Presented pursuant to the Government Resources and Accounts Act 2000 c.20, s.6.

Department of Health

Resource Accounts 2007-08

(For the year ended 31 March 2008)

Ordered by the House of Commons to be printed 9 October 2008

LONDON: The Stationery Office
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Contents

ANNUAL REPORT

SCOPE

Departmental Boundary

1.1 These accounts consolidate the financial information of organisations within the Department of Health Departmental Accounting Boundary.

1.2 The Departmental Boundary is different from the concept of the group in the commercial sector as it is based on in-year budgetary control rather than strategic control. For the Department of Health those organisations within the boundary are the Department itself and a number of bodies from the NHS in England: the NHS Purchasing and Supply Agency, those Special Health Authorities not funded by trading activities, Strategic Health Authorities and Primary Care Trusts.

1.3 A wide range of organisations lie outside the Departmental boundary but form part of the Departmental Group. These include NHS Trusts, NHS Foundation Trusts, Non-Departmental Public Bodies and those Special Health Authorities that receive their funding direct from trading activities. Note 37 provides a comprehensive list of all the organisations within the Departmental Group showing those inside and those outside the Departmental boundary.

2 Pension Liabilities

2.1 The transactions and balances of the NHS Pension Scheme are not consolidated in these accounts. The report and accounts of the NHS Pension Scheme are prepared separately; further information is available on the website: www.pensions.nhsbsa.nhs.uk.

2.2 The Department's share of the transactions and balances of the pension scheme which its employees belong to, i.e. the Principal Civil Service Pension Scheme, is also not consolidated in these accounts; separate accounts are prepared for the scheme and details can be found on the following website: www.civilservice-pensions.gov.uk/facts_and_figures.aspx

3 Financial Statements and Reporting Cycle

3.1 These accounts cover the period 1 April 2007 to 31 March 2008. They have been prepared in accordance with a direction issued by Her Majesty's Treasury (HMT) under section 7 of the Government Resources and Accounts Act 2000. A copy of this direction is available online, by accessing the HMT website at www.hm-treasury.gov.uk. All financial statements presented in these accounts are audited by the Comptroller and Auditor General (C&AG). The primary financial statements that make up the accounts are:

- a **"Statement of Parliamentary Supply"**. This is the prime Parliamentary accountability statement. It provides a comparison of resource outturn against the Supply Estimate voted by Parliament for each Request for Resources (RfR); a summary of the cash required to finance expenditure and; a summary of income both appropriated in aid of expenditure and surrendered to the Consolidated Fund.
- an **"Operating Cost Statement"**. This shows resources consumed by organisations within the Departmental boundary during the year by Request for Resources comprising administration and programme expenditure net of income.
- a **"Balance Sheet"**. This shows the assets, liabilities and taxpayers' equity of organisations within the Departmental boundary at the beginning and end of the year.
- a **"Cash Flow"** statement. This shows how cash has been used during the year for operating activities, capital expenditure and financing.
- a "**Consolidated Statement of Operating Costs by Departmental Aims and Objectives**". This shows expenditure allocated to the Department's agreed objectives.

3.2 These statements and the notes that support them have been prepared in accordance with the Government Financial Reporting Manual for 2007-08 (FReM).

3.3 There are no prior period adjustments to the opening balances of these accounts.

3.4 The Resource Accounts are one of a series of documents published each year by the Department and HM Treasury that account to Parliament and the public for the Department's performance and use of resources. The other key documents published as part of the annual reporting cycle are:

- **Departmental Report:** The most recent report was presented to Parliament in May 2008. It provides a comprehensive overview of spending and investment programmes and of the reforms accompanying this investment. The Departmental Report can be found on the Department of Health website www.dh.gov.uk
- **Estimates:** The Estimates are the Government's requests for resources from Parliament and are presented annually on the following cycle:
  - Main Supply Estimates start the supply procedure and are presented at the beginning of the financial year to which they relate;
  - Winter Supplementary Estimates are presented in November, and reflect changes to Supply, and the funds that are required by the Department, that have been identified during the year; and
  - Spring Supplementary Estimates are presented in February, and represent the final changes required by the Department.

  Supply Estimates are presented by HM Treasury and can be found on their website www.hm-treasury.gov.uk
- **Autumn Performance Report:** Following on from the Departmental Report, the Autumn Performance Report is usually published in November/December and provides a further update to the progress against the Public Service Agreement targets that are set out in Annex B of the Departmental Report. Publication dates are agreed with HM Treasury. This can again be found on the Department's website www.dh.gov.uk
- **Public Expenditure Outturn White Paper:** This is published by HM Treasury in July. For each Department this shows provisional expenditure against the Departmental Expenditure Limits and the Administrative Cost Limit which covers Departmental running costs. This is used to determine the level of underspend which can be carried forward for spending in the current or future years. The White Paper can be found on the HM Treasury website www.hm-treasury.gov.uk

4 Financial Results

4.1 These Accounts show how the Department's activities were funded and its resources deployed. In summary:

- the Department met each of its financial duties, managing within the resources voted by Parliament and the spending limits set by HM Treasury.

The financial results below are provided on a resource accounting boundary basis and a budgeting boundary basis. The definition of these are as follows:

Resource Accounting Boundary

The resource accounting boundary includes: the Department itself, the NHS Purchasing and Supply Agency, those Special Health Authorities not funded by trading activities, Strategic Health Authorities and Primary Care Trusts.

Budgeting Boundary

The budgeting boundary includes the bodies in the resource accounting boundary, plus: NHS Trusts, NHS Foundation Trusts, Non-Departmental Public Bodies and those Special Health Authorities that receive their funding direct from trading activities.

Note 37 provides a comprehensive list of all the organisations within the Departmental Group showing those inside and those outside the Departmental boundary.

Revenue

Revenue expenditure within the resource accounting boundary:

- Net revenue expenditure by organisations within the resource accounting boundary totalled £72,568 million, an increase of £7,967 million or 12.3% compared with 2006-07. This compared with provision for the year of £73,842 million, an underspend of £1,274 million or 1.7%.
- NHS expenditure growth was around 9% - in line with the growth in allocations. Central expenditure growth was around 14% mainly due to increases in clinical negligence provisions (largely due to a recent court ruling on the level of indexation applied in calculating settlements and revised actuarial

assessments) and European Economic Area provisions (due to foreign exchange differences). The overall underspend against provision is largely explained by the surplus in PCTs and SHAs.

Revenue expenditure within the budgeting boundary:

- Net revenue expenditure within the budgeting boundary totalled £88,259 million an increase of £7,544 million or 9.3% compared with 2006-07. This compared with provision for the year of £89,536 million, an underspend of £1,277 million or 1.4%.

Department of Health Administration

- Net expenditure on total Departmental administration was £236 million compared with £240 million in 2006-07 a decrease of 1.8%. This compared with provision for the year of £242 million, an underspend of £6 million or 2.5%
- Net expenditure on Departmental Administration Cost Limit (ACL) was £226 million, compared with provision of £231 million, an underspend of £5 million or 2.2%.

Capital

Capital expenditure within the resource accounting boundary:

- Net capital expenditure by organisations within the resource accounting boundary totalled £1,007 million a decrease of £1,256 million or 55.5% compared with 2006-07. This compares with a provision for the year of £2,121 million, an underspend of £1,114 million or 52.5%.
- The main reason for the large capital underspend in the Resource Account is due to lower than planned investment in Trusts. This can be explained by the availability of internal cash e.g., from the improved revenue position, early repayments of the working capital loans provided in 2006-07 and some capital slippage. The decrease in capital expenditure within the Resource Account compared to 2006-07 is primarily due to the one off injection of working capital loans to some NHS Trusts in 2006-07.

Capital expenditure within the budgeting boundary

- Net capital expenditure within the budgeting boundary totalled £3,833 million an increase of £839 million or 28.0% compared with 2006-07. This compared with provision for the year of £4,320 million, an underspend of £487 million or 11.3%.
- Net Assets Employed reduced by £2.1bn during the year. The main reason for this was a £3bn increase in provisions for clinical negligence offset by £1.1bn increase in fixed assets.

4.2 Within the public spending framework, subject to HM Treasury agreement, underspends are carried forward for utilisation in future years.

5 Management and Governance of the Department

5.1 The Department is headed by a team of Ministers, supported by officials, the most senior being: the Permanent Secretary, the NHS Chief Executive and the Chief Medical Officer.

5.2 The Permanent Secretary, Hugh Taylor, is also the Principal Accounting Officer for the Department. He is responsible for leading the Department as a whole to make sure it operates effectively, that Ministers get the advice and support they need, and that there is effective cross-government working. The NHS Chief Executive, David Nicholson, is Additional Accounting Officer for Request for Resources (RfR) 1. He is responsible for leading the NHS and is chief adviser to the Secretary of State on the NHS. The Chief Medical Officer Sir Liam Donaldson is the chief professional adviser to Ministers and across Government on medical and public health issues.

Ministers

5.3 The following Ministers were responsible for the Department in 2007-08:

- Secretaries of State for Health with overall responsibility for the work of the Department:
  - Rt Hon Patricia Hewitt MP, to 28 June 2007

- Rt Hon Alan Johnson MP, from 29 June 2007

- Ministers of State with responsibilities for the NHS and Social Care, including long term care, disability and mental health:
  - Ben Bradshaw MP, Minister of State, from 30 June 2007
  - Andy Burnham MP, Minister of State, to 29 June 2007
  - Caroline Flint MP, Minister of State, to 29 June 2007
  - Lord Phillip Hunt, Minister of State, to 29 June 2007
  - Rt Hon Dawn Primarolo MP, Minister of State, from 30 June 2007
  - Rosalie Winterton MP, Minister of State, to 29 June 2007
- Parliamentary Under Secretaries (Commons) with responsibility for Health and Public Health:
  - Ann Keen MP, from 30 June 2007
  - Ivan Lewis MP, continuous
- Parliamentary Under Secretary (Lords) with responsibility for the NHS Next Stage Review:
  - Lord Ara Darzi, from 30 June 2007

Board Structure and Membership

5.4 The Ministers were responsible for:

- setting the standards and values for the Department;
- agreeing the Department's forward plan and ensuring its delivery; and
- ensuring that the Department is well managed, with good governance and control arrangements including effective management of risk.

5.5 The Departmental Board is supported by:

- the Corporate Management Board which is chaired by the Permanent Secretary and includes all of the Department's Directors General. This Board supports the Permanent Secretary in his personal responsibility for Departmental expenditure and provides leadership for the Department; and
- the NHS Management Board which is chaired by the NHS Chief Executive and includes Strategic Health Authority Chief Executives and senior staff from the Department. This Board supports the NHS Chief Executive in his responsibility as Accounting Officer for NHS expenditure (RfR1) and provides leadership for the NHS ensuring effective two-way communication, manages NHS performance and shapes policy and strategy for the NHS
- the Audit Committee which is chaired by and comprises non-executive members. The Audit Committee advises the Accounting Officers and the Departmental Board on risk management, corporate governance and assurance arrangements in the Department and its subsidiary bodies

5.6 The Departmental Board was restructured on 1 October 2007. Membership at 31 March 2008 is shown in the table below.

Name	**Title**
Hugh Taylor	Permanent Secretary
David Nicholson	NHS Chief Executive
Sir Liam Donaldson	Chief Medical Officer
David Behan	Director General of Social Care, Local Government and Care Partnerships
Richard Douglas	Director General of Finance and Chief Operating Officer
Julie Baddeley	Non Executive member
Derek Myers	Non Executive member
Mike Wheeler	Non Executive member

5.7 The following officials also served on the Departmental Management Board during 2007-08

Name	Title	Period of service
Christine Beasley	Chief Nursing Officer	Until 30 September 2007
Mark Britnell	Director General of Commissioning and System Management	From 1 June 2007 to 30 September 2007
Andrew Cash	Director General of Provider Development	Until 30 June 2007
Clare Chapman	Director General of Workforce	Until 30 September 2007
Alan Doran	Director General of Departmental Management	Until 30 September 2007
Ivan Ellul	Acting Director General of Commissioning	From 1 May 2007 to 31 May 2007
David Flory	Director General of NHS Finance, Performance and Operations	From 1 June 2007 to 30 September 2007
Richard Granger	Director General of NHS IT	Until 30 September 2007
Sian Jarvis	Director General of Communications	From 1 June 2007 to 30 September 2007
Bill McCarthy	Director General of Policy and Strategy	Until 30 September 2007
Una O'Brien	Acting Director General of Policy and Strategy	From 1 May 2007 to 30 September 2007
Duncan Selbie	Director General of Commissioning	Until 8 July 2007
Mike Seitz	Acting Commercial Director General	Until 30 June 2007
Matt Tee	Acting Director General of Communications	Until 30 June 2007
Chan Wheeler	Commercial Director General	From 18 June 2007 to 30 September 2007

Appointment of senior officials

5.8 Senior Civil Servants, including the Permanent Secretary and Departmental Management Board members, are appointed in accordance with the Department's procedures, the Civil Service Commissioner's Recruitment Code and Guidance on Civil Service Commissioner's Recruitment to Senior Posts.

Remuneration of Ministers and senior officials

5.9 Ministers' remuneration is set by the Ministerial and Other Salaries Act 1975 (as amended by the Ministerial and Other Salaries Order 1996) and the Ministerial and Other Pensions and Salaries Act 1991.

MANAGEMENT COMMENTARY

6 Departmental aims and objectives

6.1 The Department's overall aim is to improve the health and well-being of the people of England. The Department's medium-term objectives are defined by its Public Service Agreement (PSA) agreed in Spending Reviews.

6.2 During 2007-08 the Department had seven high level objective reflecting its PSAs, these were to:

- improve and protect the health of the people of England – with special attention to the needs of disadvantaged groups and areas;
- enhance the quality and safety of services for patients and users, giving them faster access to services and more choice and control;
- deliver a better experience for patients and users, including those with long-term conditions;
- improve the capacity, capability and efficiency of the health and social care systems;
- ensure system reform, service modernisation, IT investment and new staff contracts to deliver improved value for money and higher quality;
- improve the service it provides as a Department of State to – and on behalf of – Ministers and the public, nationally and internationally; and
- become more capable and efficient in the Department, and cement its reputation as an organisation that is both a good place to do business with, and a good place to work.

6.3 The Department delivers these objectives working with Ministers, the NHS, Social Care and other partners through five distinct but inter-related roles:

- setting direction for the NHS, for adult social care and public health
- supporting delivery
- leading health and well-being for Government
- accounting to Parliament and the public; and
- supporting our staff to succeed.

Setting direction for the NHS, for adult social care and public health.

6.4 The Department has general responsibility for standards of health care in the country, including the NHS. It set the strategic framework for adult social care and influences Local Authority spend on social care. It also set the direction on promoting and protecting the public's health, taking the lead on issues like environmental hazards to health, infectious diseases, health promotion and education, the safety of medicines and ethical issues. Work on setting direction includes:

- Strategy
- Policy
- Legislation and regulation
- Allocating resources
- The NHS operating framework and
- Local Area Agreements

Supporting delivery

6.5 The Department of Health is responsible for finding the best way to support and mobilise the health and social care system to deliver improvements for patients and the public. Work in supporting delivery includes:

- Performance monitoring and evaluation
- Managerial and professional leadership for external groups
- Building capacity and capability; and
- Ensuring value for money

Leading health and well-being for Government

6.6 The Department works with other sectors, systems and Governments which it does not have a direct relationship with. It leads the integration of health and well-being into wider Government policy and integrates wider public policy into health and care services. The Department also takes the lead internationally on some health issues for the UK. Work on leading health and wellbeing for Government includes:

- working with the wider public sector, the third and private sectors on issues such as health protection or lifestyle choices, including integrating health and well-being with other Government agendas at the regional level through our regional teams
- work with international partners, including the European Union (EU), World Health Organisation (WHO) and the Organisation for Economic Co-operation and Development (OECD)

Accounting to Parliament and the public

6.7 As a Government Department, the Department of Health is responsible for supporting Ministers in accounting to the public and Parliament. Work on accounting to Parliament and the public includes:

- Answering Parliamentary questions - both written and oral and dealing with other Parliamentary business, debates and enquiries
- Responding to letters, emails, and phone calls from the public and members of Parliament
- Communicating to the public through the media and through visits and speeches

Supporting our staff to succeed

6.8 The Department can only meet its objectives through highly skilled and motivated staff who have the right tools to support them to succeed. Work on supporting our staff to succeed includes:

- the provision of training and development opportunities
- the provision of effective and efficient support functions such as IT, HR, accommodation and finance

6.9 The Department measures its performance in delivering its objectives through a comprehensive performance management system. Key performance indicators in the wider health and social care system are measured and tracked though the appropriate management and programme boards. The performance of the Department itself is reviewed by the Corporate Management Board using a performance scorecard including metrics on delivery, stakeholder feedback, resources and improvement. Target and performance data is obtained in consultation with Directors General and linked to the delivery of Directorate-level operational plans.

6.10 The Department's Performance Committee also monitors performance against Departmental Strategic Objectives (DSOs), Public Service Agreements (PSAs), Value for Money (VfM), critical programmes and projects and financial targets on behalf of the Department Board and provides a source of challenge on these to the boards with primary responsibility.

7 Dealing With Risks and Uncertainties

7.1 The Department's high-level risk register is the focal point of overall risk management in the Department. The register is updated and reviewed quarterly by the Departmental Board and the Audit Committee, with supporting Committees and Boards reviewing risks that fall within their responsibilities. The Department's Risk Forum (comprised of Directors from all directorates) also reviews the register and advises the Departmental Board on the risks contained on it.

8 Developing the Department

Capability Review and Development Plan

8.1 The Department's Capability Review was completed in 2007. In response to the findings of the review, the Department published a Development Plan in September 2007, which set out the actions needed to address the areas for improvement highlighted by the Department's Capability Review. There are five areas for action:

- establishing a vision and clear strategic direction for the health and care system;
- agreeing the Department's role, values and Business Plan;
- taking a new approach to leadership;
- supporting our staff to succeed; and
- improving the Department's organisation and business processes.

8.2 The areas for action span three main phases:

- planning our future together – September 2007 to March 2008;
- developing together – January 2008 to September 2008; and
- feeling the difference – September 2008 onwards.

8.3 Over the last six months, under the "Planning our Future Together" phase, the Department has:

- brought vision and direction to its work by clarifying its role and purpose;
- established corporate values and standards of behaviour that Departmental employees must live up to; and
- prioritised the work that will make the most difference by engaging staff from across the Department in the 2008-09 Business Planning process.

8.4 The six-month review of the programme by the Cabinet Office concluded that the Department was moving in the right direction. The Department has just completed the twelve-month review of its programme,

carried out by the Cabinet Office and will be reviewing the Development Programme in the light of the outcome of this.

Review of the Year

8.5 This section provides a brief review of the Department's activities and achievements during 2007-08. Further information on our performance for the year can be found in the Departmental Report and the Chief Executive's Annual Report. Both of these are available through the Department's website: www.dh.gov.uk

Setting direction

8.6 The 2007 Comprehensive Spending Review (CSR) was settled in September 2007 and with it new Departmental Strategic Objectives (DSOs) for the Department of Health:

- to promote better health and well-being for all – this covers the Department's objectives to help people stay healthy and well, empowering them to live independently, and tackle health inequalities;
- to ensure better care for all – this covers the Department's objectives to provide the best possible health and social care services, offering safe and effective care, when and where people need help and empowering them in their choices; and
- to ensure better value for all – this covers the Department's objectives to deliver affordable, efficient and sustainable services contributing to the wider economy and nation.

8.7 Progress against these DSOs will be measured using a set of 44 indicators, against which the Department will report on an annual basis. Where relevant, the DSOs and their indicators have been cascaded to both the NHS and Local Government as part of their new performance frameworks. In line with the Department strategic approach these indicators have not been cascaded as targets.

8.8 Following on from the CSR the Department issued the NHS Operating Framework and allocations for PCTs. The Operating Framework set out five key priority areas: improving cleanliness and reducing healthcare acquired infections; improving access through fulfilling the 18 week pledge; keeping adults and children well, improving their health and reducing inequalities; improving patient experience, staff satisfaction and public engagement; and preparing to respond in a state of emergency such as pandemic flu.

8.9 A central feature of the year was also the programme of extensive engagement that culminated in the publication of Lord Darzi's Next Stage Review in July 2008. The ***'Our NHS, our future'*** NHS next stage review actively engaged, involved and solicited the views of patients, public, staff and stakeholders. A variety of mechanisms were used to engage over 60,000 participants. The final report sets out a vision for the NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart.

8.10 Beyond the NHS the Department has also been futher developing policy in relation to social care and the wider care system. 2007-08 saw the publication of ***"Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care"*** that sets out, for the first time, the vison, ambitions and components of the future system in one place. In particular it recognises the need to empower citizens to shape their own lives and the support they receive. In February 2007, the Government formally launched details of the New Deal for Carers (a commitment from "***Our Health, Our Care, Our Say"***). The Government announced a multi-million pound package of support for carers through a range of measures – recognising carers as real partners and valuing their contribution but also their needs as individuals.

8.11 Finally, the Department introduced two new Bills to Parliament: the Health and Social Care Bill and Human Fertilisation and Embryology Bill.

Supporting delivery

8.12 The Department continued to support the health and social care systems in delivering sustainable improvements. In the NHS 2007-08 saw:

- continuing progress towards delivery of a maximum wait of 18 week from GP referral to start of treatment with the service hitting the March 2008 milestone of 85% of admitted patients and 90% of non-admitted patients receiving treatment in 18 weeks;
- a significant reduction in MRSA and Clostridium Difficile infections compared to the previous year, driven by NHS staff supported by the Clean, Safe Care Strategy;

- the introduction of vascular risk assessments for everyone between the ages of 40 and 74 which are expected to prevent at least 9,500 heart attacks a year and stop 4,000 people developing diabetes;
- a strong financial position that provides stability and flexibility to deliver further improvements in the quality and range of patient care.

Leading health and well-being for Government

8.13 In providing leadership across Government on health and well being:

- the CSR announced a new long term ambition on obesity and the Department has been working closely with Departments for Children, Schools and Families and Culture, Media and Sports. ***"Healthy Weight, Healthy Lives"*** a cross Government strategy was launched in January 2008;
- the Department has continued to focus on reducing harm from alcohol publishing ***"Safe. Sensible. Social The Next Steps in the National Alcohol Strategy"*** in June 2007 and working across Government programme of work with the Home Office, the Ministry of Justice and the Department for Children Schools and Families;
- the Department has continued to build on the introduction of smoke free legislation through the introduction of a higher age limit for the purchase of cigarettes and stop smoking services.

Accounting to Parliament and the public

8.14 The Department continues to be one of the busiest in Whitehall on accountability issues. During the year it:

- published 8 Regulatory Impact Assessments, and, following the introduction of the new format in November 2007, published 9 Impact Assessments;
- published 53 Equality Impact Assessments with policy documents;
- answered almost 1,300 freedom of information requests in 2007, representing 7.6% of all requests across Government. The Department responded to 91% of these within deadline, including permitted extensions, against a cross-Government average of 89% (source: Ministry of Justice FOI Annual Report 2007 www.justice.gov.uk);
- answered over 9,000 Parliamentary questions and led on 20 Select Committee inquiries and 6 PAC hearings;
- achieved its Gershon efficiency target and has delivered over £7 billion of annual efficiency savings from 2004-05 to 2007-08.

Supporting staff to succeed

8.15 The Department's work in this area focussed largely on the Development Plan built around a major programme of staff engagement which was used to help develop the Department's values:

- We value people: we care about people and put their health and well-being at the heart of everything we do.
- We value purpose: we focus our actions and decisions on achieving our shared goals.
- We value working together: we work together as one Department and with our partners and stakeholders.
- We value accountability: we take responsibility and are open to challenge.

8.16 These values have been at the heart of the Department's work during the year and have been used by managers to develop their ways of working and by the Department to test and refine the way it does its business.

9 Progress in relation to Public Service Agreements targets in 2007-08

9.1 The following table summarises progress against the Public Service Agreements extant during 2007-08 which were agreed as part of the 2004 Spending Review. The aims and objectives agreed in 2004 are set out below with updates on progress in 2007-08. As confirmed in the Capability Review the Department continues to perform well in delivering against key targets.

Objective I : Health of the population

	Description	Progress
Target 1A	Improve the health of the population. By 2010, increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women.	**Encouraging progress.**
Target 1B	Substantially reduce mortality rates by 2010 from heart disease, stroke and related diseases by at least 40 per cent in people under 75, with a 40 per cent reduction in the inequalities gap between the fifth areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.	**Overall mortality met early. Inequality dimension on course.**
Target 1C	Substantially reduce mortality rates by 2010 from cancer by at least 20 per cent in people under 75 with a reduction in the inequalities gap of at least 6 per cent between the fifth areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.	**Overall mortality on course. Inequality dimension met early**
Target 1D	Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20 per cent.	**Encouraging progress**
Target 2	Reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth.	**Slippage**
Target 3	Tackle the underlying determinants of health and health inequalities by	
	• reducing adult smoking rates to 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less.	Adult smoking rates **– on course** Reduction in prevalence among routine and manual groups – **encouraging progress**
	• halting the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole (joint target with DCSF and DCMS).	**Not yet assessed**
	• reducing the under-18 conception rate by 50 per cent by 2010, as part of a broader strategy to improve sexual health (joint target with DCSF).	**Slippage**

Objective II : Long-term conditions

Target 4	To improve the health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5 per cent by 2008, through improved care in primary care and community settings for people with long-term conditions.	**Met early**

Objective III : Access to services		
Target 5	By December 2008, ensure that no one waits more than 18 weeks from GP referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks).	**On course**
Target 6	Increase the participation of problem drug users in drug treatment programmes by 100 per cent by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.	Participation in drug treatment **– met early** Effectiveness of drug treatment **– on course**
Objective IV : Patient and user experience		
Target 7	Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.	**On course**
Target 8	Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by increasing • the proportion of older people being supported to live in their own home by 1 per cent annually in 2007 and 2008.	**Slippage**
	• by 2008 the proportion of those supported intensively to live at home to 34 per cent of the total of those being supported at home or in residential care.	**Met.** This is the final reporting for this target.

9.2 For more information about the individual measures and data quality, see the Department of Health's Departmental Report 2008 on our website www.dh.gov.uk

Forward Look

9.3 The Department's Business Plan for 2008-09 has been framed within the context of the outcome of the 2007 Comprehensive Spending Review and the Department's Capability Review and subsequent Development Plan. Within this framework the Departmental Board and Ministers determined that the 2008-09 priorities for the Department should be:

- a clear focus on our Department of State functions including areas such as support to Ministers, accountability to the Parliament and public, legislation and international commitments;
- high priority and time critical programmes of work linked to our DSOs as follows:
  - preparation for a possible influenza pandemic
  - developing the strategy for the reform of social care
  - leading the local transformation of the NHS
  - reducing inequalities
  - reducing the burden of lifestyle diseases
  - facilitating the delivery of improved value for money
- cross Government work linked to our better health and well being DSO
- supporting staff to develop and deliver through the provision of high quality and efficient corporate services.

9.4 Further detail can be found in the Department of Health Business Plan on our website www.dh.gov.uk

10 Summary of Financial Results

Revenue expenditure

10.1 Across the three Requests for Resources, the Department underspent in 2007-08 by a total of £1,274 million on total resource provision of £73,842 million. Table one shows the breakdown of the under spend by RfR.

Table One - 2007-08 Overall Revenue Spending Approved by Parliament

Expenditure Type	Provision £m's	Outturn £m's	Under Spend £m's
Request for Resources 1			
Securing health for those who need it	70,168	68,926	1,242
Request for Resources 2			
Securing social care and child protection for those who need it and at national level, protecting, promoting and improving the nation's health	3,660	3,628	32
Request for Resources 3			
Office of the Independent Regulator for NHS Foundation Trusts	14	14	-
Total Resources	**73,842**	**72,568**	**1,274**

10.2 Within the centrally managed programmes the significant variations are shown in table two below and also reported under Note 2.

Table Two: Significant Variations on Centrally Managed Programmes

Request for Resources 1

Estimate line	Estimate Line Description	Limit £m's	Outturn £m's	Variance under/(over) £m's
A	Strategic Health Authorities and primary care trusts unified budgets and central allocations	86,949	85,803	1,146
Mainly the net underspend in PCT and SHAs of £1.29 billion. The NHS financial surplus in 2007-08 significantly exceeded the £250 million target set in the NHS Operating Framework because: (i) organisations released contingencies in excess of the 0.5% required; (ii) a reduction of the reimbursment of generic medicines charged to PCTs; and (iii) NHS organisations which had previously forecast deficits, recorded a surplus or break-even in their accounts				
B, C and D	Pharmaceutical Services, Prescription Charges Income and General Ophthalmic Services	1,064	1,022	42
Pharmaceutical and Ophthalmic budgets are non-discretionary and demand-led. Actual expenditure was lower than planned.				
F	Strategic Health Authority and Primary Care Trust's grants to local authorities.	268	228	40
Slippage on a number of planned Local Authority schemes.				

Request for Resources 2

Estimate line	Estimate Line Description	Limit £m's	Outturn £m's	Variance under £m's
C	Other Services, including medical, scientific and technical services, grants to voluntary bodies, research and development and information services	325	281	44
Slippage on IT development				
D	Welfare Food and European Economic Area (EEA) Medical Costs	820	875	(55)
EEA Medical Costs - higher than forecast volumes of claims, exchange rate differences and the introduction of a new tracking system resulted in more accurate forecasts of income and expenditure.				
E	Other Personal Social Services	276	241	35
A budget for "Older People Hospices Improvements" included in this estimate line at Spring Supply is now included in RfR 1 "Strategic Health Authorities and Primary Care Trust unified budgets and central allocations.				

10.3 The total expenditure for which the Department is responsible includes not only voted sums but spending by organisations outside the resource accounting boundary. In 2007-08 the Department was responsible for managing a total resource budget of £90,065 million and total resource spending was £88,770 million. Table three below reconciles total resource spending to the net resource outturn shown in table one above.

Table Three: Revenue Reconciliation between Estimates, Accounts and Budgets

	2007-08 £m's	2006-07 £m's
Net Resource Outturn (Estimates)	72,568	64,601
Adjustments to remove:		
Provision voted for earlier years	0	-
Adjustments to additionally include:		
Non-voted expenditure in the OCS	0	-
Consolidated Fund Extra Receipts in the OCS	(21)	(878)
Other Adjustments		
Net Operating Cost (Accounts)	72,547	63,723
Adjustments to remove:		
Capital Grants to Local Authorities and Third Parties	(360)	(217)
Capital Grants financed from the Capital Modernisation Fund	0	-
European Union income and related adjustments	0	-
Voted expenditure outside the budget (mainly National Insurance Contributions)	17,904	16,804
Adjustments to additionally include:		
Other Consolidated Fund Extra Receipts	0	878
Resource consumption of Non Departmental Public Bodies	490	452
Unallocated resource provision	0	-
Other adjustments (mainly Trust and Foundation Trust surplus before interest and dividends)	(1,773)	(933)
Resource Budget Outturn (Budget) of which;	88,808	80,707
Departmental Expenditure Limit (DEL)	88,259	80,715
Annually Managed Expenditure (AME)	549	(9)

10.4 The primary financial control that the HM Treasury apply to the Department is the Departmental Expenditure Limit (DEL) Table four provides a breakdown of 2007-08 Revenue DEL performance across the main Department of Health spending sectors. This underspend is available to be drawn down in future years under the Treasury's rules on "end of year flexibility".

Table Four: 2007-08 Revenue DEL Position by Sector

	2007-08 DEL (Under) Spend £m's
2007-08 Total Revenue DEL Provision	**89,536**
2007-08 Revenue DEL expenditure	**88,259**
2007-08 Revenue DEL underspend	**1,277**
2007-08 Revenue DEL Underspend as a % of Provision	**1.43%**
Breakdown of 2007-08 Revenue DEL underspend:	
NHS Bodies (Primary Care Trusts, Strategic Health Authorities, NHS Trusts and Foundation Trusts)	*2,072*
Central Programme	*(801)*
Central Administration	*6*

Within the Revenue DEL control is a further financial control for Departmental Administration, known as the Administration Cost Limit (ACL). Net expenditure on Departmental ACL was £226 million, compared with a provision of £231 million, an underspend of £5 million or 2.2%. The total administration costs in the resource

account amount to £236 million, compared to a provision of £242 million. In addition to ACL expenditure, total administration includes around £10 million for other costs, mainly related to spend on frontline or in support of frontline services.

Capital Expenditure

10.5 Across the two Requests for Resources the Department underspent in 2007-08 by a total of £1,114 million on total provision of £2,121 million. Table Five shows the breakdown of the under spend by RfR .

Table Five: 2007-08 Overall Capital Spending Approved by Parliament

Expenditure Type	Provision £m's	Outturn £m's	Under Spend £m's
Request for Resources 1			
Securing health for those who need it	2,097	1,015	1,082
Request for Resources 2			
Securing social care and child protection for those who need it and at national level, protecting, promoting and improving the nation's health	24	21	3
Net movement in debtors/creditors	-	(29)	29
Total Resources	**2,121**	**1,007**	**1,114**

10.6 As with revenue expenditure the Department is responsible for capital spending for organisations outside the resource accounting boundary. Table Six below reconciles this total capital expenditure to the total capital resources approved by Parliament shown in table Five.

Table Six: Capital Reconciliation between Estimates, Accounts and Budgets

	2007-08 £m's	2006-07 £m's
Net Capital Outturn (Resource Account)	**1,007**	**2,263**
Adjustments to remove:		
Gains /losses from sale of capital assets	(6)	(194)
Adjustments to additionally include		
Capital spending by non departmental public bodies	90	80
Capital grants	360	223
Supported capital expenditure (revenue)	50	50
Other adjustments	-	-
Capital expenditure of NHS Trusts and FTs	2,480	1,988
Less net PDC and loans to trusts and FTs	(111)	(1,338)
Other	-	11
Capital Budget Outturn (Budget) of which;	3,870	3,083
Departmental Expenditure Limit (DEL)	3,833	2,994
Annually Managed Expenditure (AME)	37	89

Table Seven provides a breakdown of 2007-08 Capital DEL performance across the main Departmental spending sectors. This underspend is available to be drawn down in future years under the Treasury's rules on "end of year flexibility".

Table Seven : 2007-08 Capital DEL Position by Sector

	2007-08 DEL Under Spend £m's
2007-08 Total Capital DEL Provision	4,320
2007-08 Capital DEL expenditure	3,833
2007-08 Capital DEL underspend	487
2007-08 Capital DEL Underspend as a % of Provision	11.3%
Breakdown of 2007-08 Capital DEL underspend:	
NHS Bodies	*268*
Central Programme	*220*
Central Administration	-

11 PUBLIC INTEREST AND OTHER ISSUES

Employment of Disabled Persons policy

11.1 The Department of Health is committed to the employment and career development of disabled people. Selection to posts is based upon the ability of the individual to do the job using a competence based selection system. The Department operates the Guaranteed Interview Scheme, which guarantees an interview to anyone with a disability whose application meets the minimum criteria for the post. Once in post disabled staff are provided with any reasonable support they might need to carry out their duties.

Equal Opportunities policy

11.2 The Department of Health is committed to treating all staff fairly and responsibly. The aim of the Department's equal opportunities policy is to promote equality of opportunity whereby no employee or job applicant is discriminated against either directly or indirectly on such grounds as race, colour, ethnic or national origin, sex, marital status, responsibility for children or other dependants, disability, age, work pattern, sexual orientation, gender reassignment, Trade Union membership or activity, religion or belief. Line managers are responsible for promoting equal opportunities within their own work teams and for ensuring business compliance with equal opportunities legislation.

Payment of Suppliers

11.3 The Department complies with the CBI prompt payment code and the British Standard on prompt payment. The Department's policy is to pay bills in accordance with agreed contractual conditions or, where no such conditions exist, within thirty days. In 2007-08 the core Department paid 99% of bills (2006–07 96%), 211,927 invoices (2006–07 225,755), in accordance with the policy. The prompt payment performance of other members of the Departmental family can be found in their published annual accounts

Public Dividend Capital

11.4 Public dividend capital represents the Government investment in NHS Trusts and NHS Foundation Trusts. PDC is recorded on the balance sheet of NHS Trusts and Foundation Trusts and is an asset of the Consolidated Fund.

11.5 The rules governing public dividend capital for NHS trusts and Foundation Trusts are laid out in the NHS Act 2006. This sets out the use of PDC as originating capital for NHS trusts and initial PDC for NHS Foundation Trusts. It also sets out the powers the Secretary of State has in determining the conditions under which PDC is issued to NHS Trusts', namely with the consent of the Treasury, the Secretary of State may determine;

- the dividend which is payable at any time on any public dividend capital issued, or treated as issued, to an NHS Trust under this Act,
- the amount of any such public dividend capital which must be repaid at any time,
- any other terms on which any public dividend capital is so issued, or treated as issued.

11.6 The NHS Act 2006 also sets out how initial PDC is determined for Foundation Trusts and the powers the Secretary of State holds in determining terms under which PDC is treated as having been issued and the dividend payable. Both NHS Trusts and NHS Foundation Trusts are required to pay a PDC dividend to the Department. This is currently set as 3.5% of the estimated average net relevant assets of each NHS trust and NHS Foundation trust. The 3.5% return the Department of Health makes on its consolidated balance sheet is the actual average net relevant assets taken from the underlying accounts of those bodies.

External auditor

11.7 The resource accounts have been prepared under a direction issued by HM Treasury in accordance with the Government Resources and Accounts Act 2000 and are subject to audit by the Comptroller and Auditor General. As far as the Accounting Officer is aware, there is no relevant audit information of which the Department's auditors are unaware, and the Accounting Officer has taken all the steps necessary to make him aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

Provision of Information to, and Consultation with, Employees

11.8 The Department has a series of communication channels in place to communicate organisational and business developments to staff, and to provide an opportunity for feedback, both at a corporate and local level. The channels used range from timely electronic communications to face-to-face briefings by Corporate Management Board members and the Department's senior managers. The Department also works in partnership with the Departmental Trade Unions through consultation and negotiation to encourage involvement and build engagement in decision making processes.

Details of Company Directorships and other significant interests held by the Board

11.9 Other than those disclosed in Note 34 there are no company directorships or significant interests held by Board members.

Policy and achievement on environmental matters

11.10 The Department, as a Department of State, has a role to play in helping Government set an example by changing what is bought, how energy is used and how the environment is impacted.

11.11 The Department has worked closely with DEFRA to develop the adaptation sections of the Climate Change Bill, which will require Government to assess the risks climate change poses to the UK and to develop a programme to respond to those risks. The first risk assessment will be due around 2011 with the programme being published shortly afterwards.

11.12 Department of Health has also worked with DEFRA and other Government Departments on the development of an Adaptation Policy Framework, which will be published later this year, setting out the Government's programme of action on climate impacts.

11.13 In February 2008, the Department and Health Protection Agency published an update of the 2002 report ***'The Health Effects of Climate Change in the UK 2008***'.

11.14 Preparing for climate change is now one of the top 4 shared priorities for UK action set out in the Government's ***'Securing the Future, delivering the UK sustainable development strategy***' (2005). Publication of our report and the launch of an independently-devised leaflet on climate change are important actions being undertaken by the Department of Health to inform health professionals, as well as other initiatives such as the ***'National Heatwave Plan'*** which is launched each summer.

11.15 Protection from sunburn and skin cancers caused by UV radiation relies heavily on public health messages building, for example, on the Department's current collaboration with Cancer-Research UK for the 'SunSmart' campaign. Other cross-Government work to help reduce the expected health effects of climate change includes input to DEFRAs ***'Air Quality Strategy***', published in July 2007.

11.16 The UK has proposed a resolution on 'Climate change and health', successfully forwarded by the World Health Organisation's Executive Board to be discussed at the World Health Assembly in May 2008. Our aim is

to raise awareness of the health implications of climate change among health ministries and professionals and promote practical and sustainable action nationally and internationally to respond to these.

Sustainable development activities

11.17 The Department has a good record on the environmental management of its own estate. In March 2008 the annual ***Sustainable Development in Government*** report was published by the Sustainable Development Commission. This placed the Department top of any Government Department in 2006-07, in its overall performance against a raft of sustainable operations targets. The Department has been particularly successful in reducing the total carbon emissions from its estate and road based transport.

11.18 The NHS Management Board agreed (September 2007) to adopt a new approach for further developing sustainable development in the NHS. This will be achieved through the formation of a Sustainable Development Unit, within the East of England Strategic Health Authority working for all SHAs and the NHS in partnership with the Department. The Unit's first task will be to produce the delivery of a Carbon Reduction and subsequent Sustainability Strategy for the NHS.

11.19 In line with the Government commitment towards climate change, the NHS was set stretching mandatory energy and carbon efficiency targets: from March 2000 to March 2010 to achieve a 15 per cent energy or 0.15 million tonnes carbon efficiency saving; plus performance indicator standards for new builds/refurbishments and for the existing estate. A mid term analysis of progress shows that with a growing estate, expanding service provision and increasing use of medical and other technologies, this target is becoming more challenging and success based on the original terms of the target could not be guaranteed.

11.20 To assist the NHS, the Department made available a £100m Energy and Sustainability Capital Fund (January 2007) for the NHS to bid for schemes that demonstrate carbon efficiency with associated revenue savings. This Fund has been fully committed, and the projects funded are expected to reduce CO2 emissions by 35,000 tonnes carbon. Other Carbon savings predicted in our mid term report, based on ERIC (the Estates Returns Information Collection System), amount to a total of 100,000 tonnes leaving a shortfall of 15,000 tonnes carbon against the target requirement for 2010.

11.21 It is envisaged this shortfall could be addressed if the Department were to receive a supplement to the £100m Energy & Sustainability Capital Fund, or similar (for example £50m is included in the draft NHS Carbon Reduction Strategy by the NHS SDU); or by taking into account savings within the NHS Estate attributable to the Carbon Trust's NHS Carbon Management Programme, and by anticipated improvements that will result through new and forthcoming legislative drivers.

11.22 Work continues with the Carbon Trust on the NHS Carbon Management Programme and Site Operation Assessments which is assisting NHS organisations to identify where carbon savings can be made and is contributing very positively to the Climate Change programme. Other activities include working with the Waste Resources Allocation Programme to reduce construction waste; energy efficiency procurement and contracting.

11.23 A project with DEFRA, BERR, CLG and SDC is well advanced to redevelop the NHS Environmental Assessment Tool to conform with current Government recommendations. The tool will be re-issued as BREEAM Healthcare as a more demanding accreditation tool along with associated guidance on Sustainable Health and Social Care. Further joint work is taking place with DEFRA, the regulatory bodies and the Devolved Administrations, to produce guidance to improve Water Management and Water Efficiency in the Healthcare Sector.

Hugh Taylor *25th September 2008*

Permanent Secretary
Department of Health
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Publications List

HMT Direction for Accounts
www.hm-treasury.gov.uk/media/1/C/dao0607.pdf

Department of Health Departmental Report 2008
www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_084908

HMT Supply Estimates
www.hm-treasury.gov.uk/documents/public_spending_reporting/estimates/psr_estimates_mainindex.cfm

Department of Health Autumn Performance Report
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081330

HMT Public Expenditure White Paper
www.hm-treasury.gov.uk/economic_data_and_tools/finance_spending_statistics/pes_publications/pespub_pesa08.cfm

Chief Executive Report to the NHS
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084843

Finance Directors report to SofS on NHS Financial Performance Quarter 4
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_085244

On the state of Public Health
www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_086176

The NHS Operating Framework 2008-09
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

STATEMENT OF PRINCIPAL ACCOUNTING OFFICER'S RESPONSIBILITIES

1. Under the Government Resources and Accounts Act 2000, the Department of Health is required to prepare Resource Accounts for each financial year, in conformity with a HM Treasury direction, detailing the resources acquired, held or disposed of during the year, and the use of resources by the Department during the year.

2. The Resource Accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Department, the net resource outturn, resources applied to objectives, recognised gains and losses and cash flows for the financial year.

3. HM Treasury has appointed the Permanent Secretary of the Department as Principal Accounting Officer of the Department with overall responsibility for preparing the Department's accounts and for transmitting them to the Comptroller and Auditor General.

In preparing the accounts, the Principal Accounting Officer is required to comply with the Financial Reporting Manual, prepared by HM Treasury, and in particular to:

- observe the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards, as set out in the Financial Reporting Manual, have been followed, and disclose and explain any material departures in the accounts; and
- prepare the accounts on a going concern basis.

4. In addition, HM Treasury has appointed:

- the Chief Executive of the NHS as an Additional Accounting Officer to be accountable for expenditure on hospital and community health services, family health services, some central health services, the drugs bill and NHS Trusts' external financing; and
- a separate Accounting Officer to be accountable for the NHS Pension Scheme and NHS compensation for premature retirement scheme Resource Account. These are produced and published as a separate account.

These appointments do not detract from the Permanent Secretary's overall responsibility as Accounting Officer for the Department's accounts.

5. The responsibilities of an Accounting Officer, including responsibility for regularity and accounting accurately for their organisation's financial position and transactions are set out by HM Treasury in *Managing Public Money*.

REMUNERATION REPORT

A - DEPARTMENTAL BOARD MEMBERS

1. The following parts of the Remuneration Report relating to Board Members are subject to audit . These items, excepting the last, are also audited for Ministers:

- Salaries and allowances
- Compensation for loss of office
- Non-cash benefits
- Pension increases and values
- Cash Equivalent Transfer Values (CETVs) and increases
- Amounts payable to third parties for the services of senior managers.

2. The Departmental Management Board (DMB) was restructured on 1 October 2007 so that it now focuses on the strategic, cross cutting issues and risks for the Department. It is chaired by the Permanent Secretary and comprises the Department's three head policy advisors, the lead policy advisor on local Government and social care and the head of finance and corporate functions, as well as three non-executive members who provide external input and challenge. The restructuring had an impact on the composition of the DMB in 2007-08.

3. During 2007-08 there has been increasing public interest in the salaries of senior staff in the public sector. In view of this the Department is disclosing in this Report the salaries and benefits received by all staff at Director General level and above.

4. Responsibility for Senior Civil Service (SCS) pay lies with the Minister for the Civil Service; it has not been delegated to Departments. Each Department is required to operate within agreed pay band structures and associated pay ranges and target rates detailed in the Senior Salaries Review Body Annual Report. Departments are given discretion in some areas to adapt the system to local needs under the auspices of a Departmental Senior Pay Strategy Committee and to produce an annual senior pay strategy agreed by the Committee. The strategy document sets out how the system operates in the Department. For awards made from 1 April 2007, the average basic pay award for members of the SCS was 2.6% of the existing paybill for such staff (paid on 1 April) and bonuses ranged from 0% to 17% (paid on 1 November). Basic pay awards are consolidated and bonuses are non-consolidated. Both are fully performance-related.

5. Permanent Secretaries' salaries are determined by the Cabinet Office. Increases to salary for other Departmental Board Members and other senior staff are determined by the Pay Committees in accordance with the Departmental SCS Pay Strategy.

6. The Senior Pay Strategy Committee is responsible for setting the Department's strategic approach to SCS pay and producing the yearly Departmental Pay Strategy, operating within the parameters set by the Cabinet Office for the whole of the Senior Civil Service. Because of the size of the SCS in the Department, it is not possible for the Pay Committee itself to make decisions regarding individual pay for the whole Department. The Senior Pay Strategy Committee therefore delegates responsibility for implementing the pay strategy to sub committees who are responsible for assessing, in the light of the strategy, the relative contribution of individual SCS members and making the final pay decisions. Each of the pay sub-committees has an independent member whose role it is to ensure consistent application of standards and provide quality assurance to the process. The independent member has no line management responsibility for any of the staff discussed at the individual Pay Committee meeting. In addition, one Pay Committee (Committee A - see below) reviews the decisions of the other Pay Committees to ensure consistency across the whole Department at SCS Pay Band 1.

7. The **Senior Pay Strategy Committee** in 2007 was chaired by Hugh Taylor (Permanent Secretary). The other members were David Nicholson (NHS Chief Executive), Sir Liam Donaldson (Chief Medical Officer), Julie Baddeley (Non Executive Director), Harbhajan Brar (Director of Human Resources), C Marc Taylor (FDA) and Kent Woods (Chief Executive, Medicines and Healthcare Products Regulatory Agency - MHRA).

8. For the 2007 pay round there were five Pay Committees reflecting the organisational structure for the main part of the reporting year.

Committee A made decisions in the case of all members of the Departmental Board, all other SCS Pay Band 3 staff and all SCS Pay Band 2 staff (excluding MHRA), considering pay for the most senior leaders in the Department in one Committee. This Committee also reviewed the decisions of Pay Committees B - D.

This Committee was chaired by Hugh Taylor. The other members were David Nicholson, Sir Liam Donaldson, Julie Baddeley and Harbhajan Brar.

Committee B made decisions in the case of all SCS staff in Pay Band 1 employed within Communications; Departmental Management; Equality and Human Rights; Finance and Investment; Health and Care Partnerships; Medicines, Pharmacy and Industry; Policy and Strategy; Social Care; and User Experience and Involvement. It also considered initial SCS2 recommendations to Pay Committee A

The Committee was chaired by Hugh Taylor. The other members were Julie Baddeley, Christine Beasley (Chief Nursing Officer), David Behan (Director General of Social Care, Local Government and Care Partnerships), Alan Doran (Director General of Departmental Management), Richard Douglas (Director General of Finance and Chief Operating Officer), Bill McCarthy (Director General of Policy and Strategy), Anthony Sheehan (Director General of Health and Care Partnerships) and Matt Tee (Director General of Communications).

Committee C made decisions in the case of all SCS staff in Pay Band 1 employed within Commissioning; Commercial; Connecting for Health/IT; Finance and Investment; Provider Development; and Workforce. It also considered initial SCS2 recommendations to Pay Committee A

The Committee was chaired by David Nicholson. The other members were Harbhajan Brar, Andrew Cash (Director General of Provider Development), Clare Chapman (Director General of Workforce), Richard Douglas, Richard Granger (Director General of NHS IT), Mike Seitz (Director General of Commercial Directorate) and Duncan Selbie (Director General of Commissioning).

Committee D made decisions in the case of all SCS staff in Pay Band 1 employed within Clinical Programmes; Government Offices Public Health; Healthcare Quality Programmes; Health Improvement; Health Protection, International Health and Scientific Development; and Research and Development. It also considered initial SCS2 recommendations to Pay Committee A

The Committee was chaired by Sir Liam Donaldson. The other members were Fiona Adshead (Deputy Chief Medical Officer - Health Improvement), Sally Davies (Director General of Research and Development), Alan Doran, David Harper (Director General of Health Improvement and Protection), Bill Kirkup (Director General of Clinical Programmes) and Martin Marshall (Deputy Chief Medical Officer - Healthcare Quality).

Committee E made decisions in the case of all SCS staff in Pay Bands 1 and 2 in the MHRA.

The Committee was chaired by Kent Woods. The other members were the MHRA Board, supplemented by Alan Doran and Lisa Arnold (MHRA Non Executive Director). The awards for the MHRA Board members were decided in a separate meeting between Kent Woods and Hugh Taylor.

9. The performance review system used for members of the SCS in the Department of Health has been developed by the Cabinet Office for use throughout the Civil Service. The record of responsibilities and agreed objectives is completed at the start of the performance review year. SCS members complete a mid-year development review with line managers. In the mid-year review, SCS members have the opportunity to discuss progress against objectives for the current year, any changes to duties and objectives as well as discussing long-term development. The outcome of the mid-year review is recorded to inform the end of year discussion between SCS members and line managers.

All managers must ensure that they discuss reporting standards with their colleagues before they complete their reports to ensure that relativities are fair, and to be rigorous in this process. Medical doctors are required to complete a slightly lengthened version of the performance review form that is also used for revalidation purposes.

10. The following two tables detail the date people took up appointment as Permanent Secretary or SCS Pay Band 3. The first table lists those still in post as at 31 March 2008 and the second lists those who were no longer a DMB member or Director General by that date. Of the 28 listed in total, 19 held permanent Senior Civil Service contracts during the year, two held a fixed term contract, six were seconded to the Department and one was a contractor employed through an agency.

DMB member* or Director General	**Current Job Title**	**Date of Appointment to grade**
Fiona Adshead	Deputy Chief Medical Officer - Health Improvement	16 February 2004
Christine Beasley	Chief Nursing Officer	19 October 2004
David Behan*	Director General of Social Care, Local Government and Care Partnerships	29 August 2006
Mark Britnell *(on secondment from South Central SHA)*	Director General of Commissioning and System Management	1 June 2007
Clare Chapman	Director General of Workforce	3 January 2007
Sally Davies *(on secondment from Northwick Park Hospital NHS Trust)*	Director General of Research and Development	1 May 2005
Sir Liam Donaldson*	Chief Medical Officer	21 September 1998
Richard Douglas*	Director General of Finance and Chief Operating Officer	1 May 2001
David Flory *(on secondment from North East Strategic Health Authority)*	Director General of NHS Finance, Performance and Operations	1 June 2007
David Harper	Director General of Health Improvement and Protection	14 October 2003
Sian Jarvis *(returned to the Department 1 June 2007)*	Director General of Communications	1 April 2004
Bruce Keogh *(on secondment from University College London Hospital NHS Trust)*	NHS Medical Director	12 November 2007
Bill Kirkup	Director General of Clinical Programmes	1 May 2005
David Nicholson*	NHS Chief Executive	1 September 2006
Una O'Brien *(Acting DG from 1 May 2007)*	Director General of Policy and Strategy	1 October 2007
Matthew Swindells *(on secondment from Royal Surrey County Hospital NHS Trust)*	Chief Information Officer	4 July 2005
Hugh Taylor*	Permanent Secretary	18 December 2006
Chan Wheeler *(Fixed Term Appointment)*	Director General of Commercial Directorate	18 June 2007

*DMB members as at 31 March 2008

DMB member* or Director General	Job Title immediately before leaving	Date of Appointment to grade
Andrew Cash *(on secondment from Sheffield Teaching Hospitals NHS Trust, until 30 June 2007)*	Director General of Provider Development	1 July 2006
Alan Doran *(until 30 September 2007)*	Director General of Departmental Management	14 July 2003
Ivan Ellul *(until 31 May 2007)*	Acting Director General of Commissioning	1 May 2007
Richard Granger *(until 31 January 2008)*	Director General of NHS IT	7 October 2002
Bill McCarthy *(until 30 September 2007)*	Director General of Policy and Strategy	1 October 2005
Martin Marshall *(until 25 November 2007)*	Deputy Chief Medical Officer - Healthcare Quality	15 May 2006
Mike Seitz *(Contractor employed through Alexander Hughes, until 30 June 2007)*	Acting Director General of Commercial Directorate	1 January 2007
Duncan Selbie *(until 8 July 2007)*	Director General of Commissioning	3 November 2003
Anthony Sheehan *(until 31 May 2007)*	Director General of Health and Care Partnerships	5 November 2002
Matt Tee *(Fixed Term Appointment until 29 June 2007)*	Director General of Communications	12 December 2005

11. Because of the power of the Crown to dismiss at will, Senior Civil Servants are not entitled to a period of notice terminating employment. However, unless the employment is terminated by agreement, in practice a SCS member holding either a permanent or fixed term contract, will normally be given the following periods of notice in writing terminating their employment:

(i) if retired on age grounds, if dismissed on grounds of inefficiency, or if dismissal is the result of disciplinary proceedings in circumstances where summary dismissal is not justified:

Continuous Service for:

- Up to 4 years - 5 weeks
- 4 years and over - 1 week plus 1 week for every year of continuous service up to a maximum of 13 weeks.

(ii) if retired on medical grounds, the period of notice in (i) above or, if longer, 9 weeks, unless a shorter period is agreed.

(iii) if employment is terminated compulsorily on any other grounds, unless such grounds justify summary dismissal at common law or summary dismissal is the result of disciplinary proceedings, the period of notice is 6 months.

On the expiration of such notice, employment will terminate.

The SCS member will receive no notice if s/he agrees to flexible or approved early retirement or voluntary redundancy.

If employment is terminated without the notice which would, in practice normally be given as in (i) above, compensation may be paid in accordance with the relevant provisions of the Civil Service Compensation Scheme.

Unless otherwise agreed, the SCS member is required to give a specified period of written notice to line management and copied to the Senior Civil Service Unit if s/he wishes to terminate the employment. This notice period is usually for 3 months, however a different period can be negotiated with line management.

12. The Department of Health's policy on termination payments are outlined in the Civil Service Compensation Scheme.

13. Table 1 provides details of remuneration interests of DMB Members and other Directors General.

Table 1 - Remuneration interests of DMB Members and other Directors General

		2006-07			2007-08				
		Salary	Full Year Equivalent Salary	Benefit in Kind	Salary	Full Year Equivalent Salary	Benefit in Kind	Non Cash Remuneration Element	Compensation for Loss of Office
		£'000	£'000	£	£'000	£'000	£	£	£
Fiona Adshead	Deputy Chief Medical Officer - Health Improvement	150-155	150-155	Nil	155-160	155-160	Nil	Nil	N/A
Christine Beasley	Chief Nursing Officer	145-150	145-150	Nil	155-160	155-160	Nil	Nil	N/A
David Behan	Director General of Social Care, Local Government and Care Partnerships	100-105	170-175	Nil	180-185	180-185	Nil	Nil	N/A
Mark Britnell	Director General of Commissioning and System Management	N/A	N/A	N/A	175-180	210-215	Nil	Nil	N/A
Andrew Cash*	Director General of Provider Development	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clare Chapman	Director General of Workforce	50-55	205-210	Nil	240-245	240-245	Nil	Nil	N/A
Sally Davies*	Director General of Research and Development	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sir Liam Donaldson	Chief Medical Officer	200-205	200-205	Nil	205-210	205-210	Nil	Nil	N/A
Alan Doran	Director General of Departmental Management	155-160	155-160	Nil	90-95	170-175	Nil	Nil	Nil
Richard Douglas	Director General of Finance and Chief Operating Officer	130-135	130-135	Nil	155-160	155-160	Nil	Nil	N/A
Ivan Ellul**	Acting Director General of Commissioning	N/A	N/A	N/A	0-5	50-55	Nil	Nil	N/A
David Flory	Director General of NHS Finance, Performance and Operations	xxx	xxx	Nil	160-165	195-200	Nil	Nil	N/A
Richard Granger	Director General of NHS IT	290-295	290-295	Nil	250-255	300-305	Nil	Nil	Nil
David Harper	Director General of Health Improvement and Protection	120-125	120-125	Nil	135-140	135-140	Nil	Nil	N/A
Sian Jarvis	Director General of Communications	N/A	N/A	Nil	110-115	130-135	Nil	Nil	N/A
Bruce Keogh*	NHS Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Bill Kirkup	Director General of Clinical Programmes	195-200	195-200	6,200	205-210	205-210	25,800	Nil	N/A
Bill McCarthy	Director General of Policy and Strategy	130-135	130-135	Nil	80-85	140-145	Nil	Nil	Nil
Martin Marshall	Deputy Chief Medical Officer - Healthcare Quality	130-135	150-155	Nil	100-105	155-160	Nil	Nil	Nil
David Nicholson	NHS Chief Executive	95-100	195-200	Nil	215-220	215-220	37,600	Nil	N/A
Una O'Brien	Director General of Policy and Strategy	N/A	N/A	Nil	115-120	125-130	Nil	Nil	N/A
Mike Seitz***	Acting Director General of Commercial Directorate	70-75	295-300	Nil	70-75	295-300	Nil	Nil	Nil
Duncan Selbie	Director General of Commissioning	190-195	190-195	Nil	70-75	200-205	Nil	Nil	Nil
Anthony Sheehan	Director General of Health and Care Partnerships	125-130	125-130	Nil	20-25	115-120	Nil	Nil	Nil
Matthew Swindells*	Chief Information Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hugh Taylor	Permanent Secretary	160-165	160-165	Nil	165-170	165-170	Nil	Nil	N/A
Matt Tee	Director General of Communications	130-135	130-135	Nil	50-55	140-145	Nil	Nil	Nil
Chan Wheeler	Director General of Commercial Directorate	N/A	N/A	N/A	145-150	185-190	132,600	Nil	N/A

* On secondment from an organisation that falls outside the resource accounting boundary
** Employed part time by the Department (0.5 Full Time Equivalent)
*** Figures exclude VAT

xxx Information not available at the time of completing the report

14. Table 2 provides details of pension interests of DMB Members and other Directors General.

Table 2 - Pension interests of DMB Members and other Directors General

		Real increase in pension	Real increase in lump sum	Pension at End Date	Lump sum at End Date	CETV at Start Date (31/03/07)	CETV at End Date (31/03/08)	Employee contribut-ions and transfers in	Real increase in CETV as funded by employer
		£'000	£'000	£'000	£'000	£'000	£'000	To the nearest £100	To the nearest £100
Fiona Adshead	Deputy Chief Medical Officer - Health Improvement	0-2.5	0	5-10	0	73	112	5,500	21,800
Christine Beasley	Chief Nursing Officer	0-2.5	2.5-5.0	50-55	150-155	1,151	1,251	2,100	31,000
David Behan	Director General of Social Care, Local Government and Care Partnerships	0-2.5	0	0-5	0	16	51	6,100	26,100
Mark Britnell	Director General of Commissioning and System Management	0	0	25-30	75-80	311	311	xxx	xxx
Andrew Cash	Director General of Provider Development	xxx	xxx	xxx	xxx	1,118	xxx	xxx	xxx
Clare Chapman	Director General of Workforce	0-2.5	0	0-5	0	6	37	7,600	22,100
Sally Davies	Director General of Research and Development	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
Sir Liam Donaldson	Chief Medical Officer	0-2.5	5.0-7.5	90-95	275-280	1,955	2,260	8,300	43,600
Alan Doran	Director General of Departmental Management	0-2.5	0	75-80	0	1,427	1,506	2,700	22,000
Richard Douglas	Director General of Finance and Chief Operating Officer	2.5-5.0	7.5-10.0	50-55	150-155	816	984	2,000	48,100
Ivan Ellul	Acting Director General of Commissioning	0-2.5	0	0-5	0	14	14	100	800
David Flory	Director General of NHS Finance, Performance and Operations	0-2.5	2.5-5.0	10-15	35-40	158	182	xxx	xxx
Richard Granger*	Director General of NHS IT	5-7.5	N/A	25-30	N/A	237	309	6,800	62,000
David Harper	Director General of Health Improvement and Protection	0-2.5	5.0-7.5	40-45	120-125	677	821	1,800	42,500
Sian Jarvis	Director General of Communications	0-2.5	2.5-5.0	10-15	35-40	162	213	1,700	14,400
Bruce Keogh	NHS Medical Director	xxx	xxx	65-70	200-205	xxx	1,146	xxx	xxx
Bill Kirkup	Director General of Clinical Programmes	10.0-12.5	0	90-95	0	1,494	1,937	3,400	245,900
Bill McCarthy	Director General of Policy and Strategy	0-2.5	0	40-45	0	497	517	2,100	11,600
Martin Marshall	Deputy Chief Medical Officer - Healthcare Quality	0-2.5	0	0-5	0	15	29	2,000	12,600
David Nicholson	NHS Chief Executive	0-2.5	0	0-5	0	14	48	7,100	25,100
Una O'Brien	Director General of Policy and Strategy	2.5-5.0	10.0-12.5	25-30	85-90	415	565	1,700	67,400
Mike Seitz**	Acting Director General of Commercial Directorate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Duncan Selbie	Director General of Commissioning	0-2.5	0	10-15	0	124	121	2,100	11,200
Anthony Sheehan	Director General of Health and Care Partnerships	0-2.5	0-2.5	35-40	110-115	510	475	300	3,500
Matthew Swindells	Chief Information Officer	xxx	xxx	25-30	80-85	xxx	345	6,800	xxx
Hugh Taylor	Permanent Secretary	0-2.5	2.5-5.0	65-70	200-205	1,415	1,634	2,300	34,100
Matt Tee	Director General of Communications	0-2.5	0	0-5	0	13	17	1,200	5,800
Chan Wheeler	Director General of Commercial Directorate	0-2.5	0	0-5	0	0	29	5,200	23,600

No lump sum payable to premium scheme members

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 benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The figures include the value of any pension benefit in another scheme or

arrangement which the individual has transferred to the Civil Service pension arrangements. They also include any additional pension benefit accrued to the member as a result of their purchasing additional pension benefits at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries 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 drawn.

Due to certain factors being incorrect in last year's CETV calculator there may be a slight difference between the final period CETV for 2006-07 and the start of period for 2007-08

* Member of Supplementary Scheme
** The Department makes no contribution towards Mike Seitz's pension
xxx Information not available at the time of completing the report

15. The only person to have received any benefits in kind other than as reimbursement of expenses directly incurred in the performance of their duties was Chan Wheeler (relocation allowance).

16. Payments were made to third parties for the services of Andrew Cash (£55,000-£60,000), Sally Davies (£265,000-£270,000), Bruce Keogh (£90,000-£95,000), Matthew Swindells (£195,000-£200,000) and Mike Seitz (£70,000-£75,000). The first four of these were repayments to the organisations from which secondments took place, where the organisations fell outside the resource accounting boundary (see footnote to Table 1). The fifth was a payment to an Agency through whom a Contractor was employed. The Department also made repayments for the services of Mark Britnell and David Flory to the organisations from which they were seconded

B - MINISTERS

1. Ministers are political appointments made by the Prime Minister; they do not have contracts of employment. Consequently notice periods and termination periods do not apply.

2. The following Ministers were in post during 2007-08 financial year:

Minister		**Date Appointed**
Ben Bradshaw MP	Minister of State	30 June 2007
Andy Burnham MP	Minister of State	6 May 2006**
Lord Ara Darzi	Parliamentary Under Secretary	30 June 2007
Caroline Flint MP	Minister of State***	8 May 2006**
Rt Hon Patricia Hewitt MP	Secretary of State	6 May 2005*
Lord Phillip Hunt	Minister of State	5 January 2007**
Rt Hon Alan Johnson MP	Secretary of State	29 June 2007
Ann Keen MP	Parliamentary Under Secretary	30 June 2007
Ivan Lewis MP	Parliamentary Under Secretary	6 May 2006
Rt Hon Dawn Primarolo MP	Minister of State	30 June 2007
Rosalie Winterton MP	Minister of State	14 June 2003**

* to 28 June 2007
** to 29 June 2007
*** Parliamentary Under Secretary from 10 May 2005

3. There is no provision for compensation for early termination. Compensation for loss of office is payable to former Ministers at the flat-rate of three month's salary. This is set out in legislation rather than an approved Compensation Scheme. There is no other liability in the event of early termination.

4. Table 3 provides details of remuneration interests of Ministers.

Table 3 - Remuneration interests of Ministers

	2006-07		2007-08				
	Salary	Lords Ministers Night Subsistence	Salary	Full Year Equivalent Salary	Lords Ministers Night Subsistence	Full Year Equivalent Lords Ministers Night Subsistence	Compensation for Loss of Office
Minister	£	£	£	£	£	£	£
Ben Bradshaw	N/A	N/A	30,031	39,893	N/A	N/A	N/A
Andy Burnham	33,574	N/A	9,862	39,893	N/A	N/A	N/A
Lord Ara Darzi*	N/A	N/A	32,235	42,822	15,934	21,168	N/A
Caroline Flint	38,489	N/A	9,862	39,893	N/A	N/A	Nil
Patricia Hewitt	74,902	N/A	19,975	76,904	N/A	N/A	19,226
Lord Phillip Hunt	14,253	5,848	20,150	81,504	8,675	35,090	Nil
Alan Johnson	N/A	N/A	58,105	76,904	N/A	N/A	N/A
Ann Keen	N/A	N/A	22,794	30,280	N/A	N/A	N/A
Ivan Lewis	24,655	N/A	30,280	30,280	N/A	N/A	N/A
Dawn Primarolo	N/A	N/A	30,031	39,893	N/A	N/A	N/A
Rosalie Winterton	39,404	N/A	9,862	39,893	N/A	N/A	Nil

* Lord Ara Darzi works part time at 0.6 of a full time equivalent

5. Table 4 provides details of pension interests of Ministers.

Table 4 - Pension interests of Ministers

Minister	Real increase in pension	Pension at End Date	CETV at Start Date	CETV at End Date	Minister's contributions and transfers in	Real increase in CETV funded by employer
	£'000	£'000	£'000	£'000	£	£
Ben Bradshaw	0-2.5	5.0 - 7.5	41	50	3,019	3,373
Andy Burnham	0-2.5	0 - 2.5	11	13	970	593
Lord Ara Darzi	0-2.5	0 - 2.5	0	12	5,314	6,702
Caroline Flint	0-2.5	2.5 - 5.0	25	27	981	884
Patricia Hewitt	0-2.5	10.0 - 12.5	122	127	1,255	1,794
Lord Phillip Hunt	0-2.5	10.0 - 12.5	124	132	2,004	3,163
Alan Johnson	0-2.5	7.5 - 10.0	74	87	3,880	6,301
Ann Keen	0-2.5	0 - 2.5	0	7	2,275	4,249
Ivan Lewis	0-2.5	5.0 - 7.5	34	42	3,028	2,257
Dawn Primarolo	0-2.5	10.0 - 12.5	138	152	3,008	6,524
Rosalie Winterton	0-2.5	5.0 - 7.5	44	47	981	958

C - NON EXECUTIVE DIRECTORS

1. The Department appointed two Non Executive Directors to the Management Board for the first time in 2005. A third Non Executive Director joined the Management Board in June 2006. Guidance about the reimbursement for Non Executive Directors is available from Cabinet Office and reimbursement ranges from simply reimbursing expenses to significant payments for quite substantial roles.

2. Non Executive Directors are not employees of the Department. The Non Executive Directors are normally appointed for a fixed term of three years with the possibility of extension. They are appointed primarily to attend DMB meetings which involve an estimated time commitment of eleven four-hour meetings and two overnight events per year. They also attend some other Departmental Committees and meetings with senior officials

3. Either party may terminate the contract for any reason before the expiry of the fixed period by giving one month's notice in writing. There is no provision for compensation for early termination.

4. Derek Myers is not personally reimbursed for his role as a Non Executive Director. His employer is reimbursed for £500 for every day worked, totalling £10,125 in 2007-08. Julie Baddeley and Mike Wheeler receive a fee of £2,000 per day, with payments to Julie Baddeley totalling £24,500 in 2007-08 and to Mike Wheeler totalling £31,500. All these amounts exclude VAT.

5. Non Executive Directors fees are not pensionable.

Hugh Taylor *25th September 2008*
Permanent Secretary
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

RELATIONSHIP BETWEEN ACCOUNTING OFFICERS IN THE DEPARTMENT OF HEALTH, ITS AGENCIES AND THE NHS

1. This Note sets out the nature of the relationship between Accounting Officers in the Department of Health, its Agencies and the NHS. It refers to *Managing Public Money* published by HM Treasury

2. As Principal Accounting Officer, the Permanent Secretary of the Department of Health is accountable for the Department's administration, some central health and miscellaneous health services, those elements of social services expenditure within the Department's responsibilities, Welfare Foods, European Economic Area (EEA) medical costs and resources voted for the Office of the Independent Regulator for NHS Foundation Trusts. These are covered by the Request for Resources 2 and Request for Resources 3 in the Department's Estimates and Accounts. As Head of the Department, he takes responsibility for the consolidation of the Department's Accounts and for the voted cash requirement, and has the Department-wide responsibility for the good management of the Department as a whole, including a high standard of financial management. This includes the parts of the Department managing the NHS (as distinct from the NHS itself) and the Department's Agencies, since they are parts of the Department operating in support of the Secretary of State. He is responsible for carrying out the duties set out in Chapter 3 of *Managing Public Money*.

3. As an Additional Accounting Officer the Chief Executive of the NHS is directly responsible to the Secretary of State for the management of the NHS. He is accountable for expenditure on hospital and community health services, family health services, some central health services, the drugs bill and NHS Trusts' external financing. These are covered by the Request for Resources 1 in the Department's Estimates and Accounts. He is responsible for carrying out the duties set out in Chapter 3 of *Managing Public Money*. He is also the Accounting Officer for the Summarised Accounts of NHS Trusts, Primary Care Trusts, Strategic Health Authorities, and Special Health Authorities where required.

4. Each year the Permanent Secretary agrees with the Chief Executive of the Purchasing and Supply Agency within the Department of Health a budget for the administration costs to cover its responsibilities, and delegates to him immediate responsibility for the good management of the Agency. The Chief Executive is designated as an Agency Accounting Officer and his responsibilities are set out in the Agency's Framework Documents and his letters of designation as Agency Accounting Officer.

5. The Chief Executive of the Medicines & Healthcare Products Regulatory Agency is accountable for the expenditure relating to this Trading Fund. He is responsible for carrying out the duties set out in Chapter 3 of *Managing Public Money* for the Agency. His accountability is subject to the Permanent Secretary's overall responsibility for the organisation and management of the Department of Health.

6. Chief Executives of NHS Trusts, Primary Care Trusts and Strategic Health Authorities are designated as Accountable Officers and Chief Executives of Special Health Authorities are designated as Accounting Officers, who are accountable to Parliament through the NHS Chief Executive for the efficient, effective and proper use of all the resources in their charge. The Chief Executives of Special Health Authorities are accountable for the expenditure relating to those bodies. They are responsible for carrying out the duties set out in *Managing Public Money* in respect of those Authorities. Their accountability is subject to the Permanent Secretary's overall responsibility for the organisation and management of the Department of Health

7. The Chief Executive of the NHS Business Services Authority is also the Accounting Officer for the NHS Pension Scheme. He is responsible for carrying out the duties set out in Chapter 3 of *Managing Public Money* in relation to the operation of the NHS Pension Scheme. In respect of the administrative expenditure of the Authority, the Chief Executive's responsibilities are set out in the Authority's Framework Document and his letter of designation as Authority Accounting Officer.

8. The Chief executives of Non Departmental Public Bodies are designated as Accounting Officers who are accountable to Parliament through either the Permanent Secretary or the NHS Chief Executive, depending upon designation, for the efficient, effective and proper use of all the resources in their charge. They are responsible for carrying out the duties set out in *Managing Public Money* in respect of those bodies.

STATEMENT ON INTERNAL CONTROL

Scope of Responsibility

1. As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Department of Health's policies, aims and objectives, while safeguarding the public funds and Departmental assets for which I am personally responsible. This is in accordance with the responsibilities assigned to me in Government Accounting.

2. This Statement is given in respect of the Resource Account for the Department of Health, which incorporates the transactions and net assets of the core Department, its Executive Agencies and other bodies falling within the Departmental boundary for resource accounting purposes. This includes English NHS bodies except NHS Trusts and Foundation Trusts (although the Department's investment in them is included) and certain Special Health Authorities. As Accounting Officer for the Department, I acknowledge my overall personal responsibility for ensuring that the Department, its Executive Agency and other Arms Length and NHS bodies maintain a sound system of internal control. I am supported in exercising the responsibility by the Additional Accounting Officer (the Chief Executive of the NHS) for the NHS (RfR1). The Additional Accounting Officer's and my roles and responsibilities are set out in a Memorandum of Understanding between us both. In particular, I have drawn on the overall statements of internal control for Strategic Health Authorities, Primary Care Trusts and NHS Trusts, which he has approved, to support this Statement of Internal Control.

The purpose of the system of internal control

3. The Department of Health's system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve the Department's policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of Departmental policies, aims and objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised,
- manage them efficiently, effectively and economically, and
- regularly review the risks being managed.

4. The system of internal control was in place in the Department of Health for the financial year ending 31 March 2008, and has remained in place up to the date of final approval of the Department's Annual Report and Resource Accounts. The Department's system of internal control accords with Treasury guidance. Some improvements to the system of internal control were identified in 2006-07 which were put in place during 2007-08. This includes:

- taking further steps to embed risk management in Directorate Business Plans for 2007-08 and beyond, underpinned by a Department of Health policy on risk and associated guidance on risk management, which accords with the latest guidance on risk management in central Government from the Office of Government Commerce (OGC) (paragraph 7)
- further improvements in Business Planning (paragraph 9), and
- acting in 2008-09 and 2009-10 on the recommendations on governance structures and risk management made by the Cabinet Secretary's report of the Capability Review of the Department of Health (paragraphs 23 and 24).

Capacity to handle risk

5. The internal control system is based on a clear risk management framework and accountability process that is embedded in the Department and its Agencies via delivery and business planning processes.

6. Leadership of the system of internal control has been shown by senior staff in visibly owning and supporting risk assessment and control activity, in particular in support of the delivery programmes for PSA targets and other priorities. Also during 2007-08, work on accountability and governance was progressed following a high level review and the findings of the Capability Review of the Department of Health, which reported in June 2007. This has resulted in a revised governance structure with a much smaller **Departmental Board** within the strategic framework set by Ministers focusing on the biggest strategic, cross cutting issues and risks for the

Department and its work programmes. The Board is supported by the following Boards and Committees (also see paragraph 21 that includes information about the new **Performance Committee**) with defined responsibilities for areas of the Department's business:

- **Corporate Management Board** which supports me in my responsibility as Accounting Officer for Departmental expenditure and provides leadership for the Department. This Board is supported by two sub-committees:
    - *Corporate Management and Improvement Committee* which is responsible for ensuring that, operationally, the Department is managed in a consistent, efficient and effective manner, focusing on capability, planning, performance and risk management, corporate policy making, internal communication, environmental, reputational and social issues; and
    - *Policy Committee* which is responsible for policy governance and also advises CMB on relative priorities, resourcing and the overall deliverability of the total policy programme by the health and care system, including fit with Departmental strategy, costs, risks, and the robustness of project plans for each policy being developed
- **NHS Management Board** and its Executive Groups which support the NHS Chief Executive in his responsibility as Accounting Officer for NHS expenditure and provides leadership for the NHS ensuring effective two-way communication, manages NHS performance and shapes policy and strategy for the NHS
- **Audit Committee** which advises me, the additional Accounting Officer, and the Departmental Board on risk management, corporate governance and assurance arrangements in the Department and its subsidiary bodies.

7. The Department's policy and guidance on risk management was updated in January 2008, to ensure that it is fully in line with the latest OGC and Treasury guidance, and underpinned by a single IT system for capturing and monitoring information about risks. The Department's policy is to know about its risks; have clear accountabilities in place for the management of them; have robust and consistent procedures in place for risk management; and to have staff at all levels who possess the necessary competencies in risk management. The framework makes clear that all staff have a responsibility for identifying, assessing, addressing, and monitoring and reviewing risks to the achievement of objectives in the areas of work for which they are responsible. Directors General in the Department are responsible for ensuring staff are appropriately trained in risk management. To support the risk management structure in the Department, a Director level Risk Forum was established during 2007-08 to review and advise the Department's Board on the strategic high level risks facing the Department.

The risk and control framework

8. Within the Department, I operate an accountability process based around compliance with five core assurance standards:

i risk management
ii planning and delivery
iii resource management
iv policy development, and
v governance of Arms Length Bodies.

9. Risk management has been integrated into the Departmental Business Planning process and further improvements have been implemented to link Directorate level operational risks with strategic risks in the corporate risk register. The 2008-09 Business Plan now provides a stronger basis on which to take forward work on embedding the Assurance Framework in 2008-09 and beyond. Similarly, my 2008-9 Budget Accountability letters to Directors General were accompanied by guidance on the Department's corporate core assurance standards, which sets out how Directorates can judge and report on their compliance against the five core assurance standards.

10. The Board is responsible for the ownership and management of high level strategic risks. Throughout the year the Board, supported by its Audit Committee and other Committees, and advised by the Director level Risk Forum, has maintained an oversight on these high-level risks, presented in a high-level risk register. During 2007-08, following the Audit Committee's suggestions, the Department improved the high-level risk register to make it a tool to assist strategic decision making by top management. The NHS Management Board also

considered risks escalated to it from individual delivery programmes, and has identified issues and risks arising for Strategic Health Authorities and the Department.

11. There has been continuing challenge to the assessments of likelihood and impact of the risks identified and contained in the high-level risk register. When appropriate, some risks have been removed from the register to be managed by one of the Department's Boards and Committees, and new risks added. The Department continues to be responsible for high risk activity, including leadership of work across Government on preparations for a possible flu pandemic or major incident arising from a natural disaster for example.

12. During 2006-07, the Departmental Management Board (reconstituted from Autumn 2007 as the Departmental Board) was presented with a proposed strategy for the implementation of an Assurance Framework. This was accepted by the Board, and is being used to develop an overall framework, which will identify and quantify the value of the internal and external assurances available to the Department.

How I gain assurance

13. Directorate level operational risks are monitored using the Enterprise Project Management system and reviewed on a monthly basis using the Directorate performance scorecards linked to each Directorate's risk register. Where necessary, operational risks are escalated to the Departmental performance scorecard and corporate risk register through a monthly risk review.

14. The Department's Audit Committee advises the Accounting Officers and the Board on the quality of risk management, corporate governance and internal control. The Committee considers the risk management requirements of subordinate bodies and the key governance information flowing to the Chief Executives from these bodies. It has reviewed this statement in draft and its comments on evidence of assurances received have been reflected.

15. Within the Department, the Assurance Strategy and Audit (ASA) team provides an independent assurance function on the robustness of governance and internal control processes. ASA resources for 2007-08 were determined on the assumption that the implementation of an assurance framework would enable all Directorates in the Department to embed assurance within their operations, draw on the targeted assurance activity of ASA, and commission further assurance (from whatever source) where gaps were identified. The Head of Internal Audit (ASA) has provided me with his annual opinion which has highlighted the need to embed new governance arrangements and the risk management and internal control systems underpinning these.

16. Directors General, and certain other senior managers, are required to provide me with assurance statements at the end of the financial year which address the extent to which the five core assurance standards have been met in their Directorates.

17. In addition to the Department's internal processes, I gain assurance from:

- assessments by Strategic Health Authorities which, as part of their role of performance management of PCTs and NHS Trusts, identify local risks to delivery, where necessary coordinate mitigation actions, and report into NHS Management Board discussions;
- work by the Healthcare Commission during the year;
- reports from the National Audit Office (Annex A) and Audit Commission resulting from their work in the Department and the NHS, and the Public Accounts Committee (Annex B);
- the Department's Assurance Strategy and Audit Unit report for 2007-08;
- Gateway reviews of large projects; and
- assessments of the Department's work by other external units, including for example the Prime Minister's Delivery Unit.

Review of effectiveness

18. As Principal Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. This is informed by:

- the work of the executive managers within the Department, who have responsibility for the development and maintenance of the internal control framework;
- the work of the internal auditors; and
- comments made by the external auditors in their management letters and other reports.

19. I have reviewed through a summary report (prepared by my Governance Branch) the assurance statements Directors General have provided me which recorded the position in their business groups over the year. This indicates that internal control and assurance arrangements are being strengthened.

20. We have made progress in the overall delivery of SR04 PSA targets for 2007-08 with some slippage on infant mortality and life expectancy at birth, where more needs to be done to tackle the widening gap of health inequalities; and older people supported to live at home, reflecting a trend for more intensive services. Slippage on teenage conception rates provides the biggest challenge that we would need to accelerate progress to meet the 2010 target.

21. In strengthening our arrangements for the SR07 Department's PSAs from 2008-09, I have implemented a new approach to new governance and control through establishing an overarching **Performance Committee**, which oversees the work of the Department on PSAs and reports to the Departmental Board. The Performance Committee is supported by two PSA Boards and together they will encourage and support the importance of working with other Government Departments to deliver the cross-Government PSAs.

22. Because of its size and importance, the NHS IT programme is run as a managed programme by a separate unit, Connecting for Health. The Director General responsible for Connecting for Health left the Department in January 2008. Interim arrangements were established until two new key senior appointments were made in August 2008 with both positions taken up in September 2008. Best practice structures have been established to deliver the programme which is subject to regular Gateway reviews by OGC.

23. On 12 September 2007, the Department published a Department of Health Development Plan which set out a two year programme of action in response to the main areas for action identified by the Capability Review report published in June 2007 to the Cabinet Secretary. A Programme Board with non-executive director representation, was set up to oversee implementation of the Plan. A Cabinet Office review of progress after six months concluded that the Department was moving in the right direction.

24. In July 2008, the Capability Review Team returned to the Department to assess the progress at the 12-month stage. The team highlighted many successes and much progress since last year's Review. They also pointed to some areas where there is more to do. The Department will focus on sustaining the impressive improvements and progress made to date so that all staff truly start 'feeling the difference' as we enter the final phase of the Development Plan.

25. For the Department's Arm's Length Bodies (ALBs), I have reviewed a summary of the key points raised in the Statement on Internal Control that each body's Accounting Officer makes as part of their annual accounts, and of the opinions of their external auditors. I have similarly reviewed assurance statements provided by the senior member of staff in the Department responsible for sponsoring each body. On this basis I have concluded that at least minimum assurance standards are being met, and that there are no significant control issues in the ALBs which need to be included in this SIC. There is one issue to Note, however, relating to the NHS Institute for Innovation and Improvement (NHS Institute) which has received a qualification to its accounts for 2007-08 in relation to advance payments of £2,445,000 made to suppliers towards the end of 2007-08 which were not properly due. Managing Public Money requires such advance payments to be made only where a good value for money case can be made for them. Advance payments are regarded as novel and contentious and require prior Treasury approval. This approval was not received and therefore the Comptroller and Auditor General concluded that the payments did not conform to the authorities which govern them and qualified his regularity opinion on the Institute's financial statements for 2007-08. The NHS Institute is aware of their need to work more closely with the Department's Financial and Operations Directorate to ensure that HM Treasury rules are better understood by the Board of the NHS Institute, and I do not expect any such misunderstanding of the rules to occur in future years. Overall, I have noted that the standards applied to the internal governance, financial management and reporting procedures relating to all of the Department's arm's length bodies continues to improve. However, there continue to be areas where further improvements could be made and we therefore await the NAO's overall ALB Management Letter, when the ALB Business Support Unit will ensure that these are addressed.

26. For the Department's Regional Public Health Offices, I have been assured that risk is understood and incorporated into management and performance management.

27. The Statements of Internal Control prepared for the NHS Summarised Accounts, approved by the NHS Chief Executive as Additional Accounting Officer for RfR1, have been drawn on in compiling this Statement. The significant control issues disclosed by the NHS Bodies are included in paragraph 32 below.

28. The compilation of the Statements of Internal Control for the NHS Summarised Accounts also drew on the Auditors' Local Evaluation assessments coordinated by the Audit Commission. This assesses how well NHS trusts and PCTs have implemented their systems of internal control. The assessment showed that 98 per cent of NHS bodies demonstrated adequate or more than adequate performance in their implementation of systems

of internal control, while two per cent failed to meet the minimum requirements. One NHS trust and one PCT demonstrated systems of internal control that met the highest possible standard.

29. In 2007-08, NHS expenditure remained within the sums voted by Parliament and the Departmental resources expenditure limit set by HM Treasury. Overall, there was a net surplus of £1.67bn. This surplus resulted from the delivery of the £250m initial planned surplus by the NHS, the positive impact of lower prescribing costs from nationally negotiated drug price reductions, and the release of uncommitted contingency budgets set aside by most NHS organisations. The NHS is planning to deliver a similar level of surplus in 2008-09.

30. Following the Cabinet Office Data Handling Review Team request in January 2008 about managing information risk, the Department began reviews of the assurance over the implementation of measures to manage information risk across Department of Health and our delivery chains. The work we began, which concentrated on the following areas, will form the Department's Strategy on managing information risk during 2008-09:

- identify the nature, size and location of the personal data sets held;
- identify and review the risks to this data, including when it is moved or transferred within or by Department of Health or handled in Arms' Length bodies;
- determine what level of residual risk is acceptable;
- mitigate risks to that acceptable level; and
- assess compliance with policies for detecting and investigating non-compliance and for reacting to and recovering from incidents.

31. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and the Audit Committee and plan to address weaknesses and ensure continuous improvement of the systems in place.

Significant internal control problems

32. 66 PCTs and 67 NHS Trusts (which are outside the Department's resource accounting boundary), together disclosed a total of 442 significant control issues[1] in their statements of internal control. The majority of these were failures to comply, or having assurance of complying, with the core Standards for Better Health. Strategic Health Authorities will continue to monitor and review the ongoing development and embedding of systems of internal control by PCTs and NHS Trusts.

33. In compiling the Statements of Internal Control for the NHS Summarised Accounts, it was noted that the accounts of six PCTs were qualified on the grounds of regularity.

34. During 2007-08, the Department reported one personal data security incident relating to the core Department to the Information Commissioner. This concerned the Medical Training Application Service website where personal details of some junior doctors were erroneously made available as a result of action taken by a third party managing data on the Department's behalf which was contrary to the instructions on data handling issued to them by the Department. The site was closed down as soon as the breach was discovered and a full security review undertaken. Additional incidents in organisations within the Resource Account boundary are reported in their individual accounts.

35. Following difficulties during the 2007 recruitment of doctors to specialty training, the Modernising Medical Careers programme (MMC) fundamentally revised its governance and approach. MMC now has a strengthened Programme Board (PB), a single Senior Responsible Officer, and a Chief Operating Officer to manage according to strong programme management principles, with enhanced stakeholder engagement, and expert advice from trusts, deaneries, the Foundation Programme Office and the GP National Recruitment Office.

36. For 2008 recruitment a low-risk, deanery-based process was adopted and the central IT system discarded. In response to the Tooke Inquiry (initiated by the previous Secretary of State to review MMC), and also in the light of the commitments made by the Next Stage Review in "A High Quality Workforce" in Summer 2008, the future structure of medical education and training is under consideration by the PB with policy decisions and implementation plans to follow. The MMC Team will introduce limited web-based support to the deanery-based

[1] In 2007-08, for the first time, each breach of any of the core Standards for Better Health is being counted as a significant control issue, as is any Serious Untoward Incident involving data security. For this reason the total number of significant control issues is not comparable to the totals in previous years.

recruitment process in 2009, separately considering the reintroduction of 'national' IT using an appropriate model, that will have been tested within the Service, for 2010 onwards.

37. In my last report, I set out the work we were doing to meet concerns raised by the Commission for Racial Equality (CRE) in the course of their formal investigation into the Department's compliance with race equality legislation. That investigation reported in September 2007 when the CRE served on the Department a Compliance Notice on the basis that our Single Equality Scheme, published in July 2007, was not compliant with the legislative requirements.

38. As a result of the recommendations made in the course of CRE's investigation, and in the light of other comments received from the Disability Rights Commission (DRC) and the Equal Opportunities Commission (EOC) the Department's Single Equality Scheme was revised and the accompanying action plan updated. The Scheme will better reflect the progress we had made in a number of areas as well as acknowledge those areas where further work is needed. The Equalities and Human Rights Commission took over the responsibilities of the CRE, DRC and EOC on 1 October 2007. During the year, we worked with the EHRC to ensure that our revised Scheme will properly meet the requirements of the legislation while remaining a practical and useful tool for colleagues in the Department. Our revised Scheme is due for publication during 2008-09 and will set out a robust and challenging agenda for the Department over the period 2008-09 to 2010-11.

Conclusion

39. I conducted my review of the effectiveness of the system on internal control in the Department of Health jointly described above, in parallel with that of the NHS Chief Executive as Additional Accounting Officer. We identified control issues, in respect of Modernising Medical Careers (MMC), the Equality and Human Rights Commission's formal compliance notice for non-compliance with equality legislation, and some failures in some NHS bodies. The Department has maintained a vigorous programme of action initiated in 2006-07 to address the NHS financial position, and the underlying need of NHS bodies to improve financial management processes. NHS bodies that have assessed themselves as failing to meet Standards for Better Health are taking local action to ensure compliance, or have already done so. Action has already been taken, and will continue through 2008-09, to address and prevent the reoccurrence of the MMC, healthcare associated infections, compliance with the equality legislation issues.

40. Overall, leadership of the system of internal control has been shown by senior staff in visibly owning and supporting risk assessment and control activity, in particular in support of the delivery programmes for PSA targets and other priorities. During 2007-08 a revised governance structure with a much smaller Departmental Board within the strategic framework set by Ministers focusing on the biggest strategic, cross cutting issues and risks for the Department and its work programmes was established and governance supported by an updated Department of Health specific policy and guidance on risk management.

Hugh Taylor
Permanent Secretary and Principal Accounting Officer
25th September 2008

THE CERTIFICATE OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSE OF COMMONS

I certify that I have audited the financial statements of the Department of Health for the year ended 31 March 2008 under the Government Resources and Accounts Act 2000. These comprise the Statement of Parliamentary Supply, the Operating Cost Statement, the Statement of Recognised Gains and Losses, the Balance Sheet, the Consolidated Cashflow Statement, the Consolidated Statement of Operating Costs by Departmental Aim and Objectives and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer is responsible for preparing the Annual Report, which includes the Remuneration Report and the financial statements in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions made thereunder and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements and the part of the Remuneration Report to be audited in accordance with relevant legal and regulatory requirements, and with International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the HM Treasury directions issued under the Government Resources and Accounts Act 2000. I report to you whether, in my opinion, information given in the Annual Report, which comprises "Scope" and "Management Commentary" and the unaudited part of the Remuneration Report is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In addition, I also report to you if the Department has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by relevant authorities regarding other transactions is not disclosed.

I review whether the Statement on Internal Control reflects the Department's compliance with HM Treasury's guidance, and I report if it does not. I am not required to consider whether this statement covers all risks and controls, or to form an opinion on the effectiveness of the Department's corporate governance procedures or its risk and control procedures.

I read the other information published in the Annual Report and consider whether it is consistent with the audited financial statements. I consider the implications for my certificate if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinions

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the Accounting Officer in the preparation of the financial statements, and of whether the accounting policies are most appropriate to the Department's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or error, and that in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the Government Resources and Accounts Act 2000 and directions made thereunder by HM Treasury, of the state of the Departments' affairs as at 31 March 2008, and the net cash requirement, net resource outturn, net operating cost, operating costs applied to objectives, recognised gains and losses and cash flows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the HM Treasury directions issued under the Government Resources and Accounts Act 2000; and
- information given within the Annual Report, which comprises "Scope" and "Management Commentary" and the unaudited part of the Remuneration Report, is consistent with the financial statements.

Opinion on Regularity

In my opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Emphasis of matter: Consolidated Statement of Operating Costs by Departmental Aim and Objective

Without qualifying my opinion, I draw your attention to the Consolidated Statement of Operating Costs by Departmental Aim and Objectives which analyses the Department's resources by objective in accordance with the methodology set out in Note 1.24.This information is collected at a local level and subject to Departmental review. The extent of judgement required in this process means that significantly different, yet still defensible, allocations of income and expenditure could have been reported to provide indicative spend.

Report

Further information on my audit work on the NHS will be discussed in the forthcoming Report on the NHS Summarised Accounts: Financial Management in the NHS, HC 1043-II, due to be published in November.

T J Burr
Comptroller and Auditor General

National Audit Office
151 Buckingham Palace Road
Victoria
London
SW1W 9SS

3 October 2008

Statement of Parliamentary Supply

for the year ended 31 March 2008

Summary of Resource Outturn 2007-08

								2007-08	2006-07
		Estimate			Outturn				Outturn
Request for Resources	Note	Gross Expenditure £'000	A-in-A £'000	Net Total £'000	Gross Expenditure £'000	A-in-A £'000	Net Total £'000	outturn compared with Estimate savings /(excess) £'000	Net Total £'000
1	2	91,148,669	20,981,089	70,167,580	89,482,375	20,556,416	68,925,959	1,241,621	61,287,750
2	2	3,718,997	59,052	3,659,945	3,687,544	59,052	3,628,492	31,453	3,301,374
3	2	14,007	-	14,007	13,507	-	13,507	500	12,324
Total resources	3	**94,881,673**	**21,040,141**	**73,841,532**	**93,183,426**	**20,615,468**	**72,567,958**	**1,273,574**	**64,601,448**
Non-operating cost A-in-A				**1,808,538**			**1,577,064**	**(231,474)**	**1,601,202**

Net cash requirement 2007-08

				2007-08	2006-07
				outturn compared with estimate Saving/ (excess)	
	Note	Estimate £'000	Outturn £'000	£'000	Outturn £'000
Net cash requirement	4	71,080,010	68,658,849	2,421,161	64,561,827

Summary of the income payable to the Consolidated Fund

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

		Forecast 2007-08 £'000		Outturn 2007-08 £'000	
	Note	Income	Receipts	Income	Receipts
Total	5	-	-	20,897	*20,897*

Explanations of variances between Estimate and outturn are given in Note 4 and in the Management Commentary.

The notes on pages 44-79 form part of these accounts

Operating Cost Statement

for the year ended 31 March 2008

		2007-08							2006-07
		Core Department			Consolidated				
		Staff Costs	Other Costs	Income	Staff Costs	Other Costs	Income	Core Department	Consolidated
	Notes	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Administration Costs:									
Staff costs	9	134,281			134,281			137,175	137,175
Other administration costs	10		107,228			107,228		107,873	107,873
Operating income	12			(5,924)			(5,924)	(5,165)	(5,165)
Programme Costs									
Request for Resources 1									
Securing health care for those who need it.									
Staff Costs	9	148,123			7,423,953			157,903	7,186,033
Programme Costs	11		6,178,370			82,058,422		6,209,112	73,631,368
Income	12			(1,275,568)			(20,556,416)	(1,322,513)	(20,407,635)
Request for resources 2:									
Securing social care and child protection for those who need it and, at national level, protecting, promoting and improving the nation's health.									
Staff Costs	9	5,265			21,081			361	16,184
Programme Costs	11		3,439,834			3,424,954		3,090,109	3,102,252
Income	12			(74,004)			(74,025)	(55,484)	(56,945)
Request for resources 3:									
Office of the Independent Regulator for NHS Foundation Trusts									
Staff Costs	9	-			-			-	-
Programme Costs	11		13,507			13,507		12,324	12,324
Income	12			-			-	-	-
Totals		287,669	9,738,939	(1,355,496)	7,579,315	85,604,111	(20,636,365)	8,331,695	63,723,464
Net Operating Cost	3,13			**8,671,112**			**72,547,061**	**8,331,695**	**63,723,464**

Statement of Recognised Gains and Losses

for the year ended 31 March 2008

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Net gain on revaluation of tangible fixed assets	21,112	405,200	27,947	317,698
Net gain on revaluation of investments	98,632	98,834	-	402
Receipt/revaluation of donated assets	-	13,835	-	19,700
Impairment of fixed assets	-	(33,406)	-	(19,290)
Total recognised gains for the year	**119,744**	**484,463**	**27,947**	**318,510**

The notes on pages 44-79 form part of these accounts

Balance Sheet

as at 31 March 2008

		2008 £'000			2007 £'000	
	Note	Core Department		Consolidated	Core Department	Consolidated
Fixed assets:						
Tangible assets	14	598,004		7,304,878	626,858	7,131,418
Intangible assets	15	1,305,717		1,322,871	926,215	942,578
Investments	16	24,006,968		24,051,613	23,400,305	23,438,751
			25,910,689		**24,953,378**	**31,512,747**
Debtors falling due after more than one year	18		**134,100**	**186,890**	**99,524**	**157,655**
Current assets:						
Stocks	17	337,403		409,776	390,021	456,170
Debtors	18	507,597		2,157,327	603,387	2,163,782
Cash at bank and in hand	19	2,245,086		2,446,682	1,292,394	1,438,492
		3,090,086		**5,013,785**	**2,285,802**	**4,058,444**
Creditors (amounts falling due within one year)	20	(3,111,571)		(9,062,636)	(2,105,961)	(7,919,740)
Net current Liabilities			**(21,485)**	**(4,048,851)**	**179,841**	**(3,861,296)**
Total assets less current liabilities			**26,023,304**	**28,817,401**	**25,232,743**	**27,809,106**
Creditors (amounts falling due after more than one year)	20	(182,075)		(362,278)	-	(192,553)
Provisions for liabilities and charges	21	(1,610,149)		(14,372,351)	(1,494,354)	(11,350,497)
			(1,792,224)	(14,734,629)		
Net Assets			**24,231,080**	**14,082,772**	**23,738,389**	**16,266,056**
Taxpayers' equity						
General fund	22		23,809,817	11,051,206	23,412,465	13,603,372
Revaluation reserve	23.1		421,263	2,881,254	325,924	2,519,902
Donated asset reserve	23.2		-	150,312	-	142,782
			24,231,080	**14,082,772**	**23,738,389**	**16,266,056**

The notes on pages 44-79 form part of these accounts

Hugh Taylor *25th September 2008*
Permanent Secretary
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Consolidated Cash Flow Statement

for the year ended 31 March 2008

	Note	2007-08 £'000	2006-07 £'000
Net cash flow from operating activities	24.1	(67,606,440)	(61,356,670)
Capital expenditure and financial investment	24.2, 24.3	(1,035,428)	(2,166,794)
Payments of amounts due to the Consolidated Fund		(397,877)	(1,044,181)
Financing	24.4	70,052,136	65,106,693
Increase in cash in the period	24.5	**1,012,391**	**539,048**

The notes on pages 44-79 form part of these accounts

Consolidated Statement of Operating Costs by Departmental Aim and Objectives

for the year ended 31 March 2008

	2007-08 £m	2006-07 £m
Objective I		
Access to Services	25,255	23,322
Objective II		
Improving the Patient / User Experience	7,857	5,990
Objective III		
Health of the Population	29,106	26,788
Objective IV		
Long Term Conditions	16,264	14,353
Other	14,701	13,740
	93,183	84,193
Total Income	(20,636)	(20,470)
Net Operating Cost	**72,547**	**63,723**

Note

The majority of income comes from National Insurance Contributions and is treated as central funding rather than allocated as a particular objective. Therefore gross operating figures have been disclosed for each objective.

The presentation above provides high level indicative spend against the key Departmental objectives applying a method based on outturn data already collected by the NHS. Although Departmental and NHS activity can contribute to several objectives at the same time, the adopted method provides a high-level and fair assessment of spend by objective. The NHS response to many conditions contributes to more than one objective, but the model used to derive the schedule outturn assigns individual PSA target expenditure to single objectives. As a result the figure on long term conditions excludes some spend on conditions which are usually considered long term conditions, because these are included in health of the population. These figures should not be taken as absolute, however.

Costs have been allocated to these objectives in accordance with the methodology set out in Note 1.24 using the latest available data and for reference costs this is the final 2006-07 data. This information is collected at a local level and subject to Departmental review. The extent of judgement required in this process means that significantly different, yet still defensible, allocations of income and expenditure could have been reported.

See Note 25 for further analysis of these objectives.

The notes on pages 44-79 form part of these accounts.

NOTES TO THE DEPARTMENTAL RESOURCE ACCOUNTS

1 Statement of accounting policies

The financial statements have been prepared in accordance with the The Government Financial Reporting Manual (FReM) for 2007-08 issued by HM Treasury. The accounting policies contained in the FReM follow UK generally accepted accounting practice for companies (UK GAAP) to the extent that it is meaningful and appropriate to the public sector. In addition to the primary statements prepared under UK GAAP, the FReM also requires the Department to prepare two additional primary statements. The Statement of Parliamentary Supply and supporting notes show outturn against Estimate in terms of the net resource requirement and the net cash requirement. The consolidated Statement of Operating Costs by Departmental Aim and Objectives and supporting notes analyse the Department's income and expenditure by the objectives agreed with Ministers. Where the FReM permits a choice of accounting policy, the accounting policy which has been judged to be most appropriate to the particular circumstances of the Department for the purpose of giving a true and fair view has been selected. The Department's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

The accounts include five departures from FReM which have been agreed with HM Treasury:

- Public Dividend Capital issued by the Department due to the creation of new NHS Trusts and written-off due to the dissolution of existing NHS Trusts is debited or credited to the General Fund rather than the Operating Cost Statement.
- Income from NHS bodies received by the Department or bodies within the accounting boundary is excluded and netted off the relevant expenditure.
- National Insurance Contributions are accounted for on a cash basis.
- In the Consolidated Statement of Operating Costs by Departmental Aim and Objectives costs have been allocated using 2006-07 data.
- In the Analysis of net operating cost by spending body, Note 13, the Department has group bodies rather than listing them individually.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of fixed assets and stocks where material at their value to the business by reference to their current cost.

1.2 Basis of consolidation

These accounts consolidate financial information for the Department of Health (core Department), its supply-financed Executive Agency, and other NHS bodies funded directly by the Department that fall within the Departmental boundary as defined in the Government Financial Reporting Manual issued by HM Treasury. The Medicines & Healthcare Products Regulatory Agency, NHS Trusts, Foundation Trusts and all, except NHS Tribunals, of the Department's non-Departmental Public Bodies are excluded from the consolidation. Note 37 contains a full list of bodies consolidated within and excluded from the accounts. More information on entities within the Departmental family can be found in the annual reports and accounts of the Executive Agency or in the individual and summarised accounts of NHS Trusts, Strategic Health Authorities, Special Health Authorities, Foundation Trusts and Primary Care Trusts which are published separately.

1.3 Intangible fixed assets

The following intangible fixed assets are capitalised:

— Purchased computer software licences
— Licences and trademarks
— Development expenditure

Expenditure incurred on the National Programme for IT has been split between capital and revenue expenditure using a financial model that analyses contractor costs over the life of the project. As the majority of assets generated by this project are software related, including the purchase of licences, they have been capitalised within intangible fixed assets. These are being amortised over the life of the project.

1.4 Tangible fixed assets

Fixed assets other than purchased computer software and licenses are capitalised as a tangible asset where expenditure of £5,000 or more is incurred on:

i) a discrete asset;

ii) a collection of assets which, individually may be valued at less than £5,000 but which together form a single collective asset because the items fulfil all of the following criteria:
   - the items are functionally interdependent;
   - the items are acquired at about the same date and are planned for disposal at about the same date; and
   - the items are under single managerial control.

iii) a collection of assets which individually may be valued at less than £5,000 but which form part of the initial equipping and setting-up cost of a new building; and

iv) enhancing an existing asset beyond its previously assessed standard of performance.

Fixed assets are valued as follows:

i) The Civil Estate was valued as at 30 June 2000, and revalued as at 1 September 2005 for the Central Department's Land and Building, by independent valuers employed by the Department. For other NHS bodies, Civil Estate Land and Building valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and were applied as at 31 March 2005. All valuations have been according to RICS guidelines. Between valuations, IPD indices for Civil Estate assets and NHS indices for all other assets are applied to arrive at current values; and

ii) The Retained Estate was valued as at 31 March 2005 by professional valuers. Specialised operational property is valued at depreciated replacement cost, non-specialised operational property is valued on an existing use value and non-operational and surplus property are valued at open market value; and

iii) Other land and buildings are restated at current cost using professional valuations every five years and appropriate indices in intervening years. The buildings indexation is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building and land values reported in the Property Market Report published by the Valuation Office and included in the Manual for Accounts. Valuations are carried out by the District Valuers of the HMRC at five-yearly intervals. A five-yearly revaluation was carried out as at 1 April 2005.
   The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and have been applied as at 31 March 2005.
   The valuations have been carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property, and

iv) IT equipment, assets in the course of construction, transport equipment, furniture and fittings and plant and machinery held for operational use are valued at net current replacement cost using an appropriate index. Surplus equipment is valued at the net recoverable amount.

1.5 Depreciation

Depreciation is charged on a straight-line basis on each main class of fixed asset as follows:

- Freehold land and land and buildings surplus to requirements are not depreciated. Assets in the course of construction and residual interests in off-balance sheet Private Finance Initiative contract assets are not depreciated until the asset is brought into use or reverts to the Primary Care Trust, respectively.
- Buildings, and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer, between 1 year and 115 years.
- Leaseholds are depreciated over the primary lease term.

The following fixed assets are depreciated on current cost evenly over the estimated life of the assets which fall within the following ranges:

- Transport equipment: between 1 year and 15 years,
- Information technology: between 1 year and 20 years,
- Plant and machinery: between 1 year and 34 years,
- Furniture and fittings: between 1 year and 51 years,

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset for sale, depreciation is charged to bring the value of the asset to its value at the point of sale.

1.6 Amortisation of Intangible Fixed Assets

Intangible assets are amortised over the estimated lives of the assets as follows:

- Licences and trademarks and purchased computer software licences are amortised over the life of the licences, between 1 year and 10 years.
- Development expenditure is amortised over the life of the project, between 2 years and 25 years.
- Capitalised costs of the National Programme for IT are being amortised over the life of the project, between 2 years and 8 years.

1.7 Donated assets

Donated tangible fixed assets are capitalised at their valuation on receipt; this value is credited to the donated assets reserve. Subsequent revaluations are also taken to this reserve. Each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the Operating Cost Statement.

1.8 Leases

Assets held under finance leases and hire purchase contracts are capitalised in the balance sheet and are depreciated over their useful lives. Rentals under operating leases are charged as operating costs on a straight-line basis over the lease term. Leasing rental income, where the Department acts as a lessor in shared buildings, is recognised as it falls due.

1.9 Investments

Investments held in the group relate mainly to transactions between the Department and its bodies. These include Public Dividend Capital (PDC), and any loans, issued by the Department to NHS Trusts, Foundation Trusts and the Medicines & Healthcare Products Regulatory Agency. The Department additionally holds investments in Community Health Partnerships, Shared Business Services, Plasma Resources UK Limited and Credit Guarantee Funds. All these investments are valued at estimated market value except for the Portsmouth Credit Guarantee Loan which is indexed at the balance sheet date using RPI and the Leeds Credit Guarantee Loan which is at historic cost.

PCTs have investments in LIFT companies which are valued at current cost.

1.10 Stocks

Stocks are valued at the lower of purchase cost (calculated on a first-in, first-out basis) and net realisable value.

1.11 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project
- the related expenditure is separately identifiable
- the outcome of the project has been assessed with reasonable certainty as to:
    - its technical feasibility
    - its resulting in a product or service which will eventually be brought into use
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It is

revalued on the basis of current cost. The amortisation charge is calculated on the same basis as for depreciation. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Primary Care Trusts are unable to disclose the total amount of research and development expenditure charged to the Operating Cost Statement because some research and development activity cannot be separated from patient care activity.

Expenditure on research is not capitalised. Expenditure on development in connection with a product or service which is to be supplied on a full cost recovery basis is capitalised if it meets those criteria specified in the FReM which are adapted from SSAP 13 to take account of the not-for-profit context. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Primary Care Trusts are unable to disclose the total amount of research and development expenditure charged to the Operating Cost Statement because some research and development activity cannot be separated from patient care activity. Fixed assets acquired for use in research and development are depreciated over the life of the associated project, or according to the asset category if the asset is to be used for subsequent production work.

1.12 Operating income

Operating income is income related directly to the operating activities of the Department. It comprises principally, fees and charges for services provided, on a full cost basis, to external customers and public sector repayment work, but also includes other income such as that from investments. It includes Appropriations-in-Aid (A-in-A) and Consolidated Fund Extra Receipts (CFERs) treated as income but excludes A-in-A and CFERs treated as capital. National Insurance Contributions are included in operating income. Operating income is stated net of VAT.

1.13 Administration and programme expenditure

The Operating Cost Statement is analysed between administration and programme costs. Administration costs reflect the costs of running the Department. These include both administrative costs and associated operating income. Income is analysed in the notes between that which, under the administrative cost-control regime, is allowed to be offset against gross administrative costs in determining the outturn against the administration cost limit, and that operating income which is not. Programme costs reflect non-administration costs, including payments of grants and other disbursements by the Department, as well as certain staff costs where they relate directly to service delivery. The classification of expenditure and income as administration or as programme follows the definition of administration costs set by HM Treasury.

1.14 Capital charge

A charge, reflecting the cost of capital utilised by the Department, is included in operating costs. The charge is calculated at the real rate set by HM Treasury (currently 3.5 per cent) on the average carrying amount of all assets less liabilities, except for:

a) donated assets, and cash balances with the Office of the Paymaster General, where the charge is nil; and

b) investments in NHS Trusts, Foundation Trusts and in Trading Funds where the charge is applied to their underlying assets at a rate agreed with HM Treasury.

1.15 Audit costs

A charge reflecting the cost of audit is included in operating costs. The Department of Health is audited by the Comptroller and Auditor General. No charge is made for this service but a notional charge representing the cost of the audit is included in the accounts. This charge covers all audit costs on the main Department accounts, and the audit of all the summarised accounts prepared under s232 of the NHS Act 2006 (Note 10). Other Group bodies are audited by the Comptroller and Auditor General or the Audit Commission-appointed auditor and are charged audit fees (Note 11).

1.16 Foreign exchange

The large majority of the Department's foreign currency transactions relate to EEA medical costs. Because of delays in submission of medical cost claims by member states, the Department estimates annual medical costs and adjusts future years' expenditure when actual costs are claimed. Estimated costs are converted into sterling at average rates calculated using EU published rates. Payments made are valued at prevailing exchange rates. Amounts in the balance sheet at year-end are converted at forward contract rates with the balance of the liabilities at the exchange rate ruling at the balance sheet date. Exchange rate gains or losses are calculated in accordance with accepted accounting practice.

1.17 Principal Civil Service Pension Scheme

Past and present employees are covered by the provisions of the Civil Services Pension Schemes which are described at Note 9. The defined benefit schemes are unfunded and are non-contributory except in respect of dependents benefits. The Department recognises the expected costs of these elements on a systematic and rational basis over the period during which it benefits from the employees' services by payment to the Principal Civil Service Pension Scheme (PCSPS) of amounts calculated on an accruing basis. Liability for payment of future benefits is a charge on the PCSPS. In respect of the defined contribution schemes, the Department recognises the contributions payable for the year.

The Cabinet Office publishes a separate scheme statement for PCSPS as a whole.

1.18 NHS Pension Scheme

Present and past employees of NHS bodies funded directly by the Department are covered by the provisions of the NHS Pension Scheme. This is notionally funded. It is a statutory, defined benefit scheme, the provisions of which are contained in the NHS Pension Scheme Regulations (SI 1995 No.300). Under these regulations the Department is required to pay an employer's contribution, a percentage of pensionable pay as determined from time to time by the Government Actuary's Department.

The NHS compensation for premature retirement scheme is funded by special contributions paid by the employer. These contributions can be paid quarterly over the life of the former employee; paid in five annual instalments; or settled in one lump-sum.

Both the NHS Pensions Scheme and the NHS Compensation for Early Retirements Scheme are administered by the Business Services Authority. Further details are given in the annual financial statements for the 'NHS Pension Scheme and NHS Compensation for Premature Retirement Scheme'.

1.19 Clinical negligence costs

Clinical negligence costs are managed through the following different schemes by the NHS Litigation Authority.

The Existing Liability Scheme and Ex-Regional Health Authority schemes are funded by the Department of Health, and the Clinical Negligence Scheme for Trusts, from Trust contributions. The accounts for the schemes are prepared in accordance with FRS 12. A provision for these schemes is calculated in accordance with FRS 12 by discounting the gross value of all claims received; this is disclosed in Note 21.

The calculation is made using:

i) probability factors. The probability of each claim having to be settled is assessed between 10% and 94%. This probability is applied to the gross value to give the probable cost of each claim; and

ii) a discount factor calculated using the real discount rate of 2.2%, RPI of 3% and claims inflation (varying between schemes) of between 3% and 6%, is applied to the probable cost to take into account the likely time to settlement.

The difference between the gross value of claims and the amount of the provision calculated above is also discounted, taking into account the likely time to settlement, and is included in contingent liabilities as set out in Note 31.

Existing Liabilities Scheme (ELS) and Ex-Regional Health Authorities (Ex-RHA) Scheme

Claims are included in the ELS provision on the basis that the incident ocurred on or before 31st March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to the Authority with effect from 1st April 1996.

The NHS (Residual Liabilities) Act 1996 requires the Secretary of State to exercise her/his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This would include the liabilities assumed by the Litigation Authority in respect of these schemes.

Clinical Negligence Scheme for Trusts (CNST)

A provision for this scheme is calculated in accordance with FRS12 by discounting the gross value of all claims received relating to incidents which occurred on or before 31 March 2007 and after 1 April 1995. This is disclosed in Note 21.

Claims are included in the provision on the basis that the CNST members have assessed:-

a. the probable cost and time to settlement in accordance with scheme guidelines;

b. that they are qualifying incidents; and

c. that the Trust remains a member of the scheme.

As at 31st March 2002 all outstanding claims for incidents post 1st April 1995 became the direct responsibility of the NHSLA. This 'call in' of CNST claims effectively means that member trusts are no longer reponsible for accounting for claims made against them although they do remain the legal defendant.

The NHS (Residual Liabilities) Act 1996 requires the Secretary of State to exercise his/her statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This would include the liabilities assumed by the Authority in respect of this scheme.

Incidents Incurred but not reported (IBNR)

FRS 12 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to the NHS Litigation Authority as at 31 March 2007 where the following can be reasonably forecast:

a) that an adverse incident has occurred; and
b) that a transfer of economic benefit will occur; and
c) that a reasonable estimate of the likely value can be made.

The NHSLA uses its actuaries, Lane, Clark & Peacock, to assess the potential value of IBNRs against each of the schemes it operates. The actuaries review existing claims records, and using an appropriate model, calculate values in respect of IBNRs for all schemes. The provisions and contingent liabilities arising are shown in notes 21 and 31 respectively. The sums concerned are accounting estimates, and although determined on the basis of information currently available, the ultimate liabilities may vary as a result of subsequent developments.

1.20 Derivatives and other financial instruments

The Department of Health mainly relies on Parliamentary voted funding and receipt of a proportion of National Insurance Contributions to finance its operations. The Department holds investments in private limited companies, see Note 16, and other items such as trade debtors and creditors that arise from its operations and cash resources. It holds no other financial instruments nor enters into derivative transactions or interest rate swaps. The Department enters into forward contracts where a specific amount of foreign currency is required at a particular date in the future.

The Department has transactions with other EEA member states for medical costs.

1.21 Contingent liabilities

In addition to contingent liabilities disclosed in accordance with FRS 12, the Department discloses for Parliamentary reporting and accountability purposes certain contingent liabilities where the likelihood of a transfer of economic benefit is remote. These comprise:

— items over £100,000 (or lower, where required by specific statute) that do not arise in the normal course of business and which are reported to Parliament by Departmental Minute prior to the Department entering into the arrangement
— all items (whether or not they arise in the normal course of business) over £100,000 (or lower, where required by specific statute or where material in the context of Resource Accounts) which are required by the Financial Reporting Manual to be noted in the Resource Accounts.

Where the time value of money is material, contingent liabilities which are required to be disclosed under FRS 12 are stated at discounted amounts and the amount reported to Parliament separately noted. Contingent liabilities that are not required to be disclosed by FRS 12 are stated at the amounts reported to Parliament.

1.22 Value added tax

Most of the activities of the Department are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.23 Funds Held on Trust

Some organisations received donations which are held on trust. These funds are administered by Trustees and accounted for separately from other funds for which the Department retains control.

1.24 Consolidated Statement of Operating Costs by Departmental Aim and Objectives

The Government Financial Reporting Manual (FReM) requires a primary statement analysing net operating cost by Departmental aims and objectives (Consolidated Statement of Operating Costs by Departmental Aim and Objectives). The Department of Health's objectives used are those agreed and published in the "Spending Review 2004: Public Service Agreements" White Paper. Each objective is supported by one or more Public Service Agreement (PSA) targets which relate directly to the services delivered by the NHS and Social Care systems.

Departmental expenditure has been allocated to the PSA targets using "programme budget categories", indicative provider costs (reference costs) and prescribing data. Primary Care Trusts have allocated their spend at the local level and reported within defined activity categories. Consolidated Statement of Operating Costs by Departmental Aim and Objectives has been built from this underlying data, assigning expenditure to meeting the PSA targets and using the PSA targets to allocate between the objectives.

This method provides high level indicative spend against the key Departmental objectives applying a method based on outturn data already collected by the NHS. Although Departmental and NHS activity can contribute to several objectives at the same time, the adopted method provides a high-level and fair assessment of spend by objective. These figures should not be taken as absolute, however.

1.25 Provisions

The Department provides for legal or constructive obligations which are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the real rate set by HM Treasury (currently 2.2 per cent).

1.26 Private Finance Initiative (PFI) transactions

The Department of Health follows HM Treasury's 'Technical Note 1 (Revised) How to Account for PFI transactions' which provides practical guidance for the application of the FRS 5 Amendment and the guidance 'Land and Buildings in PFI Schemes (version 2). PFI schemes are schemes under which premises and facilities are constructed and run by private sector organisations in return for annual payments from Primary Care Trusts for the services provided at those premises or facilities.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where Primary Care Trusts have contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Operating Cost Statement. Where, at the end of a PFI contract, a property reverts to the Primary Care Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset. Where the balance of risks and rewards of ownership of the PFI property are borne by the Primary Care Trusts, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.27 Assets belonging to third parties

Assets belonging to third parties (such as money held on behalf of Patients) are not recognised in the accounts since the Department has no beneficial interest in them. These amounts are disclosed in Note 35.

1.28 Cash, Bank and Overdraft

Cash, bank and overdraft balances are recorded at current values. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, 'Interest receivable' and ' Interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.29 Losses and Special Payments

Loses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled. Futher information can be

found on
www.hm-treasury.gov.uk/documents/public_spending_reporting/governance_risk/psr_managingpublicmoney_annexes.cfm

Losses and special payments are charged to the relevant functional headings, including losses which would have been made good through insurance cover had Resource Accounting Boundary bodies not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 Grants Payable

Grants made by the Department are recorded as expenditure in the period in which the claim is paid, as the grant funding is not intended to be directly related to activity in a specific period.

2 Analysis of net resource outturn by section:

This note compares outturn with the figures approved by Parliament.

	Admin	Other Current	Grants	Gross Resource Expenditure	A-in-A	Outturn Net Total	Estimate	Net total Outturn compared with Estimate savings /(excess)	Prior year outturn
						2007-08 £'000			2006-07 £'000
Request for Resources 1:									
Securing health care for those who need it.									
Spending in Departmental Expenditure Limits(DEL)									
Central government spending									
Strategic health authorities and primary care trusts unified budgets and central allocations		87,247,710	262,955	87,510,665	(1,707,287)	85,803,378	86,949,092	1,145,714	77,115,612
		87,247,710	**262,955**	**87,510,665**	**(1,707,287)**	**85,803,378**	**86,949,092**	**1,145,714**	**77,115,612**
FHS-Pharmaceutical Services		1,053,795	-	1,053,795	-	1,053,795	1,075,195	21,400	1,033,473
FHS-Prescription charges income		-	-	-	(432,215)	(432,215)	(421,000)	11,215	(411,715)
FHS-General Dental Services		-	-	-	-	-	-	-	19,086
FHS-General Ophthalmic Services		400,206	-	400,206	-	400,206	410,000	9,794	380,588
		1,454,001	**-**	**1,454,001**	**(432,215)**	**1,021,786**	**1,064,195**	**42,409**	**1,021,432**
Support for Local Authorities									
Strategic health authority and primary care trusts grants to local authorities	-	-	228,160	228,160	-	228,160	268,334	40,174	272,272
	-	**-**	**228,160**	**228,160**	**-**	**228,160**	**268,334**	**40,174**	**272,272**
Spending in Annually Managed Expenditure (AME)									
Central Government spending									
Hospital financing for Credit Guarantee Finance (CGF) pilot projects	**-**	**109,425**	**-**	**109,425**	**(25,037)**	**84,388**	**71,865**	**(12,523)**	**(8,627)**
Non-budget (not DEL or AME)									
Grant in aid to Non-departmental Public Bodies, NHS Trusts and Foundation Trusts PDC issues and repayments, Foundation Trusts loans and repayments and repayment of interest	-	**-**	180,124	180,124	(1,161,145)	(981,021)	(969,688)	11,333	(907,668)
National Insurance Contributions	-	-	-	-	(17,230,732)	(17,230,732)	(17,216,218)	14,514	(16,205,271)
	-	**-**	**180,124**	**180,124**	**(18,391,877)**	**(18,211,753)**	**(18,185,906)**	**25,847**	**(17,112,939)**
	-	**88,811,136**	**671,239**	**89,482,375**	**(20,556,416)**	**68,925,959**	**70,167,580**	**1,241,621**	**61,287,750**

								2007-08 £'000	2006-07 £'000
	Admin	Other Current	Grants	Gross Resource Expenditure	A-in-A	Outturn Net Total	Estimate	Net total Outturn compared with Estimate savings /(excess)	Prior year outturn
Request for Resources 2:									
Securing social care and child protection for those who need it and at national level, protecting, promoting and improving the nation's health									
Spending in Departmental Expenditure Limits(DEL)									
Central Government Spending									
Central Department	231,383	10,122	4	241,509	(5,924)	235,585	241,503	5,918	239,884
NHS Purchasing and Supplies Authority	-	26,530	-	26,530	(21)	26,509	24,772	(1,737)	25,048
Other Services, including medical, scientific and technical services, grants to voluntary bodies, research and development and information services	-	234,852	48,897	283,749	(2,934)	280,815	325,465	44,650	275,437
Welfare Food and European Economic Area Medical costs	-	924,365	-	924,365	(48,888)	875,477	819,792	(55,685)	708,411
Other Personal Social Services	-	26,716	215,593	242,309	(962)	241,347	276,181	34,834	131,456
Medicines and Healthcare Products Regulatory Agency loans, repayment of loans and interest on loans	-	188	-	188	(323)	(135)	(742)	(607)	
Support for local Authorities									
AIDS support grant	-	1	19,587	19,588	-	19,588	19,600	12	18,573
Services for people with a mental illness	-	-	147,525	147,525	-	147,525	147,525	-	132,239
Carers' grant	-	-	185,000	185,000	-	185,000	185,000	-	185,000
Preserved rights grant	-	-	275,248	275,248	-	275,248	275,248	-	297,530
Improving Information management (capital)	-	-	24,882	24,882	-	24,882	25,000	118	24,802
National training strategy	-	-	107,859	107,859	-	107,859	107,859	-	107,859
Access and systems capacity grant	-	-	546,000	546,000	-	546,000	546,000	-	546,000
Human resources development strategy	-	-	49,750	49,750	-	49,750	49,750	-	49,750
Children and adolescents mental health grant	-	-	88,503	88,503	-	88,503	89,289	786	90,169
Delayed discharged grant	-	-	100,000	100,000	-	100,000	100,000	-	100,000
Assistive technology:older people	-	-	50,000	50,000	-	50,000	50,000	-	30,000
Preventive Service Pilot:older people	-	-	39,325	39,325	-	39,325	39,722	397	19,887
Extra Care housing grant	-	-	38,080	38,080	-	38,080	40,000	1,920	19,882
Individual Budget Pilots	-	-	3,340	3,340	-	3,340	3,271	(69)	3,136
	231,383	**1,222,774**	**1,939,593**	**3,393,750**	**(59,052)**	**3,334,698**	**3,365,235**	**30,537**	**3,005,063**
Non-budget									
Grant in Aid funding Non-departmental public bodies and special health authorities	-	-	293,794	293,794	-	293,794	294,710	916	296,311
	231,383	**1,222,774**	**2,233,387**	**3,687,544**	**(59,052)**	**3,628,492**	**3,659,945**	**31,453**	**3,301,374**

								2007-08 £'000	2006-07 £'000
	Admin	Other Current	Grants	Gross Resource Expenditure	A-in-A	Outturn Net Total	Estimate	Net total Outturn compared with Estimate savings /(excess)	Prior year outturn
Request for Resources 3:									
Office of the Independent Regulator for NHS Foundation Trusts									
Non-budget									
Grant in aid funding to the Office of the Independent Regulator for NHS Foundation Trusts	-	-	13,507	13,507	-	13,507	14,007	500	12,324
Resource Outturn	**231,383**	**90,033,910**	**2,918,133**	**93,183,426**	**(20,615,468)**	**72,567,958**	**73,841,532**	**1,273,574**	**64,601,448**
Reconciliation to Operating Cost Statement									
Income from Consolidated Fund Extra Receipts	-	-	-	-	(20,897)	(20,897)	-	20,897	(877,984)
Net operating cost	**231,383**	**90,033,910**	**2,918,133**	**93,183,426**	**(20,636,365)**	**72,547,061**	**73,841,532**	**1,294,471**	**63,723,464**

Explanations of variances between Estimate and outturn are given in the Management Commentary.

From 2006-07 the former non discretionary General Dental Service (GDS) funding was included in Primary Care Trust allocations. The relatively small outturn of £19m appearing in the 2006-07 Annual Account is the arrears payments to and refunds from dentists that were not actioned before the end of 2005-06.

The NHS receives a contribution from the National Insurance Fund. This is the statutory fund into which all National Insurance contributions payable by employers, employees and the self-employed are paid. The contributions from the National Insurance Fund are treated as non budget income which offset expenditure within the Resource Account but not included within budgetary controls

3 Reconciliation of outturn to net operating cost and against Administration Budget

3.1 Reconciliation of net resource outturn to net operating cost

				2007-08 £'000	2006-07 £'000
	Note	Outturn	Supply Estimate	Outturn compare with Estimate	Outturn
Net Resource Outturn	2	72,567,958	73,841,532	1,273,574	64,601,448
Non-supply income (CFERS)	5	(20,897)	-	20,897	(877,984)
Net Operating Cost		**72,547,061**	**73,841,532**	**1,294,471**	**63,723,464**

3.2 Outturn against final Administration Budget

	2007-08 £'000		2006-07 £'000
	Budget	**Outturn**	**Outturn**
Gross Administration Budget	236,942	231,383	234,446
Income allowable against Administration Budget	(5,939)	(5,585)	(5,095)
Net outturn against final Administration Budget	**231,003**	**225,798**	**229,351**

4 Reconciliation of resources to cash requirement

	Note	Estimate £'000	Outturn £'000	Net Total outturn compared with Estimate saving/(excess) £'000
Net Resource Outturn	2	73,841,532	72,567,958	1,273,574
Capital		3,929,537	2,583,848	1,345,689
Non operating A-in-A		(1,808,538)	(1,577,064)	(231,474)
Accruals adjustments				
Non-cash items	10	(4,948,784)	(6,053,875)	1,105,091
Changes in working capital other than cash		(1,034,522)	(154,120)	(880,402)
Changes in creditors falling due after more than one year	20	-	(169,725)	169,725
Use of provision	21	1,100,785	1,469,926	(369,141)
Other		-	(8,099)	8,099
Net cash requirement		**71,080,010**	**68,658,849**	**2,421,161**

Explanations of variations

The Department stayed within its overall cash limit, with an underspend of £2.4bn or 3.4%. The cash underspend is consistent with the net revenue (£1311m) and capital (£1140m) resource underspends in the Resource Account.

The variations on non-cash items and changes in working capital are linked and are mainly as a result of increases in clinical negligence provisions largley due to a recent court ruling on the level of indexation applied in calculating settlements and revised actuarial assessments.

5 Analysis of income payable to the Consolidated Fund

In addition to appropriations in aid, the following is the only income that relates to the Department and is payable to the Consolidated Fund (cash receipts being shown in italics)

		Forecast 2007-08 £'000		Outturn 2007-08 £'000	
	Note	**Income**	**Receipts**	**Income**	**Receipts**
Operating income and receipts-excess A-in-A		-	-	20,825	*20,825*
Other operating income and receipts not classified as A-in-A		-	-	72	*72*
Total income payable to the Consolidated Fund		**-**	**-**	**20,897**	**20,897**

6 Reconciliation of income recorded within the Operating Cost Statement to operating income payable to the Consolidated Fund

	Note	2007-08 £'000	2006-07 £'000
Operating income	12	20,636,365	20,469,745
Gross income		20,636,365	20,469,745
Income authorised to be appropriated-in-aid		(20,615,468)	(19,591,761)
Operating income payable to the Consolidated Fund	5	**20,897**	**877,984**

7 Non-operating income – Excess A-in-A

The Department did not receive any Non-operating Income - Excess A-in-A in 2007-2008 or 2006-2007

8 Non-operating income not classified in A-in-A

The Department did not receive any Non-operating income not classified as A-in-A in 2007-2008 or 2006-2007

9 Staff numbers and related Costs

9.1 Staff costs consist of

					2007-08 £'000	2006-07 £'000
	Total	Permanently employed staff	Others	Ministers	Special Advisers	Total
Salaries and Wages	6,416,340	5,795,936	619,945	324	135	6,159,243
Social Security costs	426,005	415,433	10,529	29	14	435,480
NHS Pension	703,774	689,345	14,429	-	-	702,458
Other pension costs	43,669	42,600	1,056	-	13	51,838
Sub-total	**7,589,788**	**6,943,314**	**645,959**	**353**	**162**	**7,349,019**
Less recoveries in respect of Outward Secondments	(10,473)	(10,473)	-	-	-	**(9,627)**
Total Net Costs *	**7,579,315**	**6,932,841**	**645,959**	**353**	**162**	**7,339,392**
* Of which Core Department is	287,669	152,079	135,075	353	162	295,439

Staff costs does not include £37,641,440 of capitalised costs.

Principal Civil Service Pension Scheme (PCSPS)

The Principal Civil Service Pension Scheme (PCSPS) to which most of the core Department's employees are members is an unfunded multi-employer defined benefit scheme which prepares its own scheme statements, but the Department of Health is unable to identify its share of the underlying assets and liabilities. A full actuarial valuation was carried out at 31 March 2007 and details can be found on the Civil Service Pensions website (www.civilservice-pensions.gov.uk).

For 2007-08, normal employer contributions of £21,789,000 were payable to the PCSPS at rates in the range 17.1 per cent to 25.5 per cent of pensionable pay, based on salary bands. Rates will remain the same next year, subject to revalorisation of the salary bands, but will change from 1 April 2009. Employer contribution rates are reviewed every four years following a full scheme valuation by the Government Actuary. The contribution rates reflect benefits as they are accrued, not when the costs are actually incurred; and they reflect past experience of the scheme.

Employees joining on or after 1 October 2002 could opt to open a partnership account, a stakeholder pension with an employer contribution. For employees joining on or after 30 July 2007, the defined benefit scheme open to them (nuvos) is based on pension building up at 2.3% of pensionable earnings each scheme year, rather than on final salary. From the same date arrangements were introduced for partial retirement, which were extended to classic, classic plus and premium scheme members on 1 March 2008.

Contributions due to the partnership pension providers at the balance sheet date were Nil. Contributions prepaid at that date were Nil.

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme provisions as at 31 March 2008

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's

pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

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 the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

9.2 Average number of persons employed

The average number of whole-time equivalent persons employed during the year was as follows. These figures include those working in the Department as well as in agencies and other bodies included within the consolidated Departmental Resource Account.

					2007-08 Number	2006-07 Number
	Total	Permanent staff	Others	Ministers	Special Advisers	Total
Core Department	2,844	2,153	682	6	3	2,873
Connecting for Health	1,444	31	1,413	-	-	1,774
Primary Care Trusts	196,305	183,815	12,490	-	-	199,671
Strategic Health Authorities	2,771	2,282	489	-	-	3,949
Special Health Authorities	4,269	3,852	417	-	-	5,130
Others	284	258	26	-	-	327
Total whole time equivalent persons	**207,917**	**192,391**	**15,517**	**6**	**3**	**213,724**

10 Other administration costs

	Note	2007-08 £'000	2006-07 £'000
Rental under operating leases:			
Hire of plant and machinery		101	76
Other operating leases		12,960	11,624
Research and Development Expenditure		274	443
Non cash items (See Note b below):			
Depreciation		15,413	12,496
Amortisation		208	221
Profit on disposal of fixed assets		(4)	-
Loss on disposal of fixed assets		-	826
Impairment/permanent diminution of asset values		-	-
Cost of capital charges		3,421	2,435
Auditors' remuneration	a	542	542
Provision provided for in year	21	3,586	6,746
Unwinding of discount on provisions	21	535	556
Other non-cash		(626)	-
Building and related costs		17,514	23,970
General office expenditure		26,394	22,573
Other expenditure		26,910	25,365
Total		**107,228**	**107,873**

Note a-The audit fee represents the cost for the audit of the Department's Consolidated Accounts and the Summarised Accounts of the NHS carried out by the Comptroller and Auditor General. This amount does not include fees in respect of non-audit work.

Note b - the total of non-cash transactions included in the Reconciliation of Operating Costs to Operating Cash flows in the Consolidated Cash Flow Statement and the reconciliation of resources to net cash requirement comprises:

	2007-08 £'000	2006-07 £'000
Other administration costs - non-cash items (Note 10)	23,075	23,822
Programme costs - non-cash items (Note 11)	6,038,116	3,719,505
other non-cash amounts charged to operating expenditure	-	49,830
Less non-cash income: -deferred donation income released from the Donated Asset Reserve	(7,316)	(9,178)
Other: Stock Write-off, bad debt expenses	-	3,728
Total non-cash transactions	**6,053,875**	**3,787,707**

11 Programme Costs

		2007-08 £'000		2006-07 £'000	
	Note	Core Department	Consolidated	Core Department	Consolidated
Current grants and other current expenditure		6,638,678	78,322,697	6,483,515	71,999,880
Rental under operating leases:					
Hire of plant and machinery		31	12,425	-	10,084
Other operating leases		8,916	247,003	9,121	191,578
Interest Charges		6	12,242	-	8,387
PFI Service Charges		-	63,008	-	49,634
Research and Development expenditure		801,392	801,392	766,876	766,876
Non cash items (See Note b above):					
Depreciation		99,900	423,879	33,587	289,245
Amortisation		145,301	150,136	113,955	118,059
Profit on disposal of fixed assets		(19,706)	(42,018)	(6,957)	(47,026)
Loss on disposal of fixed assets		25,040	33,825	236,230	240,650
Impairment/permanent diminution of asset values		26,948	112,886	4,014	48,167
Cost of capital charges		1,195,789	876,372	1,150,900	887,004
Write-(on)/off of Investment		-	-	-	-
Provision provided for in year	21	683,507	4,419,607	497,460	2,089,893
Unwinding of discount on provisions	21	30,650	68,052	28,392	99,009
Other Non-cash expenditure		(4,741)	(4,623)	(5,548)	(5,496)
Total		**9,631,711**	**85,496,883**	**9,311,545**	**76,745,944**

	2007-08 £'000	2006-07 £'000
Auditor's Remuneration - Audit Fees	37,927	48,519
Auditor's Remuneration - Other Fees	5,383	2,754

The audit fee represents the cost of the audit of the financial statements of group bodies consolidated within the Resource Account. The Comptroller and Auditor General and auditors appointed by the Audit Commission undertake these audits.

12 Income

Operating Income analysed by classification and activity, is as follows:				**2007-08 £'000**	**2006-07 £'000**
	RfR1	**RfR2**	**RfR3**	**Total**	**Total**
Administration Income:					
Allowable within the administration cost limit	-	5,585	-	5,585	5,057
Not allowable within the administration cost limit	-	339	-	339	108
	-	5,924	-	5,924	5,165
Programme Income:					
Fees and charges to external customers	128,424	-	-	128,424	121,985
Fees and charges to other departments	(324,172)	-	-	(324,172)	1,259,354
Prescription, dental and ophthalmic charges	970,541	-	-	970,541	915,275
National Insurance Contribution	17,230,732	-	-	17,230,732	17,082,125
Other	2,550,891	74,025	-	2,624,916	1,085,841
	20,556,416	74,025	-	20,630,441	20,464,580
Total Income*	**20,556,416**	**79,949**	**-**	**20,636,365**	**20,469,745**
* Of which Core Department is	1,275,568	79,928	-	1,355,496	1,383,162

13 Analysis of net operating cost by spending body

		2007-08 £'000	**2006-07 £'000**
	Estimate	**Outturn**	**Outturn**
Spending body:			
Core Department	241,503	235,585	239,884
Purchasing and Supplies Agency	24,772	26,509	25,048
Entities within departmental boundary	70,475,555	69,233,125	60,409,766
Local authorities	1,954,445	1,916,447	2,064,918
Other bodies	1,145,257	1,135,395	983,848
Net Operating Cost	**73,841,532**	**72,547,061**	**63,723,464**

Note: Entities within Departmental boundary include all NHS bodies, i.e. both consolidated and not consolidated in the Department Resource Accounts as listed in Note 37.

14 Tangible fixed assets

	Land and Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture and Fittings	Plant & Machinery	Transport Equipment	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation								
At 1 April 2007	6,519,912	36,213	628,025	181,550	136,920	262,175	16,496	7,781,291
Additions-purchased	179,124	51	218,411	146,607	16,513	34,223	1,960	596,889
Additions-donated	2,388	-	16	783	197	988	-	4,372
Impairment	(59,402)	-	(1,098)	-	-	(3)	-	(60,503)
Transfers	2,109	-	(40,911)	(14,640)	3,774	(1,336)	(177)	(51,181)
Reclassifications	68,714	24	14,355	(90,236)	3,805	5,165	318	2,145
Revaluation and indexation	427,407	2,897	(151)	1,924	2,756	6,433	355	441,621
Disposals	(315,250)	(167)	(16,228)	(2,140)	(3,922)	(13,389)	(3,582)	(354,678)
At 31 March 2008	**6,825,002**	**39,018**	**802,419**	**223,848**	**160,043**	**294,256**	**15,370**	**8,359,956**
Depreciation								
At 1 April 2007	193,426	2,596	261,382	-	56,517	124,051	11,901	649,873
Charged in year	195,206	2,919	190,175	-	18,368	31,389	1,235	439,292
Impairment	78,021	4,134	1,231	-	86	2,262	54	85,788
Transfers	(3,283)	-	(79,964)	-	1,170	(1,078)	(128)	(83,283)
Reclassifications	400	-	(285)	-	767	(1,434)	242	(310)
Revaluation and indexation	1,928	8	(170)	-	753	2,790	241	5,550
Disposals	(11,352)	(10)	(14,066)	-	(2,649)	(10,877)	(2,878)	(41,832)
At 31 March 2008	**454,346**	**9,647**	**358,303**	**-**	**75,012**	**147,103**	**10,667**	**1,055,078**
Net Book Value At 31 March 2008	**6,370,656**	**29,371**	**444,116**	**223,848**	**85,031**	**147,153**	**4,703**	**7,304,878**
At 31 March 2007	6,326,486	33,617	366,643	181,550	80,403	138,124	4,595	7,131,418
Asset financing:								
Owned	6,209,833	29,371	444,026	223,848	81,667	127,745	4,703	7,121,193
Finance Lease	158,623	-	90	-	3,364	19,408	-	181,485
On-balance sheet PFI contracts	2,200	-	-	-	-	-	-	2,200
Net book value at 31 March 2008	**6,370,656**	**29,371**	**444,116**	**223,848**	**85,031**	**147,153**	**4,703**	**7,304,878**

The net book value of land and buildings at 31 March 2008 comprises:	
Freehold	6,115,767
Long leasehold	204,124
Short leasehold	80,136
Total	**6,400,027**

The net book value of tangible fixed assets comprises:

	Land and Buildings (excluding dwellings)	Dwellings	Information Technology	Payments on Account & Assets Under Construction	Furniture and Fittings	Plant & Machinery	Transport Equipment	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Core Department 2007-08	332,310	3,310	174,859	79,702	7,802	21	-	**598,004**
Other NHS Bodies 2007-08	6,038,346	26,061	269,257	144,146	77,229	147,132	4,703	**6,706,874**
Core Department 2006-07	402,062	3,310	141,858	71,768	7,691	171	(2)	**626,858**
Other NHS Bodies 2006-07	5,924,424	30,307	224,785	109,782	72,712	137,953	4,597	**6,504,560**

15 Intangible Fixed Assets

Intangible fixed assets comprise, Purchased Software Licences, Trade Marks and Artistic Originals, and Development Expenditure, and NPFIT for the Department and entities consolidated within these statements.

	2007-08 £'000
Cost or valuation	
At 1 April 2007	1,201,172
Additions-purchased	559,424
Additions-Donated	20
Impairment	-
Transfers	46,303
Reclassification	(2,397)
Revaluation and indexation	-
Disposals	(1,011)
At 31 March 2008	**1,803,511**
Amortisation	
At 1 April 2007	258,594
Charged in year	150,344
Impairment	1
Transfers	72,577
Reclassification	44
Disposals	(920)
At 31 March 2008	**480,640**
Net book value at 31 March 2008	**1,322,871**
Net book value at 31 March 2007	942,578
Analysis of intangible fixed assets	
The net book value of intangible fixed assets comprises:	
Core Department at 31 March 2008	1,305,717
Other NHS Bodies 31 March 2008	17,154
Core Department at 31 March 2007	926,215
Other NHS Bodies 31 March 2007	16,363

16 Investments

	In NHS Trusts, Trusts Public Dividend Capital (PDC)	NHS Loans	Foundation Trusts (PDC)	Foundation Trusts Loans	In Other Bodies PDC	In Other Bodies Loan	In Other Bodies Share Capital	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance as At 1 April 2007	18,434,965	777,881	3,472,684	109,525	1,328	524,704	117,664	23,438,751
Issued:								
To newly established bodies	711,544	-	-	-	-	-	-	711,544
To existing bodies	836,696	52,272	389,863	55,993	-	73,933	18,778	1,427,535
Loans issued in previous years	-	-	-	-	-	-	-	-
Repaid:								
By continuing bodies	(824,588)	(209,704)	(148,561)	(10,087)	-	(62,976)	(14)	(1,255,930)
Written off:								
By or on behalf of dissolved bodies*	(359,321)	-	-	-	-	-	-	(359,321)
Other:								
Revaluation	-	-	-	-	-	10,692	88,142	98,834
Loan repayable within 12 months transferred to debtors	-	-	-	-	-	-	-	-
Impairment	-	-	-	-	-	-	-	-
Reclassification	(4,077,460)	(9,800)	4,077,460	-	-	-	-	(9,800)
Balance as at 31 March 2008	**14,721,836**	**610,649**	**7,791,446**	**155,431**	**1,328**	**546,353**	**224,570**	**24,051,613**
Investments held by Core Department	14,721,836	610,649	7,791,446	155,431	1,328	522,926	203,352	24,006,968
Investments held by other NHS bodies	-	-	-	-	-	23,427	21,218	44,645

The Department can analyse its investments in other bodies as follows:								**Percentage Shareholding**
MHRA (Medicines and Healthcare products Regulatory Agency)					1,328	2,407	500	100%
Community Health Partnerships					-	10,000	100,000	100%
Plasma Resources UK Ltd					-	5,003	102,846	100%
Credit Guarantee Fund					-	483,094	-	-
SBS					-	22,422	6	50%

* There is no overall loss of PDC, see Note 33.

In addition Primary Care Trusts have investments of £32,645,000 in LIFT companies. Details of their investments can be found in their individual accounts. The Information Centre also has an investment of £12,000,000 in a Joint Venture arrangement known as Dr Foster Intelligence.

CGF is a loan, guaranteed by banks, monolines or other acceptable financial institutions, from the sponsoring Department to a PFI project SPV on 'market' terms. The CGF undertaken by the Department are pilots at two NHS PFI projects – Leeds and Portsmouth. Other than the pilots, the Department will not be undertaking any further CGF loans as Treasury intend to develop the specific powers which will enable them to lend directly to the private sector should the pilots be successful.

The iSOFT loan had a balance of £37,418,000 at 1 April 2007, this was fully repaid by 31 March 2008.

The Department's share of the net assets and results of the relevant bodies are summarised below.

	NHS Trusts	Foundation Trusts	Medicines and Healthcare products Regulatory Agency	Plasma Resources UK Limited	Community Health Partnerships	Joint Ventures SBS
	£'000	£'000	£'000	£'000	£'000	£'000
Net Assets at 31 March 2008	23,906,171	14,017,343	13,160	14,286	51,985	211
Turnover	33,233,986	16,161,900	93,463	67,837	2,326	15,607
Surplus/profit for the year (before financing)	1,152,934	747,900	3,838	9,744	(1,169)	(3,676)

The figures for Plasma Resources UK are for its financial year end of 31 December 2007 and those for Community Health Partnerships for its financial year end 30 April 2008.

17 Stocks and work in progress

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Stocks	337,403	409,776	390,021	456,170
	337,403	**409,776**	**390,021**	**456,170**

18 Debtors

18.1 Analysis by type

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Amounts falling due within one year:				
Trade debtors	93,217	422,920	52,779	508,728
Deposits and advances	-	-	320	320
Capital debtors	-	40,222	750	143,638
Other debtors	122,851	784,272	121,768	712,564
Consolidated Fund Extra Receipts Receivable	1	1	1	1
Other prepayments and accrued income	291,528	909,912	427,769	798,531
	507,597	**2,157,327**	**603,387**	**2,163,782**
Amounts falling due after more than one year:				
Trade debtors and advances for house purchases	-	3,610	-	3,953
Deposits and advances	716	716	-	-
Capital debtors	-	7,277	-	20,114
Other debtors	113,384	141,867	87,496	111,123
Prepayments and accrued income	20,000	33,420	12,028	22,465
	134,100	**186,890**	**99,524**	**157,655**
Total debtors	**641,697**	**2,344,217**	**702,911**	**2,321,437**

18.2 Intra-Government balances

	Amounts falling due within one year		Amounts falling due after more than one year	
	£'000	£'000	£'000	£'000
	2007-08	2006-07	2007-08	2006-07
Balances with other central government bodies	49,695	54,374	-	3,544
Balances with local authorities	333,563	226,162	-	5,132
Balances with NHS Trusts	383,721	440,194	-	409
Balances with Public Corporations and Trading Funds	207	34,312	-	-
Subtotal: Intra-government balances	**767,186**	**755,042**	**-**	**9,085**
Balances with bodies external to government	1,390,141	1,408,740	186,890	148,570
Total debtors at 31 March 2008	**2,157,327**	**2,163,782**	**186,890**	**157,655**

19 Cash at bank and in hand

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Balance as at 1 April	1,292,394	1,438,492	779,762	901,626
Net change in cash balance	952,692	1,008,190	512,632	536,866
Balance at 31 March	**2,245,086**	**2,446,682**	**1,292,394**	**1,438,492**
The following balances at 31 March were held at:				
Office of HM Paymaster General	2,245,086	2,441,718	1,292,392	1,436,674
Commercial banks and cash in hand	-	4,964	2	1,818
Balance at 31 March	**2,245,086**	**2,446,682**	**1,292,394**	**1,438,492**

20 Creditors

20.1 Analysis by type

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Amounts falling due within one year:				
Bank Overdraft	-	4,624	-	8,825
VAT	-	203	-	-
Other taxation and social security	3,140	74,881	4,578	85,361
Trade creditors	37,753	4,271,866	36,012	4,358,356
Capital creditors	595	89,997	194,236	230,798
Other creditors	1,846	290,003	154,124	440,436
Early retirement costs payable within one year	-	-	-	8,519
Accruals and deferred income	626,179	1,881,160	287,344	1,350,366
Current part of finance lease	-	7,844	-	7,412
Amount issued from the Consolidated Fund for supply but not spent at year end	2,421,161	2,421,161	1,428,536	1,428,536
Consolidated fund extra receipts due to be paid to the Consolidated Fund - Received	20,897	20,897	1,131	1,131
	3,111,571	**9,062,636**	**2,105,961**	**7,919,740**
Amounts falling due after more than one year:				
Finance leases	-	162,269	-	166,779
Trade creditors	-	4,302	-	11,590
Other Creditors	182,075	195,707	-	14,184
	182,075	**362,278**	**-**	**192,553**

20.2 Intra-Government balances

	Amounts falling due within one year		Amounts falling due after more than one year	
	£'000	£'000	£'000	£'000
	2007-08	2006-07	2007-08	2006-07
Balances with other central government bodies	118,215	117,343	-	37,912
Balances with local authorities	170,460	246,401	-	5,283
Balances with NHS Trusts	1,386,903	1,832,213	-	24,031
Balances with Public Corporations and Trading Funds	98	3,218	-	6
Subtotal: Intra-government balances	1,675,676	2,199,175	-	67,232
Balances with bodies external to government	7,386,959	5,720,565	362,278	125,321
Total creditors at 31 March	**9,062,636**	**7,919,740**	**362,278**	**192,553**

21 Provisions for liabilities and charges

	Core Department					Consolidated					
	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Other £'000	Total £'000	Early departure costs £'000	Injury Benefits £'000	EEA medical costs £'000	Clinical Negligence £'000	Other £'000	Total £'000
Balance At 1 April 2007	78,327	665,938	683,169	66,920	1,494,354	468,801	665,938	683,169	9,094,713	437,876	11,350,497
Provided in the year	7,258	60,092	514,479	129,097	710,926	42,177	60,092	514,479	3,861,080	496,274	4,974,102
Provisions utilised in the year	(10,248)	(83,343)	(496,026)	(12,866)	(602,483)	(108,767)	(83,171)	(496,026)	(633,325)	(148,637)	(1,469,926)
Provisions not required written back	(423)	(8,628)	-	(14,782)	(23,833)	(11,165)	(8,628)	-	(439,868)	(91,248)	(550,909)
Unwinding of discount	1,731	13,639	14,994	821	31,185	9,797	13,639	14,994	28,223	1,934	68,587
Balance as at 31 March 2008	**76,645**	**647,698**	**716,616**	**169,190**	**1,610,149**	**400,843**	**647,870**	**716,616**	**11,910,823**	**696,199**	**14,372,351**

Clinical Negligence

The Department of Health provides for future costs where it is the defendant in a number of actions by claimants for damages arising from the effects of alleged clinical negligence. The clinical negligence provision reflects an actuarially determined assessment of incidents that have occurred, including those not yet reported, where it is more than 50% probable that the claim will be successful and the amount of the claim can be reliably estimated. The amount provided is calculated on a percentage expected probability basis. Expenditure is likely to be incurred over a period of more than twenty years.

Clinical negligence claims which may possibly succeed but are less likely or cannot be reliably estimated are shown as contingent liabilities.

Strategic Health Authorities, Primary Care Trusts, Foundation Trusts and NHS Trusts (which are outside the resource accounting boundary) retain legal liability for all liabilities covered by the clinical negligence schemes, the Ex-Regional Health Authority Scheme (RHA), Existing Liabilities Scheme (ELS) and Clinical Negligence Scheme for Trusts (CNST), but the NHS Litigation Authority (NHSLA) accounts for all liabilities under the ELS, CNST and RHA schemes. The NHSLA's actuaries undertake reviews regularly to identify likely future settlements under these schemes and these are recorded in the accounts of the NHSLA.

In its judgment on Thompstone v Tameside and Glossop Acute Services NHS Trust, in January 2008, the Court of Appeal upheld rulings that future damages for these seriously injured claimants should be linked to a sub-set of the Annual Survey of Hours and Earnings (ASHE) rather than to the Retail Prices Index (RPI), which had been standard practice until late 2006. This decision is highly significant from the NHS perspective because historically, this ASHE measure has risen much faster than RPI. The consequence is that, should this pattern be repeated in future, damages payments will increase significantly. The global value of this increase in provisions recorded in these accounts as at 31st March 2008 is £1.5billion.

Clinical negligence provisions in the accounts of the NHSLA as at 31 March 2008 include £42,204,000 for the RHA scheme, £1,925,245,000 under the ELS and £9,943,374,000 for CNST.

Of the total £11,910,823,000 clinical negligence provisions, £1,302,585,000 is expected to be payable within 1 year, £3,734,513,000 in 1 to 5 years and £6,873,725,000 after 5 years.

Early Departure

This Account provides for the additional future costs, beyond the normal benefit awards for which employees are eligible under the terms of their pension scheme, arising from compensation payment for termination of employment through redundancy, severance or early retirement. The provision also takes account of arrangements with pension schemes under which employees could make prepayments to meet future liabilities. On the basis of the age of retirees, expenditure is likely to be incurred over a period of up to nine years.

The provision mainly relates to early retirement liabilities in Primary Care Trusts totalling £315,952,000. Of the total, £34,393,000 is expected to be payable within 1 year, £116,801,000 in 1 to 5 years and £164,758,000 after 5 years.

Further amounts of £4,675,000 are included in Strategic Health Authorities, £3,571,000 in Special Health Authorities, and £76,645,000 in the Department of Health, of which £10,515,000 is expected to be payable within 1 year, £30,444,000 in 1 to 5 years and £35,686,000 after 5 years.

Injury Benefits

This Account provides for the future costs of permanent Injury Benefits awarded up to April 1997, to NHS staff injured in the course of their duties. From this date the respective NHS body which employed the injured person has been liable for the costs. The Injury Benefit awards are guaranteed minimum income levels in nature and are granted for the life of the individual. The award is based on an assessment of the nature of the injury and the effect on the earning capacity of that individual as a result. Total claim provided for is £647,870,000 of which £44,230,000 is expected to be payable within 1 year, £164,165,000 in 1 to 5 years and £439,475,000 after 5 years.

EEA Medical Costs

EEA Medical Costs are medical costs incurred by UK Citizens in other European countries which are liabilities payable by the UK to those European countries.

The total cost provided for is £716,616,000 of which £269,000,000 is expected to be payable within 1 year and £447,616,000 in 1 to 5 years.

Other

This account has other provisions of £669,199,000. These include the following.

Provision has been made for future support for patients who contracted HIV from contaminated blood supplies. Total claim provided for is £35,613,000 of which £3,920,000 is expected to be payable within 1 year, and £14,854,000 in 1 to 5 years and £16839,000 after 5 years.

Other legal claims against Primary Care Trusts are £36,441,000 of which £15,083,000 is expected to be payable within 1 year, £8,673,000 in 1 to 5 years and £12,685,000 after 5 years. Further amounts of £7,598,000 are included in Strategic Health Authorities, of which £3,416,000 is expected to be payable within 1 year, £4,182,000 in 1 to 5 years.

Restructuring provisions by Primary Care Trusts are £21,515,000 of which £17,995,000 is expected to be payable within 1 year, £2,385,000 in 1 to 5 years and £1,135,000 after 5 years. Further amounts of £3,205,000 are included in Strategic Health Authorities, of which £3,205,000 is expected to be payable within 1 year.

This Account provides for a scheme for persons infected by Hepatitis C contracted through blood and blood products in the course of treatment by the NHS. The amount provided is £45,946,000 of which £7,000,000 is expected to be payable within 1 year, £32,803,000 in 1 to 5 years and £6,143,000 after 5 years.

Other miscellaneous provisions is £545,881,000 of which £329,602,000 payable within 1 year, £159,700,000 in 1 to 5 years and £56,579,000 after 5 years.

22 General Fund

The General Fund represents the total assets less liabliities of each of the entities within the accounting boundary, to the extent that the total is not represented by other reserves and financing items.

		2007-08 £'000		2006-07 £'000	
	Note	Core Department	Consolidated	Core Department	Consolidated
Balance at 1 April		23,412,465	13,603,372	21,112,697	11,920,659
Net Parliamentary Funding					
Draw Down	24.5	8,920,541	70,048,220	9,426,394	65,100,021
Deemed		1,031,790	1,031,790	890,342	890,342
Year end adjustment					
Supply Creditor - current year	4	(2,421,161)	(2,421,161)	(1,428,536)	(1,428,536)
Net Transfer from Operating Activities					
Net Operating Cost	2	(8,671,112)	(72,547,061)	(8,331,695)	(63,723,464)
CFERs repayable to Consolidated Fund		(20,897)	(20,897)	(168,220)	(1,045,074)
Non Cash Charges					
Cost of Capital	10,11	1,199,210	879,793	1,153,335	889,439
Auditors' remuneration	10,11	542	542	542	542
PDC Investment adjustment		336,245	336,245	544,913	544,913
Transfers from Revaluation Reserve	23.1	24,405	109,276	212,693	277,739
Other Transfers		(2,211)	31,087	-	176,791
Balance at 31 March		**23,809,817**	**11,051,206**	**23,412,465**	**13,603,372**

23 Reserves

23.1 Revaluation Reserve

The revaluation reserve reflects the unrealised element of the cumulative balance of indexation and revaluation adjustments (excluding donated assets)

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Balance at 1 April	325,924	2,519,902	510,670	2,498,831
Arising on revaluation during the year (net)	119,744	504,034	27,947	318,100
Impairment	-	(33,406)	-	(19,290)
Transferred to General Fund in respect of realised element of revaluation reserve	(34)	(84,905)	(2,431)	(67,477)
Transferred to General Fund on disposal	(24,371)	(24,371)	(210,262)	(210,262)
Balance at 31 March	**421,263**	**2,881,254**	**325,924**	**2,519,902**

23.2 Donated assets reserve

The donated asset reserve reflects the net book value of assets donated to the Department or other bodies within the Resource Account boundary.

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Balance at 1 April	-	142,782	1,021	131,641
Additions arising in year	-	4,533	-	13,367
Revaluation and indexation	-	9,302	-	6,333
Release to the Operating Cost Statement in respect of:				
- Depreciation	-	(6,897)	(1,021)	(7,070)
- Disposals	-	(419)	-	(1,515)
Other movements	-	1,011	-	26
Balance at 31 March	**-**	**150,312**	**-**	**142,782**

24 Notes to the Consolidated Cash Flow Statement

24.1 Reconciliation of operating cost to operating cash flows

	Notes	2007-08 £'000	2006-07 £'000
Net operating cost	13	72,547,061	63,723,464
Adjustment for non-cash transactions	10	(6,053,875)	(3,787,707)
(Increase)/Decrease in Stock		(46,394)	159,456
Decrease in Debtors		22,780	501,942
less movements in debtors relating to items not passing through the OCS		116,253	(128,694)
Increase in creditors		(1,312,622)	(1,014,642)
less movements in creditors relating to items not passing through the OCS		863,311	788,952
Use of provisions	21	1,469,926	1,113,899
Net cash outflow from operating activities		**67,606,440**	**61,356,670**

24.2 Analysis of capital expenditure and financial investment

	Notes	2007-08 £'000	2006-07 £'000
Fixed assets	14,15	1,301,192	914,301
Proceeds of disposals of fixed assets		(437,387)	(245,123)
Purchase of Investments	16	1,427,535	2,698,308
Proceeds from disposal of Investments	16	(1,255,930)	(1,227,385)
Transfer of assets		18	26,693
Net cash outflow from investing activities		**1,035,428**	**2,166,794**

24.3 Analysis of capital expenditure and financial investment by Request for Resources

	Capital expenditure	Loans and Investments	A-in-A	Net total
	£'000	£'000	£'000	£'000
Request for resources 1	1,280,559	1,427,535	(1,693,317)	1,014,777
Request for resources 2	20,633	-	-	20,633
Net movement in debtors/creditors	(144,879)	-	116,253	(28,626)
Total 2007-08	**1,156,313**	**1,427,535**	**(1,577,064)**	**1,006,784**
Total 2006-07	**1,166,110**	**2,698,308**	**(1,601,202)**	**2,263,216**

24.4 Analysis of financing

		2007-08	2006-07
	Notes	£'000	£'000
From the Consolidated Fund (Supply)-current year	22	70,048,220	65,990,363
Repayment of supply creditor		-	(890,342)
Advances from the Contingencies fund		-	-
Repayment to the Contingencies fund		-	-
Other		3,916	6,672
Net financing		**70,052,136**	**65,106,693**

24.5 Reconciliation of Net Cash Requirement to (increase) in cash

		2007-08	2006-07
	Notes	£'000	£'000
Net cash requirement		68,658,849	64,561,827
From the Consolidated Fund (Supply)-current year	24(4)	(70,048,220)	(65,990,363)
Repayment of supply creditor	24(4)	-	890,342
Amount due to the Consolidated Fund received in prior year and paid over		397,877	237
Amount due to the Consolidated Fund -received and not paid over	3(1)	(20,897)	(1,130)
Other		-	39
(Increase) in cash		**(1,012,391)**	**(539,048)**

25 Notes to the Consolidated Statement of Operating Costs by Departmental Aim and Objectives

Programme grants and other current expenditure (excluding administration costs) have been allocated as follows:

	2007-08	2006-07
	£m	£m
Objective 1-Access to Services	25,255	23,322
Objective 2-Improving the Patient/User Experience	7,857	5,990
Objective 3-Health of the Population	29,106	26,788
Objective 4-Long Term Conditions	16,264	14,353
Other	14,459	13,506
	92,941	**83,959**

This Note apportions costs across the Department's objectives for 2007-08 as agreed in the 2004 Spending Review. The PSA targets associated with the objectives are detailed in paragraph 9 of the management commentary in the Annual Report above.

Costs have been apportioned using the best available data, primarily:

- programme budgeting data which collects NHS costs by disease;
- reference costs that record costs of hospital admissions and treatments;
- prescription costs;
- personal social services expenditure as recorded.

The programme budgeting and reference cost data sources are from 2006-07 and all other sources from 2007-08.

The **"Other"** category includes all activities that do not contribute directly to achieving the PSA targets, including the Workforce Development Confederation costs and funding for arms-length bodies not delivering front-line services.

26 Capital Commitments

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Contracted capital commitments at 31 March 2008 for which no provision has been made	3,262,665	3,332,424	2,899,785	2,952,884

The vast majority of Core Department capital commitments relate to contracts entered into by Connecting for Health for the delivery of the National Programme for IT (see Note 29 for further details). The Department has a Captal Commitment for the purchase of residual interests in ISTC schemes. The total capital commitment is £188m falling due between 31 March 2010 and 31 March 2013

27 Commitments under leases

27.1 Operating leases

Commitments under operating leases to pay rentals during the year following the year of these accounts are given in the table below, analysed according to the period in which the lease expires.

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Obligations under operating leases comprises:				
Land and buildings:				
Expiry within 1 year	-	13,051	7,996	21,746
Expiry after 1 year but not more than 5 years	11,106	58,283	18,937	47,849
Expiry thereafter	12,106	232,927	10,159	155,913
	23,212	**304,261**	**37,092**	**225,508**
Other:				
Expiry within one year	41	14,873	58	12,514
Expiry after 1 year but not more than 5 years	384	22,630	107	24,161
Expiry thereafter	-	162	-	1,138
	425	**37,665**	**165**	**37,813**

27.2 Finance leases

Obligation under finance leases are as follows.

	2007-08		2006-07	
	Core Department	Consolidated	Core Department	Consolidated
Rentals due within 1 year	-	13,625	686	8,098
Rentals due after 1 year but within 5 years	-	159,129	2,662	131,619
Rentals due thereafter	-	35,070	1,636	72,027
	-	**207,824**	**4,984**	**211,744**
Less interest element	-	(37,711)	(2,243)	(34,812)
	-	**170,113**	**2,741**	**176,932**

28 Commitments under PFI contracts

PFI Schemes deemed to be off balance sheet

In this financial year, 38 Primary Care Trusts reported off balance sheet PFI schemes over £1million (2006-07: 30 Primary Care Trusts). The estimated capital value of these schemes over £1 million is £512.0 million (2006-07: £446.0 million). The amount included within operating expenses for these schemes is £63.0 million (2006-07: £49.6 million). Primary Care Trusts are committed to make the following payments under off balance sheet PFI contracts during 2008-09, analysed by the period during which the commitment expires

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Expiry within 11 to 15 years	-	414	-	399
Expiry within 16 to 20 years	-	1,508	-	1,032
Expiry within 21 to 25 years	-	35,916	-	22,791
Expiry within 26 to 30 years	-	33,983	-	35,098
Expiry within 31 to 35 years	-	2,464	-	5,617
Expiry within 36 and beyond	-	-	-	-
	-	**74,285**	**-**	**64,937**

PFI schemes deemed to be on balance sheet

Devon PCT has entered into an on-balance sheet PFI contract. The asset is treated as an asset of the PCT. The substance of this contract is the PCT has a finance lease and payments comprise an imputed finance lease charge and a service charge. The value of assets brought on balance sheet in respect of this scheme is £2.2 million (2006-07: £3.5 million)

The total amount charged in the Operating Cost Statement in respect of on-balance sheet PFI transactions and the service element of on-balance sheet PFI transactions was £292,000 (2006-07: £275,000) and the payments to which the Department is committed during 2007-08, analysed by the period during which the commitment expires, is as follows.

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Rentals due within 1 year	-	300	-	300
Rentals due within 2 to 5 years	-	1,406	-	1,321
Rentals due thereafter	-	6,554	-	6,939
	-	8,260	-	8,560
Less interest element	-	(3,125)	-	(3,729)
	-	**5,135**	**-**	**4,831**

29 Other Financial Commitments

	2007-08 £'000		2006-07 £'000	
	Core Department	Consolidated	Core Department	Consolidated
Expire within 1 year	336,987	337,831	277,658	278,527
Expire within 2 to 5 years	1,148,266	1,158,432	1,409,666	1,409,666
Expire thereafter	616,278	624,895	1,132,961	1,133,025
	2,101,531	**2,121,158**	**2,820,285**	**2,821,218**

At the balance sheet date Connecting for Health had entered into contracts which if delivered according to the terms of those contracts would result in commitments of £2,101,531,000 (2006-07: £2,820,286,000) over the next 8 years. The contracts are for National Programme for IT, which is being delivered by the NHS Connecting for Health, part of the Department of Health, which is bringing modern computing systems into the NHS to improve patient care and service. Over the life of the programme, NHS Connecting for Health will convert over 30,000 GPs in England, almost 300 hospitals and give patients access to their personal health and care information, transforming the way NHS works. The contracts are such that the obligation to pay does not arise until the suppliers have implemented the solution to the required locations and it has been accepted after a period of live running.

30 Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the relationship that the Department has with NHS bodies and the way those bodies are financed, the Department as a whole is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The Department has limited powers to borrow or invest surplus funds, financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Department in undertaking its activities. As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from the currency profile.

Liquidity risk

The Department's net operating costs are financed from resources voted annually by Parliament. The Department also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. The Department is not, therefore, exposed to significant liquidity risks.

Currency Risk

Bodies within the resource accounting boundary have no or a relatively small amount of foreign currency income or expenditure except for EEA medical costs for which the Department has financial liabilities at 31 March 2008 totalling £716,616,448. These liabilities are payable in the local currencies of the EEA member countries, primarily Euros. The Department enters into forward contracts for the purchase of Euros for the purpose of paying EEA medical costs in-line with existing arrangements where a specific amount of Euros are

required at a particular date. As at 31 March 2008 the Department had entered into forward contracts to purchase €140m on 17 July 2008 and €140m on 11 December 2008.

Interest-Rate Risk

All of the Department's financial assets and financial liabilities carry nil or fixed rates of interest. The Department is not, therefore, exposed to significant interest-rate risk.

31 Contingent Assets and Liabilities disclosed under FRS 12

31.1 Contingent Assets

The Department has no contingent assets.

31.2 Contingent Liabilities

The Department is the actual or potential defendant in a number of actions regarding alleged clinical negligence. In some cases, costs have been provided for or otherwise charged to the accounts. In other cases, there is a large degree of uncertainty as to the Department's liability and to the amounts involved. Possible total expenditure might be estimated at £5.98 billion (2006-07: £4.71 billion), although £5.211 billion (2006-07: £4.136 billion) relating to the Clinical Negligence Scheme for Trusts (CNST), Property Expense Scheme (PES) and Liability to Third Parties Scheme (LTPS) would be expected to be met by payments receivable from NHS Trusts.

Within Primary Care Trusts' accounts at 31 March 2008, there were net contingent liabilities of £53,681,000 (2006-07: £78,404,000). These are mainly for continuing care and agenda for change. Primary Care Trusts have provided for these liabilities where they can reasonably estimate the likely value of potential claims received. Where these obligations cannot be reliably estimated a contingent liability has been recorded.

The joint venture contract between The Information Centre and Dr Foster LLP includes a put option whereby if, anytime from 1 January 2009 to 31 December 2013, Dr Foster LLP shareholders wish to sell their share in the investment, the IC would be obliged to buy out their share of the business, at market value, if no other buyer can be found.

An investigation into the administration of the injury benefits scheme began in 2006 following a decision by the Pensions Omubdsman's. As a result of the review monies were due to be paid to some 10,000 people who had not received the correct payments due to irregularities in the administration of the injury benefits scheme between 1972 and 2006. It has not been possible to make full payment to all the affected individuals in this financial year. There are 217 cases where we are seeking information from the Estate and around 200 people for whom we have no current address. An information campaign seeking claims from individuals who may also have been affected has resulted in 1136 information packs being issued and 217 claims being made. It is not possible at this stage to estimate how many of these claims will be successful nor how much benefit may be owed.

32 Contingent Liabilities not required to be disclosed under FRS 12 but included for Parliamentary reporting and accountability

32.1 Quantifiable

The Department of Health has entered into the following quantifiable contingent liabilities by offering indemnities or by giving letters of comfort. None of these is a contingent liability within the meaning of FRS12 since the likelihood of a transfer of economic benefit in settlement is too remote.

	1 April 2007		Increase in year	Obligation expired in year	31 March 2008		Amount reported to Parliament by departmental Minute
	£'000	No.	£'000	£'000	£'000	No.	£'000
Guarantees:	-	-	-	-	-	-	-
Indemnities:	156,250	4	2,050	60,000	98,300	3	98,300
	156,250	**4**	**2,050**	**60,000**	**98,300**	**3**	**98,300**

32.2 Unquantifiable

The Department of Health has entered into a number of unquantifiable or unlimited contingent liabilities with various health bodies and private companies. There were 31 indeminities.

None of these is a contingent liability within the meaning of FRS 12 since the possibility of a transfer of economic benefit in settlement is too remote.

Full details of these can be found in the Statement of Contingent or Nominal Liabilities held at the Department.

33 Losses and Special Payments and other Accounting Notes

33(a) Losses

		2007-08 Total		2006-07 Total
	Cases	£'000	Cases	£'000
Total	41,848	528,416	127,784	1,076,241
Details of cases over £250,000				
Cash Losses-cancelled PDC	2	359,323	41	911,512
Claims abandoned	-	-	9	37
Administrative write-offs	1	1,313	26	5,902
Fruitless payments	-	-	7	6,819

£359,323,000 PDC was cancelled in 2007-08 by means of a treasury minute laid before Parliament. This was the outstanding PDC of two of the four NHS trusts which were dissolved during 2007-08. These two trusts were dissolved because they were involved in a merger to form a new NHS Trust to which £671,957,000 PDC was issued in the form of Originating Capital by means of a Statutory Instrument. The difference of £312,634,000 between the total cancelled PDC and that newly issued PDC reflects movements in the composition and valuation of the assets of the dissolved trusts in the years since their initial establishment. There is consequently no overall loss of PDC. The other two NHS trusts dissolved during the year merged with existing trusts and there was no requirement to write off existing PDC. In addition, NHS Direct NHS Trust, which was formed from NHS Direct Special Health Authority, was issued with Originating Capital of £23,611,000.

The NHS Injury Benefits Scheme makes payments to NHS staff who become ill or who are injured as a result of their work. The Scheme is regulated by the NHS (Injury Benefit) Regulations 1995 and is administered by the Pensions Division of the NHS Business Services Authority. The administrators identified anomalies dating back to 1972 and following Ministerial agreement have taken corrective action and all those known to be affected (circa 10,000) have had their claims reviewed. On the advice of lawyers and officials Ministers agreed that recovery of any overpayments should not be pursued. The overpayments occurred due to official error and individuals could establish a robust defence based on Estoppel – reasonably relying on past official advice. Some individuals were both over and underpaid at different times during the period they had been receiving injury benefits. Ministers agreed to the recommendation from officials (supported by lawyers) that it was reasonable to offset any overpayments in redressing any underpayments. Off-setting would reduce the burden on the public purse and any dispute could be settled, as far as possible, out of Court.

PCTs had a case in 2007-08 that involved a bad debt written off in respect of Surestart Government Grant Scheme £1,313,000.

		2007-08 Total	2006-07 Total
	Cases	£'000	£'000
Store losses	2	47,880	25,487

The majority of the loss was influenza vaccine that was bought for a new policy of immunising poultry workers. Uptake for this policy was lower than expected. The second biggest loss was BCG vaccine. Due to the short expiry on this vaccine and unpredictable issue figures, 4357 packs date expired before they could be issued to the field. One box of oral polio is held at our distributors as a first line defence against an outbreak of polio. This box has date expired. The remainder was due to vaccines being damaged or not kept in the recommended conditions by either the supplier or distributor.

The Department of Health authorised write-offs relating to date expired stock items. NHS Supply Chain holds stocks of CBRN countermeasures on behalf of the Department, for use in the event of a natural emergency or terrorist attack involving chemical, biological, radiological or nuclear agents. If no such incidents occur then the stocks inevitably reach the end of their useable life and need to be disposed of and replaced with new stocks in order to maintain a measure of protection for the UK's populace. The value of stocks written-off in the year due to expiration of their shelf life was £47.880m. This cost was borne by the Department of Health.

33(b) Special Payments

		2007-08 Total		2006-07 Total
	Cases	£'000	Cases	£'000
Total	1,172	30,342	1,424	11,079
Details Of Cases Over £250,000	9	22,527	3	8,144

PCTs made an ex gratia redundancy payment of £253,000 and a severance payment under legal obligation £254,000.

There were 2 cases in respect of asbestos claims totalling £2,855,000.

ISTC Payments

Payments for the termination of ISTC Contracts (£12.5m)

Two ISTC Diagnostic contracts, North West and South West Diagnostics, were terminated in July 2007. Following mediation, a payment of £2.5m was agreed, which mitigates the Department's exposure to further significant liability.

In November 2007 the Secretary of State announced that a contract for diagnostic services in the West Midlands should be terminated. Waiting times for diagnostic treatments in the region fell dramatically and poor take-up of the service meant it could no longer be justified on value for money grounds. The payment of £10m compensation is a contractual liability resulting from the termination of the contract.

Payments in relation to wasted bid costs for ISTC schemes (£6.7m)

A contribution to the sum of £1.6m towards wasted costs was made, arising from the withdrawal of the Hemel Hemstead site. As a result of a revalidation exercise, various other Independent Sector Treatment Centre Phase 2 schemes were cancelled or re-scoped, resulting in payments of £1.2m for Avon Gloucestershire and Wiltshire and £3.9m for London South.

Whilst the Department does not accept liability for any costs incurred as a result of a scheme being cancelled or re-scoped the Department has made discretionary, ex-gratia contributions towards claims in line with established policy.

34 Related Party Transactions

The Department is the parent of the executive agencies and other bodies within the group and sponsor of trading funds, executive non-Departmental public bodies disclosed in Note 37. These bodies are regarded as related parties with which the Department has had various material transactions during the year.

In addition the Department has had a small number of transactions with other Government Departments and other central Government bodies.

Other related parties transactions and the extent of the transactions are summarised below:

	Sub Note	Purchases from related party 2007-08 £000's	Sales to related party 2007-08 £000's
York University	1	2,953	98
Sheffield University	2	31	-
Thames Valley University	3	10	-
Marie Curie	4	1657	38
The School of Medicine based at Kings College	5	4,152	-
Section of Epidemiology and Public Health Royal Society of Medicine	6	14	-
National Heart Forum	7	1,161	20
Kings Fund	8	1,166	-
Cambridge Univeristy	9	125	-
SBS	10	23	1
Faculty of Public Health	11	1,071,656	
Dr Foster	12	16,371,372	

Sub Note

1) Andrew Cash is the Visiting Chair in Leadership Development at York University.
2) Andrew Cash is the Visiting Chair in School of Management and Leadership at Sheffield University.
3) Chris Beasley is a Pro-Vice Chancellor for Thames Valley University.
4) Chris Beasley is also a Trustee for Marie Curie.
5) Duncan Selbie is a Board Member at King's Medical School.
6) Fiona Adshead is a Council Member for Section of Epidemiology and Public Health Royal Society of Medicine
7) Fiona Adshead is a Trustee for National Heart Forum
8) Mark Britnell is a Senior Associate at Kings Fund
9) Sally Davies' husband is employed by Cambridge University as an academic clinician
10) Shared Business Services is a joint venture between the Department of Health and Steria
11) Fiona Adshead is a member of and policy advisor at the Faculty of Public Health
12) Matt Tee is a shareholder in Dr Foster

35 Third Party Assets

	31 March 2008 £'000	Gross inflows £'000	31 March 2007 £'000
Monetary assets			
Bank balances	12,719	4,109	8,610

The above monetary assets, at 31 March 2008, are £4,096,000 which is held by PCTs at bank and in hand in respect of monies held by PCTs on behalf of patients and £8,623,000 which is held by the Department of Health in an Escrow account.

36 Post Balance Sheet Events

The contract with Fujitsu for the provision of the Care Records Service in the South was terminated by NHS Connecting for Health on the 28th May 2008. A Short Form Agreement has been put in place to enable the transition of existing service to an alternative supplier. The Agreement covers the period 28th May 2008 to

28th November 2008. The Agreement has been agreed by both the Department of Health and HM Treasury. At this stage no discussion has taken place or agreement reached over any compensation due by either party in respect of the termination.

The Accounts were authorised for issue by the Accounting Officer on the 3 October 2008.

37 Entities within the Departmental boundary

Ministers had some degree of responsibility for the following bodies during the year 2007-08:

Consolidated in the Department's Resource Accounts

Supply financed agencies

NHS Purchasing and Supply Agency

Other Bodies

Strategic Health Authorities
Primary Care Trusts
Special Health Authorities:
NHS Business Services Authority
Mental Health Act Commission***
The Information Centre
National Institute for Health and Clinical Excellence
NHS Litigation Authority
National Treatment Agency for Substance Misuse
National Patient Safety Agency
NHS Institute for Innovation and Improvement

Not Consolidated

Trading Funds

Medicines & Healthcare Products Regulatory Agency

Executive Non-Departmental Public Bodies

Appointments Commission
National Biological Standards Board
Human Fertilisation and Embryology Authority**
General Social Care Council
Alcohol Education Research Council
Health Protection Agency
Commission for Patient and Public Involvement in Health
Independent Regulator of NHS Foundation Trusts
Council for Healthcare Regulatory Excellence
Commission for Social Care Inspection
Health Care Commission***
Human Tissue Authority **
Postgraduate Medical Education and Training Board

NHS Trusts
Food Standards Agency
NHS Blood and Transplant
NHS Direct
NHS Professionals
Social Care Institute for Excellence
Foundation Trusts

** To be part of Regulatory Authority for Tissues and Embryos

*** To be merged with Commission for Social Care Inspection.

Annex A

GLOSSARY OF GOVERNMENTAL TERMS

Administration Cost Limit An overall limit applied to administration costs within the Department which should not be exceeded by the administration expenditure for the year.

Annually Managed Expenditure (AME) A Treasury budgetary control for spending that is generally difficult to control, large as a proportion of the Department's budget, and volatile in nature

Appropriations in Aid (A in A) Expected income that arises during the normal course of business that the Department is authorised to retain. The income is voted by Parliament in the Estimate and is available to offset against expenditure in the current financial year. Any Excess A-in-A over the authorised limit must be surrendered to the Consolidated Fund. These are included within the Operating Cost Statement and disclosed separately in the Summary of Resource Outturn.

Comptroller & Auditor General. Head of the National Audit Office. Responsible for auditing the Department's Resource Accounts.

Consolidated fund. The Treasury's account at the Bank of England which is used by most Government Departments for processing payments or receipts.

Consolidated Fund Extra Receipts (CFERs). Receipts which the Department cannot use to finance expenditure and which are surrendered to the Consolidated Fund. CFERs can be revenue or capital in nature.

Core Department. The Department of Health only. It does not include any of the bodies listed in Note 37.

Cost of Capital Charge A charge to reflect the opportunity cost of Government funding invested in assets of the Department and included to ensure that the full cost of services is reflected in departmental accounts. It is calculated at a rate of 3.5% (2006-07 3.5%) on the average net assets (capital employed) held by the Department over the year. The charge is included in the Operating Cost Statement and apportioned between administration and programme costs.

Departmental Expenditure Limit (DEL) A Treasury budgetary control for spending that is within the department's direct control and which can therefore be planned over an extended (Spending Review) period (such as the costs of its own administration, payments to third parties, etc).

Estimate A summary of the resources and cash voted by Parliament to the Department for a particular year and against which expenditure is monitored. It is analysed by Requests for Resources, each being monitored separately.

General Fund The General Fund represents the historic cost of the total assets less liabilities of the Department, to the extent that it is not represented by other reserves and financing items. It is included in Taxpayer's Equity on the Balance Sheet.

Net Cash Requirement The amount of cash required and authorised from the Consolidated Fund for the Department to carry out the functions specified in the Estimate. Actual cash used during the year is described as the outturn of the net cash requirement.

Net Resource Outturn This is the net total of income and expenditure consumed by the Department during the financial year.

Non-budget Expenditure that is not included in either DEL or AME. For Department of Health this includes, the grant in aid to non-departmental public bodies, NHS Trusts and Foundation Trusts Public Dividend Capital issues and repayments and NHS Trusts and Foundation Trusts loans and repayments and repayment of interest.

Non-operating Cost A in A Comprises proceeds from sales of assets and repayment of voted loans which can be retained by the Department. These are included in the Summary of Resource Outturn.

Programme costs. Programme costs include the running costs of NHS bodies funded directly by the Department but otherwise reflect non-administration costs, including payments of grants and other disbursements by the Department.

Request for Resources (RfR) The basic unit of Parliamentary control for which resources to the Department are granted. Each RfR within the Estimate represents an accruals based measure of expected expenditure within the Department for items which fall within that RfR. The Summary of Resource Outturn, the Operating Cost Statement and Note 2 analyse net resource outturn by RfR.

Annex B

NAO REPORTS PRINCIPALLY FOR Department of Health

Pay modernisation: A new contract for consultants in England (April 2007)

The report concluded that by 2000, there was general agreement on the need for a new consultant contract. Consultant pay was falling behind that of other comparative professions, and the NHS needed to increase the size and commitment of the consultant workforce if it was to deliver the NHS reform agenda and comply with the requirements of the European Working Time Directive to reduce consultants' hours. There was also poor information and understanding on the amount and type of work that consultants actually did.

The report stated that the contract had delivered some benefits in management of consultant time, prevention of an increase in private practice, securing extra work at plain-time and increasing participation. However, the NAO felt that greater attention also needed to be applied to assessing activities such as research, clinical audit and teaching, in order to introduce further clarity and evaluate their value to both the consultant and trusts.

The NAO concluded that the contract was not delivering the full value for money to the NHS and patients that had been expected from it although Department of Health believes that it is too early to judge this. However, the contract has helped to align consultants' pay levels with their contribution to the NHS which was in line with the Department's objective to reward consultants more appropriately for their NHS work.

Prescribing costs in primary care (May 2007)

The report found that wastage of drugs, under-prescribing, and over prescribing, whenever they occur, represent poor value for money. However, because levels of drugs wastage are not monitored, the NAO found it difficult to form a view on whether the current anti-wastage measures are proportionate. Assessing whether local prescribing volumes are consistent with clinical need is complex. Combining prescription data with local prevalence data can provide benchmark information for PCTs and GP practices to help identify opportunities for improving the value for money they get from their prescribing.

The NAO found that drugs wastage is a significant cost for the NHS: at least £100 million a year, or more, although the lack of robust data, and the wide range of reasons for waste, makes quantification difficult.

The report concluded that there were ways in which DH and NHS bodies could help make growth more affordable without affecting patient care, and hence enable more people to be treated or expensive treatments to be made more widely available. The report also concluded that DH and NHS bodies could seek to influence doctors' prescribing decisions, for example where different drugs have the same clinical effect but different prices.

Improving services for people with dementia (July 2007)

Dementia presents a significant and urgent challenge to health and social care in terms of both numbers of people affected and cost. It is also a major personal challenge to anyone experiencing early symptoms and seeking diagnosis, which merits the seriousness accorded to, say, cancer.

The NAO concluded overall that services were not delivering value for money to taxpayers or people with dementia and their families:

- Health and social care services are spending significantly on dementia.
- Spending is late – too few people are being diagnosed or being diagnosed early enough. Early interventions that are known to be cost-effective, and which would improve quality of life, are not being made widely available. This results in spending at a later stage on necessarily more expensive services.

- Services in the community, care homes and at the end of life are not delivering consistently or cost effectively against the objective of supporting people to live independently as long as possible in the place of their choosing.

The ageing population means costs will rise and services are likely to become increasingly inconsistent and unsustainable without redesign. Given the data now available on the scale and impact of dementia, the evidence base for cost-effective intervention, and the growing consensus for action among health and social care bodies, the opportunity now exists to address these challenges.

Helping people through mental health crisis: the role of Crisis Resolution and Home Treatment services (December 2007)

Crisis Resolution Home Treatment (CRHT) teams have been rapidly implemented across most areas of England. £183 million was spent on providing CRHT services in 2006-07, an increase of 409 per cent in real terms since 2002-03. The Public Service Agreement target of establishing 335 teams was met by 2005. The target for treating 100,000 people a year has not yet been achieved, with 95,397 episodes of CRHT provided to 75,868 individual people reported in the year to 31 March 2007. From 2008-09, DH plans to introduce more locally managed and outcomes-based metrics of performance alongside these targets.

Yet the NAO's sample testing of 500 admissions showed that only half, rather than all as intended, had been assessed by CRHT staff before being admitted. Around one in five of the sample admissions were considered by ward managers to be appropriate candidates for CRHT. Other health professionals making referrals to acute mental health services could have better awareness and understanding of how the community and inpatient elements of an acute service operate, which would make the user's route through such services more efficient.

The report estimated that an acute mental health service making full use of CRHT services in appropriate cases costs approximately £600 less per crisis episode than one in which CRHT is not available – chiefly because some admissions will be avoided altogether and others will be shorter, reducing the costs incurred with overnight stays. Increasing the proportion of cases in which CRHT is considered offers scope for further efficiency savings – on a cautious estimate of some £12 million a year and potentially much more.

NHS summarised accounts 2006-07: achieving financial balance (December 2007)

DH made financial recovery a priority in 2006-07 and one of its objectives was to deliver net financial balance across the NHS. This target envisaged that after deductions to recover the deficit reported in 2005-06, the sum of deficits and surpluses reported by NHS organisations would be zero. The NHS delivered a net surplus of £515 million (representing 0.6 per cent of total available resources); an improvement of over £1 billion from the £547 million net deficit (representing 0.7 per cent of total available resources) reported for 2005-06.

The report stated the fact that a number of NHS organisations still have significant deficits. Eighty per cent of the gross deficit of £917 million exists in just 10 per cent of NHS organisations. DH has identified significant reduction of the gross deficit as a key financial priority for 2007-08. Improving the financial performance of these organisations is an important factor for embedding good financial management across the NHS as a whole.

The report also found that the turnaround programme achieved its aim of making significant improvements in the financial position of most NHS organisations that were in deficit and needed support in achieving financial balance.

Caring for vulnerable babies: the reorganisation of neo-natal services in England (December 2007)

The report found the reorganisation of care into neonatal networks improved the coordination and consistency of services, pointing to increased effectiveness. There are still serious capacity and staffing problems and a

lack of clear data on outcomes. In addition, the variable state of financial management makes it difficult to judge the economy and efficiency of the service.

The NAO were unable to say whether or not networks have improved the overall value for money of the service. Nonetheless the majority of parents are grateful for the care their babies receive. Given the rising demand for the service and the constraints within the system, parents' views are an important indicator of achievement, but the lack of robust evidence on outcomes makes it difficult to reach an objective view of the quality of the service.

Releasing resources to the frontline: the Department of Health's Review of its Arm's Length Bodies (January 2008)

The report stated that in 2004 DH announced its ALB Review, which aimed to reconfigure and streamline the ALB sector so that it would be able to deliver its services more efficiently. The NAO found that DH is on track to meet the key targets set for the ALB Review in 2004 and that definitions of how the Review's targets would be measured were clear, agreed with Ministers, and in conformity with the prevailing criteria for assessing efficiency savings at that time.

Around half of the reduction in posts has been achieved by reassigning existing posts to new categories. Nurses working for NHS Direct who have been reassigned to the 'frontline' count as staff reductions even though their duties remain as they were. Consequently, the exercise has certainly cut costs, posts and the number of bodies, and in this sense has improved value for money in ALB sector and secured some notable savings. In the wider context of developments in efficiency measurement since 2004, there remain some areas in which further evidence would be required to quantify unequivocally the overall value for money achieved.

For the future, to ensure that further efficiencies are delivered in accordance with the requirements of the 2007 Comprehensive Spending Review, DH will have to work within the tighter requirements for demonstrating efficiency gains that have been announced by the Government since the previous Spending Review.

NHS Pay Modernisation: New contracts for general practice services in England (February 2008)

The report stated that in 2001, DH and the other UK Health Departments gave the NHS Confederation a mandate to act on their behalf in negotiating a new contract with the BMA. In June 2003, the negotiating parties agreed the terms of a new contract, following Department of Health's concession to provide a Minimum Practice Income Guarantee. The allocation formula was also changed so that it was based on practice list sizes and not census population estimates. MPIG was seen as a transitional arrangement based on historic funding for core services. The new GMS practice based contract was implemented from April 2004.

The report found that the new contract for GPs cost more than DH intended but had started to deliver some of the intended benefits. Recruitment and retention has improved, services provided in GP practices have been extended and PCTs have the contractual tools to be able to commission local services. The introduction of the QOF improves consistency of care, for example in identifying and treating long term conditions. The contract also rewards clinical practice where evidence suggests intervention should lead to improved health outcomes.

The report concluded that a new contract for GPs was needed and the terms negotiated provide PCTs the levers to be able to commission services with GPs in a way that more closely aligns to patient needs. The contract has given GP practices more control and management of its workload by removing responsibility for providing services over and above what are considered to be essential services. PCTs now have the responsibility for commissioning out of hours and other enhanced services. However, in the first two years of the new contract, the higher than expected cost of the new GMS and PMS contracts has limited the opportunities to develop local enhanced services and other flexibilities envisaged by the new contract.

RELEVANT REPORTS COVERING SEVERAL DEPARTMENTS

Shared services across Government (November 2007)

The report focussed on the work of Cabinet Office but used the NHS Shared Business Service, operational since April 2005, as a case study. The analysis of results and forecasts estimated that NHS Shared Business Services would potentially deliver net present value savings of £250 million over eleven years, of which £160 million was likely to occur within the first nine years and it would break even after five years.

The report found that organisations receiving the shared services reported early problems but stated that this is a common experience with large transformation programmes. Difficulties stem mainly from operational problems associated with the challenge of implementing large and complex systems and from the cultural changes necessary in customer organisations. Evidence from NHS Shared Business Services is that customer satisfaction levels rise over time.

The report stated that most customers of NHS Shared Business Services have seen substantial savings in procurement costs as well as better management information, paperless transaction processing, faster transaction processing and a step change in the robustness of processes.

Annex C

RECENT PAC REPORTS / HEARINGS: MAIN ISSUES

Pay modernisation: A new contract for NHS consultants in England (April 2007)

The PAC examined the Department about how the new contract was supposed to influence the recruitment and retention of hospital consultants. The Department hoped to reward those consultants who made the biggest contribution to NHS work and reduce the average number of hours worked per consultant, in exchange for increased productivity. These benefits were dependent on the introduction of a mandatory and rigorous process of workload planning for individual consultants (job planning).

They concluded that the implementation of the contract had been rushed and, in April 2007, the NHS had yet to see many of the intended benefits. Over the first three years, the Department allocated an additional £715 million to NHS trusts which was £150 million more than originally estimated as necessary to fund the contract. NHS trusts still believe, however, that the contract has been underfunded.

Prescribing costs in primary care (June 2007)

The PAC examined DH officials about the costs of prescribing in the primary care setting. One of the primary topics discussed was the amount of wastage caused by patients not taking the drugs they were prescribed and whether putting the price of the tablets on the bottle would be an effective counter. DH cited research it had done on the idea, wherein it had found that if the cost were put on the bottle, it could lead to two detrimental effects – if the cost were very high then some people thought they should not take it because it was too expensive whereas if the costs were low, some people thought they should have a slightly more expensive drug.

The Committee concluded that there are potentially serious public health and financial implications from drug wastage, as not only do PCTs have to pay for the drugs which are unused, but they also have to pay to dispose of them and for the consequences of patients not taking their medicines correctly.

The Committee also examined the issue of prescribing generics and highlighted the prescribing of generic statins over non-generics. They concluded that our own data on statin prescribing show that the drugs being dispensed by pharmacists are in many cases not the most cost effective and that £85 million a year could have been saved by more cost-effective statin prescribing. They also found that there could be scope for further savings on the rest of the drugs bill – in the four areas considered by the NAO £227 million could have been saved between August 2005 and July 2006 if all PCTs had prescribed with the same efficiency in these areas as the top 25% of PCTs.

Improving services for people with dementia (October 2007)

The PAC examined Department of Health about the prevalence and costs of dementia, diagnosis and early intervention, access to and quality of support services, and experiences of people with dementia in hospital and care homes. The Committee found that despite its significant human and financial impact, DH had not given dementia the same priority status as cancer and coronary heart disease. As a result, they concluded that the NHS had not afforded dementia the same focus for improvement. Large numbers of people do not receive a formal diagnosis for a variety of reasons including GPs' lack of knowledge and/or confidence to make a diagnosis, fear of dementia, and a perception amongst the public and professionals that little can be done to help people with dementia.

The Committee also heard that where a diagnosis is made, it is often not communicated sensitively or appropriately, with patients and their families left without adequate advice or support. People with late-onset dementia have all the additional health problems that accompany old age, and they require support from multiple health and social care service providers. But the task of managing and co-ordinating this care usually falls to their carers.

The PAC concluded that carers bear a heavy burden, saving the taxpayer millions of pounds by caring for relatives with dementia at home. Carers are often poorly supported however, with few receiving their entitlement to a carer's assessment and many unable to access good quality respite care or domiciliary care. As a result people with dementia may be admitted to a hospital where they experience longer lengths of stay and poorer outcomes than people who are psychiatrically well; or to a care home, earlier than might otherwise be the case. Both of these outcomes are more costly than domiciliary care. Once in a care home, a lack of dementia beds and staff with appropriate training in dementia care can lead to poor medicines management and other examples of inadequate care.

NHS summarised accounts 2006-07: achieving financial balance (January 2008)

The PAC examined the Department on the financial performance of the NHS, how the financial turnaround was achieved, and the impact of this turnaround on services and the future. The Committee questioned whether financial balance was achieved through sustainable improvements in NHS financial management or through tighter central control and service reductions.

The PAC found that some allocations were required to be withheld from NHS organisations notably through the top-slicing of Primary Care Trust budgets and through diversion of training expenditure to support deficits. As a result, some Primary Care Trusts were unable to deliver all of the health care they might have, with some delivery against local priorities being reduced or delayed through limits on health care activity. Overall, the quality of service improved during the year, as rated by the Healthcare Commission.

The PAC concluded that the return to financial balance is the result of the tighter performance management of NHS finances in the way funding flowed through the NHS together with a programme of support for local organisations with particular financial difficulties. In the short term, this largely centralist approach was appropriate. However, the PAC also concluded that for the future, if the NHS is to remain in financial balance, more health organisations locally need to improve their financial management and that failure to keep a tight grip on financial performance could undermine health care for patients.

Caring for vulnerable babies: the reorganisation of neo-natal services in England (February 2008)

The PAC examined whether the NHS still has limited data on patient outcomes, other than mortality rates which show unexplained variations between networks. They found that while these variations may be due to the demographics of the population covered by the network, such as high and low maternal age, obesity and smoking, other factors, such as access to care during pregnancy and speed of access to the right level of neonatal care, may also have an influence.

The PAC discussed whether constraints in capacity mean that DH is still struggling to meet the demand for neonatal services, and problems over recruiting, retaining and training the staff required to deliver the service remains a major challenge and concluded that financial management at the unit level needs to be improved. Neonatal units were considered to have a poor understanding of the costs of running their unit and there were differences in how units determine their charge for a cot day with wide variations in charges between similar types of unit.

Pay modernisation: GP contracts (March 2008)

The PAC examined DH officials about the cost implications of the new contract for non-salaried GPs. The chairman congratulated DH for "making an attempt to get a better quality outcome for patients seeing their GP." However, there was concern from the Committee about the reported increase in expenditure and the reported decrease in productivity from GPs.

The Committee challenged the Department on the issue of the Quality & Outcomes Framework (QOF), saying that because 96% of doctors achieved the available points, it set the standards too low, that doctors met these outcomes too easily and that whereas some PCTs which were perhaps better resourced, better managed, more skilful, do seem to have achieved some improved outcomes but that the picture is very mixed.

The Department responded that the QOF was being used to target some health inequalities, through better care for patients with cardio-vascular disease and diabetes and that in subsequent phases of the QOF, it was intended to get local QOF criteria for local health inequality issues. The new contract has also directly led to an increase in the time GPs spend with patients with more complex problems because practice nurses are able to do reviews of patients with chronic diseases.

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