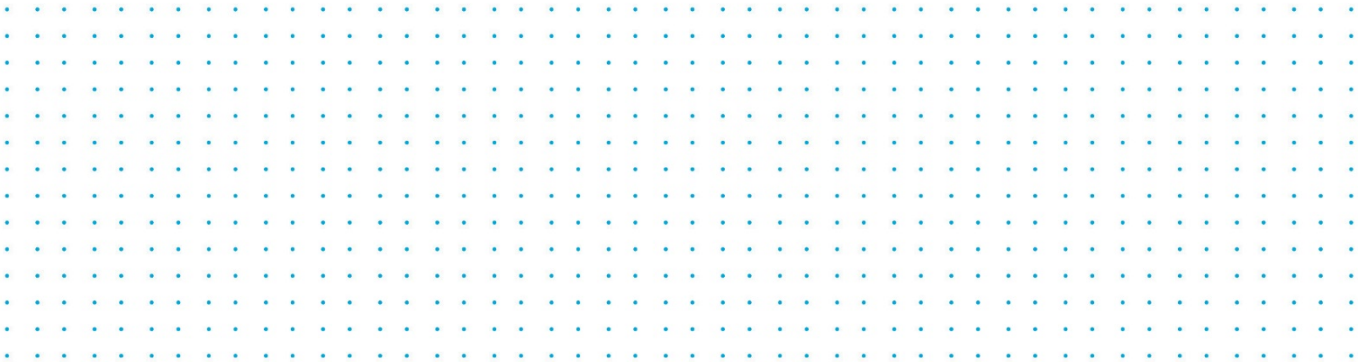
NHS England

Our 2021/22 Annual Report

Health and high quality care for all,
now and for future generations



THE NHS CONSTITUTION
the NHS belongs to us all

HC 1011

NHS Commissioning Board

Annual Report and Accounts 2021/22

For the period 1 April 2021 to 31 March 2022

NHS England is legally constituted as the National Health Service Commissioning Board.

Presented to Parliament pursuant to Section 13U of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

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A view from Richard Meddings CBE, Chair

When I was appointed as Chair of NHS England in late March 2022, I was greatly humbled to be joining an NHS that was still battling one of the greatest health challenges of our time. The most affecting of the many insights shared by my predecessor, Lord David Prior, was the incredible effort and sacrifice made by NHS staff to keep the population safe in the face of the pandemic. In my first several months as Chair I have been hugely privileged to see this first hand through meeting many of our frontline staff across the country, and I thank them for their passion, dedication, and sheer hard work.

As we enter the 75th year since the founding of the NHS it is important that we reflect on our successes, while not losing sight of the very real challenges ahead. The ongoing effects of the COVID-19 pandemic continue to put pressure on services and, while many areas are delivering at higher than pre-pandemic levels, creative solutions will be required to meet increasing demand. It is also true to say the NHS entered the pandemic years already facing severe operational stresses and missing its targets in several delivery and service areas.

To give a couple of examples, an astonishing 320 million appointments were delivered by GPs and their teams in the financial year, providing a sense of the scale at which the NHS operates. However, we know that many of the public still struggle to access primary care in the way they would like. Similarly, mental health services have put a huge effort into recovery but are seeing record numbers of people, including a significant increase in young people presenting, requesting help, including more complex needs.

Add to this the demands of an ageing population and a difficult economic forecast: it is abundantly clear that the NHS must continue to be innovative, preventative, and embrace new technologies if it is to remain true to its founding principles. And it must do all of this while providing value for money to the taxpayer.

Much of how the NHS operates is challenged by its multiple and legacy technology systems and its data, with far too much paper based. Where we do have digital systems, too often they do not communicate with each other nor use common definitions. We have recently launched a procurement for a Federated Data Platform, essentially an intermediate connecting layer, which will be a significant step forward in connecting the systems and helping to drive more uniform definitional coding. The NHS is also investing significantly in increasing the functionality of the NHS App where already some 30 million of the population have activated the service.

However, the fundamental issue that the NHS faces is starkly insufficient capacity, be it workforce or beds or scanners and at the same time facing fast growing demand from a population which both grows but also ages. There also exists a significant dependency on resourcing in the social care system, where the lack of key resources in that sector directly impacts the operational ability of the NHS.

To meet these challenges locally, the NHS must adapt to the communities it serves and work more closely with local councils, the voluntary, community, and social enterprise sector, and other vital partners. In July the Health and Care Act 2022 came into effect, but much of the work was already well underway. Integrated Care Systems and their Boards have been busy establishing local relationships and gaining better insights into the particular health needs of their growing populations.

Collaborative whole-system partnerships provide an opportunity for a more efficient and joined-up approach. This in turn supports a greater focus on prevention, reducing health inequalities and improving outcomes for local populations. Integrated Care Systems must be supported towards greater devolution if we are to empower local systems to respond to local needs.

The new operating framework requires NHS England and other national bodies to change the way we interact with the system. NHS England and NHS Improvement have been working as a single organisation since 2019, fully merging in 2022. Following the instruction from the Secretary of State for Health and Social Care in November 2021, NHS England, Health Education England, and NHS Digital are now also in the final stages of coming together. A headcount reduction at the centre, and after merging these organisations, of at least 30 and up to 40 percent, will further help NHS England to reduce bureaucracy and create a leaner but still expert centre and with fewer priorities.

But, of course, we cannot achieve more for patients without the right workforce. If we are to become a more preventative, agile, and innovative system we need to make sure we have the necessary skills and cultures. If we have an insufficient workforce in size and in particular disciplines, combined with inadequate physical capacity, then the whole system is stressed and spends its time firefighting, which impacts workforce morale and the quality of care provided to patients.

The NHS must be a desirable place to work, where people feel that their expertise is valued and that they are able to do the job for which they are trained. Key to achieving this is having the right number of people in the right places: which is why NHS England has worked hand in glove with Health Education England to produce a long-term workforce plan. We look forward to its publication in the Spring. This plan considers not just how many people we will need in 5-, 10- and 15-years' time, but also what we need to do to support and retain this workforce of the future. The plan considers skill mix, changes in working practices, the impact of

technology, productivity, and a shift of provision much more towards primary care and the community and further recognises the need for a substantial increase in our workforce even to reach international averages.

The Board recognises the importance of having a long-term workforce plan in reducing the current burden on staff and we will continue to support the Government on this seminal piece of work.

In the meantime, I would again like to express on behalf of the Board our heartfelt thanks to all NHS staff as we enter our 75th year, a year in which we intend a better informed understanding of the excellent levels of service so often provided as well as the urgent focus on the areas where we are not performing well and which are under intense operational pressure. It will be a year where we continue the many reforms and innovations and changes already underway, which will improve what we do, along with improving the understanding of the basic foundational capacity we need if we are to provide a national health service for the population.

Richard Meddings CBE Chair of NHS England

About NHS England

NHS England was established by Parliament in 2012 as an independent statutory body. It leads the NHS, sets its strategic direction through the NHS Long Term Plan, and funds key priorities for improvement.

In 2021/22 Parliament and government entrusted NHS England with £150 billion to commission healthcare services for the people of England, directly or via Clinical Commissioning Groups (CCGs, before their abolition from 1 July 2022). NHS England allocated £108 billion of this funding to the 106 CCGs to commission services for their local populations.

NHS England also directly commissions services including specialised care. Further detail is presented from page 85.

NHS England shares with the Secretary of State for Health and Social Care the legal duty to promote a comprehensive health service in England, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and most recently the Health and Care Act 2022).

We have a mandate from government, which in 2021/22 brought together the annual mandate to NHS England and the annual remit for NHS Improvement. This prioritised continuing to lead the NHS response to COVID-19 and implementing the NHS Long Term Plan by focusing on transforming services.

As a custodian of the NHS Constitution, which establishes the values, principles and rights underpinning the NHS, we are committed to putting patients at the heart of everything we do, promoting transparency and equity while ensuring the most efficient use of public taxpayer resources.

How we operate

During 2021/22, NHS England and NHS Improvement worked together as a single organisation, which we had done since 1 April 2019. On 1 July 2022, the legal merger of NHS England and NHS Improvement took place when the Health and Care Act 2022 became law, with NHS Improvement's constituent bodies (Monitor and the NHS Trust Development Authority (NHS TDA)) abolished and its staff, functions and resources transferring to NHS England.

NHS England is governed by a Board which provides strategic leadership and accountability to government, Parliament and the public. The Board is supported by committees which undertake detailed scrutiny in their respective areas of responsibility and provide it with regular reporting and formal assurance. Further details can be found from page 85.

During the year we had a single leadership model under the overall leadership of the Chief Executive Officer (CEO) of NHS England, and a single Chief Operating Officer (COO). National directors, either reporting to the NHS England CEO or COO, operated across both organisations.

Our national teams provided expertise, support and intervention, working closely with CCGs, Trusts, GP practices, local authorities, health and wellbeing boards and the voluntary sector.

Our regional teams, led by regional directors with a single reporting line to the COO, were responsible for overseeing the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

These regional teams collaborated with the 42 integrated care systems (ICSs), with staff roles aligned to ICS geographical footprints to support closer working. We support and rely on local healthcare professionals and systems making decisions about services in partnership with patients and local communities.

Following the Secretary of State's announcement, on 22 November 2021, on bringing together NHS Digital, NHSX and Health Education England (HEE) with NHS England and NHS Improvement, we are working with colleagues across all the organisations to ensure the new organisation can best support the wider NHS to improve patient care and outcomes, and deliver the biggest possible benefits to patients for the resources allocated by Government and Parliament.

Our work is also supported by third party organisations including NHS Business Services Authority (NHS BSA), NHS Shared Business Services (NHS SBS), NHS Property Services Ltd (NHS PSe) and Primary Care Support England (PCSE), the latter of which is provided by Capita. Additionally, NHS England hosts NHS Interim Management and Support and sponsors the Sustainability Unit on behalf of the NHS.

NHS England also oversees commissioning support units (CSUs). The CSU staff group are employed by the NHS BSA but are formally a part of NHS England. CSU activities are included in our report and accounts except where otherwise indicated. Detail on how we assure the activity of our organisation is presented in this annual report from page 85.

For further information about how we operate please visit our website.

Performance Report

Amanda Pritchard
23 January 2023

Accounting Officer

Chief Executive's overview

April 2021, the first month of the period covered by this report, was a time of real hope for many people. Thanks to the incredible success of the NHS in rolling out the first two doses of the new COVID-19 vaccines to the most at-risk groups, the acute impact of the once-in-a-century pandemic was waning, and the country was firmly on the road to opening back up after a year of restrictions.

But pandemic viruses have no respect for accounting periods. COVID-19 was, and is, still with us. We will continue to feel its effects – directly and indirectly – for years to come, with the most complex challenges only now emerging.

It is worth taking a moment to remember that over the course of financial year 2021/22, by the Government's official measure, more than 34,000 people died in England within 28 days of a positive COVID-19 test, with each of those individual lives lost touching many more.

The NHS therefore continued to operate in an extraordinary way – simultaneously working to recover from the disruption of 2020/21, while also remaining the front line of the national response to an ongoing pandemic.

An average of 5,811 people with COVID-19 were being treated by hospital teams every day during 2021/22, with two peaks of Omicron variant infections in January and March 2022 seeing significantly more inpatients requiring life-saving care. This would have been far higher were it not for the 89 million doses of COVID-19 vaccines we delivered over the year - in particular the rapid speed with which we delivered the Omicron booster campaign in December - or the new Covid Medicine Delivery Units stood up to provide effective new treatments to prevent tens of thousands of clinically vulnerable patients from deteriorating.

But just like in 2020/21 – and to a far greater degree thanks to the vaccine programme and other innovations and adaptations – the NHS was far from being a Covid-only service in 2021/22. Activity rebounded across all service areas, despite the ongoing restrictions on productivity caused by infection prevention and control measures, with a record number of people coming forward for cancer checks (a record likely to be beaten again in 2022/23), more than 15 million elective pathways completed, and 320 million GP appointments delivered.

Over the course of 2021/22 the NHS also successfully prepared for the transition to a new structure built on local partnership and collaboration through Integrated Care Systems and Boards, which gained legal status in July 2022 following a short delay in the passage of the Health and Care Act. Through the necessity of COVID-19 and the opportunity of these preparations, we have not just adjusted how we are legally organised; we have developed a new way of working together – locally, with local authorities, the voluntary sector and other partners, and nationally in the relationship between NHS England and the wider service, too.

This way of working is about recognising our respective strengths and the unique contributions we can make towards achieving our shared goal of better meeting the needs of patients and the wider communities we all serve. It is in service of this goal that, following an announcement from the Secretary of State for Health and Social Care in November 2021 and subsequent Parliamentary approval through the Health and Care Act, NHS England, NHS Digital and Health Education England began work to bring together our three organisations from April 2023 (with the legal merger of NHS England and NHS Digital since accelerated to February 2023, subject to further parliamentary approval).

Aside from the many other significant aspects of this process - including our plans to reduce the number of roles across the three organisations by a minimum of 30%, and up to 40% - it afforded an opportunity for extensive engagement with local and regional leaders over 2021/22 on how the new organisation best supports systems to deliver on their aims and objectives for improving services, which formed the basis for the first iteration of the new NHS Operating Framework published in October.

As I noted in my overview for last year's Annual Report, the historical capacity efficiency of the NHS has meant that significant levels of additional funding have been required to meet the additional demands of the pandemic. However, our ongoing commitment to living within the resources allocated by the Government and Parliament means I can again report that both NHS England as an organisation, and the wider NHS as a whole, returned a small underspend on non-ringfenced revenue funding during the financial year, as we have done for each of the past nine years, and we met all of our financial performance metrics.

The end of the 2021/22 accounting period did however see the first signs of the changing economic context which would develop further into 2022/23. Finances have been stretched as a result of rapidly increasing inflation, particularly in energy costs. The NHS has adjusted to protect frontline care, and in the Autumn Statement 2022 we now have the certainty of an improved settlement over the next two years.

As ever, none of these achievements would have been possible without the sustained herculean effort, and expertise, of the entire NHS workforce, and on behalf of everyone at NHS England I thank them once again for their individual and collective contributions. We know, however, that thanks are not going to be enough; it is part of our responsibility, alongside Government, to help tackle the issues which matter most to them. Chief among those issues is having enough people with the right skills and in the right places to be able to deliver safe, high-quality care sustainably for our growing and ageing population, now and in the years ahead.

Following a commission from the Secretary of State in January 2022, NHS England and Health Education England started work on a plan to achieve this, with expected publication in Spring 2023 following independent review of the modelling.

Of all the many imperatives that exist for the coming months and years, showing visible commitment and progress on a long term workforce plan is among the biggest – not just in practical terms, but symbolically too, as a sign to the current NHS workforce that we recognise the immense pressure they are under, and are working to ensure things will be better in the future.

NHS England is committed to doing exactly that, and to continuing our many other efforts to meet our new, shared purpose – as we come together with NHS Digital and Health Education England - to lead the NHS in England to deliver high-quality services for all by:

- Enabling local systems and providers to improve the health of their people and patients, and reduce health inequalities;
- Making the NHS a great place to work, where our people can make a difference and achieve their potential;
- Working collaboratively to ensure our healthcare workforce has the right knowledge, skills, values, and behaviours, to deliver accessible, compassionate care;
- Optimising the use of digital technology, research and innovation, and;
- Delivering value for money.

Each of these 'missions' on their own would be a significant ask for any organisation, particularly one of the size and complexity of the NHS, and we are realistic about that fact.

But the ingenuity, commitment and collaboration we continued to see over 2021/22 also allows us to approach them with optimism that, as the NHS has done for almost 75 years, we can, and we will deliver on them for our patients and the public.

Amanda Pritchard CEO of NHS England, and Accounting Officer.

How we measure performance

The NHS Constitution sets out the rights of patients, the public and staff. We measure and monitor performance against a wide range of constitutional performance standards and publish statistics relating to these core constitutional standards on the NHS England website every month[1].

Supported by the legislative provisions enabled by the *Health and Care Act 2022* we have developed the NHS Oversight Framework for 2022/23, which reinforces our vision for system-led delivery of integrated care. This updated framework sets out how we and the new Integrated Care Boards (ICBs) which were created on 1 July 2022, replacing Clinical Commissioning Groups (CCGs) that demised on 30 June 2022.

All ICBs, NHS trusts and foundation trusts were allocated into one of four support segments, determined by assessing the level of required support and ranged from no specific support needs (segment one) to a requirement for mandated national intensive support (segment four). These decisions have been routinely reviewed and updated throughout the year and are published on our website.

Performance of clinical commissioning groups

In 2021/22 we maintained a statutory obligation to assess the performance of each CCG using a range of measures, as well as consultation with their system partners where appropriate, to develop a balanced judgement of their effectiveness.

We maintained a similar simplified approach to CCG performance assessment as was undertaken in 2020/21 due to the continued impact of COVID-19 and the planned dissolution of CCGs. We assessed the performance of each CCG and the responsible Regional Director wrote a letter to each CCG Accountable Officer in response to their audited annual report, setting out how we assessed that the CCG had met its statutory duties as well as their performance against national NHS priorities. Each CCG was asked to publish a copy of this letter on their website alongside their final annual report. At the end of March 2022 there were formal powers of direction in place against one CCG. It is anticipated that the underlying issues for which powers of direction have been deemed necessary will be addressed by the transition of commissioning responsibility to the relevant ICB.

From 2022/23 we have a statutory obligation to undertake a performance assessment of each ICB, replacing the duty to assess each CCG. For 2022/23 the assessment will be in narrative form and will assess performance against statutory duties, identify areas of good and/or outstanding performance, areas of improvement, and any areas of particular challenge. We will publish a summary of the findings of all annual assessments.

[1] https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/

Performance overview

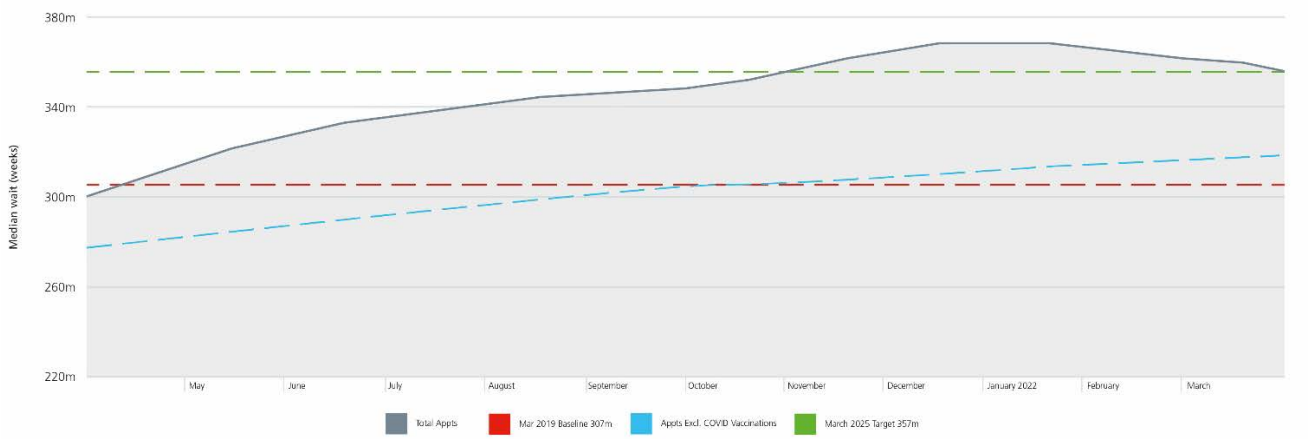
This year was the second in which the NHS managed additional demand from people seriously ill in hospital or cared for in virtual wards with COVID-19, while delivering a world class COVID-19 vaccination service, maintaining a wide range of essential services and continuing the recovery of those services hardest hit by the pandemic.

Over the course of the financial year, NHS acute hospitals admitted 275,977 people with COVID-19, with an average of 5,811 beds occupied by someone with COVID-19 per day. Thanks to the successful vaccine rollout, this is lower than the previous financial year (357,556 admissions, and an average 9,418 beds occupied by someone with COVID-19), but still high enough to put pressure on the system, with total occupancy in acute trusts above 90%.

COVID-19 booster vaccinations were offered to all eligible adults by 31 December 2021, a month ahead of the original planned milestone, and alongside the most successful flu vaccination programme in the history of the NHS.

There were 361 million appointments in primary care, of which 41 million were for COVID-19 vaccinations, exceeding pre-pandemic levels even when excluding the additional activity for COVID-19 vaccinations.

12 month rolling total estimated GP appointments



Community pharmacy relieved pressure on other parts of the NHS with over 840,000 referrals from NHS 111 for urgent medicines supply and minor illness consultations.

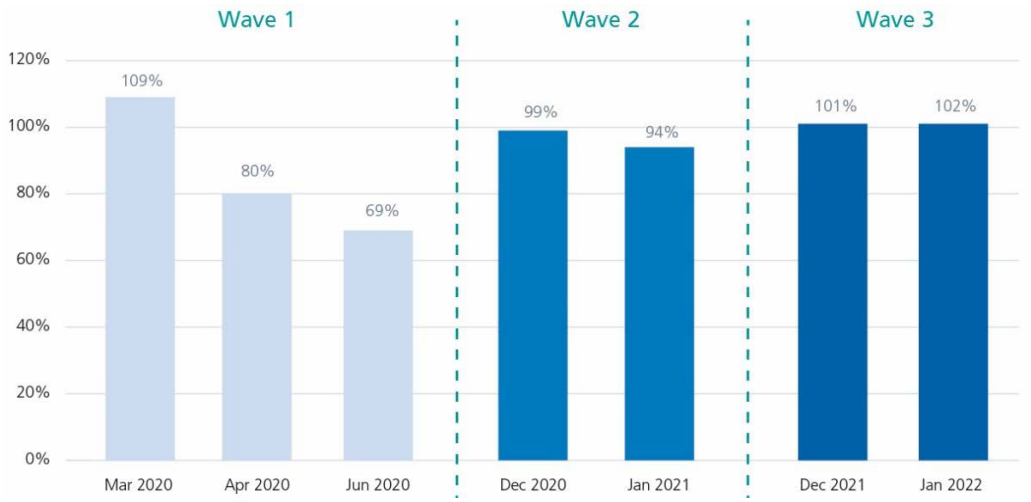
Over 600 urgent dental centres remained mobilised to ensure access to urgent care was maintained.

Unlike in 2020/21, increases in hospitalisations with COVID-19 were not accompanied with reductions in people coming forward for other emergency care to the same extent. Emergency admissions via Accident and Emergency (A&E) were 12% higher than 2020/21 and December saw a record number of the most serious ambulance call outs.

In order to address these pressures, there was a £98 million investment in NHS 111, supporting services to meet the record demand, with 7% more calls responded to than in 2020/21. There are now 185 designated Urgent Treatment Centres across England, and same-day emergency care (SDEC) services have been maximised where possible to restore them to pre-pandemic levels. Ten major capital schemes were completed, adding 382 waiting spaces, 175 major cubicles, 42 resus cubicles and 177 SDEC cubicles.

The NHS learned lessons from previous waves to ensure that periods of high COVID-19 infection rates had a lower impact on pre-planned care, meaning the reduction in elective activity in the January 2022 peak was smaller than for the April 2020 and January 2021 peaks, while the number of first cancer treatments exceeded pre-pandemic levels for the January 2022 peak.

Cancer first treatments during COVID-19 peaks relative to pre-pandemic levels



In February 2022, NHS England and NHS Improvement published the Delivery plan for tackling the COVID-19 backlog of elective care[2], the first milestone in which was to virtually eradicate waits of two years or more. At the end of March 2022, the number of patients waiting over 104 weeks in acute providers was below 15,000.

During 2021/22, a record 2,678,976 people were seen following an urgent suspected cancer referral – 12% above pre-pandemic levels. 315,549 people started cancer treatment, 93% of them within a month of a decision to treat.

The record number of people coming forward - including as a result of NHS symptom awareness campaigns - has meant some patients have waited longer for diagnostic tests than we would want. The NHS is putting in place the extra capacity needed to meet this demand, with cancer prioritised - £2.3 billion for Community Diagnostic Centres and extra endoscopy capacity - and £1.5 billion for additional treatment capacity.

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf

In 2021/22 an additional £95 million was invested in maternity services across England, leading to an increase of nearly 1,700 full time equivalents (FTE) for midwifery and over 180 FTE obstetricians, exceeding the stated aim for the funding. Recent data confirms the achievement of the 2020 ambitions to reduce stillbirths (down from 5.1 to 3.8 per 1,000) and neonatal mortality (down from 2.0 to 1.3).[3] This means around 1,000 more babies survive each year compared to ten years ago.

An additional £500 million investment for mental health was made available to respond to pressures and continue service expansion. Many existing commitments were achieved ahead of plan, such as the roll-out of 24/7 all age mental health crisis helplines, two years ahead of schedule. 1.2 million people accessed IAPT services in 2021/22, with a recovery rate of 50.5%. The NHS continues to meet the Early Intervention in Psychosis (EIP) two-week waiting time standard, achieving 68% as of March 2022.

We have already met the commitment in the NHS Long Term Plan of 2.5 million people having received personalised care, two years ahead of the stated target, and have agreed a revised ambition that 4 million people benefit from personalised care by March 2024.

As of 31 March 2022, there were more people working in the NHS than ever before, with 30,332 more nurses towards the 50,000 manifesto commitment; 1,462 more GPs and 18,221 Additional Roles in primary care against the 6,000 and 26,000 manifesto commitments; and 5,767 more Healthcare Support Workers since January 2020.

Management and treatment of COVID-19

During 2021/22, NHS England and NHS Improvement continued to lead the UK-wide policy and access arrangements which enabled the timely rollout of new COVID-19 treatments to eligible patients. The Research to Access Pathway for Investigational Drugs for COVID-19 multi-agency collaboration has ensured that UK-wide adoption of decisions has continued to be based on the latest high quality UK and international research.

In December, alongside the already established hospital based COVID-19 treatment options, the NHS made available new cutting-edge antiviral and monoclonal antibody treatments to patients in the community through new COVID-19 Medicine Delivery Units (CMDUs). Up to March 2022, CMDUs had treated nearly 30,000 patients at highest potential risk of hospitalisation or death from COVID-19 across England. In addition to those receiving the repurposed medicine dexamethasone, a further 52,000 commissioned COVID-19 treatments were also provided to hospitalised patients with COVID-19 in England during 2021/22[4].

[3] ONS Child and infant mortality in England and Wales 2020 - https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2020

[4] https://www.england.nhs.uk/statistics/statistical-work-areas/covid-therapeutics-antivirals-and-neutralising-monoclonal-antibodies/

NHS hospital and primary care teams have continued to be at the forefront of recruitment into and delivery of clinical trials which have helped identify effective COVID-19 treatments, benefiting patients across the NHS and around the world. More than a million people have taken part in COVID-19 research in the UK. National Institute for Health and Care Research sponsored trials, including the innovate adaptive 'platform' trials such as RECOVERY, REMAP-CAP and PANORAMIC, have been pivotal in generating key evidence for mortality reduction and recovery benefits across a range of new treatments.

Better clinical understanding of the disease also enabled improvements in care for our most severely unwell patients. Treatment changed as clinicians learned more about COVID-19, so that more patients were cared for using non-invasive ventilation in general wards, rather than being sedated on a mechanical ventilator in intensive care.

The NHS rapidly implemented COVID-19 'Oximetry at home' and COVID-19 'virtual ward' models, offering supported self-management and monitoring at home for silent hypoxia (where blood oxygen levels fall without obvious symptoms) and supported discharge/alternative to admission respectively. By March 2022, over 150,000 patients were estimated to have benefited from both pathways.

Post COVID-19 assessment services were established to assess people with long-term effects of COVID-19 and direct them to effective treatment pathways, including a digital self-management platform.

COVID-19 vaccination deployment

As of 31 March 2022, the NHS had administered a total of 119 million doses in England with 44 million first doses, 41.5 million second doses and 32 million third doses. This extraordinary achievement, managed alongside winter pressures and the demands of treating patients with COVID-19, would not have been possible without the dedication of tens of thousands of NHS staff and volunteers, working with our local authority and community partners.

Over 250,000 staff and volunteers have been recruited throughout the lifetime of the vaccination programme and nearly 14,000 people have decided that their future lies in the NHS.

Our approach has flexed over time as local partners, working with their communities, have adapted our offer to meet the needs of communities, ensuring safe and easy access for local people. At the peak of the rollout, we had a fully-supplied network of 239 hospital hubs, 1,582 Community pharmacies, 1,080 Primary Care services and 133 vaccination centres, ensuring that over 99% of the population in England lived within 10 miles of an NHS vaccination site. We also put in place a school-based vaccination programme to offer all 12-15-year olds a COVID-19 vaccine, which was further supplemented by an out of school offer later in the year. By 18 July 2021, all adults aged 18 or over had been offered a first dose.

With the emergence of the B1.1529 Omicron variant, the NHS and partners mobilised an emergency response to ensure all eligible adults were offered a booster vaccination by 31 December 2021, bringing delivery of this planned milestone forward by a month. This incredible achievement resulted in nearly 13 million adults taking up the offer of a booster vaccination in December 2021.

The Spring Booster campaign was launched in March 2022 to top up immunity for adults aged 75 years and over, residents of older adult care homes and individuals aged 12 years and over who are immunosuppressed.

Building confidence, reducing complacency, and optimising convenience continues to sit at the heart of the programme, to maximise uptake across all communities. Local engagement and collaboration between the NHS, local authorities and voluntary, and faith sectors, as well as communities themselves, has helped us to respond to the needs of these local communities, for example, by offering mobile and pop up clinics in temples, gurdwaras, mosques, workplaces, shopping centres and sports venues, at times that work. As we prepare for an Autumn Booster programme and continue to work with community organisations to build confidence and continue to offer first, second and booster doses to those yet to come forward, we will continue to build on what we have learned, listening to communities and responding to what they tell us.

Performance analysis

Primary and community health services

General practice

General practice capacity remains a priority, supported by the £120 million General Practice COVID-19 Capacity Expansion Fund for April to September 2021. Further to this, in October NHS England published "Our plan for improving access for patients and supporting general practice"[5] alongside a new £250 million Winter Access Fund to March 2022. The aim was to improve variation in access and encourage good practice, including building referral pathways to divert appropriate patients to access the GP Community Pharmacist Consultation Service.

Rapid transformation meant that large numbers of patient contacts could be delivered virtually, including around 600,000 per week via online consultation systems, which is significantly above pre-pandemic levels and exceeds the Long Term Plan ambition.

PCNs firmly established themselves as an integral part of the primary care landscape, with 99% of practices now part of a PCN. They have played a critical part in the COVID-19 response, delivering c. 70% COVID-19 vaccinations alongside community pharmacies, while at the same time delivering the best ever flu vaccination performance (see NHS immunisations and public seasonal flu programmes on page 32). Through the Enhanced Health in Care Homes framework, PCNs – working with community services – provided enhanced clinical support to Care Homes with regular multi-disciplinary team discussions and care planning.

Social prescribing services have begun in most PCNs, with over 2,500 Social Prescribing Link Workers responding to 535,036 referrals in 2021/22.

Wider workforce numbers continue to rise, supported by the Additional Roles Reimbursement Scheme[6], with over 18,200 additional staff in place at year end compared to the March 2019 baseline. This is in line with the government commitment of delivering 26,000 additional roles in primary care by March 2024. Continued progress has also been made towards the government's commitment for an additional 6,000 full-time equivalent doctors in general practice, with 1,462 more in March 2022 than March 2019. Targeted efforts to retain GPs in the workforce, with a specific focus on working with systems to communicate and adopt the enhanced package of GP retention initiatives in 'Investment and evolution: updates to the GP Contract 2020/21 to 2023/24'[7].

[5] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/10/BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf

[6] https://www.england.nhs.uk/wp-content/uploads/2019/12/network-contract-des-additional-roles-reimbursement-scheme-guidance-december2019.pdf

[7] https://www.england.nhs.uk/publication/investment-and-evolution-update-to-the-gp-contract-agreement-20-21-23-24/

Building on the coaching initiatives introduced in 2020/21 - the 'Looking After You' and 'Looking After Your Team' services - a 'Looking After Your Career' coaching service was subsequently launched in 2021/22.

An evaluation conducted by the Institute of Employment Studies showed that participation in the award-winning 'Looking After You' coaching led to a significant increase in staff wellbeing and resilience. A specific 'Looking After You' pilot for Trust staff from black and minority ethnic backgrounds was successfully conducted between February and March 2021, and a coaching offer for primary care staff was successfully rolled out over the course of the year.

Community pharmacy

New services were set up at pace to support the pandemic response including the NHS Medicines Delivery Service[8] and Pharmacy Collect[9] (Lateral Flow Tests). Smaller community pharmacies continue to play an important role in ensuring COVID-19 vaccination is accessible to our more deprived and ethnic minority communities.

The Community Pharmacist Consultation Service[10] has relieved pressure on other parts of the NHS throughout the pandemic. Over 2021/22 there were 515,514 referrals from NHS 111 to community pharmacy for urgent medicines supply and 334,000 referrals for minor illness consultation as part of the NHS community pharmacist consultation service.

Community Pharmacy is also contributing to reducing health inequalities and improving access; for example, a Contraceptive Management Service pilot is ongoing aimed at expanding access for all to contraception and increasing capacity in general practice.

Key achievements supporting recovery and implementation of the NHS Long Term Plan include the launch across England of:

- a community pharmacy Hypertension Case Finding Service[11] – October 2021, with 75,052 clinical blood pressure cheeks and 2,428 Ambulatory BP Checks delivered up to end of February 2022
- a Smoking Cessation Service for patients recently discharged from acute NHS Trusts[12] – March 2022. Implementation across England planned to complete by end of March 2024 as hospital smoking cessation services mobilise.

Following the achievements of both general practice and community pharmacy in delivering the accelerated COVID-19 vaccination booster campaign, we asked that practices and PCNs

[8] https://www.england.nhs.uk/coronavirus/documents/home-delivery-of-medicines-and-appliances-during-the-covid-19-outbreak-service-specifications-and-guidance-march-2021/

[9] https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/community-pharmacy-covid-19-lateral-flow-device-distribution-service

[10] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/community-pharmacist-consultation-service/

[11] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/nhs-community-pharmacy-bp-checks-and-hypertension-case-finding-advanced-service/

[12] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/nhs-smoking-cessation-transfer-of-care-pilot-from-hospital-to-community-pharmacy/

focus on three key priority areas from January to March 2022, while continuing to use their professional judgement to clinically prioritise care:

- continued delivery of general practice services, including ongoing access for urgent care with clinical prioritisation, the ongoing management of long-term conditions, suspected cancer, routine vaccination and screening, annual health checks for vulnerable patients, and tackling the backlog of deferred care events
- management of symptomatic COVID-19 patients in the community, as part of the local system approach, including supporting monitoring and access to therapeutics where clinically appropriate
- ongoing delivery of the COVID-19 vaccination programme with a focus on reaching the most vulnerable people and minimising inequalities in uptake. PCNs were asked to prioritise booster vaccination of care home residents and staff, those with underlying health conditions and carers.

Dentistry and optometry

Dentistry capacity remined constrained due to enhanced Infection Prevention Control (IPC) guidance issued by Public Health England (PHE) (now UK Health Security Agency (UKHSA)). A networked of 600 urgent dental centres remained to protect access to urgent care. The overall activity thresholds increased from 60% of contracted levels in the first half of the year to 85% by Q4, leading to observed activity rising from 67% of that contracted in April 2021 to 83% in March 2022. In January 2022 a further £50 million was available to regions to secure additional dental activity outside of contract hours focused upon those with urgent care needs and identified priority groups such as children.

Optical services were able to resume pre-COVID-19 activity levels within high street practices. However domiciliary eye care services remained challenged as access to care/nursing homes was restricted across the year. The Special School Eye Care Service Proof of Concept commenced in May 2021 to provide sight tests to children with a learning disability and/or autism in a special educational setting as detailed in the NHS Long Term Plan. As of 31 March 2022, 3,681 actual sight tests have been claimed by contractors. Of these, 3,298 (89.60%) are first time tests for the child. As a result of these tests, 1,592 (43.25%) children have been issued glasses.

Community Health Services

Community health services have provided care to people in their own homes throughout the pandemic and redeployed staff from their traditional roles to ensure care could be delivered to those most in need.

During the pandemic, community health services were asked to:

- take immediate full responsibility for discharge of all eligible patients identified by acute providers on a discharge list, as set out in the guidance for Hospital Discharge Service Requirements
- use digital technology, by default, to provide advice and support to patients remotely wherever possible
- manage local demand for services, as set out in the guidance for COVID-19 prioritisation within, and later restoration of, children's' and young peoples' community health services guidance prioritising support for high-risk individuals when advised to self-isolate for 12 weeks
- apply the principle of mutual aid with health and social care partners, as decided through their local resilience forum
- enhance levels of support for people living in care homes and in receipt of home care, working with primary care
- take a key role in leading COVID-19 vaccinations through large scale centres or with primary care network sites.

Capacity was created to support higher numbers of people admitted with COVID-19, the NHS and Local Authorities were asked to jointly focus on four specifics:

- improving support to enable more people to be cared for at home with effective, reablement and rehabilitation
- maximise the numbers given an alternative to being admitted to acute care, through remote monitoring of conditions using virtual wards and where possible the introduction/extension of hospital at home schemes
- increase the bed capacity in care centres, for those being discharged into bedded care for recovery, rehabilitation and reablement
- the actions NHS acute hospitals can take to discharge more people per day who no longer meet the reasons to reside in an acute bed and those with delays associated with internal hospital factors.

Urgent and emergency care (UEC)

The UEC Recovery 10 Point Action Plan – Implementation Guide[13] (September 2021) set out the immediate actions to be taken collectively across all parts of the health and care pathway in every ICS. It represents the first step towards full recovery from the impact of the pandemic and will be built on in 2022/23 with the development of the longer term UEC strategy.

Demand for UEC services has gradually returned throughout 2021/22, as public behaviours moved back towards normal. There were on average 66,800 A&E attendances per day in 2021/22, compared to 47,800 in 2020/21, and approximately 68,500 in 2019/20. Emergency admissions via A&E were 12% higher this past year when compared to 2020/21, and just 4% lower than in 2019/20.

The 2021/22 Winter period (defined as November through to February) was particularly pressured as services responded to the end of the Delta variant wave and the subsequent Omicron variant wave. These waves were particularly challenging for UEC services as we did not experience the same reductions in non-COVID-19 urgent care activity that had been seen during previous waves. In February 2022, headline A&E performance reached a low point of 73.3% during this period against the 95% standard.

To support the timely admission and discharge of patients from hospital, the SAME DAY strategy was launched in early 2021. During 2021/22 a median of 39% patients were admitted as an emergency and were subsequently assessed, treated and discharged on the same day, up from 32% at the start of the pandemic. 2021/22 saw the second phase of £450 million for increasing capacity in emergency departments and SDEC units.

NHS 111 demand and activity remained high in 2021/22 seeing further year-on-year increases in demand, around 24% up on levels that would have been expected pre-pandemic. An additional £98 million of targeted funding was provided to increase capacity and resilience to respond to 7% more calls than in 2020/21.

The challenges across the UEC pathway, and particularly with patient flow and discharge, were felt most acutely by ambulance services. Despite extensive system wide and ambulance sector actions taken during 2021/22, Summer 2021 saw ambulance response times and 999 call handling times increase, with category 2[14] response times increasing significantly, linked to an unseasonal and significant rise in the time lost handing over patients to hospitals. This trend continued into Winter 2021 where ambulance services faced ongoing challenges including unprecedented demand, notably in December 2021, with a record number of ambulance call outs. Ambulances responded to 82,000 category 1 calls, an average of one every 33 seconds, and higher than any other month on record.

[13] https://www.england.nhs.uk/wp-content/uploads/2021/09/Urgent-and-emergency-care-recovery-10-point-action-plan.pdf

[14] There are four categories of ambulance call. The details can be found on our website https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/

Conveyances to Emergency Department from ambulance services continued to remain proportionally low compared to pre-pandemic levels at 52% (compared to 57.1% in 2019/20). Support to ambulance services was provided through £55 million of funding for the second half of 2021/22. This was made available to stabilise and improve performance by delivering increased call handling and operational response capacity, additional clinical support, and to provide hospital ambulance liaison officer support for acute trusts with continued challenges in the handover of patients. By the end of March 2022, trajectories reported by ambulance services indicated that c.400 additional call handlers were in place nationally compared to Summer 2021.

Elective care

In February 2022, NHS England and NHS Improvement published the Delivery plan for tackling the COVID-19 backlog of elective care[15], which outlines a set of clear ambitions for the recovery of elective services over the next three years.

The plan details the key activities the NHS will undertake to increase the amount of elective activity through expanding capacity; ensuring care is prioritised based on clinical need; transforming services to improve productivity; embedding new models of care and technologies; and, empowering patients with the information and support they need whilst they wait. These are supported by progressive commitments to patients about the recovery of elective services.

NHS England continues to support local systems to maximise the use of and grow their workforce, minimise the impact of treating patients with COVID-19 on elective services, continue utilising the independent sector where appropriate, increase validation of referrals, and make the most effective use of the physical estate through separation of physical elective and non-elective capacity.

As at 31 March 2022, there were almost 6.4 million incomplete RTT pathways (up from 5 million in March 2021), with 62% waiting less than 18 weeks. Around 80% of the waiting list is for outpatient-based care only, with just 4% requiring overnight admission for surgery and the remainder being treated as admitted day cases. Elective activity in March 2022 (total completed pathways) was at 93% of equivalent levels in 2019/20.

Long waits

The first target in the delivery plan is that, by July 2022, no one will wait longer than two years for elective care, apart from those who choose to wait longer, and a very small number of specific highly specialised areas. At the end of March 2022, the number of patients waiting over 104 weeks in acute providers was below 15,000. Since April 2021, the NHS has treated

[15] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf

over 400,000 patients who, if not treated, would have been waiting over two years by the end of March 2022.

Targeted Investment Fund (TIF)

The £700 million TIF was made available through the second half of the financial year planning process, with £500 million available as capital and half of this (£250 million) ringfenced for technology that enables elective recovery. As at the end of March 2022, £679.7 million had been drawn down against the fund, supporting a total of 1,020 schemes.

Good waiting list management

We have supported good waiting list management through the national clinical validation and prioritisation programme. By March 2022, 92% of the surgical waiting list and 86% of the diagnostic waiting list had a prioritisation code, supporting a clinically safe waiting list.

Work with the Independent Sector

We have worked closely with independent sector providers to maximise the capacity, by building on existing local relationships and enabling long-term contract arrangements at the local level to secure capacity.

Evidence based interventions

The Evidence Based Interventions programme provides guidance on when it is and is not appropriate to carry out specific interventions. In 2021/22 more than 800,000 interventions of limited clinical value were removed from waiting lists, so that resources are prioritised for the maximum public benefit.

Outpatient Transformation

Significant work was undertaken during 2021/22 to give patients greater control of their NHS secondary care pathway, making more efficient use of existing outpatient services and releasing clinical capacity. Interventions include telephone or video consultations, PIFU and use of specialist advice to prevent additional onward referrals. Several pilot sites have been set up to determine how existing interventions can be extended and accelerated.

Specific workstream achievements

PIFU is now being delivered across every secondary care trust across England, empowering patients to take control of their care. By February 2022, nearly 90,000 people each month were benefitting from PIFU, around 700,000 people in total throughout the year.

In line with the NHS Long Term Plan, NHS England and NHS Improvement has focussed its work in 2021/22 on supporting patient choice around the use of remote consultations. A significant part of this work has also been to start to address the recommendations of the 2021 published Equalities and Health Inequalities Impact Assessment for video consultations.

During 2021/22, the use of specialist advice[16] has continued to increase, with the projected number of requests over 3 million; a doubling compared to the previous year. Current data indicates in excess of 1.3 million fewer unnecessary outpatient attendances by the end of March 2022 as a direct result of advice and guidance, an increase of a third from the previous year.

Mental health

In the context of rising mental health demand and COVID-19 pressures, we worked with systems to ensure that mental health service provision, particularly face-to-face contact, was maintained where possible.

An additional £500 million investment for mental health was made available via the government's 2021/22 COVID-19 mental health and wellbeing recovery action plan[17], £330 million of which was allocated by the NHS England and NHS Improvement Mental Health programme. Systems used this funding to recover 2021/22 trajectories as far as possible.

COVID-19 became the catalyst for some existing commitments to be realised sooner than planned, including the roll-out of 24/7 all age mental health crisis lines two years ahead of schedule; and fast-tracking the expansion of Mental Health Support Teams in schools. Additionally, new services were established in response to the pandemic, including 40 mental health and wellbeing hubs for health and care staff across England.

COVID-19 continues to impact mental health through increased prevalence, acuity and complexity. While more people could access mental health support than ever before, service capacity was restricted due to staff absences, IPC requirements, and inevitable impacts on referrals.

Between April 2021 and March 2022, 674,485 children and young people (CYP) accessed support, over 160,500 above the target of 513,964. Mental Health Support Teams in schools now cover 26% of the pupil population, meaning the NHS is ahead of the original Long Term Plan commitment of 20-25% coverage by 2023/24.

Demand for CYP eating disorder services at year-end remained higher than pre-COVID-19 levels. 590 urgent cases were accepted for treatment in Q4 2021/22 compared to 353 during the same period of 2019/20, whilst 2,396 routine cases were accepted for treatment compared to 1,853 in Q4 2019/20. This increased demand had an impact on waiting times, with 64% of patients accessing treatment within four weeks (routine referrals) and 62% within one week (urgent referrals) against the 95% standard.

[16] Specialist advice, encompassing A&G and referral assessment services/triage models, enables primary care clinicians to access specialist advice to help avoid unnecessary outpatient appointments in hospital settings.

[17] https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-recovery-action-plan

National coverage for 24/7 crisis provision services for CYP that cover the four minimum specified functions offered to people aged 0-18 years is 72%, ahead of the trajectory of 57% coverage target for 2021/22. Integrated adult primary and community care teams saw 182,915 people in 2021/22, exceeding the target of 126,000.

IAPT waiting time standards continued to be met, with 89.3% of people waiting less than six weeks (against a standard of 75%) for treatment and 98.4% of people waiting less than 18 weeks (against a standard of 95%). Nationally, the IAPT recovery rate was 50.5%. 1.2 million people accessed IAPT services in 2021/22, lower than the target of 1.6 million due to a combination of COVID-19 pressures, workforce shortfalls and interrupted referral pathways. The NHS continued its focus on advancing mental health equalities, in Quarter 1 of 2021/22 the overall IAPT recovery rate for ethnic minorities was on target for the first time.

Data for Quarter 4 shows that 227,000 people with serious mental illness received a physical health check against a target of 302,000 for 2021/22, and 19,000 people had accessed Individual Placement Support services against a target of 32,000. Specialist community perinatal mental health services saw a total of 43,550 women, which was below the target of 57,000. The NHS continues to meet the EIP two-week waiting time standard, achieving 68% as of March 2022.

Referrals to community crisis teams have risen 30% prior to pre-pandemic levels and the all age crisis lines brought-forward to respond to the pandemic are fielding around 200,000 calls per month. 100% of acute hospitals now have adult mental health liaison teams available, with 55% providing a ‘core-24’ offer.

Adult acute bed occupancy remains high, over the maximum safe levels of 85% as of end of year 2021/2022. Despite this the number of inappropriate out of area placements have remained broadly stable (53,575 bed days in the rolling quarter to April 2022), and the number of new people being admitted out of area has reduced to approximately 300 placements in the months to the end of 2021/22.

The 2023/24 deliverable for Rough Sleeping has already been met and our Long Term Plan target exceeded, with 22 sites receiving funding to roll-out specialist rough sleeping mental health support.

NHS England and NHS Improvement continued to work with Patient and Carers Race Equality Framework pilot trusts to improve Black, Asian and minority ethnic experiences of care. Each trust was supported to undertake community engagement with voluntary and community sector partners to explore how mental health services can provide more culturally appropriate care. The findings of this engagement will inform the Framework, which will be tested in 2022/23.

People with a learning disability and autistic people

We supported primary care to deliver learning disability Annual Health Checks to over two hundred thousand (214,622) people by the end of March 2022. This was more than seven in ten people (71.3%) compared to 73.5% in the 12 months to March 2021. We also established a pilot programme to encourage the take up of annual health checks.

We published a new Learning from lives and deaths (LeDeR) policy in March 2021, which now includes reviews of the deaths of autistic people as well as deaths of people with a learning disability. At the end of March 2022, 97% of eligible LeDeR reviews had been completed.

To support autistic people, in 2021/22 we invested one off funding that will support future improvements: £7 million for local areas to test ways to improve the quality of autism diagnostic pathways; £1.5 million supported autism training for staff working in adult mental health inpatient settings; £4 million for projects to improve the sensory environment of mental health hospitals

We asked the University of Reading to develop a sensory assessment tool for use in mental health hospitals. We commissioned the National Development Team for Inclusion to refresh the ten sensory principles and the Green Light Toolkit (resources to support good care in hospital). Work to develop a Reasonable Adjustment Digital Flag[18] in patient records is being tested in 12 pilot sites across the country to support the flag being made available across the NHS.

Throughout 2021/22, work to reduce reliance on mental health inpatient care for autistic children and young people and those with a learning disability included:

- £15 million for keyworkers for children and young people with complex needs supported 27 new keyworker services in local areas and over 1,000 children and young people
- £10 million for community support included roll out of Autism in Schools project in over 200 schools; project to identify and take action on children at particular risk of hospital admission and health-funded respite care
- to showcase innovative community services, we hosted a series of events which were accessed by over 250 health and social care professionals.

A Senior Children's Intervenor programme has enabled discharge planning for young people with complex needs and extended lengths of hospital stay.

This year, through the Children's Transformation Programme, additional funding has been allocated to source a national special educational needs and disability team to support

[18] https://www.england.nhs.uk/learning-disabilities/improving-health/reasonable-adjustments/

regions and systems in meeting their responsibilities and duties for CYP with special educational needs and disability.

The number of people with a learning disability and autistic people in mental health inpatient settings continued to fall, but the pandemic impacted upon progress, particularly for adults. At the end of March 2022, there were 2,005 people with a learning disability, autism or both in a mental health inpatient setting: 200 fewer than in March 2021[19]. We invested £25 million in community health services (intensive support, forensic and crisis support) as alternatives to inpatient care.

In 2021/22 we developed and delivered a Safe and Wellbeing programme to review the quality of care and plans for discharge for people with a learning disability and autistic people in mental health inpatient settings. At the end of April 2022, 99% of reviews had been completed.

We worked with partners to provide independent Care, Education and Treatment Reviews for people in long-term segregation in hospital; piloted a Senior Intervenors programme for adults; supported 250 people to have a Life Plan completed and commissioned the HOPES programme to help improve the quality of care in mental health hospitals.

More action on health inequalities and prevention of ill-health

The NHS Digital Weight Management Programme successfully launched in June 2021 and received 115,000 referrals from Primary Care and NHS Staff Self-referral in its first year. The programme, as part of the NHS Long Term Plan commitment, delivered a targeted support offer and access to weight management services in primary care for people living with obesity with a diagnosis of diabetes or hypertension. The proportion of people referred to the programme is higher in those from Black, Asian and minority ethnic communities, and the majority of referrals were from the most deprived socioeconomic groups.

Progress was made on implementing the alcohol and tobacco dependence interventions outlined in the NHS Long Term Plan, with 24 sites being established for tobacco and 10 for Alcohol Care Teams.

The Latent Tuberculosis Infection Testing and Treatment Programme continues to support CCGs and now ICBs with the greatest number of high-risk patients at increased risk of developing active tuberculosis. The Latent Tuberculosis Infection Testing and Treatment Programme has also supported the provision of screening in response to arrivals from Afghanistan and Ukraine.

[19] From Assuring Transformation dataset: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/assuring-transformation/reports-from-assuring-transformation-collection

Through the NHS Antimicrobial Resistance Programme, the NHS continues to work towards the UK 5 Year Antimicrobial Resistance Programme plan to reduce the rates of healthcare-associated Gram-negative Bloodstream Infections by 50% by 2024. Prescribing levels are still within the 2024 target levels, despite increased prescribing as normal activity returns following reduction due to the pandemic.

NHS Diabetes Prevention Programme

Referrals to the NHS Diabetes Prevention Programme have steadily recovered to pre-pandemic levels, and by adopting remote and digital delivery the programme has remained open and achieved 60% of the Long Term Plan target. There have now been 1 million referrals into the programme and approximately 490,000 people have joined the programme so far. Work is ongoing with systems to support recovery and further expansion of the programme to meet the Long Term Plan of 200,000 people supported on the programme each year from 2023/24.

New independent research from the University of Manchester shows that people completing the programme reduce their chances of developing Type 2 Diabetes by 37%, and that rollout of the programme across the country between 2016 and 2018 was associated with a 7% reduction in the rate of new-onset diabetes.

Non-cancer adult and young person screening

The majority of NHS Abdominal Aortic Aneurysm screening programme providers have now recovered services for people waiting to be offered screening during 2020/21, with 95% of providers fully recovered. For the NHS Diabetic Eye Screening programme, 77% of providers have fully restored to pre-pandemic provision levels for routine screening.

NHS immunisations and public seasonal flu programmes

The UK remains a world leader in uptake across many immunisation programmes, and public confidence in vaccinations remains high. In 2021/22 the NHS achieved the highest flu vaccination rates on record for the, with 22.2 million people taking up the offer of a vaccination, compared to 19.2 million in 2020/21. Improvements were seen in the over 65 years, clinical at-risk cohorts as well children, 3.8 million of whom were vaccinated by the end January 2022 compared to 3.3 million the previous year.

Coverage of the NHS school aged immunisation service (SAIS) has improved from levels reported for the 2019/20 academic year, with SAIS providers working to vaccinate those children who were missed in 2019/20 due to school closures and wider impacts of the COVID-19 pandemic alongside vaccinating the 2021/22 cohort.

In the 2020/21 academic year:

- HPV vaccine coverage was: 76.7% for dose 1, in year 8 females, compared with 59.2% in 2019 to 2020

- meningococcal bacteria – A, C, W and Y (MenACWY) vaccine coverage in the local authorities where NHS England commissioned providers delivered the MenACWY vaccine to year 9 students (born between 1 September 2006 and 31 August 2007) was 76.5%, compared to 58.3% in 2019 to 2020
- Td/IPV vaccine coverage in the local authorities where NHS England commissioned providers delivered the Td/IPV vaccine to year 9 cohorts (born between 1 September 2006 and 31 August 2007) was 76.4%, compared to 57.6% in 2019 to 2020.

For routine child immunisations, measles, mumps and rubella (MMR) catch up remains a priority, a focused call/recall catch up will be delivered from July 2022. Coverage remains below the 95% target for two MMR doses evaluated at 5 years, but the decline in coverage has halted for first time since the start of pandemic.

The neonatal Bacillus Calmette-Guérin (BCG) vaccination programme was re-commissioned, and a new delivery model successfully implemented in September 2021, to avoid any baby with a suspected severe combined immunodeficiency being vaccinated with BCG.

During 2021/22, with the alignment of flu and COVID-19 vaccination programmes ensuring co-promotion and co-administration, this has led to work commencing on designing an integrated NHS vaccination service.

Maternity and neonatal services

The ambition of 20% reduction in the rate of stillbirths, neonatal deaths, maternal deaths, and serious intrapartum brain injuries from a 2010 baseline by 2020 was exceeded, down from 5.1 to 3.8 per 1,000, and neonatal mortality fell from 2.0 to 1.3 per 1,000.[20] This means around 1,000 more babies survive each year compared to ten years ago.

Throughout the pandemic, maternity services continued to provide a full range of antenatal, intrapartum and postnatal care, whilst adapting to new guidance and addressing workforce challenges as a result of COVID-19 related absence.

NHS Trusts have made progress implementing actions and learning from the interim report[21] on Shrewsbury and Telford NHS Trust in 2020. 30% of Trusts with maternity services reported that they are fully compliant with all twelve clinical priorities. 75% of Trusts were fully compliant with at least 10 of the 12 clinical priorities and working towards compliance in the remaining priority areas. For some Trusts, full compliance against these interim actions will take time as they have required additional workforce and service reconfiguration at the same time as managing the pandemic.

[20] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2020

[21] https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

The final Ockenden report on Shrewsbury and Telford NHS Trust [22] published in March 2022 proposed 15 areas for national action. The NHS Chief Executive wrote[23] to Trusts asking their Boards to review the report and act, paying particular attention to the report's four pillars: safe staffing levels, a well-trained workforce, learning from incidents, and listening to families.

In 2021/22, we invested £40.8 million across 128 units and Trusts, which will help to address the varying levels of digital maturity within trusts across England and put in place the digital foundations services require.

We have commissioned 15 Maternal Medicine Networks, which will ensure specialist management and care for women with chronic and acute medical problems around pregnancy across England, tackling the biggest contributor to maternal mortality.

We have funded 14 Local Maternity Systems to implement Perinatal Pelvic Health Services to improve prevention, identification, and treatment of pelvic floor issues; at least nine further systems are due to begin as Fast Followers in 2022/23.

We have expanded specialist community perinatal mental health services; 33 maternal mental health services are being established for women who experience moderate to severe or complex mental health issues directly related to a trauma or loss. Our ambition is to have one in each ICS by 2024.

The Saving Babies' Lives Care Bundle Version 2[24] defines a package of good practice interventions being implemented by all Trusts including, for example, reducing smoking in pregnancy which has now fallen to the lowest rate on record[25]. Whilst COVID-19 pressures have delayed the full implementation of version 2 bundle in 2021/22, we are working with Trusts to implement all five elements and develop a further version 3 to be rolled out in 2023/24.

NHS Antenatal and newborn screening programmes

Coverage for the six ANNB programmes remained high during the year - more than 96% for all six programmes - with over 98% of new born babies and 99% of antenatal women receiving screening within the target timescales.

The NHS ANNB programme has also taken on responsibility for two in-service evaluations for the UK National Screening Committee, previously run by PHE - Non-Invasive Pre-natal Testing rollout within the Fetal Anomaly Screening Programme and the introduction of Severe Combined Immuno-Deficiency into the newborn blood spot screening programme.

[22] https://www.gov.uk/government/publications/final-report-of-the-ockenden-review
[23] https://www.england.nhs.uk/wp-content/uploads/2020/12/B1523-ockenden-final-report-letter-1-april-22.pdf
[24] https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf
[25] The proportion of women in England known to be smokers at the point of delivery fell from 10.4% in 19-20 to 9.6% in 2020/21

Cancer

A record 2,678,976 people were seen following an urgent suspected cancer referral in 2021/22: 12% above pre-pandemic levels. 315,549 people started cancer treatment, 93% of them within a month of a decision to treat.

The NHS ran multiple phases of the 'Help Us Help You' public awareness campaigns to encourage people to come forward promptly if they have symptoms they're worried could be cancer. The NHS also partnered with Prostate Cancer UK to deliver a campaign urging men to use the charity's online risk checker. More than 550,000 men used the risk checker during the campaign and the NHS saw an all-time record number of urgent urological cancer referrals in March 2021.

The record number of people coming forward following these campaigns has meant some patients have waited longer for diagnostic tests. The NHS is putting in place the extra capacity needed to meet this demand with cancer prioritised in £2.3 billion for Community Diagnostic Centres and extra endoscopy capacity and £1.5 billion for additional treatment capacity.

A new Faster Diagnosis framework is helping to ensure that cancer pathways run more efficiently:

- Non-symptom-specific pathways – 86 of which were live by the end of 2021/22 – are providing GPs with a route to refer people with general symptoms which could be an indication of various cancers like weight loss, fatigue or loss of appetite. Nearly 38,000 patients have been referred on these pathways so far and 1,800 cancers diagnosed.
- Seven new or refreshed best practice timed pathways have been published, providing step-by-step guides to ensuring pathways are as efficient and as speedy as possible.
- The NHS is also focusing particular attention on the more challenged pathways, with interventions such as tele-dermatology for skin cancer pathways and the increased use of faecal immunochemical test kits for triaging those with suspected bowel cancer, backed up by a £5.5 million incentive included in the GP Contract to increase use in primary care.

In March 2022 the NHS launched a public consultation on prosed new standards for cancer care as part of the clinical review of standards, which recommended simplifying the performance measures for cancer from nine to three: the Faster Diagnosis Standard (ensuring patients receive a diagnosis or ruling out of cancer within 28 days of being referred); a maximum of 62 days from referral to receiving a first definitive treatment; and, a maximum of 31 days from a decision to treat to receiving a first definitive treatment. The outcome of the consultation is expected during 2022/23.

By March 2022, the Targeted Lung Health Checks programme was issuing 30,000 invitations a month to people who have ever smoked in disadvantaged areas with some of the highest mortality from lung cancer in the country. The programme has identified over 600 people with

cancer, more than three quarters of which have been found at stage 1 or 2, compared with the overall lung cancer early diagnosis rate of 28%.

Innovation is at the core of the early diagnosis strategy. The NHS Galleri trial – the world's first and largest trial of its kind is assessing the effectiveness of a blood test devised by a company called Grail as a screening tool in asymptomatic patients and is now at the halfway stage. More than 2,000 'pill-cams' have been swallowed by patients – a camera in a pill-sized capsule swallowed that helps diagnose bowel cancer. 2,000 patients have also benefited from Cytosponge – a sponge on a string swallowed by patients looking for pre-cancerous cells in the oesophagus. The second round of an open call to fund new technology and artificial intelligence (AI) in clinical settings will see more innovations funded in 2022/23.

The first ever Under 16s Cancer Patient Experience Survey was published in 2021 and showed parents and carers gave a mean rating of 9.21 out of 10 for the overall experience of their child's care, while for the adult Cancer Patient Experience Survey results ranged between 8.2 and 9.1 out of 10. The first ever cancer patients' Quality of Life survey was also published providing vital insights into the experiences of patients living with and beyond cancer 18 months after diagnosis.

NHS cancer screening

Normal screening intervals for the cervical screening programme, designed to detect HPV, were restored by October 2020 and this standard has been maintained. The national 14-day turnaround time for screening results continues to be significantly better compared to pre-pandemic performance in 2019/20 and 2020/21.

To drive improvements in uptake, a national cervical screening campaign ran throughout February and March 2022 to encourage people to come forward for their screen as soon as possible and included headline messages on HPV screening. It was aimed at eligible women and people with a cervix, and included focused activity aimed at lesbian, gay, bisexual, transgender (LGBT+) and ethnic minority group communities to improve inequalities.

The NHS bowel cancer screening programme performed strongly throughout the year, with now only a small number of providers inviting people over the 6-week recommended target. Uptake has exceeded the expected standards while extending the programme to include 56-year olds in 2021/22 in line with Long Term Plan ambition.

The NHS breast screening programme was significantly impacted by the COVID-19 pandemic. The backlog in sending out screening invitations continues to fall and activity levels in mammography being delivered by NHS providers continues to increase.

The NHS People Plan

In July 2020, in partnership with HEE, we published the People Plan 2020/21: action for us all[26] in order to deliver the ambitions of the Long Term Plan. Alongside this, we published the NHS People Promise[27], setting out seven elements developed with thousands of colleagues across the NHS representing what matters most to them and which will make the greatest difference in improving their experience of work, aiding retention.

For 2021/22, we acted on feedback from systems and regions to prioritise a smaller number of People Plan actions, taking account of reduced capacity due to the pandemic. This made sure our collective efforts were focused on the things that would make the most difference to the workforce: supporting staff to be safe and well; ensuring their voices were heard; delivering safe staffing for the COVID-19 response and vaccination programme; and sustaining other services with greater use of innovation, technology, and new ways of working. A set of priority actions was set out in the national planning guidance, which had our strongest ever focus on people and workforce as a strategic priority.

Pressure on our workforce is greater than ever, due to the cumulative impact of the pandemic and the determination to address the backlog of patients waiting to be treated. The 2021 Staff Survey (redesigned to align with the seven elements of the People Promise) showed a drop in engagement and morale.

Efforts to date have resulted in:

- 30,332 more nurses towards the 50,000 manifesto commitment (Sep 2019 - Feb 2022), including 12,062 more nurses in the past 12 months
- 1,462 more GPs and 18,221 Additional Roles in primary care against the 6,000 and 26,000 manifesto commitments (March 2022)
- 5,767 more Healthcare Support Workers since January 2020
- over 500,000 volunteers supported the national NHS pandemic response and the vaccination programme
- 4,098 people returned to work in the NHS, 1,306 of whom were employed on the vaccination programme, and at peak of the pandemic, more than 2,500 military colleagues were deployed
- Over 40,000 students, learners and trainees stepped forward to support the COVID-19 response, including nursing, midwifery and AHP students, and 3,800 final year medical students
- 23 People Promise Exemplar site trusts from all regions have been selected to implement a bundle of actions with support from national and regional teams to improve staff experience and retention

[26] https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf
[27] https://www.england.nhs.uk/wp-content/uploads/2020/07/NHS-People-Promise.pdf

- Proportion of staff in senior leadership roles who are from a BME background is 9.2% (band 8c and above). Other senior bands also show an improvement
- 193,879 leaders enrolled for support through national leadership programmes and Graduate Management Training Scheme to date. All leadership development programmes refreshed and digital by default.

Digitally enabled care

Policy makers and commissioners continue to collaborate with clinical and technology experts on the digital transformation of health and social care across England.

During the 2021/22 period, the 'What Good Looks Like' framework was published to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. In addition, the 'Who Pays for What' guidance was published to clarify how technology funding should be made available to the system.

Basic Shared Care Records are now available in every ICS nationwide, allowing health and care staff to view and edit the same version of a person's medical history across different settings so that they can collectively deliver safer, joined up care. Analytics teams across the NHS made improvements to enable the transfer of patient data safely across health systems and the COVID-19 data store.

Developed to support the health and care system with near-real-time data in its response to the pandemic, it delivered crucial insights to stem the spread of the disease and deliver an effective vaccine rollout.

Over 2021/22 ICSs were supported to implement population health analytics; in particular, Cheshire and Mersey ICS who built a data platform to harness health insights from 17 million citizens.

As part of a wider shift to care provision at home, progress was also made to the development of digitally enabled virtual wards. West Hertfordshire Hospitals NHS Trust was the first trust to set up their own virtual hospital, the first of its kind in the country (spurred by the pandemic). As of March 2022, a further 44 virtual wards were developed across the country, caring for over 2,500 patients. This programme was further bolstered through the recent NHS England planning guidance and accompanying funding, ensuring virtual wards continue to play a role in the NHS landscape. Working within regional ICSs, clinicians were able to remotely monitor the health and needs of approximately 200,000 people with long-term health conditions.

The NHS AI Lab has continued to work alongside other healthcare agencies to design the world's first comprehensive regulatory framework for AI in health. As a result of the pandemic, the lab established a national COVID-19 chest imaging database. As of March 2022, this database hosted over 40,000 images from more than 20 Trusts, to help researchers and developers train new AI tools to better detect and treat COVID.

The NHS App and NHS.uk continued to help people with advice support and access to services. The NHS App enabled millions of people to travel abroad and attend events more safely. Adding the NHS COVID Pass to the NHS App led it to become the most downloaded free iPhone app of 2021 and, by March 2022, the number of registered users grew to 24 million. The NHS also worked with industry partners to enable additional features within the App. By December 2021, the NHS App had been used to register 38,000 organ donation preferences, order 1.5 million repeat prescriptions, and view over 11 million GP records. The NHS App is just one platform of engagement with patients, the NHS website (NHS.UK) received over a billion visits in 2021.

Other key achievements include:

- to help NHS organisations digitise more quickly and cost effectively we are actively sharing best practice, with 188 blueprints (step by step guides to digital transformation)
- publication in October 2021 of the digital blueprint for the New Hospital Programme[28], setting out how digital technologies are to be designed into new hospital build initiatives
- we have supported clinical teams to transform patient care through the publication of more digital playbooks from cancer and musculoskeletal to dermatology and eyecare. These playbooks showcase proven technologies and have had over 130,000 views
- publication of a draft data strategy for health and care in 2021, setting out a clear vision and action plan to make better use of data to save lives
- we have increased access to the Electronic Prescription Service, with the first hospital now accessing the system to support remote outpatient consultations. Every provider of hospital outpatient prescribing systems can now work to add in this functionality
- we supported publication of a new standard to ensure medicines and prescriptions information is shared in a standard way across Health and Social Care to improve patient safety
- we supported the publication of the People at the Heart of Care White Paper for Adult Social Care, with a commitment to invest at least £150 million in digitisation as a key enabler for reform and ensured that digital, data and technology provisions were embeded in the Government's white paper, Health and social care integration: joining up care for people, places and populations[29]
- launch of the assured supplier list for Digital Social Care Records, supporting a diverse marketplace of electronic systems that are interoperable with the NHS
- publication of simple, empowering guidance on sharing patient records safely, endorsed by the ICO and the NDG, providing clinicians with the confidence they could share data when they needed to do so
- the 'Control of Patient Information Regulations (2002)' were used to ensure information could be shared to support the COVID-19 response

[28] https://files.smartsurvey.io/2/0/KOLVQ6T1/0940__NHP_Digital_Blueprint_and_Financial_Model.pdf

[29] https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

- in collaboration with NHS Digital's Cyber Security Operations Centre, we have provided 24/7/365 cyber incident and response capability across 1.6 million endpoints and thousands of servers across the health and care system, enabling the prevention of 5 'WannaCry-style' cyber-attacks
- for the first time ever, we provided system CEOs with key metrics so they can understand the cyber risk to their clinical services and take appropriate action to address them
- our 'Better Security, Better Care' programme has delivered direct support to care providers to comply with health and care cyber standards, resulting in care provider compliance with cyber standards going from under 10% (prior to the pandemic) to over 40% today.

Digital transformation of screening and vaccinations

We are learning from the successful delivery of all vaccination programmes in 2021/22 to ensure all section 7A programmes benefit from the data capture architecture and other digital innovations such as a national booking system.

The Transformation Directorate (which includes the former NHSX) continued to lead the digital child health strategy to secure resolution to the future of Child Health Information Services (CHIS) and to ensure integration of the planning (tripartite and with CYP team) into the immunisation data tech solutions and ANNB screening requirements.

How NHS England and NHS Improvement supported the wider NHS

Emergency Preparedness, Resilience and Response (EPRR)

As in 2020/21, the response to the coronavirus pandemic was the priority through 2021/22, with national incident management arrangements stood up throughout the year. Although the COVID-19 response reduced to level 3 in March 2020 (with co-ordination moving to regional level), there was still a need to maintain a national incident infrastructure. In December 2021, a level 4 incident was again declared in response to the Omicron variant and other Winter pressures.

In January 2022, as part of preparations for a potential wave of Omicron admissions, eight Nightingale surge hubs were erected to improve NHS resilience should existing capacity be at risk from a surge in admissions. Trusts were also asked to identify areas that could be converted to accommodate patients to create up to an additional 4,000 super surge beds.

A significant number of other incidents occurred throughout the year, requiring incident management mechanisms to be established:

- operation Forth Bridge plans activated following the death of the Duke of Edinburgh in April 2021
- damage to the helipad at Addenbrookes hospital during the departure of a US Air Force aircraft in April 2021
- support to the G7 Leaders' summit in the South West in June 2021
- flooding at Whipps Cross Hospital (July 2021) and Queen Alexandra Hospital, Portsmouth (January 2022)
- Plymouth shootings in August 2021
- supporting the health input into the Afghan Relocations and Assistance Policy and Managed Quarantine Service setup for those travelling to England from red list countries
- impact on the NHS of increased demand for road fuel supplies in September 2021
- Coordination of potential health support following a tanker explosion in Freetown, Sierra leone in November 2021
- taxi explosion outside Liverpool Women's Hospital in November 2021, which was declared a terrorist incident
- IT disruption to the South East Coast Ambulance Service Computer Aided Dispatch system in November 2021
- impacts from a number of severe weather events including Storms Arwen, Eunice and Franklin in November 2021 and February 2022
- supporting NHS Digital and NHSX with a number of High Severity Alerts for cyber security, including the Log4J issue in December 2021
- monitoring of avian influenza cases, and response to a human case in the South West in December 2021
- declaration of critical incidents due to system pressures between January and March 2022.

An increased number of supply disruptions occurred throughout 2021/22. Field Safety Notices were issued for continuous positive airway pressure and Bilevel Positive Airway Pressure devices used by patients with Obstructive Sleep Apnoea and type 2 respiratory failure. A shortage in the supply of blood specimen collection tubes which are used for a wide range of diagnostic tests across Pathology networks. These incidents were supported by either Incident Management Teams or by the Clinical Cell providing advice on the management of the disruption and communications to those areas affected.

The UK terrorism threat level was increased to Severe following the explosion outside Liverpool Women's Hospital in November 2021. This was reduced to Substantial in February 2022.

Productivity and efficiency

Our Commercial Medicines Directorate (CMD) is aligned to the clinical priorities in the NHS Long Term Plan and supports the broader ambitions of the UK's Life Sciences Vision[30] to ensure frontline staff have access to healthcare innovation that can improve outcomes of the patients they care for, while providing the best possible value for money. CMD's approach to delivery is set out in the NHS Commercial Framework for New Medicines.[31]

In July 2021, we announced a new Innovative Medicines Fund (IMF) to provide early access to potentially life-saving new medicines with a consultation on proposals now complete ahead of the IMF's launch in 2022/23.[32] Along with the existing £340 million Cancer Drugs Fund (CDF), which is guaranteed its current funding levels, this new £340 million initiative means from 2022/23 a total of £680 million of ringfenced NHS England funding will be available to deploy on fast-tracked drugs that show clinical promise, but where there remains uncertainty around clinical and cost-effectiveness. This uncertainty is then resolved through real-world data collection in the IMF or CDF.

The CMD used the national buying power of the NHS to accelerate access to effective treatments at-scale. Most notably in November 2021, CMD concluded national agreements to enable more than 600,000 people to benefit from direct oral anticoagulants, capitalising on the opportunity to avert tens of thousands of potentially fatal cardiovascular events over the next three years.[33]

Building on activity in 2020/21, the Commercial Medicines Unit (CMU) continued to surpass savings expectations this year with over £300 million realised against reduced spend in NHS trusts. The CMU also progressed with implementation of a value-based generics strategy which includes a requirement for suppliers to hold buffer stock in the UK, improving supply

[30] https://www.gov.uk/government/publications/life-sciences-vision
[31] https://www.england.nhs.uk/publication/nhs-commercial-framework-for-new-medicines/
[32] https://www.england.nhs.uk/2021/07/nhs-england-announces-new-innovative-medicines-fund-to-fast-track-promising-new-drugs/
[33] https://www.england.nhs.uk/2021/11/thousands-spared-strokes-thanks-to-new-nhs-drug-agreements/

chain resilience and supporting clinical decision-making by enabling continued availability of first-choice treatments for patient. The CMU also demonstrated its abilities to support the NHS respond to global supply pressures, notably with immunoglobulin (ImGo) following a worldwide fall in plasma donations due to the pandemic, whereby working with partners – including in industry – the ImGo volumes required for NHS patients were secured.

Ensuring supply of COVID-19 medicines is an ongoing priority for CMD. Over the past year our CMU and Medicines Policy and Analysis (MPA) teams, working in partnership with colleagues across the NHS, government, and industry have continued to support clinical services in their delivery of patient care and treatment.

The MPA teams have made good progress in leading the implementation of the recommendations of the independent review of overprescribing[34], with around 6.5% of all hospital admissions caused by the adverse effects of medicines, demonstrating the opportunities for improved patient care and greater utilisation of finite NHS resources.[35] Addressing overprescribing also has important implications for sustainability as medicines represent about 20% of the NHS's carbon footprint and more than half of NHS supply chain emissions.[36]

Building the structures required for a more systematic approach to medicines optimisation at all levels has also continued through the year, supporting ICSs ahead of the statutory establishment of ICBs in July 2022 to embed effective and efficient delivery for patients and taxpayers.

The CMD has expanded its commercial negotiation capabilities to conclude more pioneering agreements across pharmaceuticals and medical technologies. This investment in the team will enable CMD to build on a track-record of commercial deals that provided for patient access to new innovations, including:

- Atidarsagene autotemcel (Libmeldy®) – a life-saving gene therapy that offers the prospect of a normal life for children with metachromatic leukodystrophy[37]
- Risdiplam (Evrysdi®) – the first 'at home' oral treatment for spinal muscular atrophy (SMA) and the third new SMA treatment secured by the NHS for patients in England in less than three years[38]
- Crizanlizumab (Adakveo®) – a new first sickle cell drug in two decades, that could be used to treat thousands of people that have experienced sickle cell crises[39]

[34] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1019475/good-for-you-good-for-us-good-for-everybody.pdf
[35] https://www.gov.uk/government/news/government-pledges-to-reduce-overprescribing-of-medicines
[36] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/areas-of-focus/
[37] https://www.england.nhs.uk/2022/02/nhs-to-roll-out-life-saving-gene-therapy-for-rare-disease-affecting-babies/
[38] https://www.england.nhs.uk/2021/11/nhs-deal-on-spinal-muscular-atrophy-at-home-treatment/
[39] https://www.england.nhs.uk/2021/10/nhs-announces-deal-for-life-changing-sickle-cell-treatment/

- Pertuzumab with trastuzumab and hyaluronidase (PHESGO®) – a '5 minute' breast cancer treatment, enabling thousands of people to receive faster treatment that limits the time they need to spend in hospital[40]
- Inclisiran (Leqvio®) – a world-leading population health deal secured the 'cholesterol-busting jab' for NHS patients, creating an opportunity to save thousands of lives over the decade[41]
- Sotorasib (Lumykras®) – a first in Europe early access deal that enabled NHS patients with certain lung cancers to receive the first drug to target the so called 'death star' mutation.[42]

Research and innovation

NHS England continues to support innovation, research, and life sciences to improve patient outcomes and reduce health inequalities. The Accelerated Access Collaborative (AAC) provides patients with access to proven innovations through its work. It is hosted by the Innovation, Research and Life Sciences (IRLS) team within NHS England and brings together key partners from across government, charities, NHS and industry.

The NHS has a strong track-record of supporting the adoption of proven innovation to increase capacity and improve patient outcomes and over 2 million patients have benefited from IRLS and AAC programmes to date.

Over the last year, we have:

- helped patients spend over 10,300 fewer days in hospital
- supported over 3,000 innovations, across 287 sites
- helped over 2,800 innovators, including over 171 NHS staff as part of the NHS Clinical Entrepreneurs Programme (over 700 people since the programme started)
- saved the NHS over £18 million.

During 2021/22 over 1.1 million people took part in research, with COVID-19 research continuing and research into other conditions building back.

Our innovation programmes are focussed on priority clinical areas, including prevention and treatment of cardiovascular disease and diabetes; addressing health inequalities; and moving towards 'net zero'. Specific commitments around innovation were delivered, including:

- launching the MedTech Funding Mandate[43] to support the adoption of proven medical devices, diagnostics, and digital products
- the beta launch of the NHS Innovation Service, providing a single point of access for the support needed from AAC partner organisations to develop and launch innovations

[40] https://www.england.nhs.uk/2021/04/thousands-of-patients-set-to-benefit-from-five-minute-breast-cancer-treatment-2/
[41] https://www.england.nhs.uk/2021/09/nhs-cholesterol-busting-jab-to-save-thousands-of-lives/
[42] https://www.england.nhs.uk/2021/09/lung-cancer-patients-to-get-breakthrough-drug-on-nhs/
[43] https://www.england.nhs.uk/aac/what-we-do/how-can-the-aac-help-me/the-medtech-funding-mandate/

- delivering the AAC Rapid Uptake Product[44] programme, which supported the accelerated uptake of several areas of innovation, that, despite approval from the National Institute for Health and Care Excellence, have had lower-than-expected uptake in the NHS. The programme identifies what the specific barriers are to their uptake and identifies the solutions to remove them to form bespoke packages of support for each innovative product.

Delivering a net zero National Health Service

In 2020, the NHS became the world's first national health service to commit to net zero and charted a course which will result in both direct and indirect improvements to people's health and patient care. Alongside other direct actions, over the first year of delivering a Greener NHS:

- the NHS launched the world's first zero emission ambulance at the 26th United Nations Climate Change Conference (COP26)
- 15 key suppliers, with combined emissions larger than many developed national economies, collaborated with the NHS to match our 2045 net zero commitment
- over £310 million of capital from the NHS Energy Efficiency Fund and the Public Sector Decarbonisation Scheme was invested in renewable energy generation, energy efficiency measures, and lighting
- the Chief Sustainability Officer's clinical fellowship scheme was launched, to embed sustainability at the heart of clinical leadership
- a total of £1 million was awarded to 10 pioneering net zero MedTech and Digital Innovations to support high quality, efficient, and more accessible healthcare
- a 10% carbon weighting was embedded into the tendering criteria of all future procurement decisions
- 100% of Trusts developed their own strategies to chart their course to net zero, with almost all Trusts appointing board level leads to ensure the delivery of these plans
- the number of Trusts using 100% renewable certified energy increased to 124
- in response to a survey in August 2021, over nine out of 10 staff clearly stated their support for the' net zero commitments.

The NHS successfully delivered this ambitious and world leading programme of work to save over 1.2 million tonnes of carbon, significantly exceeding the requirement outlined in the Climate Change Act for a 51% reduction by 2025, and ensures that we remain on track against the trajectories set out within our October 2020 publication, *Delivering a Net Zero NHS*[45].

[44] https://www.england.nhs.uk/aac/what-we-do/what-innovations-do-we-support/rapid-uptake-products/

[45] Report: NHS England (2020) *Delivering a Net Zero National Health Service*. Available at https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/

Reducing health inequalities

NHS England and NHS Improvement undertook a range of work to reduce health inequalities in 2021/22, particularly to bring focus to system efforts and strengthen accountability and capability, building on learning from the COVID-19 pandemic.

Our strategic approach to reducing healthcare inequalities

Priorities for tackling healthcare inequalities

The COVID-19 pandemic highlighted the urgent need to prevent and manage ill health, particularly in groups that experience the worst outcomes. To help achieve this, in August 2020, we issued guidance as part of our phase three response to the pandemic, setting out eight urgent actions for tackling healthcare inequalities.

Systems were subsequently asked to focus on five priority areas for tackling healthcare inequalities in the first half of 2021/22, distilled from the eight urgent actions:

- priority 1: Restore NHS services inclusively
- priority 2: Mitigate against digital exclusion
- priority 3: Ensure datasets are complete and timely
- priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- priority 5: Strengthen leadership and accountability

Framework for action

In November 2021, we launched Core20PLUS5, an approach to support reductions in healthcare inequalities at both national and system level. The approach defines a target population comprising the most deprived 20% of the population of England (the Core20), and other population groups identified by local population health data such as ethnic minority communities (PLUS groups). It sets out five clinical area of focus:

1. early cancer diagnosis (screening and early referral)
2. hypertension case finding
3. chronic respiratory disease (driving COVID-19 and flu vaccination uptake)
4. annual health checks for people with serious mental illness
5. continuity of maternity carer plans.

We have mobilised the Core20PLUS5 approach across the NHS, running over 20 stakeholder focus groups and a range of introductory engagement sessions with audiences across the NHS and wider partners, including public health teams, local authorities, and voluntary sector organisations. We received around 600 responses to a survey[46] seeking

[46] https://www.england.nhs.uk/blog/core20plus5-you-said-were-doing/

feedback on the Core20PLUS5 approach. In response to feedback, to provide tailored support to systems on driving forward the Core20PLUS5 approach, we launched the Core20PLUS Connectors programme which is funding community-based support in 11 sites based across seven regions. We also commissioned the Institute for Health Improvement to establish a multi-sectoral network to drive a quality improvement approach to tackling health inequalities, the Core20PLUS Collaborative.

Governance and partnerships

We have several governance and accountability mechanisms for engaging with national, regional, and local stakeholders on the health inequalities agenda.

- the Health Inequalities Improvement Board coordinates and support efforts across NHS England and NHS Improvement programmes and policy areas to deliver the vision of exceptional quality healthcare for all. Board members include NHS England and NHS Improvement programme directors and regional Senior Responsible Officers (SRO) for health inequalities. The Board met monthly, considering a range of programme activity to tackle inequalities and monitoring progress on our priority areas
- the Health Inequalities Clinical Network provides clinical and professional advice and helps to shape deliverables that support our key priorities for tackling health inequalities. Fortnightly meetings were held throughout 2021/22, open to National Clinical Directors, National Specialty Advisors, and clinical and professional leads from across regions, ICS localities, PCNs and trusts
- the Health Inequalities Forum provides an opportunity for nominated health inequalities leads in systems, regions, trusts and PCNs to share updates, showcase learning and improvements, and outline any issues, challenges and risks to implementing and delivering on the health inequalities improvement agenda. This forum meets on a fortnightly basis.

We have established the Health Inequalities Futures Platform, sharing key information and system support on health inequalities with an online community with evidence of high levels of user engagement.

We have also continued our work with partners, including the NHS Race and Health Observatory, the Health Foundation, and the NHS Confederation. For example, with the Health Foundation, we have implemented The Health Anchors Learning Network. The UK wide network provides spaces and opportunities for participants to learn with peers and experts about how anchor organisations can consciously use their resources, influence, and work in partnership to improve the social determinants of health and help reduce inequalities.

Data to support action

We launched a Healthcare Inequalities Improvement Dashboard[47] for NHS users in October 2021. This brings together a range of indicators from national to local level, understand where health inequalities exist in their area; what is driving inequalities; and what local insights and actions they can take to drive improvement.

We have also taken steps to improve data collected through clinical audits and outcome reviews. We commissioned the National Confidential Enquiry into Patient Outcomes and Deaths to produce a thematic review of healthcare inequalities which will be updated annually.

Progress on key priorities

Priority 1: Restore NHS services inclusively

The Elective Recovery Fund, which was in place in the in the first half of 2021/22 included five requirements on health inequalities helping to bring focus to the agenda. We have reviewed all ICS plans to understand how they respond to the priority of inclusive elective recovery. The delivery plan for tackling the COVID-19 backlog of elective care,[48] put reducing inequalities at the core of recovery plans and performance monitoring, ensuring that this is part of how we hold systems to account for delivery.

Priority 2: Mitigate against digital exclusion

Following the independent review by Laura Wade-Gery the SRO role for Health Inequalities now incorporates oversight of digital inclusion, and a Digital Inclusion Steering Group has been established to co-ordinate and steer our approach to digital inclusion. The 'What Good Looks Like' framework[49] published in August 2021 set out success measures for digital transformation.

Priority 3: Ensure datasets are complete and timely

Our guidance on inclusive elective recovery asked systems to delineate waiting list and performance data by deprivation and ethnicity, monitor system performance for ethnic minority groups and the most deprived communities, and evaluate the impact of elective recovery plans on disparities in waiting lists. We have monitored health inequalities across a range of national programmes to inform actionable insights, including cancer, COVID-19 vaccination, and diabetes.

[47] https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/hi-improvement-dashboard/
[48] Coronavirus » Delivery plan for tackling the COVID-19 backlog of elective care (england.nhs.uk)
[49] What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate (nhsx.nhs.uk)

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

The UK COVID-19 vaccine uptake plan was published in February 2021, with an emphasis on ensuring system partners work together to address inequalities in uptake and access.[50] We established the COVID-19 Vaccine Equalities Connect and Exchange Hub for systems to share experiences and best practice examples.[51] We developed the award-winning NHS COVID-19 Vaccine Equalities tool, which updates daily to provide detailed data on vaccine uptake among underserved communities[52], and has been used to target uptake efforts at specific populations and communities at national, regional and local level.

Priority 5: Strengthen leadership and accountability

Our governance networks, forums and boards that focus on health inequalities, provide opportunities for engagement across the system and assurance that we are delivering at pace and scale to tackle inequalities. We continue to drive action on inequalities through our regional and system leadership. Alongside Senior Responsible Officers and Executive Leads for health inequalities across all our regions and ICSs, we have established regional health inequalities programme leads and support officer roles to ensure delivery capacity for regions and systems. We provided funding of £1.7 million for ICSs, via regions, to provide additional capacity to address health inequalities. The funding was provided on a fair shares basis, and allowed for some local level flexibility in delivery, with many systems recruiting for a specific health inequalities programme role.

We have undertaken activity to build capability to address healthcare inequalities, commissioning NHS Confederation to develop a leadership framework for tackling health inequalities. Phase one of the framework has been delivered through a series of webinars for ICS Chairs, Non-Executive Directors, and partners.

[50] https://www.gov.uk/government/publications/COVID-19-vaccination-uptake-plan/uk-COVID-19-vaccine-uptake-plan#our-approach
[51] https://future.nhs.uk/NationalCOVID19VaccineEquality/grouphome
[52] https://www.gov.uk/government/news/analysis-in-government-award-winners-2021

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2022 are presented later in this document on a going concern basis (as per note 1.5 of the accounts) and show the performance of both the consolidated group – covering the whole of the commissioning system – and NHS England as the parent of the group. The group comprises NHS England and 106 CCGs and from 1 October 2021, Supply Chain Coordination Limited (SCCL).

We are required to manage spending within a fixed revenue limit. The total revenue limit was £150,614 million. This was an increase on 2020/21 of £1,141 million, driven by a £4,834 million funding increase for core (pre-COVID-19) NHS services, which also reflected savings against the original Long Term Plan settlement. The funding increase for core services was offset by a £3,693 million reduction in 2021/22 COVID-19 funding (£16.3 billion) compared to 2020/21 (£20.0 billion). The fall in COVID-19 funding was mainly driven by the end of the 2020/21 acute independent sector national contracts as part of the immediate COVID-19 response, reduced funding requirement for the discharge programme and ending other initiatives such as the Nightingales programme.

In the Autumn of 2021/22, the NHS also agreed a financial settlement with the Government for the following three years. The funding represents a real terms cut in total funding for 2022/23 as the NHS seeks both to boost activity, deal with new demands from the pandemic, recover backlogs and reduce long waiting times, vaccinate the population as directed by the Government as well as reduce the costs inevitably incurred in seeking to respond to the COVID-19 emergency over the last couple of years. By 2024/25 funding will have returned to the Long Term Plan trend allowing for additional funding to deal with elective backlogs, any ongoing vaccine programme and enduring higher costs where we are still dealing with higher COVID-19 demands.

Financial management and the finance community's response to the pandemic

The continued challenges of the pandemic meant that our focus remained on ensuring that the frontline of the NHS had the resources needed to continue to provide urgent services and as much routine and planned care as possible.

The significant changes made to the NHS financial framework in 2020/21 were continued throughout 2021/22 to maintain simplicity and certainty and remove transactional bureaucracy in the system. Throughout the financial period, focus has continued on good financial management – including the requirement for CCGs and systems to break even within a fixed budget envelope.

Providers of healthcare have continued to see significant additional costs as a consequence of the COVID-19 pandemic – these changes included:

- patient segregation and distancing to reduce the risk of infection, which reduced the number of patients that clinicians could care for at any one time and the number of beds available for patients
- additional preventative measures, which have increased the time taken to perform many tasks, for example, testing protocols and donning and doffing of Personal Protective Equipment
- increased staff sickness and self-isolation levels, which have meant lower clinical capacity and an increase in agency utilisation to fill absences.

We have, however, continued to see progress in the adoption of major innovations. In particular, we have continued to adopt remote monitoring technologies and virtual methods of delivery which improve outcomes and lower costs.

Financial performance

Our focus in-year has been on providing financial certainty and enabling the system to respond to the pandemic, effectively deliver the vaccine roll out and recover activity while maintaining appropriate financial rigour and discipline.

This year we delivered an underspend of £697 million against the increased revenue resource budget. Of this, £604 million was against specific budgets which were not available to support general spending in particular. The remaining £93 million underspend was against non-ringfenced budgets. Financial performance – Revenue Department Expenditure Limit (RDEL) general (non-ringfenced).

	2021/22				2020/21		2019/20		2018/19		2017/18		2016/17	
	Expenditure		Under / (over) spend against plan		Under / (over) spend against plan		Under / (over) spend against plan		Under / (over) spend against plan		Under / (over) spend against plan		Under / (over) spend against plan	
	Plan	Actual												
	£m	£m	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
CCGs	114,975	114,780	195	0.2%	154	0.2%	(507)	(0.6%)	(150)	(0.2%)	(213)	(0.3%)	154	0.2%
Direct commissioning	29,068	28,758	310	1.1%	1,087	3.9%	390	1.5%	310	1.3%	223	0.9%	296	1.2%
NHS England admin/central progs/other[53]	6,571	6,379	192	2.9%	4,132	21.3%	1,113	14.2%	755	17.0%	960	23.2%	452	13.0%
Total	**150,614**	**149,917**	**697**	**0.5%**	**5,373**[54]	**3.6%**	**996**	**0.8%**	**915**	**0.8%**	**970**	**0.9%**	**902**	**0.9%**

[53] Historic Continuing Healthcare claims administered on behalf of CCGs included in 'other'.

[54] The underspend in 2020/21 includes £2,567 million relating to specific ringfenced budgets included in DHSC's financial directions to NHS England with these amounts not available to support general spending.

Performance against wider financial metrics

Within the mandate the DHSC sets a number of technical financial targets for the NHS England Group, including the core operational limit (general RDEL) described above. These limits are ringfenced, which means that underspends on the other revenue limits cannot be used to support core patient services covered by the general RDEL limit.

Performance against key financial performance duties

a) Revenue limits

	Mandate limit (£m)	Actual (£m)	Underspend (£m)	Target met	Underspend as % of mandate
RDEL – general	150,614	149,917	697	✓	0.5%
RDEL – ringfenced for depreciation and operational impairment	197	197[55]	0	✓	0.0%
Annually Managed Expenditure limit for provision movements and other impairments	150	122	28	✓	18.7%
Technical accounting limit (including for capital grants)	200	1	199	✓	99.5%
Total revenue expenditure	**151,161**	**150,237**	**924**[56]		**0.6%**

b) Administration costs (within overall revenue limits above)

Total administration costs	**1,785**	**1,542**	**243**	✓	**13.6%**

c) Capital limit

Capital expenditure contained within our Capital Resource Limit	**337**	**291**	**46**	✓	**13.5%**

Allocations

The revised funding regime established for the second half of 2020/21 was continued throughout 2021/22 in response to the continued impact of COVID-19. The financial framework in operation in 2021/22 comprised:

- system-level (geography) funding envelopes, made up of adjusted CCG allocations and additional funding to support delivery of a system breakeven position
- block contract arrangements between commissioners and NHS trusts and foundation trusts to support financial stability
- additional funding to support underlying growth in the cost base, linked to planned allocation growth for the CCGs in the system
- funding for directly commissioned services

[55] An additional £0.14 million of ringfenced RDEL depreciation expenditure in 2021/22 has been charged against the non-ringfenced RDEL general budget as agreed with the Department of Health and Social Care.

[56] The underspend in 2021/22 includes £604 million (2020/21: £2,567 million) relating to specific ringfenced budgets included in DHSC's financial directions to NHS England with these amounts not available to support general spending.

- additional funding to support systems to meet COVID-19 demand and the additional costs of delivering healthcare during the pandemic
- nationally funded or reimbursed system funding for specific COVID-19 services, including the vaccination programme and the enhanced discharge programme.

Financial priorities for 2022/23

Our priorities are continuing to make sure that the frontline of the NHS has the resources it needs to respond to the ongoing direct and indirect demands of the pandemic while treating as many patients who are waiting for elective care as we can. We must also recognise the continuing efforts of NHS staff and ensure that people are able to take a proper break. This must be done in the longer-term context of returning to a sustainable financial footing.

We will be working with ICSs to:

- ensure we have physical and workforce capacity to manage COVID-19 in the long term
- deliver the multi-year New Hospital Programme and invest in our estate
- use the additional resources we have been provided with to invest in reducing the number of people waiting for elective procedures and continue to increase our investment in mental health and primary care services
- continue the journey towards greater system working and integrated care budgets
- maintain spending controls and deliver care as efficiently as we can in the context of ongoing operational constraints.

Julian Kelly
Chief Financial Officer

Accountability Report

Amanda Pritchard
23 January 2023

Accounting Officer

Corporate Governance Report

Directors' Report

The Board is the senior decision-making structure for NHS England. It has reserved key decisions and matters for its own decision, including strategic direction, overseeing delivery of the agreed strategy, the approach to risk, and establishing the culture and values of the organisation.

Key responsibilities to support its strategic leadership to the organisation include:

- approving the strategic plan and monitoring performance against it
- holding the organisation to account for performance and the proper running of the organisation (including operating in accordance with legal and governance requirements)
- determining which decisions, it will make and which it will delegate to the Executive via the Scheme of Delegation
- providing effective financial stewardship
- promoting effective dialogue between NHS England, NHS Improvement, government departments, other Arm's length bodies (ALBs), partners, ICSs, their constituent organisations and the communities they serve.

The Board

The composition of the Board is essential to its success in providing strong and effective leadership. NHS England's Board members bring a wide range of experience, skills and perspectives. With their diverse leadership experience, together they set the strategic direction of the organisation and ensure robust and open debate.

The Board is comprised of the Chair, at least five non-executive directors and five executive directors. The number of executive directors on the Board must not exceed the number of non-executive directors.

Appointments

The Chair and non-executive directors are appointed by the Secretary of State for Health and Social Care and executive directors are appointed by the non-executive directors. The appointment of the Chief Executive is subject to the Secretary of State for Health and Social Care's consent.

During the year, the Secretary of State for Health and Social Care approved the appointment of Richard Meddings CBE as the new Chair as of 25 March 2022. As noted beneath the table above, various members temporarily transferred between the boards of NHS England and NHS Improvement or were extended to ensure that the Boards of the organisations are appropriately constituted ahead of the legislative changes to the organisations in 2022.

Board members

Directors who served on the NHS England Board during the year are listed in the table below, along with their attendance[57].

Members	Role	Term ends/notes	Number of eligible Board meetings attended
Lord David Prior[58]	Chair	Left on 24 March 2022	5/5
Richard Meddings CBE[59]	Incoming Chair	24 March 2026	0/0
Wol Kolade[60]	Incoming Deputy Chair	24 March 2025	0/0
Michael Coupe	Senior Independent Director	31 December 2023	5/5
Prof. Lord Ara Darzi of Denham[61]	Non-Executive Director	30 June 2022	5/5
Susan Kilsby	Non-Executive Director	30 December 2023	2/5
Laura Wade-Gery	Non-Executive Director	31 July 2023	4/5
Amanda Pritchard[62]	Chief Executive Officer		4/4
Julian Kelly CB	Chief Financial Officer		4/5
Ruth May	Chief Nursing Officer		5/5
Prof. Stephen Powis	National Medical Director		5/5
Sir David Sloman[63]	Chief Operating Officer		2/2
Ian Dodge	National Director: Strategy and Innovation	Non-voting	5/5
Former members	**Role**		
Mark Cubbon[64]	Interim Chief Operating Officer	Left on 13 December 2021	2/2
Dr Emily Lawson	Chief Commercial Officer (non-voting)	Left on 19 July 2021	1/1
Rakesh Kapoor[65]	Non-Executive Director	Left on 1 May 2021	0/0
Lord Simon Stevens	Chief Executive	Left on 31 July 2021	1/1
David Roberts CBE	Vice-Chair & Senior Independent Director	Left on 30 June 2021	1/1
Jeremy Townsend[66]	Non-Executive Director	Left on 25 March 2022	5/5

[57] Biographical details may be viewed on our website https://www.england.nhs.uk/about/board/nhs-england-board/members/

[58] Lord David Prior's tenure as the Chair ended on 24 March 2022.

[59] Richard Meddings CBE was appointed chair as of 25 March 2022 and attended two Board meetings as a guest leading up to his appointment.

[60] Wol Kolade's directorship was transferred from NHS Improvement to NHS England on 25 March 2022 so whilst appointed to the board there were no qualifying meetings to attend in this period.

[61] Prof. Lord Ara Darzi's directorship was extended from 31 July 2021 to 30 June 2022, the final day before legislation came into effect to abolish Monitor and NHS Trust Development Authority (operating under the name of NHS Improvement) and a new NHS England Board was created.

[62] Amanda Prichard was appointed Chief Executive from 1 August 2021 and ceased her role as the Chief Operating Officer on 31 July 2021.

[63] Sir David Sloman was appointed Chief Operating Officer on the 14 December 2021.

[64] Mark Cubbon stepped down as the Interim Chief Operating Officer on the 13 December 2022 and took up the role as the Chief Delivery Officer on 14 December 2021.

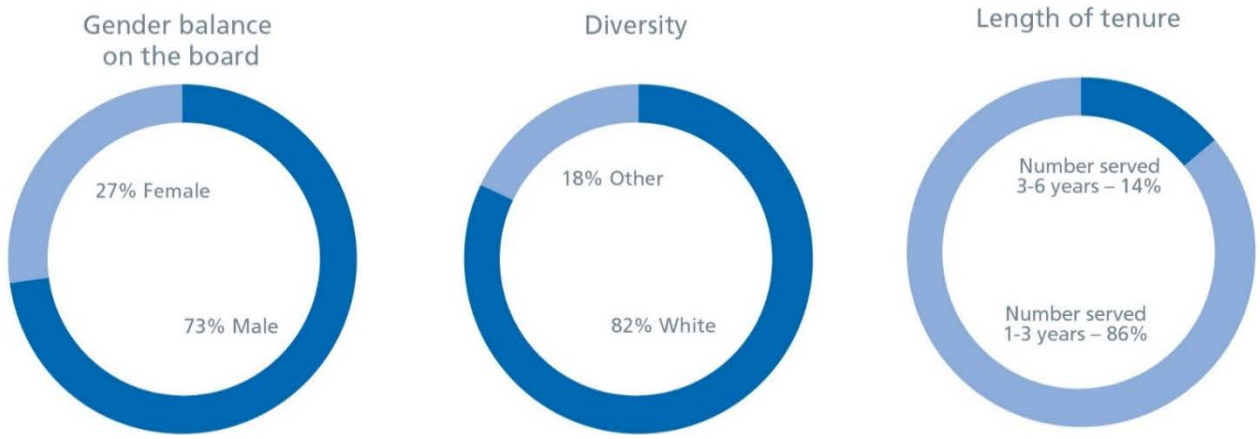
[65] Rakesh Kapoor's directorship was temporarily transferred to NHS Improvement on 1 May 2021.

[66] Jeremy Townsend's directorship was temporarily transferred to NHS Improvement on 24 March 2022, returning 1 July as described in the Events after the reporting period section on page 75.

Board diversity

The charts below show the composition of the Board members by gender, diversity and tenure as of 31 March 2022.

Board diversity



The governance structure

Prior to the legal merger on 1 July 2022, NHS England and NHS Improvement could not legally have one joint board or joint board committees. Each organisation retained its given statutory functions and NHS England could not delegate its functions to NHS Improvement, or vice versa.

Nevertheless, the organisations operated as one, with the Boards and their committees meeting in common during the year on shared business whilst having separate membership and the ability to take their own decisions. The governance framework included established procedures for dealing with situations in which a director may find they have a direct or indirect functional, operational or personal interest that conflicts with that of either organisation. Further detail on the Separation of Functions and Conflicts of Interest policy can be found on page 72.

In June 2021, the Boards agreed to stand down the time-limited COVID-19 National Incident Response Board, and replaced it with an executive forum, that was responsible for the operational delivery of nationally agreed strategies and programmes, including NHS recovery and ongoing COVID-19 incident response. The System Oversight Committee was established and with its NHS Improvement counterpart they reflect the transition to a 'system by default' approach to oversight, including formal intervention and mandated support where required.

An overview of the Board governance framework is shown on the next page and individual Board Committee reports can be found from page 63 to 71. A report detailing the business considered by the Board Committees is provided to each Board meeting and the terms of reference for each committee are on our website.

NHS England Board governance framework and committees

NHS England Board

Committees operating as a committee-in-common with NHS Improvement

Audit and Risk Assurance Committee	People, Remuneration and Nominations Committee	Digital Committee	Quality and Innovation Committee	System Oversight Committee (from 1 August 2021)	COVID-19 National Incident Response Board (to 31 July 2021)
Main responsibilities					
• Provide an independent and objective view of internal control, governance and risk management including overview of internal and external audit services, governance, risk management, counter fraud and financial reporting.	• Oversee the delivery of the overall people strategy for the NHS. • Oversee the implementation of key provisions in the NHS People Plan. • Approve the framework and policy for executives for submission to DHSC. • Approve individual executive remuneration packages, • Approves employee policies. • Review employee engagement initiatives.	• Ensure effective delivery of the digital commitment of the NHS Long Term Plan. • Ensures alignment of technology initiatives and spend across the system to ensure they are focused on commitments of the NHS Long Term Plan.	• Determine whether the NHS is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan. • Oversee implementation of innovation strategies.	• Ensure consistent approach to oversight of ICSs and constituent organisations. • Oversee the development and delivery of oversight and regulatory policy • Approve mandated support for ICS and CCGs where appropriate. • Approve applications for the establishment of CCGs.	• Oversee the organisation's response to the COVID-19 incident and EU Exit Programme. • Oversee NHS operational delivery and performance in relation to incident recovery in light of the commitments publicly set out in the NHS Long Term Plan and the NHS People Plan.

Executive HR Group
Appointments & Approvals Committee

Joint Finance Advisory Group (NHS Improvement and NHS England)	The group has no executive responsibility and oversees and provides advice to the Boards on the financial position across the NHS, including delivery of system-wide efficiency savings, and implementation of NHS England/NHS Improvement's national productivity programme.

NHS Executive Group

The NHS Executive Group includes the corporate and regional directors of each of the directorates. The Group is chaired by the Chief Executive of NHS England and advises on the development and implementation of national policies and programmes, NHS performance and performance of the joint organisation, and any other matters that require executive-level oversight. The Group is supported by several other management groups and processes.

Key Board roles and responsibilities

Through the reporting period to 24 March 2022, Lord David Prior was the Chair of NHS England. This responsibility moved to Richard Meddings CBE on 25 March 2022.

Amanda Pritchard took up the role of Chief Executive of NHS England on 1 August 2021. Mike Coupe is the Senior Independent Director, and Wol Kolade was appointed the Deputy Chair on 25 March 2022. Their key areas of responsibility are:

Chair

Responsible for the leadership and effectiveness of the Board. This involves encouraging a culture of openness and debate to allow the Board to both challenge and support management. The Chair is also responsible for the Board governance, Board performance and stakeholder engagement. He ensures new board members receive a tailored induction and works with the chair of NHS Improvement and the Head of Board Governance to agree joint board training and development sessions.

Chief Executive

Responsible for the day-to-day leadership of the organisation and the delivery of the strategy. The Chief Executive is supported by their senior leadership team and together they are responsible for the implementation and execution of NHS England's and NHS Improvement's strategy. The Chief Executive is also the Accounting Officer responsible for ensuring that public funds are properly safeguarded and are used in line with NHS England's functions and responsibilities as set out in HM Treasury guidance Managing Public Money.

Deputy Chair

Is supporting the Chair in effective running of the Board and deputises for the Chair as appropriate.

Senior Independent Director

In addition to the role of non-executive board member, the senior independent director acts as confidante to the Chair and an intermediary for other Board members. The senior independent director also performs the annual evaluation of the Chair's performance.

Non-executive directors

Support executive management, whilst providing constructive challenge and rigour and bring sound judgement and objectivity to the Board's decision-making process. Monitor the delivery of strategy within governance framework as set by the Board. Their independence is reviewed annually, and all make monthly declarations of interest. All non-executive directors are considered to be independent.

Executive directors

Executive directors support the Chief Executive in leading the organisation to deliver its strategic objectives.

Board activity and administration

The Board held five scheduled Board meetings in common during the year. Each had a public and a private session. Members of the public can observe the public sessions, which are available to watch live, or after the event, on our website. The agenda, papers and minutes for the public sessions are also published on our website. In addition, the Boards held two strategy sessions and a number of topic specific deep dive learning sessions. There were also a number of Board calls where the non-executive directors were primarily updated on the organisations' response to the COVID-19 pandemic.

Board meetings are generally pre-scheduled on a rolling basis. There are also regular meetings between the Chair and the non-executive directors, and between the Chief Executive and the non-executive directors, to allow discussions about the effectiveness of the Board and general matters and views to be shared.

Key items considered by the NHS England and NHS Improvement Boards during the year were[67]:

Strategy

- NHS Recovery Programme
- COVID-19 vaccine deployment
- development of integrated care systems
- refresh of the NHS Long Term Plan
- strategic opportunities and challenges facing the NHS
- accelerating digital enabled transformation in the NHS
- approved the transfer of Supply Chain Coordination Limited to NHS England
- endorsed work to support the NHS to embed and accelerate clinical innovations that had arisen in response to COVID-19 and the role of life sciences in the NHS
- progress in achieving a 'Net Zero' NHS.

Performance

- updates on the organisation's response to COVID-19 and the associated recovery and restoration of NHS services
- operational, quality and financial performance of NHS providers and the commissioning sector
- approved the approach to financial allocations and the financial framework for 2022/23
- approved the System Oversight Framework for 2021/22

[67] Where applicable the individual boards have made the decisions.

- approved NHS England's and NHS Improvement's response to the recommendations in the Ockenden Review
- updates on Mental Health Services.

Leadership and people

- approved NHS England's and NHS Improvement's response to the Kark recommendations
- considered progress in tackling inequalities in the NHS
- approved the 2022/23 Slavery and Human Trafficking statement
- considered progress in NHS England's and NHS Improvement's Internal Freedom to Speak Up.

Governance and risk

- approved changes to the Board governance framework
- approved changes to corporate risk register and an updated risk appetite
- received updates on the development of the Health and Social Care Act
- merger of HEE, NHS Digital and NHSX with NHS England and NHS Improvement.

Review of Board effectiveness and performance evaluation

An informal internal review of board governance was led by the Senior Independent Director for NHS England, Mike Coupe, in the Summer of 2021 resulting in a number of improvements made to the governance framework, including the approach to Board meetings and the introduction of an annual strategy session. In light of the appointment of a new Chair and changes introduced by the Health and Care Act 2022 with the abolition of NHS Improvement, it was agreed that a review of the Board effectiveness would be carried out as part of the work to establish the new NHS England Board for 1 July 2022, the result of which will be reported in next year's report.

It is recognised that the Chair's effectiveness is also vital to the operation of the Board. Given that Richard Meddings was only in post for the last few days of 2021/22, it was agreed that an evaluation of his effectiveness as Chair would be carried out at the end of the 2022/23 financial year.

Board committees

COVID-19 National Incident Response Board

Role of the committee

On 1 April 2020 NHS England's and NHS Improvement's Boards each established a time-limited[68] Board Committee, the COVID-19 National Incident Response Board (the COVID-19 Board). The COVID-19 Board was responsible for the strategic direction and providing oversight of NHS England's and NHS Improvement's response to the COVID-19 incident. The COVID-19 Board was disbanded on 31 July 2021 and replaced with an executive forum that is responsible for the operational delivery of nationally agreed strategies and programmes, including NHS recovery and ongoing COVID-19 incident response.

Committee members

Until its disbandment, the COVID-19 Board met an average of twice per week, with members attending most of these meetings.

Members	Comment
Amanda Pritchard (Chair)	In her capacity as the former Chief Operating Officer
Julian Kelly	Chief Financial Officer
Prof. Stephen Powis	National Medical Director
Dr. Jonathan Berger	Interim Chief Medical Officer, NHS Digital
Ian Dodge	National Director: Strategy and Innovation
Simon Enright	Director of Communications
James Lyons	Director of Communications
Matthew Gould	National Director Digital Transformation and former Chief Executive NHSX
Stephen Groves	Director of EPRR (National)
Prerana Issar	Chief People Officer
Dr. Nikita Kanani	Medical Director for Primary Care
Dr. Emily Lawson	Chief Commercial Officer
Ruth May	Chief Nursing Officer
Claire Murdoch	National Director Mental Health
Pauline Philip	National Director Emergency and Elective Care
Prof. Sir Keith Willett	Strategic Incident Director
Seven regional representatives	Rotational between Regional Directors and their senior teams

Attendees

In addition, the Director General, DHSC, and the Deputy Director, National Infection Service, PHE were invited to attend these meetings to support delivery of the Government's cross-departmental strategy and approach to COVID-19.

[68] The COVID-19 National Incident Response Board was established for an initial term of 1 April to 31 September 2020. On 1 October 2020, the Boards approved an extension to its operation from 1 October 2020 to 31 March 2021 to continue to oversee the NHS's operational response to COVID-19 and was formally disbanded on 31 July 2021.

Principal activities during the year

The COVID-19 Board oversaw NHS England's and NHS Improvement's response to the COVID-19 incident and NHS operational delivery and performance in relation to incident recovery. To support this the COVID-19 Board operated as the key oversight and assurance forum for the work carried out through NHS England's and NHS Improvement's COVID-19 incident response cells.

Audit and Risk Assurance Committee

Role of the committee

The Committee's primary role is to assist the Board in fulfilling its oversight responsibilities in relation to financial reporting, systems of internal control and risk management processes. This includes an overview of the quality and integrity of NHS England's and NHS Improvement's financial reporting and the management of the internal and external audit services.

The Committee meets in common with NHS Improvement's Audit and Risk Assurance Committee (ARAC).

Committee members

The Committee met six times and the following table details membership, and the number of meetings attended by each member during the year:

Members	Number of eligible meetings attended	Comment
Jeremy Townsend [69]	6/6	Non-Executive Director, Chair to 25 March 2022
Wol Kolade [70] (Chair)	0/0	Non-Executive Director, Chair from 25 March 2022
Susan Kilsby	5/6	Non-Executive Director
Gerry Murphy	6/6	Non-executive Chair of DHSC's Audit Committee (non-voting member)

Jeremy Townsend was the Chair of the Committee to 25 March 2022, when his directorship was temporarily transferred to NHS Improvement. On the same day, Wol Kolade's directorship was transferred from NHS Improvement to NHS England. As the previous chair of the NHS Improvement Committee Wol Kolade has assumed the role of the chair of the NHS England Committee, and similarly Jeremy Townsend has assumed the role of the chair of the NHS Improvement Committee. Jeremy Townsend is a qualified accountant and has considerable experience in chairing audit committees in other organisations. Wol Kolade is the managing partner of a private equity firm with valuable and recent financial experience.

[69] Jeremy Townsend's directorship was temporarily transferred to NHS Improvement on 25 March 2022 and he has taken over the chair of NHS Improvement's Audit and Risk Assurance Committee.

[70] Wol Kolade's directorship was transferred from NHS Improvement to NHS England on 25 March 2022 and he has taken over the chair of the Audit and Risk Assurance Committee.

Good governance provides that an audit and risk committee should consist of three independent non-executive directors. As the Committee considers mainly joint organisation business and meets in common with NHS Improvement's committee, it was agreed, and was supported by the internal and external auditors, that the Committee should comprise of two non-executive directors because together there are four non-executive directors involved in deliberations. This is a time-limited arrangement pre-legislative change.

As a Committee there is a good balance of skills and knowledge covering accounting and finance, audit committee best practice and clinical services.

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2021/22 these included, among others, the Chief Executive Officer, the Chief Financial Officer, the Director of Governance Legal and Inquiry, the Director of Financial Control as well as representatives from the external auditors the National Audit Office (NAO), the internal auditors Deloitte LLP and DHSC. The Committee is able to meet with the internal and external auditors without management when required and the auditors have full access to the organisations.

Principal activities during the year

As part of ensuring the integrity of the organisation's financial statements, systems of internal control and risk management processes, the Committee:

- approved the internal audit plan and considered regular progress reports from the internal auditors and the annual Head of Internal Audit Opinion
- reviewed NHS England's and NHS Improvement's joint Corporate Risk Register
- considered a number of risk deep dives, including data and analytics, maternity, workforce and integrated care systems
- received updates on data security and cyber risks
- approved changes in accounting policies and reviewed areas of significant estimation or judgement
- assessed the integrity of NHS England's financial reporting
- approved NHS England's 2020/21 Annual Report and Accounts
- received updates on delivery of the objectives set out in the Economic Crime Strategy – Tackling Fraud Bribery and Corruption
- approved Governance Manual Changes for 2021/22, including approval of the joint NHS England and NHS Improvement Standing Financial Instructions
- oversaw the re-procurement of the internal audit service
- considered NAO reports and management letters, and received an update on the status of the NAO Value for Money Programme.

Internal audit

The joint internal auditor, Deloitte LLP, plays an important part in supporting the assurance role of both the NHS England and NHS Improvement Committees.

At the start of each financial year the Committee approves an annual plan of internal audit activity, which is structured to align with key strategic priorities and key risks and is developed with input from management. At each meeting the Committee receives an independent assurance from the internal auditor and reviews the result of that work together with management's progress in strengthening and enhancing internal controls where areas for improvement have been identified. The Committee works closely with the Head of Internal Audit and their teams who have full access to the organisation.

Digital Committee

Role of the committee

The Committee's role is to provide advice and, where appropriate, make recommendations on strategic implications of technology within the context of the NHS Long Term Plan, and to ensure effective delivery of digital commitments and alignment of technology initiatives and spend across the system to focus on those commitments in the NHS Long Term Plan. The Committee is also responsible for providing assurance on the operating model and governance of digital implementation within the remit of NHS England, NHS Improvement, NHS Digital and other ALBs.

The Committee meets in common with NHS Improvement's Digital Committee.

Committee members

The Committee met three times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Laura Wade-Gery (Chair)	3/3	Non-Executive Director and Chair of NHS Digital
Michael Coupe	3/3	Non-Executive Director
Simon Eccles	3/3	Chief Clinical Information Officer
Dr. Timothy Ferris[71]	3/3	National Director of Transformation
Matthew Gould	2/3	National Director Digital Transformation
Hugh McCaughey	0/3	National Director of Improvement
Former members		
Lord David Prior[72]	3/3	NHS England Chair, left on 24 March 2022
Rakesh Kapoor[73]	0/0	Non-Executive Director, left on 1 May 2022

[71] Dr. Timothy Ferris took up the role as the National Director of Transformation from 10 May 2021 and was appointed an executive member of the Committee on 19 May 2021.

[72] Lord David Prior stepped down as the Chair of NHS England on 24 March 2022.

[73] Rakesh Kapoor's directorship was temporarily transferred from NHS England to NHS Improvement on 1 May 2021 and his Committee membership was transferred on the 19 May 2021 to NHS Improvement's Digital Committee.

Attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2021/22 these included, amongst others, the Chief Executive of NHS Digital and non-executive directors of NHS Digital and NHS Resolution.

Principal activities during the year

Considerable time was spent during the year to consider the digital transformation across the NHS and priorities for the Transformation directorate. Reports considered by the Committee included:

- transformation directorate priorities
- putting data, digital and tech at the heart of transforming the NHS, including architecture, priorities and funding allocations
- digital innovation and transformation across ICSs
- deep Dives: digitally enabled transformation plans across UEC, mental health and elective recovery
- roll-out of a universal Electronic Patient Record system.

People, Remuneration and Nominations Committee

Role of the committee

The Committee's role is to set an overall people strategy and oversee the delivery of the NHS People Plan and provide the Board with assurance and oversight of all aspects of strategic people management and organisational development. The Committee is also responsible for people and organisational development policies and ways of working designed to ensure the workforce of NHS England is appropriately engaged and motivated, including workforce engagement. This includes reviewing the organisation's gender pay gap and ensuring that NHS England and NHS Improvement develop policies and actions to reduce this, and reviews progress in increasing BME representation at senior levels within the organisation and initiatives relating to diversity and inclusion.

The Committee ensures that NHS England and NHS Improvement have a single formal, robust and transparent remuneration policy that is in line with Department of Health and Social Care's (DHSC) Executive and Senior Manager Pay Framework for ALBs (DHSC's pay framework). The Committee considers and approves remuneration, benefits and terms of service for senior executives covered by DHSC's pay framework before submission to DHSC for approval. The Committee's role also involves employee remuneration and engagement matters.

The Committee meets in common with NHS Improvement's People, Remuneration and Nominations Committee and has delegated certain functions to the Executive HR Group. The Committee receives regular reports from the group and the sub-committees on cases considered and approved.

Committee members

Committee met three times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Michael Coupe (Chair)[74]	3/3	Non-Executive Director
Laura Wade-Gery	2/3	Non-Executive Director
Former members		
David Roberts CBE	1/1	Non-Executive Director, left on 30 June 2021
Lord David Prior	3/3	Non-Executive Director, left on 24 March 2022

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2021/22 these included the Chief People Officer and the Director of Human Resources and Organisation Development.

Principal activities during the year

Matters considered by the Committee included:

- updates on the implementation of the NHS People Plan, including in the context of Elective Recovery Programme
- considered initiatives to improve retention in the NHS
- considered proposals for workforce transformation and innovation
- considered NHS England's and NHS Improvement's response to the Kark review recommendations
- endorsed 'The Future of NHS Human Resources and Organisational Development' report.
- reviewed the NHS England and NHS Improvement staff survey results
- considered the NHS and NHS England's and NHS Improvement's Diversity and Inclusion Strategies, including the approach to diversity and inclusion
- approved, in line with DHSC pay framework, the remuneration and appointment of a number of senior executives
- approved, in line with DHSC recommendation, annual salary increases for executive senior managers (ESMs) and medical colleagues on local pay arrangements
- approved the publication of the NHS England and NHS Improvement gender and ethnicity pay gap reports.

During the year, the Committee established a sub-committee, the Approvals and Appointments to assist with the appointments, remuneration and tenure of chairs of ICSs and the appointment of the ICS chief executive by the ICS chair. The sub-committee consists of the Committee Chair, the COO and two Regional Directors (rotating annually).

[74] Michael Coupe took over as the Chair of the Committee on 1 July 2021

Quality and Innovation Committee

Role of the committee

This Committee's primary role is to support the Board in ensuring that areas concerning patient safety, the quality of care provided to patients and patient experience are continuing to improve and develop to meet the needs of patients in England. In doing so the Committees will ensure strategies are continually improving quality, safety and experience of care. The Committee meets in common with NHS Improvement's Quality and Innovation Committee.

Committee members

The Committee met four times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Prof. the Lord Ara Darzi of Denham (Chair)	2/4	Non-Executive Director
Aidan Fowler	3/4	National Director of Patient Safety
Dr. Timothy Ferris[75]	3/4	National Director of Transformation
Rakesh Kapoor[76]		Non-Executive Director
Ruth May	4/4	Chief Nursing officer
Prof. Stephen Powis	4/4	National Medical Director/NHS Improvement Chief Executive
Patient and Public Voice members	4/4	

Committee attendees

Additional attendees are invited to attend meetings to assist with committee business. For 2021/22 these included the Director of Clinical Policy, Quality and Operations, Director for Experience, Participation and Equalities, and the Head of Quality Strategy.

Principal activities during the year

A large part of the Committee's remit is to monitor and determine whether the NHS is maintaining and improving the quality of patient care and health outcomes within the context of delivering The NHS Long Term Plan. In doing this, matters considered by the Committee included:

- lessons and actions from independent reviews into maternity services, including recommendations in the Ockenden Review
- considered updates on the Maternity Transformation Programme and governance and oversight arrangements for maternity services
- considered the impact and lessons learned from the COVID-19 pandemic
- considered proposals for strategic oversight of NHS quality issues and performance

[75] Dr. Timothy Ferris took up the role as the National Director of Transformation from 10 May 2021 and was appointed an executive member of the Committee from 19 May 2021.

[76] Rakesh Kapoor's directorship was temporarily transferred from NHS England to NHS Improvement on 1 May 2021 and his Committee membership was transferred on the 19 May 2021 to NHS Improvement's Quality and Innovation Committee.

- considered updates on the implementation of the NHS Patient Safety Strategy and related systems
- considered patient safety improvements, and training and education impacting on patient safety across systems
- reviewed the quality risks and associated mitigations.

Other items considered included:

- regular updates from the Executive Quality Group and National Quality Board
- the development of an NHS quality dashboard
- patient experience, from hearing personal accounts.

System Oversight Committee

In August 2021, the System Oversight Committee, which meets in common with NHS Improvement's System Oversight Committee was formed. Together they ensure a consistent approach to oversight of integrated care systems and their constituent organisations, including determining appropriate support where required to organisations and systems in order for them to improve population health outcomes and address health inequalities. This assists the Board with their formal intervention powers, including deciding on entry into and exit from the Recovery Support Programme and segment 4 of the System Oversight Framework (SOF). It also provides strategic oversight of transactions and investments involving clinical commissioning groups and their system partners.

Committee members

Since its inauguration, the Committee met six times and the following table details membership and attendance:

Members	Number of eligible meetings attended	Comment
Prof. Steve Powis (Chair)	6/6	National Medical Director/ Chief Executive of NHS Improvement
Ronke Akerele	3/6	Director of Culture Transformation (deputising for Chief People Officer)
Mark Cubbon	5/6	Chief Delivery Officer (interim Chief Operating Officer from August 2021 to Dec 2021)
Ian Dodge	2/6	National Director: Strategy and Innovation
Iain Eaves	6/6	Director of Planning and Oversight
Dr Timothy Ferris	3/6	National Director of Transformation
Sue Holden	5/6	National Director of Improvement/Director of Intensive Support for Challenged Systems
Julian Kelly CB	1/6	Chief Financial Officer
Alex Kirkpatrick	6/6	Interim Director of Provider Development
Matthew Neligan	6/6	Director of System Transformation
Peter Ridley	5/5	Deputy Chief Financial Officer - Operational Finance (from October 2021)
Simon Rogers	6/6	Deputy Director of Legal (non-voting)
Sir David Sloman	2/3	Chief Operating Officer (from Dec 2021)
Seven Regional Directors of Strategy and Transformation		

Committee attendees

In addition, the Executive Director of Performance and Deputy Chief Financial Officer (Strategic Finance), were also invited to attend these meetings.

Principal activities during the period

- updates on the implementation of the SOF for 2021/22, including segmentation
- at recommendations made by the regions, approval for a number of organisations and systems to enter into or exit the Recovery Support Programme
- updates on the implementation of the Maternity Safety Support Programme and its alignment with the Recovery Support Programme
- oversight of and support levers for independent providers of NHS services, including quality governance and finance, sustainability of services, and financial oversight of commissioner requested services
- development of the NHS Oversight Framework for 2022/23
- the approach to Use of Resources assessments for 2022/23 and for the future, linking to the Care Quality Commission's rating approach
- revised guidance on assuring and supporting complex change: Statutory and other transactions, and complex provider governance arrangements.

Board disclosures

NHS England and NHS Improvement's joint working arrangements involve the exercise of statutory functions of the organisation's constituent bodies in an aligned way under a single operating model. Directorates and teams within the structure may be performing both NHS England and NHS Improvement functions. NHS England, Monitor and NHS TDA however remain separate bodies with distinct statutory roles and responsibilities. In some cases, the functions and decision-making of those bodies must remain independent and separate, to ensure compliance with the bodies' respective statutory functions and/or to avoid inherent conflicts of interest that would arise if the functions were exercised by the same part of the organisation ('functional conflicts'). In addition, even where a standing separation of functions is not required, the exercise of different functions by the same directorate or team may give rise to an actual or potential conflict in an individual case ('operational conflicts').

NHS England and NHS Improvement must ensure the effective discharge of their respective statutory functions in accordance with public law principles and be able to identify and manage the risk of conflict (real or perceived) appropriately and transparently.

To manage this, the bodies have a Separation of Functions and Conflicts of Interest policy which provides guidance for staff on managing functional and operational conflicts. This policy is not concerned with the declaration and management of personal interests held by individuals. Such conflicts continue to be dealt with in accordance with the Standards of Business Conduct policy which applies to the NHS as a whole.

Register of Board members interests

Personal interests held by Board and Committee members is managed by the NHS England Standing Orders, NHS Improvement Rules of Procedure and the Standards of Business Conduct policy. The organisation also maintains a register of members interests to ensure that potential conflicts of interests can be identified and addressed before Board and Committee discussions. Board members and executives are also required at the commencement of each Board and Committee meeting to declare any personal interest they might have in any business on the agenda and abstain from relevant Board or Committee discussion as required. Where potential conflicts arise, they are recorded in the Board and Committee minutes along with any appropriate action to address them. Any interests declared are then recorded on the register and signed off by the Board and executives on a regular basis. A copy of the register of interest is available on our website

Details of related party transactions, where NHS England has transacted with other organisations during the year to which a Board or an executive is connected, are set out in Note 19 on page 195.

Directors' third-party indemnity provisions

NHS England has appropriate directors' and officers' liability indemnification in place for legal action against, among others, its executive and non-executive directors. NHS England did not indemnify any director during 2021/22.

Human rights

NHS England and NHS Improvement support the Government's objectives to eradicate modern slavery and human trafficking. A joint NHS England and NHS Improvement Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 was published on our website[77] in March 2022. Our strategy on tackling fraud, bribery and corruption can be found on our website[78].

[77] https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-13.2-slavery-and-human-trafficking-statement.pdf
[78] https://www.england.nhs.uk/publication/tackling-fraud-bribery-and-corruption-economic-crime-strategy-2018-2021/

Disclosure of personal data-related incidents

NHS England and NHS Improvement follow the NHS Digital Data Security and Protection incident reporting process guidance in the reporting of incidents. This is in line with data protection legislation (UK General Data Protection Regulation (GDPR)).

The guidance [79] sets out the reporting requirements for NHS organisations where a potential or an actual incident may lead to a personal data breach defined under the Data Protection Act 2018 and UK GDPR. The scoring criteria references the circumstances where notification to the Information Commissioner's Office (ICO) may not be necessary and has resulted in a reduction in the number of incidents classified as notifiable over recent years.

As at 31 March 2022, a total of three notifiable incidents had occurred relating to the loss of personal data. Incidents are logged and a full investigation is undertaken. Unless otherwise stated in the tables below, remedial actions were implemented for all incidents and the ICO kept informed as appropriate.

Summary of incident	Date of incident	Nature of incident	Number of individuals affected	How patients were informed	Lessons learned
Four copies of a case file concerning a patient's eligibility for Continuing Healthcare funding following an Independent Review Panel which was in the process of being sent from a printing company back to an NHS England employee via a courier service failed to arrive.	08/12/21	Lost in transit	1	Letter	Transition to digital service should negate the requirement to use printing companies or couriers for this purpose. In the interim where printing and onward transfer is required increased verification with each company involved in the process has been implemented.
A Courier company used by PCSE had a service centre broken into resulting in a number of patient records obtained from a GP practice being unaccounted for and presumed stolen	18/12/21	Theft	4	Letter	PCSE investigated. Medical records to be reconstructed. The courier service has reissued guidance on secure storage of patient records received from GPs to its sites and PCSE will update audit checklist and ensure audits of courier sites completed annually.
Hard copy notes extracted from a patient's medical record sent to NHS England complaints team by a GP Practice in connection with a complaint were reportedly delivered to the NHS England site but were not received by the complaints team	28/02/22	Lost in transit	1	Letter	Local NHS England site's process for receiving mail sent by recorded delivery reviewed and updated

[79] http://www.dsptoolkit.nhs.uk?Help/29

Directors' responsibility statement

The Annual Report and Accounts have been reviewed in detail by NHS England's ARAC and Board. At each point it has been confirmed that the Annual Report and Accounts, taken as a whole, are considered to be fair, balanced and understandable. They provide the information necessary for NHS England's stakeholders to assess the business model, performance and strategy.

Events after the reporting period

On 1 July 2022, NHS Improvement was abolished and a number NHS Improvement's non-executive directorships were transferred to NHS England:

Professor Sir Munir Pirmohamed, Jeremy Townsend and Rakesh Kapoor's temporary non-executive directorships with NHS Improvement came to an end and their directorships were transferred back to NHS England on 1 July 2022. On the same day, Sir Andrew Morris's directorship was also transferred to NHS England.

Sir David Behan, who served as an associate non-executive director on the NHS Improvement board from February 2019 to June 2022 and on the NHS England Board from July to end of August 2022, was appointed as a Non-Executive Director on the NHS England Board on 1 September.

Lord Ara Darzi stepped down from the NHS England Board on 30 June 2022.

In May 2022, the NHS England Board approved a revised Board governance framework and details of the new framework will be provided in the 2022/23 Annual Report and Accounts.

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health and Social Care (with the consent of HM Treasury) has directed NHS England to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS England and of its income and expenditure, statement of financial position and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual (HM Treasury, December 2021)[80] and in particular to:

- observe the Accounts Direction issued by DHSC, including 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 Government Financial Reporting Manual, have been followed and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis
- confirm that the Annual Report and Accounts are fair, balanced and understandable, and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that they are fair, balanced and understandable.

The National Health Service Act 2006 (as amended) schedule A1 paragraph 15(4) states that the Chief Executive shall be the Accounting Officer of the National Health Service Commissioning Board (known as NHS England). The responsibilities of the Accounting Officer, including responsibilities for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding NHS England's assets, are set out in Managing Public Money (HM Treasury, July 2013, as amended March 2022).[81]

As the Accounting Officer for NHS England, I have taken the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS England's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements.

[80] https://www.gov.uk/government/publications/government-financial-reporting-manual-2021-22
[81] https://www.gov.uk/government/publications/managing-public-money

Governance statement

This governance statement covers NHS England, its system leadership role of the NHS, directly commissioned health services, and oversight and assurance of the commissioning system.

As Accounting Officer, I have responsibility of the system of internal controls supporting and enabling the achievement of NHS England's aims and objectives, while safeguarding the public funds and assets for which I am personally responsible in accordance with Managing Public Money and as set out in my Accounting Officer appointment letter. This includes assurance of a number of organisations which are part of the wider commissioning system, including those organisations hosted by NHS England. My responsibilities in relation to the assurance of CCGs are set out from page 91.

Board arrangements

Information on our Board and its Committees is set out from page 63.

NHS England's and NHS Improvement's joint operating model

NHS England and NHS Improvement established a joint operating model in 2019 to work together to deliver both nationally agreed and locally owned priorities to improve health and patient care.

The Health and Care Act 2022 has introduced several structural changes for the NHS, most notably creating ICSs as NHS statutory bodies and formally abolishing Monitor and NHS TDA, transferring their functions into NHS England. As ICSs mature, the balance of activities that take place nationally, in regions and in ICSs will shift in line with the principle of subsidiarity and accountability for delivery will increasingly sit with systems, supported by the new NHS England. The future NHS England operating model has been designed to reflect this direction of travel and will continue to adapt as ICSs mature. By working in a more integrated way at all levels we will deliver better outcomes for patients, better value for taxpayers and better job satisfaction for our staff.

Freedom to speak up

Our report on whistleblowing disclosures made by NHS workers is published on our website.[82]

[82] https://www.england.nhs.uk/ourwork/freedom-to-speak-up/whistleblowing-disclosures/

Governance arrangements and effectiveness

Governance framework

The Governance Manual brings together all key strands of governance and assurance; including Standing Orders, Standing Financial Instructions (SFI), Scheme of Delegation, Standards of Business Conduct Policy, Risk Management Framework and the three lines of defence model. Separate operating frameworks exist for each CSU.

Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017 Compliance Checklist

As part of implementing best practice, an assessment is undertaken each year against the Corporate Governance in Central Government Departments: Code of Good Practice 2017 (HM Treasury). NHS England is compliant against the provisions of the code, with the following exceptions[83]:

Ref	Code provision	Exception
4.7	Through the Board Secretariat, the Department provides the necessary resources for developing the knowledge and capabilities of Board members, including access to its operations and staff.	This responsibility is shared between the Chair, the Chief Executive's private office and Board Secretary.
4.11	The Board Secretary's responsibilities include: Arranging induction and professional development of Board Members.	This responsibility is shared between the Chair, Chief Executive's office and Board Secretary.
5.5	The Head of Internal Audit is periodically invited to attend Board meetings, where key issues are discussed relating to governance, risk management, or control issues across the department and its ALBs.	The Head of Internal Audit routinely attends meetings of the ARAC.
5.9	The Board and Accounting Officer should be supported by an ARAC, comprising at least three members.	ARAC is comprised of at least two non-executive board members. The Committee meets in common with NHS Improvement's ARAC and consequently there are in total four non-executive directors involved in deliberations. The majority of business considered by the Committee is joint NHS England and NHS Improvement business.

[83] It should be noted that the following provisions in the code are not applicable to NHS England: Sections 1, 2.3, 2.11, 3.3a, 3.3b, 3.3c, 3.6e, 3.7, 3.8, 3.9, 3.14, 3.19, 4.9, 4.12, 4.13, 4.14, 5.7, 5.8 and 6.

Corporate assurance

The NHS corporate assurance framework, set out below, provides for continuous and reliable assurance on organisational stewardship and the management of significant risks to organisational success and the delivery of improved, cost-effective, public services.

Assurance activity	How does it add value?
Organisational change framework Guidelines for assessing and implementing major changes across the organisation.	The framework provides a consistent approach to thinking about the impact of organisational change, including on people, infrastructure, financial and legal issues.
Risk management framework Our approach to managing risk, including tools and methodologies for identifying, assessing, documenting, and reporting risk.	The framework enables a consistent approach to be taken across the organisation, allowing identification of cross-directorate risks and challenges. It provides a mechanism for managers to identify risks with a route of escalation to those accountable.
SFIs, Scheme of Delegation and Standing Orders These documents protect both the organisation's interests and officers from possible accusation that they have acted less than properly.	Together, these documents ensure that our financial transactions, accountabilities and responsibilities are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.
Programme management framework The policies, tools, methodology and resources that provide an approach to managing, controlling and assuring the delivery of projects and programmes in the organisational portfolio.	Provides staff with a framework to manage, control and deliver projects and programmes. Provides the organisation with consistency of reporting and monitoring, confidence of delivery of outcomes to enable decision-making and better resource control.
Third-party assurance framework Guidelines for the assurance required for managing third-party contracts.	Ensures directorates responsible for major contracts assign a contract manager and put arrangements in place to monitor supplier performance. Obtains assurance over the services provided.
Corporate policy framework The methodology and approach for creating, maintaining and amending policies.	Provides an approach to help ensure policy documents are not developed in isolation, so they are balanced against the priorities of the organisation.

We work with the support of both our internal and external auditors to strengthen and embed our assurance framework. Each directorate and region have designated leads with responsibility for ensuring that risk management, implementation of internal audit actions and other key assurance activities are carried out and approved by the relevant senior director, including appropriate regular reporting and exception escalation processes. The leads link with the governance, audit and risk teams to provide increased focus, accountability and improved communication at operating level across the organisation.

During 2021/22, the corporate governance and compliance team have worked with teams across the organisation to embed controls and underpin processes including by:

- in line with the Standards of Business Conduct Policy ensuring that officers undertook Staff Declarations and Assurance Certifications despite the pressures on teams through responding to the COVID-19 pandemic
- targeted interventions with teams to ensure the timely completion of priority 1 actions arising from internal audit reviews.

Management assurance

Throughout 2021/22, the Board has been provided with regular performance updates on the implementation of the priorities and programmes committed to in the NHS Long Term Plan. The report integrates performance against constitutional standards, NHS Long Term Plan commitments and workforce and quality metrics.

In addition, the ARAC considers the outcomes of internal audit reviews of programmes and the Strategic Risk Group reviews our corporate risks, which can include causes, consequences, controls, and actions relating to individual programmes.

Underpinning the above corporate governance arrangements, individual programme boards and oversight groups meet frequently, with the attendance of representatives from national and regional teams, each with responsibility for delivery of their programme, for example UEC and primary care etc.

Assuring the quality of data and reporting

The Board has agreed the information it requires in order to carry out its duties. The Board is confident that performance reports have been through appropriate management review and scrutiny and that reporting continues to evolve to meet changing organisational needs.

Risk governance

The NHS England and NHS Improvement Boards are responsible for ensuring delivery of the strategies and goals outlined in their business plan.

Detailed plans are drawn up for each area with input from staff, and risks against their achievement are reported to the Boards. The internal audit team consider the risks to NHS England and NHS Improvement, which in turn determines the internal audit priorities reflected in the annual internal audit plan.

NHS England's ARAC is responsible for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control covering NHS England's activities. The committee considers risks faced by the joint organisation on a quarterly basis and reports conclusions directly to the Boards. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives.

The internal audit team provides regular reports to the ARAC based on their work programme. The Boards discuss the most significant risks and actions identified to mitigate their likelihood and impact. Each year, the ARAC evaluates the effectiveness of the risk management framework and approves the annual internal audit plan for the following year.

In 2021/22, the position of Chief Risk Officer/ SRO for risk for NHS England and NHS Improvement was delivered by the Chief Financial Officer, to further ensure senior sponsorship for risk at executive level. In March 2022 this position moved to the Chief Delivery Officer.

The executive team owns the corporate risks and nominates a responsible officer for each one. The approach is supported by the joint NHS England and NHS Improvement risk management framework which underpins the monitoring and management of risk.

The Strategic Risk Group is responsible for assuring the ARAC about how risks across the joint organisation are being managed. This group reviews the risks escalated to it and considers which risks should be managed through the Corporate Risk Register (CRR) and associated processes. The ARAC oversees implementation of NHS England's and NHS Improvement's joint risk management framework. The NHS Executive also periodically reviews the CRR and when appropriate undertakes in-depth review. The National Incident Response Board also considers the strategic risks in responding to the COVID-19 incident and these are fed into the CRR where relevant and reported to the NHS Executive.

Our executives are responsible for managing risk at a directorate/regional level (that is, at the project delivery and day-to-day operational level). Each directorate therefore also holds its own risk register and reviews its risks on a regular basis.

The joint risk management framework mirrors the three lines of defence of our overarching assurance framework.

Risk and control framework

In 2021/22 NHS England and NHS Improvement continued to embed their joint risk management framework to ensure that employees follow a single process for identifying and managing risks that may threaten delivery of services and achievement of objectives. This framework aligns with the overarching principles of HM Treasury's Orange Book and is informed by DHSC's risk management policy, ISO 31000 Risk management principles and guidelines, and the UK Corporate Governance Code.

In implementing the framework, our corporate risk function and directorate risk leads continued to share good practice, provide information on new and existing risks, and co-ordinate and support the embedding of an appropriate risk management culture. The quality of directorate risk registers continued to improve through 2021/22. We aim to continually improve our risk management maturity and risk culture year-on-year.

Principal risks

The CRR considers a full cross-section of risks to the organisations, including strategic, reputational, financial and operational risks, and risks to the achievement of the organisations' shared objectives and external threats. NHS England and NHS Improvement's principal risks in 2021/22 were:

Risk	Key mitigations in place
Future progression of COVID-19: If wider government action is unsuccessful, available NHS capacity could be exceeded during potential further waves. Care quality could be compromised.	• workforce capacity plans to activate when pre-agreed trigger points reached • surge capacity plans in place across all regions • Nightingale hospitals • Independent Sector support • tailored COVID-19 comms and deployment in communities with high prevalence.
Pandemic increases non-COVID-19 healthcare needs: Population outcomes impacted, some patients face longer waits and some NHS Long Term Plan deliverables may need rephasing.	• regular data-gathering and analysis to monitor and report service restoration and performance • clinically-led review of key themes to manage the 'demand capacity gap' • UEC Recovery Action Plan published in September 2021 to support actions on NHS 111, ambulance services, discharge and other domains, supporting a whole system recovery approach, incorporating a bespoke ambulance plan • elective recovery plan, including independent sector provision • continued push to deliver NHS Long Term Plan mental health commitments and investment of additional £0.5 billion in 2021/22 for mental health services.
Workforce capacity: The NHS workforce will not be sufficient to meet the challenges of the current pandemic, recovery in the NHS and the NHS Long Term Plan; particularly relevant in key staff groups.	• new supply: Existing commitments to 50,000 nursing manifesto, 6,000 GP and 26,000 additional roles in general practice. Focus on 111 recruitment • investment in international recruitment • workforce planning: to align activity, finance and workforce capacity • health and wellbeing interventions and psychological support via 40 mental health hubs • volunteers, reservists and the national retention programme.
Social care resilience and capacity: Social care provision may become more fragile due to local authority social care funding pressures and workforce shortages, resulting in unplanned pressures on frontline healthcare provision and timeliness of hospital discharge.	• 'Discharge to Assess' model and robust controls and oversight at ICS and regional level, with the option to escalate to national team for action • Better Care Fund guidance includes system discharge approach. The planning requirements for this were published in September 2021 • National Discharge Taskforce established to provide executive cross-agency oversight of hospital discharge processes, activities and improvement support.
Quality of care: Is part of multi-agency systems of regulation and improvement, NHS bodies and staff may not sufficiently prevent and respond to quality concerns.	• capacity and operational planning: elective recovery programme, 2021/22 priorities and operational planning guidance; clinical pathway transformation; co-ordinated national work on children and adolescent mental health services (CAMHS); additional investment in 111 and 999 call handling • quality surveillance: Revision of National Quality Board quality guidance for ICB structures; enhanced quality oversight of maternity services • patient Safety Strategy.
Data and digital security: Patient data could be misused and/or security compliance compromised, including through cyber-attacks. Appropriate data sharing ceases.	• new data strategy focuses on clarity, simplification, transparency and data/cyber security • NHS England and NHS Improvement meet the Data Security and Protection Toolkit (DSPT) standard • internal audit and corporate controls around the use of technology • NHSX hosting regular system-wide cyber drills to rehearse responses.
Supply mechanism: The fragility of suppliers and increased global demand affects price and availability across all NHS settings.	• align with DHSC, MHRA and other Government departments on regulatory easements to mitigate supply issues • established shortages management process in place to manage and mitigate against shortages • NHS England and NHS Improvement owned Supply Chain Coordination Ltd. responsible for managing the sourcing, delivery and supply of some healthcare products and services.

Risk appetite

In 2021/22 NHS England and NHS Improvement continued a joint approach to risk appetite, which we define as "the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives".

Our risk appetite is grounded in the NHS Constitution, which sets out the rights to which patients, the public and staff are entitled, and the pledges the NHS seeks to honour, together with the responsibilities the public, patients and staff have to one another to ensure the NHS operates fairly and effectively. We believe no risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of patients and taxpayers. Our approach to risk appetite inevitably involves risk trade-offs and a consideration of the counterfactual; this gives us the flexibility to try new things, make agile decisions and find a balance between boldness and caution, risk and reward, cost and benefit. It also provides a balance between an excessively bureaucratic and burdensome approach and one that lacks rigor.

We tolerate some risks more than others. For example, we seek to minimise avoidable risks to care quality and have a very low appetite for risk in this area, whereas for innovation or proof of concept we are prepared to take managed 'moderate to high risk' on the proviso that the following have been undertaken:

- an assessment of what and where the current risks are
- that the potential future impact has been understood and agreed
- rapid cycle monitoring is in place to enable swift corrective action should things go wrong
- consideration of the system's ability to respond (that is, different regions face different circumstances and some areas are very challenged)
- trade-off between risks and cost–benefit is understood/impacts on other risks have been assessed (that is, whether these will increase or decrease)
- cost–benefit analysis and preference stated
- consideration of the reliability and validity of data used to make the assessment
- consideration of the counterfactual risks to ensure any learning is applied before taking the risk
- significant and measurable potential benefits (that is, enhanced efficiency and/or value-for-money delivery).

Our risk appetite by category of risk

Category of risk	Risk appetite
Patient safety and quality of care	Very low
Operational performance (across the system)	Medium
Innovation	High
Financial	Low
Compliance and Regulatory	Medium
Reputation	Low
Operational delivery across NHS England and NHS Improvement	Medium

Quality oversight and assurance

Quality care is defined by the National Quality Board as care that is safe, effective, provides a personalised experience, and is well-led and sustainable.

All NHS organisations, including NHS England and NHS Improvement, have a statutory responsibility to continually improve the quality of services. Quality is therefore considered within all policy programmes and functions such as patient safety, improvement, specialised commissioning and the NHS Long Term Plan programmes (eg cancer and mental health) – where defined quality governance and management is in place to ensure the delivery of high quality care.

Assuring the quality of services

The NHS England and of NHS Improvement Boards have both established Quality and Innovation Committees to meet in common to support the discharge of each Board's respective duties and powers, and their combined responsibilities for quality; by securing continuous improvement in the quality of services and outcomes.

Assurance of quality functions and duties

The Quality and Innovation Committee seeks assurance from executives that robust mechanisms are in place to manage quality functions, including that quality risks and issues are managed at regional to national levels. It also receives reports and updates on relevant NHS England and NHS Improvement quality functions, programmes and initiatives. This includes statutory functions such as arrangements for safeguarding and controlled drugs; clinical effectiveness functions such as the commissioning of national clinical audits; patient safety functions and implementation of the patient safety strategy; and patient experience functions including complaints and surveys.

Quality improvement

A manageable number of quality indicators are selected to show national trends over time and provide a balance across the domains of quality (effective, safe and positive experience) and across care settings. The Quality and Innovation Committee uses high-level indicators aligned to the NHS Long Term Plan. When any of these selected indicators show significant deterioration or moderation in the rate of improvement, the committee discusses potential causes and directs a bespoke analysis. The Committee also conducts thematic reviews based on the above inputs and intelligence from members and in-depth analysis. This analysis is used to determine strategic actions to initiate/accelerate improvement.

The Boards also look at national improvement programmes, their models for improvement and how they are ensuring those improvements result in better outcomes for patients.

During the COVID-19 pandemic, NHS England and NHS Improvement adapted their quality and safety functions in a proportionate manner that maintained oversight of quality but gave

focus to the response to COVID-19. Regional medical directors and regional chief nurses are responsible for escalating issues to the Executive Quality Group (EQG), while also observing regional EPRR escalation processes. The EQG met virtually and continued to take regional reports.

Escalation of quality issues and sharing of learning

The committee facilitates the sharing of data and intelligence about quality risks and issues and of learning and best practice at national level. It is supported in this by regional routine reporting, which is filtered up through the EQG. This group is co-chaired by the National Medical Director and Chief Nursing Officer and brings together regional medical directors, regional chief nurses, directors of clinical quality and senior national colleagues, including the Directors for Patient Safety, Clinical Effectiveness, Patient Experience and Quality. This builds on the arrangements that have been in place for several years in NHS England and NHS Improvement prior to the joint working arrangements. The EQG receives routine quarterly reports from the regional teams and provides a forum to share intelligence and escalate quality risks. It takes collective action to address risks and issues raised by co-ordinating national and regional action and will escalate to the Quality and Innovation Committee if required.

Together the EQG and the Quality and Innovation Committee:

- oversee the identification and deployment of appropriate resources to tackle escalated quality risks and issues, and support quality improvement activities at national level
- provide a coherent governance structure in which quality risks can be escalated if required
- refer national cross-system quality risks and issues to the National Quality Board where appropriate
- share relevant and transferable learning gathered by national or regional teams.

Assurance of the commissioning system

Specialised commissioning

Specialised services support people with a range of rare and complex conditions. They often involve innovative treatments for patients with rare cancers, genetic disorders, complex medical conditions or surgical needs.

The specialised commissioning allocation was £20.7 billion at the end of 2021/22. Most of this allocation went towards nationally calculated NHS provider block contracts which were introduced as a part of an interim finance regime, due to COVID-19.

During 2021/22 the Specialised Commissioning and Health and Justice Strategy and Policy Group (SCHJSPG) set the strategic direction for specialised commissioning. Assurance was provided via reporting from the Specialised Commissioning and Health and Justice Delivery

Group (SCHJDG) over quality, performance and value for money, together with broader regional reporting mechanisms. The Clinical Priorities Advisory Group (CPAG) made formal recommendations on the commissioning position of treatments and interventions for adoption, or otherwise endorsed CPAG recommendations for prioritisation and in-year service developments.

Health and justice and sexual assault services

NHS England commissions healthcare for 112 adult prisons, immigration removal centres and the children and young people's secure estate. This includes primary care, dentistry, public health, optometry, podiatry and a range of other services. NHS England is also responsible for co-commissioning 47 sexual assault referral centres (SARCs) to support victims and survivors of sexual assault and abuse. While the strategic direction for these services is set at a national level via the Specialised Commissioning and SCHJSPG, commissioning responsibilities are discharged regionally.

During 2021/22, reporting from the SCHJDG provided assurance on quality, performance and value for money. The Health and Justice Governance Group, Health and Justice Clinical Reference Group, Children and Young People Governance Group, Non-custodial Partnership Advisory Group and Sexual Assault and Abuse Advisory Group made formal recommendations on the commissioning of services.

There was an ongoing focus on COVID-19 response management and vaccine delivery across secure and detained settings, ensuring outbreaks were contained and infections and deaths minimised. As part of a Government commitment to address hidden harms arising during the pandemic, we also launched a campaign[84] to raise awareness of SARCs and encourage victims and survivors to seek help.

In addition, work progressed on delivering the NHS Long Term Plan commitments:

- enabled by increased funding, 100% coverage of mental health treatment needs (an alternative to short custodial sentences) across England and Criminal Courts by 2024; nearly a third of the country was covered by March 2022
- to support care in custody, launch of the new patient registration function across male prisons and secure settings ensured clinicians in these settings have full access to patient clinical histories. This has been supported by the implementation of a health and justice safeguarding training programme to improve operational staff's understanding and knowledge of when to refer and escalate potential safeguarding issues and concerns
- for vulnerable prisoners moving back into the community, the rollout of RECONNECT care from the point someone starts a custodial sentence, with 33% of prisons covered by the end of March 2022.

[84] https://www.england.nhs.uk/2022/02/nhs-pledges-more-support-for-victims-and-survivors-of-sexual-assault-and-abuse-alongside-powerful-awareness-campaign/

Underpinning our work is the Health and Justice Inclusive Workforce Programme, which seeks to recruit those with lived experience into NHS roles, raise the profile of health and justice careers and reduce inequalities for the vulnerable patients we serve. We progressed the implementation of the Framework for Integrated Care (SECURE STAIRS) for the most vulnerable individuals in the children and young people secure estate, with all 17 sites quality assured via a collaborative multi-agency annual review and an associated independent evaluation of the framework.

Armed Forces health

Responsibility for Armed Forces commissioning is discharged nationally for individuals registered with a Defence Medical Services practice, and through CCGs for individuals registered with an NHS GP, such as the families of serving personnel and veterans. NHS England also commissions some bespoke services for veterans.

During 2021/22, assurance was provided via reporting from the SCHJDG and the Armed Forces Oversight Group on quality, performance and value for money. The Armed Forces Clinical Reference Group made formal recommendations on the commissioning of services.

Work has progressed on the delivery of the commitments set out in 'Healthcare for the Armed Forces community: a forward view'[85], which includes achieving national coverage of Op COURAGE: The Veterans Mental Health and Wellbeing Service, as well as mobilising additional support for veterans impacted by events in Afghanistan.

In response to findings from engagement in 2020 on the health needs of Armed Forces families, we launched three pilot single point of contact services to support this cohort access NHS services. Furthermore, we funded research into the health needs of mobile Armed Forces families to inform future care in this area and help remove disadvantage. Work also progressed on establishing fully functioning clinical pathways for the veterans' trauma network and social prescribing support, as well for veterans in the criminal justice system.

We continued to work closely with charities, such as supporting Fighting With Pride to develop standards for caring for veterans who identify as LGBT+, alongside ensuring our commissioned provider collaboratives include representation from this sector.

Lived experience is at the heart of everything we do, with our national Armed Forces Patient and Public Voice Group embedded in all of our work. This includes, for example, lived experience representation on the newly established Serving and Ex-Serving Women's Health Improvement Group to improve health and wellbeing outcomes during and post Service.

As part of managing the COVID-19 response, we continued to work with the Ministry of Defence to ensure full operational support across the NHS and support vaccination of the

[85] https://www.england.nhs.uk/wp-content/uploads/2021/03/Healthcare-for-the-Armed-Forces-community-forward-view-March-2021.pdf

serving population. Despite system pressures, rollout of the Royal College of General Practitioners and NHS England Veteran Friendly Practice Accreditation Programme continued, with almost 1,300 practices accredited by March 2021.

Co-commissioning of primary care services

Since 1 April 2021, all CCGs have had delegated arrangements for primary medical services. This has provided CCGs with the responsibility for the commissioning of general practice services and has been at the forefront of our vision to support more integrated care by ensuring local health and care leaders take collective responsibility for system performance and the transformation of care to improve population health, including general practice.

We confirmed in July 2021 our plans for giving ICBs delegated responsibility for direct commissioning primary care services and that will now proceed following the Health and Social Care Act . All ICBs will therefore assume delegated responsibility for primary medical services from 1July 2022. In addition to this some ICBs have chosen to take delegated responsibility for dental (primary, secondary and community), general ophthalmic services and pharmaceutical services from 1July 2022 as well, but all remaining ICBs will be expected to take on take on delegated responsibility for these services from April 2023.

Where NHS England delegates its functions to CCGs currently, it has, until the COVID-19 pandemic hit, obtained assurances that these functions are being discharged effectively. Ordinarily this would be through the national framework in place for the internal audit of CCGs' delegated primary medical care commissioning arrangements, providing information to NHS England on the running of this function and where it can be improved, which in turn provides aggregate information to support assurance and facilitate support for improvement where needed.

However, this framework has not been reintroduced following its necessary suspension during the pandemic to free up and prioritise management capacity to support the pandemic response, and in view of the need to review how NHS England assures across all primary care functions that will be delegated to ICBs. In view of reported high levels of assurance for delegated primary medical care commissioning from the original framework, we were confident this could be safely suspended, particularly with primary care commissioning committees being in place, which have further matured and continued the work that was previously reported on. In addition, our incident co-ordination structures established to respond to the pandemic provided opportunities for more regular feedback from CCGs on the discharge of their functions. NHS England has been working to review arrangements and will shortly introduce a new assurance framework for its delegated primary care commissioning functions.

Screening and immunisation

NHS England Public Health Commissioning and Operations commissions 11 screening programmes, 18 routine immunisation programmes and the seasonal influenza programme.

The Section 7A (S7A) agreement between NHS England and DHSC sets out the arrangements under which the Secretary of State delegates responsibility to the NHS England Board for commissioning certain NHS public health services, including:

- NHS national cancer and non-cancer screening services
- NHS national routine immunisation services in general practice and school age delivery
- CHIS including Red Book
- NHS SARCs (under Specialised Commissioning and led by the NHS England and NHS Improvement Health and Justice Commissioning Team)
- NHS Public Health services for people in secure and detained settings (under Specialised Commissioning and led by the NHS England and NHS Improvement Health and Justice Commissioning Team).

The key objectives of the S7A agreement for NHS England are to:

- commission high quality public health services, with efficient use of S7A resources, seeking to achieve positive health outcomes and to promote equality and reduce health inequalities
- implement planned changes in S7A services in a safe and sustainable manner
- meet the key performance indicators for the programmes.

Delivery of S7A NHS public health services depends on the joint operating model with the regions and good matrix working with other central directorate teams to deliver the ambitions in the NHS Long Term Plan around prevention, early diagnosis of cancer and reducing inequalities, as well as ensuring contractual and procurement arrangements are in place.

NHS England is held to account by ministers for delivery of its S7A responsibilities through established monitoring and accountability mechanisms.

Internal assurance is provided via the NHS England and NHS Improvement Public Health Oversight Group and informed by a suite of programme-specific boards for each screening, immunisations, flu and CHIS programme. The allocation for screening and immunisations in 2021/22 was £1.2 billion and £44 million of centrally held screening contracts were novated to NHS England and NHS Improvement from PHE in October 2021.

Sustainability and Transformation Partnership (STPs) and ICSs

In line with the NHS Long Term Plan commitment, 42 systems across England were designated as ICSs by 1 April 2021. Following a major engagement exercise, and learning from local partnership working during the pandemic, NHS England and NHS Improvement had recommended to government that these arrangements be placed on a statutory footing. Legislation, including measures to promote collaboration and integration across health and care, was introduced in July 2021 and received Royal Assent as the Health and Care Act in April 2022.

During 2021/22, we worked with system leaders and our national partners to prepare for the introduction of statutory ICSs, including the creation of ICBs, by 1 July 2022, and the associated closure of CCGs. This included co-producing the policy framework for ICSs with system leaders and stakeholders, initiating recruitment to designate ICB leadership roles, and supporting local leaders plan for transition to the proposed arrangements.

Commissioning support units

With a workforce of 7,300 people, CSUs delivered a range of support services to a number of organisations including ICS, CCGs, local authorities and non-NHS bodies. Their services have been independently assessed to ensure that the NHS receives the advantages of the benefits of scale. With expertise in transformational change, CSUs are at the forefront of system developments across the country.

Throughout the year the CSUs have been part of the national response to the COVID-19 pandemic and have supported the ongoing delivery of other health and care services. Being reliant on income for services delivered, CSUs must be responsive to the needs of their local health system as well as delivering against national priorities. They do this by developing innovative solutions to areas of support that includes managing waiting times, Information Communication Technology (ICT) services, data analytics, cyber security and transformation of local health systems.

As an integral part of the NHS, CSUs operate in accordance with good governance principles. Each CSU is led by a Managing Director who is accountable to NHS England for the performance and delivery of their CSU. This includes regular monitoring of CSU activity and the delivery of a monthly assurance statement to NHS England confirming adherence to appropriate governance processes and policies.

During the second half of the year, there was a consolidation of service delivery in London and there are now four NHS CSUs operating across the whole country. In 2021/22 CSUs once again achieved their financial targets.

Clinical commissioning groups

CCGs are clinically led and responsible for commissioning high quality healthcare services for their local communities. NHS England is accountable for assuring the commissioning system and has a statutory duty to assess the performance of each CCG every year to determine how well it has discharged its functions. On 1 April 2021, 38 CCGs merged to 9, reducing the total number to 106 (from 135 in 2020/21), each of which is an independent statutory membership organisation with an appointed accountable officer.

NHS England allocates a large proportion of the funding it receives from the DHSC to CCGs and supports them to commission services on behalf of their patients. In turn, CCGs are required to demonstrate probity and good governance in managing their finances and performance. Together, CCGs are responsible for approximately 76% of the NHS England budget.

Our assurance and oversight functions seek to ensure that CCGs are delivering the best outcomes for their patients and have a high standard of financial management, are administering resources prudently and economically and are safeguarding financial propriety and regularity. Increasingly, account has been taken of CCGs' performance within their system and of system-level performance. Parliament has provided for specified but limited rights of intervention by NHS England into CCG functions, such as the power to issue directions to CCGs under certain circumstances.

Legislation requires an annual assessment of performance to be carried out at an individual CCG level. NHS England has the option of using its statutory powers, conferred by section 14Z21 of the National Health Service Act 2006 (as amended), to support CCG improvement where a CCG is failing or at risk of failing to discharge its functions. Details of CCG directions can be found on our website.[86] 8 CCGs were reported by their auditors to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 due to forecasting that expenditure would exceed income during the financial year.

CCG annual reports

CCGs published their 2021/22 annual reports on their individual websites. A list of CCGs and links to their websites can be found on the NHS England website[87].

A review of the CCG interim governance statements found that comments from CCG internal auditors over the year primarily focused on 'quality and performance' and 'finance, governance and control', with the majority of control issues raised relating to delivery of performance targets in secondary care, referral to treatment times and achievement of

[86] https://www.england.nhs.uk/commissioning/regulation/ccg-assess/directions/
[87] https://www.england.nhs.uk/ccg-details/

financial balance. This is closely aligned with the issues highlighted by CCGs in their earlier exception reports.

The NHS England group account has been prepared using unaudited information for three CCGs (NHS North East Essex CCG, NHS Ipswich and East Suffolk CCG and NHS West Suffolk CCG) as their audit reports remain outstanding at the time of finalising this account due to irregularities with an exit package as shown in the losses and special payments disclosures on page 132. More information is also provided in note 1.3 to the consolidated financial statements on page 155.

SCCL

Ownership and responsibility for oversight of SCCL was transferred to NHS England from DHSC on 1 October 2021, to strengthen NHS England's ability to deliver savings in procurement, as committed in the NHS Long Term Plan. SCCL is a UK incorporated company and their Articles of Association include a range of matters reserved for shareholder decision. SCCL had a limitation of scope qualification on their 2020/21 account relating to inventory, as management were unable to provide all of the necessary assurance as part of the year end stocktake. New processes and controls have been implemented by SCCL to reduce the risk of reoccurrence in current and future financial years. The NHS England group accounts have been prepared using unaudited information for SCCL as the audit was not complete at the time of finalising the NHS England group accounts.

Timeliness of local accounts

In preparing the consolidated NHS England account we use financial information extracted centrally from the single integrated financial environment and other information from schedules submitted to us by group bodies. This is assured based on audited annual reports and accounts provided to us by each CCG, other than the three CCGs listed above.

We, and the Department of Health and Social Care, issue directions to our group bodies on the timing by which these should be submitted. In the current year the timeliness in submitting audited accounts for the commissioning sector has deteriorated. While the majority of commissioners were able to comply with the specified deadline, the number of late accounts for 2021/22 had an impact on the finalisation of these consolidated accounts. This also poses a significant risk to the ambition across the Departmental group to return to earlier finalisation of the NHS England group and DHSC group accounts in future years. We have worked with the audit community to agree a deliverable accounts timetable for 2022/23, recognising there are challenges associated with a greater number of health bodies in 2022/23 as a result of the mid-year changes in commissioning body arrangements, with many fewer bodies from 2023/24.

The timeliness of local accounts in the public sector is a matter under consideration in conjunction with other stakeholders including the Department for Levelling Up, Housing and Communities.

Other assurance

Cyber and data security

The Joint Cyber Security Unit provides the strategic direction for cyber security and works to strengthen cyber resilience across health and care, ensuring organisations comply with relevant standards, protect patient data and are able to respond effectively in the event of a data breach.

Working in partnership with NHS Digital and the National Cyber Security Centre, the strategy has been to increase central monitoring, assurance and regulation to hold organisations to account, whilst simultaneously centrally procuring services to assist local organisations to improve their cyber security posture and reduce overall risk. Over the past year, the programme has continued to increase the cyber resilience of the NHS.

During 2021/22 a total of 13 high severity cyber security alerts were issued by NHS Digital, with the most complex being the Log4Shell vulnerability in December 2021, which was one of the most serious IT vulnerabilities to have been discovered in recent history. Working with NHS Digital, significant improvements and enhancements have been made to the Respond to an NHS Cyber Alert Portal, improving the overall user experience.

In 2021/22 as part of the COVID-19 recovery phase the team worked with Regional Directors to reset an understanding of the cyber security risk across senior leaders. Chief Executive Officers from NHS organisations and system leaders were briefed on the current cyber security threat and key oversight actions for Boards to take.

Operational advice and instructions on improving cyber security resilience were issued to NHS organisations in March 2022, outlining priority actions to take to ensure that the NHS is prepared and ready to deal with any new or emerging threats.

Through the Unified Technology Fund, £26.9 million in capital funding was allocated to NHS organisations, which helped to address infrastructure weaknesses and increase their overall cyber resilience. In addition, a total of £5.7 million revenue funding was allocated to assist local NHS organisations with technical remediation. NHS England and NHS Improvement regional digital transformation teams worked with local organisations to identify priorities for available capital investment, ensuring the priorities were consistent with local plans for digital transformation.

NHS Digital's Cyber Security Operations Centre has benefitted from recent enhancements, giving it greater oversight and threat detection, through the integration of additional data and threat feeds to detect and protect against ransomware and COVID-19 phishing efforts. Protective monitoring services continue to be delivered to critical national services.

The Better Security, Better Care Programme, provides a range of tailored local and national support to help adult social care providers complete the DSPT, improving their overall data

and cyber security. The DSPT helps organisations understand their data and cyber security risks and measures their compliance with mandatory cyber standards relevant to their sector. Between March 2021 and March 2022, the number of adult social care providers completing the DSPT to at least Approaching Standards status almost tripled from 15% of providers to 43% of providers.

The Network and Information Systems Regulations have continued to be used to increase compliance in the NHS, specifically in relation to managing unsupported systems, and to improve responses to high severity cyber alerts.

The Cyber Associates Network (CAN), established in partnership with NHS Digital, continues to be the leading network for cyber security professionals working in the health and care sector. The CAN virtual conference events held in October 2021 were attended by more than 1200 members of the network, providing key opportunities for collaboration and knowledge sharing. The conference has been further supported by a series of technical briefing webinars throughout the year.

Information governance

Our IG operating model provides the framework for NHS England and NHS Improvement to remain compliant in relation to data protection, records management and information security activities.

The Corporate IG and the Transformation Directorate IG teams together supported NHS England and NHS Improvement's implementation of appropriate governance controls around the acquisition and use of data to manage the pandemic and to ensure all records are appropriately declared and retained. We provided advice and guidance to support the completion of data protection impact assessments, data processing agreements, data sharing agreements and provision of data notices associated, including for several high-profile initiatives:

- the COVID-19 Datastore and Foundry platform
- the OpenSafely Platform, which supports us to evaluate linked, de-identified GP data and support research associated with the pandemic
- the National Immunisation Management Service, which manages the vaccination service
- provision and acquisition of data under the Control of Patient Information Regulations 2002 notices, and transition away from the use of such notices
- the COVID-19 Vaccination Programme, including but not limited to COVID-19 Passport, Vaccine Data Resolution Service, Overseas Vaccine Data Service, Vaccine Contact Preference Service and cross-Border vaccination data flows.

The teams continued to support all other areas of NHS England and NHS Improvement work to ensure that business as usual processes and new programmes obtained and used data appropriately to support their work. They helped ensure that during the transition of PHE into

NHS England and NHS Improvement flows of data were maintained and migrated to comply with data protection legislation. The Getting It Right First Time programme ensures that NHS Improvement meets its statutory duties, while work on the NHS Improvement Model Hospital maintains improvement in practice. The NHS England and NHS Improvement Specialised Commissioning team is currently reviewing clinical registries, which requires intensive IG support as many pre-date UK data protection legislation.

The Corporate Records and Information Management team leads on the records management programme for the COVID-19 Programme Management Office, supplying advice and guidance to ensure records are available for this and other legal inquiries.

Business critical models

NHS England and NHS Improvement recognise the importance of quality assurance across the full range of their analytical work and have an approach that is consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government analytical models (2013). NHS England and NHS Improvement analysts are expected to ensure consistent performance and quality assurance across their analytical work. For business-critical models, where an error would have a significant patient care or other impact, NHS England and NHS Improvement operate a register of business critical models and audit of the quality assurance strategy associated with them, overseen by a committee of experienced analysts. To date all relevant NHS England and NHS Improvement models in the register have passed.

Service auditor reporting and third-party assurances

NHS England relies on a number of third-party providers (such as NHS SBS, NHS BSA, NHS Digital and Capita) to provide a range of transactional processing services ranging from finance to data processing. Our requirements for the assurance provided by these organisations are reviewed every year. Appropriate formal assurances are obtained to supplement routine customer/supplier performance oversight arrangements.

During 2021/22 service auditor reports were specifically commissioned to provide assurance over the operation of our control environment and we are working, where appropriate, with our suppliers to implement International Standard on Assurance Engagements (ISAE) 3402 or similar standards to make sure that the relevant internal controls and control procedures operated by our service organisations have operated effectively. Service providers are requested to address any control weaknesses identified during the ISAE 3402 reporting process within an appropriate timescale.

The service auditor reports commissioned for 2021/22 have been reviewed and where necessary action plans are being agreed to address any control issues identified. There are a limited number of other issues which service auditors have referred to in their opinion and these are being addressed by services providers as a matter of priority. The issues identified

are not considered to have a significant impact on the overall NHS England control environment.

Internal audit

The internal audit service plays a significant role in independently reviewing management controls, risk management, compliance and governance:

- reviewing key systems and processes
- advising managers on internal control implications of proposed and emerging changes
- guiding managers and staff on improvements in internal controls
- focusing audit activity on key business risks.

Our internal audit service, provided by Deloitte LLP, operates in accordance with public sector audit standards and to an annual internal audit plan approved by the ARAC. It reports regularly on the effectiveness of our systems of internal control and management of key business risks, together with recommendations for improvement by management (including an agreed timetable for action). The status of audit recommendations is reported to each meeting of ARAC. The Head of Internal Audit Opinion for 2021/22 is set out from page 102.

External audit

During the year, the ARAC has worked constructively with the NAO Director responsible for the NHS England audit and their team. The work of external audit sits outside our governance arrangements but independently informs our consideration of control, compliance, governance, and risk. The work of external audit is monitored by the ARAC through regular progress reports. These include summaries of the value for money work that is either directly relevant to our work or may provide useful insights to the committee.

Control issues

Managing third-party contracts

We have continued to roll out our approach to third-party contract management, based on Government Commercial Function guidance and methodologies for clarity of responsibility and accountability. We categorise our contracts to assign the appropriate resource and expertise to each, with a commercial contract manager working with the business contract manager. This enables us to manage risk and use central commercial expertise where necessary.

Our central Commercial team manages about 500 contracts worth almost £1.7 billion, and its approach was highly commended in the contract management category of the 2020 Government Commercial Function Awards. All members of the central Contract Management team have Government Commercial Function contract management accreditation. In line with the government's transparency agenda, we have started to publish quarterly key performance indicator (KPI) data for our gold/strategic contracts, and for better assurance we have migrated our contract management platform to join the pan-Health Family e-Commercial system. In 2021/22 we focused on building contract managers' capability and supporting the wider sustainability agenda.

Improving control processes for clinical off-payroll workers

From 01 April 2021, clinical off payroll workers whose status has been assessed as employed for tax purposes are now paid directly through payroll, to ensure compliance with HMRC tax and NI requirements.

Primary Care Support England performance management

Primary care support services are administration and payment services for the effective running of primary care. They are delivered by partner organisations: Capita Business Services Ltd and three commissioning support units.

The services:

- support over 40,000 GP practices, dentists, opticians and pharmacists
- pay over £10 billion each year to primary care providers for NHS services
- invite over 4.5 million women each year for NHS cervical screening
- process registrations for over 6 million patients joining or changing GP
- move 5.8 million patient medical records each year between GPs.

During 2021/22 we supported primary care to respond to the pandemic, for example by making vaccination payments and handling increased volumes of patient registrations and demographic changes.

We made further operational improvements delivering new software systems to reduce the level of risk associated with providing services. The PCSE contract saves the NHS over £30

million each year compared to the previous in-house arrangement, and we have decided to extend the contract until 2025.

The project to assure the quality of historical GP pensions data, held by PCSE and NHS Pensions, made significant progress, though work continues through 2022. One improvement was a new GP pensions and payments IT system introduced in June 2021.

Other system and service improvements include supporting NHS Digital to build replacement software systems for the NHS cervical screening programme and patient registration function. In 2021/22 the new patient registration function launched in male prisons and secure settings, giving clinicians full access to their patients' clinical histories to enable better care. A project is underway to remove the need for GPs to handle paper patient medical records. This requires new systems to maintain the continuity of electronic records and a new service to centrally manage paper records for GP practices. We expect to pilot our new approaches in 2022/23 ahead of introduction across England in 2023/24.

Improving control processes for accounting for accruals

During 2021/22 we have continued work to increase awareness of the requirement to ensure accruals are correctly accounted for. We undertook a lessons learned review on the sample errors identified on the 2020/21 financial statement audit to feedback to the NHS England regional entities and the CSUs. This also included guidance for NHS England regional entities and CSUs to consider when accounting for accruals for the 2021/22 year end. On a monthly basis a detailed review of significant manual accrual balances in NHS England has continued with requests for additional information where necessary. We implemented enhanced standardised data collection requirements to allow a detailed review of accrual balances for the month 9 and month 12 accounts preparation.

We have implemented further reconciliation controls on pharmacy and dental costs and are working on a wider ranging action plan to further strengthen controls in this area.

Improving controls on exit payments

To further strengthen authorisation and review controls surrounding severance payments made by CCGs, from 2021/22 onwards NHS England Regional leads are required to provide positive assurance statements confirming that CCG severance packages agreed in year meet the guidelines set down by HM Treasury and also any additional DHSC group requirements. There is a further requirement which took effect in 2022/23 for all CCG/ICB severance packages to be reviewed by NHS England Regional leads prior to agreement to ensure all required governance requirements are met.

Together, these controls provide the opportunity for completeness verification with records held by NHS England. As noted in the losses and special payments disclosures, in the accountability report from page 132, one CSU and five CCGs approved and paid special severance payments without following the required authorisation process directed by NHS

England in 2021/22 (3 in 2020/21). Due to the recent implementation of the additional controls noted above, we anticipate seeing improved compliance with severance payment processes in 2022/23.

Overpayments to medical practitioners

If a medical practitioner is suspended, they may be entitled to receive payments under the statutory regulations.

During the reporting period, NHS England identified payments to two medical practitioners beyond the entitlement period and sum respectively. This resulted in two overpayments equating to £964k as noted in the losses and special payment disclosures.

New management processes with regard to suspension payments helped to identify these payments, whereby incorrect application of the policy occurred, resulting in an overpayment and failure to cease suspension payments when the practitioner was no longer eligible.

NHS England has taken several steps to improve the internal controls of how suspension payments are managed. This includes implementing new procedural guidance that ensures that payments are not made to medical practitioners until entitlement to suspension payment is validated by a named responsible individual in the region. All regional leads now complete monthly monitoring of suspensions, their status and payments being made. There is further improvement to controls by reporting all current suspension payments monthly via a Professional Standards Oversight Group, which contains national medical representation, which allows for peer review and improves visibility of all current cases. A training process for regional leads has also been carried out with emphasis on the policy and its application.

Review of economy, efficiency and effective use of resources

Allocations

NHS England has responsibility for allocating the NHS funding agreed with DHSC as part of our mandate. Please see page 52, within the Chief Financial Officer's Report, for information on allocations.

Financial performance monitoring

In 2021/22 the financial position across the commissioning system was reported monthly using the Integrated Single Financial Environment system and supporting information collections. The financial position across NHS Providers was reported monthly using the Provider Financial Monitoring System and supporting information collections. This reporting has enabled a detailed monthly review by regional and national finance leadership teams, and the Chief Financial Officer (CFO).

Individual CCG, direct commissioning and provider financial performance is monitored against KPIs including balance sheet indicators, performance against efficiency plans and specific categories of COVID-19 expenditure, in addition to the reported forecast and year-to-date position.

We have aligned financial performance monitoring across commissioner and provider sectors. At all levels we assess the combined financial and operational position locally and nationally, resulting in joint reporting and review. Commissioner and provider positions are combined to review the performance of local systems in readiness for the statutory basis for ICBs in 2022/23.

The financial position of commissioners is consolidated and reported in the overall NHS England accounts. The provider positions, NHS trusts and foundation trusts, are not recorded in the accounts of Monitor or the TDA: these are reported as separate consolidations.

Cabinet Office efficiency controls

As part of the government's control of expenditure, we are subject to specified expenditure controls. These controls cover a range of expenditure categories and require proposed expenditure to be approved to secure best value for money and ensure efficiency is being maximised. For expenditure above certain thresholds in specified categories (including professional services and consultancy), onward approval is also sought from DHSC and for some cases this also requires approval from the Cabinet Office and/or HM Treasury.

During the COVID-19 pandemic, additional commercial guidance was issued internally in alignment with Cabinet Office guidance to ensure control and best value for money could be secured in a timely way. However, this process is now aligning with standard procedures as we transition out of the pandemic.

Counter fraud

NHS England and NHS Improvement directly employs a counter fraud team which investigates allegations of fraud related to our functions and ensures that appropriate anti-fraud arrangements are in place.

The Director of Financial Control has day-to-day operational responsibility for the NHS England and NHS Improvement counter fraud function, and the CFO provides executive support and direction.

The NHS Counter Fraud Authority (NHSCFA) undertakes an annual high-level estimate of the amount vulnerable to fraud, bribery and corruption, affecting the whole of the NHS, which the NHSCFA and its partners, including NHS England and NHS Improvement, hold the responsibility for tackling.

The ARAC receives updates regarding the counter fraud function. Counter fraud was the focus of a Deep Dive by the committee. This included reviewing the 2021 NHSCFA estimate

of fraud vulnerability, the 2020/21 Counter Fraud Annual Report, proactive counter fraud work and fraud investigations.

During 2021/22, NHS England and NHS Improvement have continued to work collaboratively with key partners such as the DHSC, NHSCFA, NHSBSA, NHS Digital and others, including law enforcement. A major focus of this work continued to be addressing fraud risks associated with the COVID-19 response.

Successful prosecutions arising from investigations undertaken by the counter fraud team were featured in two episodes of the BBC series *Fraud Squad*. This publicised the effective reactive work of the team to protect NHS resources.

Ministerial directions

On 29 March 2020 the Secretary of State wrote to NHS England confirming that the availability of funding would not be a barrier or cause delay to the actions that needed to be taken in response to the pandemic, even where this this would result in spending being in excess of formal delegated limits. This direction remained effective until the end of the 2021/22 reporting period.

On 8 January 2022, the Secretary of State wrote to NHS England acknowledging that, as we continue to respond to the COVID-19 pandemic, in particular the emergence of the Omicron variant, the need to protect NHS services and prevent a further reduction in NHS capacity are compelling reasons to justify increasing the use of available capacity in the independent sector[88]. This ministerial direction remained effective until the end of March 2022.

[88] https://www.gov.uk/government/publications/coronavirus-covid-19-ministerial-direction-on-independent-sector-contracting

Head of Internal Audit opinion

In the context of the overall environment for NHS England and Improvement for 2021/22, in my opinion the framework for governance in 2021/22 is effective.

The design of the risk management framework at the year-end provides the foundation of a framework to take the organisation forward during 2022/23.

With respect to the internal control environment, progress has been made in addressing open internal audit actions. On this basis, the framework for internal control has been appropriately implemented in the organisation through 2021/22, except for the need to address significant weaknesses in the control framework for clinical off-payroll workers, which NHS England and Improvement is aware of.

The recommendations raised by internal audit have been accepted by management, actions have been agreed to address these and considerable focus continues to be placed on the implementation of the actions in a timely manner.

The opinion is based on the underlying internal audit programme of work, designed to address the specific assurance requirements of the NHS England Board and focused on areas of risk identified by management. The planned internal audit programme, including revisions to the programme during the year, has been reviewed and approved by the ARAC. Results of internal audit work, including action taken by management to address issues included in internal audit reports, have been regularly reported to management and ARAC.

The COVID-19 pandemic has continued to result in a rapidly evolving risk environment during 2021/22. To enable internal audit to adapt to these changing circumstances, as in 2020/21, an initial six-month internal audit plan for 2021/22 was reviewed and agreed by the ARAC. The plan for the second half of the year was then updated considering the emerging risks and agreed by the ARAC in September 2021.

Some weaknesses in internal controls in core processes were identified and reported during the internal audit work completed during the year, which were assessed as being fundamental to the system of controls.

There remains significant reliance on third party providers of core services and there remains a requirement to further embed the contract management framework to obtain assurance over the delivery of services.

Summary

Over the year we have continued to build on our approach to governance, risk and internal controls and it is positive that internal audit actions are being closed in a timely manner. We remain committed to delivering improvements in the areas highlighted in the audit opinion and work is well underway to prepare for the legislative changes which will be enacted in 2022.

Remuneration and Staff Report

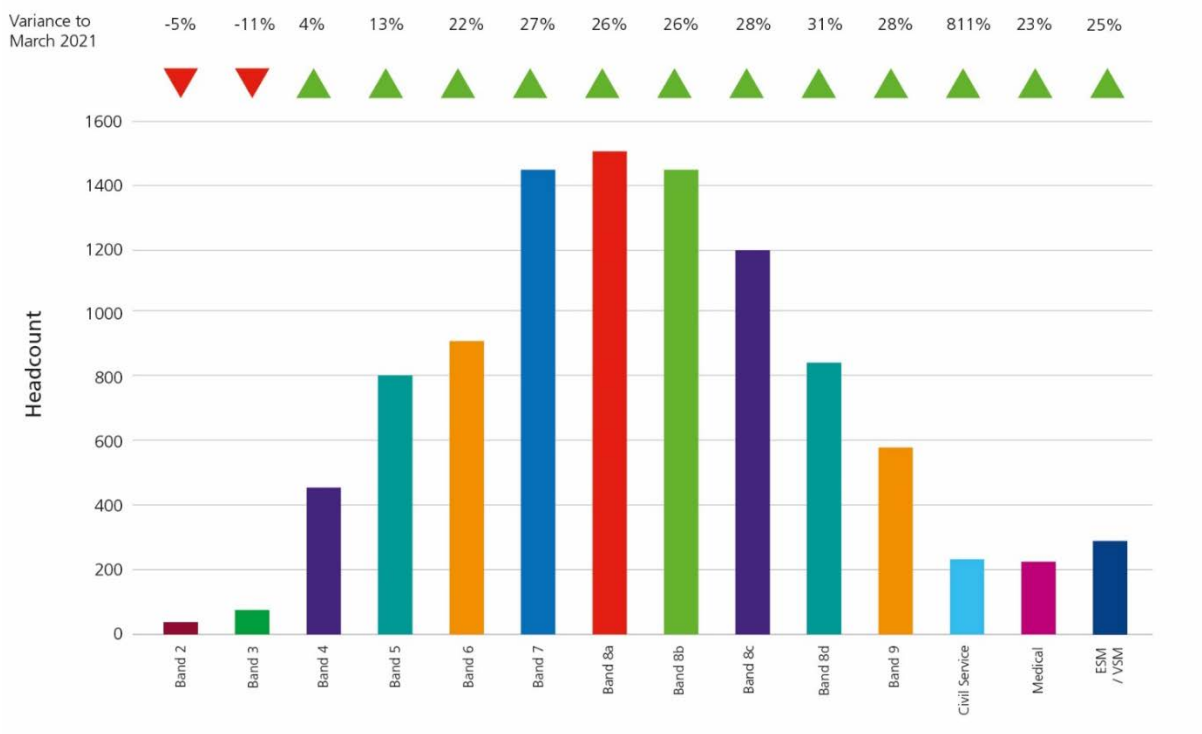
Our People

Our NHS People Plan[89] ambitions and values drive our workforce strategy, which aims for more staff working differently in a compassionate and inclusive culture. Alongside our People Plan, our NHS People Promise[90] sets out our pledge to one another of how we want to work together to improve the experience of working in the NHS for everyone.

Staff numbers

On 31 March 2022, NHS England directly employed 10,100 staff (9,495 full time equivalents). Of these, 8,853 were permanently employed, and 1,247 were employed on-payroll on fixed-term contracts of employment. A further 981 individuals were engaged in an off-payroll capacity which includes agency staff and secondees.

All staff by grade



Detail on staff numbers and costs for NHS England and the consolidated group, including CSUs, are presented from page 110. The chart above shows headcount by pay band as at 31 March 2022.

The headcount of permanent and fixed-term staff in NHS England increased by 21% since 2020/21.

The growth in headcount in NHS England can be attributed to several factors, including:

[89] https://www.england.nhs.uk/ournhspeople/

[90] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/

- setting up and recruiting to establish a new People Directorate function
- the transfer in of around 600 PHE staff in October 2021
- setting up and recruiting to establish a new NHSX function (now part of our Transformation Directorate)
- resourcing of priority programmes, for example, vaccinations to support the COVID-19 response
- In 2022/23, the NHS England Board has committed to reduce the size of NHS England by 30-40%.

Staff turnover

Turnover has increased in 2021/22 compared to 2020/21. Both headcount and the number of people leaving the organisation have also increased.

Staff turnover (%)

	April 2018 to March 2019	April 2019 to March 2020	April 2020 to March 2021	April 2021 to March 2022
NHS England	14.0%	13.2%	4.88%	9.65%
NHS TDA	14.9%	15.2%	4.65%	7.30%
Monitor	19.4%	29.5%	4.13%	11.58%
Total	**14.7%**	**14.0%**	**4.85%**	**9.32%**

NHS Digital, NHSX and Health Education England merger with NHS England and NHS Improvement

Following the announcement[91] from the Secretary of State on 22 November 2021 on bringing together NHS Digital, NHSX and HEE with NHS England, we're working closely with colleagues across all of the organisations. We want to ensure we bring together the vital enablers of workforce and digital with the functions of NHS England to support the transformation across the NHS to continually improve patient care and achieve the best possible outcomes for our population. The 'merger' is a complex programme of work and significant planning has taken place to date, with the first step of the merger of NHS England and NHS Improvement now complete. In 2022/23, the NHS England Board has committed to reduce the size of the combined organisation by 30-40%. At the very heart of our discussions is how we come together as an effective organisation, with the right vision, values and culture to deliver the very best for our patients, communities and people.

Employment policies

We have a range of employment policies to support our staff in line with our ambition to be an employer of choice. A priority for us in the last year has been to ensure that our policies align to government guidelines. During the pandemic we implemented 21 temporary policy

[91] https://www.gov.uk/government/publications/health-education-england-mandate-2022-to-2023/the-department-of-health-and-social-care-mandate-to-health-education-england-april-2022-to-march-2023

changes to support our staff working from home and keep them safe when coming into the office. These have been kept under regular review through our formal partnership working arrangements, with 14 temporary policy changes currently still live.

We continued to harmonise key employment policies across our three organisations, NHS England, TDA and Monitor, ahead of full merger helping us to ensure consistency in the way staff are managed and rewarded.

Partnership working

Partnership working with our trade unions is instrumental to help us shape and develop a range of support products for line managers and staff.

The National Partnership Forum, meets quarterly and provides strategic direction for other important subgroups which focus on specific issues, including Policy, Organisational Change, Equality and Diversity and the Health and Safety Committee. In addition, we have regional and corporate partnership forums to address any local issues, which can be escalated to the national partnership structure(s) if necessary.

Following the transfer of 600 staff from PHE in October 2021 we are also in the process of setting up a local negotiating committee, with the British Medical Association and British Dental Association to focus on areas relating to clinical staff, such as clinical excellence awards.

Equality, diversity, and inclusion

Workforce Disability Equality Standard

NHS England has an action plan to improve working conditions for people with disabilities, drawing on the Workforce Disability Equality Standard (WDES).

The first priority has been to increase the disability declaration level in the electronic staff record (ESR) as there is a large disparity between those who declare their disability status in ESR and the disability data collected as part of the annual NHS staff survey.

From April 2020 ESR showed 5.6% of our workforce declared a disability, whereas the staff survey (which is completed anonymously) showed that 19.9% of our workforce reported to have a disability. We have seen a small improvement to 6.1% of our people now declaring their disability status in ESR.

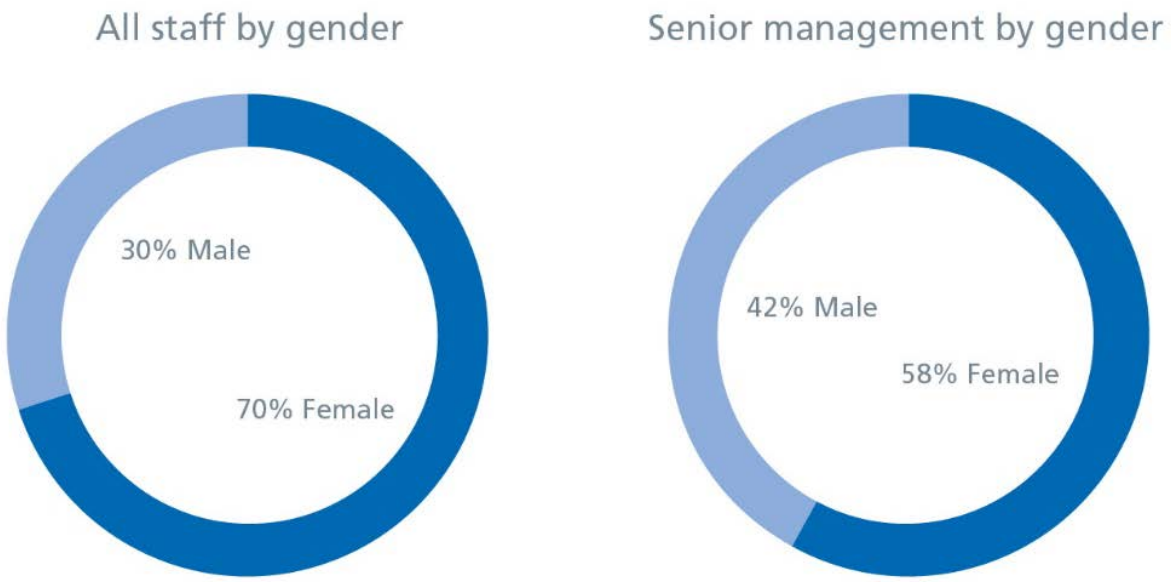
Stonewall Workplace Equality Index

NHS England and NHS Improvement submitted the Stonewall Workplace Equality Index[92] in September 2021, which was developed in partnership with our internal LGBT+ Staff Network. We placed 58 out of 403 employers (internationally) and 53 in England.

Gender of all staff and senior managers

The female gender profile of the total NHS England 'on payroll' workforce increased by 1% between 31 March 2021 to 31 March 2022. There has been a 1.3% increase in the number of female senior managers to 58%. The gender diversity of Board members is set out on page 58.

All staff and senior managers by gender



Gender pay gap

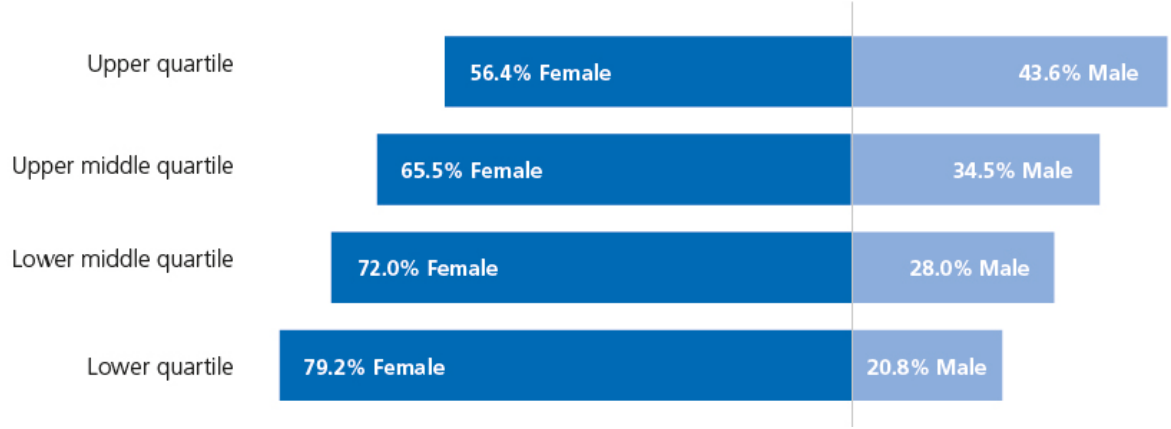
Based on the government's methodology, the mean gender pay gap across NHS England and NHS Improvement is 16.2%, an improvement from 16.7% the previous year.

Year	Mean gender pay gap
2021	16.2%
2020	16.7%
2019	18.3%
2018	19.5%

[92] https://www.stonewall.org.uk/full-list-top-100-employers-2022

Pay quartiles by gender in NHS England and NHS Improvement

The proportion of males and females in each pay quartile is detailed below, as of 31 March 2022. Women represent the majority of staff in the upper pay quartile.



Working in partnership with our recognised trade unions and our Women's Network we continue to progress initiatives which aim to address gender equality in our workforce.

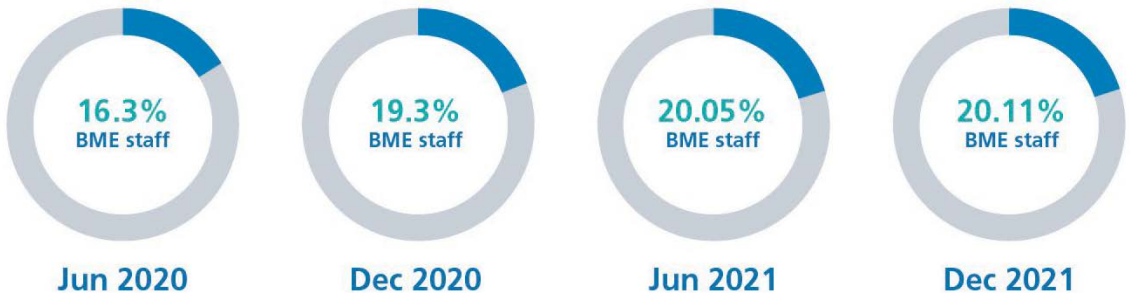
Our Gender Pay Action Plan includes specific priorities around recruitment practice, reward and recognition, flexible working, developing talent pipelines and intersectionality. The Gender Pay Gap Report is available on our website.[93]

Ethnicity of all staff and senior managers

19% black, Asian and minority ethnic aspirational target across all pay bands

In March 2020, we set a black, Asian and minority ethnic aspirational target to achieve 19% representation across all pay bands in the organisation by 2025. Since the target was set, there has been good progress as highlighted below.

Figures below show the overall percentage of BME staff and the change over the last two years:

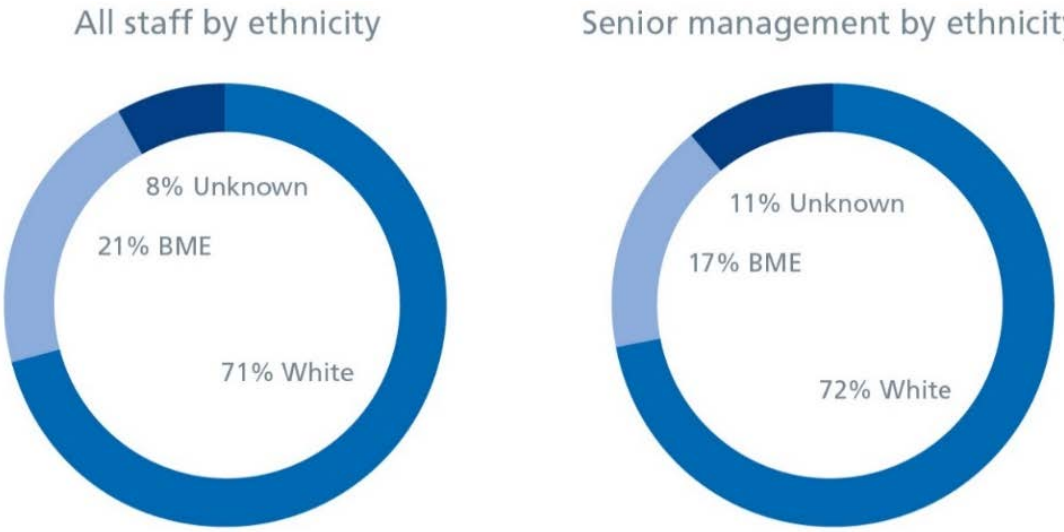


Our focus on BME talent is evidenced through proportionally more BME staff (20.43%) than white staff (15.81%) being promoted between January 2021 and December 2021.

[93] https://www.england.nhs.uk/publication/gender-pay-gap-report-2021/

The proportion of people employed by NHS England who consider themselves to be from a BME heritage has increased from 20% (in 2020/21) to 21%. The proportion of senior managers who identify as BME has also increased from 14% (in 2020/21) to 17%.

All staff and senior managers by ethnicity

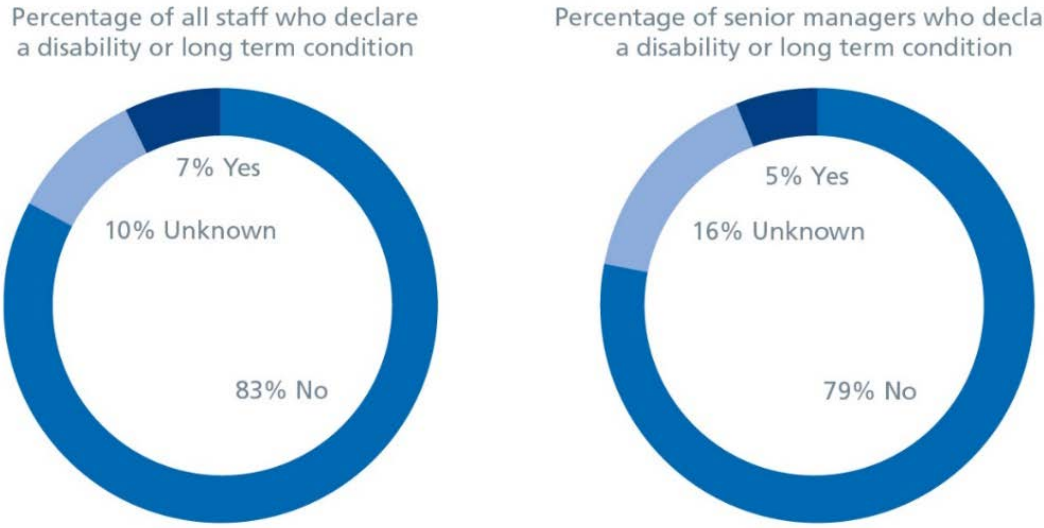


For information on board diversity please see page 58.

Declarations of disability or long-term conditions

We have continued to work with our Disability and Wellbeing Network (DAWN) to support employees. The percentage of staff who have declared a disability or long-term condition are given in the charts below.

Proportion of staff and senior managers declaring a disability or long-term condition

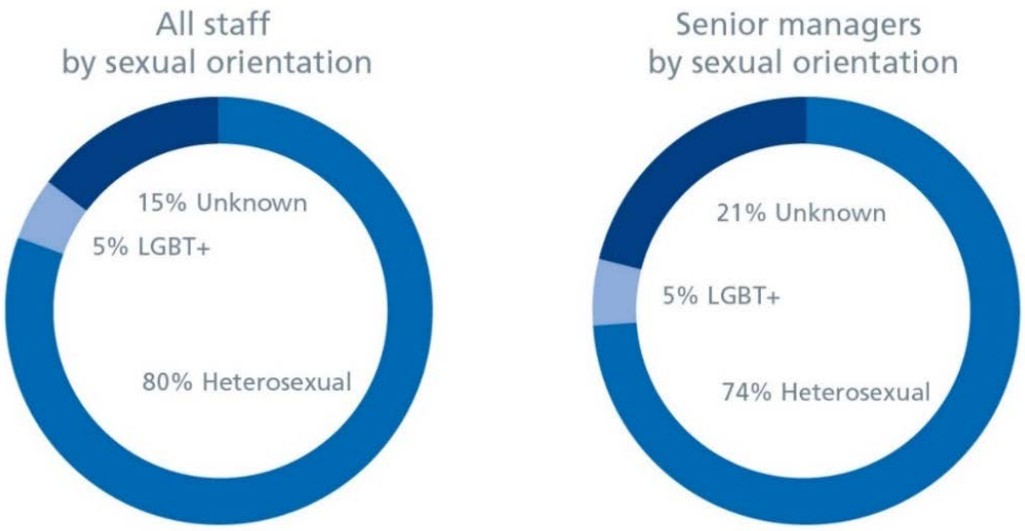


As a Disability Confident Employer, recognised by the Department for Work and Pensions, we continue to work towards fulfilling our commitments to employ more disabled staff, and support disabled staff to work, develop and progress.

Sexual orientation of staff and senior managers

The percentage of staff who disclose their identity as lesbian, gay, bisexual and transgender+ LGBT+ is given below.

Staff and managers by sexual orientation



Talent management and development

Our approach to apprenticeships continues to make progress with over 100 apprentices currently in training. We have partnered with NHS organisations in Leeds to create a cohort of data analyst apprentices who will be able to share experience and skills, so creating a future talent pool of a much-needed skill. We have 44 data analysts in training with the remaining apprentices focused on leadership and management disciplines.

Staff engagement and feedback

In addition to regular staff check-ins throughout the year we carried out a full staff survey during October 2021, with a response rate of 70%.

Trade union facility time disclosures

We have fulfilled our obligation under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for the year 2021/22 by reporting facility time data.[94]

a) Trade union representatives – the total number of employees who were trade union representatives during the relevant period:

Number of employees who were relevant union officials during the relevant period	FTE employee number
46	41.4

b) Percentage of time spent on facility time (duties and activities):

Percentage of time	Number of employees
0%	25
1-50%	20
51-99%	1
100%	N/A

c) Percentage of pay bill spent on facility time – the figures requested in the first column of the table below will determine the percentage of the total pay bill spent on paying employees who were trade union representatives for facility time during the relevant period:[95]

Description	Figures
Provide the total cost of facility time	£49,917
Provide the total pay bill	£751,640,622
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time – total pay bill) x 100	0.01%

d) Paid trade union activities – as a percentage of total paid facility time hours, how many hours were spent by employees who were trade union representatives during the relevant period on paid trade union activities:

Description	Figures
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by representatives during the relevant period ÷ total paid facility time hours) x 100	15.02%

[94] These activities cross NHS England and NHS Improvement, because the data cannot be split, we have provided a figure for both organisations.

Employee benefits and staff numbers (subject to audit)

Detail on staff numbers and costs for NHS England and the consolidated group, including CSUs, are presented in the following tables:

Average number of people employed

Parent	2021/22					2020/21				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	7,754	6,897	844	430	**15,925**	6,477	6,459	1,035	325	**14,296**
Of the above:										
Number of whole time equivalent people engaged on capital projects	-	-	-	-	-	-	-	-	-	-

Consolidated group	2021/22					2020/21				
	Permanently employed number	CSU employed number	Other number	CSU other number	Total number	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	27,777	6,897	2,814	430	**37,918**	25,188	6,459	2,546	325	**34,518**
Of the above:										
Number of whole time equivalent people engaged on capital projects	-	-	-	-	-	-	-	-	-	-

Employee benefits

Parent	2021/22					2020/21				
	Permanently employed	Permanent CSU employees	Other	CSU other	Total	Permanently employed	Permanent CSU employees	Other	CSU other	Total
Employee benefits	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	491,283	301,959	61,913	22,514	**877,669**	375,643	275,568	77,607	26,589	**755,407**
Social security costs	56,417	32,803	-	5	**89,225**	42,705	29,779	-	-	**72,484**
Employer contributions to NHS Pension Scheme	90,413	55,335	-	-	**145,748**	67,214	50,424	-	-	**117,638**
Other pension costs	-	7	-	-	**7**	-	-	-	-	**-**
Apprenticeship Levy	2,447	2,858	-	-	**5,305**	1,836	1,329	-	-	**3,165**
Other post-employment benefits	-	154	-	-	**154**	-	-	-	-	**-**
Termination benefits	542	705	-	-	**1,247**	(1,078)	751	-	-	**(327)**
Gross employee benefits expenditure	**641,102**	**393,821**	**61,913**	**22,519**	**1,119,355**	**486,320**	**357,851**	**77,607**	**26,589**	**948,367**
Less: Employee costs capitalised	-	-	-	-	**-**	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**641,102**	**393,821**	**61,913**	**22,519**	**1,119,355**	**486,320**	**357,851**	**77,607**	**26,589**	**948,367**
Less recoveries in respect of employee benefits	(274)	-	(32)	-	**(306)**	(464)	-	-	-	**(464)**
Total net employee benefits	**640,828**	**393,821**	**61,881**	**22,519**	**1,119,049**	**485,856**	**357,851**	**77,607**	**26,589**	**947,903**

Employee benefits

Consolidated group	2021/22					2020/21				
	Permanently employed	Permanent CSU employees	Other	CSU other	Total	Permanently employed	Permanent CSU employees	Other	CSU other	Total
Employee benefits	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	1,485,366	301,959	195,976	22,514	**2,005,815**	1,314,252	275,568	180,085	26,589	**1,796,494**
Social security costs	167,266	32,803	547	5	**200,621**	144,008	29,779	485	-	**174,272**
Employer contributions to NHS Pension Scheme	272,369	55,335	453	-	**328,157**	236,849	50,424	474	-	**287,747**
Other pension costs	1,147	7	-	-	**1,154**	254	-	-	-	**254**
Apprenticeship Levy	6,017	2,858	-	-	**8,875**	4,536	1,329	-	-	**5,865**
Other post-employment benefits	-	154	-	-	**154**	-	-	-	-	**-**
Termination benefits	3,814	705	-	-	**4,519**	5,826	751	-	-	**6,577**
Gross employee benefits expenditure	**1,935,979**	**393,821**	**196,976**	**22,519**	**2,549,295**	**1,705,725**	**357,851**	**181,044**	**26,589**	**2,271,209**
Less: Employee costs capitalised	-	-	-	-	**-**	-	-	-	-	**-**
Net employee benefits excluding capitalised costs	**1,935,979**	**393,821**	**196,976**	**22,519**	**2,549,295**	**1,705,725**	**357,851**	**181,044**	**26,589**	**2,271,209**
Less recoveries in respect of employee benefits	(11,810)	-	(32)	-	**(11,842)**	(7,765)	-	-	-	**(7,765)**
Total net employee benefits	**1,924,169**	**393,821**	**196,944**	**22,519**	**2,537,453**	**1,697,960**	**357,851**	**181,044**	**26,589**	**2,263,444**

CSUs are part of NHS England and provide services to CCGs.

The employment contracts or secondment agreements of almost all these staff are held for NHS England on a 'hosted basis' by the NHS BSA.

In October 2021 NHS England, the Parent, acquired 100% of the shareholding of Supply Chain Coordination Limited (SCCL). As a result, the assets, liabilities and ongoing operational income and expenditure form part of the NHS England consolidated group account from this date. There has therefore been a significant growth in income and expenditure year on year.

Sickness absence

Sickness absence for the period 1 January 2021 to 31 December 2021 was as follows:

	Whole time equivalent days available	Whole time equivalent days lost to sickness absence	Average sick days per whole time equivalent
NHS England	2,661,777	58,317	2.19%
CSU	2,355,893	56,730	2.4%
Total	**5,017,670**	**115,047**	**2.29%**

Exit packages, severance payments and off-payroll engagements

Expenditure on consultancy and contingent labour

Expenditure on consultancy is detailed in the Annual Accounts under Note 4: Operating expenses. NHS England and CSUs procured consultancy services worth £33.9 million during the financial year, an increase of £20.3 million since previous year (2020/21: £13.6 million).

Across the group, there was a total spend of £76 million on consultancy services during the period, against £52 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given in the employee benefits table on page 111, under the 'other' column.

Net expenditure for NHS England and CSUs in this area was £85 million in 2021/22, against £104 million in 2020/21. Across the group, there was a total spend of £220.5 million on contingent labour during the year, against £208 million the previous year.

Further detail on efficiency controls, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our governance statement from page 77.

Off-payroll engagements

NHS England and NHS Improvement are committed to employing a capable, talented and diverse on-payroll workforce to support the delivery of its business. It is recognised that in some specific circumstances the use of off-payroll workers, working alongside our on-payroll workforce, can be helpful. For some of our time-limited programmes, short-term contracts are appropriate. The following tables identify off-payroll workers engaged by NHS England as at March 2021.

Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2022, covering those earning more than £245 per day and staying longer than six months are as follows:

	NHS England (number)	CSUs (number)	SCCL (number)	Total (number) incl SCCL	Total (number) excl SCCL
Number of existing engagements as of 31 March 2022	106	142	93	341	248
Of which, the number that have existed:					
for less than 1 year at the time of reporting	41	127	45	213	168
for between 1 and 2 years at the time of reporting	18	14	27	59	32
for between 2 and 3 years at the time of reporting	40	1	17	58	41
for between 3 and 4 years at the time of reporting	7	0	4	11	7
for 4 or more years at the time of reporting	0	0	0	0	0

The majority of off-payroll workers that provide services to NHS England are clinical medical staff. All existing off-payroll engagements, outlined above, have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, assurance has been sought.

New off-payroll engagements

New off-payroll engagements or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months are as follows:

	NHS England (number)	CSUs (number)	SCCL (number)	Total (number) incl SCCL	Total (number) excl SCCL
Number of off-payroll workers engaged during the year ended 31 March 2022	164	430	93	687	594
Of which:					
Number not subject to off-payroll legislation	161	0	0	161	161
Number subject to off-payroll legislation and determined as in-scope of IR35	3	430	52	485	433
Number subject to off-payroll legislation and determined as out of scope of IR35	0	0	41	41	0
Number of engagements reassessed for compliance or assurance purposes during the year	50	0	0	50	50
Of which:					
Number of engagements that saw a change to IR35 status following review	0	0	0	0	0
Of which:					
Number of engagements that saw a change to IR35 status following review	0	0	0	0	0

Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2021 and 31 March 2022 are shown in the table below:

	NHS England (number)	CSUs (number)	SCCL (number)	Total (number) incl SCCL	Total (number) excl SCCL
Number of off-payroll engagements of Board members and/or senior officers with significant financial responsibility, during the financial year	0	0	0	0	0
Total number of individuals on-payroll and off-payroll who have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year	359	34	0	393	393

Senior officials are defined as those at pay grade ESM1 and ESM2, shown on the chart on page 103.

Details of exit packages agreed over the year are detailed in the following tables. All contractual severance payments were subject to full external oversight by DHSC.

Exit packages agreed during the year (subject to audit)

Parent	2021/22			2020/21		
	Compulsory redundancies	Other agreed departures	Total	Compulsory redundancies	Other agreed departures	Total
	Number	Number	Number	Number	Number	Number
Less than £10,000	1	1	2	3	2	5
£10,001 to £25,000	1	-	1	5	1	6
£25,001 to £50,000	2	-	2	3	-	3
£50,001 to £100,000	3	-	3	5	-	5
£100,001 to £150,000	1	-	1	2	-	2
£150,001 to £200,000	1	-	1	2	-	2
Over £200,001	-	-	-	-	-	-
Total	**9**	**1**	**10**	**20**	**3**	**23**
Total cost (£000)	**601**	**5**	**606**	**1,155**	**19**	**1,174**

Parent	Departures where special payments have been made		Departures where special payments have been made	
	2021/22		2020/21	
	Number	£	Number	£
Less than £10,000	1	5,256	-	-
Total	**1**	**5,256**	**-**	**-**

Consolidated group	Compulsory redundancies	Other agreed departures	Total	Compulsory redundancies	Other agreed departures	Total
	Number	Number	Number	Number	Number	Number
Less than £10,000	7	12	19	34	28	62
£10,001 to £25,000	7	10	17	28	21	49
£25,001 to £50,000	11	5	16	22	15	37
£50,001 to £100,000	4	4	8	14	14	28
£100,001 to £150,000	11	-	11	8	9	17
£150,001 to £200,000	7	4	11	12	6	18
Over £200,001	-	-	-	3	-	3
Total	**47**	**35**	**82**	**121**	**93**	**214**
Total cost (£000)	**3,319**	**1,424**	**4,743**	**6,110**	**4,303**	**10,413**

Consolidated group	Departures where special payments have been made		Departures where special payments have been made	
	2021/22		2020/21	
	Number	£	Number	£
Less than £10,000	3	19,902	-	-
£10,001 to £25,000	2	35,251	-	-
£25,001 to £50,000	2	61,128	3	114,032
£50,001 to £100,000	2	137,152	-	-
Total	**9**	**253,433**	**3**	**114,032**

Analysis of other agreed departures (subject to audit)

Parent	2021/22		2020/21	
	Other agreed departures		Other agreed departures	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	3	19
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HM Treasury approval	1	5	-	-
Total	**1**	**5**	**3**	**19**

Consolidated group	2021/22		2020/21	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	7	805	23	2,464
MARS contractual costs	1	90	32	631
Early retirements in the efficiency of the service contractual costs	-	-	3	236
Contractual payments in lieu of notice	19	276	35	839
Exit payments following Employment Tribunals or court orders	1	13	1	18
Non-contractual payments requiring HM Treasury approval	8	241	3	114
Total	**36**	**1,425**	**97**	**4,303**

As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number of exit packages will not necessarily match the total number in the table above.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of NHS England.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where NHS England and CCGs have agreed early retirements, the additional costs are met by NHS England or the CCG and not by the NHS Pension Scheme and are included in the

tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

Included in the non-contractual payments requiring approval are three payments made by CCGs that are irregular because they did not receive HM Treasury approval. Full details of the payments can be found in the losses and special payments note from page 132.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report.

People, Remuneration and Nominations Committee

Detail on the role and activity of the Strategic HR and Remuneration Committee is given in our Directors' Report on page 67.

Percentage change in remuneration of highest paid director (subject to audit)

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3.81%	0%

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS England in the financial year 2021/22 was £255,000 to £260,000 (2020/21: £255,000-£260,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

2021/22	25th percentile	Median	75th percentile
Total remuneration (£)	32,306	47,126	63,862
Salary component of total remuneration (£)	32,306	47,126	63,862
Pay ratio information	7.97:1	5.46:1	4.03:1
2020/21			
Total remuneration (£)	31,365	45,753	62,001
Salary component of total remuneration (£)	31,365	45,753	62,001
Pay ratio information	8.21:1	5.63:1	4.15:1

In 2021/22, no employees received remuneration in excess of the highest-paid director / member (2020/21: none). Remuneration ranged from £7,883 to £260,000 (2020/21: £7,883-£260,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on remuneration of senior managers

The framework for the remuneration of executive directors is set by DHSC through the ESM pay framework for ALBs.

It is NHS England and NHS Improvement policy to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience for the effective running of a more than £150 billion organisation, while recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for executive directors is undertaken by the People, Remuneration and Nominations Committees. Final decisions are made by the DHSC ALB Remuneration Committee and HM Treasury, where appropriate.

Performance related pay (PRP)

The PRP arrangements for national (executive) directors are set out in the ESM pay framework for ALBs. They follow guidance prescribed by DHSC and are in line with HM Treasury requirements. As a local policy decision, NHS England and NHS Improvement do not currently allocate any funding for PRP non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Strategic HR and Remuneration Committee and Nomination and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2021/22. Secondees are subject to the terms and conditions of their employing organisation.

Policy on senior managers' contracts

Contracts of employment for senior managers are open-ended and recurrent, unless otherwise specified. Notice periods follow the provisions of the ESM contract of employment, as applied by NHS England and NHS Improvement, of six months contractual notice. Termination payments are only able to be authorised where these are contractual and, subject to the value involved, may still require further approval from the DHSC Governance and Assurance Committee. Any proposed non-contractual special severance payment requires formal approval from the DHSC and HM Treasury.

Payments for loss of office (subject to audit)

No payments were made to any senior manager to compensate for loss of office in 2021/22.

Payments to past directors (subject to audit)

No payments have been made to past directors and no compensation has been paid on early retirement.

Senior managers' service contracts

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Sir Simon Stevens Chief Executive Officer	1 April 2014	6 months		Left NHS England on 31 July 2021
Amanda Pritchard Chief Operating Officer – Joint	1 August 2019	6 months		Left this position 31 July 2021
Amanda Pritchard Chief Executive Officer	1 August 2021	6 months		
Mark Cubbon Interim Chief Operating Officer – Joint	1 August 2021	6 months		Left this position 13 December 2021
Sir David Sloman Chief Operating Officer – Joint	14 December 2021	6 months		
Ian Dodge National Director for Primary Care, Community Services and Strategy – Joint	7 July 2014	6 months		
Dr Emily Lawson Chief Commercial Officer – Joint	1 April 2020	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Left this position 18 July 2021
Blake Dark Interim Chief Commercial Officer – Joint	1 August 2021	6 months		Left this position 31 December 2021
Jacqueline Rock Chief Commercial Officer – Joint	1 January 2022	6 months		
Professor Stephen Powis National Medical Director – Joint	1 March 2018	6 months		
Julian Kelly CB Chief Financial Officer – Joint	1 April 2019	6 months		
Ruth May Chief Nursing Officer – Joint	7 January 2019	6 months		
Prerana Issar Chief People Officer – Joint	1 April 2019	6 months		
Matthew Gould CMG MBE National Director for Digital Transformation – Joint	1 July 2019	6 months		
Dr Tim Ferris National Director of Transformation – Joint	10 May 2021	6 months		

The senior managers indicated as 'joint' in the above table were jointly appointed across NHS England and NHS Improvement (consisting of NHS TDA and Monitor). Full salary disclosures are included within the Remuneration Reports of all three entities and the costs are split equally between NHS England and NHS Improvement, with NHS Improvement costs being split at a ratio of 2:1 TDA-to-Monitor.

Remuneration (salary, benefits in kind and pensions) 2021/22 (subject to audit)

Name and title	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term Performance pay and bonuses (bands of £5,000)	(e) Pension-related benefits to the nearest £1,000	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Sir Simon Stevens Chief Executive Officer[95]	65-70	0	0	0	0	**65-70**
Amanda Pritchard Chief Executive Officer[96]	255-260	0	0	0	74	**330-335**
Mark Cubbon Interim Chief Operating Officer[97]	80-85	300	0	0	16	**95-100**
Sir David Sloman Chief Operating Officer[98]	65-70	1300	0	0	0	**65-70**
Ian Dodge National Director for Primary Care, Community Services and Strategy	170-175	0	0	0	0	**170-175**
Dr Emily Lawson Chief Commercial Officer[99]	65-70	0	0	0	0	**65-70**
Blake Dark Interim Chief Commercial Officer[100]	75-80	0	0	0	19	**95-100**
Jacqueline Rock Chief Commercial Officer[101]	55-60	0	0	0	13	**70-75**
Professor Stephen Powis National Medical Director	225-230	0	0	0	0	**225-230**
Julian Kelly CB Chief Financial Officer	205-210	0	0	0	50	**255-260**
Ruth May Chief Nursing Officer	180-185	0	0	0	33	**210-215**
Prerana Issar Chief People Officer	230-235	0	0	0	54	**280-285**
Matthew Gould CMG MBE National Director for Digital Transformation[102]	100-105	0	0	0	21	**120-125**
Dr Tim Ferris National Director of Transformation[103]	170-175	0	0	0	0	**170-175**

[95] On joining NHS England on 1 April 2014, Sir Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive, which would normally be within the range £215,000–£220,000. He continued with this voluntary reduction in pay during 2021/22 and until he left NHS England on 31 July 2021. The full year equivalent salary is £195,000-£200,000.

[96] During the period 1 April 2021 to 31 July 2021 the salary for Amanda Pritchard was recharged to NHS England and NHS Improvement from Guy's and St Thomas' NHS Foundation Trust where she was also formally employed and retained a post. From 1 August 2021 Ms Pritchard replaced Sir Simon Stevens as Chief Executive Officer for NHS England.

[97] Mark Cubbon replaced Amanda Pritchard as Interim Chief Operating Officer for the period 01 August 2021 to 13 December 2021. His salary was re-charged to NHS England and NHS Improvement from Portsmouth Hospitals NHS Trust, where he was also formally employed and retained a post. The full year equivalent salary is £225,000-£230,000.

[98] Sir David Sloman replaced Mark Cubbon as Chief Operating Officer on 14 December 2021. His salary was re-charged to NHS England and NHS Improvement from Royal Free London NHS Foundation Trust, where he was also formally employed and retained a post. The full year equivalent salary is £230,000-£235,000.

[99] Dr Emily Lawson left the position of Chief Commercial Officer on 18 July 2021. The full year equivalent salary is £230,000-£235,000.

[100] Blake Dark replaced Dr Emily Lawson as Interim Chief Commercial Officer for the period 01 August 2021 to 31 December 2021. The full year equivalent salary is £190,000-£195,000.

[101] Jacqueline Rock replaced Blake Dark as Chief Commercial Officer on 01 January 2022. The full year equivalent salary is £230,000-£235,000.

[102] 80% of the salary costs for Matthew Gould are recharged to NHS England and NHS Improvement from DHSC where he is also formally employed and retains a post. As such, the above figures disclose 80% of salary and pension benefits, with DHSC disclosing the remaining 20%. The full year equivalent salary is £125,000-£130,000.

[103] Dr Tim Ferris commenced in the joint post on 10 May 2021. 80% of the salary costs are recharged to NHS England and NHS Improvement from Mass General Brigham Inc. where is he is also formally employed and retains a post, with NHS England and Improvement directly funding the remaining 20%. The full year equivalent salary is £190,000-£195,000. Incorrect enrolment into the NHS Pension Scheme on commencement resulted in under-payment of salary during 2021/22 due to pension contributions being deducted from his salary in error.

Remuneration (salary, benefits in kind and pensions) 2020/21 (subject to audit)

Name and title	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term Performance pay and bonuses (bands of £5,000)	(e) Pension-related benefits to the nearest £1,000[104]	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Sir Simon Stevens Chief Executive Officer[105]	195-200	0	0	0	0	195-200
Amanda Pritchard Chief Operating Officer[106]	255-260	0	0	0	60	315-320
Ian Dodge National Director for Primary Care, Community Services and Strategy[107]	170-175	0	0	0	0	170-175
Dr Emily Lawson Chief Commercial Officer[108]	230-235	0	0	0	0	230-235
Professor Stephen Powis National Medical Director	225-230	0	0	0	0	225-230
Julian Kelly CB Chief Financial Officer	205-210	0	0	0	50	255-260
Ruth May Chief Nursing Officer[109]	180-185	0	0	0	91	270-275
Prerana Issar Chief People Officer	230-235	0	0	0	53	280-285
Matthew Gould CMG MBE National Director for Digital Transformation[110]	100-105	0	0	0	42	140-145

[104] The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.

[105] On joining NHS England on 1 April 2014, Simon Stevens voluntarily reduced his pay by 10% from the substantive rate of pay for the post of Chief Executive, which would normally be within the range £215,000–£220,000. Mr Stevens has continued with this voluntary reduction in pay throughout 2020/21.

[106] The salary for Amanda Pritchard is recharged to NHS England and NHS Improvement from Guy's and St Thomas' NHS Foundation Trust where she is also formally employed and retains a post.

[107] The position title for Ian Dodge was updated to National Director for Primary Care, Community Services and Strategy from 01 April 2020.

[108] Dr Emily Lawson commenced in the role of Chief Commercial Officer on 1 April 2020; immediately prior to that she held the role of National Director of Transformation and Corporate Development.

[109] Ruth May's Pension-related benefits in column (e) and Total in column (f) have been re-stated since the publication of the 2020/21 Annual Report and Accounts, following receipt of corrected 2020/21 pension disclosure values from NHS Pensions.

[110] 80% of the salary costs for Matthew Gould are recharged to NHS England and NHS Improvement from DHSC where he is also formally employed and retains a post. As such, the above figures disclose 80% of salary and pension benefits, with DHSC disclosing the remaining 20%. The full year equivalent salary is £125,000-£130,000.

Pension benefits (subject to audit)

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021[111]	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sir Simon Stevens[112] Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amanda Pritchard Chief Executive Officer and Chief Operating Officer	5-7.5	0-2.5	80-85	130-135	1,142	45	1,229	0
Mark Cubbon Interim Chief Operating Officer[113]	0-2.5	(2.5)-0	60-65	110-115	957	12	1,025	0
Sir David Sloman Chief Operating Officer[114]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ian Dodge National Director for Strategy and Innovation[115]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr Emily Lawson Chief Commercial Officer[116]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blake Dark Interim Chief Commercial Officer[117]	0-2.5	N/A	10-15	N/A	113	9	163	0
Jacqueline Rock Chief Commercial Officer[118]	0-2.5	N/A	0-5	N/A	0	6	14	0
Professor Stephen Powis National Medical Director[119]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Julian Kelly CB Chief Financial Officer	2.5-5	N/A	10-15	N/A	99	22	152	0
Ruth May Chief Nursing Officer	2.5-5	2.5-5	80-85	235-240	1,670	59	1,763	0
Prerana Issar Chief People Officer	2.5-5	N/A	10-15	N/A	98	20	151	0
Matthew Gould CMG MBE National Director Digital Transformation[120]	0-2.5	N/A	50-55	N/A	732	5	780	0
Dr Tim Ferris National Director of Transformation[121]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[111] As per previous submissions, the column Cash Equivalent Transfer Value at 31 March 2021 is the uninflated value whereas the real Increase in CETV is the employer funded increase.

[112] Simon Stevens chose not to be covered by the NHS Pension arrangements during the reporting year.

[113] Mark Cubbon covered this post on an interim basis for the period 01 August 2021 to 13 December 2021, therefore the Pension Benefits disclosed are pro-rata for this period.

[114] Sir David Sloman chose not to be covered by the NHS Pension arrangements during the reporting year.

[115] Ian Dodge chose not to be covered by the NHS Pension arrangements during the reporting year.

[116] Dr Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting year.

[117] Blake Dark covered this post on an interim basis for the period 01 August 2021 to 31 December 2021, therefore the Pension Benefits disclosed are pro-rata for this period.

[118] Jacqueline Rock commenced in post on 01 January 2022.

[119] Professor Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting year.

[120] 80% of the pension costs for Matthew Gould are recharged to NHS England and NHS Improvement from DHSC where he is also formally employed and retains a post. As such, the above figures disclose 80% of pension benefits, with DHSC disclosing the remaining 20%.

[121] Dr Tim Ferris was not eligible to be covered by NHS Pension arrangements during the reporting year.

Cash Equivalent Transfer Values (CETV) (subject to audit)

A CETV is the actuarially assessed capital 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 (or other allowable beneficiary'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 CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred into the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Policy on remuneration of non-executive directors

The remuneration of non-executive directors is set by DHSC on appointment and is non-pensionable. All non-executive directors are paid the same amount, except the Chair, Vice Chair and Chair of ARAC, to reflect the equal time commitment expected from each non-executive director. The Chair, Vice Chair and Chair of ARAC are entitled to higher amounts to reflect the increased time commitment associated with their respective roles.

Some non-executive directors, including the Vice Chair, have opted to waive their contractual remuneration. Non-executive directors do not receive PRP or pensionable remuneration.

Non-executive director service contracts

Name and title	Date of appointment	Unexpired term at 31 March 2022	Notice period	Provisions for compensation for early termination	Other details
Lord David Prior Chair	31 October 2018	0 months	6 months	None	Left NHS England 24 March 2022
Richard Meddings CBE Chair	25 March 2022	48 months	3 months	None	
David Roberts CBE Vice Chair	1 July 2014, reappointed to a second term on 1 July 2018	0 months	None	None	Waived entitlement to remuneration Left NHS England 30 June 2021
Wol Kolade Vice Chair	25 March 2022	24 months	None	None	Transferred from NHS Improvement to NHS England on 25 March 2022 and has waived entitlement to remuneration
Prof. Lord Ara Darzi Non-Executive Director	1 April 2020	3 months	None	None	
Jeremy Townsend Non-Executive Director	1 October 2020	18 months	None	None	Temporarily transferred to NHS Improvement on 25 March 2022 until 30 June 2022
Laura Wade-Gery Non-Executive Director	6 November 2020	16 months	None	None	
Rakesh Kapoor Non-Executive Director	1 January 2021	21 months	None	None	Temporarily transferred to NHS Improvement on 01 May 2021 until 31 March 2022
Susan Kilsby Non-Executive Director	1 January 2021	21 months	None	None	
Michael Coupe Non-Executive Director	1 January 2021	21 months	None	None	

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2021/22 (subject to audit)

Name of non-executive director	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term performance pay and bonuses (bands of £5,000)	(e) Pension-related benefits to the nearest £1,000[122]	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Lord David Prior[123]	60-65	0	0	0	N/A	60-65
Richard Meddings CBE[124]	0-5	0	0	0	N/A	0-5
David Roberts CBE[125]	0	0	0	0	N/A	0
Wol Kolade[126]	0	0	0	0	N/A	0
Prof. Lord Ara Darzi	5-10	0	0	0	N/A	5-10
Jeremy Townsend	10-15	0	0	0	N/A	10-15
Laura Wade-Gery	5-10	0	0	0	N/A	5-10
Rakesh Kapoor	5-10	0	0	0	N/A	5-10
Susan Kilsby	5-10	0	0	0	N/A	5-10
Michael Coupe	5-10	0	0	0	N/A	5-10

Salaries and allowances 2020/21 (subject to audit)

Name of non-executive director	(a) Salary (bands of £5,000)	(b) Benefits in kind (taxable) rounded to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term performance pay and bonuses (bands of £5,000)	(e) Pension-related benefits to the nearest £1,000[127]	(f) TOTAL (a to e) (bands of £5,000)
	£000	£s	£000	£000	£000	£000
Lord David Prior	60-65	0	0	0	N/A	60-65
David Roberts CBE[128]	0	0	0	0	N/A	0
Noel Gordon	5-10	0	0	0	N/A	5-10
Joanne Shaw[129]	10-15	0	0	0	N/A	10-15
Professor Sir Munir Pirmohamed[130]	0-5	0	0	0	N/A	0-5
Lord Ara Darzi[131]	5-10	0	0	0	N/A	5-10
Jeremy Townsend[132]	5-10	0	0	0	N/A	5-10
Laura Wade-Gery[133]	0-5	0	0	0	N/A	0-5
Rakesh Kapoor[134]	0-5	0	0	0	N/A	0-5
Susan Kilsby[135]	0-5	0	0	0	N/A	0-5
Michael Coupe[136]	0-5	0	0	0	N/A	0-5

[122] Non-executive directors do not receive pensionable remuneration and therefore have no pension-related benefits.

[123] Lord David Prior left NHS England on 24 March 2022. The full year equivalent salary remains at £60,000-£65,000.

[124] Richard Meddings CBE joined NHS England on 25 March 2022 and waived his entitlement to non-executive director remuneration. The full year equivalent salary is £60,000-£65,000.

[125] David Roberts CBE waived his entitlement to non-executive director remuneration and left NHS England on 30 June 2021.

[126] Wol Kolade joined NHS England on 25 March 2022 and waived his entitlement to non-executive director remuneration

[127] Non-executive directors do not receive pensionable remuneration and therefore have no pension-related benefits.

[128] David Roberts CBE has waived his entitlement to non-executive director remuneration.

[129] Joanne Shaw left NHS England on 30 September 2020. The full year equivalent salary is £25,000-£30,000.

[130] Professor Sir Munir Pirmohamed transferred to NHS Improvement on 6 November 2020.The full year equivalent salary is £5,000-£10,000.

[131] Lord Ara Darzi joined NHS England on 1 April 2020.

[132] Jeremy Townsend joined NHS England on 1 October 2020. The full year equivalent salary is £10,000-£15,000.

[133] Laura Wade-Gery transferred to NHS England from NHS Improvement on 6 November 2020. The full year equivalent salary is £5,000-£10,000.

[134] Rakesh Kapoor joined NHS England on 1 January 2021. The full year equivalent salary is £5,000-£10,000.

[135] Susan Kilsby joined NHS England on 1 January 2021. The full year equivalent salary is £5,000-£10,000.

[136] Michael Coupe joined NHS England on 1 January 2021. The full year equivalent salary is £5,000-£10,000.

Parliamentary Accountability and Audit Report

All elements of this report are subject to Audit

Remote contingent liabilities

There were no remote contingent liabilities

Notation of gifts over £300,000

NHS England made no political or charitable donations of gifts during the 2021/22 financial year

Regularity of expenditure: Losses and special payments

Losses 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 and are therefore subject to special control procedures compared to the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Details of any losses and special payments relating to CCGs can be found within individual CCG annual reports which are published on CCG websites. A list of CCGs, along with links to their websites, can be found on the NHS England website.

Losses

The total number of NHS England losses cases, and their total value, was as follows:

	Parent				Consolidated group			
	Total number of cases	Total value of cases	Total number of cases	Total value of cases	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	2021/22	2021/22	2020/21	2020/21	2021/22	2021/22	2020/21	2020/21
	Number	£000	Number	£000	Number	£000	Number	£000
Administrative write-offs	41	82	1	7	555	2,875	431	2,199
Fruitless payments	188	24,206	1,391	13,326	195	26,373	1,400	13,496
Stores losses	-	-	-	-	3	4	13	14
Bookkeeping losses	43	21	42	17	44	23	42	17
Constructive losses	1	383	2	15,186	2	384	2	15,186
Cash losses	22	22,033	55	31,594	28	22,065	60	32,491
Claims abandoned	2	395	16	262	96	4,746	31	309
Total	**297**	**47,120**	**1,507**	**60,392**	**923**	**56,470**	**1,979**	**63,712**

2021/22 Disclosure: Fruitless payments

£2.1 million. This case relates to a procurement challenge as a result of a breach of Procurement Contract regulations 2015. The breach is in relation to NHS England's incorrect application of a framework agreement which has resulted in a claim for damages for loss of a chance to provide services and legal costs incurred. The case was settled in favour of the claimant and is therefore reported to reflect the court outcome.

£17.8 million. This cost relates to a contractual amount to be paid by NHS England to exit a long-term contract for a university medical school where no future value to the entity is expected. The total represents the sum to be paid from 2023 to 2029. The cost represents a stream of funding for medical schools funding which began in 1988 when it was provided by the Regional Health Authority as part of a national policy to fund clinical academic posts. The funding and governance have passed through numerous organisations and oversight committees across the period as the NHS evolved through regular structural changes. The accrual of £17.8 million is representative of an unpaid discounted future cost that is payable to the Universities, however, any final settlement will need to be approved by Treasury.

£6.2 million. This payment made by NHS England to HMRC is for back taxes, national insurance and related interest for the historical treatment of a cohort of clinical workers who have been paid in an off-payroll capacity. The workers should have been paid as "employed" for tax purposes. This sum is in the process of being settled by NHS England.

2021/22 Disclosure: Constructive losses

£383k included in the parent figure for NHS England relates to provision of enemas to support the Bowel Scope Screening programme. The manufacturer of the enema products decided to cease manufacturing the enema product as it was not one of their main areas of business. It was agreed to bulk order 2 years' worth of the enema product to give time for either another product to be sourced or a decision to be made on the future of the Bowel Scope programme in light of the bowel screening age extension. Due to the bulk order in 2019, there was a large element of unused enema products that were out of date and not required due to the impact of COVID-19 on activity and decommissioning of the bowel scope service.

2021/22 Disclosure: Cash losses

£4.2 million. This relates to the review of the GP Contract Vaccinations and Immunisations programmes within NHS England. The outcome of the review confirmed that some contractors could not meet the vaccination targets that were set in relation to routine childhood vaccination and immunisation, therefore, resulted in an overpayment. The vaccinations and immunisations repayment mechanism is intended to limit financial gain by practices with lower levels of performance. Having reviewed a large volume of commissioner

and practice queries, it became apparent that practices were struggling to meet the performance threshold. The main reasons for this are issues outside of a practice's control such as increased vaccine hesitancy, people either not coming forward when invited or declining, less ability to opportunistically offer vaccination when children are present in practice for another reason and the COVID-19 pandemic has impacted on practice capacity.

£15.7 million. This cost relates to pharmacy cash advances paid by NHS England as decided and directed by DHSC. At the start of the COVID-19 pandemic community pharmacies faced significant and unexpected cash flow pressures. These were caused by several issues, including a sharp increase in prescription items in March and April 2020, higher drug prices, delayed payments for the Pharmacy Quality Scheme and extra COVID-19 related costs. The government decided and agreed to provide an urgent uplift to the normal advance payments to support pharmacies with their cash flow pressures and to help them stay open to continue to provide vital NHS pharmaceutical services. The cash advances were made on the basis that payments would be recovered from Pharmacies in 2021/22, however a significant number of pharmacy contractors closed down between April 2020 and March 2022 making recovery of the advanced sum infeasible.

£964k. This relates to two suspended GPs within NHS England that had salary overpayments, one due to being ineligible for suspension payments and one due to being paid more than they were entitled to. Recovery of £473k of the £964k is being pursued as part of an ongoing criminal investigation, the remainder is not able to be recovered due to legal advice that estoppel would be applicable. New management processes with regard to suspension payments helped to identify these payments. These new processes have improved controls and are intended to prevent recurrence of such cases. Actions such as a new payment mechanism and authorisation procedures have been implemented along with training on application of the suspension payment rules.

£1 million relates to an overpayment made on a contract with an independent sector service provider in response to the COVID pandemic. NHS England has reached an agreement to recover the full amount in due course. Having made this agreement, the service provider made a repayment of £82.5k and went into administration by October 2022. Measures have been implemented within NHS England to prevent recurrence of such cases.

2021/22 Disclosure: Claims abandoned

£382k relates to Dentaris (a dental provider) that went into liquidation 21st April 2020. The provider owed money relating to 2017/18 and 2018/19 underperformance of activity on the contract. The company was dissolved at Companies House on 21st April 2021, and no creditor will receive any dividend in respect of monies owed from Dentaris. The practice closed without prior notification to NHS England. Until the closure, the practice and NHS England had agreed a repayment plan for the moneys owing, which had been agreed to

support the practice to remain open and therefore supportive of patients continuing to receive care.

2020/21 Disclosure: Fruitless payments

Included within the parent loss table above are the following fruitless payments:

- £160k of payments were made in respect of administration costs for cancelled events in 2020/21 as a direct consequence of COVID-19 restrictions
- a fruitless payment to HMRC of £3.2 million for taxation and national insurance relating to the misclassification of the employment status of off payroll workers
- payments of £9.9 million relating to the acquisition of COVID-19 priority drugs by the Commercial medicines team using letters of intent, which committed the organisation to the payment for those drugs. The value relates to surplus amounts of those drugs.

2020/21 Disclosure: Constructive losses

This total cost is made up of the following:

- £13 million. This cost relates to emergency beds that were procured for the Nightingale hospitals at the beginning of the pandemic and includes storage costs. These were bespoke beds for field hospitals and the order made was based on the demand projections at the time. After the closure of the nightingale hospitals, it was deemed that the beds could not be used in any other existing hospitals as the specifications were not to the current standard as implemented in all hospitals. These beds are now subject to renewed plans for redeployment to the new field hospitals
- £2.2 million. This cost represents 301 ultra-low temperature freezers, which have been deemed as surplus to requirements. At the start of the COVID-19 vaccination programme 440 ultra-low temperature freezers were procured for the storage of the Pfizer vaccine. This was an unprecedented situation, with critical timelines to support the response to the pandemic and the national vaccine programme. The quantity was determined from modelling designed to safeguard against a rapidly growing global demand which was placing pressure on the supply of these freezers. At that time, these freezers were crucial to the successful storage and delivery of the vaccine based on the supplier's specification for storage of this particular vaccine.

2020/21 Disclosure: Cash losses

Included within the parent loss table above are the following cash losses:

- £1.6 million represents a payment made to an independent service provider. This is classified as an overpayment as the basis of the payment was not on contractual terms, i.e. the service was part of an ongoing tendering process by NHS England. NHS England has taken the appropriate steps to recover the overpaid sum as part of an ongoing process with NHS England legal representatives. This case has been brought to the attention of DHSC only, as part of the initial consultation process, before approaching HM Treasury

- £28.4 million represents GP seniority payments made to GP partners based on individuals' years of NHS reckonable service, that were paid to the GP practice on a quarterly basis.
  The payments were calculated based on the GP annual estimated income. This determined whether the GP received payment in full or if the payment was abated to 60%. Prior to the commencement of the Capita PCSE contract in 2015 there was inconsistency in the approach to adjustments across the regions, meaning that reconciliation exercises and payment adjustments may not have routinely been undertaken by all areas. This resulted in GPs receiving payments not aligned to entitlement. Reconciliation exercises to determine GPs correct level of entitlement resulted in the overpayments figures that have been reported as part of the cash losses for the year.

NHS England's service management team is currently seeking legal advice to determine the appropriate actions to take, in order to ensure recovery of the overpaid sums. The main issues being considered are:

- how to recover the overpaid sums from GPs when the payments were made to the GP practices
- application of The Limitation Act in relation to the payments made long ago
- the assessment of whether the GPs are still in service in order to enable recovery.

This consultation process remains ongoing with the legal team. Once it is concluded NHS England will ensure that DHSC and HM Treasury are consulted in order to seek the appropriate approvals.

- £585k represents a cash loss incurred relating to a rental dispute for a GP premises, where NHS England were reimbursing the notional rent on a building fully owned by the GPs. It was later established that the information supplied to assure the payment was disputed leading to NHS England deeming the payment was made in error
- £915k represents transformation funding that was claimed under a new model of care Vanguard project between April 2015 and March 2018. NHS England engaged with an audit firm to establish the level of overclaims. As part of the ongoing mediation process it was agreed that whilst an amount of £5 million would be recovered, a sum of £915k would not be pursued due to the fact that the service provider claims NHS England should pay its outstanding invoices of £4 million on the basis that there are no overclaims.

Included within the group loss table are the following cash losses:

- £316k. A case declared by NHS Walsall CCG in respect of under-performance on out of hours and urgent care services for the first two years of the contract with the provider. The CCG were subsequently advised that the provider had gone into administration and recovery of the debt became unlikely
- during 2020/21 a number of irregular payments were identified by Harrow CCG. These are currently subject to further investigation. These payments total £564k and occurred

over the accounting periods 2018/2019 to 2020/21, with £93k of the total relating to 2020/21. The full £564k is included in the 2020/21 column of the consolidated group table above.

Special payments

The total number of NHS England special payments cases, and their total value, was as follows:

	Parent				Consolidated group			
	Total number of cases	Total value of cases	Total number of cases	Total value of cases	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	2021/22	2021/22	2020/21	2020/21	2021/22	2021/22	2020/21	2020/21
	Number	£000	Number	£000	Number	£000	Number	£000
Compensation payments	1,008	311	1	50	1,013	353	9	126
Compensation payments Treasury approved	-	-	3	2,259	1	32	79	2,502
Extra contractual payments	-	-	1	92	1	1	3	202
Ex gratia payments	475	314	3	39	488	409	14	258
Ex Gratia Payments Treasury Approved	-	-	-	-	1	18	-	-
Extra statutory extra regulatory payments	-	-	-	-	-	-	2	1
Special severance payments - Treasury approved	-	-	-	-	1	57	-	-
Special severance payments	1	5	-	-	6	167	3	114
Total	**1,484**	**630**	**8**	**2,440**	**1,511**	**1,037**	**110**	**3,203**

All cases classified as special severance payments are subject to HM Treasury approval

2021/22 Disclosure: Ex gratia disclosure

During the year three CSUs paid ex gratia payments to current and former employees in relation to monies received from NHS Fleet Solutions relating to refunds of VAT obtained as a result of the decision in the Northumbria Healthcare NHS Foundation Trust v HMRC on salary sacrifice lease cars of £314k.

2021/22 Disclosure: Special severance payments

There was one Treasury approved special severance payment as follows:

NHS Surrey Heartlands CCG

During 2021/22 the CCG has paid one special severance payments recorded in their accounts for £56,416.75. The CCG sought approval from NHS England and HM Treasury prior to agreement and payment and approval was granted.

There were six special severance payments that do not have HMT approval, as follows:

NHS North of England CSU

During 2021/22 the CSU has paid one special severance payment in the parent account for £5,256. It relates to a non-contractual PILON payment made to the individual. This payment was not approved by NHS England and is therefore irregular.

NHS Kernow CCG

During 2021/22 the CCG has paid three special severance payments as recorded in their accounts for £22,751, £24,497 and £28,800 respectively. They relate to non-contractual PILON payments made to the individuals. This payment should have been submitted to NHS England and HMT for review and approval prior to being paid. This approval was not in place prior to making the payment. The CCG sought retrospective approval, but this was not granted and therefore the payments are considered irregular.

NHS North East Essex CCG, NHS Ipswich and East Suffolk CCG and NHS West Suffolk CCG

The three CCGs recorded a special severance payment in their accounts totalling £81k in June 2022, under a settlement agreement with a former senior employee. This payment should have been submitted to NHS England for review and approval prior to being paid. The CCG sought retrospective approval from NHS England which was granted. However, HM Treasury did not approve the payment and, as this was not granted, the payment is irregular.

NHS Bristol, North Somerset and South Gloucestershire CCG

During 2021/22 a non-contractual special severance payment of £5,389 was made by the CCG. This required approval from NHS England and the CCG has sought retrospective approval.

2020/21 Disclosure: Compensation payments

NHS England managed the process of obtaining HM Treasury approval for special payments in the NHS resulting from the national settlement of liabilities following the decision of the Employment Appeal Tribunal in Flowers and others versus the East of England Ambulance Trust and this judgement being applied to all employers. This approval on NHS providers' behalf totalled £159.9 million, in addition to the £1 million relating to NHS England group bodies included in the table above which is split £758k in the NHS England parent and £243k in the CCGs.

The sum of compensation payments with Treasury approval, includes a sum equating to £1.5 million which was approved for payment to GPs who are members of the NHS Pension scheme. The payments were approved to compensate GPs for the pension contribution

administrative errors, due to incomplete legacy data of GP contributions and issues with service delivery resulting in a backlog of missed or inaccurate pension contract payments.

2020/21 Disclosure: Special severance payments

The three special severance payments are detailed below:

NHS Waltham Forest CCG

A payment of £49,000 was made by the CCG during 2020/21 as a settlement with a former employee relating to a claim that had been brought against the CCG. This payment should have been submitted to NHS England for review and approval prior to being paid. In line with the CCG's Standing Financial Instructions, this payment should also have been reviewed and approved by the CCG Governing Body or a nominated sub-committee prior to being recommended. These approvals were not in place prior to making the payment. The CCG sought retrospective approval from NHS England but this was not granted. This type of payment also requires HM Treasury approval. As this was not given the payment is therefore irregular.

NHS Barking and Dagenham CCG, NHS Havering CCG and NHS Redbridge CCG

A payment totalling £28,224 was agreed by three CCGs as an additional termination payment to a former employee in recognition of additional responsibilities undertaken in their capacity as the Nurse Director and serving member of the CCGs governing bodies within the Barking, Havering and Redbridge system. This payment was made during 2020/21. It should have been submitted to NHS England for review and approval prior to being paid. The CCGs sought retrospective approval from NHS England, but this was not granted. This type of payment also requires HM Treasury approval. As this was not given the payment is therefore irregular.

NHS Berkshire West CCG

During 2020/21 the CCG decided to award an extra-contractual severance payment of £51,000 to their outgoing accountable officer and provided for this in their 2020/21 accounts. Per Managing Public Money, such payments always require Treasury approval. The CCG should therefore have followed the NHS England special severance payment guidance and obtained HMT approval before the award was offered to the employee. This was not done, and the CCG subsequently sought retrospective approval in 2021/22 from NHS England but this was not granted.

In 2021/22 the CCG decided to award an extra-contractual payment of £36,808 to the same individual (which was paid in August 2021), instead of the £51,000 referred to above. Whilst some consultation with NHS England was carried out at a regional level this payment request should also have been submitted to NHS England for formal review and approval prior to being offered to the individual, but the correct approvals were not in place prior to the

payments being made. This payment also required HM Treasury approval. As this was not obtained the transaction is therefore irregular.

The three payments noted above are also included in the Exit Packages disclosures on page 115.

Cost allocation and setting of charges

NHS England certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

		Parent			Consolidated group		
2021/22	Note	Income	Full cost	Surplus / (deficit)	Income	Full cost	Surplus / (deficit)
		£000	£000	£000	£000	£000	£000
Dental	2 & 4	633,809	(3,099,805)	(2,465,996)	633,847	(3,099,805)	(2,465,958)
Prescription	2 & 4	641,033	(2,351,608)	(1,710,575)	651,964	(11,430,430)	(10,778,466)
Total fees and charges		**1,274,842**	**(5,451,413)**	**(4,176,571)**	**1,285,811**	**(14,530,235)**	**(13,244,424)**

		Parent			Consolidated group		
2020/21		Income	Full cost	Surplus / (deficit)	Income	Full cost	Surplus / (deficit)
		£000	£000	£000	£000	£000	£000
Dental	2 & 4	277,611	(3,061,746)	(2,784,135)	277,665	(3,061,746)	(2,784,081)
Prescription	2 & 4	606,434	(2,135,603)	(1,529,169)	615,251	(11,184,193)	(10,568,942)
Total fees and charges		**884,045**	**(5,197,349)**	**(4,313,304)**	**892,916**	**(14,245,939)**	**(13,353,023)**

The fees and charges information in this note is provided in accordance with section 3.2.12 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges[137] are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2020/21, the NHS prescription charge for each medicine or appliance dispensed was £9.15, and in 2021/22 it was £9.35. However, around 90% of prescription items[138] are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £30.25 for three months or £108.10 for a year. A number of other charges were payable for wigs and fabric supports.

[137] https://www.legislation.gov.uk/uksi/2021/178/made

[138] https://digital.nhs.uk/data-and-information/publications/statistical/prescriptions-dispensed-in-the-community/prescriptions-dispensed-in-the-community-england---2007---2017

Those who are not eligible for exemption are required to pay NHS dental charges[139] which fall into three bands depending on the level and complexity of care provided. In 2021/22, the charge for Band 1 treatments was £23.80, for Band 2 was £65.20 and for Band 3 was £282.80. Dental patient charges have not changed since 14th December 2020.

[139] https://questions-statements.parliament.uk/written-statements/detail/2020-11-23/hcws593

The Certificate of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of the NHS Commissioning Board (known as NHS England) its Group for the year ended 31 March 2022 under the Health and Social Care Act 2012.

The financial statements comprise NHS England and its Group's:

- Statement of Financial Position as at 31 March 2022;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the Group financial statements is applicable law and UK adopted International Accounting Standards.

In my opinion, the financial statements:

- give a true and fair view of the state of NHS England and its Group's affairs as at 31 March 2022 and its net expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Qualified opinion on regularity

In my opinion, except for the effects of the matters described in the Basis for qualified opinion on regularity section below, in all material respects, the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

I have qualified my opinion on regularity because of ineligible payments made to suspended medical practitioners, where the transactions do not conform to the relevant statutory regulations specifying entitlement to such payments. The expenditure is therefore irregular.

Two suspended medical practitioners received, respectively, suspension payments of £489,766 (during the financial years 2017-18 to 2021-22 (of which £37,864 was paid in 2021-22)) and £476,747 (during the financial years 2018-19 to 2021-22 (of which £32,669 was paid in 2021-22)) to which they were not entitled. Such payments were not in accordance with statutory regulations governing entitlement to suspension payments to suspended medical practitioners and therefore, in my opinion, the payments are irregular.

In respect of these payments, I consider that insufficient regard has been paid to the framework of authorities and use of public funds. These payments are therefore material by virtue of their nature. Further detail can be found in my report on page 143.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 Audit of Financial Statements and Regularity of Public Sector Entities in the United Kingdom. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2019. I have also elected to apply the ethical standards relevant to listed entities. I am independent of NHS England and its Group in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that NHS England and its Group's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on NHS England and its Group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Board and the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for NHS England and its Group is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report, but does not include the financial statements nor my auditor's certificate and report. The Board and Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the Health and Social Care Act 2012.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of NHS England and its Group, and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Reports.

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit; or
- adequate accounting records have not been kept by NHS England and its Group or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or

- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the board and Accounting Officer are responsible for:

- maintaining proper accounting records;
- the preparation of the financial statements and Annual Report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the Annual Report and accounts as a whole is fair, balanced and understandable;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error; and
- assessing NHS England and its Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS England and its Group will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2012.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, we considered the following:

- the nature of the sector, control environment and operational performance including the design of NHS England and its Group's accounting policies, key performance indicators and performance incentives.
- inquiring of management, NHS England's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS England and its Group's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS England and its Group's controls relating to NHS England and its Group's compliance with the Health and Social Care Act 2012 and Managing Public Money.
- discussing among the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within NHS England and its Group for fraud and identified the greatest potential for fraud in the following areas: revenue recognition, posting of unusual journals, complex transactions and bias in management estimates. In common with all audits under ISAs (UK), I am also required to perform specific procedures to respond to the risk of management override of controls.

I also obtained an understanding of NHS England and its Group's framework of authority as well as other legal and regulatory frameworks in which NHS England and its Group operates, focusing on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of NHS England and its Group. The key laws and regulations I considered in this context included the Health and Social Care Act 2012, Managing Public Money, employment law, tax legislation, relevant legislation relating to fees charged by NHS England, and regulations relating to suspension payments to suspended medical practitioners.

In addition, I considered regulations and regularity relating to exit packages and, in particular, special severance payments, as I identified the completeness and regularity of exits packages as a significant risk.

Audit response to identified risk

As a result of performing the above, the procedures I implemented to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- enquiring of management, the Audit and Risk Assurance Committee and in-house legal counsel concerning actual and potential litigation and claims;
- reading and reviewing minutes of meetings of those charged with governance and the Board and internal audit reports;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- substantive testing of all exit packages disclosed within NHS England Parent Remuneration and Staff Report and review of all special severance payments included in NHS England Group Remuneration and Staff Report.

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including significant component audit teams and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

Other auditor's responsibilities

I am required to obtain evidence sufficient to give reasonable assurance that the income and expenditure reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Gareth Davies **24 January 2023**

Comptroller and Auditor General

National Audit Office, 157-197 Buckingham Palace Road, Victoria, London, SW1W 9SP

The Report of the Comptroller and Auditor General to the Houses of Parliament

Introduction

1. The *Health and Social Care Act 2012* requires the NHS Commissioning Board (known as NHS England) to prepare consolidated annual accounts for each financial year. The consolidated accounts must contain NHS England's annual accounts and a consolidation of NHS England's annual accounts and the annual accounts of each Clinical Commissioning Group (CCG)[140].

2. From 1 October 2021 the accounts of Supply Chain Coordination Limited (SCCL) were also consolidated into NHS England's consolidated accounts, as the shareholding of SCCL transferred from the Department of Health and Social Care ('DHSC') to NHS England on that date.

3. I am required to examine, certify, and report on NHS England's consolidated accounts. I provide an opinion on whether the consolidated accounts give a 'true and fair' view of NHS England's finances for the year. I also provide an opinion on whether the transactions recorded in NHS England's consolidated accounts have been applied to the purposes intended by Parliament and whether they conform to the authorities which govern them ('regularity').

4. In this report, I explain why I have qualified my regularity opinion on NHS England's 2021-22 consolidated accounts. I also provide an update on irregular special severance payments, which resulted in me qualifying the regularity opinion on NHS England's 2020-21 consolidated accounts, and on the performance of CCGs in delivering accounts to support the timely production of NHS England's consolidated accounts.

Qualification of regularity opinion due to irregular suspension payments to suspended medical practitioners

5. Under certain qualifying circumstances NHS England is required to make suspension payments to medical practitioners[141] who have been suspended as set out in relevant statutory regulations. Under statutory regulations issued by the Secretary of State for Health and Social Care, NHS England may suspend a medical practitioner, when satisfied that it is necessary to do so for the protection of patients or members of the public or that it is otherwise in the public interest. A suspended medical practitioner may be entitled to receive suspension payments if the medical practitioner meets certain qualifying conditions.

[140] There were 106 CCGs in 2021-22.
[141] A medical practitioner could be a doctor, dentist or optician.

If the medical practitioner qualifies for suspension payments, such payments may continue until a relevant tribunal has considered the suspension and either ends the suspension or removes the medical practitioner from the medical register.

For example, the General Medical Council (GMC) maintains a medical register of doctors licensed to practice medicine. The GMC considers suspensions concerning doctors. The General Dental Council and General Optical Council perform a similar role for dentists and opticians, respectively.

6. NHS England made suspension payments to a medical practitioner who was never entitled to suspension payments. A doctor received suspension payments totalling £489,766 over the financial years 2017-18 to 2021-22. In 2021-22, NHS England discovered that this doctor should never have received any suspension payments and that a serious control failing in 2017-18 had led to the commencement of suspension payments in error. The suspension payments continued until 2021-22, when a change in how suspended medical practitioners were paid suspension payments by NHS England brought this case to light. In this case NHS England is not pursuing recovery of the overpaid suspension payments following legal advice.

7. NHS England made suspension payments to a medical practitioner beyond the period to which the medical practitioner was entitled to receive such payments. A doctor began receiving suspension payments in May 2017 following their suspension. The doctor was removed from the medical register by the General Medical Council during 2018-19. NHS England should have stopped paying suspension payments to this doctor following their removal from its medical performers list. However, NHS England continued making suspension payments to this individual until May 2021. Consequently, NHS England made payments of £473,747 over the financial years 2018-19 to 2021-22 in error. This was a serious control failing resulting from an absence of appropriate checks to ensure the ongoing entitlement. In this case NHS England is pursuing recovery of the overpaid suspension payments but considers the prospect of recovery is low.

8. I have qualified my regularity opinion in relation to these payments. As the suspension payments I refer to in paragraphs 6 and 7 were made contrary to the statutory regulations governing such payments, I consider them to be irregular. I consider that insufficient regard has been paid to the framework of authorities and use of public funds and that the payments are therefore material by virtue of their nature. Removal of a medical practitioner from the medical register can often involve serious misconduct and I consider ineligible payment in those circumstances to be contentious. NHS England should have had checks in place to prevent or detect such payments. I have therefore qualified my regularity opinion on the consolidated accounts. My regularity opinion is on page 137.

9. NHS England has changed the process regarding assessing initial entitlement to suspension payments to medical practitioners and reviewing ongoing entitlement. NHS England has changed the processes and controls for assessing entitlement to suspension payments and reviewing ongoing entitlement, to reduce the likelihood of irregular suspension payments.

Special severance payments

10. In 2020-21, I qualified my regularity opinion on NHS England's consolidated accounts[142] due to a special severance payment which had not been submitted to HM Treasury for approval. A provision was made in 2020-21 by Berkshire West CCG, which consolidated into NHS England's consolidated accounts, for a special severance payment to its outgoing accountable officer. The CCG subsequently made the payment of £36,809 in August 2021. Such a payment is outside the CCG's and NHS England's authority under Managing Public Money and therefore requires explicit HM Treasury approval. HM Treasury approval was not sought and therefore, in my opinion, the payment was irregular.
I considered that insufficient regard has been paid to the framework of authorities and use of public funds and the payment was therefore material by virtue of its nature.

11. In 2021-22, I identified a significant risk over the completeness and regularity of exit packages in the NHS England consolidated accounts. I identified this risk because of the case referenced above and due to further cases and weaknesses as set out in NHS England's 2020-21 governance statement[143]. In my group audit instructions to auditors of CCGs, I requested that auditors alert me to any potential irregularities regarding exit packages and losses and special payments disclosed in the CCG annual report and accounts.

12. In 2021-22 special severance payments continued to be made across the NHS England group without HM Treasury approval. In 2021-22, six special severance payments were made across the NHS England group without HM Treasury approval. Five of these occurred within CCGs and one within the NHS England parent (at a Commissioning Support Unit). I consider these special severance payments to be irregular. I have reviewed the circumstances of each of these payments and concluded that none were material by nature (or value) to the NHS England consolidated accounts. Consequently, I have not qualified my regularity opinion for 2021-22 in this regard. CCG auditors have considered the special severance payments that occurred at the bodies they audit and where they deemed necessary have qualified the regularity opinion.

[142] NHS Commissioning Board annual report and account 2020-21, pages 136-141.
[143] NHS Commissioning Board annual report and account 2020-21, pages 98-99 and 133-134.

13. The regulatory framework for special severance payments is still not sufficiently well understood across the NHS England group. The creation of Integrated Care Boards (ICBs) on 1 July 2022 provides NHS England with a good opportunity to embed new processes and controls across the group. I consider the structural changes across the NHS England group that take place during 2022-23 mean there continues to be an increased likelihood of further exit packages and specifically special severance payments.

Oversight of bodies within the NHS England group

14. I refer to the explanatory report that I have included alongside my audit certificate on the DHSC 2021-22 annual report and accounts. The report is relevant to the NHS England consolidated accounts because it reports on the timetable for the preparation and audit of NHS England group bodies and the structural changes that are taking place in the NHS England group in 2022-23.

Gareth Davies **24 January 2023**

Comptroller and Auditor General

National Audit Office, 157-197 Buckingham Palace Road, Victoria, London, SW1W 9SP

Annual Accounts

Amanda Pritchard
23 January 2023

Accounting Officer

Statement of comprehensive net expenditure for the year ended 31 March 2022

		Parent		Consolidated group	
	Note	2021/22	2020/21	2021/22	2020/21
		£000	£000	£000	£000
Income from sale of goods and services	2	(1,770,922)	(1,353,925)	(3,219,691)	(1,399,245)
Other operating income	2	(11,049)	(13,585)	(85,105)	(87,428)
Total operating income		**(1,781,971)**	**(1,367,510)**	**(3,304,796)**	**(1,486,673)**
Staff costs	3	1,119,355	948,367	2,549,295	2,271,209
Purchase of goods and services	4	149,813,284	143,025,780	148,881,815	142,570,469
Depreciation and impairment charges	4	180,166	157,939	197,142	172,635
Provision expense	4	78,008	249	150,813	86,475
Other operating expenditure	4	431,549	731,860	1,897,079	870,975
Total operating expenditure		**151,622,362**	**144,864,195**	**153,676,144**	**145,971,763**
Net operating expenditure		**149,840,391**	**143,496,685**	**150,371,348**	**144,485,090**
Finance income		-	-	-	(52)
Finance expense	13	2,805	5,028	3,424	5,169
Net expenditure for the year		**149,843,196**	**143,501,713**	**150,374,772**	**144,490,207**
Other (gains)/losses		-	-	1,699	1,711
Net (gain)/loss on Transfer by Absorption	12	(154,540)	-	(139,840)	-
Total net expenditure for the year		**149,688,656**	**143,501,713**	**150,236,631**	**144,491,918**
Other comprehensive net expenditure					
Items which will not be reclassified to net operating costs					
Net (gain)/loss on revaluation of Financial Assets*		17,808	-	-	-
Actuarial (gain)/loss in pension schemes		-	-	(4,172)	3,508
Movements in general fund		-	-	-	31
Total other comprehensive net expenditure		**17,808**	-	**(4,172)**	**3,539**
Comprehensive net expenditure for the year		**149,706,464**	**143,501,713**	**150,232,459**	**144,495,457**

In October 2021 NHS England, the Parent acquired 100% of the shareholding of SCCL. As a result, the assets, liabilities and ongoing operational income and expenditure form part of the NHS England Consolidated Group Account from this date. There has therefore been a significant growth in income and expenditure year on year.

*The net loss on revaluation of financial assets represents the loss on equity instruments measured at fair value through OCI.

The notes on pages 155 to 198 form part of this statement.

Statement of financial position as at 31 March 2022

		Parent		Consolidated group	
		31 March 2022	31 March 2021	31 March 2022	31 March 2021
	Note	£000	£000	£000	£000
Non-current assets:					
Property, plant and equipment	6	396,194	453,415	474,993	473,837
Intangible assets	7	56,119	45,680	58,223	47,235
Trade and other receivables	9	-	-	1,496	295
Other financial assets	9	141,192	-	2,106	2,106
Total non-current assets		**593,505**	**499,095**	**536,818**	**523,473**
Current assets:					
Inventories	8	29,911	58,829	193,056	71,268
Trade and other receivables	9	724,623	1,009,334	3,738,887	1,573,323
Cash and cash equivalents	10	229,575	150,032	385,172	159,230
Total current assets		**984,109**	**1,218,195**	**4,317,115**	**1,803,821**
Total assets		**1,577,614**	**1,717,290**	**4,853,933**	**2,327,294**
Current liabilities					
Trade and other payables	11	(3,021,567)	(3,958,272)	(11,022,960)	(11,056,822)
Other financial liabilities	11	-	-	(10,538)	-
Provisions	14	(82,584)	(37,684)	(250,926)	(183,992)
Total current liabilities		**(3,104,151)**	**(3,995,956)**	**(11,284,424)**	**(11,240,814)**
Total assets less current liabilities		**(1,526,537)**	**(2,278,666)**	**(6,430,491)**	**(8,913,520)**
Non-current liabilities					
Trade and other payables	11	(31)	(30)	(876)	(5,496)
Other financial liabilities	11	-	-	(2,234,536)	-
Provisions	14	(352,452)	(323,257)	(413,543)	(357,368)
Total non-current liabilities		**(352,483)**	**(323,287)**	**(2,648,955)**	**(362,864)**
Total assets less total liabilities		**(1,879,020)**	**(2,601,953)**	**(9,079,446)**	**(9,276,384)**
Financed by taxpayers' equity and other reserves					
General fund		(1,861,212)	(2,601,953)	(9,076,430)	(9,269,196)
Revaluation reserve		-	-	18	18
Other reserves		(17,808)	-	(3,034)	(7,206)
Total taxpayers' equity		**(1,879,020)**	**(2,601,953)**	**(9,079,446)**	**(9,276,384)**

The notes on pages 155 to 198 form part of this statement.

The financial statements on pages 149 to 154 were approved by the Board on 23 January 2023 and signed on its behalf by:

Amanda Pritchard, Accounting Officer

Statement of changes in taxpayers' equity for the year ended 31 March 2022

Parent	General fund	Revaluation reserve	Other reserves	Total taxpayers' equity
Changes in taxpayers' equity for 2021/22	**£000**	**£000**	**£000**	**£000**
Balance at 01 April 2021	(2,601,953)	-	-	(2,601,953)
Total Net Expenditure for the year	(149,688,656)	-	-	(149,688,656)
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	-	-	(17,808)	(17,808)
Transfers by absorption to (from) other bodies	-	-	-	-
Comprehensive net expenditure for the year	**(149,688,656)**	**-**	**(17,808)**	**(149,706,464)**
Grant in Aid	150,429,397	-	-	150,429,397
Balance at 31 March 2022	**(1,861,212)**	**-**	**(17,808)**	**(1,879,020)**

Parent	General fund	Revaluation reserve	Other reserves	Total taxpayers' equity
Changes in taxpayers' equity for 2020/21	**£000**	**£000**	**£000**	**£000**
Balance at 1 April 2020	(3,878,186)	-	-	(3,878,186)
Total net expenditure for the year	(143,501,713)	-	-	(143,501,713)
Comprehensive net expenditure for the year	**(143,501,713)**	**-**	**-**	**(143,501,713)**
Grant in aid	144,777,946	-	-	144,777,946
Balance at 31 March 2021	**(2,601,953)**	**-**	**-**	**(2,601,953)**

Consolidated group	General fund	Revaluation reserve	Other reserves	Total taxpayers' equity
Changes in taxpayers' equity for 2021/22	**£000**	**£000**	**£000**	**£000**
Balance at 01 April 2021	(9,269,196)	18	(7,206)	(9,276,384)
Total Net Expenditure for the year	(150,236,633)	-	-	(150,236,633)
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	-	-	-	-
Movements in other reserves	2	-	4,172	4,174
Movements in general fund	-	-	-	-
Comprehensive net expenditure for the period	(150,236,631)	-	4,172	(150,232,459)
Grant in Aid	150,429,397	-	-	150,429,397
Balance at 31 March 2022	**(9,076,430)**	**18**	**(3,034)**	**(9,079,446)**

Consolidated group	General fund	Revaluation reserve	Other reserves	Total taxpayers' equity
Changes in taxpayers' equity for 2020/21	**£000**	**£000**	**£000**	**£000**
Balance at 1 April 2020	(9,555,193)	18	(3,698)	(9,558,873)
Total net expenditure for the year	(144,491,918)	-	-	(144,491,918)
Movements in other reserves	-	-	(3,508)	(3,508)
Movements in general fund	(31)	-	-	(31)
Transfers between reserves	-	-	-	-
Comprehensive net expenditure for the year	**(144,491,949)**	**-**	**(3,508)**	**(144,495,457)**
Grant in aid	144,777,946	-	-	144,777,946
Balance at 31 March 2021	**(9,269,196)**	**18**	**(7,206)**	**(9,276,384)**

The general fund is used in public sector accounting to reflect the total assets less liabilities of an entity, which are not assigned to another reserve.

Other reserves in the parent relate to fair value losses on equity investments designated as fair value through other comprehensive income under IFRS 9.

Other reserves in the group reflect pension assets/liabilities in respect of staff in non-NHS defined benefit schemes in CCGs. Full details can be found in the CCG statutory accounts published on their websites.

The notes on pages 155 to 198 form part of this statement.

Statement of cash flows for the year ended 31 March 2022

		Parent		Consolidated group	
		2021/22	2020/21	2021/22	2020/21
Cash flows from operating activities	**Note**	**£000**	**£000**	**£000**	**£000**
Net expenditure for the financial period		(149,688,656)	(143,501,713)	(150,236,778)	(144,491,918)
Depreciation and amortisation	4	180,166	157,939	196,400	172,313
Impairments and reversals	4	-	-	742	321
Other non cash adjustments*		-	-	89	4
Movement due to transfers by absorption**	12	(160,543)	-	(145,845)	(1,915)
Interest paid		-	-	150	-
(Gain)/Loss on disposal		-	-	1,699	1,711
Unwinding of discount	14	2,726	5,028	3,118	5,136
Change in discount rate	14	(23,209)	40,291	(23,040)	40,216
(Increase)/decrease in inventories	8	28,918	(12,661)	32,963	(6,558)
(Increase)/decrease in trade and other receivables	9	283,963	(748,277)	366,041	(582,018)
Increase/(decrease) in trade and other payables	11	(947,384)	(468,624)	(791,650)	237,042
Provisions utilised		(8,326)	(3,663)	(37,483)	(20,880)
Increase/(decrease) in provisions	14	102,903	(40,042)	177,711	46,884
Net cash outflow from operating activities		**(150,229,442)**	**(144,571,722)**	**(150,455,883)**	**(144,599,662)**
Cash flows from investing activities					
Interest received		-	-	-	(52)
Payments for property, plant and equipment		(100,634)	(163,826)	(111,838)	(173,413)
Payments for intangible assets		(20,488)	(43,541)	(21,714)	(43,641)
(Payments) for other financial assets		-	-	-	(500)
Proceeds from disposal of assets		710	(508)	776	(457)
Net cash outflow from investing activities		**(120,412)**	**(207,875)**	**(132,776)**	**(218,063)**
Net cash outflow before financing activities		**(150,349,854)**	**(144,779,597)**	**(150,588,659)**	**(144,817,725)**
Cash flows from financing activities					
Grant in aid funding received		150,429,397	144,777,946	150,429,397	144,777,946
Other loans received		-	-	150,000	-
Capital element of payments in respect of finance leases		-	-	(98)	(95)
Cash transferred under absorption	12	-	-	269,704	-
Net cash inflow from financing activities		**150,429,397**	**144,777,946**	**150,849,003**	**144,777,851**
Net increase/(decrease) in cash and cash equivalents		**79,543**	**(1,651)**	**260,344**	**(39,874)**
Cash and cash equivalents at the beginning of the financial year	10	150,032	151,683	114,411	154,285
Cash and cash equivalents at the end of the financial year	10	**229,575**	**150,032**	**374,755**	**114,411**

The notes on pages 155 to 198 form part of this statement.

*Other non cash adjustments comprise a pension charge of £102k and £13k credit on account for the straight lining of an operating lease cost. There is no separate disclosure under IAS 7 for cash and non cash movements for financing activities because the values are immaterial.

** Movement due to transfer by absorption for parent includes £6 million related to payables and receivables for the transfer in of PHE.

Notes to the financial statements

1. Statement of accounting policies

These financial statements have been prepared in a form directed by the Secretary of State under Schedule 1(A), paragraph 15(2) of the Health and Social Care Act 2012 and in accordance with the 2021/22 DHSC Group Accounting Manual (GAM) issued by the Department of Health & Social Care and comply with HM Treasury's Financial Reporting Manual 2021/22 (FReM). The accounting policies contained in the DHSC GAM apply IFRS as adapted or interpreted for the public sector context. Where the DHSC GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS England for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS England are described below. They have been applied consistently in dealing with items considered material to the accounts.

The functional and presentational currency is pounds sterling and figures are expressed in pounds thousands unless expressly stated. Two sets of figures are presented - the first relating to NHS England itself (the Parent) and a second set of consolidated figures (Consolidated Group). The entities making up the Consolidated Group are declared in Note 22.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Net Expenditure in the period in which they arise.

1.1 Operating segments

Income and expenditure are analysed in the Operating Segments note (note 18) and reflect the management information used within NHS England. Information on assets less liabilities is not separately reported to the Chief Operating Decision Maker and therefore in accordance with IFRS 8 does not form part of the disclosure in note 18.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

1.3 Basis of Consolidation

These accounts comprise the results of the NHS England statutory entity as well as the consolidated position of NHS England, 106 related CCGs and Supply Chain Coordination Limited. Transactions between entities included in the consolidation are eliminated.

For 2021/22 three CCG audits and the SCCL audit are incomplete at the time of finalising the NHS England group account. Unaudited information from these bodies has been used to prepare the NHS England group account.

NHS North East Essex CCG, NHS Ipswich and East Suffolk CCG and NHS West Suffolk CCG

The conclusion of the local accounts for the three CCGs has been delayed whilst the auditor, BDO, which covers all three CCGs, considers the outcome of information provided in relation to a single exit package that is shared across the three CCGs. As detailed in the losses and special payments note on page 132, this exit package has been deemed irregular.

The individual financial statements of each CCG is immaterial to the NHS England group account, however the aggregated expenditure balance is material. We have therefore performed additional procedures on the unaudited expenditure figures of the three CCGs, to satisfy ourselves that expenditure consolidated into the NHS England Group account is fairly stated and presents a true and fair view.

CSUs form part of NHS England and provide services to CCGs. The CSU results are included within the Parent accounts as they are not separate legal entities.

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2021.

1.5 Going Concern

Whilst a joint leadership structure has been operating since 1 April 2019, the underlying legal entities of NHS England, NHS TDA and Monitor remain in place for the year ended 31 March 2022. The Heath and Care Act 2022 received royal assent on 28 April 2022 and enables the statutory merger of NHS England, NHS TDA and Monitor. This transfer took place on 1 July 2022 and NHS England's underlying activities will continue.

NHS England's financial statements are produced on a going concern basis. NHS England is supply-financed and draws its funding from the DHSC. Parliament has demonstrated its commitment to fund the DHSC for the foreseeable future via the latest Spending Review and the passing of the Health and Social Care Act 2012. In the same way, the DHSC has demonstrated commitment to the funding of NHS England. It is therefore considered appropriate to adopt the going concern basis for the preparation of these financial statements.

1.6 Transfer of Functions

As public sector bodies within a Departmental Boundary are deemed to operate under common control, business reconfigurations are outside the scope of IFRS 3 Business Combinations. When functions transfer between two public sector bodies the GAM requires the application of "absorption accounting". Absorption accounting requires that entities account for their transactions in the period in which those transactions took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Net Comprehensive Expenditure and is disclosed separately from operating costs.

1.7 Revenue Recognition

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- as per paragraph 121 of the Standard NHS England will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less
- NHS England is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date
- the GAM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires NHS England to reflect the aggregate effect of contracts modified before the date of initial application.

The main source of funding for NHS England is grant-in-aid from the Department of Health & Social Care. NHS England is required to maintain expenditure within this allocation. The Department of Health & Social Care also approves a cash limit for the period. NHS England is required to draw down cash in accordance with this limit. Grant-in-aid is drawn down and credited to the general fund. Grant-in-aid is recognised in the financial period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

IFRS 15 is applicable to revenue in respect of dental and prescription charges in line with the adaptation in IFRS 15 which states that the definition of a contract includes revenue received under legislation and regulations. Revenue for these charges is recognised when the performance event occurs e.g. the issue of a prescription or payment for dental treatment.

Income received in respect of penalty charge notices issued in relation to non-payment of prescribing and dental charges is recognised on a cash receipts basis.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Other operating revenue is recognised when the service is rendered and the stage completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that the economic benefit associated with the transaction will flow to the group. Income is measured at fair value of the consideration receivable.

The value of the benefit received when NHS England accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 Employee Benefits

Recognition of short-term benefits - retirement benefit costs:

Past and present employees are covered by the provisions of the NHS Pensions Schemes. The schemes are unfunded, defined benefit schemes that cover NHS employers, general practitioners and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the organisation commits itself to the retirement, regardless of the method of payment.

Salaries, wages and employment related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following year.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Value Added Tax

Most of the activities of the group are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the group
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000, or
- collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where an asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Measurement of property, plant and equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historical cost as a proxy for current value in existing use. This is in accordance with GAM requirements as these assets have short useful lives or low values or both.

Balances held in the Revaluation reserve relate to balances inherited as at 1 April 2013. In line with our accounting policy, no further revaluation gains have been recognised.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is charged to operating expenses.

1.12 Intangible non-current assets

Intangible non-current assets are non-monetary assets without physical substance that are capable of sale separately from the rest of the group's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the group; where the cost of the asset can be measured reliably; and where the cost is at least £5,000 with each individual item costing more than £250.

Intangible non-current assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

Following initial recognition, intangible assets are carried at depreciated historic cost as a proxy for current value in existing use.

1.13 Research and development

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to reliably measure the expenditure attributable to the intangible asset during its development.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.14 Depreciation, amortisation and impairments

Freehold land, assets under construction, investment properties, stockpiled goods and assets held for sale are neither depreciated nor amortised.

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any

residual value, on a straight line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which economic benefits or service potential is expected to be obtained from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

Depreciation/amortisation is charged as follows:

	Minimum life (years)	Maximum life (years)
Buildings excluding dwellings	5	20
Plant and machinery	5	10
Transport equipment	5	10
Information technology	2	10
Furniture and fittings	5	10
Computer software: purchased	2	5
Licences and trademarks	2	5
Development expenditure (internally generated)	2	5

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.15 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is satisfied once both of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; and
- the sale is highly probable.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the statement of comprehensive net expenditure. On disposal, the balance for the asset in the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the statement of comprehensive net expenditure.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value and are utilised using the First in First Out method of inventory controls.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and are readily convertible to known amounts of cash with insignificant risk of change in value.

In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management. Cash, bank and overdraft balances are recorded at current values.

1.20 Provisions

Provisions are recognised when there exists a present legal or constructive obligation as a result of a past event, it is probable that the group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Provisions are subject to three separate discount rates according to the expected timing of cashflows:

- a nominal short term rate of 0.47 percent (2020/21: -0.02 percent in real terms) is applied to inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date
- a nominal medium-term rate of 0.70 percent (2020/21: 0.18 percent in real terms) is applied to inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date
- a nominal long-term rate of 0.95 percent (2020/21: 1.99 percent in real terms) is applied to inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

1.21 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which NHS England and CCGs pay an annual contribution to NHS Resolution, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability rests with the group.

1.22 Non-clinical risk pooling

The NHS England group participates in the Property Expenses Scheme and the Liabilities to Third Parties scheme. Both are risk pooling schemes under which NHS England and CCGs pay an annual contribution to NHS Resolution and, in return, receive assistance with the cost of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when they become due.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities that are required to be disclosed under IAS37 are stated at discounted amounts.

1.24 Financial assets

Financial assets are recognised on the statement of financial position when the group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred and the group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

As available for sale financial assets, the group's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the consolidated statement of net comprehensive expenditure on de-recognition.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.24.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.24.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows, and selling financial assets and where the cash flows are solely payments of principal and interest.

1.24.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.24.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, NHS England recognises a loss allowance representing expected credit losses on the financial instrument.

NHS England adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. NHS England therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and NHS England does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.25 Financial liabilities

Financial liabilities are recognised in the statement of financial position when the group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged; that is, the liability has been paid or has expired. Financial liabilities are initially recognised at fair value.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Accounting standards that have been issued but have not yet been adopted

The FReM does not require the following Standards and Interpretations to be applied in 2021/22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases – The standard is effective from 1 April 2022 as adapted and interpreted by the FReM.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 leases

IFRS 16 – Leases replaces IAS 17 - Leases, IFRIC 4 Determining whether an arrangement contains a lease and, SIC 27 - Evaluating the substance of transactions involving the legal form of a lease and introduces a single, on statement of financial position lease accounting model for lessees.

The NHS England group contains SCCL who reports under EU adopted IFRS following the Companies Act 2006. As the Standard is EU adopted it implemented IFRS 16 in the 2019/20 financial year. The necessary adjustments have been made, in respect of SCCL, to disapply IFRS 16 for 2021/22 in the consolidated financial statements.

Currently, the NHS England parent and the group recognises operating lease expenses on a straight line basis over the term of the lease, and recognises assets and liabilities only to the extent that there is a timing difference between actual lease payments and the expense recognised. Under IFRS 16 it will recognise a right of use asset representing its right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases it assesses fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the Statement of Comprehensive Net Expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right of use asset.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

IFRS 16 is effective for periods beginning on or after 1 January 2019 but under the requirements of the GAM NHS England group will not adopt it until 1 April 2022.

NHS England has estimated the impact of initial application as described below. The actual impact may change however because:

a) The value and nature of the leases that the group holds at the time of implementation may change,

b) Processes and controls to identify and account for right of use assets under IFRS 16 are continuing to be developed.

Impact

Note 5 contains details of operating lease expenditure at 31 March 2022. An assessment of the nature of leases within other indicates that these comprise mainly low value office items that would fall under the short term lease or low value lease exemptions in IFRS 16 and therefore, this expense will continue to be treated as straight line operating expenditure.

The most significant impact will be that the group will need to recognise right of use assets and lease liabilities for any buildings currently treated as operating leases that meet the recognition criteria in IFRS 16. At 31 March 2022 the future minimum lease payments amounted to £210 million and this means that the nature of this expense will be assessed and change from being an operating lease expense to depreciation and interest expense.

Transition

The NHS England parent and the CCGs will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HMT have interpreted this to mandate this practical expedient and therefore the group will apply IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022. However, during the 21/22 financial year the NHS England core department, CSUs and CCGs have continued to review material contracts to ensure they

have been correctly treated under IAS 17. This has resulted in immaterial amendments to the transactions treated as operating leases but there has been no prior year adjustment under IAS 8 on the grounds that the change is not material.

The group will utilise three further practical expedients under the transition approach adopted:

a) the election to not make an adjustment for leases for which the underlying asset is of low value

b) the election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application

c) the election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

Other accounting standards issued but not yet adopted

Full assessments of the impact of the remaining standards issued but not yet adopted will be completed by NHS England in due course following any relevant guidance issued in the Government Financial Reporting Manual

2. Operating income

	Parent		Consolidated group	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Income from sale of goods and services (contracts)				
Education, training and research	2,180	2,460	12,269	12,075
Non-patient care services to other bodies	403,229	385,506	1,665,898	262,623
Prescription fees and charges[144]	641,033	606,434	651,964	615,251
Dental fees and charges[141]	633,809	277,611	633,847	277,665
Other contract income	90,366	81,450	243,871	223,866
Recoveries in respect of employee benefits	305	464	11,842	7,765
Total income from sale of goods and services	**1,770,922**	**1,353,925**	**3,219,691**	**1,399,245**
Other operating income				
Rental revenue from finance leases	-	-	87	-
Rental revenue from operating leases	-	-	2,053	24
Charitable and other contributions to revenue expenditure: non-NHS	48	140	684	1,461
Receipt of donations (capital/cash)[145]	-	9,579	-	9,579
Non-cash apprenticeship training grants revenue	848	273	1,313	689
Other non-contract revenue	10,153	3,593	80,968	75,675
Total other operating income	**11,049**	**13,585**	**85,105**	**87,428**
Total operating income	**1,781,971**	**1,367,510**	**3,304,796**	**1,486,673**

Intercompany trading is eliminated between bodies within the NHS England group upon consolidation.

In October 2021 NHS England, the Parent, acquired 100% of the shareholding of SCCL. As a result, the assets, liabilities and ongoing operational income and expenditure form part of the NHS England consolidated group account from this date. There has therefore been a significant growth in income and expenditure year on year.

[144] In line with the adaptation in the HM Treasury Financial Reporting Manual prescription fees and charges and dental fees and charges are treated as revenue arising from a contract and accounted for under IFRS15.

[145] The receipts of donation(capital/cash) is in relation to donated imaging assets from Department of Health and Social Care

2.1 Disaggregation of revenue

We disaggregate our revenue from contracts with customers by the nature of the revenue. This is shown in Note 2. Note 2.1 provides the disaggregation in line with our operating segments reported in Note 18.

Parent 2021/22	CCG	SCCL	Direct commissioning	NHS England	Other	i/co eliminations	Total
	£000	£000	£000	£000	£000	£000	£000
Income from sale of goods and services (contracts)							
Education, training and research	-	-	844	688	649	(1)	2,180
Non-patient care services to other bodies	-	-	2,665	7,296	614,063	(220,795)	403,229
Prescription fees and charges	-	-	641,033	-	-	-	641,033
Dental fees and charges	-	-	633,809	-	-	-	633,809
Other contract income	-	-	12,100	31,474	19,938	26,854	90,366
Recoveries in respect of employee benefits	-	-	-	336	-	(31)	305
Total income from sale of goods and services	**-**	**-**	**1,290,451**	**39,794**	**634,650**	**(193,973)**	**1,770,922**

Parent 2020/21	CCG	SCCL	Direct commissioning	NHS England	Other	i/co eliminations	Total
	£000	£000	£000	£000	£000	£000	£000
Income from sale of goods and services (contracts)							
Education, training and research	-	-	228	1,721	511	-	2,460
Non-patient care services to other bodies	-	-	1,890	3,980	566,866	(187,230)	385,506
Prescription fees and charges	-	-	606,434	-	-	-	606,434
Dental fees and charges	-	-	275,865	-	1,746	-	277,611
Other contract income	-	-	11,824	15,582	25,523	28,521	81,450
Recoveries in respect of employee benefits	-	-	35	429	-	-	464
Total income from sale of goods and services	**-**	**-**	**896,276**	**21,712**	**594,646**	**(158,709)**	**1,353,925**

Consolidated group 2021/22	CCG	SCCL	Direct commissioning	NHS England	Other	i/co eliminations	Total
	£000	£000	£000	£000	£000	£000	£000
Income from sale of goods and services (contracts)							
Education, training and research	10,364	-	844	688	649	(276)	12,269
Non-patient care services to other bodies	353,943	1,477,301	2,665	7,296	614,063	(789,370)	1,665,898
Prescription fees and charges	10,931	-	641,033	-	-	-	651,964
Dental fees and charges	38	-	633,809	-	-	-	633,847
Other contract income	185,570	-	12,100	31,474	19,938	(5,211)	243,871
Recoveries in respect of employee benefits	11,148	1,516	-	336	-	(1,158)	11,842
Total income from sale of goods and services	**571,994**	**1,478,817**	**1,290,451**	**39,794**	**634,650**	**(796,015)**	**3,219,691**

Consolidated group 2020/21	CCG	SCCL	Direct commissioning	NHS England	Other	i/co eliminations	Total
	£000	£000	£000	£000	£000	£000	£000
Income from sale of goods and services (contracts)							
Education, training and research	9,615	-	228	1,721	511	-	12,075
Non-patient care services to other bodies	364,786	-	1,890	3,980	566,866	(674,899)	262,623
Prescription fees and charges	8,817	-	606,434	-	-	-	615,251
Dental fees and charges	54	-	275,865	-	1,746	-	277,665
Other contract income	147,180	-	11,824	15,582	25,523	23,757	223,866
Recoveries in respect of employee benefits	7,980	-	35	429	-	(679)	7,765
Total income from sale of goods and services	**538,432**	**-**	**896,276**	**21,712**	**594,646**	**(651,821)**	**1,399,245**

3. Employee benefits

3.1. Employee benefits table

	Parent		Consolidated group	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Employee benefits				
Salaries and wages	877,669	755,407	2,005,815	1,796,494
Social security costs	89,225	72,484	200,621	174,272
Employer contributions to NHS Pension scheme	145,748	117,638	328,157	287,747
Other pension costs*	7	-	1,154	254
Apprenticeship levy	5,305	3,165	8,875	5,865
Other post-employment benefits	154	-	154	-
Termination benefits	1,247	(327)	4,519	6,577
Gross employee benefits expenditure	**1,119,355**	**948,367**	**2,549,295**	**2,271,209**
Less: Employee costs capitalised	-	-	-	-
Gross employee benefits excluding capitalised costs	**1,119,355**	**948,367**	**2,549,295**	**2,271,209**
Less recoveries in respect of employee benefits	(306)	(464)	(11,842)	(7,765)
Net employee benefits	**1,119,049**	**947,903**	**2,537,453**	**2,263,444**

Staff numbers can be found in the Accountability Report on page 103.

*Other pension costs relate to contribution made to workforce pension scheme Nest Pension

3.2 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on NHS Pensions[146]. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM[147] requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

[146] www.nhsbsa.nhs.uk/pensions

[147] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1041651/20_FReM_-_Dec_21.pdf

3.2.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This uses an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme accounts. These accounts can be viewed on the NHS Pensions website[148] and are published annually. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021[149]) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website[150].

[148] www.nhsbsa.nhs.uk/pensions

[149] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023845/The_Public_Service_Pensions_Valuations_and_Employer_Cost_Cap__Amendment__Directions_2021.pdf)

[150] https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

3.2.2 Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

- the scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based on total pensionable earnings over the relevant pensionable service
- with effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax-free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'
- 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 12 months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index has been used and replaced the Retail Prices Index
- 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 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 employer
- members can purchase additional service in the scheme and contribute to money purchase additional voluntary contributions run by the scheme's approved providers or by other free standing additional voluntary contributions providers.

3.2.3 Local government pension schemes

Within the group there are CCGs who account for defined benefit pension scheme assets and liabilities primarily in respect of local government superannuation schemes. These schemes are immaterial to the group financial statements and therefore have not been disclosed separately. Full disclosures are available in the underlying CCGs published accounts.

3.2.4 Principal Civil Service Pension Scheme

Past and present employees are covered by the provisions of the Principal Civil Service Pension Scheme and the Civil Servant and Other Pension Scheme. These schemes are unfunded, defined benefit schemes covering civil servants. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined

contribution schemes: the cost to NHS England of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For defined contribution schemes, such as Civil Service partnership pensions, NHS England recognises the contributions payable for the year.

NHS England recognises the full cost of benefits paid under the Civil Service Compensation Scheme, including the early payment of pensions.

4. Operating expenses

	Parent		Consolidated group	
	2021/22 Total £000	2020/21 Total £000	2021/22 Total £000	2020/21 Total £000
Purchase of goods and services – cash				
Services from other CCGs and NHS England	12,201	4,354	-	-
Services from foundation trusts	18,674,370	21,033,035	68,920,966	63,153,860
Services from other NHS trusts	7,558,049	9,591,707	32,958,715	31,830,848
Provider Sustainability Fund [151]	-	(10,921)	-	(10,921)
Services from other 'whole of government accounts' (WGA) bodies [152]	8,776	10,216	66,774	66,757
Purchase of healthcare from non-NHS bodies	1,207,066	3,534,992	17,029,247	18,374,804
Purchase of social care	-	2	931,424	851,720
General dental services and personal dental services	3,099,805	3,061,746	3,099,805	3,061,746
Prescribing costs	21,122	20,848	9,089,310	9,059,707
Pharmaceutical services	2,330,486	2,114,755	2,341,120	2,124,486
General ophthalmic services	545,904	578,154	561,006	590,306
GP primary care services	1,278,041	1,150,931	11,365,278	10,399,490
Supplies and services – clinical	(417,252)	(184,924)	(351,453)	(120,175)
Supplies and services – general	526,520	688,817	1,335,720	1,700,347
Consultancy services	33,899	13,633	75,764	51,552
Establishment	317,982	301,056	608,015	599,035
Transport	1,503	382	111,117	88,734
Premises	68,545	105,030	372,604	447,912
Audit fees [153]	480	480	10,964	10,720
Other non-statutory audit expenditure	-	-	2,418	3,741
Other professional fees	153,789	92,798	237,105	161,523
Legal fees	7,594	21,466	23,521	36,636
Education and training	58,482	51,333	91,082	86,952
Funding to group bodies [154]	114,325,074	100,845,617	-	-
Total purchase of goods and services – cash	**149,812,436**	**143,025,507**	**148,880,502**	**142,569,780**
Other operating expenditure – cash				
Chair and non-executive members	121	123	32,637	38,997
Grants to other bodies	244,560	354,619	300,071	378,468
Clinical negligence	-	-	335	220
Research and development (excluding staff costs)	454	707	17,122	13,080
Other expenditure	46,721	45,395	61,693	84,408
Total other operating expenditure – cash	**291,856**	**400,844**	**411,858**	**515,173**
Total operating expenses – cash	**150,104,292**	**143,426,351**	**149,292,360**	**143,084,953**

[151] The Provider Sustainability Fund (PSF) has not been in operation during 2020/21. During 2020/21 £10,219k of PSF income awarded in 2019/20 was recovered.

[152] Services from other WGA bodies comprises expenditure with the Department of Health and Social Care (DHSC), DHSC Arm's Length Bodies and NHS Blood and Transplant.

[153] In both financial years NHS England purchased no Non Audit services from NAO. Details of CCG non audit expenditure can be found in the underlying individual CCG accounts.

[154] Funding to group bodies is shown above and represents cash funding drawn down by the CCGs. These balances are eliminated on consolidation.

	Parent		Consolidated group	
	2021/22 Total £000	2020/21 Total £000	2021/22 Total £000	2020/21 Total £000
Depreciation and impairment charges – non-cash items				
Depreciation	166,390	155,901	181,604	168,300
Amortisation	13,776	2,038	14,796	4,013
Impairments and reversals of property, plant and equipment	-	-	742	249
Impairments and reversals of intangible assets	-	-	-	73
Total depreciation and impairment charges - non-cash	**180,166**	**157,939**	**197,142**	**172,635**
Provision expense – non-cash items				
Change in discount rate	(23,209)	40,291	(23,040)	40,216
Provisions	101,217	(40,042)	173,853	46,259
Total provision expense - non-cash	**78,008**	**249**	**150,813**	**86,475**
Purchase of goods and services – non-cash				
Non-cash apprenticeship training grants	848	273	1,313	689
Total purchase of goods and services – non-cash	**848**	**273**	**1,313**	**689**
Other operating expenditure – non-cash items				
Expected credit loss on receivables	1,418	3,652	1,344	16,752
Inventories written down	-	-	1,529	-
Inventories consumed	138,275	327,364	1,482,348	339,050
Total other operating expenditure - non-cash	**139,693**	**331,016**	**1,485,221**	**355,802**
Total operating expenses – non-cash	**398,715**	**489,477**	**1,834,489**	**615,601**
Total operating expenditure	**150,503,007**	**143,915,828**	**151,126,849**	**143,700,554**

Intercompany trading is eliminated between bodies within the NHS England group upon consolidation.

In October 2021 NHS England, the Parent, acquired 100% of the shareholding of SCCL. As a result, the assets, liabilities and ongoing operational income and expenditure form part of the NHS England consolidated group account from this date. There has therefore been a significant growth in income and expenditure year on year.

5. Operating leases as lessee

5.1 Payments recognised as an expense

Parent	2021/22			2020/21		
	Buildings	Other	Total	Buildings	Other	Total
	£000	£000	£000	£000	£000	£000
Payments recognised as an expense						
Minimum lease payments	49,087	465	**49,552**	60,312	875	**61,187**
Total	**49,087**	**465**	**49,552**	**60,312**	**875**	**61,187**

Consolidated group	2021/22			2020/21		
	Buildings	Other	Total	Buildings	Other	Total
	£000	£000	£000	£000	£000	£000
Payments recognised as an expense						
Minimum lease payments	120,934	1,235	**122,169**	180,833	1,742	**182,575**
Contingent rents	-	1,531	**1,531**	-	2,839	**2,839**
Total	**120,934**	**2,766**	**123,700**	**180,833**	**4,581**	**185,414**

5.2 Future minimum lease payments

Parent	2021/22			2020/21		
	Buildings	Other	Total	Buildings	Other	Total
	£000	£000	£000	£000	£000	£000
Payable:						
No later than one year	26,069	199	**26,268**	36,648	183	**36,831**
Between one and five years	25,787	137	**25,924**	40,087	71	**40,158**
After five years	6,654	-	**6,654**	3,872	-	**3,872**
Total	**58,510**	**336**	**58,846**	**80,607**	**254**	**80,861**

Consolidated group	2021/22			2020/21		
	Buildings	Other	Total	Buildings	Other	Total
	£000	£000	£000	£000	£000	£000
Payable:						
No later than one year	52,001	684	**52,685**	57,220	650	**57,870**
Between one and five years	99,539	533	**100,072**	81,290	654	**81,944**
After five years	59,341	-	**59,341**	18,706	-	**18,706**
Total	**210,881**	**1,217**	**212,098**	**157,216**	**1,304**	**158,520**

6. Property, plant, and equipment

Parent 2021/22	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	**221**	**-**	**794**	**591**	**814,714**	**4,764**	**821,084**
Additions purchased	-	-	-	-	109,555	1,801	**111,356**
Reclassifications	-	(1,539)	-	-	(3,197)	-	**(4,736)**
Disposals	(8)	-	(324)	-	(65,705)	(251)	**(66,288)**
Transfer (to)/from other public sector body	-	1,539	-	-	-	-	**1,539**
Cost or valuation at 31 March 2022	**213**	**-**	**470**	**591**	**855,367**	**6,314**	**862,955**
Depreciation 1 April 2021	**170**	**-**	**595**	**345**	**363,855**	**2,704**	**367,669**
Reclassifications	-	-	-	-	(1,010)	-	**(1,010)**
Disposals	(8)	-	(324)	-	(65,705)	(251)	**(66,288)**
Charged during the year	43	-	97	118	165,375	757	**166,390**
Transfer (to)/from another public sector body	-	-	-	-	-	-	**-**
At 31 March 2022	**205**	**-**	**368**	**463**	**462,515**	**3,210**	**466,761**
Carrying value at 31 March 2022	**8**	**-**	**102**	**128**	**392,852**	**3,104**	**396,194**
Asset financing:							
Owned	8	-	102	128	392,852	3,104	**396,194**
Total at 31 March 2022	**8**	**-**	**102**	**128**	**392,852**	**3,104**	**396,194**

Parent 2020/21	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2020	**221**	**-**	**925**	**591**	**804,488**	**7,820**	**814,045**
Additions purchased	-	-	-	-	154,588	331	**154,919**
Reclassifications	-	-	-	-	(140)	140	**-**
Disposals	-	-	(131)	-	(144,222)	(3,527)	**(147,880)**
Cost or valuation at 31 March 2021	**221**	**-**	**794**	**591**	**814,714**	**4,764**	**821,084**
Depreciation 1 April 2020	**126**	**-**	**567**	**227**	**353,795**	**4,705**	**359,420**
Reclassifications	-	-	-	-	(114)	141	**27**
Disposals	-	-	(131)	-	(144,020)	(3,528)	**(147,679)**
Charged during the year	44	-	159	118	154,194	1,386	**155,901**
At 31 March 2021	**170**	**-**	**595**	**345**	**363,855**	**2,704**	**367,669**
Carrying value at 31 March 2021	**51**	**-**	**199**	**246**	**450,859**	**2,060**	**453,415**
Asset financing:							
Owned	51	-	199	246	450,859	2,060	**453,415**
Total at 31 March 2021	**51**	**-**	**199**	**246**	**450,859**	**2,060**	**453,415**

Consolidated group 2021/22	Buildings excluding dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	**2,643**	**115**	**10,337**	**694**	**878,009**	**16,007**	**907,805**
Addition of assets under construction and payments on account	-	15,154	-	-	-	-	**15,154**
Additions purchased	-	-	125	-	113,179	1,891	**115,195**
Reclassifications	(38)	(16,527)	11	-	11,362	(38)	**(5,230)**
Disposals	(216)	(115)	(3,267)	-	(84,358)	(3,183)	**(91,139)**
Transfer (to)/from another public sector body	6,675	27,392	23,687	-	13,176	6,365	**77,295**
Cost or valuation at 31 March 2022	**9,064**	**26,019**	**30,893**	**694**	**931,368**	**21,042**	**1,019,080**
Depreciation 1 April 2021	**896**	**-**	**7,864**	**448**	**413,065**	**11,695**	**433,968**
Reclassifications	(38)	-	12	-	(1,441)	(35)	**(1,502)**
Disposals	(127)	-	(2,902)	-	(83,583)	(2,799)	**(89,411)**
Impairments charged	742	-	-	-	-	-	**742**
Charged during the year	572	-	2,667	118	176,060	2,187	**181,604**
Transfer (to)/from another public sector body	1,154	-	10,881	-	5,874	777	**18,686**
At 31 March 2022	**3,199**	**-**	**18,522**	**566**	**509,975**	**11,825**	**544,087**
Carrying value at 31 March 2022	**5,865**	**26,019**	**12,371**	**128**	**421,393**	**9,217**	**474,993**
Asset financing:							
Owned	5,865	26,019	11,860	128	421,393	9,217	**474,482**
Held on finance lease	-	-	511	-	-	-	**511**
Total at 31 March 2022	**5,865**	**26,019**	**12,371**	**128**	**421,393**	**9,217**	**474,993**

Consolidated group 2020/21							
Cost or valuation at 1 April 2020	**2,662**	**427**	**10,769**	**694**	**879,055**	**19,374**	**912,981**
Addition of assets under construction and payments on account	-	-	-	-	-	-	**-**
Additions purchased	-	-	166	-	156,055	338	**156,559**
Reclassifications	-	(312)	(2)	-	81	140	**(93)**
Disposals	(19)	-	(596)	-	(146,773)	(3,830)	**(151,218)**
Impairments charged	-	-	-	-	(85)	-	**(85)**
Transfer (to)/from another public sector body	-	-	-	-	(10,324)	(15)	**(10,339)**
Cost or valuation at 31 March 2021	**2,643**	**115**	**10,337**	**694**	**878,009**	**16,007**	**907,805**
Depreciation 1 April 2020	**644**	**-**	**7,570**	**330**	**405,529**	**12,448**	**426,521**
Reclassifications	-	-	-	-	(204)	140	**(64)**
Disposals	(19)	-	(557)	-	(146,387)	(3,651)	**(150,614)**
Impairments charged	-	-	26	-	71	67	**164**
Charged during the year	271	-	825	118	164,380	2,706	**168,300**
Transfer (to)/from another public sector body	-	-	-	-	(10,324)	(15)	**(10,339)**
At 31 March 2021	**896**	**-**	**7,864**	**448**	**413,065**	**11,695**	**433,968**
Carrying value at 31 March 2021	**1,747**	**115**	**2,473**	**246**	**464,944**	**4,312**	**473,837**
Asset financing:							
Owned	1,747	115	1,877	246	464,944	4,312	**473,241**
Held on finance lease	-	-	596	-	-	-	**596**
Total at 31 March 2021	**1,747**	**115**	**2,473**	**246**	**464,944**	**4,312**	**473,837**

7. Intangible non-current assets

Parent 2021/22	Computer software: purchased	Development expenditure (internally generated)	Total
	£000	£000	£000
Cost or valuation at 1 April 2021	**46,886**	**4,216**	**51,102**
Additions purchased	9,103	11,386	**20,489**
Reclassifications	3,197	1,539	**4,736**
Disposals	(1,444)	-	**(1,444)**
At 31 March 2022	**57,742**	**17,141**	**74,883**
Amortisation 1 April 2021	4,218	1,204	**5,422**
Reclassifications	1,010	-	**1,010**
Disposals	(1,444)	-	**(1,444)**
Charged during the year	12,118	1,658	**13,776**
At 31 March 2022	**15,902**	**2,862**	**18,764**
Carrying value at 31 March 2022	**41,840**	**14,279**	**56,119**
Asset financing:			
Owned	41,840	14,279	**56,119**
Total at 31 March 2022	**41,840**	**14,279**	**56,119**

Parent 2020/21	Computer software: purchased	Development expenditure (internally generated)	Total
	£000	£000	£000
Cost or valuation at 1 April 2020	**8,202**	**2,122**	**10,324**
Additions purchased	41,447	2,094	**43,541**
Reclassifications	-	-	-
Disposals	(2,763)	-	**(2,763)**
At 31 March 2021	**46,886**	**4,216**	**51,102**
Amortisation 1 April 2020	**5,474**	**700**	**6,174**
Reclassifications	(27)	-	**(27)**
Disposals	(2,763)	-	**(2,763)**
Charged during the year	1,534	504	**2,038**
At 31 March 2021	**4,218**	**1,204**	**5,422**
Carrying value at 31 March 2021	**42,668**	**3,012**	**45,680**
Asset financing:			
Owned	42,668	3,012	**45,680**
Total at 31 March 2021	**42,668**	**3,012**	**45,680**

Consolidated group 2021/22	Computer software: purchased	Development expenditure (internally generated)	Total
	£000	£000	£000
Cost or valuation at 1 April 2021	**55,979**	**5,851**	**61,830**
Additions purchased	10,327	11,386	**21,713**
Reclassifications	3,690	1,540	**5,230**
Disposals	(5,127)	-	**(5,127)**
Transfer (to)/from other public sector body	1,142	-	**1,142**
At 31 March 2022	**66,011**	**18,777**	**84,788**
Amortisation 1 April 2021	**12,197**	**2,398**	**14,595**
Reclassifications	1,502	-	**1,502**
Disposals	(5,089)	-	**(5,089)**
Charged during the year	12,917	1,879	**14,796**
Transfer (to) from another public sector body	761	-	**761**
At 31 March 2022	**22,288**	**4,277**	**26,565**
Carrying value at 31 March 2022	**43,723**	**14,500**	**58,223**
Asset financing:			
Owned	43,723	14,500	**58,223**
Total at 31 March 2022	**43,723**	**14,500**	**58,223**

Consolidated group 2020/21	Computer software: purchased	Development expenditure (internally generated)	Total
	£000	£000	£000
Cost or valuation at 1 April 2020	**19,662**	**3,757**	**23,419**
Additions purchased	41,717	2,094	**43,811**
Reclassifications	93	-	**93**
Disposals	(4,774)	-	**(4,774)**
Transfer (to)/from another public sector body	(719)	-	**(719)**
At 31 March 2021	**55,979**	**5,851**	**61,830**
Amortisation 1 April 2020	**12,904**	**1,674**	**14,578**
Reclassifications	64	-	**64**
Disposals	(3,414)	-	**(3,414)**
Impairments charged	73	-	**73**
Charged during the year	3,289	724	**4,013**
Transfer (to)/from another public sector body	(719)	-	**(719)**
At 31 March 2021	**12,197**	**2,398**	**14,595**
Carrying value at 31 March 2021	**43,782**	**3,453**	**47,235**
Asset financing:			
Owned	43,782	3,453	**47,235**
Total at 31 March 2021	**43,782**	**3,453**	**47,235**

8. Inventories

Parent 2021/22	Consumables	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000
Balance at 1 April 2021	15,966	-	42,863	**58,829**
Additions	-	-	109,357	**109,357**
Inventories recognised as an expense in the period	(8,438)	-	(129,837)	**(138,275)**
Balance at 31 March 2022	**7,528**	**-**	**22,383**	**29,911**

Parent 2020/21	Consumables	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000
Balance at 1 April 2020	-	-	46,168	**46,168**
Additions	15,966	-	324,059	**340,025**
Inventories recognised as an expense in the period	-	-	(327,364)	**(327,364)**
Balance at 31 March 2021	**15,966**	**-**	**42,863**	**58,829**

Consolidated Group 2021/22	Consumables	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000
Balance at 1 April 2021	17,640	9,814	43,814	**71,268**
Additions	1,336,502	3,280	111,133	**1,450,915**
Inventories recognised as an expense in the period	(1,345,363)	(4,774)	(132,211)	**(1,482,348)**
Write-down of inventories (including losses)	(1,529)	-	-	**(1,529)**
Transfer (to)/from other public sector body	152,434	-	2,316	**154,750**
Transfer (to) from - goods for resale	-	-	-	**-**
Balance at 31 March 2022	**159,684**	**8,320**	**25,052**	**193,056**

Consolidated Group 2020/21	Consumables	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000
Balance at 1 April 2020	3,583	11,676	49,451	**64,710**
Additions	16,059	5,491	324,058	**345,608**
Inventories recognised as an expense in the period	(1,410)	(7,353)	(330,287)	**(339,050)**
Write-down of inventories (including losses)	-	-	-	**-**
Transfer (to)/from other public sector body	-	-	-	**-**
Transfer (to) from - goods for resale	(592)	-	592	**-**
Balance at 31 March 2021	**17,640**	**9,814**	**43,814**	**71,268**

9. Trade and other receivables

	Parent				Consolidated group			
	Current	Non-current	Current	Non-current	Current	Non-current	Current	Non-current
	2021/22	2021/22	2020/21	2020/21	2021/22	2021/22	2020/21	2020/21
	£000	£000	£000	£000	£000	£000	£000	£000
NHS receivables: revenue	67,029	-	221,448	-	324,737	-	294,931	-
NHS prepayments	72,474	-	24,909	-	155,247	-	70,333	-
NHS accrued income	11,668	-	5,892	-	76,913	-	50,960	-
NHS non-contract	1,658	-	-	-	491	-	623	-
Non-NHS and other WGA receivables: revenue	263,340	-	214,355	-	431,777	-	405,569	-
Non-NHS and other WGA receivables: capital	-	-	710	-	-	-	710	-
Non-NHS and other WGA prepayments	89,254	-	407,652	-	203,127	238	517,954	295
Non-NHS and other WGA accrued income	190,772	-	108,508	-	2,203,102	-	189,398	-
Non-NHS and other WGA non-contract	400	-	-	-	2,413	-	5,682	-
Non-NHS contract assets	-	-	-	-	-	-	577	-
Expected credit loss allowance-receivables	(10,868)	-	(3,972)	-	(27,725)	-	(27,651)	-
VAT	37,230	-	28,309	-	334,141	-	48,477	-
Finance lease receivables	-	-	-	-	363	1,258	-	-
Other receivables and accruals	1,666	-	1,523	-	34,301	-	15,760	-
Total	**724,623**		**1,009,334**	**-**	**3,738,887**	**1,496**	**1,573,323**	**295**
Other financial assets	-	141,192	-	-	-	2,106	-	2,106
Total current and non-current	**865,815**		**1,009,334**		**3,742,489**		**1,575,724**	

Other financial assets in the parent comprises the 100% shareholding of SCCL.

SCCL is consolidated into the NHS England group account and the investment is therefore eliminated from the NHS England group figures. The measurement basis for the investment is a net asset basis that is reviewed annually. The classification of the inputs used to value the equity investment as required by IFRS 13 is at Level 2.

10. Cash and cash equivalents

		Parent		Consolidated group	
		2021/22	2020/21	2021/22	2020/21
	Note	£000	£000	£000	£000
Balance at 1 April		150,032	151,683	114,411	154,285
Transfer in from other org under absorption		-	-	269,704	-
Net change in year		79,543	(1,651)	(9,360)	(39,874)
Balance at statement of financial position date		**229,575**	**150,032**	**374,755**	**114,411**
Made up of:					
Cash with the Government Banking Service		214,719	98,054	370,517	106,885
Hosted cash/cash in hand		13,634	52,092	13,433	52,459
Current investments		1,222	(114)	1,222	(114)
Cash and cash equivalents as in statement of financial position		**229,575**	**150,032**	**385,172**	**159,230**
Bank overdraft: Government Banking Service	11	-	-	(10,417)	(44,819)
Total bank overdrafts		**-**	**-**	(10,417)	**(44,819)**
Balance at statement of financial position date		**229,575**	**150,032**	**374,755**	**114,411**

For details of bank overdraft see note 11.

Included within hosted cash/cash in hand above is £13.6 million (2020/21 £51.2 million) held on behalf of NHS England by the NHS Business Services Authority.

Current investments within cash and cash equivalents include cash held in solicitor commercial escrow accounts that is not available for use by the group.

11. Trade and other payables

	Parent				Consolidated group			
	Current	Non-current	Current	Non-current	Current	Non-current	Current	Non-current
	2021/22	2021/22	2020/21	2020/21	2021/22	2021/22	2020/21	2020/21
	£000	£000	£000	£000	£000	£000	£000	£000
NHS payables: revenue	178,777	-	174,766	-	340,774	-	259,187	-
NHS payables: capital	22,622	-	31,786	-	103	-	3,249	-
NHS accruals	633,882	-	1,084,415	-	904,319	-	1,270,004	-
NHS deferred income	1,081	-	2,147	-	40,268	-	967	-
NHS contract liabilities	-	-	-	-	96,519	-	-	-
Non-NHS and other WGA payables: revenue	204,405	-	236,856	-	1,772,912	-	1,373,165	-
Non-NHS and other WGA payables: capital	60,292	-	40,406	-	62,730	-	41,272	-
Non-NHS and other WGA accruals	1,418,112	-	1,666,221	-	6,309,794	-	6,407,446	-
Non-NHS and other WGA deferred income	1,866	-	7,470	-	41,154	612	25,673	435
Non-NHS contract liabilities	-	-	-	-	10,336	-	390	-
Social security costs	13,043	-	11,650	-	30,487	-	27,074	-
VAT	-	-	-	-	54,039	-	50	-
Tax	24,890	-	23,232	-	40,108	-	37,210	-
Payments received on account	-	-	75	-	160	-	102	-
Other payables and accruals	462,597	31	679,248	30	1,319,257	264	1,566,093	4,333
Total	**3,021,567**	**31**	**3,958,272**	**30**	**11,022,960**	**876**	**11,011,882**	**4,768**
Other financial liabilities								
Bank overdraft: Government Banking Service	-	-	-	-	10,417	-	44,819	-
Finance lease liabilities	-	-	-	-	121	544	121	642
Other financial liabilities - other	-	-	-	-	-	72	-	86
Loans from Department of Health and Social Care [155]	-	-	-	-	-	2,233,920	-	-
Total	**-**	**-**	**-**	**-**	**10,538**	**2,234,536**	**44,940**	**728**
Total trade and other payables (current)	**3,021,567**		**3,958,272**		**11,033,498**		**11,056,822**	
Total trade and other payables (non-current)		**31**		**30**		**2,235,412**		**5,496**
Total trade and other payables (current and non-current)		**3,021,598**		**3,958,302**		**13,268,910**		**11,062,318**

[155] Loans from the Department of Health and Social Care represent amounts issued to Supply Chain Coordination Limited to provide a working capital facility

12. Net gain/(loss) on transfer by absorption

Business combinations within the public sector are accounted for using absorption accounting principles.

On 1 October 2021 the activities of PHE were divided between DHSC, the UK Health Security Agency, NHS Digital and NHS England. The assets and liabilities transferred to NHS England, the parent, are included in the table below.

On 1 October 2021 the entire shareholding of Supply Chain Coordination Limited (SCCL) transferred from DHSC to NHS England, the parent entity. On consolidation into the NHS England group this equity investment is eliminated and replaced with the net assets and liabilities of SCCL. The value of the net assets transferred under the absorption method is included in the table below.

	Parent		Consolidated Group	
	PHE	DHSC	PHE	SCCL
	2021/22	2021/22	2021/22	2021/22
	£'000	£'000	£'000	£'000
Transfer of property plant and equipment	-	-	-	57,270
Transfer of intangibles	1,543	-	1,543	380
Transfer of financial assets	-	159,000	-	-
Transfer of cash and cash equivalents	-	-	-	269,704
Transfer of inventories	-	-	-	154,751
Transfer of receivables	727	-	727	370,615
Transfer of other current assets	-	-	-	2,162,901
Transfer of payables	(6,730)	-	(6,730)	(189,221)
Transfer of other current liabilities	-	-	-	(595,377)
Transfer of provisions	-	-	-	(2,803)
Transfer of non current borrowings	-	-	-	(2,083,920)
Net (gain) loss on transfers by absorption	**(4,460)**	**159,000**	**(4,460)**	**144,300**

13. Finance costs

	Parent		Consolidated Group	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Interest				
Interest on loans and overdrafts	-	-	150	-
Interest on obligations under finance leases	-	-	27	30
Interest on late payment of commercial debt	-	-	-	3
Other interest expense	79	-	79	-
Total interest	**79**	**-**	**256**	**33**
Other finance costs	-	-	50	-
Provisions: unwinding of discount	2,726	5,028	3,118	5,136
Total finance costs	**2,805**	**5,028**	**3,424**	**5,169**

14. Provisions

Parent	Current	Non-current	Current	Non-current
	2021/22	2021/22	2020/21	2020/21
	£000	£000	£000	£000
Restructuring	3,651	-	551	-
Redundancy	1,686	-	-	-
Legal claims	133	158	85	70
Continuing care	5,228	-	8,654	-
Clinician Tax Charge	2,955	286,607	-	302,900
Other	68,931	65,687	28,394	20,287
Total	**82,584**	**352,452**	**37,684**	**323,257**
Total current and non-current	**435,036**		**360,941**	

	Restructuring	Redundancy	Legal Claims	Continuing Care	Clinician Tax Charge	Other	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2021	**551**	**-**	**155**	**8,654**	**302,900**	**48,681**	**360,941**
Arising during the year	3,651	1,686	291	10,150	8,575	119,609	**143,962**
Utilised during the year	-	-	(73)	(2,486)	(591)	(5,175)	**(8,325)**
Reversed unused	(551)	-	(82)	(11,268)	(1,830)	(27,328)	**(41,059)**
Unwinding of discount	-	-	-	62	3,893	(1,229)	**2,726**
Change in discount rate	-	-	-	116	(23,385)	60	**(23,209)**
Transfer (to) from other public sector body	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	**-**
Balance at 31 March 2022	**3,651**	**1,686**	**291**	**5,228**	**289,562**	**134,618**	**435,036**
Expected timing of cash flows:							
Within one year	3,651	1,686	133	5,228	2,955	68,931	**82,584**
Between one and five years	-	-	158	-	10,163	61,474	**71,795**
After five years	-	-	-	-	276,444	4,213	**280,657**
Balance at 31 March 2022	**3,651**	**1,686**	**291**	**5,228**	**289,562**	**134,618**	**435,036**

Consolidated Group	Current	Non-current	Current	Non-current
	2021/22	2021/22	2020/21	2020/21
	£000	£000	£000	£000
Restructuring	14,040	984	5,233	111
Redundancy	5,980	-	3,362	43
Legal claims	8,651	1,065	2,695	541
Continuing care	86,532	31,646	82,683	14,745
Clinician Tax Charge	2,955	286,607	-	302,900
Other	132,768	93,241	90,019	39,028
Total	**250,926**	**413,543**	**183,992**	**357,368**
Total current and non-current	**664,469**		**541,360**	

	Restructuring	Redundancy	Legal Claims	Continuing Care	Clinician Tax Charge	Other	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2021	5,344	3,405	3,236	97,428	302,900	129,047	**541,360**
Arising during the year	11,115	5,544	8,242	85,642	8,575	170,496	**289,614**
Utilised during the year	(789)	(991)	(216)	(16,734)	(591)	(18,162)	**(37,483)**
Reversed unused	(1,458)	(1,578)	(1,723)	(48,568)	(1,830)	(56,746)	**(111,903)**
Unwinding of discount	47	-	-	379	3,893	(1,201)	**3,118**
Change in discount rate	32	-	177	31	(23,385)	105	**(23,040)**
Transfer (to) from other public sector body	733	(400)	-	-	-	(333)	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	2,803	**2,803**
Balance at 31 March 2022	**15,024**	**5,980**	**9,716**	**118,178**	**289,562**	**226,009**	**664,469**
Expected timing of cash flows:							
Within one year	14,040	5,980	8,651	86,532	2,955	132,768	**250,926**
Between one and five years	984	-	1,065	31,646	10,163	80,261	**124,119**
After five years	-	-	-	-	276,444	12,980	**289,424**
Balance at 31 March 2022	**15,024**	**5,980**	**9,716**	**118,178**	**289,562**	**226,009**	**664,469**

NHS Continuing Healthcare is a package of health and social care arranged and funded solely by the NHS for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness. Where an individual has both health and social care needs, but they have been assessed as having a 'primary health need' under the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, the NHS has responsibility for providing for all of that individual's assessed needs, both the health and social care. The amount included in the table above as 'Continuing Care'

represents the best estimate, at the year-end date, of the liabilities of NHS England group relating to the obligation of the NHS to pay for cases of such care and hence its responsibility for reimbursing patients and their families for costs incurred.

The pensions reimbursement provision In the parent is £290 million for the commitment to pay clinicians in the NHS Pension Scheme for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement, in line with the ministerial direction to DHSC and NHS England.

Other provisions in both the parent and the group is primarily provisions for pension disputes and dilapidations.

The NHS Resolution financial statements disclose a provision of £74,786,491 as at 31 March 2022 in respect of clinical negligence liabilities and employment liability scheme of NHS England (31 March 2021: £43,449,741).

15. Contingencies

	Parent		Consolidated Group	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Contingent liabilities				
Employment tribunal	338	133	438	140
NHS Resolution employee liability claim	9	7	10	7
Continuing healthcare	-	-	12,955	14,479
Legal claims	2,278	6,834	2,589	6,948
Legacy Pension issues	250	10,250	250	10,250
His Majesty's Revenue and Customs	-	-	-	409
Sandwell Children's Trust Complex Placements	-	-	1,592	-
GP Non Reimbursable property costs	-	-	2,990	-
Other	1,673	-	1,673	618
Total contingent liabilities	**4,548**	**17,224**	**22,497**	**32,851**

	Parent		Consolidated Group	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Contingent assets				
Legal cases	2,522	2,188	2,522	2,188
Employee pension issues	-	75	-	75
Rates Rebates	-	-	251	329
Total contingent assets	**2,522**	**2,263**	**2,773**	**2,592**

Contingent liabilities are those for which provisions have not been recorded as there is a possible obligation depending on uncertain future events, or a present obligation where payment is not probable or the amount cannot be measured reliably.

Contingent assets are those where a possible asset arises from a past event and whose existence will be confirmed only by the occurrence or non-occurrence of an uncertain future event not wholly within the control of the entity. These are disclosed only when the inflow of economic benefit is probable.

16. Commitments

16.1 Capital commitments

	Parent		Consolidated group	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Property, plant and equipment	32,734	30,790	37,626	30,790
Total	**32,734**	**30,790**	**37,626**	**30,790**

16.2 Other financial commitments

NHS England has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	Parent		Consolidated group	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
In not more than one year	517,836	269,783	777,875	447,971
In more than one year but not more than five years	505,649	443,372	590,205	480,643
In more than five years	-	-	44,716	68,294
Total	**1,023,485**	**713,155**	**1,412,796**	**996,908**

In the parent account the most significant contracts relate to:

- contract with Capita for the delivery of administration services for Primary Care
- PET Scanner contract with Alliance Medical
- Health & Justice contract with Spectrum
- Health & Justice contracts with Care UK
- NHS 111.

Excluding the largest parent financial commitments already disclosed, the most significant other group commitments relate to:

a) a contract between NHS Banes, Swindon & Wiltshire CCG and Wiltshire Health & Care Ltd in relation to the Adult Community Services.

17. Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS England is financed through parliamentary funding, it 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 listed companies, to which the financial reporting standards mainly apply. NHS England has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day

operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS England standing financial instructions and policies agreed by the CCG Governing Bodies. Treasury activity is subject to review by the NHS England internal auditors.

17.1.1 Currency risk

NHS England is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based.

NHS England has no overseas operations. NHS England therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

NHS England does not have any borrowings that are subject to interest rate risk.

17.1.3 Credit risk

Because the majority of NHS England revenue comes from parliamentary funding, NHS England has low exposure to credit risk. The maximum exposure as at the end of the financial year is in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk

NHS England is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament.

NHS England draws down cash to cover expenditure, as the need arises. NHS England is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

18. Operating segments

Consolidated group 2021/22	CCGs	SCCL	Direct commissioning	NHS England	Other	Intra-group eliminations	NHS England group total
	£000	£000	£000	£000	£000	£000	£000
Income	(658,908)	(1,480,957)	(1,290,789)	(49,033)	(636,122)	811,013	(3,304,796)
Gross expenditure	115,514,149	1,484,067	30,176,545	5,595,599	1,582,080	(811,013)	153,541,427
Total net expenditure	**114,855,241**	**3,110**	**28,885,756**	**5,546,566**	**945,958**	**-**	**150,236,631**
Revenue resource expenditure							
Revenue departmental expenditure limit							150,113,603
Annually managed expenditure							121,752
Technical expenditure							1,276
Total net expenditure							**150,236,631**

Consolidated group 2020/21	CCGs	SCCL	Direct commissioning	NHS England	Other	Intra-group eliminations	NHS England group total
	£000	£000	£000	£000	£000	£000	£000
Income	(642,139)	-	(896,382)	(31,943)	(597,893)	681,632	(1,486,725)
Gross expenditure	102,477,960	-	28,050,741	5,200,129	10,931,445	(681,632)	145,978,643
Total net expenditure	**101,835,821**	**-**	**27,154,359**	**5,168,186**	**10,333,552**	**-**	**144,491,918**
Revenue resource expenditure							
Revenue departmental expenditure limit							144,272,533
Annually managed expenditure							87,223
Technical expenditure							132,162
Total net expenditure							**144,491,918**

The reportable segments disclosed within this note reflect the current structure of NHS England with the activities of each reportable segment reflecting the remit of the organisation. These operating segments are regularly reported to the NHS England Board of Directors for financial management and decision making purposes.

The activities of each segment are defined as follows:

CCGs - clinically led groups that are responsible for commissioning healthcare services as defined in the Health and Social Care Act 2012.

SCCL - the management function for the NHS Supply Chain operating model

Direct Commissioning - the services commissioned by NHS England (via Local Offices and Specialised Commissioning Hubs) as defined in the Health and Social Care Act 2012.

NHS England - the central administration of the organisation and centrally managed programmes.

Other - includes commissioning support units, national reserves, technical accounting items and legacy balances.

Multiple transactions take place between reportable segments, all of which are eliminated upon consolidation as shown in the ""Intra-group eliminations"" column. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure.

19. Related party transactions

As disclosed in note 1.3 NHS England acts as the parent to 106 CCGs and SCCL, whose accounts are consolidated within these Financial Statements. These bodies are regarded as related parties with which the Parent has had various material transactions during the year; those transactions are disclosed in those entities' financial statements.

The Department of Health and Social Care, as the parent of NHS England, is regarded as a related party. During the year NHS England has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

For example:

- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority
- NHS Property Service
- NHS Health Education England
- NHS Shared Business Services (DH Equity Investment).

In addition, NHS England has had a number of significant transactions with other government departments and their agencies including HMRC, Ministry of Justice and His Majesty's Prison and Probation Service. No related party transactions were noted with key management personnel other than the compensation paid to them, which can be found in the remuneration report from page 121.

20. Events after the end of the reporting period

There are no adjusting events after the reporting period which will have a material effect on the financial statements of NHS England.

From 1 April 2021 a number of CCGs commenced delegated commissioning arrangements, taking the total number operating under the initiative to 106 (all CCGs)

From 1 July 2022 NHS England will take on the functions of NHS TDA and Monitor. On this date their functions, asset and liabilities were transferred.

On 22 November 2021 DHSC announced the intention to merge the body responsible for the education and training of NHS staff, Health Education England (HEE) with NHS England and NHS Improvement and accepted a recommendation from the Chair of NHS Digital to merge NHS Digital and NHSX into NHS England. The changes are subject to legislation and the expected date for the transfer of assets and liabilities of NHS Digital to NHS England is 1 February 2023 and 1 April 2023 for HEE. The change has no impact on NHS England's accounts for 2021/22 and no adjustments have been made as a result.

From 1 July 2022 the CCGs were dissolved under the provisions of the Health and Care Act 2022 and 42 ICBs were created. The operational activities, assets and liabilities of the CCGs were transferred in full to the ICBs. These transfers were reflected as absorption transfers in the underlying ICB accounts. All the affected entities are within the NHS England group and therefore there is no impact on the NHS England group position.

The Accounts were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller & Auditor General.

21. Financial performance targets

The Mandate: A mandate from the Government to NHS England: April 2021 to March 2022 published by the Secretary of State under section 13A of the National Health Service Act 2006, and the associated Financial Directions as issued by the Department of Health and Social Care, set out NHS England's total revenue resource limit and total capital resource limit for 2021/22 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to Department of Health and Social Care.

	2021/22						2020/21
	Revenue Departmental Expenditure Limit			Annually managed expenditure	Technical	Total	Total
	Non ringfenced	Ringfenced	Total RDEL				
	£000	£000	£000	£000	£000	£000	£000
Mandate Limit	150,614,000	197,000	150,811,000	150,000	200,000	151,161,000	149,947,206
Actual expenditure [156] [157]	149,916,602	197,000	150,113,602	121,752	1,277	150,236,631	144,491,918
Surplus	**697,398**	**-**	**697,398**	**28,248**	**198,723**	**924,369**	**5,455,288**

	2021/22	2020/21
	Capital resource limit	Capital resource limit
	£000	£000
Limit	337,000	365,000
Actual expenditure [158]	291,417	331,118
Surplus	**45,583**	**33,882**

NHS England is required to spend no more than £1,785,000k of its Revenue Departmental Expenditure Limit mandate on matters relating to administration. The actual amount spent on RDEL administration matters to 31st March 2022 was £1,542,499k as set out below:

	2021/22	2020/21
Administration Limit:	**£000**	**£000**
Net administration costs before interest	1,597,217	1,568,965
Less:		
Administration expenditure covered by AME/Technical funding	(54,718)	(2,814)
Administration costs relating to RDEL	1,542,499	1,566,151
RDEL Administration expenditure limit	1,785,000	1,765,000
Underspend	**242,501**	**198,849**

The various limits of expenditure set out in the table above stem from the limits imposed by HM Treasury on the Department of Health and Social Care. Departmental Expenditure Limits

[156] Actual expenditure figures are for the full group including Supply Chain Coordination Ltd.

[157] An additional £144,000 of ringfenced DEL depreciation expenditure in 2021/22 has been charged against the non-ringfenced DEL budget as agreed with the Department of Health and Social Care.

are set in the Spending Review, and government departments may not exceed the limits they have been set. This control is passed down to NHS England by Department of Health and Social Care and NHS England may not therefore exceed its Departmental Expenditure Limit.

Annually Managed Expenditure is subject to budgets set by HM Treasury. Departments must manage AME closely and inform HM Treasury if they expect AME to rise above forecast. Any increase requires HM Treasury approval.

22. Entities within the consolidated group

NHS England acts as the Parent of the group comprising 106 CCGs (2020/21: 135 CCGs) whose accounts are consolidated within these Financial Statements.

A full list of the CCGs can be found on the NHS England website.

From 1 October 2021 NHS England acts as the Parent of SCCL whose accounts are consolidated within these financial statements. Copies of their accounts can be found on their website[158].

The parent entity of NHS England is the Department of Health and Social Care.

The largest group of entities for which group accounts are drawn up and of which NHS England is a member is the Department of Health and Social Care Group.

Copies of the accounts can be obtained from the Government website[159].

[158] https://www.supplychain.nhs.uk/sccl/
[159] www.gov.uk/government/publications

Appendices

Appendix 1: How we delivered against the government's mandate to the NHS

The government's mandate to NHS England sets out the strategic direction of the organisation, describes the government's healthcare priorities and the contribution NHS England and NHS Improvement are expected to make within the allocated budget, and helps ensure the NHS is accountable to both Parliament and the public.

The 2021/22 mandate was set as we began to emerge from the COVID-19 pandemic, continuing to respond to it through treatment and vaccination while also recovering other services to pre-pandemic levels. Core performance objectives were set and, to assess against these objectives, 17 deliverables were agreed with the DHSC for assurance alongside a further requirement to ensure robust financial performance in 2021/22.

The assessment of performance against 2021/22 mandate captures our broad assessment of our performance against the backdrop of pandemic response and recovery, which follows assessments by policy teams at NHS England and NHS Improvement and DHSC.

In summary, as of January 2023 NHS England have delivered the majority of the commitments in the mandate at either Green or Amber/Green RAG ratings.

Objective 1: Continue to lead the NHS response to COVID-19

This objective focused on how NHS England and NHS Improvement would continue to lead the NHS in providing effective care to patients with COVID-19 both inside and outside hospital, support research and innovation in COVID-19 treatments to improve patient outcomes, and support the health and wellbeing of NHS staff. To this end, NHS England and NHS Improvement's success was measured on best practice for all COVID-19 patients and those with "long COVID-19", the rollout of the vaccine, and meeting Accessible Information Standards.

To ensure all COVID-19 patients were treated in accordance with emerging best practice, NHS England and NHS Improvement established 90 post- COVID-19 services and 14 paediatric specialist hubs, as well as the monthly publication of post- COVID-19 service performance data from September 2021. In addition to this, guidance was published to support NHS staff experiencing long- COVID-19 symptoms and vocational rehabilitation training provided through national webinars.

Vaccines have continued to be deployed at pace. Between April 2021 and March 2022, the COVID-19 vaccination programme delivered 89 million doses and a total of 123 million have been delivered since the programme was launched. Of these, 32 million have been third doses and boosters.

Ensuring that the NHS is meeting Accessible Information Standards continued through the commencement of a review of the standards by the Patient Equalities Team at NHS England

and NHS Improvement and the North of England Commissioning Support Unit. The consultation and engagement phase of this review was completed on time and recommendations are now being piloted, with supporting documentation due to be published in Q4 of 2022/23.

Objective 2: Continue to implement the NHS Long Term Plan, focusing on transformation of services, to support NHS resilience, and continue to inspire public confidence

Objective 2 captures the 52 metrics identified to measure progress against implementation of key Long Term Plan programmes. As agreed with the government, NHS England and NHS Improvement reports on performance against these metrics quarterly to DHSC.

The pandemic has had a significant, and variable impact on these metrics. For some we have seen an acceleration of delivery plans to assist with our response to COVID-19. However, delivery against many of the metrics has been severely negatively impacted by our need to focus on the pandemic response, the additional disease burden or the reduced productivity we have had to manage in the NHS in order to keep our patients and staff safe.

Objective 3: With support from Government, deliver the manifesto priorities that will enhance delivery of the NHS Long Term Plan

The Government's 2019 manifesto set out a number of commitments which NHS England and NHS Improvement will continue to take forward alongside their response to the pandemic. Objective 3 was measured on NHS England and NHS Improvement's adherence to conditions for the Better Care Fund (BCF) including the NHS contribution to the BCF, and NHS England's willingness to consult the government before approving BCF plans.

To this end, the Better Care Fund plans for 2021/22 were assured by the NHS and local government regional teams, and recommendations were agreed with the BCF Programme Board (Chaired by DHSC and Department for Levelling Up, Housing and Communities), prior to approval by NHS England regional directors on behalf of the NHS England Executive Group.

Objective 4: Improving prevention of ill health and delivery of NHS public health services

This objective focused on the urgency that the pandemic brought in highlighting the need for the government and NHS England to take broader action on preventable ill health. This included investment in evidence-based programmes on smoking, alcohol and secondary prevention of heart attacks, stroke, diabetes and dementia.

NHS England and NHS Improvement's success was measured on; timely influenza vaccine rollout, efforts to recover NHS public health services, including school aged vaccinations and cancer and non-cancer screening programmes that had paused or reduced due to the pandemic, meaningful action on measles and rubella, the age extension of the NHS bowel

cancer screening programme, weight management services including increasing access and coverage, and tackling health inequalities.

Vaccinations and immunisations (additional to COVID-19 vaccinations) continued to be delivered at pace, with 22.2 million flu vaccines being administered in 2021/22, the highest ever since the programme began in the late 1960s. In addition to this, the update of school age immunisations was 20% higher in 2021/22 than in 2020/21.

On cancer screening, the invitation backlog continued to decrease as mammogram screening activity by NHS providers remained at higher levels than pre-pandemic. In addition to this, budgetary approval was given to commence the build of interface to allow AI reads of images directly into breast screening systems.

On weight management services, new NHS-commissioned weight management services were mobilised from April 2021, with a digital referral hub for GPs operational from late April. An acceleration of referrals was observed in Q4 21/22 with 113,990 referrals recorded by the Digital Weight Management Programme (DWMP) to end March 2023. GP incentives for referrals to weight management services continues throughout 2022/23.

Progress on tackling health inequalities continued, with the Health Inequalities Improvement Dashboard being launched with local authorities, ICSs and PCNs having access – allowing them to build on learning from the COVID-19 pandemic around the importance of good quality data to provide insights to drive improvements in tackling health inequalities.

Objective 5: Maintain and improve information sharing

Sharing information with government has been an essential part of our pandemic response and supporting the Secretary of State to fulfil his functions. In meeting this objective, NHS England continued to embed a culture of transparency and openness through the NHS, reducing barriers to information sharing (including between providers of services) to ensure that patients receive high quality, safe and integrated care, whatever service they are using, while at the same time, continuing to work with Government and wider NHS partners to improve data collection processes, reducing unnecessary administrative burdens on frontline organisations.

Recognising the importance of transparency and openness, NHS England's IG Portal brings together national guidance on information governance to ensure frontline staff and IG professionals understand how to use information appropriately to support health and care purposes. NHS England and NHS Improvement have also been working in partnership with NHSX (now the NHS Transformation Directorate) and other national organisations to use their health and care data to minimise the burden of collecting more data from frontline service providers.

Financial objectives

The final budget for the year included an additional £16.3 billion of revenue resource to support NHS England and NHS Improvement with ongoing COVID-19 costs. With this funding, NHS England and NHS Improvement were able to deliver financial balance in 2021/22.

Robust financial performance was achieved through delivering timely updates on both capital and revenue spending plans including data on capital deployment.

Appendix 2: Public and patient contact and complaints

It is important that the NHS listens to patients, carers and customers to make improvements to services. We need to ensure the experience of complaining and providing feedback is as easy as possible and that the experience is a positive one for everyone involved.

This year we have seen the number of complaints rise to a comparable level with pre-pandemic numbers. We have been working hard with providers to respond to those complaints and cases received during the pandemic while the service was 'paused'. Unfortunately, this has meant that in some cases we have taken longer than we would normally to provide a full and detailed response. We will continue to address this during 2022/23.

The Customer Contact Centre (CCC) has continued to deal with an increased volume of contacts. Dental contacts account for 60% of total volume and these mainly relate to people being unable to access local dentistry care. As a result, the CCC is operating on reduced hours to manage the high volume.

During 2021/22 we continued to provide thematic complaints information to regional and national commissioning colleagues as well as national policy leads. We worked with our regional complaints colleagues to help them identify complaints and themes of interest which could be shared by the national team.

Our face-to-face training programme for GPs and dentists, helping them to improve their complaint handling, resumed after being paused due to the pandemic. Feedback was universally positive, and we hope it will lead to better outcomes for patients complaining directly to providers in primary care.

In October 2021 we took over the responsibility for the National Complaints Managers Forum. This was previously run on a voluntary basis and is a source of support and information for complaints handlers across the NHS.

Actions for the year ahead include:

- working with the National Dental Team to streamline and improve the service when dental calls are presented to the CCC
- working with the Parliamentary and Health Service Ombudsman around the launch of their Complaints Standards which are due to be finalised in 2023
- supporting the transition to ICBs and work with the system to make necessary changes to the way complaints are managed by commissioners
- expanding the audience for thematic complaints information and continuing the regional deep dives with complaints teams.

Parliamentary and Health Service Ombudsman

The table below shows activity relating to complaints managed by NHS England; this activity was closed by the Parliamentary and Health Service Ombudsman (PHSO) between 1 April 2021 and 31 March 2022. Some of these complaints will have been received by NHS England prior to 1 April 2021 but have since progressed to the PHSO (after 1 April 2021), and hence are included in these figures. The PHSO paused its complaint investigation in 2020 in response to the COVID-19 pandemic and as a result we have seen fewer than usual cases being resolved in 2020/21.

All recommendations relating to partially upheld and fully upheld complaints were accepted and implemented

	Upheld	Partially upheld	Not upheld	Discontinued or other	Total cases
Number of Cases	2	0	5	1	8

KPI performance

	Target	2020/21	Q1	Q2	Q3	Q4	2021/22
General Enquiries							
No. of cases received		**176,999**	60,423	66,439	64,975	59,810	251,647
Resolved within 3 working days	95%	**89.9%**	70.2%	71.1%	81.1%	95.6%	79.3%
FOI							
No. of cases received		**3,427**	1,137	1,076	966	851	4,030
Resolved within 20 working days	80%	**63.2%**	67.46%	83.83%	78.78%	73.33%	75.8%
Concerns							
No. of cases received		**5,732**	2,897	2,340	2,128	2,188	9,553
Resolved within 10 working days	80%	**83.4%**	55.7%	71.5%	91.5%	93.5%	76.2%
Complaints							
No. of cases received		**5,096**	1,814	1,754	1,640	1,694	6,902
Acknowledged within 3 working days	100%	**91.7%**	86.9%	92.0%	93.2%	93.2%	91.3%
Resolved within 40 working days	90%	**26.1%**	23.2%	22.0%	23.2%	31.7%	25.0%
Median response time (working days)	<= 40	**66**	74	79	77	74	76
Admin Closures[160]							
No. of cases received		**10,568**	4,539	4,305	3,839	3,203	15,936

[160] An admin closure is where a case does not reach a conclusion, such as where a complainant does not consent to an investigation or an investigation is not permitted under NHS policy.

Who contacted us?

The table below shows the types of people who contacted us.

	2020/21	2021/22
Caller Type		
Member of the public	**95%**	92%
NHS Staff	**4%**	1%
Other	**1%**	7%

Contact Method

The table below shows the ways people contacted us

	2020/21	2021/22
All Cases		
Phone	**58%**	45%
Email	**39%**	54%
Post	**1%**	0%
Other (Facebook, Webchat, etc)	**2%**	1%
Complaints		
Phone	**36%**	34%
Email	**58%**	61%
Post	**3%**	2%
Other (Facebook, Webchat, etc)	**3%**	3%

Complaints by service are

The table below shows proportion of complaints concerning each service

	2020/21	2021/22
Service Area		
GP Surgery	**74%**	71%
Dental Surgery	**15%**	18%
Pharmacy	**5%**	5%
Commissioning	**0%**	1%
Prison or Detention	**2%**	1%
Other	**4%**	4%

Appendix 3: Meeting our Public Sector Equality Duty

Advancing equality for patients, the COVID-19 pandemic and addressing health inequalities

Key areas of patient equality focused work undertaken in 2021/22, by reference to protected characteristics, are described in Annex A under equality objectives (EO) 1, 3, 4, 5 and 7 of our full review report.[161]

In addition to extending and publishing, extended equality objectives for NHS England and NHS Improvement for 2021/22[162], key work focused on improving the capability of staff (EO1); improving the experience of LGBT staff (EO3); reducing language barriers (EO4); identifying how to improve equality information (EO5); and ensuring that the COVID-19 response effectively considered the Public Sector Equality Duty (PSED), equality considerations and associated health inequalities. We also worked on the publication of the 2020/21 Specific Equality Duties (SED) report, which was published in February 2022.[163] We also undertook a rapid review, engagement activities and key work to produce our future equality objectives report for 2022/23 and 2023/24 and develop targets for 2022/23.

At the end of March 2021, we published Priorities and Operational Planning Implementation Guidance for 2021/22[164]. This set out five key priority actions for the NHS to tackle health inequalities, and address equality considerations by reference to protected characteristics, which were:

- Priority 1: Restore NHS services inclusively
- Priority 2: Mitigate against digital exclusion
- Priority 3: Ensure datasets are complete and timely
- Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- Priority 5: Strengthen leadership and accountability.

This is an area of joint interest that engaged both the PSED and the health inequalities duties. The priorities were set by the national Healthcare Inequalities Improvement Programme and the programme is overseeing their implementation. Key work undertaken is described in Annex 1, Equality Objective 7 of our full review report.[165]

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[161] NHS England and NHS Improvement: Equality objectives and information as at 31 March 2022

[162] NHS England's and NHS Improvement's equality objectives for 2020/21 and 2021/22, https://www.england.nhs.uk/about/equality/equality-objectives-for-20-21-and-21-22/

[163] NHS England's and NHS Improvement's equality objectives for 2020/21 and 2021/22, https://www.england.nhs.uk/about/equality/equality-objectives-for-20-21-and-21-22/

[164] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

[165] NHS England and NHS Improvement: Equality objectives and information as at 31 March 2022

Our current equality objectives

The equality objectives for NHS England during 2020/21 and 2021/22 addressed our role as an NHS system leader, commissioner and our own role as an employer. The first six equality objectives have been in place since 2016/17 although they, and their associated targets, were reviewed in 2018. For 2019/20, 2020/21 and 2021/22, our seventh equality objective was approved by the Boards of NHS England and NHS Improvement. The seven equality objectives in place as at March 2022 were:

1. to improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the PSED and duties to reduce health inequalities set out in the Health and Social Care Act 2012
2. to improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS
3. to improve the experience of LGBT+ patients and improve LGBT+ staff representation
4. to reduce language barriers experienced by individuals and specific groups of people who engage with the NHS, with specific reference to identifying how to address issues in relation to health inequalities and patient safety
5. to improve the mapping, quality and extent of equality information in order to better facilitate compliance with the PSED in relation to patients, service-users and service delivery
6. to improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice
7. to ensure that the equality and health inequality impacts of COVID-19 are fully considered and that clear strategies are developed and implemented for the NHS workforce and patients. To ensure that the proposed NHS People Plan and patient focused strategies reflect this and make an effective contribution to advancing equality for all protected characteristics and to reducing associated health inequalities.

National Advisor for LGBT+ Health

During 2021/22, the National Advisor for LGBT Health and his team continued to work on a number of priorities to reduce health inequalities, to improve the experience of healthcare for LGBT+ people and to address the inequalities of experience of the LGBT+ NHS workforce.

This work focused on three key areas: improving data collection and monitoring, education, training and workforce development and supporting the NHS to deliver LGBT+ inclusive services. In 2021/22, we worked with NHS England's Insight and Feedback team to include, for the first time, an inclusive question on gender identity and trans status in the Cancer Patient Experience Survey. This work has enabled us to better understand the experiences of trans and non-binary people of cancer care and will support improving data collection and

monitoring in other settings. We also worked with the Mental Health Team to include a similar question in the Mental Health Services Dataset.

In 2021/22, we expanded the commissioning of 'Phase 2' of the Rainbow Badge project to build on the successful Rainbow Badge initiative by developing a quality assurance framework to support a further 40 NHS trusts in their work to address LGBT+ health inequalities and to ensure an inclusive workplace for their LGBT+ staff. We also worked closely with the Maternity Team to deliver the 'Improving Trans and non-binary people's Experience of Maternity Services' project which produced a number of recommendations to improve antenatal and postnatal care for trans people and have supported work on developing more inclusive language in maternity services which will be relevant for other clinical and policy areas across NHS England and NHS Improvement.

Equality and Inclusion Team focused on workforce

With the launch of the People Directorate in April 2020, the Equality and Inclusion team was established, with a mandate to develop a national strategy to make the NHS future-proofed in EDI where everyone counts and experiences a sense of belonging – part of our NHS constitutional values. The NHS workforce is not immune to the inequalities that pervade society at large and the COVID-19 pandemic illustrated groups with some protected characteristics (e.g. race, disability) within the workforce who were disproportionately affected by a combination of the virus, long term structural inequality, process deficits and the collateral impacts of the emergency and pandemic response.

Workforce Race Equality Standard

Since 2015, NHS England has set the standards and guidance on the data, analysis and strategic direction for workforce race equality in the NHS. The WRES supports all organisations involved in NHS service delivery to identify and evidence progress and close gaps in experience between BME and White staff. WRES reports since 2015 show year-on-year improvements across some WRES indicators. The next stage is developing means and measures on leadership accountability, provider responsibility and strategies to deliver sustainable, evidence-based and future-focused advancement of race equality across all professional groups and hierarchies.

Two published frameworks underpinning this work are: (i) Model Employer to increase BME representation across the NHS workforce pipeline and at leadership levels using evidence-based action plans; and (ii) A Fair Experience for All framework to support NHS organisations in closing the ethnicity gap in the application of disciplinary action between staff groups. Current and future WRES reports and wider work are aligned with the NHS People Plan, the NHS Long Term Plan and the wider priority of reducing avoidable health inequalities using an intersectional lens where data permits.

The forthcoming race equality strategy has been developed to support senior decision-makers to use targeted, measurable actions to improve their WRES indicators, especially in the areas of workforce development, retention, progression and experience. National WRES work will also include further development to compare effective actions and share learning across operations, while engaging and collaborating with wider stakeholders.

Workforce Disability Equality Standard

Similar to the strategic direction provided by the WRES on race equality, the WDES provides a strategic direction for disability equality.

The WDES was launched in 2019 following extensive engagement with Disabled staff, key stakeholders, leaders and national bodies.[166] The WDES is a collection of ten metrics that compare the experiences of Disabled and non-disabled staff. A WDES national data collection takes place annually, with trusts collecting, reporting and publishing their WDES metrics data. A national WDES report was produced with analysis of trends and key findings. The WDES is mandated to NHS trusts and NHS foundation trusts and was extended, on a voluntary basis, to ALBs in 2020. Like the WRES, the WDES supports trusts and ALBs to identify and close the gaps in experience between disabled and non-disabled staff.

The three years of metrics data that have been collected have informed a national programme of work, including the development of new innovative practice initiatives and resources, along with the establishment of national networks, such as the Disabled NHS Directors Network and the National Ambulance Disability Network. Trusts and ALBs have started to produce annual action plans setting out the key priorities that they will work towards in response to their local metrics data. Building on the work to date, a national plan is being developed to inform the direction of the WDES for the next three years. Read our full report on SED compliance for 2021/22.[167].

[166] https://www.england.nhs.uk/about/equality/equality-hub/wdes/

[167] https://www.england.nhs.uk/publication/nhs-england-and-nhs-improvement-equality-objectives-and-information-as-at-31-march-22/

Appendix 4: Working in partnership with people and communities

In 2021/22 our work has focussed on using the learning from the COVID-19 pandemic to shift how health and care services work with people and communities to a more community-centred approach. The pandemic saw communities mobilise themselves to support each other and encourage vaccine take-up, developing approaches that fitted local circumstances and needs. Communities worked alongside health and care partners to find innovative solutions to new challenges. The learning from this needs to be transferred to help meet other challenges, developing the assets and skills that communities have, and building in to the new 'business as usual' model of practice.

We have undertaken a significant amount of engagement throughout the year with a diverse range of stakeholders to develop new statutory guidance for Integrated Care Boards, NHS Trusts and Foundation Trusts on working with people and communities, to align with the structural changes taking place with the proposed Health and Care Bill. These changes align with our new focus, and we look forward to this being published in 2022/23 and then supporting ICBs to develop meaningful and impactful approaches to working with people and communities in 2022/23.

To complement the new statutory guidance, we have refocused our work in a variety of ways, including updating and developing our learning and support offers; rebranding our network and events for those who work in engagement to #StartWithPeople; and building the range of partners that we work with and seek to influence. These include new and existing networks and partnerships with communities, the Voluntary, Community and Social Enterprise Sector (VCSE) sector, ALBs and Government departments.

Alongside our existing forums, including the NHS Citizen Advisory Group, Learning Disability and Autism Advisory Group and the NHS Youth Forum, we have relaunched the Older People's Sounding Board and started preparation to launch a new LGBT+ Sounding Board in 2022/23.

We made improvements in the way we support Patient and Public Voice (PPV) Partners, and in April 2021 we changed our processes for issuing involvement payments to ensure compliance with His Majesty's Revenue and Customs (HMRC) requirements.

We have supported and advised professionals working across health and care, to ensure public participation is embedded into ways of working. This includes supporting staff to engage during the pandemic and in the recovery of services, through the delivery of 72 online training and learning sessions accessed by 1,778 individuals. Internally this has included assuring NHS England's duty to involve the public in commissioning (section 13Q of the NHS Act 2006). Our Engagement Practitioners Network events, #StartWithPeople, in April and November 2021 attracted over 700 people, with sessions from strategic engagement through to practical examples of good engagement.

We continue to build our internal network of engagement, equality and equity champions and provide them with support and resources to fulfil their role. The champions are senior managers who promote the benefits and embed the practice of working with people and communities in their directorates and regions.

Working with the Voluntary, Community and Social Enterprise Sector

We have continued to work closely with our partners in the sector both on a local and national level to understand the ongoing impact of both the pandemic and health inequalities on vulnerable communities.

Nationally, working in partnership with DHSC, the VCSE Health and Wellbeing Alliance amplified the voices of communities experiencing the greatest health inequalities to inform national policy and delivery. This included 36 research and co-production projects. We have also funded several partners to reach out to their communities to improve uptake of the COVID-19 vaccination.

As we approached the potential confirmation of ICBs as legal entities through legislation, we have worked closely with VCSE and system stakeholders. Our aim was to equip them to meet the requirement that the VCSE is embedded in ICB governance and decision-making arrangements. This has included the delivery of a national development programme across all 42 ICBs and the provision of advice and practical tools to overcome key challenges identified through earlier research.

NHS England also funded 13 projects on a local and national level to respond to the rise in respiratory illnesses in children. This work supported groups which experience health inequalities to keep their babies and young children safe and well.

Following the significant success of the NHS Volunteer Responders programme as a pandemic emergency response we started redeveloping it as a long-term resource. This involved engagement with VCSE and health and care system stakeholders and volunteers to capture learning from the programme.

To harness the enormous benefits of volunteering and the VCSE sector within health and care we established an NHS Volunteering Taskforce. This will harness the experience of a wide range of VCSE sector and health leaders to identify key opportunities for strategic improvement. The Taskforce will report its findings in Summer 2022.

Supporting PCNs to work with people and communities

In 2021/22 the PCN people and communities workstream built on the previous years' work to continue to test out various approaches through our test and learn sites, share the learning from those sites and build capacity and confidence around using community centred approaches. We have also started to develop a network of people utilising community

centred approaches to support and develop communities at a PCN level to understand the impact of this way of working in primary care.

One of our Test and learn sites is Central Liverpool PCN[168] who have, with the support CoCreate[169], set out to learn and develop sustainable engagement approaches as a way to tackle racial health inequalities. You can read an evaluation of the project[170] which shares their approach and gives some powerful reflections from some of the clinicians involved. They are undertaking a filming project to further share this work nationally and inspire other PCNs.

Working in partnership with National Association for Patient Participation, The Patients Association, Healthwatch and National Voices we have developed an animation[171] and an NHS Futures[172] site to support PCNs develop their Patient Participation Groups (PPGs) and wider community engagement. Building a network of practitioners is working to challenge the present static model of PPGs often used and share other, dynamic approaches and models to engagement in General Practice. There is a particular focus on encouraging practices to understand and reach out to their whole populations including those people they are not connected with.

Access to employment – supporting people with experience of homelessness into Health care Support Worker (HCSW) Roles

Working with our programme partners; Pathway[173], Groundswell[174] and The Royal Society for Public Health (RSPH)[175], we are identifying and addressing some of the systematic and individual barriers to employment. To achieve this, we have been working with Trusts to examine culture, employment practices and the readiness to adopt 'trauma informed' employment practice – something that can support the recruitment of people with a lived experience of homelessness into employment as HCSWs.

Pathway has led on the engagement with Trusts and is developing an evidence base of evaluated approaches to the sustainable employment of people who have experienced homelessness in NHS careers, specifically HCSW roles. Pathway is also developing a 'toolkit of policy and practice' to support the wider application and adoption of approaches that improve the inclusiveness and accessibility of NHS careers, specifically into nursing roles through the HCSW entry point, for people who have experienced homelessness and other marginalised groups.

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[168] https://clpcn.co.uk/tackling-racial-inequality-working-group/
[169] https://www.wearecocreate.com/wp-content/uploads/Co-create-CLPCN-Tackling-Racial-Inequality-Engagement-Project-Evaluation-1.pdf
[170] https://www.wearecocreate.com/wp-content/uploads/Co-create-CLPCN-Tackling-Racial-Inequality-Engagement-Project-Evaluation-1.pdf
[171] https://www.youtube.com/watch?v=4_Y1FLMrdsw
[172] https://future.nhs.uk/PPGnetwork/grouphome
[173] https://www.pathway.org.uk/
[174] https://groundswell.org.uk/
[175] https://www.rsph.org.uk/

Groundswell is working with local VCSE organisations to identify potential candidates interested in HCSW roles, to take part in the Access to Employment course developed and delivered by RSPH as part of this project. The course is delivered alongside trust's individual recruitment practices and will equip candidates with the necessary skills and core values to support them in applying for vacant HCSW roles at their local trust.

RSPH is supporting those taking the course to understand the core skills and values required in the role of a HCSW and is helping participants to recognise their ownership of those same skills and values, as well as supporting them in to be able to evidence situations in which they have had to demonstrate them. RSPH is also supporting participants to build their skills and knowledge around health and wellbeing, through access to the RSPH Level 1 Award in Health Improvement and is assisting participants to identify and apply for HCSW roles in their local area and to access any support they need in order to do this.

The project is in its latter stages and due to finalise delivery in June 2022. There have been some excellent examples of Trusts adapting their approaches to support people into these roles. Pennine Care[176] developed a leaflet which set out how the Trust would support people and eliminated the need for complex application forms supporting people to apply via a short CV. These approaches have been shared across all the Trusts involved.

Work with young people

We have fulfilled our NHS Long Term Plan objective to increase youth volunteering within the NHS in two ways:

1. Through the ongoing development of the NHS Cadets[177] scheme which enables 14 to 18-year olds from deprived communities and under-represented groups to volunteer in health and care. NHS Cadets has involved 2,729 young people across 98 groups, many of which met virtually during the pandemic and are now beginning to meet in person. Cadets have been developing their first aid, mental health, leadership and communication skills, and volunteering with the aim of considering a career in health and care. The programme is run in partnership with St John Ambulance.
2. Through our support for the Pears #IWill Fund[178] to embed youth volunteering within 32 NHS trusts. This focused on the development of best practice youth volunteering models, collaboration with clinicians and local partners and increasing diversity within volunteering. The learning will be shared in a research report due to be published in early 2022/23.

The long-established NHS Youth Forum has continued to meet, run in partnership with the Council. Consisting of 25 young people, appointed for 1-3 years, from across the country,

[176] https://www.penninecare.nhs.uk/
[177] https://www.sja.org.uk/get-involved/young-people/nhs-cadets/
[178] https://pearsfoundation.org.uk/partners/nhs-trusts-young-volunteer-programmes/

they have advised on a wide range of topics via regular 'consultation cafes'. They have additionally planned and delivered three, youth-led projects, engaging over 1,000 young people, focusing on:

- young people's mental health and digital services, including delivery of a high-level presentation to NHS England's Children and Young People's Mental Health team on their preliminary findings, influencing the team's business planning
- young people's health inequalities, including presented their project and preliminary findings at an #IWill Health and Social Care Alliance network event on young people's health inequalities
- widening access to NHS careers, including an initial discussion with the NHS Workforce Improvement team about their project findings.

Working in partnership with parents and carers of young people

In 2021/22 we published the #Gettingthrough guides for parents and carers of young people in secure mental health units. The published booklets were sent to over 80 young peoples' inpatient mental health units.

#Gettingthrough the First Few Days[179] sets out important information family members need when their child or young person has been admitted to a CAMHS inpatient unit. This is part of a wider collection of guides created by and for families in collaboration between the NHS and parents and young people. Taking the time to talk through this information will help build trust from the outset and provide the reassurance families need. Staff and parents complete the booklet together, giving an invaluable opportunity to build an early relationship between parents and unit, as well as enabling the sharing of valuable information which will help support the care of the children and young people.

These guides will support our CAMHS units and will be highlighted in our Tier 4 CAMHS service specifications. The Royal College of Psychiatrists will also include the #Gettingthrough guides in their quality network standards.

Networks and forums

Across the organisation, we run a wide range of forums, advisory groups and sounding boards, involving people from different communities and health interests.

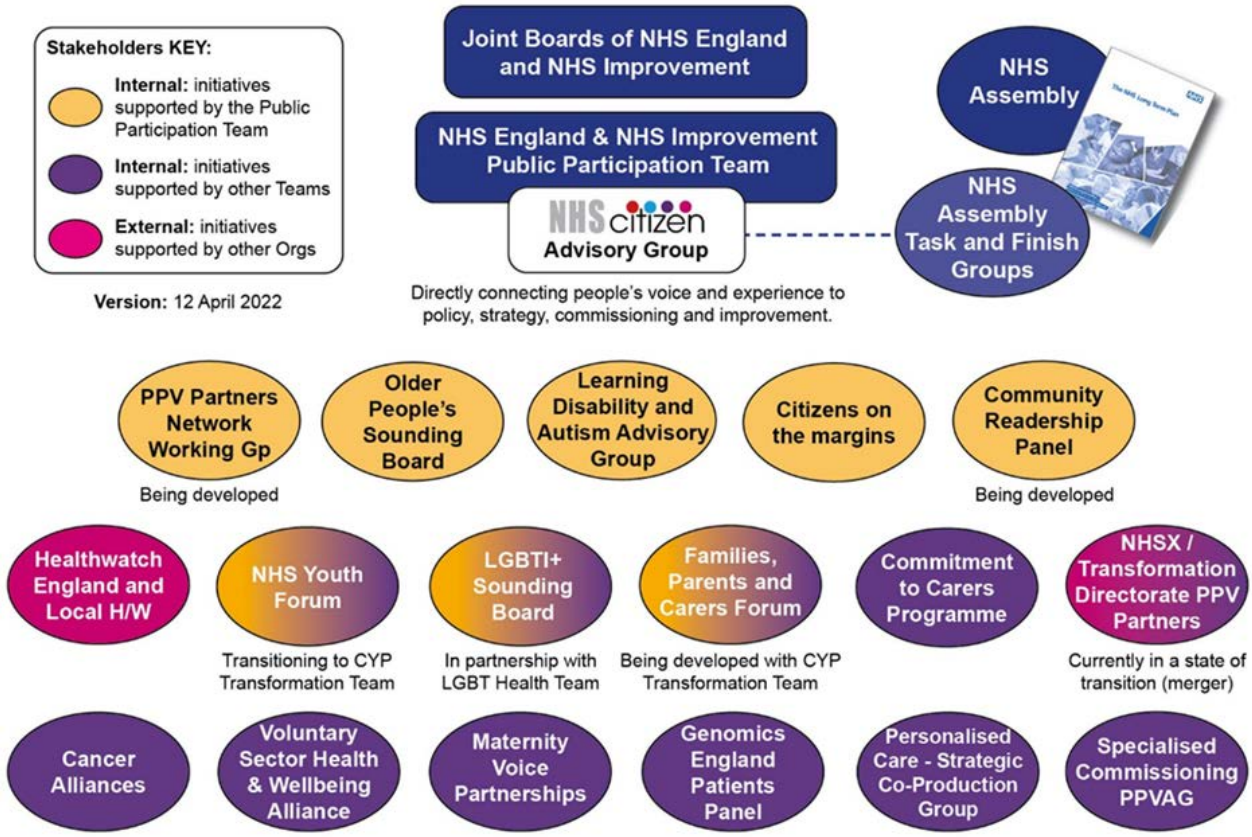
One of these is the NHS Citizen Advisory Group, which brings together a wide range of people who are committed to working with people and communities as partners. Members are mostly PPV partners, or 'experts by experience', who are involved in NHS England forums and networks. Together, they are supported by staff members, who often attend meetings to listen and learn. The Advisory Group acts as a critical friend within a safe space -

[179] https://www.england.nhs.uk/publication/gettingthrough-the-first-few-days/

providing constructive challenge and feedback on our work programmes, policy areas, and the engagement approaches used to inform them.

The group meets on a bi-monthly basis, as well as hosting ad-hoc 'hot-topic' sessions for quickly evolving programmes, such as the Elective Recovery strategy, for rapid and timely feedback which helped with the ongoing development.

NHS Citizen advisory group



Learning Disability and Autism Advisory Group

The Learning Disability and Autism Advisory Group has continued to advise on changes which affect autistic people and people with a learning disability. They have worked on a review of GP services since -19, making sure changes work well for everyone. They have advised on the roll out of the Integrated Care Systems, in particular to ensure that the new commissioning structures work with and listen to autistic people and people with a learning disability.

The group has supported the review of the care, education and treatment review policy, to help people get the right mental health support and avoid inappropriate mental health hospital admission. The group has also influenced the development of learning from the lives and deaths of people with a LeDeR. The group had previously advocated for the LeDeR programme to be extended to work towards preventing autistic people's premature deaths. This has now happened and the group advised on their role in making this successful.

The group has provided advise to influence the development of safe and wellbeing reviews to make sure people with a learning disability and autistic people who are in mental health hospitals are safe and well. We coproduced (with clinicians, autistic people and people with a learning disability) simple questions that the commissioners could ask, that could really get to the point around people's care and quality of life in mental health hospitals.

Appendix 5: Sustainability

This sustainability report outlines our progress against the Greening Government Commitments (GGCs)[180] and the Greener NHS commitment to be a net-zero health service by 2040. Our progress is measured against 2017/18 as the baseline year, in line with the GGCs.

More in-person working over the past 12 months has resulted in increased utilities use and higher levels of business travel than last year. Levels are still lower than pre-pandemic however, and the related emissions are significantly lower than 2017/18.

Building on our Interim Green Plan last year, we have spent this year developing our Green Plan which will be published in Summer 2022. As part of this, we've re-worked the data for all years from 2017/18; firstly, to include data which wasn't available previously and secondly to ensure a consistent method was used when estimating any missing data. The figures for all years included in this report have been updated to reflect the most accurate position possible with the information we have and to make it easier to draw comparisons over time.

Scope

All reporting in this sustainability report covers NHS England, NHS Improvement and the CSUs. For ease of comparison, the joint figures for previous years have been included where they previously may have been reported separately.

CCGs report on sustainability within their individual annual reports which are published on their respective websites. A list of CCGs, and links to their websites, can be found on the NHS England website.[181]

Reporting for multi-occupancy buildings

Within this annual report we are reporting on the proportion of the NHS PSe buildings occupied by NHS England and NHS Improvement and CSUs. Where we are a tenant of a government department of other ALB, energy, waste and water information will be reported within its annual report and published on its respective websites.

[180] Greening Government Commitments 2021 to 2025 - GOV.UK (www.gov.uk)
[181] www.england.nhs.uk/ccg-details

Provision of data

NHS PSe is the landlord for most of NHS England and NHS Improvement and CSU offices and we rely on them for utilities and waste data. The energy and water data provided for this financial year comes with the following guidance from NHS PSe:

All consumption and costs are apportioned by the percentage occupancy at each property.

Data has been estimated where it is not readily available; all water data is estimated.

Estimations have been based on actual data, considering floor area and site type.

February to March 2022 data has been estimated due to the invoices not being available at the time of writing this report.

NHS PSe has also been able to provide partial data for waste collected from our sites. It has not provided estimates where data is unavailable, so we have made our own estimates based on the averages per m^2 of the data that has been provided. NHS PSe continues to work on improving its data collection ability.

Mitigating climate change: working towards Net Zero by 2040

2021-25 GGCs headline target:

Reduce the overall greenhouse gas emissions from a 2017/18 baseline and reduce direct greenhouse gas emissions from the estate and operations from a 2017/18 baseline.

2021-25 GGC sub-targets:

Reduce the emissions from domestic business flights by at least 30% from a 2017/18 baseline and report the distance travelled by international business flights.

Contextual information

	2018/19	2019/20	2020/21	2021/22[182]	Change from 2017/18 baseline
Net Internal Area reported in m^2	75,644	73,942	68,016	56,347	-52%
FTEs reported	14,119	15,408	15,801	16,318	+24%

[182] North East London CSU NIA and FTE has been included although it ceased to exist on 1 November 2021.

Greenhouse gas emissions[183]

		2018/19	2019/20	2020/21	2021/22	Change from 2017/18 baseline
Scope 1 emissions tCO_2e	Emissions from organisation-owned fleet vehicles	151	243	57	14	
	Gas	1,513	2,034	936	1,005	
	Total Scope 1[184] (tCO_2e)	**1,664**	**2,277**	**993**	**1,018**	**-61%**
Scope 2 emissions tCO_2e	Electricity	3,288	2,892	1,592	1,273	
	Total Scope 2[185] (tCO_2e)	**3,288**	**2,892**	**1,592**	**1,273**	**-85%**
Scope 3 emissions tCO_2e	Road travel	3,735	2,851	465	330	
	Rail Travel	1,651	1,418	50	161	
	Domestic air travel	45	32	1	2	
	International air travel	44	55	2	2	
	Total Scope 3[186] (tCO_2e)	**5,431**	**4,356**	**519**	**494**	**-99%**
	Total (tCO_2e)	**10,383**	**9,524**	**3,104**	**2,786**	**-94%**

Related use and cost

			2018/19	2019/20	2020/21	2021/22
Scope 1 Related use	Miles	Scope 1 business travel	605,576	836,735	226,492	51,897
	kWh	Gas	8,226,032	11,062,757	5,089,362	5,486,632
	Cost	Scope 1 business travel	£263,417	£367,840	£26,984	£24,044
		Gas	£315,331	£410,829	£161,714	£192,395
Scope 2 Related use	kWh	Electricity	10,702,260	10,428,921	6,288,476	5,997,467
	Cost	Electricity	£1,650,135	£1,785,300	£1,071,000	£778,529
Scope 3 Related use	Miles	Road travel	6,671,729	10,166,014	1,678,725	1,236,664
		Rail Travel	27,684,993	21,404,609	843,910	2,816,243
		Domestic air travel	199,514	155,961	6,381	9,686
		International air travel	390,579	253,062	14,798	12,102
	Total miles (scope 1 and 3)		**35,552,391**	**32,816,381**	**2,770,306**	**4,126,802**
	Cost	Road travel	£5,381,636	£4,951,830	£593,452	£639,481
		Rail Travel	£13,608,738	£10,355,117	£832,278	£1,310,779
		Domestic air travel	£81,195	£67,119	£6,381	£3,735
		International air travel	£56,234	£29,082	£14,798	£2,314
	Total cost of business travel (scope 1& 3)		**£19,391,220**	**£15,770,987**	**£1,473,893**	**£1,980,353**
	Total cost of related use (all scopes)		**£21,356,685**	**£17,967,116**	**£2,706,607**	**£2,951,277**

[183] Figures have been rounded to the nearest whole number

[184] Scope 1 emissions arise from organisation owned and operated vehicles, plant and machinery

[185] Scope 2 emissions arise from the consumption of purchased electricity, heat, steam and cooling.

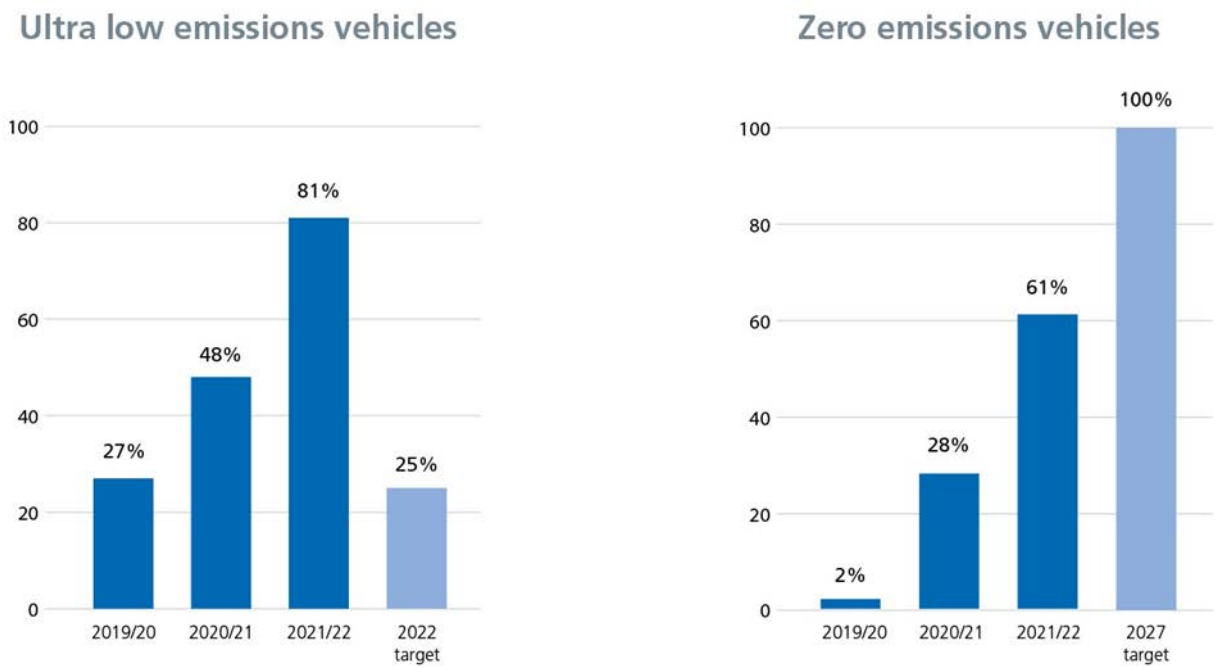
[186] Scope 3 emissions arise from official business travel by vehicles not owned by the organisation

Car fleet

2021-25 GGC sub-target:

Meet the government fleet commitment for 25% of the government car fleet to be ultra-low emission vehicle by 31 December 2022, and 100% of the government car and van fleet to be fully zero emission at the tailpipe by 31 December 2027. This commitment covers vehicles which are leased by employees through the employer's salary sacrifice.

Vehicle emissions



Minimising waste and promoting resource efficiency

2021-25 GGC headline target:

Reduce the overall amount of waste generated by 15% from the 2017/18 baseline.

Sub-targets:

- reduce the amount of waste going to landfill to less than 5% of overall waste
- increase the proportion of waste which is recycled to at least 70% of overall waste
- reduce government's paper use by at least 50% from a 2017/18 baseline
- remove CSUP from the central government office estate
- report on the introduction and implementation of reuse schemes.

	2018/19	2019/20	2020/21	2021/22	Change from 2017/18 baseline
Total (tonnes)	1,012	1,440	291	225	-23%
Recycled (tonnes)	451	1,241	177	103	
Incinerated with heat recovery (tonnes)	537	190	109	100	
Incinerated without heat recovery [187]	-	-	-	14	
Landfill (tonnes)	24	10	6	7	
Waste to landfill (%)	2%	1%	2%	3%	+1%
Recycling (%)	45%	86%	61%	46%	+1%
Cost of waste disposal	£364,615	£199,127	£96,175	[188]	
Paper use (sheets)	54,447,709	45,576,477	4,913,241	3,017,582	-95%

Although the overall amount of waste has decreased over the last three years, the proportion of recycling has also decreased to below the 70% target. The proportion of waste going to landfill has also increased over time, although it remains below the 5% target. This is likely to be the result of COVID-19 protective measures, including disposable face coverings and increased cleaning, coupled with a significantly smaller amount of waste overall.

The waste we have reported above covers our general office waste. Large waste removals, like office furniture, for example, have not been included although we are working with suppliers to provide this information in future. We also work in partnership with NHS PSe which helps co-ordinate the removal of office furniture from its sites where necessary and possible. Through its contract with a resource redistribution network, it can arrange collection and redistribution of surplus furniture on our behalf.

ICT waste

We maintain the use of information and communications technology equipment for as long as possible. When items become obsolete, we work in partnership with other organisations to process our ICT waste responsibly and sustainably. This may be through approved authorised treatment facilities, following Waste Electrical and Electronic Equipment Regulations or using corporate recycling schemes. All partner organisations operate a zero-waste to landfill policy.

[187] This is the first year we have made a distinction between waste being incinerated with and without heat recovery.

[188] The cost of waste disposal during 2021/22 was not provided by NHS Property Services in time for the publication of this report.

Reducing our water use

2021-25 GGC headline target:

Reduce water consumption by at least 8% from the 2017/18 baseline

Sub-targets:

- ensure all water consumption is measured
- provide a qualitative assessment to show what is being done to encourage the efficient use of water.

	2018/19	2019/20	2020/21	2021/22	Change from 2017/18 baseline
Water used (m^3)	59,919	54,974	15,779	24,964	-85%
Cost of water used	£360,368	£216,318	£33,518	£73,169	

The water reported above is entirely water which has been purchased through the mains water supply. We do not own or control any water sources such as lakes or reservoirs for example.

Water use has significantly reduced from the baseline year. This is a combination of a reduction in the size of our corporate estate and less in-person working since the start of the pandemic.

Procuring sustainable products and services

2021-25 GGC headline commitment:

Continue to buy more sustainable and efficient products and services with the aim of achieving the best long-term, overall value for money for society.

With the publication of the Delivering a 'net zero' National Health Service[189], the NHS affirmed the need to take action on climate change and set ambitious reduction targets, including a commitment that before the end of the decade, the NHS will no longer purchase from suppliers that do not meet or exceed our commitment to net zero. In September 2021, the NHS England and NHS Improvement Board approved the Net Zero Supplier Roadmap,[190] which sets out the key milestones for suppliers through 2030.

Our commitments to deliver a net zero health service go beyond carbon reduction. It is imperative that alongside our environmental efforts, we make every effort to stamp out modern slavery throughout our supply chain. We also have a duty to use the money spent

[189] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf
[190] https://www.england.nhs.uk/greenernhs/get-involved/suppliers/

through the NHS to generate more social value for the communities that we serve, reducing health inequalities and improving the wider determinants of health.

Within NHS England and NHS Improvement, we have integrated metrics that measure these benefits and include them as part of our procurement evaluations. We are aligned with the government's procurement policy note on social value, mandating that a minimum weighting of 10% of the total score for net zero and social value should be applied in all procurements,[191] and we have adopted this into the NHS England and NHS Improvement procurement strategy. Since April 2021, all our procurements must include a minimum weighting of 10% on net zero and social value, and this was expanded to cover the wider NHS from April 2022 as part of the net zero supplier roadmap.

Our sustainable procurement programme continues to grow, and we are committed to leading by example across the wider health system.

Climate change adaptation

Our business continuity plans take account of the impacts of climate change. These plans ensure we will continue to operate during unplanned disruptions, including extreme weather events.

With PHE and others, we continue to produce a national Heatwave Plan[192] each year. This is intended to protect the population from heat-related harm to health. We also contribute to the Cold Weather Plan,[193] which gives advice to help prevent the major avoidable effects on health during periods of cold weather in England.

The Greener NHS national programme

The Greener NHS national programme was launched in 2020, alongside the appointment of the NHS's first Chief Sustainability Officer, to deliver the world-leading commitment of a net zero national health service. This programme is important because:

- climate change threatens the public's health and impacts on the NHS's ability to deliver high quality care
- the NHS's response to climate change is set to deliver unprecedented health benefits through cleaner air, healthier diets, increased energy security and more liveable communities
- there is strong support from the system's 1.3 million staff, with over nine out of 10 supporting the NHS's net zero ambitions.

The Greener NHS national programme is led by the NHS sustainability board and reports to the NHS England and NHS Improvement board twice annually. The programme is delivered

[191] B1030-applying-net-zero-and-social-value-in-the-procurement-of-NHS-goods-and-services-march-2022.pdf(england.nhs.uk)
[192] https://www.gov.uk/government/publications/heatwave-plan-for-england
[193] https://www.gov.uk/government/publications/cold-weather-plan-cwp-for-england

in the way that is most appropriate and sensitive to each local context by working carefully through the NHS regions and systems.

Supporting sustainability across the NHS

This year, to achieve the carbon savings required to realise a net zero NHS, an ambitious change programme was delivered to improve patient care and health outcomes and secure long-term savings. Action was taken across several key thematic areas.

NHS estate

Reductions to the carbon footprint were achieved by 94 trusts as a result of £310 million of capital investment from the Public Sector Decarbonisation Scheme, and the NHS Energy Efficiency Fund. Examples range from Milton Keynes University Hospital fitting over 2,500 solar panels, producing 853 megawatt hours per year, through to the installation of heat pumps and other low-carbon heating measures to reduce reliance on fossil fuel.

NHS fleet

As well as unveiling the world's first zero emission ambulances, the NHS partnered with the Department for Transport to deploy 11 electric 19-tonne trucks, together with the required charging infrastructure. Progress towards a wider zero emissions fleet is also gaining momentum, with the NHS Non-Emergency Patient Transport review[194] published in July 2021 setting out plans for a zero emission non-emergency patient transport fleet by 2035, and several trusts already adopting electric vehicles for rapid response, patient transport and logistics.

NHS Supply Chain

With more than 60% of the NHS carbon footprint based within the NHS supply chain, we need the support of every supplier if we are to reach net zero by 2045. This year, the NHS launched a roadmap[195] to help suppliers align with our net zero ambition between now and 2030, and in April 2022 the NHS adopted a minimum 10% weighting for net zero and social value in the award of NHS contracts.

Medicines

A small number of medicines account for a large portion of NHS emissions, with anaesthetic gases and inhalers making up 5% of the total NHS carbon footprint. This year, the Primary Care Network Investment and Impact Fund included an incentive for primary care networks to prescribe lower-carbon inhalers where clinically appropriate and as part of a shared decision-making conversation with patients. In addition,149,000 tonnes of carbon were saved

[194]Report: NHS England (2021) *Improving non-emergency patient transport services: Report of the non-emergency patient transport review*. Available at: https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/nepts-review/

[195] Webpage: NHS England (2021). Available at: https://www.england.nhs.uk/greenernhs/get-involved/suppliers/

on nitrous oxide emissions through improved stock management, repairs to manifold leaks and demand reduction. Desflurane usage also decreased significantly, now comprising less than 10% of all volatile usage, with 40 trusts eliminating it altogether.

Staff engagement

In 2021/22 the NHS led a wide variety of activities, coalescing at the 26th United Nations Climate Change Conference (COP26). A new staff campaign, 'Healthier Planet, Healthier People', focused on what individual health professionals can do, or are already doing, to support our net zero ambitions. A regional roadshow from Cornwall to COP26 was held across each of the seven regions, with over 220 NHS trusts and integrated care systems, and nine national leaders participating.

Adaptation and resilience

In 2021, NHS England and NHS Improvement and the UKHSA published the third *Health and care adaptation report.*[196] It provides an overview of the next steps required at a local, regional and national level to address any identified risks and build resilience, while delivering on net zero commitments. Adapting the World Health Organization's *Operational framework for building climate-resilient health systems*,[197] the report covers three broad areas: health information systems, service delivery and leadership, workforce development and resourcing. As climate change could widen existing health inequalities, the report also outlines how to support those most vulnerable to the systemic shocks associated with climate change.

[196] Report: NHS England (2021) *Health and care adaptation report 2021.* Available at: https://www.england.nhs.uk/publication/health-and-care-adaptation-reports/

[197] Report: World Health Organization (2015) *Operational framework for building climate resilient health systems.* Available at: https://www.who.int/publications/i/item/9789241565073

Appendix 6: Acronyms

A

A&E Accident and Emergency

AAC Accelerated Access Collaborative

AI Artificial Intelligence

ALB Arm's Length Body

ANNB Antenatal and Newborn screening programmes

ARAC Audit and Risk Assurance Committee

B

BCF Better Care Fund

BCG Bacillus Calmette-Guérin

BME Black, Asian and Minority Ethnic

C

CAMHS Children and Adolescents Mental Health Services

CAN Cyber Associates Network

CCC Customer Contact Centre

CCG clinical commissioning group

CDF Cancer Drugs Fund

CEO Chief Executive Officer

CETV Cash Equivalent Transfer Value

CFO Chief Financial Officer

CHIS Child health information services

CMD Commercial Medicines Directorate

CMDU COVID-19 Medicine Delivery Units

CMU Commercial Medicines Unit

COO Chief Operating Officer

CPAG Clinical Priorities Advisory Group

CRR Corporate Risk Register

CSU Commissioning Support Unit

CYP Children and Young People

D

DAWN Disability and Wellbeing Network

DHSC Department of Health and Social Care

DSPT Data Security and Protection Toolkit

E

EIP Early Intervention in Psychosis

EO Equality Objectives

EPRR Emergency Preparedness, Resilience and Response

EQG Executive Quality Group

ESM Executive Senior Manager

ESR Electronic Staff Record

F

FReM Financial Reporting Manual

FTE Full-time Equivalent

G

GAM Group Accounting Manual

GDPR General Data Protection Regulation

GGC Greening Government Commitments

H

HCSW Health care Support Worker

HEE Health Education England

HMRC His Majesty's Revenue and Customs

HPV Human Papillomavirus

I

IAPT Improving Access to Psychological Therapies

ICB Integrated Care Boards

ICO Information Commissioner's Office

ICS Integrated Care System

ICT Information and Communications Technology

IFRS International Financial Reporting Standard

IG Information Governance

IMF Innovative Medicines Fund

ImGo Immunoglobulin

IPC Infection Prevention Control

IRLS Innovation, Research and Life Sciences

ISA International Standards on Auditing

ISAE International Standard on Assurance Engagements

K

KPI Key Performance Indicator

L

LeDeR Learning Disability Mortality Review

LGBT+ Lesbian, gay, bisexual, transgender +

M

MARS Mutually Agreed Resignations

MenACWY Meningococcal bacteria – A, C, W and Y

MMR Measles, Mumps and Rubella

MPA Medicines Policy and Analysis

N

NAO National Audit Office

NHS BSA NHS Business Services Authority

NHS PSe NHS Property Service

NHS SBS NHS Shared Business Services

NHS TDA NHS Trust Development Authority

NHS CFA NHS Counter Fraud Authority

P

PCN Primary Care Network

PCSE Primary Care Support England

PHE Public Health England

PHESGO Pertuzumab with trastuzumab and hyaluronidase

PHSO Parliamentary and Health Service Ombudsman

PIFU Patient Initiated Follow-up

PPG Patient Participation Groups

PPTS Percentage Points

PPV Patient and Public Voice

PRP Performance Related Pay

PSED Public Sector Equality Duty

PSF Provider Sustainability Fund

R

RDEL Revenue Department Expenditure Limit

RSPH The Royal Society for Public Health

S

SAIS School Aged Immunisation Service

SARCs Sexual Assault Referral Centres

SCCL Supply Chain Coordination Limited

SCHJDG Specialised Commissioning and Health and Justice Delivery Group

SCHJSPG Specialised Commissioning and Health and Justice Strategy and Policy Group

SDEC Same Day Emergency Care

SED Specific Equality Duties

SFI Standing Financial Instructions

SMA Spinal Muscular Atrophy

SOF System Oversight Framework

SRO Senior Responsible Officer

STP Sustainability and Transformation Partnership

T

TIF Targeted Investment Fund

U

UEC Urgent Emergency Care

UKHSA UK Health Security Agency

V

VAT Value Added Tax

VCSE voluntary, community and social enterprise

W

WDES Workforce Disability Equality Standard

WGA Whole of Government Accounts

WRES Workforce Race Equality Standard

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