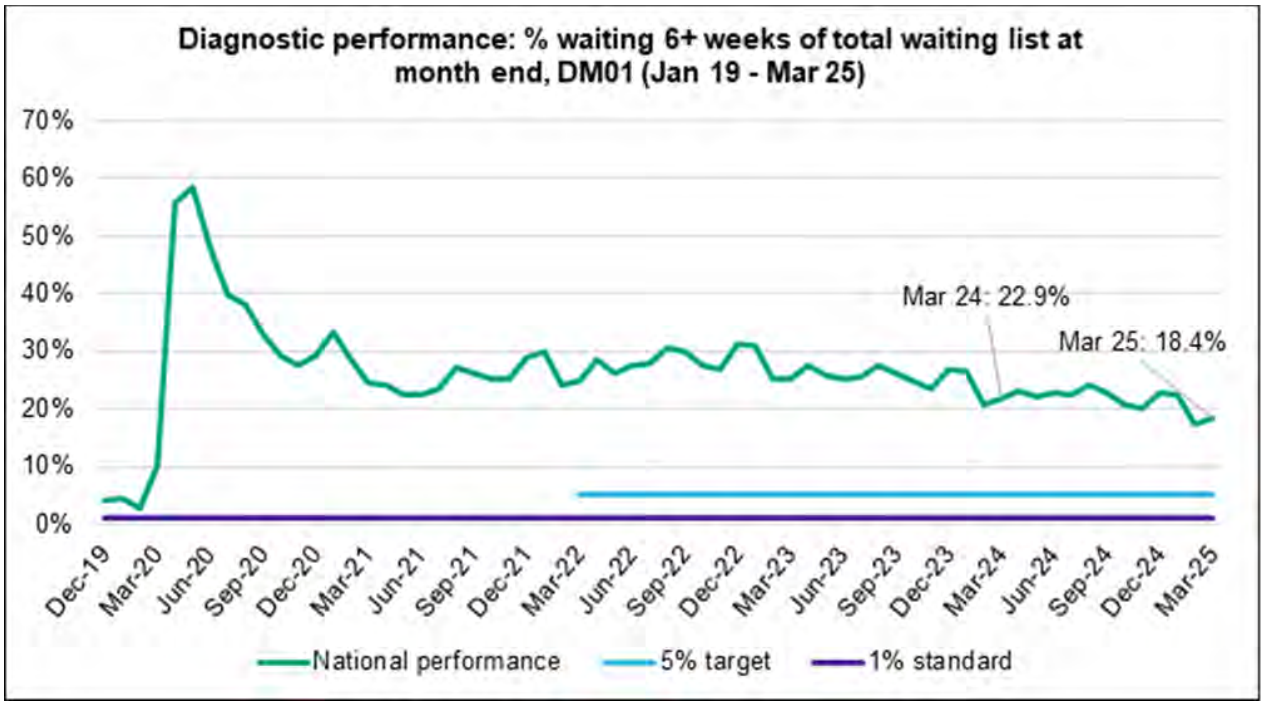
Performance against the headline metric of percentage of patients waiting six weeks or more improved from the start of 2024-25. At the end of March 2025, the diagnostic waiting list stood at 1,703,242, of which 312,744 (18.4%) were waits of 6 weeks or more. This compares to March 2024 where the waiting list was 1,624,628 of which 354,940 (21.8%) were waits of six weeks or more. In order to meet the 95% ambition set out in the Elective Recovery Plan, we would expect performance to show <5% patients waiting 6 weeks or more at month end.

The 95% ambition has been removed from planning guidance for 2025-26 in line with the recommendations from Lord Darzi's investigation report for fewer targets for the NHS. Diagnostics remains critical to delivering the standard of 92% of patients being treated within 18 weeks of referral, and the 2025-26 target of 65% of patients being treated within 18 weeks of referral.

NHS England continued across 2024-25 to deliver the final year of the diagnostic transformation programme funding agreed at Spending Review 2021, including continuing rolling out CDCs and new diagnostic equipment in acute settings.

At the end of 2024-25, 169 CDCs were operational, either fully or via temporary facilities. In total they had delivered approximately 14.8 million tests cumulatively since the programme started reporting in July 2021. In 2024-25 CDCs delivered 6.8 million tests. As part of the Elective Reform Plan published in January 2025, the government committed to open new CDCs and expand the number of CDCs offering services 12 hours a day, 7 days a week.

Figure 3: Diagnostic performance (operational standard: 1%, elective recovery target: 5% by March 2025) DM01 is a collection of 15 key diagnostic tests. (Performance is measured as the percentage waiting over 6 weeks of the total waiting at month end)



Surgical hubs

Elective surgical hubs continue to be launched to increase elective activity, with a focus on providing high volume, low complexity surgery in dedicated elective spaces distinct from acute activity. The Elective Reform Plan reinforced the importance of surgical hubs, committing to 17 new or expanded hubs by June 2025.

In 2024-25, 14 additional elective surgical hubs became operational bringing the total number of surgical hubs to 112. Five of these 14 additional hubs were those committed to open before June 2025 in the Elective Reform plan. There are plans to open more hubs over the next three years so more operations can be carried out.

NHS England continues to 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.

As of March 2025, 43 surgical hubs had been accredited for clinical and operational excellence, an increase of six hubs since March 2024 from a total of six planned. There is a pipeline of hubs to be accredited agreed for 2025-26. To ensure best practice is being adopted in all surgical hubs, NHS England will further develop the Get It Right First Time Elective Hub Accreditation programme throughout 2025-26.

Independent sector

The independent sector continues to play a vital role supporting the NHS to get on top of the waiting list backlog, delivering more than 100,000 elective appointments and procedures every week for the NHS. In 2024-25, over 1.6 million patient pathways were taken off the waiting list by independent sector providers.

In January 2025, alongside publication of the Elective Reform Plan, the NHS and the Independent Healthcare Provider Network established a partnership agreement, the first of its kind for 25 years, outlining plans to work together to reduce the elective waiting list. The NHS and independent sector will work together to encourage long-term relationships and continue to drive patient choice of providers. The independent sector will also aid the elective workforce's growth, provide training opportunities and offer greater support in the most challenged specialities such as ear, nose and throat, and gynaecology.

General practice

GP contract

On 28 February 2024, NHS England published a letter setting out the changes to the GP contract for 2024-25, which set out the requirements of general practice and Primary Care Networks (PCNs) from 1 April 2024 to 31 March 2025. The 2024-25 contract was the first contract following the five-year framework ('Investment and Evolution'). The changes to the 2024-25 contract were focused on improving patient experience of access, providing more flexibility at practice and PCN level and reducing bureaucracy for practices.

Changes were made to the Additional Roles Reimbursement Scheme as part of the 2024-25 GP contract, including introducing greater flexibility by removing existing caps and introducing enhanced practice level nurses.

To support practices with cash flow and increase financial flexibilities, we raised the Quality and Outcomes Frameworks (QOF) aspiration payment (the advance payments made to general practices to support their cash flow before the final QOF achievement payments are calculated and made) from 70% to 80% of the total payment and made it possible for

the Capacity and Access Improvement Payment (CAIP) to be paid at any point in the year, once PCNs confirmed they met the simple criteria for payment.

The contract also cut bureaucracy for practices by suspending and income-protecting 32 out of the 76 QOF indicators. The Investment and Impact Fund (IIF) indicators were also reduced from five to two, and the Capacity and Access Payment (CAP) was increased by £46 million to £292 million by retiring three IIF indicators.

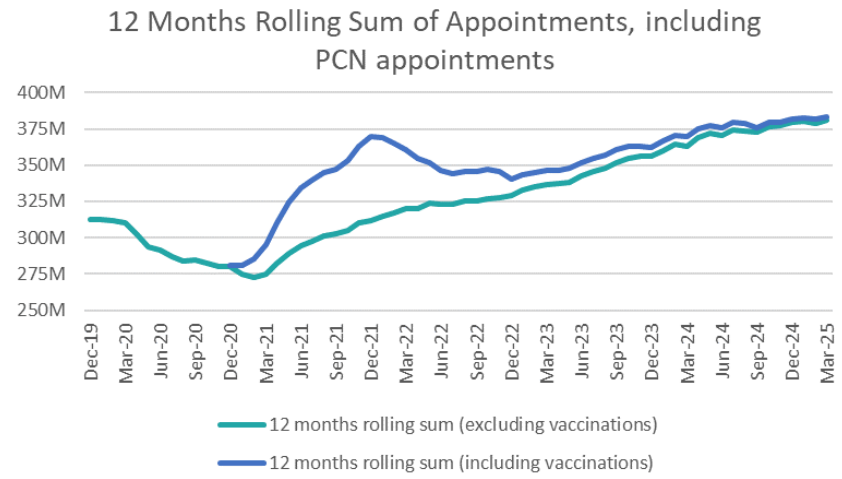
To improve patient experience of access, the contract asked PCNs and practices to review the data that digital telephony systems generate with a quality improvement focus, ahead of national extraction of the data from October 2024. The purpose of extracting this data was to better understand overall demand on general practice in advance of winter.

In response to reports of GP unemployment over the summer, in-year changes were made to the Additional Roles Reimbursement Scheme. From 1 October 2024, recently qualified GPs have been in a reimbursable role and as of March 2025, 1,503 GPs have been recruited through the scheme.

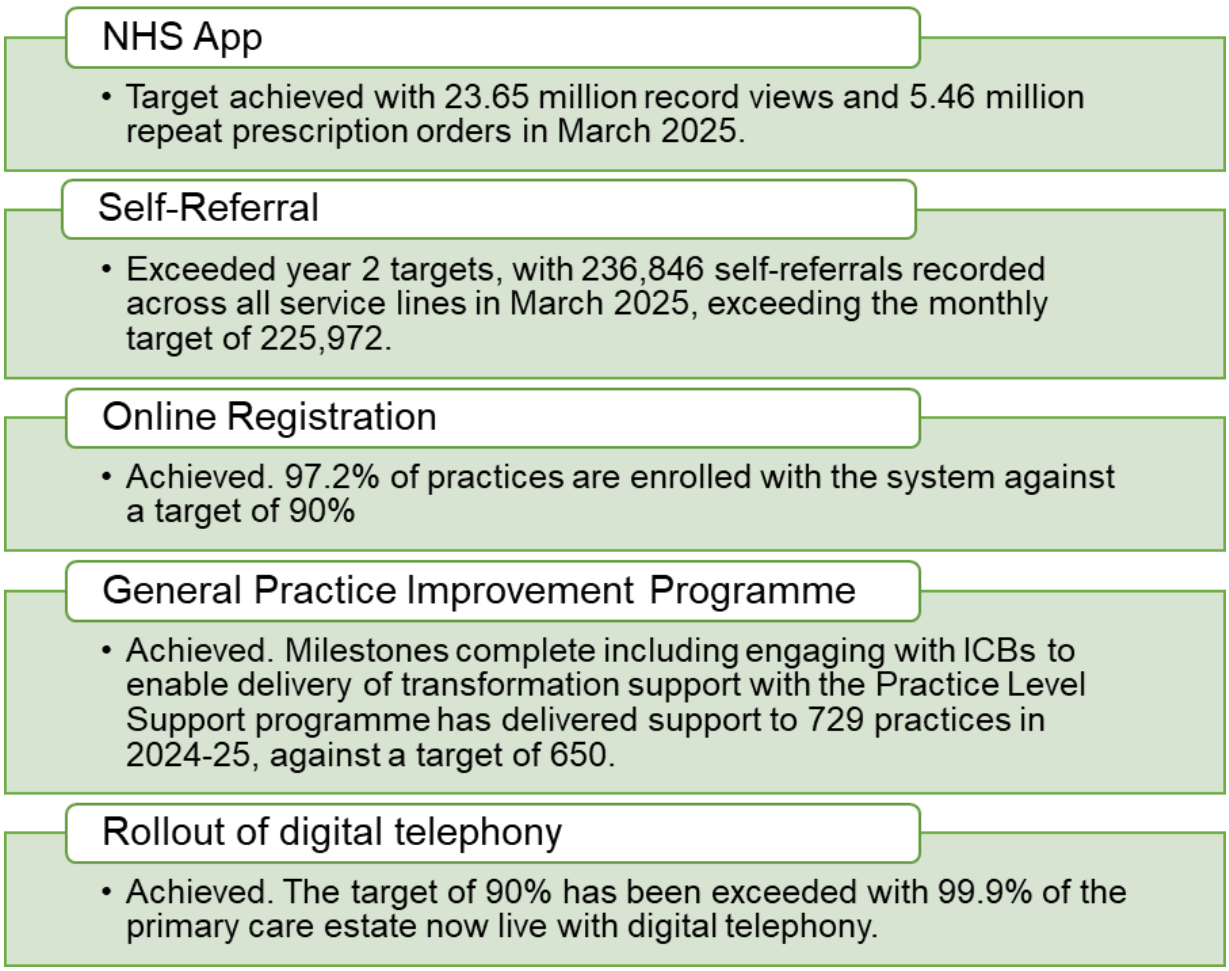
GP appointment data

Appointment numbers in 2024-25 were consistently higher than in 2023-24. As shown in **Figure 4**, in the 12 months to March 2025, an estimated 383.4 million appointments were booked across all general practices PCNs in England. This is an increase of 3.7% compared to the 12 months up to March 2024 (369.7 million) and an increase of 23.6% compared to the 12 months up to March 2020 (310.3 million).

Figure 4: 12 month rolling sum of appointments, including PCN appointments

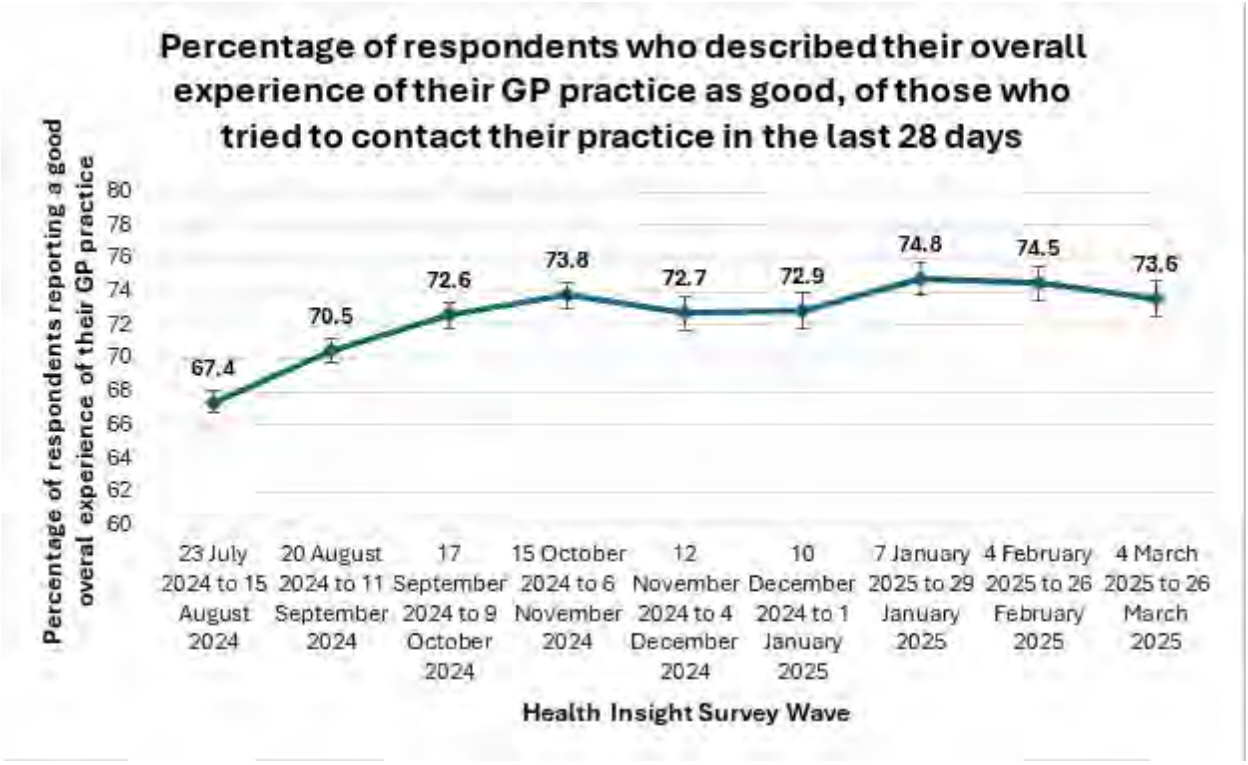


We are on track to achieve most deliverables for Year 2 of the Primary Care Access Recovery Plan, with some delays impacting delivery of digital telephony data and online consultation data targets:



The ONS Health Insight Survey, which was launched in July 2024, shows an overall increase in patient satisfaction with GP practices, as shown in **Figure 5**:

Figure 5: Percentage of respondents who described their overall experience of their GP practice as good, of those who tried to contact their practice in the last 28 days

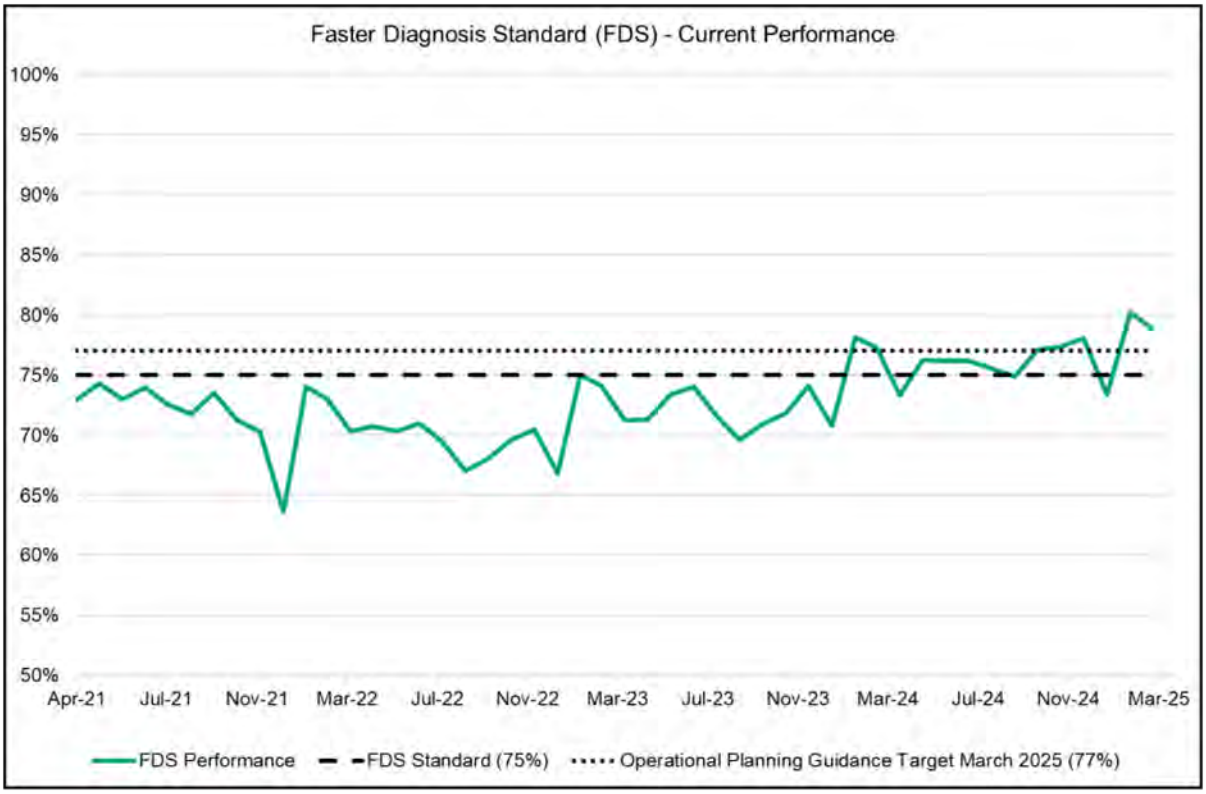


Cancer waiting times and diagnosis performance

Cancer survival in the UK is at the highest it has ever been, and ten-year survival for all cancers combined has doubled since the early 1970s. The latest rapid registration data shows that the 12-month early diagnosis rate reached 59.1% as of March 2025; this is 3.2% higher than pre-pandemic levels. This means approximately 7,200 more people are being diagnosed with cancer at the earlier stages (stage 1 and 2).

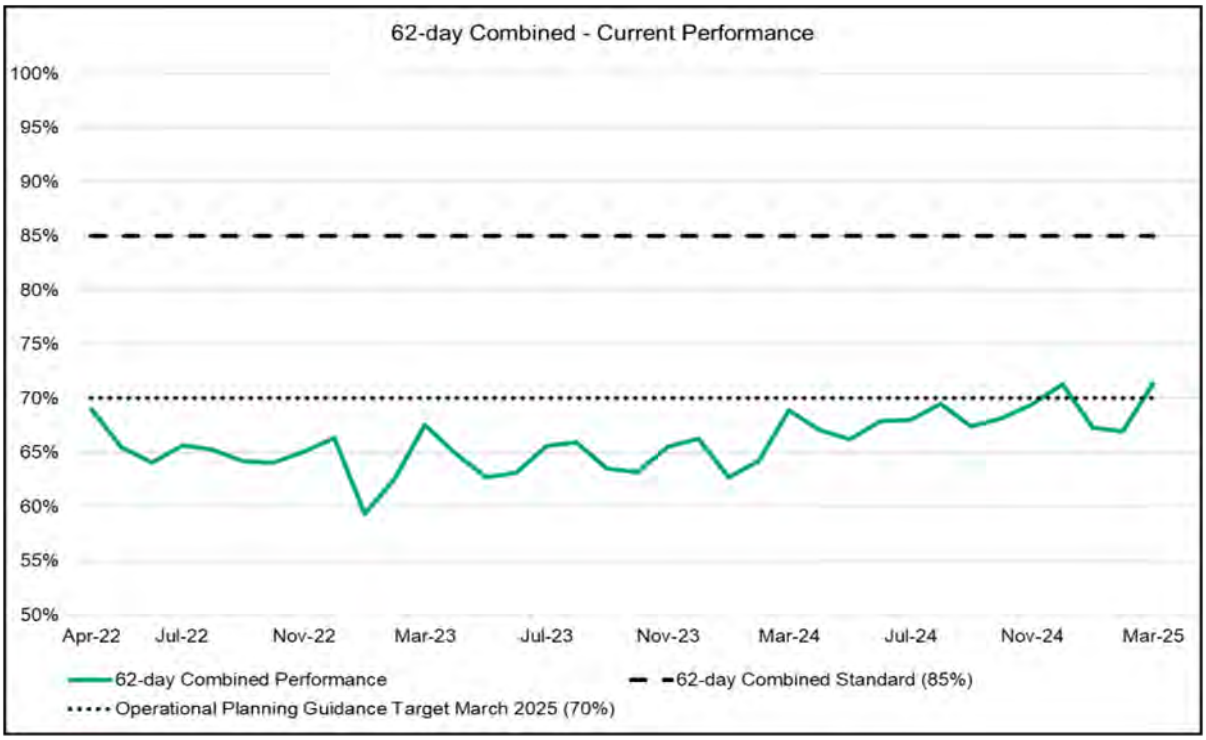
The 2024-25 Planning Guidance set two priority ambitions for cancer waiting times. The first cancer priority ambition was to improve performance against the 28-day Faster Diagnosis Standard (FDS) to 77% by March 2025. This was met in March 2025 with FDS performance at 78.9%, exceeding the 75% operational standard.

Figure 6: Performance against the Faster Diagnosis Standard (FDS)



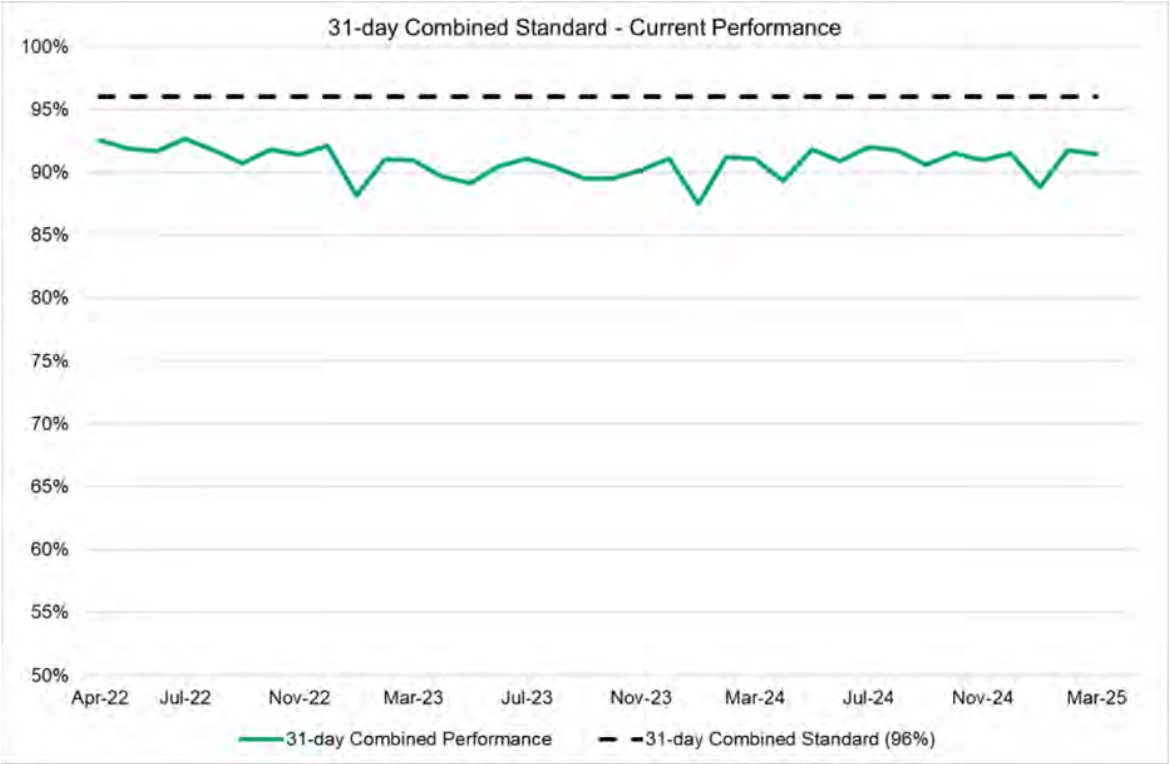
The second cancer priority ambition was to improve performance against the headline 62-day standard to 70% by March 2025. By March 2025, performance was at 71.4%, meeting the 2024-25 operational guidance objective. However, the 62-day referral to treatment performance is still not meeting the 85% operational standard.

Figure 7: Performance against the 62-day standard



Finally, against the 31-day decision to treat to first or subsequent treatment operational standard, in March 2025 performance was 91.4%, remaining below the 96% standard.

Figure 8: Performance against the 31-day standard



We are seeing continued high levels of urgent cancer referrals with over 3.1 million people seen following an urgent GP referral for suspected cancer in the 12 months to March 2025. This is up by 40% compared to the 12 months to March 2019 (pre-pandemic). This increase in referrals is due to the NHS prioritising cancer care following the pandemic and due to NHS England awareness campaigns.

The backlog showing the number of patients waiting more than 62 days to start treatment following a suspected cancer referral stood at 14,512 for week ending 30 March 2025, falling by 57% since its peak in the pandemic (34,050 week ending 24 May 2020).

As the first step to ensure faster diagnosis and treatment, the government has achieved its manifesto pledge to deliver an additional 2 million appointments in its first year, with more than 3 million extra appointments delivered by the end of March 2025.

The full rollout of non-specific symptom (NSS) pathways, designed to speed up the diagnosis of cancer, has been achieved across England. There are currently 115 live NSS services.

The NHS is prioritising the rollout of additional diagnostic capacity, delivering the final year of the three-year investment plan for establishing CDCs, with capacity prioritised for cancer diagnostics. £70 million will be spent on new radiotherapy machines, to ensure the most advanced treatment is available to patients who need it.

Urgent and emergency care

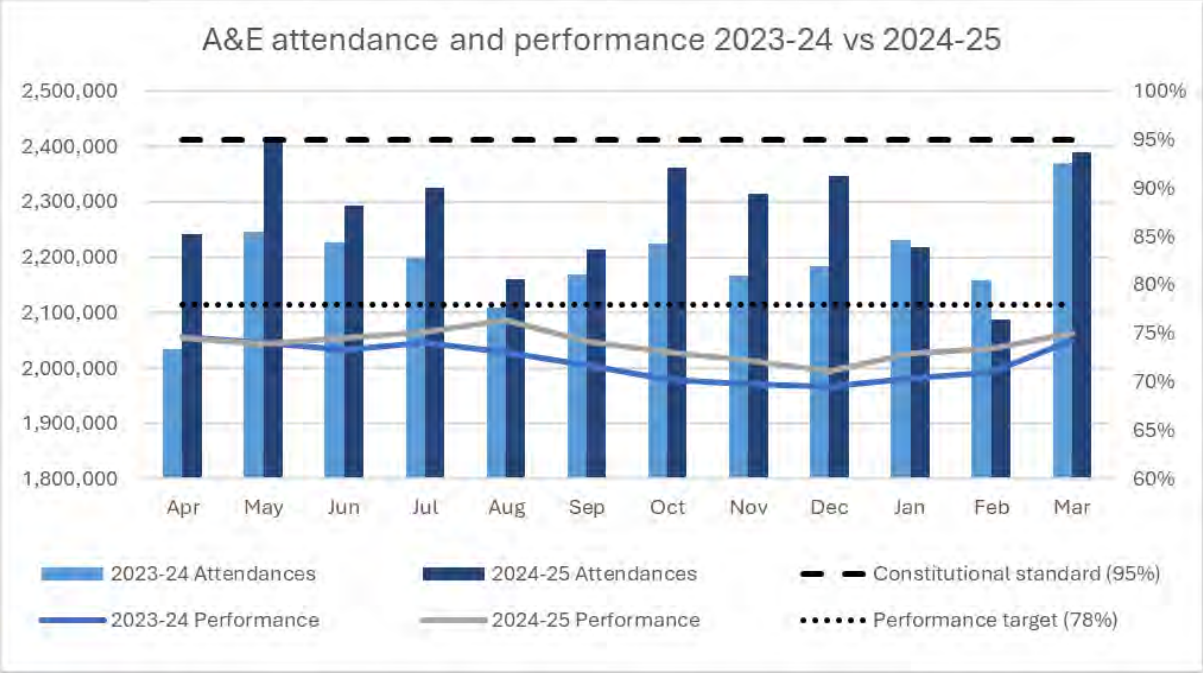
Urgent and Emergency Care services continued to be under pressure in 2024-25 with performance targets set at the start of the year:

- to improve A&E wait times to a minimum of 78% of patients being admitted, transferred, or discharged within four hours by March 2025, and
- to reduce average Category 2 ambulance response times to 30 minutes over 2024-25.

Neither of these performance targets were met in 2024-25, although both showed a year-on-year improvement. Against a long-term trend of declining performance, this was the second year of year-on-year improvements.

As shown in **Figure 9**, performance in March 2025 was 75%, below the performance target of 78% and the constitutional standard of 95%. Average monthly A&E attendances increased by 4.0% from 2,193,422 in 2023-24 to 2,280,633 in 2024-25. Average monthly emergency admissions increased by 1.7%, from 534,219 in 2023-24 to 543,568 in 2024-25.

Figure 9: A&E attendance and performance in 2023-24 and 2024-25



Source: A&E Attendances and Emergency Admissions

In addition, a further indicator of A&E services pressures is the proportion of patients who spend more than 12 hours in A&E. Despite 12-hour performance improving from 10.1% of A&E patient attendances in March 2024 to 9.7% in March 2025, overall year on year performance has seen a deterioration from 9.7% in 2023-24 to 10.4% in 2024-25.

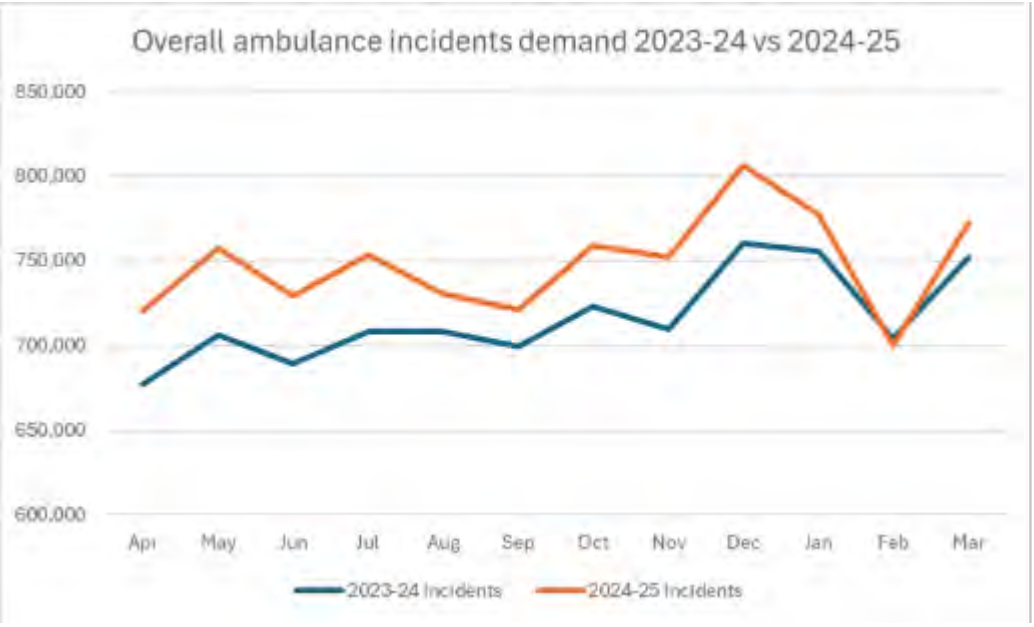
As shown in **Figure 10**, general and acute (G and A) bed occupancy levels remained consistently high throughout 2024-25, reaching a maximum occupancy of 94.2% in January and February 2025. This is a slight improvement compared to 2023-24's peak figure of 94.8% in November 2023 (Type 1 acute trusts only).

Figure 10: General and acute (G and A) occupancy, type 1 trusts only

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

Figure 11 sets out overall monthly ambulance incidents. In 2024-25, this equated to, on average, 24,602 incidents per day, 4.8% higher than in the previous year and 2.5% higher than the pre-pandemic baseline of 23,998 per day (2019-20).

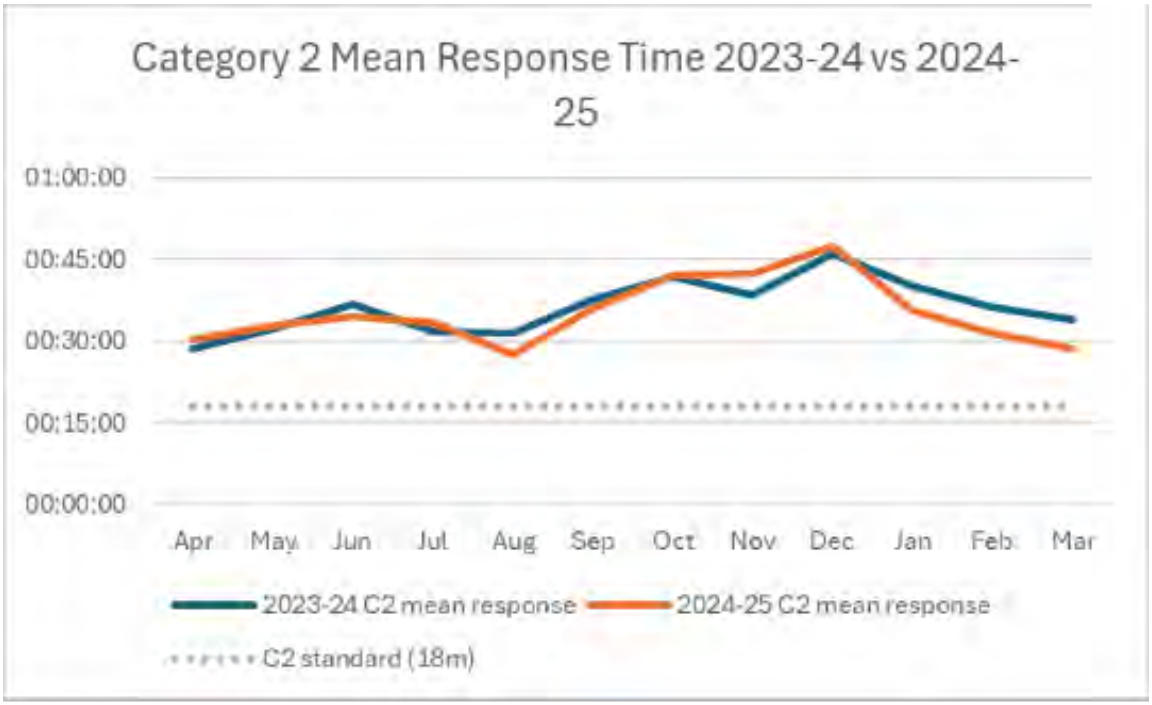
Figure 11: Overall ambulance incidents demand 2023-24 and 2024-25



Source: [Ambulance Quality Indicator]

The average Category 2 (main headline indicator for ‘emergency call’ ambulance responses) response time was 35 minutes and 22 seconds, improving by one minute and one second compared to 2023-24 but exceeding the recovery plan performance target of 30 minutes and the constitutional standard of 18 minutes. **Figure 12** compares Category 2 response times in 2023-24 and 2024-25.

Figure 12: Category 2 mean ambulance response time 2023-24 and 2024-25



Source: Ambulance Quality Indicator

NHS England 2025-26 priorities and operational planning guidance contains the operational delivery detail for local NHS systems. This includes performance targets for:

- four-hour A&E performance reaching at least 78% by March 2026, and
- ambulance category 2 incident response average 30 minutes across the year.

These represent a success measure for a higher proportion of patients admitted, discharged and transferred from emergency departments within 12 hours across 2025-26 compared to 2024-25.

Better care and discharge funds

In 2024-25, £1 billion was deployed through the Discharge Fund to support the NHS and local authorities to improve timely and effective discharge from hospital, an increase of £400 million compared to 2023-24. We are working with National Institute for Health and Care Research and the University of York to carry out an evaluation of the impact of the Discharge Fund (2023-24 and 2024-25) on health and social care outcomes. An interim report on the 2023-24 findings was received June 2025 and a full report is expected to be published in May 2026.

On 30 January 2025, the government published a revised Better Care Fund (BCF) policy framework for 2025-26, aligning its objectives to the government's health mission. Local BCF plans are now focused on three headline metrics: emergency admissions to hospital for people aged 65+, the average length of hospital discharge delays and long-term care home admissions for people aged 65+. The revised BCF policy framework also includes a more targeted approach to oversight and support for local areas with the greatest challenges in relation to these three measures.

In 2024-25, there were, on average, 12,663 acute hospital beds per day occupied by adult patients with delayed discharges, compared with 12,693 on average in 2023-24, a reduction of 0.24%. This was in the context of a 1.7% increase in emergency admissions.

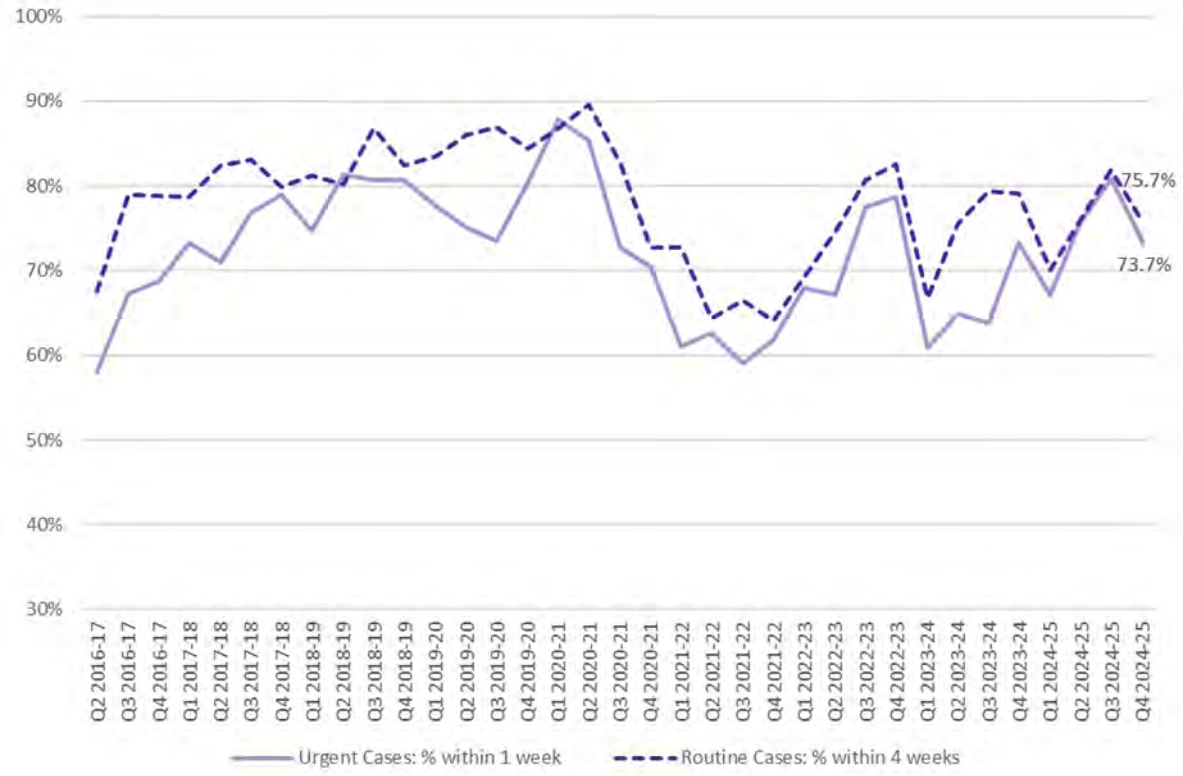
Mental health waiting time standards

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 Services.

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 four weeks for routine cases.

As shown in **Figure 13**, for completed pathways, 73.7% of young people (303 out of 411) started treatment for an urgent case within one week and 75.7% (1,902 out of 2,511) started treatment for a routine case within 4 weeks, between January and March 2025. Both of these were below the national target of 95%.

Figure 13: Children and young people with an eating disorder waiting times in England (completed pathways)



Source: Mental Health Services Monthly Statistics, NHS England Digital

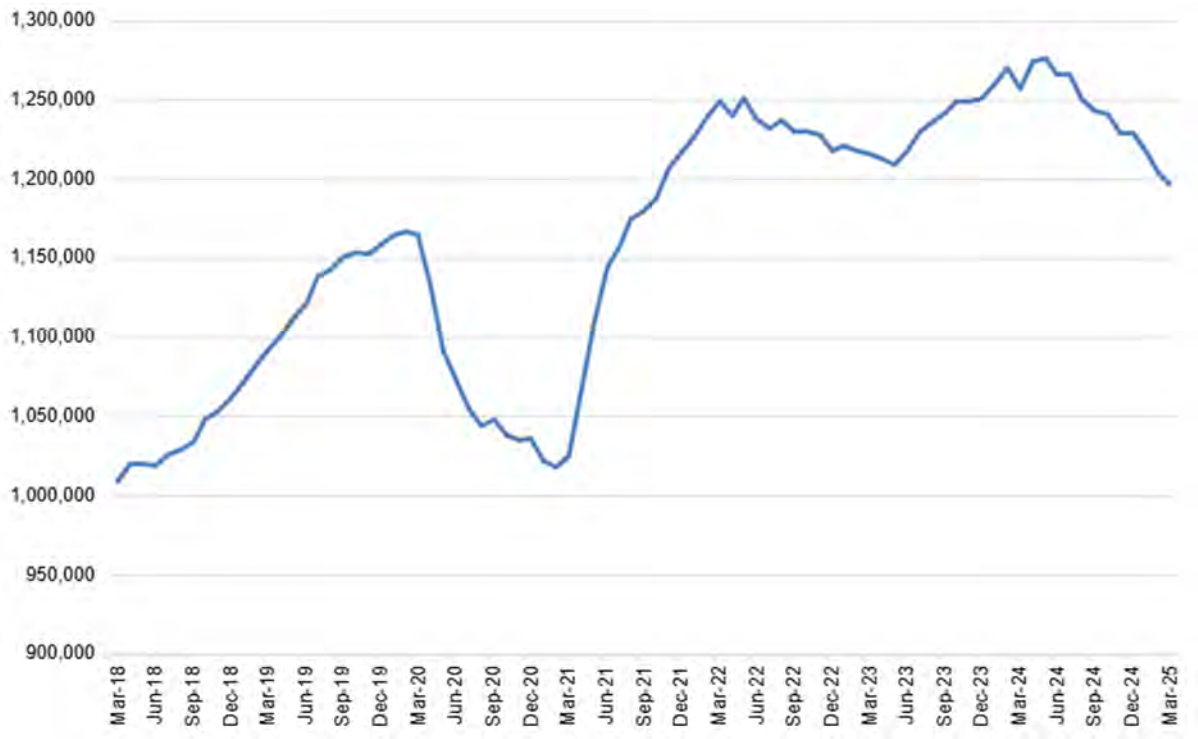
For incomplete pathways, the number of children and young people referrals with eating disorder issues waiting for treatment and categorised as urgent was 841 at the end of March 2025, a 3.3% increase from 814 at the end of March 2024. The number waiting to start treatment for routine cases was 4,873 at the end of March 2025 falling by 15.4% from 5,757 at the end of March 2024.

The total number of children and young people with eating disorder issues entering treatment increased 9.0% from 10,606 in 2023-24 to 11,557 in 2024-25.

The number of referrals to NHS Talking Therapies (previously known as the 'Improving Access to Psychological Therapy' (IAPT) programme) fell slightly in 2024-25.

As shown in **Figure 14**, in the 12 months to March 2025, 1,212,244 referrals entered treatment, which was a 3.8% decrease compared with the 12 months to March 2024. During the same period, 670,419 referrals completed a course of treatment, which was a 0.2% decrease compared with the 12 months to March 2024.

Figure 14: Number of referrals entering treatment through NHS Talking Therapies in England (rolling 12-month period)



Source: NHS Talking Therapies Statistics, NHS England Digital. Figures in the chart may differ slightly to those in the text due to revised annual figures being published for previous years.

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 2024-25, 91.6% 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 2024-25 when the rate was 50.5%.

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 two weeks of referral. As seen in **Figure 15**, in the period of January to March 2025, 66.3% of referrals (2,838 out of 4,282) started treatment within two weeks, above the 60% standard.

Figure 15: 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

Pharmacy and eye care

Eye care

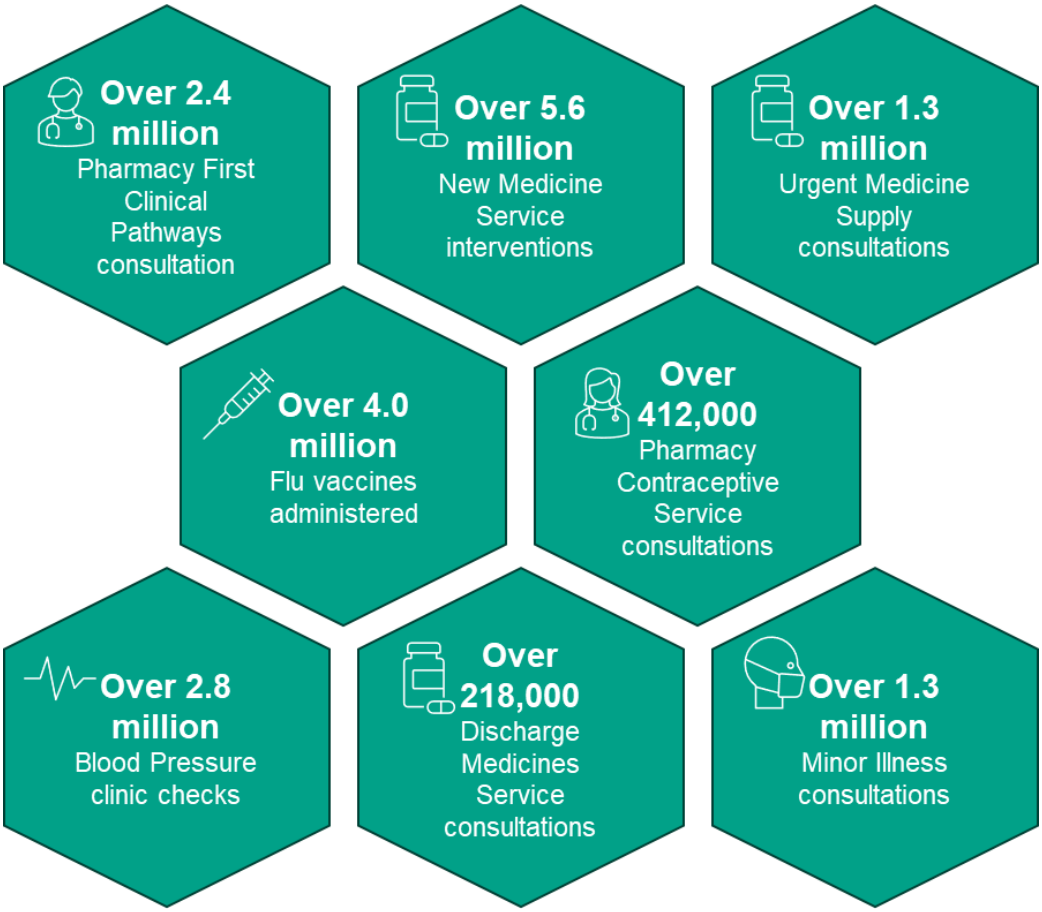
Over 13 million NHS sight tests were delivered in 2024-25. Those eligible for free NHS sight tests include children, people aged 60 and over, people on income related benefits, and certain groups at particular risk of eye disease.

In 2024-25 regulations were laid to support the roll out of free sight testing and dispensing of spectacles to children and young people in special education settings following a pilot. NHS England subsequently published service specifications to enable Integrated Care Boards (ICBs) to commission the service. NHS England continued to pilot how IT connectivity between primary and secondary eye care services could improve the triage and referrals of patients and allow more patients to be managed in the community, to increase secondary care capacity.

Community pharmacy

In 2024-25, there was continued delivery of the service offer delivered in 2023-24. Funding through the Community Pharmacy Contractual Framework rose to £2.698 billion for 2024-25 to cover the growth in activity delivered by the sector through the year, an increase of 4.1% on 2023-24 funding levels. Community pharmacy continued to provide information, health advice and a range of clinical services. Contractors also ensured access to

pharmacy medicines and signposted people to other services to best support individuals in managing their health. There was continued growth in the uptake of the commissioned clinical services over the year.



Dentistry

DHSC's aim for the first half of 2024-25 was to deliver and implement the policies in Faster, Simpler, Fairer: our plan to recover and reform NHS dentistry, which was published under the previous government in February 2024. The aim of the recovery plan was to deliver an additional 1.5 million courses of treatment in 2024-25 through the New Patient Premium (NPP) to encourage dentists to see new patients, a Golden Hello scheme to encourage dentists to work in under-serviced areas, and an increase to the minimum Unit of Dental Activity rate from £23 to £28.

DHSC worked closely with NHS England to implement all of the above. The NPP scheme was rolled out in March 2024 and ran until the end of March 2025. The scheme was not extended as the data showed it had not achieved its objective of increasing the number of new patients seen, with the latest data available (March – October 2024) showing that on average the number of treatments delivered to new patients per working day had dropped by 5% since the introduction of the new patient premium (Source: Dental New Patient Premium – Datasets – Open Data Portal.)

The Golden Hello recruitment incentive scheme was rolled out in May 2024 and although the target of 240 dentists recruited by the end of March 2025 was missed the scheme has been extended into 2025-26. As of end March 2025, 53 dentists were recruited and in post, with a further 44 dentists recruited but yet to start in post, and 256 live adverts.

Outside of delivering the Dentistry Recovery Plan, in April 2024, the government increased dental patient charges by 4%. The uplifts in 2023-24 and 2024-25 were higher than GDP to account for the lack of uplifts in the two years immediately prior. This generated £797 million in 2024-25 which made an important contribution to NHS budgets.

Although in 2024-25 activity continued to recover, there are some significant challenges facing NHS dentistry. 18.5 million adults (39.8%) were seen by an NHS dentist in the 24 months up to 30 June 2025, an increase of 55,000 (0.3%) when compared to the previous year, but 3.4 million (16%) lower than the pre-pandemic figure (24 months to September 2019). 35.4 million Courses of Treatment (CoT) were delivered in 2024-25, an increase of 3.8% compared to the previous year, but this is still 8.8% lower than the number of CoT that were delivered in a typical pre-pandemic year.

The annual GP Patient Survey (GPPS) for 2024 found that 34% of patients who had not been to a practice before were able to get an NHS dental appointment, compared to 85% of patients who had previously visited the practice. In light of the change of government in July 2024 DHSC's focus switched to delivering the new government's commitment to deliver a dentistry rescue plan.

In February, DHSC announced that ICBs would be asked to deliver an additional 700,000 urgent dental appointments in 2025-26. In March 2025, DHSC announced the roll-out of a supervised toothbrushing programme, supported by £11 million investment to local authorities in 2025-26, alongside an innovative partnership with Colgate-Palmolive, that will reach up to 600,000 three to four and four to five-year-olds, targeting the most deprived areas of England. In the same month, following a public consultation, DHSC announced an expansion of community water fluoridation across the North-East of England. This intervention is expected to reach an additional 1.6 million people and reduce tooth decay and inequalities in dental health. We expect this to be a five-year programme with first additional fluoridated water starting by the end of 2027-2028.

The 10 Year Health Plan includes commitments to require newly qualified dentists to work in the NHS for a minimum period, fundamentally reform the dental contract and embed dental care professionals in neighbourhood teams.

Patient safety

In 2024-25, DHSC and NHS England have continued to take forward key measures to advance patient safety and a learning culture in the NHS so that harmful patient events are significantly reduced.

This includes delivery of the NHS Patient Safety Strategy which is overseen by NHS England. The Strategy is now achieving its aims of saving an extra 1,000 lives per year and £100 million in care costs per year. By April 2025, the Strategy's patient safety improvement programmes had led to over 1,500 neonatal lives saved, over 500 fewer cerebral palsy cases in premature babies, and more than 1,900 deaths prevented overall through medicines safety improvement, including work to reduce long-term opioid use.

The Strategy includes other key programmes, such as the Patient Safety Incident Response Framework, the Learn From Patient Safety Events service, the NHS Patient Safety Syllabus, and the Framework for Involving Patients in Patient Safety, that are focused on improving the NHS's systems, capability and capacity to improve safety. NHS England plans to update the Strategy following publication of the 10 Year Health Plan, and an overarching Quality Strategy (planned for March 2026) to refresh the approach for the next five years.

Other measures during 2024-25 included implementing Martha's Rule in 143 hospital sites, which has led to hundreds of life-saving interventions and changes to care that have avoided harm. 2024-25 has also seen the implementation of medical examiners to scrutinise all deaths that are not investigated by a coroner, in order to facilitate learning and improvement at a local level.

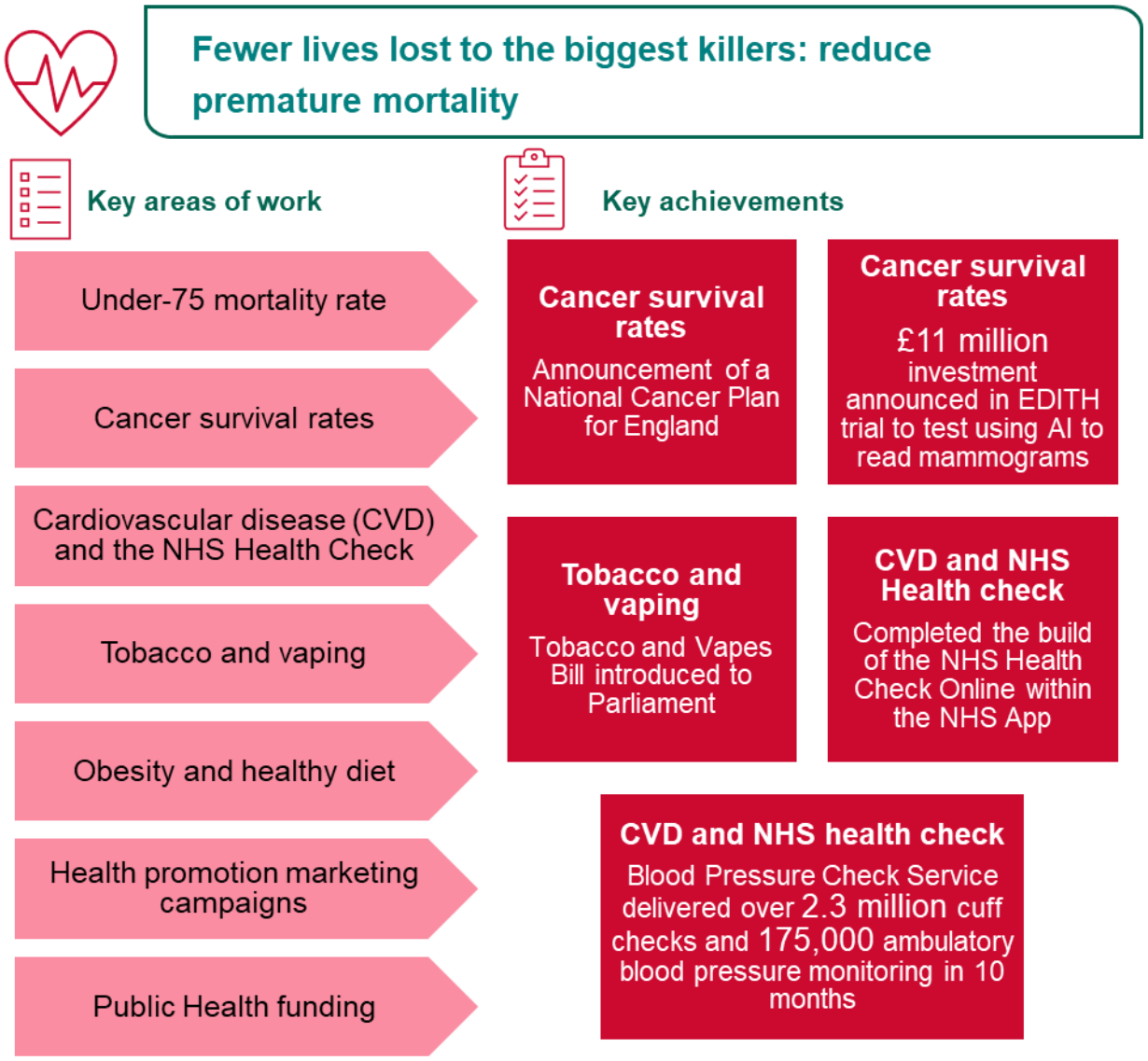
The independent review of the patient safety landscape across health and care, led by Dr Penny Dash, has been published, recommending significant changes to streamline the current system.

The review found that despite considerable investment in patient safety, the landscape of approximately 40 organisations with formal safety roles has created a complex environment which is difficult for providers and patients to understand and navigate.

The review sets out nine key recommendations, which helped inform – and should be read alongside – Chapter Six of the 10 Year Health Plan, which sets out broader action to improve quality of care through greater transparency. The review's recommendations include:

- revitalising the National Quality Board to lead a coherent quality strategy
- clarifying the roles of the Care Quality Commission (CQC) and Health Services Safety Investigation Body (HSSIB), and
- establishing a new directorate for patient experience within NHS England (and ultimately the DHSC when the integration of the two organisations has taken place).

Strategic outcome two



Under-75 mortality rate

The under-75 mortality rate from all causes decreased between 2021 and 2024 by 10% for males and 9% for females.

People are living too long in ill health, there are still healthy life expectancy inequalities between rich and poor, and over one in five children leave primary school with obesity. Our overall goal is to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and to raise the healthiest generation of children ever. This will boost our health but also ensure the future sustainability of the NHS and support economic growth. We will achieve our goals by harnessing a huge cross-societal energy on prevention. We will work with businesses, employers, investors, local authorities and mayors to create a healthier country together.

Public health funding

Public health services commissioned by upper tier local authorities in England are mainly funded through a ring-fenced public health grant. In 2024-25, funding for all local authorities through the public health grant, and the 100% retained business rates arrangement for local authorities in Greater Manchester, increased by 3.7% in cash terms relative to 2023-24, taking total funding to £3.660 billion. The grant allocations were updated to include the additional in-year cost impact of the NHS pay awards for health services commissioned by local authorities and funded through the public health grant.

In addition to the public health grant, DHSC also provided £447 million of targeted funding to local authorities in England to support improvements in the quality and capacity of drug and alcohol treatment and Start for Life services, and new investment in local authority led stop smoking services.

All upper tier local authorities must report on how they spend their grant and the Chief Executive or Section 151 Officer and the Director of Public Health provide a written statement of compliance with public health grant conditions. On behalf of the Secretary of State, DHSC Regional Directors of Public Health undertake additional assurance activity with local authorities.

Cancer survival rates

In February 2025, the Secretary of State for Health and Social Care announced the development of a National Cancer Plan for England. The Prime Minister's health mission sets the objective of building an NHS fit for the future, and an essential part of this is achieving our goal to reduce the number of lives lost to cancer. The National Cancer Plan will have patients at its heart and will cover the entirety of the cancer pathway, from referral and diagnosis to treatment and ongoing care, as well as prevention, and research and innovation. On 4 February 2025 the call for evidence was launched for the National Cancer Plan. Over 11,000 responses were received from individuals, professionals and organisations. These submissions are being used to inform our plan to improve cancer care. Publication is expected in the new year.

As of March 2025, there were over 1,800 full time equivalent (FTE) doctors working in clinical oncology in NHS trusts and other core organisations in England. This is over 150 (9.1%) more than last year, over 450 (33.3%) more than 2020, and almost 810 (79.1%) more than in 2010.

On 4 February 2025, DHSC announced that nearly 700,000 women across the country will take part in a world-leading trial to test how cutting-edge AI tools can be used to read mammograms in the breast cancer screening programme. The EDITH trial (Early Detection using Information Technology in Health) is backed by £11 million of government support via the National Institute of Health and Care Research (NIHR).

In September 2024, the National Bowel Cancer Audit released a Quality Improvement Plan. The plan sets out the scope, care pathway, five quality improvement goals and ten performance indicators for the bowel cancer audit. This includes recommendations for improving the diagnostic pathway.

A new national NIHR Brain Tumour Research Consortium was established in December 2024 to bring together researchers from a range of different disciplines and institutions with the aim of driving scientific advancements in how we prevent, detect, manage and treat rarer but less survivable cancers, in both adults and children.

In January 2025, the Targeted Lung Health Check project changed its name to the Lung Cancer Screening programme in recognition of its plan for national implementation by 2029-30. The programme is designed to identify cancers at an earlier stage and is aimed at high-risk individuals or people with a history of smoking between the ages of 55-74.

Finally, the 2024 Cancer Patient Experience Survey (with 64,055 respondents) reported the average rating of care as 8.94 out of 10, with 87.6% rating care administration as Very Good or Good.

Cardiovascular disease (CVD) and the NHS Health Check

Too many lives are lost prematurely to heart disease and stroke. In 2023, 29% of all CVD-related deaths in England occurred in people under the age of 75. In 2024-25, DHSC has:

- set an ambition to reduce premature mortality from heart disease and stroke by 25% in the next 10 years

- continued to invest in the NHS Health Check, a core component of England's CVD prevention programme, and in the development of a new digital service – NHS Health Check Online (see separate section below)

- launched the trial of a new programme to deliver lifesaving heart health checks in the workplace. These checks can be completed quickly and easily to help people to understand and act on their CVD risk. By bringing heart health checks to where people work, we aimed to remove barriers to access and find people at risk of CVD in groups that traditionally do not engage. 48 local authorities partnered with a range of large and small local public and private sector employers to deliver the pilot. We are working with researchers to publish the results of the evaluation by the end of 2025

- continued investing in the Blood Pressure Check Service, which enables community pharmacists to identify people with undiagnosed hypertension. Between April 2024 and March 2025, the service delivered 2,840,103 cuff checks and 226,496 ambulatory blood pressure monitoring checks, and

- brought in changes to the Quality and Outcomes Framework (QOF) for the 2025-26 contract year to improve CVD prevention and make progress towards the government's health mission on cardiovascular disease by incentivising GPs to focus on the identification and management of hypertension and cholesterol. We have raised the upper threshold of CVD indicators in order to stimulate a step-wise change in performance and improve CVD outcomes for patients.

Table 1: Progress on key secondary prevention indicators

Planning guidance 25-26 aspiration	March 2024 performance	March 2025 performance
Increase the % of patients with hypertension treated according to National Institute for Health and Care Excellence guidance	70%[1]	75%[1]
Increase the % of patients with CVD who have their cholesterol levels managed to NICE guidance	Not available	48%

Other key interventions	March 2024 performance	March 2025 performance
Patients with hypertension who have received a blood pressure reading in the last 12 months	89%	90%
Patients <80 with blood pressure treated to target	67%[2]	68%[2]
Patients with a QRISK[3] score of >20% treated with lipid lowering therapy	62%	64%
Patients with CVD treated with lipid lowering therapy.	85%	86%

Data source: All values in this table are taken from the national Cardiovascular Disease Prevention Audit except where indicated otherwise.

1.Taken from the NHS England QOF. The two age specific indicators HYP008 and HYP009 have been combined to make an all age indicator.

2.Taken from the NHS England QOF indicator number HYP008.

3.Online calculator used to understand someone's risk of CVD.

NHS Health Check

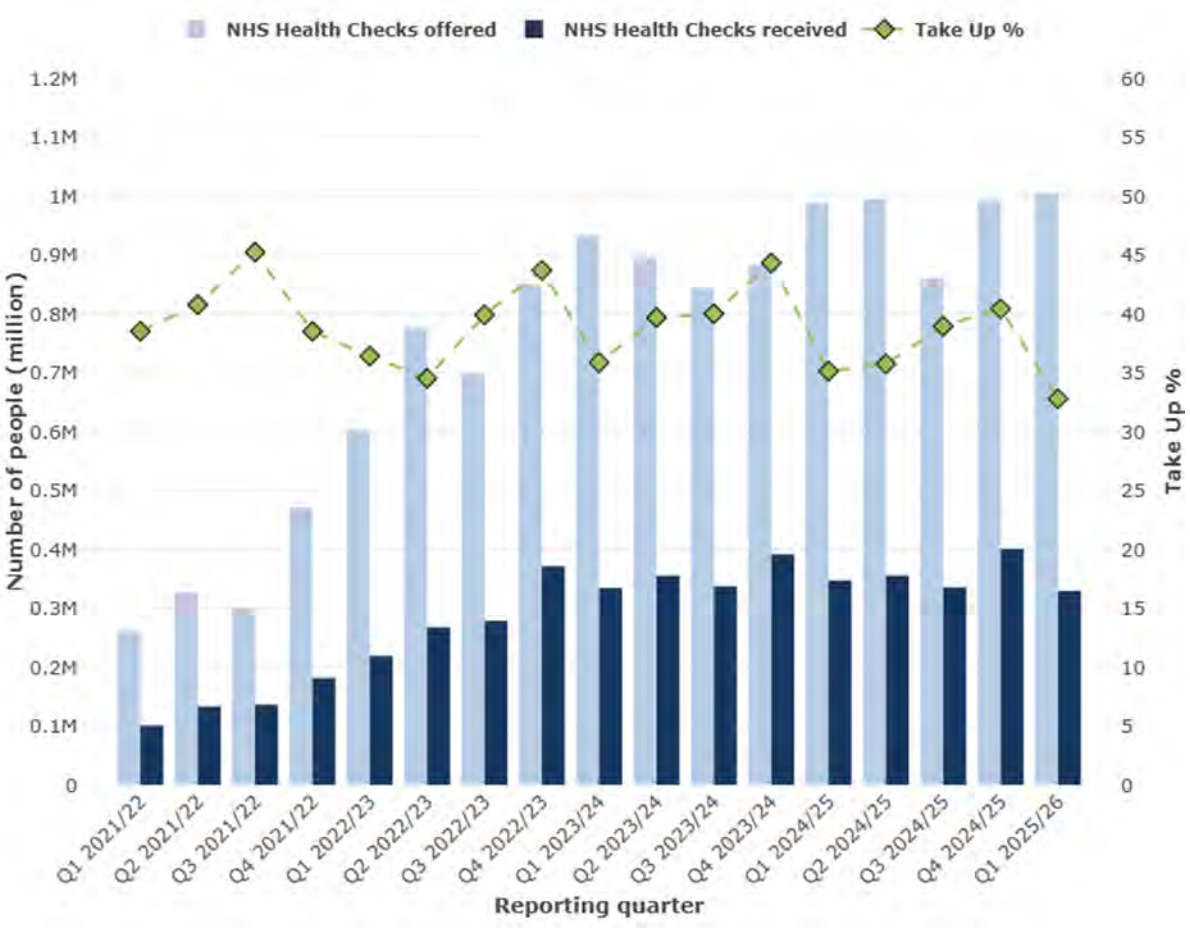
The NHS Health Check programme is a core component of England's CVD prevention programme. It aims to detect people at risk of heart disease, stroke, type 2 diabetes and kidney disease by assessing the top risk factors for CVD in adults aged between 40-74.

A total of 3,835,288 NHS Health Checks were offered in 2024-25 and 1,438,781 have been delivered. Quarter 1 of 2024-25 saw the highest number of NHS Health Checks offered (941,908) and completed (343,368) at Quarter 1 since the current programme began in 2013.

Table 2: NHS Health Checks offered and delivered

	Number of NHS Health Checks offered	Number of NHS Health Checks delivered
Total for 2024-25	3,835,288	1,438,781

Figure 16: Quarterly activity in England since April 2020: number of NHS Health Checks offered, number delivered and percentage take-up of offers.



Source: [NHS Health Check – Data | Fingertips | Department of Health and Social Care]

The NHS Health Check programme engages over 1.4 million people a year and, through behavioural and clinical interventions, prevents around 300 premature deaths, and 500 heart attacks or strokes each year. Annually, the NHS Health Check identifies over 340,000 people with high blood pressure, over 330,000 people living with obesity and over 900,000 people with raised cholesterol. Six years after attending an NHS Health Check,

individuals are, on average, likely to have a reduced average body mass index (BMI), reduced smoking intake, and reduced blood pressure.

As the recently published NAO report 'Progress in preventing cardiovascular disease' has highlighted, we know there is more to be done to improve the impact of the NHS Health Check Programme, with uptake from the current five-year cycle showing 38.8% of eligible people offered a check completed one.

To improve access and engagement with the NHS Health Check, we are developing the NHS Health Check Online service that people can use at home, at a time convenient to them, to understand and act on their CVD risk. In 2024-25, an Expression of Interest exercise was launched to seek willing local authorities to participate in the pilot which began in late June 2025 and will end in late December 2025. Lambeth, Medway and Norfolk were selected and have worked closely with DHSC and general practices in their areas to prepare for the launch. Subject to the outcome of the pilot, the aim is to roll out more widely from spring 2026, delivering around one million checks in the first 4 years.

The NHS App which will deliver the NHS Health Check Online gained class 1 medical device registration in 2024-25. The digital product took longer than expected to develop, due to the need to build in additional functionality following NHS England's clinical safety risk assessment and procuring a supplier for home blood sampling.

The current five-year cycle was impacted by the Covid pandemic as local authorities paused the NHS Health Check programme during 2020-22.

Tobacco and vaping

The government has set out a clear ambition to create the first smoke-free generation for a smoke-free UK and clamp down on youth vaping. In November 2024, the government introduced the landmark UK-wide Tobacco and Vapes Bill in Parliament. The Bill will ensure that children turning 16 this year and those younger than them will never legally be sold tobacco, guaranteeing a long-term end to the sale of tobacco products across the country. The Bill will strengthen the existing ban on smoking in public places to reduce the harms of passive smoking in certain outdoor settings, particularly for children and vulnerable people. Alongside these measures, the Bill will also ban vapes and nicotine products from being deliberately branded, promoted, and advertised to children.

In 2024-25, the government continued to provide support for existing smokers to quit. This includes an additional £70 million in funding for local authority-led Stop Smoking Services in England. Further investment has also been directed towards the National Smoke-free Pregnancy Incentives Scheme, which launched in November 2024, and the Swap to Stop scheme which helps existing adult smokers to switch to vapes. The scheme provided over 430,000 vape starter kits to local authorities in 2024-25. Alongside these programmes, the government continues to work closely with the NHS to integrate opt-out smoking cessation

interventions in all routine care within hospitals. Our work to create a smoke-free UK forms part of the health mission to shift from treatment to prevention.

Obesity and healthy diet

The government set an ambition to tackle the childhood obesity crisis and raise the healthiest generation of children ever. Obesity is estimated to cost the NHS £11.4 billion per year, with 64% of adults (around 29 million) in England currently living with overweight or obesity. At the start of primary school 22% of children aged four to five years (around 280,000 children) are living with overweight or obesity. This increases to 36% of children aged 10 to 11 years (around 510,000 children).

To address this, we are delivering the government's manifesto commitment to implement advertising restrictions for less healthy food or drink on TV between 5.30am and 9pm and at any time online. We laid legislation in December 2024 to set out the businesses, services and products in scope of the restrictions as well as providing guidance to businesses. To provide further certainty to regulators and industry, we will be bringing forward an exemption for brand advertising in legislation this year. To do this we have moved the date the restrictions will take legal effect from 1 October 2025 to 5 January 2026, but we have also secured a unique agreement from industry to implement the restrictions on a voluntary basis from 1 October 2025 as though they had taken effect. We estimate that the advertising restrictions will remove up to 7.2 billion calories from UK children's diets per year and deliver around £2 billion in health benefits to the economy over the lifetime of the policy, derived from preventing obesity-related illnesses in this generation of children once they become adults.

The NHS and Local Authorities continue to deliver weight management services and treatments to help individuals living with obesity to lose weight. The NHS is making new medicines that have been approved by the NIHR for managing obesity available in line with its commissioning responsibilities. NHS England has a plan to make tirzepatide available to 220,000 people over the next three years, prioritised based on clinical need. In our 10 Year Health Plan for England, we also committed to expanding access to the NHS Digital Weight Management Programme to 125,000 more people per year, and to establish pioneering relationships with industry to test innovative models of delivering services and treatments.

To that end, in August 2025 we announced a new Obesity Pathway Innovation Programme, with joint government and industry investment to explore new innovative approaches to treating obesity in the NHS. In July 2025, the 10 Year Health Plan for England included a commitment to create a new digital NHS points scheme where people are rewarded for taking positive actions to improve their health. The plan references the pilot of a health incentive scheme in Wolverhampton – which rewarded some people with points exchangeable for gift vouchers for making healthy choices – and helped increase participants' physical activity and improved their diets. We will shortly launch a market

engagement process to start the conversation with business about what behaviours could be incentivised.

Alongside these important commitments, we laid legislation in 2024 to introduce the mandatory fortification of non-wholemeal wheat flour with folic acid from 2026. We have worked with the Department for Environment, Food and Rural Affairs and devolved governments to deliver this significant public health intervention across the UK, which will improve the maternal health of women and prevent around 200 neural tube defects in babies, including life-changing conditions such as Spina Bifida.

Health promotion marketing campaigns

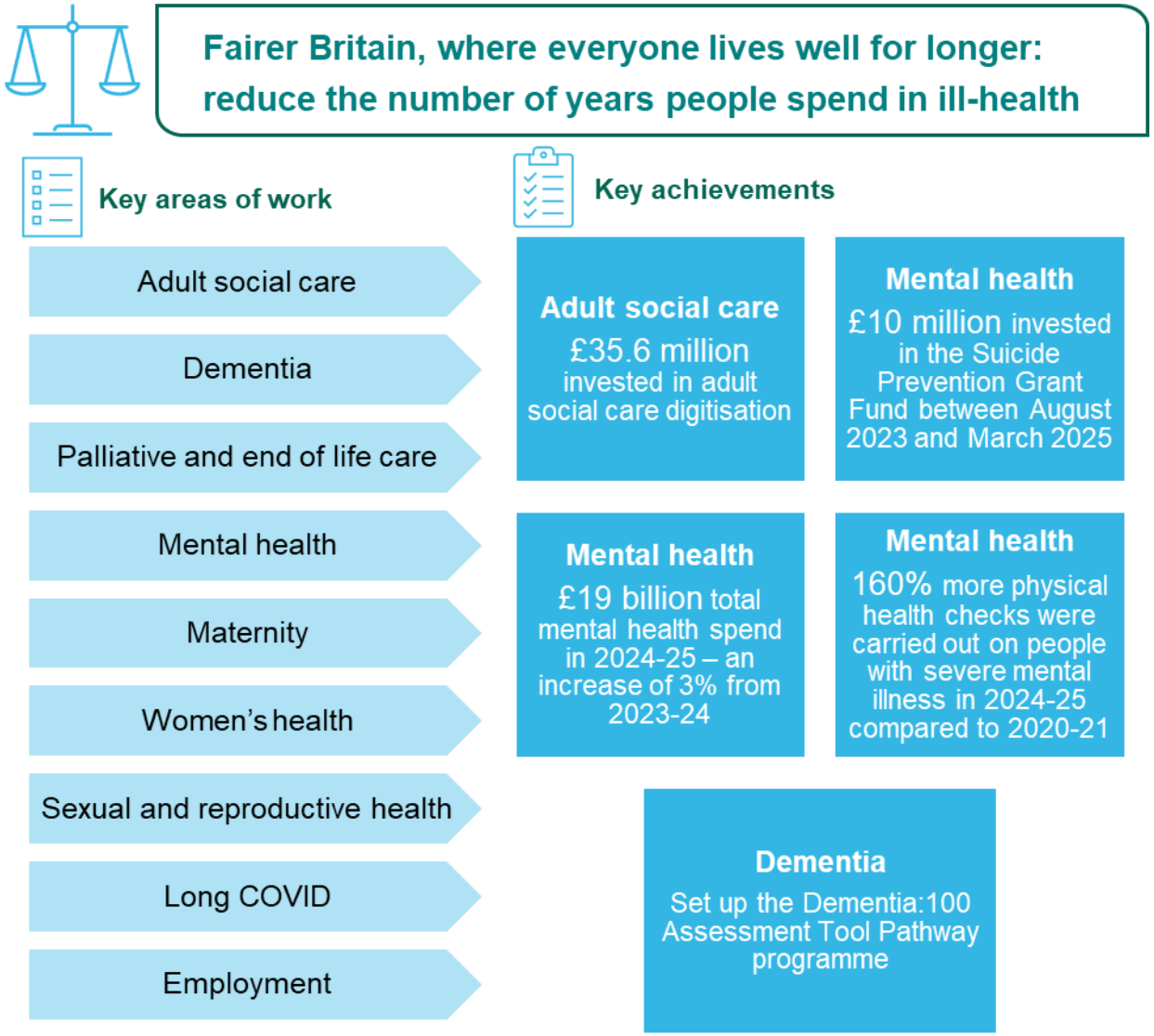
In 2024, there was an overall increase of over three million in user interactions across the Better Health app and web portfolio with 19.8 million user interactions. Our running app, Couch to 5k, was downloaded 820,800 times and there were 2.4 million active users. A New Year promotional push in partnership with the BBC saw BBC Morning Live launching a Couch to 5k challenge, which invited viewers to sign-up and share their stories. In the first 24 hours there were over 1,000 sign-ups.

Toolkits and assets were provided to partners to plan local activity for Stoptober; there were 22,069 total downloads of assets, a 122% increase from 2023. In addition to Stoptober, a further smoking cessation campaign ran from December 2024 to April 2025. The campaign was supported by Kim Marsh, who spoke about her experience of quitting smoking for her family. During this four-month period there were nearly 80,000 downloads of the Quit Smoking app. One-in-two app users who start a quit attempt achieve 28 days smokefree that year, meaning they’re five times more likely to quit for good.

A Youth Vaping campaign, aimed at 13- to 18-year-olds, highlighted that young people are vulnerable to health risks. This campaign was primarily on social media and used influencers to speak directly to a younger audience.

Start for Life also ran a campaign with the Department for Education on the Home Learning Environment called Little Moments Together, which focused on encouraging parents to undertake behaviours to increase their child’s speech and language skills.

Strategic outcome three



Adult social care

DHSC worked with the adult social care sector and other partners to help drive improvements in the quality of adult social care, maintain the operational resilience of the adult social care system and support effective flow between health and social care settings.

By helping people maintain their independence and wellbeing, supporting unpaid carers and supporting recovery after illness or injury, adult social care makes a direct and lasting contribution to healthier, longer lives. In 2024-25, DHSC announced and progressed adult social care reforms, which focus on three key objectives:

- help people and their carers to be empowered in their community to lead fulfilling, independent lives, managing their care and support in a way that works for them
- join up services at a neighbourhood level so people receive seamless support, and

- radically improve the quality of social care through a professionalised and valued workforce. Social care workforce is covered at page 69 in the Workforce cross-cutting chapter of this Performance Report.

These reforms are helping to build the foundations for a National Care Service, on which the independent commission chaired by Baroness Casey will make recommendations. They are also supporting the development of more integrated health and social care services, in line with the aims and objectives of the neighbourhood health service set out in the 10 Year Health Plan for England.

Adult social care outcomes

The Adult Social Care Outcomes Framework (ASCOF) tracks how well adult social care supports people's lives. The latest data (published December 2024, covering 2023–24) shows the key 'adjusted quality of life' score remains stable at 0.417 out of 1.000. This suggests that, on average, local authority-funded care is improving people's quality of life by the equivalent of nearly £30,000 a year in social value (using 2020-21 Green Book Quality Adjusted Life Years values).

Table 3: Adjusted social care-related quality of life (out of 1.000)

Year	Adjusted social care-related quality of life score (out of 1.000)
2023-24	0.417
2022-23	0.411
2021-22	0.407
2020-21	-
2019-20	0.401

Source: Adult Social Care Outcomes Framework 2023-24. The gap in 2020-21 is due to the impact of the Covid pandemic.

Adult social care user satisfaction

In 2023-24 (latest data available), 65% of adult social care users were extremely or very satisfied with their care and support in England, compared to 64% in 2022-23, as reported in the Adult Social Care Outcomes Framework.

CQC local authority assessments

Under the Health and Care Act 2022, the CQC has a duty to assess local authorities' delivery of their adult social care duties. Assessments started in December 2023 and in 2024-25, CQC published its first reports of how local authorities are meeting their duties under Part 1 of the Care Act 2014. By March 2025, CQC had published 27 assessments, with ratings of Outstanding (4% of local authorities rated by 31 March 2025), Good (57% of local authorities rated by 31 March 2025) and Requires Improvement (38% of local authorities rated by 31 March 2025). Ratings and reports are published on the CQC's

website. The assessments identify local authorities' strengths and areas for improvement, facilitating the sharing of good practice and helping target support where it is most needed.

CQC social care provider assessments

The proportion of social care settings rated Good or Outstanding by the CQC as of 1 August 2024 reduced by one percentage point compared with the previous year, from 83.4% to 82.4%. The proportion is 2.3 percentage points lower than at 31 July 2021, when it was 84.7%. These percentages are based on the most recent rating for each location, which have become more outdated on average over time. Dr Penny Dash found that CQC ratings for social care settings were over three years old on average in her 2024 interim and final reports into CQC's operational effectiveness.

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
1 August 2024 (2023-24 report)	82.4%
1 August 2023 (2022-23 report)	83.4%
31 July 2022 (2021-22 report)	83.3%
31 July 2021 (2020-21 report)	84.7%

Source: CQC State of Care annual reports

Adult social care funding

At the Autumn Statement 2022, the then government announced a two-year settlement for social care, making available up to £4.7 billion in additional funding for 2024-25 in local authorities in England to help support adult social care and discharge. This included £2 billion of new grant funding, of which £1.05 billion was provided through the Market Sustainability and Improvement Fund, including £162 million from the previously announced Fair Cost of Care, and £1 billion was provided through the Discharge Fund.

Local authorities were also allowed to increase the adult social care precept by up to 2% in 2024-25, which raised a total of £609 million.

Local authorities budgeted for their net current expenditure on adult social care (which excludes spending funded via the NHS) to be £24.5 billion in 2024-25, £2.1 billion (+9.1%) higher in real terms than in 2023-24.

Adult social care resilience

DHSC continues to work closely with cross-government and sector partners to monitor emerging and ongoing risks to operational resilience in the adult social care sector. The most significant risk is major provider failure (MPF), which appears on the National Risk

Register overseen by the Cabinet Office. Contingency planning for MPF remained an important element for DHSC's work on adult social care throughout 2024-25.

DHSC continued to monitor and plan contingencies for a wider set of acute risks, including cyber-attacks, fuel shortages, national power outages and infectious disease outbreaks, working with key sector and government partners. We have well-established channels for communicating with the adult social care sector to co-ordinate a system response when needed, for example, when Mpox Clade I was declared a public health emergency by the World Health Organization in August 2024.

We are applying lessons from COVID-19 and our response to Mpox Clade I and continue to build capability to respond to a future pandemic.

Digitising social care

During 2024-25, £35.6 million was invested in adult social care digitisation, building on over £90 million from previous years. Delivered in partnership with NHS England through the Digitising Social Care programme, the investment targeted the adoption of digital social care records (DSCRs) and other promising care technologies by care providers.

DSCR adoption rose from 63% in March 2024 to at least 75% of CQC-registered providers in March 2025, covering 85% of people in receipt of care. By March 2025, 16 DSCR solutions had met assured standards, including GP Connect integration, which expanded to 3,245 providers from 1,646 providers in March 2024.

The Adult Social Care Technology Fund supported eight projects across England to scale and evaluate a range of care technologies. Evaluation reports from these projects are expected from late 2025 through to 2026, building the evidence base for future investment.

DHSC also continues to work with the Better Security, Better Care Programme to strengthen compliance with cyber standards across adult social care. Compliance with the Data Security and Protection Toolkit has gone from 69% in March 2024 to over 72% as of March 2025, helping to ensure digital transformation is safe and secure.

Adult social care data transformation

In 2024-25 work on data transformation for adult social care focused on consolidating existing efforts to develop new data collections and publications, improve existing ones and address gaps in the availability and completeness of adult social care data. Data use was expanded to measure key outcomes and monitoring to support quality and delivery of care. Published data and statistics volumes increased. The Client Level Data (CLD) dashboard was developed further for use by local authorities – 97% of local authorities had used it to access data and one third returned monthly for data updates. Expanded use of CLD provided greater insight into the characteristics, needs, experiences and waiting times of individuals using local authority funded care.

Regular (monthly and ad-hoc) data collection from care providers was maintained via the Capacity Tracker and with sector collaboration to improve and simplify data collection. New CLD and Capacity Tracker statistics were included in the monthly adult social care publication. February 2025 saw the release of the 2023 Adult Social Care Workforce Survey findings, revealing how working conditions, system capacity, skills, and relationships affect workforce wellbeing and recruitment/retention.

Improvement and support for adult social care

In 2024-25, £17.6 million was provided to sector partners (Local Government Association, Association of Directors of Social Services, Social Care Institute for Excellence, Think Local Act Personal, and Care Providers Alliance) to deliver a programme of support to local authorities. The programme helped local authorities and their partners to meet their statutory duties, improve services and tackle operational challenges. It 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, including support after CQC local authority assessments.

The Health and Care Act 2022 established new powers for the Secretary of State to intervene where a local authority is failing to discharge Care Act functions to an acceptable standard. The Secretary of State did not use these powers in 2024-25. We have continued to prepare to support local authorities should they be found to be failing, including by growing our pool of sector experts to deliver intensive support on behalf of the Secretary of State, should they be needed.

Innovation in adult social care

In 2023 DHSC launched the Accelerating Reform Fund, which provided grant funding to local authorities to support innovation and scaling in adult social care, and to drive improvements in services to support unpaid carers. This fund ran throughout 2024-25, building on the £20 million of grant funding provided in March 2024 with a further £22.6 million released to local authorities in December 2024. An independent evaluation of the fund is being conducted by Ipsos and is due to be completed by July 2025.

In 2025-26, we will be undertaking further work to support local authorities to digitise and streamline their assessment processes, including testing the need for a national platform to improve access to the adult social care system and publishing procurement guidance, termed the Foundational Specification, setting out ‘what good looks like’ for local authority digital care systems to promote efficient and effective procurement.

Housing/ Disabled Facilities Grant

Funding for the Disabled Facilities Grant of £625 million was allocated to local authorities in May 2024. The Autumn Budget provided an extra £86 million for 2024-25 to support

around an additional 7,800 adaptations to homes for those with social care needs to reduce hospitalisations and prolong independence. This uplift was distributed in February 2025 and brought the total for 2024-25 to £711 million.

The independent report by the Older People's Housing Taskforce 'Our future homes: housing that promotes wellbeing and community for an ageing population' was published in November 2024. This taskforce, which launched in May 2024 and ran for 12 months, considered options for the provision of greater choice, quality and security of housing for older people. Its objectives were to examine enablers to increased supply and improving housing options for older people in later life, and to explore ways to unblock any challenges.

Independent Commission into adult social care and immediate reforms

Baroness Casey was asked by the Prime Minister earlier this year to lead an independent commission into adult social care. This will set out the roadmap towards delivering a National Care Service and building an affordable, high quality social care system sustainable for the future. The first phase will report in 2026 and the second phase by 2028. The Commission launched in April 2025.

The Commission sits alongside the government's immediate reforms to adult social care announced in January 2025, which include increasing digitisation and adoption of care technologies across providers and local authorities, funding thousands more home adaptations, supporting care workers to deliver health interventions in the home and professionalising the workforce.

Dementia

Following an initial investment of £460,138 in 2023-24, in 2024-25 the government invested £57,570 in the Dementia 100: Assessment Tool Pathway programme, which brings together multiple resources into a single, consolidated tool.

Designed to reflect best practice and assess the effectiveness of dementia services, these criteria include 14 top-priority areas and support high-quality, person-centred and integrated care. By helping places and systems identify where improvement needs to be targeted, the tool continues the work of the Dementia Care Pathway, covering all elements of the Well Pathway from Prevention through to Dying Well.

The tool can be downloaded and used locally and includes a range of supporting information and links to national policy and guidance. Additionally, it provides an easy-to-use dashboard and improvement plan to aid strategy and service development. Local systems will be able to use the toolkit to inform their commissioning of dementia care and improve their support offer to people living with dementia.

Palliative care and end-of-life care

The NHS, alongside the independent sector, continued to provide palliative and end of life care throughout 2024-25. In 2023-24,(the most recent year for which data is available) the number of people on the supportive palliative care register increased by 18.9 per cent from 290,443 to 345,261 (Palliative and End of Life Care Profiles | Fingertips | Department of Health and Social Care).

Palliative care and end of life care are broad, holistic approaches provided through a range of professionals and providers, generalist and specialist across the NHS, social care and voluntary sector organisations. Therefore, the cost of provision is difficult to measure as relevant consultations and tasks are not always coded as palliative care or end of life care. However, we have supported the hospice sector with a £100 million capital funding boost - £25 million in 2024-25 and £75 million in 2025-26 – for adult and children's hospices, to ensure they have the best physical environment for care, and a further £26 million revenue in 2025-26 (increased from £25 million in 2024-25) to support children and young people's hospices.

We are focused on long-term sector sustainability within the context of our 10-Year Health Plan and this will improve data collection.

Social prescribing

Social prescribing is a key component of the NHS's universal personalised care and is a way for GPs, other statutory services and local agencies to refer people to a social prescribing link worker. 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 activities are commissioned locally, utilising community assets often in the voluntary, community and social enterprise sector.

As of end of March 2025, the number of social prescribing link workers recruited was 3,479 full time equivalents (FTE) since the beginning of the national roll out in 2019. In September 2024 there had been over 2.8 million referrals (rolling referral numbers are no longer measured beyond this date). There is a growing evidence base for the effectiveness of social prescribing and research by the National Academy for Social Prescribing (NASP) suggests social prescribing schemes can deliver between £2.14 and £8.56 in social and economic value for every £1 invested. Details are in the Building the economic case for social prescribing report.

Phase 2 of the cross-government 'Preventing and tackling mental ill health through Green Social Prescribing' programme, led by Defra, came to an end on 31 March 2025. An evaluation of this phase will be published at the end of 2025.

Mental health and neurodevelopmental conditions

Lord Darzi's Independent investigation of the NHS in England confirmed around one million people were waiting for mental health services as of April 2024 and demand remained high throughout 2024-25.

As part of the government's mission to build an NHS that is fit for the future DHSC committed to providing access to a specialist mental health professional in every school in England, creating a network of open access community Young Futures hubs, recruiting 8,500 mental health workers and modernising the Mental Health Act. DHSC has been working closely with NHS England and other cross-government and sector partners to scope and take forward the early work on these commitments. This has also included work to ensure mental health is embedded and considered across all government missions. In November 2024, the Mental Health Bill was introduced into the House of Lords.

The Bill will modernise the Mental Health Act to give patients greater choice, autonomy, enhanced rights and support, and ensure everyone is treated with dignity and respect throughout treatment. The Bill also includes measures to improve the care and support of people with a learning disability and autistic people, reducing reliance on hospital-based care for people who could be better supported in the community. The Bill is expected to receive Royal Assent in by the end of 2025 subject to Parliamentary scheduling.

Between August 2023 and March 2025, £10 million was made available through the national Suicide Prevention Grant Fund 2023 to 2025 to 79 voluntary, community and social enterprises in England focused on supporting priority groups and reducing inequalities. An evaluation of the impact of the Grant Fund and the services provided by the grant-funded organisations is ongoing.

DHSC launched a Shared Outcomes Fund project, backed by £8 million, to boost and evaluate the impact of 24 existing early support hubs, which offer mental health support and advice to young people without the need for a referral by a doctor or school. Funding of £7 million is being made available in 2025-26 and the findings from the external evaluation of the project are expected by summer 2026.

NHS England launched six pilot 24/7 neighbourhood mental health centres bringing together community, crisis and evidence based inpatient care to support patients with their mental health, welfare, employment, and social care needs.

In the Autumn 2024 Budget, the government announced that funding would be prioritised to deliver expansions of NHS Talking Therapies for common mental health conditions and Individual Placement and Support schemes for people with severe mental illness. £26 million in capital investment was also committed to open new mental health crisis centres to reduce pressure on busy A&E services.

Total mental health spend increased from £14.3 billion in 2020-21 to £19 billion in 2024-25, an increase of around 33%.

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 2024-25.

The NHS has made progress in expanding mental health services. In the 12 months until the end of March 2025, 829,308 children and young people were in contact with NHS mental health services (45% more than March 2021), and 63,784 people accessed perinatal mental health services (102% more than in March 2021). 315,118 physical health checks were carried out on people with severe mental illness in 2024-25,160% higher than 2020-21 with 121,030 physical health checks (note: the data collection for SMI health checks changed in March 2024 and therefore figures may not be directly comparable).

Lord Darzi's report highlighted that, nationally, demand for assessments for autism and attention-deficit hyperactivity disorder (ADHD) has grown significantly in recent years and that people are experiencing severe delays for accessing such assessments.

In March 2024, NHS England commissioned an independent ADHD taskforce which brought together those with lived experience with experts from the NHS, education, charity and justice sectors to consider the challenges affecting those with ADHD, including in accessing services and support, and how to address them. The Taskforce worked closely with the Department for Education's neurodivergence task and finish group and the Department for Work and Pension's expert academic panel on neurodiversity and employment. We are pleased that the final report NHS England Report of the independent ADHD Taskforce was published on 6 November 2025 and we are carefully considering its recommendations.

NHS England continued to support local systems and services to support them in implementing NHS England's national framework and operational guidance for autism assessment services, published in April 2023.

Maternity

The programme of work to make maternity and neonatal care safer, more personalised and more equitable continued through NHS England's three-year delivery plan (2023-2026). Actions implemented through that plan in 2024-25 include:

- concluding the pilot of a training programme to help avoid brain injury in childbirth, improving safety for mothers and their babies, ahead of national rollout

- senior leadership from all 152 perinatal sites across England have now participated in the Perinatal Culture and Leadership Programme. This programme supports the development of compassionate, inclusive and collective leadership

- continued implementation of version three of the 'Saving Babies' Lives Care Bundle' which brings together evidence-based best practice to reduce perinatal mortality. By the end of 2024-25, over 90% of maternity providers in England were on track to fully implement the bundle

- 86% of trusts were providing seven-day maternity and neonatal bereavement services by the end of 2024-25 (up from 70% in July 2024) so more families have access to this specialist care when they need it most

- an additional £3 million of funding for maternity and neonatal voice partnerships (MNVPs) in 2025-26 and 2026-27, with a part-year effect of £1.2 million in 2024-25. This funding is part of additional investment in maternity and neonatal services over three years that was announced in the spring budget. ICBs should already be providing appropriate levels of funding and resourcing to MNVPs, and therefore the additional funding recognises the central role MNVPs play in helping to improve care as outlined in Maternity and neonatal voices partnership guidance, and the need to strengthen the neonatal parental voice component

- as of March 2025, Maternal Mental Health Services were live in 41 Integrated Care Services (ICSs), but in two the service did not cover the whole ICB area. 64,772 service users had been supported by Specialist Perinatal or Maternal Mental Health Community Services over the previous 12 months. This is an 11% increase from March 2024 when 58,303 service users were supported by these services. Maternal Mental Health Services were live in all 42 ICSs by July 2025, and

- an early warning system designed to help drive down rates of avoidable term events including stillbirth, neonatal death and brain injuries (the Maternity Outcomes Signal System) was piloted in seven trusts.

In October 2024, the Baby Loss Certificate service was extended to historic losses, with no backdate, as well as future losses. Over 100,000 certificates had been issued by 31 March 2025, with almost 60,000 issued in 2024-25. We also delivered other recommendations from the Pregnancy Loss Review including the publication of updated guidance on the sensitive handling of pregnancy remains to help ensure appropriate disposal in healthcare settings.

DHSC continued to monitor progress against the National Maternity Safety Strategy ambition 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, which means the figures below

do not reflect the impact of most recent interventions to improve the following outcomes published in the ONS Child and Infant Mortality statistics:

- stillbirth rate for England was 3.9 per 1,000 births in 2023 (2,230 stillbirths in total). This is 22% lower than the rate in 2010

- neonatal mortality rate for England was 1.4 per 1,000 live births born at 24 weeks or over in 2023 (799 neonatal deaths in total). This is 28% lower than the rate in 2010, and

- pre-term birth rate for England was 8.1 per 100 total births in 2023 (45,655 pre-term births in total). This is 10% higher than the rate in 2010.

- In addition, as per figures published in MBRRACE-UK Maternal Mortality data, maternal mortality rate for England was 12.7 maternal deaths per 100,000 maternities in 2021-23 (254 maternal deaths in total). This is 19% higher than the rate in 2010.

There was significant growth in the maternity and neonatal workforce throughout 2024-25, including improved retention demonstrated by sustained falls in leaver and turnover rates. In line with safe staffing levels, in February 2025, there were 24,991 FTE midwives in post, an increase of 8% (over 1,300 FTE) on the previous 12 months.

In September 2024, the Care Quality Commission (CQC) published its national review of maternity services in England. The Maternity Inspection Programme inspected 131 maternity units and the findings echoed those of previous reports. DHSC and NHS England continues to take into account the CQC's findings and recommendations within ongoing work to improve maternity services and to ensure that trusts failing on maternity care are supported to make rapid improvement.

In March 2025, and following his appointment by DHSC in July 2023, Dr Bill Kirkup CBE presented his report to DHSC with recommended actions to improve teamwork and culture in maternity services. This report built on recommendations from his 2022 report, 'Reading the Signals: maternity and neonatal services in East Kent'.

On 23 June 2025, the Secretary of State for Health and Social Care announced that we will be launching an independent Investigation into NHS maternity and neonatal services. This will seek to understand the systemic issues behind why so many women, babies and families experience unacceptable care, and to rapidly put in place solutions to improve maternity safety and quality. The investigation will produce, by December 2025, one set of clear national recommendations to drive the improvements needed to ensure high quality care and that women are listened to. We are also establishing a National Maternity and Neonatal Taskforce, which the Secretary of State will chair. The Taskforce will use the recommendations from the investigation to develop a national plan to drive improvements across maternity and neonatal care.

Start for Life

March 2025 marked the end of the first three years of the joint DHSC and Department for Education Family Hubs and Start for Life programme. In 2022, DHSC invested £176 million over three years in 75 local authorities in England with high levels of deprivation to establish Start for Life services, to support the period from conception to the age of two. Start for Life services are delivered through networks of family hubs, and we have seen thousands of babies and their families benefitting from services in their area.

In May 2024, Ofsted and the CCQ published a thematic review into families' experiences of Start for Life services. Findings include: families accessing Start for Life services through a family hub have a positive experience; parents reported that they were more confident in feeding their infants; that they had better perinatal mental health themselves; and that they felt that their children achieved better outcomes.

Regional delivery teams worked with and supported the 75 funded Local Authorities (LAs) throughout 2024-25 to deliver the programme expectations. Achievements include:

- all 75 LAs have a clear and joined up universal Start for Life offer, that provides the essential support that families need
- all 75 LAs have established parent and carer panels, through which caregivers can share their views on both the design and delivery of local support
- delivery of new and enhanced local 1:1 support to help parents to meet their breastfeeding goals, and
- delivery of new and enhanced perinatal mental health, parent-infant relationship and parenting support.

In 2024-25 DHSC also delivered a number of national initiatives as part of the Family Hubs and Start for Life programme including:

- new trusted NHS advice and guidance for families to access to help build a secure relationship with their baby and support development, through the 'If they could tell you' public awareness campaign (March 2024)
- providing access to round-the-clock support and advice about breastfeeding through the extension of the National Breastfeeding Helpline opening hours (May 2024)
- the delivery of national training programmes for frontline practitioners to provide evidence-based support for parent-infant relationships (March 2025)

- launching the National Centre for Supervision for Parent-Infant Relationships, which provides high quality reflective supervision to practitioners (May 2024)

- publishing guidance for practitioners on starting conversations about parent-infant relationships to help identify babies, parents and carers who could benefit from support (March 2024), and

- continuing to improve our knowledge of innovative workforce models through the delivery of pilots in five local authority areas to test ideas on how best to support the workforce.

Whilst considerable achievements have been made, challenges persist. One of the most significant is workforce, recruitment of trained healthcare professionals such as health visitors and the limited capacity of others such as midwives is challenging in most areas.

In January 2025, the government announced funding for the continuation of the Family Hubs and Start for Life programme in 2025-26, delivering on the government's Plan for Change. DHSC will invest a further £57 million in 2025-26 to ensure the 75 Local Authorities currently on the programme continue to deliver Start for Life services for babies and their families.

Women's health

Women's health hubs

During 2024-25, rollout of at least one pilot women's health hub in every local system continued under a £25 million pilot programme. As of March 2025, 41 out of 42 ICBs reported to NHS England that they had opened at least one women's health hub.

Network of women's health champions

The Network of Health Champions met seven times between 1 April 2024 and 31 March 2025. The network is made up of representatives from each integrated care system and was set up to share insights and discuss best practice on local implementation of women's health services.

Gynaecology waiting lists

The Elective Reform Plan discussed at page 21, also addressed gynaecology waiting lists through offering patients care closer to home, piloting gynaecology pathways in CDCs and supporting DHSC's partnership with the independent sector to reduce waiting lists.

Eliminating cervical cancer by 2040

In March 2025 NHS England published their cervical cancer elimination by 2040 – plan for England.

Hormone replacement therapy pre-payment certificate

542,269 pre-payment certificates for hormone replacement therapy (HRT) were purchased between April 2024 and March 2025. The HRT prescription prepayment certificate enables women to pay under £20 for all their listed HRT prescriptions for the year, improving access to treatment for menopause symptoms.

Sexual and reproductive health

The government is committed to ensuring good sexual and reproductive health for everyone. As set out in the manifesto, it has commissioned a new Human Immunodeficiency Virus (HIV) Action Plan (HIVAP) to end HIV transmission in England by 2030. DHSC has also begun work on the HIVAP 2025 – 2030, with a DHSC-led working group together with NHS England and the UK Health Security Agency.

15 roundtables and discussions have been held with system partners, including the voluntary and community sector and people with lived experience. £27 million of additional funding from DHSC budgets has also been confirmed to expand the highly successful NHS emergency department opt-out HIV testing programme in 2025-26.

DHSC has also committed an additional £1.5 million of funding to extend the delivery of the National HIV Prevention Programme for England to 2025-26, including National HIV Testing Week (NHTW) and other campaigns to improve information and testing for HIV and other sexually transmitted infections. NHTW 2025 delivered more than 22,000 self-testing and self-sampling kits to key populations, showing great results with communities disproportionately affected by HIV such as people from black African ethnicities and women. Self-testing by women increased in every region of England, with a nearly 41% increase in total self-testing orders when compared with 2023 and orders from women from an ethnic minority background formed 49% of the total orders of self-testing kits placed by women. The Get Ready for a Hot Summer campaign was also delivered in summer 2024, focusing on raising awareness of why and how to prevent sexually transmitted infections including HIV.

On 19 September 2024, DHSC announced that Nexplanon (the UK's only contraceptive implant) was due to be published in the Statement of Financial Entitlements on 1 October 2024. From 1 January 2025, general practices have been able to order, keep in stock and administer Nexplanon to their patients as needed. We expect this change will reduce barriers for younger women in particular accessing Nexplanon as they are more likely to use the contraceptive implant to prevent pregnancy.

DHSC has also 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.

Long Covid

Data on long Covid service use and waiting times is not available at the national level for 2024-25.

During 2024-25, following the transition to ICB commissioning and oversight at the beginning of the financial year, funding for long Covid services was allocated based on the 2023-24 distribution, to minimise disruption to funding flows and to maintain services for people with long Covid. In the commissioning guidance for post-Covid services for adults, children and young people, published in 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 onwards.

NHS England completed a long Covid and Myalgic Encephalomyelitis (ME)/Chronic Fatigue Syndrome (CFS) stocktake in January 2025, aiming to provide a nationwide overview of service delivery in commissioning and contracting, assessing access, activity and outcomes. The findings confirmed the widely recognised challenges of significant variation in care delivery across England and a lack of comprehensive activity data. Executive NHS England board members were updated on the current provision of long Covid and ME/CFS services, noting those challenges. Discussions considered service prioritisation and potential Covid inquiry recommendations. It was agreed that long Covid and ME/CFS services are rightly commissioned by ICBs, which have responsibility for ensuring coverage for their population.

Employment

Unemployment is associated with an increased risk of mortality, long-term illness, cardiovascular disease, poor mental health, suicide, and health-harming behaviours. Good quality employment is an important determinant of good health.

Among the working age population, long-term health conditions and disability are common, and often act as a barrier to employment. In the first quarter of 2025, an estimated 2.78 million people were economically inactive citing long-term sickness as the primary reason. The proportion of economically inactive disabled people who wanted a job in 2023-24 was 20.6%.

Alongside the £22 billion investment to the NHS at the Autumn Budget 2024, the Government also announced a £240 million Get Britain Working fund ensuring every area has a plan to tackle economic inactivity, backed up by new funding for making a more locally led system a success. Some of the activity commences in the 2025-26 financial year, notably the Joint Work and Health Directorate and NHS England Health and Growth Accelerators programme.

Further investment was announcement at the Spring Statement 2025 for health, skills and employment support from 2026-27.

The Joint Department for Work and Pensions (DWP) and DHSC Work and Health Directorate was created in recognition of the significant link between work and health and to reflect a shared agenda of opening up opportunities for disabled people and people with health conditions. Work delivered that was jointly funded by DHSC and DWP has included:

- Employment Advisors in NHS Talking Therapies which is an integrated service to improve both mental health and employment outcomes. Employment support has been provided across 156 sites in all 42 NHS ICBs. Employment Advisers in NHS Talking Therapies was accessed by 90,019 people during 2024-25 and the goal of providing employment support in every NHS ICB by March 2025 has been met. However, meeting recruitment targets for Employment Advisors has been challenging due to funding uncertainty post-March 2025, and

- Occupational Health Innovation Fund projects, which have increased access to Occupational Health services for self-employed, micro, small, and medium-sized enterprises.

Work funded by DWP which was delivered in partnership with DHSC has included:

- the WorkWell pilot was launched in October 2024 to tackle ill-health related economic inactivity by providing low-intensity support to help people stay in or return to work. It is funded by DWP and delivered by 15 NHS ICBs, providing a single gateway to local services through joining up the NHS, local authorities, Job Centres and voluntary sector organisations. As of March 2025, around 5,000 people have started the WorkWell programme. Demographic data demonstrates that support is being utilised by both in-work and out-of-work groups. An externally commissioned evaluation will provide fuller evidence on the process, impact and value for money of the WorkWell programme. The evaluation began in April 2024 and will run consecutively culminating in a final evaluation report in autumn 2028

- Getting It Right First Time (GIRFT) Musculoskeletal (MSK) Community Delivery Programme funded by the Joint Work and Health Directorate aims to enhance access to quality treatment for MSK conditions and reduce waiting times for community MSK appointments, improving health outcomes and reducing health-related barriers to work. NHS ICBs participating in the GIRFT MSK Community Delivery Programme have reported overall reductions of over 20% to Community MSK 18+ week waiting list numbers between December 2024 and March 2025. Evaluation activity is planned to establish the impact of the programme on waiting list reductions, and

- support with Employer Health and Disability which is an online service designed to help employers support employees with health conditions and disabilities in the workplace. This service helps businesses navigate the government’s offer and

apply it in practice. In 2024, digital discoveries identified areas of need or duplication across workplace-facing products and services to help shape the future offer to employers and employees. This includes working with other areas of government and expert stakeholders, including disabled people’s organisations, to improve user experience.

Cross-cutting work area 1 – Workforce

Cross-cutting work area 1: Workforce

NHS workforce

Workforce numbers

As of March 2025, there were over 7,100 more doctors and over 14,100 more nurses and health visitors working in the NHS in hospital and community health service settings than in March 2024.

As shown in **Table 5**, data for March 2025, published by NHS England, shows that there are almost 1.38 million full-time equivalent (FTE) staff working in the NHS. This is an increase of over 33,400 compared to March 2024.

Table 5: FTE workforce numbers since 2020

	Doctors	Nurses and Health Visitors	All Staff
Mar-20	118,449	300,497	1,139,422
Mar-21	124,078	311,137	1,197,747
Mar-22	128,392	321,624	1,226,677
Mar-23	133,807	334,132	1,280,350
Mar-24	140,774	355,283	1,345,047
Mar-25	147,931	369,449	1,378,470

Source: NHS England workforce statistics

As of March 2025, vacancy rates in NHS providers are lower than pre-pandemic rates. Data published by NHS England showed that there were over 100,100 vacancies in NHS provider trusts as of March 2025, equivalent to 6.7% of the workforce. This is slightly below the 6.9% vacancy rate in March 2024 (100,600 vacancies) and below the 8.1% in March 2019, when there were 96,300 vacancies but a smaller overall workforce.

GP workforce data

The number of doctors in general practice has shown positive signs of growth over the last 12 months. As of March 2025, there were 938 FTE more doctors working in general practice compared to March 2024, an increase of 2.5%, as well as 341 FTE more GPs working in PCNs over the same period, an increase of 92%. The Additional Roles Reimbursement Scheme has been a key driver of this growth, having increased the number of newly qualified GPs in the workforce by 1,145 FTE in March 2025.

Workforce planning

The 10 Year Health Plan (10YHP) has set the strategic direction for the health service over the next decade, and includes a chapter entitled ‘An NHS Workforce Fit For the Future’. As set out at the start of this Annual Report, this chapter was developed based on a mass engagement exercise, including with over 4,000 staff and public workshops and deliberative events, and an enabler group of experts from across the system. We are exploring ways the workforce will need to adapt to meet the ambition to make the three shifts (described on page 6 of this Annual Report and Accounts) set out in the plan a reality. This will include how we can free up more time for staff to spend delivering patient care. Following the publication of the 10YHP, we will deliver the refreshed workforce plan. This will set out in more detail how the government will support and enable the workforce to deliver the transformed service.

Industrial action

DHSC has worked closely with unions and key stakeholders to help improve the working conditions and lives of NHS staff. This work includes:

- reforming exception reporting for resident doctors (formerly, junior doctors) to ensure they are fairly compensated for the additional work they do, and unsafe working practices are identified quickly and addressed
- delivering non-pay workstreams for Specialist and Associate Specialist (SAS) doctors and consultants, and
- accepting 36 of 37 non-pay recommendations for Agenda for Change staff from the 2023 Pay Deal, including investment for a digital job evaluation system.

During 2024-25, resident doctors took five days of strike action from 27 June to 2 July 2024. The resident doctor pay dispute (2022-2024) formally ended in September 2024 following the agreement of a deal with the British Medical Association (BMA) Resident Doctor Committee (RDC).

In 2025-26, the BMA RDC entered into dispute and subsequently secured a mandate for industrial action. They took five days of strike action from 25 to 30 July 2025 and a further five days of strikes began on 14 November 2025. While the BMA’s Consultants and Specialist and Associate Specialist Doctors committees have entered dispute, we hope to work constructively with all unions to avoid disruptive industrial action, improve the working conditions of all NHS staff, and rebuild the NHS.

Pay round

The government accepted the 2024-25 headline pay recommendations in full. We are committed to improving the pay round timetable and we remitted the Pay Review Bodies for recommendations on pay for 2025-26 on 30 September 2024, which is far earlier than in previous years.

We received the NHS pay review body (NHSPRB) and Review Body on Doctors and Dentists Remuneration (DDRB) reports in April 2025 and the Senior Salaries Review Body (SSRB) report in May 2025. The government has formally accepted the independent recommendations made by the pay review bodies. These above-inflation pay uplifts will be backdated to 1 April 2025. NHS staff on Agenda for Change will receive a 3.6% uplift and doctors will receive a 4% uplift. Resident doctors will also receive an additional £750 consolidated payment. We are also funding pay rises of 4% for GPs, with dentists also receiving a contract uplift to increase their pay.

Medical and clinical expansion

205 and 350 new additional medical school places were funded to start in 2024 and 2025 respectively. This included providing government funded medical school places to three new schools for the first time. Any subsequent expansion plans will be confirmed as part of future workforce planning.

We are committed to training the staff we need to get patients seen on time, including more clinical healthcare professionals, and are working closely with partners in education to ensure they remain an attractive career choice. We will publish a refreshed workforce plan to deliver the transformed health service we will build over the next decade and treat patients on time again.

International recruitment

The Code of practice for international recruitment of health and social care personnel in England ensures stringent ethical standards when recruiting health and social care staff from overseas. The Code was republished in March 2025 with minor updates to streamline and improve the guidance. The Code follows the latest guidance from the World Health Organization and active recruitment from ‘red list’ countries with the most vulnerable health systems is prohibited.

Health and Care Worker visa data shows that across 2021 to 2023 the average quarterly number of Health and Care Worker visas granted for healthcare professions was over 8,800. This has fallen more recently, with the latest data from the Home Office showing over 2,700 granted in Quarter 4 of 2024. The decrease in Health and Care Worker visa grants is likely due to a number of factors including the end of the centrally supported nurse international recruitment programme and changes in demand for international staff.

Leadership and professional regulation

There is a significant programme of work underway to strengthen and professionalise NHS leadership, which builds on the Kark (2019) and Messenger (2022) Review recommendations. This includes the Manifesto commitments to introduce professional regulation for NHS managers and the establishment of a College of NHS leadership, plus

wider work (being led by NHS England) to develop professional standards, a national code of practice, and a core training curriculum for NHS managers at all levels.

As a first step towards delivering this commitment, DHSC launched a consultation in November 2024 on options for regulating NHS managers in England. Our response, published on 21 July 2025, sets out plans to regulate NHS managers via a statutory barring system. We will take forward legislative changes so that the Health and Care Professions Council can operate a barring mechanism for NHS board level managers and their direct reports within this Parliament.

These measures will ensure that managers and leaders are equipped to deliver transformation in the NHS and to build a positive and compassionate culture.

Staff experience and retention

Retaining skilled and experienced NHS staff remains a priority. Through its National Retention Programme, NHS England has continued to drive a consistent, system-wide approach to staff retention across NHS trusts. The NHS People Promise Exemplar programme has delivered improvements in staff experience by focusing on flexible working opportunities, leadership and organisational culture. Data published by NHS England on 4 March 2025 has confirmed that this scheme has helped reduce the numbers of workers leaving the NHS, with participating trusts seeing leaver rates fall by an average of 11.8% more than non-exemplar trusts, equating to 4,500 members of staff who have been supported to stay in the NHS.

In March 2025, the Secretary of State launched a joint programme of work with Nuffield Health to provide 4,000 free places to NHS staff to help them manage chronic conditions associated with joint pain such as arthritis. NHS England has also agreed to match fund a programme of work with NHS Charities Together. This will enable local organisations to request grant funding to introduce health and wellbeing initiatives in their organisations. 2024-25 also saw considerable work undertaken by NHS England to address sexual misconduct in the NHS through the publication of a Sexual Safety Charter, with over 400 signatories as well as a refresh of their NHS Violence Prevention and Reduction Standard, which seeks to support employers in assessing risks, identifying training needs and supporting staff who are victims of violence in the workplace.

The 2024 NHS Staff Survey was published on 13 March 2025 and continued to show some small improvements compared to previous years. The staff engagement score has remained at a similar level compared to previous years scoring 6.85 (out of 10) for 2024. This is also the case for the morale score – 5.96 in 2024 compared to 5.94 in 2023. There was a notable increase in medical and dental staff reporting improvements in their satisfaction with pay with an increase of 16 percentage points to 48.40% compared to 32.05% in 2023 (returning close to pre-industrial action levels).

Pensions

There is a growing take up of retirement flexibilities that were introduced to help employers retain the skills and experience of their older staff for longer. Over 28,000 applications for partial retirement have now been received. This option, available since October 2023 as an alternative to full retirement, allows older staff to draw down some or all their pension whilst continuing to work in the NHS.

A major focus for the scheme administrators is delivery of the McCloud remedy for around 1.1 million current and former scheme members. This is a very large programme of work with considerable complexity. DHSC has worked closely with the NHS Business Services Authority to increase their service delivery capacity to address delays and issues in rolling out the remedy.

Looking to the future, the NHS Business Services Authority is scoping a transformation programme to explore the steps necessary to modernise and develop the pension service to provide an excellent member experience.

Adult social care workforce

Adult social care workforce capacity

The latest annual adult social care workforce data from Skills for Care shows that in 2024-25 there were 1.60 million filled posts in the adult social care sector, an increase of 3.4% (52,000 posts) from 2023-24. This follows a 7.4% increase (110,000 posts) in 2023-24.

Skills for Care data shows staff turnover rates in local authorities and the independent sector decreased from 25.8% in 2023-24 to 24.7% in 2024-25. Reductions in workforce turnover indicate more workers chose to remain in posts in the sector, delivering greater continuity of care for users. Data from Skills for Care in 2023-24 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. The turnover rate in 2024-25 (24.7%) was 6.9 percentage points lower than in 2021-22 before the increase in international recruitment.

Fair pay agreement for adult social care

On 10 October 2024, the government published the Next Steps to Make Work Pay plan and introduced the Employment Rights Bill to Parliament. DHSC clauses in the Bill establish a framework for fair pay agreements, through which an agreement for the adult social care sector can be negotiated and reached. The Bill passed scrutiny in the House of Commons in March 2025 and entered the House of Lords.

This plan set out a significant and ambitious agenda to ensure workplace rights are fit for a modern economy, empower working people and deliver economic growth. It laid out the ambition to implement a fair pay agreement (FPA) in adult social care.

In November 2024, DHSC launched the FPA Working Group, a quarterly meeting engaging partners in England FPA development. In addition, five task and finish groups were held between December 2024 and March 2025, working with wider sector partners to focus on specific areas of policy development.

Adult social care workforce careers

In partnership with Skills for Care, DHSC revised and updated the first part of the Care Workforce Pathway. The first part, published in January 2024, focused on direct care and support roles at four levels. The pathway sets out the knowledge, skills, values and behaviours needed to work in adult social care, as well as a clear career structure for the workforce. This will help guide staff to build their careers through training and development and give proper recognition, support integration, and show opportunities for care workers to develop and progress their careers, if that is right for them. Since the Learning and Development Support Scheme launched in September 2024, thousands of care employers have signed up to claim funding towards learning and development for their staff.

Cross-cutting work area 2 – Data and technology

Cross-cutting work area 2: Data and technology

Data for research and development programme

The NHS Research Secure Data Environment (SDE) Network brings together and links data from multiple sources – including imaging, GP and hospital records to support research at scale, providing clinical researchers with richer insights. The NHS Research SDE Network includes the NHS England SDE and 11 regional SDE teams, covering all of England through a federation approach. The Network is able to support research use cases from Artificial Intelligence (AI) development and epidemiology to health systems research and real-world studies. The NHS Research SDE Network is the foundational layer to a strong, data and evidence-based innovation ecosystem.

As of May 2025:

- the NHS Research SDE Network has 420 research projects live or completed within SDEs

- data requests are being turned around in one month by regional SDEs
- the NHS Research SDE Network is supporting 834 users
- as of March 2025, there were 534 unique data sets available across the Network, holding over 200m patient records
- the SDE Network has moved from a system of thousands of data controllers to 12, making it much easier for researchers to easily identify and safely access the data they need
- the NHS Research SDE Network has enabled access to hundreds of billions of individual rows of health records, imaging, pathology, and genomic data sets
- the NHS Research SDE Network has agreed to adopt the Observational Medical Outcomes Partnership – Common Data Model which brings consistency to health data regardless of which SDE it is in
- the SDE Network holds a range of data (different SDEs have different data depending on local buy-in) including genomic, pathology, imaging and GP data, and
- the 'Powerful moments, powered by NHS data' campaign provides real world examples of how the NHS is using patient data to benefit patients and society, including a Stephen Fry fronted video (part of the Prostate Progress initiative) showing how combining clinical data with patient experiences has the potential to revolutionise prostate cancer treatment and care.

Public engagement on data

In order to put public trust and transparency at the forefront of data policy development, DHSC and NHS England are running a national programme of public engagement on data. This £1.5 million programme of engagement aims to meaningfully involve the public in decisions and changes in how their health and care data is used.

Running across 2024-25, the programme has conducted three cohorts of engagement. Each cohort covered a different topic, including:

- the use of data for research – focusing on the governance of secure research environments, and public expectations on commercial models and the value of NHS data
- a single patient record

- the use of GP data for planning and research, including data controllership arrangements, and

- the opt-out landscape.

The programme reached 8,615 people over 2024-25, and thanks to this programme of work, we have generated 29 recommendations across cohorts 1 and 2 from the public (cohort 3 is still in development), which is directly impacting policy development across a range of data topics.

Electronic Patient Record

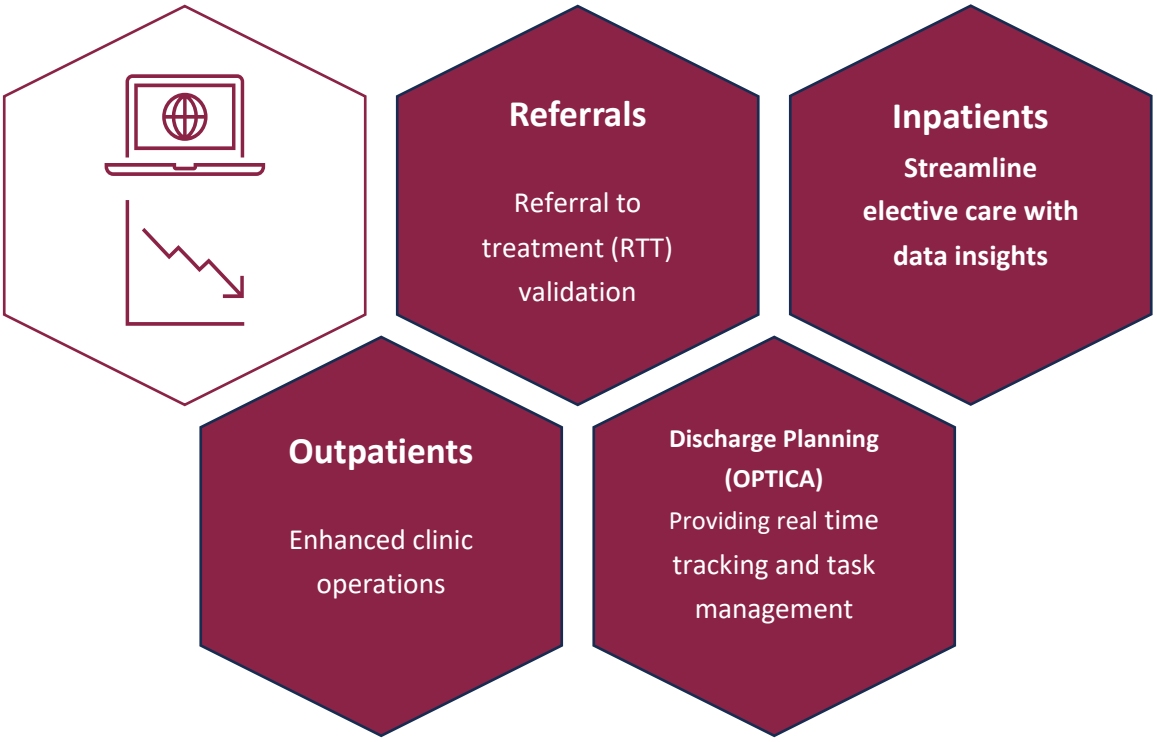
The NHS successfully rolled out Electronic Patient Records in 92% of secondary care trusts, enhancing data accessibility, reducing duplication, improving clinical decision-making, and ultimately leading to more efficient healthcare delivery and better patient outcomes.

Federated Data Platform

The Federated Data Platform (FDP) is a software solution developed by NHS England which enables NHS organisations to securely access, connect, and use operational data from various separate systems. With the total contract valued at £330 million over seven years, total spend on the FDP in 2024-25 amounted to £101 million, which included programme costs and support, internal staff, product delivery, consumption, FDP platform, privacy enhancing technology and internal recharges for cyber and IT operations. In the first full year of operation, the FDP has demonstrated the demand for, and value of, its service, bringing together the data which trusts and ICBs need from different services into a single, secure environment.

As of May 2025, 124 trusts and 41 ICBs have formally signed up to implement the platform. 79 trusts and 39 ICBs are live or in delivery, with 72 trusts realising benefits. NHS England is aiming for 85% coverage of all acute trusts by the end of March 2026. The NHS Manchester ICB is the single ICB to have not yet signed a memorandum of understanding to join the FDP. Work is continuing with the ICB to understand where the FDP can enhance the local investment they have made in systems that currently meet their local needs effectively. This reflects the broader variation in digital maturity across ICBs and trusts nationally, which the FDP programme is designed to support and harmonise over time, enhancing local solutions rather than replacing them. Increased adoption of the FDP throughout 2024-25 means that, on average, an additional 119 patients are being treated per month in theatres.

There are four core products in use now to support elective recovery, with benefits being realised:



Nearly 70,000 extra patients have had procedures in theatres since the NHS FDP began roll out in April 2024, while over 1.1 million records have been reviewed and validated to ensure patients will be seen in the right place at the right time. Further statistics can be found on the NHS England website.

DHSC Chief Data Officer directorate

DHSC's Chief Data Officer directorate leads the development of a DHSC facing data strategy, ensuring data is fit for purpose, improving the flow and speed of data sharing, and ensuring the provision of trusted, curated data sets which are 'analysis-ready'. We run data services that inform decision-enabling resources for ministers and other stakeholders.

We do this through our data services including:

- the Abortion Notification System enabling the Chief Medical Officer to monitor the implementation of the 1967 Abortion Act
- the National Drug Alcohol and Treatment Monitoring System assessing data on substance misuse
- fingertips service, providing access to public health data, providing analysis and insight to inform Public Health Outcomes Framework and a range of Official

Statistics. It allows access to the data directly via API and downloads, as well as managing access to static reports and hosting data, and

- Analytical Cloud Platform, an in house built, DHSC owned Azure data platform. It provides data pipelines for primarily NHS England data with tools for analysts, including compute clusters and dashboarding abilities.

Funding for these services for 2024-25 was costed at £5.5 million.

Artificial intelligence

Artificial intelligence (AI) has the potential to have a transformative effect on the delivery of public services, including in healthcare. We are committed to making the most of the opportunities created by AI, which is why in January the Prime Minister accepted all 50 recommendations from Matt Clifford's AI Opportunities Action Plan. This includes using a 'scan, pilot, scale' model approach to investing and supporting AI development, to ensure that useful AI tools are quickly identified, tested and, where successful, adopted to improve the lives of UK citizens.

In 2019, NHS England jointly with DHSC launched a national AI programme with the aim to accelerate the safe adoption of AI in health and social care settings (known as the NHS AI Lab). The AI Lab had a total spend of £142 million in 2024-25 with some legacy projects stretching into the 2025-26 financial year, with the majority of funding allocated to the AI Award programme, aimed at accelerating technology that aligned with the NHS Long Term Plan. The AI Lab was the first of its kind in the world, with the goal of increasing adoption of AI in the NHS buttressed by a political ambition for the UK to stimulate the economy through AI. The work of the AI Lab has ensured that the UK remains a key player in this field and, if appropriately managed, the foundations established by the AI Lab will continue to deliver benefits in the future.

The AI Lab programme closed in March 2025 and a final evaluation was published.

From 2025-26 the NHS AI Lab project will move to a business-as-usual model, supporting the development, regulation and adoption of AI technologies within our health and care system.

DHSC is testing AI in areas that cause the most harm to health and to our economy, including the following areas:

- **direct care:** to support diagnostic decision-making or note taking
- **non-clinical activities:** to automate routine administrative tasks such as triaging, appointment scheduling and hospital bed management

- **corporate services:** to automate certain back-office functions like finances, estates and hospital administration

- **public health and prevention:** to improve public health campaigns, screening services or using patient-facing apps to encourage healthy habits, and

- **life sciences:** to improve clinical trials, drug discovery or personalised medicines development.

Some examples of work to date include:

- particularly significant progress has been made on the deployment of AI within the stroke pathway – Stroke AI tools that can support doctors to interpret acute stroke brain scans and make decisions about treatment are now in use across 100% of stroke units in England. Early data has shown patient 'door-in door-out' time reduction from 140 to 79 minutes and tripling the chance of independent living following a stroke when these tools are employed. Our objective is to try and replicate this success on deployment across other critical pathways, such as lung cancer

- targeted interventions to accelerate adoption of AI responsibly, for example £21 million ring-fenced for NHS trusts to procure AI diagnostic imaging technologies through the AI Diagnostic Fund targeted at key clinical areas, particularly chest X-Ray and computerised tomography scans. This fund received bids from 95% of acute trusts in the NHS in England, with deployments of AI to target lung cancer diagnosis in 65 acute trusts (50% of the total in England) due to conclude by the end of the year, at which point they will continue on two-year licenses

- speeding up diagnosis: an AI tool that supports the triage of skin lesions suspected of cancer has been deployed across 26 NHS sites. An independent evaluation commissioned by NHS England was published in 2024 that indicates the tool may be at least as good as face-to-face dermatologists in ruling out melanoma. It also found that for each £1 spent using the tool autonomously (without dermatologist review for benign lesions) there is the potential to return £2.3 in savings by triaging benign lesions away from the urgent suspected skin cancer pathway

- improving patient experience and tackling the elective care backlog: During 2024-25, 8,130,747 outpatient appointments were missed, with these missed appointments often termed as 'Did not Attends' (DNAs). In 2023, NHS England highlighted the need to reduce DNAs, in order to improve patient experience and tackle the elective care backlog and suggested that implementation of digital solutions could potentially be a solution. As part of the AI Lab programme, one of the awardees provided their technology which focused on reviewing patient

attendance records to help allocate appointments and reduce the number of DNAs, and

- AI can also increase staff productivity by freeing up staff time from some routine and administrative work. Several NHS trusts are running trials, including a multi-site assessment of the impact of using automated transcription software. The NHS AI team is monitoring these developments and developing guidance for the responsible use of these tools. This guidance will be informed by the government's broader guidance on the use of Generative AI in the public sector.

Promising and reliable estimates of returns on investment have been identified, particularly in relation to research investments in relatively mature technologies and where technological system implementation was accompanied by process and pathway changes. However, the outcomes of experimental investments are difficult to demonstrate in the short-to medium-term. Many benefits are likely to materialise over the long-term and are hard to measure (such as the benefits of regulatory reform and advancing early innovations). However, there are also some benefits in the near term which are easy to measure associated with automation. Some of the most advanced projects funded by the AI Lab have evidenced significant benefits enabled by targeted funding for in-depth evaluation. One successful diagnostic AI Award (E-Stroke by Brainomix) provided £44 million in benefits which is significantly more than the £1.9 million invested in it.

DHSC has developed networks to share insights from the evaluation and lessons learned, supporting broader understanding and adoption of AI in health and care. As part of this effort, the team has set up an AI Ambassador network, where members can connect, share knowledge, and ask questions related to the application and governance of AI across the sector.

Through the National Institute for Health and Care Research (NIHR), DHSC funds awards that utilise AI for a variety of healthcare applications. These include increasing operational efficiencies for the NHS, better ways to diagnose and treat medical conditions and improvements to guide care choices for patients and service users. NIHR funding also enables the linkage, federation, and curation of data to facilitate the development of future clinical uses of AI.

In 2024-25, through NIHR, DHSC invested £87.5 million in research and development of AI in health and social care. Through NIHR research, cutting-edge AI technology is being trialled to help radiologists detect breast cancer earlier. Nearly 700,000 women will take part in the landmark NIHR-funded EDITH ('Early Detection using Information Technology in Health') trial, which was launched in February 2025.

Breast cancer is the most common type of cancer in women, with around 56,000 diagnosed with the disease every year. Currently, women between the ages of 50 and 71

are invited to screening every 3 years. This equates to around 2.1 million breast cancer screenings annually. This helps prevent around 1,300 deaths.

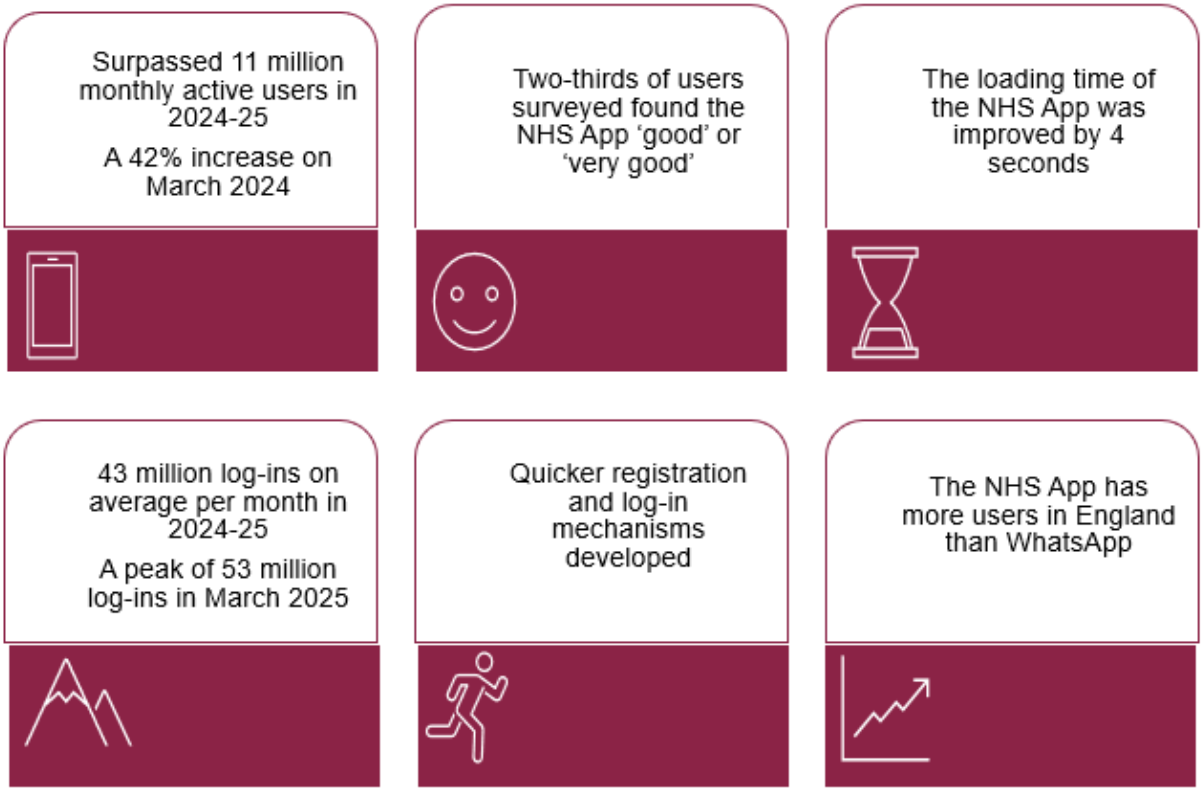
Thirty testing sites will be enhanced with the latest digital AI technologies as part of the trial, enabling women already booked in for routine NHS screenings to take part. The AI will be used to help radiologists identify changes in breast tissue that show possible signs of cancer and, if the trial is successful, it could free up hundreds of radiologists and other specialists to see more patients. The trial marks a significant step in the shift from analogue to digital, using cutting edge technology to speed up treatment and reduce waiting lists.

NHS app

Key developments and achievements

In 2024-25, a total of £34.13 million was spent exclusively on the NHS App, NHS login, and NHS website channels. It is important to note that the NHS app is part of a wider transition to patient centred care as outlined in the 10 Year Health Plan. It goes across care stages, from initial GP and clinical access via online consultations to secondary care follow ups, as well as long-term condition monitoring through the GP record, to prevention services such as vaccinations.

The NHS App, for instance, has now saved over 730,000 hours of clinical time, and 3.2 million hours of administrative time across primary and secondary care; over 860,000 outpatient DNAs have been avoided due to patient use of the app, equating to £103 million in appointment costs.



Supporting elective recovery

Patients in the care of 87% of acute trusts can now manage appointments in the NHS App, as well as six specialist acute and three mental health trusts. Recent analysis showed that acute hospital trusts that procured a Patient Engagement Portal, implemented the business change required, and switched on all of the available NHS App features performed 3 percentage points better against their Referral to Treatment targets than trusts who did not.

People were taken off waiting lists through NHS App based waitlist validation, whilst 253,000 pre-operative assessments undertaken through the NHS App saved clinical time.

Supporting primary care access

Over 7 million people across 1,483 community pharmacies can now track their prescriptions in the NHS App following the launch of prescription tracking, including all branches of Boots. While over 74% of general practices have enabled patients to contact them to request help and appointments via the NHS App, with over 22 million interactions in the last year.

People viewed their GP health record over 260 million times in the NHS App. This 126% growth was driven by the ability for users to view their GP test results in the NHS App.

The first phase of a new Proxy Service launched allowing parents and carers to easily access health information and manage transactions on behalf of others, with over 50 general practices seeing time savings and positive patient feedback.

Sickness to prevention

93% of flu and COVID-19 vaccinations were booked digitally saving money on letters and SMS, while Respiratory Syncytial Virus vaccinations and cervical screening invites were delivered for the first time via the NHS App. In addition, the first stage of rolling out NHS Health Checks Online started with three general practices, to identify people with the risk of developing heart disease.

Increasing NHS efficiency and reducing costs

Redesigning test results screens, including graphs and reference ranges helped to make this complex information easy to understand. This has helped to increase usage by 72% year on year and repeat visits have risen by 200%, saving staff time in each general practice.

Over 55 million repeat prescription orders were undertaken in the NHS App, saving significant time for general practices and patients in processing these.

Costs were saved by sending fewer letters and SMS in the year, with communication through the NHS App increasing by 285% to 221 million messages, as all care settings enabled more secure and inexpensive communication in the NHS App inbox.

Addressing digital exclusion

A partnership was launched with over 1,400 public libraries across England to support their service users to access their NHS account via the NHS app and website to better understand and manage their health and wellbeing.

The NHS App team has conducted dedicated user research sessions in partnership with Royal National Institute of Blind People, testing the app with users who have sight loss, including those with full visual impairment.

We have started British sign language pilots, exploring the use of generative AI alongside human translation on NHS.UK.

Over 1,800 Accessibility Lab attendees have taken part in testing of our digital services, with Accessibility Audits now in place to support releases of new features.

New linked data by deprivation and age is allowing us to understand usage by groups often at risk of digital exclusion and health inequalities.

Over 12,000 users were involved in research in the past year, including those with low digital skills. The NHS App team have mandated that every round of research must involve at least one person with access needs.

Cross-cutting work area 3 – Improving infrastructure

Cross-cutting work area 3: Improving infrastructure

The New Hospital Programme (NHP) was established in October 2020 to address the crumbling, outdated hospital estate. The NHP represents significant investment in the estate with the overall aim of transforming how health infrastructure is delivered for the future of NHS patients and staff.

In January 2025, the Secretary of State for Health and Social Care announced the outcome of a review of the NHP, publishing a new, credible NHP Plan for Implementation. The NHP Plan for Implementation sets out that hospitals will be delivered through five-year waves of investment which will increase to up to £15 billion over each consecutive five-year wave, averaging around £3 billion a year from 2030.

Up to the end of the 2024-25 financial year, the NHP funded, supported and delivered seven hospitals which are now complete and fully open to patients: the Northern Centre for Cancer Care; Royal Liverpool University Hospital; Dyson Cancer Centre, Bath; Greater Manchester Major Trauma Hospital; Midland Metropolitan University Hospital; Brighton 3T's Hospital (Stage 1); and Northgate Hospital, (Phase 1 and Phase 2 of the CEDAR programme).

Two of these schemes have additional phases and are being supported by the NHP to complete these: Brighton 3T's Stage 2 and 3, and Phase 3 of the CEDAR programme.

Six more schemes are in construction and are being supported by the NHP: Oriel Eye Hospital; the National Rehabilitation Centre; Alumhurst Road Children's Mental Health Unit; Dorset County Hospital; Royal Bournemouth Hospital; and St Ann's Hospital.

The NHP continues to work closely with trusts to progress their schemes in line with the timelines set out in the published plan for Implementation. Wave 1 includes seven hospitals built wholly or primarily from reinforced autoclaved aerated concrete (RAAC), which are being prioritised to protect patient and staff safety. Schemes in Wave 2 and 3 are receiving funding when necessary to ensure readiness for main construction in line with the programme's delivery schedule.

In addition, there are four hospitals within the NHP which have identified RAAC in limited or specific areas. RAAC at these sites will be eradicated through the NHS England National RAAC Programme. The seven hospitals built wholly or primarily from RAAC and the four with RAAC in limited or specific areas also receive funding from the NHS England National RAAC Programme for mitigations and failsafe works.

The NHP is working with trusts and industry, taking a programmatic approach that will deliver hospitals more efficiently and cost effectively, whilst recognising the individual needs and circumstances of each hospital scheme. The NHP's approach to standardising the design and operation of 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, safety, sustainability, and excellent patient care.

The NHP has launched the formal procurement process for its Hospital 2.0 Alliance Framework, which is expected to be awarded in early 2026. The Hospital 2.0 Alliance is a strategic, long-term, multi-supplier framework agreement that will be used by trusts across the country to appoint alliance partners for the detailed design, construction and handover of individual new hospital schemes between 2025 and 2040.

Cross-cutting work area 4 – Medicines supply

Cross-cutting work area 4: Medicines supply

DHSC's role, working with other partners, is to help reduce the frequency of medicine shortages and minimise patient impact when they occur. We have worked to manage a wide range of specific risks to UK supply, to ensure that the UK is getting a fair access to global supply, and to continually refine our tools, methods and ability to identify, manage and mitigate potential disruptions to supply.

The primary route for DHSC becoming aware of a supply issue is a formal notification from pharmaceutical suppliers via DHSC's online reporting portal, known as the Discontinuations and Shortages portal, which was launched in October 2020. The number of supply issue notifications increased in 2024 to 1,900, which is approximately 20% higher compared to 2022 and 2023 when the rate of notifications remained relatively stable, at around 1,600 notifications per annum.

In October to November 2024, DHSC responded to an acute shortage of technetium 99m, a medical radioisotope used for imaging and diagnostics, including for cancers. Through collaboration with industry, devolved governments and the NHS, DHSC supported

reallocation of limited supply through mutual aid between trusts. This minimised regional disparities and ensured that patients with urgent needs were given priority.

Ongoing management of the supply issue with Pancreatic Enzyme Replacement Therapy (PERT) has resulted in further stock being made available for patients to reduce the gap in supply. This management involved working closely with UK suppliers to increase supplies, sourcing unlicensed stock from other markets via specialist importers, issuing Serious Shortage Protocols to limit quantities of PERT supplied to patients to assist with equitable distribution of available stock, and the issuing of two National Patient Safety Alerts to provide guidance and actions for the NHS to take to mitigate the shortage.

To strengthen winter resilience DHSC and NHS England stood up additional supply and demand monitoring, supporting earlier detection of potential issues. DHSC is also working closely with industry and NHS England to update the 2013 medicine supply guidance to reflect legal requirements and recommendations for manufacturers, wholesalers, NHS provider trusts, pharmacies and dispensing doctors, to strengthen supply of medicines.

Cross-cutting work area 5 – Research

Cross-cutting work area 5: Research

In 2024-25, DHSC invested £1.6 billion in domestic health and social care research and £130 million in global research through the National Institute for Health and Care Research (NIHR), the research operational arm of DHSC.

NIHR research ranges from pioneering new approaches to preventing ill health, to enabling earlier diagnosis, faster treatment, and ultimately, reducing waiting times and enhancing the effectiveness of care. DHSC-funded discoveries directly improve outcomes for individuals and strengthen our health and care system. Research funded by the DHSC and implemented through the NIHR is underpinning the government's three shifts. For example, in February 2025, the landmark NIHR-funded EDITH trial was launched. Cutting-edge AI technology is being trialled to detect breast cancer earlier. Thirty testing sites will be enhanced with the latest digital AI technologies, enabling nearly 700,000 women already booked in for routine NHS screening to take part. If the trial is successful, it could free up hundreds of radiologists and other specialists to see more patients. The trial marks a step in the shift from analogue to digital, using cutting edge technology to speed up treatment and reduce waiting lists.

NIHR research is also a powerful engine for economic growth, supporting thousands of high-value jobs across the life sciences sector and attracting crucial investment into the UK as well as delivering better health care. For every £1 invested by the government,

NIHR research delivers a return of over £13 in economic benefit to the nation. Clinical trials contributed £7.4 billion annually to the UK economy, supporting 65,000 jobs and generating £1.2 billion of revenue for the NHS. This demonstrates the profound dual dividend of investing in health and care research: healthier lives and a stronger economy.

Through the NIHR, DHSC drives health and social care improvement through impact, inclusion, innovation and investment. Below are a number of health and care research highlights from across 2024-25, arising from NIHR research and collaboration with partners:

- **impact**: in March 2025, the first NIHR Impact Prizes celebrated high impact research. Amongst the winners were the STAMPEDE trial team whose study findings have extended survival rates for men with advanced prostate cancer – with an estimated 1 million life years gained globally through this work, and the multi-disciplinary Imperial Critical Care Research team, whose research has improved the care of severely ill patients with sepsis, saving hundreds of thousands of lives

- **inclusion**; including the voices, experiences and insights of everyone across the diverse communities of the UK is vital for high quality research that will reduce health inequalities. In November 2024, inclusion became a requirement for all NIHR funding. Over half a million people from across the UK have signed up to the Be Part of Research volunteer registry. This is a free, online service that matches people to suitable health and care research, based on their interests. By giving people more choice to search and take part in studies taking place online or near their home, research comes closer to the communities we serve. In February 2025, NIHR celebrated 10 years since the launch of Join Dementia Research. More than 89,000 people are now signed up to take part in dementia research across the UK. This year the national Participant in Research Experience Survey showed that taking part in research has been a positive experience for so many, with 91% of adults and 87% of children and young people in England stating they would consider taking part in research again

- **innovation:** is woven into our NIHR research infrastructure (which brings together specialist facilities, research delivery teams and leading experts from across universities, the NHS, local authorities, charities, industry and wider partners). These networks have delivered some of this year’s game changing studies, including a trial of the world’s first mRNA immunotherapy for skin cancer, accelerated by the transformative DHSC-funded UK Vaccine Innovation Pathway, and

- **investment:** throughout 2024-25, the NIHR has been at the forefront of creating a faster, more efficient, accessible and innovative clinical research delivery system to boost economic investment in the UK. As part of this, new Commercial Research Delivery Centres were established across the four nations which will act as regional

hubs to support the rapid set-up of commercial studies. These centres will increasingly shift research into communities and allow more people to access cutting-edge treatments faster, marking a pivotal shift in the UK's world-leading offer for clinical trial delivery. In October 2024, NIHR launched the Research Delivery Network (RDN) – infrastructure to make the UK a more attractive place to conduct high quality research for the benefit of patients and the public. The work of the RDN will ensure that more people can take part in research wherever they live, helping to address population needs, support our health and care system, and embed research as a routine part of care.

Cross-cutting work area 6 – Pandemic preparedness

Cross-cutting work area 6: Pandemic preparedness

During 2024-25, DHSC continued to develop its Pandemic Preparedness Portfolio and worked on four key areas for embedding its new strategic approach, working with UK Health Security Agency and NHS England. These were:

- completing its review of health and care capabilities, which informed proposals for the Spending Review. In the Autumn 2024 budget, the government announced it is strengthening the UK's pandemic preparedness and health protection with £460 million of investment

- developing a pandemic preparedness strategy, which DHSC committed to in the government's response to the Module 1 report of the Covid Inquiry. The strategy will set out how the health and care system is implementing the principles of its new strategic approach to pandemic preparedness, including wider interdependencies, and refer to some of the strategic tools used to manage wider impacts of the pandemic

- developing a full Respiratory Response Plan that will outline actions that the UK health and care systems will take to respond to a respiratory pandemic using current capabilities, followed by work to adapt this to plan for other routes of transmission, and

- preparations for a national (Tier 1) pandemic risk exercise (Exercise Pegasus).

The Emergency Preparedness, Resilience and Response section on page 152 of the Governance Statement of this Annual Report and Accounts sets out further details of the actions we have taken to fulfil our accountabilities as lead government department for preparedness for human disease risks, including a potential pandemic.

Secretary of State for Health and Social Care Annual Report 2024-25

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 Report and Accounts 2024-25.

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 2024-25 can be found in the ‘Detailed performance analysis’ section at page 17 of this Annual Report and Accounts 2024-25. 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 2024-25, there was a focus on recovering emergency and elective performance in the NHS, underpinned by a set of Operational Planning Guidance targets for the year, which in elective care focused on reducing the longest waits. In this period, the government communicated its commitment to return to the 18-week referral to treatment NHS constitutional standard by March 2029 in the Plan for Change, published in

December 2024. The Elective Reform Plan, which was published in January 2025, set out the productivity and reform efforts required to support the commitment. Between March 2024 and March 2025, the NHS made progress on long waits but did not meet the Operational Planning Guidance target to virtually eliminate waits of over 65 weeks by September 2024, at which point there were 22,884 pathways remaining. This target was subsequently met at the end of the financial year in March 2025. Over the year, the total waiting list reduced from 7.54 million to 7.42 million and performance against the 18-week standard improved by 2.6 percentage points to 59.8% in March 2025. NHS England 2025-26 priorities and operational planning guidance was published in January and confirmed the shift to focus on the 18-week standard. From July 2024, the current government confirmed its commitment to address the elective waiting list and in 2024-25 delivered on key electives initiatives, including its pledge to deliver an additional 2 million appointments, tests and operations in its first year, with more than 3 million additional appointments having been delivered by the end of March 2025.

The annual four-hour A&E performance was higher in 2024-25 than it was in 2023-24, and performance against the four-hour A&E standard was higher in March 2025 than March 2024. However, performance was below the urgent and emergency care recovery plan year 2 target. This is against a backdrop of increased demand for urgent and emergency care services, with over one million more A&E attendances in 2024-25 than the previous year.

DHSC's aim for general practice in 2024-25 was to improve access for patients and respond to growing demand. Appointment numbers in 2024-25 were consistently higher than 2023-24, and numbers of FTE doctors and other direct patient care staff also increased.

In 2024-2025, more appointments were delivered in general practice in comparison to 2023-2024. The 2025 GP Patient Survey showed that 75.4% of respondents had a positive overall experience with their GP practice, an increase of 1.5 percentage points from 2024 (73.9%); additionally, when asked about waiting times for appointments, over two-thirds of patients (67.2%) described the wait as 'about right'. Previous reports highlight a steady decline in satisfaction rates, dropping from 83.8% in 2018 to just 71.3% in 2023, however it must be noted that significant changes in the methodology after 2023 means these results are no longer directly comparable to more recent data.

Improving NHS mental health, learning disabilities and autism services in England remained a priority through 2024-25. The introduction of the Mental Health Bill was accompanied by work to deliver more mental health workers, more mental health support teams in schools and more talking therapies and crisis services in line with the shift to prevention, earlier intervention and getting the right support to people at the right time. As part of our mission to build an NHS that is fit for the future and that is there when people need it, the government is recruiting an additional 8,500 mental health workers by the end of this Parliament. Almost 7,000 of these workers have been recruited since June 2024,

meaning we are more than halfway towards our target. This will help to ease pressure on busy mental health services.

Work also continued to improve women's health outcomes, including through implementation of the women's health hubs pilot programme. Whilst it is clear there is still significantly more work to be done, progress was also made in the delivery of the three-year plan to improve maternity and neonatal services and provide safe and compassionate care including operationalising mental health services for women needing that support throughout their maternity experience. DHSC also extended eligibility for the Baby Loss Certificates Service to officially recognise baby loss before 24 weeks, regardless of how long ago it occurred.

NHS Planning Guidance 2024-25 set out an ask of systems to increase referrals to and capacity of urgent community response (UCR) services, whilst still ensuring a timely response. The UCR service aims to reach people within two hours with the aim of, where appropriate, providing care where they live. Total UCR activity increased over 2024-25, with referrals growing nationally by 8.9% (between April 2024 and March 2025). The subset of UCR referrals within scope of the 2-hour standard increased by 13.8% during the same period. Despite the increased pressure, performance remained above 83% and therefore consistently achieving the standard of 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. 18.5m adults (39.8%) were seen by an NHS dentist in the 24 months up to 30 June 2025, an increase of 55,000 (0.3%) when compared to the previous year, but 3.4 million (16%) lower than the pre-pandemic figure (24 months to September 2019). 35.4 million Courses of Treatment (CoT) were delivered in 2024-25, an increase of 3.8% compared to the previous year, but this is still 8.8% lower than the number of CoT that were delivered in a typical pre-pandemic year. The government is tackling the challenges for patients trying to access NHS dental care with a rescue plan to provide 700,000 more urgent dental appointments and by recruiting new dentists to areas that need them most. In March 2025, a national supervised toothbrushing programme was launched to prevent tooth decay, targeting up to 600,000 three to five-year-olds in the most deprived areas. A ground-breaking partnership with Colgate-Palmolive will donate 23 million toothbrushes and toothpastes over five years.

The Joint DWP and DHSC Work and Health Directorate facilitates the significant link between work and health and builds the evidence base to improve employment opportunities for disabled people and people with health conditions. During this reporting year, WorkWell pilot sites went live in 15 NHS integrated care boards (ICBs) in England to deliver integrated work and health support designed by local partnerships. Additionally, Employment Advisors in NHS Talking Therapies services were accessed by 74,788 users across 156 sites in all 42 NHS ICBs. ICBs participating in the [Getting it Right First Time] GIRFT MSK Community Delivery programme (funded by DWP in 2024-25) have reported

overall reductions of over 20% to 18+ week waiting list numbers between December 2024 and March 2025, and, the Get Britain Working White Paper, launched in November 2024, will see health systems work in partnership to drive forward approaches to tackling economic inactivity and work towards the long-term ambition of an 80% employment rate.

Progress was made in working towards preventing and/or delaying 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). Since the first national breast cancer screening campaign was launched, smoking cessation and youth vaping campaigns have successfully influenced behaviour change and investment in Better Health digital prevention tools and HIV prevention have made a positive impact. Heart health checks were successfully trialled in workplaces in partnership with local authorities, and a new online NHS Health Check service has been built for future trial. During 2024-25, we have laid the foundations to support our prevention agenda for future generations. In November 2024, we introduced the landmark Tobacco and Vapes Bill to create the first smoke-free generation and to clamp down on youth vaping.

Protection or improvement of public health

The Public Health Outcomes Framework was last updated on 7 May 2025. The Public Health Outcomes Framework examines indicators that help us understand trends in public health and is updated three times a year.

Adult social care

The total number of people receiving long-term support in England showed an increase from 646,000 on 31 January 2024 to 666,000 on 31 December 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 465,000 on 31 January 2024 to 485,000 on 31 December 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) in March 2024, and have continued to publish these quarterly. The publications of the Activity and Finance Report and ASCOF towards the end of 2025 (covering April 2024 to March 2025) will be calculated using CLD, having previously drawn from the Short and Long-Term (SALT) collection.

Patient safety

The NHS Patient Safety Strategy is in its sixth year and achieving aims of saving an extra 1000 lives and £100m in care costs per year from 2024. By April 2025, the Strategy's patient safety improvement programmes had led to over 1500 neonatal lives saved, over 500 fewer cerebral palsy cases in premature babies, and more than 1900 deaths prevented overall through medicines safety improvement, including work to reduce long-term opioid use.

Dr Dash completed a review of the Care Quality Commission's (CQC's) operational effectiveness and published her findings in October 2024. The government and the CQC agreed to implement all her recommendations. The review found significant failings in the internal workings of CQC, which had led to a substantial loss of credibility within the health and social care sectors. DHSC is supporting CQC as well as holding it to account to ensure that improvements in the areas identified by Dr Dash are made rapidly. Dr Dash's review of patient safety across the health and care landscape was published in July 2025. Dr Dash made nine recommendations which the government has accepted in full. Dr Dash's findings and recommendations have fed into the 10 Year Health Plan. These changes will improve quality, including safety, by making it clear where responsibility and accountability sits at all levels of the system, and making it easier for staff, patients and users to directly feed into the system to improve quality of care. The review focused on six key organisations overseen by DHSC: the CQC, the National Guardian's Office, Healthwatch England (and the local Healthwatch network), the Patient Safety Commissioner, the Health Services Safety Investigations Body and the patient-safety learning related functions of NHS Resolution.

The Strategy's other 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 2024-25, all NHS Trusts had transitioned to PSIRF, all NHS Trusts were providing real-time reporting through LFPSE and over 1.5 million staff had completed Level 1 of the patient safety syllabus (the first standardised approach to patient safety training across the NHS). A primary care patient safety strategy was published in September 2024, in recognition that while the NHS Patient Safety Strategy applies to all sectors, it needs more specific interpretation for primary care.

NHS England reviews hundreds of incidents reported through LFPSE each week, looking for new and under recognised risks that can be acted on. This work continues to save an estimated 160 lives per year and to save £13.5m in additional treatment costs per year through mitigation of risk. In 2024-25, examples of impact include a National Patient Safety Alert providing instructions to all maternity services to reduce the risk of inadvertent administration of oxytocin (a safe medicine used widely in maternity care, but which can cause severe harm if given at the wrong dose or time).

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 May 2024 NHS England started implementation of Martha's Rule in 143 hospital pilot sites, empowering patients, families, carers and staff to ensure that their concerns are listened to and acted upon. The initiative is already showing impact; in the first six months, 47% of the 2389 calls related to acute deterioration with 129 calls resulting in potentially life-saving escalations of care and around a third leading to a change in management or treatment.

In September 2024, the statutory medical examiner system came into force. All deaths in England and Wales are now being independently reviewed, either by a medical examiner or a coroner. The system aims to provide extra safeguarding for the public, support the bereaved, and improve the quality of information about causes of death so that the NHS can learn from these, to improve patient care and outcomes.

DHSC 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. The Thirlwall Inquiry has concluded hearing evidence. On 19 March, the Lady Justice Thirlwall, Chair, delivered her formal ruling refusing the application made to her to pause the Inquiry. The latest update on the Thirlwall Inquiry's website states the Chair expects to publish her report in early 2026. The Lampard Inquiry heard commemorative and impact accounts from the families in October 2024. In April 2025, the Inquiry started to hear substantive evidence which will continue over the next two years, and

- DHSC 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. The Phase 2 Report looks at the wider national lessons for the NHS and was published in July 2025.

During 2024-25, the Health Services Safety Investigations Body (HSSIB) has made significant progress towards its strategic aims and vision. Their investigations continue to have a positive impact on the lives of patients in England and beyond. HSSIB have published 19 reports in the last financial year spanning a wide range of patient safety concerns. These include medication safety, workforce safety and resourcing, digital tools and technology, care co-ordination, use of healthcare equipment and prison healthcare. HSSIB has also given focus to mental health through many of their investigations, including the most recent Secretary of State-directed investigations into mental health

inpatient care. For this, HSSIB worked extensively with patients, families and patient groups using a trauma-informed engagement approach. The four investigations published contained individual findings but there were common themes in all, highlighting some of the biggest risks to mental health inpatients and the critical areas for reform. The findings and recommendations that emerged are intending to support ongoing NHS transformation in mental health care.

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 2024 and 31 March 2025, NICE fully updated 2 quality standards on meningitis and ovarian cancer. NICE also aligned 50 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 have identified the NHS as broken but not beaten, and that improvements were required across these areas. DHSC and NHS England began taking the required action across the remainder of the year.

On July 3 2025, the government published the 10 Year Health Plan, designed to create a new model of care, fit for the future through three radical shifts; hospital to community, analogue to digital and sickness to prevention. This transformational change will guarantee the sustainability of the NHS for generations to come, and improved services and outcomes for individuals.

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

An update on public health and health disparities can be found under the 'Detailed Performance Analysis' section of the DHSC Annual Report and Accounts 2024-25 and the Public Health Outcomes Framework (last updated on 7 May 2025).

NHS England continued to implement the Core20PLUS5 approach for adults and children and young people to support integrated care systems to reduce inequalities. The approach for adults focuses on improving cardiovascular disease, cancer, respiratory, maternity and mental health outcomes in the poorest 20 per cent of the population, along with ethnic minorities and inclusion health groups.

NHS England introduced the Core20PLUS5 approach in 2021 as a framework to support systems with targeted activity, focusing on measurable priorities for reducing inequalities

amongst underserved communities. The approach defines a target population, Core20PLUS, the most deprived 20% of the population and other disadvantaged groups determined locally. There are ‘5’ clinical areas of focus requiring accelerated improvement.

We are giving greatest attention to the biggest drivers of inequalities in life expectancy and healthy life expectancy, including cancer, cardiovascular diseases, and mental illness. The clinical areas of focus support the government’s health mission to reduce lives lost to the biggest killers.

To support delivery in 2024-25, NHS England developed metrics for measuring healthcare inequalities for the five key Core20PUS5 clinical programmes for adults allow us to demonstrate measurable improvements and understand geographic variation in deprivation and ethnicity-based inequalities in access and outcomes for our clinical priority areas.

In line with legal duties, NHS England is required to assess the performance of each integrated care board (ICB) and publish a summary of the outcomes of its assessments. The assessment includes the extent to which ICBs have fulfilled their statutory obligations regarding health inequalities. NHS bodies are required, in their annual reports, to review the extent to which the body in question has exercised its functions consistently with NHS England’s views set out in the statement on information on health inequalities. The review of 2023-24 reports, which included a health inequalities summary for each ICB was published in January 2025.

Overall assessment (section 1C)

The Secretary of State’s assessment of how well the health inequalities duty has been fulfilled in 2024-25 is that there was some progress, but more can and must be done in the years ahead. The 10 Year Health Plan aims to establish a service equipped to narrow health inequalities, while 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 DHSC group is contained within the overall budgets approved by Parliament as set out in **Table 6** (note: table may not cast due to roundings).

Table 6: DHSC Departmental Outturn 2024-25 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)	198,491	198,192	299	SOPS 1.1, Annex B
of which: Resource Administration	3,266	2,554	712	SOPS 1.1, Annex B
Capital Departmental Expenditure Limit (CDEL)	11,644	11,471	173	SOPS 1.2, Annex B
Resource Annually Managed Expenditure (RAME)	8,780	2,388	6,392	SOPS 1.1, Annex B
Capital Annually Managed Expenditure (CAME)	813	660	153	SOPS 1.2, Annex B
Net Cash Requirement	180,026	176,288	3,739	SOPS 3
Further HM Treasury Controls:				
Ringfenced Resource DEL	5,190	4,954	236	Annex B
Non-ringfenced Resource DEL	193,301	193,238	62	Annex B

Resource departmental expenditure limit (RDEL)

DHSC's 2024-25 budgets were agreed as part of the 2021 Spending Review (SR21). During 2024-25, 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 total RDEL funding by £0.3 billion, comprised of a £0.1 billion underspend against the RDEL non-ringfenced budget, and a £0.2 billion underspend against the RDEL ringfenced budget.

The non-ringfenced RDEL underspend of £0.1 billion (0.03% of the budget) was comprised of a £56 million overspend in the NHS, offset by a £129 million net underspend across DHSC and its non-NHS arm's length bodies, mainly in the UK Health Security Agency (UKHSA) relating to the Covid vaccine unit.

The ringfenced RDEL underspend of circa £0.2 billion (5% of the budget) was because actual depreciation and impairments expenditure was lower than the forecasts available when agreeing the final budget in the Supplementary Supply Estimate.

Further detail on the RDEL outturn is set out in **Annex B**.

Capital departmental expenditure limit (CDEL)

The DHSC's 2024-25 budgets were agreed as part of the SR21. £11.5 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 £0.2 billion (1.5% of the capital budget), most of which was unavoidable due to uncertainty and complexity, mainly relating to IFRS 16. Like other government departments, DHSC has followed IFRS 16, the international accounting standard for leases, since 2022-23. The associated capital costs in 2024-25 were around £0.2 billion lower than expected.

Further detail on the CDEL outturn is set out in **Annex B**.

Annually managed expenditure (AME)

Expenditure which 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 direct control, such as changes to the discount rates in measuring the value of long-term provisions liabilities.

The final Resource AME (RAME) budget in 2024-25 was £8.8 billion and included a £2.1 billion decrease to budget in the 2024-25 supplementary supply estimate. This reduction was primarily driven by a change in the discount rates used to value long-term provisions. DHSC underspent against the Resource AME (RAME) limit by circa £6.4 billion.

This mainly comprised lower than planned RAME in NHS Resolution (NHSR) and DHSC core.

Following changes to the discount rates prescribed by HM Treasury, used to value provisions, the budget was changed as part of the Supplementary Supply Estimates based on a range of estimates produced by NHSR's actuarial advisers. As a result of favourable reductions, including assumptions around inflationary costs, the estimated quantum of future clinical negligence expenditure in NHS Resolution was £3.2 billion lower than the forecast used to set the final budget.

The DHSC RAME was reduced due to the derecognition of a provision relating to the infected blood inquiry. The government has confirmed that the Infected Blood Support Schemes (IBSS) will remain open prior to the Infected Blood Compensation Authority (IBCA) taking responsibility for making Support Scheme payments as part of the Infected Blood Compensation Scheme. A £1.4 billion provision was recognised in IBCA's 2024-25 Annual Report and Account to reflect the support scheme payments that it is expecting to

make following this transfer of responsibility for IBSS, and has therefore been derecognised from the DHSC Annual Report and Account. This was done in accordance with relevant accounting standards and to avoid duplication across government, resulting in a reduction in DHSC RAME. Further detail on the AME outturn is set out in **Annex B**.

Net cash requirement

DHSC underspent against its cash limit by circa £3.7 billion (2.1%). 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 £0.2 billion of the underspend is explained by the resource non-ringfenced and capital DEL underspends of circa £0.1 billion and circa £0.2 billion, respectively. The variance arose mainly because the timing of actual payments across the group were later than expected, meaning less cash was needed in-year than forecast at Supplementary Estimates. Estimating working capital is inherently complex, particularly around year-end, when relatively small shifts in activity or supplier payment behaviour can produce large swings.

Sustainability

We recognise that the climate and nature emergency is also one of health, which threatens DHSC's vision to help people live more independent, healthier lives for longer. We are, therefore, committed to minimising the environmental footprint of our departmental estate and operations, ensuring that we are resilient to projected climate impacts and embedding sustainability at the heart of our work.

DHSC's progress and key activity in 2024-25

Embedding sustainability

Launched a bespoke Carbon Literacy training programme open to all DHSC staff

Buildings and energy use

Saved an estimated 18 tonnes of CO_2e by reusing furniture at our Nottingham office refurb

Waste

Achieved reductions in single use-plastics via a new office stationery process and procedure

Procurement

Refreshed DHSC's sustainable procurement policy covering net zero, social value and modern slavery

Digital

Worked with suppliers to implement a new IT waste disposal process, prioritising reuse over recycling

Progress in 2024-25

The following table sets out progress in 2024-25 in further detail:

Progress in 2024-25

Embedding sustainability

- Our Sustainability Team launched a bespoke, Carbon Literacy training programme, open to all DHSC staff, with monthly training sessions to educate staff on climate change, and its interaction with health, and equip colleagues to take meaningful action within their own work area.
- Ran regular internal communications showcasing the Sustainability Team's activity and empower colleagues to support relevant initiatives.
- Updated our staff induction pack, to ensure that new joiners know how they should align with DHSC's environmental goals and champion sustainable ways of working.
- Almost 100 DHSC staff participated in environmental volunteering, generating sustainable outcomes within our communities. We removed approximately 1 tonne of litter, supported local green space management and redistributed 4,400 meals' worth of surplus food to charitable organisations.
- DHSC hosted two sustainability forums with our Arm's Length Bodies (ALBs) during 2024-25 to share best practice amongst our network and encourage improvements in collective performance.
- Sustainability considerations are factored into DHSC's programme and project management assurance processes (for example gateway reviews) as appropriate. For example, for construction specifically, net zero requirements are considered in the investment appraisal.
- Worked with the National Infrastructure and Service Transformation Authority (NISTA) in their trial capture of sustainability data as part of Government Major Projects Portfolio reporting.
- Our Risk, Governance and Capabilities Team support DHSC on its legal obligations to consider the Environment Principles Policy Statement Duty by providing materials and training to assist policymakers and ministers to effectively consider environmental impacts of their policies. DHSC continues to work closely with the Department for Environment, Food and Rural Affairs and other government departments to share lessons learnt and improve our related practices.

Buildings and energy use

- Focused on DHSC's Nottingham office, as the highest priority property for sustainability and net zero reporting given its long lease length.
  - Completed the first stage of LED lighting installation, with support from Government Property Agency (GPA).
  - Concluded the first stage of wider office refurbishment works with all incoming furniture (apart from bespoke items) sourced second-hand from across DHSC's estate or from other government departments and agencies. By opting for reuse, we saved an estimated 18 tonnes of CO2 equivalent emissions.
  - Planning for the final stages of refurbishment and net zero works (including the remaining LED installation, addition of solar panels and a heat decarbonisation project, with support from GPA).
- Our facilities management provider has continued its building management system (BMS) optimisation project at Wellington House, London. This has reduced gas and electricity usage and is associated with approximately £30,000 of savings across the financial year.
- Re-procured DHSC's facilities management contract with sustainability requirements embedded in the supplier questionnaire. Once this new contract is underway, DHSC intends to work at pace with our new supplier to plan and deliver further net zero initiatives at our highest priority sites.

Travel

- DHSC's business travel policy states that staff must (a) ensure that any journeys made are business critical, with no reasonable digital alternatives, and (b) select the most environmentally friendly mode of transport wherever possible, meaning that, where staff have a reasonable rail option, this should be prioritised over air.
- This now also states that domestic business flights are not permitted unless under a defined set of exceptional circumstances, given their carbon intensity relative to other modes of transport.
- Prioritised sustainability in the re-procurement of DHSC's new vehicle hire contract, by selecting a supplier with electric car availability across the country.
- Our Active Travel Network, relaunched last year, supports staff to cycle, run, walk and incorporate other physical activity into their commute. The network has site-specific champions in London and Leeds and marked UK Bike Week with activities at both locations. DHSC has an active travel guide for staff, outlining the provisions and facilities available, which is updated regularly.

Waste

- In 2024-25, DHSC procured approximately 754,469 consumer single-use plastic (CSUP) items, of which 72% related to cleaning, 20% to catering and 8% to stationery.
  - The requirement to eliminate cleaning and catering-related consumer single-use plastic items (CSUP) was included in DHSC's new facilities management contract. These services will launch in winter 2025-26.
  - During Quarter 4, we achieved a 91% reduction in CSUPs and 60% reduction in costs relating to stationery (compared to the previous three quarters) by implementing communal stores for stationery, developing a new standard product selection based on sustainability, and selecting a new supplier to accommodate our requirements.
- DHSC generated approximately 0.21 tonnes of food waste at our two office catering facilities. We have now upgraded our office recycling stations, including the addition of food waste recycling bins, in line with new rules on simpler recycling in workplaces.
- DHSC donated 200 items of furniture to public sector partners, including NHS trusts, following a reorganisation of our London headquarters. This prevented around eight tonnes of reusable items from entering the waste stream, with £100,000 savings to the public purse compared to recipients purchasing new furniture.

Water

- Renewed the water monitoring system in place at our two London offices, which provides 24-hour major leak detection, flow rates, and temperature levels.
- Taken steps to reduce our indirect water use by sourcing second-hand goods where possible.
- DHSC's Sustainability Team undertook Water Literacy training, to better understand the environmental impacts of water scarcity in the UK and help to inform direct and indirect water saving initiatives on our estate.

Procurement

- DHSC's sustainable procurement policy, covering net zero, social value and modern slavery has been refreshed:
  - supplementary resources have been created (including a one-page 'quick checklist') and guidance on policy application has been tailored to different categories of products, services and market capabilities, to generate more sustainable outcomes
  - four training sessions have been held
  - the policy has been shared with our ALBs.
- We have continued to implement and embed PPN 006 (taking account of Carbon Reduction Plans in the procurement of major government contracts), PPN 016 (Carbon Reduction Contract Schedule) and PPN 009 (tackling modern slavery in government supply chains) in all commercial practices.
- Questions on net zero and modern slavery were included in DHSC's business case templates, so that these policies are considered even where the procurement is out of scope of the mandatory requirements.
- DHSC has pledged to put an end to modern slavery in the NHS.
  - Creating regulations to eradicate the use of goods and services tainted by slavery and human trafficking within the health service
  - Working with NHS England to create guidance to aid procurement professionals when applying these measures.
  - A public consultation, gave public bodies, suppliers and interested members of the public an opportunity to consider and provide feedback on these draft regulations and supporting guidance; this closed on 13 February 2025. The new modern slavery regulations have been laid in Parliament for approval and are expected to be in force in spring 2026.
- We comply with PPN 06/20, with social value explicitly evaluated in new procurements, with five priority themes for suppliers including 'fighting climate change'. We are also the first government department to begin implementing a new social value model, PPN 002 (taking account of social value in the award of contracts), which introduces new priorities and model award criteria, within our e-procurement system, Atamis, on behalf of DHSC and NHS England. We are working with Cabinet Office to share learnings and reduce duplication for others using the same system. We are also collaborating with Cabinet Office on their refresh of the social value model, with our 10 Year Health Plan Team working to develop a new theme aligned to government's mission to build an NHS fit for the future.
- DHSC recently transitioned to PPN 013 (using standard contracts). As part of training for this transition, we taught staff how to bolster sustainability efforts by using contract clauses (the rules and requirements written into the contract) and optional schedules (additional requirements for specific areas).

Nature recovery

- 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), but recognises the role everyone can play in making space for wildlife. As such, DHSC previously sought advice from Natural England on how we can maximise our contribution to nature recovery at our two highest priority properties, and we will now aim to plan and commence delivery of relevant interventions during 2025-26, supported by our new facilities management contract.

Climate change adaptation

- This year, we completed our first departmental climate change risk assessment and adaptation plan in line with guidance from Office of Government Property. This sets out the key risks that climate change poses to DHSC's own estate and operations and the steps that we will take to mitigate these. This document will be updated regularly in line with any organisational changes. Further information about climate change adaptation can be found in the section on Task Force on Climate-Related Financial Disclosures

Digital

- In 2024-25, DHSC's data hosting was responsible for approximately 12 tonnes of carbon dioxide equivalent (tCO2e), having completed our transition to a fully cloud-based service.
- We produced 2.4 tonnes of IT (information technology) waste, of which 14% has been sent for reuse (via commercial sale and charitable donation) and 86% was recycled, with zero to landfill. DHSC's expenditure in relation to this IT waste disposal was £16,883.
- Promoting circular economy principles, our IT services provider has continued to clean, repair, refurbish and return DHSC kit where suitable for redeployment, prolonging asset lifecycles. Where IT waste is generated, we are working with our suppliers to move items up the waste hierarchy, by implementing a new disposal process that prioritises reuse over recycling; we have applied this to an initial batch of 177 laptops, where 84% have been assessed as suitable for reuse, with some to be resold to offset costs of donating the remainder to charitable causes. We intend to scale up this process in 2025-26, as 3,500 DHSC laptops are due to become redundant.
- We ran a trial this year of not-for-profit search engine Ecosia, which uses its ad revenue to fund tree planting projects around the world. We are currently assessing the outcomes of this trial to inform a potential, department-wide rollout in 2025-26.
- Nine DHSC colleagues (including our Head of Technology Services) participated in 'Digital Collage' workshops, to improve our local understanding of the impact of digital technologies on the environment and how to reduce it, to enable further departmental action

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 disclosures around:

- governance – recommended disclosures (a) and (b)
- risk management – recommended disclosures (a) to (c), and
- metrics and targets – recommended disclosure (b)

Please note that we have not provided information against Metrics and Targets recommended disclosures (a) and (c), as climate is not currently identified as a principal risk for DHSC; however, preparations have begun to escalate this for consideration within DHSC's existing risk management structures and a materiality assessment will be made on this basis in future years.

Our reporting is in line with the central government's TCFD-aligned disclosure implementation timetable for Phase 2. DHSC plans to provide recommended disclosures for Strategy (plus the remaining areas of Metrics and Targets, in the instance that this is agreed as a principal risk for DHSC's in future), in line with the central government implementation timetable.

TCFD – governance

Please note that the following disclosures around governance relate to the core department only and do not cover our ALBs, as there is a varied landscape across our organisations that cannot currently be conflated into a singular statement. In-scope ALBs will be required to provide their own TCFD-aligned disclosures within their Annual Report and Accounts.

This implementation of our Internal Sustainability Strategy covering DHSC estate and operations is directly overseen by the Director for Workspace, Information, Security and Technology and two other directors also agreed to support as senior sponsors – the Northwest Regional Director of 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 two 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 twice during 2024-25.

Alongside this, our Sustainability Team produces regular, written reports for DHSC's Executive Committee (ExCo), summarising key messages, including any climate-related risks, issues and opportunities on our estate. ExCo received three sustainability reports in 2024-25, with these updates sponsored by the Director General for Finance and Group Operations. These included details of progress made towards our net zero target, plus the proactive work taking place to reduce DHSC's environmental footprint, make us more resilient to climate impacts, and 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 Committee.

Mitigations to climate change risks such as overheating and flooding also form a key objective of the Risk, Governance and Capabilities team within the Emergency Preparedness and Health Protection Directorate. The directorate is directly overseen by the Director for Emergency Preparedness and Health Protection, and Director General for Global and Public Health. In 2024-2025, identification of environmental hazards such as extreme weather associated with climate change was part of the core quarterly business objectives submitted by the Risk, Governance and Capabilities team to the Performance and Risk Committee.

Further context on DHSC's broader governance structures is provided at pages 138 to 147 of the Governance Statement of this Annual Report and Accounts.

TCFD – risk management (internal risks)

This year, the sustainability team conducted a climate change risk assessment and adaptation plan to monitor and reduce the risk faced by DHSC's estates from climate change. This exercise focused on the five buildings where DHSC holds operational control, while also considering risks faced by staff working from home and in other government offices. The assessment used the Office for Government Property's Estates Adaptation Framework and relied on hazard data from the UK Climate Change Committee's Independent Assessment of Climate Risk. Priority risks were identified based on both likelihood and impact, with climate hazards themselves judged to pose a greater threat to our estate than future regulatory requirements. This work was developed in consultation with relevant teams, including the Sustainability Delivery Board and the Business Continuity Team, to ensure that outputs feed into DHSC's wider estate's risk management strategy.

We have agreed adaptation actions in response to the highest priority risks, with sign off from the relevant branch lead. Going forward, progress against the adaptation plan will be monitored by the Sustainability Delivery Board, with key risks reassessed at regular intervals.

TCFD – risk management (health system risks)

Under the government's third National Adaptation Plan (NAP3), DHSC is responsible for mitigating risks to health and social care delivery from climate change, risks to UK public health from climate change overseas and risks to health from vector borne diseases. These risks have been identified and prioritised for departmental action under the third UK Climate Change Risk Assessment which forms the basis for NAP3. DHSC is working alongside other government departments and health system partners to progress actions to adapt to the impacts of climate change. DHSC's progress against these actions is reported bi-annually as part of the wider government NAP3 reporting process as led by the Department for Environment, Food, and Rural Affairs (Defra), and through the Climate Resilience Steering Board jointly run by Cabinet Office, and Defra.

TCFD – metrics and targets

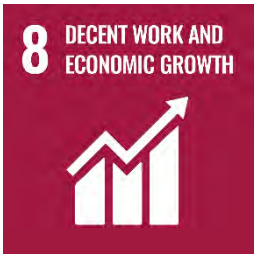
DHSC calculates its own scope 1, 2 and 3 emissions on a quarterly basis, in line with our Greening Government Commitments reporting requirements to Defra, and combines this with counterpart data from our in-scope ALBs. This data is summarised in **Table 8** below.

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 7** below. Our latest progress can be found in the performance section of this report.

Table 7: 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. 	1.5 To reduce the number of years people spent in ill-health, and support the health mission shift from treatment to prevention, by leading on evidenced-based policies to create a smoke-free UK, tackle obesity and poor diet, improve physical activity and reduce drug, alcohol and gambling related harms. 2.3 Lead the policy, delivery and evaluation required to secure the healthiest generation of children ever.

SDG 5: Achieve gender equality and empower all women and girls. 	2.1 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. Improve women's health outcomes including the way the health and care system listens to women. Improve maternity and neonatal outcomes for women and their babies, including reducing inequalities. Support parity of access to health and care for patients in all detained settings.
SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all. 	2.5 Support disabled people and people with health conditions to get work and get on in work by delivering health and employment initiatives, enabling them to live healthier, more independent lives, contributing to the 80% employment rate ambition. 3.2 Ensure a strong, engaged and highly skilled workforce that is able to provide good quality, effective, and appropriate care to patients into the future. 3.5 Ensure a well-functioning medicines system, which improves patient outcomes, delivers value for money, and supports economic growth. 4.1 To be well on the way to establishing a ten-year plan for social care reform, including legislating to establish a Fair Pay Agreement, and building towards a National Care Service, underpinned by national standards. 5.1 Improve the health and wealth of the nation through science, research, and evidence to inform policy and practice. 6.5 Shaping the design and capability of DHSC, ensuring our leaders and workforce have the right capabilities, skills, and culture to deliver our priorities.

SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation. 	1.2 To help ensure continuity of supply of medical products to UK patients and promote long-term supply chain resilience. 3.6 Support development of emerging innovation, accelerate access for patients to the most effective tech and ensure value for money of current spend. 3.7 Improve the health and wealth of the nation through a strong, resilient, and innovative life sciences industry in the UK, working in partnership to deliver, once drafted and approved, the Life Sciences Plan. 6.1 To help people live more independent and healthier lives for longer, through the best possible use of capital investment and infrastructure across the health and social care systems. 6.3 Provide DHSC and wider health system with the appropriate commercial strategy, leadership, insight and advice to enable delivery of the Health Mission, consistently maximising value for money. 6.4 To drive transformation in how healthcare infrastructure is delivered by the NHS, including new integrated, innovative standards for hospitals. Contribute to the Growth agenda at national and regional level and establish enduring capability for enhanced healthcare infrastructure delivery in the future. 6.8 Drive the transformation of our health and care system from analogue to digital, to provide high quality and secure care. We will do this by fixing the digital infrastructure, modernising our data platforms and transforming citizen interactions and services through the NHS App.

SDG 10: Reduce inequality within and among countries. 	1.6 To support delivery of healthcare and improve health outcomes and experiences for individuals affected by multiple disadvantage or displacement; to advise ministers on effective immunisation programmes; to ensure that local, regional and national systems, drive better and more equal health outcomes. 1.3 To lead DHSC's work to improve global health and protect the UK's global health interests. 2.6 To deliver public health in national and regional priorities on prevention and health inequalities and supporting a systems approach to local delivery and improved outcomes. 5.3 Improve the use of data across DHSC, putting data in the hands of local and national decision makers and enabling wider analysis to improve health outcomes and reduce health inequalities.

Rural proofing

The Health and Care Act 2022 established integrated care boards (ICBs) 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.

ICBs previously 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 guidance for ICBs requires they update their joint five-year forward plan, providing the opportunity to reflect current priorities and operational guidance.

Greening Government Commitments

Tables 8 to **13** combine data from both DHSC and its in-scope ALBs, demonstrating our collective performance against the Greening Government Commitments, with a 2017-18 baseline. In-scope ALBs are Care Quality Commission (CQC), Health Research Authority (HRA), Human Fertilisation and Embryology Authority (HFEA), Human Tissue Authority (HTA), Medicines and Healthcare products Regulatory Agency (MHRA), NHS Business Services Authority (NHSBSA), NHS Counter Fraud Authority (NHSCFA), NHS England (NHSE), NHS Resolution (NHSR), National Institute for Health and Care Excellence (NICE) and UK Health Security Agency (UKHSA).

The tables also allow comparison with our earlier performance in 2021-22, 2022-23 and 2023-24 – the previous reporting years under the current Greening Government Commitments framework. The targets referenced are the overall aims by 2024-25, rather than progress that is left for us to make.

Table 8: Overall greenhouse gas emissions (tCO_2e)

	2017-18 (baseline)	2021-22	2022-23	2023-24	2024-25	Performance	Target by 2024-25
Scope 1	16,699	9,668	6,134	6,204	5,423	−68%	−20%
Scope 2	23,703	11,870	8,099	8,442	8,424	−64%	-
Scope 3	5,469	2,271	3,955	4,620	4,696	−14%	-
Total	**45,871**	**23,809**	**18,188**	**19,266**	**18,543**	**−60%**	**−44%**

The table above differentiates between scope 1,2 and 3 emissions, as defined in the Greenhouse Gas Protocol. Scope 1 is comprised of direct emissions from sources that our organisations own or control. Scope 2 is comprised of indirect emissions from the generation of electricity that our organisations purchase. Scope 3 is comprised of other indirect emissions that occur in our organisations' value chains; for the purposes of the Greening Government Commitments specifically, scope 3 includes emissions from business travel (excluding international flights and staff commutes) and electricity transmission/distribution only. Within the health group, £Nil was spent on accredited carbon offsets in 2024-25.

Table 9: Energy use (kWh)

	2017-18 (baseline)	2021-22	2022-23	2023-24	2024-25 kWh	2024-25 Cost	Performance
Gas	74,683,131	50,071,329	30,355,246	29,430,465	27,938,535	£2,120,507	−63%
Gas oil	5,504,907	230,614	1,509,385	856,865	480,816	£51,722	−91%
Electricity	67,422,670	55,905,390	41,883,125	40,770,048	40,686,136	£9,897,655	−40%
Diesel oil	-	-	-	10,571	7,642	£1,046	-
Hydrotreated vegetable oil	-	199,910	-	50,000	100,000	£22,548	-
Electricity from renewable sources	-	1,386,917	1,316,825	1,333,778	1,450,826	-	-
Heat from non-renewable sources	584,699	-	-	-	-	-	−100%
Total	**148,195,407**	**107,794,160**	**75,064,581**	**72,451,727**	**70,663,955**	**£12,093,478**	**−52%**

Table 10: Business travel (tCO_2e)

	2017-18 (baseline)	2021-22	2022-23	2023-24	2024-25				
					tCO_2e	Distance travelled (km)	Cost	Performance	Target by 2024-25
Rail	1,688	370	1,277	1,717	1,822	51,499,714	-	+8%	-
Road	1,968	1,064	1,906	2,141	2,122	13,512,257	-	+8%	-
Air – Domestic	453	24	134	156	134	830,977	-	−70%	−30%
Air – International	2,304	228	785	1,628	2,014	15,709,876	-	−13%	-
Total	**6,413**	**1,686**	**4,102**	**5,642**	**6,092**	**81,552,824**	**£15,864,298**	**−5%**	**-**

Of the distance travelled by international air, 12% is associated with short haul journeys and 64% with long haul, with the remaining 24% unknown. Broken down by flight class, 85% were economy, 3% premium economy, 11% business and less than 1% first (however, please note that the proportion of first, business, and premium economy class flights reported here may be an overestimation, due to an ongoing issue with our flights data that we are working with our suppliers to resolve).

With regard to our progress against the Government Fleet Commitment, of our 11 vehicles, 55% are ultra-low emissions vehicles (ULEV). 0% of our vehicle fleet are zero emissions at the tailpipe, against our target to achieve 100% by 2027; whilst we reported a much higher percentage (77%) last year, it was confirmed during 2024-25 that salary sacrifice vehicles are no longer in scope of this target, which has had a negative impact on our overall performance. As such, we will now focus our attention on decarbonisation the remaining, in-scope vehicles in the coming years.

Table 11: Waste (tonnes)

	2017-18 (baseline)	2021-22	2022-23	2023-24	2024-25		Performance	Target by 2024-25
					Tonnes	Cost		
Recycled	1,410	1,210	1,418	997	917	£215,593	−35%	-
Composted/food waste	-	30	32	37	41	£22,356	-	-
Incinerated with energy recovery	176	473	551	458	377	£316,279	+114%	-
Incinerated without energy recovery	189	159	150	150	153	£168,472	−19%	-
Landfill	1,738	457	21	17	16	£27,757	-99%	-
Total	**3,513**	**2,329**	**2,172**	**1,659**	**1,504**	**£750,457**	**−57%**	**−15%**

Waste to landfill represents 1% of all waste (against a target of less than 5% by 2024-25). Waste that is recycled (including waste composted) represents 64% of overall waste (against a target of at least 70% by 2024-25). We have not met the target for percentage of waste recycled; however, this is due to organisations having intentionally reduced paper use by 76% since 2017-18, which has led to a large reduction in the quantity of recyclable paper being disposed of.

Table 12: Paper purchased (A4 reams)

2017-18 (baseline)	2021-22	2022-23	2023-24	2024-2025	Performance	Target by 2024-25
150,215	28,175	30,145	35,265	35,605	−76%	−50%

Table 13: Water consumption (m^3)

2017-18 (baseline)	2021-22	2022-23	2023-24	2024-25 plus expenditure		Performance	Target by 2024-25
283,469	170,720	161,212	149,226	147,245	£475,615	−48%	−8%

Other performance reporting

Parliamentary questions

Between April 2024 and March 2025, DHSC responded to 8,131 Parliamentary Questions (PQs), more than any other government department. While this represents a slight overall dip in volumes compared to the previous financial year (a reduction of 4.5 per cent), volumes in the second half of the financial year rose to similar levels as during the Covid pandemic.

In the first term of the new Parliament (July-December 2024), our Ordinary PQ on-time rate fell to 77 per cent against the 85 per cent target set by Parliament, with Named Day PQs being answered on-time at a rate of 60 per cent. The House of Commons Procedure Committee subsequently wrote to DHSC on its PQ performance and invited the Secretary of State to appear before the Committee to discuss this further.

Minister Smyth and the Second Permanent Secretary appeared on the Secretary of State's behalf to set out the work DHSC is undertaking to improve PQ performance against increased volumes. Minister Smyth wrote to the Procedure Committee in July 2025, providing an update on DHSC's PQ performance since her appearance and the ongoing work to improve PQ processes. We continue to work further on bolstering DHSC's PQ processes and exploring avenues for potential gains in performance.

Freedom of information requests

In the calendar year 2024, DHSC responded to 1,668 Freedom Of Information (FOI) requests. DHSC answered 92 per cent of these within the statutory 20 working day deadline (or Public Interest extension). The overall volume of FOIs received in 2024 was almost identical to that received in the previous year (1,665). In 2023, DHSC answered 95 per cent of cases within the statutory 20 working day deadline (or Public Interest extension); the Information Commissioner's Office's minimum target is 90 per cent.

Source: Freedom of Information statistics: annual 2024 tables

Correspondence and complaints

As shown in **Table 14**, DHSC answered 38,315 pieces of correspondence due in 2024, compared to 29,515 in the previous year. Receipts for ministerial correspondence fell slightly compared to 2023 due to the general election. Receipts for public enquiries increased, due to high volumes of campaign correspondence, where the public raised issues to the new administration.

In line with standard correspondence reporting across government, the data shown is for the calendar year 2024. The cross-government target across all correspondence is to

respond to 80 per cent of cases within 20 working days. DHSC is committed to bringing performance on ministerial correspondence in line with this target.

Table 14: Other classes of correspondence 2024

Case Type	Due in 2024	Answered on time	Percentage on time
Ministerial	12,716	6,472	50.9%
Public	25,599	21,528	84.1%
Total	**38,315**	**28,000**	**73.1%**

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

In 2024-25 DHSC received 20 complaints.

As shown in **Table 15**, in 2023-24 (the last year for which published results are available), the PHSO received 19 enquiries regarding complaints about the core department, of which 9 progressed to assessment (primary investigation). No cases were accepted for detailed investigation.

Table 15: PHSO complaints 2023-24

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]
19	9	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 2022-23 but not completed it until the following year 2023-24. Similarly, it may have completed an investigation in 2023-24 which we originally accepted for investigation in the previous year 2022-2023.
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 sized businesses that may not be able to fully operate with longer payment terms are not disadvantaged by late payments.

Table 16 details the percentage and value of undisputed invoices paid by NHS provider organisations within the agreed terms over the last three years.

Table 16: Prompt payment of undisputed invoices

	NHS provider invoices paid within target	
Financial Year	Percentage	Value (£m)
2024-25	90	68,283
2023-24 (restated)	91	66,925
2022-23 (restated)	91	67,121

Source: NHS provider accounts

NHS England monitors Better Payments Practice Code 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 per cent of undisputed invoices within 30 days.

NHS England discusses performance with providers with poor or deteriorating working capital position and supports individual providers in seeking ways to improve this position. Data for the core department's performance against this standard is published quarterly.

Fraud and error analysis

Fraud

The Strategic Intelligence Assessment (SIA) 2025 estimates that the financial vulnerability to fraud in the NHS, in England, is £1.346 billion. DHSC has a comprehensive Counter Fraud Strategy for 2023-26 in place, with a vision of 'A system-wide approach to tackling fraud which protects taxpayers' money for better patient care'. It focuses on four key areas - proactivity and prevention, utilising digital and data analytics, collaboration and coordination, and response and enforcement.

The DHSC Anti-Fraud Unit (AFU) has developed an enterprise and thematic Fraud Risk Assessment (FRA), to expand the oversight and understanding of fraud risk across departmental activity and groups. We have improved the fraud risk template to contribute greater detail to the enterprise and thematic processes. DHSC AFU has worked with teams across DHSC, including Government Major Projects Portfolio (GMPP) and Investment Appraisals, to strengthen guidance and oversight of Initial Fraud Impact Assessments (IFIAs). Guidance has been published encouraging the use of IFIAs for capital spend above £30 million and emphasising mandatory completion for all GMPP programmes. The New Hospitals Programme (NHP) is an active DHSC GMPP programme and is listed on the Public Sector Fraud Authority (PSFA) High Fraud Risk Portfolio. DHSC AFU is proactively engaged with stakeholders including PSFA, NHS England, DHSC programme leads and the NHS Counter Fraud Authority to manage fraud risks within the programme. Further details, including on the Counter Fraud Strategy for 2023-26 are set out at pages 158 – 160 of the Governance Statement of this Annual Report and Accounts.

Error

The Strategic Intelligence Assessment referenced above does not consider error. However, DHSC has arrangements in place to record and monitor error. In particular DHSC participates in the quarterly Consolidated Data Return (CDA) process, overseen by the PSFA, which requires it to report the levels of error it has detected, prevented and recovered during the quarter. The CDR returns for 2024-25 confirm that the overall level of error identified by DHSC is immaterial, and in many cases, errors such as overpayments are subsequently recovered. In addition, there are no areas of DHSC's spend which are considered to be at significant risk of error.

DHSC also complies with the requirements set out in Managing Public Money to report losses over £300,000 in its accountability report. Details of such losses recorded by the core department can be found at pages 212 to 213. Details of the losses recorded by DHSC's ALBs can be found in the annual report and accounts of the relevant organisations.

Official development assistance

DHSC's expenditure on official development assistance (ODA) totalled £316.6 million in the 2024-25 financial year (2023-24: £394.2 million). 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 33 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).

DHSC's expenditure on ODA delivered a targeted set of high-ambition programmes to reduce the impact of devastating health threats on some of the poorest people in the world. 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. The GHS and GHR programmes are complemented by a further two programmes: the Global Health Workforce Programme which works towards building capacity in the health workforce of Low- and Middle-Income Countries (LMICs) and a project which supports the

implementation of the World Health Organization's (WHO's) Framework Convention on Tobacco Control in LMICs.

The GHR portfolio funds high quality applied (near-patient) research and capacity strengthening, including through clinical trials, to build the evidence base needed to impact health policy and practice, and ultimately improve service delivery and health outcomes of people in LMICs. This is delivered through the world-class expertise of the National Institute for Health and Care Research and strategic partnerships with global funders and international organisations. In 2024-25, the portfolio aims were delivered through a mix of researcher-led and targeted, thematic calls to support equitable partnerships in areas including research on pandemic preparedness, vaccines for pathogen and AMR control, virus genomics for outbreak response, non-communicable diseases and health system strengthening, and through initiatives to strengthen research capacity in LMICs to develop the research leaders of tomorrow.

In 2024-25, the GHS is made up of five projects: the Fleming Fund, the UK Vaccine Network, the Global Antimicrobial Resistance Innovation Fund, the International Health Regulations Strengthening project and the UK Public Health Rapid Support Team. The portfolio of activities strengthens the ability of developing countries to prepare, prevent, detect and respond to the threat of infectious diseases of epidemic and pandemic potential and antimicrobial resistance (AMR). Notably, in 2024-25, the GHS portfolio co-funded the Global Research on Antimicrobial Resistance (GRAM) project, through the Fleming Fund. In 2024, the latest GRAM paper was published which provides the most comprehensive analysis of antimicrobial resistance (AMR) trends to date and for the first time forecasts the future burden of AMR deaths.

DHSC pays an annual membership fee to WHO and takes the overall lead for the government's engagement with the organisation. The annual contribution to WHO's budget is linked to the UN Scales of Assessment. These scales are in accordance with the UN Charter and UK membership obligations and based on factors including members' share of the global gross national income. In 2024, a portion of DHSC ODA funded the first twelve months of asylum seekers' healthcare costs following their arrival in the UK. These healthcare costs relate to asylum seekers and individuals within the Ukraine Support Schemes.

Performance Report Accounting Officer Sign-Off

4 December 2025
Samantha Jones
Permanent Secretary

Accountability report

Structure of the Accountability Report

This accountability report sets out how DHSC meets its accountabilities to Parliament. It includes:

- Names of ministers and directors with oversight of DHSC and their interests
- Explains the governance of DHSC (in the **Governance Statement**)
- Presents staff numbers and costs and discloses the remuneration of our ministers and directors (**Remuneration and Staff report**)
- Presents expenditure against budgets set by Parliament and the Report of the Comptroller and Auditor General

DHSC is led by a ministerial team and a staff of civil servants. Our non-executive board members are independent of the DHSC and government and provide advice and challenge to our ministers and senior staff.

Our ministers at 31 March 2025

Rt Hon Wes Streeting MP

Secretary of State for Health and Social Care and Chair of Departmental Board
Appointed 5 July 2024

Stephen Kinnock MP

Minister of State for Care
Appointed 8 July 2024

Karin Smyth MP

Minister of State for Health (Secondary Care)
Appointed 8 July 2024

Baroness Gillian Merron

Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health
Appointed 9 July 2024

Ashley Dalton MP

Parliamentary Under-Secretary of State for Public Health and Prevention
Appointed 10 February 2025

Other ministers who served in DHSC since 1 April 2024 were:

Andrew Gwynne MP
Parliamentary Under Secretary of State from 9 July 2024 to 8 February 2025

Rt Hon Victoria Atkins MP
Secretary of State for Health and Social Care from 13 November 2023 to 5 July 2024

Andrew Stephenson
Minister of State from 13 November 2023 to 5 July 2024

Rt Hon Dame Andrea Leadsom
Parliamentary Under Secretary of State from 13 November 2023 to 5 July 2024

Helen Whately MP
Minister of State for Social Care from 26 October 2022 to 5 July 2024

Maria Caulfield
Parliamentary Under Secretary of State and Minister for Women for the Equality Hub from 27 October 2022 to 5 July 2024

Lord Markham CBE
Parliamentary Under Secretary of State (Minister for the Lords) from 22 September 2022 to 5 July 2024

Our non-executive board members at 31 March 2025

Rt Hon Alan Milburn

Lead non-executive board member since 8 November 2024

Alan Milburn was a Member of Parliament from 1992 to 2010. He served as Chief Secretary to the Treasury from 1998 to 1999, Secretary of State for Health from 1999 to 2003, and Chancellor of the Duchy of Lancaster from 2004 to 2005. He was the Independent Reviewer on Social Mobility and Child Poverty under the Coalition Government and became Chair of Child Poverty Commission between 2012 and 2017. He is currently Chancellor of Lancaster University, Chair of the Social Mobility Foundation and runs his own consultancy firm AM Strategy Ltd.

Sir Richard Douglas

Non-executive board member and appointed as chair of Audit and Risk Committee from 1 August 2024

Richard's current roles include chair of the South East London Integrated Care Board, an advisory role with Incisive Health, trustee for the children's mental health charity, Place2be, 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 financial roles in the Civil Service. Richard held the role of Acting Permanent Secretary at DHSC for a brief period in 2010.

Samantha Jones OBE

Non-executive board member from 14 February 2023 to 14 June 2025

Samantha was appointed as a non-executive board member 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 of two 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 resigned as a NEBM following her appointment as DHSC Permanent Secretary on 15 June 2025.

Naomi Eisenstadt CB

Non-executive board member since 13 January 2025

Naomi Eisenstadt CB is the Chair of the NHS Northamptonshire Integrated Care Board. She also serves as a Non-Executive Board Member for the Department for Education. Beginning her career in the voluntary sector, she was Chief Executive of a child poverty charity before joining the Civil Service. She became the first Director of Sure Start in 1999. After seven years in that post, she served for three years as director of the Social Exclusion Task Force. She has served as an adviser on Poverty and Inequality to the First Minister of Scotland, held trustee roles on several charity boards, and served as a non-executive director of an NHS primary care trust. She has published two books and has been an honorary research fellow at Columbia University, the University of Oxford, and the London School of Economics.

Phil Jordan

Non-executive board member since 13 January 2025

Phil Jordan had an executive career as Chief Information Officer (CIO) leading Global Business, Digital and Data Transformations across a range of sectors, including telecoms, media and retail. He recently retired as Group CIO at Sainsbury's and, prior to that, was Global CIO at Telefonica and CIO for Vodafone UK and Ireland. He now has a Non-Executive and Advisor Portfolio that has included clients such as Sainsbury's, TalkTalk, HSBC, AND Digital and Deloitte.

Baroness Camilla Cavendish

Non-executive board member since 13 January 2025

Baroness Camilla Cavendish is Contributing Editor and Columnist for The Financial Times, a Research Fellow at Harvard University's Kennedy School and a crossbench peer in the House of Lords. She has a background in policy with expertise in health and care. She is a former Head of the Downing Street Policy Unit under Prime Minister David Cameron, author of two independent reviews for government into health and social care, a former non-executive director of the Care Quality Commission and former chair of the national social work charity, Frontline: Changing Lives.

Other Non-Executive Board Members who served in DHSC during 2024-25 were:

- Gerry Murphy resigned as a non-executive board member and chair of Audit and Risk Committee on 31 July 2024
- Steve Rowe resigned as a non-executive board member on 10 January 2025
- Will Harris resigned as a non-executive board member on 18 September 2024
- Doug Gurr resigned as a non-executive board member on 10 January 2025
- Sir Roy Stone resigned as a non-executive board member on 10 January 2025. Alan Milburn pays tribute to Sir Roy in his lead NEBM's statement on page 3 of this Annual Report and Accounts.

Our executive board members at 31 March 2025

Prof. Sir Chris Whitty KCB
Interim Permanent Secretary (16 December 2024 to 15 June 2025) and Chief Medical Officer

Tom Riordan
Second Permanent Secretary from 23 September 2024

Andy Brittain
Director General Finance and Group Operations

Other senior officials at 31 March 2025

Matthew Style
Director General for Secondary Care and Integration

Jonathan Marron CB
Director General for Primary Care and Prevention (until 11 July 2025)

Professor Lucy Chappell
Chief Scientific Officer

Michelle Dyson
Director General for Adult Social Care (until 18 July 2025)

Sally Warren
Director General for the 10 Year Health Plan (from 8 July 2024)

Catherine Frances CB
Director General for Global and Public Health (from 7 January 2025)

Lorraine Jackson CBE
Director DWP and DHSC Joint Work and Health Directorate

Jenny Richardson
Director of Human Resources (from 17 April 2024)

Paul Macnaught
Director Ministers, Accountability and Strategy (from 1 May 2024)

Other senior officials who served DHSC in 2024-25 were:

- Sir Chris Wormald KCB - Permanent Secretary until 15 December 2024
- Shona Dunn CB - Second Permanent Secretary until 3 June 2024
- Zoe Bishop - Interim Director of Human Resources until 21 April 2024
- Hugh Harris – Director of Ministers, Accountability and Strategy until 30 April 2024
- Clara Swinson CB – Director General for Global and Public Health until 22 September 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 relating to personal data-related incidents is reported to the Information Commissioner's Office and, if applicable, is 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 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 2024-25 financial year

NEBM	Held by	Name of Company	Position Held	Type of Interest	Other Information
Alan Milburn	Self	AM Strategy Ltd	Director	Remunerated and shareholding	
Alan Milburn	Self	Bridgepoint Capital Ltd	Shareholder	Minority equity interest	
Alan Milburn	Self	Huma Therapeutic Ltd	Shareholder	Shareholding	
Alan Milburn	Self	Mars Incorporated	Advisor		Ended December 24
Alan Milburn	Self	Lancaster University	Chancellor	Not remunerated	
Alan Milburn	Self	Social Mobility Foundation	Chair	Not remunerated	
Alan Milburn	Self	Yorkshire Sculpture Park	Vice-Chair	Not remunerated	
Alan Milburn	Self	PwC	Advisor	Remunerated	
Doug Gurr	Self	CommentSold	Director	Minority equity interest	
Doug Gurr	Self	Natural History Museum	Director	Salary	
Doug Gurr	Self	Permira Ltd	Advisor	Fees	
Doug Gurr	Self	The Alan Turing Institute	Chair	Fees	
Doug Gurr	Self	UK Biobank	Director	Volunteer (not remunerated)	
Doug Gurr	Self	Competition & Markets Authority	Interim Chair	Fees	
Doug Gurr	Self	Genomics England	Director	Volunteer (not remunerated)	
Camilla Cavendish	Self	Extra Time Partners Limited	Director/Owner	Majority Equity Interest	
Camilla Cavendish	Self	Financial Times	Columnist	Salaried	
Gerry Murphy	Self	Currys PLC	Non-Executive Director	Remunerated and shareholding	
Gerry Murphy	Self	Capital & Regional PLC	Non-Executive Director	Remunerated and shareholding	

NEBM	Held by	Name of Company	Position Held	Type of Interest	Other Information
Naomi Eisenstadt	Self	Northamptonshire Integrated Care Board	Chair	Salaried	
Naomi Eisenstadt	Self	Social Mobility Commission	Advisor	Fees	
Naomi Eisenstadt	Self	Department for Education	Non-Executive Director	Remunerated	
Naomi Eisenstadt	Self	Education Endowment Fund	Trustee	Not remunerated	
Naomi Eisenstadt	Self	Financial Fairness Trust	Trustee	Not remunerated	
Naomi Eisenstadt	Self	Sutton Trust	Advisor	Not remunerated	
Naomi Eisenstadt	Son	Kindling Interventions	Director	Shareholding and remunerated	
Phil Jordan	Self	ANDGITAL Ltd	Non-Executive Director	Fees	
Phil Jordan	Self	@PVJCIO Ltd	Director	Shareholding	
Phil Jordan	Spouse	Cole Close Management Co Ltd	Director	Shareholding	
Sir Roy Stone	Self	Sir Roy Stone Limited	Director		
Samantha Jones	Husband	Milton Keynes University Hospital NHS Foundation Trust	Chief Executive	Remunerated	
Samantha Jones	Husband	NHS England	Director of Digital Channels	Remunerated	Ended August 2025
Samantha Jones	Husband	Oxford Academic Health Science Network	Member	Not remunerated	
Samantha Jones	Husband	NHS Employers Policy Board	Chair	Not remunerated	

NEBM	Held by	Name of Company	Position Held	Type of Interest	Other Information
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	Ended March 2025
Samantha Jones	Self	Alzheimer's Society	Trustee	Not remunerated	Ended October 2024
Samantha Jones	Self	National Association of Primary Care	Advisor	Remunerated for work undertaken	Ended early June 2025
Samantha Jones	Self	G Square Capital	Advisor	Remunerated for work undertaken	Ended early June 2025
Samantha Jones	Self	Keys Group	Non-Executive Director	Salaried/fees	Ended early June 2025
Samantha Jones	Self	Bain Consulting Group	Advisor	Remunerated for work undertaken	Ended early June 2025
Samantha Jones	Self	CeraCare	Advisory Board Member	Minor shareholding	Ended early June 2025
Samantha Jones	Self	Huma	Shareholder	Minor shareholding	Ended early June 2025
Samantha Jones	Self	Accurx	Advisory and Board Member	Remuneration and minor shareholding	Ended early June 2025
Samantha Jones	Self	HSBUK	Advisor	Remunerated for work undertaken	Ended early June 2025
Samantha Jones	Self	PA Consulting	Advisor	Remunerated for work undertaken	Ended early June 2025
Samantha Jones	Self	System C	Advisor	Minor shareholding	Ended early June 2025

NEBM	Held by	Name of Company	Position Held	Type of Interest	Other Information
Samantha Jones	Self	Samatha Jones Ltd	Director	Shareholding	Ended early June 2025
Samantha Jones	Self	HCA Healthcare UK	Advisor	Remunerated for work undertaken	Ended early June 2025
Samantha Jones	Self	XLinks Ltd	Chief Operating Officer	Salaried	Ended early June 2025
Steve Rowe	Self	Westfalia Fruit International Ltd	Non-Executive 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	

Senior Official	Held by	Name of Company	Position Held	Type of Interest	Other Information
Professor Sir Chris Whitty KCB	Self	Gresham College	Visiting professor	Stipend	Ended September 2024
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	

Senior Official	Held by	Name of Company	Position Held	Type of Interest	Other Information
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	Salaried and shareholding	
Professor Sir Chris Whitty KCB	Self	University College London Hospitals and HTD	Consultant physician	Not remunerated	
Professor Sir Chris Whitty KCB	Self	University College London	Honorary Professor	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	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	

Senior Official	Held by	Name of Company	Position Held	Type of Interest	Other Information
Jonathan Marron CB	Self	Institute of Lifecourse Development, University of Greenwich	Advisory Board Member	Unpaid	
Jonathan Marron CB	Self	Downing Battock Institute	Advisory Board Member	Unpaid	
Matthew Style	Partner	Macmillan Cancer Support	Chief Executive	Salary	
Michelle Dyson	Brother	Advantage Mentoring Community Interest Corporation	Member and Director		
Michelle Dyson	Brother	Healthcare team at Apax Partners UK Ltd	Partner	Share of profits	
Michelle Dyson	Self	Norwood Ravenswood (charity)	Committee Member		
Shona Dunn CB	Partner	Thales UK	Tax Advisor		
Prof Lucy Chappell	Self	Medical Research Council	Member	Non-remunerated	
Catherine Frances	Partner	Senior Clinician at King's College Hospital NHS Foundation Trust	Employee	Salaried	

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.

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 in January 2025 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 Secretary, and other SCS who are board members at least annually within its annual report and accounts 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. They are published as part of the register of board members' interests. 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 considers all returns, and relevant interests are set out in public:

Special adviser name	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:** Caroline would recuse herself from any involvement with interactions with the organisations above. Other than declaration no other mitigations were required.
Robert Ede (Joined November 2022. Left July 2024)	Robert's wife works in a government-facing role at Biogen UK. **Mitigation:** Mitigations were in place including Robert not having any involvement with any dealings, discussion or advice related to Biogen and/or potential future contracts or bids. Robert also agreed to recuse himself from discussions of any report he authored before joining DHSC.
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 did 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 have arisen with respect to his former clients through his work as a special adviser, Peter would have declared this to the Permanent Secretary in a timely manner and recuse himself if appropriate.

Fergus Cameron Watt (Joined November 2023, Left May 2024)	Fergus was recused from involvement in discussions or matters relating to Bain & Co.

In July 2024, Thomas Gardiner, Sarah Harrison, Kirsty O'Brien and Will Prescott joined DHSC. Heather Iqbal joined DHSC in January 2025. They do not have any interests 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 and 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 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 435 of which 30 were senior civil servants. 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 17**, DHSC set BAR conditions for 11 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 17: BAR applications in DHSC 2024-25

Grade	Number of BAR applications assessed	Number of BAR conditions set
AO	0	0
EO	0	0
HEO	0	0
SEO	1	1
Grade 7	2	1
Grade 6	3	2
SCS	5	4
Special Adviser	3	3
Minister	0	0

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 two years. Individuals are required to submit BAR applications to their line manager prior to them accepting an outside appointment. Line managers are required to review this information and provide advice on any concerns, issues, or associated risks. They should also confirm that the information provided is accurate, add any further detail they feel is relevant and suggest conditions to be set. HR Operations review the application and confirm that enough detail has been provided for consideration.

For SCS3 applications, the HR Director reviews and sets conditions and these are then forwarded to the Advisory Committee on Business Appointments 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 DHSC 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 Senior Civil Servant leavers at both six 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

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 (HMT) 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 2024 no.1323 (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 income and expenditure, statement of financial position and cash flows of the departmental group for the financial year.

HMT has appointed the Permanent Secretary of DHSC as Principal Accounting Officer of DHSC. In preparing the accounts, the Principal Accounting Officer of DHSC is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by HMT, 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 non-departmental and other arm's length public 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.

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 funds 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 bodies for which the Principal Accounting Officer is responsible, are set out in Managing Public Money published by HM Treasury.

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 herself aware of any relevant audit information and to establish that DHSC's auditor is aware of that information.

Sir Chris Wormald was the Accounting Officer prior to his departure on 13 December 2024 and Professor Sir Chris Whitty assumed interim Accounting Officer responsibilities for the period of 16 December 2024 until my appointment on 16 June 2025. Following the provision of a range of assurances, I took on the role of Accounting Officer. As such, I have assumed responsibility for signing off the Governance Statement for the year 2024-25.

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 2024-25 and is current up to the date this annual report was signed.

As Principal Accounting Officer for the DHSC 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'. Further detail regarding the Government Internal Audit Agency's audit opinion is provided at page 163.

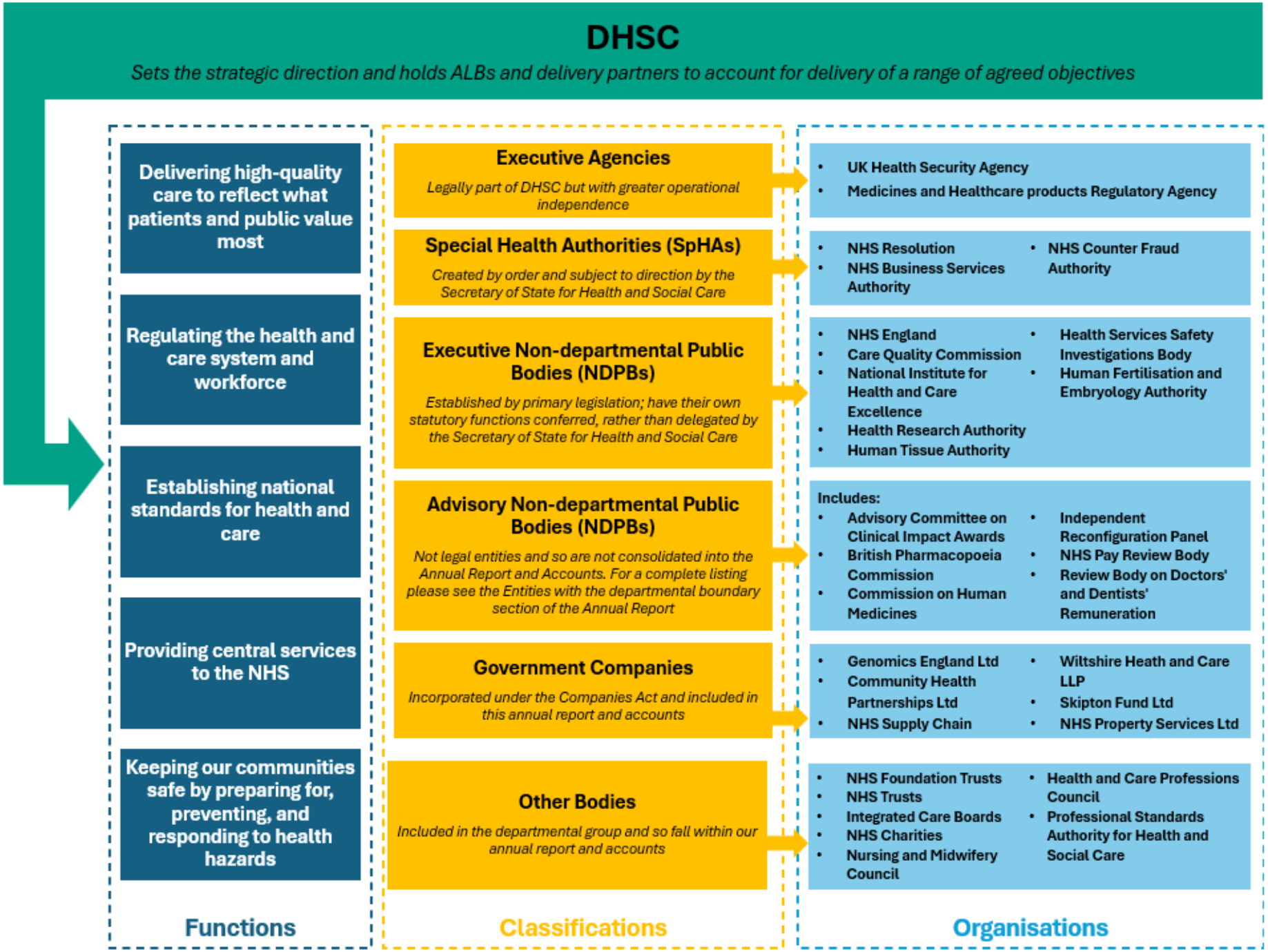
The departmental group is described at pages 317– 320 of this Annual Report and Accounts. Each body within this group has its own constitution and formal relationship with DHSC. As guardian of the system overall, DHSC is responsible for providing oversight and direction, and retains overall accountability for the use of resources and delivery of objectives.

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 DHSC staff. Each year I issue formal, written delegations of accountability to my directors general who in turn send such delegations to their directors. Each accountability letter sets out 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 departmental sponsorship responsibilities 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, as can be seen in the infographic below:


DHSC
Sets the strategic direction and holds ALBs and delivery partners to account for delivery of a range of agreed objectives
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
Functions
Executive Agencies
Legally part of DHSC but with greater operational independence
Special Health Authorities (SpHAs)
Created by order and subject to direction by the Secretary of State for Health and Social Care
Executive Non-departmental Public Bodies (NDPBs)
Established by primary legislation; have their own statutory functions conferred, rather than delegated by the Secretary of State for Health and Social Care
Advisory Non-departmental Public Bodies (NDPBs)
Not legal entities and so are not consolidated into the Annual Report and Accounts. For a complete listing please see the Entities with the departmental boundary section of the Annual Report
Government Companies
Incorporated under the Companies Act and included in this annual report and accounts
Other Bodies
Included in the departmental group and so fall within our annual report and accounts
Classifications
UK Health Security Agency
Medicines and Healthcare products Regulatory Agency
NHS Resolution
NHS Business Services Authority
NHS Counter Fraud Authority
NHS England
Care Quality Commission
National Institute for Health and Care Excellence
Health Research Authority
Human Tissue Authority
Health Services Safety Investigations Body
Human Fertilisation and Embryology Authority
Includes:
Advisory Committee on Clinical Impact Awards
British Pharmacopoeia Commission
Commission on Human Medicines
Independent Reconfiguration Panel
NHS Pay Review Body
Review Body on Doctors' and Dentists' Remuneration
Genomics England Ltd
Community Health Partnerships Ltd
NHS Supply Chain
Wiltshire Heath and Care LLP
Skipton Fund Ltd
NHS Property Services Ltd
NHS Foundation Trusts
NHS Trusts
Integrated Care Boards
NHS Charities
Nursing and Midwifery Council
Health and Care Professions Council
Professional Standards Authority for Health and Social Care
Organisations

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 (directors general or directors) who oversee DHSC's relationship with their ALBs. They are responsible for ensuring that activities across the six capabilities outlined in the Cabinet Office ALB Sponsorship Code of Good Practice are met. Senior sponsors are supported in delivering this responsibility by a sponsorship team, in addition to DHSC corporate teams.

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.

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 board is supported by the committees shown in the structure chart at **Figure 17**. Updates are provided to the Departmental Board on the activities of the Executive Committee, the Audit and Risk Committee (ARC) and other major subcommittees.

To manage any conflicts of interest, DHSC maintains a register of board member interests. Board members are required to declare any potential conflicts that arise. Where a potential conflict is identified, board members are not involved in discussions or decisions on the matter in question.

The board and its committees consider management information covering a variety of disciplines, including financial data and information on departmental strategies and risks. High level risks were regularly reviewed by ARAC and the Performance and Risk Committee.

Corporate governance code

In 2024–25, DHSC continued to align its governance approach with the principles set out in Corporate Governance for Central Government Departments (2017). While full compliance with the Code was not achieved, DHSC remained committed to upholding best practice standards wherever possible.

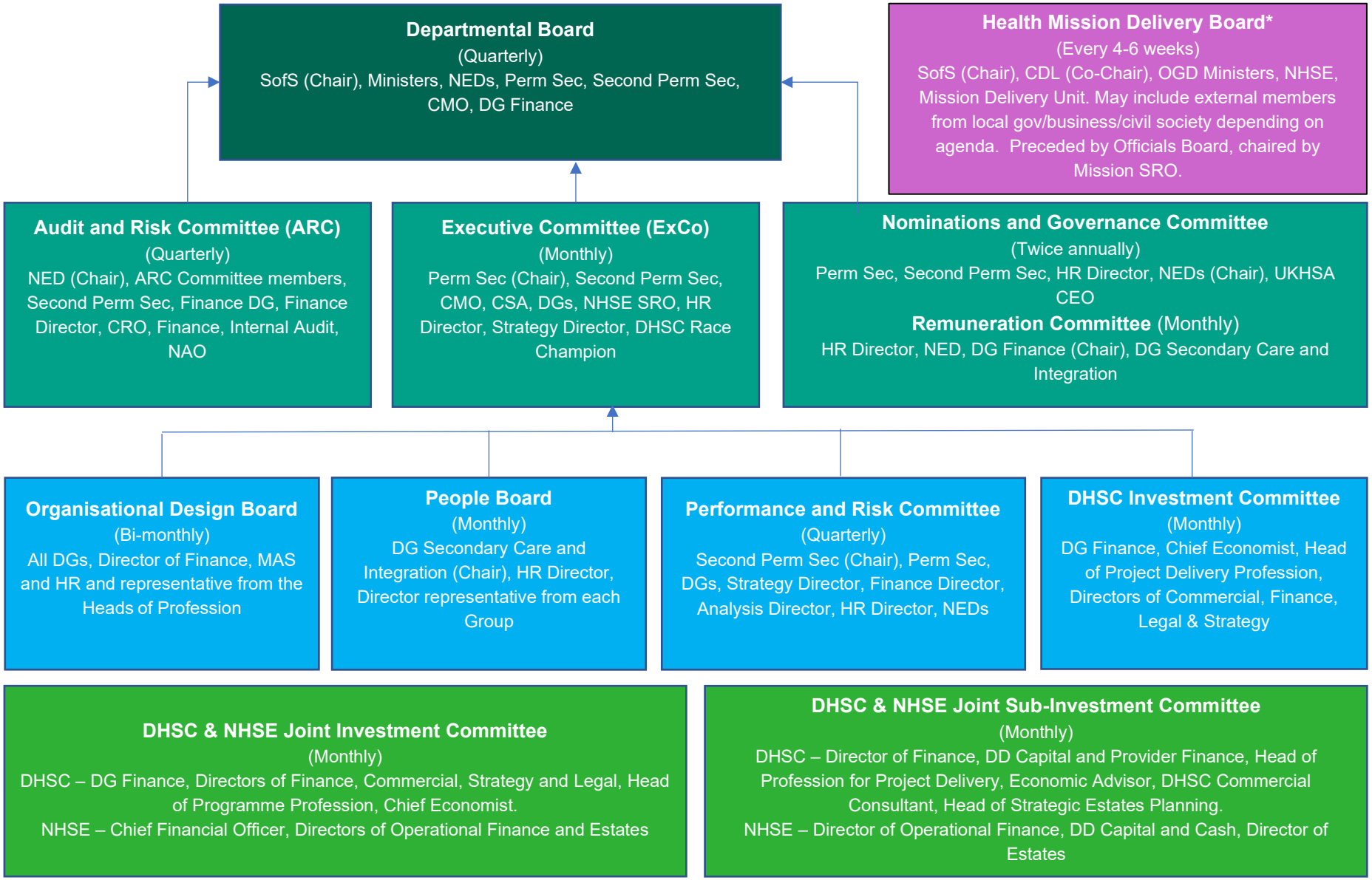
The Secretary of State decided to refresh the non-executive membership of the Departmental Board, following the formation of the new government in July 2024. Although

the transition period meant that no Board meetings were held while awaiting the appointment of new non-executive members — who formally joined in January 2025 — existing non-executives remained in post to maintain continuity. A Board meeting was convened at the earliest opportunity in early February 2025.

There was therefore a period of approximately six months when the Departmental Board did not meet. As a consequence of this, we did not achieve full compliance with the Corporate Governance code. To ensure that the refreshed Board and new governance arrangements had time to develop, the Board Effectiveness Evaluation was rescheduled for the 2025-26 financial year, with no evaluation conducted in 2024-25. This pause will allow for a more meaningful assessment of governance now the new structures are fully embedded.

Throughout this period, executive governance of DHSC continued without interruption, and the Audit and Risk Committee (ARC) remained active under the leadership of the non-executive chair, who continued in post into 2025-26.

Figure 17: Departmental Board and Committees structure



The committees are responsible for the following:

Executive Committee: DHSC's major decision-making body and oversees strategy, finance, performance, and corporate issues in DHSC. It reports to the Departmental Board quarterly, with reports from various sub-committees.	Met 11 times in reporting year
Discussed: delegated (non-senior civil service) and senior civil service grades pay award; people survey (twice); Office for Health Improvement and Disparities (three times); cyber risks; Infected Blood Inquiry lessons learned; health and economic growth; equality, diversity and inclusion; new government priorities; health inequalities; and major projects.	

Remuneration Committee: Acts on behalf of the Secretary of State for Health and Social Care and has ultimate accountability for the ALBs' adherence to the executive and senior manager pay framework and governance processes. This role also applies to the approval of senior pay (£150,000 and above) in DHSC's government-owned companies.	Met 12 times in reporting year. Reviewed three senior pay cases out of committee.

Nominations and Governance Committee: advises on matters relating to senior leadership and succession planning for DHSC.	Met twice in reporting year
Discussed: end-of-year performance assessments and ratings for the directors general and CEOs for the UK Health Security Agency and Medicines and Healthcare products Regulatory Agency and their talent management and development.	

Audit and Risk Committee: has a standing meeting agenda for its four full committee meetings which covers finance, internal and NAO audits, value-for-money studies, departmental risk appetite and the board assurance framework. It also regularly discusses Public Accounts Committee reports and recommendations, counter fraud, cyber security, DHSC's major projects portfolio and the Government Major Projects Portfolio.	Met four times in reporting year

In 2024-25, there were deep dive discussions on winter planning, cyber security, and supply chain resilience. The committee also held discussions on DHSC critical models, finance transformation, NHS Resolution, the National Security Risk Assessment, the NHS BSA, finance pre-recess options, UKHSA, and the transformation programme.

Table 18 summarises respective committee or board member attendance at the Departmental Board and the four next-tier committees.

Table 18: 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 1 time	Met 11 times	Met 4 times	Met 2 times	Met 12 times
Rt Hon Wes Streeting MP	1	-	-	-	-
Stephen Kinnock MP	-	-	-	-	-
Karin Smyth MP	-	-	-	-	-
Ashley Dalton MP	-	-	-	-	-
Baroness Gillian Merron	-	-	-	-	-
Andrew Gwynne MP	-	-	-	-	-
Rt Hon Victoria Atkins MP	-	-	-	-	-
Maria Caulfield MP	-	-	-	-	-
Helen Whately MP	-	-	-	-	-
Andrew Stephenson MP	-	-	-	-	-
Rt Hon Dame Andrea Leadsom MP	-	-	-	-	-
Lord Markham	-	-	-	-	-
Officials					
Sir Chris Wormald	-	10 (out of 11)	-	1 (out of 1)	-
Professor Sir Chris Whitty	1	9 (out of 11)	-	2	-
Shona Dunn	-	2 (out of 2)	-	-	2 (out of 2)
Tom Riordan	1	6 (out of 6)	-	1 (out of 1)	-
Clara Swinson	-	3 (out of 4)	-	-	-
Jonathan Marron	-	10 (out of 11)	-	-	-
Professor Lucy Chappell	-	7 (out of 11)	-	-	-
Michelle Dyson	-	11 (out of 11)	-	-	-
Andy Brittain	1	7 (out of 11)	4 (out of 4)	-	11 (out of 12)
Matthew Style	-	11 (out of 11)	-	-	9 (out of 12)
Catherine Frances	-	3 (out of 3)	-	-	-
Jenny Richardson	-	8 (out of 11)	-	1 (out of 1)	11 (out of 12)
Lorraine Jackson	-	10 (out of 11)	-	-	-
Paul Macnaught	-	10 (out of 11)	-	-	-
Hugh Harris	-	1 (out of 1)	-	-	-

Jenny Harries		-	-	2 (out of 2)	-
Zoe Bishop	-	0 (out of 1)	-	-	-
Non-Executive Directors					
Rt Hon Alan Milburn	1	-	-	1 (out of 1)	-
Sir Richard Douglas	1	-	4	1 (out of 1)	6 (out of 8)
Samantha Jones	1	-	-	-	1 (out of 10)
Gerry Murphy	-	-	1	-	3 (out of 4)
Naomi Eisenstadt CB	1	-	-	-	-
Phil Jordan	1	-	-	-	-
Baroness Camilla Cavendish	1	-	-	-	-
Will Harris	-	-	-	-	-
Sir Roy Stone	-	-	-	0 (out of 1)	-
Steve Rowe	-	-	-	-	-
Doug Gurr	-	-	-	-	-
Independent Members					
Anne Barnard	-	-	4	-	-
Graham Clarke	-	-	4	-	-
Richard Hornby	-	-	2 (out of 4)	-	-
Chris Young	-	-	1 (out of 1)	-	-

DHSC also has the following other major committees:

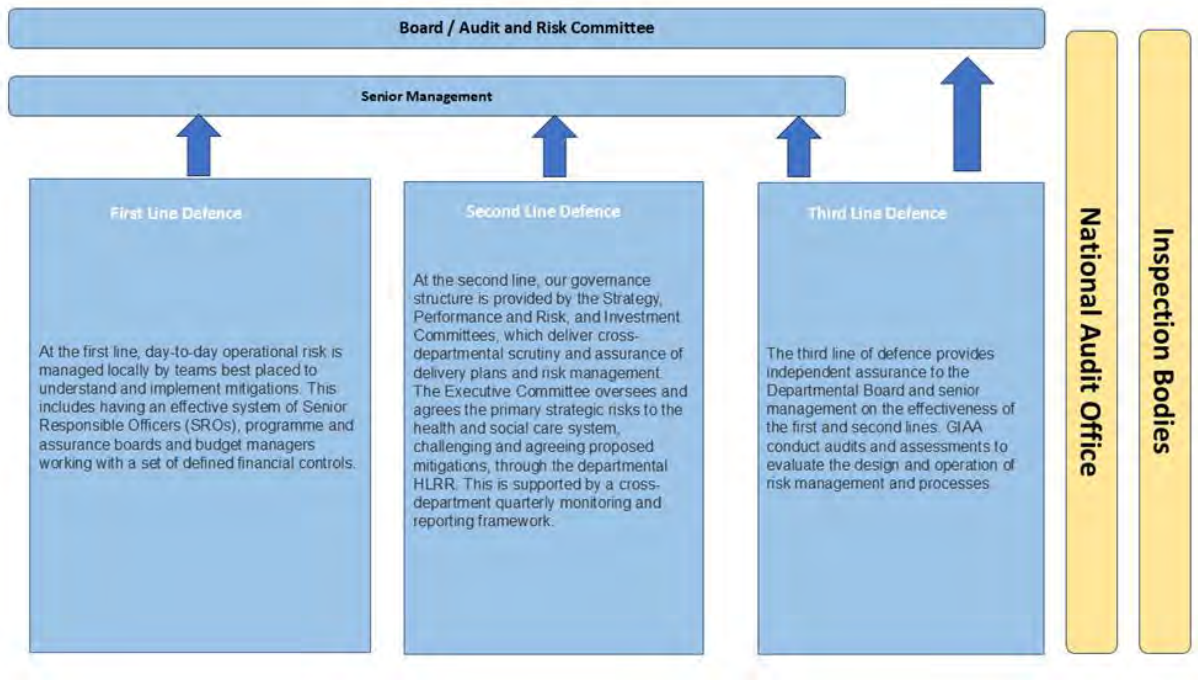
Performance and Risk Committee: oversees departmental performance and management of DHSC's high-level risks. By making a regular assessment of DHSC's performance and risks to delivery, the Committee ensures that the Departmental Board and the Executive Committee are supported and held to account for the delivery of the business plan/Outcome Delivery Plan.	Met four times in reporting year
Discussed: achievements and concerns, overall progress towards objectives, manifesto commitments, core metrics and key risks to performance and the performance of key corporate functions.	

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. 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.

People Board: As a sub-committee of the DHSC Executive Committee, People Board channels all the key people matters with DHSC-wide implications into one forum and oversees delivery of people-related initiatives in DHSC, ensuring activity is aligned to DHSC strategy and priorities.	Met ten times in reporting year
Discussed: 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'. PB 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.	

Core assurance framework, risk management and control

Three lines of defence



DHSC applies the 'three lines of defence' principle to its management of risk illustrated above. At a departmental level we maintain a High-Level Risk Register (HLRR) of the top strategic risks. The risks range from external threats such as pandemics, cyber-attack, and risks to delivery of performance improvement in the NHS and social care, through to internal risks on finance. The HLRR is reviewed on a quarterly basis by PRC (second line of defence) and receives independent quarterly review by the ARC, (third line of defence).

Through this scrutiny 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 ARC.

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. ARC meets quarterly to provide independent

challenge, non-executive scrutiny, and hold DHSC's senior leadership to account. This includes:

- challenging and assessing the robustness of how DHSC manages financial and strategic risk
- reviewing and recommending the departmental Annual Report and Accounts (ARA) are signed off, and
- ensuring DHSC is meeting recommendations from the NAO and Public Accounts Committee reports and investigations.

The PRC chair also 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 and maintains the HLRR, 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 PRC and ARC. 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 2024-25 have included:

External risks	System-wide risks	Change based risks
➢ The health and care system's resilience to cyber-attack ➢ The global threat of antimicrobial resistance and risk relating to pandemics/major infectious disease outbreaks ➢ The threat of chemical, biological, radiological or nuclear attack ➢ Risks to Critical National Infrastructure	➢ The risk of demand for NHS services growing beyond that assumed in the long-term plan ➢ Health disparities ➢ Inadequate levels of funding ➢ The risk of industrial action ➢ The risk that the system does not recruit and retain the right numbers and skills of staff needed to deliver care, across	➢ The risk that DHSC's workforce has insufficient capacity and/or capability to provide a quality service

➢ Continuity of supply of medicines and medical products	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	

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 also receives the quarterly performance and risk packs of ARC and PRC 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 2024-25, directors and directors general participated in the quarterly performance and risk reporting and bi-annual assurance meeting (BAM) process. For director general groups where meetings have not taken place due to scheduling conflicts, full BAM reports have been completed and 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 2024-25, DHSC used 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. Governance, scrutiny and challenge continue to be delivered through the Portfolio Oversight Board which has refined its data set for reporting over the past year. The Senior Responsible Owner (SRO) network continues to meet and discuss common issues, areas

of challenge to delivery, best practice and learning. This has been of particular value when addressing some of the issues across the MPP that have impacted delivery confidence. Advice has been given to ExCo on the approach to the MPP to deal with risks of declining delivery confidence including approaches to funding, approvals and resourcing.

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 National Infrastructure and Service Authority. There has been a successful move to the Government Reporting Integration Platform (GRIP) from the Treasury Online System for Central Accounting and Reporting (OSCAR) for GMPP Reporting.

Changes in the reporting year have seen the pausing of reporting for the Science Hub programme while scope and policy is settled. Also, in the year, we have seen the early closure of a programme of work on Adult Social Care Workforce due to shift in policy and the closure of the AI Lab programme as it had arrived at 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. 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. Details of the latest return can be found here.

On 17 July 2025 the Secretary of State for Health and Social Care confirmed that the government would proceed with the construction of a new, state-of-the-art health security campus - including new high containment laboratory facilities - in Harlow, Essex. This site will replace the UK Health Security Agency's (UKHSA) existing facilities in Colindale and Porton Down and will form part of the government's network of National Biosecurity Centres as announced in the National Security Strategy.

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 and promoting growth. 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. Where regulation is required DHSC's Better Regulation Unit works closely

with teams to consider how best to develop proportionate and targeted regulatory solutions through the development of policy.

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. DHSC monitors its regulatory policies and reports regularly to the Department for Business and Trade (DBT) on qualifying regulatory measures. DBT is also leading the cross-Whitehall regulatory reforms into which DHSC is contributing.

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 in May 2024. In the 2024-2025 reporting period, fewer than five formal whistleblowing concerns were raised in DHSC. Figures of five or fewer whistleblowing concerns are not published to protect anonymity.

During 2024-2025, 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 through an ongoing 'safe to challenge' programme.

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 six months by DHSC's People Board.

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 2023-24 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.

As part of this, the core department continues to provide strong support to and oversight of UKHSA financial management, in particular, under the leadership of the DHSC Director

General Finance. This includes attendance at quarterly senior governance meetings and monthly assurance meetings.

Finalisation of group entities' accounts

DHSC is committed to laying its ARA in as timely a manner as is possible as this is critical for Parliamentary scrutiny and is implementing a multi-year plan which aims to bring forward the publication of the DHSC group ARA each year and return to pre-recess publication as soon as practicable.

Under this plan, we published last year's 2023-24 ARA on 17 December 2024, nearly six weeks earlier than the 2022-23 ARA (25 January 2024). We had intended to publish the 2024-25 ARA in November 2025. However, delays to the certification of the Consolidated Provider Account have resulted in a revised laying date for the group ARA of December 2025. The later certification of the CPA was due to delays to the audited accounts of one foundation trust. Following late completion to audited accounts in 2023-24, the trust experienced difficulties in preparing its 2024-25 draft accounts which has delayed completion of the associated audit, alongside a revised audit risk profile. As the CPA is a material component of the DHSC group, these delays have also led to DHSC not achieving its November target for its group ARA. Further detail regarding the timeliness of the CPA can be found in the CPA annual report and accounts.

Significant progress has been made in the preparation and audit of the UKHSA ARA in 2024-25. Details of the improvements and challenges will be disclosed in the UKHSA ARA.

Regarding the NHS sector, there have been fewer delayed local audits in 2024-25. However, NHS audit timescales remain highly dependent on the capacity of the private sector firms undertaking them and the regulatory requirements and standards to which the firms must work, which is further impacted by the application of ISA 600. These are factors which are largely outside DHSC's control and remain the key risks to our multi-year plan.

DHSC plans to accelerate the publication of its 2025-26 ARA, into October 2026, whilst taking into account next year's conference Parliamentary recess timings.

It is imperative that DHSC continues to work in partnership with the private sector audit firms to set achievable audit timescales. DHSC has therefore engaged with audit firms to agree stretching but deliverable deadlines for NHS audits each year, alongside work with all key stakeholders to reform and build capacity in the local audit market. DHSC is also actively working to bring forward the NHS financial planning timetable, as part of the wider efforts to create new financial foundations for the NHS as set out in the 10 Year Health Plan for England in July 2025.

Our aspiration is that, over the longer-term, capacity and resilience of the private sector audit market will be strengthened for NHS bodies and support accelerated audit

timescales, potentially paving the way to a return to pre-summer recess laying of the full group ARA.

DHSC contract management

Through 2024-25 the commercial operations team 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 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 three-tiered approach based on the proportionate application of resource, governance, and process determined by the strategic importance of each contract. Classifying a contract involves reviewing factors that would have an impact on DHSC should the contract, for any reason, fail. These factors include the total value of the contract, risk profile, and market insights.

Commercial leads from the commercial operations team engage with senior contract owners of the highest risk contracts to reinforce the importance of contract management and their respective roles and responsibilities through an annual ‘assurance framework attestation’ process.

Contract management capacity is regularly reviewed to ensure 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. As at 31 March 2025, the DHSC contract portfolio stood at 377 contracts with total value of £2.8 billion; the portfolio consists of 14 gold contracts, 56 silver, 216 bronze and 91 transactional contracts.

DHSC information risk management and assurance

Information risk management and assurance expertise continued to provide DHSC advice throughout 2024-25, ensuring information is effectively used, lawful, kept securely, and shared responsibly to support DHSC in decision-making and improving services. Reporting into the Information Governance Committee which acts as supervisory and strategic decision-making body and escalation route for information governance and data protection across DHSC. The Committee holds overall accountability for the management of DHSC’s information and data protection risks and reports into the Senior Information Risk Owner.

DHSC recorded 93 data-related incidents between April 2024 and March 2025, a decrease of 20 on the previous year. Of the 93 reported incidents, one met the criteria to be referred to the Information Commissioner’s Office (ICO) (compared to zero in the previous year),

following the unauthorised sharing to a political website of comments made by DHSC staff on the intranet in respect of signposting to mental health support following the nationwide rioting following the Southport knife attack. No personal data was published. We continue to work with the ICO, to ensure that data protection implications and obligations are considered and met.

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 individuals in DHSC. Staff are encouraged to consider equality from the perspective of improving outcomes for people, rather than as a legal duty or process, to ensure that equality is put at the heart of all policy and decision-making. Training sessions on the public sector equality duty and how it applies to DHSC are made available. Staff are also encouraged to engage with lawyers during the policy and decision-making process to ensure that legal duties are met.

Equity and human rights compliance is considered through the DHSC BAM meetings with each director general group so that where issues arise during the year, they are appropriately reported and discussed. It also addresses identified weaknesses to drive improvements.

Staff are required to consider compliance with the public sector equality duty and evidence of this is provided in submissions to ministers which include a checklist that highlights the public sector equality duty as something that must be considered by the lead policy team developing the policy. The most current information on how DHSC complies with the public sector equality duty can be found in the Equality in 2024; how DHSC met the public sector equality duty report published in September 2025.

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.

As LGD for pandemic preparedness, DHSC is responsible at a national level for leading work to identify serious risks and ensuring that the right planning, response and recovery arrangements are in place.

DHSC is embedding a new strategic approach to pandemic preparedness, including learning 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 range of scenarios, and this has been used to inform the development of the Respiratory Response Plan, the pandemic preparedness strategy and to inform proposals for the Spending Review. DHSC continues to evaluate pandemic capabilities to identify future improvements. Details on Spending Review Phase 1 outcome are included in the performance section earlier in this Annual Report.

A Tier 1 exercise (Exercise Pegasus) was held in autumn 2025 to test our readiness to respond to a major pandemic.

As part of its pandemic preparedness, DHSC seeks to ensure ready access to appropriate clinical countermeasures when needed through stockpiling or other contractual arrangements as appropriate. These include personal protective equipment (PPE), hygiene consumables, medicines (including antivirals and antibiotics), medical consumables, and an advance purchase agreement for a pandemic specific influenza vaccine.

DHSC is committed to learning lessons from the Covid 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. PPE stockpiles have been replenished where appropriate using excess stock originally procured for the Covid pandemic. Dynamic stockpiling (where stock is rotated into business-as-usual) is being implemented where possible, which can reduce re-procurement and disposal costs and represent better value for money. A longer-term strategy for pandemic countermeasures is in development, taking into account lessons from the Covid pandemic and recommendations made by DHSC’s Review of Emergency Clinical Countermeasures. The longer-term strategy will consider other approaches to ensure ready access to countermeasures when needed, such as alternative contractual arrangements and incentivising UK manufacturing.

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.

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 2024-25 we have continued to increase cyber resilience across the health and care sector.

Since the March 2023 publication of the Cyber security strategy for health and social care: 2023 to 2030, the programme has invested in new capabilities and services to enable good foundations to be put in place to improve Cyber resilience. This includes direct funding to the frontline to target critical risk reduction activity, increasing the Cyber workforce through bespoke training offers, launching a cyber apprenticeship scheme and delivering a threat intelligence sharing capability.

Funding constraints outside of the programme's control and the need to reprioritise over the last few years has meant the programme has been unable to deliver to the level of transformation laid out in the original business case to 2025. Despite this, the programme however has delivered a significant number of technical remediation projects which have reviewed local infrastructure vulnerabilities and where possible corrected these; launched a Threat Intelligence Sharing Platform which provides real-time information, enabling healthcare organisations to rapidly receive and share threat intelligence to enable an informed cyber threat response; enabled Tamper Protection across the whole NHS estate which protects against cyber attacks that disable security features on devices, allowing the installation of malware, and the exploitation of data, identity and devices; aligned the Data Security Protection Toolkit to the National Cyber Security Centre's Cyber Assessment Framework to support organisations to remain current with new security measures to meet new threats and risks and supported the development of the cyber profession within the NHS by publishing a cyber competency framework and job description library, a cyber mentoring scheme, cyber apprenticeships and a cyber school. The programme has developed the Programme Business case for 2026-2030 and this provides the opportunity to deliver on the ambitions of the Cyber Strategy.

In 2024-25 under NHS England's transformation directorate, DHSC continued to work in partnership with NHS England to reduce exposure to cyber risk in its ALBs, 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 £17 million capital to 121 NHS trusts and five ALBs. This was to invest in numerous cyber risk reduction initiatives, including vulnerability management, network segmentation, backup capability, secure access and security event logging. A further £4 million of capital and £10 million of revenue funding was invested in centrally

developed and procured services to assess and improve critical infrastructure in selected NHS trusts. As well as continuing other foundational work, DHSC focused on meeting the ambitions of the Cyber Security Strategy for Health and Social Care to 2030.

In September 2024, the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. Moving the DSPT from the National Data Guardian standards to the NCSC CAF, changed the evidence requirements for cyber standards for NHS organisations and provides a framework for increasing standards to 2030. As of July 2025, there were over 61,000 DSPT submissions across health and adult social care, with all NHS trusts, ALBs, Commissioning Support Units and ICBs publishing independently audited CAF based DSPT submissions providing a re-baselining of standards and performance. 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 2025, 72% of adult social care providers had met or exceeded the DSPT standard. This is a slight increase from 70% at March 2024.

Microsoft Defender for Endpoint 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 (JCU) works with NHS England to issue high severity alerts (HSA) to warn and inform NHS organisations what action they need to take. During the reporting year, we had 16 HSAs and have made significant improvements and enhancements to the alert process, improving the overall user experience.

In 2024-25, we continued to use our regulatory powers under the Network and Information Systems (NIS) Regulations to address some of the biggest risks to the sector. This year there was a particular focus on Multi-Factor Authentication (MFA), with 11 NIS notices issued to drive compliance with the NHS England's MFA Policy.

Cyber Incidents, including WannaCry in 2017, Advanced in 2022, and Synnovis in 2024, demonstrate the frequency and impact of significant cyber-attacks on health and social care. The Synnovis attack had a significant impact on healthcare and patients, including an estimated financial impact of £32.7 million as reported in accounts filed with Companies House. Following debriefs and interviews with key participants from the incident, DHSC JCU have identified a set of lessons from the Synnovis attack and are in the process of assigning recommendations to owners and producing a final internal report.

The cyber-attack on pathology supplier Synnovis in June 2024 further highlighted the increasing and changing threat to the supply chain. Improving the cyber security resilience of the supply chain is highlighted in the Cyber Strategy to 2030 and is being addressed through key programmes of work such as the recently launched supply chain charter

which is the first step towards more formal regulated relationships with suppliers and the development of a national platform to identify and manage supplier risk.

We acknowledge that this cyber-attack has been identified, both in media coverage and in reports by the Integrated Care Board, as a contributing factor in the tragic death of a patient. This is the first time a cyber-attack has been publicly linked to a patient death.

In June, further media attention followed a Health Service Journal article reporting that King's College Hospital had conducted a harm review across NHS services in London, including hospitals, primary care, and mental health trusts. The review confirmed that a patient died after experiencing a delay in receiving blood test results. While the delay was one of several contributing factors, it highlights the serious impact that disruptions to healthcare systems can have on patient safety. Further information, including questions and answers which address common concerns, can be found on the NHS England website.

JCU continually work with NHS England Cyber Operations to respond to further lower-profile but still significant incidents, such as the attack on HCRG Care Group. DHSC and NHS staff supported the company in their response and recovery and worked with affected organisations to assist in managing the impacts.

In response to the threat, JCU have been working with key stakeholders to develop a strategy and programme of cyber exercising to test and improve resilience and capacity across the system. The team is also using lessons learned from recent incidents and exercises to improve processes and policy around our response to cyber incidents.

COVID-19 Inquiry

The UK COVID-19 Inquiry was set up to examine the UK's response to the Covid pandemic, assess its impact and identify lessons to guide future preparedness.

In 2025, further to modules 1 to 3 hearings last year, hearings for module 4 (vaccines and therapeutics), module 5 (procurement), module 6 (care sector), module 7 (test, trace and isolate) and module 8 (children and young people) are now complete and reports are being drafted by the Inquiry. Hearings for module 9 (economic response) will take place from 24 November to 18 December 2025. Hearings for module 10 (impact on society) will take place from 16 February to 5 March 2026.

The government responded to the Inquiry's module 1 report on resilience and preparedness in January 2025. The first update on the implementation of the recommendations was submitted to the Inquiry and published to GOV.UK on 8 July 2025. Further updates will be published at six-month intervals, with the next scheduled for January 2026.

The Inquiry's module 2 report on core UK decision-making and political governance was published on 20 November 2025. The Prime Minister issued a written ministerial statement following its publication and the laid the report in both Houses. The government is considering the Inquiry's findings and recommendations in detail and will respond in due course, and it remains committed to learning the lessons needed to protect and prepare us for the future.

DHSC remains committed to responding to the Inquiry with openness and transparency. At the end of November 2025, DHSC had submitted more than 58,000 pieces of evidence to the Inquiry, including written individual witness and corporate statements, and has supported 35 witnesses, including then serving and former ministers and senior civil servants to give evidence at the hearings.

Clinical negligence

DHSC spent £3.1 billion on clinical negligence payments across all clinical schemes in 2024-25, of which £2.9 billion (2023-24: £2.6 billion) related to the largest scheme, the clinical negligence scheme for trusts. Repeated inquiries and investigations have highlighted significant issues with patient safety, and DHSC 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, and
- external factors including demand and financial pressures.

Problems normally arise in systems due to the complex interplay of these factors.

The NHS Resolution Annual Report and Accounts 2024-25 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.

The rising costs of clinical negligence claims against the NHS in England are of great concern to government. The total of payments made by NHS Resolution for clinical negligence claims in 2024-25 of £3.1 billion represents a doubling in the last ten years. The causes of the overall cost rise are complex and there is no single fix - costs are likely to be rising because of a range of factors, including higher compensation payments and legal costs rather than more claims or a decline in patient safety.

In the 10 Year Health Plan we announced David Lock KC will be providing expert policy advice on the rising legal costs and how we can improve patients' experience of clinical negligence claims, ahead of a review by DHSC in the autumn. The results of David Lock's work will inform future policy making in this area.

Fraud prevention

DHSC anti-fraud unit

DHSC remains committed to ensuring that public funds are used effectively and transparently to deliver on the Secretary of State's priorities. Fraud diverts resources from patients and frontline services and undermines public trust. Preventing and responding to fraud is integral to ensuring we have an NHS fit for the future.

Over the past year, the DHSC Anti-Fraud Unit (DHSC AFU) has continued to strengthen its counter fraud framework at a national level, aligned with the Government Counter-Fraud Functional Standard (GCFFS also known as 'GovS 013') and taken a risk-based approach to protecting funds across core priority areas. The DHSC AFU has worked in partnership with all parts of DHSC, its ALBs and owned companies.

A comprehensive Counter Fraud Strategy for 2023-26 is in place, with a vision of 'A system-wide approach to tackling fraud which protects taxpayers' money for better patient care'. It focuses on four key areas, namely:

- proactivity and prevention
- utilising digital and data analytics
- collaboration and coordination, and
- response and enforcement.

Our response to tackling fraud has been, and continues to be, based on the following principles:

- clear lines of accountability;
- a collaborative approach between organisations
- recognising that reducing fraud or financial loss is the responsibility of all staff.
- ensuring fraud risks are assessed and fraud prevention and detection are supported by effective monitoring, and
- acknowledging that work on fraud and other types of financial loss is critical to maintaining a sustainable and financially balanced NHS.

DHSC AFU continues to maintain a close working relationship with the Public Sector Fraud Authority (PSFA). The Counter Fraud Board (CFB) also brings together DHSC, health facing ALBs and the PSFA. We also report quarterly action plan updates to the PSFA. A close relationship with the PSFA ensures we are at the forefront of any government counter fraud developments and a counter fraud response that is aligned with the wider system.

The DHSC AFU have developed an enterprise and thematic Fraud Risk Assessment (FRA), to expand the oversight and understanding of fraud risk across departmental activity and groups. We have improved the fraud risk template to contribute greater detail to the enterprise and thematic processes. We also advise colleagues across DHSC on how to complete Full FRAs for specific spend areas and offer assurance on these assessments, as well as guidance on how to reduce identified risks where possible. DHSC AFU has worked with teams across DHSC, including Government Major Projects Portfolio (GMPP) and Investment Appraisals, to strengthen guidance and oversight of Initial Fraud Impact Assessments (IFIAs). Guidance has been published encouraging the use of IFIAs for capital spend above £30 million and emphasising mandatory completion for all GMPP programmes. DHSC had no GMPP programmes which necessitated an IFIA in 2024-25.

The New Hospitals Programme (NHP) is an active DHSC GMPP programme and is listed on the PSFA High Fraud Risk Portfolio. DHSC AFU is proactively engaged with stakeholders including PSFA and NHS England, DHSC programme leads and the NHSCFA to manage fraud risks within the programme.

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 2024 to provide detailed insight of the counter fraud capability across government.

NHS Counter Fraud Authority (NHSCFA)

The NHSCFA is a special health authority established in November 2017, DHSC AFU are the departmental sponsor. It is responsible for preventing, detecting and investigating fraud, corruption or other unlawful activities, carried out against or otherwise affecting the NHS and the wider health sector in England.

The NHSCFA had an average FTE of 185 during the reporting period which includes nine FTE on short-term contracts. NHSCFA implements DHSC's strategic plan under the sponsorship of DHSC AFU.

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. 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 to aid delivery of the 10 Year Health Plan, modernise the NHS and protect funds meant for patient care.

The Strategic Intelligence Assessment (SIA) 2025 (using 2023-2024 financial data and 2024-2025 reporting data) estimates the financial vulnerability to fraud in the NHS, in England, is £1.346 billion (not actual fraud losses) compared to £1.316 billion for 2023-2024. The increase is primarily linked to increased overall expenditure in the NHS, rather than evidence of higher levels of fraud, and we saw an overall decrease in the percentage of the budget vulnerable to fraud. The fraud vulnerability estimate remains less than 1% of the total NHS budget for 2024-25. This demonstrates an effective counter fraud approach across the health sector in England.

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 £10 million in the NHS Counter Fraud Authority over two years. This includes Project Athena, which 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. Project Athena has been able to support the sector in demonstrating a counter fraud financial impact of £28.5 million in its first year.

Further information regarding measures being taken to combat fraud can be found in the 2025 SIA.

Local counter fraud work

The NHS Standard Contract requires all organisations commissioning and providing NHS services to put in place and maintain appropriate counter fraud arrangements. NHS England has also published statutory guidance for ICBs on their counter fraud responsibilities.

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 2025, there were 231 LCFSs. Other NHS-facing ALBs with national coverage routinely undertake activity to tackle NHS fraud such as fraud awareness, prevention and detection.

Counter fraud oversight

The CFB maintains oversight and coordination of the response to fraud by key national organisations. 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, DHSC's best estimate is that 2.4% (£324 million of £13.8 billion) of expenditure on PPE was fraudulent and, to date, we have recovered £70 million and also assess a further £163 million was prevented from being lost in the first place.

The DHSC AFU is not currently investigating any further cases of fraud connected to COVID-19, however, cases of suspected fraud have been referred to the National Crime Agency and other law enforcement agencies, including HMRC, where there are suspicions of criminal conduct. Examples of suspected criminal conduct include, but are not limited to, provision of suspected false or forged certificates of conformity, false representations in bidding for the contract and not supplying any goods despite taking a sizeable deposit.

UK PPE supplier data has also been shared with HMRC under a Memorandum of Understanding. This has supported HMRC tax investigations into UK based PPE suppliers and/or company directors.

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

The 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, and
- providing advice to management on internal control implications of proposed and emerging changes.

The team operates in accordance with the Global Internal Audit Standards and to an internal audit plan, which has been agreed with the Accounting Officer and the DHSC 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

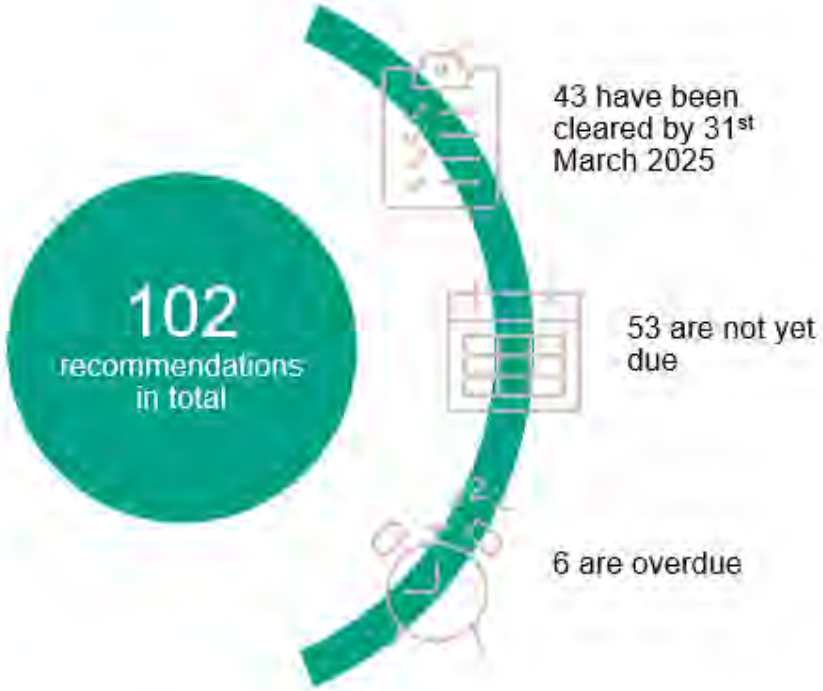
have been discussed and the resulting action plan is agreed by management and includes a timetable for implementation.

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 Director General for Finance and Group Operations 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 2024-25. A 'moderate' opinion was also provided in 2023-24.

A summary of the internal audit engagements reported on in 2024-25 is shown below:



Engagement	Report date
Fleming Fund	23/07/2024
Validation of Self-Assessment against Grant Standard	26/11/2024
Voluntary Scheme for Branded Medicines Pricing, Access, and Growth	16/12/2024
Social Care Reform Programme Governance	05/03/2025
Micro Entities	28/03/2025
National Institute for Health & Care Research: Standard Operating Procedures	08/05/2025
Company Management	03/09/2024
DHSC Data Hub	10/09/2024
Procurement Regulations	04/10/2024
Onboarding - pre-employment checks	21/10/2024
Better Care Fund Programme Board	06/11/2024
Atamis - system security/ access	21/11/2024
Private Finance Initiatives	09/12/2024
Provider Viability	17/03/2025
Creditors	17/04/2025
Learning and Development	16/04/2025
Fixed Assets	25/04/2025
Antimicrobial resistance governance	17/04/2025
Fraud Risk Assessments	18/09/2024
Vaccines	22/01/2025
New Hospitals Programme – governance and sponsorship arrangements	27/11/2024
Cyber Security Resilience and Disaster Recovery	17/01/2025
Drugs Development Programme	06/12/2024
Transparency Reporting	16/04/2025
Local Assurance Frameworks	29/04/2025

As regards the six overdue recommendations as of 31 March 2025, one related to engagements where ‘moderate’ assurance was provided and five recommendations related to engagements where ‘limited’ assurance was provided.

In forming the opinion of ‘moderate’ assurance, the Head of Internal Audit observed that, overall, DHSC had an adequate framework in place to ensure the effectiveness of risk management and noted that he has continued to see improvements in DHSC’s oversight and governance of risk management, as evidenced by observation of risk management reporting to ARC and associated deep dive activity carried out by ARC. He stated that for some audits, he identified a few areas where, at an operational level, risk management could be improved further.

The Head of Internal Audit also confirmed that the work of his team throughout the year has continued to provide assurance that there are adequate governance structures and processes within DHSC. Following on from his positive 2023-24 Governance: structures and sub-boards audit report, he has continued to observe appropriate departmental oversight arrangements. The sub-committees continue to operate efficiently which enhances the chances of accomplishing strategic outcomes (as described in the Performance Report of this Annual Report). ARC has driven improvements in tracking and implementing assurance actions, helping produce a significant fall in overdue audit recommendations during the second half of the year.

On the effectiveness of controls and compliance with required controls, the Head of Internal Audit noted that he has seen continued strengthening of the control environment particularly in relation to core financial controls, commercial management and people management. Whilst individual audits have identified some areas for improvement, these are specific to the area audited, rather than being illustrative of pervasive control weaknesses.

Since September 2021, functional standards have set expectations for the consistent management of 13 central functions across government departments and their ALBs. DHSC internal audit reviews DHSC compliance with these functional standards where they are relevant to the audit subject on a case-by-case basis.

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 19 provides a summary of the key reports published by the NAO in 2024-25, that reflect on activities of DHSC:

Table 19: Key NAO reports

Title of significant NAO report	Date of publication
NHS Financial Management and Sustainability	July 2024
Progress in preventing cardiovascular disease	November 2024
Investigation into the NHS dental recovery plan	November 2024
Investigation into how government is addressing antimicrobial resistance	February 2025
NHS England's management of elective care transformation programmes	March 2025
DHSC Annual Report and Accounts 2023-24	December 2024

Table 20: Key PAC reports

Title of PAC report	Date of publication
DHSC Annual Report and Accounts 2022-23	May 2024
NHS financial sustainability	January 2025

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. 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 Accounting Officers, Director General of Finance, and other senior officials give evidence to the Public Accounts Committee (PAC) by appearing at hearings in Parliament. Accounting Officers also have responsibility for approving the subsequent Treasury minutes which are government's response to the recommendations the PAC makes in its reports. In 2024-25, DHSC officials attended six PAC hearings, the details of which can be found via the Committee's website. A quarterly updates paper on NAO and PAC activity is provided to DHSC's ARC.

NHS 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 mandate to NHS England was published on 30 January 2025. 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 £186 billion in 2024-25) with a view to bringing about measurable improvements in health outcomes for the population.

ICBs, 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. 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. Following the Prime Minister’s announcement of the abolition of NHS England, DHSC and NHS England have been working closely to ensure continued effective accountability, joint working and the removal of duplication.

NHS England/DHSC integration oversight and governance

On 13 March 2025, the Prime Minister announced that NHS England would be brought into DHSC and form a new joint national centre. NHS England will continue to carry out its statutory duties until Parliamentary time allows for legislation to be brought forward to amend DHSC’s responsibilities, working towards the two-year delivery timetable already announced. The integration will also result in a large reduction in the headcount across the two organisations which will be considered through careful design and consultation with staff.

Formal governance is in place to manage transition risks and oversee delivery. Richard Barker is senior responsible owner for the programme and chairs the Programme Delivery Group, which reports to ExCo and oversees progress across workstreams including legislation, organisational design, and corporate systems. The group scrutinises and holds workstream owners to account for delivery of work on time and on budget, in a way which realises the benefits outlined by the Secretary of State. The whole programme is overseen and steered by a Transformation Oversight Group, jointly chaired by Dr Penny Dash (chair, NHS England) and Alan Milburn (lead non-executive board member, DHSC).

As an important step towards the single, integrated organisation, from 3 November 2025 a single Joint Executive Team has been in place to provide unified leadership of DHSC and NHSE, Further details are available on the Our Management section of the DHSC web page.

Inquiries and reviews

DHSC currently oversees a range of inquiries and investigations, which are discussed further below. DHSC is sponsoring two independent statutory public inquiries: the Lampard Inquiry (formerly the Essex Mental Health Independent Inquiry) and the Thirlwall Inquiry into the Countess of Chester Hospital. DHSC also sponsors the Fuller Inquiry which published its Phase 1 report in November 2023 and a Phase 2 interim report in October 2024 on the funeral sector. 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.

The Cabinet Office sponsored Infected Blood Inquiry reported on 20 May 2024. In June 2024, DHSC established a response programme board, coordinating the response to health specific recommendations for inclusion in the government's overall response that was published on 14 May 2025.

Lampard inquiry (formerly the Essex mental health independent inquiry)

The Lampard Inquiry is a statutory inquiry investigating mental health inpatient deaths in Essex. On 27 October 2023, DHSC issued a formal notice of conversion, confirming the Inquiry's statutory status and formally appointing Baroness Lampard as chair. In October 2024, the Inquiry heard testimony from the Essex trusts and heard impact and commemorative accounts from families.

Oral hearings covering evidence from affected families, the South Essex Partnership Trust, the North Essex Partnership Trust and the Essex Partnership University Trust are scheduled throughout 2025 and are expected to conclude in autumn 2026. DHSC anticipates giving evidence to the Inquiry during 2026.

The Thirlwall inquiry

The Thirlwall Inquiry was established in October 2023 following the trial and subsequent convictions of former neonatal nurse Lucy Letby. The Inquiry, chaired by Lady Justice Thirlwall, is examining the wider circumstances of what happened at the Countess of Chester Hospital, including the handling of concerns and governance. It is also looking at what actions were taken by regulators and the NHS, and the NHS culture.

The Inquiry's [oral] hearings ran from September 2024 to March 2025. The Inquiry heard evidence from the infants' families, and staff and management from the Countess of Chester Hospital, including former executives and board members. It also heard evidence from national oversight and regulatory bodies and a range of experts. DHSC gave evidence to the Inquiry in January 2025. The Inquiry's hearings have now concluded.

The Chair is expected to publish her report in early 2026 and she will make recommendations as she considers appropriate. DHSC has confirmed to the Chair that any recommendations which are addressed to NHS England, as currently constituted, should also be addressed to DHSC. Responsibility for any outstanding work in respect of the recommendations will transfer to DHSC as co-recipient when NHS England ceases to exist, ensuring there is no shortfall in accountability.

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 one 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 provided preliminary recommendations on safeguarding the security and dignity of the deceased in the funeral sector.

Phase 2 of the inquiry, which looked at the broader national picture, reported on 15 July 2025 and considered if procedures and practices in other hospital and non-hospital settings where deceased people are kept safeguard the security and dignity of the

deceased. The Phase 2 report sets out 75 recommendations for NHS England, NHS trusts, Local Authorities, independent hospitals, medical education, hospices, ambulance services, care homes, the funeral sector and faith organisations, making specific recommendations to improve the care of the deceased. The overarching recommendation is for UK government to establish an independent statutory regulatory regime for the care of the deceased across all sectors in England. The government will publish an interim update on progress by the end of 2025 and a full response by summer 2026.

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. The final report is expected to be published in June 2026.

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). The first set of regulations to establish the Infected Blood Compensation Scheme (IBCS) and the core compensation route for the infected were made on 24 August 2024. On 31 March 2025 a second set of regulations came into force 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 IBCA began making payments to people who are infected by the end of 2024, and the government expects payments to the affected to begin later in 2025.

These regulations also made provisions for the transfer to IBCA of the England Infected Blood Support Scheme (EIBSS). While the IBCA and compensation scheme are being established, DHSC remains responsible for making payments under the EIBSS, administered by NHS Business Services Authority. Responsibility for EIBSS was planned to transfer to IBCA on 23 March 2026. However, regulations were laid in draft on 30 October 2025 in Parliament, which move the date of transfer of EIBSS payments to IBCA to 2027. These regulations will be debated in Parliament and, subject to approval, will become law by the end of 2025.

In October 2022 the first interim payments of £100,000 were made to the living infected people and their bereaved partners with further interim payments of £210,000 made to living infected people in June 2024. In October 2024, the government opened applications for interim payments of £100,000 to the estates of the deceased infected people, to recognise those that have not yet received compensation, and those estate payments began in December 2024.

On 14 May 2025, the government published its full response to the recommendations made by the Infected Blood Inquiry in its May 2024 report. DHSC 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 then Healthcare Safety Investigation Branch (HSIB), and then part of NHS England. Following the passing of the Health and Care Act 2022, HSIB became the Health Services Safety Investigations Body (HSSIB). 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 1 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; to be a system expert in standards for maternity investigations; and collaborate with system partners to escalate safety concerns.

Outcomes relating to maternity and neonatal services are discussed at pages 56 - 58 of the Performance Report of this Annual Report and Accounts, along with details of the independent investigation announced by the Secretary of State on 23 June 2025.

NHS financial and audit governance

Financial risk and sustainability in the NHS

Ensuring the financial sustainability of the NHS is more important than ever, underpinning the government’s ambition to build an NHS ‘fit for the future’ and the three shifts that the Secretary of State has set out as strategic ambitions for the NHS in England. To support this, the government has set a 2% annual productivity growth target for the NHS for this Spending Review period. This is a stretching but essential requirement, to ensure the NHS’s full recovery from the impact of the Covid pandemic and support its longer-term financial health.

In recognition of the need for both investment and reform, the Spending Review settlement provided record levels of investment in the health service: £29 billion more day-to-day funding in real terms in 2028-29 than 2023-24 and a £2.3 billion real terms increase in capital spending from 2023-24 to 2029-30.

DHSC began to implement a full financial reset of the NHS in 2024-25, with NHS England making significant progress in strengthening financial control and discipline across the system. NHS England set out a very clear expectation that all NHS bodies must prioritise financial management, introducing tough new measures such as a more robust approach to the national Recovery Support Programme for trusts and ICBs and a more stringent approach to cash support. The Secretary of State also accepted in full the NAO's recommendations in its July 2024 report on NHS Financial Management and Sustainability which has informed further action under this agenda.

These efforts are bearing fruit. In 2024-25, ICBs and providers delivered £8.7 billion of efficiencies and savings, an increase from £7.3 billion in 2023-24. This was achieved due to a wide range of NHS initiatives to reduce waste and drive value for money, for example by reducing temporary staffing, improving procurement, delivering service redesign, and improving clinical and operational services. The NHS is also meeting the government's 2% annual productivity target. In 2024-25, NHS England figures for acute productivity show 2.7% growth over the course of the year, achieved through the delivery of a comprehensive NHS productivity plan, currently focused on operational and clinical improvements, technology transformation and workforce. Further detail on NHS productivity performance is included at page 17 in the Performance Report of this Annual Report and Accounts.

In addition, NHS system overspends reduced to £600 million over the course of 2024-25, compared to £1.4 billion in 2023-24. However, whilst very significant efficiencies, cost savings and underspends were delivered across NHS budgets, they did not entirely offset these overspends. Ultimately, 2024-25 saw a small overspend – equivalent to less than 0.05% of budgets - against the NHS Non-Ringfenced Resource Departmental Expenditure Limit. DHSC agreed to absorb this within wider Group budgets, ensuring that the DHSC group managed spending within all Parliamentary approved limits.

Progress in strengthening NHS financial management and governance has continued into 2025-26. NHS England published its 2025-26 priorities and operational planning guidance for the NHS, and issued financial allocations on 30 January 2025, significantly earlier than in previous years, enabling local plans to be finalised at the beginning of the financial year. NHS England also rolled out a new NHS Oversight Framework and Provider Improvement Programme in the first quarter of 2025-26 in order to drive further financial and wider performance improvement across the NHS. The latest NHS England data suggests that the NHS is continuing to meet the 2% annual productivity growth target; the aim is to publish this data going forward to increase transparency on NHS productivity performance.

DHSC's focus is now on implementing the commitments in the 10 Year Health Plan, to build a new financial foundation for the NHS and sustain NHS productivity improvements. The reinvigoration of the NHS foundation trust model through the introduction of 'advanced foundation trust' status for high-performing providers, the phasing out of deficit support funding to NHS bodies and the shift to longer-term financial planning are key elements of these reforms. Multi-year planning is now well underway across the NHS following the publication of the Medium-Term Planning Framework on 24 October 2025 and subsequent release of more detailed guidance and integrated care board financial allocations for 2026-27 to 2028-29.

Overpayments to medical practitioners

Following the identification of overpayments to medical practitioners in 2021-2022 and 2022-2023, a new process was implemented by NHS England. Since April 2024, all payments to suspended medical practitioners have been centralised and are now processed by the NHS England national team.

The new process guarantees that a standardised approach to applying the guidance is in place and the monthly assurance process to reconfirm eligibility ensures that changes to circumstances can be actioned quickly to prevent overpayments. During 2024-25 one minor overpayment occurred but this was due to unique circumstances, which do not undermine the new control environment. Recoveries of previously identified overpayments continue to be pursued subject to legal advice.

Special severance payments

Any proposed non-contractual special severance payment in the NHS requires formal approval from DHSC and HMT. At the time of finalising the disclosures in the consolidated provider accounts on 3 November 2025, there were 4 outstanding cases where payments were made without prior authorisation.

These have been submitted to HMT retrospectively and HMT's view is awaited. These cases, while currently irregular, have been judged as individually and collectively not material by nature to both the consolidated provider accounts and the departmental group accounts.

NHS England will continue to reinforce the requirement that such payments be approved by HM Treasury in advance of offers being made.

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 EPN727 guidance.

The following elements of the remuneration report are subject to audit:

- salaries (including non-consolidated performance pay, pay multiples) and allowances
- compensation for loss of office
- non-cash benefits
- pension increases and values, and
- Cash Equivalent Transfer Values (CETV) and increases.

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 2024-25

- Rt Hon Victoria Atkins MP resigned as Secretary of State for Health and Social Care on 5 July 2024
- Andrew Stephenson resigned as Minister of State on 5 July 2024
- Helen Whately MP resigned as Minister of State on 5 July 2024
- Andrea Leadsom resigned as Parliamentary Under-Secretary of State on 5 July 2024
- Maria Caulfield resigned as Parliamentary Under-Secretary of State on 5 July 2024

- Lord Markham CBE resigned as Parliamentary Under-Secretary of State on 5 July 2024
- Rt Hon Wes Streeting MP was appointed as Secretary of State for Health and Social Care on 5 July 2024
- Stephen Kinnock MP was appointed Minister of State for Care on 8 July 2024
- Karin Smyth MP was appointed Minister of State for Health (Secondary Care) on 8 July 2024
- Baroness Gillian Merron was appointed Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health on 9 July 2024
- Andrew Gwynne MP was appointed Parliamentary Under-Secretary of State for Public Health and Prevention on 9 July 2024 and resigned on 10 February 2025
- Ashley Dalton MP was appointed Parliamentary Under-Secretary of State for Public Health and Prevention on 10 February 2025

Remuneration of senior officials and ministers

The Accountability Report outlines the senior officials and ministers of DHSC and their dates of appointment (and departure where appropriate). The remuneration of ministers is detailed in **Table 21**, and of senior officials in **Table 22**.

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 21**.

The remuneration of senior civil servants is determined in accordance with the rules set out in the Civil Service Management Code and in line with the annual SCS framework guidance issued by Cabinet Office.

Non-consolidated performance pay

SCS non-consolidated performance pay is agreed each year following the Senior Salaries Review Body recommendations and is expressed as a percentage of DHSC's total base pay bill for the SCS. Non-consolidated performance 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 2024-25 figures relates to awards made in respect of the 2023-24 performance year but paid in the 2024-25 financial year. An award of £7,500 was paid to SCS receiving an 'Exceeding' performance rating and an award of £4,000 was paid to SCS receiving a 'High Performing' performance rating in each SCS pay 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 and Customs (HMRC) as a taxable emolument. For its direct employees, DHSC pays the individual a net sum and pays tax directly to HMRC. DHSC's Second Permanent Secretary, Tom Riordan, received £18,000 benefits in kind during 2024-25, to cover the dual location of his role and this is shown in **Table 22**.

Tables 21 and **22** provide details of remuneration interests of the ministers of DHSC and senior officials serving on the Departmental Board.

Table 21: Remuneration of ministers of the department (subject to audit)

Ministers	2024-25 Salary (£)[1]	2024-25 Gross benefits in kind (to nearest £100)	2024-25 Pension benefits (to nearest £1000)	2024-25 Total (to nearest £1000)	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)
Wes Streeting MP (from 05/07/2024)	49,903		13,000	63,000	-	-	-	-
Secretary of State								
Full year equivalent	67,505							
Karin Smyth MP (from 08/07/2024)	23,164		6,000	29,000	-	-	-	-
Minister of State								
Full year equivalent	31,680							
Stephen Kinnock MP (from 08/07/2024)	23,164		6,000	29,000	-	-	-	-
Minister of State								
Full year equivalent	31,680							
Baroness Gillian Merron (from 09/07/2024)	78,193	100	13,000	92,000	-	-	-	-
Parliamentary Under-Secretary of State								
Full year equivalent: Lords Office-Holder	36,366							
Full year equivalent: Parliamentary Under-Secretary of State	70,969							
Ashley Dalton MP (from 10/02/2025)	3,130		1,000	4,000	-	-	-	-
Parliamentary Under-Secretary of State								
Full year equivalent	22,375							
Andrew Gwynne MP (from 09/07/2024 to 08/02/2025)	18,698		3,000	22,000	-	-	-	-
Parliamentary Under-Secretary of State								
Full year equivalent	22,375							
Victoria Atkins MP (from 13/11/2023 to 05/07/2024)	34,660		4,000	39,000	22,502		8,000	30,000
Secretary of State								
Full year equivalent	67,505				72,454			
Helen Whately MP (from 26/10/2022 to 05/07/2024)	16,266		2,000	18,000	31,680		8,000	40,000
Minister of State								
Full year equivalent	31,680				31,680			
Andrew Stephenson MP (from 13/11/2023 to 05/07/2024)	16,266		2,000	18,000	10,560		4,000	14,000
Minister of State								
Full year equivalent	31,680				34,742			
Andrea Leadsom MP (from 13/11/2023 to 05/07/2024)	11,487		1,000	13,000	8,577		2,000	11,000
Parliamentary Under-Secretary of State								
Full year equivalent	22,375				24,947			
Maria Caulfield MP (from 17/09/2021 to 06/09/2022, 27/10/2022 to 05/07/2024)	11,487		1,000	13,000	22,375		6,000	28,000
Parliamentary Under-Secretary of State, Minister of State, Parliamentary Under Secretary of State								
Full year equivalent	22,375				22,375			
Lord Markham CBE (from 22/09/2022 to 05/07/2024)	-	-	-	-	-	-	-	-
Parliamentary Under-Secretary of State								
Full year equivalent								
Neil O'Brien MP (from 08/09/2022 to 12/11/2023)	-	-	-	-	20,510		3,000	24,000
Parliamentary Under-Secretary of State								
Full year equivalent					22,375			
Steve Barclay MP (05/07/2022 to 05/09/2022, 25/10/2022 to 12/11/2023)	-	-	-	-	45,003		10,000	55,000
Secretary of State								
Full year equivalent					72,454			
William Quince MP (from 07/09/2022 to 12/11/2023)	-	-	-	-	29,040		4,000	33,000
Minister of State								
Full year equivalent					31,680			

1. The government has determined that ministers should receive salaries at the same rate as claimed by equivalent ministers in previous governments since 2010. Therefore, the serving ministers have agreed to waive any ministerial increases in their salary for the duration of this Parliament. Figures include any severance payment/compensation in lieu of notice payment received by ministers.
2. Lord Markham’s role as Parliamentary Under-Secretary of State was unpaid.

Table 22: Remuneration of senior officials of DHSC (subject to audit)

Officials	2024-25 Salary and allowances (£'000)	2024-25 Non consolidated performance related pay (£'000)[1]	2024-25 Gross benefits in kind (to nearest £100)	2024-25 Pension benefits (to nearest £1000)[2,3]	2024-25 Employer contribution to external pension scheme (to nearest £1,000)	2024-25 Total (£'000)	2023-24 Salary and allowances (£'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]	2023-24 Total (£'000)
Professor Sir Chris Whitty[4] Chief Medical Officer for England & Permanent Secretary (from 16/12/2024)	230-235	-	-	89,000		320-325	220-225	-	-	51,000	270-275
Tom Riordan (from 23/09/2024) Second Permanent Secretary	100-105	-	18,000	40,000		160-165	-	-	-	-	-
Full year equivalent	200-205										
Jonathan Marron Director General Primary Care and Prevention	145-150	-	-	80,000		225-230	140-145	-	-	69,000	210-215
Matthew Style Director General Secondary Care and Integration	165-170	0-5	-	90,000		260-265	155-160	-	-	51,000	205-210
Michelle Dyson Director General Adult Social Care	145-150	-	-	86,000		230-235	135-140	0-5	-	58,000	200-205
Andy Brittain Director General, Finance	145-150	-	-	95,000		240-245	135-140	-	-	60,000	195-200
Sally Warren[5] (from 08/07/2024) Director General 10-Year Health Plan	105-110	-	-	27,000	4,000	135-140	-	-	-	-	-
Full year equivalent	145-150										
Catherine Frances (from 07/01/2025) Director General Global and Public Health	35-40	-	-	48,000		80-85	-	-	-	-	-
Full year equivalent	150-155										
Lucy Chappell[6] Chief Scientific Adviser	110-115	-	-	-		110-115	120-125	-	-	-	120-125
Jenny Richardson Director of Human Resources	135-140	0-5	-	133,000		270-275	65-70	5-10	-	49,000	120-125
Full year equivalent							115-120				
Lorraine Jackson Director, DWP and DHSC Joint Work and Health Directorate	105-110	0-5	-	58,000		170-175	100-105	5-10	-	67,000	175-180
Paul Macnaught[7] (from 01/05/2024) Director Ministers, Accountability and Strategy	105-110	5-10	-	93,000		205-210	-	-	-	-	-
Full year equivalent	115-120										
Sir Christopher Wormald KCB (to 15/12/2024) Permanent Secretary	150-155	15-20	-	165,000		330-335	200-205	-	-	169,000	370-375
Full year equivalent	200-205										
Shona Dunn[8] (to 03/06/2024) Second Permanent Secretary	75-80	-	-	20,000		95-100	165-170	-	-	51,000	220-225
Full year equivalent	175-180										
Clara Swinson CB[9] (to 22/09/2024) Director General Global and Public Health	80-85	5-10	-	44,000		130-135	145-150	5-10	-	54,000	205-210
Full year equivalent	160-165										
Hugh Harris[10] (to 30/04/2024) Director Ministers, Accountability and Strategy	5-10	-	-	53,000		60-65	105-110	-	-	66,000	170-175
Full year equivalent	120-125						115-120				
Zoe Bishop (to 21/04/2024) Director of Human Resources	0-5	0-5	-	2,000		10-15	35-40	-	-	19,000	55-60
Full year equivalent	100-105						95-100				

1. Non-consolidated performance pay paid in 2024-25 relates to the 2023-24 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 did not receive any additional remuneration for taking on the role of interim Permanent Secretary. Therefore the salary stated in the table represents the full-year equivalent for both roles.
5. Sally Warren joined DHSC via secondment agreement on 8 July 2024 and was subsequently appointed on a fixed-term appointment on 7 October 2024, joining ExCo from arrival.
6. Professor Lucy Chappell was appointed on 1 August 2021 on secondment from King’s College, London, for four days a week. The figures in the table represent the proportion DHSC paid only, not the full salary. DHSC contributes to her pension scheme with Kings College, London.
7. Paul Macnaught joined ExCo on 1 May 2024.
8. Shona Dunn’s salary includes payment in lieu of notice.
9. Clara Swinson’s salary includes a refund following closure of a childcare account.
10. Hugh Harris ceased being a member of ExCo on 30 April 2024.

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 23**.

Table 23: Pay ratios for core department and executive agencies

	Core department 2024-2025	Core department 2023-2024	Core department & executive agencies 2024-2025	Core department & executive agencies 2023-2024
25th Percentile pay ratio	5.7:1	5.5:1	6.4:1	6.3:1
Median pay ratio	4.1:1	4.1:1	5:1	4.9:1
75th Percentile pay ratio	3.7:1	3.6:1	3.8:1	3.8:1

1. Pay ratio compares the percentile pay benefits to the highest paid director.

Table 24: Total remuneration and salary element for core department and executive agencies

	Core department 2024-2025	Core department & executive agencies 2024-2025
25th Percentile total remuneration (salary element)	41,026 (41,026)	36,969 (36,210)
Median total remuneration (salary element)	56,036 (46,245)	46,746 (45,996)
75th Percentile total remuneration (salary element)	62,337 (62,324)	61,370 (59,970)

1. Total remuneration includes salary, non-consolidated performance 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.

In 2024-25 the median earning of the core department has increased by 1.4%, or £773, compared to 2023-24, where the increase of median earnings was £3,936. Core department staff, excluding the highest-paid director, had an average increase in pay and benefits of 1.0%. See **Table 25**.

The increase in median earnings of the core department can be attributed to changes in the composition of the workforce in 2024-25 such as grade distribution and implementation of the 2024-25 pay award (in line with Civil Service Pay Guidance). It is consistent with the pay, reward, and progression policies for the core department.

Table 25: Percentage change in remuneration from 2023-24

	Core department		Core department & executive agencies	
Percentage change in total remuneration	Highest paid director	Average of total employees	Highest paid director	Average of total employees
Change from 2023-24	4.5%	1.0%	4.5%	2.9%
Salary and allowances	4.5%	3.2%	NA	NA
Bonus	0.0%	-56.8%	NA	NA

In 2024-25, the banded remuneration of the highest-paid director increased to £230,000 – £235,000 (see **Table 26**). Banded remuneration for the core department staff remained the same in 2024-25 for the lowest paid, ranging between £20,000 - £25,000. The change in average bonus seen is due to the additional £1,500 non-consolidated payment as part of the Civil Service pay remit guidance which was paid to those civil servants at delegated grades during 2023-24. A full breakdown of the components 'Salary and allowance' and 'Bonus' across DHSCs Executive Agencies is not available, therefore cannot be reported. No employees received remuneration at a higher level than the highest-paid director in 2024-25 or 2023-24.

Table 26: Banded remuneration range for core department and executive agencies

	Core department		Core department & executive agencies	
	2024-2025	2023-2024	2024-2025	2023-2024
Band of highest paid director's total remuneration (£000)[1]	230-235	220-225	230-235	220-225
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 EPN737 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: three providing benefits on a final salary basis (classic, premium, or classic plus) with a normal pension age of 60; and one providing benefits on a whole career basis (nuvos) with a normal pension age of 65.

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 their 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.

Further details about the Civil Service pension arrangements can be found at the Civil Service Pensions website.

Changes to civil service pensions under remedy

In 2015 the 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 in 2023 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 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 27 and **28** provide details of the pension interests for DHSC's ministers and senior officials for 2023-24 and 2024-25 and are subject to audit.

Cash equivalent transfer values (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by 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 27: Pension interests of ministers (subject to audit)

	Accrued pension at age 65 as at 31/03/25 £'000	Real increase in pension at age 65 £'000	CETV at 31/03/25[1] £'000	CETV at 31/03/24 £'000	Real increase in CETV £'000
Wes Streeting MP from 05/07/2024	0-5	0-2.5	12	-	6
Karin Smyth MP from 08/07/2024	0-5	0-2.5	8	-	5
Stephen Kinnock MP from 08/07/2024	0-5	0-2.5	7	-	4
Baroness Gillian Merron from 09/07/2024	0-5	0-2.5	19	-	13
Ashley Dalton MP from 10/02/2025	0-5	0-2.5	1	-	1
Andrew Gwynne MP 09/07/2024 - 08/02/2025	0-5	0-2.5	4	-	2
Victoria Atkins MP 13/11/2023 - 05/07/2024	0-5	0-2.5	57	52	2
Helen Whately MP 26/10/2022 - 05/07/2024	0-5	0-2.5	40	37	1
Andrew Stephenson MP 13/11/2023 - 05/07/2024	0-5	0-2.5	48	46	1
Andrea Leadsom MP 13/11/2023 - 05/07/2024	5-10	0-2.5	102	99	1
Maria Caulfield MP 27/10/2022 - 05/07/2024	0-5	0-2.5	28	27	1

1. The figures given are based solely on the individual benefits as a minister and will not reflect any pension in respect of their MP salary. Where an individual has left or joined DHSC part way through the year, the figures are calculated according to the period in-post.

Table 28: Pension information of senior officials of DHSC (subject to audit)

`		Accrued pension at pension age as at 31/03/25 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/03/25	CETV at 31/03/24	Real increase in CETV	Employer contribution to external pension scheme (to nearest £1,000)
Professor Sir Chris Whitty	Chief Medical Officer for England & Permanent Secretary	5-10	5-7.5	138	48	67	
Tom Riordan	Second Permanent Secretary	0-5	0-2.5	37	-	29	
Jonathan Marron	Director General for Office for Health Improvement and Disparities	30-35	2.5-5	624	530	60	
Matthew Style	Director General NHS Policy and Performance	50-55	5-7.5	926	822	59	
Michelle Dyson	Director General for Adult Social Care	50-55 plus a lump sum of 120-125	2.5-5 plus a lump sum of 2.5-5	1,102	985	69	
Andy Brittain	Director General Finance	60-65 plus a lump sum of 155-160	5-7.5 plus a lump sum of 2.5-5	1,402	1,266	79	
Sally Warren	Director General 10-Year Health Plan	0-5	0-2.5	21	-	15	4
Catherine Frances	Director General Global and Public Health	45-50	2.5-5	894	847	42	
Lucy Chappell[2]	Chief Scientific Advisor	80-85 plus lump sum of 95-100	-	1,473	1,490	-	
Jenny Richardson	Director of Human Resources	50-55	5-7.5	932	786	104	
Lorraine Jackson	Director, DWP and DHSC Joint Work & Health Directorate	50-55	2.5-5	1,058	967	47	
Paul Macnaught	Director Ministers, Accountability and Strategy	45-50 plus a lump sum of 110-115	2.5-5 plus a lump sum of 5-7.5	949	852	77	
Sir Christopher Wormald KCB	Permanent Secretary	120-125	7.5-10	2,477	2,238	157	
Shona Dunn	Second Permanent Secretary	65-70 plus a lump sum of 165-170	0-2.5 plus a lump sum of 0-2.5	1,476	1,447	16	
Clara Swinson CB	Director General for Global Health	50-55 plus a lump sum of 125-130	0-2.5 plus a lump sum of 0-2.5	1,066	998	33	
Hugh Harris	Director of Ministers, Accountability and Strategy	45-50	2.5-5	829	777	48	
Zoe Bishop	Director of Human Resources	5-10	0-2.5	99	93	1	

1. Professor Sir Chris Whitty was previously a member of Partnership pension scheme.
2. Professor Lucy Chappell was appointed on 1 August 2021 on secondment from King's College, London (KCL) for four days per week. Her pension is with the NHS Pension Scheme and DHSC contributes 80% of the costs paid into the scheme by KCL. Her full pension accrual is shown the table above.

Non-executive directors

Non-executive directors (NEDs) (see **Table 29**) 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. Non-executive directors also make a significant contribution to departmental business by working through committees and with senior officials.

The Departmental Board holds positions for six non-executive directors. The non-executive directors sitting on the Departmental Board during 2024-25 are detailed in the Accountability Report. There are also three independent members of Audit and Risk Committee.

One of the non-executive board members chairs DHSC's Audit and Risk Committee (which meets four-five times per year). The lead NEBM chairs the DHSC's Nominations and Governance Committee, which has an additional NED. NEDs have been able to attend all the boards we would expect from a governance perspective.

Table 29: NEDs and members of DHSC (subject to audit)

Non-Executive	Position	Term	2024-25 Fee received to nearest £1,000	2024-25 Annual fee entitlement to nearest £1,000	2023-24 Fee received to nearest £1,000	2023-24 Annual fee entitlement to nearest £1,000
Alan Milburn [1]	Non-Executive Board Member & Lead Non-Executive	8 November 2024 - 8 November 2027	8,000	20,000		
Samantha Jones [2]	Non-Executive Board Member & Lead Non-Executive (to 07/11/24)	14 February 2023 - 15 June 2025	18,000	20,000	19,000	20,000
Richard Douglas [3]	Non-Executive Board Member	7 March 2024 - 6 March 2027	19,000	20,000	-	15,000
Camilla Cavendish	Non-Executive Board Member	13 January 2025 - 12 January 2028	3,000	15,000		
Phil Jordan	Non-Executive Board Member	13 January 2025 - 12 January 2028	3,000	15,000		
Naomi Eisenstadt	Non-Executive Board Member	13 January 2025 - 12 January 2028	3,000	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
Roy Stone	Non-Executive Board Member	24 April 2023 - 10 January 2025	12,000	15,000	14,000	15,000
Doug Gurr	Non-Executive Board Member	1 December 2020 - 10 January 2025	12,000	15,000	15,000	15,000
Steve Rowe	Non-Executive Board Member	7 March 2024 - 10 January 2025	13,000	15,000	-	15,000
Chris Young	Non-Executive Member of Audit & Risk Committee	1 February 2025 - 31 January 2028	Non-remunerated role	Non-remunerated role	-	-
Richard Hornby	Independent Member of Audit & Risk Committee	1 January 2020 - 11 October 2024	-	Non-remunerated Civil Servant	-	Non-remunerated Civil Servant
Will Harris	Non-Executive Board Member	24 April 2023 - 18 September 2024	7,000	15,000	14,000	15,000
Gerry Murphy	Non-Executive Board Member & Chair Audit & Risk Committee	1 August 2017 - 31 July 2024	7,000	20,000	20,000	20,000
Kate Lampard	Non-Executive Board Member & Lead Non-Executive	1 October 2017 - 7 September 2023	-	-	10,000	20,000

1. Alan Milburn was appointed lead NED on 8 November 2024.
2. Samantha Jones became interim lead NED on 29 September 2023 and was formally appointed to the role in December 2023. Since the end of the audited year, Samantha Jones was appointed as DHSC's Permanent Secretary on 16 June 2025. Her term as NED therefore ended on 15 June 2025.
3. Richard Douglas received £20,000 from 1 August 2024 on taking the role of Audit and Risk Committee Chair.

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.

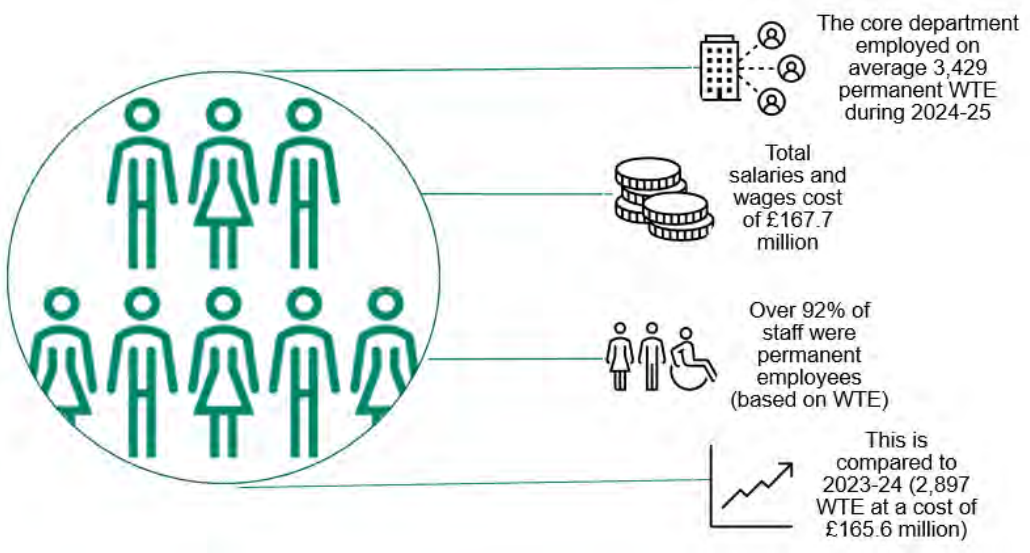
DHSC paid severance payments to the following ministers in the 2024-25 financial year:

- Victoria Atkins (Secretary of State for Health and Social Care) received a severance payment of £16,876
- Andrew Stephenson (Minister of State) received a severance payment of £7,920
- Helen Whately (Minister of State) received a severance payment of £7,920
- Andrea Leadsom (Parliamentary Under-Secretary of State) received a severance payment of £5,593
- Maria Caulfield (Parliamentary Under-Secretary of State) received a severance payment of £5,593, and
- Andrew Gwynne (Parliamentary Under Secretary of State) received a severance payment of £5,593

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.

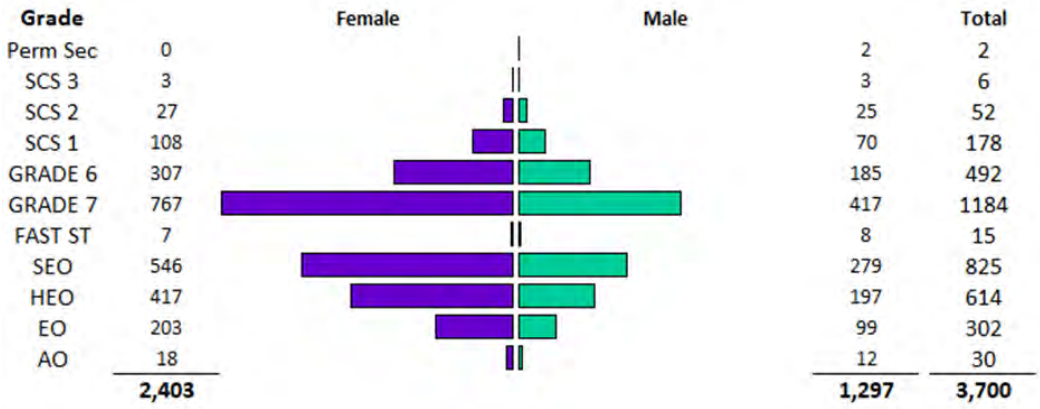


A breakdown of staff numbers and associated costs for the core department together with its executive agencies and for the overall departmental group are included in **Tables 35** and **36**.

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 18** below outlines the headcount and gender distribution of core departmental staff in post at 31 March 2025 and is consistent with Office for National Statistics (ONS) reporting methodologies. This does not include staff on secondment to DHSC.

Figure 18: Gender distribution of core department staff (headcount)



Staff sickness

72% of staff with no recorded sickness in the year ending 31 December 2024

The core department has seen a small increase in the number of days lost to short-term sickness, rising from 6,401 in the rolling calendar year up to 31 December 2023 to 6,432 up to 31 December 2024. There has also been a decrease in days lost to long-term sickness reported over the same period, from 10,471 to 9,790. Over the same rolling calendar year up to 31 December 2024, the average number of working days lost stands at 4.9, a decrease from 5.2 as at December 2023. Some 72 per cent of our staff have no recorded sickness in the calendar year up to 31 December 2024, slightly down from 73 per cent at the same point in the previous year.

Staff turnover

The core department has experienced a 7% turnover of staff during the 2024-25 financial year. This has been calculated in line with Cabinet Office guidance. This is a decrease from the 2023-24 year when staff turnover in the core department was 15%. Turnover was higher during 2023-24 due to leavers through DHSC's Voluntary Exit Scheme.

Staff redeployment

During 2024-25, 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 30**.

Table 30: Staff Redeployment by Grade

Grade	Cost incurred by DHSC Number	Cost not incurred by DHSC Number	Total Number
HEO and SEO	13	0	13
G7 and G6	22	0	22
SCS	5	0	5
Totals	**40**	**0**	**40**

1. For those individuals where the cost was incurred by the DHSC, the estimated average cost was £62,036.

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 2024-25, there were eight reported accidents (two of which resulted in absence) and no near misses.

Staff engagement

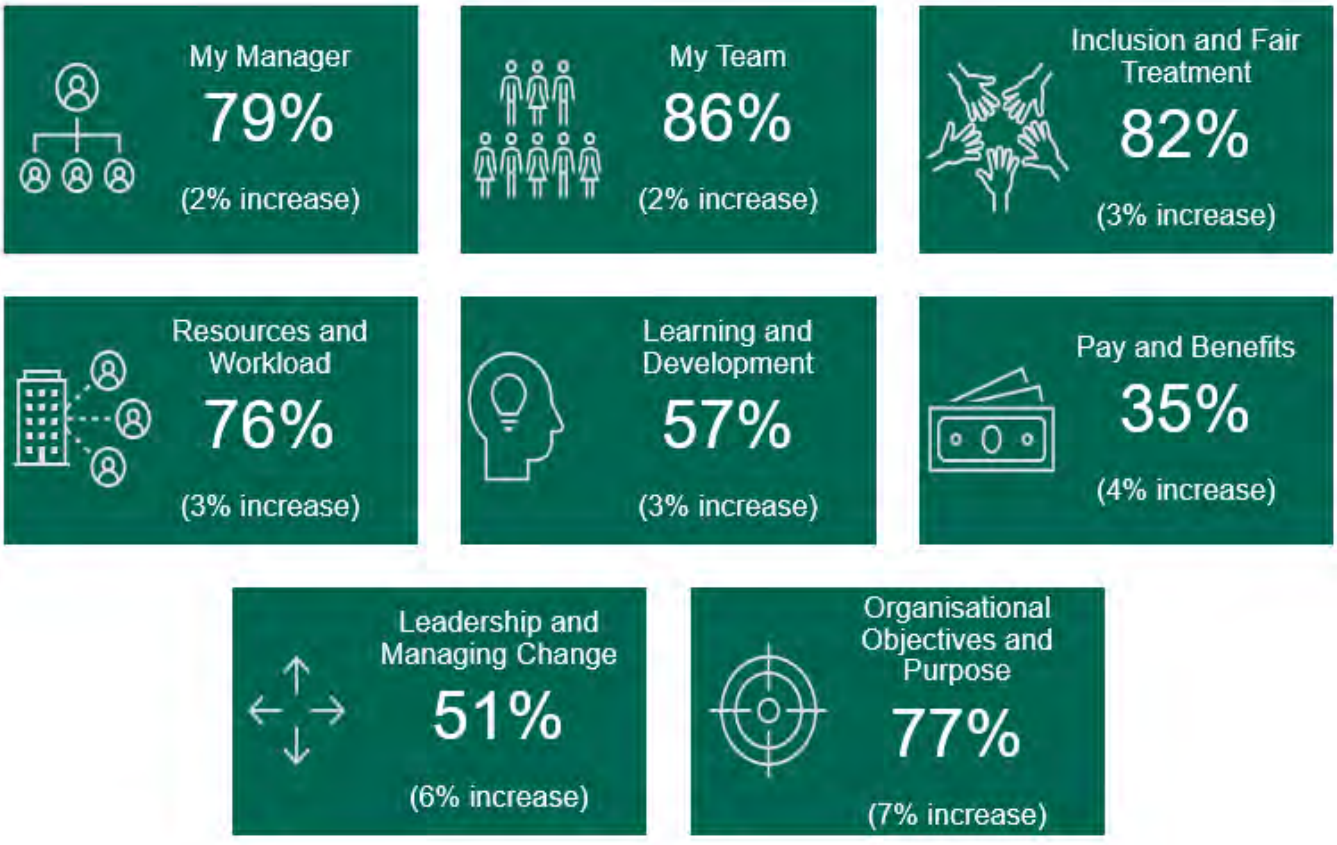
The annual Civil Service People Survey looks at civil servants' attitudes to, and experience of working in government departments. Every year, a Civil Service benchmark report is published alongside a summary of main department scores.

DHSC's response rate this year was 83% (2930 responses out of c.3500 who were invited). This is significantly above the Civil Service average (61%) and broadly in line with previous years.

DHSC saw an increase in its Employee Engagement Index by five percentage points from last year, rising from 57% to 62%. This remains below the Civil Service benchmark of 64% and the DHSC peak in 2020 (69%).

There are nine 'core themes' recorded on the People Survey. In DHSC, eight of these core themes saw a statistically significant increase in their scores from the 2023 results. The remaining one core theme (My Work) remained broadly in line with the previous year's results at 78%.

Whilst we are below the Civil Service benchmark in two areas (organisation objectives and purpose and leadership and managing change), these have seen significant improvement for DHSC as follows:



Equal opportunities policy

DHSC is committed to promoting and supporting inclusion in the workplace and to treating all staff fairly and responsibly, in line with DHSC values and our legal duties as a public sector body. DHSC's refreshed Equality Objectives: 2023-27. are underpinned by the Civil Service Diversity and Inclusion (D and I) Strategy 2022-2025, and our internal equal opportunities policies and are delivered in collaboration with our leaders, staff networks, and employees.

The departmental Inclusion Plan and its actions are designed to fulfil its commitments under the refreshed equality objectives above and are stress-tested and supported by DHSC governance. Equality, Diversity and Inclusion (EDI) is discussed quarterly between the Executive Board and People Board, ensuring that EDI matters are at the forefront of DHSC's agenda.

In recognition of the importance of championing EDI visibly at senior leadership level, the Second Permanent Secretary acts as the DHSC's Senior EDI champion and is supported by a group of EDI Champions from the senior leadership team. These leaders work with our staff networks and individually focus on areas including:

DHSC staff networks provide support to employees, increase knowledge and awareness of specific EDI topics or experiences, provide insight to aid the development of HR policy and initiatives, and contribute to creating an inclusive environment in which individuals can thrive. The EDI networks focus on the protected characteristics (as outlined by the Equality Act), with other staff groups working to support activity relating to grades, professions, and other workplace matters.

Additionally, during 2024-25, DHSC:

- launched Cohort 2 of the Experience Exchange Mentoring Programme for senior leaders to learn from under-represented staff and for those staff to benefit from building senior networks
- continued to grow our Speak Up Adviser Service, recruiting more advisers across our locations in 2024-25
- updated our policy and improved processes for raising a concern
- brought together our senior leaders and staff networks leads for open discussions on world events affecting staff
- increased office facilities in London to accommodate religious requirements
- piloted five business areas to measure intervention readiness in tackling bullying, harassment and discrimination through use of a new diagnostic tool
- developed policy knowledge and capability on EDI matters through the line manager programme, and
- implemented the Civil Service EDI expenditure guidance that introduced effective controls and accountability for EDI expenditure to provide greater transparency and deeper assurance and alignment with government priorities.

DHSC strives to embed an evidence-based and outcome-focused approach in all that we do to progress equality, diverse representation, and inclusion. Diversity data is regularly monitored, helping to identify areas for improvement and to 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). DHSC's most recent diversity data set is available on the Civil Service Diversity and Inclusion Dashboard.

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 and works closely with staff network groups in reviewing these and developing specific guidance. This includes guidance in relation to workplace adjustments, mental health support, support for carers, anti-bullying, harassment and discrimination, occupational health support, and menopause.

During 2024-25, DHSC continued to attract diverse candidates from within and outside DHSC. The central HR team introduced new delegated recruitment processes to reduce timeframes and allow more flexibility. Selection panels at delegated grades (AA to G6)

must have at least one panel member from an underrepresented group. The aim is to reduce bias from the selection process, ensuring robust decision making when identifying the successful candidate. DHSC renewed its Disability Confident Leader level 3 status in March 2024 for three years under the Disability Confident Scheme, guaranteeing an interview for disabled candidates who demonstrate the minimum requirement at sift.

DHSC, under the Equality Act 2010, provides support to employees with a disability or health condition in the form of reasonable workplace adjustments. 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, created a Workplace Adjustment Advisor role in 2023, 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 and develop diverse talent, including those employees and underrepresented candidates from lower socio-economic backgrounds, who might otherwise not have access to formal education or training. This includes a departmental care leavers internship scheme, offering 18-month work placements to care leavers aged between 18 and 30, and the annual cross-Government Beyond Boundaries development programme, targeted at developing junior talent and careers within the Civil Service. For the latter, the DHSC reserved 65% of places in its 2024 cohort for those with a disability, long-term condition, who were from an ethnic minority background, and/or were from a lower-socio-economic background.

All employees have access to an Employee Assistance Programme for independent advice from qualified external professionals on topics including 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, and 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 at 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 31** to **34**) 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 report and accounts enable statutory reporting requirements to be met.

Table 31: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
49	47.95

Table 32: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	3
1-50%	46
51-99%	0
100%	0

Table 33: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£139,406
Total pay bill	£770,165,207
Percentage of total pay bill spent on facility time	0.0181%

Note: The total pay bill percentage is calculated as: (total cost of facility time ÷ total pay bill)

Table 34: 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 the 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 35, **36** and **37** summarise key staff information for the departmental group.

Table 35: Staff costs for the departmental group (subject to audit)

	2024-25 Permanently employed staff £'000	2024-25 Others £'000	2024-25 Ministers £'000	2024-25 Total £'000	2023-24 Total £'000
Salaries and wages	70,060,056	6,937,788	237	76,998,081	71,651,885
Social security costs	7,843,254	204,024	26	8,047,304	7,611,280
NHS pension	13,503,503	271,952	-	13,775,455	10,924,954
Other pension costs	197,094	8,407	-	205,501	176,822
	91,603,907	**7,422,171**	**263**	**99,026,341**	**90,364,941**
Termination benefits	39,421	5,704	44	45,169	75,183
	91,643,328	**7,427,875**	**307**	**99,071,510**	**90,440,124**
Less income in respect of secondments	(36,046)	(117,084)	-	(153,130)	(139,983)
Total staff costs	**91,607,282**	**7,310,791**	**307**	**98,918,380**	**90,300,141**

Special advisers are temporary civil servants. In order 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 36: Average number of whole-time equivalents employed – departmental group (subject to audit)

	2024-25 Permanent staff	2024-25 Others	2024-25 Ministers	2024-25 Total	2023-24 Total
Core department and agencies	9,904	925	5	10,834	9,875
Other designated bodies	1,411,997	143,584	-	1,555,581	1,524,991
Total	**1,421,901**	**144,509**	**5**	**1,566,415**	**1,534,866**

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 ONS categorisation.

Of the figures shown in **Table 36**, staff engaged on capital projects are shown in **Table 37**.

Table 37: Breakdown of staff engaged on capital projects (subject to audit)

	2024-25 Permanent staff	2024-25 Others	2024-25 Ministers	2024-25 Total	2023-24 Total
Core department and agencies	216	-	-	216	312
Other designated bodies	4,043	478	-	4,521	4,427
Total	**4,259**	**478**	**-**	**4,737**	**4,739**

Consultancy, temporary and agency workers

Table 38 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 2024-25 the core department spent £2.0 million on consultancy compared to £3.9 million in 2023-24; and £3.7 million on temporary staff compared to £4.2 million in 2023-24. 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 38: Expenditure on consultancy, agency and temporary workers

	2024-25 Consultancy £'000	2024-25 Temporary agency £'000	2023-24 Consultancy £'000	2023-24 Temporary agency £'000
DHSC core	1,990	3,651	3,938	4,174
Executive agencies	14,887	12,083	1,280	33,742
Other designated bodies	235,066	3,977,648	252,134	5,027,886
Gross total	**251,943**	**3,993,382**	**257,352**	**5,065,802**
Eliminations	(21)	-	-	-
Total after eliminations	**251,922**	**3,993,382**	**257,352**	**5,065,802**

The numbers reported above for agency include staff categorised as 'bank staff' by NHS providers. These are not included within 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 39,** includes all off-payroll engagements (either during 2024-25 in totality or 'as at' 31 March 2025) for a day-rate of more than £245.

A regular dialogue has continued between DHSC and the Tax Centre of Excellence throughout the 2024-25 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.

The core department has not paid any penalties for non-compliance.

Table 39: Off-payroll engagements

Table 39a: For all off-payroll engagements as of 31 March 2025, for more than £245 per day

	Core department	ALBs	Total
Number of existing engagements as of 31 March 2025	**15**	**1,219**	1,234
Of which:			
Number that have existed for less than one year at time of reporting	7	472	479
Number that have existed for between one and two years at time of reporting	2	387	389
Number that have existed for between two and three years at time of reporting	-	326	326
Number that have existed for between three and four years at time of reporting	1	20	21
Number that have existed for four years or more years at time of reporting	5	14	19

Table 39b: For all off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day

	Core department	ALBs	Total
Number of temporary off-payroll workers engaged between 1 April 2024 and 31 March 2025	**34**	**2,151**	**2,185**
Of which:			
Number not subject to off-payroll legislation	32	2,012	2,044
Number subject to off-payroll legislation and determined as in scope of IR35	-	97	97
Number subject to off-payroll legislation and determined as out of scope of IR35	2	42	44
Number of engagements reassessed for compliance or assurance purposes during the year	-	-	-
Of which: number of engagements that saw a change to IR35 status following review	-	-	-

Table 39c: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

	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.	155	639	794

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 40 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.

No individuals within the core department have received over £95,000 as an exit package due to entitlement on voluntary or compulsory redundancy arrangements in 2024-25. In 2023-24, one individual within the core department received over £95,000 as an exit package due to entitlement on voluntary redundancy arrangements, and there was one further individual 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 40a: Exit packages (subject to audit)
Core department and agencies for the year ended 31 March 2025

	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	13	17	30	-
£10,001 to £25,000	18	2	20	-
£25,001 to £50,000	5	4	9	-
£50,001 to £100,000	2	3	5	-
£100,001 to £150,000	-	3	3	-
£150,001 to £200,000	-	4	4	-
More than £200,000	-	5	5	-
Total number	**38**	**38**	**76**	**-**
Total cost (£)	**615,092**	**2,885,943**	**3,501,035**	**-**

Table 40b: 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. Where a compulsory redundancy is indicated, these were terminations of fixed-term contracts.

Table 40c: Exit packages (subject to audit)
Departmental group for the year ended 31 March 2025

	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	437	2,369	2,806	22
£10,001 to £25,000	429	649	1,078	33
£25,001 to £50,000	381	341	722	10
£50,001 to £100,000	333	243	576	9
£100,001 to £150,000	112	69	181	1
£150,001 to £200,000	60	23	83	-
More than £200,000	2	6	8	1
Total number	**1,754**	**3,700**	**5,454**	**76**
Total cost (£)	**70,517,500**	**63,181,970**	**133,699,470**	**2,706,789**

Table 40d: 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**

Other departures

Table 41 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 41** will not necessarily match the total number in **Table 40**, which represents the number of individuals where exit packages have been agreed.

Table 41: Analysis of other departures (subject to audit)

	2024-25 Departmental group Number	2024-25 Departmental group £'000
Voluntary redundancies including early retirement costs	425	24,552
Mutually agreed resignation schemes (MARS)	570	15,049
Contractual payments in lieu of notice	2,701	19,148
Exit payments following Employment Tribunals or court orders	89	1,887
Non contractual payments requiring HMT approval	68	2,546
Total	**3,853**	**63,182**

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 International Financial Reporting Standards (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 Houses of Parliament.

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 has 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 (**SOPS 1**); a reconciliation of outturn to net operating expenditure in the statement of comprehensive net expenditure, to tie the SOPS to the financial statements (**SOPS 2**); a reconciliation of outturn to net cash requirement (**SOPS 3**); and an analysis of income payable to the Consolidated Fund (**SOPS 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. **Figure 1** at page 8 of this Annual Report and Accounts 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 2024-25

	SOPS note	Outturn Voted £'000	Outturn Non-voted £'000	Outturn Total £'000	Estimate Voted £'000	Estimate Non-voted £'000	Estimate Total £'000	Outturn vs estimate: saving / (excess) Voted £'000	Outturn vs estimate: saving / (excess) Total £'000	Prior year outturn total £'000
Departmental expenditure limit										
Resource	1.1	168,028,194	30,164,029	198,192,223	168,327,044	30,164,029	198,491,073	298,850	298,850	182,818,606
Capital	1.2	11,471,292	-	11,471,292	11,644,349	-	11,644,349	173,057	173,057	10,519,244
Total		**179,499,486**	**30,164,029**	**209,663,515**	**179,971,393**	**30,164,029**	**210,135,422**	**471,907**	**471,907**	**193,337,850**
Annually managed expenditure										
Resource	1.1	2,387,981	-	2,387,981	8,780,000	-	8,780,000	6,392,019	6,392,019	(9,730,033)
Capital	1.2	660,486	-	660,486	813,000	-	813,000	152,514	152,514	31,655
Total		**3,048,467**	**-**	**3,048,467**	**9,593,000**	**-**	**9,593,000**	**6,544,533**	**6,544,533**	**(9,698,378)**
Total budget										
Resource	1.1	170,416,175	30,164,029	200,580,204	177,107,044	30,164,029	207,271,073	6,690,869	6,690,869	173,088,573
Capital	1.2	12,131,778	-	12,131,778	12,457,349	-	12,457,349	325,571	325,571	10,550,899
Total budget expenditure		**182,547,953**	**30,164,029**	**212,711,982**	**189,564,393**	**30,164,029**	**219,728,422**	**7,016,440**	**7,016,440**	**183,639,472**

Net cash requirement 2024-25

	SOPS Note	Outturn £'000	Estimate £'000	Outturn vs estimate: saving/ (excess) £'000	Prior year outturn £'000
Net cash requirement	3	176,287,546	180,026,201	3,738,655	160,749,151

Administration costs 2024-25

	Outturn £'000	Estimate £'000	Outturn vs estimate: saving/ (excess) £'000	Prior year outturn £'000
Administration costs	2,554,116	3,266,132	712,016	2,571,282

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) £'000	Prior year outturn total £'000
	Administration			Programme			Total £'000	Total £'000	Virements £'000	Total incl. Virements £'000		
	Gross £'000	Income £'000	Net £'000	Gross £'000	Income £'000	Net £'000						
Departmental expenditure limit (DEL)												
Voted expenditure												
NHS England net expenditure	1,750,184	-	1,750,184	30,644,611	-	30,644,611	32,394,795	36,892,265	(4,497,470)	32,394,795	-	27,857,107
NHS providers net expenditure	-	-	-	125,147,653	-	125,147,653	125,147,653	120,412,609	4,735,044	125,147,653	-	114,691,376
DHSC programme and administration expenditure	435,664	(3,657)	432,007	2,200,900	(2,185,247)	15,653	447,660	892,696	(237,574)	655,122	207,462	453,477
Local authorities	-	-	-	3,425,796	-	3,425,796	3,425,796	3,368,797	56,999	3,425,796	-	3,301,393
Executive agencies	181,260	(14,771)	166,489	2,340,634	(396,745)	1,943,889	2,110,378	2,175,625	(56,999)	2,118,626	8,248	2,629,150
Special health authorities expenditure	237,240	(122,267)	114,973	3,369,475	(53,896)	3,315,579	3,430,552	3,455,640	-	3,455,640	25,088	3,771,079
Non-departmental public bodies net expenditure	94,318	-	94,318	116,172	-	116,172	210,490	151,982	65,116	217,098	6,608	203,613
Arm's length and other bodies net expenditure	(3,855)	-	(3,855)	864,725	-	864,725	860,870	977,430	(65,116)	912,314	51,444	855,900
	2,694,811	**(140,695)**	**2,554,116**	**168,109,966**	**(2,635,888)**	**165,474,078**	**168,028,194**	**168,327,044**	**-**	**168,327,044**	**298,850**	**153,763,095**
NHS England expenditure financed by NI contributions	-	-	-	30,164,029	-	30,164,029	30,164,029	30,164,029	-	30,164,029	-	29,055,511
Total spending in DEL	**2,694,811**	**(140,695)**	**2,554,116**	**198,273,995**	**(2,635,888)**	**195,638,107**	**198,192,223**	**198,491,073**	**-**	**198,491,073**	**298,850**	**182,818,606**
Annually managed expenditure (AME)												
Voted:												
NHS England net expenditure	-	-	-	(28,442)	-	(28,442)	(28,442)	250,000	-	250,000	278,442	(80,093)
NHS providers net expenditure	-	-	-	2,260,251	-	2,260,251	2,260,251	2,400,000	-	2,400,000	139,749	2,158,520
DHSC programme and administration expenditure	-	-	-	(1,733,781)	-	(1,733,781)	(1,733,781)	1,061,017	(4,157)	1,056,860	2,790,641	(466,781)
Executive agencies	-	-	-	(23,213)	-	(23,213)	(23,213)	1,000	-	1,000	24,213	(160,517)
Special health authorities expenditure	-	-	-	1,844,846	-	1,844,846	1,844,846	5,002,000	-	5,002,000	3,157,154	(11,132,970)
Non-departmental public bodies net expenditure	-	-	-	180	-	180	180	2,000	-	2,000	1,820	(50,717)
Arm's length and other bodies net expenditure	-	-	-	68,140	-	68,140	68,140	63,983	4,157	68,140	-	2,525
Total spending in AME	**-**	**-**	**-**	**2,387,981**	**-**	**2,387,981**	**2,387,981**	**8,780,000**	**-**	**8,780,000**	**6,392,019**	**(9,730,033)**
Total resource	**2,694,811**	**(140,695)**	**2,554,116**	**200,661,976**	**(2,635,888)**	**198,026,088**	**200,580,204**	**207,271,073**	**-**	**207,271,073**	**6,690,869**	**173,088,573**

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	598,247	-	598,247	464,272	133,975	598,247	-	376,068
NHS providers net expenditure	7,710,874	-	7,710,874	8,265,237	(396,728)	7,868,509	157,635	7,753,801
DHSC programme and administration expenditure	2,796,795	(44,527)	2,752,268	2,499,171	253,097	2,752,268	-	2,143,363
Executive agencies	103,063	(21,425)	81,638	71,982	9,656	81,638	-	(93,031)
Special health authorities expenditure	22,931	(196)	22,735	26,180	-	26,180	3,445	24,172
Non-departmental public bodies net expenditure	11,287	-	11,287	14,207	-	14,207	2,920	20,804
Arm's length and other bodies net expenditure	294,243	-	294,243	303,300	-	303,300	9,057	294,067
Total spending in DEL	**11,537,440**	**(66,148)**	**11,471,292**	**11,644,349**	**-**	**11,644,349**	**173,057**	**10,519,244**
Annually managed expenditure (AME)								
Voted expenditure								
NHS England net expenditure	241	-	241	13,378	-	13,378	13,137	(1,237)
NHS providers net expenditure	6,299	-	6,299	20,000	-	20,000	13,701	16,843
DHSC programme and administration expenditure	662,260	-	662,260	779,622	(1,615)	778,007	115,747	5,060
Executive agencies	1,575	-	1,575	-	1,575	1,575	-	-
Special health authorities expenditure	40	-	40	-	40	40	-	-
Arm's length and other bodies net expenditure	(9,929)	-	(9,929)	-	-	-	9,929	10,989
Total spending in AME	**660,486**	**-**	**660,486**	**813,000**	**-**	**813,000**	**152,514**	**31,655**
Total capital	**12,197,926**	**(66,148)**	**12,131,778**	**12,457,349**	**-**	**12,457,349**	**325,571**	**10,550,899**

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 £10 million 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**.

Estimates in tables A to D below are stated before virements.

Further explanation of SOPS 1.1 and 1.2

Table A: Comparison of resource DEL estimate and outturn

Resource DEL		Estimate £m	Outturn £m	Variance £m	Variance %	Explanation of significant variances
A	NHS England net expenditure	36,892	32,395	4,497	12%	The variance across the NHSE and NHS Providers estimate lines is £0.2 billion and mainly relates to higher than forecast intragroup income and expenditure eliminations.
B	NHS providers net expenditure	120,413	125,148	(4,735)	-4%	
C	DHSC programme and administration expenditure	893	448	445	50%	The £0.4bn variance is comprised as follows: 1. £0.3bn relates to intra-group budget transfers not wholly completed at the time of finalising the Supplemetary Supply Estimate; and 2. £0.1bn relates to lower than forecast net intra group eliminations.
D	Local authorities (public health)	3,369	3,426	(57)	-2%	
E	Executive agencies	2,176	2,110	65	3%	
F	Special health authorities expenditure	3,456	3,431	25	1%	
G	Non departmental public bodies net expenditure	152	210	(59)	-38%	The £0.1bn variance mainly relates to higher than forecast income and expenditure eliminations.
H	Arm's length and other bodies (net)	977	861	117	12%	The £0.1bn variance mainly relates to lower than forecast intragroup eliminations.
I	NHS England expenditure financed by NI contributions	30,164	30,164	0	0%	
Total RDEL		198,491	198,192	299		

Annex B includes a more detailed explanation of the DHSC's administrative spend. Totals in the table may not sum due to rounding.

For elimination variances please see the explanation provided in **Annex B**.

Table B: Comparison of resource AME estimate and outturn

	Resource AME	Estimate £m	Outturn £m	Variance £m	Variance %	Explanation of significant variances
J	NHS England net expenditure	250	(28)	278	111%	Net provisions expenditure was lower than forecast when setting the final budget.
K	NHS providers net expenditure	2,400	2,260	140	6%	
L	DHSC programme and administration expenditure	1,061	(1,734)	2,795	263%	Net provisions expenditure was lower than forecast when setting the final budget.
M	Executive agencies	1	(23)	24	2421%	Net provisions expenditure was lower than forecast when setting the final budget.
N	Special health authorities expenditure	5,002	1,845	3,157	63%	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	0	2	91%	
P	Arm's length and other bodies (net)	64	68	(4)	-6%	Net provisions expenditure was higher than forecast when setting the final budget.
Total RAME		**8,780**	**2,388**	**6,392**		

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.

Totals in the table may not sum due to rounding.

Table C: Comparison of capital DEL estimate and outturn

	Capital DEL	Estimate £m	Outturn £m	Variance £m	Variance %	Explanation of significant variances
A	NHS England net expenditure	464	598	(134)	-29%	The final 2024-25 NHSE CDEL budget as published in the 2024-25 revised financial directions to NHSE was c.£626m. The majority of the outturn variance against Supplementary Estimate is attributable to intra-group transfers into NHSE CDEL ahead of year-end, in accordance with section 223D of the National Health Service Act 2006.
B	NHS providers net expenditure	8,265	7,711	554	7%	The majority of the outturn variance against Supplementary Estimate is attributable to intra-group transfers out of NHS Providers to both NHSE and non-NHS CDEL budgets ahead of year-end.
C	DHSC programme and administration expenditure	2,499	2,752	(253)	-10%	To utilise NHS underspends, a decision was made to accelerate spend in various DHSC core programmes, resulting in an overspend in DHSC central budgets.
D	Local authorities (public health)	0	0	0		
E	Executive agencies	72	82	(10)	-13%	The £0.01bn variance mainly relates to intra-group budget transfers not wholly completed at the time of finalising the Supplemetary Supply Estimate.
F	Special health authorities expenditure	26	23	3	13%	
G	Non departmental public bodies net expenditure	14	11	3	21%	
H	Arm's length and other bodies (net)	303	294	9	3%	
Total CDEL		**11,644**	**11,471**	**173**		

Totals in the table may not sum due to rounding.

Table D: Comparison of capital AME estimate and outturn

	Capital AME	Estimate £m	Outturn £m	Variance £m	Variance %	Explanation of significant variances
J	NHS England net expenditure	13	0	13	98%	IFRS 16 dilapidations provisions expenditure was lower than forecast when setting the final budget. NHS England outturn is less than £0.5m.
K	NHS providers net expenditure	20	6	14	69%	IFRS 16 dilapidations provisions expenditure was lower than forecast when setting the final budget
L	DHSC programme and administration expenditure	780	662	117	15%	IFRS 16 dilapidations provisions expenditure was lower than forecast when setting the final budget
M	Executive agencies	0	2	(2)	0%	
N	Special health authorities expenditure	0	0	(0)	0%	
O	Non departmental public bodies net expenditure	0	0	0	0%	
P	Arm's length and other bodies (net)	0	(10)	10	0%	
Total CAME		**813**	**660**	**153**		

SOPS 2 Reconciliation of net resource outturn to net operating expenditure

	SOPS note	2024-25 Outturn £'000	2023-24 Outturn £'000
Total resource outturn	1.1	**200,580,204**	**173,088,573**
Add: Capital Grants		1,024,638	763,964
Research and development expenditure		2,020,554	1,506,936
Infected blood compensation payments		663,240	-
Service concession arrangement expenditure under IFRS		3,495,614	4,596,438
Service concession arrangement income under IFRS		(530,757)	(512,331)
Other		16,887	244,821
		6,690,176	**6,599,828**
Less: Income payable to the Consolidated Fund	4	(1,076)	(14,034)
Donated asset and government grant income		(446,131)	(361,907)
Service concession arrangement expenditure under UK GAAP		(2,660,764)	(2,586,324)
Loss on transfers by absorption		(1,801)	(971)
		(3,109,772)	**(2,963,236)**
Net operating cost in consolidated statement of comprehensive net expenditure before absorption transfers		**204,160,608**	**176,725,165**

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. The main reconciling items are described below:

- 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 outturn and net operating expenditure.

- Infected blood compensation payments in the year score to the capital AME budget in line with HM Treasury classification but are accounted for as expenditure in the financial statements and therefore are reconciling items between resource outturn and net operating expenditure. This amount will not agree to note 4.1 due to the utilisation of the prior year provision, already recognised in expenditure.

- As noted in note 1.14 below, 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. In line with Consolidated Budgeting Guidance, service concession arrangements which are subject to IFRIC 12 in accounts, are measured according to ESA10 standards set out in the Manual on Government Deficit and Debt.

The reconciling items above reflect this differing treatment and impact on resource outturn.

- 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.

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	**200,580,204**	**207,271,073**	**6,690,869**
Total capital outturn	1.2	**12,131,778**	**12,457,349**	**325,571**
Adjustments for ALBs:				
Remove voted resource and capital		(169,525,199)	(170,230,663)	(705,464)
Add cash grant-in-aid, PDC, loans and share capital from core department, and expenditure financed by parliamentary funding		162,768,622	164,957,904	2,189,282
Adjustments to remove non-cash items:				
Depreciation		(226,884)	(514,194)	(287,310)
New provisions and adjustments to previous provisions		(2,885,817)	(10,099,367)	(7,213,550)
Service concession arrangement revenue adjustments		105,412	-	(105,412)
Adjustment for stockpiled goods		12,062	-	(12,062)
Non-cash investment additions		(8,121)	-	8,121
Net gain/loss on transfers by absorption		1,485	-	(1,485)
Other non-cash items		(1,421,225)	-	1,421,225
Adjustments to reflect movements in working balances:				
Increase / (decrease) in inventories		(16,190)	-	16,190
COVID-19 budgeting impacts on non-cash transactions		(1,005)	-	1,005
Transfers to non-current assets		3,480	-	(3,480)
Increase / (decrease) in receivables		114,736	2,000,000	1,885,264
Movement in Consolidated Fund receivables		(42)	-	42
Movement in current financial assets		114,898	-	(114,898)
Movements in finance lease receivables		4,198	-	(4,198)
Capital element of finance lease receivables		(12,647)	-	12,647
(Increase) / decrease in payables		748,754	-	(748,754)
Movement in payables to the Consolidated Fund		(360,791)	-	360,791
Movement in finance lease/PFI payables		(426)	-	426
Capital element of finance lease/PFI payables		40,188	-	(40,188)
Use of provisions		4,281,774	4,348,128	66,354
		206,449,244	**210,190,230**	**3,740,986**
Removal of non-voted budget items:				
National Insurance contributions		(30,164,029)	(30,164,029)	-
Other adjustments		2,331	-	(2,331)
Net cash requirement		**176,287,546**	**180,026,201**	**3,738,655**

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 207 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).

	2024-25 Outturn		2023-24 Outturn	
	Accruals £'000	*Cash basis £'000*	Accruals £'000	*Cash basis £'000*
Income outside the ambit of the Estimate	1,076	*1,034*	14,034	*14,021*
Excess cash surrenderable to the Consolidated Fund	-	-	-	-
Total amount payable to the Consolidated Fund	**1,076**	***1,034***	**14,034**	***14,021***

Parliamentary accountability disclosures

Regularity of expenditure (subject to audit)

We are custodians 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 is detailed within the Statement of Accounting Officer Responsibilities and the Governance Statement.

Losses (subject to audit)

Table 42: Losses statement

		Core department and agencies		Departmental group	
		2024-25	2023-24	2024-25	2023-24
Total losses	**Cases**	**327**	**1,512**	**158,000**	**467,842**
	£'000	**2,084,720**	**8,988,276**	**1,999,364**	**9,093,885**
Cases over £300,000					
Cash losses	Cases	1	-	1	-
	£'000	586	-	586	-
Claims abandoned	Cases	6	1	10	3
	£'000	38,087	7,070	40,955	8,933
Cancellation of public dividend capital	Cases	2	-	-	-
	£'000	226,724	-	-	-
Fruitless payments	Cases	-	222	5	222
	£'000	-	2,480,678	21,866	2,480,678
Constructive losses	Cases	5	310	6	311
	£'000	1,817,474	6,442,148	1,817,862	6,443,314
Store losses	Cases	-	-	7	11
	£'000	-	-	4,063	7,898

The narrative disclosures below relate to the core department only. Further disclosures of losses and special payments for other bodies can be found within the accounts of those entities.

Claims waived and abandoned

In total, DHSC waived or abandoned claims of £572 million against 25 PPE suppliers during 2024-25. Other than 4 of these cases, totalling £21.3 million, these have not been included in the table above as losses have already been disclosed in previous financial years in relation to the associated inventory. The Covid Counter-Fraud Commissioner (CCFC), appointed in December 2024 by the Chancellor of the Exchequer, has reviewed these cases and has

agreed with the claims waived or abandoned loss position and course of action taken by DHSC in each of these cases.

Constructive losses

There were two constructive losses occurring in 2024-25, of £856 million and £393 million respectively, relating to two COVID-19 antiviral medicines which reached their expiry dates during the year. The bulk of these items were procured in response to the emergence of the Omicron variant at a time when its severity and potential impact on vaccine efficacy were uncertain. The actual impact was less severe than previous variants and as a result, not all medicines purchased were used prior to their expiry dates.

The vast majority of these medicines had already been impaired in the financial statements in previous years to reflect that they were not expected to be used, but the reportable loss only crystallises when the expiry date of the medicines is actually reached. This occurred during the 2024-25 financial year.

Cash losses

There was one cash loss above the £300,000 reporting threshold in the core department during 2024-25. This related to a suspected fraud case identified during the year totalling £930k, of which £344k has subsequently been recovered. No further information can be disclosed at present as an investigation is ongoing.

Special payments (subject to audit)

Table 43: Special payments

		Core department and agencies		Departmental group	
		2024-25	2023-24	2024-25	2023-24
Total special payments	**Cases**	**54**	**28**	**8,358**	**7,411**
	£'000	**790**	**2,341**	**25,013**	**20,755**
Cases over £300,000	Cases	-	1	5	4
	£'000	-	1,395	7,910	4,474

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.

There were no core department special payments over £300,000 in 2024-25.

Other payments (subject to audit)

There have been no other payments made by the core department for 2024-25 or in 2023-24.

Table 44: Fees and charges (subject to audit)

Fees and charges for the year ended 31 March 2025

	Fees and charges income £'000	Full cost of service £'000	Surplus/(deficit) £'000
Dental	796,508	3,552,908	(2,756,400)
Prescription	730,413	12,776,122	(12,045,709)
Other fees and charges for which the cost of providing the service is over £1million	502,561	487,050	15,511
Total	**2,029,482**	**16,816,080**	**(14,786,598)**

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)**

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 2024-25, the NHS prescription charge for each medicine or appliance dispensed was £9.90. However, around 95% 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 £32.05 for three months or £114.50 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 2024-25, the charge for Band 1 treatments was £26.80, for Band 2 was £73.50 and for Band 3 was £319.10.

Included in the 'Other fees and charges' (for which the cost of providing the service is over £1.0 million) is £227 million (2023-24: £223 million) of fees and charges and £232 million (2023-24: £222 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.

Quantifiable remote contingent liabilities are as shown below:

Indemnities (£m)		
1	The core department has issued an indemnity in relation to the operations of the Human Fertilisation and Embryology Authority (HFEA).	1.5[1]
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 circumstances and practices surrounding the deaths of mental health inpatients in Essex.	N/A[2]
4	The core department holds an indemnity provided to Oxford University for unexpected tax implications as a result of the National Institute for Health Research (NIHR) National Biosample Centre transfer to DHSC.	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 DHSC.	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]
8	Sensitive contingent liabilities, nature not disclosed	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 body's 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[1]	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.

10	The core department holds an obligation to indemnify reasonable capital and operating costs incurred by the following water companies that fluoridate water in England: • Anglian Water • Northumbrian Water • Severn Trent Water • South Staffs Water • United Utilities
11	Sensitive contingent liabilities nature not disclosed.
Other Remote Unquantifiable Contingent Liabilities	
12	UKHSA maintains a stockpile of medical countermeasures for responding to Chemical, Biological, Radiological and Nuclear (CBRN) incidents. Some of these products are unlicensed because no licensed alternatives are available in the UK. Similarly, UKHSA also holds stocks of unlicensed anti-venoms and anti-toxins. If any recipients were to suffer an adverse reaction to using these products UKHSA would be liable.
13	UKHSA holds remote contingent liabilities relating to contract disputes, primarily relating to contracts let in response to the Covid pandemic.
14	UKHSA holds liabilities in respect of commercial contract obligations. These liabilities include contractual indemnities DSHC 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.
15	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.

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 2024-25, 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

4 December 2025
Samantha Jones
Permanent Secretary

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSES OF PARLIAMENT

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 2025 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 2024. The financial statements comprise: the department's and the departmental group's:

- Consolidated Statement of Financial Position as at 31 March 2025;
- Consolidated Statement of Comprehensive Net Expenditure, Consolidated Statement of Cash Flows and Consolidated 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, the financial statements:

- give a true and fair view of the state of the department and the departmental group's affairs as at 31 March 2025 and its net expenditure for the year then ended; and
- have been properly prepared in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions issued thereunder.

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 2025 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 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 (2024). My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2019. I am independent of the department and its group in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

The framework of authorities described in the table below has been considered in the context of my opinion on regularity.

Framework of authorities	
Authorising legislation	Government Resources and Accounts Act 2000
Parliamentary authorities	Supply and Appropriation Acts
HM Treasury and related authorities	Managing Public Money

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the department and its group's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the department or its group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for the department and its group is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which requires entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Overview of my audit approach

Key audit matters

Key audit matters are those matters that, in my professional judgment, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditor, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team.

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, the completeness and accuracy of intra-group transactions and balances, or from gaps in assurance arising from the audit of the UK Health Security Agency.

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 145-147.

There are no significant changes to the risks identified in my prior year report.

Valuation and disclosure of the clinical negligence provision in the departmental group accounts

Description of risk

The departmental group recognised provisions in relation to clinical negligence totalling £60.0 billion at 31 March 2025 (31 March 2024: £58.2 billion). See note 16 to the financial statements.

There are significant judgements implicit in the valuation of the clinical negligence provisions. The valuation requires the support of actuarial experts and involves the use of actuarial assumptions, models, and data held within the NHS Resolution Claims Management System. The 'incurred but not reported' (IBNR) provision includes a greater level of estimation uncertainty, as judgements are required by management in respect of the level of claims that will be received for incidents that occurred prior to the reporting date but have not yet been reported to NHS Resolution.

The highly material value of the provisions and the level of judgement and estimation uncertainty inherent in the calculation could have resulted 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

I have:

- evaluated the design and implementation of the controls in place in respect of management's review of the valuation prepared by the actuarial adviser (the 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 applied, including the use of relevant indices.

I have assessed the adequacy of the financial statements disclosure, set out on pages 306 to 311.

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.

Property valuations in the departmental group accounts

Description of risk

The departmental group reported property recognised under IAS 16: Property, Plant and Equipment *with a net book value £54.4 billion and property recognised under* IFRS 16: Leases *as right-of-use assets of net book value £3.7 billion (31 March 2024: Property recognised under* IAS 16 *£52.7 billion and property recognised as*

right-of-use assets under IFRS 16 *£3.8 billion). See 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) approach. The valuation of these property assets represents a significant accounting estimate in each NHS provider's accounts, which is 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 needed to consider the impact of factors such as the presence of reinforced autoclaved aerated concrete (RAAC) and movements in the inflation rate in reaching their valuations as at 31 March 2025.

There is a high level of judgement involved in the selection and application of the 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

I have:

- reviewed the adequacy of the design and implementation of controls in operation at NHS England (for its production of the Consolidated NHS Provider Accounts), Community Health Partnerships Limited and NHS Property Services Limited in respect of property valuations;
- obtained specific information on NHS provider's valuation methodologies and approach, and key assumptions in respect of properties;
- evaluated this information in aggregate to establish the appropriateness and consistency of the valuation bases applied at group level for NHS providers;

- selected a risk-based sample of NHS provider audit files and reviewed substantive procedures performed by the NHS provider auditors to address the risk around valuation of property assets, including consideration of the method used for depreciation;

- assessed the appropriateness of the methodology and assumptions, and substantively tested the data inputs, used in the valuation of NHS Property Services Limited's property portfolio; and

- assessed the appropriateness of the methodology and assumptions, and substantively tested the data inputs, used in the valuation of Community Health Partnerships Limited's property portfolio.

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.

Valuation of the infected blood provision in the core and agencies accounts and departmental group accounts

Description of risk

The department recognised provisions in relation to the infected blood support scheme totalling £0.2 billion as at 31 March 2025 (31 March 2024: £2.0 billion). The provision represents the department's estimate of its liabilities due to 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 in May 2024, and recommended a compensation scheme, to be administered by the newly-formed

Infected Blood Compensation Authority (IBCA), an arms-length body of the Cabinet Office. IBCA is responsible for payments from 23 March 2026 based on the legislation in force at the reporting date. Accordingly, the department has derecognised from its accounts the liability for future payments expected from 23 March 2026, with £0.2 billion remaining at 31 March 2025 in respect of payment it expects to make up to 23 March 2026. Draft legislation was laid in Parliament in October 2025 to delay the date of transfer to 23 March 2027, however this does not require adjustment in the financial statements.

How the scope of my audit responded to the risk

I have:

- Evaluated the design and implementation of the controls in place in respect of the valuation of the contaminated blood provision. This included evaluation of controls in respect of the significant inputs and assumptions applied in the model;
- 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;
- 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. I 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 in the model. I concluded that the assumptions used were appropriate. I also performed sensitivity analysis;
- Assessed the completeness and accuracy of the claimant data which forms the basis of the input data into the model;
- Critically assessed the key judgment over the point in time at which the liability transfers from the department to IBCA for accounting purposes; and
- Assessed the adequacy of the financial statements disclosures in relation to the provision, including

disclosures made in respect of the transfer of obligations to IBCA.

Key observations

The accounts presented for audit included provision for all future English Infected Blood Support Scheme payments. I concluded that the constructive obligation at the reporting date for payments to be made on or after 23 March 2026 resides with IBCA. In response to my challenge, the department reduced the value of its provision by £1.4 billion so that its accounts only reflected payments to be made up to 23 March 2026. I have obtained sufficient assurance over this risk through my substantive testing. I did not identify further significant misstatements in the valuation of the infected blood provision as a result of the work I have performed.

Classification, existence, rights and obligations, presentation, and valuation of the department's financial assets in the core and agencies accounts

Description of risk

The department held financial assets valued at £45.3 billion as at 31 March 2025 (31 March 2024: £43.8 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 2025:

- *Public Dividend Capital (PDC) to NHS providers of £39.4 billion (31 March 2024: £37.4 billion);*
- *Share capital investments of £3.9 billion (31 March 2024: £4.3 billion);*
- *Loans to NHS providers of £1.8 billion (31 March 2024: £1.9 billion); and*
- *Loans to other bodies of £0.2 billion (31 March 2024: £0.2 billion).*

This key audit matter is in relation to the department's Public Dividend Capital (PDC) to NHS providers and its share in 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 2025.

The department undertook a desk-based valuation exercise of its share capital investments as at 31 March 2025 with the assistance of an investments expert.

I identified a risk of misclassification between PDC and loans to NHS providers, and inherent risks regarding the existence and rights and obligations of financial assets. I identified a 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 in the NHS providers, Community Health Partnerships Limited, Genomics England Limited, NHS Property Services Limited, and Supply Chain Coordination Limited and are eliminated on consolidation in the departmental group financial statements.

How the scope of my audit responded to the risk

I reviewed the design and implementation of controls around the valuation of financial assets including PDC and share capital investments.

I tested in-year PDC additions and PDC assets as at 31 March 2025 to confirm that the assets exist and that the rights and obligations of the assets were held by the Department.

I assessed and confirmed the appropriateness of the department's impairment policy for PDC. 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 260.

I engaged a valuations expert to assist me in:

- assessing 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;
- assessing and challenging management's assumptions applied in the valuations, including the discount rate applied, to ensure that these were appropriate; and
- assessing 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 294 to 296

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	£1.9 billion	£1.9 billion
Basis for determining materiality	Approximately 1% of departmental group gross expenditure (£220.7 billion). Materiality set at planning based on a lower gross expenditure level has been retained. The basis for determining materiality for the 2024-25	Approximately 1% of core and agencies gross expenditure (£207.3 billion). Materiality set at planning based on a lower gross expenditure level has been retained. The basis for determining materiality for the 2024-25

	financial statements remains largely the same as that used in 2023-24, when materiality was £2.0 billion. The previous basis adjusted gross expenditure to exclude expenditure arising from changes in the discount rate for provisions, which would otherwise have resulted in significant year-on-year changes in materiality, given the significant fluctuations in the discount rate between 2020 and 2023. Discount rates have stabilised since 2023 and, therefore, no such adjustment is now made.	financial statements remains largely the same as that used in 2023-24, when materiality was £1.8 billion. The previous basis capped materiality as lower than departmental group materiality. Revisions to auditing standards mean that materiality for the department does not need to be capped, as the component performance materiality set for the department reduces the risk of material aggregated misstatements for the departmental group.
Rationale for the benchmark applied	As a public sector department responsible for the provision of health and social care services, the departmental group is primarily funded by amounts drawn down from the Consolidated Fund. Gross expenditure is the primary driver of the departmental group financial statements; the provision of health and social care in England is the department's primary purpose and a focus of both Parliamentary and public interest. In line with Practice Note 10, I have therefore chosen gross expenditure as the appropriate benchmark to apply.	The rationale for the benchmark applied is consistent with that of the departmental group.

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 2024-25 audit (2023-24: 75%). In determining performance materiality, I also 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. 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 £1 million, 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, if adjusted, would have decreased net expenditure and increased net assets by £406 million.

Audit scope

The scope of my group audit was determined by obtaining an understanding of the department's and departmental group's environment, including department-wide and group-wide controls, and assessing the risks of material misstatement at the group level.

In line with revisions to *ISA (UK) 600 Special Considerations - Audits of Group Financial Statements (Including the Work of Component Auditors)* I assessed my approach to the audits of the department and of the departmental group considering the risks of material misstatement given the size, estimation, and/or complexity of various classes of transactions, account balances and disclosures with the department financial statements and the departmental group financial statements. I used this risk assessment to determine the audit procedures I required to be performed under my direction, supervision and review.

Based on my risk assessment, I included in the scope of my audit of the departmental group various classes of transactions, account balances and disclosures arising from the following components:

- the department;
- Community Health Partnerships Limited;
- Consolidated NHS Provider Accounts;
- NHS Business Services Authority;
- NHS England;
- NHS Property Services Limited; and
- NHS Resolution.

Based on my risk assessment, I included in the scope of my audit of the department various classes of transactions, account balances and disclosures arising from the following components:

- the core department; and
- UK Health Security Agency.

My audit included coverage of 99.5% of the departmental group's expenditure, 94.1% of its income, 99.3% of its assets, and 99.7% of its liabilities through the work performed directly as a group auditor and through work performed by component auditors.

I audited the core department component as part of my audit of the department. I have had direct involvement in the audit strategy with all component auditors. I issued group audit instructions which enabled me to direct component auditors to carry out the procedures required for my audit opinion on the department's and on the departmental group's consolidated financial statements. I am the appointed auditor for all of the components of the department and of the departmental Group, with the exception of the following departmental group bodies:

- Charitable trusts, the trustees of which are an NHS Foundation Trust or an NHS Trust, and which are not consolidated into the trustee body's accounts;
- Community Health Partnerships Limited;
- Genomics England Limited;
- Skipton Fund Limited; and
- Wiltshire Health & Care LLP.

Audit procedures in accordance with UK adaptations of International Standards on Auditing have been conducted for classes of transactions, account balances and disclosures included in the scope of my audit and I have satisfied myself that sufficient work has been undertaken to provide the necessary assurances for my audit opinion on the department's and on the departmental group's consolidated financial statements.

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.

I have nothing 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, 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.

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.

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- Adequate accounting records have not been kept by the department and its group or returns adequate for my audit have not been received from branches not visited by my staff; or
- I have not received all of the information and explanations I require for my audit; or
- 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[1], 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:

[1] Non-compliance is defined as acts of omission or commission intentional or unintentional, committed by the entity, or by those charged with governance, by management or by other individuals working for or under the direction of the entity, which are contrary to the prevailing laws or regulations. Non-compliance does not include personal misconduct unrelated to the business activities of the entity. ISA 700 uses the word "irregularities" to describe non-compliance with laws and regulations. We do not use the word irregularities to describe non-compliance within our certificates and reports as it has another meaning in the context of PN10.

- 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 2024;

- 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 relevant 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 and bias in management estimates. 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 operate. 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 2024, Local Government Act 2003, The Infected Blood Compensation Scheme Regulations 2025, 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 tested 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 of 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 relevant 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.

Report

I have no observations to make on these financial statements.

Gareth Davies **Date 8 December 2025**
Comptroller and Auditor General

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

Financial statements

Structure of the Financial Statements

The financial statements set out the DHSC group's financial position and performance. It includes:

- The Consolidated Statement of Comprehensive Net Expenditure
- The Consolidated Statement of Financial Position
- The Consolidated Statement of Cash Flows
- The Consolidated Statement of Changes in Taxpayers' Equity
- Notes to the 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.

Other comprehensive net expenditure includes items which will not be reclassified to net operating costs.

In all material respects, the income and expenditure disclosed in the consolidated statement of comprehensive net expenditure relates to activities that are continuing.

Consolidated statement of financial position

This statement presents the financial position of DHSC. It comprises three main components: assets owned, controlled, or receivable from other bodies; liabilities owed to other bodies; and equity, the remaining value of the entity.

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 DHSC 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 DHSC. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to DHSC's future public service delivery.

Consolidated statement of changes in taxpayers' equity

These statements show 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 recorded as the initial capital funding provided by government 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 the department, to the extent that the total is not represented by other reserves and financing items.

Consolidated statement of comprehensive net expenditure for the year ended 31 March 2025

	Note	Core department and agencies 2024-25 £m	Core department and agencies 2023-24 £m	Departmental group 2024-25 £m	Departmental group 2023-24 £m
Income from contracts	5	(2,632)	(2,666)	(12,575)	(12,209)
Non-contract income	5	(1,121)	(1,086)	(1,718)	(1,489)
Income received by NHS charities		-	-	(138)	(141)
Total operating income		**(3,753)**	**(3,752)**	**(14,431)**	**(13,839)**
Staff costs	3	814	753	98,525	89,949
Purchase of goods and services	4	2,045	2,255	94,004	86,844
Depreciation and impairment charges	4	999	6,336	6,291	5,880
Provision expense	4	(790)	673	3,001	(8,400)
Other operating expenditure	4	10,466	9,333	14,126	12,889
Grant in aid to NDPBs		191,590	176,843	-	-
Funding to group bodies		581	547	-	-
Resources expended by NHS charities		-	-	71	143
Total operating expenditure		**205,705**	**196,740**	**216,018**	**187,305**
Net operating expenditure		**201,952**	**192,988**	**201,587**	**173,466**
Finance income		(72)	(71)	(650)	(696)
Finance expense	4	147	123	3,223	3,955
Net (gain)/loss on transfers by absorption		(1)	(3)	2	1
Net expenditure for the year		**202,026**	**193,037**	**204,162**	**176,726**
Other comprehensive net expenditure					
Net (gain)/loss on:					
- revaluation of property, plant and equipment	6	(19)	(76)	(1,180)	(1,664)
- revaluation of intangibles	7	-	(1)	(1)	(6)
- revaluation of right of use assets	8	-	-	(9)	(17)
- revaluation of charitable assets		-	-	2	(23)
- net impairments taken to revaluation reserve	4.3	10	-	1,158	1,737
- equity instruments measured at fair value	11	581	1,479	113	-
Actuarial (gains)/losses on pension schemes		-	-	(29)	(10)
Other pension remeasurements		-	-	46	12
Other (gains) and losses		-	-	417	(7)
Comprehensive net expenditure for the year		**202,598**	**194,439**	**204,679**	**176,748**

Consolidated statement of financial position as at 31 March 2025

	Note	Core department and agencies 2024-25 £m	Core department and agencies 2023-24 £m	Departmental group 2024-25 £m	Departmental group 2023-24 £m
Non-current assets					
Property, plant and equipment	6	926	911	69,520	68,387
Investment property		42	43	262	282
Intangible assets	7	190	125	3,226	2,940
Right of use assets	8	122	155	4,458	4,575
Net pension asset		-	-	32	45
Non-current investments	11	45,326	43,812	524	639
Charitable investments		-	-	325	350
Other non-current assets	14	277	255	850	792
Total non-current assets		**46,883**	**45,301**	**79,197**	**78,010**
Current assets					
Assets held for sale		5	10	101	65
Inventories	12	676	692	2,385	2,311
Trade and other receivables	14	328	376	3,980	3,905
Other current assets	14	1,226	942	3,529	2,990
Other financial assets (investments)	14	220	335	136	104
Cash and cash equivalents	13	1,927	2,370	13,509	14,592
Charitable cash		-	-	177	204
Total current assets		**4,382**	**4,725**	**23,817**	**24,171**
Total assets		**51,265**	**50,026**	**103,014**	**102,181**
Current liabilities					
Trade and other payables	15	(76)	(64)	(9,080)	(8,621)
Other liabilities	15	(4,279)	(5,051)	(22,188)	(23,849)
Provisions	16	(702)	(815)	(5,285)	(5,562)
Total current liabilities		**(5,057)**	**(5,930)**	**(36,553)**	**(38,032)**
Total assets less current liabilities		**46,208**	**44,096**	**66,461**	**64,149**
Non-current liabilities					
Other payables	15	(29)	(37)	(1,273)	(955)
Provisions	16	(1,520)	(3,166)	(59,109)	(58,922)
Financial liabilities	15	(219)	(212)	(20,193)	(20,326)
Total non-current liabilities		**(1,768)**	**(3,415)**	**(80,575)**	**(80,203)**
Total assets less liabilities		**44,440**	**40,681**	**(14,114)**	**(16,054)**
Taxpayers' equity and other reserves					
General fund		41,323	36,999	(29,632)	(32,286)
Revaluation reserve		342	330	14,855	15,410
Other reserves		2,775	3,352	173	307
Total equity		**44,440**	**40,681**	**(14,604)**	**(16,569)**
Charitable funds		-	-	490	515
Total reserves		**44,440**	**40,681**	**(14,114)**	**(16,054)**

Comparative figures for 2023-24 for the departmental group have been re-presented where 2024-25 amounts have been reorganised.

4 December 2025
Samantha Jones
Permanent Secretary

Consolidated statement of cash flows for the year ended 31 March 2025

	Note	Core department and agencies 2024-25 £m	Core department and agencies 2023-24 £m	Departmental group 2024-25 £m	Departmental group 2023-24 £m
Net cashflow from operating activities					
Net expenditure for the year		(202,026)	(193,037)	(204,162)	(176,726)
Adjustments for non-cash transactions	4.2	2,012	8,634	12,378	(135)
Adjustments for net finance costs		(65)	(65)	1,101	2,232
Other non cash movements in statement of financial position items		(24)	(15)	3	(48)
Adjustments for charities		-	-	17	22
(Increase)/decrease in trade and other receivables	14	(143)	430	(704)	(105)
(Increase)/decrease in inventories	12	16	361	(74)	291
Increase/(decrease) in trade and other payables	15	(761)	746	(1,017)	5,933
Movements arising from absorption transfers		-	14	2	1
Working capital movements not in net expenditure		234	(1,268)	290	(9,343)
Use of provisions	16	(446)	(528)	(3,872)	(3,591)
Transfer of provisions to payables/ inventories	16	(699)	(906)	(747)	(955)
Cash payments in respect of pensions		-	-	(4)	(3)
Other operating cashflows		(1)	(10)	(28)	10
Net cash outflow from operating activities		**(201,903)**	**(185,644)**	**(196,817)**	**(182,417)**
Cash flows from investing activities					
Purchase of property, plant, equipment and investment properties		(204)	(101)	(7,664)	(7,341)
Purchase of intangible assets		(64)	(78)	(961)	(836)
Purchase of investments		(4,845)	(5,110)	(12)	(19)
Proceeds of disposal of property, plant and equipment		5	9	84	119
Proceeds of disposal of intangibles		-	-	1	1
Proceeds of disposal of right of use assets		-	3	-	1
Proceeds of disposal of assets held for sale		1	1	64	63
Proceeds of disposal of investments		435	1,035	21	24
Receipts in respect of finance leases		14	13	11	8
Interest received from group bodies		61	65	-	-
Interest received from external bodies		-	-	640	672
Non-cash disposals of financial assets		-	(1)	1	(1)
Payment of direct costs in respect of obtaining right of use assets		-	-	(4)	(1)
Other investing cashflows		5	-	35	39
Net cash outflow from investing activities		**(4,592)**	**(4,164)**	**(7,784)**	**(7,271)**
Cash flows from financing activities					
From the Consolidated Fund (Supply) - current year	SoCTE	175,940	162,150	175,940	162,150
Net financing from the National Insurance Fund	SoCTE	30,164	29,056	30,164	29,056
Net movements of capital element of loans		-	-	(44)	(27)
Payments in respect of leases		(37)	(41)	(793)	(811)
Capital payments in respect of PFI contracts		-	-	(756)	(775)
Interest paid to group bodies		(1)	(1)	-	-
Interest paid to external bodies		-	-	(994)	(907)
Other financing cashflows		-	(1)	(2)	(11)
Net cash outflow from financing activities		**206,066**	**191,163**	**203,515**	**188,675**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund		**(429)**	**1,355**	**(1,086)**	**(1,013)**
Payment of amounts due to the Consolidated Fund		(14)	(1)	(14)	(1)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund		**(443)**	**1,354**	**(1,100)**	**(1,014)**
Cash and cash equivalents at the beginning of the period		2,370	1,016	14,767	15,781
Cash and cash equivalents at the end of the period		**1,927**	**2,370**	**13,667**	**14,767**

Comparatives for 2023-24 have been re-presented where figures for 2024-25 have been reorganised.

Consolidated statement of changes in taxpayers' equity: core department and agencies

For the year ended 31 March 2025

	Note	General fund £m	Revaluation reserve £m	Other reserves £m	Taxpayers' equity £m
Balance at 1 April 2024		**36,999**	**330**	**3,352**	**40,681**
Prior period adjustments in local accounts		(3)	4	-	1
Parliamentary and other funding					
Parliamentary funding - drawn down	SoCF	175,940	-	-	175,940
Parliamentary funding - deemed		3,059	-	-	3,059
Parliamentary funding - amounts unspent at period end	15	(2,712)	-	-	(2,712)
Amounts payable to the Consolidated Fund	15	(1)	-	-	(1)
National Insurance Fund contributions	SoCF	30,164	-	-	30,164
Comprehensive net expenditure for the year					
Net expenditure for the year	SoCNE	(202,026)	-	-	(202,026)
Non-cash auditor's remuneration	4.1	2	-	-	2
Net gain/(loss) on revaluation of non-current assets		-	19	-	19
Net impairments	4.3	-	(10)	-	(10)
Fair value gains/(losses) on equity instruments	11	(3)		(578)	(581)
Other movements					
PDC impairments	4.3	129	-	-	129
PDC written off		(227)	-	-	(227)
Other movements		2	(1)	1	2
Balance at 31 March 2025		**41,323**	**342**	**2,775**	**44,440**

For the year ended 31 March 2024

	Note	General fund £m	Revaluation reserve £m	Other reserves £m	Taxpayers' equity £m
Balance at 1 April 2023		**40,565**	**235**	**4,746**	**45,546**
Prior period adjustments in local accounts		(25)	26	-	1
Parliamentary and other funding					
Parliamentary funding - drawn down	SoCF	162,150	-	-	162,150
Parliamentary funding - deemed		1,658	-	-	1,658
Parliamentary funding - amounts unspent at period end	15	(3,059)	-	-	(3,059)
Amounts payable to the Consolidated Fund	15	(14)	-	-	(14)
National Insurance Fund contributions	SoCF	29,056	-	-	29,056
Comprehensive net expenditure for the year					
Net expenditure for the year	SoCNE	(193,037)	-	-	(193,037)
Non-cash auditor's remuneration	4.1	2	-	-	2
Net gain/(loss) on revaluation of non-current assets		-	77	-	77
Fair value gains/(losses) on equity instruments	11	(85)	-	(1,394)	(1,479)
Other movements					
Transfers between reserves		8	(8)	-	-
PDC impairments	4.3	(227)	-	-	(227)
Other movements		7	-	-	7
Balance at 31 March 2024		**36,999**	**330**	**3,352**	**40,681**

Consolidated statement of changes in taxpayers' equity: departmental group

For the year ended 31 March 2025

	Note	General fund £m	Revaluation reserve £m	Other reserves £m	Taxpayers' equity £m	Charitable funds £m	Total reserves £m
Balance at 1 April 2024		**(32,286)**	**15,410**	**307**	**(16,569)**	**515**	**(16,054)**
Prior period adjustments in local accounts		40	130	(8)	162	2	164
Parliamentary and other funding							
Parliamentary funding - drawn down	SoCF	175,940	-	-	175,940	-	175,940
Parliamentary funding - deemed		3,059	-	-	3,059	-	3,059
Parliamentary funding - amounts unspent at period end	15	(2,712)	-	-	(2,712)	-	(2,712)
Amounts payable to the Consolidated Fund	15	(1)	-	-	(1)	-	(1)
National Insurance Fund contributions	SoCF	30,164	-	-	30,164	-	30,164
Net expenditure for the year	SoCNE	(204,137)	-	-	(204,137)	(25)	(204,162)
Non-cash auditor's remuneration	4.1	3	-	-	3	-	3
Other comprehensive net expenditure							
Net gain/(loss) on revaluation of non-current assets		-	1,190	-	1,190	-	1,190
Fair value gains/(losses) on equity instruments		-	-	(113)	(113)	-	(113)
Net gain/(loss) on revaluation of charitable assets		-	-	-	-	(2)	(2)
Net impairments	4.3	-	(1,158)	-	(1,158)	-	(1,158)
Net actuarial gain/(loss) on defined benefit pension scheme		29	-	-	29	-	29
Other pensions remeasurements		(30)	-	(16)	(46)	-	(46)
Other gains and losses		(417)	-	-	(417)	-	(417)
Other movements							
Transfers between reserves		713	(715)	2	-	-	-
Other movements		3	(2)	1	2	-	2
Other transfers		-	-	-	-	-	-
Balance at 31 March 2025		**(29,632)**	**14,855**	**173**	**(14,604)**	**490**	**(14,114)**

For the year ended 31 March 2024

	Note	General fund £m	Revaluation reserve £m	Other reserves £m	Taxpayers' equity £m	Charitable funds £m	Total reserves £m
Balance at 1 April 2023		**(39,151)**	**15,810**	**201**	**(23,140)**	**590**	**(22,550)**
Prior period adjustments in local accounts		(47)	(4)	89	38	(1)	37
Application of IFRS 16 measurement principles to PFI liability		(6,397)	(152)	-	(6,549)	-	(6,549)
Parliamentary and other funding							
Parliamentary funding - drawn down	SoCF	162,150	-	-	162,150	-	162,150
Parliamentary funding - deemed		1,658	-	-	1,658	-	1,658
Parliamentary funding - amounts unspent at period end	15	(3,059)	-	-	(3,059)	-	(3,059)
Amounts payable to the Consolidated Fund	15	(14)	-	-	(14)	-	(14)
National Insurance Fund contributions	SoCF	29,056	-	-	29,056	-	29,056
Net expenditure for the year	SoCNE	(176,629)	-	-	(176,629)	(97)	(176,726)
Non-cash auditor's remuneration	4.1	3	-	-	3	-	3
Other comprehensive net expenditure							
Net gain/(loss) on revaluation of non-current assets		-	1,687	-	1,687	-	1,687
Net gain/(loss) on revaluation of charitable assets		-	-	-	-	23	23
Fair value gains/(losses) on equity instruments	11	(1)	-	1	-	-	-
Net impairments	4.3	-	(1,737)	-	(1,737)	-	(1,737)
Net actuarial gain/(loss) on defined benefit pension scheme		10	-	-	10	-	10
Other pensions remeasurements		(15)	-	3	(12)	-	(12)
Other gains and losses		7	-	-	7	-	7
Other movements							
Transfers between reserves		151	(165)	14	-	-	-
Other movements		(35)	(2)	(1)	(38)	-	(38)
Other transfers		27	(27)	-	-	-	-
Balance at 31 March 2024		**(32,286)**	**15,410**	**307**	**(16,569)**	**515**	**(16,054)**

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 2024-25 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 2024-25 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 is 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 Statement of the Actuary, which forms part of the NHS Pension Scheme annual report and 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 (considering recent demographic experience), and to recommend contribution rates payable by 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.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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 DHSC 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. Most payments are due within one month of the end of each quarter. Where revenue has been recognised but the related payment has not yet been received, the amount is recorded as accrued income.

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 2024-25 Main Supply Estimate paragraph 23, page 9.

National Insurance contributions are classified as funding rather than income and are therefore credited to the general fund upon receipt.

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.

1.8 Property, plant, and equipment

1.8.1 Recognition

Property, plant and equipment are 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 property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets in use that are held for their service potential are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date. Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Further detail is provided in note 6.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost (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, furniture and fittings, and plant and machinery (including transport equipment) held for operational use are valued at depreciated historic cost. This approach is applied where the assets have short useful economic lives, low values, or both, as depreciated historic cost 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 DHSC 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.

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.

Where assets donated do not qualify for capitalisation an amount equivalent to the value of the items is taken to expenses on receipt.

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 4.72% for leases entered into, or appropriately modified or remeasured, from 1 January 2024 and 4.81% from 1 January 2025.

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 property, plant and equipment (PPE) when they come into use.

Service concession assets and related liabilities are initially measured in accordance with the principles of IFRS 16. This includes recognition of a right of use asset and a corresponding lease liability based on the present value of future lease payments.

Subsequently, PFI and LIFT assets are measured at current value in existing use, as detailed in note 1.8.2.

An annual finance cost is recognised in expenditure, calculated by applying the interest rate implicit in the lease to the lease liability for the period. Variable lease payments that depend on an index or rate are included in the measurement of the lease liability and updated when the relevant index or rate changes.

Service concession liabilities are remeasured when cash flows change as a result of change in an index or rate. The net change in lease liabilities from such remeasurement is charged to finance costs within expenditure.

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 component being replaced is derecognised at that point, through disposal, write-off, or impairment, as appropriate.

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 (NHSR) in accordance with IAS 37. Further detail as to the management of the schemes can be found in NHS Resolution Annual Report and Accounts 2024-25. 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 DHSC'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 millions 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, amendments and interpretations that have been issued but have not yet been adopted

IFRS 17 Insurance Contracts

IFRS 17 Insurance Contracts will be implemented across the public sector from 1 April 2025, replacing IFRS 4. While IFRS 17 introduces a more detailed and consistent framework for accounting for insurance contracts, its scope and key definitions broadly align with those under IFRS 4.

As part of the transition to IFRS 17, DHSC is undertaking an assessment of relevant arrangements. NHS Resolution's indemnity schemes, which were out of scope under IFRS 4, have been reviewed in relation to the requirements under IFRS 17.

Following a detailed assessment, NHS Resolution has concluded that the schemes it administers on behalf of the Secretary of State for Health and Social Care do not meet the definition of insurance contracts as set out under IFRS 17, as adapted by the Government Financial Reporting Manual (FReM). Therefore, there is no change in their classification upon adoption of IFRS 17.

This conclusion is based on the FReM's interpretation of IFRS 17 for the public sector, which clarifies that legislation and regulations alone do not constitute insurance contracts. Where scheme rules do not create additional financial rights or obligations beyond those already established in legislation, the scheme is deemed outside the scope of IFRS 17.

The most significant of these schemes is the Clinical Negligence Scheme for Trusts (CNST), which represents approximately 92% of the total provision as at 31 March 2025 of the indemnity schemes administered by NHS Resolution. The CNST was established under the National Health Service Act 2006 and governed by the National Health Service (Clinical Negligence Scheme) Regulations 2015 (SI 2015/559). A full review was performed of the clauses within the Scheme Rules to confirm that no additional financial rights or obligations were created beyond those that were already established within the relevant legislation.

This assessment applies similarly to all other schemes administered by NHS Resolution. Further detail can be found in the NHS Resolution Annual Report and Accounts 2024–25.

IFRS 17 will be adopted using a full retrospective approach where practicable. Prior year comparatives will be restated accordingly, with 1 April 2024 being the date of transition.

DHSC is currently assessing the overall impact of IFRS 17 implementation. While the financial impact is still being evaluated, preliminary analysis indicates that the adoption of the standard is not expected to have a material effect on DHSC's financial position, performance, or disclosures.

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. The expected impact of applying the standard in future periods has not yet been assessed.

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. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation

Following a thematic review of non-investment asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5-year transition period. DHSC is adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification/ terminology to be implemented by DHSC from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented by DHSC in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.

- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

1.25 Critical accounting judgements and key sources of estimation uncertainty

Estimates and the underlying assumptions are reviewed on a regular basis by DHSC'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 DHSC'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. In line with NHS Resolution, DHSC has assessed the applicability IFRS 17 and concluded that clinical negligence provisions are outside the scope of the standard; accordingly, provisions will continue to be accounted for under IAS 37. 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, Professional Standards Authority for Health and Social Care, Wiltshire Health and Care LLP 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.

2.1 Departmental group summary

For the year ended 31 March 2025

	DHSC core £m	Executive agencies £m	Special health authorities £m	NHS providers £m	NHS England group £m	Non-departmental public bodies £m	Other group bodies £m	NHS charities £m	Group eliminations and adjustments £m	Departmental group £m
Gross expenditure (2.2)	205,374	2,509	6,059	144,715	197,105	415	1,946	163	(339,045)	219,241
Income (2.3)	(3,339)	(488)	(3,671)	(141,608)	(6,398)	(272)	(1,646)	(138)	142,479	(15,081)
Net expenditure before absorption gains and losses	**202,035**	**2,021**	**2,388**	**3,107**	**190,707**	**143**	**300**	**25**	**(196,566)**	**204,160**
Capital grants	(812)	-	-	-	(213)	-	-	-	-	(1,025)
Service concession arrangement adjustments	(105)	-	-	(109)	-	-	(90)	-	-	(304)
Compensation payments adjustment	(663)	-	-	-	-	-	-	-	-	(663)
Capital provision movement	-	-	-	1	1	-	-	-	(1)	1
Research and development	(2,021)	-	-	-	-	-	-	-	-	(2,021)
Other budgeting adjustments	(1)	17	-	418	-	-	6	(9)	1	432
Budgeting adjustments	**(3,602)**	**17**	**-**	**310**	**(212)**	**-**	**(84)**	**(9)**	**-**	**(3,580)**
Budget outturn, of which:	**198,433**	**2,038**	**2,388**	**3,417**	**190,495**	**143**	**216**	**16**	**(196,566)**	**200,580**
Resource DEL	200,167	2,061	543	1,076	190,523	143	168	16	(196,505)	198,192
Resource AME	(1,734)	(23)	1,845	2,341	(28)	-	48	-	(61)	2,388

For the year ended 31 March 2024

	DHSC core £m	Executive agencies £m	Special health authorities £m	NHS providers £m	NHS England group £m	Non-departmental public bodies £m	Other group bodies £m	NHS charities £m	Group eliminations and adjustments £m	Departmental group £m
Gross expenditure (2.2)	195,961	2,900	(7,220)	134,125	179,959	338	2,088	238	(317,129)	191,260
Income (2.3)	(3,361)	(466)	(3,458)	(129,612)	(5,837)	(261)	(1,628)	(141)	130,229	(14,535)
Net expenditure before absorption gains and losses	**192,600**	**2,434**	**(10,678)**	**4,513**	**174,122**	**77**	**460**	**97**	**(186,900)**	**176,725**
Capital grants	(677)	-	-	-	(87)	-	-	-	-	(764)
Service concession arrangement adjustments	(84)	-	-	(1,102)	-	-	(312)	-	-	(1,498)
Research and development	(1,507)	-	-	-	-	-	-	-	-	(1,507)
Other budgeting adjustments	(150)	-	-	326	96	(95)	27	(70)	(1)	133
Budgeting adjustments	**(2,418)**	**-**	**-**	**(776)**	**9**	**(95)**	**(285)**	**(70)**	**(1)**	**(3,636)**
Budget outturn, of which:	**190,182**	**2,434**	**(10,678)**	**3,737**	**174,131**	**(18)**	**175**	**27**	**(186,901)**	**173,089**
Resource DEL	190,649	2,594	455	1,352	174,211	33	193	27	(186,695)	182,819
Resource AME	(467)	(160)	(11,133)	2,385	(80)	(51)	(18)	-	(206)	(9,730)

2.2 Departmental group detail – expenditure

For the year ended 31 March 2025

	DHSC core £m	Executive agencies £m	Special health authorities £m	NHS providers £m	NHS England group £m	Non-departmental public bodies £m	Other group bodies £m	NHS charities £m	Group eliminations and adjustments £m	Departmental group £m
Staff costs	280	535	279	93,074	3,660	311	420	-	(34)	98,525
Purchase of healthcare from non-NHS bodies	-	-	-	3,714	20,375	-	-	-	-	24,089
Goods and services from other NHS bodies	-	-	-	16	121,832	-	9	-	(121,842)	15
Utilisation and write down of COVID-19 inventories	-	-	-	9	-	-	-	-	-	9
Purchase of social care	-	-	-	285	1,325	-	-	-	-	1,610
Dental services	-	-	-	-	3,719	-	-	-	(166)	3,553
Establishment	186	-	18	1,234	1,160	36	12	-	(96)	2,550
Premises	21	38	27	4,640	351	12	341	-	(485)	4,945
Service concession arrangements	-	-	-	1,222	-	-	114	-	(1)	1,335
Multi professional education and training	-	-	-	-	5,777	-	-	-	(4,140)	1,637
Prescribing costs	-	-	-	-	10,548	-	-	-	(5)	10,543
Primary care services	-	-	-	-	13,652	-	-	-	(36)	13,616
Pharmaceutical services	-	-	-	-	2,242	-	-	-	(8)	2,234
Supplies and services - clinical	-	-	-	21,578	2,718	-	6	-	(3,236)	21,066
Supplies and services - general	19	933	110	1,994	2,250	9	147	-	(982)	4,480
Dividends payable on public dividend capital	-	-	-	1,085	-	-	-	-	(1,085)	-
Rentals under operating leases	-	-	-	193	1	-	29	-	(33)	190
Interest charges	6	1	-	1,465	10	-	371	-	(102)	1,751
Research and development	1,922	1	-	349	22	-	6	-	(1,151)	1,149
Clinical negligence	-	-	-	2,857	-	-	-	-	(2,855)	2
Grant in aid	191,590	-	-	-	-	-	-	-	(191,590)	-
Ophthalmic services	-	-	-	-	655	-	-	-	-	655
Business rates	1	-	-	570	1	1	68	-	-	641
Education, training and conferences	5	5	-	401	175	2	6	-	(97)	497
Consultancy	2	15	-	160	48	1	26	-	-	252
Legal fees	46	6	2	137	331	7	15	-	(9)	535
Funding to group bodies	2,610	-	-	-	-	-	-	-	(2,610)	-
Funding for additional pensions uplift	-	-	-	-	5,248	-	-	-	(5,248)	-
Auditor remuneration including fees	1	1	1	68	22	1	2	-	(1)	95
Infected blood compensation payments	640	-	-	-	-	-	-	-	-	640
Other	817	9	612	1,614	22	11	(34)	-	(380)	2,671
Material expenditure items	**198,146**	**1,544**	**1,049**	**136,665**	**196,144**	**391**	**1,538**	**-**	**(336,192)**	**199,285**

For the year ended 31 March 2025 (continued)

	DHSC core £m	Executive agencies £m	Special health authorities £m	NHS providers £m	NHS England group £m	Non-departmental public bodies £m	Other group bodies £m	NHS charities £m	Group eliminations and adjustments £m	Departmental group £m
Grants to other bodies	674	-	-	-	16	-	-	-	-	690
Grants to local authorities	3,949	-	-	-	-	-	-	-	-	3,949
Capital grants	811	-	-	-	213	-	-	-	-	1,024
Total grants expenditure	**5,434**	**-**	**-**	**-**	**229**	**-**	**-**	**-**	**-**	**5,663**
Movement in expected credit loss allowances	(5)	7	1	128	34	-	34	-	(12)	187
Depreciation on property, plant and equipment	60	92	8	3,309	140	2	254	-	2	3,867
Depreciation on right of use assets	15	6	4	844	51	3	78	-	(319)	682
Amortisation on intangible assets	10	15	16	469	138	10	6	-	(1)	663
Net impairments (excluding COVID-19 inventory impairment)	2,389	21	-	2,662	-	-	15	-	(2,398)	2,689
Net provisions arising	(847)	66	4,729	45	41	1	27	-	1	4,063
Movement in pension liability	-	-	-	1	-	-	3	-	-	4
Provisions - unwinding of discount	140	-	1,306	14	11	-	1	-	-	1,472
Provisions - change in discount rate	(9)	-	(1,054)	(1)	(2)	-	-	-	-	(1,066)
Non-cash expenditure	**1,753**	**207**	**5,010**	**7,471**	**413**	**16**	**418**	**-**	**(2,727)**	**12,561**
Non-material expenditure categories	**14**	**103**	**-**	**579**	**319**	**8**	**(10)**	**163**	**(125)**	**1,051**
Covid-19 expenditure (core and agencies)	**27**	**655**	**-**	**-**	**-**	**-**	**-**	**-**	**(1)**	**681**
Total expenditure	**205,374**	**2,509**	**6,059**	**144,715**	**197,105**	**415**	**1,946**	**163**	**(339,045)**	**219,241**

Grants to local authorities include £3,426m (2023-24: £3,301m) relating to the Local Authority Public Health Grant.

For the year ended 31 March 2024

	DHSC core £m	Executive agencies £m	Special health authorities £m	NHS providers £m	NHS England group £m	Non-departmental public bodies £m	Other group bodies £m	NHS charities £m	Group eliminations and adjustments £m	Departmental group £m
Staff costs	269	483	227	84,696	3,634	292	392	-	(44)	89,949
Purchase of healthcare from non-NHS bodies	-	-	-	3,535	18,109	-	-	-	-	21,644
Goods and services from other NHS bodies	-	-	-	3	112,694	-	6	-	(112,697)	6
Utilisation and write down of COVID-19 inventories	-	-	-	42	-	-	-	-	-	42
Purchase of social care	-	-	-	240	1,196	-	-	-	-	1,436
Dental services	-	-	-	-	3,108	-	-	-	(150)	2,958
Establishment	236	-	17	1,291	921	29	12	-	(147)	2,359
Premises	29	45	27	4,604	347	9	347	-	(512)	4,896
Service concession arrangements	-	-	-	1,201	-	-	109	-	-	1,310
Multi professional education and training	-	-	-	-	5,361	-	-	-	(3,996)	1,365
Prescribing costs	(1)	-	-	-	10,346	-	-	-	(6)	10,339
Primary care services	-	-	-	-	12,507	-	-	-	(32)	12,475
Pharmaceutical services	-	-	-	-	2,146	-	-	-	1	2,147
Supplies and services - clinical	-	-	-	19,710	2,470	-	5	-	(2,642)	19,543
Supplies and services - general	31	991	105	1,947	2,096	6	118	-	(1,180)	4,114
Dividends payable on public dividend capital	-	-	-	1,027	-	-	-	-	(1,027)	-
Rentals under operating leases	-	-	-	187	-	-	40	-	(41)	186
Interest charges	5	1	-	2,446	8	-	559	-	(91)	2,928
Research and development	1,430	3	-	287	22	-	5	-	(892)	855
Clinical negligence	-	-	-	2,641	-	-	-	-	(2,641)	-
Grant in aid	176,843	-	-	-	-	-	-	-	(176,843)	-
Ophthalmic services	-	-	-	-	614	-	-	-	-	614
Business rates	2	-	-	488	2	1	64	-	-	557
Education, training and conferences	4	6	-	416	84	2	5	-	(17)	500
Consultancy	4	1	-	167	56	1	27	-	1	257
Legal fees	38	(4)	1	107	252	13	11	-	(12)	406
Funding to group bodies	2,540	-	-	-	-	-	-	-	(2,540)	-
Funding for additional pensions uplift	-	-	-	-	3,195	-	-	-	(3,195)	-
Auditor remuneration including fees	2	1	1	59	22	1	2	-	(2)	86
Other	856	1	3	1,598	51	12	1	-	153	2,675
Material expenditure items	**182,288**	**1,528**	**381**	**126,692**	**179,241**	**366**	**1,703**	**-**	**(308,552)**	**183,647**

For the year ended 31 March 2024 (continued)

	DHSC core £m	Executive agencies £m	Special health authorities £m	NHS providers £m	NHS England group £m	Non-departmental public bodies £m	Other group bodies £m	NHS charities £m	Group eliminations and adjustments £m	Departmental group £m
Grants to other bodies	692	-	621	-	36	-	-	-	(621)	728
Grants to local authorities	4,031	-	-	-	-	-	-	-	-	4,031
Capital grants	677	-	-	-	87	-	-	-	-	764
Total grants expenditure	**5,400**	**-**	**621**	**-**	**123**	**-**	**-**	**-**	**(621)**	**5,523**
Movement in expected credit loss allowance	-	(2)	4	107	20	-	34	-	(3)	160
Depreciation on property, plant and equipment	14	109	8	3,067	155	3	237	-	-	3,593
Depreciation on right of use assets	18	7	4	845	59	3	83	-	(330)	689
Amortisation on intangible assets	13	29	20	410	135	9	7	-	-	623
Net impairments (excluding COVID-19 inventory impairment)	7,270	297	-	2,188	1	-	39	-	(7,401)	2,394
Net provisions arising	895	85	5,405	170	(26)	3	(5)	-	(1)	6,526
Movement in pension liability	-	-	-	2	-	-	3	-	(1)	4
Provisions - unwinding of discount	116	-	885	11	14	-	-	-	1	1,027
Provisions - change in discount rate	(307)	-	(14,553)	(16)	(48)	-	(6)	-	-	(14,930)
Non-cash expenditure	**8,019**	**525**	**(8,227)**	**6,784**	**310**	**18**	**392**	**-**	**(7,735)**	**86**
Non-material expenditure categories	**107**	**131**	**5**	**649**	**285**	**(46)**	**(7)**	**238**	**(192)**	**1,170**
Covid-19 expenditure (core and agencies)	**147**	**716**	**-**	**-**	**-**	**-**	**-**	**-**	**(29)**	**834**
Total expenditure	**195,961**	**2,900**	**(7,220)**	**134,125**	**179,959**	**338**	**2,088**	**238**	**(317,129)**	**191,260**

Grants to local authorities includes £3,426 million (2023-24: £3,301 million) relating to the Local Authority Public Health Grant.

2.3 Departmental group detail - income

For the year ended 31 March 2025

	DHSC core £m	Executive agencies £m	Special health authorities £m	NHS providers £m	NHS England group £m	Non-departmental public bodies £m	Other group bodies £m	NHS charities £m	Group eliminations and adjustments £m	Departmental group £m
Income from local authorities	-	-	-	(2,301)	-	-	(1)	-	-	(2,302)
Income from private patients	-	-	-	(783)	-	-	-	-	-	(783)
Income from injury costs recovery	-	-	-	(213)	-	-	-	-	-	(213)
Income from DHSC/NHS bodies	-	-	-	(121,407)	-	-	(98)	-	121,338	(167)
Other non-NHS patient care services	-	-	-	(773)	(244)	-	-	-	(1)	(1,018)
Income for additional pension uplift	-	-	-	(5,244)	-	-	(4)	-	5,248	-
Non patient care services to other bodies	(21)	-	(132)	(1,013)	(4,185)	-	(397)	-	4,808	(940)
Education, training and research	-	(4)	-	(5,660)	(18)	(1)	(1)	-	5,061	(623)
Branded medicines income	(2,087)	-	-	-	-	-	-	-	-	(2,087)
Fees and charges	-	(306)	(3,537)	(283)	(1,527)	(256)	(154)	-	3,932	(2,131)
Other contract income	(3)	(174)	-	(2,034)	(326)	(8)	-	-	588	(1,957)
Non-material contract income categories	(42)	-	-	(341)	(5)	(1)	(2)	-	37	(354)
Income from contracts	**(2,153)**	**(484)**	**(3,669)**	**(140,052)**	**(6,305)**	**(266)**	**(657)**	**-**	**141,011**	**(12,575)**
Rental revenue from operating leases	(4)	-	-	(99)	(1)	-	(820)	-	514	(410)
PDC dividend income	(1,085)	-	-	-	-	-	-	-	1,085	-
Charitable and other contributions to expenditure	-	-	-	(109)	(1)	-	-	-	14	(96)
Other non-contract income	(26)	-	-	(24)	(89)	(4)	(126)	-	(259)	(528)
Non-material non-contract income categories	(3)	-	(2)	(701)	(2)	(2)	(26)	-	52	(684)
Non-contract income	**(1,118)**	**-**	**(2)**	**(933)**	**(93)**	**(6)**	**(972)**	**-**	**1,406**	**(1,718)**
Income received by NHS charities	-	-	-	-	-	-	-	(138)	-	(138)
Finance income	(68)	(4)	-	(623)	-	-	(17)	-	62	(650)
Total income	**(3,339)**	**(488)**	**(3,671)**	**(141,608)**	**(6,398)**	**(272)**	**(1,646)**	**(138)**	**142,479**	**(15,081)**

For the year ended 31 March 2024

	DHSC core £m	Executive agencies £m	Special health authorities £m	NHS providers £m	NHS England group £m	Non-departmental public bodies £m	Other group bodies £m	NHS charities £m	Group eliminations and adjustments £m	Departmental group £m
Income from local authorities	-	-	-	(2,214)	-	-	(1)	-	-	(2,215)
Income from private patients	-	-	-	(750)	-	-	-	-	-	(750)
Income from injury costs recovery	-	-	-	(195)	-	-	-	-	-	(195)
Income from DHSC/NHS bodies	-	-	-	(112,174)	-	-	(96)	-	112,133	(137)
Other non-NHS patient care services	-	-	-	(759)	(171)	-	-	-	-	(930)
Income for additional pension uplift	-	-	-	(3,193)	-	-	(2)	-	3,195	-
Non patient care services to other bodies	(23)	-	(111)	(990)	(3,720)	-	(396)	-	4,336	(904)
Education, training and research	-	(3)	-	(5,147)	(18)	(1)	(1)	-	4,519	(651)
Branded Medicines income	(2,139)	-	-	-	-	-	-	-	-	(2,139)
Fees and charges	-	(292)	(3,347)	(260)	(1,471)	(247)	(149)	-	3,717	(2,049)
Other contract income	(23)	(169)	-	(2,097)	(327)	(9)	-	-	704	(1,921)
Non-material contract income categories	(22)	(1)	-	(335)	(5)	(1)	(1)	-	47	(318)
Income from contracts	**(2,207)**	**(465)**	**(3,458)**	**(128,114)**	**(5,712)**	**(258)**	**(646)**	**-**	**128,651**	**(12,209)**
Rental revenue from operating leases	(5)	-	-	(104)	-	-	(805)	-	532	(382)
PDC dividend income	(1,027)	-	-	-	-	-	-	-	1,027	-
Charitable and other contributions to expenditure	-	-	-	(99)	(1)	-	-	-	15	(85)
Donation of assets	-	-	-	(29)	-	-	-	-	29	-
Other non-contract income	(44)	(1)	-	(15)	(124)	(1)	(139)	-	(147)	(471)
Non-material non-contract income categories	(6)	-	-	(587)	-	(2)	(20)	-	64	(551)
Non-contract income	**(1,082)**	**(1)**	**-**	**(834)**	**(125)**	**(3)**	**(964)**	**-**	**1,520**	**(1,489)**
Income received by NHS charities	-	-	-	-	-	-	-	(141)	-	(141)
Finance income	(72)	-	-	(664)	-	-	(18)	-	58	(696)
Total income	**(3,361)**	**(466)**	**(3,458)**	**(129,612)**	**(5,837)**	**(261)**	**(1,628)**	**(141)**	**130,229**	**(14,535)**

3. Staff costs

Staff costs for the departmental group comprise:

	2024-25 £m	2023-24 £m
Salaries and wages	76,999	71,652
Social security costs	8,047	7,611
NHS pension	13,775	10,925
Other pension costs	206	177
Termination benefits	45	75
	99,072	**90,440**
Less income in respect of secondments	(154)	(140)
Total staff costs	**98,918**	**90,300**
Less: amounts charged to capital	(393)	(351)
Total staff costs recognised in expenditure	**98,525**	**89,949**

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	Core department and agencies 2024-25 £m	Core department and agencies 2023-24 £m	Departmental group 2024-25 £m	Departmental group 2023-24 £m
4.1 (a) Purchase of goods and services					
Cash items					
Healthcare supplies and services					
Purchase of healthcare from non NHS bodies		-	-	24,089	21,644
Supplies and services - clinical		-	-	21,066	19,543
Supplies and services - general		951	1,019	4,480	4,114
COVID-19 vaccines		711	596	711	596
Other COVID-19 expenditure		48	158	56	170
Goods and services from other NHS bodies		-	-	15	6
Direct commissioning and prescriptions					
Primary care services		-	-	13,616	12,475
Prescribing costs		-	(1)	10,543	10,339
Dental services		-	-	3,553	2,958
Pharmaceutical services		-	-	2,234	2,147
Ophthalmic services		-	-	655	614
Estates costs					
Establishment		187	236	2,550	2,359
Premises		60	75	4,945	4,896
Transport (business travel)		8	9	379	352
Rentals under leases		-	-	190	186
Other goods and services					
Purchase of social care		-	-	1,610	1,436
Multi professional education and training		-	-	1,637	1,365
Consultancy		17	5	252	257
Education, training and conferences		9	10	497	500
Insurance		-	-	123	120
Legal fees		52	34	535	406
NHS informatics		-	112	172	275
Audit fees - statutory audit (cash)		-	-	63	54
Auditor remuneration - other		-	-	30	29
Non-cash items					
Audit fees - statutory audit - non-cash		2	2	3	3
Purchase of goods and services		**2,045**	**2,255**	**94,004**	**86,844**

Comparatives for 2023-24 have been re-presented where figures for 2024-25 have been reorganised.

Analysis of expenditure (continued)

	Notes	Core department and agencies 2024-25 £m	Core department and agencies 2023-24 £m	Departmental group 2024-25 £m	Departmental group 2023-24 £m
4.1 (b) Depreciation and impairment charges					
Non-cash items					
Depreciation on property, plant and equipment	6	152	121	3,867	3,593
Amortisation on intangible assets	7	25	42	663	623
Depreciation on right of use assets	8	22	25	682	689
Impairments and reversals	4.3	800	6,148	1,079	975
Depreciation and impairment charges		**999**	**6,336**	**6,291**	**5,880**
4.1 (c) Provision expense					
Non-cash items					
Movement in pension liability		-	-	4	4
Net provisions arising	16	(781)	980	4,063	6,526
Provisions - change in discount rate	16	(9)	(307)	(1,066)	(14,930)
Provision expense		**(790)**	**673**	**3,001**	**(8,400)**
4.1 (d) Other operating expenditure					
Cash items					
Grants					
Grants to local authorities		3,949	4,031	3,949	4,031
Grants to other bodies		674	692	690	728
Capital grants		811	677	1,024	764
Other costs					
Service concession arrangements		-	-	1,335	1,310
Research and development		1,922	1,431	1,149	855
Infected blood compensation payments		640	-	640	-
Business rates paid to local authorities		1	2	641	557
Chair and non-executive directors' costs		-	-	43	45
Clinical negligence		-	-	2	-
Prior period adjustments in local accounts		-	-	(107)	(12)
Realised foreign exchange rate (gains)/losses		9	(9)	9	(9)
Other cash expenditure		828	856	2,669	2,674
Non-cash items					
Inventories write down					
COVID-19 inventories write downs		1,532	1,529	1,534	1,530
Inventories write down		46	33	69	54
Other costs					
Movement in expected credit loss allowances		1	(1)	187	160
Apprenticeship training grant		-	-	175	157
Prior period adjustments in local accounts		41	95	57	81
Loss on disposal of assets		12	6	34	34
Unrealised foreign exchange rate (gains)/losses		-	4	-	4
Changes in fair value		1	1	29	(23)
Capital grants in kind		1	-	1	-
Other non-cash expenditure		(2)	(14)	(4)	(51)
Other operating expenditure		**10,466**	**9,333**	**14,126**	**12,889**
4.1 (e) Finance expense					
Service concession arrangements					
Remeasurement of liabilities		-	-	659	1,860
Interest on obligations		-	-	982	957
Provisions					
Unwinding of discount		140	116	1,472	1,027
Other costs					
Interest on obligations under leases		6	5	98	81
Interest on loans and overdrafts		-	-	-	9
Interest on late payment of commercial debt		-	-	1	1
Other interest expense		1	2	11	20
Finance expense		**147**	**123**	**3,223**	**3,955**

Comparatives for 2023-24 for the departmental group have been re-presented where figures for 2024-25 have been reorganised.

Other cash expenditure in the departmental group compromises several items for which information would not be material. The largest balance included in other cash expenditure related to transport costs in the provider sector of £755 million (2023-24: £742 million), made up of expenditure such as fuel costs, vehicle parts and other fleet related costs.

Grants to local authorities include £3,426 million (2023-24: £3,301 million) relating to the Local Authority Public Health Grant.

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:

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Non-cash expenditure after financing activities	2,743	9,535	13,615	1,220
Non-cash income after financing activities	(2)	(6)	(290)	(265)
Total non-cash transactions	**2,741**	**9,529**	**13,325**	**955**
Movement in expected credit loss allowances	(1)	1	(187)	(160)
Inventories write down	(1,578)	(1,561)	(1,603)	(1,584)
Impairment of inventories	1,609	1,419	1,610	1,420
Utilisation of COVID-19 related inventory	(759)	(754)	(767)	(766)
Less non-cash movements analysed separately in the cash flow statement	**(729)**	**(895)**	**(947)**	**(1,090)**
Total non-cash transactions as per consolidated statement of cash flows	**2,012**	**8,634**	**12,378**	**(135)**

4.3 Impairments

	Notes	Core department and agencies 2024-25 £m	Core department and agencies 2023-24 £m	Departmental group 2024-25 £m	Departmental group 2023-24 £m
Impairments charged to consolidated statement of comprehensive net expenditure					
Property, plant and equipment impairments	6	6	314	2,464	2,248
Intangible asset impairments	7	-	1	70	78
Right of use asset impairments	8	38	5	129	51
Non-current investments impairments	11	2,365	7,247	25	(2)
Assets held for sale impairments		-	-	1	20
Inventory impairments	12	(1,609)	(1,419)	(1,610)	(1,420)
		800	**6,148**	**1,079**	**975**
Impairments charged to revaluation reserve					
Property, plant and equipment impairments	6	10	-	1,149	1,726
Intangible asset impairments	7	-	-	-	2
Right of use asset impairments	8	-	-	9	9
		10	**-**	**1,158**	**1,737**
Impairments charged to general fund					
Non-current investments impairments	11	(129)	227	-	-
		(129)	**227**	**-**	**-**
Total impairments charged in year		**681**	**6,375**	**2,237**	**2,712**

The above table includes both impairments and impairment reversals.

Non-current investments impairments

Non-current investments impairments include public dividend capital impairments (included in note 11) and advance payment impairments for COVID-19 vaccines (included in note 14).

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 to expenditure in 2024-25 was £2,341 million (2023-24: £7,247 million). In 2023-24 there was a significant increase in impairments of PDC, which partly resulted from the implementation of IFRS 16 principles to the measurement of service concession liabilities in providers, which reduced net assets.

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 2024-25 an impairment reversal of £129 million (2023-24: £227 million charge) was recognised.

Inventory impairments

The impact on expenditure of impairments and write downs for 2024-25 and 2023-24 can be summarised as follows:

	Core department and agencies			Departmental group			2024-25
	Impairment charge / (credit) £m	Write down £m	Total charge / (credit) to expenditure £m	Impairment charge / (credit) £m	Write down £m	Total charge / (credit) to expenditure £m	
Personal protective equipment	(333)	338	5	(333)	338	5	
COVID-19 medicines	(1,257)	1,249	(8)	(1,257)	1,249	(8)	
COVID-19 vaccines	-	(55)	(55)	-	(55)	(55)	
Other COVID-19 related equipment and consumables	(19)	-	(19)	(20)	2	(18)	
Total	**(1,609)**	**1,532**	**(77)**	**(1,610)**	**1,534**	**(76)**	

	Core department and agencies			Departmental group			2023-24
	Impairment charge / (credit) £m	Write down £m	Total charge / (credit) to expenditure £m	Impairment charge / (credit) £m	Write down £m	Total charge / (credit) to expenditure £m	
Personal protective equipment (PPE)	(800)	818	18	(800)	819	19	
COVID-19 Medicines	(367)	343	(24)	(367)	343	(24)	
COVID-19 Vaccines	-	93	93	-	93	93	
NHS Test and Trace consumables	(5)	-	(5)	(5)	-	(5)	
Other COVID-19 related equipment and consumables	(247)	275	28	(248)	275	27	
Total	**(1,419)**	**1,529**	**110**	**(1,420)**	**1,530**	**110**	

It should be noted that the write downs in the tables above only relate to COVID-19 inventory and therefore do not agree to the total inventory write downs in note 12. All impairments of inventory relate to COVID-19 inventory and will therefore agree to impairments in note 12.

Personal Protective Equipment (PPE)

PPE inventory was increased in carrying value due to a net reversal of impairments of £333 million during 2024-25 (2023-24: £800 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 £338 million (2023-24: £819 million) relating to PPE inventory in 2024-25 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 £5 million in 2024-25 (2023-24: £19 million).

Additionally, £8 million (2023-24: £2 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.

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. The carrying value of COVID-19 vaccine

inventories has increased in value by £55 million (2023-24: £93 million reduction) as a result of the reversal of inventories written off.

The carrying value of COVID-19 vaccine inventories has also been reduced in value by £118 million (2023-24: £224 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

DHSC 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 £8 million credit in 2024-25 (2023-24: £24 million credit).

There has been no utilisation of onerous contract provision in 2024-25 (2023-24: £124 million).

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 2025.

5. Income

	2024-25 Core department and agencies £m	2023-24 Core department and agencies £m	2024-25 Departmental group £m	2023-24 Departmental group £m
Revenue from patient care activities				
Income from local authorities	-	-	2,302	2,215
Income from private patients	-	-	783	750
Income from overseas patients	-	-	142	123
Income from injury costs recovery	-	-	213	195
Income in respect of reciprocal healthcare claims	43	22	43	22
Income from DHSC/NHS bodies	-	-	167	137
Other non-NHS patient care services	-	-	1,018	930
Other contract income				
Non-patient care services to other bodies	21	23	940	904
Education, training and research	4	3	623	651
Prescription fees and charges	-	-	730	693
Dental fees and charges	-	-	797	777
Other fees and charges	301	287	604	579
Income in respect of staff costs	-	-	169	173
Branded medicines income	2,087	2,139	2,087	2,139
Other contract income	176	192	1,957	1,921
Income from contracts	**2,632**	**2,666**	**12,575**	**12,209**
Rental revenue from finance leases	-	-	1	-
Rental revenue from operating leases	4	5	410	382
PDC dividend received	1,085	1,027	-	-
Charitable and other contributions to expenditure	-	-	96	85
Receipts of donations for capital acquisitions	-	-	223	165
Receipt of grants for capital acquisitions	-	-	156	140
Profit on disposal	2	5	57	41
Dividends	-	-	16	13
Other non-cash income	-	-	34	30
Apprenticeship training grant (non-cash)	-	-	175	157
Funding from other government departments	-	-	2	2
Prior period adjustments in local accounts	-	-	20	3
Other non contract income	30	49	528	471
Non-contract income	**1,121**	**1,086**	**1,718**	**1,489**

Other contract income includes £1,470 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 2025

	Land £m	Buildings (excluding dwellings) £m	Dwellings £m	Information technology £m	Assets under construction £m	Furniture and fittings £m	Plant and machinery £m	Stockpiled goods £m	Total £m
Cost or valuation									
At 1 April 2024	**5,864**	**47,488**	**409**	**6,596**	**7,332**	**754**	**12,419**	**439**	**81,301**
Prior period adjustments in underlying accounts	(9)	6	(9)	(91)	(54)	(10)	(147)	-	(314)
Additions	22	1,440	6	494	4,295	42	720	112	7,131
Donations	1	63	-	2	270	1	88	16	441
Impairments and reversals	(217)	(2,923)	(35)	(7)	(396)	(6)	(8)	(6)	(3,598)
Transfers	-	(3)	(1)	(1)	(5)	4	6	2	2
Reclassifications	(42)	3,891	-	294	(4,902)	52	516	-	(191)
Revaluation and indexation	54	(533)	2	(14)	4	1	1	-	(485)
Disposals	(21)	(71)	-	(770)	(8)	(53)	(781)	(27)	(1,731)
Recognition due to termination of sub-leasing	-	4	-	-	-	-	-	-	4
Derecognition due to finance leasing	-	-	-	-	-	-	(1)	-	(1)
At 31 March 2025	**5,652**	**49,362**	**372**	**6,503**	**6,536**	**785**	**12,813**	**536**	**82,559**
Depreciation									
At 1 April 2024	**9**	**1,035**	**16**	**4,024**	**-**	**451**	**7,181**	**198**	**12,914**
Prior period adjustments in underlying accounts	(9)	(108)	(9)	(94)	-	(12)	(183)	-	(415)
Charged in year	-	1,791	14	844	-	66	1,064	88	3,867
Impairments and reversals	4	(4)	2	(1)	-	(1)	5	9	14
Transfers	-	(1)	(1)	-	-	(1)	-	1	(2)
Reclassifications	-	(23)	-	-	-	7	(5)	-	(21)
Revaluation and indexation	(4)	(1,633)	(16)	(14)	-	2	-	-	(1,665)
Disposals	-	(65)	-	(768)	-	(53)	(752)	(15)	(1,653)
At 31 March 2025	**-**	**992**	**6**	**3,991**	**-**	**459**	**7,310**	**281**	**13,039**
Net book value at 31 March 2025	**5,652**	**48,370**	**366**	**2,512**	**6,536**	**326**	**5,503**	**255**	**69,520**
Net book value at 31 March 2024	5,855	46,453	393	2,572	7,332	303	5,238	241	68,387
Asset financing									
Owned - purchased	5,184	34,096	286	2,481	6,087	310	4,871	255	53,570
Owned - donated	88	1,811	15	25	435	16	446	-	2,836
PFI contracts	380	12,463	62	6	14	-	186	-	13,111
PFI residual interests	-	-	3	-	-	-	-	-	3
Net book value at 31 March 2025	**5,652**	**48,370**	**366**	**2,512**	**6,536**	**326**	**5,503**	**255**	**69,520**

Departmental group for the year ended 31 March 2024

	Land £m	Buildings (excluding dwellings) £m	Dwellings £m	Information technology £m	Assets under construction £m	Furniture and fittings £m	Plant and machinery £m	Stockpiled goods £m	Total £m
Cost or valuation									
At 1 April 2023	**6,212**	**46,325**	**395**	**6,379**	**7,146**	**728**	**12,213**	**393**	**79,791**
Prior period adjustments in underlying accounts	6	(149)	(2)	(3)	(149)	20	(12)	(36)	(325)
Additions	21	1,453	11	514	4,561	35	756	30	7,381
Donations	1	49	-	3	224	1	71	-	349
Impairments and reversals	(458)	(3,064)	(7)	(8)	(350)	(1)	(10)	(3)	(3,901)
Transfers	-	-	-	2	(41)	7	24	70	62
Reclassifications	(9)	3,043	1	271	(4,025)	35	420	-	(264)
Revaluation and indexation	109	(115)	12	(3)	1	(1)	(11)	21	13
Disposals	(18)	(54)	(1)	(559)	(35)	(70)	(1,032)	(36)	(1,805)
Derecognition due to finance leasing	-	-	-	-	-	-	-	-	-
At 31 March 2024	**5,864**	**47,488**	**409**	**6,596**	**7,332**	**754**	**12,419**	**439**	**81,301**
Depreciation									
At 1 April 2023	**8**	**1,146**	**18**	**3,806**	**-**	**468**	**7,289**	**183**	**12,918**
Prior period adjustments in underlying accounts	-	(177)	(2)	(8)	-	6	(35)	2	(214)
Charged in year	-	1,720	12	811	-	48	962	40	3,593
Impairments and reversals	26	41	3	1	-	-	2	-	73
Transfers	-	(2)	-	-	-	-	-	1	(1)
Reclassifications	-	(57)	-	(30)	-	-	(14)	-	(101)
Revaluation and indexation	(25)	(1,589)	(14)	(4)	-	(1)	(18)	-	(1,651)
Disposals	-	(47)	(1)	(552)	-	(70)	(1,005)	(28)	(1,703)
At 31 March 2024	**9**	**1,035**	**16**	**4,024**	**-**	**451**	**7,181**	**198**	**12,914**
Net book value at 31 March 2024	**5,855**	**46,453**	**393**	**2,572**	**7,332**	**303**	**5,238**	**241**	**68,387**
Net book value at 31 March 2023	6,204	45,179	377	2,573	7,146	260	4,924	210	66,873
Asset financing:									
Owned - purchased	5,389	32,436	304	2,544	6,868	286	4,660	241	52,728
Owned - donated	88	1,659	17	23	448	17	420	-	2,672
PFI contracts	378	12,358	69	5	16	-	158	-	12,984
PFI residual interests	-	-	3	-	-	-	-	-	3
Net book value at 31 March 2024	**5,855**	**46,453**	**393**	**2,572**	**7,332**	**303**	**5,238**	**241**	**68,387**

Comparatives for 2023-24 have been re-presented where figures for 2024-25 have been reorganised.

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 2025 was £47.5 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 – 22 years
- Furniture and fittings 1 – 45 years
- Plant and machinery 1 – 35 years

7. Intangible assets

Departmental group for the year ended 31 March 2025

	IT & software £m	Development expenditure £m	Other £m	Total £m
Cost or valuation				
At 1 April 2024	**5,093**	**473**	**610**	**6,176**
Prior period adjustments in underlying accounts	(19)	16	(4)	(7)
Additions	232	299	403	934
Donations	1	-	1	2
Impairments and reversals	(11)	(4)	(40)	(55)
Transfers	19	1	(21)	(1)
Reclassifications	237	23	(172)	88
Revaluation and indexation	(7)	-	(10)	(17)
Disposals	(528)	(60)	(7)	(595)
Other movements	(4)	-	4	-
At 31 March 2025	**5,013**	**748**	**764**	**6,525**
Amortisation				
At 1 April 2024	**2,918**	**275**	**43**	**3,236**
Prior period adjustments in underlying accounts	(9)	(4)	-	(13)
Charged in year	503	155	5	663
Impairments and reversals	5	-	10	15
Reclassifications	1	3	-	4
Revaluation and indexation	(8)	-	(10)	(18)
Disposals	(524)	(59)	(5)	(588)
At 31 March 2025	**2,886**	**370**	**43**	**3,299**
Net book value at 31 March 2025	**2,127**	**378**	**721**	**3,226**
Net book value at 31 March 2024	2,175	198	567	2,940

Departmental group for the year ended 31 March 2024

	IT & software £m	Development expenditure £m	Other £m	Total £m
Cost or valuation				
At 1 April 2023	**4,869**	**334**	**641**	**5,844**
Prior period adjustments in underlying accounts	22	5	18	45
Additions	242	181	401	824
Donations	1	-	2	3
Impairments and reversals	(65)	(6)	(12)	(83)
Transfers	35	15	(52)	(2)
Reclassifications	435	(15)	(387)	33
Revaluation and indexation	9	9	1	19
Disposals	(455)	(50)	(2)	(507)
At 31 March 2024	**5,093**	**473**	**610**	**6,176**
Amortisation				
At 1 April 2023	**2,891**	**183**	**35**	**3,109**
Prior period adjustments in underlying accounts	(2)	-	-	(2)
Charged in year	469	148	6	623
Impairments and reversals	(3)	(1)	-	(4)
Transfers	-	1	-	1
Reclassifications	5	(11)	3	(3)
Revaluation and indexation	7	5	1	13
Disposals	(449)	(50)	(2)	(501)
At 31 March 2024	**2,918**	**275**	**43**	**3,236**
Net Book Value at 31 March 2024	**2,175**	**198**	**567**	**2,940**
Net Book Value at 31 March 2023	1,978	151	606	2,735

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 – 20 years
- Other 1 – 20 years

8. Right of use assets

Departmental group for the year ended 31 March 2025

	Property £m	Information technology £m	Furniture and fittings £m	Plant and machinery £m	Intangible assets £m	Total £m
Cost or valuation						
At 1 April 2024	**4,777**	**148**	**12**	**1,254**	**11**	**6,202**
Prior period adjustments in underlying accounts	8	(1)	-	(30)	-	(23)
Additions	353	30	1	236	-	620
Rerecognition due to termination of finance sub-lease	5	-	-	-	-	5
Remeasurements	159	(1)	-	29	-	187
Disposals and derecognitions	(159)	(21)	-	(94)	(4)	(278)
Capital provisions and reversals	(1)	-	-	-	-	(1)
Impairments and reversals	(144)	-	-	(3)	-	(147)
Revaluation and indexation	(20)	-	-	(4)	-	(24)
Reclassifications	(6)	(4)	-	(9)	-	(19)
At 31 March 2025	**4,972**	**151**	**13**	**1,379**	**7**	**6,522**
Depreciation						
At 1 April 2024	**956**	**81**	**6**	**575**	**9**	**1,627**
Prior period adjustments in underlying accounts	-	-	-	(11)	-	(11)
Charged in year	436	23	2	221	-	682
Rerecognition due to termination of finance sub-lease	1	-	-	-	-	1
Disposals and derecognitions	(83)	(14)	-	(84)	(4)	(185)
Impairments and reversals	(8)	-	-	-	-	(8)
Revaluation and indexation	(29)	-	-	(4)	-	(33)
Reclassifications	(2)	(4)	-	(3)	-	(9)
At 31 March 2025	**1,271**	**86**	**8**	**694**	**5**	**2,064**
Net book value at 31 March 2025	**3,701**	**65**	**5**	**685**	**2**	**4,458**
Net book value at 31 March 2024	3,821	67	6	679	2	4,575

Departmental group for the year ended 31 March 2024

	Property £m	Information technology £m	Furniture and fittings £m	Plant and machinery £m	Intangible assets £m	Total £m
Cost or valuation						
At 1 April 2023	**4,436**	**133**	**12**	**1,105**	**10**	**5,696**
Prior period adjustments in underlying accounts	(10)	-	-	3	-	(7)
Additions	444	24	-	172	-	640
Remeasurements	83	1	-	9	-	93
Disposals and derecognitions	(139)	(11)	-	(62)	-	(212)
Capital provisions and reversals	33	-	-	-	-	33
Impairments and reversals	(48)	(1)	-	-	-	(49)
Revaluation and indexation	(13)	-	-	1	-	(12)
Transfers	5	-	-	(1)	1	5
Reclassifications	(14)	2	-	27	-	15
At 31 March 2024	**4,777**	**148**	**12**	**1,254**	**11**	**6,202**
Depreciation						
At 1 April 2023	**576**	**69**	**4**	**407**	**8**	**1,064**
Prior period adjustments in underlying accounts	(2)	-	-	1	-	(1)
Charged in year	444	22	2	221	-	689
Disposals and derecognitions	(38)	(9)	-	(54)	-	(101)
Impairments and reversals	11	-	-	-	-	11
Revaluation and indexation	(29)	-	-	-	-	(29)
Transfers	(2)	-	-	-	1	(1)
Reclassifications	(4)	(1)	-	-	-	(5)
At 31 March 2024	**956**	**81**	**6**	**575**	**9**	**1,627**
Net book value at 31 March 2024	**3,821**	**67**	**6**	**679**	**2**	**4,575**
Net book value at 31 March 2023	3,860	64	8	698	2	4,632

Comparatives for 2023-24 have been re-presented where figures for 2024-25 have been reorganised.

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.

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Property, plant and equipment	24	10	2,533	2,510
Intangible non-current assets	7	5	114	136
	31	**15**	**2,647**	**2,646**

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.

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Not later than 1 year	1	1	178	174
Later than 1 year and not later than 2 years	1	1	151	137
Later than 2 years and not later than 3 years	1	1	135	126
Later than 3 years and not later than 4 years	1	1	122	115
Later than 4 years and not later than 5 years	1	-	113	107
Later than 5 years	4	-	876	896
	9	**4**	**1,575**	**1,555**

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 (2023-24: 304). The substance of each contract is that DHSC 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:

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Not later than 1 year	-	-	286	273
Later than 1 year and not later than 5 years	-	-	1,212	1,100
Later than 5 years	-	-	3,510	3,708
	-	**-**	**5,008**	**5,081**
Less interest element	-	-	(1,909)	(2,041)
Present value of obligations	**-**	**-**	**3,099**	**3,040**

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 £76 million (2023-24: £72 million).

Total future obligations in respect of these charges are given in the table below:

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Not later than 1 year	-	-	78	75
Later than 1 year and not later than 5 years	-	-	327	318
Later than 5 years	-	-	383	462
	-	**-**	**788**	**855**

9.3.3 PFI schemes deemed to be on-statement of financial position

In this financial period there were 161 on-statement of financial position PFI schemes (2023-24: 167). The substance of each contract is that DHSC 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:

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Not later than 1 year	-	-	1,371	1,387
Later than 1 year and not later than 5 years	-	-	5,450	5,420
Later than 5 years	-	-	14,230	15,447
	-	**-**	**21,051**	**22,254**
Less interest element	-	-	(6,988)	(7,965)
Present value of obligations	**-**	**-**	**14,063**	**14,289**

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 £1,260 million (2023-24: £1,237 million).

Total future obligations in respect of these charges are given in the table below:

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Not later than 1 year	-	-	1,255	1,183
Later than 1 year and not later than 5 years	-	-	5,013	4,785
Later than 5 years	-	-	12,469	13,317
	-	**-**	**18,737**	**19,285**

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.

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Not later than 1 year	1,884	2,242	3,993	4,234
Later than 1 year and not later than 5 years	4,176	3,587	6,439	4,972
Later than 5 years	1,459	2,192	1,970	2,370
	7,519	**8,021**	**12,402**	**11,576**

Included within the core department and agencies and departmental group figures for 2024-25 are financial commitments of £3,803 million relating to UKHSA (2023-24: £4,197 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 maximum 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

Core department and agencies

	31 March 2025 £bn	31 March 2024 £bn
Financial assets	9.8	10.4
of which:		
held at amortised cost	5.9	6.1
held at fair value through other comprehensive expenditure	3.9	4.3

Departmental group

	31 March 2025 £bn	31 March 2024 £bn
Financial assets	20.1	20.8
of which:		
held at amortised cost	19.5	20.1
held at fair value through other comprehensive expenditure	0.6	0.7

10.3 Analysis of financial liabilities

Core department and agencies

	31 March 2025 £bn	31 March 2024 £bn
Financial liabilities	4.5	5.2

Departmental group

	31 March 2025 £bn	31 March 2024 £bn
Financial liabilities	49.7	51.0

At both 31 March 2025 and 31 March 2024, all financial liabilities were held at amortised cost.

11. Non-current investments

Core department and agencies for the year ended 31 March 2025

	Public dividend capital issued to NHS providers £m	Loans issued to NHS providers £m	Loans issued to other bodies £m	Share capital issued to other bodies £m	Total £m
Balance at 1 April 2024	**37,404**	**1,943**	**198**	**4,267**	**43,812**
Issued	4,467	47	136	204	4,854
Repaid	(51)	(9)	(119)	-	(179)
Net transfer to current receivables	-	(138)	(3)	-	(141)
Written off	(227)	-	-	-	(227)
Changes in fair value through other comprehensive income	-	-	-	(581)	(581)
Other impairments and reversals	(2,212)	-	-	-	(2,212)
Balance at 31 March 2025	**39,381**	**1,843**	**212**	**3,890**	**45,326**

Core department and agencies for the year ended 31 March 2024

	Public dividend capital issued to NHS providers £m	Loans issued to NHS providers £m	Loans issued to other bodies £m	Share capital issued to other bodies £m	Total £m
Balance at 1 April 2023	**40,053**	**2,170**	**940**	**5,636**	**48,799**
Issued	4,879	50	80	110	5,119
Repaid	(54)	(14)	(762)	-	(830)
Net transfer to current receivables	-	(263)	(60)	-	(323)
Changes in fair value through other comprehensive income	-	-	-	(1,479)	(1,479)
Other impairments and reversals	(7,474)	-	-	-	(7,474)
Balance at 31 March 2024	**37,404**	**1,943**	**198**	**4,267**	**43,812**

Departmental group for the year ended 31 March 2025

	Loans £m	Share capital and other investments £m	Total £m
Balance at 1 April 2024	**3**	**636**	**639**
Issued	5	8	13
Disposals	-	(16)	(16)
Repaid	-	(3)	(3)
Net transfer to current receivables	(2)	(1)	(3)
Changes in fair value through other comprehensive income	-	(113)	(113)
Changes in fair value through net expenditure	-	2	2
Other impairments and reversals	-	(1)	(1)
Other movements	(1)	7	6
Balance at 31 March 2025	**5**	**519**	**524**
Investments held by core department and agencies			45,326
Less elimination of intra-group investments			(45,209)
Investments held by other group bodies			407
Total			**524**

Departmental group for the year ended 31 March 2024

	Loans £m	Share capital and other investments £m	Total £m
Balance at 1 April 2023	**4**	**647**	**651**
Issued	-	19	19
Disposals	-	(17)	(17)
Repaid	(1)	(2)	(3)
Net transfer to current receivables	-	(1)	(1)
Changes in fair value through net expenditure	-	4	4
Other impairments and reversals	-	1	1
Other movements	-	(15)	(15)
Balance at 31 March 2024	**3**	**636**	**639**
Investments held by core department and agencies			43,812
Less elimination of intra-group investments			(43,579)
Investments held by other group bodies			406
Total			**639**

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 trusts 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 2024-25 the value of impairment in respect of public dividend capital charged to the expenditure was £2,341 million (2023-24: £7,247 million charge) and the value of impairments credited to reserves was £129 million (2023-24: £227 million charge). 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 2025

Entity	Valuation basis	Level 1 £m	Level 2 £m	Level 3 £m	Total £m
Community Health Partnerships Ltd	Net assets	-	-	-	-
NHS Property Services Ltd	Net assets	-	3,041	-	3,041
Genomics England Ltd	Capital invested	-	738	-	738
NHS Professionals Ltd	Discounted cash flow	-	-	102	102
Other share capital investments	Various	-	-	9	9
		-	**3,779**	**111**	**3,890**

For the year ended 31 March 2024

Entity	Valuation basis	Level 1 £m	Level 2 £m	Level 3 £m	Total £m
Community Health Partnerships Ltd	Net assets	-	-	-	-
NHS Property Services Ltd	Net assets	-	3,449	-	3,449
Genomics England Ltd	Capital invested	-	588	-	588
NHS Professionals Ltd	Discounted cash flow	-	-	222	222
Other share capital investments	Various	-	-	8	8
		-	**4,037**	**230**	**4,267**

12. Inventories

Core department and agencies for the year ended 31 March 2025

	Notes	Vaccines £m	COVID-19 medicines £m	COVID-19 vaccines £m	Consumables £m	Other £m	Total £m
Balance at 1 April 2024		**439**	**46**	**172**	**9**	**26**	**692**
Prior period adjustments in underlying accounts		(11)	-	-	(1)	1	(11)
Inventory additions		595	-	829	35	9	1,468
Inventory consumed/disposed of		(583)	(37)	(711)	(44)	(9)	(1,384)
Write downs		(46)	(1,249)	55	(338)	-	(1,578)
Impairments and reversals	4.3	-	1,257	-	352	-	1,609
Transfers		(5)	-	-	-	2	(3)
Transfers from provisions		-	-	(118)	(8)	(1)	(127)
Other		6	(1)	1	2	2	10
Balance at 31 March 2025		**395**	**16**	**228**	**7**	**30**	**676**

Core department and agencies for the year ended 31 March 2024

	Notes	Vaccines £'m	COVID-19 medicines £'000	COVID-19 vaccines £'000	Consumables £'000	Other £'000	Total £'000
Balance at 1 April 2023		**431**	**57**	**316**	**239**	**10**	**1,053**
Prior period adjustments in underlying accounts		1	-	(45)	6	-	(38)
Inventory additions		597	153	813	16	3	1,582
Inventory consumed/disposed of		(560)	(66)	(596)	(136)	(1)	(1,359)
Write downs		(33)	(343)	(93)	(1,092)	-	(1,561)
Impairments and reversals	4.3	-	367	-	1,052	-	1,419
Transfers		3	-	-	(73)	1	(69)
Transfers from provisions		-	(124)	(224)	(2)	-	(350)
Other		-	2	1	(1)	13	15
Balance at 31 March 2024		**439**	**46**	**172**	**9**	**26**	**692**

Comparatives for 2023-24 have been re-presented where figures for 2024-25 have been reorganised.

Departmental group for the year ended 31 March 2025

	Notes	Vaccines £m	Drugs £m	COVID-19 medicines £m	COVID-19 vaccines £m	Consumables £m	Other £m	Total £m
Balance at 1 April 2024		**439**	**534**	**46**	**172**	**1,009**	**111**	**2,311**
Prior period adjustments in underlying accounts		(11)	5	-	-	(8)	3	(11)
Inventory additions		595	10,164	-	829	5,044	634	17,266
Inventory consumed/disposed of		(583)	(10,112)	(37)	(711)	(4,995)	(629)	(17,067)
Write downs		(46)	(15)	(1,249)	55	(347)	(1)	(1,603)
Impairments and reversals	4.3	-	-	1,257	-	353	-	1,610
Transfers		(5)	-	-	-	-	2	(3)
Transfers from provisions		-	-	-	(118)	(8)	(1)	(127)
Other		6	(1)	(1)	1	-	4	9
Balance at 31 March 2025		**395**	**575**	**16**	**228**	**1,048**	**123**	**2,385**

Departmental group for the year ended 31 March 2024

	Notes	Vaccines £m	Drugs £m	COVID-19 medicines £m	COVID-19 vaccines £m	Consumables £m	Other £m	Total £m
Balance at 1 April 2023		**431**	**511**	**57**	**316**	**1,180**	**107**	**2,602**
Prior period adjustments in underlying accounts		1	1	-	(45)	6	(1)	(38)
Inventory additions		597	9,325	153	813	4,829	554	16,271
Inventory consumed/disposed of		(560)	(9,288)	(66)	(596)	(4,887)	(558)	(15,955)
Write downs		(33)	(15)	(343)	(93)	(1,099)	(1)	(1,584)
Impairments and reversals	4.3	-	-	367	-	1,053	-	1,420
Transfers		3	-	-	-	(73)	1	(69)
Transfers from provisions		-	-	(124)	(224)	(2)	-	(350)
Reclassification		-	-	-	-	5	(5)	-
Other		-	-	2	1	(3)	14	14
Balance at 31 March 2024		**439**	**534**	**46**	**172**	**1,009**	**111**	**2,311**

Comparatives for 2023-24 have been re-presented where figures for 2024-25 have been reorganised.

13. Cash and cash equivalents

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Balance at 1 April 2024	**2,370**	**1,016**	**14,592**	**15,561**
Net change in cash	(443)	1,354	(1,083)	(969)
Balance at 31 March 2025	**1,927**	**2,370**	**13,509**	**14,592**
The following balances at 31 March were held at:				
Government Banking Service	1,927	2,369	13,017	13,915
Commercial banks and cash in hand	-	1	314	281
Short term investments	-	-	178	396
Balance at 31 March 2025	**1,927**	**2,370**	**13,509**	**14,592**

14. Trade receivables and other assets

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Amounts falling due within one year:				
Trade receivables	55	71	2,652	2,630
Deposits and advances	-	-	6	5
Capital receivables	8	-	81	55
Interest receivable	-	-	21	23
Other receivables	265	305	1,220	1,192
Trade and other receivables	**328**	**376**	**3,980**	**3,905**
Contract assets	8	6	10	9
Other prepayments and accrued income	1,218	936	3,322	2,814
Service concession arrangement prepayments	-	-	24	29
Capital prepayments	-	-	138	111
Other current assets	-	-	3	3
Charitable other current assets	-	-	32	24
Other current assets	**1,226**	**942**	**3,529**	**2,990**
Loans receivable	220	335	4	2
Other current financial assets	-	-	132	102
Other financial assets	**220**	**335**	**136**	**104**
Total current receivables	**1,774**	**1,653**	**7,645**	**6,999**
Amounts falling due after more than one year:				
Trade receivables	1	-	185	179
Deposits and advances	-	-	7	7
Capital receivables	-	-	4	25
Contract assets	-	-	5	5
Other receivables	227	255	297	274
Other prepayments and accrued income	49	-	80	29
Service concession arrangement prepayments	-	-	52	59
Capital prepayments	-	-	218	212
Charitable non-current assets	-	-	2	2
Other non-current assets	**277**	**255**	**850**	**792**
Total receivables	**2,051**	**1,908**	**8,495**	**7,791**

Comparatives for 2023-24 for the departmental group have been re-presented where figures for 2024-25 have been reorganised.

15. Trade payables and other liabilities

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Amounts falling due within one year:				
Trade payables	51	36	4,691	4,180
Capital payables	10	1	2,103	2,173
Other payables	15	27	2,286	2,268
Trade and other payables	**76**	**64**	**9,080**	**8,621**
Bank overdrafts	-	-	19	29
VAT	-	-	68	54
Other taxation and social security	26	24	1,918	1,876
Deferred tax liability	-	-	2	-
Reciprocal healthcare payables	735	730	735	730
Contract liabilities	16	526	1,497	1,922
Other accruals	668	513	12,345	13,316
Deferred income	88	147	296	307
Lease liabilities	33	38	590	641
Service concession arrangements	-	-	682	661
Amount issued from the Consolidated Fund for supply but not spent at year end	2,712	3,059	2,712	3,059
Consolidated Fund extra receipts due to be paid to the Consolidated Fund - Received	1	14	1	14
Loans payable to entities outside the group	-	-	35	47
Pension liabilities	-	-	1,230	1,112
Other current liabilities	-	-	12	17
Charitable liabilities	-	-	46	64
Other liabilities	**4,279**	**5,051**	**22,188**	**23,849**
Total current payables	**4,355**	**5,115**	**31,268**	**32,470**
Amounts falling due after more than one year:				
Lease liabilities	219	212	3,713	3,657
Service concession arrangements	-	-	16,480	16,669
Financial liabilities	**219**	**212**	**20,193**	**20,326**
Trade payables	-	-	2	2
Contract liabilities	6	12	127	186
Other accruals	-	-	1	3
Capital payables	-	-	7	22
Other payables	-	-	815	382
Deferred income	3	5	95	101
Loans payable to entities outside the group	-	-	226	259
Loans payable by DHSC to group bodies	20	20	-	-
Other payables	**29**	**37**	**1,273**	**955**
Total non-current payables	**248**	**249**	**21,466**	**21,281**
Total payables	**4,603**	**5,364**	**52,734**	**53,751**

Comparatives for 2023-24 for the departmental group have been re-presented where figures for 2024-25 have been reorganised.

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.

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:

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Current lease liabilities	33	38	590	641
Non-current lease liabilities	219	212	3,713	3,657
Total lease liabilities	**252**	**250**	**4,303**	**4,298**

Maturity analysis

	Core department and agencies		Departmental group	
	2024-25 £m	2023-24 £m	2024-25 £m	2023-24 £m
Undiscounted lease payments falling due in:				
Not later than 1 year	40	43	702	690
Later than 1 year and not later than 5 years	116	117	1,959	1,857
Later than 5 years	156	123	2,447	2,342
Sub-total	**312**	**283**	**5,108**	**4,889**
Less interest element	(60)	(33)	(805)	(591)
Total lease liabilities	**252**	**250**	**4,303**	**4,298**

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 2025

	Infected blood £m	Reciprocal healthcare costs £m	Injury benefits £m	Early departure costs £m	Other £m	Total £m
Balance at 1 April 2024	**1,968**	**1,164**	**434**	**65**	**350**	**3,981**
Prior period adjustments in underlying accounts	-	-	-	-	37	37
Provided in the year	24	909	29	9	129	1,100
Provisions not required written back	(1,760)	-	(19)	(4)	(98)	(1,881)
Transfers	-	-	-	-	(1)	(1)
Provisions utilised in the year	(153)	(186)	(47)	(10)	(50)	(446)
Transfers to accruals and inventories	-	(571)	-	-	(128)	(699)
Borrowing costs (unwinding of discount)	84	33	17	1	5	140
Change in discount rate	(11)	1	1	-	-	(9)
Balance at 31 March 2025	**152**	**1,350**	**415**	**61**	**244**	**2,222**
Included in						
Current provisions	152	334	45	10	161	702
Non current provisions	-	1,016	370	51	83	1,520
Total	**152**	**1,350**	**415**	**61**	**244**	**2,222**
Expected timing of cash flow						
not later than 1 year	152	334	45	10	161	702
later than 1 year, not later than 5 years	-	1,016	166	35	37	1,254
later than 5 years	-	-	204	16	46	266
Total	**152**	**1,350**	**415**	**61**	**244**	**2,222**

Core department and agencies for the year ended 31 March 2024

	Infected blood £m	Reciprocal healthcare costs £m	Injury benefits £m	Early departure costs £m	Other £m	Total £m
Balance at 1 April 2023	**2,230**	**1,080**	**468**	**69**	**760**	**4,607**
Prior period adjustments in underlying accounts	-	-	-	-	13	13
Provided in the year	83	808	39	12	140	1,082
Provisions not required written back	(5)	-	(18)	(4)	(69)	(96)
Provisions utilised in the year	(146)	(186)	(46)	(12)	(138)	(528)
Transfers to accruals and inventories	-	(556)	-	-	(350)	(906)
Borrowing costs (unwinding of discount)	71	27	14	1	3	116
Change in discount rate	(265)	(9)	(23)	(1)	(9)	(307)
Balance at 31 March 2024	**1,968**	**1,164**	**434**	**65**	**350**	**3,981**
Included in						
Current provisions	143	393	45	10	224	815
Non-current provisions	1,825	771	389	55	126	3,166
Total	**1,968**	**1,164**	**434**	**65**	**350**	**3,981**
Expected timing of cash flow						
not later than 1 year	143	393	45	10	224	815
later than 1 year, not later than 5 years	458	771	169	37	79	1,514
later than 5 years	1,367	-	220	18	47	1,652
Total	**1,968**	**1,164**	**434**	**65**	**350**	**3,981**

Comparatives for 2023-24 have been re-presented where figures for 2024-25 have been reorganised.

Departmental group for the year ended 31 March 2025

	Clinical negligence £m	Infected blood £m	Reciprocal healthcare costs £m	Injury benefits £m	Early departure costs £m	Other £m	Total £m
Balance at 1 April 2024	**58,156**	**1,968**	**1,164**	**656**	**186**	**2,354**	**64,484**
Prior period adjustments in underlying accounts	-	-	-	-	-	62	62
Provided in the year	8,202	24	909	49	24	815	10,023
Provisions not required written back	(3,533)	(1,760)	-	(26)	(10)	(632)	(5,961)
Transfers	-	-	-	-	-	(1)	(1)
Provisions utilised in the year	(3,088)	(153)	(186)	(63)	(28)	(354)	(3,872)
Transfers to accruals and inventories	-	-	(571)	(3)	(3)	(170)	(747)
Borrowing costs (unwinding of discount)	1,301	84	33	23	5	26	1,472
Change in discount rate	(1,054)	(11)	1	2	(1)	(3)	(1,066)
Balance at 31 March 2025	**59,984**	**152**	**1,350**	**638**	**173**	**2,097**	**64,394**
Included in							
Current provisions	3,648	152	334	63	28	1,060	5,285
Non current provisions	56,336	-	1,016	575	145	1,037	59,109
Total	**59,984**	**152**	**1,350**	**638**	**173**	**2,097**	**64,394**
Expected timing of cash flow							
not later than 1 year	3,648	152	334	63	28	1,060	5,285
later than 1 year, not later than 5 years	12,137	-	1,016	243	99	356	13,851
later than 5 years	44,199	-	-	332	46	681	45,258
Total	**59,984**	**152**	**1,350**	**638**	**173**	**2,097**	**64,394**

Departmental group for the year ended 31 March 2024

	Clinical negligence £m	Infected blood £m	Reciprocal healthcare costs £m	Injury benefits £m	Early departure costs £m	Other £m	Total £m
Balance at 1 April 2023	**69,256**	**2,230**	**1,080**	**701**	**199**	**2,898**	**76,364**
Prior period adjustments in underlying accounts	-	-	-	-	-	11	11
Provided in the year	9,317	83	808	61	26	832	11,127
Provisions not required written back	(3,940)	(5)	-	(24)	(9)	(591)	(4,569)
Provisions utilised in the year	(2,822)	(146)	(186)	(61)	(25)	(351)	(3,591)
Transfers to accruals and inventories	-	-	(556)	(4)	(4)	(391)	(955)
Borrowing costs (unwinding of discount)	882	71	27	18	4	25	1,027
Change in discount rate	(14,537)	(265)	(9)	(35)	(5)	(79)	(14,930)
Balance at 31 March 2024	**58,156**	**1,968**	**1,164**	**656**	**186**	**2,354**	**64,484**
Included in							
Current provisions	3,666	143	393	63	29	1,268	5,562
Non current provisions	54,490	1,825	771	593	157	1,086	58,922
Total	**58,156**	**1,968**	**1,164**	**656**	**186**	**2,354**	**64,484**
Expected timing of cash flow							
not later than 1 year	3,666	143	393	63	29	1,268	5,562
later than 1 year, not later than 5 years	12,368	458	771	242	101	449	14,389
later than 5 years	42,122	1,367	-	351	56	637	44,533
Total	**58,156**	**1,968**	**1,164**	**656**	**186**	**2,354**	**64,484**

Comparatives for 2023-24 have been re-presented where figures for 2024-25 have been reorganised.

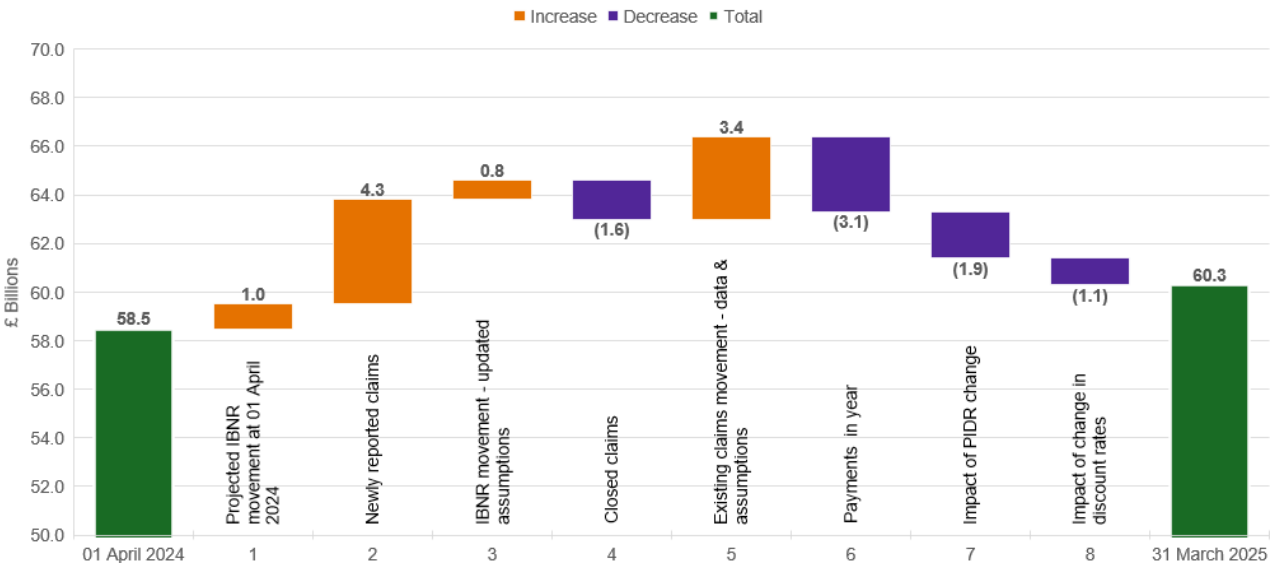
Clinical negligence

The departmental group, through the operations of several schemes under NHS Resolution, recognises a clinical negligence provision. The provision represents the best estimate of future obligations from clinical negligence as a result of incidents up to 31 March 2025. The three key elements of the provision are:

- Known claims – where a claim has been received by NHS Resolution but not yet settled.
- Settled claims – Where a claim has been settled in the past but involves ongoing future payments.
- Incurred but not reported (IBNR) claims– claims that have not been received but where it can be reasonably predicted that:
    - an adverse incident has occurred, and
    - a transfer of economic benefits will occur, and
    - a reasonable estimate of the likely value can be made.

Key movements in the provision

The value of the clinical negligence provision has increased by £1.8 billion in 2024-25 from £58.2 billion at 31 March 2024 to £60.0 billion at 31 March 2025. The below diagram and accompanying table show the key movements of the provisions held by NHS Resolution, of which £0.3 billion relates to non-clinical negligence schemes.



Item(s)	Commentary
1,2	Increase from another year's worth of activity in 2024-25 for all schemes for all incident years is £5.3 billion.
3	Net increase of £0.8 billion due to changes in assumptions affecting the IBNR provision across all schemes. The main drivers relate to the clinical negligence scheme for trusts (CNST) which makes up £22.7 billion of the total IBNR provision of £24.1 billion. The drivers of the increase of £0.5 billion in the CNST IBNR provision include: • An increase of £1.7 billion in respect of claim number projections • An increase of £0.3 billion for changes in average cost assumptions • Net of a £0.7 billion reduction from updates to long-term inflation assumptions, £0.3 billion from COVID-19 related provisions, £0.3 billion following an update to the approach for provisioning for known incidents, and £0.2 billion due to the inception of the claims evolution programme.
4	Reduction of £1.6 billion in respect of claims closed during this financial year.
5	Increase of £3.4 billion in respect of changes in data and assumptions affecting known claims.
6	Decrease of £3.1 billion from amounts paid out during the financial year in relation to claims.
7	Decrease of £1.9 billion due to changes in the personal injury discount rate (PIDR). This rate is used to calculate how much defendants must pay in lump sum damages to claimants in personal injury cases which has increased from negative 0.25% to positive 0.50%, effective from 11 January 2025.
8	There is a decrease in the provision of £1.1 billion due to updates to the discount rates specified for use by HM Treasury (HMT). Further details are provided below.

Further information can be found in the NHS Resolution Annual Report and Account.

Effect of change in discount rate

One of the key assumptions used in calculating the provisions is the discount rate used to place a present value on projected future cashflows. Since the discount rates are prescribed by HM Treasury, the rates are outside the formal control of NHS Resolution.

The clinical negligence provision is particularly sensitive to the long-term and very long-term discount rates. This reflects the long-term nature of the liabilities which is driven by the

reporting and settlement delays as well as the fact that many high-value claims are settled as a periodical payment order (PPO) with payments provided over the remaining lifetime of the claimant.

In prior years, large changes in the discount rate have led to significant changes in the provision value. These changes reflect how adjustments to the discount rate, set by HMT, directly impact the calculated present value of future liabilities for clinical negligence claims, thereby affecting the reported provision. In 2024-25, there have been relatively minor changes to the discount rates prescribed by HMT, leading to a decrease in the provision of £1.1 billion.

Although the change in discount rates affects the value of the provision, 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 PIDR). As such, decrease in the provision reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

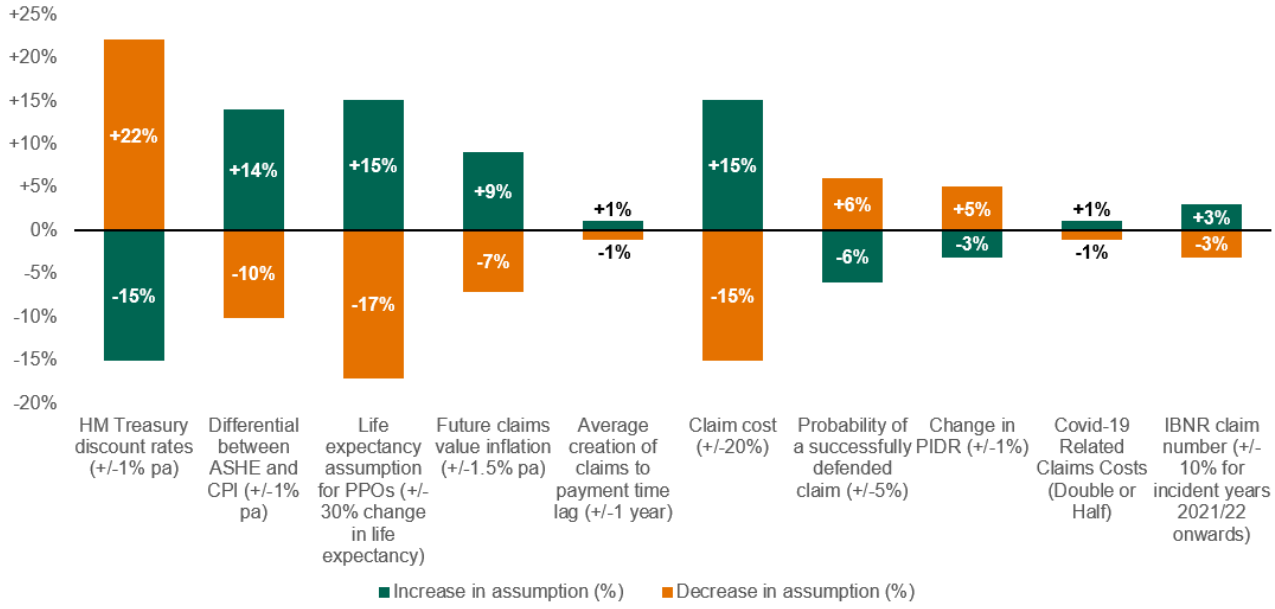
Key areas of uncertainty

Due to the long-term nature of the liabilities and the assumptions on which the estimate of the clinical negligence provision is based, some uncertainty about the value of the liability remains. This is particularly relevant to the IBNR element of the provision, as the method used to calculate these provisions assumes future experience will be in line with past experience, making adjustments for emerging risks and changes where relevant.

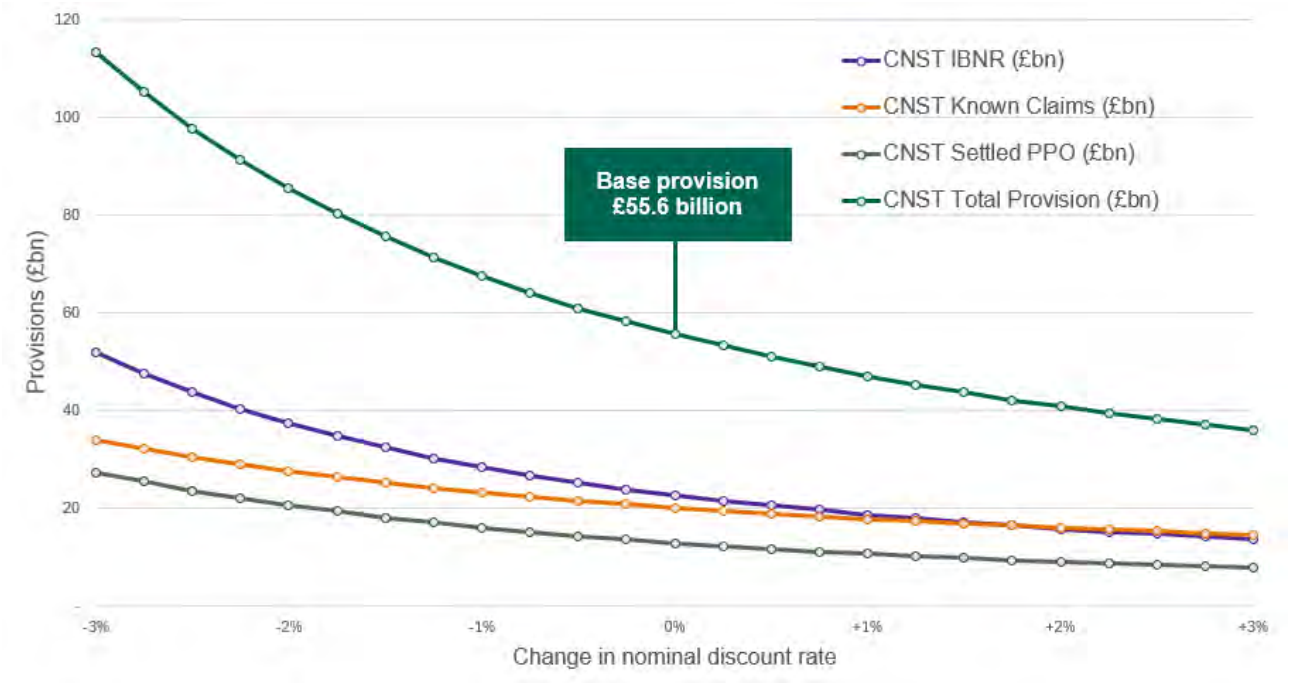
Claims settling as PPOs also remain a key area of uncertainty, given the high value of PPO settlements and the relatively small number of claims that settle on this basis. PPO claim settlements are paid over the lifetime of the claimant, and consequently there are additional inflation and longevity uncertainties, compared to equivalent lump sum settlements.

The largest scheme within the clinical negligence provision is the CNST which accounts for £55.6 billion of the total provision of £60.0 billion. Changes to the assumptions underpinning this element have the greatest potential to affect the estimate of the total provision. The graphs below outline the impact of changes in assumptions on the CNST provision, as the largest scheme.

The following graph shows the value and percentage impact of variations in the key assumptions on the CNST provision. The ranges of the sensitivity tests that follow are based on potential levels of variability for each assumption, including observations 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.

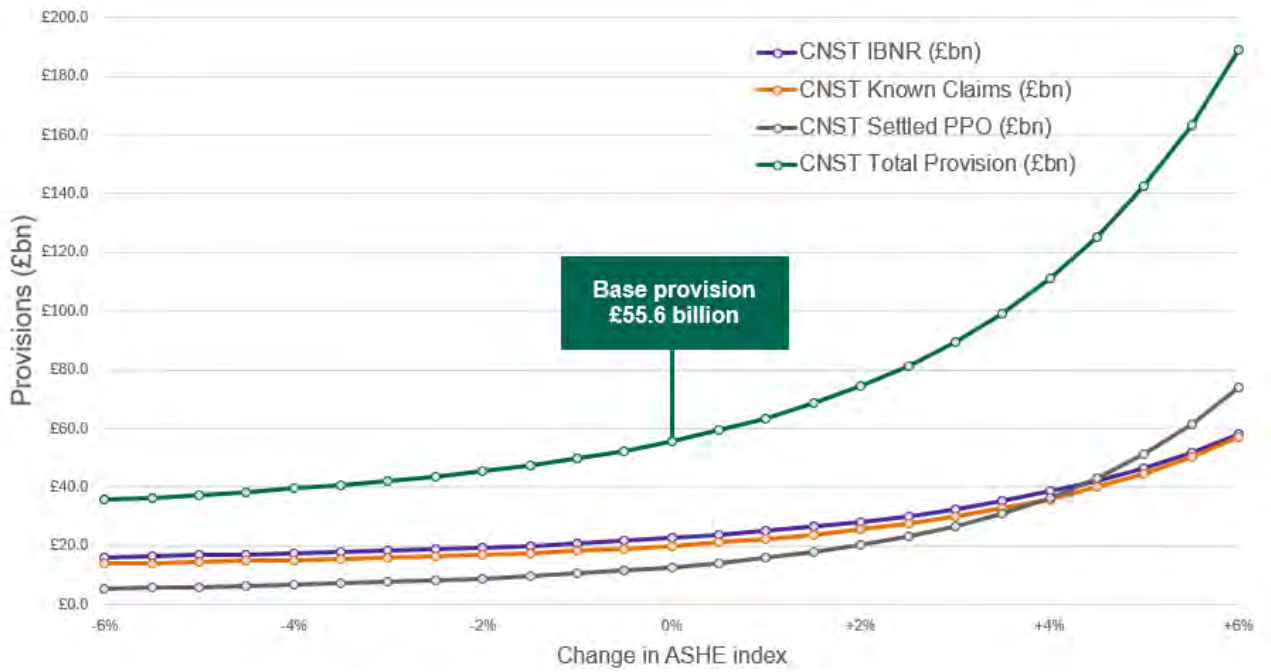


As mentioned above, the clinical negligence provision's value is particularly sensitive to changes in the discount rate given its nature. The graph below shows the impact of percentage changes in the discount rate for the CNST provision. The graph highlights the sensitivity of the IBNR provision, especially, to changes in the discount rate.



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 the Annual Survey of Hours and Earning (ASHE), a wage inflation index, over the long-term and life expectancy.

The ASHE index, used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers. The following graph shows the sensitivity of the CNST provision to the differential between ASHE and CPI.



Interaction between the clinical negligence provision and contingent liability

As well as the clinical negligence provision detailed above, the DHSC group also holds a contingent liability for clinical negligence (See **note 17**).

The provision represents the best estimate, as at 31 March 2025, of the cost to settle clinical negligence cases taking into consideration the probability that damage payments will be awarded. The contingent liability represents the best estimate, as at 31 March 2025, of the costs to settle all clinical negligence without reflecting the probability of damages being awarded, in excess of the provision amount. In both cases the amount represents the present value, and therefore amounts are inflated and discounted to the present value of the claim based on the expected settlement dates.

When taken as a whole, the total balance reflects the position if damage payments were awarded on all clinical negligence cases. In 2024-25, there has been an increase in this total balance of £2,297m which mostly relates to the provision amount. See above for detailed analysis of the increase in the provision amount.

	Departmental group	
	31 March 2025 £m	31 March 2024 £m
Clinical negligence:		
Provision	59,984	58,156
Contingent liability	25,023	24,554
Total	**85,007**	**82,710**

Further information regarding both the provision and contingent liability can be found in the NHS Resolution Annual Report and Account.

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 to be made by DHSC 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.

DHSC has assessed that, as at 31 March 2025, the department has a constructive obligation for payments made under the England Infected Blood Support Scheme (EIBSS), up to 23 March 2026, the date when the newly established Infected Blood Compensation Authority (IBCA) was planned to assume responsibility. Therefore, the provision has been reassessed at 31 March 2025 to only reflect payments which DHSC would make in future and to remove the impact of payments which IBCA would be obligated to make. This has resulted in a release of the provision of £1,415 million.

Regulations were subsequently laid in draft on 30 October 2025 in Parliament. These move the date of transfer of EIBSS payments to IBCA to 2027. These will be debated in Parliament and, subject to approval, will become law by the end of 2025. The provision at 31 March 2025 has not been adjusted for this change as it is a non-adjusting event after the reporting period.

Provision is also included for the expected future cost of payments as at 31 March 2025 due to be made under the Infected Blood Interim Compensation Payment Scheme.

Other provisions

Other provisions are made up of several small provisions from 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		31 March 2025 £m	31 March 2024 £m
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. See **note 16** for further details.	25,023.1	24,553.8
Legal Cases			
2	Employment tribunal cases Not disclosed due to sensitive nature of the contingent liabilities.	n/a	n/a
3	Legal cases – DHSC as claimant – liability in relation to potential costs Not disclosed due to sensitive nature of the contingent liabilities.	n/a	n/a
4	Legal cases – DHSC as defendant Not disclosed due to sensitive nature of the contingent liabilities.	n/a	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	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. 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.	n/a	n/a
NHS England Group and Consolidated Provider Account			
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 an off-payroll liability to HMRC.	94.2	29.8
8	There were contingent liabilities of NHS providers at 31 March 2025.	126.8	113.1
NHS Resolution			
9	At 31 March 2025, 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.	219.2	226.9
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	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.	1.1	0.4
12	Compensation payments due to individuals unable to be traced	0.4	0.4

	There are uncertainties around timing, likelihood and expected costs.		
13	Sensitive Contingent Liability. Not disclosed due to sensitive nature of the contingent liabilities.	n/a	n/a
14	UKHSA is involved in a variety of material contract disputes, three over £300,000 which UKHSA believe constitute contingent liabilities, primarily relating to contracts let in response to the Covid 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	n/a
15	UKHSA holds unquantifiable contingent liabilities in relation to potential remedial works relating to radiological contamination at its radiological scientific sites at the end of their lifespans. This is unquantifiable because until the sites are vacated (which is not currently planned) the extent of any contamination cannot be determined and therefore no calculation of potential liabilities can be made.	n/a	n/a
16	The Nursing and Midwifery Council has an unquantifiable contingent liability for potential additional liabilities following the High Court's ruling on Virgin Media's pension scheme. There is uncertainty with regards to monetary value of the potential additional liabilities.	n/a	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 (including their subsidiaries, joint ventures, and associates) 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 2024-25.

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, DHSC may enter into business transactions with such outside organisations or related parties.

In cases where an individual within DHSC 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	Organisation role	Organisation	Payables with related party 2024-25 £'000	Purchases from related party 2024-25 £'000	Receivables with related party 2024-25 £'000	Sales to related party 2024-25 £'000	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
Doug Gurr[1]	Non Executive Board Member	The Alan Turing Institute	-	125	-	-	-	1,221	-	-
Samantha Jones[2]	Trustee	NHS Confederation	-	10,132	-	-	-	9,718	-	-
Samantha Jones[3]	Advisory Board Member	Accurx Ltd	-	-	-	-	-	1,331	-	-
Samantha Jones[4]	Trustee	Alzheimer's Society	-	-	-	482	-	-	899	1,197
Richard Douglas[5]	Trustee	Place2Be	-	400	-	-	-	-	-	-
Alan Milburn[6]	Chancellor	Lancaster University	31	3,043	-	-	-	-	-	-

1. Doug Gurr holds the position of Chair at the Alan Turing Institute on a remunerated basis.
2. An individual related to Samantha Jones is a Trustee at the NHS Confederation on a non-remunerated basis.
3. Samantha Jones held the position of board member at Accurx Ltd during 2024-25.
4. Samantha Jones held the position of Trustee at Alzheimer's Society during 2024-25.
5. Richard Douglas holds the position of Trustee at Place2Be.
6. Alan Milburn holds the position of Chancellor of Lancaster University.

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 DHSC 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.

DHSC occupy space in the NAO headquarters building, through a lease entered into by the Secretary of State for Levelling Up, Housing and Communities on behalf of the Government Property Agency, in order to accommodate the Lampard Inquiry. Whilst this is not a related party transaction, given the role of the NAO, it may be of interest to users of the ARA and has therefore been disclosed for the purposes of transparency. The amount relating to this lease was £222k for 2024-25.

19. Events after the reporting period

Health and Social Care System Reform

On 13 March 2025, the Prime Minister announced NHS England would be brought back into the core department. As announced in the 10 Year Health Plan for England, the abolition of NHS England will be completed within the next two years. As functions transfer to the core department, these will be accounted for as transfers by absorption. As both organisations are already included in the departmental group, there will be no impact on the departmental group consolidated financial statements.

On 3 July 2025, the 10 Year Health Plan for England announced that the Health Services Safety Investigations Body's functions will be transferred to the Care Quality Commission as part of a wider effort to simplify the regulatory landscape. As functions transfer, these will be accounted for as transfers by absorption. As both organisations are already included in the departmental group, there will be no impact on the departmental group consolidated financial statements.

The 10 Year Health Plan set out DHSC's plan for a new model of care, fit for the future. As part of this change in model, significant reforms including the 50% reduction to the combined central organisation, were announced. DHSC will make further disclosures in future Annual Reports and Accounts as specifics are announced.

PPE Medpro

In October 2025 the High Court ordered PPE Medpro to repay £122 million to the government for supplying faulty, non-sterile surgical gowns during the Covid pandemic.

None of the above are adjusting events after the reporting period, and will be reflected in future years.

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 Regulatory 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	Available at companies house
The Nursing and Midwifery Council	The Nursing and Midwifery Council - The Nursing and Midwifery Council (nmc.org.uk)
Wiltshire Health and Care LLP	Available at companies house
Supply Chain Coordination Limited (known as NHS Supply Chain)	Supply Chain Coordination Limited: Home

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 accounts of the entities listed above. 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.

DHSC's registered office is 39 Victoria Street, London, SW1H 0EU.

Annexes: Not subject to audit - presented for further information

Annex A – regulatory reporting – government core tables

The figures in **Core Tables 1** and **2** are from HM Treasury's public expenditure database OSCAR. This is consistent with HM Treasury publications.

Core table 1: public spending

		2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Outturn	2025-26 Plan
Resource DEL							
A	NHS England	25,597,500	23,371,789	14,524,033	27,857,107	32,394,795	39,113,310
B	NHS providers	93,119,985	99,849,097	107,932,134	114,691,376	125,147,653	126,329,200
C	DHSC programme and administration	26,540,107	13,268,380	5,065,263	453,477	447,660	2,259,894
D	Local authorities (public health)	4,205,920	4,217,325	3,195,761	3,301,393	3,425,796	3,607,176
E	Executive agencies	1,480,833	10,181,091	3,737,212	2,629,150	2,110,378	1,165,247
F	Health Education England [1]	1,448,640	1,595,487	1,789,611	-	-	-
G	Special health authorities	2,650,888	2,868,350	2,969,741	3,771,079	3,430,552	3,278,117
H	Non departmental public bodies	723,579	875,334	769,729	203,613	210,490	162,089
I	Arm's length bodies	2,849,887	2,124,627	844,324	855,900	860,870	956,049
J	NHS England financed from National Insurance contributions (non voted)	22,823,176	25,196,757	36,266,858	29,055,511	30,164,029	31,268,364
Total Resource DEL		**181,440,515**	**183,548,237**	**177,094,666**	**182,818,606**	**198,192,223**	**208,139,446**

		2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Outturn	2025-26 Plan
Capital DEL							
A	NHS England	330,577	291,416	238,684	376,068	598,247	394,000
B	NHS providers	7,281,187	6,833,740	7,537,572	7,753,801	7,710,874	9,837,000
C	DHSC programme and administration	4,677,582	1,795,522	1,987,401	2,143,363	2,752,268	2,783,314
D	Local authorities (public health)	-	-	-	-	-	-
E	Executive agencies	21,022	(221,171)	(274,232)	(93,031)	81,638	183,600
F	Health Education England [1]	532	1,119	1,889	-	-	-
G	Special health authorities	47,320	30,623	23,715	24,172	22,735	54,100
H	Non departmental public bodies	156,325	187,746	129,542	20,804	11,287	15,993
I	Arm's length bodies	189,762	200,041	203,379	294,067	294,243	347,570
Total Capital DEL		**12,704,307**	**9,119,036**	**9,847,950**	**10,519,244**	**11,471,292**	**13,615,577**

		2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Outturn	2025-26 Plan
Resource AME							
K	NHS England	86,125	119,445	10,693	(80,093)	(28,442)	250,000
L	NHS providers	1,978,051	1,100,553	962,326	2,158,520	2,260,251	2,500,000
M	DHSC programme and administration	1,997,564	3,115,133	(3,519,936)	(466,781)	(1,733,781)	2,168,800
N	Executive agencies	13,831	269,629	(483,838)	(160,517)	(23,213)	1,000
O	Health Education England [1]	159	596	(856)	-	-	-
P	Special health authorities	(1,266,873)	43,308,197	(58,933,071)	(11,132,970)	1,844,846	5,002,000
Q	Non departmental public bodies	23,207	25,429	16,508	(50,717)	180	2,000
R	Arm's length bodies	49,696	31,745	(23,742)	2,525	68,140	76,200
Total Resource AME		**2,881,760**	**47,970,727**	**(61,971,916)**	**(9,730,033)**	**2,387,981**	**10,000,000**

		2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Outturn	2025-26 Plan
Capital AME							
K	NHS England	-	-	-	(1,237)	241	15,000
L	NHS providers	-	-	16,807	16,843	6,299	20,000
M	DHSC programme and administration	(7,355)	-	2,654	5,060	662,260	230,000
N	Executive agencies	-	-	-	-	1,575	-
O	Health Education England [1]	-	-	-	-	-	-
P	Special health authorities	-	-	-	-	40	-
Q	Non departmental public bodies	-	-	-	-	-	-
R	Arm's length bodies	-	-	868	10,989	(9,929)	-
Total Capital AME		**(7,355)**	**-**	**20,329**	**31,655**	**660,486**	**265,000**

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

	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Outturn	2024-25 Outturn	2025-26 Plan
Administration Budgets						
A NHS England	1,488,859	1,474,998	1,789,448	1,851,566	1,750,184	2,280,380
B NHS providers	-	-	-	-	-	-
C DHSC programme and administration	449,061	522,365	390,591	352,766	432,007	654,072
D Local authorities (public health)	-	-	-	-	-	-
E Executive agencies	51,140	174,753	201,661	169,540	166,489	167,585
F Health Education England (1)	58,970	60,183	60,709	-	-	-
G Special health authorities	192,996	167,127	121,647	112,112	114,973	124,086
H Non departmental public bodies	258,655	280,647	241,300	89,600	94,318	107,396
I Arm's length bodies	(6,850)	(5,461)	3,003	(4,302)	(3,855)	2,002
Total Administration Budget	**2,492,831**	**2,674,612**	**2,808,359**	**2,571,282**	**2,554,116**	**3,335,521**

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 the Performance Report of this Annual Report and Accounts 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 400 health and care organisations and cover a wide range of activities: from front-line treatment of patients, training of medical professionals, public health and social care, through to the running costs of each organisation within the group.

Spending for all government departments is measured against a set of metrics as agreed in HM Treasury's spending review. **Figure 19** provides a breakdown of the consolidated budgets for all bodies in the DHSC group into the main spending metrics.

Figure 19: DHSC group budget – spending metrics

Total Department Expenditure Limit (TDEL)	Total Annually Managed Expenditure (TAME)
£204.9bn	**£7.8bn**
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)
£198.5bn	**£11.6bn**	**£8.8bn**	**£0.8bn**
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 IFRS 16 lease dilapidation provisions expenditure and Infected Blood Inquiry interim compensation payments.

Administration (Admin)
£3.3bn
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) is a spending measure, not formally managed, and consistent with the presentation of spending in HM Treasury publications. It is calculated as the sum of resource departmental expenditure limit (RDEL) plus capital departmental expenditure limit (CDEL) less depreciation.

TDEL spending decreased in 2021-22 and 2022-23 due to the significantly reduced level of COVID-19 spending from the prior year. However, spending increased in 2023-24 and 2024-25, with TDEL outturn now at the highest level since 2020-21.

Table 45 details TDEL spending outturn from 2020-21 to 2024-25.

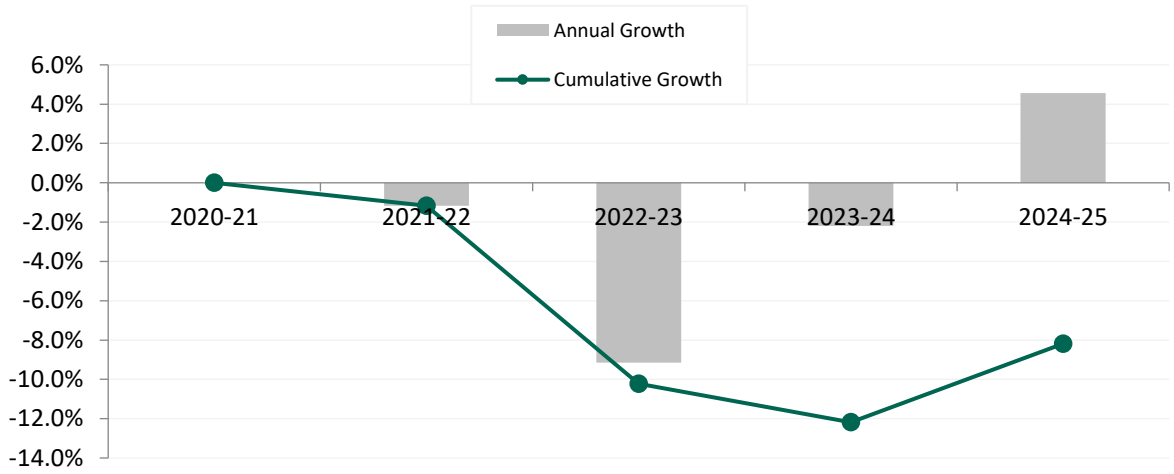
Table 45: Total departmental expenditure limit spending outturn

	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
TDEL spending	**190,610**	**187,274**	**182,131**	**188,614**	**204,710**
Nominal growth (£)		(3,336)	(5,143)	6,483	16,096
Nominal growth (%)		(1.8%)	(2.7%)	3.6%	8.5%

This table has been adjusted to reflect the reclassification of NHS provider depreciation to RDEL RF.

Figure 20 shows TDEL spending in real terms over 2020-21 to 2024-25. In 2024-25 DHSC real-terms annual growth was 4.6% higher than in 2023-24, and cumulative growth was 8.2% lower than in 2020-21

Figure 20: Real terms spending growth



1. Cumulative growth figures are from 2020-21.
2. GDP deflators at March 2025 used to calculate real terms growth.

The changes to TDEL growth results from:

- the funding secured in the SR21
- cumulative real-term decreases in 2020-21 to 2023-24 are mainly as a result of the DHSC group's response to the Covid pandemic, for which the TDEL spending (nominal terms) was £46.2 billion in 2020-21, and reduced over the following years to £36.9 billion in 2021-22 and £12.6 billion in 2022-23
- the TDEL real terms increase in 2024-25 spending is driven by the increase to DHSC's RDEL budget allocated in the Autumn Budget 2024

The 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)	198,491	198,192	299
of which: resource administration	3,266	2,554	712
Capital departmental expenditure limit (CDEL)	11,644	11,471	173
Resource annually managed expenditure (RAME)	8,780	2,388	6,392
Capital annually managed expenditure (CAME)	813	660	153
Net cash requirement	180,026	176,288	3,739
Further HM Treasury controls:			
Ringfenced resource DEL	5,190	4,954	236
Non-ringfenced resource DEL	193,301	193,238	62

The following narrative, with commentary and supporting tables, provides an explanation of the financial performance of the system, including financial outturn against the department's own spending controls.

Resource departmental expenditure limit (RDEL)

The DHSC's total 2024-25 resource departmental expenditure limit (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 core 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 2024-25, National Insurance contributions receipts of £30.1 billion were in line with the non-voted funding set out in the Parliamentary estimate.

Table 47 summarises the RDEL outturn against budget since 2020-21; highlighting the £0.3 billion, 0.2% total RDEL underspend in 2024-25.

Table 47: Resource DEL

	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
RDEL budget	201,996	186,895	176,148	183,861	198,491
RDEL spending outturn	**181,441**	**183,548**	**177,095**	**182,819**	**198,192**
Underspends /(overspends) (£m)	*20,556*	*3,347*	*(946)*	*1,043*	*299*
Underspends /(overspends) (%)	*10.2%*	*1.8%*	*(0.5%)*	*0.6%*	*0.2%*

RDEL: Funding flows and sector breakdown

Of the DHSC's total £198.5 billion 2024-25 RDEL budget, £191.6 billion was allocated directly to NHS commissioners, with the remaining £6.9 billion funding allocated to ALBs and the DHSC'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 intra-group trading needs to be eliminated on consolidation when preparing the departmental group account (via an 'Agreement of Balances' exercise).

Approximately £125.4 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 2024-25 the DHSC group received around £14.1 billion of RDEL income from varying sources. This was mainly received by NHS providers and included prescribing and dental charges, income from trading with local authorities and 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)	186,838	186,894	(56)
Non-NHS RDEL (excl. depreciation)	6,463	6,344	119
DHSC group RDEL (excl. depreciation)	**193,301**	**193,238**	**62**
NHS RDEL (depreciation)	4,781	4,704	77
Non-NHS (depreciation)	410	250	159
DHSC group RDEL (incl. depreciation)	**198,491**	**198,182**	**299**

Table may not sum due to roundings.

As set out in DHSC group financial performance section (page 93), the DHSC underspent against the RDEL by circa £0.3 billion. The net underspend mainly comprised:

- **RDEL non-ringfenced**: DHSC underspent the available RDEL non-ringfenced funding by circa £0.1 billion (0.03% of the budget). Further details of the NHS and non-NHS performance is set out below.

- **RDEL ringfenced**: DHSC underspent the available RDEL budget ringfenced for depreciation and impairments by circa £0.2 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 2024-25.

The Financial Directions to the Government's revised NHS mandate for 2024-25 separately sets out the resource and capital funding limits against spending controls for the NHS. These spending controls stem from the same controls that HM Treasury apply to the 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
NHS England central	39,321	329
Integrated care boards	150,872	-
Net NHS England group outturn	**190,193**	**329**
NHS trusts and foundation trusts	(3,299)	4,375
Net NHS outturn as per SOPS	**186,894**	**4,704**
Budgets as per 2024-25 financial directions	**186,838**	**4,781**
Under/ (overspend)	**(56)**	**77**

The RDEL non-ringfenced budget of circa £186.8 billion is used to fund the costs of healthcare services delivered in England. In 2024-25, the NHS have ended the year with a small overspend against the RDEL non-ringfence budget.

The majority of the NHS RDEL budget is allocated to integrated care boards (ICBs), who together with their partners in integrated care systems (ICS) will use that to fund healthcare services in their respective local areas. In 2024-25, ICBs and NHS providers, collectively as 'NHS systems', reported a year-end overspend of circa £0.6 billion. This overspend was offset by underspends on other NHS England centrally managed budgets, but these pressures were not fully mitigated, resulting in the small overspend reported above. **Table 50** provides a further breakdown of the NHS' outturn by sector.

Table 50: Breakdown of NHS spending outturn against revenue DEL budget, excluding depreciation and impairments[1]

	Plan	Outturn	Under/ (Overspend)
NHS England central	39,946	39,321	625
NHS systems (ICBs+NHS providers)	151,044	151,648	(604)
Classification adjustments	(4,152)	(4,075)	(77)
Net NHS outturn as per SOPS	**186,838**	**186,894**	**(56)**

1. As per 2024-25 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)	**190,990**	**190,195**	**796**
Of which,			
Elective recovery (ringfenced within 6A.1)	5,370	5,370	-
Individual placement support (ringfenced within 6A.1)	20	20	-
NHS England administration limit	1,979	1,684	295
Revenue departmental expenditure limit (depreciation and impairments)	**393**	**329**	**64**

1. As per 2024-25 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		150,872	
NHS providers' adjusted financial performance		776	
Total adjusted financial performance	**151,044**	**151,648**	**(604)**

	Plan	Outturn	*Variance*
Number of NHS systems in balance	42	4	(38)
Number of NHS systems in surplus	-	21	21
Number of NHS systems in deficit	-	17	(17)

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

The DHSC group's non-NHS sector contained resource expenditure within DEL spending limits. The non-NHS sector is the core department and it's non-NHS ALBs.

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 2024-25

	Plan £m	Outturn £m	Under/ (Overspend) £m
Non-NHS RDEL (excl. depreciation) -			
UK Health Security Agency	2,108	1,890	218
Other ALBs	562	472	90
Public health local authority grants	3,426	3,426	-
Voluntary scheme for branded medicines pricing and access	(2,076)	(2,109)	33
Public dividend capital (PDC) payments and loan interest	(1,210)	(1,241)	31
European Economic Area (EEA) medical costs	847	848	(1)
Adult social care	225	224	1
Other DHSC central budgets	2,581	2,818	(237)
NHS charities	-	16	(16)
Total non-NHS RDEL (excl. depreciation)	**6,463**	**6,344**	**119**
Non-NHS (depreciation)	410	250	159
Non-NHS RDEL (incl. depreciation)	**6,872**	**6,594**	**278**

Excluding depreciation, the non-NHS sector's RDEL outturn was around £0.1 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

There was a £0.2 billion overall underspend in UK Health Security Agency (UKHSA). The Covid vaccine unit at UKHSA has been responsible for purchasing COVID-19 vaccines since October 2022. The demand for vaccines is influenced by policy decisions based on recommendations from the Joint Committee on Vaccination and Immunisation (JCVI). As a result, there was an underspend in the 2024-25 compared to the spending review budget allocation. Additionally, there was an underspend due to the timing of the write-off of potentially unrecoverable debt, which did not take place in 2024-25.

Other ALBs

The £0.1 billion underspend is mainly driven by underspends in NHS Resolution, NHS Business Services Authority and Community Health Partnerships Ltd., alongside other variances across the ALB sector.

Other DHSC central budgets

The £0.2 billion variance is a result of managing pressures in the overall group position, mainly NHS pay and GP industrial action.

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 £3.3 billion the DHSC group underspent by £0.7 billion, and this mainly comprised:

- circa £0.2 billion underspend on depreciation and impairments
- circa £0.5 billion underspend RDEL excluding depreciation and impairments

Table 54 shows the DHSC group administration outturn (excluding depreciation and impairments) between 2020-21 and 2024-25.

Table 54: DHSC Administration

	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
Administration outturn	2,405	2,575	2,665	2,428	2,374

Figures do not include depreciation and as a result will not directly reconcile to the admin outturn in the statement of outturn against parliamentary supply £2.6 billion.

Spending on administration reduced in 2024-25 by circa £0.1 billion compared to 2023-24, mainly driven by a reduction in NHS England administration expenditure.

Capital departmental expenditure limit (CDEL)

£11.5bn CDEL spend

The DHSC group's total 2024-25 CDEL outturn is the consolidated net capital spending of all bodies within the departmental group.

Table 55 summarises the CDEL outturn against budget since 2020-21, highlighting the £0.2 billion (1.5%) underspend in 2024-25.

Table 55: Capital DEL

	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
CDEL budget	12,918	10,447	11,193	10,989	11,644
CDEL spending outturn, of which:	**12,704**	**9,119**	**9,848**	**10,519**	**11,471**
CDEL underspend	214	1,328	1,345	470	173
CDEL underspend %	1.7%	12.7%	12.0%	4.3%	1.5%

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	7,797	7,653	144
Non-NHS capital DEL	2,937	3,097	(161)
Sub-total (excluding IFRS 16)	**10,734**	**10,750**	**(17)**
IFRS 16 (NHS)	901	879	22
IFRS 16 (non-NHS and group)	10	(158)	168
Sub-total (IFRS 16)	**911**	**721**	**190**
Total CDEL	**11,644**	**11,471**	**173**

As set out in performance summary, DHSC underspent the capital departmental expenditure limit (CDEL) by circa £0.2 billion. This was mainly due to:

- **IFRS 16:** the DHSC has followed the accounting standard for leases since 2022-23. Additional capital funding was secured for its impact, however the associated capital costs in 2024-25 were around £0.2 billion lower than expected

- **Other capital:** net overspends of circa £0.02 billion occurred across a range of capital budgets, the details of which are on pages 333 and 339.

CDEL NHS: financial performance capital DEL spending

Summary

The summarised CDEL outturn compared to plan for key elements of the NHS sector is shown in **Table 57**.

Table 57: NHS capital DEL

	Budget £m	Outturn £m	Under/ (overspend) £m
NHS providers business as usual activities	7,189	7,077	112
NHS England business as usual activities	608	576	32
NHS providers IFRS 16	883	846	37
NHS England IFRS 16	18	33	(15)
TOTAL NHS CDEL, of which:	**8,697**	**8,532**	**166**
NHS providers		7,923	
NHS England		609	

NHS providers

NHS provider CDEL expenditure was £7.9 billion in 2024-25 (exclusive of net capital investment of NHS charities and inclusive of IFRS 16 spend). This is broadly similar to the equivalent net investment in 2023-24 (£8.0 billion). Capital budgets are allocated to NHS providers via operational capital and various national programmes. The NHS provider capital outturn is detailed in **Table 58** below.

Table 58: NHS provider capital DEL

	2024-25 £m
Capital DEL outturn [1]	**7,923**
Of which	
Operational capital expenditure [2]	3,748
National programmes	3,117
IFRS 16	846
PFI residual interest [3]	212

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 2024-25 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.

As in previous years, 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

	2024-25 £m
New hospital programme/upgrades	852
Diagnostics	644
NHS technology and digital	393
Reinforced autoclaved aerated concrete	339
Elective recovery fund	255
Critical infrastructure risk	133
Additional capacity targeted investment fund	125
ICB additional targeted capital schemes	116
National energy efficiency fund	94
Mental health capacity and safety	92
Eradicating mental health dormitories	72
Other strategic investment	2
NHS providers national PDC total	**3,117**

New hospital programme

The New Hospital Programme (NHP) was established in October 2020, having been set up to address the crumbling, outdated hospital estate. The NHP represents a reinvesting in the estate with the overall aim to transform how health infrastructure is delivered for the future of the NHS, and its staff and patients.

In January 2025, the government announced the NHP Plan for Implementation, which includes a new, costed plan and timeline. The plan sets out that the Programme will be delivered through waves of investment, which will increase to up to £15 billion over each consecutive five-year wave, averaging around £3 billion a year from 2030. The exact profile of funding will be confirmed in rolling five-year waves at regular Spending Reviews and will ensure there is always a balanced portfolio of schemes at different development stages being delivered. By the end of the financial year 2024-25, seven hospitals schemes are completed and open to patients. The NHP Plan for Implementation sets out that the NHP comprises of four wave groups. Each wave comprises a group of new hospital schemes that will commence main construction within that period but may complete after then. Wave 1 includes seven hospitals built wholly or primarily from reinforced autoclaved aerated concrete (RAAC), which are being prioritised to protect patient and staff safety.

The NHP is working with trusts and industry, using a national programmatic approach that will deliver hospitals more efficiently and cost effectively, whilst recognising the individual needs and circumstances of each hospital scheme. The programme is standardising the design and delivery of hospitals through its Hospital 2.0 approach, which will enable simultaneous and industrialised hospital construction. This will mean hospitals can be built more quickly and will result in facilities at the cutting edge of modern technology, innovation, sustainability, and excellent patient care.

Hospital upgrades

As part of the Spending Review 2020, DHSC received £1.7 billion for over 70 hospital upgrades, continuing a programme of investment that had previously been announced. These investments are helping to modernise and transform the NHS's 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. This funding has been 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.

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). There are 169 CDC sites operational as of March 2025. CDCs increase diagnostic capacity, supporting faster, earlier diagnosis and reduced waiting times for better patient outcomes.

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.

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 2024-25 for NHS technology programmes totalled £393 million. 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.

Reinforced autoclaved aerated concrete

£339 million was issued 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.

Elective recovery

The £1.5 billion targeted investment fund 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 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.

Critical infrastructure risk

£133 million of funding was issued to NHS providers to address the most severe categories of backlog maintenance classified as Critical Infrastructure Risks (CIR) across

the NHS estate, as defined in the Estates Returns Information Collection (ERIC) 2023-24.

The funding was used to establish three multi-year projects at East Kent, Doncaster, and Lynfield Mount, as well as a range of in-year schemes to address critical infrastructure risks across various NHS estate, improving safety and reducing risks of service disruption. These projects targeted urgent estate risks.

Urgent and emergency care additional capacity targeted investment

This funding supports the NHS to bolster emergency department infrastructure and capacity; to support alternatives to A&E attendance and enable flow across acute and mental health settings. Schemes included those that helped non-admitted and admitted pathways flow ensuring patients are triaged and directed to the right service as quickly as possible through establishing urgent treatment centres. As well as expanding same day emergency care services, reconfiguring streaming, redirection pathways and assessment unit services.

ICB additional targeted capital schemes

£116 million of additional targeted capital was allocated to ICBs to support efficiencies, and the delivery of core performance targets across the healthcare system.

The funding supported a range of initiatives such as ambient voice technology, the refurbishment of operating theatres, supporting increases in ward capacity, and the replacement of outdated medical equipment to improve reliability and service quality.

National energy efficiency fund

The national energy efficiency fund invested £94 million in NHS capital schemes that reduced trust energy consumption and costs, with associated benefits in reducing carbon emissions. There were three eligible technologies selected; LED lighting, solar photovoltaic systems (and/or solar battery storage), and building management systems (BMS). This total investment included funding from the Department for Energy Security and Net Zero.

Mental health

More than £400 million was 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 SR21 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 240 schemes such as crisis cafes, crisis houses and crisis hubs. Stepdown 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.

CDEL non-NHS: financial performance capital DEL spending

Outside of the NHS sector, the DHSC's non-NHS sector capital expenditure was around £7 million 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 2024-25 non-NHS

Non-NHS Capital DEL	Plan	Outturn	Under/ (Overspend)
	£m	£m	£m
UK Health Security Agency	53	52	1
Other ALBs	414	382	32
Research and development	1,937	1,938	(1)
Disabled facilities grant	711	711	-
Core IFRS 16	110	21	89
Other DHSC central budgets	(278)	(147)	(131)
NHS charities	-	(17)	17
Total non-NHS CDEL	**2,947**	**2,940**	**7**

Details of the main components of the underspend are set out below.

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.

Other DHSC central budgets

To ensure adherence to the fiscal rules set in the Autumn Budget 2024 and HMT's consolidated budgeting guidance regarding capital to revenue switches, CDEL underspends identified in the year were not switched to the RDEL budget. To utilise NHS underspends, a decision was made to accelerate spend in various programmes including disabled facilities grant and research and development, resulting in a £0.1 billion overspend in other DHSC central budgets.

Annually managed expenditure (AME)

Details of the DHSC group's total 2024-25 AME budget and expenditure are set out in **Table 61**, which shows the group underspent by £6.4 billion against its final resource AME budget, and £0.2 billion against its capital AME budget.

£3.0bn AME outturn

Table 61: Annually managed expenditure

	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
Resource AME Budget	10,002	49,000	(35,957)	(2,272)	8,780
RAME Outturn	**2,882**	**47,971**	**(61,972)**	**(9,730)**	**2,388**
Underspend/(Overspend) £m	7,120	1,029	26,015	7,458	6,392
Underspend/(Overspend) %	71.2%	2.1%	(72.3%)	(328.3%)	72.8%
Capital AME Budget	15	15	106	106	813
Capital AME Outturn	**(7)**	**-**	**20**	**32**	**660**
Underspend/(Overspend) £m	22	15	85	74	153
Underspend/(Overspend) %	149.0%	100.0%	80.7%	70.0%	18.8%

The DHSC group's AME provision (resource and capital) is set annually outside of the spending review. 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 2024-25 was set at £8.8 billion and included a £2.1 billion decrease to budget in the 2024-25 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 resource AME (RAME) £2.4 billion outturn and resultant £6.4 billion underspend are due to:

- NHS Resolution's (NHSR) AME outturn of £1.4 billion was £3.2 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 DHSC RAME was reduced due to the derecognition of a provision relating to the infected blood inquiry. The government has confirmed that the Infected Blood Support Schemes (IBSS) will remain open prior to the Infected Blood

Compensation Authority (IBCA) taking responsibility for making Support Scheme payments as part of the Infected Blood Compensation Scheme. A £1.4 billion provision was recognised in IBCA's 2024-25 Annual Report and Accounts to reflect the support scheme payments that it is expecting to make following this transfer of responsibility for IBSS, and has therefore been derecognised from the DHSC Annual Report and Accounts. This was done to avoid duplication across government, resulting in a reduction in DHSC RAME.

- The non-NHS sector's AME outturn, comprising net provisions movement; and impairments expenditure was around £1.4 billion lower than anticipated when setting the final budget

DHSC's capital AME expenditure has included specific budgeting relating to IFRS 16, the accounting standard for leases, since its implementation in 2022-23. 2024-25 capital AME budgets and outturn also include infected blood inquiry interim compensation payments, relating to payments for infected blood support schemes, announced by the government on 21 May 2024.

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** sets out the NHS outturn for 2019-20 to 2024-25, and planned NHS spend for 2025-26 to 2028-29, as per the Spending Review (SR) 2025.

Table 62: NHS outturn versus budget – timeseries

	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	2027-28 £m	2028-29 £m
(a) NHS RDEL (excl depreciation), of which:	**126,442**	**146,018**	**152,317**	**160,939**	**171,271**	**186,894**	**195,593**	**204,905**	**215,386**	**226,131**
Spending Outturn as per SOPS[1,3]	126,442	146,018	152,317	160,939	171,271	186,894				
Planned spending as per SR25[2]							195,593	204,905	215,386	226,131
(b) NHSE CDEL, of which:	**371**	**411**	**394**	**384**	**388**	**609**	**394**	-	-	-
Spending Outturn as per SOPS[1,4]	371	411	394	384	388	609				
Planned spending as per SR25[2]							394			
NHS TDEL (a+b)	**126,813**	**146,429**	**152,711**	**161,323**	**171,659**	**187,503**	**195,987**	**N/A**	**N/A**	**N/A**

1. 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.
2. Full details of budgets and planned spending can be found in the government's financial directions to the NHS.
3. Table 49 of the DHSC Annual Report and Accounts 2024-25
4. Table 57 of the DHSC Annual Report and Accounts 2024-25

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	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
Gross Deficit	1,560	158	126	1,001	1,606	1,094
Gross Surplus	(567)	(363)	(442)	(299)	(305)	(318)
Reporting Adjustment	(323)	(450)	(240)	(252)	12	(0)
NHS providers - adjusted financial performance	**670**	**(655)**	**(556)**	**450**	**1,312**	**776**
Plus additional RDEL adjustment	338	(77)	(39)	528	69	293
Depreciation classification adjustment	(2,043)	(2,341)	(2,641)	(3,293)	(3,874)	(4,368)
Net NHS providers RDEL NRF	**(1,035)**	**(3,073)**	**(3,236)**	**(2,315)**	**(2,492)**	**(3,299)**

Table 64 provides a timeseries of the aggregate surplus/deficit position across NHS systems (ICBs and NHS providers). 2022-23 was the first year that commissioners and providers work together as ICS to manage to an agreed financial plan and therefore prior year comparators are not available.

Table 64: ICS financial performance – timeseries

NHS systems financial performance - timeseries	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
Integrated care boards/clinical commissioning groups				119,088	133,632	150,872
NHS providers adjusted financial performance				450	1,312	776
NHS providers reporting adjustments				252	-	-
Net outturn				**119,790**	**134,944**	**151,648**
Plan				**119,273**	**133,566**	**151,044**
Under /(overspend)				**(517)**	**(1,378)**	**(604)**

Purchase of healthcare from non-NHS providers

Most healthcare services are purchased from NHS providers (NHS trusts and foundation trusts); however, £20.4 billion of these types of services were purchased from non-NHS healthcare providers in 2024-25. These non-NHS providers include local authorities, voluntary sector/not for profit organisations, devolved administrations and private sector providers. **Table 65** provides data between 2019-20 and 2024-25.

Table 65: NHS England's purchase of healthcare from non-NHS providers

Purchase of healthcare from non-NHS providers	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
Independent sector providers	9,692	12,139	10,854	11,015	12,357	14,136
Voluntary sector / not for profit	1,705	1,866	1,791	1,734	1,841	1,992
Local authorities	2,984	4,312	4,318	3,805	3,825	4,141
Devolved administrations	49	36	48	59	56	63
Other group bodies	-	31	35	28	27	31
Sub-total	**14,430**	**18,384**	**17,046**	**16,640**	**18,108**	**20,363**
Total DHSC RDEL	**134,183**	**181,441**	**183,548**	**177,095**	**182,819**	**198,192**
Spend with private sector as a % of total RDEL	7%	7%	6%	6%	7%	7%
Spend on all non-NHS bodies as a % of total RDEL	11%	10%	9%	9%	10%	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)

The table below discloses ALB income and expenditure figures alongside detail pertaining to staff costs and numbers. The table reflects the data reported to DHSC and included within these consolidated financial statements and does not include any central adjustments, the results of NHS charities or intragroup eliminations.

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	(3,339,219)	205,374,020	202,033,316	3,429	264,038	220	16,937
UK Health Security Agency	(330,061)	2,307,980	1,977,919	5,237	374,534	532	53,908
Medicines and Healthcare products Regulatory Agency	(158,579)	202,151	43,572	1,238	105,638	173	2,468
NHS England group	(6,397,757)	197,104,290	190,707,573	37,771	3,099,466	8,133	569,100
NHS providers	(141,578,353)	144,685,334	3,109,227	1,355,534	86,790,620	134,034	6,781,182
Care Quality Commission	(230,672)	289,243	58,571	3,241	197,912	45	24,031
National Institute for Health and Care Excellence	(27,983)	86,191	58,208	774	60,885	6	520
Human Fertilisation and Embryology Authority	(7,098)	7,265	167	79	5,467	2	183
Human Tissue Authority	(5,454)	5,935	481	57	4,297	1	69
Health Research Authority	(405)	20,256	19,851	245	16,300	1	84
Health Services Safety Investigations Body	(237)	6,057	5,820	52	4,686	1	91
NHS Counter Fraud Authority	(285)	19,311	19,026	201	13,826	6	429
NHS Business Services Authority	(742,153)	989,446	247,293	4,470	203,515	157	7,005
NHS Resolution	(2,929,613)	5,051,720	2,122,107	765	57,413	12	983
NHS Property Services Ltd	(824,149)	938,011	113,862	5,407	188,798	923	6,580
Community Health Partnerships Ltd	(558,228)	611,865	53,637	246	17,305	24	1,200
Genomics England Ltd	(30,441)	144,568	114,127	540	51,262	21	970
Skipton Fund Ltd	(264)	264	-	-	-	-	-
Nursing & Midwifery Council	(108,669)	130,629	21,960	1,173	68,191	78	3,673
Health & Care Professions Council	(43,610)	39,948	(3,662)	308	16,337	33	889
Wiltshire Health and Care LLP	(78,014)	77,987	(27)	1,086	54,537	106	6,211
Professional Standards Authority for Health and Social Care	(6,070)	6,119	49	48	4,013	1	92

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	28,813	94,211	(65,398)
2	The Clinical Negligence Scheme for Coronavirus	16,460	5,217	11,243
3	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.	-	-	-
4	DHSC holds a contingent liability for the provision of life assurance cover for individuals transferred to DHSC.	400	1,147	(747)
5	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 DHSC.	3,200	3,200	-
6	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 DHSC.	14,900	14,925	(25)

7	The core department holds a contingent liability for compensation payments due to individuals unable to be traced.	400	400	-
8	The core department holds a contractual liability for redundancy payments.	500	519	(19)
9	NHS Resolution non-clinical contingent liabilities	226,900	219,177	7,723
10	Legal cases – DHSC as defendant	-	N/A[1]	N/A
11	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[1]	N/A
12	Legal cases – DHSC as claimant	-	N/A[1]	N/A
13	NHS Providers at 31 March 2025 had net contingent liabilities	113,000	126,806	(13,806)
14	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	24,554	25,017,864	(24,993,310)
15	The core department has issued an indemnity in relation to the operations of the Human Fertilisation and Embryology Authority (HFEA).	1,500	1,500	-
16	The core department is involved in a number of Employment Tribunal cases.	-	N/A[1]	N/A
17	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[1]	N/A

1. 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 14 and is due to the incorrect factor being used in the Supplementary Estimate, which will be corrected for 2025-26 during the Supplementary Estimate process.

The value for the items 10,11,12,16 and 17 have not been disclosed due to the sensitive nature of the contingent liabilities. 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 its expert advisory committees: a. Advisory Committee on Dangerous Pathogens (ACDP) (and their associated Working Groups);	Yes	Yes	N/A

	b. Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI); c. New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG); d. The Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO).			
5	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
6	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
7	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).	Yes	Yes	N/A
8	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
9	UK Health Security Agency maintains a stockpile of medical countermeasures for responding to Chemical, Biological,	Yes	Yes	N/A

	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.			
10	The core department holds a contingent liability relating to contracts signed between His Majesty's Government and Pfizer/BioNTech for their COVID-19 vaccine.	Yes	Yes	N/A
11	The core department holds a contingent liability relating to the contracts signed between His Majesty's Government and Moderna for their COVID-19 vaccine.	Yes	Yes	N/A
12	The core department holds a contingent liability relating to the two contracts signed between His 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
13	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
14	The core department has issued an indemnity in respect of a DHSC established statutory, independent inquiry into the care and treatment pathways and the circumstances and practices surrounding the deaths of mental health inpatients in Essex.	Yes	Yes	N/A

15	The core department holds an indemnity in relation to the Mpox vaccine.	Yes	Yes	N/A
16	The core department entered into contracts for the supply of PPE during the Covid pandemic, which were found to be not suitable. Legal proceedings have been initiated against DHSC for the balance of the contract and damages.	Yes	No	See below
17	Legal cases – DHSC as defendant.	No	Yes	See below
18	The core department holds an obligation to indemnify reasonable capital and operating costs incurred by the following water companies that fluoridate water in England: • Anglian Water • Northumbrian Water • Severn Trent Water • South Staffs Water • United Utilities	No	Yes	See below
19	NHS Property Services has an unquantifiable contingent liability regarding its ability to claim capital allowances on inherited assets.	Yes	Yes	N/A
20	UKHSA holds contingent liabilities relating to contract disputes, primarily relating to contracts let in response to the Covid pandemic.	Yes	Yes	N/A
21	UKHSA holds unquantifiable contingent liabilities in relation to potential remedial works relating to radiological contamination at its radiological scientific sites at the end of their lifespans.	No	Yes	See below

22	The Nursing and Midwifery Council has an unquantifiable contingent liability for potential additional liabilities following the High Court's ruling on the Virgin Media pension scheme.	No	Yes	See below

Items 17, 21 and 22 are part of the normal course of business and therefore not subject to Parliamentary approval. Item 18 was not included in the supplementary supply estimate, as DHSC was not aware of this obligation at the time of agreement of the estimate. Item 16 has expired and therefore is not disclosed in the ARA.

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