NHS England

Our 2015/16 Annual Report

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

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England

Annual Report and Accounts 2015/16

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A WELCOME BY PROFESSOR SIR MALCOLM GRANT, CHAIR

NHS England is an independent organisation established by Parliament at arm's length from Government and charged with the stewardship of the NHS. Each year, the Government sets out its expectations of us, and the funding we will receive, in the form of a mandate which is also laid before Parliament. For 2015/16, the Government allocated us £102 billion and set some challenging objectives.

We are required to ensure that comprehensive health and care services are available to all, where there is clinical need, and regardless of an individual's ability to pay. We are custodians of the values of the NHS Constitution, committed to putting patients at the heart of everything we do, promoting transparency and accountability of our work to citizens, and ensuring the most efficient, fair and inclusive use of finite taxpayer resources.

It is our responsibility to continually improve health outcomes for individuals, communities and society as a whole by investing the NHS budget strategically to ensure real value for money. Central to our role is the commissioning of health services. We commission some services directly (mainly specialised and primary care services), but allocate the majority of the resources we receive to clinical commissioning groups, who commission services at local level, overseen by us.

This annual report describes our work in 2015/16 and outlines some of our most significant achievements. We have faced significant challenges too. Demand for services has continued to rise at a greater rate than funding, placing GPs and hospitals under

huge pressure and making it more difficult to achieve the high service standards enshrined in the NHS Constitution. The last year has also seen a protracted dispute between the Government and the BMA over the new junior doctors' contract.

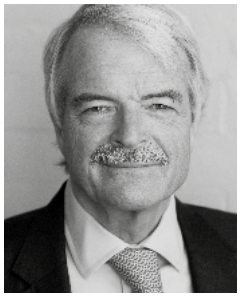
2015/16 saw the establishment of NHS Improvement, created by the coming together of the NHS Trust Development Authority and Monitor. We are in strong support of this move and will be working in partnership with NHS Improvement at every level to ensure consistency and continuity of national leadership and support for providers of healthcare to ensure better care for our patients.

The NHS Five Year Forward View, published in 2014, set out a compelling vision for the future and we have worked tirelessly over the last year to begin to bring the vision to reality. The new Government elected in May 2015 endorsed the Forward View vision and, in the comprehensive spending round, committed additional resources to the NHS over the next five years to support implementation.

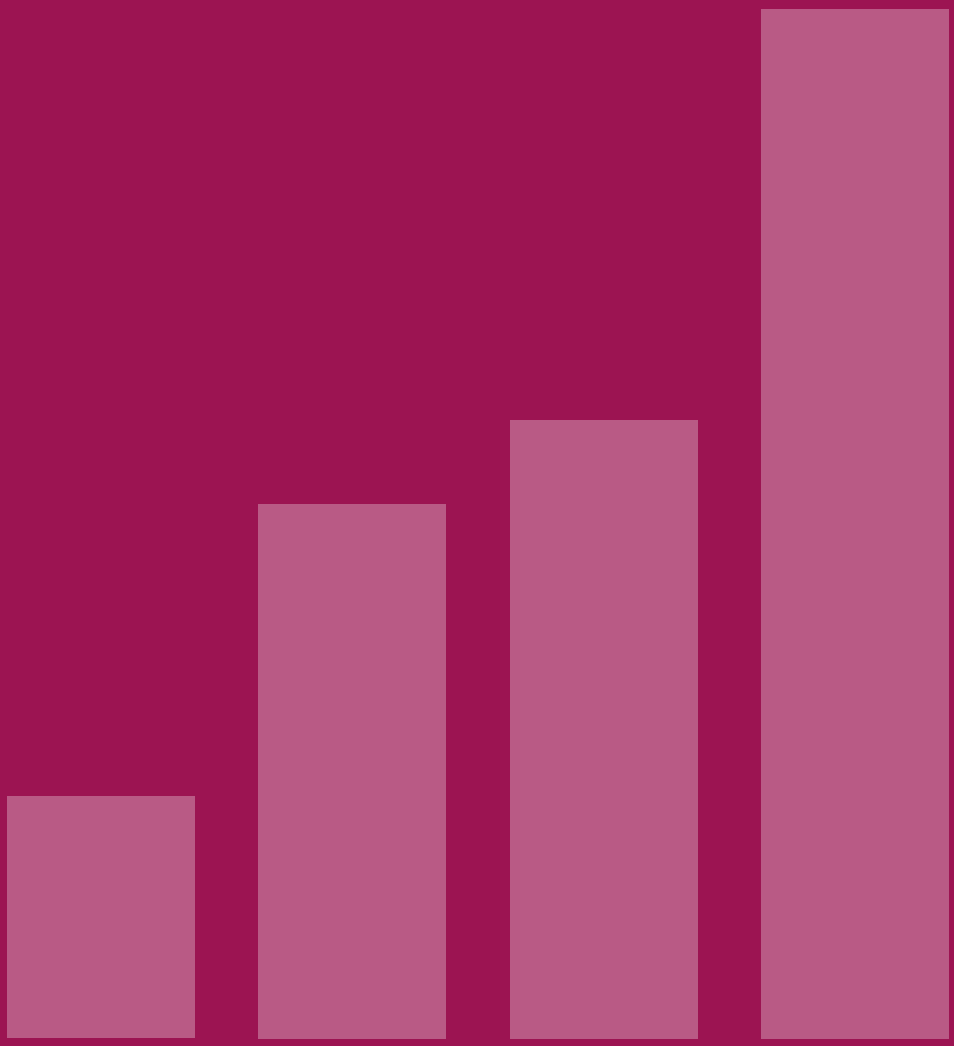
It is truly a privilege to chair NHS England, and to be supported on the Board by such a strong team. I pay tribute to the hard work and dedication of our directors, coupled with particular thanks to those who have left the Board during the course of the year. Sir Ciarán Devane and Margaret Casely-Hayford, two of the original directors, reached the end of their terms and Ed Smith stood down upon his appointment as chair of NHS Improvement. Dame Barbara Hakin decided to retire after 41 years working in the NHS and Tim Kelsey took up a new appointment as commercial director at Telstra Health.

I am grateful to all our staff for their ongoing efforts and commitment. The achievements outlined in this annual report are testament to their hard work, and we are profoundly grateful to them for consistently going the extra mile.

And looking beyond NHS England itself, I wish to place on record the Board's deep appreciation of the work of all NHS staff across England in ensuring that the millions of people every day who use health services continue to receive excellent care. The NHS remains one of this country's most cherished and trusted institutions, due in large measure to the sheer professionalism and commitment of clinicians, managers and other NHS staff.



Professor Sir Malcolm Grant, Chair



PERFORMANCE REPORT

Simon Stevens
Accounting Officer
8 July 2016

CHIEF EXECUTIVE'S OVERVIEW

At times of national uncertainty and debate, the National Health Service continues to offer high quality care to the people of this country, unifying the nation through our mutual commitment to care for all, across the generations.

Our NHS Five Year Forward View, published in October 2014, set the shared strategic direction for the NHS, giving practical life to the 'Triple Aim' of improved health and redesigned high quality care, underpinned by sustainable financial stewardship. In moving to implement the Forward View, 2015/16 was a year of both progress and challenge.

NHS England's independent taskforces published widely supported national improvement blueprints for cancer care, mental health, and maternity services. We set a clear new direction for strengthened GP and primary care, and for redesigned urgent and emergency services. 'Vanguard' areas covering five million people got to work on our 'triple integration' agenda, joining up primary and specialist care, physical and mental health, and health and social care. We sponsored the novel 'Devo Manc' partnership between the NHS and local government for 2.8 million people in the North West. And we helped lead the national debate on one of our greatest public health threats – childhood obesity – and backed that with action by commissioning the world's first nationally-scaled diabetes prevention programme and wide-ranging new NHS staff health incentives.

NHS England's local teams and emergency preparedness experts led the operational response of the NHS to various 'civil contingencies', including strike action by junior doctors, flooding in Cumbria and the international outbreak of Ebola. This came as GP services, mental health providers, NHS hospitals and social care all faced sustained operational pressures, which in turn meant headline waiting times targets were often missed. Despite that, over the last year, no other major industrialised nation can claim to have cared for 9 out of 10 A&E patients within four hours, and provided 9 out of 10 planned hospital appointments and treatments within 18 weeks.

In November NHS England secured a frontloaded NHS funding settlement from the Government's Spending Review. This will kick start the Forward View, albeit that we also argued that success will inevitably depend on intensified prevention and public health, a well functioning social care system, and targeted revenue and capital funding for service transformation.

As set out on page 51, NHS England met each of the financial duties placed on us by Parliament in 2015/16, including once again balancing our budget of just over £100 billion. We are committed to playing our full part in the wider financial challenges facing the NHS, while recognising that – as laid out in the Governance Statement on page 81 – under the Health and Social Care Act 2012 NHS England is not itself legally empowered to oversee the financial performance of providers of NHS-funded care, or to manage the Department of Health's overall budget. In 2015/16 we contributed a £0.6 billion managed underspend to help offset substantial overspends elsewhere.

These pressures underscore the size of the challenge facing the NHS. In the year ahead we will therefore support NHS Improvement to 'reset' providers' 2016/17 financial deficits and operational performance. We will work with local communities and health and care leaders to agree and support viable local Five Year Forward View implementation plans, across all 44 'sustainability and transformation' areas. And we will get going on delivering our national improvement priorities – including primary care, urgent and emergency care redesign, cancer services and mental health.

While the outcome of the recent 'Brexit' vote may affect our operating and financial environment – at least over the short to medium term – it does not alter these critical tasks in front of us. Constancy of direction, consistency of leadership, and effectiveness of delivery are what the NHS now needs. That's what NHS England – working hand in glove with our partners – is committed to providing.

Simon Stevens, Chief Executive Officer

A snapshot of 2015/16

ONE FIFTH of the NHS workforce is of black or minority ethnic backgrounds

85% of patients rated their experience of their general practice as good

More than **5 MILLION** GP consultations took place each week

An increase of **176,427** urgent cancer referrals made by GPs

A new healthy workforce programme is now working to support **1.3 MILLION** NHS workers

10 HEALTHY new towns covering more than 76,000 new homes and 170,000 residents

350,000 more patients received consultant led care than in 2014/15

23 Urgent and emergency care networks now cover the whole of England

Cost of Type 2 diabetes is **£8.8 BILLION** a year

48 Transforming Care Partnerships support those with learning disabilities

GP Access Fund now covers over **18 MILLION** patients

Almost **23 MILLION** patients attended A&E

2.6 MILLION fewer prescriptions for antibiotics were prescribed by GPs

20 MILLION pieces of patient feedback have been received through the Friends and Family Test

Specialised Services budget was just under **£15 BILLION**

First wave of RightCare covers **19 MILLION** people

50 vanguards received **£131 MILLION** funding

Over **95%** of GPs can offer patients online access to their detailed health record

Over **1.7 MILLION** patient safety incidents were reported

A **THIRD** of all prescriptions are now transmitted electronically

We received over **198,000** customer contacts from patients and the public

The UK now has **THE LARGEST** whole genome sequencing database in the world

Analysis of our performance in 2015/16

The NHS budget of £102 billion for 2015/16 was entrusted to NHS England which shares, with the Secretary of State for Health, the legal duty to promote a comprehensive health service in England in accordance with the NHS Act 2006 (as amended by the Health and Social Care Act 2012). NHS England oversees the delivery of NHS funded services – and the continuous improvements to the quality of treatment and care. In doing so, we both support and rely upon local healthcare professionals making decisions about services based on the needs of, and in partnership with, their patients and communities.

Performance in 2015/16

The NHS provided more than 5 million GP consultations each week, managed 2.9 percent more emergency admissions to hospital, and responded to 7.2 percent more calls to NHS 111 than in the previous year.

Almost 15 million patients received NHS care led by a consultant in 2015/16. Despite the increase in demand, 91.5 percent of patients on the waiting list at the end of March 2016 had been waiting for less than 18 weeks.

But with demand from patients continuing to rise, pressure on primary care, mental health, accident and emergency (A&E) and waits for operations, and budgets tightly constrained, the NHS faces a major challenge in the coming years.

Securing funding in 2015/16: planning for greater investment

In October 2014, national leaders in health and care published the Five Year Forward View setting out how the NHS is to meet the challenges ahead. It identified funding requirements for the NHS as an extra £8 billion to £21 billion by 2020/21, dependent on demand, productivity and support for service transformation. The Government responded by pledging to invest an additional £8.4 billion in real terms annually by 2020/21. The Five Year Forward View can be found on our website at www.england.nhs.uk/ourwork/futurenhs/.

In recognition of the immediate pressures faced by the NHS, the Government announced in the Autumn Statement in November 2015 that the revenue settlement would be frontloaded to provide £3.8 billion (3.7 percent) real terms growth in 2016/17, and £1.4 billion (1.3 percent) in 2017/18.

The financial outlook remains very challenging, and sustained action is needed to deliver the necessary efficiencies implied by this funding settlement. This will require a continuing focus on prevention, on involving patients in their own care, on a resilient social care system and on redesigning services.

More investment in transforming care

A key element of the focus on transforming care has been to establish a new Sustainability and Transformation Fund to stabilise NHS finances, in tandem with higher rates of efficiency growth, and to provide funding for transition to more effective models of care.

The fund is worth £2.14 billion in 2016/17, £1.8 billion of which will be deployed on sustainability to stabilise NHS operational performance. £340 million will be used for transformation to invest in new care models and facilitate progress with clinical priorities such as earlier cancer diagnosis, diabetes prevention and improved mental health, as set out in the Five Year Forward View.

The Sustainability and Transformation Fund will grow to £2.9 billion in 2017/18 and £3.4 billion in 2020/21, with an increasing proportion deployed on transformation.

More investment in primary care

All local commissioners have been given firm budgets for the next three years and indicative budgets for the final two years to allow them to plan how to use their purchasing power most effectively. Primary medical care, including GP services, which have been under particular pressure, has been allocated an above average increase. In addition, clinical commissioning groups (CCGs) have the option to top investment up further, especially where they have assumed greater responsibility for commissioning primary care services under the delegation and co-commissioning arrangements introduced last year.

The General Practice Forward View, published in April 2016, sets out a plan, backed by a multi-billion pound investment, to stabilise and transform general practice. It has been developed with Health Education England (HEE) and in discussion with the Royal College of General Practitioners (RCGP) and other GP representatives.

It commits to an extra £2.4 billion a year to support general practice services by 2020/21. This means spending will rise from £9.6 billion in 2015/16 to over £12 billion by 2021 – a 14 percent real terms increase. This investment will be supplemented by a one off five-year £500 million national sustainability and transformation package to support GP practices, and includes additional funds from local CCGs.

The plan also contains specific, practical and funded steps to grow and develop the workforce, drive efficiencies in workload and relieve demand, modernise infrastructure and technology, and support local practices to redesign the way modern primary care is offered to patients.

A fairer deal for local areas

Historically, some CCGs have received less funding than they have been entitled to under the formula used for calculating the health needs of their populations. In 2015/16, we halved the number of CCGs that were more than five percent below their target allocations, from 34 to 17. For 2016/17, we have taken actions to ensure that no CCG is now more than five percent below its fair share funding; similarly in 2016/17 the place based allocation, which considers CCG commissioned activity, primary medical care and specialised services together, is no more than five percent below target for any CCG area.

The Government's mandate to NHS England

The mandate sets out the goals for the NHS. Most of the goals for 2015/16 were met or close to being met. NHS England met its overriding financial duty to keep spending within the agreed budget set by government. Further detail is presented in Appendix 1.

Corporate priorities for 2015/16

We identified key priorities for improvement in 2015/16, following publication of the Five Year Forward View which were detailed in our business plan for 2015/16. They include some services which will require sustained action over years. They include cancer care, mental health, learning disabilities, obesity and diabetes prevention. The focus of our care redesign work was on primary care, urgent and emergency care (UEC), specialised services and the development of new, and more integrated, care models. Building the NHS of the Five Year Forward View: NHS England Business Plan 2015/16 can be viewed on our website at www.england.nhs.uk/publications/business-plan/.

A summary of progress against each of our corporate priorities is set out below. Detail on how we assure delivery against these objectives can be found in the Governance Statement.

Improving the quality of care and access to cancer treatment

The NHS provides a very high standard of cancer care. Our cancer outcomes have improved significantly over recent years, including our survival rates, which have never been higher. There are also more people being diagnosed with cancer and living with the condition. Current figures show that one in two people born after 1960 will be diagnosed with cancer in their lifetime, and it is expected that 3.4 million people will be living with cancer by 2030. However, we know that more work is required to ensure that everyone with cancer receives truly world-class care, support and treatment.

To chart the key improvements for the next five years, NHS England commissioned an independent Cancer Taskforce. Their report, Achieving World-Class Cancer Outcomes (July 2015) included 96 recommendations designed to achieve six goals: a radical upgrade in prevention; a drive for earlier diagnosis; improved patient experience; a transformation in care for those living with and beyond cancer; investment in modern high quality services; and reformed processes for commissioning, provision and accountability. This is available to read at www.england.nhs.uk/ourwork/cancer.

We have made a good start in implementing the recommendations in the report, led by the newly created National Cancer Transformation Board which includes representatives from NHS England, Public Health England (PHE), HEE, the Care Quality Commission (CQC), and NHS Improvement. Advice and challenge to the cancer programme is provided by a new National Cancer Advisory Group comprised of patient representatives, cancer charities and royal colleges.

We have begun to issue interim reports giving practical guidance on delivering earlier and faster cancer diagnosis based on learning from the first wave of 60 test sites under our Accelerate, Coordinate and Evaluate (ACE) programme. The first three reports cover variation in performance and practice on lung cancer pathways, direct referral by non GP primary cancer health professionals, and pharmacy training for early diagnosis of cancer. We have also recruited to six test sites for our next wave of activity to evaluate the impact of multidisciplinary diagnostic centres for investigation of symptoms of concern which do not map onto other pathways. These sites will go live in 2016/17.

We have also begun to develop rules for the new 28 Day Faster Diagnosis Standard for Cancer, which will ensure patients have their potential cancer diagnosed or ruled out within 28 days of a GP referral. In 2016/17, we will be recruiting five test sites across England to help us robustly roadtest the new standard.

During 2015/16, the volume of urgent GP referrals, where cancer was suspected, increased by 11.4 percent on 2014/15. This is 176,427 more patients being seen compared with 2014/15.

In 2015/16, 82.4 percent of patients began a first definitive treatment within 62 days from an urgent GP referral for suspected cancer against a target of 85 percent and prior year performance of 83.4 percent. As at the end of October 2015, 75 trusts were not meeting the 62 day cancer standard and were required to develop recovery plans. The plans have been assured, and high risk trusts are being reviewed each month on their progress. However, during 2015/16, the volume of patients on the 62 day pathway receiving a first definitive treatment for cancer increased by 6 percent compared with 2014/15.

During 2015/16, we consulted on substantial revisions to the Cancer Drugs Fund (CDF) so that from 2016/17 it will be used to test 'real world patient outcomes' from the most promising cancer therapies where clinical uncertainty exists at the time of its licensing. This will also ensure the CDF is managed within its expanded budget of £340 million.

We have now published an implementation plan outlining a wide range of specific steps designed to increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond the disease. A new Cancer Waiting Times Delivery Group, formed jointly with NHS Improvement, has begun to tackle waiting times and specifically improve performance against the 62 day maximum wait from receipt of urgent GP referral to start of treatment.

Upgrading the quality of care and access to mental health and dementia services

A quarter of the population experience mental ill health at some point in their lives. Yet mental health services have historically lagged behind physical health services in funding growth, and many people have struggled to get the help they need, enduring worse outcomes than those with physical health problems and suffering stigma and discrimination. The human cost has rightly been seen as unacceptable, with wider economic benefits of improved mental health in the population also not fully realised.

The Five Year Forward View set out a vision of a reformed service that would provide better prevention, improved crisis care and early access to evidence based treatment, integrated services for mental and physical health, and new ways of delivering care coupled with routine outcome monitoring.

In 2015/16, we made progress towards making this a reality. We improved outcomes and increased access to evidence based psychological therapies with treatment success rates at record levels. We plan to further increase access to reach 25 percent (from the current 15 percent) of need by 2020/21 so that at least 600,000 more adults with anxiety and depression can receive care. Every CCG created a joint agency plan with local partners to improve care for children and young people and received a share of the new money allocated in the Autumn Statement 2014 and Spring Budget 2015.

We have extended the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) transformation programme to cover services working across 82 percent of 0-19 year olds, and we are on target for 100 percent coverage by 2018. The first referral to treatment time standard specifically for those under 18 years old with an eating disorder was published in August 2015. We worked with the Department for Education (DfE) to support a single point of contact pilot between the NHS and schools to improve access and referral pathways, including 27 CCGs and 255 schools.

The number of adults who recover following treatment under the IAPT programme continues to increase, with 167,320 recovering in the nine months to December 2015. This is a 33 percent increase on the same period in 2014/15. However, there is still a wide regional and sub-regional variation in both access and recovery rates.

In January 2016, the statistics showed that 84.3 percent of people referred to IAPT services began treatment within six weeks and 96.4 percent within 18 weeks.

We have taken steps to improve crisis care since the 2014 launch of the Crisis Care Concordat with the establishment of a major five year national improvement programme with the aim that people will be able to access high quality urgent and emergency mental health care 24 hours a day, seven days a week, 365 days of the year, in the same way as we expect for physical health care. The use of police cells under 'Section 136' arrangements at times of mental health crisis has more than halved in recent years, with further progress planned in 2016/17.

The mandate for 2015/16 required that a new access and waiting time standard was introduced this year to ensure that, by April 2016, more than 50 percent of people experiencing a first episode of psychosis commence treatment with a National Institute of Clinical Excellence (NICE) approved package of care within two weeks. The focus of work this year has been on ensuring system and workforce readiness to implement the new standard.

NHS England recognises that there are workforce issues and is working closely with HEE who are establishing a workforce strategy to support the mental health providers to deliver this standard.

The Prime Minister's challenge on dementia 2020 (February 2015) required that at least two thirds of the estimated number of people with dementia should be diagnosed. This target diagnosis rate was achieved in November 2015, and statistics show this has been maintained and improved over subsequent months, and the national estimated rate at the end of March 2016 is confirmed as 67.5 percent. We have developed a new evidence based care pathway for people living with dementia and their carers and established an expert group to help develop our approach to implementation.

In February 2016, we published the report of our independent Mental Health Taskforce, the Five Year Forward View for Mental Health for the NHS in England (February 2016) at www.england.nhs.uk/mentalhealth/taskforce/ which set out plans to transform mental health services by 2020/21. It proposed a three pronged approach to improving care through prevention, providing seven day access to treatment in a crisis and integrating physical and mental health care.

In response to the taskforce's call for extra investment we have pledged to help more than a million extra people and invest more than £1 billion pounds extra a year by 2020/21. This will fund increased access to the evidence based care set out as the key priorities in the taskforce report.

As described by the National Audit Office (NAO), successful implementation will require cross-system alignment and a Mental Health and Dementia Board across arm's length bodies has been established to bring together key partners in governing the programme as it develops.

Transforming care for people with learning disabilities

We committed to improving the lives of the 1.2 million people with learning disabilities last year, and significantly reducing the inequalities in health and care that they face.

In October 2015, we published Building the Right Support (October 2015) which is available to read at www.england.nhs.uk/learningdisabilities/natplan/. Developed jointly with our partners, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), and with active input from people who use the services and

their families, this is an ambitious three year national plan to develop community services and deliver our commitment to close outdated long stay hospitals and inpatient facilities.

Our plan gives commissioners a clear framework to develop more community services for people with a learning disability and/or autism with behaviour that challenges, and it aims to close 35-50 percent of inpatient care over the next three years, including Calderstones, the last remaining standalone learning disability hospital in England.

Six fast-track partnerships, supported by a total of £10 million funding, provided vital learning for the national plan and as a result there are now 48 Transforming Care Partnerships (TCPs) across the country, bringing together CCGs, local authorities and NHS England specialised commissioners. TCPs will be supported by £30 million transformation funding to make this plan a reality and give people and their families more choice and say in their care and support.

Alongside the national plan we published a new service model, which was tested by the fast track areas. This describes what good services should look like and gives people a clear picture of what they can expect from the services they use, while at the same time allowing partnerships the flexibility to design and commission services that meet the needs of people in their area. TCPs are learning from the impact which the fast tracks have achieved, and we are focused on accelerating this process.

Care and Treatment Reviews (CTRs) have been tested and rolled out across the country, designed to help reduce unnecessary admissions and lengthy stays in specialist hospitals.

We have worked with the Association of Directors of Children's Services and DfE to ensure that CTRs properly meet the needs of children who are inpatients and in 52 week residential school placements.

Over 2,000 CTRs have been carried out this year, helping to increase the number of people discharged from hospital. However, while the number of people still in hospital has been reduced by 6.4 percent to 2,615, progress needs to accelerate over the next year and beyond.

People with a learning disability and/or autism have poorer physical and mental health compared to others, and a lower life expectancy. As part of our commitment to address this, we began working with the University of Bristol to develop a new national learning

disability mortality review which will help us to understand why this is happening, address health inequalities and improve care.

We also finalised plans to support more people with a learning disability and/or autism to have better quality annual health checks, and worked to create easy to read learning disability tools and guidance to support the recruitment and employment of people with learning disabilities into the NHS.

Tackling obesity and preventing diabetes

Type 2 diabetes affects 2.8 million people in Britain, with a further 5 million at risk. The cost to the NHS of caring for those with Type 2 diabetes is £8.8 billion a year. In the Five Year Forward View we announced our ambition to become the first country in the world to implement a national, evidence based, diabetes prevention programme.

In 2015/16, we established a joint plan with PHE and Diabetes UK based around seven demonstrator sites to design the prevention programme, deliver behavioural interventions – supporting people to lose weight, take exercise and eat better – and guide its implementation.

Four providers of the programme were selected in March 2016 from 11 organisations invited to tender. Contracts to deliver services have been awarded in 10 areas, and a further 17 will go live this summer covering almost half the population of England. An initial cohort of CCGs is expected to join the programme by July 2016.

The programme is on track to deliver services making up to 20,000 places available to at-risk individuals in 2016/17, expanding to around 100,000 people a year over subsequent years.

As part of efforts to encourage healthier lifestyles, plans to create 10 NHS supported healthy new towns were announced in March 2016 covering more than 76,000 new homes and 170,000 residents.

We will also be developing a diabetes treatment programme in 2016/17 which will take into account recommendations from the 2015 NAO report to continue to improve services and performance.

Case study: Diabetes

Dorothy Hall (60) was dancing at her local club twice a week, doing about 3,000 steps a day, and thought she was getting her 5-a-day until a spot health check showed she was at high risk of Type 2 diabetes.

Dorothy was referred to the Just Beat It programme, run by Durham County Council and Durham's two CCGs. The scheme is one of seven demonstrator sites for the NHS Diabetes Prevention Programme. It includes six months of education and exercise, plus 18 months follow-up and support. The education focuses on eating 5-a-day, behaviour change and dealing with stress. Since being referred to the scheme, Dorothy has lost 3kg and 10cm off her waist.

> "Getting support from the Just Beat It programme was excellent. Changing your diet and lifestyle isn't easy, so it was really good to always have someone to turn to for advice and support. There needs to be greater support to help people eat more healthily, and be more active, which is why I think the NHS Diabetes Prevention Programme is a magnificent initiative, and I would most definitely recommend it to everyone!"

Redesigning urgent and emergency care services

In November 2013, we published a review of urgent and emergency care which set out a new strategy: to provide people with urgent but non-life threatening needs with highly responsive, effective and personalised services outside of hospital and closer to their homes; and to provide people with more serious or life threatening emergency needs with rapid treatment in centres of excellence with the very best expertise and facilities to maximise their chances of survival and a good recovery.

Since the publication of the review, 23 UEC networks, covering the whole of England, have been established to lead implementation in their local area. In July 2015, eight vanguards were selected as early test beds for new initiatives, including a 24/7 mental health crisis response service, support for clinical decision making in urgent and emergency situations (such as by highlighting variation from best practice) and new outcome measures.

Across England, urgent and emergency care (UEC) services are under pressure. Rising demand from an ageing population, confusion among patients about where to get help, and pressure on general practice, all contribute to increasing the burden on A&E departments, emergency ambulances and the NHS 111 service. Almost 23 million patients attended A&E in 2015/16, an increase of 2.3 percent on the level of attendances in 2014/15.

In response to increasing demand and as part of NHS England's ongoing Urgent and Emergency Care Review, a new service model is being introduced, bringing together NHS 111, GP out of hours and clinical advice. This offers patients improved access to a new 24/7 urgent clinical assessment, advice and treatment service, and is being rolled out across England. The operational standard for A&E waiting times is that 95 percent of patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department. In 2015/16, 91.9 percent of patients attending A&E were either admitted, transferred or discharged within four hours. Performance has varied across the country with the causes of poor performance being multi-factorial. While the increase in activity is one cause, there are a number of others that need to be addressed. Flow through the acute sector, delays in discharges linked to social care pressures, lack of available alternatives to A&E, system leadership and other factors contribute to performance to a greater or lesser extent across the country.

Emergency admissions over the past twelve months were up 2.9 percent on the preceding twelve month period, in line with expectations.

NHS Improvement, with support from NHS England, is developing a plan to support recovery of A&E performance in 2016/17. The plan focuses on ensuring that all health systems adopt five best practices drawing on the NHS England report on transforming UEC services, Safer, Faster, Better (August 2015) which can be read at www.ecip.nhs.uk/resource/safer-faster-better.

Access to patients' medical records is vital to enable clinicians to deliver the best care. Among patients registered with a GP, 96 percent now have an electronic Summary Care Record (SCR); with the patient's consent, clinicians can access these in 51 percent of A&E departments, 88 percent of NHS 111 service providers and 82 percent of ambulance services.

Reforms to the 999 ambulance service were tested in 2015/16 to improve performance by delivering help on the phone, face to face in the patient's home, or transport to hospital in the right vehicle with the right urgency, as appropriate. A pilot programme called Dispatch on Disposition gives 999 call handlers additional time to determine accurately when an emergency ambulance is needed in non-life threatening situations. This is being independently evaluated before a decision is made on national roll out.

Networks for acute stroke care are being developed in several areas across England, building on the published success of the London model.

Case study: Urgent and emergency care

A call came in to 111 from a daughter of an 86 year old patient who was in increasing pain and becoming very agitated. The call handler saw that there was a Special Patient Note stating the patient was for palliative care only. The call handler excluded any need for an emergency response and referred the patient to the specialist palliative nurse in the call centre. The nurse, with patient consent, was able to access the GP/community notes. The care plan was clear that the patient wanted to die in the hospice where she had been an inpatient. The palliative care nurse assessed that the patient was in terminal agitation. She contacted the hospice who agreed to admit her. She was then able to arrange transport by one of Yorkshire Ambulance Service's dedicated palliative care ambulances to take her to the hospice, where she died peacefully, surrounded by her family, some 24 hours later.

Strengthening primary care services

Primary care services such as GP surgeries, pharmacies, dentists and opticians are the cornerstone of the NHS, providing vital health services to local communities. In 2015/16, the overall budget for primary care increased by 4.1 percent.

Most of the contact that patients have with the NHS is through their GP surgery, and more than eight out of ten patients rate their experience of GP services as good. But services are under real pressure with rising workloads and patients increasingly concerned about access to services.

Improvements in general practice infrastructure are vital in enabling the type of transformation that we all want to see. Work has been underway, and during 2015/16 NHS England has been leading a multi-million pound transformation fund to support primary care and general practice to make improvements in premises and technology. This is already having an impact in local GP surgeries, and investment will continue over the coming years with CCGs leading the way in developing plans for investment in line with their local digital and estates strategies.

In January 2015, a ten point Building the Workforce plan was published to increase recruitment to general practice, retain more doctors in practice and support more to return. As part of this, we introduced a revised scheme to provide doctors with a clearer and easier route to return to general practice, targeting locations with the greatest GP shortages and encouraging GPs to work in these areas. We also invested £31 million in an additional 400 clinical pharmacists in general practice as part of work to expand the primary care workforce. This has since been expanded as part of the General Practice Forward View to £112 million for 1,500 new clinical pharmacists in general practice by 2020. This plan can be read at www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan.

In April 2016 we published the General Practice Forward View which set out a multi-billion pound plan to support general practice by increasing the number of GPs and other staff, improving access to services and investing in new ways of improving primary care for patients.

The General Practice Forward View builds on this workforce investment, supporting the Government's commitment to increasing the number of doctors in general practice by 5,000 and other staff working in general practice by the same amount, by 2020.

The GP Access Fund (formerly the Prime Minister's Challenge Fund) was established to help improve access to general practice and stimulate innovative ways of providing primary care services. Since the programme launch in October 2013, NHS England is now managing 57 schemes covering over 18 million patients (30 percent of the country) in over 2,500 GP practices. Patients are benefitting from improved access and transformational change at a local level. This includes extended access to services, better care navigation and increased use of technology such as video consultation.

In 2015/16, a majority of CCGs took on greater responsibility for commissioning GP services as part of the co-commissioning agenda. This marks a critical step towards more joined up health commissioning and enabling the development of more integrated care for patients set out in the Five Year Forward View.

For the first time in 2015/16, a national service for pharmacists to provide the NHS influenza vaccine direct to patients was established. Half a million patients chose to take up their vaccination from their community pharmacy, twice the number in the previous year when access to the vaccine via local pharmacies was only available through local schemes.

Timely access to high quality elective care

Nearly 15 million patients started consultant-led treatment in the 12 months to March 2016, up 2.5 percent compared to the previous financial year. Of all patients on the waiting list at the end of March 2016, 91.5 percent had been waiting less than 18 weeks, compared to the 92 percent standard set under the NHS Constitution.

Over the last decade, waiting times have fallen dramatically. From the beginning of 2015/16, we have used a single waiting time measure, known as the incomplete standard. This standard focuses on all those patients whose treatment is still incomplete at the end of each month, rather than just on those treated in that particular month. The incomplete standard is that 92 percent of those still waiting to start treatment have been waiting less than 18 weeks. This change is intended to cut extended waits by ensuring hospitals are encouraged to, and not penalised for, treating patients that have waited longer than 18 weeks, as was the case with the former admitted and non-admitted standards.

We have continued to make strides in cutting long waits and the number of long wait patients treated per working day in the six months to March 2016 was a third higher than in the same period a year earlier, which as a proportion of all activity, was up from 7.4 percent to 9.7 percent. Patients waiting more than a year were over 5,000 in 2012 and are now down to within hundreds.

Despite continued pressure on waiting lists, the incomplete standard was met in most months of 2015/16 (it was just missed in December, January and March). Extra effort to maintain it will be needed as pressure on NHS capacity increases further.

To ensure maximum use of NHS capacity, a mechanism was established with NHS Improvement to support the transfer of patients from NHS trusts under the greatest pressure to those with available capacity, including the independent sector. A specific arrangement was put in place for endoscopy procedures which were under particular pressure.

Work is also underway to modernise the referral system to ensure it is effective, clinically-led and provides patients with a genuine choice over how and where to have their treatment.

We consolidated and simplified the advice on recording and reporting of waiting time data, with refreshed guidance for NHS trusts. We ensured consistent national messages were provided about the changes to the waiting time standard and provided support to improve demand and capacity planning.

In February 2016 Better Births, the national maternity review, was published. This is a five year plan for maternity services to make care safer and give women greater control and more choice. A key element of the plan is to ensure maternity care is centred on the woman, her baby and family, by providing access to information and support that is based around their needs and circumstances. The aim is to improve outcomes, particularly for vulnerable women, and reduce health inequalities.

Ensuring high quality and affordable specialised care

Specialised services include those for patients with rare conditions and those of very high cost. They often require specialised multidisciplinary teams working together to achieve the best outcomes and patient experience. Over the past three years, significant progress has been made in developing consistent national standards and gaining control of one of the most challenged budgets within the NHS – just under £15 billion in 2015/16. To the envy of many other countries, any patient who needs it can access these high quality, often world class treatments free at the point of use; be it for rare cancers, genetic diseases, infectious diseases such as hepatitis C or specialised medical or surgical conditions.

In 2015/16, for the first time, NHS England successfully balanced its specialised commissioning budget, whilst also continuing to expand services and treatments available.

However, as recent reports from the NAO point out, the rapidly rising demand for new, innovative but often expensive treatments, particularly drugs, means that the demand for specialised services continues to grow at a rate that is considerably more than other parts of the NHS. In addition, there continues to be variation in access, outcomes and cost for some specialised services.

To help address this, we are exploring the use of innovative approaches to commissioning high cost interventions, for example in rare diseases, such as the Managed Access Agreement successfully negotiated in December 2015 for elosulfase alfa for the ultra-rare Morquio A syndrome. This approach allows patients access to treatment at a substantially discounted cost, whilst they are monitored to see how the intervention has worked in practice before final funding decisions are taken.

Following significant engagement and consultation with industry and patient groups, we have also set out new arrangements for the CDF so that the most effective treatments can continue to be offered to patients, whilst stopping those that are less effective to ensure that new and more effective treatments can be added within the budget available.

Following consultation on the principles and process by which NHS England makes investment decisions, 23 additional clinical policies were approved in July 2015 as part of the annual prioritisation round. These include new treatments for Parkinson's disease, cystic fibrosis, HIV, prostate cancer and tuberculosis, as well as policies widening access to Proton Beam Therapy and a range of genetic tests that can help prevent breast and ovarian cancer. These new policies will help us to improve and extend thousands of lives for years to come through prevention, identification and treatment.

We know that we must continue to build on this progress and accelerate transformation – with specialised care embedded in patient pathways and more personalised care – whilst ensuring best value from the resources available. Under plans set out in the Five Year Forward View, in 2016/17 we are moving from the provision of treatments for individual services to population based allocation of specialised services budgets. To drive this agenda, collaborative commissioning committees are now established in all 10 commissioning hubs, and plans have been developed at a local level to identify those services that could benefit from closer collaboration between NHS England and CCGs. This will help to ensure that fair and timely decisions are made for patients and that the public get the best value from the services.

Whole system change for future clinical and financial stability

The Five Year Forward View set out a clear direction for the NHS but acknowledged that there is no one-size-fits-all answer to the multiple challenges the health care system faces. Its proposals were based on finding diverse solutions to diverse problems and creating partnerships between national and local organisations. This is a new approach for NHS

England which involves working more closely with other health sector bodies including NHS Improvement, CQC, HEE, NICE and PHE. These bodies have come together with NHS England in the Five Year Forward View Board, which is developing a strategy for the future.

The Spending Review for the NHS in England initiated three interdependent and essential tasks: to restore and maintain financial balance; to deliver core access and quality standards for patients; and to implement the Five Year Forward View.

The NHS Shared Planning Guidance, published in December 2015, asked every health and care system to come together to create its own ambitious local blueprint for accelerating implementation of the Forward View and to close these health, care and financial gaps by 2020/21.

As a result, neighbouring health and care services have come together to form 44 defined footprints – geographic areas, in which people and organisations are working together to develop robust plans to transform the way that care is delivered. These footprints will develop Sustainability and Transformation Plans (STPs), place-based, strategic plans built around the needs of local populations. They will help drive improvements in patient experience, health outcomes, and efficiency in the longer term whilst also securing affordable solutions to the NHS's more immediate challenges.

New care models

Since its launch in March 2015, the new care models programme has supported the establishment and growth of 50 vanguards and the ongoing development of 25 integrated care pioneers to lead on developing new care models that will act as blueprints for the NHS and an inspiration for the future of the health and care system.

By 2020, it is envisaged that at least half of the country will be covered by the new care models. Separately and together the 50 vanguards are designing and implementing new ways of working which are focused around the needs of patients, creating networks of care and breaking down the traditional barriers between hospital, community services, primary care and social care. Though no single model of care will work everywhere, they are identifying and testing out common needs and approaches, led by frontline clinicians, managerial staff and patients working with their local partners.

The vanguards were selected following a rigorous process involving a range of national NHS bodies, as well as the royal colleges, social care, clinicians, and patient representative groups.

In 14 areas, GP practices and partners in the community are working together as multispecialty community provider vanguards. They are focused on moving care out of hospital into the community, bringing care closer to where people live, ensuring their medical and social needs are looked at in a joined up way rather than in isolation.

In nine areas, hospital and community services, together with mental health and community care, have joined up as integrated primary and acute care system vanguards, creating a single organisation responsible for people's care, whatever they need.

In six areas, enhanced health in care home vanguards are joining up health, care, and rehabilitation services for elderly and frail populations. They include dedicated teams of physiotherapists, chiropodists and other clinicians and are working to harness new technology such as telehealth.

There are eight urgent and emergency care vanguards working to reduce pressure on A&E departments by delivering the recommendations of the 2015 UEC review faster than the rest of the NHS.

The 13 acute care collaboration vanguards are developing networks to share clinical expertise, joining up hospitals in different areas or selecting one NHS organisation to provide specialist care on different sites, whilst focusing specifically on reducing variation in care and efficiency.

The 50 vanguards received total funding of £131 million in 2015/16, and are supported by more than 1,000 GP practices and over 40 CCGs. The funding that vanguards received is helping them make the necessary change while establishing a robust governance structure around their individual programmes. Vanguards have been provided with support, including training, advice, and access to experts, which has helped to ensure the successful development of their new care models.

During 2015/16, the programme focused on the selection, development and growth of the new care models with increasing focus on spreading the new care models across the country and a rigorous approach to prioritisation of funding based on detailed assessment of value propositions submitted by each vanguard. In 2016/17, the programme is moving to the next phase of delivery to ensure quantifiable impact, and to support wider spread and the mainstreaming of new care models from 2017/18. Our work with the NHS Confederation, NHS Providers, NHS Clinical Commissioners, LGA and the RCGP is supporting this by spreading the learning from the vanguards with the wider NHS and care services.

Evaluation is at the heart of the programme in order to provide robust results and learning. Improvements in outcomes and the cost-effectiveness of changes made will be rapidly disseminated across the NHS and elsewhere. The new care models programme is complex in its breadth and depth, and combines experimental discovery with standardisation. This calls for an innovative, sophisticated and multi-faceted approach to measurement and evaluation.

The impact of the vanguards on health and wellbeing, care and quality, and efficiency, is being evaluated nationally using a set of national metrics: high level outcome indicators for each care model type are reported quarterly through a dashboard, comparing with a do-nothing baseline. Vanguards will report on progress against their plans against a set of local metrics and we will also be looking at a small set of common national enabler metrics showing progress towards the core components (such as multidisciplinary teams, integrated care records, and whole population budget). Information from measurement, reporting and local intelligence will be collated and synthesised. A Health Data Lab is being developed with the Health Foundation to strengthen our capability to measure the impact of NHS transformation programmes. This will provide selected vanguards with the capability to rapidly evaluate the impact of specific interventions, by comparing results in an intervention area against counterfactuals, such as matched controls.

Case study: Partnership working in the Isle of Wight

Isle of Wight's My Life a Full Life change programme brings together the CCG, Isle of Wight NHS Trust, Isle of Wight Council, the voluntary and independent sectors and the island's GP federation, One Wight Health. It followed significant consultation with residents about their priorities for health and social care.

Over the last five years, the island has established a central hub, which co-locates a range of services for early intervention and diversion of patients away from hospital admission where appropriate.

The hub includes 999 emergency calls operators; NHS 111 call handlers; paramedic clinical advisers; GP out of hours services; district nurses; social workers; pharmacists; Wightcare, who provide alarms for vulnerable people; occupational therapists; the charity Age UK; and a crisis response team. It allows instant access to the patient's records from all the organisations involved.

The crisis response team is made up of district nurses, coronary care nurses, clinical assessors, paramedics, an occupational therapist, a social worker and an Age UK representative. The team provide wrap around care for people at risk of hospital admission, usually older people, and those with long term conditions and mental health needs.

Between April and December 2015, the crisis team saw 489 people, and spent an estimated £725,000 less than it would have done with a more traditional approach. Of those 489 people, just 58 were admitted to hospital, mostly due to complications of existing long term conditions.

Personalisation and choice

Patients are the focus of the NHS, but they have not always been involved in decisions about their treatment. The Five Year Forward View set out a commitment to ensure that when people need health services they will have greater control over where and how they receive care, and to move from a one-size-fits-all approach towards care personalised to each individual. NHS England has established a personalisation and choice programme dedicated to driving forward these plans, including giving choice to women over how they are cared for in pregnancy and childbirth and to people with terminal illnesses requiring end of life care.

A cost effective way of giving people control over their care is to provide them with a Personal Health Budget (PHB) to buy the services they need. This improves quality of life and reduces reliance on unplanned care. Building on learning in social care, from September 2014 people with long term, complex conditions who receive NHS Continuing Healthcare, or continuing care in the case of children, have had a legal right to have a PHB, and the number of people holding them has begun to increase. 4,700 patients took up the offer in the first half of 2015/16, a 60 percent increase on the previous year. Our target is to raise the number to 50,000-100,000 by 2020.

As highlighted in a recently published NAO report there is widespread support for personalised commissioning in social care. Building on this and the demand for greater integration for people with complex health and social care needs, in April 2015 we introduced Integrated Personal Commissioning (IPC) which blends health and social care funding together and gives people more choice and control over how this is used. Nine demonstrator sites have been established and are developing local processes with the national team. The IPC programme will be evaluated and learning shared across health and care community over the coming years.

Financial sustainability

During 2015/16, we completed our modelling of the NHS' impending challenge and, in December 2015, we built the impact of the Spending Review settlement into our allocations. We have mobilised key efficiency programmes within our scope that will help us in our objective of achieving financial sustainability, and have started work to develop an approach to measurement, evaluation and benefits realisation for each of our efficiency workstreams. We have initiated the development of a model and an approach to support

local systems in delivering financial sustainability, ahead of the STP process which will be the vehicle through which we will demonstrate routes to financial sustainability in every health economy around the country.

The RightCare programme is a core element of our efficiency programme. It has grown at a rapid rate throughout the year, having been rolled out to 65 local health economies covering 19 million people in 2015/16, with a launch to all remaining areas of England planned for the end of 2016.

RightCare is a proven improvement approach to tackling unwarranted variation and improving value. It has been tested successfully and has shown both to improve patient outcomes and to free up funds.

A series of Commissioning for Value and new focus packs have been published throughout the year to take a more detailed look at how treatment of numerous conditions vary across England. These have so far included cardiovascular disease, neurological conditions, respiratory, cancer and tumours, maternity and early years, mental health and dementia and musculoskeletal.

Case study: Ashford CCG

Demand for orthopaedic services in East Kent was increasing to the point of unsustainability. Ashford CCG wanted to ensure that it was making maximum use of available resources and that patients were receiving the best care. The CCG implemented the RightCare approach to achieve this.

RightCare identified that, compared to similar locations, a high proportion of Ashford's musculoskeletal patients were being referred directly to hospital. The RightCare approach found significant variation in rates of referrals by GPs.

The CCG introduced a new triage service, run by GPs and aimed at delivering the best pathway for patients. GPs received specialist support, and focus was placed on delivery of the 18 week wait target.

Outcomes for patients were improved, with more being seen in the right setting and, as a result of the reduced waiting times, far quicker than under previous arrangements. In its first 12 months of operation, the approach resulted in a reduction of 30 percent in referrals to secondary care, with annual savings of £1 million.

Foundations for improvement

Patient and public participation

In November 2015, we published our Patient and Public Participation Policy to embed the participation of patients and the public in all areas of our activity, supported by a 10 point action plan. The plan includes providing training, information and resources to help people make their voices heard and increase involvement in our decision making. This policy can be viewed at www.england.nhs.uk/ourwork/patients/ppp-policy/.

We are also introducing frameworks for participation in all of NHS England's areas of direct commissioning, and our NHS Citizen programme has paved the way for two way communication using online fora, social media and face to face events.

People's lives can be transformed when they are helped to manage their health, shape their care, and choose what is important to them. As part of our Self Care programme we will support the knowledge and confidence of people to manage their own health, using the Patient Activation Measure (PAM). This is a validated, evidence based survey tool that measures individuals' knowledge, skills and confidence to manage their own health, and the measure will be rolled out over the next five years to 1.8 million people, through key NHS change programmes, including the new care model vanguards and IPC demonstrator sites. By knowing the activation level of their population, health and care systems can begin to tailor their services in order to support people on a journey of activation, helping them lead better lives at a lower cost to the system.

In August 2015, we completed the final stage of the Friends and Family Test (FFT) rollout across the NHS. As at end of March 2016, this had provided 20 million pieces of feedback to the NHS. We are also working to ensure that our national patient and staff surveys continue to identify trends in experience of different demographic groups.

Case study: Wessex Community Voices: Partnership working with Healthwatch and the voluntary and community sector to influence the commissioning cycle

Wessex Community Voices was developed by NHS England in Wessex and the Wessex Healthwatch Partnership, including the voluntary and the community sector. It includes a training and support programme to develop public understanding of commissioning. The project developed a guide for staff about public and patient engagement, called Choosing and Buying Services Together including examples of how the public can be involved at each stage of the commissioning cycle and participation techniques and methods. A Healthwatch worker also maintains a network of people able to contribute to commissioning work programmes, supports training, supports engagement with seldom heard individuals and groups, and provides independent evaluation of public consultations.

Case study: Sheffield CCG

In Sheffield CCG, the PAM is being integrated in general practice into the delivery of existing services for routine diabetes care. In the redesigned appointment system, clinical time is reallocated to offer a longer appointment to tailor discussion to the appropriate level of activation. This is helping to remove barriers to providing person-centred care, such as clinical availability/ time, training and delivering support relevant to the patients' needs. The PAM is an integral tool in ensuring that resources are allocated appropriately and patients receive care tailored to their needs.

> "This person-centric approach will eventually liberate us from wasting time doing the wrong things, in the wrong way, and help healthcare professionals to shape our systems around what patients need at each stage of their life."
>
> Dr Ollie Hart, a GP in Sheffield

Harnessing the information revolution

In April 2015, England became the first country in the world to enable its citizens to book GP practice appointments, order prescriptions and access their medical records online. By April 2016, over 95 percent of GPs were able to offer patients online access to their detailed health record.

This underpins our work to encourage better use of data and technology to extend patient choice, enable citizens to take more control, be more engaged in their own health and care, improve outcomes, and at the same time reduce the administrative burden on the NHS.

In February 2016, DH announced £4.2 billion of funding for NHS technology over the next five years, including £1.8 billion to create a paper free health and care system, following the publication in November 2014 of the National Information Board's strategy, which will support the transformation of care. This funding is underpinned by a benefits case with efficiencies mapped out over the next five years.

In September 2015, we launched guidance for CCGs on extending electronic health records and the development of local digital roadmaps to realise a paper free health and care system by 2020.

Over 17 million patients are able to use the Electronic Prescription Service, which allows them to collect medicines direct from the pharmacy without visiting their GP, or even have them delivered. A third of all prescriptions are now transmitted electronically.

A new E-Referrals system was launched in June 2015, which provides a safe and secure mechanism for patients and referrers to select a provider of their choice and convenient time and date for their appointment.

Over 96 percent of patients now have an electronic SCR, which can be accessed by health professionals with the patient's consent. Its use is increasing on occasions when urgent care is needed, with over 3 million views a year.

Case study: Learning from the Patient Online programme

The Swan Practice in Buckingham sees about 70 patients per day for tests and samples. Until recently, patients had to ring or visit the practice to get their results. Each call lasts approximately two minutes, but can easily take up more time when the patient wants the receptionist to read out the results.

Since August 2015, when the practice started offering online test results to their patients, the number of calls has dropped to 25 per day. This has freed up valuable time for both administrative and clinical staff.

Research and innovation

Genomics

NHS England is a major partner with Genomics England in the 100,000 Genomes Project, a £300 million scheme to collect and decode 100,000 human genomes – complete sets of people's genes. The project, which is looking at certain cancers and rare disorders, has the potential to improve the prediction and prevention of disease, introduce more precise diagnostic tests and lead to the development of new drugs and diagnostics.

In 2015/16 the number of NHS genomic medicine centres was increased from 11 to 13, ensuring equitable access to eligible participants, and 42 NHS trusts are now actively recruiting patients, with a further 50-60 planning to go live during the lifetime of the project. Some patients with rare diseases have received a diagnosis for the first time as a result of having their whole genome sequenced. This is a world leading project, which will result in the use of genomic technologies linked with deep clinical and diagnostic information being mainstreamed in the NHS.

Small Business Research Initiative

This £20 million investment programme is intended to speed up the adoption of new products by the NHS. In 2015/16, three competitions were held for companies to propose new technologies and ideas for improving UEC, the care of older people with multiple conditions and the care of children and adolescents with mental health problems.

258 applications were received, with 26 phase 1 companies being financially supported (up to £100,000 each) to test feasibility of the solutions to the NHS, and 18 companies were funded (up to £1 million each), for phase 2 from previous competitions, to produce their prototypes and test these in healthcare settings.

Test Beds

Seven real world NHS Test Beds were established in January 2016 for evaluating new technologies that offer better care at the same or lower overall cost. They will begin implementing their projects in 2016 and produce evidence of the impact and cost effectiveness of their innovations in 2018.

National Innovation Accelerator

This scheme, launched in January 2015, supports individuals to develop innovations for the NHS. Of 125 applications, 17 fellows were selected and joined the programme in July 2015.

By autumn 2015, 68 more organisations were using National Innovation Accelerator innovations than at the start of the programme. £8.35 million of external funding has been awarded to support further roll out, and six awards have been won. Another eight fellows will be recruited during the summer 2016.

Excess treatment costs

Research is an important core activity of the NHS that NHS England is keen to promote and support in line with its statutory responsibility. It also has a responsibility to ensure that the treatment costs of patients involved in non-commercial research funded by the Government and research charities are met. Anecdotal evidence suggests that the payment of these treatment costs, specifically treatment costs in excess of normal care (excess treatment costs) have become a point of friction between providers and commissioners, both of whom want to support research in the interests of healthcare for patients. This is despite the value of NHS excess treatment costs being small in the context of overall NHS funding.

NHS England worked with DH and other key stakeholders to develop an effective approach to address these issues. As a result, in November 2015 NHS England published new guidance to help clarify the rules and expectations. Development of a costing template, to bring greater transparency, is underway with stakeholders.

How we support the wider NHS

Commissioning

Commissioning is a key driver of quality and efficiency in the NHS. A large part of the funds NHS England receives, amounting to £73 billion, is allocated to the 209 CCGs who use it to buy hospital and other services for their local populations.

During 2015/16, nearly three quarters of CCGs took on an increased role in the commissioning of GP services, and 63 CCGs took on full delegated responsibility, to promote integration of hospital and primary care services.

NHS England provides support to CCGs to ensure they deliver the best outcomes for their patients and obtain the best value from their funds. To help them, commissioning support units (CSUs) were established in 2013 to offer data analysis and advice on procurement, service transformation, contracting, HR and financial management. With new business of £50 million in-year as part of a total income of £630 million, indications are that the CSUs are offering the services their customers seek.

Further detail on our assurance of the commissioning system is included in our Governance Statement from page 101.

Emergency preparedness, resilience and response

NHS England and the NHS in England have considerable experience in emergency preparedness, resilience and response (EPRR), and during the year we responded successfully to a number of potential threats to patient and public safety. We have also been involved in a number of key training and exercise events, to test the EPRR plans in place for a series of scenarios including significant widespread power loss, marauding terrorism, and infectious diseases. The impact of this work includes:

- leading the UK health response to suspected Ebola cases in people travelling back to the UK during the Ebola outbreak in West Africa, which was unprecedented in its scale, severity, and complexity
- working closely with local resilience forums following Storm Desmond, to ensure continued safe access to healthcare for patients. This storm caused large scale flooding and power interruption to the north of the UK – particularly Cumbria – requiring homes to be evacuated, and roads to be closed

- the establishment of a national incident control centre to assure the ongoing delivery of safe patient care during the industrial action undertaken by junior doctors, working closely with key partners.

Equality and health inequalities

NHS England is committed to ensuring fair and equitable access to high quality and appropriate health services which are planned and delivered in proportion to need, with a specific focus upon protected characteristics and disadvantaged groups and areas. Alongside this, we have a legal duty to promote equality under the Equality Act 2010. A report on how we have met the requirements of the specific duties of this Act is now available to read at www.england.nhs.uk/wp-content/uploads/2016/02/nhse-specific-duties-equality-act.pdf.

Our priority for the year has been to promote equality as a system leader and in collaboration with other parts of the health system, achieved largely through our leadership of the NHS Equality and Diversity Council (EDC). Key achievements include:

- establishing a Quick Wins programme for 2016/17 to improve equity of access to services – and outcomes – for protected groups and people with lived experience of stark inequalities
- publishing new principles for registering patients with GP practices to make it easier for patients to access the healthcare they are entitled to – available to read at www.england.nhs.uk/commissioning/primary-care-comm/resource-primary/
- progressing a unified information standard for all protected groups, and piloting a similar standard on sexual orientation
- mandating the Workforce Race Equality Standard (WRES) and use of EDS2 – the equality delivery system for the NHS – through the NHS Standard Contract in April 2015.

Alongside this, lessons from the first year of the mandatory WRES are being used to develop a new Workforce Disability Equality Standard. In 2015/16, we commissioned primary research from Middlesex University to explore what issues and measures this should comprise, focusing on the experiences of staff with disabilities working within the NHS.

Appendix 2 sets out our assessment that in fulfilling our health inequalities duties in 2015/16 as required by the Health and Social Care Act 2012, we have made reasonable progress but more needs to be done.

Workforce Race Equality Standard

One fifth of the workforce is from a Black or Minority Ethnic (BME) background, but evidence suggests BME staff do not always experience equitable treatment compared to other staff and are not properly represented at senior management levels.

Since mandating the WRES through the NHS Standard Contract, we have worked with the CQC to embed the standard within its inspection programme for hospitals.

The WRES requires NHS organisations to demonstrate progress against a number of indicators of workforce race equality, including a specific indicator to address the low levels of BME Board representation. 82 percent of NHS provider organisations submitted their baseline data against the nine WRES indicators for 2015/16. The data has been analysed and was published in June 2016. Work on implementing the WRES across the NHS is on track and we expect to see the changes it seeks to achieve over the next few years.

Patient safety

The safety of patients is paramount, but healthcare inevitably carries risks. Understanding and managing these risks is vital to secure the best outcomes.

Staff are encouraged to report all patient safety incidents, whether minor or serious, and increasing numbers of reports are seen as a good sign of an improving safety culture. The National Reporting and Learning System is the most comprehensive database of patient safety information in the world, having amassed over 12 million reports since it was established in 2004. Over 1.7 million incidents were recorded in the last year, a pleasing increase of over 10 percent on the previous year, suggesting greater awareness and transparency around patient safety. Ten patient safety alerts were issued in 2015/16, based on these incident reports. This increase in incident reporting should not be taken as an indication of worsening patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

New standards on invasive procedures were published in 2015 to reduce the incidence of Never Events – patient safety incidents that can be very serious but which are wholly preventable if national guidance and recommendations are followed.

15 Patient Safety Collaboratives have been developed in partnership with the Academic Health Science Networks (AHSNs) focused on local safety priorities in their areas.

Working with the Health Foundation, 231 patient safety and quality improvement experts were recruited to the Q initiative which is helping connect a critical mass of people highly skilled in quality and safety improvement.

A key source of learning is to study the care of people who died in hospital. We have commissioned the Royal College of Physicians to develop a standard way of doing this.

The rise of antimicrobial resistance poses a major threat to global health. We helped reduce the number of GP prescriptions for antibiotics by more than 2.6 million in 2015/16 compared with the previous year through the introduction of the antimicrobial resistance quality premium and will use similar levers to support this work in hospitals.

The Patient Safety domain and its statutory responsibilities transferred from NHS England to NHS Improvement on 1 April 2016.

Customer contact and complaints

We value feedback from patients and the public about the NHS services we provide and commission, and we use it to improve the quality of services.

In 2015/16, we received 198,100 contacts (including general contacts, complaints and Freedom of Information (FoI) requests, down 5 percent on the previous year. We will be publishing more detailed data on the breakdown between these areas in our customer contact annual report, which will be published on the NHS England website later this year.

We have set out to improve the quality of our customer contacts in a number of ways. We have restructured the contact centre and increased the number of staff answering calls; implemented a new case management system; developed a web portal for launch during 2016/17 and launched a British Sign Language video service for the deaf and hard of hearing. We expect these measures to improve access and performance further.

We have also implemented the Complaints Quality Framework in January 2016. This is a framework for complaints handling; its aim is to improve the quality and consistency of complaints handling across NHS England.

In the past year we centralised oversight of NHS England complaints which progress to the Parliamentary and Health Service Ombudsman (PHSO). This ensures a consistent quality of information sharing between NHS England and the PHSO, permits an overview of all cases in the system, and helps us understand any themes or trends emerging from these complaints. The number of cases referred to the PHSO over 2015/16 was as follows:

Cases referred to the PHSO by outcome and region

	Upheld	Not Upheld	Partially Upheld	Discontinued	Total Cases
North	2	4	2	0	8
Midlands and East	1	2	3	4	10
South	1	2	4	1	8
London	1	2	1	3	7
National	0	1	0	0	1
TOTAL	**5**	**11**	**10**	**8**	**34**

Sustainability

Our performance on sustainability is detailed in Appendix 3.

Our priorities for 2016/17

NHS England's continuing contribution to the delivery of the Five Year Forward View is set out in its business plan for 2016/17 and is summarised in this section.

1

IMPROVING THE QUALITY OF CARE AND ACCESS TO CANCER TREATMENT

2

UPGRADING THE QUALITY OF CARE AND ACCESS TO MENTAL HEALTH AND DEMENTIA SERVICES

3

TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES

4

TACKLING OBESITY AND PREVENTING DIABETES

5

STRENGTHENING PRIMARY CARE SERVICES

6

REDESIGNING URGENT AND EMERGENCY CARE SERVICES

7

PROVIDING TIMELY ACCESS TO HIGH QUALITY ELECTIVE CARE

8

ENSURING HIGH QUALITY AND AFFORDABLE SPECIALISED CARE

9

TRANSFORMING COMMISSIONING

10

CONTROLLING COSTS AND ENABLING CHANGE

WE HAVE 10 PRIORITIES FOR 2016/17

Our mission is to improve health and secure high quality healthcare for the people of England, now and for future generations.

Improving health – closing the health and wellbeing gap

- We will drive down waiting times for cancer treatment, increase diagnostic capacity and develop a modern national radiotherapy network, as recommended in the Cancer Taskforce report published in July 2015.
- For people with mental health problems, we will increase early intervention, shorten waits for treatment and expand crisis services, in line with the Mental Health Taskforce report, published in February 2016.
- We will increase the number of people with learning disabilities living in homes in the community in place of specialist inpatient units, so that they have a chance of a better life.
- We will roll out a national programme aimed at lowering the risk of developing Type 2 diabetes for individuals and slowing the rise in incidence of the disease.

Transforming care – closing the care and quality gap

- We will improve access to urgent and emergency care services by creating a single point of urgent telephonic contact through NHS 111, and we will support hospitals to extend emergency consultant cover and diagnostic services seven days a week.
- We will improve access to primary care and support GPs to extend services by widening the workforce, harnessing digital technology and increasing use of pharmacists.
- We will commit an extra £2.4 billion a year to support general practice services by 2020/21. This means spending will rise from £9.6 billion in 2015/16 to over £12 billion by 2020/21 – a 14 percent real terms increase.
- We will support hospitals to hold down waiting times for elective care, including through patient choice.
- We will tackle unwarranted variations in the cost of specialised services, implement a prioritisation framework and use our national leverage to improve outcomes and value for money.
- We will support the continued development of commissioning, encourage demonstrative integration of primary and acute care and plan for the spread of new care models.

Controlling costs and enabling change – closing the finance and efficiency gap

- We will work to ensure delivery of NHS England's contribution to the NHS efficiency challenge.
- We will roll out the RightCare programme to obtain the best value care by optimising spending across areas and specialties.
- We will support NHS Improvement to implement the recommendations of the Carter Review, deliver year on year trust deficit reduction plans, and reduce spending on agency staff.
- We will focus, with our partners, on making better use of technology, further developing leadership and supporting scientific research and innovation.
- We will involve the public by empowering patients and engaging communities, increasing patient choice and developing more personalised services in maternity and end of life care.

Chief Financial Officer's Report

The financial statements for the year ending 31 March 2016 are presented later in this document 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 209 clinical commissioning groups (CCGs), consolidated through the Integrated Single Financial Environment (ISFE), a financial accounting and reporting system covering all of the organisations concerned.

NHS England had a revenue resource limit of £101,708 million in 2015/16. The organisation is responsible for using this money wisely and fairly to secure the best possible outcomes for both patients and taxpayers. As shown later in this report, the group fulfilled all of the financial duties set out in the mandate for 2015/16, covering revenue spending, administration costs and capital expenditure. Although not legally responsible for ensuring financial balance across providers of NHS funded services, or for ensuring the Department of Health (DH) meets its overall Revenue and Capital Departmental Expenditure Limits; throughout 2015/16 NHS England has actively sought to maximise the contribution of the commissioning sector to the overall DH financial position in light of the scale of provider deficits.

Long term expenditure trends from the establishment of NHS England in 2013/14 are set out in the Parliamentary Accountability and Audit Report on page 115.

A full list of CCGs can be found on the NHS England website at: www.england.nhs.uk/resources/ccg-directory/.

Operational performance

The core measure for the financial performance of NHS commissioners is the non-ringfenced Revenue Departmental Expenditure Limit (RDEL), or general RDEL. The plan was for in-year expenditure of £100,882 million against this limit, and actual expenditure was £100,283 million, which represents an underspend equivalent to 0.6 percent of planned expenditure.

The key features of the 2015/16 financial position are shown in more detail in the following table:

Financial performance 2015/16 – RDEL general (non-ringfenced)	Expenditure		Under/(over)spend against plan	
	Plan £m	Actual £m	£m	%
Clinical commissioning groups	72,244	72,259	(15)	0.0
Direct commissioning	26,769	26,687	82	0.3
NHS England/central programmes	1,585	1,245	340	21.4
Historic continuing healthcare claims administered on behalf of CCGs	284	92	192	67.7
Total RDEL – general	**100,882**	**100,283**	**599**	**0.6**

NHS England has generated an underspend of £599 million (0.6 percent of plan) against the core performance metric. It should be noted, however, that the major contributions to this underspend have been either non-recurrent in nature or have been adjusted for in budget setting for 2016/17 to maximise funding available for frontline services and transformation in a year of exceptional challenge for the NHS.

At the year end, 62 CCGs reported underspends totalling £122 million against their annual plan, and 39 CCGs reported overspends totalling £151 million. The overall CCG position included a £13 million underspend on Quality Premium. 31 CCGs finished the year with cumulative deficits, 10 of which were unplanned. The measures to improve CCG resilience, which we have taken in 2015/16, have resulted in a reduction in the number and scale of significant overspends. Only four CCGs overspent by more than two percent (2014/15: eight percent), and the largest CCG overspend was five percent (2014/15: 10 percent).

In direct commissioning, specialised services teams achieved a small underspend (£14 million) on their operational performance, reflecting the significant programme of measures undertaken over the last two years to improve management processes and controls. At the end of 2015/16, three out of four regions balanced overall within their specialised allocations. However, despite this improved performance, when adding into

specialised commissioning the Cancer Drugs Fund (CDF), it overspent by £112 million in total due to overspends on the CDF of £126 million (37 percent) despite reprioritisations undertaken during the year. A new approach to prioritisation and financial management of drugs within the CDF will be introduced in July 2016 following the recent consultation process in partnership with the National Institute for Clinical Excellence (NICE). This is designed to provide access to potentially effective cancer drugs in a way which secures value for money and ensures that the fund remains within the agreed envelope of £340 million. These variances were offset by underspends in other areas of direct commissioning amounting to 1.6 percent.

Central programme and running costs underspent by £340 million, primarily due to reduced redundancy and transition costs, underspends on DH managed budgets hosted by NHS England, unplanned rates rebates, underspends on a number of directorate programme budgets and the freezing of contingencies. The bulk of these variances relate to non-recurrent budgets and income available to NHS England in 2015/16, and the recurrent elements have been reflected in reduced central budgets for 2016/17.

The other significant underspend in 2015/16 was on settlements relating to legacy continuing healthcare claims. This amounted to £192 million (on a general RDEL basis). In the light of experience in 2014/15 and 2015/16, the budget in 2016/17 has been reduced to reflect the likely levels of claim settlement.

Performance against wider financial metrics

Within the mandate, DH sets a number of technical financial targets, including the general RDEL metrics described above, against which NHS England is expected to deliver. These limits are ringfenced, which means that underspends in other areas cannot be used to support core patient services covered by the general RDEL limit.

Delivery against NHS England's full range of financial performance duties is summarised in the table below:

	Target			
Revenue limits	**Mandate limit £m**	**Actual £m**	**Underspend £m**	**Target met**
RDEL – general	100,882	100,283	599	✓
RDEL – ringfenced for depreciation and operational impairment	166	89	77	✓
Annually Managed Expenditure limit for provision movements and other impairments	300	(254)	554	✓
Technical accounting limit (e.g. for capital grants)	360	73	287	✓
Total revenue expenditure	**101,708**	**100,191**	**1,517**	
Administration Costs (within overall revenue limits above)				
Total administration costs	**1,862**	**1,649**	**213**	✓
Capital Limit				
Capital expenditure contained within our Capital Resource Limit (CRL)	**300**	**176**	**124**	✓

Allocations

NHS England has responsibility for the allocation of NHS funding agreed with DH as part of our mandate. Funding objectives contained within the mandate require NHS England to operate a transparent allocation process to ensure equal access for equal need. The Health and Social Care Act 2012 also requires NHS England to have regard to reducing inequalities in access to, and outcomes from, healthcare.

Following the outcome of the Spending Review in November 2015, the NHS England Board approved allocations for the commissioning sector for the next five years, 2016/17 to 2020/21, with firm allocations for the first three years and indicative allocations for the final two years.

These allocations were intended to achieve:

- faster progress towards our strategic goals, particularly through higher funding growth for GP services, increased operational and transformational investment in mental health and the establishment of a Sustainability and Transformation Fund of £2.14 billion for 2016/17, of which £1.8 billion is being deployed on sustainability to stabilise NHS operational performance, and £340 million for transformation to continue the vanguard programme and invest in other key areas, prioritised within the Five Year Forward View
- greater equity of access, by bringing allocated funding closer to target levels, with all CCGs no more than five percent under target for CCG commissioned services and all CCG areas no more than five percent under target for the total commissioning streams for their population
- closer alignment with population need through improved allocation formulae, including improvements to inequalities adjustments and a new sparsity adjustment for remote areas
- better visibility of projected total commissioning resources by locality to stimulate and support the development of place-based commissioning and stronger long term collaboration between commissioners and providers.

Future financial sustainability

The Five Year Forward View set out how, in the absence of further annual efficiencies in the NHS, a combination of growing demand from an ageing population, increases in the costs of running the NHS and constrained funding growth would produce a significant mismatch between the growth in resources available and the funding required to deliver what patients need. It estimated the incremental real annual funding requirement of the NHS at between £8 billion and £21 billion by 2020/21.

The subsequent Spending Review modelling of cost pressures and investments remained broadly in line with the modelling conducted a year earlier, as part of the Five Year Forward View. In November 2015, the Government set out the financial settlement for the NHS to 2020/21. Annual funding will rise by £3.8 billion above inflation in 2016/17 and £8.4 billion above inflation in 2020/21, which is reflected in NHS cash funding growth from £101.0 billion in 2015/16 to £119.6 billion in 2020/21. In May 2016, we published a recap briefing for the Health Select Committee on technical modelling and scenarios for the Five Year Forward View which can be viewed at www.england.nhs.uk/ourwork/futurenhs/#related.

While this implies an efficiency requirement of £22 billion by 2020/21, the majority of these efficiencies are not cost reductions per se, but rather the more effective use of resources within a growing budget. Furthermore, the Spending Review assumes that around £7 billion of the total efficiencies will be delivered nationally, leaving £15 billion to be sourced locally. We expect that these local contributions will be delivered through a combination of actions by commissioners and providers. Commissioners will work with partners across their health economies to moderate the level of activity growth through care redesign, promotion of self care, investments in prevention, and the delivery of best possible value through programmes such as RightCare, whilst providers across the full range of NHS services will be supported to deliver a significant programme of operational efficiency improvement.

During 2015/16, NHS England has supported the mobilisation and implementation of key efficiency programmes within our scope. Throughout 2016/17, we will continue to ensure NHS England's contribution to the overall efficiency agenda by delivering our contribution to the closure of the finance and efficiency gap. STPs, drawn up by 44 geographical footprints, will be the vehicle through which we will demonstrate routes to financial sustainability in every health economy around the country.

ACCOUNTABILITY REPORT

Simon Stevens
Accounting Officer
8 July 2016

Directors' Report

The Board

The NHS England Board consists of a Chair and eight non-executive directors and four voting executive directors. This complies with the requirements of the National Health Service Act 2006. A number of non-voting executive directors regularly attend Board meetings.

Roles and responsibilities of the Board

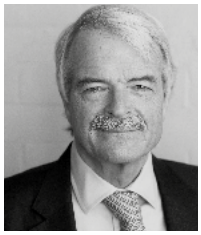
The Board is the senior decision-making structure in NHS England. It provides strategic leadership to the organisation and, in support of that, it:

- sets the overall direction of NHS England, within the context of the NHS mandate
- approves the business plan, which is designed to support achievement of NHS England's strategic objectives and monitors NHS England's performance against it
- holds NHS England's executive group to account for this performance and for the proper running of the organisation (including operating in accordance with legal and government requirements)
- determines which decisions it will make and which it will delegate to the executive group via the Scheme of Delegation
- ensures high standards of corporate governance and personal conduct
- monitors the performance of the group against core financial and operational objectives
- provides effective financial stewardship
- promotes effective dialogue between NHS England, government departments, other arm's length bodies, its partners, clinical commissioning groups (CCGs) and providers of healthcare and communities served by the commissioning system.

Board members bring a range of complementary skills and experience in areas such as finance, governance and health policy. New appointments take account of the skills already represented on the Board and recognise where there are gaps that could be filled. A register of the Board's members during 2015/16 is set out at Appendix 4, and a summary of committee membership and attendance is given in Appendix 5.

NHS England's non-executive directors

NHS England's current non-executive directors are:



Chairman: Professor Sir Malcolm Grant CBE

Malcolm Grant is Chancellor of the University of York, and immediate past President and Provost of University College London from 2003-2013. He is a barrister and a Bencher of Middle Temple. As an academic lawyer he specialised in planning, property and environmental law, and was Professor and Head of Department of Land Economy (1991-2003) and pro-vice chancellor (2002-2003) of Cambridge University, and professorial fellow of Clare College. He has served as Chair of the Local Government Commission for England, of the Agriculture and Environmental Biotechnology Commission and the Russell Group. He is currently a trustee of Somerset House, President of the Council for At-Risk Academics, a director of Genomics England Ltd and a UK Business Ambassador.

Non-executive Director: Lord Victor Adebowale CBE

Victor Adebowale is currently Chief Executive and company secretary of Turning Point. He is a cross-bench peer and Visiting Professor and Chancellor at the University of Lincoln, a Fellow of the City and Guilds of London Institute, an associate member of the Health Service Management Centre at the University of Birmingham and of Cambridge University Judge Business School. He is a director of Leadership in Mind and THP Innovate and Chair of youth charity Urban Development. Victor is on the Board of Governors for the London School of Economics, and is President of the International Association of Philosophy and Psychiatry. His previous roles include being the Chief Executive at Centre Point, the youth homelessness charity and membership of the United Kingdom Commission for Employment and Skills.

Non-executive Director from March 2016: Wendy Becker

In her executive career, Wendy Becker had many years of experience leading consumer-related organisations, creating strategies and driving change. Wendy spent 15 years at McKinsey and Company in both San Francisco and London with nine years as a partner. She has held a number of senior roles in industry including as Chief Executive Officer of Jack Wills and as Global Chief Marketing Officer and member of the Executive Committee at Vodafone plc. Wendy is a Non-Executive Director for Whitbread plc, the Deputy Chairman of Cancer Research UK, and a Trustee of the Prince's Trust. She holds a BA in Economics from Dartmouth College and an MBA from Stanford's Graduate School of Business.

Non-executive Director: Professor Sir John Burn

John Burn is a senior clinical geneticist and academic, based in Newcastle. He holds the NHS Endowed Chair in Clinical Genetics at Newcastle University, and conceived and helped to bring to fruition the Millennium Landmark Centre for Life in Newcastle. He is a distinguished academic, clinician, and clinical entrepreneur, as founder of two spin out companies in the field of genetic diagnostics. He is Chairman of QuantuMDx ltd, a medical device company developing point of care DNA testing for the developing world.

Non-executive Director and Chair of the Investment Committee: Dame Moira Gibb

Moira Gibb is Chair of Skills for Care and Chair of City Lit Adult Education College. She is a non-executive director of the UK Statistics Authority and a member of the Council of Reading University. Her career was in social services and local government, latterly as Chief Executive of Camden Council. She was a Civil Service Commissioner from 2012-2015 and a Director of the London Marathon from 2005-2011.

Non-executive Director and Chair of Specialised Services Commissioning Committee: Noel Gordon

Formerly an economist, Noel spent most of his career in consultancy until his retirement in 2012 including, for the last 16 years, with Accenture where he was global managing director of the Banking Industry Practice. He has extensive practical experience of driving fundamental innovations in transforming industries, and of big data, analytics, mobile and digital technologies. Noel is a non-executive director of NHS England and Chair of its Specialised Commissioning Committee. In June 2016 he also became Chair of NHS Digital, formerly known as HSCIC. He is a member of the Advisory Committee of the Department of Health's Accelerated Access Review, a non-executive director of the Payments Systems Regulator, a member of the Audit and Risk Committee of the University of Warwick, a member of the Development Board of Age UK, and Chairman of the Board of Trustees of User Voice.

Non-executive Director from March 2016: Michelle Mitchell OBE

Michelle Mitchell is Chief Executive Officer of the Multiple Sclerosis Society UK. She is currently a trustee of the MS International Federation. She was previously a Trustee of the King's Fund. Michelle is a Managing Member of the Progressive MS Alliance. Michelle has extensive voluntary sector experience at a leadership level. Before joining the MS Society, she was Director General for Age UK. Prior to that, Michelle was Chair of the Fawcett Society. Michelle has a BA in Economics, an MA in Politics and Administration and an International Executive Diploma from INSEAD. Michelle is an alumna of the Innovations in Government Programme at Harvard University JFK School.

Non-executive Director, Vice-Chair, Chair of the Commissioning Committee and Chair of the Audit and Risk Assurance Committee from October 2015: David Roberts

David Roberts took over as Chairman of Nationwide Building Society in July 2015. From 2010 to 2014 he was on the Board of Lloyds Banking Group, where he was Group Deputy Chairman and Chairman of the Board Risk Committee. David has many years of experience at board and executive level in retail and commercial banking in the UK and internationally. He joined Barclays in 1983 and held various senior management positions culminating in Executive Director, member of the Group Executive Committee and Chief Executive, International Retail and Commercial Banking, a position he held until December 2006. He is a former Non-Executive Director of BAA plc and Absa Group SA, and was Chairman and Chief Executive of Bawag PSK AG, Austria's second largest retail bank. David has a degree in Mathematics from Birmingham University and holds an MBA and Honorary Doctorate in Business Administration from Henley Business School. He is a fellow of the Chartered Institute of Financial Services and a Member of the Strategy Board of Henley Business School at the University of Reading.

The following non-executive directors left during the year:

Non-executive Director: Sir Ciarán Devane (until 31 December 2015)

Ciarán Devane was educated at University College, Dublin and George Washington University, Washington DC and worked for ICI for eight years before becoming a management consultant. Ciarán was Chief Executive of Macmillan Cancer Support from 2007 to 2014 and in January 2015 he joined the British Council as Chief Executive. Ciarán is a trustee of the National Council for Voluntary Organisation and has been nominated to join the Board of Social Finance but has not yet taken up this role.

Deputy Chairman and Chair of the Audit and Risk Assurance Committee: Ed Smith, CBE (until 30 September 2015)

Ed Smith is currently the Chairman of NHS Improvement and the lead non-executive director for the Department for Transport. Ed is the Pro-Chancellor and Chairman of Council at the University of Birmingham, a member of the Competition and Markets Authority panel and Treasurer of Chatham House. He was the former Global Assurance Chief Operating Officer and Strategy Chairman of PricewaterhouseCoopers (PwC). Before retiring he had a successful 30-year career with PwC, holding many leading board and top client roles in the UK and globally as a Senior Partner.

Non-executive Director: Margaret Casely-Hayford (until 31 March 2016)

Margaret Casely-Hayford is a lawyer with a special interest in governance. Appointed Chair of the charity Action Aid UK in 2014, she was previously Director of Legal Services and Company Secretary for the John Lewis Partnership (JLP) for almost 10 years and a partner with city solicitors Dentons, where she worked for 20 years. She read law at Oxford University and qualified both as a barrister and as a solicitor. She was both a Government appointed special trustee for Great Ormond St Children's Hospital Charity and trustee of the Geffrye Museum from 2000-2008; she was the JLP representative on the Board of the British Retail Consortium until she retired from retail in 2014. Margaret currently sits on the Metropolitan Police Panel overseeing investigations into police corruption.

NHS England's Executive Group

Chief Executive: Simon Stevens

Simon Stevens is responsible for the overall leadership of NHS England. As NHS England's Accounting Officer, he is accountable to Parliament for over £100 billion of annual health service funding. Simon joined the NHS in 1988 and has worked as a frontline NHS manager, as the Prime Minister's Health Advisor at 10 Downing Street, and has led a wide variety of international health systems.

Chief Financial Officer: Paul Baumann

Paul Baumann is NHS England's Chief Financial Officer, providing system leadership to the NHS in delivering best value and financial sustainability. The Finance Directorate, under Paul's leadership, aims to provide a first class financial management service ensuring NHS England is well advised and provided with excellent financial services at all times. Paul is a Fellow of the Chartered Institute of Management Accountants. Paul is also executive lead for Devolution. Since its creation in 2011, Paul has chaired the NHS Financial Leadership Council which advises on development and capability building for the NHS finance function.

Chief Nursing Officer: Professor Jane Cummings

Jane Cummings is the executive lead for maternity, patient experience and the professional lead for nursing and midwifery in England. Jane was the Senior Responsible Officer for Learning Disability at NHS England until January 2016 and now has executive oversight of this area. In January 2016, Jane also became executive lead for Patient and Public Participation.

National Medical Director: Professor Sir Bruce Keogh

Bruce Keogh is NHS England's Medical Director and professional lead for NHS doctors. He is responsible for promoting clinical leadership and quality. Bruce previously had a distinguished career in surgery. He was Director of Surgery at the Heart Hospital and Professor of Cardiac Surgery at University College London. He has been President of the Society for Cardiothoracic Surgery in Great Britain and Ireland, Secretary-General of the European Association for Cardio-Thoracic Surgery, International Director of the US Society of Thoracic Surgeons, and President of the Cardiothoracic Section of the Royal Society of Medicine. He has served as a Commissioner on the Commission for Health Improvement and the Healthcare Commission. He was knighted for services to medicine in 2003.

Interim National Director: Commissioning Operations: Richard Barker

Richard Barker became the interim National Director: Commissioning Operations in January 2016. He was responsible for the oversight of operational delivery in NHS England, the support and assurance of clinical commissioning groups and the work of NHS England's regional teams. Richard returned to his substantive role as Regional Director: North, at the end of May 2016, when Matthew Swindells took on the National Director role substantively.

National Director: Commissioning Strategy: Ian Dodge

Ian Dodge joined NHS England in July 2014. His directorate leads the organisation's work on: NHS strategy; sustainability and transformation; planning and implementing the Five Year Forward View; vanguards and the new care models programme; giving power to patients through personalisation and choice; commissioning strategy and development; and prioritising science and innovation.

National Director: Transformation & Corporate Operations: Karen Wheeler CBE

Karen Wheeler is responsible for ensuring NHS England's governance, organisation and corporate services are effective and support staff to deliver their objectives. Karen oversees delivery of all NHS England's Business Plan priorities and major change programmes, and she manages the delivery of Primary Care Support services. In December 2015, Karen took on responsibility for commissioning support units, and temporarily for the development of Information and Technology pending the arrival of Matthew Swindells as National Director: Operations and Information.

The following national directors left during the year:

National Director for Patients and Information: Tim Kelsey

(until 31 December 2015)

Tim Kelsey was National Director for Patients and Information in NHS England – a role which combined the functions of chief technology and information officer with responsibility for patient and public participation. Tim was also National Information Director for health and care in England and Chair of the National Information Board which advises the Secretary of State for Health on national priorities for data and technology.

National Director: Commissioning Operations: Dame Barbara Hakin (until 31 December 2015)

Barbara Hakin was the National Director responsible for overseeing operational delivery within NHS England, which included responsibility for oversight of NHS England's directly commissioned services including: specialised services, primary care, public health, health and justice and services for the armed forces. Barbara had responsibility, through NHS England's regional and local teams, for oversight, support and assurance of CCGs, as well as overseeing NHS England's CSUs.

Register of Members' Interests

NHS England is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish a Register of Members' Interests which draws together Declarations of Interest made by Board members.

All Board members are required to record any interests relevant to their role on the Board. In addition, members of the Board are required at the commencement of each Board meeting and whenever relevant matters are raised to declare any personal interest they may have in any business on the agenda. The register is reviewed on a monthly basis.

The Register of Members' Interests is a public document which is open to public scrutiny and is published on NHS England's website at www.england.nhs.uk/about/whos-who/reg-interests/.

Disclosure of personal data-related incidents

As at March 2016, nine Serious Incidents Requiring Investigation (SIRI) had occurred relating to the loss of personal sensitive data. All incidents are logged and a full investigation undertaken. Full details are given in Appendix 6.

Unless otherwise stated, remedial actions were implemented for all incidents and the Information Commissioner's Office were kept informed as appropriate. In all but one case, information was fully contained within the NHS and no harm occurred. This single incident occurred in a commissioning support unit (CSU) and at the time of writing this report is still being investigated.

Board Statement

The Board confirms that the Annual Report and Accounts for 2015/16, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the performance, strategy and business model of NHS England.

Statement of Disclosure to Auditors

Each individual who is a member of the Board at the time the Directors' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which NHS England's external auditor is unaware
- the member has taken all the steps that they ought to have taken as a member in order to make him or herself aware of any relevant audit information and to establish that NHS England's external auditor is aware of that information.

Our organisation and people

Staff report

In March 2016, NHS England permanently employed 5,017† people based around the country within seven directorates:

Directorate	Number of people employed
Chair and Chief Executive's Office	19
Commissioning Operations	3,475
Commissioning Strategy	257
Finance	214
Medical	182
Nursing	135
Transformation and Corporate Operations	735
Total number of people employed	**5,017**

CSUs additionally employed an average of 7,373 people throughout 2015/16. Further detail on staff numbers can be found in Note 3.2 of the Annual Accounts.

The primary care support (PCS) service, comprising around 900 people, transferred out of NHS England to Capita on a seven year contract effective from 1 September 2015, rebranding to PCS England from that date.

Staff costs (subjected to audit)

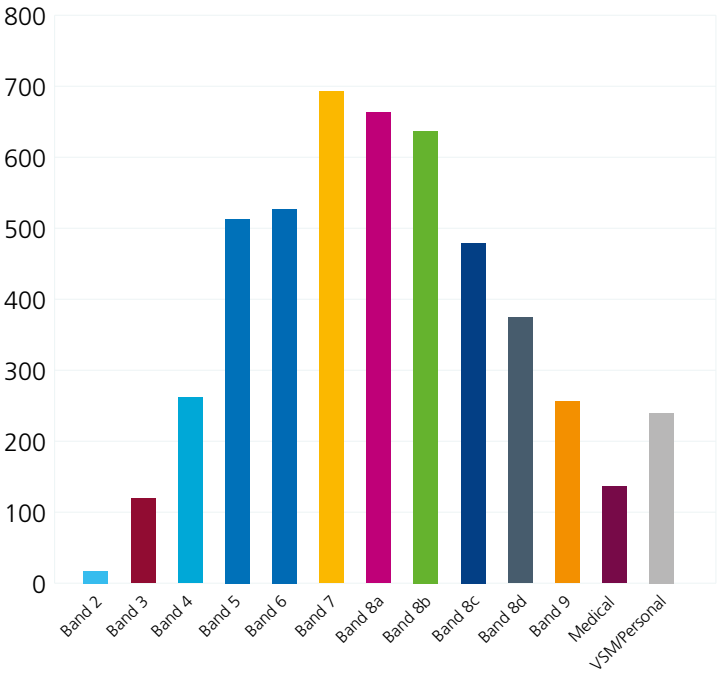
An analysis of staff costs is detailed in the Annual Accounts under Note 3: Employee Benefits and Staff Numbers.

† This presents the position as at 31 March 2016. See Annual Accounts, Note 3.2 for an average number of people employed throughout the year.

Our people

The following tables give a further breakdown of the 5,017 people directly employed by NHS England†, as at end of March 2016, including the seven executive directors. Of these five were male, and two were female. Additionally, NHS England had eight non-executive directors as at end of March 2016, three of whom were female and five male. Further detail can be found within our Directors' Report.

All staff by payband



17	0.3%	Band 2
119	2.3%	Band 3
363	7.2%	Band 4
513	10.2%	Band 5
527	10.5%	Band 6
693	13.8	Band 7
663	13.2%	Band 8a
637	12.7	Band 8b
479	9.5	Band 8c
374	7.5	Band 8d
256	5.1	Band 9
136	2.7%	Medical
240	4.9%	VSM/Personal
5017	100%	Total

Senior manager by gender

Headcount	Percent	
396	51.6%	Female
371	48.4%	Male
767	100%	Total

All staff by gender

Headcount	Percent	
3507	70%	Female
1510	30%	Male
5017	100%	Total

Senior manager by ethnicity

Headcount	Percent	
530	72.5%	White
49	5%	BME
188	22.5%	Unknown
767	100%	Total

All staff by ethnicity

Headcount	Percent	
3634	72.4%	White
566	11.2%	BME
817	16.2%	Unknown
5017	100%	Total

† CSU staff are employed via the NHS Business Services Authority and are therefore not included in this analysis.

Senior manager by disability

	Headcount	Percent	
	552	72%	No
	31	4%	Yes
	184	24%	Unknown
	767	100%	Total

All staff by disability

	Headcount	Percent	
	4027	80.2%	No
	264	5.2%	Yes
	726	14.5%	Unknown
	5017	100%	Total

Senior manager by sexual orientation

	Headcount	Percent	
	13	1.5%	Gay
	359	61.5%	Heterosexual
	1	0.2%	Lesbian
	1	0.2%	Bisexual
	298	36.5%	Unknown
	767	100%	Total

All staff by sexual orientation

	Headcount	Percent	
	89	1.8%	Gay
	3664	73%	Heterosexual
	22	0.43%	Lesbian
	21	0.42%	Bisexual
	1221	24%	Unknown
	5017	100%	Total

'Senior manager' denotes all staff at Agenda for Change Pay Point 49 and above (or equivalent). This includes the top tier of Band 8d.

Organisational alignment and capability programme

The third and final phase of our organisational alignment and capability programme has included:

- the restructuring of our Clinical Senate and Clinical Network staff to ensure our important clinical engagement work aligns with and supports our national priorities
- the transition of NHS Improving Quality from being a hosted organisation to an internal team – the Sustainable Improvement team – organised to provide improvement capability to support clinical and primary care commissioning service improvements. This affected 245 people
- the transfer of the hosting arrangements for the NHS Leadership Academy to Health Education England (HEE), affecting 75 people
- patient safety functions and staff transferring from NHS England to NHS Improvement in line with recommendations made in the Culture Change in the NHS: Applying the lessons of the Francis Inquiry report (DH, 2015), affecting 84 people.

The programme and consultation will close in 2016.

Improving NHS England during 2015/16

66 percent of staff participated in our fifth staff barometer, of which 63 percent responded positively about working in NHS England. This is consistent with last year's results. Responses also identified a number of areas where we need to improve how we work. Our Improving NHS England programme was established to manage those improvements, and in particular to drive streamlined procurement, resourcing and recruitment processes, as well as accommodation, to meet the needs of an evolving organisation.

Developing our staff

In October 2015, we implemented a new online portal for learning and development solutions, providing access to over 3,000 courses and programmes. These are procured through the Government's wider public sector framework agreement to achieve economies of scale and maximum value for money.

We have continued to extend talent management through the organisation, completing 780 talent development conversations with people in Band 8c and above.

Supporting diversity and inclusion

We are committed to encouraging all NHS employing bodies, including NHS England, to create a more inclusive workforce that is fully representative of the patients and communities that the NHS serves. Building on work to support the recruitment and employment of people with learning disabilities into the NHS as outlined in our Performance Report, we appointed five people with learning disabilities to roles within the organisation during the year.

We have also supported the introduction of four staff networks to help us create a fairer and more diverse workforce: the BME network; the Lesbian, Gay, Bisexual, Trans + Network; the Disability and Wellbeing Network; and the Women's Development network.

Staff policies

In January 2016, we also refreshed our staff policy and procedures on equality, diversity and inclusion to remove bias and embrace an inclusive culture where we work together to better reflect the population we serve. One aim of these policies is to make sure we give full and fair consideration to applications for employment by people with disability, arrange appropriate training for people we employ who are disabled and support their ongoing career and development whilst they are employed by us.

This year, we have achieved an improved ranking in the Stonewall Workplace Equality Index by 184 places. We are now ranked 168 out of 415 organisations that have entered the index, as a result of improvements made in networking groups, career development, training and community engagement.

Our wellbeing (sickness absence)

To ensure our people are supported to maintain their health, wellbeing and safety whilst at work, we updated guidance to better support attendance and absence and enable our people to access the right help and adjustments at the right time.

We continue to develop and promote health and wellbeing for all of our people, including tools to help staff develop their resilience and our network of mental health first aiders, with over 300 colleagues trained across the organisation to provide timely and accessible peer support. In 2015/16, the average number of sick days taken by whole time equivalent employees decreased by 1.4 days against last year.

Sickness absence for the period 1 January to 31 December 2015 was as follows:

	WTE days available	WTE days lost to sickness absence	Average sick days per WTE
NHS England	1,866,202	50,449	6.1
CSUs	2,736,279	79,276	6.5
Total parent	**4,602,481**	**129,725**	**6.3**
CCGs	5,242,230	134,117	5.8
Consolidated group	**9,844,711**	**263,842**	**6.0**

Looking forward to 2016/17

We will make further progress in four priority areas: increasing our diversity and inclusion; continuing to help our people stay physically and mentally healthy; promoting development and talent; and enabling staff to feel engaged, supported and proud to work for NHS England.

Exit packages, severance payments and off-payroll engagement

Expenditure on consultancy and contingent labour (subjected to audit)

Expenditure on consultancy is detailed in the Annual Accounts under Note 4: Operating Expenses. NHS England and CSUs procured consultancy services worth £25 million during 2015/16, a decrease from £44 million in 2014/15. Across the group, there was a total spend of £113 million on consultancy services during the year, against £158 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given in the Annual Accounts under Note 3: Employee Benefits and Staff Numbers under the Other column. Net expenditure for NHS England and CSUs in this area was £176 million in 2015/16, against £193 million in 2014/15. Across the group, there was a total spend of £346 million on contingent labour during the year, against £336 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.

Off-payroll engagements

NHS England is committed to employing a capable, talented and diverse on-payroll workforce to support the delivery of its Business Plan. It is recognised that in some circumstances the use of off-payroll workers, working alongside NHS England's on-payroll workforce, represents the most effective use of NHS resources in the organisation's pursuit of specific business objectives. At a time of reducing running costs, occasional use of fixed term or non-permanent roles can help reduce our future redundancy liabilities and costs. Furthermore, for some of our time-limited programmes, it makes sense to use short-term contracts.

The following tables identify off-payroll workers engaged by NHS England as at March 2016†.

†. Note that these tables do not include medical appraisers who perform ad hoc short engagements to support the medical revalidation process. Appraisers are selected from a total pool of around 3,000 appraisers, and engagements do not total six months for any one appraiser.

Off-payroll engagements as at 31 March 2016, covering those earning more than £220 per day and staying longer than six months are as follows:

	NHS England number	CSUs number	Total number
Number of existing engagements† as of 31 March 2016	594	298	892
Of which, the number that have existed:			
for less than one year at the time of reporting	282	174	456
for between one and two years at the time of reporting	168	83	251
for between 2 and 3 years at the time of reporting	144	41	185
for between 3 and 4 years at the time of reporting	0	0	0
for 4 or more years at the time of reporting	0	0	0

All existing off-payroll engagements outlined above have, at some point, 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, that assurance has been sought.

New off-payroll engagements between April 2015 and 31 March 2016, for more than £220 per day and that have lasted longer than six months are as follows:

	NHS England number	CSUs number	Total number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	432	255	687
Number of new engagements which include contractual clauses giving NHS England the right to request assurance in relation to Income Tax and National Insurance obligations	417	92[1]	509
Number for whom assurance has been requested	362	229	591
Of which:			
assurance has been received	267	174	441
assurance has not been received	95[2]	34	129
engagements terminated as a result of assurance not being received	0	21	21

Off-payroll engagements of Board members and / or senior officials with significant financial responsibility between 01 April 2015 and 31 March 2016 are shown in the table below. There have been no off payroll engagements concerning Board members during the financial year, and as such, no exceptional circumstances to report.

1. Assumption based on Contingent Labour One Contracts, the Crown Commercial Service framework.
2. Of these 95 engagements, 76 engagements are no longer active as determined by the contract end dates (meaning they cannot be terminated).

	NHS England	CSUs	Total
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0	0	0
Total number of individuals on payroll and off-payroll that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	354	18	354

Improving control processes around off-payroll workers is also identified as a control issue in our Governance Statement (see page 96).

Exit packages including severance payments (subjected to audit)

NHS England operates robust internal controls in respect of such matters, and any proposed non-contractual severance payment would first have to be scrutinised and approved by the Executive HR Sub-Committee before being considered by DH and HM Treasury.

However, in order to achieve planned reductions in NHS England's running costs, a number of posts were removed from the organisational structure during 2014/15 and 2015/16, and the associated contractual severance costs were then incurred. These contractual severance payments were subject to full external oversight, scrutiny and approval by DH.

Details of exit packages agreed over the year can be found in the Annual Accounts under Note 3.3.

Remuneration Report

Strategic HR and Remuneration Committee

The Strategic HR and Remuneration Committee provides the Board with assurance and oversight of all aspects of strategic people management and organisational development, and it approves the appointment, remuneration and terms of service for the Chief Executive and executive directors, and other very senior managers (VSMs) in line with recommendations from the Senior Salaries Review Body on the pay of senior staff in the public sector. It also considers some issues in relation to all staff.

The Committee does not deal with the appointment, terms of service or remuneration of the Chair and non-executive directors. These matters fall within the responsibilities of the Secretary of State for Health under the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Over the year, the work of the Committee has focused on:

- NHS England's organisation and core capabilities
- changes to NHS England executive directors, including appointments, resignations and retirements
- NHS England staff engagement, talent management and first year outcomes of the Workforce Race Equality Standard.

Pay multiples (subjected to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid member of the Board in the financial year 2015/16 was £205,000-£210,000 (2014/15: £205,000-£210,000). This was 5.42 times (2014/15: 5.66) the median remuneration of the workforce, which was £38,300 (2014/15: £36,666).

In 2015/16, no employees received remuneration in excess of the highest paid member of the Board (2014-15: 0). Remuneration ranged from £143 to £210,000.

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

Policy on remuneration of senior managers

The framework for the remuneration of executive directors is set by DH through the VSM pay framework for arm's length bodies.

It is the policy of NHS England to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience necessary for the effective running of such a large organisation, whilst 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 Strategic HR and Remuneration Committee of the Board, with final decisions being made by the DH arm's length bodies' Remuneration Committee.

Performance related pay

The performance related pay arrangements for executive directors are set out in the VSMs pay framework for arm's length bodies and follow guidance prescribed by DH and are in-line with HM Treasury requirements. In recognition of current economic austerity measures, the decision was taken by the Strategic HR and Remuneration Committee not to award bonuses during this year.

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 contracts, unless otherwise specified. Notice periods generally follow the provisions of the VSM contract of employment, as applied by NHS England, 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 DH Governance and Assurance Committee. Any proposed non-contractual special severance payment requires formal approval from DH and HM Treasury.

No payments were made to any senior managers to compensate for loss of office.

Senior managers service contracts (not subject to audit)

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Paul Baumann Chief Financial Officer	1 April 2013	6 months	Option to provide taxable pay in lieu of part or all of the notice period	
Professor Jane Cummings Chief Nursing Officer	1 April 2013	6 months		
Ian Dodge National Director: Commissioning Strategy	7 July 2014	6 months		
Dame Barbara Hakin National Director: Commissioning Operations	1 April 2013	6 months		Left NHS England on 31 December 2015
Tim Kelsey National Director for Patients and Information	2 July 2012	6 months		Left NHS England on 31 December 2015
Professor Sir Bruce Keogh National Medical Director	1 April 2015	12 months		
Richard Barker Interim National Director: Commissioning Operations	1 January 2016	6 months		
Simon Stevens Chief Executive Officer	1 April 2014	6 months		

Secondments

Name and title	Date of appointment	Unexpired term at 31 March 2016	Notice period	Provisions for compensation for early termination	Other details
Karen Wheeler National Director: Transformation and Corporate Operations	1 April 2014	1 year	3 months	n/a	3 year secondment from the Department of Health

Salaries and allowances 2015/16 (subjected to audit)

	2016					
Name and Title	(a) Salary (bands of £5,000) £000	(b) Benefits in Kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Paul Baumann Chief Financial Officer	205-210	0	0	0	22.5-25.0	230-235
Richard Barker Interim National Director: Commissioning Operations from 1 January 2016[1]	40-45 (pro-rata)	0	0	0	0.0-2.5 (pro-rata)	40-45 (pro-rata)
Professor Jane Cummings Chief Nursing Officer	165-170	0	0	0	2.5-5.0	170-175
Ian Dodge National Director: Commissioning Strategy	160-165	0	0	0	45.0-47.5	205-210
Dame Barbara Hakin National Director: Commissioning Operations to 31 December 2015	155-160 (pro-rata)	0	0	0	–	155-160 (pro-rata)
Tim Kelsey National Director for Patients and Information to 31 December 2015	135-140 (pro-rata)	0	0	0	27.5-30.0 (pro-rata)	165-170 (pro-rata)
Professor Sir Bruce Keogh National Medical Director[2]	190-195	0	0	0	2.5-5.0	195-200
Simon Stevens Chief Executive Officer[3]	190-195	0	0	0	40.0-42.5	230-235
Karen Wheeler National Director: Transformation and Corporate Operations[4]	155-160	0	10-15	0	70-72.5	235-240

1. Richard Barker took up post from 1 January 2016, replacing Dame Barbara Hakin who retired on 31 December 2015. The figures shown reflect this part year adoption as a National Director position.
2. An overpayment was made to Professor Sir Bruce Keogh, which is subject to recovery in 2016. The amount of the overpayment is not included in the total remuneration figures disclosed.
3. 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 Officer, which would normally pay within the range £210-215k. Simon Stevens has continued with this voluntary reduction in pay throughout 2015/16.
4. Karen Wheeler is seconded from DH and her salary recharged to NHS England. As such, she is subject to terms and conditions of her employing organisation. The non-consolidated bonus relates to 2014/15 but was paid in 2015/16. The bonus for 2015/16 is subject to moderation and any award will be paid 2016/17.

Salaries and allowances 2014/15

	2014/15					
Name and Title	(a) Salary (bands of £5,000) £000	(b) Benefits in Kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Paul Baumann Chief Financial Officer	205-210	0	0	0	20.0-22.5	225-230
Professor Jane Cummings Chief Nursing Officer	165-170	5,800	0	0	(20.0)-(22.5)	150-155
Ian Dodge National Director: Commissioning Strategy from 7 July 2014	90-95 (pro-rata)	0	0	0	15.0-17.5 (pro-rata)	105-110 (pro-rata)
Dame Barbara Hakin National Director: Commissioning Operations	205-210		0	0	(10.0)-(12.5)	195-200
Tim Kelsey National Director for Patients and Information	180-185	3,600	0	0	30.0-32.5	215-220
Professor Sir Bruce Keogh National Medical Director[1]	190-195	0	0	0	(20.0)-(22.5)	170-175
Bill McCarthy National Director: Policy to 30 June 2014	40-45 (pro-rata)	0	0	0	(15.0)-(17.5) (pro-rata)	25-30 (pro-rata)
Rosamond Roughton Interim National Director: Commissioning Development to 31 July 2014	45-50 (pro-rata)	0	0	0	(0)-(2.5) (pro-rata)	45-50 (pro-rata)
Simon Stevens Chief Executive Officer[2]	190-195	0	0	0	35.0-37.5	225-230
Karen Wheeler National Director: Transformation and Corporate Operations[3]	155-160	0	15-20	0	62.5-65.0	230-235

1.Professor Sir Bruce Keogh was seconded to NHS England from UCLH NHS Foundation Trust and his salary was paid by the organisation and recharged to NHS England. He transferred onto the NHS England payroll from 1 April 2015.
2. 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 Officer, which would normally pay within the range £210–215k.
3. Karen Wheeler is seconded from DH and her salary recharged to NHS England. The non-consolidated bonus relates to 2013/14 but was paid in 2014/15. The bonus for 2014/15 is subject to moderation and any award will be paid in 2015/16.

Pension benefits as at 31 March 2016 (subjected to audit)

Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2016 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000 £000	Cash Equivalent Transfer Value at 31 March 2015[1] £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to partnership pension £000
Paul Baumann Chief Financial Officer	0.0-2.5	5.0-7.5	20-25	65-70	378	431	24	0
Professor Jane Cummings Chief Nursing Officer	0.0-2.5	2.5-5.0	75-80	225-230	1,434	1,492	20	0
Ian Dodge National Director: Commissioning Strategy	2.5-5.0	n/a	0-5	n/a	15	47	15	0
Dame Barbara Hakin National Director: Commissioning Operations to 31 December 2015	n/a	n/a	0	0	n/a	n/a	0	0
Tim Kelsey National Director for Patients and Information to 31 December 2015	0.0-2.5	0	10-15	0	108	137	14	0
Professor Sir Bruce Keogh National Medical Director	0.0-2.5	2.5-5.0	80-85	250-255	n/a	n/a	n/a	0
Richard Barker Interim National Director: Commissioning Operations from 1 January 2016[2]	0.0-2.5	2.5-5.0	60-65	190-195	1,206	1,282	30	0
Simon Stevens Chief Executive	2.5-5.0	0.0-2.5	25-30	55-60	360	403	19	0
Karen Wheeler National Director: Transformation and Corporate Operations	2.5-5.0	0	50-55	0	930	1,089	0	0

1. As per previous submissions, CETVs given as at 31 March 2015 are the uninflated values whereas the Real Increase in CETV is the difference between the inflated 2015 and actual 2016 figure.
2. Richard Barker took up post on 1 January 2016 replacing Dame Barbara Hakin who retired on 31 December 2015. The figures shown are the absolute values attributed to Richard Barker for 2015/16.

Cash equivalent transfer values (subjected to audit)

A cash equivalent transfer value (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 to 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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0 percent to 2.8 percent. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension Scheme are based on the previous discount rate and have not been recalculated.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, 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 DH upon appointment. All non-executive directors are paid the same amount, except the Chair and Vice Chair, to reflect the equal time commitment expected from each non-executive. The Chair and Vice Chair are entitled to higher amounts to reflect the increased time commitment associated with their respective roles. In the case of the Vice Chair, this includes his role as the Chair of the Audit and Risk Assurance Committee. Some of the non-executive directors, including the Vice Chair, have opted to waive their contractual remuneration. Non-executive directors do not receive performance related pay or pensionable remuneration.

Salaries and allowances 2015/16 (subjected to audit)

	2015/16					
	(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) All pension-related benefits[1] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name of non-executive director	£000	£s	£000	£000	£000	£000
Lord Victor Adebowale	5-10	0	0	0	n/a	5-10
Professor Sir John Burn	5-10	0	0	0	n/a	5-10
Margaret Casely-Hayford To 31 March 2016	5-10	0	0	0	n/a	5-10
Sir Ciarán Devane Until 31 December 2015	5-10	0	0	0	n/a	5-10
Dame Moira Gibb	5-10	0	0	0	n/a	5-10
Noel Gordon	5-10	0	0	0	n/a	5-10
Professor Sir Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts Vice Chair from October 2015[2]	0	0	0	0	n/a	0
Ed Smith Vice Chair until 30 September 2015	10-15	0	0	0	n/a	10-15
Wendy Becker From 1 March 2016	0-5	0	0	0	0	0-5
Michelle Mitchell From 1 March 2016	0-5	0	0	0	0	0-5

1. Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.
2. David Roberts has waived his entitlement to non-executive director remuneration.

Salaries and allowances 2014/15

	2014/15					
Name of non-executive director	(a) Salary (bands of £5,000) £000	(b) Benefits in Kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits[1] (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Lord Victor Adebowale	5-10	0	0	0	n/a	5-10
Professor Sir John Burn From 1 July 2014	0-5	0	0	0	n/a	0-5
Margaret Casely-Hayford Until 31 March 2016[2]	5-10	0	0	0	n/a	5-10
Sir Ciarán Devane Until 31 December 2015	5-10	0	0	0	n/a	5-10
Dame Moira Gibb	5-10	0	0	0	n/a	5-10
Noel Gordon From 1 July 2014	5-10	0	0	0	n/a	5-10
Professor Sir Malcolm Grant Chair	60-65	0	0	0	n/a	60-65
David Roberts From 1 July 2014[3]	0	0	0	0	n/a	0
Ed Smith Vice Chair	25-30	0	0	0	n/a	25-30

1. Non-executive directors do not receive pensionable remuneration, and therefore have no pension related benefits.
2. Margaret Casely-Hayford waived her entitlement to non-executive director remuneration between April and July 2014, but received remuneration from August 2014.
3. David Roberts has waived his entitlement to non-executive director remuneration.

Statement of Accounting Officer's responsibilities

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 (which disclose with reasonable accuracy at any time the financial position of the National Health Service Commissioning Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the National Health Service Commissioning Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accounting Officer appointment letter, supported by Managing Public Money issued by HM Treasury.

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health (with consent of HM Treasury) has directed the National Health Service Commissioning Board 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 the National Health Service Commissioning Board and of its net resource outturn, application of resources, changes in taxpayers' equity 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 and in particular to:

- observe the Accounts Direction issued by the Department of Health, 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.

Governance Statement

NHS England is an executive non-departmental public body which leads and oversees the commissioning of healthcare to improve health and well being, secure high quality care and ensure the future NHS is sustainable. We have an annual planned expenditure of £102 billion, which is used to commission health care services both directly by NHS England and by the 209 CCGs.

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

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS England's aims and objectives, whilst 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 CCGs and the NHS Leadership Academy, and those organisations which NHS England hosts.

Under the Health and Social Care Act 2012 and related legislation, NHS England is responsible for ensuring its expenditure does not exceed the annual budget it is allocated. NHS England is not legally responsible for the financial performance of providers of NHS-funded care, nor for the Department of Health's (DH) overall revenue and capital budgetary position.

The Government's mandate to NHS England

NHS England is accountable, through its Board, to the Secretary of State for Health for delivery of the mandate. The mandate sets the strategic direction for NHS England, ensures it is democratically accountable and is the main basis of ministerial instruction to the NHS. The Chair of the Board and Chief Executive meet the Secretary of State regularly to provide assurance on progress against mandate objectives, and our progress is reviewed annually by Government via an assessment given to Parliament. The mandate can be viewed at www.gov.uk/government/publications/nhs-mandate-2016-to-2017.

Separate from the mandate, a framework agreement between NHS England and DH sets out the mechanisms through which the accountability relationship is managed and also the ways in which DH and NHS England work in partnership. This includes the principles which underpin our partnership working with DH and other organisations, patients and the public, including commitment to the values in the NHS Constitution.

Our purpose and role

In addition to its leadership and commissioning oversight role, NHS England directly commissions £27 billion† of healthcare services, mainly in specialised and primary care services.

As an organisation, we operate through our central teams and four regional teams, working closely with partner organisations that provide regulatory and support services to the health and care system. Additionally, we hosted other bodies: NHS Improving Quality (until November 2014), NHS Interim Management and Support, and we funded and sponsored the NHS Leadership Academy and the Sustainability Unit, on behalf of the NHS. We also oversee commissioning support units (CSUs), whose staff are employed via the NHS Business Services Authority (NHS BSA).

Our work is supported by a number of NHS and third party organisations including the Health and Social Care Information Centre (HSCIC), NHS BSA, NHS Shared Business Services (NHS SBS), Capita and NHS Property Services Ltd.

Governance arrangements and effectiveness

Governance framework

The governance framework is clearly set out in the Standing Orders, Standing Financial Instructions, Scheme of Delegation and CSU operating frameworks. Last year NHS England appointed a Director of Governance and Assurance who was tasked with reviewing our governance and assurance arrangements to ensure they were appropriate for an organisation of our size and growing complexity. That review was delivered to the Audit and Risk Assurance Committee (ARAC) in December 2015 which subsequently agreed with the Chief Executive a full project to deliver the suggested outcomes supported by an appropriate team.

† Figure has decreased from £28 billion last year due to transfer of commissioning responsibilities from NHS England to local authorities (c. £0.45 million) and CCGs (c. £2 billion) during 2015/16.

The Governance and Assurance Project was launched in January 2016 and runs until March 2017, reporting to the Chief Executive and ARAC. Its purpose is to improve the assurance and control environment with the organisation, addressing National Audit Office (NAO) and internal audit recommendations and strengthening management accountabilities. An assurance certification process is now in place for senior management, supplemented by additional delegation processes and an improved risk management framework.

There is also a full plan of work to enhance the governance manual and a number of key frameworks – for instance the three lines of defence model and enterprise wide risk management framework – and controls supporting a systematic approach to assurance at all levels of the organisation. Further work will also be undertaken to strengthen assurance provided by our service partners and to introduce a programme management framework.

Compliance with the UK Corporate Governance Code

NHS England's arrangements generally comply with the best practice described in the UK Corporate Governance Code. As part of implementing best practice, an assessment is undertaken each year against the code and the Corporate Governance in central government departments: Code of good practice 2011 (HM Treasury). The exceptions arising from this year's assessment are shown in Appendix 7.

The Board

The Board arrangements comply with the National Health Service Act 2006 (as amended) which requires that the Board consists of at least five non-executive directors, other than the Chair, and that the number of executive directors is less than the number of non-executive directors (including the Chair). The Chair and non-executive directors are appointed by the Secretary of State for Health; executive members are appointed by the Board. During 2015/16, three non-executive directors left NHS England, with two new non-executive Directors appointed in March 2016.

Further information about the roles and responsibilities of the Board and details of all Board members can be found in the Directors' Report.

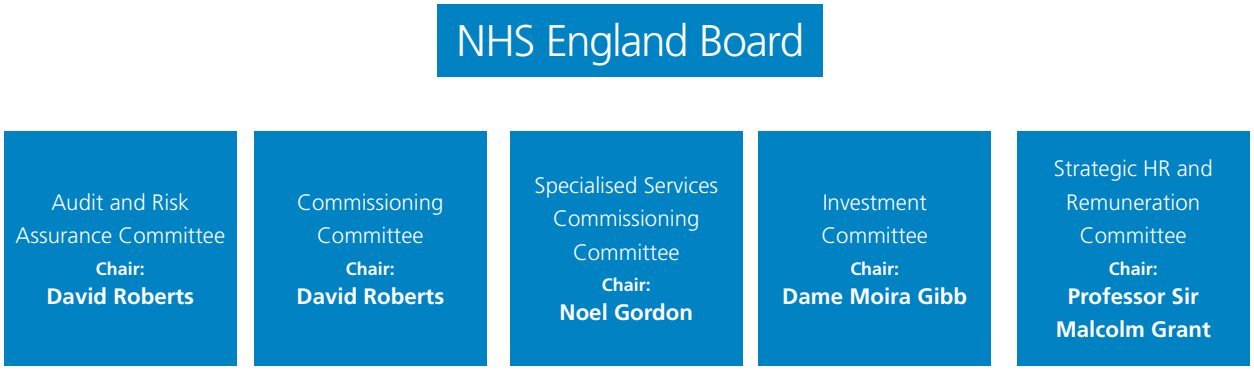
NHS England remains committed to transparency and regularly holds public Board meetings. Board papers, and the minutes of those meetings, are published on the

NHS England website. In addition, and in accordance with the Board decision taken in November 2014, arrangements exist to publish the agenda and papers from the private meetings one year after the meeting, where this does not compromise commercial or other confidentiality requirements.

Board performance

The Board plans to undertake a review of its performance as part of a development session in autumn 2016. This review will identify areas for further development and follows a similar review undertaken in 2014/15 which concluded that the Board had been effective in establishing the organisation but also identified areas for further development, including risk management and talent development. Progress within these areas – as detailed in this Governance Statement and in our Staff Report – will be considered by the Board as part of the autumn review.

Board committees



The Board is supported by a number of committees which underpin the Board's assurance and oversight of the organisation. The Board and its committees are part of NHS England's formal governance structure and provide the Board with regular reporting and formal assurance. This helps the Board to spend a significant proportion of its time on strategic decision-making, whilst obtaining proper assurance that decisions across the organisation have been made effectively based on the correct information. Committee chairs report to the Board on their activities following each meeting of their respective committee. An overview of Board membership of committees, and a summary of attendance, is given in Appendix 5.

Where to find further information	
Audit and Risk Assurance Committee	Governance Statement **See page 85**
Commissioning Committee	Governance Statement **See page 90**
Specialised Services Commissioning Committee	Governance Statement **See page 101**
Investment Committee	Governance Statement **See page 110**
Strategic HR and Remuneration Committee	Remuneration Report **See Page 70**

Audit and Risk Assurance Committee

The Committee provides independent and objective assurance to the Board on how NHS England manages its risks and controls and ensures that its system of internal control, governance and risk management is effective. It has an overview of internal and external audit services, governance and risk management and financial reporting. It has met six times since April 2015.

The Committee provides a report to the Board of each meeting, and in this way the Board is kept informed of how the Committee has discharged its delegated responsibilities. The Accounting Officer, as well as being a member of the Board, is also appraised of the Committee's activities through discussions with the committee chair. The Committee has operated with two members since the previous Chair, Ed Smith, left NHS England in November 2015. David Roberts has acted as interim Chair for the remainder of 2015/16 and has provided regular progress reports to the Board on its key duties which included:

- commissioning and receiving reports from the internal auditors on the adequacy of NHS England's internal control systems, risk management and corporate governance
- considering all relevant reports from the Comptroller and Auditor General of the NAO, the external auditor, including reports on NHS England's accounts and achievement of value for money
- reviewing the organisation's risk profile and reporting to the Board on managing and mitigating current and emerging risks
- ensuring that all corporate risks and mitigations have an accountable Board member and delegated risk owner

- evaluating the effectiveness of NHS England's control environment
- oversight of the organisation's arrangements for counter fraud
- assessing the integrity of NHS England's financial reporting and satisfying itself that any significant financial judgements made by management were sound
- reviewing the activities and performance of the internal and external auditors, including monitoring their independence and objectivity.

The Committee has sought assurance on specific issues including the following:

- progress on addressing key risk and control priorities identified by internal audit
- the organisation's resilience in respect of the accountabilities for data and cyber security
- the organisation's capacity and capability in respect of programme delivery.

Impact

The committee has held management to account over the last year, as it has continued to develop an appropriate governance and risk assurance framework, and implement an effective system of internal control.

It has had robust discussions about the resources needed to execute the internal control system, which have led to effective prioritisation and the acquisition of additional resources to support the new Director of Governance and Assurance to implement the governance and assurance project.

It has also provided strong guidance on a range of challenges which needed to be grasped quickly so that issues were resolved early.

Finally, the committee and executive colleagues have continued with their successful engagement with CCG audit committee chairs through regular national workshops. As well as sharing policy developments, insights and best practice, this has ensured guidance was both given and received on delivering the necessary assurances to, and by, CCGs.

Assurance statement

As a consequence of the above activities, the Committee confirms that it has fulfilled its duties in respect of:

- monitoring the provision of internal audit services, including the approval of an appropriate risk based programme of work for 2015/16, and approving the plan for 2016/17
- monitoring the provision of counter fraud services, including the approval of an appropriate programme of work for 2015/16 and future years
- overseeing the production of the annual report and accounts, including the related external audit programme
- considering and monitoring the governance arrangements for the organisation for 2015/16.

Risk management

The importance of effective risk management in NHS England was underlined at the beginning of the year with the appointment of a Chief Risk Officer, supporting the National Director: Transformation and Corporate Operations, who leads the organisation's risk management activities. During the year, the organisation has received reports from internal audit indicating the need to review elements of our risk management approach. To address this, we have developed an enhanced enterprise wide risk management framework as part of the wider governance and assurance project to address points raised in the 2014/15 audit of this area.

Further measures to strengthen the organisation's approach, including improving engagement at all levels of the organisation, will be taken forward as part of an implementation and training plan during 2016/17. This framework focuses on a no blame culture, but with clear risk ownership and accountability, assurance regarding the management of risks and informed decision making.

Risk management is currently maintained in the activities of the organisation through a number of policies and frameworks and supporting reporting processes:

- the risk management strategy and policy
- the Executive Risk Management Group (ERMG)
- the committee structures described in this report
- the CCG Assurance Framework
- incident reporting frameworks (such as information governance)
- policies and procedures on tackling fraud, bribery and corruption.

All national and regional teams within NHS England are required by the policy to identify, manage and report risks, these are captured on a regular basis and escalated to the Corporate Risk Register where appropriate. The ERMG reviews the Corporate Risk Register at each meeting. Where appropriate, risks are escalated and brought to the attention of NHS England's Executive Group, the Board or one of its committees.

The Corporate Risk Register is available at each meeting of the ARAC, where the organisation's risk profile is discussed and deep dives into individual risks are undertaken as required. The summary position of our corporate risks, with necessary escalations, is reported to the Board as part of performance reporting.

Responsibility for mitigating quality and clinical risks in the health system is systemic: no one organisation can be solely responsible for quality. The primary duty on NHS England is to drive continuous improvement in the quality of the services it commissions, working with partners such as CQC and NHS Improvement. This work is overseen by the Commissioning and Specialised Commissioning Committees as detailed later in this statement.

Key risks from the corporate risk register are listed in Appendix 8.

Other sources of assurance

Internal control assurance framework

NHS England has continued to develop its assurance framework to ensure it covers weaknesses in internal controls identified through internal audit. While significant improvements have been made during the year on the specific issues identified, further work is planned over the coming year to ensure it is completed and embedded into the organisation.

To ensure progress with recommendations identified across a range of internal audits, each directorate has a nominated director – responsible to the respective national or regional director – for reporting against outstanding actions on a monthly basis to the governance team. The reports provided by our auditors have formed the baseline for the implementation of systemic changes which are now being taken forward as part of the governance and assurance project. This covers the area's roles and responsibilities, processes and controls, risk and organisational policies.

As well as issues identified in year, particular focus has been given to work addressing control issues identified in the NAO completion report and internal audit reports from 2014/15. An assurance statement process for each director to signify compliance with policy and controls for their area(s) of responsibility is in place, and will be reported on a quarterly basis. In particular, whilst there is more work to be done, we have made significant progress in a number of areas by:

- appointing a new Head of Commercial and Procurement bringing responsibility for commercial services in-house, and delivering improvements to procurement processes, assurance and compliance
- strengthening programme management through the implementation of a team focused specifically on supporting and assuring delivery of major corporate priority programmes, which will be further enhanced by the development and implementation of a programme management framework during 2016/17
- developing a policy and project to redesign the processes and supporting systems to address control weaknesses in the appointment, authorisation and control of off-payroll workers, management of permanent establishment and the administration of travel and expenses (see also Control Issues section).

Assuring delivery of corporate priorities

Throughout 2015/16, NHS England has put in place more robust governance and assurance of its ten corporate priorities and supporting programmes. These are responsible for delivering the commitments listed in our business plan.

Following an early stocktake to assess the state of readiness of NHS England's corporate priorities, the Corporate Executive Group was formed in June 2015. This Group operates on behalf of, and reports into, NHS England's Executive Group, and scrutinises NHS England's corporate delivery on a regular basis. A Delivery Assurance Team, reporting directly to the National Director: Transformation and Corporate Operations, was established in December 2015 to assure delivery of the organisation's corporate priorities and stocktakes are held every six months. This reporting informs Board performance reporting, with risks and issues escalated to the Board, ARAC or the Corporate Executive Group as necessary.

Whilst these arrangements have significantly increased assurance of delivery of our priorities, more will be done in 2016 to embed programme disciplines and capability in all of our programmes.

The NHS England programme portfolio additionally includes other programmes, such as those forming our contribution to the Government Major Projects Portfolio and informatics programmes overseen by DH's Informatics Portfolio Management Board. Major programmes are subject to additional external assurance by the Cabinet Office's Infrastructure and Projects Authority.

Assuring quality and effective delivery of services

The Commissioning Committee was established in March 2015 to advise the Board on the development and implementation of strategy for the commissioning sector, agree commissioning priorities and allocation of resources, and receive assurance that performance, quality and financial outcomes are delivered, including taking over responsibility for financial performance monitoring from the Investment Committee with effect from January 2016. It also oversees assurance and development of the commissioning system. Over the year, the committee has:

- reviewed and agreed recommendations for CCGs taking on the delegation of primary medical care commissioning functions on behalf of NHS England's Board
- overseen the allocations process and agreed final allocations for 2015/16 and indicative allocations to 2020/21

- overseen the CCG assurance process, ensuring that CCGs meet their statutory duties regarding quality and the requirements of patients and the public, including authorising recommendations for the exercise of statutory powers of intervention and placing CCGs into special measures where this is appropriate
- considered a range of operational and strategic issues, including those highlighted through performance reports for directly commissioned and CCG commissioned services, and from the clinical corporate priority reviews
- received assurance on progress with the devolution programme, and agreed the process and governance for calls for devolution of NHS England's functions for approval by the Committee and applied them in decision-making with regard to Greater Manchester
- overseen development of NHS England's commissioning strategy, setting out NHS England's expectations of the commissioning system in delivering the Five Year Forward View and the actions it will take in support of that.

Meeting our duty to involve the public in commissioning

As part of our work to strengthen patient and public participation, we published a comprehensive statement of arrangements in November 2015 setting out how NHS England meets its legal duty to involve the public in commissioning. Both this statement and the patient and public participation policy to which it is linked were produced in collaboration with patients, the public, staff and partner organisations. Both publications can be found on our website at www.england.nhs.uk/ourwork/patients/ppp-policy/.

Whistleblowing

NHS England has policies and arrangements in place to enable whistleblowing for NHS England staff and staff in external organisations. Voicing your concerns for staff, our internal whistleblowing policy, was published in January 2016 and is located on our staff intranet.

In July 2015, the Board considered how to implement Sir Robert Francis' Freedom to Speak Up report (2013), and reached agreement for NHS England to become a Prescribed Person for primary care services under the provisions within the Small Business, Enterprise and Employment Bill 2015 with effect from April 2016. This allows whistleblowers to disclose information to an appropriate or independent recipient in addition to their own employer.

As a Prescribed Person, NHS England will be required to report on whistleblowing for primary care services, assigning any concerns raised for further investigation and providing support to individuals that have suffered fiscal or professional detriment as a result of whistleblowing. This includes signposting whistleblowers to the correct organisation responsible for dealing with their concerns. The scope of this responsibility relates to those organisations involved in the provision of primary medical services; primary dental services; primary ophthalmic services and local pharmaceutical services only.

NHS England has appointed the National Director: Transformation and Corporate Operations as the Freedom to Speak Up guardian for NHS England, and Professor Sir Malcolm Grant, Chair of NHS England, as the Board lead. The annual report on whistleblowing will form a specific part of this report from the 2017/18 reporting year.

Harris Review

Having regard to the wider implications of the Harris Review, which recommended an explicit assurance that all statutory duties and powers are understood and complied with, NHS England reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 and Health and Social Care Act 2012. As a result, NHS England is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions, and regularly reviews this for completeness. Responsibility for each duty and power has been clearly allocated to a national director and the register is regularly reviewed.

Data quality

The Board receives an integrated performance report that covers finance and operational performance for NHS England, as well as the wider commissioning system and NHS. The data contained in the report is subject to significant scrutiny and review by both management and Board committees. The processes being put in place by the governance and assurance project will provide further data to support assurance of activities. The Board is confident that the information it is presented with has been through appropriate review and scrutiny, and that it continues to develop with organisational needs.

Information governance, cyber and data security

Cyber and data security continues to be an important focus for NHS England and the NHS in England. Several reports and updates were presented to ARAC over the last year about the actions required between NHS England, HSCIC and others to improve protections across the wider NHS.

In January 2015, NHS England's National IG Steering Group approved an updated cyber risk management approach to make sure information and communication technology (ICT) programmes and projects adhere to security standards and that, where necessary, access to data and systems is risk assessed in line with information governance regulations. NHS England also requires all system suppliers to be working towards being certified with the cyber essentials standard as recommended by the Cabinet Office Government in April 2014 and updated during February 2015.

Throughout 2015/16, improved processes have been implemented for the management of cyber incidents as part of our routine business processes, with the corporate ICT security team responding to threats and reporting any cyber Serious Incidents Requiring Investigation (SIRI) to DH and HSCIC where appropriate.

Work continues to improve communications and alerts relating to threats and vulnerabilities. NHS England is now an active member of the Care Computer Emergency Response Team community that was established during 2015 to provide advance alerting, cyber guidance and expertise. During 2015, NHS England also registered as a member of the Centre for the Protection of National Infrastructure's Cyber Information Sharing Platform. This enables public and private organisations to share anonymised threat data and alerts as well as industry best practice to help mitigate against cyber threats.

Business critical models

NHS England recognises the importance of quality assurance across the full range of its analytical work. In partnership with analysts in DH, we have developed an approach that is fully consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government analytical models (2013). It is mandatory that NHS England analysts take part in workshops to ensure consistent performance and quality assurance across the full range of analytical work, and we routinely provide opportunities for them to do so.

For business critical models, where an error would have a significant reputational, financial or patient care impact, NHS England operates a joint approach with DH and other arm's

length bodies which includes the maintenance of a register of business-critical models and audit of the quality assurance strategy associated with them, overseen by a joint committee of experienced analysts. This committee reviews the quality assurance arrangements for business critical models, based on a self-reported template. Models are regularly reassessed and, to date, all relevant NHS England models in the register have passed.

Business critical models operated by NHS England

Name of model	Type
High level allocations model	Allocation
CCG, primary medical care and specialised allocation model	Allocation
Quality outcomes framework model	Financial evaluation
Pricing analysis tool	Financial evaluation
Referral to treatment system model	Forecasting

Service auditor reporting and third party assurances

NHS England relies on a number of third party providers (such as NHS SBS, NHS BSA, Capita, NHS Property Services Ltd and the HSCIC) to provide a range of transactional processing services ranging from finance to data processing. Our requirements for the assurance provided by these organisations are being increased to ensure appropriate formal assurances are obtained to supplement responsibilities for relationship and service provision, and routine customer/supplier performance oversight arrangements.

During the year, service auditor reports have been specifically commissioned to provide assurance over the operation of our control environment, and we are working, where appropriate, with our suppliers to implement ISAE 3402 or similar standards to make sure that the relevant internal controls and control procedures operated by our service organisations have operated effectively. Control issues have been identified within primary care and actions are being taken, including development of appropriate action plans, to address these. Shared assurance work has been undertaken with the NAO to gain a better understanding of some key control areas, and the new assurance frameworks will review the levels of assurance required and received.

Given the significant reliance on third parties for our delivery, we have identified a programme of work to further strengthen our arrangements with these organisations.

Internal audit

NHS England's internal audit service plays a crucial role in the review of the effectiveness of management controls, risk management and governance by:

- auditing the application of risk management and the internal control framework
- reviewing key systems and processes
- providing advice to management on internal control implications of proposed and emerging changes
- being available to guide managers and staff on improvements in internal controls
- focusing audit activity on the key business risks.

The internal audit service, provided by Deloitte LLP, operates in accordance with the Public Sector Internal Audit Standards and to an annual internal audit plan approved by ARAC. Internal audit updates the plan to reflect changes in risk profile, and any revisions are reviewed and approved by ARAC. The internal audit service submits regular reports on the effectiveness of NHS England's systems of internal control and the 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, which has placed strong emphasis on reducing overdue actions to acceptable levels during the past year.

The planned audit programme this year has continued to focus on the organisation's core internal control mechanisms.

The Head of Internal Audit opinion for 2015/16 can be found on page 112 of this report.

External audit

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

The certification of the Comptroller and Auditor General can be found on page 119 of this report.

Control issues

We have identified the following areas requiring improvement, all of which are a high priority to the organisation and for which we have worked to build further controls into normal management processes:

Strengthening establishment controls (on-payroll)

Work has continued to address control issues by further strengthening existing processes and controls to manage the on-payroll establishment of NHS England. A new workflow system will improve the controls environment, covering access to cost centres, change control and management of security passes and IT devices. Changes to the on-payroll establishment are formally approved and captured on the Electronic Staff Record (ESR) system, and effective controls are in place, based on new workflow involving both finance and human resources teams. Business planning for 2016/17 includes increased resource to implement a workforce systems team to enhance capacity in this area and the management of off-payroll workers.

Improving control processes for off-payroll workers

Significant work has been undertaken to improve management and control processes around off-payroll workers. An off-payroll policy has been developed and approved by the Executive HR Sub Committee.

The end to end process for the utilisation of off-payroll resources has been reviewed and a new process will be implemented in early 2016/17. As part of this review off-payroll worker information will be migrated to the ESR system to provide a single point of information. This will be supported by a new electronic workflow system which will improve reporting and the co-ordination of necessary approvals prior to engaging any off-payroll workers. All engagements will be through the appropriate procurement route including the use of the contingent labour one framework and will be supported by a purchase order and contract as part of the wider NHS England 'no purchase order, no contract, no pay' initiative.

This new functionality means that no off-payroll worker can be added to ESR unless appropriate approvals are in place including HM Revenue and Customs assurance. Access to NHS England IT equipment, e-mail accounts and premises will not be provided without a valid ESR reference.

The assurance of off-payroll workers is a priority for the organisation. For workers taken on prior to the introduction of these improved controls, where appropriate assurance is not forthcoming, NHS England will terminate the assignment and close the purchase order to minimise the risk to the organisation.

Providing stronger controls around business travel and expenses

A follow-up audit confirmed that improvements in this area have been successfully implemented, in particular, the electronic expenses system, which is now fully embedded across the organisation. This supports stronger controls and assurance and allows inappropriate claims to be blocked or flagged.

The Business Travel and Expenses policy is currently being reviewed and this will lead to further improvements being introduced for 2016/17.

Improving procurement practices and compliance

The appointment of a new Head of Commercial and Procurement and the commencement in September 2015 of an upskilled commercial team has helped to drive forward plans for the improvement of commercial elements of the control framework. Improvements in the period up to year end have included the introduction of more effective business partnering, implementing new governance and assurance arrangements, and work to develop our strategic procurement, supplier relationship management and contract management. The new team is building a procurement pipeline for 2016/17 as part of the wider corporate planning process. Assurance is also being strengthened through an improved approvals structure which requires approval at two key stages of the commercial lifecycle – procurement strategy (including business case) and contract award – by the Commercial Executive Group where the commitment exceeds £1 million or relates to a novel or contentious project, or the Commercial Panel in other cases.

The Commercial Panel and Commercial Executive Group review and approve business cases for NHS England. The Commercial Panel is made up of commercial and governance experts from NHS England's commercial team. Decisions on business cases for £1 million and above, single tender actions and retrospective applications are considered by the Commercial Executive Group.

The effect so far has been a significant improvement in the quality and content of the business cases, speedier approvals and greater opportunities to deliver value for money savings. More effective contract management processes and tools are being developed and implemented to manage performance of contracts and related risk. Whilst progress has been recognised, there remains a significant programme of work to be delivered to underpin improvements in this area and this will continue throughout 2016/17.

Embedding strong programme and project management practice

Work has been undertaken to improve the quality and frequency of reporting and assurance across major programmes delivering our corporate priorities. Further details can be found on page 90.

During 2016/17, the governance and assurance project will implement a framework to ensure all major programmes meet required standards of programme management and assurance in accordance with best practice and reflecting previous findings.

NHS Shared Business Services incident

In March 2016, a serious incident was identified when NHS SBS, who provided primary care support (PCS) services to NHS England in several geographical areas during the financial year, reported a large backlog of unprocessed correspondence relating to patients. A national incident team was immediately established, and is currently managing the incident to make sure that all correspondence has been reviewed and associated patient-related issues followed up appropriately. Our internal audit services have been asked to review and report implications for PCS control and other NHS SBS services.

Assuring commissioning support units

All CSUs make monthly returns to NHS England as part of an operational assurance dashboard, which includes a governance assurance statement covering issues such as compliance with Standing Financial Instructions (SFIs).

CSUs have internal management assurance frameworks, governance controls and processes in place which are reviewed by NHS England on a regular basis. Two dedicated governance assurance meetings per CSU take place each year. At the first meeting, the focus is on the CSU demonstrating and explaining their internal governance and management assurance processes. The second focuses on specific issues and enables NHS England to probe their systems in a little more detail. This provides a focus on issues of strategy, delivery and compliance, providing NHS England with an overview of CSU internal control processes and where concerns are evident, action is taken to support improvement.

CSUs have adopted the service auditor reporting approach to provide assurance to their customers.

A whistleblowing policy for CSUs based on the findings of Freedom to Speak Up is currently under review.

Strengthening the management of conflicts of interest across the NHS
NHS England is working with its partners to strengthen the way that conflicts of interest are managed in the NHS. The aim of this work is to strengthen and improve the consistency of the rules that NHS organisations, including NHS England itself, have in place to manage conflicts of interest, gifts and hospitality. The core components of this work are as follows:

- **Strengthened CCG statutory guidance:** We are strengthening the statutory guidance on managing conflicts of interest for CCGs in light of the findings from the NAO's report on conflicts of interest management in CCGs, the 2015/16 NHS England co-commissioning conflicts of interest audit and feedback received from a range of stakeholders and partners. Revised guidance was published in June 2016.
- **A cross NHS approach:** We have established a cross system task and finish group, chaired by Professor Sir Malcolm Grant, to develop a set of rules that can be applied consistently across the health system – across all national bodies and agencies including the arm's length bodies, professional regulators, local commissioners and NHS providers. The group will consolidate good practice across the NHS and beyond to tackle current inconsistencies in the way conflicts are managed, and it will develop proposals for consultation in the autumn.
- **Strengthening NHS England's internal policy:** We will review and revise NHS England's internal conflict of interest policy to implement the findings of the task and finish group, and bring it into line with wider good practice.

Supporting robust information governance, cyber and data security

NHS England has established a range of systems and controls relating to information governance (IG), cyber and data security. At an operational level, the Corporate IG Operations Group reviews IG, data and cyber risks, and receives updates on related incidents and breaches.

At a strategic level, the National IG Steering Group chaired by NHS England's Senior Information Risk Owner (SIRO) reviews data and cyber risks in addition to receiving regular cyber security updates. ARAC also receives regular updates on data and cyber assurance covering the wider commissioning system from the NHS England SIRO as a standing agenda item, informed by internal audit assessments, and this continues to be an area of focus for the committee.

Assurance of the commissioning system

NHS direct commissioning

Specialised Commissioning

The Specialised Services Commissioning Committee was established to oversee the development and implementation of NHS England's strategy for specialised commissioning and ensure that quality and performance standards for each specialised service are defined and maintained. It also agrees specialised commissioning priorities and work programmes, receiving assurance that these are delivered. Over the year, the committee has:

- considered a range of operational and strategic issues, and received updates on priority issues for specialised services, including the congenital heart disease review, child and adolescent mental health, drugs and devices. It has also had regular updates on hepatitis C services, in particular the introduction of NICE-approved drugs through Operational Delivery Networks and local clinical leadership
- provided assurance on the adoption and implementation of a prioritisation framework for making investment decisions in specialised services for 2015/16. This framework was developed following a period of consultation. The Committee has developed this further for 2016/17
- provided assurance on the financial position of specialised services and sought assurance on the actions being taken to mitigate financial risks throughout the year
- received information about provider derogations, where providers are not fully compliant with service specifications for specialised services, and provided assurance about the actions being taken locally and nationally to resolve these
- received updates on NHS England's work to involve patients and the public in specialised commissioning decisions
- considered the future strategic direction of specialised services, including: collaborative commissioning of specialised services with CCGs; strengthening the involvement of patients and the public; and potential improvement to the provision of specialised services.

Non-specialised commissioning

NHS England has a statutory duty to directly commission non-specialised healthcare services (primary care, public health commissioning, armed forces and health and justice commissioning) and ensure that we:

- plan for the services based on the needs of the population
- secure services that meet those needs
- monitor the quality of care provided.

NHS England discharges this duty through our national and integrated regional teams. Within the context of planning and securing services, specific annual objectives are agreed which meet the needs of the population. Quality monitoring and delivery assurance is overseen by specific oversight groups, which individually report to the Commissioning Committee.

During 2015/16, NHS England has overseen the safe transition of commissioning responsibilities for services for children aged 0-5 from NHS England to local authorities.

In total, direct commissioning for specialised and non-specialised services accounts for £27 billion of total commissioning funds.

Clinical commissioning groups

NHS England is accountable for overseeing and assuring the commissioning system, in particular the 209 CCGs, to ensure that it is working effectively. CCGs are independent membership organisations, each of which has an appointed Accountable Officer. They are clinically led and responsible for commissioning high quality healthcare services for their local communities.

NHS England allocates a large proportion of the funding it receives from DH to CCGs and supports them to commission services on behalf of their patients according to evidence-based quality standards. In turn, CCGs are responsible for demonstrating probity and good governance in managing their finance and performance. Together they account for £73 billion of total commissioning funds. NHS England's role is to ensure that CCGs deliver the best outcomes for their patients and have a high standard of financial management which administers resources prudently and economically and safeguards financial propriety and regularity. Parliament has specified limited rights of intervention by NHS England into each CCG.

In September 2015, DH confirmed that health bodies will move to a new audit framework under the Local Audit and Accountability Act 2014. This will require CCGs to select and appoint their own external auditors and directly manage contracts for audits from April 2017. This will increase local accountability and move CCGs into line with NHS foundation trusts. NHS England has engaged with CCGs to advise them of these requirements and offer support.

Assurance

NHS England's first assurance framework successfully provided assurance about CCG capability and added significant value to CCGs as part of their development. Recognising that CCGs have been in existence for two years, and that there have been a number of changes to the commissioning environment since CCGs were first authorised, NHS England developed a new CCG assurance framework for 2015/16. The framework strengthens the focus on a CCG's track record and ongoing performance in delivering improvements for patients, as well as continuing to assess a CCG's capability and fitness to take on additional roles and responsibilities under the co-commissioning agenda.

The framework describes a risk-based, continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients. Since CCGs were authorised to operate, the NHS has had to respond to more challenging performance and financial issues, as well as changes within the commissioning landscape. The continuous process facilitates the early identification of emerging patterns of poor performance, or any areas of potential risk, which would trigger more in-depth diagnosis and agreement of an improvement plan.

CCGs are assessed across the five components of assurance (well-led organisation, performance, financial management, planning, delegated functions) resulting in one of the following categories: outstanding; good; requires improvement; or inadequate. NHS England has available to it a number of responses to assurance, including a new special measures regime and its statutory powers of intervention. Special measures provide enhanced oversight and support to a CCG that is failing to discharge its commissioning functions to the required level. It has been applied once during 2015/16 to Shropshire CCG. NHS England has used its statutory powers, conferred by section 14Z21 of the NHS Act 2006 (as amended), to issue directions to six CCGs: NHS Bedfordshire; NHS Enfield; NHS Surrey Downs; NHS North East and West Devon; NHS East Surrey; and NHS Kernow. Directions were lifted from NHS Barnet CCG in August 2015.

On 31 March 2016, NHS England published the new CCG Improvement and Assessment Framework (IAF) for 2016/17 to replace the existing assurance framework. This new framework provides a greater focus on assisting improvement alongside our statutory assessment function. It closely aligns NHS England's operational and national policy teams to diagnose issues, set out what good and outstanding looks like and apply the most effective support and resources to help CCGs achieve this.

It draws together in one place the NHS Constitution and other core performance and finance metrics, outcome goals, and transformational challenges. The IAF is intended as a focal point for joint work, support and dialogue between NHS England and CCGs. It can be viewed on the NHS England website at www.england.nhs.uk/commissioning/ccg-auth/.

CCG Annual Reports

CCGs are due to publish their individual annual reports via their websites in June 2016. A list of CCGs, and links to their websites, can be found at www.england.nhs.uk/ccg-details/.

As part of improving our overall governance, processes were introduced during 2015/16 to support the consolidation and verification of CCG annual reports. A review of CCG Governance Statements found that the primary focus of CCG internal auditors over the year was in the areas of: finance; corporate governance; commissioning; information and communications technology and clinical governance. This is in line with expectations and issues previously highlighted by CCGs through earlier exception reports.

Co-commissioning

Co-commissioning of general medical services commenced on 1 April 2015. England worked with NHS Clinical Commissioners and CCGs to develop three models of co-commissioning for general practice services:

- **Greater involvement:** Is an invitation to CCGs to collaborate more closely with their NHS England teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy.
- **A joint commissioning** model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their NHS England sub-region via a joint committee.
- **Delegated commissioning** offers an opportunity for CCGs to assume full responsibility for the commissioning of general practice services.

CCGs wishing to take on delegated commissioning of primary medical care underwent a regional assessment process and national moderation prior to approval. In 2015/16, 63 CCGs implemented delegated arrangements, 87 CCGs joint arrangements and 59 CCGs the greater involvement model. During 2016/17, CCGs with joint and greater involvement co-commissioning will be encouraged to make arrangements to move to delegated commissioning by 2017/18.

The assurance framework took into account the need for NHS England to have specific additional assurances from CCGs who took on responsibility for the commissioning of primary medical services (delegated commissioning) or a joint commissioning arrangement with NHS England.

Each delegated CCG was required to prepare a quarterly self-certification of compliance against the five components of the CCG assurance framework, which includes a self-declared assurance rating signed off by CCG governing bodies. This included the requirement for each CCG to have reviewed its conflicts of interest policy in line with the statutory guidance on managing conflicts of interest. The self-certification fed into overarching assurance discussions with local teams and informed the overall assurance ratings.

NHS England also launched a qualitative evaluation programme during 2015/16 consisting of a co-commissioning survey, learning and development webinars and a three year research programme led by the Policy Research Unit in Commissioning and the Health Care System, involving 49 CCGs. This will consider how co-commissioning is helping to prevent widening gaps in the health and care of communities.

Early findings indicate CCGs can develop greater benefits and opportunities from delegated commissioning, than the joint and greater involvement models through:

- a clearer, more joined-up vision for primary care, which is aligned to their wider system priorities. This is leading to improved access and more equitable services, as well as allowing CCGs to develop more cost effective care pathways
- commissioning whole pathways of care (primary, community and secondary care services), allowing CCGs to respond to local inequalities by targeting those who are hard at reach or have the greatest need

- increased clinical leadership within primary care commissioning, giving GPs greater ability to influence and shape local primary care services, and develop new ways of working and more innovative services to meet local needs, such as the use of new technologies
- improved insight into their GP practices and performance, giving them greater opportunities to drive improvements to quality and delivery of care
- increased public involvement in primary care commissioning, ensuring services meet the needs of the local population.

To support CCGs to manage conflicts of interest in co-commissioning arrangements, NHS England provided tailored training to over 300 lay members from 145 CCGs between March and June 2015. Further training was held in February and March 2016, attended by 124 CCG lay members.

To evaluate compliance with the statutory guidance on managing conflicts of interest for CCGs, NHS England commissioned a sample audit of 10 co-commissioning arrangements. The audit found that the CCG guidance had been well received by CCGs, with all audit sites having reviewed their governance processes. The audit identified a number of examples of good practice, but also highlighted some inconsistencies in the processes established by the audit sites to manage conflicts of interest. These included:

- governance arrangements, as processes for managing conflict of interest breaches were not defined with sufficient clarity in some sites
- training arrangements, as not all audit sites had a structured conflicts of interest training programme
- processes to declare and record conflicts, including inconsistencies in minute taking and frequency of updating Declarations of Interest.

The findings of the audit have helped to inform the development of strengthened conflicts of interest guidance for CCGs, which is due to be published in June 2016 as detailed under the section on Control Issues. A follow-up audit will be undertaken in 2016/17.

Commissioning support units (CSUs)

CSUs were established in 2013 to provide excellent and affordable services to CCGs and other commissioners. The range of services is extensive, covering areas such as data analysis, information to support commissioning decisions, procurement advice, service transformation, contracting, human resources and financial management.

During the year, CCGs began a series of competitive procurements for CSU services in line with the NHS England Lead Provider Framework. During 2015/16, two CSUs closed down, and from April 2016 six CSUs will operate on the framework alongside private sector providers, offering further economies of scale for all customers.

Assurance

Each CSU produces an annual business and finance plan which is reviewed on submission and monitored throughout the year. They are subject to an in-year assurance programme which regularly reports on their risk, viability, development and compliance with NHS England's standing financial instructions. NHS England acts upon any exceptions reported in service auditor reports (e.g. use of bank overdrafts), and any management actions are managed through the CSU's finance director, with oversight by the CSU's leadership team and NHS England's CSU Transition Team. Every exception identified via service auditor reports is tracked, as well the action taken or planned by the CSU in-year to resolve the issue(s). Timescales for completion and evidence of the actions taken (e.g. lessons learnt sessions for staff, use of date stamped evidence) are also provided.

Progress is then reported to ARAC and the Commissioning Committee also receive regular information on CSU assurance, performance and risk.

Further detail on CSUs can be found under Control Issues and within Appendix 8: Key risks for the organisation.

Review of economy, efficiency and effectiveness of the use of resources

The Five Year Forward View forecast that the NHS would have a £30 billion gap in funding by 2020/21 if current demand trends continued, the NHS received flat real terms funding and no further efficiencies were delivered.

The subsequent Spending Review modelling of cost pressures and investments remained broadly in line with the modelling conducted a year earlier, as part of the Five Year Forward View, with a total potential unmitigated gap of around £30 billion by 2020/21.

In November 2015, the Government set out the financial settlement for the NHS to 2020/21. Annual funding will rise by £3.8 billion above inflation in 2016/17 and £8.4 billion above inflation in 2020/21, which equates to NHS funding growing from £101.0 billion in 2015/16 to £119.6 billion in 2020/21.

While this implies an efficiency requirement of £22 billion by 2020/21, the majority of these efficiencies are not cost reductions per se, but action to moderate the counterfactual rate of spending growth. Furthermore, the Government's Spending Review assumes that around £7 billion of the total will be delivered nationally, leaving £15 billion to be sourced locally.

We have already begun to develop plans to secure £1 billion of efficiencies from non-NHS provider contracts and CCG running cost reductions.

This leaves £14 billion of efficiencies to find over the period. We expect that these will need to be delivered through achieving the following:

- **Activity:** Moderating the level of activity growth through care redesign, and interventions such as RightCare and Self Care.
- **NHS secondary care provider productivity:** Achieving 2 percent productivity improvements each year across NHS secondary care providers, delivering £8.6 billion in savings.
- **Other efficiencies:** Including operational efficiency within other elements of CCG and non-secondary care commissioning.

The aggregate underlying provider deficit for 2015/16 was higher than anticipated by NHS Improvement and its predecessor bodies, creating an additional efficiency requirement.

During 2015/16, we have started to mobilise key programmes of work that will help in achieving financial sustainability. As set out in our Business Plan for 2016/17, we will be providing leadership to the NHS, in partnership with DH and other national bodies, so that individual organisations can realise their own internal efficiency gains, whilst supporting optimisation of the whole system and reducing the demand placed on the NHS as a whole.

Allocations, planning and in-year performance monitoring

In December 2013, NHS England's Board approved allocations for the commissioning sector for 2014/15 and indicative allocations for 2015/16. The Autumn Statement in December 2014 announced additional funding for front-line services and transformation amounting to £1.98 billion, and the Board subsequently agreed allocations for 2015/16 incorporating this increased resource. Further detail is included in the Chief Financial Officer's report from page 48.

NHS England gains assurance about the use of financial resources by commissioners (within the bounds of the Health and Social Care Act 2012, and recognising the freedoms allowed to GP led commissioners) through the annual planning process, and the in-year monitoring process.

The annual planning guidance specifies the financial business rules that commissioners operate within. For the planning round in financial year 2015/16, NHS England finance teams reviewed all CCG and direct commissioning plans to verify the extent to which they demonstrated achievement of these business rules, realism of savings plans and the value for money of any new investments. We also worked with relevant arm's length bodies to secure alignment of commissioner and provider plans.

In year, the financial position across the commissioning system is reported on a monthly basis using the ISFE reporting system. This enables a detailed monthly review by the Finance Leadership team and Chief Financial Officer, leading to regular updates to NHS England's Executive Group, relevant Board committees and the Board.

Individual CCG and direct commissioning variances from plan are rated against business rules (Red-Amber-Green), and reported analysis includes narrative and presentation of any risks and mitigations in addition to the reported forecast position. Quarterly financial performance information at an organisational level is published on NHS England's website at www.england.nhs.uk/publications/financial-performance-reports/.

NHS England has also given particular focus during 2015/16 to improving the financial resilience of CCGs, developing a work programme to deliver effective mechanisms to detect deteriorating financial performance earlier and take robust action where required. 170 out of 209 CCGs achieved their planned financial position in 2015/16 (81 percent). Of those 170, 62 overachieved against their plans. 35 of the 39 CCGs which failed to achieve their plans, underachieved by less than 2 percent of their recurrent allocations.

NHS England central programme costs

National programme costs are subject to scrutiny at the planning stage through the lens of agreed NHS England corporate priorities. Through this process, spend is prioritised and budgets allocated. Spend is then monitored against budget during the year. Individual purchases are subject to further scrutiny and approval in line with SFIs and internal and external efficiency controls, depending on the level of individual spending.

Cabinet Office efficiency controls

As part of the Government's control of expenditure, NHS England is subject to expenditure control in the same way as Government departments and other arm's length bodies. As a consequence, business cases are approved before spending can occur in a range of areas in order to secure best value for money and ensure efficiency is being maximised. For expenditure above certain thresholds in certain categories (e.g. consultancy), approval is also sought from DH, and for some cases this also requires approval from Ministers, the Cabinet Office and/or HM Treasury.

Investment Committee

The Investment Committee receives assurance and agrees recommendations on business cases for activities related to NHS England's functions on behalf of the Board. It also oversees the assurance of reconfigurations and has delegated powers to make decisions on those requiring Board sign-off. The Committee also monitored the in-year financial position of the commissioning sector, including central NHS England spending, before this responsibility transferred to the Commissioning Committee in 2016. Over the year, the Committee has:

- overseen the investment of transformation funding across a range of priority areas, including an assessment of 2016/17 vanguard funding using a value-based decision making methodology

- assured and made decisions on reconfiguration cases and oversaw the pipeline of activity presented by the Oversight Group for Service Change and Reconfiguration
- made a number of approvals relating to capital expenditure business cases in line with SFIs, and agreed the annual capital budget across NHS England and CCGs
- monitored the in-year financial performance of the commissioning sector on a monthly basis. This included in-depth analysis of risks and mitigations and assurance of a range of initiatives to improve CCG financial resilience
- received updates on the progress of the annual financial planning process.

Counter fraud

NHS England is responsible for investigating allegations of fraud related to our functions and work, where this is not undertaken by NHS Protect and for ensuring that appropriate anti-fraud arrangements are in place. NHS England has established an enhanced local counter fraud function covering reactive and proactive counter fraud work. This has included the creation of a substantive Counter Fraud Lead post within the Financial Control team. Training and education has continued through the year to raise fraud awareness amongst all staff. NHS England's policy on tackling fraud, bribery and corruption was reviewed during the year and communicated to all staff and is available on the public website. In addition to this, NHS England is working closely with a number of other bodies, including NHS Protect, to establish appropriate and efficient anti-fraud arrangements across the wider commissioning system, and to comply with the standards set out by NHS Protect.

A number of initiatives are underway to tackle the fraud risk in primary care, including significant extension of the Prescription Exemption Checking Service (PECS), the Dental Benefit Eligibility Checking Service (BECS) and others managed by NHS BSA on behalf of NHS England. These schemes have led to net recoveries of £26.7 million in 2015/16, with further expansion planned for 2016/17. NHS England also received over £2.4 million in recoveries as a result of NHS Protect investigations. The recoveries received demonstrate that the current initiatives are producing results, as well as creating an expected deterrent effect. The further development of the counter fraud service in the coming years aims to amplify this effect.

An updated counter fraud strategy to further strengthen and coordinate NHS England's arrangements was presented to ARAC in May 2016.

Head of Internal Audit opinion

My Head of Internal Audit has informed me that based on the internal audit work undertaken during 2015/16 and in the context of the overall environment for NHS England for 2015/16, in their opinion the frameworks for governance and risk management have been adequate in 2015/16; however, a number of the actions implemented through the Governance and Assurance Project need to be embedded during 2016/17.

With respect to the internal control environment significant effort has remained focussed on implementing the structures designed through the 2013/14 and 2014/15 years, albeit that some structures, for example procurement and off-payroll workers, continued to remain in the design stage during the year. On this basis the framework for internal control has continued to evolve and be implemented within the organisation, for the majority of areas, through the 2015/16 year. At 31 March 2016, the majority of the internal control framework is in place, although internal audit work has identified some specific continued areas of non-compliance with the designed framework, some areas where the design of the internal control framework remains ongoing and opportunities to improve the design of some areas of the internal control framework.

All of the recommendations raised by internal audit have been accepted by management; actions have been agreed to address these and considerable focus has been placed on the implementation of the actions in a timely manner. However, despite sustained focus on the implementation of agreed management actions there remains a number of longer outstanding recommendations, where the actions are still to be fully implemented and embedded by the due date, or where considerable effort is prioritised prior to internal audit activity and not undertaken in a consistent proactive manner to make the change, as a result of the action, sustained.

In addition, the following factors should be taken into consideration with respect to their assessment:

- The internal audit work for 2015/16 has focused on assessing the operational effectiveness of the core processes. However, there remain some core processes where readiness assessments were undertaken during 2015/16 including procurement, whistle blowing and primary care support services (transition management).

- 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. These include risk management, project and programme management, procurement, payroll, off-payroll workers, establishment control, payments and travel and expenses processes. Management actions have been agreed to address all of these observations, a significant number of which have been completed by year end. However, given the nature of the agreed management actions, some of which require a timeframe in excess of 12 months to implement, not all of these have been completed by year end. Where possible interim solutions have been put in place whilst activity remains focused on the implementation of the longer term actions.
- There were a number of areas of concern identified by NHS England management for example with respect to procurement, off-payroll workers and individual projects. Projects have remained in place to rectify the identified gaps, in some cases with the assistance of the internal audit team.
- There remains significant reliance on third party providers of core services including:
  - NHS SBS for the ISFE, transaction processing, procurement and payroll services
  - NHS BSA for human resources and procurement services
  - NHS Property Services for building and estates management
  - Capita for PCS services
  - Health and Social Care Information Centre for data processing.

The understanding of the assurance requirements from these providers has further evolved during the year. The assurances to be obtained for the 2015/16 year have improved, for example with the receipt of a Service Auditor Report from the Health and Social Care Information Centre and provide the foundations for a robust assurance base for the 2015/16 year. There does however remain a requirement for continuing change with respect to understanding respective responsibilities in an environment where significant transaction processing is provided by third parties.

Overall summary

We started the year with a number of recommendations, identified by management, the NAO and our internal audit team, to implement in pursuit of our commitment to continually improve our organisation and exemplify the highest standards of governance.

We have made progress during the year, but there is still more to do to improve our assurance. Over the coming year, we will continue to focus significant attention on enhancing our processes and controls, demonstrating the effectiveness of the changes we have made, and embedding them into our ways of working.

Parliamentary accountability and audit report

All elements of this report are subjected to audit.

Remote contingent liabilities

There were no remote contingent liabilities with the exception of those ordinarily disclosed under IAS37.

Notation of gifts over £300,000

NHS England made no political or charitable donations or gifts during the current financial year, or previous financial periods.

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. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. The total number of NHS England losses and special payments cases, and their total value, is set out in the following tables.

Losses

	Parent				Consolidated Group			
	Total number of cases 2015/16 Number	Total value of cases 2015/16 £000	Total number of cases 2014/15 Number	Total value of cases 2014/15 £000	Total number of cases 2015/16 Number	Total value of cases 2015/16 £000	Total number of cases 2014/15 Number	Total value of cases 2014/15 £000
Administrative write-offs	168	809	38	29,352	387	11,875	151	32,377
Fruitless payments	4	916	-	-	40	1,434	11	6
Store losses	75	19	58	92	78	19	58	92
Bookkeeping losses	6	4,071	-	-	7	4,071	3	3
Cash losses	-	-	-	-	7	2	1	3
Claims abandoned	-	-	-	-	1	1	-	-
Total	**253**	**5,815**	**96**	**29,444**	**520**	**17,402**	**224**	**32,481**

2015/16 Disclosure: Bookkeeping losses: Further review has been conducted on balances transferred to NHS England following the reforms to health and social care. This has identified that information has not been sufficient to enable NHS England to recognise some of these assets previously held in primary care trust balance sheets and therefore the assets have been written off. There is no evidence that any assets were lost during transition.

2014/15 Disclosure: Administrative write off: In 2014/15, a further impairment review was conducted on assets transferring from legacy organisations, resulting in a write off of £26,365,000.

Special payments†

	Parent				Consolidated Group			
	Total number of cases 2015/16 Number	Total value of cases 2015/16 £000	Total number of cases 2014/15 Number	Total value of cases 2014/15 £000	Total number of cases 2015/16 Number	Total value of cases 2015/16 £000	Total number of cases 2014/15 Number	Total value of cases 2014/15 £000
Compensation payments	2	2	1	1	10	95	21	55
Extra contractual payments	1	13	-	-	4	239	28	145
Ex gratia payments	2	101	1	3	12	162	31	123
Extra statutory extra regular payments	-	-	-	-	-	-	-	-
Special severance payments	-	-	-	-	2	34	-	-
Total	**5**	**116**	**2**	**4**	**28**	**530**	**80**	**323**

Cost allocation and setting of charges for information

NHS England certifies that it has complied with HM Treasury guidance on cost allocation and the setting of charges for information.

The fees and charges in formation in this note is provided in accordance with section 5.4.16 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for IFRS purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs.

† In 2014/15 a fine of £470,000 was levied by the Treasury in respect of two off-payroll workers. This value was deducted from the Department of Health funding allocation and a memorandum note has been made in the Losses register.

The following provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

	Parent			Consolidated Group		
2015/16	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	743,843	(3,314,086)	(2,570,243)	743,843	(3,313,160)	(2,569,317)
Prescription	517,769	(2,094,413)	(1,576,644)	523,539	(10,663,034)	(10,139,495)
Total fees & charges	**1,261,612**	**(5,408,499)**	**(4,146,887)**	**1,267,382**	**(13,976,194)**	**(12,708,812)**

	Parent			Consolidated Group		
2014/15	Income £000	Full cost £000	Surplus (deficit) £000	Income £000	Full cost £000	Surplus (deficit) £000
Dental	716,014	(3,113,516)	(2,397,502)	716,014	(3,114,073)	(2,398,059)
Prescription	501,009	(2,124,648)	(1,623,639)	503,940	(10,348,124)	(9,844,184)
Total fees & charges	**1,217,023**	**(5,238,164)**	**(4,021,141)**	**1,219,954**	**(13,462,197)**	**(12,242,243)**

Long-term expenditure trends

Long-term expenditure trends from the establishment of NHS England in 2013/14 are set out below, detailing expenditure on clinical commissioning groups, direct commissioning, and NHS England's central programme and running costs.

2015/16	Clinical Commissioning Groups £000	Direct Commissioning £000	NHS England - Admin & Central Programmes £000	Other £000	Intra-Group Eliminations £000	NHS England Group Total £000
Income	-1,037,148	-1,543,667	-50,956	-912,178	1,351,442	-2,192,508
Gross Expenditure	73,602,211	28,267,150	1,342,154	523,869	-1,351,442	102,383,942
Total Net Expenditure	**72,565,063**	**26,723,483**	**1,291,197**	**-388,309**	**-**	**100,191,434**

2014/15	Clinical Commissioning Groups £000	Direct Commissioning £000	NHS England - Admin & Central Programmes £000	Other £000	Intra-Group Eliminations £000	NHS England Group Total £000
Income	-1,156,271	-1,558,362	-26,341	-849,134	1,434,200	-2,155,908
Gross Expenditure	68,073,434	30,933,696	1,402,938	766,054	-1,434,200	99,741,922
Total Net Expenditure	**66,917,163**	**29,375,334**	**1,376,597**	**-83,080**	**-**	**97,586,014**

2013/14	Clinical Commissioning Groups £000	Direct Commissioning £000	NHS England - Admin & Central Programmes £000	Other £000	Intra-Group Eliminations £000	NHS England Group Total £000
Income	-1,167,521	-1,522,573	-30,137	-681,187	1,558,089	-1,843,329
Gross Expenditure	65,851,811	28,951,023	1,474,099	1,643,469	-1,558,089	96,362,313
Total Net Expenditure	**64,684,290**	**27,428,450**	**1,443,962**	**962,282**	**-**	**94,518,984**

Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the NHS Commissioning Board for the year ended 31 March 2016 under the Health and Social Care Act 2012. The financial statements comprise: the Group and Parent Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report that is described as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the group's and the NHS Commissioning Board's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Commissioning Board; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended

by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the group's and of the NHS Commissioning Board's affairs as at 31 March 2016 and of the group's and the parent's net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report to be audited 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 Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept 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 Remuneration and Staff Report and Parliamentary Accountability and Audit Report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

12 July 2016

Sir Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

The Explanatory Report of the Comptroller and Auditor General to the Houses of Parliament

Introduction

1. In December 2015, I reported on the 'sustainability and financial performance of acute hospital trusts', which highlighted the severe, and worse than expected, decline in the financial position in provider sector finances. As I have previously reported, this trend is not sustainable. The financial sustainability of the provider sector should be assessed against the wider backdrop of the broader health and social care sector financial position and the need to close the gap between available resources and patient needs.

2. I concluded that the Department and its arm's length bodies had yet to develop and implement a coherent plan to close the gap between resources and patients' needs. The Committee of Public Accounts (PAC) reported its concern about the absence of a plan in its report on this topic in March 2016.

3. I found that the Department, NHS England, Monitor and the NHS Trust Development Authority (NHS TDA) needed to take a more holistic, coordinated approach to tackling trusts' persistent financial problems and move beyond quick fixes to control trusts' spending growth. Until there is a clear pathway for trusts to get back to financial stability, we could not be confident that value for money, defined as financial and service sustainability, will be achieved.

4. A detailed plan should set out its objectives clearly. It should also set out the benefits to be realised; individual responsibilities for each part of the plan (this is especially important where multiple bodies are involved); and milestones, and checkpoints at which the progress towards objectives can be assessed, and corrective action taken where necessary.

5. The absence of a detailed longer term plan makes it more likely that plans will be driven by the annual accountability cycle. This can lead to short-term decision making, and a failure to invest in the future, as organisational effort and attention are spent on ensuring that annual control totals are met.

6. NHS England published in May 2016 a Recap Briefing for the Health Select Committee on Technical Modelling and Scenarios[1]. This sets out the efficiencies required by the Spending Review and the initiatives by which they will be realised. It notes that £7 billion will be delivered nationally, leaving £15 billion to be sourced locally. As set out later in this report, the primary vehicle for detailed planning for local implementation is the sustainability and transformation planning process currently underway.

7. Having now completed my financial audits of the 2015/16 Department of Health group accounts, including the NHS England financial statements, I consider it appropriate to provide an overview of the actions being taken to address the challenges. This report focuses on NHS England. I have reported separately on the Department of Health's resource accounts.

8. NHS England is responsible for spending more than £100 billion in funds and holding organisations to account for spending this money effectively for patients and efficiently for the taxpayer. A lot of the work involves the commissioning of health care services in England. NHS England commission the contracts for GPs, pharmacists, and dentists (Primary Care) and support local health services that are led by groups of GPs called clinical commissioning groups (CCGs). CCGs plan and pay for local services such as hospitals and ambulance services.

Structure of this report

9. Drawing on the findings of my audit of NHS England's 2015/16 financial statements the purpose of this report is to:

   - set out the pressures facing NHS England
   - set out how NHS England has addressed these pressures in year
   - set out assurances gained from my audit work, and what this tells me about the capacity and capability of NHS England to address the issues it faces
   - set out NHS England's plan to address the challenges it faces, particularly in relation to financial sustainability
   - set out my future work and concerns to be addressed, if NHS England is to play its part in ensuring that the National Health Service successfully addresses the challenges it faces.

1. www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf

Pressures facing NHS England

10. As acknowledged in NHS England's Performance Report and the Five Year Forward View, the National Health Service is facing three challenges:

- The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded out by the need to spend billions of pounds on wholly avoidable illness.
- The care and quality gap: unless the NHS reshapes care delivery, harnesses technology, and drives down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- The funding and efficiency gap: if the NHS fails to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

How NHS England has addressed these pressures in-year

11. As noted in the Chief Financial Officer's Report, NHS England had a revenue resource limit of £101,708 million in 2015/16. Throughout 2015/16, NHS England has sought to maximise the contribution of the commissioning sector to the overall Department position, in the light of the scale of provider deficits. For 2015/16:

- The CCGs' budget was £72.548 billion
- The Primary Care budget was £10.395 billion
- The Specialised Commissioning budget was £14.308 billion
- The Other Direct Commissioning budget, including Cancer Drugs Fund, Public Health, Justice and Armed Forces was £2.103 billion
- The Central Programmes budget was £1.766 billion.

12. Full details of NHS England's financial performance are set out in the Chief Financial Officer's Report. This section of the Annual Report notes that "NHS England has generated an underspend of £599m (0.6 percent of plan) against the core performance metric. It should be noted, however, that the major contributions to this underspend

have been either non-recurrent in nature or have been adjusted for budget setting for 2016/17 to maximise funding available for frontline services and primary care transformation in a year of exceptional challenge for the NHS."

13. NHS England recognises that despite their small surplus in 2015/16, next year will continue to be a challenge; and many of the mechanisms through which this year's budget was achieved will simply not be available in 2016/17.

Financial Audit in 2015/16

14. My audit of the financial statements was conducted in accordance with International Auditing Standards (ISAs). Among other things, these require me to identify significant risks, which are risks of material misstatement. Identification of such risks does not suggest that such risks will inevitably occur, but that the risk is sufficiently important, that I need to carry out specific work, to gain assurance that these risks have not impacted on the truth and fairness of the financial statements, or any of the other matters on which I am required to give an opinion.

15. The first significant risk is a presumed risk for all audits; under ISA (UK and Ireland) 240 The Auditor's Responsibilities Relating to Fraud in an Audit of Financial Statements. This standard requires me to consider the risk of management override of controls. The standard expects that auditors will consider significant or unusual transactions and carry out journals testing, based on the identification of risk characteristics in the journal population. Finally auditors consider and test management estimates and judgements, in the light of this risk of management override of controls. I carried out my planned testing and found no significant issues.

16. I also identified risks in respect of the implementation and accounting for the Better Care Fund; the introduction of primary care co-commissioning; and the outsourcing of primary care services. My audit did not identify any material issues in respect of these risks.

17. These financial statements include the consolidated results of NHS England and the 209 CCGs. My assurance over the figures derived from the CCG financial statements comes from the work of component auditors. In accordance with Auditing Standards, I issue group instructions, which include details on the significant risks that I have identified. I have asked their auditors to report, by exception, any issues in relation to these risks. I have not received reports from component auditors on any issues arising from these risks.

18. The assurances for my audit came mainly from substantive testing, rather than reliance on systems and controls. This is a result of the maturity of the assurances available, as reflected in the Governance Statement, and Head of Internal Audit Opinion. In summary there was a lack of reliable, timely assurances across the system (CCGs; local government and other providers; third party providers).

19. As noted in the Governance Statement, NHS England has set up a Governance and Assurance Project. This was in part designed to address the concerns that I raised in my audit completion report in June 2015, and was launched in January 2016 and runs until March 2017. There is a full plan of work including enhancing the governance manual and a number of key frameworks and controls, supporting a systematic approach to assurance at all levels of the organisation. Further work will also be undertaken to strengthen assurance provided by NHS England's partners providing services and to introduce a programme management framework. Once processes are in place, NHS England will need to embed them and help the necessary culture develop, so that the provision of such assurances becomes second nature.

NHS England plans to address financial sustainability

20. NHS England set out their approach to future financial sustainability in the Annual Report. This again states that the level of efficiencies required is £22 billion, noting that £7 billion will be delivered nationally, leaving £15 billion to be sourced locally. NHS England recognise the need for bodies across the health and social care system to collaborate, at both local and national level.

21. The Sustainability and Transformation Plans, being drawn up by 44 geographical footprints, are the mechanism through which plans will be delivered at health economy level. These will include investments in prevention; new models of care, to moderate the levels of activity growth; use of the RightCare programme to ensure best value; and a programme of operational efficiency improvement for providers, including through their response to the Carter Review. The detail of these plans is not yet available, although I understand that they will consider not just the next financial year, but the next five years.

22. Planning on a geographical footprint, which does not have a statutory basis, will mean that accountability arrangements and assurance requirements become even more complex. As already noted, assurance arrangements are not yet fully developed within the NHS England Group. The need for an overarching long term plan is therefore even

more important. An agreed framework, within which everyone is operating, would aid consistent, aligned decision-making across a complex and evolving landscape.

23. The required pace and scale of change make ensuring that suitable assurance and accountability arrangements are in place more important, but reduces the time available to put these in place.

Conclusion and future audit work

24. I have noted the focus of the Department of Health and national health care bodies on addressing the immediate issue of financial outturn for 2015/16. This is set out in more detail in my report on the Department of Health resource account. As I have reported previously, the NHS faces an unprecedented financial challenge which requires long term strategic measures to address. The Department and its national bodies have taken steps toward developing longer term strategic plans over the period of the current Parliament. I will return to these challenges, reviewing progress in developing and implementing these plans in my next report in the autumn.

25. A viable plan to deliver the £22 billion savings needed by 2020/21 could be achieved if the Department and its arm's length bodies improved transparency, set clear evidence-based targets and priorities. Improved accountability frameworks and better assurance by oversight bodies could create a stronger foundation for financial sustainability. Better monitoring of what works could support a faster pace of change.

26. As noted above, the landscape in which NHS England operates is becoming more complex. The nature of some of the relationships between the different components of the system is also changing. That makes evaluation against a clearly defined plan even more important. NHS England have recognised this need in their Annual Report, particularly in respect of the vanguards. I will return to this, as part of my value for money work on financial sustainability in 2016/17.

12 July 2016

Sir Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

ANNUAL ACCOUNTS

Simon Stevens
Accounting Officer
8 July 2016

Statement of comprehensive net expenditure for the year ended 31 March 2016

		Parent		Consolidated Group	
		2015/16	2014/15	2015/16	Restated 2014/15
	Note	£000	£000	£000	£000
Administration Income and Expenditure					
Operating revenue	2	(398,526)	(478,039)	(155,234)	(141,378)
Employee benefits	3.1	560,493	707,608	1,184,393	1,289,438
Operating expenses	4	1,485,170	1,668,188	623,538	689,469
Net administration expenditure before interest		**1,647,137**	**1,897,757**	**1,652,697**	**1,837,529**
Programme Income and Expenditure					
Operating revenue	2	(2,019,307)	(1,876,904)	(2,037,274)	(2,014,531)
Employee benefits	3.1	247,319	210,815	557,263	437,590
Operating expenses	4	99,975,370	97,118,466	100,030,150	97,321,163
Net programme expenditure before interest		**98,203,382**	**95,452,377**	**98,550,139**	**95,744,222**
Total Income and Expenditure					
Operating revenue	2	(2,417,833)	(2,354,943)	(2,192,508)	(2,155,909)
Employee benefits	3.1	807,812	918,423	1,741,656	1,727,028
Operating expenses	4	101,460,540	98,786,654	100,653,688	98,010,632
Net operating expenditure before interest		**99,850,519**	**97,350,134**	**100,202,836**	**97,581,751**
Other (gains) /losses		(1)	-	(2)	-
Finance costs	13	(11,587)	4,200	(11,400)	4,263
Net operating expenditure for the financial year		**99,838,931**	**97,354,334**	**100,191,434**	**97,586,014**
Net loss on transfers by absorption		-	-	-	-
Net operating expenditure for the financial year including absorption losses		**99,838,931**	**97,354,334**	**100,191,434**	**97,586,014**
Other comprehensive net expenditure					
Movements in other reserves		-	19,484	-	19,368
Net actuarial gain/(loss) on pension schemes *		-	-	(3,533)	2,281
Total comprehensive net expenditure for the year		**99,838,931**	**97,373,818**	**100,187,901**	**97,607,663**

The notes on pages 134 to 185 form part of this statement.

* In 2015/16 a further analysis of movement in reserves has been provided, the loss on pensions schemes relates to a Local Government Pension Scheme within one CCG. The comparatives for 2014/15 have been restated to show this.

All income and expenditure is derived from continuing operations.

Statement of financial position as at 31 March 2016

		Parent		Consolidated Group	
		31 March 2016	31 March 2015	31 March 2016	31 March 2015
	Note	£000	£000	£000	£000
Non-current assets					
Property, plant and equipment	6	205,433	196,607	246,200	231,659
Intangible assets	7	12,862	6,224	18,590	9,849
Trade and other receivables	9	-	4,043	179	4,222
Other financial assets	9.1	278	-	278	-
Total non-current assets		**218,573**	**206,874**	**265,247**	**245,730**
Current assets					
Inventories	8	150	178	5,237	2,244
Trade and other receivables	9	269,733	230,888	853,387	766,866
Cash and cash equivalents	10	261,740	129,479	283,543	150,045
Total current assets		**531,623**	**360,545**	**1,142,167**	**919,155**
Total assets		**750,196**	**567,419**	**1,407,414**	**1,164,885**
Current liabilities					
Trade and other payables	11	(2,509,649)	(2,584,030)	(7,251,664)	(6,910,966)
Borrowings	12	(10,523)	(5,921)	(16,015)	(15,605)
Provisions	14	(304,730)	(312,482)	(376,996)	(379,177)
Total current liabilities		**(2,824,902)**	**(2,902,433)**	**(7,644,675)**	**(7,305,748)**
Total assets less current liabilities		**(2,074,706)**	**(2,335,014)**	**(6,237,261)**	**(6,140,863)**
Non-current liabilities					
Trade and other payables	11	(2,440)	(2,568)	(5,377)	(8,894)
Other financial liabilities		-	-	(76)	(51)
Borrowings	12	-	(10,523)	(1,085)	(11,683)
Provisions	14	(107,353)	(354,835)	(117,107)	(368,886)
Total non-current liabilities		**(109,793)**	**(367,926)**	**(123,645)**	**(389,514)**
Assets less liabilities		**(2,184,499)**	**(2,702,940)**	**(6,360,906)**	**(6,530,377)**
Financed by taxpayers' equity					
General fund		(2,184,523)	(2,702,964)	(6,356,524)	(6,522,485)
Revaluation reserve		24	24	137	160
Other reserves		-	-	(4,519)	(8,052)
Total taxpayers' equity		**(2,184,499)**	**(2,702,940)**	**(6,360,906)**	**(6,530,377)**

The notes on pages 134 to 185 form part of this statement.

The financial statements on pages 129 to 133 were approved by the Board and signed on its behalf by:

Simon Stevens
Accounting Officer
8 July 2016

Statement of changes in taxpayers' equity for the year ended 31 March 2016

Parent	General fund	Revaluation reserve	Other reserves	Taxpayers' equity
	£000	£000	£000	£000
Changes in taxpayers' equity for 2015/16				
Balance at 1 April 2015	**(2,702,964)**	**24**	**-**	**(2,702,940)**
Changes in taxpayers' equity for 2015/16				
Net operating expenditure for the financial year	(99,838,931)	-	-	(99,838,931)
Net recognised expenditure for the financial year	**(99,838,931)**	**-**	**-**	**(99,838,931)**
Grant-in-aid	100,357,372	-	-	100,357,372
Balance at 31 March 2016	**(2,184,523)**	**24**	**-**	**(2,184,499)**

	General fund	Revaluation reserve	Other reserves	Taxpayers' equity
	£000	£000	£000	£000
Changes in taxpayers' equity for 2014/15				
Balance at 1 April 2014	(2,710,192)	164	-	(2,710,028)
Changes in taxpayers' equity for 2014/15				
Net operating expenditure for the financial year	(97,354,334)	-	-	(97,354,334)
Movements in other reserves	(19,484)	-	-	(19,484)
Release of reserves to the Statement of Comprehensive Net Expenditure	140	(140)	-	-
Net recognised expenditure for the financial year	**(97,373,678)**	**(140)**	**-**	**(97,373,818)**
Grant-in-aid	97,380,906	-	-	97,380,906
Balance at 31 March 2015	**(2,702,964)**	**24**	**-**	**(2,702,940)**

Consolidated Group

	General fund	Revaluation reserve	Other reserves	Taxpayers' equity
	£000	£000	£000	£000
Changes in taxpayers' equity for 2015/16				
Balance at 1 April 2015	**(6,522,485)**	**160**	**(8,052)**	**(6,530,377)**
Changes in taxpayers' equity for 2015/16				
Net operating expenditure for the financial year	(100,191,434)	-	-	(100,191,434)
Movements in other reserves	-	-	3,533	3,533
Release of reserves to the Statement of Comprehensive Net Expenditure	23	(23)	-	-
Net recognised expenditure for the financial year	**(100,191,411)**	**(23)**	**3,533**	**(100,187,901)**
Grant-in-aid	100,357,372	-	-	100,357,372
Balance at 31 March 2016	**(6,356,524)**	**137**	**(4,519)**	**(6,360,906)**

	General fund	Revaluation reserve	Other reserves	Taxpayers' equity
	£000	£000	£000	£000
Changes in taxpayers' equity for 2014/15				
Balance at 1 April 2014	(6,298,186)	337	(5,771)	**(6,303,620)**
Changes in taxpayers' equity for 2014/15				
Net operating expenditure for the financial year	(97,586,014)	-	-	(97,586,014)
Movements in other reserves	(19,368)	-	(2,281)	(21,649)
Release of reserves to the Statement of Comprehensive Net Expenditure	177	(177)	-	-
Net recognised expenditure for the financial year	**(97,605,205)**	**(177)**	**(2,281)**	**(97,607,663)**
Grant-in-aid	97,380,906	-	-	97,380,906
Balance at 31 March 2015	**(6,522,485)**	**160**	**(8,052)**	**(6,530,377)**

Other reserves reflect pension assets/liabilities in respect of staff in non-NHS defined benefit schemes.

The notes on pages 134 to 185 form part of this statement.

Statement of cash flows for the year ended 31 March 2016

	Note	Parent 2015/16 £000	Parent 2014/15 £000	Consolidated Group 2015/16 £000	Consolidated Group 2014/15 £000
Cash flows from operating activities					
Net operating costs for the financial year		(99,838,931)	(97,354,334)	(100,191,434)	(97,586,014)
Depreciation and amortisation	4	69,222	47,456	79,250	55,030
Impairments and reversals	4	-	18,210	336	19,131
Other non cash adjustments*		-	(4,021)	26	(3,995)
(Gain)/Loss on disposal		(1)	-	(2)	-
Unwinding of discount	14	(12,217)	3,010	(12,092)	3,012
Change in discount rate	14	384	(12,298)	341	(12,235)
(Increase)/decrease in inventories	8	28	276	(2,993)	(529)
(Increase)/decrease in trade & other receivables	9	(34,802)	57,905	(82,478)	(24,234)
Increase/(decrease) in trade & other payables **	11	(72,516)	(150,143)	341,833	148,929
Provisions utilised	14	(98,821)	(68,430)	(117,862)	(88,865)
Increase/(decrease) in provisions	14	(144,580)	(84,571)	(124,347)	(53,980)
Net cash outflow from operating activities		**(100,132,234)**	**(97,546,940)**	**(100,109,422)**	**(97,543,750)**
Cash flows from investing activities					
Payments for property, plant and equipment		(77,555)	(94,092)	(91,998)	(111,762)
Payments for intangible assets		(9,308)	(1,759)	(12,178)	(5,163)
Proceeds from disposal of assets held for sale: property, plant and equipment		185	2,386	189	2,424
Proceeds from disposal of assets held for sale: intangible assets		-	26	-	26
Loans to other bodies	9.1	(278)	-	(278)	-
Net cash outflow from investing activities		**(86,956)**	**(93,439)**	**(104,265)**	**(114,475)**
Net cash outflow before financing activities		**(100,219,190)**	**(97,640,379)**	**(100,213,687)**	**(97,658,225)**
Cash flows from financing activities					
Grant in aid funding received		100,357,372	97,380,906	100,357,372	97,380,906
Capital element of payments in respect of finance leases		(5,921)	(3,038)	(6,000)	(3,116)
Net cash inflow from financing activities		**100,351,451**	**97,377,868**	**100,351,372**	**97,377,790**
Net increase (decrease) in cash and cash equivalents		**132,261**	**(262,511)**	**137,685**	**(280,435)**
Cash and cash equivalents at the beginning of the financial year	10	129,479	391,990	140,486	420,921
Cash and cash equivalents at the end of the financial year		**261,740**	**129,479**	**278,171**	**140,486**

The notes on pages 134 to 185 form part of this statement.

*Other non-cash adjustments include a non cash charge to reflect a discount on future lease charges of £26,000.

** Consolidated Group includes an increase of £3,533,000 to reflect a reduction in Local Authority Pension Payables.

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 16(1) of the Health and Social Care Act 2012 and in accordance with the 2015/16 Government Financial Reporting Manual (FReM) as issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the 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 shown on Note 23.

1.1 Operating segments

Income and expenditure are analysed in the Operating Segments note (note18) 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 to fair value of investment property, property, plant and equipment, intangible assets, certain financial assets and financial liabilities and stockpiled goods.

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 and its 209 related clinical commissioning groups (CCGs). Transactions between entities included in the consolidation are eliminated.

Commissioning Support Units (CSUs) form part of NHS England and provide services to CCGs. The CSU results are included within the Parent accounts.

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2015.

1.5 Going concern

NHS England's financial statements are produced on a going concern basis. NHS England is supply-financed and draws its funding from the Department of Health (DH). Parliament has demonstrated its commitment to fund DH for the foreseeable future via the latest Spending Review and the passing of the Health and Social Care Act 2012. In the same way, DH has demonstrated commitment to the funding of NHS England, with funding flows for the 2016/17 financial year having already commenced. It is therefore considered appropriate to adopt the going concern basis for the preparation of these financial statements.

1.6 Revenue recognition

The main source of funding for NHS England is grant-in-aid from DH. NHS England is required to maintain expenditure within this allocation. DH also approves a cash limit for the period. NHS England is required to draw down cash in accordance with this limit. Cash drawn down is credited to the general fund. Grant-in-aid is recognised in the financial period in which it is received.

Other operating revenue in respect of fees, charges and services 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 economic benefit associated with the transaction will flow to the group. Income is measured at fair value of the consideration receivable. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.7 Employee benefits

Recognition of short-term benefits - retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practitioners and other bodies allowed under the direction of the Secretary of State in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying assets and liabilities. Therefore, the scheme is accounted for as if it 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year.

Salaries, wages and employment related payments 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.

1.8 Administration and programme expenditure

The statement of comprehensive net expenditure is analysed between administration and programme expenditure, as defined by HM Treasury. In addition to the costs of running NHS England, administration costs in the consolidated accounts include the running costs associated with the commissioning functions of CCGs. Administration costs are those that do not relate directly to the provision of frontline services.

Programme costs reflect non-administration costs, including payments of grants and other disbursements, as well as certain staff costs where they relate directly to, or support, frontline service delivery.

1.9 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.

1.10 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.

Valuation 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. All assets are measured subsequently at depreciated historical cost as a proxy for fair value.

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 fair value. This is in accordance with FReM requirements as these assets have short useful lives or low values or both.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is only recognised as an impairment charged to the revaluation reserve when it does not result from a loss in the economic value or service potential to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported in the statement of changes in taxpayers' equity.

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.

1.11 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.

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 fair value.

1.12 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.

1.13 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.

1.14 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.

1.15 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.

1.16 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.

1.17 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.18 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.

1.19 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 short term rate of minus 1.55 percent (2014/15: minus 1.50 percent) is applied to expected cash flows in a time boundary of between 0 and up to and including five years from the statement of financial position date.
- A medium term rate of minus 1 percent (2014/15: minus 1.05 percent) is applied to the time boundary of after five and up to and including 10 years.
- A long-term rate of minus 0.80 percent (2014/15: 2.20 percent) is applied to expected cashflows exceeding 10 years.

All percentages are in real terms.

1.20 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which NHS England and CCGs pay an annual contribution to the NHSLA, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the liability rests with the group.

1.21 Non-clinical risk pooling

NHS England participates in the Property Expenses Scheme and the Liabilities to Third Parties scheme. Both are risk pooling schemes under which the CCG pays an annual contribution to the NHSLA and, in return, receives 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.

1.22 Continuing healthcare risk pooling

In 2014/15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme CCGs contribute annually to a pooled fund, which is used to settle the claims. The contribution of CCGs are charged to operating income in year in the NHS England parent account.

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. Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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.

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. This is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset.

At the statement of financial position date, the group assesses whether any financial assets are impaired. Financial assets are impaired, and impairment losses recognised, if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which have an impact on the estimated future

cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of net comprehensive expenditure.

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 2015/16. The application of the Standards as revised would not have a material impact on the accounts in 2015/16, were they applied in that year:

IFRS9 Financial Instruments - effective from 2018/19

IFRS15 Revenue for Contract with Customers - effective from 2018/19

IFRS16 Leases - effective from 2019/20

1.27 Significant accounting policies and material judgements

Estimates and the underlying assumptions are reviewed on a regular basis by the group's senior management. Areas of significant judgement made by management are:
IAS37 Provisions - judgement is applied in arriving at the best estimate 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.

IAS36 Impairments - management makes judgement on whether there are any indications of impairments to the carrying amounts of the group's assets.

2. Operating revenue

Parent

	2015/16			2014/15		
	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000
Recoveries in respect of employee benefits	**1,215**	1,153	62	**570**	530	40
Prescription fees and charges	**517,769**	-	517,769	**501,009**	-	501,009
Dental fees and charges	**743,843**	-	743,843	**716,014**	-	716,014
Education, training and research	**219,353**	906	218,447	**267,614**	6,509	261,105
Charitable and other contributions to revenue expenditure: non-NHS	**406**	302	104	**478**	443	35
Non-patient care services to other bodies*	**586,291**	355,285	231,006	**685,629**	428,062	257,567
Continuing Healthcare risk pool contributions**	**250,000**	-	250,000	**94,434**	-	94,434
Other revenue	**98,956**	40,880	58,076	**89,195**	42,495	46,700
Total operating revenue	**2,417,833**	**398,526**	**2,019,307**	**2,354,943**	**478,039**	**1,876,904**

Administration revenue is income received that is not directly attributable to the provision of healthcare or healthcare services.

* Parent non-patient care services to other bodies administration revenue figures are greater than those of the consolidated group due to the elimination of intra-group trading.

**Continuing healthcare risk pool contributions comprise contributions from CCGs to a risk pool scheme for which the related continuing healthcare costs are settled by NHS England. This is eliminated on consolidation for the group account.

Consolidated Group

	2015/16			2014/15		
	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000
Recoveries in respect of employee benefits	**4,911**	4,011	900	**3,415**	2,590	825
Prescription fees and charges	**523,539**	-	523,539	**503,940**	-	503,940
Dental fees and charges	**743,843**	-	743,843	**716,014**	-	716,014
Education, training and research	**230,956**	4,739	226,217	**280,807**	10,659	270,148
Charitable and other contributions to revenue expenditure: non-NHS	**3,291**	1,184	2,107	**2,278**	1,295	983
Non-patient care services to other bodies	**383,512**	64,543	318,969	**368,116**	49,766	318,350
Rental revenue from operating leases	**302**	-	302	**-**	-	-
Other revenue	**302,154**	80,757	221,397	**281,339**	77,068	204,271
Total operating revenue	**2,192,508**	**155,234**	**2,037,274**	**2,155,909**	**141,378**	**2,014,531**

Administration revenue is income received that is not directly attributable to the provision of healthcare or healthcare services.

3. Employee benefits and staff numbers

3.1 Employee benefits

Parent

	2015/16					2014/15				
	Permanent employees	Permanent CSU employees	Other	CSU other	Total	Permanent employees	Permanent CSU employees	Other	CSU other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee benefits										
Salaries and wages	231,571	272,986	70,435	105,303	**680,295**	252,387	315,880	56,663	135,946	**760,876**
Social security costs	22,149	23,230	12	16	**45,407**	23,847	26,562	74	30	**50,513**
Employer contributions to NHS Pension Scheme	30,381	34,611	13	18	**65,023**	32,449	38,727	20	40	**71,236**
Termination benefits	4,271	12,816	-	-	**17,087**	30,109	6,038	-	-	**36,147**
Gross employee benefits expenditure	**288,372**	**343,643**	**70,460**	**105,337**	**807,812**	**338,792**	**387,207**	**56,757**	**136,016**	**918,772**
Less: recoveries in respect of employee benefits	(390)	(588)	-	(237)	**(1,215)**	(162)	(407)	-	-	**(569)**
Total net employee benefits	**287,982**	**343,055**	**70,460**	**105,100**	**806,597**	**338,630**	**386,800**	**56,757**	**136,016**	**918,203**
Less: Employee costs capitalised	-	-	-	-	**-**	-	(349)	-	-	**(349)**
Net employee benefits excluding capitalised costs	**287,982**	**343,055**	**70,460**	**105,100**	**806,597**	**338,630**	**386,451**	**56,757**	**136,016**	**917,854**

	Charged to administration budgets	Charged to programme budgets	Total gross employee benefits expenditure	Charged to administration budgets	Charged to programme budgets	Total gross employee benefits expenditure
Of which:	£000	£000	£000	£000	£000	£000
Parent excluding CSU	269,987	88,844	**358,831**	337,303	58,246	**395,549**
CSU	290,506	158,475	**448,981**	370,654	152,569	**523,223**
Gross employee benefits expenditure	**560,493**	**247,319**	**807,812**	**707,957**	**210,815**	**918,772**
less:employee costs capitalised	-	-	-	(349)	-	(349)
Gross employee benefits excluding capitalised costs	**560,493**	**247,319**	**807,812**	**707,608**	**210,815**	**918,423**

Consolidated Group

	2015/16					2014/15				
	Permanent employees	Permanent CSU employees	Other	CSU other	Total	Permanent employees	Permanent CSU employees	Other	CSU other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee benefits										
Salaries and wages	857,565	272,986	239,893	105,303	**1,475,747**	796,666	315,880	199,106	135,946	**1,447,598**
Social security costs	78,416	23,230	115	16	**101,777**	73,141	26,562	209	30	**99,942**
Employer contributions to NHS Pension Scheme	110,439	34,611	187	18	**145,255**	100,319	38,727	188	40	**139,274**
Termination benefits	6,061	12,816	-	-	**18,877**	34,525	6,038	-	-	**40,563**
Gross employee benefits expenditure	**1,052,481**	**343,643**	**240,195**	**105,337**	**1,741,656**	**1,004,651**	**387,207**	**199,503**	**136,016**	**1,727,377**
Less: recoveries in respect of employee benefits	(4,129)	(588)	-	(194)	**(4,911)**	(3,009)	(407)	-	-	**(3,416)**
Total net employee benefits	**1,048,352**	**343,055**	**240,195**	**105,143**	**1,736,745**	**1,001,642**	**386,800**	**199,503**	**136,016**	**1,723,961**
Less: Employee costs capitalised	-	-	-	-	**-**	-	(349)	-	-	**(349)**
Net employee benefits excluding capitalised costs	**1,048,352**	**343,055**	**240,195**	**105,143**	**1,736,745**	**1,001,642**	**386,451**	**199,503**	**136,016**	**1,723,612**

	Charged to administration budgets	Charged to programme budgets	Total gross employee benefits expenditure	Charged to administration budgets	Charged to programme budgets	Total gross employee benefits expenditure
Of which:	£000	£000	£000	£000	£000	£000
Parent excluding CSU	269,987	88,844	**358,831**	337,303	58,246	**395,549**
CSU	290,506	158,475	**448,981**	370,654	152,569	**523,223**
CCG	623,900	309,944	**933,844**	581,830	226,775	**808,605**
Gross employee benefits expenditure	**1,184,393**	**557,263**	**1,741,656**	**1,289,787**	**437,590**	**1,727,377**
Less:employee costs capitalised	-	-	**-**	(349)	-	**(349)**
Gross employee benefits excluding capitalised costs	**1,184,393**	**557,263**	**1,741,656**	**1,289,438**	**437,590**	**1,727,028**

CSUs are part of NHS England and provide services to CCGs. The employment contracts or secondment of almost all of these staff are held for NHS England on a "hosted basis" by the NHS Business Services Authority.

3.2 Average number of people employed

Parent

	2015/16					2014/15				
	Total number	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	**14,365**	**4,693**	**7,373**	**1,056**	**1,243**	**16,562**	**5,525**	**8,220**	**1,128**	**1,689**
Of the above:										
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**7**	**-**	**2**	**-**	**5**

Consolidated Group

	2015/16					2014/15				
	Total number	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	**30,535**	**18,807**	**7,373**	**3,112**	**1,243**	**30,642**	**17,763**	**8,220**	**2,970**	**1,689**
Of the above:										
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**13**	**1**	**2**	**5**	**5**

3.3 Exit packages agreed in the financial year

Parent

	2015/16			2014/15		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	38	8	**46**	78	40	**118**
£10,001 to £25,000	67	42	**109**	126	101	**227**
£25,001 to £50,000	57	46	**103**	78	147	**225**
£50,001 to £100,000	51	31	**82**	68	76	**144**
£100,001 to £150,000	18	22	**40**	21	26	**47**
£150,001 to £200,000	14	7	**21**	16	19	**35**
Over £200,001	6	4	**10**	24	20	**44**
Total	**251**	**160**	**411**	**411**	**429**	**840**
Total cost (£000)	**13,203**	**9,572**	**22,775**	**21,666**	**24,406**	**46,072**

Consolidated Group

	2015/16			2014/15		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	51	24	**75**	86	48	**134**
£10,001 to £25,000	90	56	**146**	142	116	**258**
£25,001 to £50,000	64	51	**115**	94	155	**249**
£50,001 to £100,000	56	35	**91**	80	90	**170**
£100,001 to £150,000	20	22	**42**	28	30	**58**
£150,001 to £200,000	14	9	**23**	20	19	**39**
Over £200,001	6	4	**10**	29	20	**49**
Total	**301**	**201**	**502**	**479**	**478**	**957**
Total cost (£000)	**14,543**	**10,630**	**25,173**	**26,118**	**26,350**	**52,468**

Parent

	2015/16		2014/15	
	Other agreed departures		Other agreed departures	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	156	9,440	429	24,406
Contractual payments in lieu of notice	3	37	-	-
Exit payments following employment tribunals or court orders	1	95	-	-
Total	**160**	**9,572**	**429**	**24,406**

Consolidated Group

	2015/16		2014/15	
	Other agreed departures		Other agreed departures	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	160	9,681	450	25,527
Mutually agreed resignations (MARS) contractual costs	1	170	-	-
Early retirements in the efficiency of the service contractual costs	-	-	1	11
Contractual payments in lieu of notice	36	648	26	803
Exit payments following employment tribunals or court orders	2	97	1	9
Non-contractual payments requiring HMT approval	2	34	-	-
Total	**201**	**10,630**	**478**	**26,350**

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, which will be the number of individuals.

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 the 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 CCGs 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.

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

3.4 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these is given overleaf:

3.4.1 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS19, 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

3.4.2 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 upon 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 HM Revenue & Customs (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 twelve months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).
- 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 NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

3.4.3 Local Government Pension Scheme

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 CCG's published accounts.

3.4.4 Principal Civil Service Pension Scheme

The Principal Civil Service Pension Scheme is an unfunded multi-employer defined benefit scheme. As such, NHS England is unable to identify its share of the underlying assets and liabilities. The scheme actuary valued the scheme as at 31 March 2012. Details can be found in the Annual Report and Accounts of the Cabinet Office: Civil Superannuation on the Civil Service website.

The scheme actuary reviews employer contributions usually every four years following a full scheme valuation.

The contribution rates are set to meet the cost of the benefits accruing during the financial year to be paid when the member retires and not the benefits paid during this period to existing pensioners.

4. Operating expenses

Parent

	2015/16			2014/15		
	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000
Other costs						
Services from CCGs	423	50,444	**50,867**	3,913	73,071	**76,984**
Services from Foundation Trusts	277	10,292,322	**10,292,599**	842	9,624,137	**9,624,979**
Services from other NHS Trusts	238	5,242,277	**5,242,515**	677	5,970,603	**5,971,280**
Services from other NHS bodies*	14	5,739	**5,753**	472	28,978	**29,450**
Purchase of healthcare from non-NHS bodies**	-	1,118,429	**1,118,429**	-	2,277,953	**2,277,953**
General dental services and personal dental services	-	3,314,086	**3,314,086**	-	3,113,516	**3,113,516**
Prescribing costs	-	158	**158**	-	3,024	**3,024**
Pharmaceutical services	-	2,094,255	**2,094,255**	-	2,121,624	**2,121,624**
General ophthalmic services	-	534,857	**534,857**	-	523,299	**523,299**
Primary care services***	38	5,263,421	**5,263,459**	60	7,264,373	**7,264,433**
Supplies and services – clinical	685	87,103	**87,788**	562	73,794	**74,356**
Supplies and services – general	90,456	582,786	**673,242**	48,264	335,299	**383,563**
Chair and lay membership body and governing body members	133	-	**133**	169	-	**169**
Consultancy services	10,762	14,289	**25,051**	30,080	13,826	**43,906**
Establishment	105,209	83,306	**188,515**	104,743	94,023	**198,766**
Transport	8,316	2,869	**11,185**	8,455	2,388	**10,843**
Premises	66,594	112,032	**178,626**	69,301	147,106	**216,407**
Audit fees	335	-	**335**	355	-	**355**
Other non statutory audit expenditure	1,095	3	**1,098**	-	-	**-**
Other professional fees excl. services provided by audit	15,182	35,576	**50,758**	19,054	24,941	**43,995**
Grants to other public bodies	7,767	48,797	**56,564**	31,451	200	**31,651**
Clinical negligence	37	21	**58**	51	-	**51**
Research and development (excluding staff costs)	497	189	**686**	846	1,915	**2,761**
Education and training	9,382	106,587	**115,969**	10,422	99,326	**109,748**
Funding to group bodies	1,139,837	71,072,722	**72,212,559**	1,289,472	65,396,012	**66,685,484**
Other expenditure	732	14,345	**15,077**	513	1,930	**2,443**
Total operating expenses - cash	**1,458,009**	**100,076,613**	**101,534,622**	**1,619,702**	**97,191,338**	**98,811,040**
Operating expenditure - non cash						
Impairments and reversals of receivables	601	208	**809**	467	10,675	**11,142**
Inventories written down	83	-	**83**	-	88	**88**
Depreciation	23,359	41,175	**64,534**	13,215	28,814	**42,029**
Amortisation	4,084	604	**4,688**	4,865	562	**5,427**
Impairments and reversals of property, plant and equipment	-	-	**-**	15,766	1,911	**17,677**
Impairments and reversals of intangible assets	-	-	**-**	531	2	**533**
Change in discount rate	2	382	**384**	-	(12,298)	**(12,298)**
Provisions	(968)	(143,612)	**(144,580)**	13,642	(98,605)	**(84,963)**
Other expenditure****	-	-	**-**	-	(4,021)	**(4,021)**
Total operating expenses - non cash	**27,161**	**(101,243)**	**(74,082)**	**48,486**	**(72,872)**	**(24,386)**
Total operating expenses	**1,485,170**	**99,975,370**	**101,460,540**	**1,668,188**	**97,118,466**	**98,786,654**

Administration expenditure is cost incurred that is not a direct payment for the provision of healthcare or healthcare services.

Funding to group bodies is shown above and represents cash funding drawn down by the CCGs. These balances are eliminated on consolidation.

Provision costs have been reduced in 2014/15 and 2015/16 by the ongoing reassessment of required provision values, particularly for legacy Continuing Healthcare. See note 14 for further details.

Parent expenditure figures may be greater than those of the consolidated group due to the elimination of intra-group trading.

*Services from other NHS bodies comprises expenditure from the DH and other am's length bodies.

** Funding of £1,278million relating to the purchase of healthcare from independent providers within purchase of healthcare non-NHS bodies has been transferred to CCGs in 2015/16 for the Better Care Fund.

*** There is a significant fall in primary care expenditure in 2015/16 due to the switch in budget from NHS England to those CCGs who have taken delegated commissioning responsibilities.

****Other non-cash expenditure relates to the release of legacy creditors.

Consolidated Group

	2015/16			2014/15		
	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000
Other costs						
Services from Foundation Trusts	5,064	39,251,449	**39,256,513**	5,005	36,847,583	**36,852,588**
Services from other NHS Trusts	3,518	23,887,705	**23,891,223**	4,177	25,680,878	**25,685,055**
Services from other NHS bodies	37	11,163	**11,200**	494	32,959	**33,453**
Purchase of healthcare from non-NHS bodies	-	12,552,868	**12,552,868**	-	11,577,570	**11,577,570**
General dental services and personal dental services	-	3,313,160	**3,313,160**	-	3,114,073	**3,114,073**
Prescribing costs	-	8,557,135	**8,557,135**	-	8,216,012	**8,216,012**
Pharmaceutical services	-	2,105,899	**2,105,899**	-	2,132,112	**2,132,112**
General ophthalmic services	-	542,339	**542,339**	-	527,709	**527,709**
Primary care services	1,187	7,796,707	**7,797,894**	3,022	7,683,683	**7,686,705**
Supplies and services – clinical	698	176,018	**176,716**	564	165,905	**166,469**
Supplies and services – general	113,950	1,002,835	**1,116,785**	77,517	522,111	**599,628**
Chair and lay membership body and governing body members	48,955	1,223	**50,178**	51,788	878	**52,666**
Consultancy services	34,079	78,885	**112,964**	64,454	93,460	**157,914**
Establishment	153,710	179,733	**333,443**	154,311	183,025	**337,336**
Transport	9,715	14,722	**24,437**	9,783	13,634	**23,417**
Premises	122,686	288,500	**411,186**	129,747	325,313	**455,060**
Audit fees	13,995	23	**14,018**	18,306	26	**18,332**
Other non statutory audit expenditure	3,345	67	**3,412**	2,791	103	**2,894**
Other professional fees excl. services provided by audit	43,529	62,432	**105,961**	52,635	42,312	**94,947**
Grants to other public bodies	7,777	100,882	**108,659**	31,736	53,060	**84,796**
Clinical negligence	328	45	**373**	367	24	**391**
Research and development (excluding staff costs)	898	12,502	**13,400**	1,908	12,045	**13,953**
Education and training	23,028	119,367	**142,395**	24,025	111,400	**135,425**
Other expenditure	2,097	40,988	**43,085**	1,752	24,139	**25,891**
Total operating expenses - cash	**588,596**	**100,096,647**	**100,685,243**	**634,382**	**97,360,014**	**97,994,396**
Operating expenditure - non cash						
Impairments and reversals of receivables	1,007	8,987	**9,994**	868	12,379	**13,247**
Inventories written down	83	2,788	**2,871**	-	88	**88**
Depreciation	28,389	45,406	**73,795**	17,181	31,698	**48,879**
Amortisation	4,230	1,225	**5,455**	5,081	1,070	**6,151**
Impairments and reversals of property, plant and equipment	119	217	**336**	15,827	2,771	**18,598**
Impairments and reversals of intangible assets	-	-	**-**	531	2	**533**
Change in discount rate	2	339	**341**	(2)	(12,233)	**(12,235)**
Provisions	1,112	(125,459)	**(124,347)**	15,601	(70,605)	**(55,004)**
Other expenditure*	-	-	**-**	-	(4,021)	**(4,021)**
Total operating expenses - non cash	**34,942**	**(66,497)**	**(31,555)**	**55,087**	**(38,851)**	**16,236**
Total operating expenses	**623,538**	**100,030,150**	**100,653,688**	**689,469**	**97,321,163**	**98,010,632**

Administration expenditure is cost incurred that is not a direct payment for the provision of healthcare or healthcare services.
Parent expenditure figures may be greater than those of the consolidated group due to the elimination of intra-group trading.

*Other non-cash expenditure relates to the release of legacy creditors.

5. Operating Leases

5.1 As lessee

The group has arrangements in place with NHS Property Services Ltd (NHSPS) and Community Health Partnerships Ltd in respect of the utilisation of various clinical and non-clinical properties. These largely relate to payments made in respect of void space in clinical properties, as well as for accommodation costs.

Although formal signed leases are not typically in place for these properties, the transactions involved do convey the right of the group to use property assets. The group has considered the substance of these arrangements under IFRIC4 'Determining whether an arrangement contains a lease' and determined that the arrangements are (or contain) leases. Work is ongoing with NHSPS to determine the future minimum lease payments.

Accordingly the payments made in 2015/16 and 2014/15 are disclosed as minimum lease payments in the buildings category in note 5.1.1. However in the absence of formal contracts it is not possible to confirm minimum lease payments for future years and hence no disclosure is made for these buildings in note 5.1.2. It is expected that the payments recognised in 2015/16 would continue to be minimum lease payments in 2016/17.

The group does not act as a lessor.

5.1.1 Payments recognised as an expense

Parent

	2015/16			2014/15		
	Buildings	Other	Total	Buildings	Other	Total
	£000	£000	£000	£000	£000	£000
Payments recognised as an expense						
Minimum lease payments	153,732	1,477	**155,209**	118,870	1,735	**120,605**
Total	**153,732**	**1,477**	**155,209**	**118,870**	**1,735**	**120,605**

Consolidated Group

Payments recognised as an expense						
Minimum lease payments	347,592	3,846	**351,438**	318,005	3,845	**321,850**
Contingent rents	-	34	**34**	-	32	**32**
Total	**347,592**	**3,880**	**351,472**	**318,005**	**3,877**	**321,882**

5.1.2 Future minimum lease payments

Parent

	2015/16			2014/15		
	Buildings	Other	Total	Buildings	Other	Total
	£000	£000	£000	£000	£000	£000
Payable:						
No later than one year	14,107	1,071	**15,178**	102,218	1,839	**104,057**
Between one and five years	33,042	2,459	**35,501**	7,436	2,110	**9,546**
After five years	108	365	**473**	6,623	-	**6,623**
Total	**47,257**	**3,895**	**51,152**	**116,277**	**3,949**	**120,226**

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Payable:						
No later than one year	25,267	2,232	**27,499**	112,326	3,260	**115,586**
Between one and five years	65,014	3,933	**68,947**	33,409	4,459	**37,868**
After five years	27,652	385	**28,037**	26,593	225	**26,818**
Total	**117,933**	**6,550**	**124,483**	**172,328**	**7,944**	**180,272**

6. Property, plant and equipment

Parent 2015/16	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 2015	**18,083**	**895**	**5,164**	**32**	**251,864**	**1,429**	**277,467**
Addition of assets under construction and payments on account	-	296	-	-	-	-	**296**
Additions purchased	7	-	165	-	73,827	1,266	**75,265**
Reclassifications	-	(744)	(337)	-	(1,933)	972	**(2,042)**
Disposals	(6,063)	-	(588)	-	(7,434)	(88)	**(14,173)**
Cost or valuation at 31 March 2016	**12,027**	**447**	**4,404**	**32**	**316,324**	**3,579**	**336,813**
Depreciation at 1 April 2015	**14,321**	**-**	**3,764**	**5**	**62,474**	**296**	**80,860**
Reclassifications	-	-	(122)	4	(27)	120	**(25)**
Disposals	(6,065)	-	(588)	-	(7,248)	(88)	**(13,989)**
Charged during the year	2,265	-	591	4	61,019	655	**64,534**
At 31 March 2016	**10,521**	**-**	**3,645**	**13**	**116,218**	**983**	**131,380**
Net Book Value at 31 March 2016	**1,506**	**447**	**759**	**19**	**200,106**	**2,596**	**205,433**
Purchased	1,506	447	759	19	200,106	2,596	**205,433**
Total at 31 March 2016	**1,506**	**447**	**759**	**19**	**200,106**	**2,596**	**205,433**
Asset financing:							
Owned	-	447	304	19	200,106	2,596	**203,472**
Held on finance lease	1,506	-	455	-	-	-	**1,961**
Total at 31 March 2016	**1,506**	**447**	**759**	**19**	**200,106**	**2,596**	**205,433**

Revaluation reserve balance for property, plant and equipment	Buildings	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
Balance as at 1 April 2015 and 31 March 2016	**-**	**-**	**-**	**-**	**7**	**12**	**19**

Parent 2014/15

	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 2014	**19,969**	**6,307**	**4,963**	**32**	**174,615**	**1,286**	**207,172**
Addition of assets under construction and payments on account	-	744	-	-	-	-	**744**
Additions purchased	-	-	262	-	97,688	1,416	**99,366**
Reclassifications	-	(6,156)	-	-	3,585	(20)	**(2,591)**
Disposals	-	-	-	-	(9,431)	(116)	**(9,547)**
Impairments charged	(1,886)	-	(61)	-	(14,593)	(1,137)	**(17,677)**
Cost or valuation at 31 March 2015	**18,083**	**895**	**5,164**	**32**	**251,864**	**1,429**	**277,467**
Depreciation at 1 April 2014	**9,092**	**-**	**2,483**	**5**	**34,092**	**320**	**45,992**
Disposals	-	-	-	-	(7,045)	(116)	**(7,161)**
Charged during the year	5,229	-	1,281	-	35,427	92	**42,029**
At 31 March 2015	**14,321**	**-**	**3,764**	**5**	**62,474**	**296**	**80,860**
Net book value at 31 March 2015	**3,762**	**895**	**1,400**	**27**	**189,390**	**1,133**	**196,607**
Purchased	3,762	895	1,400	27	189,390	1,133	**196,607**
Total at 31 March 2015	**3,762**	**895**	**1,400**	**27**	**189,390**	**1,133**	**196,607**
Asset financing:							
Owned	-	895	411	27	189,390	1,133	**191,856**
Held on finance lease	3,762	-	989	-	-	-	**4,751**
Total at 31 March 2015	**3,762**	**895**	**1,400**	**27**	**189,390**	**1,133**	**196,607**

Revaluation reserve balance for property, plant and equipment	Buildings	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
Balance at 1 April 2014	**140**	**-**	**-**	**-**	**7**	**12**	**159**
Release to general fund	(140)	-	-	-	-	-	**(140)**
At 31 March 2015	**-**	**-**	**-**	**-**	**7**	**12**	**19**

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	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 2015	**18,329**	**2,787**	**19,675**	**151**	**278,352**	**8,422**	**327,716**
Addition of assets under construction and payments on account	-	2,324	-	-	-	-	**2,324**
Additions purchased	167	-	2,038	-	83,515	2,832	**88,552**
Reclassifications	1,012	(2,636)	(337)	-	(1,053)	972	**(2,042)**
Disposals	(6,063)	-	(750)	-	(7,739)	(165)	**(14,717)**
Impairments charged	(4)	-	-	-	(238)	(94)	**(336)**
Cost or valuation at 31 March 2016	**13,441**	**2,475**	**20,626**	**151**	**352,837**	**11,967**	**401,497**
Depreciation at 1 April 2015	**14,358**	**-**	**7,283**	**67**	**72,192**	**2,157**	**96,057**
Reclassifications	-	-	(122)	4	(27)	120	**(25)**
Disposals	(6,065)	-	(750)	-	(7,550)	(165)	**(14,530)**
Charged during the year	2,320	-	2,735	33	66,945	1,762	**73,795**
At 31 March 2016	**10,613**	**-**	**9,146**	**104**	**131,560**	**3,874**	**155,297**
Net Book Value at 31 March 2016	**2,828**	**2,475**	**11,480**	**47**	**221,277**	**8,093**	**246,200**
Asset financing:							
Owned - purchased	-	2,475	10,003	47	221,277	8,093	**241,895**
Held on finance lease	2,828	-	1,477	-	-	-	**4,305**
Total at 31 March 2016	**2,828**	**2,475**	**11,480**	**47**	**221,277**	**8,093**	**246,200**

Revaluation reserve balance for property, plant and equipment	Buildings	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
Balance at 1 April 2015	**-**	**-**	**148**	**-**	**6**	**-**	**154**
Release to general fund	-	-	(19)	-	-	(4)	**(23)**
Other movements	-	-	(34)	-	11	24	**1**
At 31 March 2016	**-**	**-**	**95**	**-**	**17**	**20**	**132**

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	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 2014	**21,253**	**6,964**	**14,716**	**151**	**190,657**	**5,093**	**238,834**
Addition of assets under construction and payments on account	-	2,604	-	-	-	-	**2,604**
Additions purchased	66	-	4,056	-	109,421	4,056	**117,599**
Reclassifications	(1,097)	(6,781)	1,144	-	3,448	695	**(2,591)**
Disposals	(7)	-	(4)	-	(10,162)	(138)	**(10,311)**
Impairments charged	(1,886)	-	(237)	-	(15,028)	(1,284)	**(18,435)**
Reversal of impairments	-	-	-	-	16	-	**16**
Cost or valuation at 31 March 2015	**18,329**	**2,787**	**19,675**	**151**	**278,352**	**8,422**	**327,716**
Depreciation at 1 April 2014	**9,179**	**-**	**4,367**	**36**	**39,927**	**1,376**	**54,885**
Reclassifications	(58)	-	65	-	(27)	20	**-**
Disposals	(7)	-	(4)	-	(7,751)	(125)	**(7,887)**
Impairments charged	-	-	(39)	-	220	(1)	**180**
Charged during the year	5,244	-	2,894	31	39,823	887	**48,879**
At 31 March 2015	**14,358**	**0**	**7,283**	**67**	**72,192**	**2,157**	**96,057**
Net book value at 31 March 2015	**3,971**	**2,787**	**12,392**	**84**	**206,160**	**6,265**	**231,659**
Purchased	3,971	2,787	12,392	84	206,160	6,265	**231,659**
Total at 31 March 2015	**3,971**	**2,787**	**12,392**	**84**	**206,160**	**6,265**	**231,659**
Asset financing:							
Owned - purchased	171	2,787	10,297	84	206,160	6,265	**225,764**
Held on finance lease	3,800	-	2,095	-	-	-	**5,895**
Total at 31 March 2015	**3,971**	**2,787**	**12,392**	**84**	**206,160**	**6,265**	**231,659**

Revaluation reserve balance for property, plant and equipment	Buildings	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
Balance at 1 April 2014	**140**	**-**	**148**	**1**	**7**	**36**	**332**
Impairments	-	-	-	(1)	(1)	(36)	**(38)**
Release to general fund	(140)	-	-	-	-	-	**(140)**
At 31 March 2015	**-**	**-**	**148**	**-**	**6**	**-**	**154**

7. Intangible non-current assets

Parent 2015/16	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2015	**13,205**	**8**	**349**	**13,562**
Additions purchased	7,764	-	1,544	**9,308**
Reclassifications	2,043	-	-	**2,043**
Disposals	(2,486)	-	-	**(2,486)**
At 31 March 2016	**20,526**	**8**	**1,893**	**22,427**
Amortisation 1 April 2015	**7,292**	**8**	**38**	**7,338**
Reclassifications	25	-	-	**25**
Disposals	(2,486)	-	-	**(2,486)**
Charged during the year	4,377	-	311	**4,688**
At 31 March 2016	**9,208**	**8**	**349**	**9,565**
Net book value at 31 March 2016	**11,318**	**-**	**1,544**	**12,862**
Asset financing				
Owned	11,318	-	1,544	**12,862**
Total at 31 March 2016	**11,318**	**-**	**1,544**	**12,862**

Revaluation reserve balance for intangible assets	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Balance at 1 April 2015	**5**	**-**	**-**	**5**
At 31 March 2016	**5**	**-**	**-**	**5**

Parent 2014/15	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2014	**9,828**	**42**	**-**	**9,870**
Additions purchased	1,410	-	349	**1,759**
Reclassifications	2,625	(34)	-	**2,591**
Disposals	(125)	-	-	**(125)**
Impairments charged	(533)	-	-	**(533)**
At 31 March 2015	**13,205**	**8**	**349**	**13,562**
Amortisation at 1 April 2014	**2,005**	**5**	**-**	**2,010**
Disposals	(99)	-	-	**(99)**
Charged during the year	5,386	3	38	**5,427**
At 31 March 2015	**7,292**	**8**	**38**	**7,338**
Net book value at 31 March 2015	**5,913**	**-**	**311**	**6,224**
Asset financing				
Owned	5,913	-	311	**6,224**
Total at 31 March 2015	**5,913**	**-**	**311**	**6,224**

Revaluation reserve balance for intangible assets	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Balance at 1 April 2014	**5**	**-**	**-**	**5**
At 31 March 2015	**5**	**-**	**-**	**5**

Consolidated Group 2015/16

	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2015	**17,175**	**8**	**1,398**	**18,581**
Additions purchased	9,459	-	2,719	**12,178**
Reclassifications	2,043	-	-	**2,043**
Disposals	(2,509)	-	-	**(2,509)**
At 31 March 2016	**26,168**	**8**	**4,117**	**30,293**
Amortisation 1 April 2015	**8,048**	**8**	**676**	**8,732**
Reclassifications	25	-	-	**25**
Disposals	(2,509)	-	-	**(2,509)**
Charged during the year	4,863	-	592	**5,455**
At 31 March 2016	**10,427**	**8**	**1,268**	**11,703**
Net book value at 31 March 2016	**15,741**	**-**	**2,849**	**18,590**
Asset financing				
Owned	15,741	-	2,849	**18,590**
Total at 31 March 2016	**15,741**	**-**	**2,849**	**18,590**

Revaluation reserve balance for intangible assets	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Balance at 1 April 2015	**5**	**-**	**-**	**5**
At 31 March 2016	**5**	**-**	**-**	**5**

Consolidated Group 2014/15	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Cost or Valuation at 1 April 2014	**10,858**	**96**	**629**	**11,583**
Additions purchased	4,394	-	769	**5,163**
Reclassifications	2,679	(88)	-	**2,591**
Disposals	(223)	-	-	**(223)**
Impairments charged	(533)	-	-	**(533)**
Cost or Valuation at 31 March 2015	**17,175**	**8**	**1,398**	**18,581**
Amortisation at 1 April 2014	**2,437**	**38**	**303**	**2,778**
Disposals	(197)	-	-	**(197)**
Charged during the year	5,808	(30)	373	**6,151**
Amortisation at 31 March 2015	**8,048**	**8**	**676**	**8,732**
Net book value at 31 March 2015	**9,127**	**-**	**722**	**9,849**
Asset financing				
Owned	9,127	-	722	**9,849**
Total at 31 March 2015	**9,127**	**-**	**722**	**9,849**

Revaluation reserve balance for intangible assets	Computer software: purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Balance at 1 April 2014	**5**	**-**	**-**	**5**
At 31 March 2015	**5**	**-**	**-**	**5**

8. Inventories

Parent 2015/16

	Consumables	Loan equipment	Other	Total
	£000	£000	£000	£000
Balance at 1 April 2015	**13**	**-**	**165**	**178**
Additions	11	-	44	**55**
Inventories recognised as an expense in the period	-	-	(83)	**(83)**
At 31 March 2016	**24**	**-**	**126**	**150**

Parent 2014/15

	Consumables	Loan equipment	Other	Total
	£000	£000	£000	£000
Balance at 1 April 2014	**103**	**-**	**351**	**454**
Additions	-	-	77	**77**
Inventories recognised as an expense in the period	(13)	-	(252)	**(265)**
Write-down of inventories (including losses)	(77)	-	(11)	**(88)**
At 31 March 2015	**13**	**-**	**165**	**178**

Consolidated Group 2015/16

	Consumables	Loan equipment	Other	Total
	£000	£000	£000	£000
Balance at 1 April 2015	**317**	**-**	**1,927**	**2,244**
Additions	806	562	4,496	**5,864**
Inventories recognised as an expense in the period	-	-	(2,871)	**(2,871)**
At 31 March 2016	**1,123**	**562**	**3,552**	**5,237**

Consolidated Group 2014/15

	Consumables	Loan equipment	Other	Total
	£000	£000	£000	£000
Balance at 1 April 2014	**290**	**-**	**1,425**	**1,715**
Additions	1,205	-	2,842	**4,047**
Inventories recognised as an expense in the period	(1,101)	-	(2,329)	**(3,430)**
Write-down of inventories (including losses)	(77)	-	(11)	**(88)**
At 31 March 2015	**317**	**-**	**1,927**	**2,244**

9. Trade and other receivables

	Parent				Consolidated Group			
	Current	Non-current	Restated current	Restated non-current	Current	Non-current	Restated current	Restated non-current
	2015/16	2015/16	2014/15	2014/15	2015/16	2015/16	2014/15	2014/15
	£000	£000	£000	£000	£000	£000	£000	£000
NHS receivables: revenue	48,686	-	39,516	-	107,199	-	87,810	-
NHS prepayments*	1,969	-	1,596	-	182,696	-	167,793	-
NHS accrued income*	18,586	-	6,382	-	57,888	-	61,501	-
Non-NHS receivables: Revenue	111,978	-	87,156	-	281,513	-	237,034	-
Non-NHS prepayments*	74,845	-	71,587	964	124,399	179	121,197	1,143
Non-NHS accrued income*	16,080	-	26,178	-	94,716	-	82,714	-
Provision for the impairment of receivables	(13,373)	-	(12,476)	-	(29,780)	-	(22,822)	-
VAT	9,249	-	9,578	-	19,172	-	18,923	-
Other receivables	1,713	-	1,371	3,079	15,584	-	12,716	3,079
Total	**269,733**	**-**	**230,888**	**4,043**	**853,387**	**179**	**766,866**	**4,222**
Total current and non-current	**269,733**		**234,931**		**853,566**		**771,088**	

* In 2015/16 a further breakdown of prepayments and accrued income has been provided.
The comparatives for 2014/15 have been restated to split this balance.

9.1 Other non-current financial assets

	Parent				Consolidated Group			
	Current	Non-current	Current	Non-current	Current	Non-current	Current	Non-current
	2015/16	2015/16	2014/15	2014/15	2015/16	2015/16	2014/15	2014/15
	£000	£000	£000	£000	£000	£000	£000	£000
Loan to other bodies (Section 96 NHS Act 2006)	-	278	-	-	-	278	-	-
Total	**-**	**278**	**-**	**-**	**-**	**278**	**-**	**-**

10. Cash and cash equivalents

	Parent		Consolidated Group	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Balance at 1 April 2015	129,479	391,990	140,486	420,921
Net change in year	132,261	(262,511)	137,685	(280,435)
Balance at 31 March 2016	**261,740**	**129,479**	**278,171**	**140,486**
Made up of:				
Cash with the Government Banking Service	162,759	67,084	183,936	81,321
Hosted cash/cash in hand	98,981	62,395	99,607	68,724
Cash and cash equivalents as in statement of financial position	**261,740**	**129,479**	**283,543**	**150,045**
Bank overdraft: Government Banking Service	-	-	(5,372)	(9,559)
Total bank overdrafts	**-**	**-**	**(5,372)**	**(9,559)**
Balance at 31 March 2016	**261,740**	**129,479**	**278,171**	**140,486**

For details of bank overdraft see note 12.

Included within hosted cash/cash in hand above is £98.9million (2014/15: £62.39million) held on behalf of NHS England by the NHS Business Services Authority.

11. Trade and other payables

	Parent				Consolidated Group			
	Current	Non-current	Restated Current	Restated Non-current	Current	Non-current	Restated Current	Restated Non-current
	2015/16	2015/16	2014/15	2014/15	2015/16	2015/16	2014/15	2014/15
	£000	£000	£000	£000	£000	£000	£000	£000
NHS payables: revenue	520,136	-	570,212	-	1,260,410	-	1,326,756	-
NHS payables: capital	482	-	1,372	-	884	-	156	-
NHS accruals*	242,516	-	117,668	-	742,649	-	638,546	-
NHS deferred income*	955	-	857	-	200	-	91	-
Non-NHS payables: revenue	243,082	2,440	416,138	2,440	1,048,435	2,440	1,044,847	2,440
Non-NHS payables: capital	4,952	-	6,056	-	9,364	-	11,214	-
Non-NHS accruals*	1,215,237	-	1,257,197	-	3,742,406	-	3,520,302	-
Non-NHS deferred income*	4,545	-	4,640	128	11,947	580	12,530	709
Social security costs	5,869	-	6,897	-	15,297	-	14,580	-
VAT	-	-	-	-	290	-	-	-
Tax	6,237	-	7,553	-	15,860	-	15,641	-
Payments received on account	108	-	24	-	288	-	560	-
Other payables	265,530	-	195,416	-	403,634	2,357	325,743	5,745
Total	**2,509,649**	**2,440**	**2,584,030**	**2,568**	**7,251,664**	**5,377**	**6,910,966**	**8,894**
Total payables (current and non-current)	**2,512,089**		**2,586,598**		**7,257,041**		**6,919,860**	

* In 2015/16 a further breakdown of accruals and deferred income has been provided.

The comparatives for 2014/15 have been restated to split this balance.

12. Borrowings

	Parent				Consolidated Group			
	Current	Non-current	Restated current	Restated non-current	Current	Non-current	Restated current	Restated non-current
	2015/16	2015/16	2014/15	2014/15	2015/16	2015/16	2014/15	2014/15
	£000	£000	£000	£000	£000	£000	£000	£000
Bank overdrafts								
Government Banking Service	-	-	-	-	5,372	-	9,559	-
Total overdrafts	**-**	**-**	**-**	**-**	**5,372**	**-**	**9,559**	**-**
Finance lease liabilities	**10,523**	**-**	**5,921**	**10,523**	**10,643**	**1,085**	**6,046**	**11,683**
Total	**10,523**	**-**	**5,921**	**10,523**	**16,015**	**1,085**	**15,605**	**11,683**
Total current and non-current	**10,523**		**16,444**		**17,100**		**27,288**	

12.1 Repayment of principal falling due

	Parent				Consolidated Group			
	Department of Health	Other	Total	Total	Department of Health	Other	Total	Total
	2015/16	2015/16	2015/16	2014/15	2015/16	2015/16	2015/16	2014/15
	£000	£000	£000	£000	£000	£000	£000	£000
Within one year	-	10,523	10,523	5,921	-	16,015	16,015	15,605
Between one and five years	-	-	-	10,523	-	443	443	11,022
After five years	-	-	-	-	-	642	642	661
Total	**-**	**10,523**	**10,523**	**16,444**	**-**	**17,100**	**17,100**	**27,288**

13. Finance costs

	Parent		Consolidated Group	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Interest				
Interest on obligations under finance leases	569	1,189	614	1,236
Interest on late payment of commercial debt	-	1	15	15
Other interest expense	-	-	2	-
Total interest	**569**	**1,190**	**631**	**1,251**
Other finance costs*	61	-	61	-
Provisions: unwinding of discount	(12,217)	3,009	(12,092)	3,012
Total finance costs	**(11,587)**	**4,199**	**(11,400)**	**4,263**

* The NHS England Parent has issued a loan under the provisions of S96 NHS Act 2006 in 2015/16.

14. Provisions

Parent	Current	Non-current	Current	Non-current
	2015/16	2015/16	2014/15	2014/15
	£000	£000	£000	£000
Restructuring	317	223	1,062	223
Redundancy	6,956	-	9,506	-
Equal pay	-	-	25	-
Legal claims	1,267	428	1,519	428
Continuing care	278,345	80,653	276,435	328,860
Other	17,845	26,049	23,935	25,324
Total	**304,730**	**107,353**	**312,482**	**354,835**
Total current and non-current	**412,083**		**667,317**	

	Pensions relating to other staff	Restructuring	Redundancy	Equal pay	Legal claims	Continuing Care	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2015	**-**	**1,285**	**9,506**	**25**	**1,947**	**605,295**	**49,259**	**667,317**
Arising during the year	-	-	5,219	-	1,230	33,689	2,263	**42,401**
Utilised during the year	-	(580)	(4,573)	(25)	(174)	(91,684)	(1,785)	**(98,821)**
Reversed unused	-	(154)	(3,193)	-	(1,323)	(175,293)	(7,018)	**(186,981)**
Unwinding of discount	-	(11)	(2)	-	12	(13,368)	1,152	**(12,217)**
Change in discount rate	-	-	-	-	2	359	23	**384**
Balance at 31 March 2016	**-**	**540**	**6,957**	**-**	**1,694**	**358,998**	**43,894**	**412,083**
Expected timing of cash flows								
Within one year	-	317	6,956	-	1,267	278,345	17,845	**304,730**
Between one and five years	-	131	-	-	428	80,653	16,014	**97,226**
After five years	-	92	-	-	-	-	10,035	**10,127**
Balance at 31 March 2016	**-**	**540**	**6,956**	**-**	**1,695**	**358,998**	**43,894**	**412,083**

Consolidated Group

	Current	Non-current	Current	Non-current
	2015/16	2015/16	2014/15	2014/15
	£000	£000	£000	£000
Pensions relating to other staff	-	-	77	-
Restructuring	3,028	244	3,659	223
Redundancy	7,348	-	10,156	-
Equal pay	-	-	25	-
Legal claims	1,443	446	1,578	446
Continuing care	321,890	86,770	316,593	341,080
Other	43,287	29,647	47,089	27,137
Total	**376,996**	**117,107**	**379,177**	**368,886**
Total current and non-current	**494,103**		**748,063**	

	Pensions relating to other staff	Restructuring	Redundancy	Equal pay	Legal claims	Continuing Care	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2015	**77**	**3,882**	**10,156**	**25**	**2,024**	**657,673**	**74,226**	**748,063**
Arising during the year	-	979	5,719	-	1,407	65,675	21,927	**95,707**
Utilised during the year	(1)	(813)	(5,015)	(25)	(191)	(101,184)	(10,633)	**(117,862)**
Reversed unused	(76)	(765)	(3,510)	-	(1,365)	(200,557)	(13,781)	**(220,054)**
Unwinding of discount	-	(11)	(2)	-	12	(13,241)	1,150	**(12,092)**
Change in discount rate	-	-	-	-	2	294	45	**341**
Balance at 31 March 2016	**-**	**3,272**	**7,348**	**-**	**1,889**	**408,660**	**72,934**	**494,103**
Expected timing of cash flows								
Within one year	-	3,028	7,348	-	1,443	321,890	43,287	**376,996**
Between one and five years	-	152	-	-	446	86,770	19,460	**106,828**
After five years	-	92	-	-	-	-	10,187	**10,279**
Balance at 31 March 2016	**-**	**3,272**	**7,348**	**-**	**1,889**	**408,660**	**72,934**	**494,103**

The NHS Litigation Authority financial statements disclose a provision of £66,589,000 as at 31 March 2016 in respect of clinical negligence liabilities of NHS England (31 March 2015: £49,054,000).

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.

"Other" provisions include miscellaneous provisions inherited under the Health and Social Care Reforms (April 2012) including onerous contracts, property related provisions and dilapidations.

15. Contingencies

	Parent		Consolidated Group	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Contingent liabilities				
Employment tribunal	1,157	300	1,157	300
NHSLA employee liability claim	15	-	24	2
Continuing Healthcare	-	-	16,631	16,338
Contractual dispute	-	-	370	2,400
Employee pension	600	-	600	-
Her Majesty's Revenue and Customs	-	-	42	-
Learning disabilities disputed cases	-	-	-	457
Legal claim	8,051	2,388	8,073	2,402
NHS Property Services Ltd	-	-	3,270	2,963
NHSLA - LTPS	-	21	-	21
Older People Sec 117 recharges	-	-	1,320	-
Other employee related litigation	1,955	-	1,955	5
Retrospective social care claims	-	-	-	710
Service transformation costs	-	-	-	466
The Princess Alexandra NHS Trust	-	-	1,000	-
Under-utilised property lease liabilities	-	-	-	336
Net value of contingent liabilities	**11,778**	**2,709**	**34,442**	**26,400**

	Parent		Consolidated Group	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Contingent assets				
Legal claims	1,015	917	1,015	917
NHS Property Services Ltd	-	-	-	1,408
Net value of contingent assets	**1,015**	**917**	**1,015**	**2,325**

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.

16. Commitments

16.1 Capital commitments

	Parent		Consolidated Group	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Property, plant and equipment	332	-	429	10
Intangible assets	-	-	-	66
Total	**332**	**-**	**429**	**76**

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	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
In not more than one year	80,368	82,523	165,778	141,859
In more than one year but not more than five years	371,819	23,403	563,988	69,367
In more than five years	219,796	-	321,811	26,144
Total	**671,983**	**105,926**	**1,051,577**	**237,370**

In the parent account the most significant contracts relate to:
a) contract with Capita for the delivery of administration services for primary care
b) PET Scanner contract with Alliance Medical.

In the group account the most significant contracts relate to:
a) contract with Virgin Healthcare for the delivery of community services in Staffordshire.

17. Risk management

17.1 Financial risk management

Financial reporting standard IFRS7 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.

HM 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 governing body. 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 are 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. The 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 2015/16	Clinical commissioning groups	Direct commissioning	NHS England	Other	Intra-group eliminations	NHS England group total
	£000	£000	£000	£000	£000	£000
Income	(1,037,148)	(1,543,667)	(50,957)	(912,178)	1,351,442	**(2,192,508)**
Gross expenditure	73,602,211	28,267,150	1,342,154	523,869	(1,351,442)	**102,383,942**
Total net expenditure	**72,565,063**	**26,723,483**	**1,291,197**	**(388,309)**	**-**	**100,191,434**
Revenue resource expenditure						
Revenue departmental expenditure limit						**100,372,452**
Annually managed expenditure						**(253,960)**
Technical expenditure						**72,942**
Net operating expenditure for the financial year						**100,191,434**
Reconciliation back to SoCNE						
Net operating expenditure for the financial year						**100,191,434**
Net loss on transfer by absorption						**-**
Net operating expenditure for the financial year including absorption losses						**100,191,434**

Consolidated Group 2014/15	Clinical commissioning groups	Direct commissioning	NHS England	Other	Intra-group eliminations	NHS England group total
	£000	£000	£000	£000	£000	£000
Income	(1,156,271)	(1,558,362)	(26,341)	(849,134)	1,434,200	**(2,155,908)**
Gross expenditure	68,073,434	30,933,696	1,402,938	766,054	(1,434,200)	**99,741,922**
Total net expenditure	**66,917,163**	**29,375,334**	**1,376,597**	**(83,080)**	**-**	**97,586,014**
Revenue resource expenditure						
Revenue departmental expenditure limit						**97,659,757**
Annually managed expenditure						**(137,591)**
Technical expenditure						**63,848**
Net operating expenditure for the financial year						**97,586,014**
Reconciliation back to SoCNE						
Net operating expenditure for the financial year						**97,586,014**
Net loss on transfer by absorption						**-**
Net operating expenditure for the financial year including absorption losses						**97,586,014**

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 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.

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 CSUs, social care, 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 IFRS8, does not form part of this disclosure.

19. Pooled budgets

CCGs have the power to enter into pooled budget arrangements with other organisations such as local authorities. From 1 April 2015 this included pooled budgets under the Better Care Fund initiative.

The details of these arrangements can be found in the notes of the CCGs statutory accounts. Consolidated accounts are not presented due to the varying nature of local pooled budget arrangements, which do not permit consolidation on a consistent basis across the group.

20. Related party transactions

Details of related party transactions with individuals are as follows:

Related party transactions associated with the Parent are disclosed within this note. As disclosed in note 23, NHS England acts as the parent to 209 CCGs 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 following individuals hold director positions within NHS England and during the year NHS England has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out below.

2015/16

Name and position in NHS England	Related party	Nature of relationship	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Professor Sir Malcolm Grant - Chair	University College London (UCL)	Non-executive, former President and Provost	673	-	114	-
Professor Sir Malcolm Grant - Chair	UCL Partners	Ex Board member	4,132	-	274	-
Professor Sir Malcolm Grant - Chair	Genomics England Ltd	Director	53	-	-	-
Professor Sir Malcolm Grant - Chair	Cancer Research UK	Family member is an employee	222	368	-	77
Professor Sir Malcolm Grant - Chair	University of York	Chancellor	76	-	5	-
Lord Victor Adebowale - Non-Executive Director	Turning Point	Chief Executive Officer and Company Secretary,	1,226	-	-	-
Lord Victor Adebowale - Non-Executive Director	University of Lincoln	Chancellor & Visiting Professor	2	-	-	-
Lord Victor Adebowale - Non-Executive Director	London School of Economics	Governor	17	-	34	-
Professor Sir John Burn - Non-Executive Director	Newcastle University.	Professor of Clinical Genetics	711	-	0	-
Professor Sir John Burn - Non-Executive Director	Newcastle Hospitals NHS Foundation Trust	Honorary Consultant Clinical Geneticist	377,551	-	1,008	-
Professor Sir John Burn - Non-Executive Director	Genomics England	Science Advisory Committee,	53	-	-	-
Professor Sir John Burn - Non-Executive Director	Health Education England	Genomics Advisory Board, member	15,261	193,058	1,954	28,469
Margaret Casely-Hayford - Non-Executive Director	Metropolitan Police	Member of the Corruption Investigation Oversight Panel	130	-	-	-
Dame Moira Gibb - Non-Executive Director	Skills for Care	Chair	57	-	70	-
Dame Moira Gibb - Non-Executive Director	University of Reading	Council member	3	-	-	-
David Roberts - Non-Executive Director	Henley Business School, University of Reading	Member, Strategy Board	1	-	-	-
Wendy Becker - Non-Executive Director	Cancer Research UK	Unremunerated	222	368	-	77
Ed Smith - Non-Executive Director to 30 September 2015	PwC	Retired Senior Partner	3,301	-	-	-

Name and position in NHS England	Related party	Nature of relationship	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Ed Smith - Non-Executive Director to 30 September 2015	University of Birmingham	Pro Chancellor and Chair of Council	132	-	12	-
Ed Smith - Non-Executive Director to 30 September 2015	Crown Commercial Services	Non-Executive Chairman	33	-	-	-
Professor Jane Cummings - National Director	Macmillan Cancer Support	Director and Trustee	6	189	-	153
Professor Sir Bruce Keogh - National Director	Royal College of Surgeons in England (previous Member of Council)	Fellow	174	-	-	-
Professor Sir Bruce Keogh - National Director	Royal College of General Practitioners	Honorary Fellow	832	-	8	-
Professor Sir Bruce Keogh - National Director	Faculty of Medical Management and Leadership	Honorary Member	382	-	-	-
Professor Sir Bruce Keogh - National Director	Cancer research UK	Company Member	222	368	-	77
Dame Barbara Hakin - National Director to 31 December 2015	Ernst and Young	Family member is an employee	2,315	-	1	-
Dame Barbara Hakin - National Director to 31 December 2015	NHS Trust Development Authority	Family member is an employee	151	-	-	-
Dame Barbara Hakin - National Director to 31 December 2015	Leeds Teaching Hospitals NHS Trust	Family member is an employee	461,656	-	597	40
Tim Kelsey - National Director to 31 December 2015	ZPB	Partner is a director, this is a health strategy company	-	-	37	-

2014/15

Name and position in NHS England	Related party	Nature of relationship	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Professor Sir Malcolm Grant - Chair	University College London (UCL)	Non-executive, former President and Provost	560	-	-	-
Professor Sir Malcolm Grant - Chair	UCL Partners	Ex Board member	5,583	-	1,346	-
Professor Sir Malcolm Grant - Chair	Cancer Research UK	Family member is an employee	72	167	-	47
Professor Sir Malcolm Grant - Chair	University of York	Chancellor-elect	92	-	-	-
Lord Victor Adebowale - Non-Executive Director	Turning Point	Chief Executive Officer and Company Secretary,	2,192	-	-	-
Lord Victor Adebowale - Non-Executive Director	Tomahawk Ltd, subsidiary of Three Sixty Action Ltd, collaborative software and IT innovation – now operating as THP Innovate	Non-executive director	38	-	-	-
Professor Sir John Burn - Non-Executive Director	Newcastle University.	Professor of Clinical Genetics	80	-	-	-
Professor Sir John Burn - Non-Executive Director	Newcastle Hospitals NHS Foundation Trust	Honorary Consultant Clinical Geneticist	510,801	-	-	2,342
Professor Sir John Burn - Non-Executive Director	Health Education England	Genomics Advisory Board,	8,579	234,065	135	30,683
Margaret Casely-Hayford - Non-Executive Director	Metropolitan Police Corruption Investigation Oversight Panel	Member	7	-	-	1,083
Dame Moira Gibb - Non-Executive Director	Skills for Care	Chair	28	-	-	-
Ed Smith - Non-Executive Director	PwC	Retired Senior Partner	1,133	-	-	-
Ed Smith - Non-Executive Director	University of Birmingham	Pro Chancellor and Chair of Council,	448	-	59	-
Ed Smith - Non-Executive Director	Crown Commercial Services	Non-Executive Chairman	2	-	-	-
Professor Jane Cummings - National Director	Macmillan Cancer Support	Director and Trustee	-	141	10	178
Professor Sir Bruce Keogh - National Director	Royal College of Surgeons in England (previous Member of Council)	Fellow	141	-	-	-
Professor Sir Bruce Keogh - National Director	Royal College of General Practitioners	Honorary Fellow	457	-	-	-
Professor Sir Bruce Keogh - National Director	Faculty of Medical Management and Leadership	Honorary Member	117	-	-	-
Professor Sir Bruce Keogh - National Director	British Heart Foundation	Council	-	31	-	5
Professor Sir Bruce Keogh - National Director	Cancer Research UK	Company Member	72	167	-	47
Dame Barbara Hakin - National Director	Ernst and Young	Family member is an employee	3,327	-	-	-
Dame Barbara Hakin - National Director	NHS Trust Development Authority	Family member is an employee	5,014	195	-	94
Tim Kelsey - National Director	ZPB	Partner is a director, this is a health strategy company	15	-	24	-
Rosamond Roughton - National Director	Mike Farrar Consulting Limited	Partner is a director	2	-	-	-
Rosamond Roughton - National Director	York Health Economics	Partner is a non-executive director	63	-	-	-

The Department of Health, 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; and NHS Business Services Authority.

In addition, NHS England has had a number of material transactions with other government departments and other central and local government bodies.

The compensation paid to key management personnel can be found in the remuneration report from page 70.

21. 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.

The result of the referendum held on 23 June 2016 was in favour of the UK leaving the European Union. This is a non-adjusting event. A reasonable estimate of the financial effect of this event cannot be made.

From 1 April 2016 a further 51 CCGs commenced delegated co-commissioning arrangements, taking the total number operating under this initiative to 114. These arrangements were first introduced in 2014/15 as part of the Five Year Forward View, under which CCGs assume full responsibility for contractual GP performance management and the design and implementation of local incentive schemes. This will result in a switch in expenditure from NHS England to participating CCGs.

The date the financial statements were authorised for issue by the Accounting Officer is included at the foot of the statement of financial position.

22. Financial performance targets

The Government's mandate to NHS England for 2015/16 was published by the Secretary of State for Health under section 13A of the National Health Service Act 2006, and the associated Financial Directions as issued by DH, set out NHS England's total revenue resource limit and total capital resource limit for 2015/16 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to DH. Those limits were revised in December 2015 and NHS England's performance against those revised limits are set out in the tables below.

	2015/16					2014/15
	Revenue Departmental Expenditure Limit		Annually Managed Expenditure	Technical	Total	Total
	Non ringfenced	Ringfenced				
	£000	£000	£000	£000	£000	£000
Mandate Limit	101,379,000	166,000	300,000	360,000	**102,205,000**	**99,159,000**
Actual expenditure	100,282,873	89,579	(253,960)	72,942	**100,191,434**	**97,586,014**
Surplus	**1,096,127**	**76,421**	**553,960**	**287,058**	**2,013,566**	**1,572,986**
Revenue resource limit (excluding planned surplus c/f into 2016/17 of £497m and £467m in 14/15)	100,882,000	166,000	300,000	360,000	**101,708,000**	**98,692,000**
Surplus (excluding planned surplus c/f)	**599,127**	**76,421**	**553,960**	**287,058**	**1,516,566**	**1,105,986**

	2015/16	2014/15
	Capital resource limit	Capital resource limit
	£000	£000
Limit	300,000	270,000
Actual expenditure	176,142	189,212
Surplus	**123,858**	**80,788**

NHS England is required to spend no more than £1,862,000,000 of its Revenue Departmental Expenditure Limit (RDEL) mandate on matters relating to administration in the full year. The actual amount spent on RDEL administration matters to 31 March 2016 was £1,648,854 as set out below.

	2015/16	2014/15
Administration Limit:	**£000**	**£000**
Net administration costs before interest	1,652,709	1,837,530
Less:		
Administration expenditure covered by AME/Technical funding	(3,855)	(57,416)
Administration costs relating to RDEL	1,648,854	1,780,114
RDEL Administration expenditure limit	1,862,000	2,142,000
Underspend	**213,146**	**361,886**

The various limits of expenditure set out in the table above stem from the limits imposed by HM Treasury on DH. Departmental Expenditure Limits (DEL) 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 DH and NHS England may not therefore exceed its DEL.

Annually Managed Expenditure (AME), budgets are set by HM Treasury and may be reviewed with departments in the run-up to the Budget. Departments must manage AME closely and inform HM Treasury if they expect AME to rise above forecast. Any increase requires HM Treasury approval.

There are clear rules governing the classification of certain types of expenditure as AME or DEL.

23. Entities within the Consolidated Group

NHS England acts as the Parent of the group comprising 209 CCGs (2014/15: 211 CCGs) whose accounts are consolidated within these Financial Statements.

A full list of the CCGs can be found on the NHS England website at: www.england.nhs.uk/ccg-details/.

The parent entity of NHS England is DH.

The largest group of entities which group accounts are drawn up and of which NHS England is a member is DH. Copies of the accounts can be obtained from www.gov.uk/government/publications.

APPENDICES

APPENDIX 1: How we have delivered against the mandate

In its mandate to NHS England for 2015/16, the Government set us 25 objectives with an aim of providing the NHS with stability and continuity; it welcomed the Five Year Forward View and also asked for progress in mental health and in the integration of care across services. The preceding sections of this annual report set out NHS England's achievements against our corporate priorities; our work in all these areas contributes to progress against the 25 objectives in the Government's mandate. We have almost met the majority of these objectives in 2015/16. This annex highlights some of the progress we have made and some of the challenges.

The first of the objectives set by Government for NHS England was to demonstrate progress in the health outcome measures in its NHS Outcomes Framework. The latest data shows that the majority of measures are on a positive trajectory or stable. We have programmes in place to improve those areas where further progress needs to be made and we have developed the CCG Improvement and Assessment Framework to enable us to measure CCG performance on priority areas from 2016/17.

We have continued to make good progress in our work against the objective to become one of the most successful countries in Europe at preventing premature deaths. Initial modelling suggests we should exceed the ambition of avoiding an additional 30,000 additional premature deaths by 2020. We have taken important steps to improve cancer outcomes: including setting up a new cross-system National Cancer Transformation Board; helping the NHS to meet NHS Constitution standards on cancer and testing the new 28 day faster diagnosis standard. We have set up 23 Urgent and Emergency Care networks and are planning the staged delivery of the Urgent and Emergency Care review, including programmes to develop Seven Day Services in hospital care. We have also made progress on providing access to the electronic Summary Care Record: by March 2016 85 percent of NHS 111 service areas were using it and 63 percent of A&E departments had access to GP records.

An integrally linked mandate objective is to prevent ill health and improve access to treatment. As our Chief Executive states in his overview at the front of this report, sustained success for the NHS requires a radical upgrade in prevention and public health. There is a strong prevention element to CCG ambitions on reducing premature mortality,

the cancer strategy, the diabetes prevention programme and the tuberculosis strategy. Our NHS Diabetes Prevention Programme procurement is on track to deliver services to between 10,000 and 20,000 individuals in 2016/17, growing to 100,000 people a year over time. Work to support Public Health England's blood pressure strategy has continued to improve diagnosis and management of hypertension.

Another of NHS England's objectives is to make progress in improving patient experience: both in the measurement and understanding of patient experience and in taking action to improve it. We have made good progress in all areas. Improving experience of care is an integral feature of both the national plan for services for people with learning disability as published in October 2015, and the national maternity review as published in February 2016. Transforming care partnerships have worked with people with learning disabilities, their families and carers and stakeholders to agree implementation plans and service models based on person centred care and support. Improving maternity experience is a core part of the implementation programme for the maternity review, working in collaboration with the royal colleges and charitable groups. We have also made progress in improving children and young people's experience of care, building on the new inpatient survey. Training resources and commissioning guidance relating to complaints are in place. Use of the Friends and Family Test continues with 20 million pieces of feedback collected and acted upon as at end of March 2016.

The NHS Five Year Forward View stated that managing long term conditions is a central task for the NHS; it requires a partnership with patients so that the health and care system acts as one to provide integrated, connected care. This is a significant challenge: services need major redesign to deliver the best of person-centred care. We have a mandate objective to make measurable progress in making the NHS among the best in Europe at supporting people with ongoing health problems. Results from the NHS Outcomes Framework suggest that health related quality of life of people with long term conditions has remained stable, with over half of all patients (54 percent) reporting one or more long standing health condition, and 64 percent of those people reporting they received enough support from local services or organisations in the last six months to help them manage their condition. Our work here is interdependent with our mandate objectives on patient involvement, integration of health and care services and the quality of care especially for older people.

Increasing patient and carer involvement and choice and control is complex and requires changes in culture and systems and processes. Our work here is gaining momentum

as a result of the Support for Self-Management Programme. The roll out of PHB and other initiatives which feature care and support planning such as the Integrated Personal Commissioning programme, are also driving this agenda forward.

NHS England has made progress in achieving a significant increase in the use of technology to help people manage their health and care, another of our mandate objectives. We have supported CCGs to work with their local providers and local authorities, to develop plans – local digital roadmaps – as to how their local health and care economies will achieve the ambition of being paper free at the point of care by 2020. We have also seen further progress on patients' access to their health and care records, with over 95 percent of GPs able to offer patients access to their detailed health record. The use of digital services is increasing, and we are working to increase digital inclusion.

The second of NHS England's mission critical tasks is to lead and support a fundamental redesign of the way the NHS provides care, to make it more personal, co-ordinated and convenient. A central mandate objective is to see improvements in the way that care: is coordinated around the needs, convenience and choices of patients, their carers and families – rather than the interests of organisations that provide care. In support of this, progress on the New Care Models programme has been good and plans for 2016/17 are in place. We have also seen good progress and learning in the integrated care pioneers. Work has continued across a number of programmes to develop integrated care and is progressing as expected. Reporting suggests local delivery of Better Care Fund plans is progressing, pooled budgets have been established, and joint working relationships are generally strong. Delivery of the policy priorities set out within the 'national conditions' of the fund has been substantial, with significant progress made in key areas such as implementing seven day services that support discharge, and improving the sharing of data across health and social care.

Over the last year, NHS England has also made progress on improving children and young people's (CYP) health outcomes. This involves embedding CYP in NHS England's corporate priorities (including cancer, learning disabilities, mental health and diabetes), and there are also specific programmes and teams in place to take forward work in dedicated areas such as Special Educational Needs and Disability. Funding has been secured to develop a national child death database to improve the ability to identity and learn from preventable CYP deaths. In this period we have also strengthened national clinical leadership for CYP whilst embedding CYP in clinical network priority areas where appropriate.

The National Maternity Review has been completed and implementation planning is well underway. Implementation of the Review's recommendations will take a multi-organisational approach, with NHS England working with a number of key partners. The Review and the Saving Babies' Lives work align with and support the Secretary of State's national ambitions to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2030.

Progress is being maintained on action to reduce heath inequalities. This year has seen improved funding allocation formulae with closer alignment to population need and deprivation. There has also been continuity in the inclusion of the 'potential years of life lost' incentive within the quality premium for CCGs. This year has seen action taken to ensure that CCGs are following the requirements of the NHS Act 2006 in relation to having due regard to reduce health inequalities. Delivering the Forward View: NHS Planning Guidance for 2016/17-2020/21 also highlights reducing health inequalities as an area which needs to be addressed and asks CCGs to consider how they will assess and address their most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local authorities. The need to develop a high quality and agreed five year Sustainability and Transformation Plan (STP) is a key "must do" in pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. We intend the combined implementation of these initiatives will continue to drive progress.

An important and challenging objective is to put mental health on a par with physical health and narrow the health gap between people with mental health problems and the population as a whole. NHS England, on behalf of the NHS arm's length bodies, commissioned an independent taskforce to develop a Five Year Forward View for Mental Health, and we have made good progress in developing a major new programme to support implementation of the taskforce report. There are interdependencies with external factors such as data from NHS Digital and workforce support from Health Education England. These have been rate-limiting factors in some areas. However, we have delivered in important areas. CYP mental health funds for 2015/16 have been issued to CCGs following assurance of local transformation plans. The new waiting time standard for Improving Access to Psychological Therapies is being met, although local variation continues. Performance is steadily improving, with the access rate above the mandate commitment of 15 percent between October and December 2015. For liaison psychiatry, we have worked with DH and Mind to ensure that every community now has a refreshed Crisis Care Concordat local action plan in place.

There has been increased demand and corresponding pressures across both the planned and urgent care systems. While expected patient volumes were in line with those commissioned by CCGs from hospitals at the start of the year, hospital performance against the Constitution standards has shown an overall declining trend over the year, although there has been a significant improvement in some areas. We undertook considerable work alongside NHS Improvement to ensure that available capacity is identified and utilised, and work programmes such as the Emergency Care Improvement Programme supported Constitutional Standards. We worked to develop new work programmes including an A&E Improvement Plan for 2016/17, and a consolidated work programme with NHS Improvement for elective care services. There has been substantial focus on ensuring that commissioners agree operational plans for 2016/17 with the activity levels necessary in order that providers could meet the standards.

NHS England has demonstrated strong financial control of the budgets it oversees. We delivered the 2015/16 financial position across the commissioning system. We are also contributing significant planned underspends towards the overall DH group financial position. We collaborated with NHS Improvement during the 2016/17 planning round but there remains a significant risk to ensuring financial delivery within available resources in 2016/17. Progress has been made in mobilising national workstreams in response to the Five Year Forward View efficiency challenge, but the key challenge will be in ensuring that these are effectively embedded and delivered, including through the STPs to be developed by '44' local footprints.

APPENDIX 2: How we have acted to reduce health inequalities in 2015/16

Health inequalities cost lives, decrease the quality of life for many people and have financial consequences for the NHS. NHS England has made reasonable progress to reduce health inequalities this year, but more needs to be done and this will remain a high priority through implementing the Five Year Forward View. This appendix presents a summary of how we have met our legal duties with regard to health inequalities during 2015/16 against criteria set by the Secretary of State.

Criterion 1: An evidence-based strategic approach to reducing health inequalities based on sound governance, accountability and good partnership working

Response: Our strategy to reduce health inequalities is to embed a health inequalities "lens" in each of our main national health improvement goals, while ensuring that NHS funding is allocated so as to help support equal access for equal need across geographies, patient groups and health conditions. We build insight into how people access and experience NHS services and support a coordinated, evidence-based approach to helping reduce health inequalities. This is underpinned by the governance and accountability arrangements NHS England has in place for its major programmes of work, and our planning and assurance frameworks as detailed under Criterion 6.

The Equality and Health Inequalities Programme Board gives system-wide leadership to health inequalities within the organisation and is accountable to the NHS England Board through the Executive Group. For 2015/16, the programme board endorsed six key principles to reducing health inequalities and our Key Lines of Enquiry (KLOE) designed to strengthen how we support policy makers and managers across the organisation to consider and measure the impact of equality and health inequalities.

Criterion 2: Systematic focused action to reduce inequalities in access, outcomes and experience based on a defined and evolving set of metrics

Response: Following publication of the NHS Outcomes Framework, Indicators for Health Inequalities Assessment by DH in March 2015, inequality metrics against 11 indicators are now being developed by the Health and Social Care Information Centre (HSCIC) to inform and guide reporting in 2016/17.

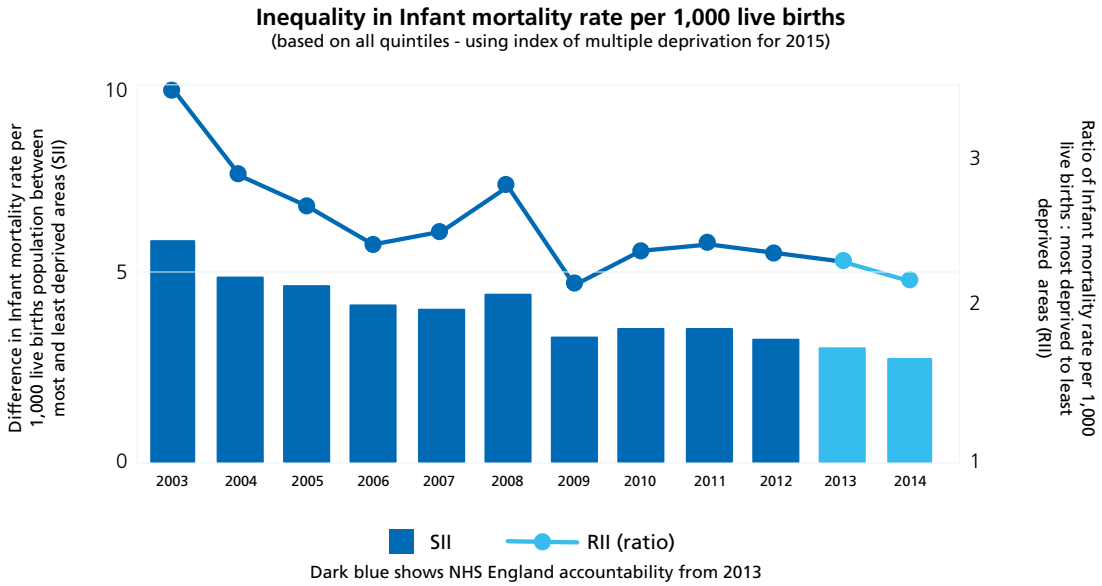
NHS England is also leading wider work on data monitoring information standards in partnership with DH and other key stakeholder organisations, overseen by a subgroup of the Equality Delivery Council (EDC). In March 2015, we published Monitoring Equalities and Health Inequalities to help NHS organisations improve local equity monitoring. This can be viewed at www.england.nhs.uk/about/gov/equality-hub/intelligence/.

Work continues to expand and improve the collection of data available to measure progress on equality and health inequalities. The information standard on sexual orientation is due to be piloted and the development, subject to sponsorship, of a unified information standard for all protected groups.

During 2015/16, there has been progress to report on key areas of inequalities, including continued reductions in cardiovascular disease and infant mortality. In some areas the existing inequality trend has remained constant and we have identified a number of areas where there have been challenges.

The following indicators show positive progress in reducing inequalities since 2013, or positive change from the previous trend[1]:

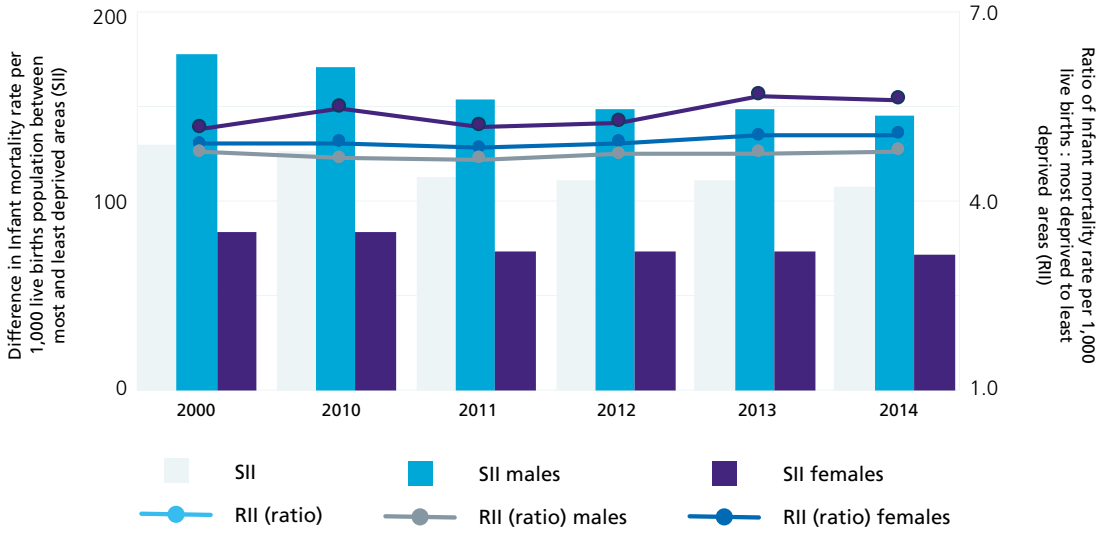
- Infant mortality by deprivation has narrowed, with the greatest gains seen amongst the most deprived cohort of the population.



1. Where the inequalities gap reduced by over 1 percent between 2013/14 and 2014/15 or a consistent decreasing trend.

- The under 75 mortality rate from cardiovascular disease by area deprivation has decreased[1].

Inequality in directly age standardised under 75 mortality from cardio vascular disease (under 75 CVD mortality) per 100k population (based on all deciles)



- The gap between those ethnic groups reporting the lowest scores for health-related quality of life for people with long-term conditions and white British people has narrowed.

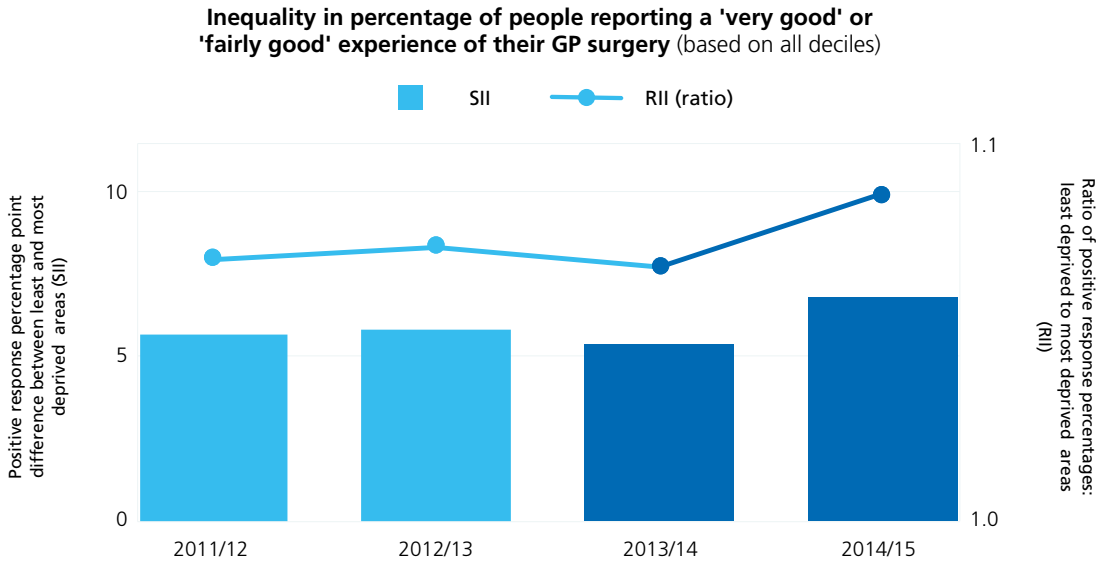
For the following indicators, the change in inequality gap by area deprivation since 2013 is consistent with previous flat trend[2]:

- Under 75 cancer mortality between 2013 and 2014.
- Health-related quality of life for people with long-term conditions.
- Potential Years of Life Lost (PYLL) for causes considered amenable to healthcare.

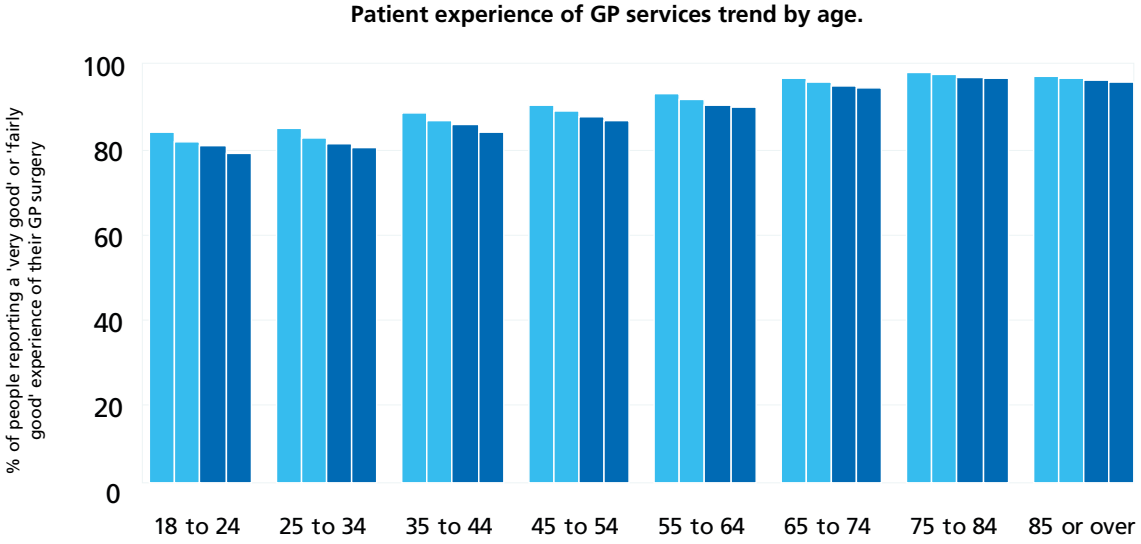
For the following indicators, the change in the inequality gap since 2013 shows poorer progress relative to previous flat or narrowing trend[3]:

- People who report[4] their experience of GP services as very good or fairly good – with an increase in the gap between areas of high and low deprivation.

1. Note that since overall CVD mortality has been reducing, the effect has been to increase the relative ratio.
2. Change in inequality gap between -1percent and +1percent between 2013/14 and 2014/15
3. Inequalities gap increased by over 1 percent between 2013/14 and 2014/15, or where there is a consistent increasing trend.
4. Source: https://gp-patient.co.uk/



- However, a high proportion of people report their experience of GP services as very good or fairly good across all groups as is illustrated by the age chart below.



- Emergency admissions for acute conditions that should not usually require hospital admission, by deprivation.

For the following indicators, only base year data (2013) is available and therefore it is too early to assess progress on reducing inequality:

- life expectancy at 75 for males
- life expectancy at 75 for females.

In 2016/17, we will increase the use of indicators to shape policy, drive improvement and assess progress in reducing inequalities. The new CCG Improvement and Assessment Framework for 2016/17 includes two health inequalities indicators, which align with Commissioning for Value packs to help CCGs set priorities for tackling inequalities and make improvements. We will continue to collaborate with DH and PHE to measure progress, and develop and implement evidence based interventions.

Criterion 3: Utilise and develop the evidence of effective interventions to reduce health inequalities

Response: In March 2015, the Equality and Health Inequalities programme board agreed a new single priority deliverable to achieve sustainable and measurable reductions in health inequalities ensuring improving health outcomes in England 2015-20.

Through the use and development of effective interventions, NHS England has made progress in a number of areas to address health inequality issues. These were presented in depth to the Board in November 2015 and work continues to strengthen our programme of work, including the Equality and Health Inequalities Hub that we share with PHE at www.england.nhs.uk/about/gov/equality-hub/resources/.

Criterion 4: Improve prevention, access and effective use of services for inclusion health groups and families on the Troubled Families programme

Response: Through the legacy of the research and evidence base of the National Inclusion Health Board, NHS England have continued to support and promote the Inclusion Health agenda. The Inclusion Health and Lived Experience sub group of the NHS Equality and Diversity Council (EDC) has been established with an agreed work plan and stated aim of supporting the council and its members to engage and work with people with lived experience to advance equity in access and improve health care experiences and outcomes for the most disadvantaged groups and those with protected characteristics by 2017, supporting healthcare commissioners and the wider system in this respect.

Criterion 5: Continue its leadership of the health system to reduce inequalities, including assessing and publishing on whether CCGs fulfil and report on their health inequalities duties in commissioning plans and annual reports

Response: Delivering the Forward View: NHS Shared Planning Guidance 2016/17 contained guidance for NHS Commissioners on Equality and Health Inequality Duties and set out requirements for all commissioners, including NHS England which has a statutory duty to make an annual assessment of each CCG's performance.

CCG Assurance Framework

Equality and health inequalities formed part of the assessment of the well-led component of the CCG Assurance Framework for 2015/16, alongside a number of other functions which require particular focus due to the complexity of the issues or degree of risk involved. These should be specific topics for discussion in assurance reviews and NHS England makes a risk-based assessment for CCGs when determining how much focus is required for each statutory function. The new CCG Improvement and Assessment Framework for 2016/17 will include two health inequalities indicators, which align with Commissioning for Value packs. This will further help CCGs to set priorities for tackling inequalities and make improvements.

CCG annual reports

Annual reporting guidance for CCGs was published in December 2015 and required NHS England regional teams to assure CCG annual reports for completeness, including whether the CCG had accurately reflected in its annual report how it has discharged its duty to reduce inequalities under section 14T of the Health and Social Care Act 2012.

Allocations

We have continued to develop our approach to ensure resources are effectively targeted to support commissioners to invest to meet the diverse needs of local people and reduce health inequalities, including through the provision of Commissioning for Value evidence packs, the Right Care Programme and the Quality Premium which provides an incentive for CCGs to reduce health inequalities and make improvements on Potential Years of Life Lost.

The Advisory Committee on Resource Allocation's recommendations for the CCG target allocations have been implemented, taking into account the latest evidence on the impact of resource distribution on reducing health inequalities. The formula from 2016/17 is detailed at www.england.nhs.uk/2016/04/allocations-tech-guide-16-17/.

Criterion 6: Continue to take action to reduce health inequalities as part of work to deliver, with partners, the Five Year Forward View and the mandate to NHS England

Response: NHS England's Business Plan for 2016/17 prioritises closing the gap for groups experiencing poorer health outcomes, a poorer experience of, and access to, healthcare. The Government's mandate to NHS England for 2016/17 also sets a specific objective on tackling health inequalities, underpinned by specific deliverables to be achieved in the short term, for the year 2016/17, and to be achieved in the long term, by 2020 or beyond. This requires NHS England to improve local and national health outcomes, particularly by addressing poor outcomes and inequalities, and through better commissioning.

The mandate also expects NHS England to demonstrate improvements against the NHS Outcomes Framework and work with CCGs to reduce variations in quality of care and outcomes at a local level, securing "measurable reductions in inequalities in access to health services, in people's experience of the health system, and across a specified range of health outcomes."

In December 2015, Delivering the Forward View: NHS Shared Planning Guidance 2016/17 - 2020/21, set out a list of national challenges – including how will you close the health and wellbeing gap – to help local systems define ambitions for their populations in their Sustainability and Transformation Plans (see page 29 for further detail). Local systems are asked how will they assess and address their most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government.

This targeted attention to reducing inequalities in access to, experience of, and outcomes from healthcare services for all, will assist us to achieve sustainable and measurable reductions in health inequalities by 2020.

APPENDIX 3: Our sustainability report

The Five Year Forward View highlights the importance of a sustainable NHS in order to continue providing comprehensive, high quality care. The sustainable development strategy for the NHS, public health and social care system is led by the Sustainable Development Unit (SDU), and sets a vision and goals to aim for by 2020 to support sustainable development, reduce emissions, save money and improve the health and resilience of people and communities. The strategy can be viewed on the SDU's website at www.sduhealth.org.uk/policy-strategy/.

Within NHS England, this work is being taken forward as part of the Improving NHS England programme. Further information on this programme of work is given in our Staff Report.

This appendix covers NHS England and Commissioning Support Units (CSUs). Clinical Commissioning Groups (CCGs) report on sustainability within their individual annual reports which are due to be published on their websites in June 2016. A list of CCGs, and links to their websites, can be found on the NHS England website at www.england.nhs.uk/ccg-details/.

Reporting for multi-occupancy buildings and provision of data

NHS Property Services Ltd (NHS PS) is the landlord for the majority of the buildings we occupy, and they are responsible for providing building-related information required for this report. Due to acknowledged inaccuracies in the data provided from NHS PS, it has not been possible to include reporting for 2015/16 for the relevant areas of energy, waste and water in this annual report.

NHS PS recognise the shortfall in providing us with the data we need to fulfil our reporting obligations in this area, and will work with NHS England to improve the provision of all the required data for future years. We intend to work with them to establish accurate data for 2015/16 over the coming months and we will then publish it on our website at www.england.nhs.uk/publications/annual-report/.

Where NHS England is a tenant of DH, energy, waste and water information will be reported within their annual report. This will be published on their website at: www.gov.uk/government/organisations/department-of-health.

Greenhouse gas emissions

Energy, waste and water

All energy and water used, and waste produced, as a result of NHS England's operations arises from the occupation of rented office spaces.

Since the publication of our last annual report, more accurate data on occupancy levels for NHS England and CSUs during 2014/15 has been worked through with NHS PS Relevant figures have been restated in the tables below.

Data for 2015/16 will be published once accurate figures are available from NHS PS. This will include a comparison of our performance against 2014/15.

	Energy Restated data for 2014/15		
	NHS England	**CSUs**	**Total**
Electricity			
KWh	2,546,462	3,231,129	5,777,591
tCO2e	1,259	1,597	2,856
Gas			
kWh	2,613,703	2,503,010	5,116,713
tCO2e	483	463	946

	Water Restated data for 2014/15		
	NHS England	**CSUs**	**Total**
Water consumption (m3)	35,393	20,637	56,030

	Waste Restated data for 2014/15		
	NHS England	**CSUs**	**Total**
Total waste (tonnes)	1,608	765	2,373
Non-recycled (tonnes)	1,188	543	1,731
Recycled (tonnes)	420	222	642
Percentage recycled (%)	26%	29%	41%

Business travel

The focus of NHS England's business travel and expenses policy is on reducing unnecessary travel, as well as prioritising more sustainable forms of travel where it is required. We continue to invest in technology to support paper ight and travel free ways of working, alongside the need for us to work closely with local delivery partners. Overall, there has been a 15 percent decrease in carbon emissions arising from business travel during 2015/16:

	NHS England		CSUs		Total	
	2015/16	**2014/15**	**2015/16**	**2014/15**	**2015/16**	**2014/15**
Road travel						
Miles	4,974,652	4,759,417	7,303,406	11,368,462	12,278,058	16,127,879
tCO2e	1,525	1,493	2,218	3,544	3,743	5,037
Rail travel						
Miles	20,274,544	14,713,705	1,854,351	1,284,390	22,128,896	15,998,095
tCO2e	1,470	1,122	134	101	1,605	1,223
Air travel						
Miles	338,497	552,104	21,393	37,289	359,890	589,393
tCO2e	57	95	5	9	62	104
Total miles (Air, Road and Rail)	25,587,693	20,025,226	9,179,150	12,690,141	34,766,844	32,715,367
Total tCO2e (Air, Road and Rail)	3,052	2,710	2,357	3,654	5,410	6,364

We are also working to help our staff keep fit, reduce their carbon footprint and spend less time in their cars. In March 2016, we introduced a new cycle to work scheme for NHS England employees as a government backed salary sacrifice initiative.

From 2016/17, NHS England will be directly in scope to contribute to the target set for DH to reduce greenhouse gas emissions as set out in the Greening Government Commitments. This policy sets out our expectations that anyone travelling on behalf of NHS England will consider the impact that business travel can have on society and the environment, and reduce their travel wherever possible. More widely, the Greening Government Commitments also consider waste, water, paper and procurement.

Procurement

NHS England follows the Government Buying Standards and gives due consideration to the Public Services (Social Value) Act 2012. Sustainability is currently evaluated as part of the tender process, in line with the procurement strategy. NHS England's standard terms and conditions of contract, which are referenced on all purchase orders, have given consideration to sustainability. They include requirements for timely payment of sub-contractors and requirements for suppliers to give consideration to environmental factors and to act in accordance with all applicable law relating to the environment and the disposal of goods.

Climate change adaptation

In partnership with PHE and others, we produce a national Heatwave Plan and Cold Weather Plan for England each year. The purpose of these plans is to reduce the number of deaths and illness by raising public awareness and triggering actions in health, social care and other organisations to support people who have health, housing or economic circumstances that increase their vulnerability to extreme weather. The plans, and associated alerts, can be viewed on our website at: www.england.nhs.uk/ourwork/eprr/sw/.

Action has been taken to ensure that those policies with long term implications are robust in the face of changing weather, extreme events and sea-level rise from climate change.

Rural proofing

NHS England has collaborated with the Department for Environment, Food and Rural Affairs (DEFRA) and DH about Lord Cameron's 2015 independent rural proofing review into how the Government is making sure rural issues are included in our policies and programmes, and has shared developments with DEFRA in respect of relevant NHS policy developments. We will continue to work with DH to support the Government's response to Lord Cameron's review and the commitment to strengthen departmental rural proofing guidance by summer 2016.

APPENDIX 4: Register of Board members

Non-executive directors

	Designation	Start date	End date	Status	Term
Professor Sir Malcolm Grant	Chairman	31.10.11	30.10.18	Current	2
Lord Victor Adebowale	Non-executive Director	01.07.12	31.12.18	Current	2
Dame Moira Gibb	Non-executive Director; Chair - Investment Committee	01.07.12	31.12.18	Current	2
David Roberts	Non-executive Director; Chair - Commissioning Committee; Chair – Audit and Risk Assurance Committee.	01.07.14	30.06.18	Current	1
Noel Gordon	Non-executive Director; Chair - Specialised Commissioning Committee	01.07.14	30.06.18	Current	1
Professor Sir John Burn	Non-executive Director	01.07.14	30.06.18	Current	1
Wendy Becker	Non-executive Director	02.03.16	29.02.20	Current	1
Michelle Mitchell	Non-executive director	02.03.16	29.02.20	Current	1

Leavers

	Designation	Start date	End date	Term
Ed Smith	Non-executive Director; Deputy Chairman; Senior Independent Director; Chair - Audit & Risk Assurance Committee.	09.11.11	30.9.15	1
Sir Ciaran Devane	Non-executive Director	01.01.12	31.12.15	1
Margaret Casely-Hayford	Non-executive Director	01.07.12	31.03.16	1

Executive directors

	Designation	Start date	End date	Voting status
Simon Stevens	Chief Executive	01.04.14	N/A	
Paul Baumann	Chief Financial Officer	01.04.13	N/A	
Professor Jane Cummings	Chief Nursing Officer	01.04.13	N/A	
Professor Sir Bruce Keogh	National Medical Director	01.04.15	N/A	
Richard Barker	Interim National Director: Commissioning Operations	01.01.16	N/A	Non-voting
Ian Dodge	National Director: Commissioning Strategy	07.07.14	N/A	Non-voting
Karen Wheeler	National Director: Transformation and Corporate Operations	01.04.14	31.03.17	Non-voting; Secondment from Department of Health

Leavers

	Designation	Start date	End date	Term
Dame Barbara Hakin	National Director: Commissioning Operations	01.04.13	31.12.15	Non-voting
Tim Kelsey	National Director for Patients & Information	02.07.12	31.12.15	Non-voting

APPENDIX 5: Membership of Board committees and attendance

This table denotes membership of NHS England's Board and its committees. The Chair and Chief Executive reserve the right to attend meetings of all committees on an ad hoc supervisory basis. All meetings of NHS England's Board in 2015/16 were quorate.

	NHS England Board		Audit & Risk Assurance Committee		Investment Committee		Commissioning Committee		Specialised Commissioning Committee		Strategic HR and Remuneration Committee	
Non-executive directors	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible	No. of meetings	No. of Eligible
Professor Sir Malcolm Grant – Chair	8	9									3 Chair	3
Lord Victor Adebowale	8	9					7	10				
Dame Moira Gibb	9	9			8 Chair	8					1	1
Margaret Casely-Hayford	7	9							4	5		
David Roberts	8	9	6 Chair (from 01.10.15)	6			10 Chair	10			2	3
Noel Gordon	9	9	6	6	7	8	10	10	5 Chair	5		
Professor Sir John Burn	9								3	5		
Wendy Becker (from 1.3.16)	1	1	0	0								
Michelle Mitchell (from 1.3.16)	1	1							0	0		
Ed Smith (until 30.09.15)	3	3	4 Chair (from 30.09.15)	4	3	4						
Sir Ciaran Devane (until 31.12.15)	5	6									2	2
Executive directors												
Simon Stevens	9	9					8	10	5	5		
Paul Baumann	8	9			8	8	10	10	5	5		
Professor Jane Cummings	8	9					6	10				
Professor Sir Bruce Keogh	9	9					9	10	5	5		
Richard Barker (from 01.01.16)	2	3					2	3				
Ian Dodge	9	9			6	8	10	10	4	5		
Karen Wheeler	9	9										
Dame Barbara Hakin (until 31.12.15)	6	6					6	7	4	4		
Tim Kelsey (until 31.12.15)	5	6							4	4		

APPENDIX 6: Disclosure of personal data-related incidents

As at March 2016, a total of nine Serious Incidents Requiring Investigation (SIRIs) had occurred relating to the loss of personal sensitive data in NHS England and CSUs. All incidents are logged and a full investigation undertaken. Unless otherwise stated in the table opposite, remedial actions were implemented for all incidents and the Information Commissioner's Office were kept informed as appropriate. In all but one case, information was fully contained within the NHS and no harm occurred. This single incident occurred in a CSU and at the time of writing this report is still being investigated.

Key lessons learnt from the outcome of these SIRIs will be disseminated to NHS England, including CSU staff, by July 2016. This is in addition to mandatory training and items highlighting good practice in regular staff communications. Topics covered include: incident reporting; keeping information safe; confidentiality; records management; and data protection.

Clinical commissioning groups

Details of any incidents occurring in CCGs can be found within individual CCG annual reports and will be published on CCG websites in June 2016.

A list of CCGs, and links to their websites, can be found on the NHS England website at www.england.nhs.uk/ccg-details/.

NHS England

Date of incident	Nature of incident	Paper	Electronic	Number of people potentially affected	Comments
May 2015	Email containing person identifiable data (staff) sent to incorrect recipients.		√	292	
March 2016	Email containing personal sensitive data (patient) was sent to an incorrect recipient in error.		√	1	Incident open – Investigation underway as at end March 2016.

Commissioning support units

Date of incident	Nature of incident	Paper	Electronic	Number of people potentially affected	Comments
June 2015	Bag containing an encrypted laptop and documents containing patient identifiable data was stolen from a staff member's car.	√	√	4	
June 2015	Bag containing electronic equipment and documents containing patient identifiable data stolen from a staff member's car overnight.	√	√	6	Remedial actions implemented and ICO kept informed of the investigation and provided with the report.
August 2015	Bag containing laptop and documents containing patient identifiable data left on train.	√	√	23	
October 2015	Personal sensitive data (patient) sent to another NHS organisation.		√	20	
October 2015	Personal sensitive data (patient) sent to another NHS organisation.		√	10,061	Remedial actions implemented and ICO kept informed of the investigation and provided with the report.
October 2015	Personal sensitive data (patient) sent to another NHS organisation.		√	470	
March 2016	Personal sensitive data (staff) disclosed in error.	√		1	Incident open – Investigation underway as at end March 2016.

APPENDIX 7: UK Corporate Governance Code Assessment

Compliance against both the UK Corporate Governance Code (September 2012) and Corporate Governance in Central Government Departments: Code of Good Practice 2011 is considered to be good practice but is not mandatory for NHS England. A number of provisions are not applicable, and others have required interpretation for the context in which NHS England operates. As NHS England operates in a comply or explain regime, set out below is a summary of the provisions which are not applicable, those against which there is an exception and those where improvement is planned.

Provisions against which there are exceptions

Ref	Code Provision	Exception
B.3.1	For the appointment of a chairman, the nomination committee should prepare a job specification, including an assessment of the time commitment expected, recognising the need for availability in the event of crises. A chairman's other significant commitments should be disclosed to the board before appointment and included in the annual report. Changes to such commitments should be reported to the Board as they arise, and their impact explained in the next annual report.	Under the National Health Service Act 2006 (as amended) the Secretary of State for Health appoints the chair. The other elements of the provision are compliant.
B4.2	The Chairman should regularly review and agree with each director their training and development needs.	The Chairman is only required to conduct regular appraisals of the non-executive directors. The Chief Executive performs this role for other executive directors in consultation with the chair.
B.5.2	All directors should have access to the advice and services of the company secretary, who is responsible to the board for ensuring that board procedures are complied with. Both the appointment and removal of the company secretary should be a matter for the board as a whole.	There is a Board Secretary whose removal and appointment is not reserved to the Board, but is undertaken by executive management.
D.2.1	The Board should establish a remuneration committee of at least three, or in the case of smaller companies' two, independent non-executive directors. In addition the company chairman may also be a member of, but not chair, the committee if he or she was considered independent on appointment as chairman.	The Chair of the Strategic HR and Remuneration Committee is also the Chair of the Board. The other elements of the provision are compliant.

Provisions which are not applicable

B.2.1, B.2.2, B.2.3, B.2.4, B.7.1, B.7.2, C.3.7, D.1.1, D.1.2, D.1.3, D.2.3, D.2.4, E.1.1, E.1.2, E.2.1, E.2.2, E.2.3, E.2.4.

Assessment against the Corporate Governance in Central Government Departments: Code of Good Practice 2011 Compliance Checklist

Provisions against which there are exceptions

Ref	Code Provision	Exception
2.12	The Board collectively affirms and documents its understanding of the Department's purpose and documents its role and responsibilities in a Board Operating Framework.	The Board initiated a project to implement strengthened governance arrangements in December 2015, and, as part of this, received proposals for a revised Governance Manual in May 2016.
3.5e	Non-executive Board members form a Nominations and Governance Committee.	NHS England does not have a Nominations Committee as appointments of the executive and non-executive members are managed as required by the National Health Service Act 2006 (as amended). Governance issues are delegated to the Audit and Risk Assurance Committee.
3.13	The Board agrees and documents in its Board Operating Framework a de minimus threshold and mechanism for board advice on the operation and delivery of policy proposals.	The Board initiated a project to implement strengthened governance arrangements in December 2015, and as part of this, received proposals for a revised Governance Manual in May 2016
4.7	The terms of reference for the Nominations and Governance Committee include at least the four central elements.	There is no Nominations and Governance Committee (see Code 3.5e). The specific Code provisions a – d are handled by the Strategic Human Resources & Remuneration Committee, the terms of reference for which will be strengthened to reflect these specific duties.
4.10	Through the Board Secretariat, the Department provides the necessary resources for developing and updating the knowledge and capabilities of Board members, including access to its operations and staff.	This responsibility is shared between the Chair, Chief Executive's office and Board Secretary.
4.14f	The Board Secretary's responsibilities include: f) arranging induction and professional development of Board Members.	This responsibility is shared between the Chair, Chief Executive's office and Board Secretary.
5.7	The Head of Internal Audit is periodically invited to attend board meetings, where key issues are discussed relating to governance, risk management, or control across the department and its ALBs	The Head of Internal Audit routinely attends meetings at the Audit and Risk Assurance Committee.

Provisions which are not applicable

Section 1, 2.4, 2.5, 2.8d (Results Focus), 2.25,3.4a, 3.4b, 3.4c, 3.5h, 3.6, 3.7, 3.12, 3.17, 4.9, 4.12, 4.15, 4.16, 4.17, 5.10, 5.11 and 6.

Provisions against which improvement is planned for 2016/17

2.8f (and 5.8): Board setting of risk appetite and controls for managing risk.

4.1f: Formal evaluation of Board, committees and Board member's performance.

5.5: Board agenda setting.

APPENDIX 8: Key risks for the organisation

The following table details continuing and emerging risks for NHS England during 2015/16:

Financial sustainability of the NHS	The NHS continues to be subject to significant cost pressures which are not in the direct control of NHS England. We will work with DH and system leaders to drive out required efficiencies to secure future financial sustainability across the life of the spending review period.
Delivering transformational change	The NHS is delivering unprecedented and far-reaching change at pace, with an increasingly complex environment. We will prioritise and balance delivery of change alongside maintaining our operational business delivery.
Enabling Sustainability and Transformation Plans to deliver	All component organisations are accountable for delivery of clear, co-designed plans that deliver the scale of change that the system needs to deliver the aims of the Five Year Forward View. We need to provide the capability and capacity to assess and support planning, delivery and associated benefits.
Capacity of primary and urgent care	To meet the current and future demand for primary and urgent care we are putting in place new programmes of work, such as those to support general practice, to align capacity and ensure patients receive the required care, in a timely manner and in the right setting, thereby reducing pressures on A&E, primary and secondary care.
Specialised Services	As we seek to manage the specialised commissioning agenda, there is a threat of challenge from a range of bodies from those representing patients to pharmaceutical companies.
Commissioning support units	Our CSUs provide key support services to CCGs. If individual CSUs were to become unviable this could impact on the service provision to CCGs, and closedown costs will arise.
Cyber threats	We continue to engage across the health and care system to raise awareness of cyber threat and to develop our defence, detection and response capabilities. The sharing of information is essential to delivering an effective and efficient service and we will continually seek to improve our assurance.
Delivering our core business	We will continue to develop the leadership and delivery capability and capacity necessary to make sure we deliver changes across the NHS without detracting from implementing longer term, cross-system changes.

APPENDIX 9: List of acronyms used in our annual report

	Acronym used	Meaning
A	A&E	Accident and Emergency
	ACE	Accelerate, Coordinate and Evaluate
	ADASS	Association of Directors and Adult Social Services
	ARAC	Audit and Risk Assurance Committee
B	BME	Black, minority, ethnic
	BECS	Dental Benefit Eligibility Checking Service
C	CCG(s)	Clinical commissioning group(s)
	CDF	Cancer Drugs Fund
	CETV	Cash Equivalent Transfer Value
	CSU(s)	Commissioning support unit(s)
	CTR	Care Treatment Reviews
	CQC	Care Quality Commission
	CYP	Children and Young People
D	DH	Department of Health
	DfE	Department for Education
E	EDC	Equality Delivery Council
	EDS2	Equality Delivery System 2
	EPRR	Emergency preparedness, resilience and response
	ESR	Electronic Staff Record
F	FYFV	Five Year Forward View
	FFT	Friends and Family Test
G	GP	General Practice / General Practitioner
H	HEE	Health Education England
	HR	Human Resources
	HSCIC	Health and Social Care Information Centre

	Acronym used	Meaning
I	IAF	Improvement and assessment framework
	IAPT	Improving access to psychological therapies
	ICT	Information and communications technology
	IG	Information governance
	IPC	Integrated personal commissioning
	ISFE	Integrated Single Financial Environment
L	LGA	Local Government Association
N	NAO	National Audit Office
	NHS	National Health Service
	NHS BSA	NHS Business Services Authority
	NHS SBS	NHS Shared Business Services
	NICE	National Institute of Clinical Excellence
	NHS PS	NHS Property Services Limited
P	PAM	Patient Activation Measure
	PCS	Primary Care Service
	PECS	Prescription Eligibility Checking Service
	PHB	Personal Health Budget
	PHE	Public Health England
R	RDEL	Revenue Departmental Expenditure Limit
	RCGP	Royal College of General Practitioners
S	SCR	Summary Care Record
	SFI	Standing Financial Instructions
	SIRI	Serious Incidents Requiring Investigation
	SIRO	Senior Information Risk Owner
	STP	Sustainability and Transformation Plans
T	TCP(s)	Transforming Care Partnerships
U	UEC	Urgent and emergency care
V	VSM	Very Senior Manager
W	WRES	Workforce Race Equality Standard

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